



State Long-Term Care Ombudsman Program



State Long-Term Care Ombudsman Program

Ombudsman Certification Training Manual

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Long-term care ombudsmen advocate for residents and are separate from HHS.



State Long-Term Care
Ombudsman Program

State Long-Term Care Ombudsman Program Certification Training

State Long-Term Care Ombudsman Program
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https://apps.hhs.texas.gov/news_info/ombudsman/

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Table of Contents

TABLE OF CONTENTS	III
INTRODUCTION: WELCOME TO THE OMBUDSMAN PROGRAM	1
WHAT IS A LONG-TERM CARE OMBUDSMAN?	1
WHAT DOES A LONG-TERM CARE OMBUDSMAN DO?	1
ON YOUR OWN – VIDEO – WHAT DOES A LONG-TERM CARE OMBUDSMAN DO?	1
WHAT ARE THE TRAINING REQUIREMENTS?	2
ARE THERE OTHER REQUIREMENTS?	3
HOW DO I GET CERTIFIED?.....	3
TRAINING MANUAL - ICONS KEY.....	4
ACRONYMS	5
TERMS USED IN THIS MANUAL	7
CHAPTER 1: THE BASICS OF LONG-TERM CARE OMBUDSMAN PROGRAMS	9
HOW LONG-TERM CARE OMBUDSMAN PROGRAMS BEGAN	10
THE LONG-TERM CARE OMBUDSMAN PROGRAM NATIONALLY.....	11
THE LONG-TERM CARE OMBUDSMAN PROGRAM IN TEXAS	11
FUNDAMENTAL PRINCIPLES OF OMBUDSMAN WORK.....	13
WHY DO LONG-TERM CARE RESIDENTS NEED ADVOCACY?	15
UNIQUE ASPECTS OF THE LONG-TERM CARE OMBUDSMAN PROGRAM	19
ATYPICAL MANDATES	21
OMBUDSMAN PROHIBITED ACTIVITIES	24
SUPPLEMENT 1-A: OMBUDSMAN PROGRAM MILESTONES	28
SUPPLEMENT 1-B: STATUTORY AND RULE REFERENCES	33
CHAPTER 2: AGING AND RESIDENTS	35
ATTITUDES ABOUT AGING	36
DEBUNKING MYTHS ABOUT OLDER ADULTS	37
DEMOGRAPHIC INFORMATION ON OLDER ADULTS.....	39
NURSING FACILITY STATISTICS.....	40
ASSISTED LIVING FACILITY STATISTICS	41
WHY LONG-TERM CARE?	42
ON YOUR OWN – QSEP COMPUTER-BASED TRAINING (CBT) & QUIZ – CMS HAND IN HAND	
DEMENTIA TRAINING – MODULES 1-4.....	44
PEOPLE WITH DEMENTIA EXPERIENCE LIFE DIFFERENTLY	49
ON YOUR OWN – VIDEO – BPSD DEMONSTRATION BY DR. ALLEN POWER, MD	50

SUPPLEMENT 2-A: EIGHT MYTHS ABOUT AGING AND THEIR REALITIES	51
SUPPLEMENT 2-B: TYPES OF SERIOUS MENTAL ILLNESS AND DEMENTIA	54
CHAPTER 3: PERSON-CENTERED COMMUNICATION	59
PERSON-CENTERED COMMUNICATION.....	60
ON YOUR OWN – VIDEO & QUIZ – PERSON-CENTERED CARE – PERSON-CENTERED LANGUAGE	62
COMMUNICATION BASICS.....	65
EMPATHY	66
ON YOUR OWN – VIDEO & QUIZ - RSA SHORT - THE POWER OF EMPATHY - BRENÉ BROWN ON EMPATHY	67
LISTENING SKILLS ASSESSMENT.....	68
COMMUNICATION WITH RESIDENTS.....	69
COMMUNICATION WITH FACILITY STAFF	81
COMMUNICATION DURING A FACILITY VISIT.....	83
CHAPTER 4: CONFIDENTIALITY, DISCLOSURE, AND CONSENT	85
CONFIDENTIALITY	86
DISCLOSURE	87
CONSENT	88
ON YOUR OWN – VIDEO – HOW TO OBTAIN CONSENT - PART 1	89
FREQUENTLY ASKED QUESTIONS – CONSENT	94
SITUATIONS WHERE CONSENT IS NOT REQUIRED TO TAKE AN ACTION	94
RESIDENT REPRESENTATIVES	97
SEEK CONSENT FROM THE APPROPRIATE RESIDENT REPRESENTATIVE	98
LEGALLY AUTHORIZED REPRESENTATIVES (LAR)	98
FREQUENTLY ASKED QUESTIONS – AGENT ON A POWER OF ATTORNEY.....	100
THE RESIDENT HAS A GUARDIAN AND IS ABLE TO CONSENT	103
FREQUENTLY ASKED QUESTIONS – GUARDIANSHIP.....	103
OTHER TYPES OF RESIDENT REPRESENTATIVES	104
SUPPLEMENT 4-A: WARD BILL OF RIGHTS	108
SUPPLEMENT 4-B: OMBUDSMAN CONSENT AND AUTHORITY FLOW CHART.....	112
CHAPTER 5: RESIDENTS’ RIGHTS.....	117
OVERVIEW OF RESIDENTS’ RIGHTS.....	118
RESIDENTS’ RIGHTS UNDER LAW.....	118
THE OMBUDSMAN ROLE	119
RESIDENTS’ RIGHTS THEMES	121

ON YOUR OWN - INFECTION CONTROL ADVOCATE & RESIDENT EDUCATION (ICARE), COMPUTER-BASED TRAINING (CBT) - LESSON 1 - COMMON INFECTIONS IN NURSING HOME COMMUNITIES	124
SPECIFIC RIGHTS.....	125
ON YOUR OWN ICARE, CBT - LESSON 2 - PREVENTING INFECTIONS IN NURSING HOME COMMUNITIES	128
ON YOUR OWN – VIDEO & QUIZ – NURSING HOME DISCHARGE	130
THE RIGHT TO BE FREE FROM ABUSE, NEGLECT, AND EXPLOITATION (ANE)	134
OMBUDSMEN ARE NOT MANDATORY REPORTERS	136
CONSENT REQUIREMENTS RELATED TO ALLEGATIONS OF ANE	137
FREQUENTLY ASKED QUESTIONS – ANE.....	139
FACILITY RESPONSIBILITIES RELATED TO ANE	141
ON YOUR OWN – CBT & QUIZ –HAND IN HAND DEMENTIA TRAINING - MODULE 5 – PREVENTING AND RESPONDING TO ABUSE BY CMS	143
ENFORCEMENT OF RESIDENTS’ RIGHTS	148
RIGHTS OF NURSING FACILITY FAMILIES AND LEGAL REPRESENTATIVES	151
RIGHTS OF ASSISTED LIVING FACILITY FAMILIES AND LEGAL REPRESENTATIVES.....	152
SUPPLEMENT 5-A: SUMMARY OF NURSING FACILITY RESIDENTS’ RIGHTS	157
SUPPLEMENT 5-B: SUMMARY OF ASSISTED LIVING FACILITY RESIDENT RIGHTS.....	161
CHAPTER 6: OMBUDSMAN PROGRAM ACCESS AND LONG-TERM CARE FACILITY OPERATIONS.....	165
OMBUDSMAN PROGRAM ACCESS	166
THE OMBUDSMAN ROLE	168
LONG-TERM SERVICES AND SUPPORTS (LTSS)	168
ASSISTED LIVING FACILITIES	170
NURSING FACILITIES.....	183
CONSISTENT STAFFING	204
ON YOUR OWN – VIDEO & QUIZ – PERSON-CENTERED CARE: CONSISTENT STAFF ASSIGNMENTS	205
EMERGENCY PREPAREDNESS AND RESPONSE PLANS	205
INFECTION PREVENTION	208
ON YOUR OWN – VIDEO – STATE LONG-TERM CARE OMBUDSMAN PROGRAM PPE FOR LONG- TERM CARE OMBUDSMAN FACILITY VISITS	209
ON YOUR OWN – CBT – INFECTION CONTROL – ICARE – LESSON 3 – SAFEGUARDING THE NURSING HOME ENVIRONMENT	209
ON YOUR OWN – CBT – INFECTION CONTROL – ICARE – LESSON 4 – HAND HYGIENE HEROES!	209

