Ombudsman Certification Training

INTRODUCTION
Welcome to the Long-term Care Ombudsman Program

Thank you for choosing to serve as a Long-term Care Ombudsman. Long-term Care Ombudsmen serve as resident-directed advocates in nursing homes and assisted living facilities. Some residents may need help to improve their quality of life and care. As an ombudsman, you provide assistance and advocacy so everyone receives respectful and competent care.

What does an ombudsman do?

Ombudsmen investigate complaints, report findings, and help achieve resolutions. They can help one person resolve a problem, address issues that affect several residents, or work to change a systemic problem.

Ombudsmen serve residents of nursing homes and assisted living facilities in the following ways:

Handle complaints and problem-solve
An ombudsman supports residents and families to resolve any complaints by defining concerns, explaining rights, and identifying possible courses of action. In all situations, confidentiality is maintained and no information is released without permission of the resident or decision-maker.

Provide information and assistance
An ombudsman is a good source of information about selecting a long-term care facility, residents’ rights, and how long-term care facilities operate.

Advocate for system and legislative changes
State and local ombudsman programs work cooperatively to recommend regulatory and legislative changes that affect older Texans.

Training Requirements:

Ombudsmen must complete a 36-hour certification training which includes:

• at least 12 hours of classroom training;
• at least 2 in-facility training sessions (provided through on-the-job training called shadow visits);
• maximum of 20 hours of self-study assignments; and
• volunteers complete a three month internship.

Other Requirements

• A sincere interest in promoting the well-being and protecting the rights of people in long-term care facilities
• An ability to work cooperatively with the people who live in nursing homes and assisted living facilities, local staff ombudsmen, and long-term care providers
• Ability to discover facts, work to resolve complaints, and impartially and objectively determine whether complaints are verified or not
• Acceptance of, and adherence to, the Texas Long-term Care Ombudsman Program (LTCOP) Code of Ethics
• Successful completion of Texas LTCOP training program and approval of the local Managing Local Ombudsman (MLO) and the State Ombudsman.
• Free of any conflict of interest

What will I learn in training?

Certification training prepares you to serve as an ombudsman. It includes information about the history of the program, laws and rules that direct ombudsman work, and the process of receiving, investigating, and resolving complaints made by, or on behalf of, residents of nursing homes and assisted living facilities.

How do I get certified?

After criminal history and conflict of interest screening, a person who applies to be a volunteer ombudsman is called an intern. After completing all training, a three-month internship, and demonstrating the ability to apply ombudsman fundamentals, an MLO may recommend an intern to be certified. The State Ombudsman makes the final decision.

Let’s get started!

Opening Exercise: Get Acquainted

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

What is your name? ____________________________________

Why are you interested in being an ombudsman? ________________________

________________________________________________________

Have you visited a nursing home? _______ Yes (Y) or No (N)

Have you visited an assisted living facility? _______ Yes (Y) or No (N)

What were your impressions of the last one visited? ________________________

____________________________________________________
Training Manual - Icons Key

- Questions about the reading above
- Exercise
- Ask the Trainer – Discussion
- Ombudsman Tip
- Very Important Information!
- Link to a website such as YouTube or Facebook
- Consultation Required
- Movie or Video Clip
## Acronyms

<table>
<thead>
<tr>
<th>Acronyms</th>
<th>Terms</th>
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<tbody>
<tr>
<td>AAA</td>
<td>Area Agency on Aging</td>
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<tr>
<td>ADL</td>
<td>Activity of Daily Living</td>
</tr>
<tr>
<td>ADON</td>
<td>Assistant Director of Nursing</td>
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<tr>
<td>ALF</td>
<td>Assisted Living Facility</td>
</tr>
<tr>
<td>ANE</td>
<td>Abuse, Neglect, and Exploitation</td>
</tr>
<tr>
<td>APS</td>
<td>Adult Protective Services</td>
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<tr>
<td>CMS</td>
<td>Centers for Medicare and Medicaid Services</td>
</tr>
<tr>
<td>CNA</td>
<td>Certified Nurse Assistant</td>
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<tr>
<td>DON</td>
<td>Director of Nursing</td>
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<tr>
<td>DPOA</td>
<td>Durable Power of Attorney</td>
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<tr>
<td>HIPAA</td>
<td>Health Insurance Portability and Accountability Act</td>
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<tr>
<td>HSC</td>
<td>Health and Safety Code</td>
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<tr>
<td>LAR</td>
<td>Legally Authorized Representative, such as a guardian, a parent, managing conservator of a minor, or an agent authorized under a power of attorney</td>
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<tr>
<td>LIDDA</td>
<td>Local Intellectual and Developmental Disability Authority</td>
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<tr>
<td>LTC</td>
<td>Long-Term Care</td>
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<td>LMHA</td>
<td>Local Mental Health Authority</td>
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<tr>
<td>LTCOP</td>
<td>Long-Term Care Ombudsman Program, i.e., a local ombudsman entity</td>
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<tr>
<td>MCO</td>
<td>Managed Care Organization</td>
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<tr>
<td>MFP</td>
<td>Money Follows the Person</td>
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<tr>
<td>MLO</td>
<td>Managing Local Ombudsman; is also a Certified Ombudsman</td>
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<tr>
<td>MOU</td>
<td>Memorandum of Understanding</td>
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<td>MPOA</td>
<td>Medical Power of Attorney</td>
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<tr>
<td>NF</td>
<td>Nursing Facility</td>
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<tr>
<td>OAA</td>
<td>Older Americans Act</td>
</tr>
<tr>
<td>PASRR</td>
<td>Preadmission Screening and Resident Review</td>
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<tr>
<td>POA</td>
<td>Power of Attorney</td>
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<tr>
<td>QMP</td>
<td>Quality Monitoring Program</td>
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<tr>
<td>QRS</td>
<td>Quality Reporting System</td>
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<tr>
<td>RP</td>
<td>Responsible Party</td>
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<tr>
<td>RS</td>
<td>Regulatory Services</td>
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<tr>
<td>SLTCO</td>
<td>State Long-Term Care Ombudsman</td>
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<tr>
<td>STAR+PLUS</td>
<td>Texas Medicaid Managed Care program (for people who have disabilities or are age 65 or older)</td>
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<tr>
<td>TAC</td>
<td>Texas Administrative Code</td>
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<tr>
<td>TMF</td>
<td>TMF Health Quality Institute</td>
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<tr>
<td>VA</td>
<td>Veteran Administration</td>
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CHAPTER 1: Long-term Care Ombudsman Programs
Chapter 1 provides an understanding of the Texas Long-term Care Ombudsman Program, its purpose, unique aspects, and history.

Learning Objectives

- Develop an understanding of the history and uniqueness of long-term care ombudsman programs
- Review and follow the long-term care ombudsman responsibilities
- Learn why residents need advocates and how ombudsmen can respond

Contents

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

DVD(s), Supplements, Forms

- DVD: Advocates for Resident Rights: The Older Americans Act Long-term Care Ombudsman Program
- Supplement 1-A: Ombudsman Program Milestones
- Supplement 1-B: Statutory and Rule References
How Long-term Care Ombudsman Programs Began

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

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

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

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

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

Each state has an office of the state long-term care ombudsman headed by a full-time state long-term care ombudsman. In Texas, the office is an independent unit within a state health and human services agency. Patty Ducayet is the Texas State Long-term Care Ombudsman.
The Managing Local Ombudsman is: ____________________________.

Phone Number: ____________________________.

My supervising staff ombudsman is ____________________________.

Phone Number: ____________________________.

The State contracts with 28 area agencies on aging (AAAs). Twenty-six AAAs operate local ombudsman programs and two AAAs subcontract the ombudsman program: Dallas County through The Senior Source and Harris County through the University of Texas Health Sciences Center.

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

**Long-term Care Ombudsman Role**

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

Long-term care ombudsmen:

- Advocate for residents of nursing homes and assisted living facilities;
- Work with the families and friends of residents as well as facility staff who make a complaint on behalf of a resident, even though ‘resident’ is used throughout this manual;
- Provide information about how to select a facility and how to get quality care;
- Identify, investigate, and resolve problems;
- Represent the resident perspective in monitoring laws, regulations, and policies, and make recommendations about needed change; and
- Prevent abuse and neglect by educating residents and supporting them if they need to report it.

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

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

Ombudsman Philosophy

People who are unable to care for themselves are entitled to dependable and consistent care. Ombudsmen advocate for residents to enjoy quality of life and receive high quality care.

Regulations pertaining to assisted living facilities do not directly address quality of life or care. However, Texas Nursing Facility Requirements (NFR) provide a definition of quality of life and care, based on federal law, and summarized below.

Quality of Life - NFR §19.701

The nursing home must care for its residents in a manner and environment to maintain or enhance each resident's quality of life. Four quality of life aspects addressed are:

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

Quality of Care - NFR §19.901

Each resident receives and the nursing home provides care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being according to the comprehensive assessment and plan of care. Unique medical and developmental needs of children should be met. Care and services to be addressed include aspects such as activities of daily living, pressure sores, urinary incontinence, mental and psychosocial functioning, accidents, nutrition, and medications.
The Texas Long-term Care Ombudsman Program advocates for quality of ____________ and quality of ____________ for people who live in nursing homes and _______________ _______________ facilities.

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

Ombudsmen also respond to and work to resolve complaints from family, friends, and facility staff - as long as the complaint pertains to residents. However, we always seek the resident’s consent and take action based on resident direction, so resident wishes supersede another complainant’s. Ombudsmen use a problem-solving process to analyze and resolve complaints. Chapter 10 describes the five-step problem-solving process in detail.

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

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

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

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

_____ Ombudsmen protect the confidentiality of all residents.

_____ Ombudsmen interns do not identify, investigate, and resolve complaints made by, or on behalf of, residents.
## Long-term Care Ombudsman Responsibilities

Review the chart to see distinctions among the state long-term care ombudsman (SLTCO), certified staff, certified volunteer, and ombudsman interns. Chapter 6 has more information on ombudsman intern activities.

<table>
<thead>
<tr>
<th>SLTCO</th>
<th>Certified Staff</th>
<th>Certified Volunteer</th>
<th>Intern</th>
</tr>
</thead>
<tbody>
<tr>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
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</table>

Provide information to and visit residents; protect the confidentiality of all residents

Promote the Ombudsman Program

Provide technical support to develop resident and family councils

Provide residents with regular and timely access to ombudsman services

Assist residents to protect their rights and express a complaint pertaining to their health, safety, welfare, and rights within a facility

Identify, investigate, and resolve complaints made by, or on behalf of, residents

Seek administrative, legal, and other remedies to protect the health, safety, welfare, and rights of residents

Analyze, comment on, and monitor development and implementation of federal, state, and local laws, regulations, and other government policies and actions on behalf of residents; make recommendations about policies and laws to improve the system

The State Ombudsman prepares and submits an annual report describing program activities, noting problems residents’ experience, and making recommendations to improve quality of care and life. The State Ombudsman also makes recommendations in laws, regulations, and policies to solve identified problems and protect resident welfare.

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

** The SLTCO report is comprised of reports made by volunteers, staff, and state office staff.
Advocates for Resident Rights: The Older Americans Act Long-term Care Ombudsman Program

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

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

____________________________________________________________________
____________________________________________________________________

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

____________________________________________________________________
____________________________________________________________________

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

____________________________________________________________________
____________________________________________________________________
____________________________________________________________________

4. What are some complaints ombudsmen work to resolve?

____________________________________________________________________
____________________________________________________________________
____________________________________________________________________

What questions do you have about being an ombudsman?

____________________________________________________________________
____________________________________________________________________
____________________________________________________________________

Why Do Residents Need Advocacy?

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

The Texas Long-term Care Ombudsman Program serves as advocates for all individuals who live in the 1,232 nursing homes and 1,821 assisted living facilities in Texas. These licensed facilities have an average occupancy rate between 64% and 69%; therefore, approximately 134,000 individuals are our clients.

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

SOURCE: Regulatory Licensing and Certification July 2015
How many people live in a nursing home or assisted living facility in Texas? __________
How many nursing homes are in Texas? __________
How many assisted living facilities are in Texas? __________

With over 600 certified volunteer ombudsmen and the full-time equivalent of 68 certified staff ombudsmen, the Texas Long-term Care Ombudsman Program has an integral role in the long-term care system. Certified ombudsmen, as advocates for residents, protect residents’ rights and the health, safety, and welfare of residents.

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

What is advocacy?
___________________________________________________________

Why do you think residents in nursing homes and assisted living facilities need advocates?
___________________________________________________________
## Barriers to Self-Advocacy

<table>
<thead>
<tr>
<th>Physical and cognitive barriers</th>
<th>Lack of information about</th>
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<tbody>
<tr>
<td>• Cognitive impairment</td>
<td>• Alternative living options</td>
</tr>
<tr>
<td>• Effects of medications</td>
<td>• Authority within the facility</td>
</tr>
<tr>
<td>• Loss of hearing, speech, sight</td>
<td>• How to improve their situation</td>
</tr>
<tr>
<td>• Loss of physical strength</td>
<td>• Legal services</td>
</tr>
<tr>
<td>• Inability to get services, care, or attention because of physical or communication problems</td>
<td>• Rights</td>
</tr>
</tbody>
</table>

### Physical and cognitive barriers
- Cognitive impairment
- Effects of medications
- Loss of hearing, speech, sight
- Loss of physical strength
- Inability to get services, care, or attention because of physical or communication problems

### Personal feelings
- Believes this is the best it can be
- Fear of being labeled a “complainer”
- Fear of retaliation
- Sense of isolation
- Sense of hopelessness or despair
- Loneliness
- Reluctance to question authority

### Other barriers
- Insufficient medical or nursing care
- Lack of privacy
- Physical or verbal abuse
- Lack of experience being assertive

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List two physical and cognitive barriers to self-advocacy

1. ________________________________________
2. ________________________________________

Two personal feelings that are barriers to self-advocacy are:

1. ________________________________________
2. ________________________________________
Unique Aspects of the Long-term Care Ombudsman Program

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

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

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

The long-term care ombudsman is a resident advocate.

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

Classical Ombudsman

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

<table>
<thead>
<tr>
<th>Purpose:</th>
<th>Impartial in investigation to:</th>
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<tr>
<td></td>
<td>• determine pertinent facts; and</td>
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<tr>
<td></td>
<td>• gather sufficient information to understand the problem in order to represent a resident’s interests; once facts are gathered, advocates for a resident-focused solution</td>
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<table>
<thead>
<tr>
<th>Setting:</th>
<th>Nursing homes and assisted living facilities</th>
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<tr>
<th>Focus:</th>
<th>Seeks a resident-directed resolution and works to overcome bureaucratic barriers</th>
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<tr>
<th>Scope</th>
<th>Seeks resolution for individual and systemic issues</th>
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Ombudsmen help residents with resolution strategies that may include:

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

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

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

Ethical Issues

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

- ombudsman work is filled with ambiguity regarding how to proceed;
- ombudsmen typically encounter issues that are not clearly right or wrong; and
- one ombudsman’s actions can impact the credibility of the statewide program.

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

- Jurisdiction is the interest of the resident.
- Resolution standard is to resolve to the resident’s satisfaction — or in absence of an identified resident, the complainant’s.
- Ombudsmen are mandated to advocate on behalf of the broad interests of residents, including public policy. This is often referred to as systems advocacy.
- Ombudsmen promote the development of groups such as citizen organizations to work with the ombudsman program and support for resident and family councils.

Atypical Mandates

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

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

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

Confidentiality
The Older Americans Act requires strict protection of the identity of residents and complainants, and information obtained about residents and complainants, during the course of ombudsman duties. To maintain confidentiality, ombudsmen must:

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

Surrogate Voice for Residents
The program is clearly directed to represent residents and act as a surrogate voice for residents. Regardless of the source of a complaint, an ombudsman serves the resident and is resident-directed.

Not Mandatory Reporters
Federal rules clearly define an ombudsman’s role and responsibilities regarding abuse, neglect, and exploitation (ANE). An ombudsman must obtain consent from a resident before reporting any complaint or taking any action, including reporting complaints involving ANE. Special considerations apply if a resident is unable to provide consent. Chapters 3 and 4 provide detailed information about
consent and the ombudsman role and responsibility related to allegations of ANE.

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

Willful Interference

Program representatives are protected from willful interference. Interference with ombudsmen performing their duties is a class B misdemeanor, according to the Texas Human Resources Code (§101A.264):

- A person commits an offense if the person:
  - intentionally interferes with an ombudsman attempting to perform official duties; or
  - commits or attempts to commit an act of retaliation or reprisal against any resident or employee of a long-term care facility for filing a complaint or providing information to an ombudsman.

Legal Counsel Must be Provided to Representatives of the Program

- If acting in good faith in performing ombudsman duties, representatives of the program, including interns and volunteers, are not liable for civil damages or subject to criminal prosecution.
- Texas Human Resources Code Chapter §101A.256 says, “The department shall ensure the Office receives adequate legal advice and representation. The attorney general shall represent the ombudsman or a representative if a suit or other legal action is brought or threatened to be brought against that person in connection with the person's performance of the official duties of the Office.”

Conflict of Interest Provisions

The program has specific conflict of interest provisions for organizational placement of the state and local programs and for individuals representing the program.

- Requirements underscore the importance of maximizing the long-term care ombudsman’s ability to adequately and independently represent residents on all levels.
- Ombudsmen need to speak honestly and publicly about conditions experienced by residents and the impact of actions, policies, and laws on residents.
In addition to prohibiting any direct or indirect financial gain in the course of ombudsman duties, state conflict of interest policies include three dimensions:

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

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

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

Accountability

Ombudsmen hold themselves accountable and continually seek input to determine if their advocacy makes a difference for residents. The program maintains accountability through documentation and reporting of ombudsman work.

Ombudsmen must submit monthly reports to their local program office. These reports document ombudsman activities and casework on behalf of residents and serve as the basis for a statewide annual report. See Chapter 11 for details on reporting.

Summary

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

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

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

Citizens have high expectations for long-term care ombudsman programs to fulfill their mandated responsibilities. Ombudsmen serve a unique and necessary role as resident advocates.
Supplement 1-A: Ombudsman Program Milestones

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

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

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

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

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

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

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

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

1977  The AoA funded the National Paralegal Institute to provide the first training program for state ombudsmen, who were called “ombudsman developmental specialists.”
In June, the AoA Advocacy Assistance grant program provided additional help for state ombudsman and legal services programs to focus on both individual and systems advocacy. Grants ranged from $50,000 for most states to $135,390 for California, which by then had the largest elderly population. To support the state and area agencies, AoA awarded contracts in 1979 and 1980 for 5 Bi-Regional Advocacy Assistance Resource Centers.

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

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

1980 The Texas Nursing Home Program became operational in October.

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

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

1983-84 AoA issued a series of twenty-two papers, which constituted chapters of an Ombudsman Technical Assistance Manual. The number of local programs and complaints and the amount of program funding increased substantially; and the number of state and local paid staff and volunteers increased 50% from 1982 levels.

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

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

1988 AoA funded the National Association of State Units on Aging (now National Association of States United for Aging and Disabilities) to operate the National Center for State Long-term Care Ombudsman Resources, in conjunction with the Consumer Voice.
1989  The 71st Texas Legislature passed state enabling legislation for the Texas Department on Aging Ombudsman Program, effective September 1, 1989.

1992  Older Americans Act amendments strengthened the ombudsman program and transferred it to a new Title VII Vulnerable Elder Rights Protection Activities, which also included:
   • programs for the prevention of elder abuse, neglect, and exploitation;
   • state elder rights and legal assistance development programs; and
   • outreach, counseling and assistance programs.

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

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

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

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

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

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

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

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

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

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

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

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

2013 and 2015 The 83rd Texas Legislature granted State funds for the express purpose of long-term care ombudsmen expanding services to residents of assisted living facilities. Funding is ongoing.
Supplement 1-B: Statutory and Rule References

Texas Long-term Care Ombudsman Program

Older Americans Act
As Amended In 2006 (Public Law 109-365)  
(FEDERAL LEGISLATION)
TITLE VII, Chapter 2
http://www.aoa.acl.gov/AoA_Programs/OAA/oaafull.asp#_Toc153957785

Code of Federal Regulations
State Long-term Care Ombudsman Programs (February 11, 2015)  
(FEDERAL RULES)
Title 45 - Public Welfare
Subtitle B - Regulations Relating to Public Welfare
Chapter Xiii - OFFICE OF HUMAN DEVELOPMENT SERVICES, DEPARTMENT OF
HEALTH AND HUMAN SERVICES
Subchapter C – ADMINISTRATION ON AGING, OLDER AMERICANS PROGRAMS
Part 1321 - GRANTS TO STATE AND COMMUNITY PROGRAMS ON AGING
Subpart B – State Agency Responsibilities
§1321.11 - State Agency Policies
http://www.ecfr.gov/cgi-bin/text-idx?tpl=/ecfrbrowse/Title45/45cfr1321_main_02.tpl

Part 1327 - ALLOTMENTS FOR VULNERABLE ELDER RIGHTS PROTECTION
ACTIVITIES
Subpart A - State Long-Term Care Ombudsman Program
http://www.ecfr.gov/cgi-bin/text-idx?mc=true&node=20150211y1.13

Human Resources Code
(STATE LEGISLATION)
TITLE 6. Services for the Elderly
CHAPTER 101A. State Services for the Aging
http://www.statutes.legis.state.tx.us/Docs/HR/htm/HR.101.htm

Texas Administrative Code
(STATE RULES)
Implementation of Older Americans Act – Long-term Care Ombudsman Program
TITLE 40. Social Services and Assistance
PART 1. Department of Aging and Disability Services
Chapter 85. Implementation of the Older Americans Act
Subchapter A. Definitions
RULE §85.2 Definitions
Subchapter E. Long-Term Care Ombudsman Program
§85.401 Long-Term Care Ombudsman Program
p_loc=&p_ploc=&pg=1&p_tac=&ft=40&pt=1&ch=85&rl=401
**Nursing Facility Requirements**
TITLE 40. Social Services and Assistance  
PART 1. Texas Department of Human Services  
CHAPTER 19. Nursing Facility Requirements for Licensure and Medicaid Certification  

**Licensing Standards for Assisted Living Facilities**
TITLE 40. Social Services and Assistance  
PART 1. Texas Department of Human Services  
CHAPTER 92. Licensing Standards for Assisted Living Facilities (92.801)  

_Patty Ducayet, LMSW_  
*State Long-term Care Ombudsman*  
_MC - W 250*  
P. O. Box 149030, Austin, TX 78714  
_Phone: 512-438-4356_  
_Fax: 512-438-3233_  
[http://www.dads.state.tx.us](http://www.dads.state.tx.us)
OLDER AMERICANS ACT of 1965 as Amended in 2006 (Public Law 109-365)
TITLE 42 – The Public Health and Welfare
CHAPTER 35 – Programs for Older Americans
SUBCHAPTER XI – Allotments for Vulnerable Elder Rights Protection Activities
CHAPTER 2 – Ombudsman Programs

Section 711. DEFINITIONS.
As used in this chapter:
   (1) OFFICE. — The term “Office” means the office established in section 712(a)(1)(A).
   (2) OMBUDSMAN. — The term “Ombudsman” means the individual described in section 712(a)(2).
   (3) LOCAL OMBUDSMAN ENTITY.— The term “local Ombudsman entity” means an entity designated under section 712(a)(5)(A) to carry out the duties described in section 712(a)(5)(B) with respect to a planning and service area or other substate area.
   (4) PROGRAM. — The term “program” means the State Long-Term Care Ombudsman Program established in section 712(a)(1)(B).
   (5) REPRESENTATIVE. — The term “representative” includes an employee or volunteer who represents an entity designated under section 712(a)(5)(A) and who is individually designated by the Ombudsman.
   (6) RESIDENT. — The term “resident” means an older individual who resides in a long-term care facility.

(42 U.S.C. 3058f)

Section 712. STATE LONG-TERM CARE OMBUDSMAN PROGRAM.

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

(D) ensure that the residents have regular and timely access to the services provided through the Office and that the residents and complainants receive timely responses from representatives of the Office to complaints;

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

(F) provide administrative and technical assistance to entities designated under paragraph (5) to assist the entities in participating in the program;

(G) (i) analyze, comment on, and monitor the development and implementation of Federal, State, and local laws, regulations, and other governmental policies and actions, that pertain to the health, safety, welfare, and rights of the residents, with respect to the adequacy of long-term care facilities and services in the State;

(ii) recommend any changes in such laws, regulations, policies, and actions as the Office determines to be appropriate; and

(iii) facilitate public comment on the laws, regulations, policies, and actions;

(H) (i) provide for training representatives of the Office;

(ii) promote the development of citizen organizations, to participate in the program; and

(iii) provide technical support for the development of resident and family councils to protect the well-being and rights of residents; and

(iv) carry out such other activities as the Assistant Secretary determines to be appropriate.

(4) CONTRACTS AND ARRANGEMENTS.—

(A) IN GENERAL.— Except as provided in subparagraph (B) the State agency may establish and operate the Office, and carry out the program, directly, or by contract or other arrangement with any public agency or nonprofit private organization.

(B) LICENSING AND CERTIFICATION ORGANIZATIONS; ASSOCIATIONS.— The State agency may not enter into the contract or other arrangement described in subparagraph (A) with—

(i) an agency or organization that is responsible for licensing or certifying long-term care services in the State; or

(ii) an association (or an affiliate of such an association) of long-term care facilities, or of any other residential facilities for older individuals.

(5) DESIGNATION OF LOCAL OMBUDSMAN ENTITIES AND REPRESENTATIVES. —

(A) DESIGNATION.— In carrying out the duties of the Office, the Ombudsman may designate an entity as a local Ombudsman entity, and may designate an employee or volunteer to represent the entity.

(B) DUTIES.— An individual so designated shall, in accordance with the policies and procedures established by the Office and the State agency —

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

(ii) ensure that residents in the service area of the entity have regular, timely access to representatives of the program and timely responses to complaints and requests for assistance;

(iii) identify, investigate, and resolve complaints made by or on behalf of residents that relate to action, inaction, or decisions, that may adversely affect the health, safety, welfare, or rights of the residents;
(iv) represent the interests of residents before government agencies and seek administrative, legal, and other remedies to protect the health, safety, welfare, and rights of the residents;

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

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

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

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

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

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

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

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

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

(D) POLICIES AND PROCEDURES.—

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

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

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

(b) PROCEDURES FOR ACCESS.—

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

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

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

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

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

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

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

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

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

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

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

(2) PROCEDURES.— The State agency shall establish procedures to ensure the access described in paragraph (1).
(c) REPORTING SYSTEM.—The State agency shall establish a statewide uniform reporting system to—
(1) collect and analyze data relating to complaints and conditions in long-term care facilities and to residents for the purpose of identifying and resolving significant problems; and
(2) submit the data, on a regular basis, to—
(A) the agency of the State responsible for licensing or certifying long-term care facilities in the State;
(B) other State and Federal entities that the Ombudsman determines to be appropriate;
(C) the Assistant Secretary; and
(D) the National Ombudsman Resource Center established in section 202(a)(21).

(d) DISCLOSURE.—
(1) IN GENERAL.—The State agency shall establish procedures for the disclosure by the Ombudsman or local Ombudsman entities of files maintained by the program, including records described in subsection (b)(1) or (c).
(2) Identity of Complainant or Resident.—The procedures described in paragraph (1) shall—
(A) provide that, subject to subparagraph (B), the files and records described in paragraph (1) may be disclosed only at the discretion of the Ombudsman (or the person designated by the Ombudsman to disclose the files and records); and
(B) prohibit the disclosure of the identity of any complainant or resident with respect to whom the Office maintains such files or records unless—
(i) the complainant or resident, or the legal representative of the complainant or resident, consents to the disclosure and the consent is given in writing;
(ii) (I) the complainant or resident gives consent orally; and
(II) the consent is documented contemporaneously in a writing made by a representative of the Office in accordance with such requirements as the State agency shall establish; or
(iii) the disclosure is required by court order.

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

(f) CONFLICT OF INTEREST.—The State agency shall—
(1) ensure that no individual, or member of the immediate family of an individual, involved in the designation of the Ombudsman (whether by appointment or otherwise) or the designation of an entity designated under subsection (a)(5), is subject to a conflict of interest;
(2) ensure that no officer or employee of the Office, representative of a local Ombudsman entity, or member of the immediate family of the officer, employee, or representative, is subject to a conflict of interest;
(3) ensure that the Ombudsman—
(A) does not have a direct involvement in the licensing or certification of a long-term care facility or of a provider of a long-term care service;
(B) does not have an ownership or investment interest (represented by equity, debt, or other financial relationship) in a long-term care facility or a long-term care service;
(C) is not employed by, or participating in the management of, a long-term care facility; and
(D) does not receive, or have the right to receive, directly or indirectly, remuneration (in cash or in kind) under a compensation arrangement with an owner or operator of a long-term care facility; and

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

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

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

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

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

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

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

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

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

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

(1) prepare an annual report —

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

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

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

(D) containing recommendations for —

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

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

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

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

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

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

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

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

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

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

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

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

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

(ii) investigative techniques; and

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

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

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

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

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

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

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

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

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

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

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

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

(j) NONINTERFERENCE.— The State shall —

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

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

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

(42 U.S.C. 3058g)
§ 1321.11 - State agency policies.

(b) The policies developed by the State agency shall address the manner in which the State agency will monitor the performance of all programs and activities initiated under this part for quality and effectiveness. The State Long-Term Care Ombudsman shall be responsible for monitoring the files, records and other information maintained by the Ombudsman program. Such monitoring may be conducted by a designee of the Ombudsman. Neither the Ombudsman nor a designee shall disclose identifying information of any complainant or long-term care facility resident to individuals outside of the Ombudsman program, except as otherwise specifically provided in §1327.11(e)(3) of this chapter.

Part 1327 - ALLOTMENTS FOR VULNERABLE ELDER RIGHTS PROTECTION ACTIVITIES

Subpart A - State Long-Term Care Ombudsman Program

§ 1327.1 Definitions.

The following definitions apply to this part:

*Immediate family,* pertaining to conflicts of interest as used in section 712 of the Act, means a member of the household or a relative with whom there is a close personal or significant financial relationship.

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

*Representatives of the Office of the State Long-Term Care Ombudsman,* as used in sections 711 and 712 of the Act, means the employees or volunteers designated by the Ombudsman to fulfill the duties set forth in § 1327.19(a), whether personnel supervision is provided by the Ombudsman or his or her designees or by an agency hosting a local Ombudsman entity designated by the Ombudsman pursuant to section 712(a)(5) of the Act.
Resident representative means any of the following:

(1) An individual chosen by the resident to act on behalf of the resident in order to support the resident in decision-making; access medical, social or other personal information of the resident; manage financial matters; or receive notifications;

(2) A person authorized by State or Federal law (including but not limited to agents under power of attorney, representative payees, and other fiduciaries) to act on behalf of the resident in order to support the resident in decision-making; access medical, social or other personal information of the resident; manage financial matters; or receive notifications;

(3) Legal representative, as used in section 712 of the Act; or

(4) The court-appointed guardian or conservator of a resident.

(5) Nothing in this rule is intended to expand the scope of authority of any resident representative beyond that authority specifically authorized by the resident, State or Federal law, or a court of competent jurisdiction.

State Long-Term Care Ombudsman, or Ombudsman, as used in sections 711 and 712 of the Act, means the individual who heads the Office and is responsible to personally, or through representatives of the Office, fulfill the functions, responsibilities and duties set forth in §§ 1327.13 and 1327.19.

State Long-Term Care Ombudsman program, Ombudsman program, or program, as used in sections 711 and 712 of the Act, means the program through which the functions and duties of the Office are carried out, consisting of the Ombudsman, the Office headed by the Ombudsman, and the representatives of the Office.

Willful interference means actions or inactions taken by an individual in an attempt to intentionally prevent, interfere with, or attempt to impede the Ombudsman from performing any of the functions or responsibilities set forth in § 1327.13, or the Ombudsman or a representative of the Office from performing any of the duties set forth in § 1327.19.

§ 1327.11 Establishment of the Office of the State Long-Term Care Ombudsman.

(a) The Office of the State Long-Term Care Ombudsman shall be an entity which shall be headed by the State Long-Term Care Ombudsman, who shall carry out all of the functions and responsibilities set forth in § 1327.13 and shall carry out, directly and/or through local Ombudsman entities, the duties set forth in § 1327.19.

(b) The State agency shall establish the Office and, thereby carry out the Long-Term Care Ombudsman program in any of the following ways:
(1) The Office is a distinct entity, separately identifiable, and located within or connected to the State agency; or

(2) The State agency enters into a contract or other arrangement with any public agency or nonprofit organization which shall establish a separately identifiable, distinct entity as the Office.

(c) The State agency shall require that the Ombudsman serve on a full-time basis. In providing leadership and management of the Office, the functions, responsibilities, and duties, as set forth in §§ 1327.13 and 1327.19 are to constitute the entirety of the Ombudsman's work. The State agency or other agency carrying out the Office shall not require or request the Ombudsman to be responsible for leading, managing or performing the work of non-ombudsman services or programs except on a time-limited, intermittent basis.

(1) This provision does not limit the authority of the Ombudsman program to provide ombudsman services to populations other than residents of long-term care facilities so long as the appropriations under the Act are utilized to serve residents of long-term care facilities, as authorized by the Act.

(2) [Reserved]

(d) The State agency, and other entity selecting the Ombudsman, if applicable, shall ensure that the Ombudsman meets minimum qualifications which shall include, but not be limited to, demonstrated expertise in:

(1) Long-term services and supports or other direct services for older persons or individuals with disabilities;

(2) Consumer-oriented public policy advocacy;

(3) Leadership and program management skills; and

(4) Negotiation and problem resolution skills.

(e) Policies and procedures. Where the Ombudsman has the legal authority to do so, he or she shall establish policies and procedures, in consultation with the State agency, to carry out the Ombudsman program in accordance with the Act. Where State law does not provide the Ombudsman with legal authority to establish policies and procedures, the Ombudsman shall recommend policies and procedures to the State agency or other agency in which the Office is organizationally located, and such agency shall establish Ombudsman program policies and procedures. Where local Ombudsman entities are designated within area agencies on aging or other entities, the Ombudsman and/or appropriate agency shall develop such policies and procedures in consultation with the agencies hosting local Ombudsman entities and with representatives of the Office. The policies and procedures must address the matters within this subsection.
(1) **Program administration.** Policies and procedures regarding program administration must include, but not be limited to:

(i) A requirement that the agency in which the Office is organizationally located must not have personnel policies or practices which prohibit the Ombudsman from performing the functions and responsibilities of the Ombudsman, as set forth in § 1327.13, or from adhering to the requirements of section 712 of the Act. Nothing in this provision shall prohibit such agency from requiring that the Ombudsman, or other employees or volunteers of the Office, adhere to the personnel policies and procedures of the entity which are otherwise lawful.

(ii) A requirement that an agency hosting a local Ombudsman entity must not have personnel policies or practices which prohibit a representative of the Office from performing the duties of the Ombudsman program or from adhering to the requirements of section 712 of the Act. Nothing in this provision shall prohibit such agency from requiring that representatives of the Office adhere to the personnel policies and procedures of the host agency which are otherwise lawful.

(iii) A requirement that the Ombudsman shall monitor the performance of local Ombudsman entities which the Ombudsman has designated to carry out the duties of the Office.

(iv) A description of the process by which the agencies hosting local Ombudsman entities will coordinate with the Ombudsman in the employment or appointment of representatives of the Office.

(v) Standards to assure prompt response to complaints by the Office and/or local Ombudsman entities which prioritize abuse, neglect, exploitation and time-sensitive complaints and which consider the severity of the risk to the resident, the imminence of the threat of harm to the resident, and the opportunity for mitigating harm to the resident through provision of Ombudsman program services.

(vi) Procedures that clarify appropriate fiscal responsibilities of the local Ombudsman entity, including but not limited to clarifications regarding access to programmatic fiscal information by appropriate representatives of the Office.

(2) **Procedures for access.** Policies and procedures regarding timely access to facilities, residents, and appropriate records (regardless of format and including, upon request, copies of such records) by the Ombudsman and representatives of the Office must include, but not be limited to:

(i) Access to enter all long-term care facilities at any time during a facility’s regular business hours or regular visiting hours, and at any other time when access may be required by the circumstances to be investigated;
(ii) Access to all residents to perform the functions and duties set forth in §§ 1327.13 and 1327.19;

(iii) Access to the name and contact information of the resident representative, if any, where needed to perform the functions and duties set forth in §§ 1327.13 and 1327.19;

(iv) Access to review the medical, social and other records relating to a resident, if—

(A) The resident or resident representative communicates informed consent to the access and the consent is given in writing or through the use of auxiliary aids and services;

(B) The resident or resident representative communicates informed consent orally, visually, or through the use of auxiliary aids and services, and such consent is documented contemporaneously by a representative of the Office in accordance with such procedures; and

(C) Access is necessary in order to investigate a complaint, the resident representative refuses to consent to the access, a representative of the Office has reasonable cause to believe that the resident representative is not acting in the best interests of the resident, and the representative of the Office obtains the approval of the Ombudsman;

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

(vi) Access of the Ombudsman to, and, upon request, copies of all licensing and certification records maintained by the State with respect to long-term care facilities; and

(vii) Reaffirmation that the Health Insurance Portability and Accountability Act of 1996 (HIPAA) Privacy Rule, 45 CFR part 160 and 45 CFR part 164, subparts A and E, does not preclude release by covered entities of resident private health information or other resident identifying information to the Ombudsman program, including but not limited to residents' medical, social, or other records, a list of resident names and room numbers, or information collected in the course of a State or Federal survey or inspection process.

(3) Disclosure. Policies and procedures regarding disclosure of files, records and other information maintained by the Ombudsman program must include, but not be limited to:

(i) Provision that the files, records, and information maintained by the Ombudsman program may be disclosed only at the discretion of the Ombudsman or designee of the Ombudsman for such purpose and in accordance with the criteria developed by the Ombudsman, as required by § 1327.13(e);

(ii) Prohibition of the disclosure of identifying information of any resident with respect to whom the Ombudsman program maintains files, records, or information, except as otherwise provided by § 1327.19(b)(5) through (8), unless:
(A) The resident or the resident representative communicates informed consent to the disclosure and the consent is given in writing or through the use of auxiliary aids and services;

(B) The resident or resident representative communicates informed consent orally, visually, or through the use of auxiliary aids and services and such consent is documented contemporaneously by a representative of the Office in accordance with such procedures; or

(C) The disclosure is required by court order;

(iii) Prohibition of the disclosure of identifying information of any complainant with respect to whom the Ombudsman program maintains files, records, or information, unless:

(A) The complainant communicates informed consent to the disclosure and the consent is given in writing or through the use of auxiliary aids and services;

(B) The complainant communicates informed consent orally, visually, or through the use of auxiliary aids and services and such consent is documented contemporaneously by a representative of the Office in accordance with such procedures; or

(C) The disclosure is required by court order;

(iv) Exclusion of the Ombudsman and representatives of the Office from abuse reporting requirements, including when such reporting would disclose identifying information of a complainant or resident without appropriate consent or court order, except as otherwise provided in § 1327.19(b)(5) through (8); and

(v) Adherence to the provisions of paragraph (e)(3) of this section, regardless of the source of the request for information or the source of funding for the services of the Ombudsman program, notwithstanding section 705(a)(6)(c) of the Act.

(4) Conflicts of interest. Policies and procedures regarding conflicts of interest must establish mechanisms to identify and remove or remedy conflicts of interest as provided in § 1327.21, including:

(i) Ensuring that no individual, or member of the immediate family of an individual, involved in the employment or appointment of the Ombudsman is subject to a conflict of interest;

(ii) Requiring that other agencies in which the Office or local Ombudsman entities are organizationally located have policies in place to prohibit the employment or appointment of an Ombudsman or representatives of the Office with a conflict that cannot be adequately removed or remedied;
(iii) Requiring that the Ombudsman take reasonable steps to refuse, suspend or remove designation of an individual who has a conflict of interest, or who has a member of the immediate family with a conflict of interest, which cannot be adequately removed or remedied;

(iv) Establishing the methods by which the Office and/or State agency will periodically review and identify conflicts of the Ombudsman and representatives of the Office; and

(v) Establishing the actions the Office and/or State agency will require the Ombudsman or representatives of the Office to take in order to remedy or remove such conflicts.

(5) Systems advocacy. Policies and procedures related to systems advocacy must assure that the Office is required and has sufficient authority to carry out its responsibility to analyze, comment on, and monitor the development and implementation of Federal, State, and local laws, regulations, and other government policies and actions that pertain to long-term care facilities and services and to the health, safety, welfare, and rights of residents, and to recommend any changes in such laws, regulations, and policies as the Office determines to be appropriate.

(i) Such procedures must exclude the Ombudsman and representatives of the Office from any State lobbying prohibitions to the extent that such requirements are inconsistent with section 712 of the Act.

(ii) Nothing in this part shall prohibit the Ombudsman or the State agency or other agency in which the Office is organizationally located from establishing policies which promote consultation regarding the determinations of the Office related to recommended changes in laws, regulations, and policies. However, such a policy shall not require a right to review or pre-approve positions or communications of the Office.

(6) Designation. Policies and procedures related to designation must establish the criteria and process by which the Ombudsman shall designate and refuse, suspend or remove designation of local Ombudsman entities and representatives of the Office.

(i) Such criteria should include, but not be limited to, the authority to refuse, suspend or remove designation a local Ombudsman entity or representative of the Office in situations in which an identified conflict of interest cannot be adequately removed or remedied as set forth in § 1327.21.

(ii) [Reserved]

(7) Grievance process. Policies and procedures related to grievances must establish a grievance process for the receipt and review of grievances regarding the determinations or actions of the Ombudsman and representatives of the Office.

(i) Such process shall include an opportunity for reconsideration of the Ombudsman decision to refuse, suspend, or remove designation of a local Ombudsman entity or
representative of the Office. Notwithstanding the grievance process, the Ombudsman shall make the final determination to designate or to refuse, suspend, or remove designation of a local Ombudsman entity or representative of the Office.

(ii) [Reserved]

(8) **Determinations of the Office.** Policies and procedures related to the determinations of the Office must ensure that the Ombudsman, as head of the Office, shall be able to independently make determinations and establish positions of the Office, without necessarily representing the determinations or positions of the State agency or other agency in which the Office is organizationally located, regarding:

(i) Disclosure of information maintained by the Ombudsman program within the limitations set forth in section 712(d) of the Act;

(ii) Recommendations to changes in Federal, State and local laws, regulations, policies and actions pertaining to the health, safety, welfare, and rights of residents; and

(iii) Provisioin of information to public and private agencies, legislators, the media, and other persons, regarding the problems and concerns of residents and recommendations related to the problems and concerns.

§ 1327.13 Functions and responsibilities of the State Long-Term Care Ombudsman.

The Ombudsman, as head of the Office, shall have responsibility for the leadership and management of the Office in coordination with the State agency, and, where applicable, any other agency carrying out the Ombudsman program, as follows.

(a) **Functions.** The Ombudsman shall, personally or through representatives of the Office—

(1) Identify, investigate, and resolve complaints that—

(i) Are made by, or on behalf of, residents; and

(ii) Relate to action, inaction, or decisions, that may adversely affect the health, safety, welfare, or rights of residents (including the welfare and rights of residents with respect to the appointment and activities of resident representatives) of—

(A) Providers, or representatives of providers, of long-term care;

(B) Public agencies; or

(C) Health and social service agencies.
(2) Provide services to protect the health, safety, welfare, and rights of the residents;

(3) Inform residents about means of obtaining services provided by the Ombudsman program;

(4) Ensure that residents have regular and timely access to the services provided through the Ombudsman program and that residents and complainants receive timely responses from representatives of the Office to requests for information and complaints;

(5) Represent the interests of residents before governmental agencies, assure that individual residents have access to, and pursue (as the Ombudsman determines as necessary and consistent with resident interests) administrative, legal, and other remedies to protect the health, safety, welfare, and rights of residents;

(6) Provide administrative and technical assistance to representatives of the Office and agencies hosting local Ombudsman entities;

(7)(i) Analyze, comment on, and monitor the development and implementation of Federal, State, and local laws, regulations, and other governmental policies and actions, that pertain to the health, safety, welfare, and rights of the residents, with respect to the adequacy of long-term care facilities and services in the State;

(ii) Recommend any changes in such laws, regulations, policies, and actions as the Office determines to be appropriate; and

(iii) Facilitate public comment on the laws, regulations, policies, and actions;

(iv) Provide leadership to statewide systems advocacy efforts of the Office on behalf of long-term care facility residents, including coordination of systems advocacy efforts carried out by representatives of the Office; and

(v) Provide information to public and private agencies, legislators, the media, and other persons, regarding the problems and concerns of residents and recommendations related to the problems and concerns.

(vi) Such determinations and positions shall be those of the Office and shall not necessarily represent the determinations or positions of the State agency or other agency in which the Office is organizationally located.

(vii) 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 Ombudsman or representatives of the Office do not constitute lobbying activities as defined by 45 CFR part 93.
(8) Coordinate with and promote the development of citizen organizations consistent with the interests of residents; and

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

(b) The Ombudsman shall be the head of a unified statewide program and shall:

(1) Establish or recommend policies, procedures and standards for administration of the Ombudsman program pursuant to § 1327.11(e);

(2) Require representatives of the Office to fulfill the duties set forth in § 1327.19 in accordance with Ombudsman program policies and procedures.

(c) Designation. The Ombudsman shall determine designation, and refusal, suspension, or removal of designation, of local Ombudsman entities and representatives of the Office pursuant to section 712(a)(5) of the Act and the policies and procedures set forth in § 1327.11(e)(6).

(1) Where an Ombudsman chooses to designate local Ombudsman entities, the Ombudsman shall:

(i) Designate local Ombudsman entities to be organizationally located within public or non-profit private entities;

(ii) Review and approve plans or contracts governing local Ombudsman entity operations, including, where applicable, through area agency on aging plans, in coordination with the State agency; and

(iii) Monitor, on a regular basis, the Ombudsman program performance of local Ombudsman entities.

(2) Training requirements. The Ombudsman shall establish procedures for training for certification and continuing education of the representatives of the Office, based on model standards established by the Director of the Office of Long-Term Care Ombudsman Programs as described in section 201(d) of the Act, in consultation with residents, resident representatives, citizen organizations, long-term care providers, and the State agency, that—

(i) Specify a minimum number of hours of initial training;

(ii) Specify the content of the training, including training relating to Federal, State, and local laws, regulations, and policies, with respect to long-term care facilities in the State; investigative and resolution techniques; and such other matters as the Office determines to be appropriate; and
(iii) Specify an annual number of hours of in-service training for all representatives of the Office;

(3) Prohibit any representative of the Office from carrying out the duties described in § 1327.19 unless the representative—

(i) Has received the training required under paragraph (c)(2) of this section or is performing such duties under supervision of the Ombudsman or a designated representative of the Office as part of certification training requirements; and

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

(4) The Ombudsman shall investigate allegations of misconduct by representatives of the Office in the performance of Ombudsman program duties and, as applicable, coordinate such investigations with the State agency in which the Office is organizationally located, agency hosting the local Ombudsman entity and/or the local Ombudsman entity.

(5) Policies, procedures, or practices which the Ombudsman determines to be in conflict with the laws, policies, or procedures governing the Ombudsman program shall be sufficient grounds for refusal, suspension, or removal of designation of the representative of the Office and/or the local Ombudsman entity.