ON YOUR OWN – CBT – INFECTION CONTROL – ICARE – LESSON 5 – GOWNS, GLOVES, AND GOGGLES: PRECAUTIONS FOR PREVENTION	210
FREQUENTLY ASKED QUESTIONS – INFECTION PRECAUTIONS AND OMBUDSMAN VISITATION	211
GOOD RELATIONSHIPS BETWEEN OMBUDSMEN, RESIDENTS, AND FACILITY STAFF	212
VOLUNTEER INTERNSHIP - ACCOMPANIED AND UNACCOMPANIED FACILITY VISITS.....	213
FACILITY VISIT GUIDE	217
FACILITY VISIT GUIDE - MEMORY CARE AND ALZHEIMER’S CERTIFIED FACILITIES.....	219
FACILITY CONTACT SHEET	221
CHAPTER 7: RESIDENT AND FAMILY COUNCILS	227
RESIDENT AND FAMILY COUNCILS	228
LAWS AND REGULATIONS RELATED TO RESIDENT AND FAMILY COUNCILS (GROUPS)	235
AN ADVOCACY ORGANIZATION.....	240
SUPPLEMENT 7-A: AGENDA TEMPLATE FOR RESIDENT OR FAMILY COUNCIL MEETINGS	241
SUPPLEMENT 7-B: SAMPLE COUNCIL MEETING MINUTES	242
SUPPLEMENT 7-C: SAMPLE RESIDENT OR FAMILY COUNCIL BYLAWS	245
CHAPTER 8: PERSON-CENTERED CARE AND SERVICE PLANNING.....	249
PERSON-CENTERED CARE	250
RESIDENT-DIRECTED CARE	251
CARE AND SERVICE PLANS	253
CARE OR SERVICE PLAN MEETING	256
NURSING FACILITY REGULATIONS RELATED TO CARE PLANS	259
ASSISTED LIVING FACILITY REGULATIONS RELATED TO SERVICE PLANS	259
BASICS OF INDIVIDUALIZED QUALITY CARE	259
ON YOUR OWN – VIDEO & QUIZ – PERSON-CENTERED CARE – HEALTH CARE SCHEDULES	260
ON YOUR OWN – VIDEO & QUIZ – PERSON-CENTERED CARE – CARE PLANS.....	261
TRAUMA-INFORMED CARE	262
THE OMBUDSMAN ROLE IN CARE OR SERVICE PLANNING	269
DISCHARGE PLANNING.....	270
REGULATIONS AND STATUTES PERTAINING TO ADVANCE CARE PLANNING	272
THE OMBUDSMAN ROLE IN ADVANCE CARE PLANNING	275
FREQUENTLY ASKED QUESTION – SERVING AS A DECISION MAKER	276
CONNECT REGULATORY COMPLIANCE WITH RESIDENT-DIRECTED CARE.....	277
CHAPTER 9: IDENTIFY, RECEIVE, AND INVESTIGATE COMPLAINTS...	293
DEFINITION OF A COMPLAINT	294

RESPOND TO COMPLAINTS.....	295
FREQUENTLY ASKED QUESTION – RESPONSE TO A COMPLAINANT.....	297
INVESTIGATE COMPLAINTS	303
THREE METHODS OF EVIDENCE COLLECTION	304
ON YOUR OWN – VIDEO & QUIZ – THE MONKEY BUSINESS ILLUSION	305
ON YOUR OWN – VIDEO & QUIZ –LONG-TERM CARE OMBUDSMAN CASEWORK: ADVOCACY AND COMMUNICATION – ANNE WALKER	308
CHAPTER 10: COMPLAINT RESOLUTION SKILLS.....	315
COMPLAINT RESOLUTION SKILLS	316
NEGOTIATION STYLES.....	319
POTENTIAL BARRIERS TO RESOLVING CONFLICT	322
ON YOUR OWN – VIDEO & QUIZ –LONG-TERM CARE OMBUDSMAN CASEWORK: ADVOCACY AND COMMUNICATION SKILLS – BRIAN BRASHEAR	324
THE FIVE-STEP PROBLEM-SOLVING PROCESS.....	326
CASE EXAMPLE - THE FIVE-STEP PROBLEM-SOLVING PROCESS.....	334
SUPPLEMENT 10-A: BASIC GUIDELINES FOR OMBUDSMAN DOCUMENTATION	341
CHAPTER 11: STAY CONNECTED AND REPORT OMBUDSMAN WORK... 345	
STAY CONNECTED WITH THE OMBUDSMAN PROGRAM.....	346
ON YOUR OWN – VIDEO – HOW TO OBTAIN CONSENT AND THE IMPORTANCE OF DOCUMENTATION, PART 2.....	349
REPORT OMBUDSMAN WORK.....	349
REPORT INFORMATION AND ASSISTANCE ACTIVITIES (I&A)	351
REPORT CASEWORK	353
COMPLAINT CODE CATEGORIES	360
PERPETRATOR ROLES & CODES	365
FREQUENTLY ASKED QUESTIONS - COMPLAINT CODES.....	366
COMPLAINT VERIFICATION.....	368
REFERRAL AGENCY	370
DISPOSITION	370
CLOSE THE CASE	373
FREQUENTLY ASKED QUESTIONS - CASEWORK DOCUMENTATION	374
TIPS FOR FILLING OUT THE HHS FORM 8620 LONG-TERM CARE OMBUDSMAN ACTIVITY REPORT.....	391
SUPPLEMENT 11-A: OMBUDSMAN COMPLAINT CODES	395
SUPPLEMENT 11-B: COMPLAINT CODES AND DESCRIPTIONS	397
SUPPLEMENT 11-C: EXERCISE-RESEARCHING STATUTORY SUPPORT - NF COMPLAINTS...	417

SUPPLEMENT 11-D: EXERCISE - RESEARCHING STATUTORY SUPPORT FOR ALF COMPLAINTS	419
SUPPLEMENT 11-E: TRAINING AND ADVOCACY RESOURCES	421
SUPPLEMENT 11-F: STATE AND FEDERAL REGULATIONS, STATUTES, AND GUIDANCE USED IN OMBUDSMAN WORK.....	422
CHAPTER 12: RESIDENT RECORDS.....	427
RESIDENT AND LAR ACCESS TO RESIDENT RECORDS	428
OMBUDSMAN ACCESS	428
REQUEST, REVIEW, AND USE OF A RECORD	429
FREQUENTLY ASKED QUESTION – OMBUDSMAN ACCESS.....	430
MEDICAL RECORDS.....	432
DOCUMENTATION OF CONSENT TO ACCESS A RECORD	436
DISCLOSURE OF CONFIDENTIAL RESIDENT RECORDS.....	437
OMBUDSMAN PROGRAM RECORDS	437
SUPPLEMENT 12-A: COMMON MEDICAL CHART ABBREVIATIONS	439
CHAPTER 13: REGULATORS AND OTHER RESOURCES	443
REGULATORS AND OTHER RESOURCES	444
OMBUDSMAN ROLE WITH REGULATORY SERVICES	455
OTHER RESOURCES	456
FEDERAL RESOURCE.....	464
RESOURCES FOR APPLYING FOR MEDICAID	465
OMBUDSMAN REFERRALS TO OUTSIDE AGENCIES.....	465
CHAPTER 14: GET ACQUAINTED WITH THE OMBUDSMAN POLICIES AND PROCEDURES MANUAL (OPPM).....	469
GET ACQUAINTED WITH THE OPPM	471
STATE LONG-TERM CARE OMBUDSMAN PROGRAM POLICIES AND PROCEDURES	485
APPENDIX 1: FORMS	487
HHS FORM 8618 – DOWNLOAD INSTRUCTIONS	487
DEBRIEF FOR ACCOMPANIED FACILITY VISITS.....	493
EVALUATION OF STATE LONG-TERM CARE OMBUDSMAN PROGRAM INITIAL CERTIFICATION TRAINING	497

Introduction: Welcome to the 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 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 Is a Long-Term Care Ombudsman?

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

Long-term care ombudsmen serve as advocate ombudsmen. Ombudsmen are impartial while investigating to determine the facts relevant to a case. Once the facts are determined, the ombudsman advocates, seeking solutions the resident wants. An advocate ombudsman does not represent their own personal views but supports those of the person they are helping. An advocate ombudsman also does not represent facility or staff interests.

What Does a Long-Term Care Ombudsman Do?

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

On Your Own – Video – What Does a Long-Term Care Ombudsman Do?

Link to video: <https://ltco.texas.gov/>

Video length: 3 minutes.

Ombudsmen Serve Residents

Handle Complaints and Problem Solve

Ombudsmen support 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 (I&A)

Ombudsmen are good sources of information about how to select a long-term care facility, residents' rights, how long-term care facilities operate, and facility regulations.

Advocate for System and Legislative Changes

State and local ombudsman programs work together to recommend regulatory and legislative changes that affect older Texans.

What Are the Training Requirements?

To get certified, ombudsmen must complete a 36-hour certification training. For volunteers, this includes:

- At least 16 hours of classroom, live webinars or virtual meetings, and telephone conference call training;
- At least 10 hours of field training including at least two facility visits accompanied by an experienced certified ombudsman for in-facility training; and at least two unaccompanied facility visits;
- A maximum of 7 hours of independent study applied to the first 36 hours of training;
- At least 3 additional hours of in-person manual review or in-facility training, or a combination of the two (to meet 36-hour requirement);
- A completed activity report for unaccompanied visits; and
- A 60-day internship for volunteers which begins on the day of the first accompanied visit (see Chapter 6 for more information).

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 and assisted living facilities.

Are There Other Requirements?

Ombudsmen must:

- Have a sincere interest in promoting the well-being and protecting the rights of people living in long-term care facilities.
- Possess the ability to work cooperatively with the people who live in nursing and assisted living facilities, local staff ombudsmen, and long-term care facility staff.
- Be able to discover facts, work to resolve complaints, and impartially and objectively determine whether complaints are verified or not verified.
- Accept and adhere to the State Long-Term Care Ombudsman Program Code of Ethics.
- Comply with the Ombudsman Policies and Procedures Manual (OPPM).
- Be free of any conflict of interest.
- Successfully complete the State Long-Term Care Ombudsman Program Certification Training.
- Have the approval of the Managing Local Ombudsman (MLO) and the State Ombudsman to serve as an ombudsman.

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, demonstrating the ability to apply ombudsman fundamentals, and volunteers served a 60-day internship, an MLO may recommend an intern to be certified. The State Ombudsman makes the final decision.

Training Manual - Icons Key



Question(s) About the Reading Above



Chapter Exercise



Discussion – Ask the Instructor



Ombudsman Tip



Important Information



Consultation Required



Quote



Link to a Website or Facebook



YouTube or Other Video



Infection Control Advocate & Resident Education (ICARE) Computer-Based Training



CMS Quality, Safety & Education Portal (QSEP) – Computer-Based Training

Acronyms

Acronym Term

AAA	Area Agency on Aging
AD	Activity Director
ADL	Activity of Daily Living
ADMIN	Administrator
ADON	Assistant Director of Nursing
ALF	Assisted Living Facility
ANE	Abuse, Neglect, and Exploitation
APS	Adult Protective Services
BOM	Business Office Manager
CBT	Computer-Based Training
CFR	Code of Federal Regulations
CII	Complaint and Incident Intake, Texas HHS Regulatory Services
CMA	Certified Medication Aide
CMS	Centers for Medicare and Medicaid Services
CNA	Certified Nurse Aide
DAHS	Day Activity and Health Services
DON	Director of Nursing
DPoA	Durable Power of Attorney
DRTx	Disability Rights Texas
EWS	Early Warning System
HCBS	Home and Community Based Services
HCSSA	Home and Community Support Services Agency
HHS	Texas Health and Human Services
HHSC	Texas Health and Human Services Commission
HIPAA	Health Insurance Portability and Accountability Act
HSC	Health and Safety Code
I&A	Information and Assistance
LAR	Legally Authorized Representative, such as a guardian, a parent, a managing conservator of a minor, or an agent authorized under a power of attorney
LIDDA	Local Intellectual and Developmental Disability Authority
LMHA	Local Mental Health Authority
LOE	Local Ombudsman Entity / Local Ombudsman Program