(d) **Ombudsman program information.** The Ombudsman shall manage the files, records, and other information of the Ombudsman program, whether in physical, electronic, or other formats, including information maintained by representatives of the Office and local Ombudsman entities pertaining to the cases and activities of the Ombudsman program. Such files, records, and other information are the property of the Office. Nothing in this provision shall prohibit a representative of the Office or a local Ombudsman entity from maintaining such information in accordance with Ombudsman program requirements.

(e) **Disclosure.** In making determinations regarding the disclosure of files, records and other information maintained by the Ombudsman program, the Ombudsman shall:

(1) Have the sole authority to make or delegate determinations concerning the disclosure of the files, records, and other information maintained by the Ombudsman program. The Ombudsman shall comply with section 712(d) of the Act in responding to requests for disclosure of files, records, and other information, regardless of the format of such file, record, or other information, the source of the request, and the sources of funding to the Ombudsman program;

(2) Develop and adhere to criteria to guide the Ombudsman's discretion in determining whether to disclose the files, records or other information of the Office; and
(3) Develop and adhere to a process for the appropriate disclosure of information maintained by the Office, including:

(i) Classification of at least the following types of files, records, and information: medical, social and other records of residents; administrative records, policies, and documents of long-term care facilities; licensing and certification records maintained by the State with respect to long-term care facilities; and data collected in the Ombudsman program reporting system; and

(ii) Identification of the appropriate individual designee or category of designee, if other than the Ombudsman, authorized to determine the disclosure of specific categories of information in accordance with the criteria described in paragraph (e) of this section.

(f) Fiscal management. The Ombudsman shall determine the use of the fiscal resources appropriated or otherwise available for the operation of the Office. Where local Ombudsman entities are designated, the Ombudsman shall approve the allocations of Federal and State funds provided to such entities, subject to applicable Federal and State laws and policies. The Ombudsman shall determine that program budgets and expenditures of the Office and local Ombudsman entities are consistent with laws, policies and procedures governing the Ombudsman program.

(g) Annual report. The Ombudsman shall independently develop and provide final approval of an annual report as set forth in section 712(h)(1) of the Act and as otherwise required by the Assistant Secretary.

(1) Such report shall:

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

(ii) Contain analysis of Ombudsman program data;

(iii) Describe evaluation of the problems experienced by, and the complaints made by or on behalf of, residents;

(iv) Contain policy, regulatory, and/or legislative recommendations for improving quality of the care and life of the residents; protecting the health, safety, welfare, and rights of the residents; and resolving resident complaints and identified problems or barriers;

(v) Contain analysis of the success of the Ombudsman program, including success in providing services to residents of, assisted living, board and care facilities and other similar adult care facilities; and

(vi) Describe barriers that prevent the optimal operation of the Ombudsman program.
(2) The Ombudsman shall make such report available to the public and submit it to the Assistant Secretary, the chief executive officer of the State, the State legislature, the State agency responsible for licensing or certifying long-term care facilities, and other appropriate governmental entities.

(h) Through adoption of memoranda of understanding and other means, the Ombudsman shall lead state-level coordination, and support appropriate local Ombudsman entity coordination, between the Ombudsman program and other entities with responsibilities relevant to the health, safety, well-being or rights of residents of long-term care facilities including, but not limited to:

(1) Area agency on aging programs;
(2) Aging and disability resource centers;
(3) Adult protective services programs;
(4) Protection and advocacy systems, as designated by the State, and as established under the Developmental Disabilities Assistance and Bill of Rights Act of 2000 (42 U.S.C. 15001 et seq.);
(5) Facility and long-term care provider licensure and certification programs;
(6) The State Medicaid fraud control unit, as defined in section 1903(q) of the Social Security Act (42 U.S.C. 1396b(q));
(7) Victim assistance programs;
(8) State and local law enforcement agencies;
(9) Courts of competent jurisdiction; and
(10) The State legal assistance developer and legal assistance programs, including those provided under section 306(a)(2)(C) of the Act.

(i) The Ombudsman shall carry out such other activities as the Assistant Secretary determines to be appropriate.

§ 1327.15 State agency responsibilities related to the Ombudsman program.

(a) In addition to the responsibilities set forth in part 1321 of this chapter, the State agency shall ensure that the Ombudsman complies with the relevant provisions of the Act and of this rule.

(b) The State agency shall ensure, through the development of policies, procedures, and other means, consistent with § 1327.11(e)(2), that the Ombudsman program has
sufficient authority and access to facilities, residents, and information needed to fully perform all of the functions, responsibilities, and duties of the Office.

(c) The State agency shall provide opportunities for training for the Ombudsman and representatives of the Office in order to maintain expertise to serve as effective advocates for residents. The State agency may utilize funds appropriated under Title III and/or Title VII of the Act designated for direct services in order to provide access to such training opportunities.

(d) The State agency shall provide personnel supervision and management for the Ombudsman and representatives of the Office who are employees of the State agency. Such management shall include an assessment of whether the Office is performing all of its functions under the Act.

(e) The State agency shall provide monitoring, as required by § 1321.11(b) of this chapter, including but not limited to fiscal monitoring, where the Office and/or local Ombudsman entity is organizationally located within an agency under contract or other arrangement with the State agency. Such monitoring shall include an assessment of whether the Ombudsman program is performing all of the functions, responsibilities and duties set forth in §§ 1327.13 and 1327.19. The State agency may make reasonable requests of reports, including aggregated data regarding Ombudsman program activities, to meet the requirements of this provision.

(f) The State agency shall ensure that any review of files, records or other information maintained by the Ombudsman program is consistent with the disclosure limitations set forth in §§ 1327.11(e)(3) and 1327.13(e).

(g) The State agency shall integrate the goals and objectives of the Office into the State plan and coordinate the goals and objectives of the Office with those of other programs established under Title VII of the Act and other State elder rights, disability rights, and elder justice programs, including, but not limited to, legal assistance programs provided under section 306(a)(2)(C) of the Act, to promote collaborative efforts and diminish duplicative efforts. Where applicable, the State agency shall require inclusion of goals and objectives of local Ombudsman entities into area plans on aging.

(h) The State agency shall provide elder rights leadership. In so doing, it shall require the coordination of Ombudsman program services with, the activities of other programs authorized by Title VII of the Act as well as other State and local entities with responsibilities relevant to the health, safety, well-being or rights of older adults, including residents of long-term care facilities as set forth in § 1327.13(h).

(i) Interference, retaliation and reprisals. The State agency shall:

(1) Ensure that it has mechanisms to prohibit and investigate allegations of interference, retaliation and reprisals:
(i) by a long-term care facility, other entity, or individual with respect to any resident, employee, or other person for filing a complaint with, providing information to, or otherwise cooperating with any representative of the Office; or

(ii) by a long-term care facility, other entity or individual against the Ombudsman or representatives of the Office for fulfillment of the functions, responsibilities, or duties enumerated at §§ 1327.13 and 1327.19; and

(2) Provide for appropriate sanctions with respect to interference, retaliation and reprisals.

(j) **Legal counsel.** (1) The State agency shall ensure that:

(i) Legal counsel for the Ombudsman program is adequate, available, has competencies relevant to the legal needs of the program and of residents, and is without conflict of interest (as defined by the State ethical standards governing the legal profession), in order to—

(A) Provide consultation and representation as needed in order for the Ombudsman program to protect the health, safety, welfare, and rights of residents; and

(B) Provide consultation and/or representation as needed to assist the Ombudsman and representatives of the Office in the performance of their official functions, responsibilities, and duties, including, but not limited to, complaint resolution and systems advocacy;

(ii) The Ombudsman and representatives of the Office assist residents in seeking administrative, legal, and other appropriate remedies. In so doing, the Ombudsman shall coordinate with the legal services developer, legal services providers, and victim assistance services to promote the availability of legal counsel to residents; and

(iii) Legal representation, arranged by or with the approval of the Ombudsman, is provided to the Ombudsman or any representative of the Office against whom suit or other legal action is brought or threatened to be brought in connection with the performance of the official duties.

(2) Such legal counsel may be provided by one or more entities, depending on the nature of the competencies and services needed and as necessary to avoid conflicts of interest (as defined by the State ethical standards governing the legal profession). However, at a minimum, the Office shall have access to an attorney knowledgeable about the Federal and State laws protecting the rights of residents and governing long-term care facilities.

(3) Legal representation of the Ombudsman program by the Ombudsman or representative of the Office who is a licensed attorney shall not by itself constitute sufficiently adequate legal counsel.
(4) The communications between the Ombudsman and legal counsel are subject to attorney-client privilege.

(k) The State agency shall require the Office to:

(1) Develop and provide final approval of an annual report as set forth in section 712(h)(1) of the Act and § 1327.13(g) and as otherwise required by the Assistant Secretary.

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

(3) Provide such information as the Office determines to be necessary to public and private agencies, legislators, the media, and other persons, regarding the problems and concerns of individuals residing in long-term care facilities; and recommendations related to such problems and concerns; and

(4) Establish procedures for the training of the representatives of the Office, as set forth in § 1327.13(c)(2).

(5) Coordinate Ombudsman program services with entities with responsibilities relevant to the health, safety, welfare, and rights of residents of long-term care facilities, as set forth in § 1327.13(h).

§ 1327.17 Responsibilities of agencies hosting local Ombudsman entities.

(a) The agency in which a local Ombudsman entity is organizationally located shall be responsible for the personnel management, but not the programmatic oversight, of representatives, including employee and volunteer representatives, of the Office.

(b) The agency in which a local Ombudsman entity is organizationally located shall not have personnel policies or practices which prohibit the representatives of the Office from performing the duties, or from adhering to the access, confidentiality and disclosure requirements of section 712 of the Act, as implemented through this rule and the policies and procedures of the Office.

(1) Policies, procedures and practices, including personnel management practices of the host agency, which the Ombudsman determines conflict with the laws or policies governing the Ombudsman program shall be sufficient grounds for the refusal, suspension, or removal of the designation of local Ombudsman entity by the Ombudsman.
Nothing in this provision shall prohibit the host agency from requiring that the representatives of the Office adhere to the personnel policies and procedures of the agency which are otherwise lawful.

§ 1327.19 Duties of the representatives of the Office.

In carrying out the duties of the Office, the Ombudsman may designate an entity as a local Ombudsman entity and may designate an employee or volunteer of the local Ombudsman entity as a representative of the Office. Representatives of the Office may also be designated employees or volunteers within the Office.

(a) Duties. An individual so designated as a representative of the Office shall, in accordance with the policies and procedures established by the Office and the State agency:

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

(2) Provide services to protect the health, safety, welfare, and rights of residents;

(3) Ensure that residents in the service area of the local Ombudsman entity have regular and timely access to the services provided through the Ombudsman program and that residents and complainants receive timely responses to requests for information and complaints;

(4) Represent the interests of residents before government agencies and assure that individual residents have access to, and pursue (as the representative of the Office determines necessary and consistent with resident interest) administrative, legal, and other remedies to protect the health, safety, welfare, and rights of the residents;

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

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

(6) Promote, provide technical support for the development of, and provide ongoing support as requested by resident and family councils; and

(7) Carry out other activities that the Ombudsman determines to be appropriate.

(b) Complaint processing. (1) With respect to identifying, investigating and resolving complaints, and regardless of the source of the complaint (i.e. complainant), the Ombudsman and the representatives of the Office serve the resident of a long-term
care facility. The Ombudsman or representative of the Office shall investigate a complaint, including but not limited to a complaint related to abuse, neglect, or exploitation, for the purposes of resolving the complaint to the resident’s satisfaction and of protecting the health, welfare, and rights of the resident. The Ombudsman or representative of the Office may identify, investigate and resolve a complaint impacting multiple residents or all residents of a facility.

(2) Regardless of the source of the complaint (i.e. the complainant), including when the source is the Ombudsman or representative of the Office, the Ombudsman or representative of the Office must support and maximize resident participation in the process of resolving the complaint as follows:

(i) The Ombudsman or representative of Office shall offer privacy to the resident for the purpose of confidentially providing information and hearing, investigating and resolving complaints.

(ii) The Ombudsman or representative of the Office shall personally discuss the complaint with the resident (and, if the resident is unable to communicate informed consent, the resident's representative) in order to:

(A) Determine the perspective of the resident (or resident representative, where applicable) of the complaint;

(B) Request the resident (or resident representative, where applicable) to communicate informed consent in order to investigate the complaint;

(C) Determine the wishes of the resident (or resident representative, where applicable) with respect to resolution of the complaint, including whether the allegations are to be reported and, if so, whether Ombudsman or representative of the Office may disclose resident identifying information or other relevant information to the facility and/or appropriate agencies. Such report and disclosure shall be consistent with paragraph (b)(3) of this section;

(D) Advise the resident (and resident representative, where applicable) of the resident’s rights;

(E) Work with the resident (or resident representative, where applicable) to develop a plan of action for resolution of the complaint;

(F) Investigate the complaint to determine whether the complaint can be verified; and

(G) Determine whether the complaint is resolved to the satisfaction of the resident (or resident representative, where applicable).

(iii) Where the resident is unable to communicate informed consent, and has no resident representative, the Ombudsman or representative of the Office shall:
(A) Take appropriate steps to investigate and work to resolve the complaint in order to protect the health, safety, welfare and rights of the resident; and

(B) Determine whether the complaint was resolved to the satisfaction of the complainant.

(iv) In determining whether to rely upon a resident representative to communicate or make determinations on behalf of the resident related to complaint processing, the Ombudsman or representative of the Office shall ascertain the extent of the authority that has been granted to the resident representative under court order (in the case of a guardian or conservator), by power of attorney or other document by which the resident has granted authority to the representative, or under other applicable State or Federal law.

(3) The Ombudsman or representative of the Office may provide information regarding the complaint to another agency in order for such agency to substantiate the facts for regulatory, protective services, law enforcement, or other purposes so long as the Ombudsman or representative of the Office adheres to the disclosure requirements of section 712(d) of the Act and the procedures set forth in § 1327.11(e)(3).

(i) Where the goals of a resident or resident representative are for regulatory, protective services or law enforcement action, and the Ombudsman or representative of the Office determines that the resident or resident representative has communicated informed consent to the Office, the Office must assist the resident or resident representative in contacting the appropriate agency and/or disclose the information for which the resident has provided consent to the appropriate agency for such purposes.

(ii) Where the goals of a resident or resident representative can be served by disclosing information to a facility representative and/or referrals to an entity other than those referenced in paragraph (b)(3)(i) of this section, and the Ombudsman or representative of the Office determines that the resident or resident representative has communicated informed consent to the Ombudsman program, the Ombudsman or representative of the Office may assist the resident or resident representative in contacting the appropriate facility representative or the entity, provide information on how a resident or representative may obtain contact information of such facility representatives or entities, and/or disclose the information for which the resident has provided consent to an appropriate facility representative or entity, consistent with Ombudsman program procedures.

(iii) In order to comply with the wishes of the resident, (or, in the case where the resident is unable to communicate informed consent, the wishes of the resident representative), the Ombudsman and representatives of the Office shall not report suspected abuse, neglect or exploitation of a resident when a resident or resident representative has not communicated informed consent to such report except as set forth in paragraphs (b)(5) through (7) of this section, notwithstanding State laws to the contrary.
(4) For purposes of paragraphs (b)(1) through (3) of this section, communication of informed consent may be made in writing, including through the use of auxiliary aids and services. Alternatively, communication may be made orally or visually, including through the use of auxiliary aids and services, and such consent must be documented contemporaneously by the Ombudsman or a representative of the Office, in accordance with the procedures of the Office;

(5) For purposes of paragraphs (b)(1) paragraph (3) of this section, if a resident is unable to communicate his or her informed consent, or perspective on the extent to which the matter has been satisfactorily resolved, the Ombudsman or representative of the Office may rely on the communication of informed consent and/or perspective regarding the resolution of the complaint of a resident representative so long as the Ombudsman or representative of the Office has no reasonable cause to believe that the resident representative is not acting in the best interests of the resident.

(6) For purposes of paragraphs (b)(1) through (3) of this section, the procedures for disclosure, as required by § 1327.11(e)(3), shall provide that the Ombudsman or representative of the Office may refer the matter and disclose resident-identifying information to the appropriate agency or agencies for regulatory oversight; protective services; access to administrative, legal, or other remedies; and/or law enforcement action in the following circumstances:

(i) The resident is unable to communicate informed consent to the Ombudsman or representative of the Office;

(ii) The resident has no resident representative;

(iii) The Ombudsman or representative of the Office has reasonable cause to believe that an action, inaction or decision may adversely affect the health, safety, welfare, or rights of the resident;

(iv) The Ombudsman or representative of the Office has no evidence indicating that the resident would not wish a referral to be made;

(v) The Ombudsman or representative of the Office has reasonable cause to believe that it is in the best interest of the resident to make a referral; and

(vi) The representative of the Office obtains the approval of the Ombudsman or otherwise follows the policies and procedures of the Office described in paragraph (b)(9) of this section.

(7) For purposes of paragraphs (b)(1) through (3) of this section, the procedures for disclosure, as required by § 1327.11(e)(3), shall provide that, the Ombudsman or representative of the Office may refer the matter and disclose resident-identifying information to the appropriate agency or agencies for regulatory oversight; protective
services; access to administrative, legal, or other remedies; and/or law enforcement action in the following circumstances:

(i) The resident is unable to communicate informed consent to the Ombudsman or representative of the Office and has no resident representative, or the Ombudsman or representative of the Office has reasonable cause to believe that the resident representative has taken an action, inaction or decision that may adversely affect the health, safety, welfare, or rights of the resident;

(ii) The Ombudsman or representative of the Office has no evidence indicating that the resident would not wish a referral to be made;

(iii) The Ombudsman or representative of the Office has reasonable cause to believe that it is in the best interest of the resident to make a referral; and

(iv) The representative of the Ombudsman obtains the approval of the Ombudsman.

(8) The procedures for disclosure, as required by § 1327.11(e)(3), shall provide that, if the Ombudsman or representative of the Office personally witnesses suspected abuse, gross neglect, or exploitation of a resident, the Ombudsman or representative of the Office shall seek communication of informed consent from such resident to disclose resident-identifying information to appropriate agencies;

(i) Where such resident is able to communicate informed consent, or has a resident representative available to provide informed consent, the Ombudsman or representative of the Office shall follow the direction of the resident or resident representative as set forth paragraphs (b)(1) through (3) of this section; and

(ii) Where the resident is unable to communicate informed consent, and has no resident representative available to provide informed consent, the Ombudsman or representative of the Office shall open a case with the Ombudsman or representative of the Office as the complainant, follow the Ombudsman program's complaint resolution procedures, and shall refer the matter and disclose identifying information of the resident to the management of the facility in which the resident resides and/or to the appropriate agency or agencies for substantiation of abuse, gross neglect or exploitation in the following circumstances:

(A) The Ombudsman or representative of the Office has no evidence indicating that the resident would not wish a referral to be made;

(B) The Ombudsman or representative of the Office has reasonable cause to believe that disclosure would be in the best interest of the resident; and

(C) The representative of the Office obtains the approval of the Ombudsman or otherwise follows the policies and procedures of the Office described in paragraph (b)(9) of this section.
(iii) In addition, the Ombudsman or representative of the Office, following the policies and procedures of the Office described in paragraph (b)(9) of this section, may report the suspected abuse, gross neglect, or exploitation to other appropriate agencies for regulatory oversight; protective services; access to administrative, legal, or other remedies; and/or law enforcement action.

(9) Prior to disclosing resident-identifying information pursuant to paragraph (b)(6) or (8) of this section, a representative of the Office must obtain approval by the Ombudsman or, alternatively, follow policies and procedures of the Office which provide for such disclosure.

(i) Where the policies and procedures require Ombudsman approval, they shall include a time frame in which the Ombudsman is required to communicate approval or disapproval in order to assure that the representative of the Office has the ability to promptly take actions to protect the health, safety, welfare or rights of residents.

(ii) Where the policies and procedures do not require Ombudsman approval prior to disclosure, they shall require that the representative of the Office promptly notify the Ombudsman of any disclosure of resident-identifying information under the circumstances set forth in paragraph (b)(6) or (8) of this section.

(iii) Disclosure of resident-identifying information under paragraph (b)(7) of this section shall require Ombudsman approval.

§ 1327.21 Conflicts of interest.

The State agency and the Ombudsman shall consider both the organizational and individual conflicts of interest that may impact the effectiveness and credibility of the work of the Office. In so doing, both the State agency and the Ombudsman shall be responsible to identify actual and potential conflicts and, where a conflict has been identified, to remove or remedy such conflict as set forth in paragraphs (b) and (d) of this section.

(a) Identification of organizational conflicts. In identifying conflicts of interest pursuant to section 712(f) of the Act, the State agency and the Ombudsman shall consider the organizational conflicts that may impact the effectiveness and credibility of the work of the Office. Organizational conflicts of interest include, but are not limited to, placement of the Office, or requiring that an Ombudsman or representative of the Office perform conflicting activities, in an organization that:

(1) Is responsible for licensing, surveying, or certifying long-term care facilities;

(2) Is an association (or an affiliate of such an association) of long-term care facilities, or of any other residential facilities for older individuals or individuals with disabilities;
(3) Has any ownership or investment interest (represented by equity, debt, or other financial relationship) in, or receives grants or donations from, a long-term care facility;

(4) Has governing board members with any ownership, investment or employment interest in long-term care facilities;

(5) Provides long-term care to residents of long-term care facilities, including the provision of personnel for long-term care facilities or the operation of programs which control access to or services for long-term care facilities;

(6) Provides long-term care coordination or case management for residents of long-term care facilities;

(7) Sets reimbursement rates for long-term care facilities;

(8) Provides adult protective services;

(9) Is responsible for eligibility determinations regarding Medicaid or other public benefits for residents of long-term care facilities;

(10) Conducts preadmission screening for long-term care facility placements;

(11) Makes decisions regarding admission or discharge of individuals to or from long-term care facilities; or

(12) Provides guardianship, conservatorship or other fiduciary or surrogate decision-making services for residents of long-term care facilities.

(b) Removing or remedying organizational conflicts. The State agency and the Ombudsman shall identify and take steps to remove or remedy conflicts of interest between the Office and the State agency or other agency carrying out the Ombudsman program.

(1) The Ombudsman shall identify organizational conflicts of interest in the Ombudsman program and describe steps taken to remove or remedy conflicts within the annual report submitted to the Assistant Secretary through the National Ombudsman Reporting System.

(2) Where the Office is located within or otherwise organizationally attached to the State agency, the State agency shall:

(i) Take reasonable steps to avoid internal conflicts of interest;

(ii) Establish a process for review and identification of internal conflicts;

(iii) Take steps to remove or remedy conflicts;
(iv) Ensure that no individual, or member of the immediate family of an individual, involved in the designating, appointing, otherwise selecting or terminating the Ombudsman is subject to a conflict of interest; and

(v) Assure that the Ombudsman has disclosed such conflicts and described steps taken to remove or remedy conflicts within the annual report submitted to the Assistant Secretary through the National Ombudsman Reporting System.

(3) Where a State agency is unable to adequately remove or remedy a conflict, it shall carry out the Ombudsman program by contract or other arrangement with a public agency or nonprofit private organization, pursuant to section 712(a)(4) of the Act. The State agency may not enter into a contract or other arrangement to carry out the Ombudsman program if the other entity, and may not operate the Office directly if it:

(i) Is responsible for licensing, surveying, or certifying long-term care facilities;

(ii) Is an association (or an affiliate of such an association) of long-term care facilities, or of any other residential facilities for older individuals or individuals with disabilities; or

(iii) Has any ownership, operational, or investment interest (represented by equity, debt, or other financial relationship) in a long-term care facility.