Acronym Term

LTC	Long-Term Care
LTCR	Long-Term Care Regulatory (Texas HHS Long-Term Care Regulatory)
LTSS	Long-Term Services and Supports
LVN	Licensed Vocational Nurse
MCO	Managed Care Organization
MFP	Money Follows the Person
MLO	Managing Local Ombudsman; is also a Certified Ombudsman
MPoA	Medical Power of Attorney
NF	Nursing Facility
OAA	Older Americans Act
OPPM	Ombudsman Policies and Procedures Manual
PASRR	Preadmission Screening and Resident Review
PNA	Personal Needs Allowance
POA	Power of Attorney
POA Agent	Power of Attorney - Agent
QMP	Quality Monitoring Program
RN	Registered Nurse
RP	Responsible Party
SNF	Skilled Nursing Facility
SOM	CMS State Operations Manual Appendix PP – Guidance to Surveyors for Long Term Care Facilities
STAR+PLUS	Texas Medicaid-managed care program for adults who have disabilities or are age 65 or older
SW	Social Worker
TAC	Texas Administrative Code
VA	Veteran Affairs

Additional Acronyms for Use in Internal Ombudsman Reporting

ED	Executive Director, Manager for Assisted Living Facility
FV	Facility Visit
MAR	Medication Administration Record
RC	Resident Council
TC	Telephone Call / Telephone Contact

Terms Used in this Manual

Ombudsman

"Ombudsman," as used in this training manual, refers to a certified ombudsman.

Interns, ombudsmen in training, are restricted from performing all the functions of a certified ombudsman. Interns do not investigate complaints nor access confidential records unless accompanied by a certified ombudsman. Interns visit with residents solely for the purpose of getting to know them and to start developing trusting relationships with residents and professional relationships with facility staff.

Resident

A resident is an individual residing in a long-term care (nursing or assisted living) facility.

Ombudsmen work on behalf of residents. Ombudsmen may also work with the families and friends of residents, as well as facility staff and others, who may make a complaint on behalf of a resident.

Let's get started!



Exercise - Get Acquainted

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

1) What is your name? _____

2) Why are you interested in being an ombudsman?

3) Have you visited a nursing facility? ____Yes ____No

4) Have you visited an assisted living facility? ____Yes ____ No

5) What were your impressions of the last facility visited?

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Chapter 1: The Basics of Long-Term Care Ombudsman Programs

Chapter 1 describes 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
- Fundamental Principles of Ombudsman Work
- Why Do Long-Term Care Residents Need Advocacy?
- Unique Aspects of the Long-Term Care Ombudsman Program
- Ombudsman Prohibited Activities

Video(s), Supplements, Forms

- Supplement 1-A: Historical 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 facility industry, and the number of nursing facilities 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 facilities. 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 an ombudsman program and envisioned it as an advocacy program for residents. He pitched the idea to the President during 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.

Older Americans Act

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

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

SOURCE: Supporting Older Americans Act of 2020 <https://www.congress.gov/bill/116th-congress/house-bill/4334/text>. Accessed September 2023.

The Long-Term Care Ombudsman Program Nationally

As required by the OAA, long-term care ombudsman programs operate in 50 states, the District of Columbia, Puerto Rico, and Guam. Many states, including Texas, incorporate volunteer ombudsmen in their program to advocate for residents. Each state has an office of the state long-term care ombudsman headed by a full-time state long-term care ombudsman.

The Long-Term Care Ombudsman Program in Texas

In Texas, the Office of the State Long-Term Care Ombudsman (the Office) is an independent unit within Texas Health and Human Services (HHS). Patty Ducayet is the State Long-Term Care Ombudsman. Patty Ducayet is responsible for overseeing the program, including:

- Ensuring that residents have access to the program.
- Responding to, resolving complaints, and assigning this work to other ombudsmen.
- Representing the interests of residents before governmental agencies.
- Ensuring all program requirements are fulfilled.
- Ensuring representatives of the Office fulfill their duties.
- Designating representatives of the Office and local ombudsman entities.

The State of Texas contracts with 28 area agencies on aging (AAAs) to provide ombudsman services locally. Twenty-five AAAs operate offices, and three AAAs subcontract the Ombudsman Program:

- Dallas County –The Senior Source
- Harris County – The University of Texas Health Science Center at Houston
- South Plains – LIFE, Inc.

Each local office has a Managing Local Ombudsman (MLO) who manages the program in their service area. Offices with fewer facilities and residents to serve may be staffed with only an MLO. Large offices have an MLO and other staff ombudsmen. All 28 local programs recruit and train volunteers to serve as ombudsmen.



Very Important Information!

Managing Local Ombudsman (MLO) Name: _____

MLO Phone Number: _____

Supervising Staff Ombudsman Name: _____

Staff Ombudsman Phone Number: _____

Mission Statement

The Texas Long-Term Care Ombudsman Program advocates for optimal quality of life and quality of care for residents in nursing 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 and assisted living facilities.

Philosophy

Individuals who live in long-term care facilities are entitled to dependable and consistent care. Ombudsmen advocate for residents to enjoy quality of life and receive high quality care no matter how they pay for their care.

Quality of Life and Care

Quality of life refers to an individual's sense of well-being, level of satisfaction with life, and feelings of self-worth and self-esteem. Quality of care is a fundamental principle that applies to all treatment and care provided to individuals living in long-term care.

State regulations pertaining to assisted living facilities do not directly address quality of life or care. Both state and federal nursing facility regulations provide definitions of quality of life and care, based on federal law (Code of Federal Regulations), which are summarized below.

Quality of Life

For nursing facility residents, quality of life includes a basic sense of satisfaction with oneself, the environment, the care received, the accomplishments of desired goals, and control over one's life.

Per nursing facility requirements, each resident must receive, and the nursing facility must provide, the necessary care and services to attain or maintain the highest practicable, physical, mental, and psychosocial well-being, consistent with the resident's comprehensive assessment and plan of care.

Aspects of quality of life include:

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

SOURCE: [26 TAC §554.701](#); [42 CFR §483.24](#). Accessed April 2025.

Quality of Care

Based on the comprehensive assessment of a resident, the nursing facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the resident's choices. Care and services to be addressed include activities of daily living, vision and hearing, skin integrity (pressure ulcers, foot care), mobility, mental and psychosocial functioning, incontinence, nutrition, and medications. For a small number of children who live in a nursing facility, their unique medical and developmental needs must be met.

SOURCE: [26 TAC §554.901](#); [42 CFR §483.25](#). Accessed April 2025.

Fundamental Principles of Ombudsman Work

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 Long-Term Care Ombudsman.

Ombudsmen also respond to and work to resolve complaints from family, friends, and facility staff - if the complaint pertains to residents. However, we

always seek the resident's consent and act based on resident direction. The resident's wishes supersede another complainant's wishes. Ombudsmen use a problem-solving process to analyze and resolve complaints. Chapter 10 describes the five-step problem-solving process in detail.

Educate and Empower

A key responsibility of the Ombudsman Program is to inform individuals about long-term care residents' rights. Ombudsmen continually educate residents, family members, facility staff, and the public. By providing information about residents' rights and person-centered care, representatives empower residents to voice their concerns and be part of the complaint resolution process to the extent possible.