(4) Where the State agency carries out the Ombudsman program by contract or other arrangement with a public agency or nonprofit private organization, pursuant to section 712(a)(4) of the Act, the State agency shall:

(i) Prior to contracting or making another arrangement, take reasonable steps to avoid conflicts of interest in such agency or organization which is to carry out the Ombudsman program and to avoid conflicts of interest in the State agency's oversight of the contract or arrangement;

(ii) Establish a process for periodic review and identification of conflicts;

(iii) Establish criteria for approval of steps taken by the agency or organization to remedy or remove conflicts;

(iv) Require that such agency or organization have a process in place to:

(A) Take reasonable steps to avoid conflicts of interest, and

(B) Disclose identified conflicts and steps taken to remove or remedy conflicts to the State agency for review and approval.

(5) Where an agency or organization carrying out the Ombudsman program by contract or other arrangement develops a conflict and is unable to adequately remove or remedy a conflict, the State agency shall either operate the Ombudsman program directly or by
contract or other arrangement with another public agency or nonprofit private organization. The State agency shall not enter into such contract or other arrangement with an agency or organization which is responsible for licensing or certifying long-term care facilities in the state or is an association (or affiliate of such an association) of long-term care facilities.

(6) Where local Ombudsman entities provide Ombudsman services, the Ombudsman shall:

(i) Prior to designating or renewing designation, take reasonable steps to avoid conflicts of interest in any agency which may host a local Ombudsman entity.

(ii) Establish a process for periodic review and identification of conflicts of interest with the local Ombudsman entity in any agencies hosting a local Ombudsman entity,

(iii) Require that such agencies disclose identified conflicts of interest with the local Ombudsman entity and steps taken to remove or remedy conflicts within such agency to the Ombudsman,

(iv) Establish criteria for approval of steps taken to remedy or remove conflicts in such agencies, and

(v) Establish a process for review of and criteria for approval of plans to remove or remedy conflicts with the local Ombudsman entity in such agencies.

(7) Failure of an agency hosting a local Ombudsman entity to disclose a conflict to the Office or inability to adequately remove or remedy a conflict shall constitute grounds for refusal, suspension or removal of designation of the local Ombudsman entity by the Ombudsman.

(c) Identifying individual conflicts of interest. (1) In identifying conflicts of interest pursuant to section 712(f) of the Act, the State agency and the Ombudsman shall consider individual conflicts that may impact the effectiveness and credibility of the work of the Office.

(2) Individual conflicts of interest for an Ombudsman, representatives of the Office, and members of their immediate family include, but are not limited to:

(i) Direct involvement in the licensing or certification of a long-term care facility;

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

(iii) Employment of an individual by, or participation in the management of, a long-term care facility in the service area or by the owner or operator of any long-term care facility in the service area;
(iv) Receipt of, or right to receive, directly or indirectly, remuneration (in cash or in kind) under a compensation arrangement with an owner or operator of a long-term care facility;

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

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

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

(viii) Serving residents of a facility in which an immediate family member resides.

(d) Removing or remedying individual conflicts. (1) The State agency or Ombudsman shall develop and implement policies and procedures, pursuant to § 1327.11(e)(4), to ensure that no Ombudsman or representatives of the Office are required or permitted to hold positions or perform duties that would constitute a conflict of interest as set forth in § 1327.21(c). This rule does not prohibit a State agency or Ombudsman from having policies or procedures that exceed these requirements.

(2) When considering the employment or appointment of an individual as the Ombudsman or as a representative of the Office, the State agency or other employing or appointing entity shall:

(i) Take reasonable steps to avoid employing or appointing an individual who has an unremedied conflict of interest or who has a member of the immediate family with an unremedied conflict of interest;

(ii) Take reasonable steps to avoid assigning an individual to perform duties which would constitute an unremedied conflict of interest;

(iii) Establish a process for periodic review and identification of conflicts of the Ombudsman and representatives of the Office, and

(iv) Take steps to remove or remedy conflicts.

(3) In no circumstance shall the entity, which appoints or employs the Ombudsman, appoint or employ an individual as the Ombudsman who:
(i) Has direct involvement in the licensing or certification of a long-term care facility;

(ii) Has an ownership or investment interest (represented by equity, debt, or other financial relationship) in a long-term care facility. Divestment within a reasonable period may be considered an adequate remedy to this conflict;

(iii) Has been employed by or participating in the management of a long-term care facility within the previous twelve months.

(iv) Receives, or has the right to receive, directly or indirectly, remuneration (in cash or in kind) under a compensation arrangement with an owner or operator of a long-term care facility.

(4) In no circumstance shall the State agency, other agency which carries out the Office, or an agency hosting a local Ombudsman entity appoint or employ an individual, nor shall the Ombudsman designate an individual, as a representative of the Office who:

(i) Has direct involvement in the licensing or certification of a long-term care facility;

(ii) Has an ownership or investment interest (represented by equity, debt, or other financial relationship) in a long-term care facility. Divestment within a reasonable period may be considered an adequate remedy to this conflict;

(iii) Receives, directly or indirectly, remuneration (in cash or in kind) under a compensation arrangement with an owner or operator of a long-term care facility; or

(iv) Is employed by, or participating in the management of, a long-term care facility.

(A) An agency which appoints or employs representatives of the Office shall make efforts to avoid appointing or employing an individual as a representative of the Office who has been employed by or participating in the management of a long-term care facility within the previous twelve months.

(B) Where such individual is appointed or employed, the agency shall take steps to remedy the conflict.

Subpart B—[Reserved]
§101A.251. DEFINITIONS. In this subchapter:

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

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

§101A.252. OPERATION OF OFFICE. (a) The department shall operate the office of the state long-term care ombudsman.

(b) The department may operate the office directly or by contract or memorandum of agreement with a public agency or other appropriate private nonprofit organization. The department may not use an agency or organization that is:

1. responsible for licensing or certifying long-term care services; or
2. an association of long-term care facilities or of any other residential facility that serves persons who are 60 years of age or older, or an affiliate of such an association.

(c) The department shall consider the views of elderly persons, provider organizations, advocacy groups, and area agencies on aging in planning and operating the office.

(d) The department shall ensure a person involved in designating the state ombudsman or in designating an employee or representative of the office does not have a conflict of interest.

§101A.253. ROLE OF OFFICE. The office and the ombudsman program shall operate in cooperation with any regulatory agency funded and mandated by the Older Americans Act of 1965 (42 U.S.C. Section 3001 et seq.), and state statute.

§101A.254. POWERS AND DUTIES OF STATE OMBUDSMAN AND OFFICE (a) The state ombudsman and the office have the powers and duties required by state and federal law.

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

§101A.255. OMBUDSMEN. (a) The office shall recruit volunteers and citizen organizations to participate in the ombudsman program. A paid staff member of an area agency on aging network or a nonprofit social service agency may be an ombudsman.

An ombudsman is a representative of the office.

(b) The office shall provide training to ombudsmen as required by this subchapter and federal law.

(c) The office shall coordinate ombudsman services with the protection and advocacy systems that exist for persons with developmental disabilities or mental illness.
§101A.256. LEGAL ASSISTANCE. The department shall ensure that the office receives adequate legal advice and representation. The attorney general shall represent the ombudsman or a representative if a suit or other legal action is brought or threatened to be brought against that person in connection with the person's performance of the official duties of the office.

§101A.257. INVESTIGATIONS. (a) The office shall have access to elderly residents and shall investigate and resolve complaints made by or on behalf of elderly residents.

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

§101A.258. ACCESS TO RECORDS AND CONFIDENTIALITY. (a) The state ombudsman or the state ombudsman's designee, specifically identified by the commissioner, shall have access to patient care records of elderly residents of long-term care facilities as provided by Subsection (a-1). The executive commissioner by rule shall establish procedures for obtaining access to the records. All records and information to which the state ombudsman or the state ombudsman's designee obtains access remain confidential.

(a-1) The state ombudsman or the state ombudsman's designee, specifically identified by the commissioner, shall have access to patient care records of elderly residents of long-term care facilities if:

1. the resident or the resident's legal representative consents to the access;
2. the resident is unable to consent to the access and the resident has no legal representative; or
3. access to the records is necessary to investigate a complaint; and:
   A. a legal guardian of the resident refuses to consent to the access;
   B. the state ombudsman or the state ombudsman's designee has reasonable cause to believe that the guardian is not acting in the best interests of the resident; and
   C. the state ombudsman approves the access.

(b) The office shall ensure that the identity of a complainant or any facility resident may be disclosed only with the written consent of the person or the person's legal representative or on court order.

(c) The information in files maintained by the office may be disclosed only by the ombudsman who has authority over the disposition of the files.

§101A.259. REPORTING SYSTEM. The office shall establish a statewide ombudsman uniform reporting system to collect and analyze information relating to complaints and conditions in long-term care facilities as long as such system does not duplicate other state reporting systems. The office shall provide the information to the department and Health and Human Services Commission.

§101A.260. ANALYSIS OF LAWS. The office shall analyze and monitor the development and implementation of federal, state, and local laws, rules, regulations, and policies relating to long-term care facilities and services and shall recommend any changes the office considers necessary.

§101A.261. PUBLIC INFORMATION. The office shall provide information to public agencies, legislators, and others that relates to the problems and concerns of elderly residents.
§101A.262. ANNUAL REPORT. (a) The office shall prepare an annual report that contains:
(1) information and findings relating to the problems and complaints of elderly residents; and
(2) policy, regulatory, and legislative recommendations to solve the problems, resolve the complaints, and improve the quality of the elderly residents' care and lives.
(b) The report must be submitted to the governor and the presiding officer of each house of the legislature not later than November 1 of each even-numbered year.

§101A.263. LIMITATION OF LIABILITY. An ombudsman or a representative is not liable for civil damages or subject to criminal prosecution for performing official duties unless the ombudsman or representative acts in bad faith or with a malicious purpose.

§101A.264. CRIMINAL PENALTY. (a) A person commits an offense if the person:
(1) intentionally interferes with an ombudsman attempting to perform official duties; or
(2) commits or attempts to commit an act of retaliation or reprisal against any resident or employee of a long-term care facility for filing a complaint or providing information to an ombudsman.
(b) An offense under this section is a Class B misdemeanor.
(c) The department shall assure that criminal sanctions will be initiated only after all administrative procedures are exhausted.

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

SUBCHAPTER A - DEFINITIONS

RULE §85.2 – Definitions
(6) Certified ombudsman--A certified staff ombudsman or a certified volunteer ombudsman.
(7) Certified staff ombudsman--A person who:
(A) meets the qualifications described in §85.401(g)(1) of this chapter (relating to Long-Term Care Ombudsman Program);
(B) is employed by or is contracting with a AAA or nonprofit organization designated in accordance with §85.401(b) of this chapter; and
(C) performs activities for the AAA or designated nonprofit organization to implement the Long-Term Care Ombudsman Program.
(8) Certified volunteer ombudsman--A person who:
(A) meets the qualifications described in §85.401(g)(1) of this chapter;
(B) is not employed by or contracting with a AAA or nonprofit organization designated in accordance with §85.401(b) of this chapter; and
(C) voluntarily performs activities for the AAA or designated nonprofit organization to implement the Long-Term Care Ombudsman Program.
(19) Friendly visitor--A volunteer for a AAA or nonprofit organization designated in accordance with §85.401(b) of this chapter who:
(A) is not a certified ombudsman or ombudsman intern;
(B) meets the qualifications described in §85.401(g)(2) of this chapter; and
(C) performs activities to further the mission of the Long-Term Care Ombudsman Program such as visiting residents and coordinating social activities.

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

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

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

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

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

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

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

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

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

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

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

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

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

(g) Qualifications for certified ombudsmen and friendly visitors.
(1) A person may be a certified ombudsman only if:
   (A) the person has not been convicted of an offense listed under Texas Health and Safety Code, §250.006;
   (B) the person successfully completes a certification training provided by the AAA in accordance with DADS Ombudsman Certification Training Manual;
   (C) for a certified volunteer ombudsman, the person successfully completes an internship in accordance with DADS Ombudsman Policies and Procedures Manual;
   (D) the AAA recommends to the Office, in writing, using DADS Certified Ombudsman Application, that the person be approved as a certified ombudsman;
   (E) the Office signs the DADS Certified Ombudsman Application approving the person to be a certified ombudsman; and
   (F) the person completes continuing education provided by the AAA in accordance with DADS Ombudsman Policies and Procedures Manual.
(2) A person may be a friendly visitor only if the person successfully completes an orientation provided by the AAA in accordance with DADS Ombudsman Policies and Procedures Manual.

(h) Access to residents and records.
(1) In accordance with §19.413 of this title (relating to Access and Visitation Rights) and §92.801 of this title (relating to Access to Residents and Records by the Long-Term Care Ombudsman Program), a representative of the Office, as described in subsection (r) of this section, is entitled to immediate access to a resident.
(2) In accordance with §19.413 of this title and §92.801 of this title a certified ombudsman and a staff person of the Office are entitled to access:
   (A) the medical and social records of a resident, if the certified ombudsman or staff person of the Office has the consent of the resident or the legally authorized representative of the resident;
   (B) the medical and social records of a resident 60 years of age or older, if such access is necessary to investigate a complaint made to the Long-Term Care Ombudsman Program and:
      (i) the resident is unable to consent to access and has no legally authorized representative; or
      (ii) the following circumstances occur:
(I) the legal guardian of the resident refuses to give consent for access to the records;
(II) the certified ombudsman or staff person of the Office has reasonable cause to believe that the guardian is not acting in the best interest of the resident; and
(III) the certified ombudsman or staff person of the Office obtains the approval of the State Long-Term Care Ombudsman to access the records without the guardian's consent; and

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

(i) Conflict of interest and identity of certain relationships.
   (1) A AAA must ensure that a certified ombudsman, an ombudsman intern, and a member of the immediate family of the managing local ombudsman are not subject to a conflict of interest.
   (2) A conflict of interest includes the following:
      (A) having a direct involvement in the licensing or certification of an LTC facility or of a home and community support services agency (HCSSA) licensed to provide home health services or hospice services in accordance with Chapter 97 of this title (relating to Licensing Standards for Home and Community Support Services Agencies);
      (B) having an ownership or investment interest (represented by equity, debt, or other financial relationship) in an LTC facility or a HCSSA licensed to provide home health services or hospice services in accordance with Chapter 97 of this title;
      (C) being employed by, or participating in the management of, an LTC facility or a HCSSA licensed to provide home health services or hospice services in accordance with Chapter 97 of this title;
      (D) receiving, or having the right to receive, directly or indirectly, remuneration (in cash or in kind) under a compensation arrangement with an owner or operator of an LTC facility or a HCSSA licensed to provide home health services or hospice services in accordance with Chapter 97 of this title; and
      (E) a certified ombudsman or ombudsman intern having a relative who is a resident in or an employee of an LTC facility in which the certified ombudsman or ombudsman intern provides Long-Term Care Ombudsman Program services.
   (3) a conflict of interest described in paragraph (2)(A) - (D) of this subsection exists only if an LTC facility is in a AAA's planning and service area or a HCSSA is providing services to an LTC facility in a AAA's planning and service area.
   (4) A AAA must specify, in writing, the mechanisms to:
      (A) identify and remove conflicts of interest; and
      (B) identify and address, if necessary, a familial or personal relationship that a certified ombudsman or ombudsman intern has with:
         (i) a staff person of an LTC facility in the AAA's planning and service area; or
         (ii) a staff person of DADS.

(j) Complaints. A AAA must:
   (1) ensure that a person is allowed to make a complaint about circumstances that may adversely affect the health, safety, welfare, or rights of a resident in the following ways:
      (A) in writing, including by electronic mail;
      (B) in person; and
      (C) by telephone, either by:
         (i) a toll-free telephone number established by the AAA; or
(ii) acceptance by the AAA of a collect telephone call;
(2) initiate a complaint if the AAA becomes aware of circumstances that may adversely affect the health, safety, welfare, or rights of a resident;
(3) unless a complaint is initiated by the AAA in accordance with paragraph (2) of this subsection, respond to the person who makes a complaint, within two business days after receipt of the complaint or sooner, if possible, if the complaint presents an emergency situation;
(4) require a certified ombudsman to initiate an investigation of a complaint as soon as practicable after receipt of the complaint;
(5) require a certified ombudsman to investigate and resolve a complaint in a fair and objective manner; and
(6) report information about complaints to DADS in accordance with instructions promulgated by the Office.

(k) Disclosure of information.
(1) For a resident for whom a AAA maintains files or records, the AAA may disclose confidential information, including the identity of the resident or information from the files or records, only if:
   (A) the resident or legally authorized representative consents to the disclosure in writing;
   (B) the resident or legally authorized representative consents to the disclosure orally and the consent is documented by a certified ombudsman, in writing, at the time the oral consent is given; or
   (C) the disclosure is required by court order.
(2) A AAA may disclose the identity of a person who files a complaint only if:
   (A) the complainant, or legally authorized representative of the complainant, consents to the disclosure in writing;
   (B) the complainant, or legally authorized representative, consents to the disclosure orally and the consent is documented by a certified ombudsman, in writing, at the time the oral consent is given; or
   (C) the disclosure is required by court order.
(3) A AAA must disclose Long-Term Care Ombudsman Program information, other than the information described in paragraphs (1) and (2) of this subsection, in accordance with Texas Government Code, Chapter 552 (the Public Information Act).

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

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

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

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

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

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

(r) **Representatives of the Office.** In accordance with Texas Human Resources Code, §101A.251(4), DADS designates the following persons as representatives of the Office:
(1) staff persons of the Office;
(2) certified ombudsmen; and
(3) ombudsman interns.
(s) **Contractor compliance.** If a AAA contracts with a nonprofit organization as described in subsection (b) of this section, the AAA must ensure that the organization complies with the requirements for a AAA described in this section.

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

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

**Ombudsman References:**

Excerpts from Nursing Facility Requirements for Licensure and Medicaid Certification

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

Subchapter B, **Definitions**

§19.101 Definitions  
The following words and terms, when used in this chapter, shall have the following meanings, unless the context clearly indicates otherwise.  
(92) **Ombudsman** — An advocate who is a certified representative, staff member, or volunteer, of the DADS Office of the State Long Term Care Ombudsman.

Subchapter E, **Resident Rights**

§19.403 Notice of Rights and Services  
(a) The facility must inform the resident, the resident's next of kin or guardian, both orally and in writing, in a language that the resident understands, of the resident's rights and all rules and regulations governing resident conduct and responsibilities during the stay in the facility. This notification must be made prior to or upon admission and during the resident's stay if changed.  
(b) The facility must also inform the resident, upon admission and during the stay, in a language the resident understands, of the following:  
(4) a written description of the services available through the DADS Office of the State Long Term Care Ombudsman. This information must be made available to each facility by the ombudsman program. Facilities are responsible for reproducing this information and making it available to residents, their families, and legal representatives; and
§19.413 Access and Visitation Rights
   (a) A resident has the right to have access to, and the facility must provide immediate access to a resident to, the following:
      (4) a representative of the Office of the State Long Term Care Ombudsman (the Office), as described in §85.401(r) of this title (relating to Long-Term Care Ombudsman Program);
   (b) A facility must provide reasonable access to a resident by any entity or individual that provides health, social, legal, or other services to the resident, subject to the resident's right to deny or withdraw consent at any time.
   (c) A facility must allow a certified ombudsman, as defined in §85.2 of this title (relating to Definitions), and a staff person of the Office access:
      (1) to the medical and social records of a resident, including an incident report involving the resident, if the certified ombudsman or staff person of the Office has the consent of the resident or the legally authorized representative of the resident;
      (2) to the medical and social records of a resident 60 years of age or older, including an incident report involving the resident, in accordance with the Older Americans Act, §712(b); and
      (3) to the administrative records, policies, and documents of the facility to which the facility residents or general public have access.

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

§19.502 Transfer and Discharge in Medicaid-Certified Facilities
   (f) Contents of the notice. For nursing facilities, the written notice specified in subsection (d) of this section must include the following:
      (5) the name, address, and telephone number of the regional representative of the Office of the State Long Term Care Ombudsman, Texas Department on Aging, and of the toll-free number of the Texas Long Term Care Ombudsman, 1-800-252-2412;

Subchapter T, Administration

§19.1923 Incident or Accident Reporting
   (e) The facility must make incident reports available for review, upon request and without prior notice, by representatives of DHS, the U.S. Department of Health and Human Services, if applicable; and the Texas Department of Protective and Regulatory Services. Reports related to specific incidents must be available to the designated regional staff ombudsman, Office of the State Long Term Care Ombudsman, Texas Department on Aging.

Subchapter U, Inspections, Surveys, and Visits

§19.2002 Procedural Requirements - Licensure Inspections and Surveys
   (f) Persons authorized to receive advance information on unannounced inspections include:
      (2) representatives of the Texas Department of Aging serving as ombudsmen or authorized to attend or participate in inspections;
   (g) DHS will conduct at least two unannounced inspections during each licensing period of each institution licensed under Health and Safety Code, Chapter 242, except as provided for in this subsection.
For at least two unannounced inspections each licensing period, DHS will invite to the inspections at least one person as a citizen advocate from the American Association of Retired Persons, the Texas Senior Citizen Association, the Texas Retired Federal Employees, the Texas Department on Aging Certified Long Term Care Ombudsman, or any other statewide organization for the elderly. DHS will provide to these organizations basic licensing information and requirements for the organizations' dissemination to their members whom they engage to attend the inspections. Advocates participating in the inspections must follow all protocols of DHS. Advocates will provide their own transportation. The schedule of inspections in this category will be arranged confidentially in advance with the organizations. Participation by the advocates is not a condition precedent to conducting the inspection.

**Subchapter BB, Preadmission Screening and Resident Review**

§19.2703 Definitions

(29) **PASRR determination** — A decision made by DADS, DSHS, or their designee regarding an individual's need for nursing facility specialized services, LIDDA specialized services, and LMHA specialized services, based on information in the PE; and, in accordance with Subchapter Y of this chapter (relating to Medical Necessity Determinations), whether the individual requires the level of care provided in a nursing facility. A report documenting the determination is sent to the individual and LAR.

§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;
2. allow access to designated residents to support educational activities about community living options arranged by the LIDDA; and
3. provide a designated resident with adequate notice and assistance to be prepared for and participate in scheduled community visits.

**Excerpts from Licensing Standards for Assisted Living Facilities**

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

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

(a) Resident's bill of rights.

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

(AA) have access to the service of a representative of the State Long Term Care Ombudsman Program, Texas Department on Aging;
§92.127 Required Postings
Each facility must prominently and conspicuously post for display in a public area of the facility that is readily available to residents, employees, and visitors: (7) the telephone number of the Office of the State Long Term Care Ombudsman.

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

§92.801 Access to Residents and Records by the Long-Term Care Ombudsman Program
(a) A resident has the right to be visited by, and a facility must provide immediate access to any resident to:
(1) a staff person of the Office of the State Long-Term Care Ombudsman (the Office) employed by DADS;
(2) a certified ombudsman; and
(3) an ombudsman intern.
(b) A facility must allow a certified ombudsman and a staff person of the Office access:
(1) to the medical and social records of a resident, if the certified ombudsman or the staff person has the consent of the resident or the legally authorized representative of the resident;
(2) to the medical and social records of a resident 60 years of age or older, in accordance with the Older Americans Act, §712(b); and
(3) to the administrative records, policies, and documents of the facility to which the facility residents or general public have access.
CHAPTER 2: Aging and Residents
Aging and Residents

Chapter 2 provides basic information about aging, demographic information, and dispels some myths and stereotypes about aging. Chapter 2 also provides training on person-centered care to people with dementia.

Learning Objectives

- Become aware of the continuous process of aging
- Discover your attitudes about aging
- Understand common myths and stereotypes as well as facts about residents and aging
- Prepare to take a person-centered approach in advocating for residents with dementia

Contents

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

DVD(s), Supplements, Forms

- DVD: CMS Hand in Hand Training Module 1: Understanding the World of Dementia: The Person and the Disease
The Physical Aging Process

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

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

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

- **Heart**: The heart muscle thickens with age as a response to the thickening of the arteries. This thicker heart has a lower maximum pumping rate, and the body’s ability to extract oxygen from blood diminishes with age.
- **Immune system**: T cells take longer to replenish in older people and their ability to function declines.
- **Arteries**: Arteries usually stiffen with age. In turn, the older heart needs to supply more force to propel the blood forward through less elastic arteries.
- **Lung**: The maximum breathing (vital) capacity of the lungs may decrease as much as 40% between 20 – 70 years of age.
- **Brain**: As the brain ages, some connections between neurons seem to be reduced or less efficient. This is not yet well understood.
- **Kidney**: Kidneys gradually become less efficient at cleaning waste from the blood.
- **Body fat**: Body fat gradually increases until middle age and then in late life body weight tends to decrease. With age, body fat redistributes in the body, shifting from just beneath the skin to deeper organs.
- **Muscle**: Muscle tone declines about 22% by age 70. Exercise can slow this rate of loss.
- **Bone**: Bone mineral is lost and replaced throughout life. Around age 35, loss begins to outstrip replacement. Regular weight bearing exercise, such as walking, running, and strength training can slow bone loss.
- **Sight**: Starting in the 40s, difficulty focusing close up may begin. From age 50, susceptibility to glare, greater difficulty in seeing at low illumination levels, and more difficulty in detecting moving objects increases. Ability to distinguish fine details may begin to decline in the 70s.
- **Hearing**: It becomes more difficult to hear high frequencies. Even with good hearing, older adults may have difficulty understanding speech especially where there is background noise. Hearing declines more quickly in men than in women.
Describe one physical change associated with aging.

If you met someone like …

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

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

Attitudes about Aging

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

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

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

True (T) or False (F)
__ 1. The majority of adults over 65 have memory loss, disorientation, or dementia.
__ 2. All five senses tend to decline in old age.
__ 3. Lung capacity tends to decline in old age.
__ 4. Physical strength tends to decline in old age.
__ 5. Older adults have no interest in sexual relations.
__ 6. Older drivers have fewer accidents per person than drivers under age 65.
__ 7. Older workers are less effective than younger workers.
__ 8. About 80% of older adults are healthy enough to carry out normal activities.
__ 9. Older adults are set in their ways and unable to change.
__ 10. Older adults usually take longer to learn something new.
__ 11. Most older adults’ reaction time tends to be slower than younger adults.
__ 12. It is almost impossible for most older adults to learn new things.
__ 13. In general, most older adults are much alike.
__ 14. Older workers have fewer accidents than younger workers do.
__ 15. The majority of older adults are socially isolated and lonely.
__ 16. Over 20% of the U.S. population is now aged 65 or over.
__ 17. Most medical professionals tend to give low priority to older adults.
__ 18. The majority of older adults have incomes below the poverty level.
__ 19. The majority of older adults work or would like to do some kind of work, including volunteering.
__ 20. In the U.S., families provide about 80% of the care for older family members.
__ 21. People tend to become more religious as they age.
__ 22. Most American workers receive private pensions and Social Security when they retire.
Exercise: Choice or Restriction

List three morning activities you routinely do.

1. ________________________________

2. ________________________________

3. ________________________________

How might you feel if others changed your routine? ________________________________

True (T) or False (F):

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

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

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

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

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

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

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

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

____________________________________________________________________________

____________________________________________________________________________

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

____________________________________________________________________________

____________________________________________________________________________

____________________________________________________________________________

____________________________________________________________________________

____________________________________________________________________________

____________________________________________________________________________

____________________________________________________________________________
If you met someone like …

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

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

Demographic Information on Older Adults

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

![Figure 1: Number of Persons 65+, 1900 to 2060 (numbers in millions)](image)

The 65+ population totaled 44.7 million in 2013.
- One person in every seven people is an older adult.

The 65+ population is projected to increase from 44.7 million in 2013 to 98.2 million in 2060.
- The 85+ population is projected to grow from 6 million in 2013 to 14.1 million in 2040.
- Minority populations are projected to increase from 9.5 million in 2013 to 21.1 million in 2030.
Average life expectancy after reaching age 65 is another 19.3 years.

- 20.5 years for females and 17.9 years for males.

In 2013, 25.1 million older women outnumber 19.6 million older men.

- 72% of older men are married, while 46% of older women are married.
- About 28% (8.8 million women, 3.8 million men) of older adults live alone.

Median income of older adults in 2013 was $29,327 for males and $16,301 for females. Their major sources of income in 2013 were:

- Social Security (86%)
- Private pensions (27%)
- Income from assets (51%)
- Government employee pensions (14%)
- Earnings (28%)

Over 4.2 million older adults (9.5%) were below the poverty level in 2013.

SOURCE: Administration on Aging prepared A Profile of Older Americans 2014

Nursing Homes and Assisted Living Facilities

While a small number (1.5 million) and percentage (3.4%) of the 65+ population lived in nursing homes in 2013, the percentage increases dramatically with age.

- 1.0% for people 65-74
- 3.0% for people 75-84
- 10.0% for people 85+

SOURCE: Administration on Aging prepared A Profile of Older Americans 2014

No national standards exist for assisted living services and settings. Limited national statistics about people living in assisted living are available in the 2010 Centers for Disease Control and Prevention, National Center for Health Statistics survey of residential care facilities.

In Texas, about 93,000 people live in nursing homes on any given day and about 41,000 people live in assisted living facilities.

SOURCE: Regulatory Licensing and Certification July 2015

What percentage of adults age 65+ live in nursing homes? __________
If you met someone like …

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

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

Fourteen Myths and Stereotypes about Older Adults

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

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

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

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

Reality: Chronic conditions, such as arthritis and diabetes, usually begin in middle age and worsen with age. Disabilities have many causes and can be influenced by diet, exercise, and lifestyle. Older adults do not suddenly become sick just because they age.

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

Reality: Adults remain adults and want to be treated as such.
Why might older adults disengage from their community?

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

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

Myth 5: Older adults are unproductive.

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

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

Myth 6: Sexual function ceases in old age.

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

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

Reality: “Senility” is one of the most misused words to describe older adults; it has little meaning. Similarly, “Alzheimer’s” has become a general term used to
describe all types of memory loss that may have different causes and different intervention strategies. Dementia prevalence increases with age, from 5% of people aged 71–79 years to 37% of those aged 90 and older.


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

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

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

Reality: Three reasons make health deterioration or decline unavoidable:

1. New disease or condition, such as heart disease
2. Disease progression, such as the medicine for Parkinson’s no longer works and the person loses mobility
3. Choosing to refuse treatment or care

One reason a person’s decline in health might be unavoidable is if _______________________________________________________.

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

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

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

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

Another term for “bed sore” is pressure _____________.

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

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

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

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

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

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

* A physical restraint is "any manual method or physical or mechanical device, material, or equipment attached or adjacent to the individual’s body that the individual cannot remove easily which restricts freedom of movement or normal access to one's body." A chemical restraint is defined as "any drug that is used for discipline or convenience and not required to treat medical symptoms." (SOM – CMS Appendix PP Guidance to Surveyors)
Using a restraint on a person puts them at risk of serious ______________ and death.

If you met someone like …

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

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

Exercise: Your Perfect Long-term Care Home

If you became unable to care for yourself in your private home, describe the home in which you would want to live and how staff will care for you.
Hand in Hand training was created by the Centers for Medicare and Medicaid Services (CMS) to provide long-term care providers training. It shows staff how to provide person-centered care to residents with dementia and how to prevent and report abuse.

Ombudsmen should keep in mind the information presented in Hand in Hand is created for facility staff, but the principles can be applied to ombudsman work. For ombudsmen, special considerations apply to allegations of abuse, neglect, and exploitation and these are addressed in Chapter 4.

Dementia is considered a late-life disease because it tends to develop mostly in older people. People in their 30s, 40s, or 50s can have dementia but it is less common. At Age 65, about 5-8% of people have some form of dementia; this number doubles every five years above that age. There are currently more than 5 million people in the U.S. living with Alzheimer’s disease and other forms of dementia, and prevalence is expected to triple over the next 40 years.

Dementia is a term that describes a wide range of symptoms associated with a decline in memory and at least one other thinking skill such as concentration, language, judgment, sequencing, visuospatial skills, and orientation. The actions and reactions of a resident with dementia are related to one or more of these challenges.

Answer the following questions about CMS Hand in Hand Module 1, Understanding the World of Dementia: The Person and the Disease

1. Define dementia: ________________________________________________________________

2. Who gets dementia?

   ________________________________________________________________

   ________________________________________________________________

   ________________________________________________________________
3. Identify three of the seven symptoms of dementia:

____________________________________________________________________________
____________________________________________________________________________
____________________________________________________________________________

4. Identify two irreversible types of dementia:

____________________________________________________________________________
____________________________________________________________________________

5. Identify two other conditions that might have symptoms that can look like dementia:

____________________________________________________________________________
____________________________________________________________________________

6. List three conditions that may worsen symptoms of dementia:

____________________________________________________________________________
____________________________________________________________________________
____________________________________________________________________________
Notes:
Notes:
CHAPTER 3: Communication and Consent
Communication and Consent

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

Learning Objectives

- Recognize the importance of active listening
- Understand the difference between empathy and sympathy
- Develop a protocol for communicating with residents
- Learn strategies for successful communication and observation during a facility visit
- Understand consent and confidentiality requirements for ombudsmen

Contents

- Communication Basics
- Communicating with Residents
- Consent

DVD(s), Supplements, Forms

- DVD: RSA Short: The Power of Empathy
- DVD: CMS Hand in Hand Training Module 3: Being with a Person with Dementia: Listening and Speaking
Communication Basics

Communication is a four step process.

- Message is sent.
- Message is received.
- Sender gets feedback.
- Another message is sent.

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

Verbal communication includes

- Tone of voice
- Word choice

Nonverbal communication (examples)

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

Listening

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

Active listening is the act of hearing what the other person is saying and responding both to the content and feeling of what is being said.

Goals for active listening are:

- Give the person your full attention.
- Be patient.
- Focus your energy on the conversation. Don’t let your thoughts stray.
- Be sincerely interested in what the other person is talking about.
- Listen for the intent and feeling of what is being said as well as the words.
• Restate what you heard the person say.
• Validate what the person said.
• Ask questions to clarify.
• Be aware of your own feelings and opinions.
• State your views only after you listen.
• Address inconsistencies in nonverbal and verbal messages.

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

Active listening requires concentration and sincerity. One goal is to hear what the person says by listening for the intent and ________ of what is being said as well as the words.

Empathy

Empathy requires an ombudsman to not only understand residents’ situations but also to relate to their feelings. Even if you are a naturally caring person, empathy can get lost in the process of “getting the job done,” particularly when the focus is on facts, not emotions.

RSA Short - The Power of Empathy
Run Time: 2 min 51 sec

Watch the RSA Short – The Power of Empathy and answer the following questions.

1. What is the difference between empathy and sympathy? ________________________________

2. What are three qualities of empathy?
   a) Ability to recognize the individual’s perspective as his or her truth.
   b) ________________________________
   c) ________________________________
Listening Skills Assessment

Most people believe they are good listeners without considering the important differences between hearing and listening. Listening means paying attention and making a conscious effort to process what you hear. It is one of an ombudsman’s most important skills. Are you a thoughtful, actively-engaged listener? Assess your listening skills using the exercise below.

Exercise: Rate Your Listening Skills

Take the listening skills assessment. It will give you an idea of which listening habits you might want to reshape. Think about how you listen and rank your behavior frequency in the list below with a 1, 2, 3, 4, or 5. Total the numbers for your score.

1 – Rarely        2 – Occasionally        3 - Neutral        4 - Fairly often        5 - Frequently

___ Talking too much, not giving the other person a chance to talk
___ Interrupting others when they are talking
___ Not looking at the person talking
___ Fidgeting with pencil and paper, tapping your legs, etc. when someone is talking
___ Having a “poker face,” blank look, or manner which makes it difficult for another to know if you are listening
___ Trying to do other things while another is talking
___ Letting emotional-laden words arouse personal ill feelings
___ Daydreaming or thinking about other things while another is talking
___ Blaming the speaking habits or mannerisms of another
___ Finishing the other person’s statements
___ Drawing conclusions about the subject before actually listening to it
___ Cleaning fingernails, glasses, etc. while the other person is talking
___ Listening only to the facts being said, not to emotional aspects
___ Sitting too close, being in another’s personal space
___ Looking frequently at your watch or clock while another is talking
___ Letting your feelings get in the way while listening
___ Asking many questions while another is talking

___ **Total score**

*(The lower the score, the better listener you are. If your score is high, you need to work on your listening skills.)*
How can you improve your listening skills? Practice. Start with the easiest habit to improve. For example, if you are prone to interrupting others, be slow to speak. Practice actively repeating what is being said to you as the speaker is speaking.

**Communicating with Residents**

Each individual who lives in an assisted living facility or a nursing home is unique in physical, mental, and psychosocial capacity. For an individual who has physical and mental challenges, communication can be difficult.

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

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

**General Communication Etiquette**

Focus on People First

- Think of the person first, not his or her disability or diagnosis.
- Assume the person has capacity to understand.
- Treat adults as adults.
- When other people are around, speak directly to the resident and not to the friend, companion, or interpreter who may be present.
- Avoid showing pity or being patronizing. Don’t pat hands or use endearments such as ‘honey’.
- Do not pet a service animal or make it the focus of conversation.
- Address people with disabilities by their first name only when extending the same familiarity to all others.
- Offer assistance completing forms or understanding written instructions and provide extra time for decision-making. Wait for the individual to accept the offer of assistance; do not "over-assist".

The Power of Attitude - Your Approach

- Approach residents from the front or within the line of vision.
- Before speaking, have the person’s attention.
- Smile and use a friendly voice and expression.
• Respect personal space.
• Be on the same level whenever possible.
• Respect all assistive devices such as canes, wheelchairs, crutches, and communication boards as personal property. Unless given permission, do not move, touch, or use them.
• If people have trouble shaking hands with the customary right hand, shake with your left or follow their lead on another greeting.
• Culture impacts communication too. Be aware of your cultural background, and the other person’s, as you respond to verbal and nonverbal communication.

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

Tips for Communicating with a Resident Who…

Appears Non-responsive
• Assume the individual has the capacity to understand and the ability to hear.
• Explain who you are and what an ombudsman is.
• Try to include the resident who appears non-responsive in the conversation, particularly if others are in the room.
• Use your “in plain sight” observational skills to determine if there are any environmental or care issues.

Appears Agitated
• Approach the resident from the front. It may startle and upset him if you touch him unexpectedly or approach him from behind.
• Act calmly; it can reduce agitation. Avoid quick, sudden, or erratic moves.
• Use short, clear, and concrete statements. Give step-by-step instructions.
• Never argue or try to reason with the person.
• Be alert for ways to gently change the subject, reduce the intensity of resident reaction, or remove yourself from the exchange.
• Ask staff for help to determine if the resident has an unmet need. The resident may be thirsty, tired, or in pain.
• Do not continue to try to calm a resident who is agitated. Ask staff for help.
• Keep out of striking distance. Never strike back.
Has Speech Impairments

- Be patient. Take as much time as necessary.
- Try to ask questions which require only short answers or a nod of the head.
- Concentrate on what the individual is saying.
- Do not speak for the individual or attempt to finish her or his sentences.
- If you do not understand something the individual says, do not pretend that you do. Ask the individual to repeat what he or she said and then repeat it back.
- Ask if the resident has a communication device.
- Consider writing as an alternative means of communicating, but first ask the individual if this is acceptable.

Aphasia is a communication disorder that results from damage or injury to language parts of the brain. It's more common in older adults, particularly those who have had a stroke.

Aphasia impairs a person's ability to use or understand words. Aphasia does not impair the person's intelligence. People who have aphasia may have difficulty speaking and finding the "right" words to complete their thoughts. They may also have problems understanding conversation, reading and comprehending written words, writing words, and using numbers.

Has Visual Impairments

- Speak to the resident when you approach.
- Identify yourself and anyone who accompanies you.
- If in a group, indicate whom you are addressing when you speak.
- Encourage and communicate using whatever vision remains.
- Leave things where they are unless the person asks you to move something.
- Allow the person to negotiate the surroundings, such as finding the door handle or locating a chair.
- You may offer assistance, but wait until your offer has been accepted. Then, ask for instructions on how you can help.
- Explain what you are doing as you are doing it.
Has Hearing Impairments

- Approach from the front or within the line of vision.
- Face the person. Maintain eye contact.
- Greet the person as you normally would.
- Lower the pitch of your voice and speak slowly.
- Speak normally. Do not shout or raise your voice unless asked to do so.
- Use simple, short sentences.
- Reduce or eliminate background noise.
- Be prepared to repeat what you say, orally or in writing. Consider writing messages.
- Minimize hand movements and keep your hands away from your face.

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

- Ask if the person reads lips, has a hearing device, has an assistive device, or prefers written communication.
- Use a picture or communication board.
- Use nonverbal communication and gestures.
- Seek help from an interpreter if the person signs.
- Don't interrupt or appear impatient.
- Help end the conversation if needed.

Who Does Not Speak English

- If you speak a resident's preferred language, use that language as much as possible.
- Learn a few words of the resident’s native language, such as good morning, hello, and thank you. Address the resident by their proper name, such as Señora Chavez.
- Use gestures and nonverbal cues to help the person understand your meaning.
- Use a communication board or a free application on your phone, such as Google Translate or iTranslate.
- Ask the resident if there is someone on staff, a family member, or another resident that the resident trusts to translate for you.
- Have Spanish ombudsman cards and brochures available, and provide to residents whose preferred language is Spanish.
• Ask if the facility has a handheld translation device, and request to use it.
• Know your local resources for in-person and telephone language services.
• If options above are not sufficient, use a translator.
• When using a translator, direct questions to the resident. Make eye contact with the resident, observe the resident’s nonverbal communication, and listen.

Has Limited Mobility

• If talking with people using a wheelchair for any length of time, try to place yourself at their eye level.
• Do not lean on a wheelchair or any other assistive device.
• Respect all assistive devices such as canes, wheelchairs, crutches, and communication boards as personal property.
• Never patronize people who use wheelchairs by patting them on the head or shoulder.
• You may offer to assist a person with a disability, but wait until your offer has been accepted. Then, ask for instructions on how you can best assist. For details on appropriate ombudsman activities, see Chapter 6.

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

Has Memory Loss

• Assume the person has the capacity to understand.
• Approach from the front and respect personal space.
• Avoid quick, sudden, or erratic moves.
• Face the person. Maintain eye contact. Smile.
• Greet the person as you normally would.
• Speak softly. Be calm and reassuring.
• Speak slowly. Ask simple “yes” or “no” questions.
• If you are in a public area with many distractions, consider moving to a quiet or private location.
• Take time to understand the individual and make sure the individual understands you.
• Don’t correct mistakes made by the person. Be sensitive to the resident’s reality and allow it to be what it is.
• Be patient, flexible, and supportive.
Dementia is a progressive decline in memory and at least one cognitive area such as abstract thinking, attention, personality, and judgment. Brain damage as a result of head injury or disease such as alcoholism, Alzheimer's disease, or Parkinson's disease may cause dementia.

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

CMS Hand in Hand Training - Module 3: Being with a Person with Dementia: Listening and Speaking
Run Time: Approximately 1 hour to view video clips and discuss

Just as staff experience frustration trying to understand what a resident with dementia is trying to communicate, the resident experiences frustration with their communication challenges.

Communicating with people with dementia involves more than words. It involves understanding the meaning and feeling behind what they are saying, so that we can respond to their emotions and fulfill their needs.

Answer the following questions about CMS Hand in Hand Module 3.

1. Because communication can be difficult for an individual with dementia, we have to learn to look for the meaning in ___________ and nonverbal communication.

2. Identify three ways memory loss affects how an individual with dementia communicates:

(1) ________________________________
(2) ________________________________
(3) ________________________________
3. In *Good Morning Video Clip 1*, what did you notice about Mrs. Caputo’s communication?

___________________________________________________________________

___________________________________________________________________

4. In *Good Morning Video Clip 1*, what did you notice about how Jane communicated with Mrs. Caputo?

___________________________________________________________________

___________________________________________________________________

5. In *Good Morning Video Clip 2*, what did you notice about Mrs. Caputo’s communication? How was she communicating?

___________________________________________________________________

___________________________________________________________________


___________________________________________________________________

___________________________________________________________________

Communication Methods

The following communication methods are tried and true and help build trusting relationships:

1. Always respect the rights and dignity of each resident.
2. Remember their room is their home.
   - Knock on doors and receive permission before entering.
   - Try to sit at eye level and sit where offered.
   - Respect privacy by offering to close the door.
   - Excuse yourself if care or services are needed and never interrupt a resident who is receiving care. Closed doors often signal that care is being provided.
3. Begin with a proper introduction, addressing residents as the adults they are.
   - Greet by Mr., Mrs., or other title and given name, unless they suggest another name.
- Avoid using words that are too simple.
- Avoid using overly complicated words and acronyms.
- Adapt your conversation to the resident’s level of understanding.

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

5. Request permission to talk.
   - “Is now a good time to talk?”
   - “Do you feel like talking?”

---

Exercise: Instructor Demonstrates an Introduction

Think about how you will introduce yourself when you meet a resident for the first time. Your instructor will demonstrate. Answer the following questions.

1. How did the ombudsman describe the role of the ombudsman?

2. What listening techniques were used?

3. What will you say when you introduce yourself to residents and staff? Create your own introduction. Practice introductions with your instructor and other trainees.

6. Keep an open body posture. Open posture is often perceived as communicating a friendly and positive attitude (uncrossed arms and leg, head upright). Establish a level of verbal warmth and trust. Be attentive and let them know you are interested.
   - Do not be in a rush to discover issues; use small talk to establish rapport, such as “Are you from this area? What caused you to move here? Do you have family around here? Are these pictures of your family?”
   - Allow the conversation, whenever possible, to go where the resident wishes. Gently look for openings to address potential issues. Don’t rush!
• Let residents set the pace of the conversations.
• Resist the impulse to talk rather than listen.

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

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

8. Discover residents’ support systems.
• Ask about contacts with family, friends, and other visitors.

9. Explore their personal history.
• Without prying, discover residents’ personal interests and life history.
• Mention interests you have in common to build rapport.

10. Discuss the history of their stay.
• After developing rapport, talk about their feelings about living in the nursing home or assisted living facility. (Gather information through conversation to find out what it’s like to live there.)
• Ask specific questions that may give clues to their feelings about where they live, such as “Does everyone here treat you well? Do you feel safe? Do you have family that visits? Do you ever feel lonely? How do staff members respond to your requests for help?”
• If they express dissatisfaction about their life in the facility, probe for more information.
• Listen carefully. Write down important information to remember. Ask permission to take notes or make notes later in a private place.
• Observe residents. Are they nervous or shaking? Do they cry easily or get angry? Do they appear fearful of being overheard by staff?
• Pursue concerns; do not ignore concerns that residents share.

11. Ask for permission before you talk to anyone about a complaint. This is also called “obtaining consent.”
• Explain the reason you want to talk with someone else and who it is.
12. Do not undermine your trusting relationship with a resident.
   • Do not ask questions of facility staff or take action that is inconsistent with resident wishes.
   • When you feel conflicted about your role, consult your supervising staff ombudsman.
   • Maintaining confidentiality is the foundation of your integrity.

13. Respect confidentiality; protect resident identity if they ask you. Complaints can be investigated and resolved without using a resident’s name. Some complaints affect several people in the facility.

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

Read how Resident Councils may be a good resource for resolving problems on behalf of residents in Chapter 7.