Generally, ombudsmen do not determine what is best for residents, nor do they make decisions for the resident, ombudsmen support and advocate on behalf of the resident's wishes. This means that sometimes a resident's wishes may conflict with the perspective of facility staff, medical professionals, family members, and others as they may want what is beneficial or "in the resident's best interests."

SOURCE: The National Long-Term Care Ombudsman Resource Center (NORC), Initial Certification Training Curriculum. https://ltcombudsman.org/omb_support/training/norc-curriculum. Accessed January 2022.

Consent and Confidentiality

More information about requirements pertaining to consent, confidentiality, and disclosure are found in Chapter 4.

Consent

In most cases, ombudsmen may not act without consent from the resident. If the ombudsman determines the resident is unable to consent, consent is obtained from the resident's legally authorized representative (LAR) which is typically a guardian or agent on a power of attorney.

Confidentiality

The Older Americans Act requires strict protection of the identity of residents and other complainants, and information obtained about residents and complainants while performing ombudsman duties. To maintain confidentiality, ombudsmen must receive consent to:

- Share the name of a resident or complainant.
- Act on behalf of a resident.
- Disclose other confidential information about a resident or complainant.

Why Do Long-Term Care 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. Because people are living longer, and many family members live far away, residents may have few visitors other than a long-term care ombudsman. The State Long-Term Care Ombudsman Program serves as advocates for all individuals who live in the 1,181 nursing facilities and 2,013 assisted living facilities in Texas. Approximately 134,000 individuals are our clients.

With 281 certified volunteer ombudsmen and the full-time equivalent of approximately 85 certified staff ombudsmen, the State 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. Facility routines and rules are often developed for facility convenience and efficiency. That means facility operations can conflict with the needs of individual residents and their individualized care or service plan. Moreover, many residents are unable to express their needs or exercise their rights without help from others.

SOURCE: Regulatory Licensing and Certification. Accessed January 2025.

Barriers to Self-Advocacy

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

- Belief that the current living situation is the best it can ever be
- Fear of being labeled a complainer
- Fear of retaliation
- Sense of isolation
- Sense of hopelessness or despair
- Loneliness
- Reluctance to question authority

Lack of Information About

- Alternative living options
- How to improve their living situations
- Legal services
- Rights

Other Barriers

- Cultural beliefs and norms
- Communication barriers like an individual's native language
- Insufficient medical or nursing care
- Limited finances
- Lack of privacy
- Physical or verbal abuse
- Lack of experience being assertive



Answer the following questions.

1) What are the four fundamental principles of ombudsman work?

2) What is the name of the Texas State Long-Term Care Ombudsman?



Exercise – Identify Long-Term Care Ombudsman Functions

Use the information in the Comparison of State Ombudsman, Certified Ombudsman, and Intern functions table to determine whether each of the following statements is true or false. Mark the correct answer.

1) ☐ True ☐ False

All ombudsmen protect the confidentiality of residents.

2) ☐ True ☐ False

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

3) ☐ True ☐ False

All certified ombudsmen help protect resident rights.

4) ☐ True ☐ False

Certified ombudsmen help facility staff solve disagreements with other staff.

5) ☐ True ☐ False

When acting as a certified ombudsman, volunteers and staff may comment on proposed laws in coordination with the State Ombudsman.

6) ☐ True ☐ False

Ombudsman interns do not identify, investigate, and resolve complaints made by, or on behalf of, residents.

Comparison of State Ombudsman, Certified Ombudsman, and Intern Functions

Review the following table to determine the distinctions among functions of the State Ombudsman, Certified ombudsmen (volunteers and staff), and Interns (volunteers in training). Chapter 6 has more information on ombudsman intern activities.

OMBUDSMAN FUNCTION	State Ombudsman	Certified Ombudsmen	Interns
Provide information to and visit residents	Yes	Yes	Yes
Protect the confidentiality of all residents	Yes	Yes	Yes
Promote the Ombudsman Program	Yes	Yes	No
Provide technical support to develop resident and family councils	Yes	Yes*	No
Provide residents with regular and timely access to ombudsman services	Yes	Yes	No
Assist residents to protect their rights and express a complaint pertaining to their health, safety, welfare, and rights within a facility	Yes	Yes	No
Identify, investigate, and resolve complaints made by, or on behalf of, residents	Yes	Yes	No
Seek administrative, legal, and other remedies to protect the health, safety, welfare, and rights of residents	Yes	Yes	No
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	Yes	Yes*	No

OMBUDSMAN FUNCTION	State Ombudsman	Certified Ombudsmen	Interns
The State Ombudsman prepares and submits an annual report that describes program activities, notes problematic residents' experiences, and makes recommendations to improve residents' quality of care and life. The State Ombudsman also makes recommendations in laws, regulations, and policies to solve identified problems and protect resident welfare.	Yes	**	No

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

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

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 resident advocates, our presence and role help balance the difference in power between residents and facility management in a nursing 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 Versus Long-Term Care (Advocate) Ombudsman

Classical Ombudsman

- Purpose:** Classical ombudsmen are impartial mediators who receive complaints, determine pertinent facts, and seek resolution.
- Setting:** They are found in many settings, both public and private.
- Focus:** They are neutral and make sure the system works as it was designed to work.
- Scope:** Their scope varies, but they usually serve within one organization.

Long-Term Care Ombudsman

- Purpose:** Long-term care ombudsmen are impartial in investigation to:
- Determine pertinent facts.
 - Gather enough information to understand the problem in order to represent a resident's interest.
 - Advocates for a resident-focused solution.
- Setting:** Long-term care ombudsmen work in nursing and assisted living facilities.
- Focus:** They seek a resident-directed resolution and work to overcome bureaucratic barriers.
- Scope:** They seek resolution for individual and systemic issues.

Ethical Issues

Ombudsmen must act ethically in behavior and decision making because:

- Ombudsman work is filled with ambiguity regarding how to proceed.
- Ombudsmen typically encounter issues that are not clearly right or wrong.

- One ombudsman's actions can impact the credibility of the statewide program.

Long-term care ombudsman programs have a few unique elements including:

- Their jurisdiction is the interest of the resident.
- Their resolution standard is to resolve to the resident's satisfaction — or in absence of an identified resident, the complainant's satisfaction.
- They are mandated to advocate on behalf of the broad interests of residents, including public policy. This is often referred to as systems advocacy.
- They promote the development of groups such as citizen organizations to work with the program and provide 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.

Conflict of Interest Provisions

The Ombudsman Program has specific conflict of interest provisions for individuals representing the program. An individual conflict of interest is a:

- Situation in which a person is involved in multiple interests, financial or otherwise, that could impact the effectiveness and credibility of the Ombudsman Program; and
- Conflict that involves an ombudsman or an immediate family member of an ombudsman.

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.

Confidentiality

The Older Americans Act requires strict protection of the identity of residents and complainants, and information obtained about residents and complainants while performing ombudsman duties.

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 600 and 800 of the Ombudsman Policies and Procedures Manual (OPPM) provide detailed information about consent and the ombudsman role and responsibilities related to allegations of ANE.