15. Be honest and direct about your intentions. Explain any risks involved in any course of action.

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

17. Avoid making promises in general about what you will accomplish.

18. Be patient, dependable, and honest.
Communication During a Facility Visit

When you enter a facility:

- Let staff know you are there to visit residents.
- Wear your ombudsman badge and lanyard so that residents, residents’ family, and staff can easily identify you as an ombudsman.
- Introduce yourself to new staff but keep your visit resident-focused.
- It is not a requirement for ombudsmen to sign the facility’s visitor log at each visit. If you have questions about a facility’s request that you sign-in at each visit, please consult your supervising staff ombudsman.
- Optional: Request the facility census (roster). You can request a list of residents by room number or by name. Ask if there are any new residents. As you visit with residents, place a check next to their name on the census to identify how many residents you visited. This is a confidential document that becomes an ombudsman record and must be safeguarded from release.

Visit with multiple residents

- If you are assigned a large facility with many residents, visit as many residents as time allows.
- Vary the residents you visit. Ensure all residents have access to the ombudsman.
- Make an effort to meet with new residents and families to share information concerning the ombudsman program and residents’ rights.
- Offer residents privacy for confidentiality in communication.

See Chapter 6 Facility Visit Guide for more information on facility visits.

Consent

Consent is required from a resident or complainant to:

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

Regardless of the source of a complaint (complainant), ombudsmen serve the resident. Offer privacy options to the resident for conversations involving complaints. Personally discuss the complaint with the resident to determine the resident’s perspective and wishes regarding resolution. Before taking any action, communication of informed consent is required from the resident. Unless a court has ruled the resident is incapacitated, the resident speaks for himself or herself.
Informed Consent

Communication of informed consent (from a resident or others) means ombudsmen:
- explain the ombudsman role;
- clarify their understanding of the resident’s problem or request;
- explain the resident’s rights;
- describe what actions can be taken;
- discuss possible outcomes or consequences, as needed;
- get direction from the resident on how to proceed; and
- receive voluntary communication of consent.

Communication of Consent

Consent may be given in writing, orally, or visually, including through the use of auxiliary aids and services such as an interpreter or electronic communication device. For all situations where consent is obtained, permission applies to the immediate case or request and does not extend to future work. A resident may withdraw consent at any time and that stops the ombudsman’s actions.

Consent is required for an ombudsman to work on a resident’s ____ ________, reveal a resident’s or complainant’s name, or access a resident’s record or other ________________ information.

Examples of how to ask for consent include:
- Would you like me to handle this concern or would you like to handle it on your own?
- Is it okay to use your name or would you prefer to be anonymous?

The ombudsman’s role is not to determine a resident’s capacity to make decisions. If you have concerns and are uncertain how much help you should give someone, consult your supervising staff ombudsman or MLO. Remember the resident keeps the right to make decisions unless a court has decided the person is incapacitated. Consult your supervising staff ombudsman if the resident:
- cannot remember you from visit to visit (you, not your name);
- has fixed, obsessional thoughts;
- is not able to understand, appreciate, and manipulate information; or
- displays unpredictable emotions.
The Ombudsman as the Complainant

If an ombudsman determines a concern impacts several residents, the ombudsman can open a complaint with the ombudsman as the complainant. In this case, the ombudsman does not identify specific residents. If an ombudsman plans to file a complaint contrary to the original resident’s wishes, notify the resident of this decision and inform the resident that his or her identity will not be revealed.

If Resident is Unable to Communicate Consent

When a resident is unable to consent, an ombudsman seeks consent from a legally authorized representative (LAR) if one exists. An LAR may be a guardian or power of attorney.

If Resident is Unable to Communicate Consent and Has No LAR

If the resident is unable to consent and there is no LAR, a consultation with the SLTCO is required.

- The ombudsman consults with the supervising staff ombudsman or MLO. Staff or MLO consult the SLTCO.
- SLTCO approval is required before any action is taken or information is disclosed.
- The SLTCO considers information about a resident’s advanced directives or previously expressed wishes to make a decision. Both ombudsmen and facility staff need to know if advanced directives are on file at the facility or if the resident’s previously expressed wishes are contrary to the action under consideration.

Consent Documentation

Ombudsmen must document consent. Use release forms, case notes, or monthly reports to document consent. Your supervising staff ombudsman will provide these items. More information about consent forms, case notes, and monthly reports is provided in Chapters 11 and 12.

Guardian (of the Person)

Confirm with facility staff or the guardian that there are current letters of guardianship of the person in the medical records. Review the documents to determine scope of the
guardian’s authority. Work with the guardian, who speaks for the resident and may consent on the resident's behalf, per the court orders. If a complainant is someone other than the guardian and the guardian does not consent, consider if the guardian is acting in the resident's best interest. Residents with a guardian may be a complainant too. If you believe the guardian is not acting in the person's best interests, an ombudsman must obtain approval from the State Long-term Care Ombudsman to take action on behalf of the resident.

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

Unless a court rules a resident is ________________, a resident speaks for himself or herself.

Powers of Attorney

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

A durable power of attorney (DPOA) takes effect in accordance with the terms of the DPOA document. Depending on how the document is written, the agent may exercise authority when the resident is able to make decisions, when the resident is incapacitated, or both. Determining the resident’s incapacity may be established in the language of the DPOA, but not always. Revocation of a DPOA is not addressed in law and if the DPOA document does not address revocation, the resident can revoke either orally or in writing as with an MPOA. Coordination or consultation with the DPOA is not required; follow the resident’s direction. More information on revocation of Powers of Attorney is detailed in Chapter 8: Care Planning.

Consent to Work on a Resident or Complainant's Behalf

A resident or complainant must provide consent for an ombudsman to work on the resident's behalf. If the complainant is not a resident, seek agreement from the resident to work on the issue.
If the resident declines consent, the resident’s wishes supersede the complainant’s and an ombudsman may:

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

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

Consent to Reveal Identity

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

In practice, a facility staff person may speculate about the identity of a resident or complainant. Without consent of the resident or complainant, do not confirm such speculation. Instead, redirect the conversation to information that is relevant and not confidential. If necessary, inform facility staff of the long-term care ombudsman program’s confidentiality law or inform staff that the question arises from the ombudsman, rather than a resident or other complainant.

Ask the trainer. Discuss the following situations with your instructor.

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

- How does the ombudsman decide whom to represent? ____________________

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

2. A resident with dementia has no legal representative. Some of her actions lead the ombudsman to wonder if her care plan needs updating.

- What is the role of the ombudsman? ____________________

- What authority, if any, does an ombudsman have to seek changes for a resident? ____________________

3. A facility asks the ombudsman what to do about a resident they are discharging.

- What is appropriate for the ombudsman to say and do? ____________________

- What should the ombudsman avoid doing? ____________________

- How does the facility’s request for help affect the ombudsman’s actions? ______

- Will the ombudsman instill trust in other residents if he or she helps facility staff in discharging the resident? ____________________

4. A resident tells you that her breakfast is always served with coffee, instead of hot tea which she has requested multiple times. You visit with the administrator about the resident’s breakfast drink preference and will watch meal service several times during the next month. Did you have consent to work the complaint?

- Yes (Y) or No (N)
Facility staff might guess who lodged a complaint. Without the complainant’s permission, do not confirm.

Consent to Access Confidential Information

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

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

Under the HIPAA Privacy Rule, a long-term care ombudsman program is a “health oversight agency.” Therefore, it does not prevent releasing resident clinical records to ombudsmen. If an ombudsman has proper consent, facilities must share information. This action does not violate HIPAA.

In anticipation of any questions of your authority, be prepared with applicable law and rules. If facility staff denies access, consult your supervising staff ombudsman. Chapter 12 describes the process for obtaining consent to access a resident record. Consent to access confidential information may be documented. For more information, see Chapter 12 and Supplements 12-B Form 8624-O (oral) and 12-C Form 8624-W (written), Consent to Release records to the Certified Ombudsman.

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

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

HIPAA applies to _______________________.

Older Americans Act applies to _______________________.

___________________

___________________________________________________

___________________

___________________
CHAPTER 4: Abuse, Neglect, and Exploitation
Abuse, Neglect, Exploitation (ANE)

Chapter 4 provides an understanding of the Texas Long-term Care Ombudsman Program response to abuse, neglect, and exploitation. This chapter also reviews advocacy reporting policies and strategies.

Learning Objectives

- Define abuse, neglect, and exploitation (ANE)
- Learn to identify types of abuse
- Understand a long-term care ombudsman’s reporting and advocacy responsibilities related to ANE

Contents

- Abuse, Neglect, Exploitation
- Facility Responsibilities
- Who Investigates ANE?
- ANE Guidelines for Ombudsmen

DVD(s), Supplements, Forms

- DVD: CMS Hand in Hand Training Module 2: What is Abuse?
- DVD: CMS Hand in Hand Training Module 5: Preventing Abuse
Overview

This chapter examines how to recognize abuse, neglect, and exploitation (ANE) and reviews an ombudsman’s reporting responsibilities. Federal requirements related to ANE and disclosure are noted.

Every resident has a right to be free from ANE. As advocates, ombudsmen are part of the elder justice system to prevent abuse and help residents and others report ANE with consent from the resident.

Since ombudsmen are directed by resident goals for complaint resolution and federal disclosure requirements, their role in allegations of abuse is unique and differs from other agencies in Texas. Respecting resident confidentiality is critical not only to maintain compliance with program requirements, but also to adhere to the fundamental ombudsman role as a resident advocate. Respecting our confidentiality mandate also maintains the integrity of the ombudsman program and fosters trust between the ombudsman and residents. However, maintaining confidentiality in response to complaints involving abuse is a challenging, complex situation that requires careful analysis and consultation with your ombudsman supervisor.

Abuse, Neglect, and Exploitation

It is important for ombudsmen to know how to recognize and respond to allegations of ANE. Ombudsmen must have a thorough understanding of our responsibilities about when and how to report it. Ombudsmen do not determine whether ANE occurred, but act as an advocate for the resident by helping report, and ensuring the resident, and other residents, are protected from further harm. Regulatory Services determines if ANE occurred.

Ombudsmen do not determine whether abuse, ________________, or exploitation happened. We act as an ____________ for the resident by helping report, and ensuring the resident, and other residents, are protected from further harm.
Abuse

Abuse is the negligent or willful infliction of injury, unreasonable confinement, intimidation, or punishment that causes physical or emotional harm or pain to a resident; or sexual abuse. It includes involuntary seclusion, any type of physical punishment, sexual harassment or coercion, deprivation, and any oral, written, or gestured language that includes disparaging or derogatory terms, regardless of the person’s ability to hear or comprehend.

Examples of abuse may include:

- An aide called a resident “the wicked witch.”
- A charge nurse told a resident he will never see his family again if he doesn’t comply with treatment.
- A staff person humiliated and reprimanded a resident who did not make it to the restroom in time.
- A nurse coerced a resident by pinching her arm.
- An aide jokingly used sexual innuendo with a male resident who is embarrassed but pretends to go along with her joke.

Neglect

Neglect is the failure to care for a person in a manner which would avoid physical or emotional harm or pain, or the failure to react to a situation which may be harmful. Neglect may or may not be intentional.

Examples of neglect may include:

- incorrect body positioning – which leads to limb contractures and skin breakdown;
- lack of toileting or changing of a disposable brief – which causes incontinence and results in a resident sitting in urine or feces, increased falls or agitation, indignity or skin breakdown;
- lack of assistance eating or drinking – which leads to malnutrition and dehydration;
- lack of assistance with walking – which leads to lack of mobility;
- poor hand washing techniques – which leads to infection;
- lack of assistance with participating in activities of interest – which leads to withdrawal and isolation; or
- ignoring call lights or cries for help.
Neglect is the failure to care for a person in a manner which would avoid ______________ or emotional harm or pain, or the failure to react to a situation which may be harmful. Neglect may or may not be intentional.

Exploitation

Exploitation is the illegal or improper act or process of a caregiver, family member, or other individual who has an ongoing relationship with a resident using the resources (money, assets, property) of the resident (or an elderly or disabled person) for monetary or personal benefit, profit, or gain without the informed consent of the resident.

Exploitation is defined as the ______________ or improper act or process of a caregiver using the resources, such as money, assets, or property, of an elderly or disabled person for ______________ or personal benefit.

Types of Exploitation

Financial mistreatment of older adults or adults with disabilities may be committed by a person known to the victim or by a stranger.

- Misappropriation of income or assets – The perpetrator obtains access to social security checks, pension payments, checking or savings accounts, credit cards, or ATM cards, or withholds portions of checks cashed for a senior citizen.
  
  Example: An aide who provides care to a resident offers to go to the store to buy snacks for her. The resident gives the aide her debit card and personal identification number. The aide gets cash back for herself.

- Charging excessive fees for goods or services – A person charges excessive rent or unreasonable fees for basic care services such as transportation, food, or medicine.

- Obtaining money or property by undue influence, misrepresentation, or fraud – An individual, staff, or family member coerces (pressures, bullies, misrepresents state of finances) a resident into signing over investments, real estate, or other assets through the use of manipulation, intimidation, or threats.

- Improper or fraudulent use of power of attorney or fiduciary authority – A person improperly uses the power of attorney or other fiduciary authority to alter a will, borrow money using the victim’s name, or dispose of assets or income.
Ombudsmen should keep in mind the information presented in Hand in Hand is created for facility staff, but many of the principles can be applied to ombudsman work. For ombudsmen, special considerations apply to reporting allegations of ANE.

Different types of abuse can occur at the same time. Abuse can be the result of escalated situations between staff and residents. Many times abuse is not witnessed, but we might see signs that abuse has occurred. Knowing residents can help you recognize changes that indicate something is wrong.

Watch CMS Hand in Hand Module 2. Answer the following questions.

1. List three types of abuse:
   a) __________________________
   b) __________________________
   c) __________________________

2. An example of verbal abuse is:
   ________________________________

3. An example of physical abuse is:
   ________________________________

4. An example of involuntary seclusion is:
   ________________________________

5. Misappropriation of property is commonly called __________, but also includes deliberately misplacing a resident’s belongings or money and using a resident’s belongings without his or her permission.

6. List some signs of abuse:
   • _____________________________
   • _____________________________
   • _____________________________
Facility Responsibilities

Employee Screening

Every facility has a responsibility to protect residents. Before a nursing home or an assisted living facility hires an employee, the facility must search the employee misconduct registry (EMR) and nurse aide registry (NAR) to determine if the person is designated in either registry as unemployable. Both registries are accessed on the internet.

A facility is prohibited from hiring or continuing to employ a person who is listed in the EMR or NAR as unemployable. Additionally, a facility may not hire a person convicted of one of the permanent bars to employment. Examples of permanent bars to employment include criminal homicide, kidnapping, Medicaid fraud, sexual or aggravated assault, and indecency with a child.

Employee Training

As a condition of employment, an employee of a facility must sign a statement that says the employee may be criminally liable for failure to report abuse. ANE training for staff must include how to recognize and report incidents. Training must include what, when, and to whom within the facility the report should be made. Each facility must have a formal reporting system that is known to staff.

Resident Screening

The facility should assess any potential resident’s needs and determine if their facility can meet those needs before a facility accepts a resident. Unmet needs can lead to abuse and neglect. Screening should include an assessment of the resident’s functional, health, nutritional, and social status, as well as mental acuity and special needs.

Facility Incident Reporting

A nursing home or assisted living facility must immediately report allegations or suspicions of ANE to Regulatory Services. For some types of ANE allegations, they must also report to local law enforcement. Depending on reporting guidelines and facility rules, providers must report other incidents including:

1. Misappropriation of funds or resident property
2. Death of a resident that involves unusual circumstances
3. Missing resident – If a resident is not located during a search of the facility, facility grounds, and immediate vicinity, and circumstances place the resident’s
health, safety or welfare at risk, a report must be made as soon as the facility becomes aware the resident is missing and cannot be located.

4. Drug diversions – The facility must make a report to the State if it has reason to believe that drugs were stolen. Staff must also notify the local police department.

5. Fires – State provider letters specify reportable fire related incidents for assisted living facilities and nursing homes.

6. Conditions that pose a threat to resident health and safety – Examples include bomb threats, floods, failure of the sprinkler system or fire alarm, and others.

7. Injuries of unknown source – In nursing homes, if no one saw the incident that resulted in the injury or the source of the injury could not be explained by the resident; and, the injury is suspicious because of the extent of the injury, the location of the injury, number of injuries observed at one point in time, or the number of injuries over time. Encourage assisted living facilities to self-report serious injuries that are suspicious (possible ANE), or that are from an unknown source.


Who Investigates ANE?

Facility

A facility must thoroughly investigate all allegations of ANE and start the facility investigation immediately. It is important for facility policies and procedures to clearly delineate roles for those responsible for investigating and to describe appropriate responses to ensure protection of the alleged victim and the integrity of the investigation. Facility responses might include suspending the alleged perpetrator, making a room or staffing change, or developing a resident treatment plan.

In nursing homes, the employee named as the abuse coordinator is responsible for conducting the investigation. In an assisted living facility, the manager or executive director is usually responsible for conducting ANE investigations.

Nursing homes and assisted living facilities must follow the rules for ANE allegations which are found in §19.601 and §92.102. Facilities:

• follow the facility’s policies and procedures for investigations of ANE;
• investigate every report or allegation;
• take action to protect the resident during the investigation and develop an immediate corrective action plan;
• take action when ANE is confirmed; and
• report the ANE investigation determination to Regulatory Services.
The facility’s investigation determination is based on the quality and quantity of evidence and whether or not it is sufficient to confirm the allegation. After the facility conducts the investigation, they must send a written report of the investigation to Regulatory Services no later than the fifth working day after the oral report was made.

Regulatory Services

Regulatory Services investigates allegations of abuse and neglect if the incident occurred while the resident was in the facility, the facility was responsible for the supervision of the resident when the incident occurred, and the alleged perpetrator is affiliated with the facility. Other complaints of abuse and neglect that do not meet the previous criteria are referred to Adult Protective Services (APS). Certain types of serious allegations require Regulatory Services and the facility to report those allegations to law enforcement for joint investigation.

Regulatory Services also investigates resident financial exploitation if the alleged perpetrator is affiliated with the facility (employee, contractor, or volunteer).

Adult Protective Services

APS investigates if an allegation of abuse or neglect states the incident occurred outside of the facility, the alleged perpetrator is a family member, caregiver or person with an on-going relationship with the resident (as determined by APS), and the facility was not responsible for supervision or service delivery at the time the incident occurred.

APS and local law enforcement investigate financial exploitation incidents that occur while the resident is in a nursing home or assisted living facility and the alleged perpetrator is family member, caregiver, or person with an on-going relationship with the resident, and is not an employee, contractor, or volunteer of the facility.

If the alleged perpetrator is unaffiliated with the facility and unrelated or unknown to the victim, neither Regulatory Services nor APS has the authority to intervene. In these cases, the responsibility goes to other state and local agencies. Local police is one option. A second option is The Office of the Attorney General, Consumer Protection Hotline (1-800-621-0508). The Consumer Protection Division works to identify and prosecute those who deceive older adults through scams or fraud.

See the Memorandum of Understanding between DFPS Adult Protective Service and Long-term Care Ombudsman Program in Chapter 13, Regulators and Resources, Supplement 13-B for more information.
Texas has mandatory reporting laws that require everyone to report suspected elder abuse. However, state law does not require an ombudsman to report suspected ANE where such reporting violates federal requirements. By federal law, an ombudsman is prohibited from the disclosure of the identity of a complainant or resident without appropriate consent.

Ombudsmen ANE Complaint Guidelines

As described in Chapter 3, consent mandates apply to complaints involving ANE. Regardless of the source of a complaint, ombudsmen serve the resident and must support resident participation in the process of resolving complaints involving ANE allegations.

If Resident is Able to Communicate Consent

Federal rules direct ombudsmen to personally discuss complaints with residents to determine their wishes concerning resolution of the complaint. This includes whether to report an ANE allegation, and, if so, whether the ombudsman may disclose identifying or other relevant information to the facility or another appropriate agency. In order to comply with the wishes of the resident, ombudsmen do not report suspected ANE if the resident did not communicate informed consent. If the resident consents, the ombudsman must help the person report if requested.

Even if an ombudsman carries a professional license (for example, a licensed social worker or nurse), the ombudsman must adhere to the federal disclosure requirements when acting as ombudsman and must not report abuse without appropriate consent or approval from the MLO and State Ombudsman.

If Resident is Unable to Communicate Consent

When a resident is unable to consent, an ombudsman seeks consent from a legally authorized representative (LAR). An LAR may be a guardian or power of attorney.
If Resident is Unable to Communicate Consent and Has No LAR

If a resident is unable to communicate consent with regards to a complaint involving ANE allegations and has no LAR, a consultation with the State Ombudsman is required. Ombudsmen contact their supervising staff ombudsman or MLO who will seek guidance from the State Ombudsman. Approval from the State Ombudsman must be obtained before any information is shared or any action is taken.

If Complainant is Someone Other than the Resident

Any allegation of ANE that names a resident requires the resident’s consent before an ombudsman takes action. If allegations of ANE are reported to an ombudsman by someone other than the resident, encourage the person to report the allegation to Regulatory Services at 1-800-458-9858. It is preferable for the person to report ANE directly so the intake worker can collect firsthand details. If the person for any reason is unable or unwilling to report, an ombudsman must report for the person if the ombudsman has permission from the resident to do so or the allegation does not include any names of residents. Speak with any named resident about an allegation, their rights, options to report, and other advocacy options.

If ANE is brought to an ombudsman’s attention by a facility, the ombudsman follows typical complaint procedures, remaining resident-directed. Follow-up with the facility to ensure they took action to investigate, report, and protect residents. Visit residents and watch for other signs of ANE. If directed by a resident, take appropriate action.

ANE Witnessed by an Ombudsman

If an ombudsman personally witnesses ANE of a resident, the ombudsman must obtain the resident’s consent prior to disclosing resident-identifying information to the facility or another agency. The ombudsman follows the direction of the resident or resident’s LAR if the resident is unable to consent. Ombudsmen do not report witnessed suspected ANE of a resident when a resident (or resident’s LAR when applicable) does not communicate informed consent.
Consultation Required

If a resident is unable to consent and has no LAR, immediately consult with your supervising staff ombudsman. Approval from the State Ombudsman is required before taking any action outside the ombudsman program.

If the ombudsman does not have resident consent but assesses the situation and believes there is an immediate threat to the health, safety, or welfare of a resident, immediately contact the supervising staff ombudsman. The MLO is responsible for immediately notifying the state office. A staff person at the state office will determine if reporting to facility management is in the best interest of residents, and may approve releasing confidential information for purposes of an ANE report.

Within two hours of witnessing the incident, create an ombudsman record that documents what you witnessed. Do not release any document without approval from the State Ombudsman.

Other Advocacy Strategies When Consent is Withheld

This section applies when a resident is capable of giving consent, but has not given it to the ombudsman. Sometimes it is necessary to employ other advocacy strategies when responding to allegations of abuse, where consent is not given, in order to protect resident confidentiality and ensure resident safety. Other advocacy strategies may include:

- Explore the reason for the resident’s reluctance to pursue the allegation of ANE.
- Offer to investigate without disclosing a name or identifying information.
- Determine whether other residents with the same issue are willing to pursue it to resolution. This strategy must be carefully executed to avoid revealing who the initial complainant was and to avoid elevating anxiety levels among other residents.
- Ask the resident if there is a friend or family member with whom this information was shared. Ask if you can talk to this person.
- Determine if the resident will consent to you reporting to a specific staff person they trust, or with you by their side.

Case Examples

Case 1: A resident tells you he was injured by someone who works at the assisted living facility where he lives. He tells you he didn’t want to shower and the shower aide tried to force him. He does not give you consent to report the ANE nor to disclose any identifying information.
Ombudsman Response: If consent is withheld, the ombudsman does not report the ANE allegation. Determine if other residents may be affected. Consider other advocacy options.

Ask the trainer. What other advocacy options might be used?

Case 2: A facility staff person shares an allegation of abuse with you.

Ombudsman Response: Remind the staff person that employees of long-term care facilities are mandatory reporters and are obligated to report their suspicions, whether or not they can prove them. Contact Regulatory Services to inquire whether an allegation of abuse from the facility staff was received. Do not reveal confidential information or information that might be used to identify the resident or complainant.

Ask the trainer. You personally witness abuse. What should you do?

During a facility visit, you see and hear an altercation between a nurse and a resident during a birthday party. The resident is crying and holding her arms up in front of her face as if to protect herself. Four residents and two aides are also in the room where the verbal confrontation is occurring. What should you do?
CMS Hand in Hand Training - Module 5: Preventing Abuse
(Begin with Lesson 2): Actions and Reactions
Run Time: Approximately 1 hour to view video clips and discuss

Abuse situations are sometimes the result of a series of actions and reactions that escalate. This chain of events is often preventable. There are many reasons why residents might act the way they do. Understanding ‘why’ will help caregivers, and ombudsmen, find a better approach to a situation and prevent a series of events that might lead to abuse.


1. Abuse sometimes results of a series of actions and __________ that could have been prevented.

2. Identify several ways to respond to a resident’s actions that might prevent abuse.
   • ______________________________________________________________________
   • ______________________________________________________________________
   • ______________________________________________________________________

3. __________ True (T) or False (F)?
   A nursing home is required by federal regulation to report alleged violations of mistreatment, neglect, or abuse to the state survey agency.

4. Facility staff must report suspicion of a crime within _______ hours, if the events result in serious bodily injury to a resident.

SOURCES: The National Long-Term Care Ombudsman Resource Center, TA Guide: Technical Assistance for LTCO Practice, Responding to Allegations of Abuse: Role and Responsibilities of Long-term Care Ombudsmen and Long-Term Care Ombudsman, The National Long-term Care Ombudsman Resource Center, Final Regulations Overview; CMS Hand in Hand Training Modules 1-6
CHAPTER 5: Residents’ Rights
Residents’ Rights

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

Learning Objectives

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

Contents

- Overview of Residents’ Rights
- Empowerment
- Ombudsman Role
- Residents’ Rights Themes
- Residents’ Rights under Law
- Incapacitated Residents
- Shadow Visit Overview
- Facility Contact Sheet

DVD(s), Supplements, Forms

- DVD: Residents Speak Out Against Retaliation
- YouTube Video: Nursing Home Transfer and Discharge Procedures
- Supplement 5-A: Nursing Home Resident Rights
- Supplement 5-B: Assisted Living Facility Resident Bill of Rights

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

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

Long-term care ombudsmen have a responsibility to:

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

Understanding rights and an ombudsman’s role to support residents in exercising their rights is essential. The ombudsman process and approach is much the same regardless of whether a resident lives in a nursing home or assisted living facility. Laws and regulations are different in these settings.

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

You have daily routines and preferences.

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

If you were a resident,

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

How might individual routines impact residents’ rights?

Empowerment

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

Empowerment is a foundation of ombudsman work. As a primary way of relating to residents, ombudsmen always encourage residents to:
• speak on their own behalf; and
• have direct, open communication with other residents, family, and staff.

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

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

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

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

• used indirect or direct approaches to work out problems;
• depended traditionally on others to speak for them; or
• accepted the status quo.

Describe Empowerment.
______________________________________
______________________________________
Once disempowered, a person may feel powerless,
______________________________________
or ____________________________________.

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

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

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

________________________
________________________
________________________
________________________
________________________

Ombudsman Role

Residents can regain personal power and voice. If a resident:
- finds it easy to speak up, an ombudsman can point them in the right direction and reassure them of their rights;
- needs more support, an ombudsman can be present as the resident expresses the need or speak on the resident’s behalf; or
- is severely impaired or unable to communicate needs, an ombudsman may need to carry more of the load.

First, get to know residents as individuals. With that connection, residents may share concerns about their experiences. How you respond and work with these concerns can go a long way to empower residents and restore their sense of self. Relate honestly and authentically to the resident and to the situation.
Voices Speak Out Against Retaliation
Run Time: 14 min

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

Answer the following questions:

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

___________________________________________________________________
___________________________________________________________________
___________________________________________________________________

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

___________________________________________________________________
___________________________________________________________________

Resident-Directed

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

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

____________________________________________________________________

____________________________________________________________________

Possible Obstacles to Implementing Resident Rights

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

SOURCE: Consumer Voice, Nursing Home Resident Rights Project

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

____________________________________________________________________

____________________________________________________________________

____________________________________________________________________
Residents’ Rights Themes

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

1. Communication
2. Choice
3. Decision-making
4. Participation

1. Communication

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

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

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

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

2. Choice

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

Exercising choice is a continual process.

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

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

Do residents have a say in this policy? _____________________________

How would you approach this problem as the ombudsman? ______________

__________________________________________________________________

3. Decision-Making

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

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

4. Participation

Residents are encouraged by law to participate in:

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

If residents want to move out of nursing homes, they participate in making decisions about the transition. Medicaid-eligible residents can work with the Money Follows the Person program or through their Medicaid managed care service coordinator. More
Residents with cognitive impairment or other disabilities can participate in planning care and exercising choice. If staff cannot honor resident preferences, they need to problem solve with the resident to find a solution as close as possible to what the resident wants.

Resident Rights under Law

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

**Federal**
- Regulation: Medicare and Medicaid Requirements for Long Term Care Facilities, 42 U.S. Code of Federal Regulations, §483

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

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**Quality of care**: provide services and activities to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident in accordance with a written plan of care.

**Quality of life**: care for residents in such a manner and in such an environment as will promote maintenance or enhancement of the quality of life of each resident.
Ask the Trainer: Late Night Television

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

- Whose rights need to be protected, the complainant or those who go to bed at 8:00? __________________________

- Are there differences in resident rights in an assisted living facility as opposed to a similar situation in a nursing home? __________________________

Specific Rights

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

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

Resident rights may be restricted only to the extent necessary to protect the resident or other residents, or to protect the rights of others, particularly rights relating to privacy and confidentiality. The following list of rights applies to nursing home and assisted living facility residents. An asterisk (*) identifies rights that only apply to nursing home residents.

Dignity and Respect

Residents have the right to:

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

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

Residents can leave their nursing home for visits and can stay overnight. ___________ True (T) or False (F)

Residents have the right to determine their personal care schedule, such as activities, bathing, and bedtime. ___________ True (T) or False (F)

Residents have the right to keep money in their room. ___________ True (T) or False (F)

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

- Do residents need permission to marry? ____________________________
- Will the newlyweds be entitled to their own room? What if a couple is not married, can they room together? ____________________________
Privacy and Confidentiality
Residents have the right to:

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

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

____________ True (T) or False (F)

Facility staff may monitor resident visits with a long-term care Ombudsman.

____________ True (T) or False (F)

Participation in Care
Residents have the right to:

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

Residents do not have the right to communicate in their native language to get or receive treatment, care, or services.

____________ True (T) or False (F)

Residents have the right to refuse food, medicine, therapy, and other services.

____________ True (T) or False (F)
Transfers and Discharges
Residents have the right to:

- Not be relocated within the facility, except in accordance with rules
- Discharge themselves unless a court determines a person is incapacitated
- Not be discharged from the facility, except as provided in regulations
- Receive a 30-day written notice sent to them and a legally authorized representative or family member
- *Appeal a discharge within 10 days of receiving notice in a Medicaid facility in order to stay in the facility until an appeal decision is made or up to 90 days to file an appeal otherwise
- *Be readmitted to the facility as provided by regulations
- Notice of immediate discharge in the event the resident becomes a threat to the health and safety of himself or others
- *Right to notice of bed hold policy

Residents should receive a _____ - day notice of a home’s intent to discharge them. It must be in ______________. The resident has ______ days to appeal in order to stay in the facility until an appeal decision is made, but up to 90 days to appeal.

For more information about transfer and discharge procedures, please watch the recorded webinar, Nursing Home Transfer and Discharge Procedures, which can be found on the Texas Long-term Care Ombudsman YouTube channel or follow this link:

http://www.youtube.com/watch?v=U1QVmySJR4Y
Run Time: 14 min 45 sec

Information
Residents have the right to:

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

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

Exercise: Residents Have Rights

Residents have a right to complain only about situations that directly affect them. 
_________ True (T) or False (F)

Only approved residents have the right to attend and participate in resident council meetings. _________ True (T) or False (F)

Use Supplement 5-A or 5-B to choose the nursing home and assisted living facility resident right to help resolve the complaint.

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

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

   ________________________________________________________________
   ________________________________________________________________

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

   ________________________________________________________________
   ________________________________________________________________

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

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

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

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

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

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

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

11. I told the nurse last week there’s a sore on my leg. No one has checked it yet.
12. This place is like a prison. I want to go home and they won’t let me.

__________________________________________________________________________

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

__________________________________________________________________________

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

__________________________________________________________________________

Rights of Families and Legal Representatives of Residents in Nursing Homes

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

- Be notified:
  - within 24 hours of an accident resulting in injury, a significant change in the resident’s physical, mental, or psychosocial status, a need to alter treatment significantly, or a decision to transfer the resident;
  - of appeal rights related to loss of benefits, services, or discharge;
  - promptly of a change in room, roommate, or in resident rights provisions; and
  - if the facility receives a waiver of licensed nurse staffing requirements;

- Participate:
  - in the care planning process; and
  - in a family council that may meet privately in space provided by the facility, and have a facility staff person serve as liaison to the council;

- Have immediate access to the resident, subject to the resident’s rights to deny or withdraw consent at any time; and

- Make recommendations to the facility. The facility must listen to the views and act on grievances and recommendations by residents and families concerning proposed policy and operational decisions affecting resident care and life in the facility.
For a resident in a nursing home, family has a right to be notified within 24 hours of an _______________ or a significant change in the resident’s physical, mental, or _______________ status. Family also has a right to participate in the ______________ planning process.

Incapacitated Residents

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

Ombudsmen should not assume a person is a legal guardian of a resident unless a letter of guardianship, dated within the current year, is made available. Powers of attorney are important advance care planning documents, but as long as residents can speak for themselves, the resident’s wishes supersede the agent’s. Read Chapter 8 for more information about advance care planning.

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

Enforcement of Resident Rights

The primary mechanism to enforce resident rights is the survey and certification process performed by Regulatory Services and described in Chapter 13. Having residents’ rights as part of federal and state laws gives emphasis to the rights. However, a lack of understanding and sensitivity to residents’ rights can hinder enforcement.
Residents’ rights can be difficult to quantify compared with other regulations. Violations may be challenging to document and prove. Correction of the violation may not be black and white for the surveyor to monitor.

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

How Facilities Can Promote Rights

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

SOURCE: Consumer Voice, Nursing Home Resident Rights Project
Supplement 5-A – Summary: Nursing Home Resident Rights

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

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

Freedom of Choice
You have the right to:
- make your own choices regarding personal affairs, care, benefits, and services
- choose your own physician at your own expense or through a health care plan
- manage your own financial affairs in the least restrictive method, or to delegate that responsibility to another person
- access money and property you have deposited with the facility and to have an accounting of your money and property that are deposited with the facility and of all financial transactions made with or on your behalf
- participate in activities inside and outside the facility
- place in your room an electronic monitoring device that is owned and operated by you or provided by your guardian or legal representative
- refuse to perform services for the person or facility providing services
- use advance directives as defined in the Texas Health and Safety Code, §166.002
- designate a guardian or representative to ensure quality stewardship of your affairs, if protective measures are required
Privacy and Confidentiality
You have the right to:

- privacy, including privacy during visits, phone calls and while attending to personal needs
- have facility information about you maintained as confidential
- send and receive unopened mail and to receive help in reading or writing correspondence

Participation in Your Care
You have the right to:

- receive all care necessary to have the highest possible level of health
- participate in developing a plan of care, to refuse treatment, and to refuse to participate in experimental research
- refuse treatment, care, or services
- receive information about prescribed psychoactive medication from the person who prescribes the medication or that person’s designee
- have any psychoactive medications prescribed and administered in a responsible manner as mandated by the Texas Health and Safety Code, §242.505, and to refuse to consent to the prescription of psychoactive medications
- access personal and clinical records, which will be maintained as confidential and may not be released without your consent
- communicate in your native language to acquire or to receive treatment, care, or services

Transfers and Discharges
You have the right to:

- not be relocated within the facility, except in accordance with nursing facility regulations
- discharge yourself from the facility unless you have been adjudicated mentally incompetent
- not be discharged from the facility, except as provided in the nursing facility regulations
- receive a 30-day written notice sent to you, your legally authorized representative, or a family member
- appeal the discharge within 10 days of receiving notice in a Medicaid facility
- be readmitted to the facility as provided by nursing facility regulations

Information
You have the right to:

- receive a written statement or admission agreement describing the services provided by the facility and the related charges
• be informed of Medicare or Medicaid benefits
• receive a copy of the Statement of Resident Rights and to be informed of revisions
• be informed in a language you understand about your total medical condition, recommended treatment and expected results (including reasonably expected effects, side effects and associated risks), and be notified whenever there is a significant change in your condition.

Complaints
You have the right to:
• complain about care or treatment and receive a prompt response to resolve the complaint without fear of reprisal or discrimination
• organize or participate in any group that presents residents’ concerns to the administrator of the facility

Your rights may be restricted only to the extent necessary to protect you or others, or to protect the rights of others, particularly those rights relating to privacy and confidentiality.

These described rights are in addition to other rights or remedies an individual may be entitled to, according to rules and under the law.

SOURCE: This list of rights is based on the Nursing Facility Requirements for Licensure and Medicaid Certification Handbook, Subchapter E
Supplement 5-B - Summary: Assisted Living Facility Resident Rights

A resident has all the rights, benefits, responsibilities, and privileges granted by the constitution and laws of this state and the United States, except where lawfully restricted. The resident has the right to be free of interference, coercion, discrimination, and reprisal in exercising these civil rights.

Dignity and Respect
You have the right to:

- be free from physical and mental abuse, including punishment or physical and chemical restraints not required to treat medical symptoms
- be treated with respect, consideration, and recognition of dignity and individuality, without regard to race, religion, national origin, gender, age, disability, marital status, or source of payment. This means that you have the right to:
  - make choices regarding personal affairs, care, benefits, and services
  - be free from abuse, neglect, and exploitation and
  - designate a guardian or representative to ensure the right to quality stewardship of your affairs
- achieve the highest level of independence, autonomy, and interaction with the community
- a safe and decent living environment
- communicate in your native language with residents or employees
- complain about care or treatment. The complaint may be made anonymously or communicated by a person you designate. The provider must:
  - promptly respond to resolve the complaint
  - not discriminate or take other punitive action against a resident who makes a complaint
- participate in a behavior modification program involving restraints with the consent of the person’s guardian, as described in TAC § 92.125

Privacy and Confidentiality
You have the right to:

- receive and send unopened mail, and have mail sent and delivered promptly
- access to a telephone
- privacy while attending to personal needs and receiving medical treatment
- a private place for receiving visitors or associating with other residents, including written communications, telephone conversations, meeting with family, and access to a resident council or group
- share a room with a spouse receiving similar services
- unrestricted communication, including visits with family members, representatives of advocacy groups and community service organizations, and other visitors at any reasonable hour
• have access to a representative of the Office of the State Long-term Care Ombudsman

Freedom of Choice
You have the right to:

• participate in activities of social, religious, or community groups and practice religion of your choice
• manage financial affairs, including written authorization of another person to manage your money. You may choose how your money is managed, including a money management program, a representative payee program, a financial power of attorney, a trust, or similar method, and may choose the least restrictive of these methods
• if the facility accepts written delegation to manage any portion of a resident’s finances, the resident must be given, upon request and at least quarterly, an accounting of financial transactions made on the resident’s behalf
• retain and use personal possessions, including clothing and furnishings. The number of personal possessions may be limited only for the health and safety of other residents
• choose dress, hair style, and other personal effects according to individual preference; the resident is responsible for maintaining personal hygiene
• retain and use personal property in your immediate living quarters and to have an individual locked area to keep personal property
• refuse to perform services for the facility, except as contracted for by the resident and operator
• have access to a representative of the State Long Term Care Ombudsman Program

Participation in Your Care
You have the right to:

• choose and retain a personal physician
• participate in developing an individual service plan that describes your medical and psychological needs and how the needs will be met
• access to personal records, which are confidential and may not be released without your consent, except:
  ▪ to another provider, if the resident transfers residence or
  ▪ if the release is required by another law
• refuse medical treatment or services after:
  ▪ being advised by the person providing services of the possible consequences of refusing treatment or services and
  ▪ acknowledging that you understand the consequences of refusing treatment or services
• execute an advance directive, under Chapter 166 of the Health and Safety Code, or designate a guardian in advance of need to make decisions regarding your health care

**Information**

You have the right to:

• be informed by the provider no later than the 30th day after admission:
  • whether the resident is entitled to benefits under Medicare or Medicaid and
  • which items and services are covered by these benefits, including items or services for which the resident may not be charged
• be fully informed in advance about treatment or care that may affect the resident's well-being

**Transfer and Discharge**

You have the right to:

• leave the facility temporarily or permanently, subject to contractual or financial obligations
• not be transferred or discharged unless:
  • the transfer is for the resident's welfare, and the resident's needs cannot be met by the facility
  • the resident's health is improved sufficiently so that services are no longer needed
  • the resident's health and safety or the health and safety of another resident would be endangered if the transfer or discharge was not made
  • the provider ceases to operate or to participate in the program that reimburses for the resident's treatment or care or
  • the resident fails, after reasonable and appropriate notice, to pay for services
• not be transferred or discharged, except in an emergency, until the 30th day after the date the facility provides written notice to the resident, the resident's legal representative, or a member of the resident's family, stating:
  • the facility intends to transfer or discharge the resident
  • the reason for the transfer or discharge
  • the effective date of the transfer or discharge
  • the location to which the resident will be transferred and
  • any appeal rights available to the resident

**SOURCE:** This list of rights is based on the Licensing Standards for Assisted Living Facilities, Residents Bill of Rights §92.125
CHAPTER 6: Facilities
Facilities

Chapter 6 is about assisted living facilities and nursing homes. People who live in either type of facility have a right to our services. Assisted living facilities and nursing homes are two living options in a continuum of long-term services and supports in Texas.

Learning Objectives

- Develop a general understanding of long-term services and supports
- Understand the long-term care ombudsman roles and responsibilities associated with facilities and helping people choose them
- Understand how most residents pay for assisted living or nursing home care
- Become familiar with long-term care management, operations, and staffing
- Identify alternatives to nursing home care
- Understand your role as a resident advocate and maintain healthy boundaries

Contents

- Long-term Services and Supports
- Ombudsman Role and Access
- Assisted Living Facilities
- Nursing Homes
- Walk the Fine Line
- Facility Visits – Intern Shadow Visits
- Ombudsman Activities
- Facility Visit Guide – Things to Look for During Visits

DVD(s), Supplements, Forms

- Walk the Fine Line
- Supplement 6-A: Managed Care Toolkit
Long-term Services and Supports

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

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

How to choose a facility:

Quality of facilities:
- Nursing Home Compare by Centers for Medicare and Medicaid Services, https://www.medicare.gov/nursinghomecompare/search.html
- Quality Reporting System for assisted living facilities, nursing homes, home health care, and adult day care by the State of Texas at: http://facilityquality.dads.state.tx.us/qrs/public/qrs.do

Home Health and Hospice Agencies

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

Home health agencies provide services such as:
- nursing, including blood pressure monitoring, and diabetes treatment;
- physical, occupational, speech, or respiratory therapy; and
- medical equipment and supplies.

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

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

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**Ombudsman Role and Access**

In a facility, long-term care ombudsmen:

• advocate for residents;
• provide information about how to select a facility;
• provide information on how to get quality care;
• identify problems in facilities and work to resolve them; and
• investigate and resolve complaints made by a resident or by another complainant on behalf of a resident.

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

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

In Texas, Ombudsmen do not provide oversight to Personal Care Homes*, Adult Day Care Facilities, and Intermediate Care Facilities Serving Persons with Intellectual or Developmental Disabilities.

* Personal care homes in Texas are private residences that offer personal care services, assistance, and supervision to four or more persons. If the care home provides personal care to four or more persons, unrelated to the owner, the home must be licensed under state licensure requirements.
Assisted Living Facilities

Assisted living as it exists today emerged in the 1990s as an alternative for people who do not need 24-hour skilled nursing care provided by a nursing home but independent living is no longer appropriate. Assisted living facilities provide individualized health and personal care assistance in a homelike setting with an emphasis on personal dignity, autonomy, independence, and privacy. Facilities can be large apartment-like settings or private residences with a few bedrooms. Services include meals, bathing, dressing, toileting, and administering or supervising medication. In Texas, a licensed assisted living facility is an establishment that:

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

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

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

Laws and Rules

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

Regulatory Services licenses and regulates assisted living facilities in Texas.

- Texas law - Health and Safety Code, Title 4, Chapter 247, Assisted Living Facilities
- Texas rule – Licensing Standards for Assisted Living Facilities, Texas Administrative Code (TAC) Title 40, Part I, Chapter 92
Typical Resident

General characteristics of an assisted living resident is a woman in her mid-eighties who is mobile, but needs assistance with approximately two to three activities of daily living (ADLs).

Resident statistics:

- Female (±74%)
- Non-Hispanic white (±91%)
- Receive dressing assistance (±52%)
- Assisted with some ADLs (over 66%)
- Alzheimer’s disease or other dementias (±40%)
- Divorced, separated or widowed (over 69%)
- Age 85 or older (±50%)
- Help transferring (±26%)
- Receive bathing assistance (±72%)


Types of Licenses

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

- **Type A.** In a Type A facility, night shift staff in a small facility must be immediately available. In a large facility, the staff must be immediately available and awake. In addition, a resident:
  - must be physically and mentally capable of evacuating the facility without physical assistance from staff, which may include an individual who is mobile, although non-ambulatory, such as an individual who uses a wheelchair or an electric chair, and has the capacity to transfer and evacuate him- or herself in an emergency;
  - does not require routine attendance during nighttime sleeping hours;
  - must be capable of following directions under emergency conditions; and
  - must be able to demonstrate to Regulatory Services they can travel from their living unit to a centralized space, such as lobby, living or dining room on the level of discharge within a 13-minute period without continuous staff assistance. Elevators cannot be used as an evacuation route.

- **Type B.** In a Type B facility, night shift staff must be immediately available and awake, regardless of the number of licensed beds. In addition, a resident may:
  - require staff assistance to evacuate;
  - require attendance during nighttime sleeping hours;
  - be incapable of following directions under emergency conditions; and
  - require assistance in transferring to and from a wheelchair, but must not be permanently bedfast.
• Type C. A Type C facility is a four-bed facility that:
  ▪ has an active contract with the State to provide adult foster care services; and
  ▪ must be contracted with the State to provide adult foster care services before it can be licensed.

As of July 2015, Texas has 1,821 assisted living facilities: 569 Type A, 1,213 Type B, and 39 Type C. Assisted living is further categorized as large or small as determined by the licensed bed capacity. If fewer than 17 beds, Type A and B facilities are designated as small; if 17 or more beds, facilities are designated as large.

Management and Operation

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

Assisted Living Facility Manager

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

Attendants

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

Financing Assisted Living Care

Personal

• Assisted living care is generally paid for with a person’s private funds.
• Long-term care insurance can provide coverage to pay for assisted living facilities. Each insurance policy differs in what services and what amounts can be paid.
Government

- Medicaid-waiver - A facility can choose to accept residents who are eligible for Medicaid-waiver services called STAR+PLUS. These services require a contract with the State and include contractual requirements that create additional oversight and enforcement options to the assisted living facility license. When an assisted living has a Medicaid-waiver contract, the Medicaid-eligible resident pays part of the cost, known as “co-pay,” and Medicaid pays the remainder of the costs. Because STAR+PLUS is a waiver program (Medicaid managed care), the managed care company pays the assisted living facility provider.