Very important information!

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. Follow the guidelines established in the OPPM.

Legal Coordination

If legal or administrative remedies are required to resolve a complaint, the program can pursue the administrative, legal, or other appropriate remedies on behalf of residents through in-house legal counsel or coordination with other legal advocacy services such as Texas Legal Services Center or Disability Rights Texas. For more information, refer to Chapter 700 of the OPPM.

SOURCE: OPPM Chapter 700.

Legal Counsel

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. The Office of the Attorney General provides legal counsel to an ombudsman in the performance of their duties. For more information, refer to Chapter 8000 of the Ombudsman Policies and Procedures manual.

Texas Human Resources Code, Title 6, §101A.256. Legal Counsel

The commission shall ensure that the office receives adequate legal advice and representation without conflict of interest as defined by the Texas Disciplinary Rules of Professional Conduct. The attorney general shall represent the state long-term care ombudsman and a representative if a suit or other legal action is brought or threatened to be brought against that person in connection with the persons performance of the official duties of the ombudsman program.

SOURCE: <https://statutes.capitol.texas.gov/Docs/HR/htm/HR.101A.htm>. Accessed February 2020.

Willful Interference

Program representatives are protected from willful interference. Interference with ombudsmen performing their duties is a Class B misdemeanor, per the Texas Human Resources Code, Title 6, §101A.264.

Texas Human Resources Code, Title 6, §101A.264. Criminal Penalty

(a) A person commits an offense if the person:

(1) by act or omission, wilfully interferes or attempts to interfere with the state long-term care ombudsman or a representative 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 the state long-term care ombudsman or a representative.

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

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

SOURCE: <https://statutes.capitol.texas.gov/Docs/HR/htm/HR.101A.htm>. Accessed May 2025.

Systems Advocacy

The Office of the State Long-Term Care Ombudsman is independent of the Texas Health and Human Services system. This ensures the State Ombudsman, and all program representatives advocate for residents' interests.

Ombudsmen work to solve individual problems and to change policy and law to protect residents. Certified ombudsmen must consult with and obtain approval from the state office before commenting on or recommending changes to a public official, governmental entity, or the media regarding the development and implementation of laws, rules, regulations, and other policies and actions that pertain to the health, safety, welfare, and rights of residents with respect to the adequacy of long-term care facilities and services (OPPM 1000).

For example, in 2023 during the 88th Legislative session, ombudsmen across the state rallied and, led by the State Ombudsman, promoted and encouraged the passage of a bill to raise the personal needs allowance of nursing facility residents. House Bill 54 passed and increased the Medicaid personal needs allowance (PNA*) from \$60 to \$75 per month.

* PNA is the money residents on Medicaid are allowed to keep for personal expenses each month; the rest of their Social Security income is paid to the facility. Commonly, the PNA is the only spending money a resident will have for the month and may be used to pay for items such as clothing, telephones, and entertainment.

SOURCES: [Older Americans Act, §712\(a\)\(3\)](#); [45 CFR §1324.11\(e\)\(5\)](#); [45 CFR §1324.13\(a\)\(7\)-\(9\)](#); [OPPM Chapter 1000](#).

Ombudsman Prohibited Activities

Ombudsmen follow the guidelines established in this manual and the OPPM.

Ombudsmen and ombudsman interns **must not**:

- 1) Disclose confidential information unless consent and disclosure requirements are met (as outlined in the OPPM, Chapter 600);
- 2) Disclose confidential information to a Regulatory Services surveyor unless the ombudsman has obtained consent or has the authority to disclose the information (as outlined in OPPM, Section 630 and Section 5090);
- 3) Disclose information provided to the ombudsman by a Regulatory Services surveyor regarding a survey or complaint investigation of a nursing or assisted living facility to a person who is not a certified ombudsman (OPPM, Chapter 5000);
- 4) Access a resident's records without informed consent of the resident, resident's legally authorized representative, or as otherwise authorized by the Older Americans Act, §712(b)(1)(B).

- 5) Visit a nursing or assisted living facility when ill (OPPM, Chapter 500);
- 6) Refer a resident to a private attorney, a for-profit organization, or to a friend or family member of the ombudsman to perform a service (OPPM, Chapter 700);
- 7) Provide legal advice;
- 8) Diagnose or recommend medications and other medical interventions, other than recommending evaluation or discussion with a medical professional;
- 9) Accept gifts or gratuities from or give gifts or gratuities to a resident, or a friend or family member of a resident or a person affiliated with a nursing or assisted living facility (OPPM, Chapter 3000);
- 10) Advertise products or services or solicit staff or residents to buy products or services (OPPM, Chapter 3000);
- 11) Communicate personal beliefs or values, such as religious or political opinions, to residents or facility staff (OPPM, Chapter 3000);
- 12) Engage in unlawful activity while performing the functions of the Ombudsman Program (OPPM, Chapter 3000);
- 13) Engage in a role that is not a function of the Ombudsman Program with residents the ombudsman serves including serving as a voter registrar, Notary Public, instructor, entertainer, spiritual counselor, animal-assisted visitor, or an activity assistant (OPPM Chapter 3000);
- 14) Consume, be under the influence of, use, or possess alcohol, illegal drugs, or inhalants while performing the functions of the Ombudsman Program (OPPM, Chapter 3000);
- 15) Bring an animal into a long-term care facility when visiting as an ombudsman or ombudsman intern, unless the animal is a service animal and only performing tasks for the benefit of the ombudsman or intern (OPPM, Chapter 3000);
- 16) Visit the site of an unlicensed facility (OPPM, Appendix I, Protocol 16-01);
- 17) Act as a first responder during a disaster (OPPM, Chapter 5000);
- 18) Investigate whether abuse, neglect, or exploitation of a resident for the purpose of determining whether it occurred (OPPM, Chapter 800);
- 19) Take a photo, make an audio, or video recording of a resident unless the ombudsman obtains written consent for the photo or recording from the

resident or resident's legally authorized representative (OPPM, Chapter 3000);

20) Transport a resident in a vehicle (OPPM, Chapter 3000); and

21) Interrupt the provision of care to a resident, such as physical therapy, wound care, bathing, or incontinence care (OPPM, Chapter 500).

Interns must not:

1) Disclose confidential information about a resident obtained during an intern's visits to a person who is not a certified ombudsman.

2) Investigate a complaint.

3) Access a resident's record.

4) Interrupt the provision of care to a resident such as physical therapy, wound care, bathing, or incontinent care.

5) Attend a care or service plan meeting without a certified ombudsman.

6) Visit a nursing or assisted living facility when the ombudsman intern is ill.

More information about prohibited activities can be found in the OPPM, Chapters 500, 600, 700, 800, 3000, 5000, and Ombudsman Protocol 16-01: Unlicensed Facilities.



Exercise: Determine if the following statements are true or false and mark the correct space.

1) ___ True ___ False

When a resident asks an ombudsman who they plan to vote for in the next election, it is okay for the ombudsman to answer.

2) ___ True ___ False

An ombudsman may take their cat to visit residents who say they miss having a cat as a pet.

3) ___ True ___ False

A facility will not take Resident Q to the bank. In this case, an ombudsman may drive the resident in their personal car to the bank.

4) ____ True ____ False

An ombudsman sells products for a direct sales company. The company's quarterly catalog offers seasonal gifts for sale. The ombudsman may NOT give a catalog to residents and staff who complain they are unable to go shopping to buy a gift.

Summary

By law, long-term care ombudsman programs provide an independent program of advocacy services for individuals who live in nursing or assisted living facilities and their representatives.

Supplement 1-A: Ombudsman Program Milestones

1972 To implement President Nixon's 1971 eight-point initiative to improve nursing facility care, the Health Services and Mental Health Administration funded nursing facility 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 facility 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 facility 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 facilities 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 facilities. The individual in the nursing facility 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.” Per 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 five 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 facility 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.

1983-1984 AoA issued a series of 22 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 residents' 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 States 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 provided services to the 2.8 million residents in over 63,000 facilities. For complaints handled, 32% involve residents' 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 called 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.

2016 Reauthorization of the Older Americans Act. Revisions include removing “older” from the definition of resident. This clarifies that the Long-Term Care Ombudsman Program has the authority to serve residents of long-term care facilities, regardless of age. The 2016 law includes a provision that required the Assistant Secretary for Aging to issue guidance to states about serving Holocaust survivors.

2020 The Supporting Older Americans Act of 2020 reauthorizes programs for FY 2020 through FY 2024. The minimum expenditure requirement for Ombudsman expenditures was changed from a base year of 2000 to 2019, which protects funding for ombudsman services within state and local offices. Clarification was added about ombudsmen serving residents who are unable to consent and have no legally authorized representative and volunteer costs were expressly recognized as a program expense.

Supplement 1-B: Statutory and Rule References

Website links for statutes and regulations governing the State Long-Term Care Ombudsman Program may be found on the program's website at this link:

<https://ltco.texas.gov/>

Federal Statutes

Older Americans Act of 1965 (OAA)

[Public Law 89-73]

[As Amended Through P.L. 114-144, Enacted April 19, 2016]

Title VII. Allotments for Vulnerable Elder Rights Protection Activities

Subtitle A. State Provisions

Chapter 2. Ombudsman Programs

Section 711 – Definitions; and

Section 712 – State Long-Term Care Ombudsman Program

Codified at 42 USC §§ 3058f-h

Federal Regulations

Code of Federal Regulations (CFR)

State Long-Term Care Ombudsman Programs (February 11, 2015)

Title 45. Public Welfare

Subtitle B. Regulations Relating to Public Welfare

Chapter XIII. Administration for Children and Families, Department of Health and Human Services

Subchapter C – The Administration for Community Living

Part 1321. Grants to State and Community Programs on Aging

Subpart B. State Agency Responsibilities

§1321.11. State Agency Policies

Part 1324. Allotments for Vulnerable Elder Rights Protection Activities

Subpart A - State Long-Term Care Ombudsman Program

State Statutes

Texas Human Resources Code

Title 6. Services for the Elderly

Chapter 101A. State Services for the Aging

Subchapter F. Office of Long-term Care Ombudsman (§101A.255 – §101A.264)

State Regulations

Texas Administrative Code

Title 26. Health and Human Services

Part 1. Health and Human Services Commission

Chapter 88. State Long-Term Care Ombudsman Program

Implementation of the Older Americans Act

Texas Administrative Code

Title 26. Health and Human Services

Part 1 – Health and Human Services Commission

Chapter 213. Area Agencies on Aging

Subchapter C. Implementation of the Older Americans Act

Chapter 2: Aging and Residents

Chapter 2 provides basic information about physical aging, dispels some myths and stereotypes about aging, provides an overview of dementia and mental illnesses, and lists aging demographic information. Chapter 2 also provides training on person-centered care to people with dementia.

Learning Objectives

- Discover your attitudes about aging
- Become aware of the continuous process of 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

- Attitudes About Aging
- Typical Aging Processes
- Demographic Information on Older Adults
- Why Long-Term Care?
- People with Dementia Experience Life Differently

Video(s), Supplements, Forms

- QSEP Computer-Based Training: Hand in Hand Dementia Training - Modules 1-4
- YouTube Video: BPSD Demonstration
- Supplement 2-A - Eight Myths About Aging and Their Realities
- Supplement 2-B - Types of Serious Mental Illness and Dementia

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. Attitudes can contribute to stereotypes of aging and ignore positive aspects. At each stage of life, people perceive pros and cons.



Exercise: What Do You Know About Aging? A Quiz

Instructions

Mark each statement below as true or false.

1) ___ True ___ False

A large percentage of people over 65 years of age have Alzheimer's disease.

2) ___ True ___ False

As people grow older, their intelligence declines.

3) ___ True ___ False

Personality changes with age.

4) ___ True ___ False

Older adults have no interest in sexual relations.

5) ___ True ___ False

Memory loss is a normal part of aging.

6) ___ True ___ False

Clinical depression occurs more frequently in older than younger people.

7) ___ True ___ False

Older adults are at risk for HIV/AIDS.

8) ___ True ___ False

Older adults have the highest suicide rate of any age group.

9) ___True ___ False

A person's height tends to decline in old age.

10) ___True ___ False

Physical strength declines in old age.

11) ___True ___ False

Bladder capacity decreases with age, which leads to frequent urination.

12) ___True ___ False

All five senses tend to decline with age.

13) ___True ___ False

A large percentage of adults aged 65 and older live in nursing homes.

Debunking Myths About Older Adults

Knowing a person's chronological age tells you almost nothing about that person's feelings or abilities. Many people, including older adults, think some generalizations about older adults are truths. Myths, stereotypes, and negative attitudes 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. Because ombudsmen are resident-directed and protect resident rights, it is important to recognize personal biases and work to overcome them. See Supplement 2-A, Eight Myths About Aging and Their Realities, at the end of this chapter for more information.

SOURCE: University of Missouri – Kansas City. Consortium for Aging in Community. Breytspraak, L. & Badura, L. (2015). Facts on Aging Quiz (revised; based on Palmore (1977; 1981)). <http://info.umkc.edu/aging/quiz/>. Accessed August 2019.

Typical Aging Processes

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

- 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.
- 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.
- Bones:** 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.
- Brain:** As the brain ages, some connections between neurons seem to be reduced or less efficient. This is not yet well understood.
- Eyes:** 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.
- 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.
- Kidney:** Kidneys gradually become less efficient at cleaning waste from the blood.
- Lung:** The maximum breathing (vital) capacity of the lungs may decrease as much as 40% between 20 – 70 years of age.

Mouth and

nose: As people age, taste buds on the tongue decrease in sensitivity. This change affects tasting sweet and salt more than bitter and sour. The ability to smell diminishes because the lining of the nose becomes thinner and drier and the nerve endings in the nose deteriorate. The change is minimal and usually affects only subtle smells. Because of these changes, many foods tend to taste bitter, and foods with subtle smells may taste bland. The mouth tends to feel dry more often, partly because less saliva is produced. Dry mouth further reduces the ability to taste food.

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

SOURCE: Merck Manual. <https://www.merckmanuals.com/home/older-people's-health-issues/the-aging-body/overview-of-aging>. Accessed July 2019.



Use the information above and Supplement 2-A, Eight Myths About Aging and Their Realities to answer the questions or fill in the blanks.

- 1) Why might older adults disengage from their community?

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

- 3) Another term for "bed sore" is pressure _____. Using a restraint on a person puts them at risk of serious _____ and death.
- 4) Describe one physical change associated with aging.

Demographic Information on Older Adults

Individuals are categorized by chronological age for research purposes. Some key statistics to describe the United States aged 65+ populations:

- The 65+ population totaled 55.7 million in 2020.
- The 65+ population is projected to increase from 55.7 million in 2020 to 94.7 million in 2060.

- The 85+ population is projected to grow from 6.7 million in 2020 to 14.4 million in 2040.
- In 2020, there were 104,819 persons 100 years old or older.
- Non-white populations are projected to increase from 13.5 million in 2020 to 27.7 million in 2040 (34% of older adults).

Life Expectancy

In 2020, persons reaching age 65 had an average life expectancy of an additional 18.5 years (19.8 years for women and 17.0 years for men). This is a decrease from 2019 when the average was 19.6 years.

Median Income

- Median income of older adults in 2020 was \$26,668 - \$35,808 for males and \$21,245 for women.
- 5 million people age 65+ lived below the poverty level in 2020.

Nursing Facility Statistics

Percent of Age 65+ Population Living in Nursing Facilities

While a small number (1.2 million) of the U.S. 65+ population lived in nursing facilities in 2019, the percentage increases with age.

- 1.0% for people 65-74
- 2.0% for people 75-84
- 8.0% for people 85+

In Texas, about 82,000 people live in nursing facilities on any given day and about 49,000 people live in assisted living facilities.

SOURCE: Administration for Community Living (ACL), Administration on Aging (AoA), U.S. Department of Health and Human Services, November 2022. 2021 Profile of Older Americans.

https://acl.gov/sites/default/files/Profile%20of%20OA/2021%20Profile%20of%20OA/2021ProfileOlderAmericans_508.pdf. Accessed July 2023.

Nursing Facility Resident Characteristics

Nursing facilities provide nursing services at all hours of the day to individuals with skilled nursing needs.

Nursing Facility Resident Demographics and Statistics (USA)

- Female ($\pm 66\%$)
- Non-Hispanic white ($\pm 69\%$) [non-Hispanic black ($\pm 13\%$); Hispanic ($\pm 17\%$)].
- Age 85 or older ($\pm 38\%$)
- Receive bathing assistance ($\pm 97\%$)
- Receive dressing assistance ($\pm 90\%$)
- Receive toileting assistance ($\pm 86\%$);
- Receive eating assistance ($\pm 61\%$)
- The most common diagnosis at admission is heart disease, followed by cognitive impairment or mental disorders.
- The typical resident takes eleven or more medications daily including over the counter medications.



Fill in the blank in the statement below.

1) What percentage of adults aged 75-84 lived in nursing facilities in 2019?

Assisted Living Facility Statistics

No national standards exist for assisted living services and settings. Limited national statistics about people living in assisted living are available in the Centers for Disease Control and Prevention (CDC) 2020 Post-Acute and Long-Term Care Study, Biennial Overview of Post-Acute and Long-Term Care in the United States study.

Assisted Living Facility Resident Characteristics

Assisted living residents may exhibit symptoms of mental or emotional disturbance, but they are not considered at risk of imminent harm to self or others. They may be hearing or speech impaired or may require self-help devices. They also may need help with movement, meals, activities of daily living (ADL), routine skin care, need reminders to encourage toilet routines to prevent incontinence, ADLs is a term used in healthcare to refer to people's daily self-care activities like dressing.

Assisted Living Facility Resident Demographics and Statistics (USA)

- Female ($\pm 70\%$)
- Non-Hispanic white ($\pm 91\%$)
- Age 85 or older ($\pm 50\%$)
- Help transferring ($\pm 26\%$)
- Receive bathing assistance ($\pm 64\%$)
- Receive dressing assistance ($\pm 49\%$)
- Receive eating assistance ($\pm 22\%$)
- Alzheimer's disease or other dementias ($\pm 42\%$)

SOURCE: National Post-acute and Long-term Care Study, Biennial Overview of Post-acute and Long-term Care in the United States. 2020 Overview. https://www.cdc.gov/nchs/data/series/sr_03/sr03_038.pdf; Accessed July 2019.

Why Long-Term Care?

There are several reasons individuals enter a nursing or assisted living facility. These include but are not limited to:

- A medical event – Examples include a fall, an accident, or a stroke.
- The progression of a chronic or a terminal illness – Examples include cancer, congestive heart failure, diabetes, or Lou Gehrig's disease (ALS).
- The progression of dementia – Even with supports and services in place at home, sometimes the progression of a person's dementia may become more than a caregiver can manage at home.

Residents who experience chronic illness or have a disability have unique needs and ways of living with their condition(s). It is important to see the person, not the disease or disability, and to understand individual needs and preferences in order to provide resident-directed advocacy.

SOURCE: [26 TAC §553.9](#), Characteristics of a Resident, Subchapter A; <https://www.cdc.gov/nchs/npals/webtables/overview.htm>. Accessed July 2019.

Physical Disabilities

A physical disability is a limitation on a person's physical functioning, mobility, dexterity, or stamina. Physical disabilities include impairments that limit aspects of daily living, like respiratory disorders, blindness, epilepsy, and sleep disorders. Resident mobility disabilities range from difficulty walking to inability to get out of bed. Causes of mobility challenges include arthritis, stroke, amputation, paralysis, multiple sclerosis, pulmonary disease, or heart disease.

Mobility impairments range from lower body impairments, which may require use of canes, walkers, or wheelchairs, to upper body impairments that may include limited or no use of the upper extremities and hands, or both.

Mental Illness and Cognitive Disorders

Mental illness refers to a wide range of mental health conditions. It is a condition that can affect a person's thinking, feeling, mood, or behavior, and affect a person's ability to relate to others and function daily. According to the National Alliance on Mental Illness (NAMI), a mental health condition is not the result of one event and research suggests multiple, linking causes like genetics, environment, and lifestyle.

Memory Loss and Dementia

Dementia is not a specific disease; it is an umbrella 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.

People with dementia may have problems with short-term memory, keeping track of important things like paying bills, planning and preparing meals, remembering appointments, or traveling. Many forms of dementia are progressive. This means symptoms start slowly and gradually get worse.

Dementia 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 five 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.

There are other conditions that can cause symptoms of dementia, including some that are reversible, such as delirium, thyroid or kidney problems, vitamin deficiencies, or medication side effects.

Intellectual and