- Veterans’ Administration (VA) - Some assisted living facilities contract with the VA and accept the VA Aid and Attendance benefit to pay for all or a portion of a resident’s assistance with activities of daily living such as grooming, showering, eating, medication management, and toileting. The Aid and Attendance benefit is for veterans age 65 and older who served during war time. It is also available to their surviving spouses. It is a tax-free benefit and is awarded by the Department of Veterans Affairs.

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

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

Comparing Assisted Living Facilities

Each licensed facility must complete an Assisted Living Disclosure Statement using Form 3647 and make it available to anyone who requests it. The disclosure statement gives prospective residents and their families consistent categories of information from which they can compare facilities, policies and services. Sections include:
Ombudsman tip: The assisted living facility disclosure statement, in addition to the agreement or contract signed at admission, is an important document for ombudsmen to be familiar with and to encourage residents and family to use as they work on resolving complaints.

Aging in Place

Over time, the appropriateness of placement of a resident in a particular facility can change due to the resident's change in condition, needed services, or ability to evacuate. According to the aging in place rule, a resident may be allowed to remain in his or her environment if the facility agrees, if certain procedures are followed, and if their health and safety needs can be met. The Assisted Living Disclosure Statement Form 3647 includes a brief statement from the facility about its general policies related to aging in place.

Inappropriately Placed Residents

All residents must be appropriate for the facility's licensure type when admitted to an assisted living facility, but residents may become inappropriately placed over time due to a change in condition.

The resident or his or her representative may prefer to remain in the facility if the resident's condition changes. The aging in place process applies only to residents who are already residents of a facility, and were originally appropriately placed into that facility. Assisted living facilities are not required to keep a resident who is no longer appropriately placed. Inappropriate placement is defined differently for each assisted living facility license type.
A facility will determine its ability to accommodate a resident and decide if it will apply for a waiver request on a case by case basis. Some of the required paperwork for a waiver includes a physician’s assessment, a resident’s request to stay, a facility’s agreement for the resident to stay, and an evacuation waiver.

Waiver requirements are defined in the rules about inappropriately placed residents and may be found in the Licensing Standards for Assisted Living Facilities in 40 Texas Administrative Code Chapter 92, Subchapter 92.41(f).

**Nursing Homes**

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

All nursing homes must be licensed by the State of Texas. If they choose to participate in government reimbursement programs as a certified nursing facility, skilled nursing facility, or both, state and federal requirements must be met.

- If they participate in the Medicaid program, they are nursing facilities.
- If participating in Medicare, they are skilled nursing facilities (free standing or hospital-based).
- If they choose not to participate in government reimbursement, they are called licensed only (or private pay).

As of July 2015, Texas has 1,232 nursing homes. Most are licensed and certified for Medicaid and Medicare reimbursement. Forty-six homes are certified only for Medicare reimbursement. Medicare certification allows the home to bill for “skilled nursing” services and the facility is referred to as a SNF. Ten homes are licensed-only, meaning they only receive private pay and private insurance to pay for services. There are 24 hospital-based skilled nursing facilities, usually rehabilitation units within a hospital. Services are paid for by Medicare and private insurance.

Regulatory Services licenses, certifies, and monitors compliance of each of these license and certification types. Chapter 13 has more information about regulators and an ombudsman’s relationship to their work.

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

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

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

- Most move to a nursing home because their ability to care for themselves has deteriorated and they require 24-hour nursing care.
- Needs vary with a wide range of cognitive impairments, mental illnesses, and physical disabilities.
- Many residents live for years in a nursing home, while others may only live there for days or weeks.
- Some go for therapy following surgery. After rehabilitation, they return home.
- Others go for respite care, staying temporarily while caregivers rest or recover.

Residents have different care needs and different care outcomes. Through the care planning process, staff and residents individualize goals of care and direct how staff will care for the person. Details on care planning are discussed in Chapter 8 of this manual.

When admitted, residents sign admission agreements that detail what residents pay and what nursing homes provide, such as room, board, and specific services. Costs vary based on level of care, setting, and location. At admission, residents also receive information about eligibility for Medicaid and Medicare benefits and rights, including a description of the long-term care ombudsman program.

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

Before admission, residents are also screened using the Preadmission Screening and Resident Review (PASRR) process. PASRR is a federal requirement to help ensure that people are not inappropriately placed in nursing homes for long-term care. It requires that all applicants, prior to admission to Medicaid-certified nursing homes, be given a preliminary assessment to determine whether they might have a mental illness or an intellectual or developmental disability. More information on PASRR can be found in Chapter 13 Regulators and Resources.
Exercise: Introduction to a Nursing Home Administrator

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

Questions about scenario:

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

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

Laws and Rules

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

Typical Resident

- Majority of residents are female (±67%) who are age 85 or older (±38%) and are non-Hispanic white (±69%) [Non-Hispanic black (±13%); Hispanic (±17%)]
- Over half of residents have Alzheimer’s disease or other dementias (±55%)
- The majority need assistance with the majority of activities of daily living (±97% require assistance bathing; ±90% require assistance with dressing; ±86% require assistance with toileting; and ±61% require assistance with eating)
- Most common diagnosis at admission is heart disease, followed by cognitive impairment or mental disorders
- Takes 11 or more medications daily including over the counter medications

Management and Operation

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

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

Administrator
- The board of directors or regional director hires a licensed administrator. The State of Texas oversees the credentialing of administrators.
- Administrator responsibilities include ensuring state and federal regulations are met, developing policies and procedures, and hiring, training, and terminating staff. He or she is responsible for all operational and financial aspects.
- Administrators have a high turnover rate; the average stay is 1½ years.

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

Medical Services

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

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

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

Nursing Services

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

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

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

Certified Nurse Aide (CNA or aide)
• An individual who provides nursing or nursing-related services to residents under the supervision of a licensed nurse. CNAs are not authorized to provide nursing
and/or nursing-related services for which a license or registration is required under state law.

- CNAs provide a majority of direct resident care.
- CNAs have a very high turnover rate and stay on average 6 months. They often work in more than one facility or care setting.

Medication Aide

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

Ombudsman tip: CNAs can provide immediate help to residents and provide insight into a person's needs and preferences. Some view the CNA as the hardest-working staff. Many CNAs appreciate praise for a job well done. “Walk the Fine Line” in Chapter 6: Facilities provides ideas on how to give praise without crossing limits with facility staff.

Other Services

Business Office Manager (BOM)

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

Ombudsman tip: Visit the business office once a month for a list of residents, their rooms, and to learn of new residents, residents who were discharged or residents who are in the hospital.
Admissions Director
- A person who oversees the admissions process in a nursing home. He or she is a resource for admissions materials.
- Sometimes the admissions director also serves as the facility social worker.

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

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

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

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

- The activity director or assistant is often a staff liaison to the resident council.

Housekeeping

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

Maintenance

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

Contracted Services

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

- Dentist
- Pharmacist
- Psychologist
- Podiatrist
- Pest Control
- Psychiatrist
- Ophthalmologist
- Therapist: Physical, Occupational, and Speech
- Hospice
- Managed Care Organizations

Exercise: Help! – Identify the Right Person

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

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

1. Mrs. Ortiz speaks Spanish, and you need an interpreter to communicate with her.

2. You notice Mr. Smith’s drinking water container is empty.

3. Mrs. McMillan reports that she lost a sweater.

4. Mr. Jones appears to be uncharacteristically depressed.

5. There is something sticky on the floor of the main entrance.
6. Several call bells are answered slowly and some not at all.

7. Mr. Jenkins is worried about his bills.

8. A resident tells you the aide named “Mary” hit her.

9. Mrs. Nelson tells you she does not get her personal needs allowance.

10. A number of residents tell you they have not seen the doctor this month.

11. The social worker asks if you can help with a resident’s Power of Attorney who is not paying the nursing home bill.

12. After speaking several times with the Director of Food Services, you find that complaints are not getting resolved.

13. You notice a resident is sliding out of a chair.

14. Mr. Sims appears lonely and bored.

15. Two roommates are arguing with each other.

Financing Nursing Home Care

Personal

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

Government

Medicare

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

Medicaid
• Assistance program covers low-income people regardless of age.
• To be eligible, a resident must have some form of monthly income.
• Has no monthly insurance fee.
• Paid by state and federal taxes.
• A majority of nursing home residents are on Medicaid.
• Once a resident is on Medicaid, they choose a Managed Care Organization (MCO). See Supplement 6-A.

Veterans’ Administration (VA)
• VA benefits vary by military branch, service-connected disability, and war-time service.
  • The Texas Veterans Land Board General Land Office operates Texas state veterans homes.
  • VA contracts with other nursing homes to provide services to veterans.
  • Some spouses and former spouses of veterans are also eligible for benefits.

Medicaid eligibility has many terms associated with the process. Ombudsmen need to understand these basics:
• About 70% of residents are eligible for Medicaid to pay for their care. Though many nursing homes will help, the person is responsible for completing paperwork to determine financial and medical eligibility.
• A Medicaid eligibility worker in the Health and Human Services Commission (HHSC) determines financial eligibility. Workers conduct their work by phone and mail. Financial eligibility is based on criteria set for a person’s maximum allowed monthly income and resources. The Medicaid Eligibility for Persons with Disabilities Handbook provides details on financial eligibility determination.
• Texas Medicaid & Healthcare Partnership (TMHP) to evaluate assessment information determines medical eligibility. To be eligible, a resident needs to meet state criteria for “medical necessity.” TMHP bases the determination on a resident’s Resident Assessment Instrument and sets a Resource Utilization Group (RUG) reimbursement rate. That rate is the amount Medicaid reimburses a nursing home each day it delivers care to that resident.
• Medicaid eligible residents pay the nursing home each month with their monthly income, usually a social security check, which is called “applied income.” Sixty
dollars per month is reserved to pay for incidental items. The remainder of the cost of the resident's care is paid for by Medicaid, which includes 60% federal funds and 40% state funds. Medicaid is considered a state program, even though the federal government provides matching funds. The 60 dollars a resident receives each month is called **Personal Needs Allowance**.

- Once a resident is eligible for Medicaid, a managed care organization (MCO) is chosen. The MCO will handle Medicaid payments to the nursing home. The MCO will also provide care authorizations and service coordination. For more information on managed care, see Supplement 6-A Ombudsman Managed Care Toolkit at the end of this chapter.

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

**Medicaid Services**

**Nursing home care** – meeting medical, nursing, and psychosocial needs of each client, to include room and board, social services, administration of medications, medical supplies and equipment, and personal needs items;

**Rehabilitative services** - physical, occupational, and speech therapy to eligible residents who are recovering from an acute illness or an injury; if a Medicaid-eligible resident needs skilled nursing facility (SNF) services, Medicaid pays for the remaining costs not covered by Medicare;

**Hospice services** - palliative care of medical, social, and support services for a person with a terminal illness diagnosis of six months or less to live;

**Emergency dental services** - reimbursement for emergency dental services; routine dental services (such as cleaning or dentures) may be paid for using the resident’s monthly income as an incurred medical expense; and

**Specialized services** - therapies and restorative nursing services to residents determined to need these services in the Pre-admission Screening and Resident Review (PASRR) process.

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

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

Access to Personal Funds

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

On average, how many nursing home residents pay with Medicaid?

______% 

A person using Medicaid to pay for nursing home care keeps $_______ each month. This is called a personal needs ______________________. 
What is “applied income?” __________________ __________________________

The State of Texas contracts with TMHP to determine a resident’s ____________________________
Alternatives to Nursing Home Care

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

The federal government approves waivers to use the money that would be paid to nursing homes to instead pay for services in other settings tend to be less costly. For Medicaid-eligible people who are elderly, have a long-lasting illness, or have a disability, Texas uses the STAR+PLUS waiver. STAR+PLUS offers health care and long-term care services and supports provided through a health plan (also called a managed care organization or MCO).

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

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

Federal and state governments appear motivated to “balance” the Medicaid payment system. Rebalancing refers to changing government policies biased towards institutional care to policies that allow individual choice to direct where a person lives. It is likely there will always be a need for nursing homes, but changes in the overall system and more options appear to be on the horizon. Chapter 15 describes systems advocacy and offers guidance to ombudsmen on how to affect change for residents to live in settings other than a nursing home.

Ombudsman tip: Provide information to residents who indicate they want to move out of the nursing home. Tell them how to contact their managed care service coordinator or facility social worker.
Walk the Fine Line

Ombudsman Role with Residents, Families, and Facility Staff

Based on long-term care ombudsman experiences, Jana Tiefenwerth, former East Texas staff ombudsman, created “Walk the Fine Line.” This perspective helps create positive working relationships that lead to successful advocacy.

During the presentation, think about how ombudsmen can achieve the following:

- Walk the fine line between residents and staff in a way that increases their trust in an ombudsman.
- Help residents see an ombudsman as a resident advocate, but do not cross the line and create a dependent relationship.
- Develop relationships with staff that improves quality of life and care for residents, without crossing a boundary with staff.

Exercise: During the presentation, consider the following questions:

How can an ombudsman ‘walk the fine line’ between residents and staff in a way that increases residents’ trust?

How can an ombudsman help residents see an ombudsman as a resident advocate, but not cross the line and create a dependent relationship?

How can an ombudsman develop relationships with staff that improves quality of life and care for residents, without crossing a boundary with staff?

Give an example of an ombudsman being pro-facility:
Facility Visits - Intern Shadow Visits

Job shadowing, or a "shadow visit", is a training technique used for new staff and interns. Essentially, it involves spending a period of time (two hours is recommended) with a seasoned certified ombudsman, watch the person as a facility visit is made. A shadow visit allows an intern to see how an ombudsman approaches residents and staff, and what is involved in performing the tasks associated with ombudsman work.

Interns must complete Chapters 1-6 of the initial certification manual, have a verified criminal history check, and have no unremedied conflicts of interest on file prior to entering a facility and interacting with residents. Interns are required to wear their 'intern identification badge' while participating in shadow visits. See Ombudsman Activities (Dos and Don'ts) later in this chapter for more information. A minimum of two shadow visits are required before certification can be recommended to the State Ombudsman.

Things to observe about the trainer during a shadow visit:

- Physical appearance
- Items carried into each facility
- Note taking
- Communication with staff
- Obtaining consent from residents and other complainants
- How the ombudsman takes direction from residents
- Not taking action on any request
- The first actions the ombudsman takes upon entering a facility

Things to ask the trainer in a private setting:

- How many residents do you usually visit?
- Do you have a protocol at the start of each facility visit?
- How do you decide which staff to talk to about a complaint
- How do you make sure all residents are visited over time?
- What support documents and materials do you keep with you or in your car?
- How do you decide whether to "go up the chain of command" on a complaint?
- How should I protect my confidential records?
- When is my monthly report due?
Ombudsman Activities

The internship provides opportunity for interns to become acquainted with residents and form trusting relationships. Ombudsman interns are restricted from certain activities while they practice the most fundamental skills of a resident advocate.

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

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

* This is only applicable to interns. A certified ombudsman (CO) accesses areas where residents live and receive services. In general, areas restricted to residents are restricted to a CO, such as kitchens, medicine storage closets, and electrical and utility rooms. If invited to view a restricted area under facility staff supervision or depending upon a specific complaint or inquiry, access is appropriate.

** This is only applicable to interns. Once certified, ombudsmen investigate and work to resolve complaints.
Facility Visit Guide - Things to Look for During Visits

The regular presence of staff and volunteer ombudsmen improves resident care and quality of life. Remember these, “Things to look for…,” during your facility visits to help you focus on residents.

<table>
<thead>
<tr>
<th>Things to look for in residents</th>
<th>Things to look for in staff</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Are residents:</strong></td>
<td><strong>Do staff:</strong></td>
</tr>
<tr>
<td>- Clean and dressed?</td>
<td>- Make eye contact and smile with residents and with you?</td>
</tr>
<tr>
<td>- Participating in regular activities?</td>
<td>- Know the residents by name?</td>
</tr>
<tr>
<td>- Receiving meals and snacks?</td>
<td>- Respond quickly to call lights?</td>
</tr>
<tr>
<td>- Asked about individual preferences?</td>
<td>- Knock on doors before entering a resident’s room?</td>
</tr>
<tr>
<td>- Inhibited by physical or chemical restraints*?</td>
<td>- Treat residents with respect, courtesy, and dignity?</td>
</tr>
<tr>
<td>- Treated with kindness and respect?</td>
<td>- Ensure residents are covered for privacy when being moved in the hallway for a bath and while providing care?</td>
</tr>
<tr>
<td>- Are residents comfortable? Observe positioning in chairs.</td>
<td>- Wear name badges?</td>
</tr>
<tr>
<td>- Encouraged to personalize their living space?</td>
<td><strong>Things to look for in the physical environment</strong></td>
</tr>
</tbody>
</table>

*Read more about restraints in Chapter 5, Residents’ rights and Chapter 15, Systems Advocacy

<table>
<thead>
<tr>
<th>Things to look for in the physical environment</th>
<th>Things to look for in management</th>
</tr>
</thead>
<tbody>
<tr>
<td>- Are there odors in the rooms and halls?</td>
<td>- Are resident rights posted?</td>
</tr>
<tr>
<td>- Do residents have outside spaces to enjoy?</td>
<td>- Is the ombudsman poster visible?</td>
</tr>
<tr>
<td>- Are there private areas for conversations and phone calls?</td>
<td>- Are visiting hours enforced against resident wishes and family schedules?</td>
</tr>
<tr>
<td>- Are there safety features such as door alarms on exits, smoke alarms and detectors, and warning signs displaying wet floors?</td>
<td>- Are resident policies fair and within resident rights?</td>
</tr>
<tr>
<td>- Do residents have ample access to water in their rooms and in public areas access to water, coffee, and other fluids?</td>
<td>- Is the menu posted and followed?</td>
</tr>
<tr>
<td>- Are public restrooms and other public areas accessible to residents?</td>
<td>- Do residents help direct menu choices?</td>
</tr>
<tr>
<td>- Does the facility have security that restricts residents’ access to the outdoors?</td>
<td>- Are resident menu preferences followed?</td>
</tr>
<tr>
<td>- Are doors to hazardous areas properly secured?</td>
<td>- Are there flexible dining hours?</td>
</tr>
<tr>
<td></td>
<td>- Is the activity calendar posted and followed?</td>
</tr>
<tr>
<td></td>
<td>- Are activities varied, meaningful, and connected with the outside community?</td>
</tr>
<tr>
<td></td>
<td>- Are Regulatory Services survey results accessible?</td>
</tr>
</tbody>
</table>
Facility Contact Sheet

Facility Name ________________________________________ ID# _______________
Owner ________________________________________________________________________
Administrator or Manager _______________________________________________________
Medical Director __________________________________________________________________
Director of Nursing ______________________________________________________________
Social Worker _____________________________________________________________________
Activity Director __________________________________________________________________
Housekeeping / Laundry __________________________________________________________
Resident Council Contact __________________________________________________________________
Family Council Contact __________________________________________________________________
Specialized Services __________________________________________________________________

__________________________________________
Community Involvement __________________________________________________________________

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

The most recent survey was conducted on ________________.

Once a year, ask for a copy of the admissions packet given to residents. Review it and check that it is easy to understand and complete with the required notices:
  • Resident rights;
  • Current information about the ombudsman program; and
  • Current policies about safety and resident responsibilities.

Inform your supervising staff ombudsman of any concerns.

Observed and prepared by:

______________________________________________ Ombudsman ________________ Date

State Long-term Care Ombudsman Program Initial Certification Training

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an ombudsman guide...

Introduction
Service Coordination
Complaints & Appeals
Eligibility & Enrollment
Communication
References

to managed care in nursing facilities.
Managed care is part of Medicaid in Texas nursing facilities.

Remember that nursing facilities still have to provide good care, and they receive a daily rate payment for each resident who is on Medicaid.

Though nursing facilities are still responsible for a resident's care, people who have Medicaid have an additional company that is part of their care - managed care organizations.

Ombudsmen help all residents, regardless of who pays for their care. For us, MCOs are simply another organization we may need to work with to fulfill our role as resident advocates.

This guide is designed to help you understand the process.
So... What is managed care?

Medicaid pays MCOs what is called a capitated rate for each resident, depending on their level of care needs.

MCOs will provide service coordination and assess and authorize some services.

The MCOs then pay each nursing home in their network based on those capitated rates.
Service coordinators are responsible for managing overall resident care, regardless of where they live. Each MCO will have one service coordinator per facility. This is an overview of service coordination in nursing homes.

NOTE: Service coordination services vary depending on the setting (e.g., nursing home vs. assisted living).

- four face-to-face visits per year
- assess and approve some services
- participate in care plan meetings
- notified of major events, like discharge

TIP: Try calling the service coordinator with MCO-related issues before filing a complaint.
In managed care, complaints and appeals mean two different things.

**Complaint**

- Definition: An expression of dissatisfaction, either orally or in writing.
- Residents can complain about things like quality of services provided, rude employees, or failure to respect rights.
- Submit complaints through the MCO hotline number. The MCO must resolve them within 30 days.

**Appeal**

- Definition: Formal challenge of an MCO action to deny, reduce, or terminate services.
- To keep services during an appeal, residents must submit within 10 days.
- Residents can choose to appeal through the MCO, through the state fair hearing, or both. Find more MCO appeal information on the next page.
If an MCO denies, reduces, or terminates a resident’s services (things like occupational therapy or a customized wheelchair), the resident can use both the MCO appeal and the state fair hearing. This appeal process does not apply to discharge.

- **Day 1**: Notice of adverse action
- **Day 10**: To keep services during appeal, file MCO appeal within 10 days of the notice
- **Day 30**: Last day to file for an MCO appeal
- **Day 60**: Last day MCO has to make a decision on the appeal (or 30 days from date MCO receives appeal)
- **Day 70**: If MCO upholds its original decision: file for state fair hearing within 10 days of notice to keep services during the appeal
- **Day 90**: Last day to file for a state fair hearing
All residents who have Medicaid will have a managed care organization. Residents will enroll in managed care AFTER their Medicaid application is accepted.

1. Introduction Letter

The resident will receive a managed care introduction letter. This letter will explain managed care and talk about they need to do next.

2. Information Packet

Soon after, the resident will get an enrollment packet. It contains information on each plan, lists of doctors and extra services, and information on how to enroll.

3. Enrollment Process

Maximus is the name of the company Texas uses for managed care enrollment. Residents will enroll by either mailing or faxing the form in, or they can call Maximus and enroll over the phone.
things to remember...

Residents with Medicaid only (not dual eligible) should check and see whether their doctors and specialists are with the health plan they want. If the doctor they prefer is not listed, they will either need to talk to that doctor about joining or choose a new doctor in the health plan's network.

Residents will become eligible for managed care AFTER they are accepted into Medicaid. The initial Medicaid eligibility and application process will remain the same.

Residents can switch to a different MCO at any time, as long as it's an MCO that operates in their area.
References

1. Medicaid Managed Care Initiatives Website
   http://www.hhsc.state.tx.us/medicaid/managed-care/mmc.shtml

2. Health and Human Services Ombudsman:
   http://www.hhsc.state.tx.us/ombudsman/

3. National Long-term Care Ombudsman Resource Center (NORC), on Managed Long-term Services and Supports (MLTSS)
   http://www.ltcombudsman.org/issues/medicare-and-medicaid#mltss

4. Justice in Aging (formerly NSCLC), on Managed Long-term Services and Supports (MLTSS)
   http://justiceinaging.org/resources-for-advocates/mltss-in-managed-care-toolkit/
Notes: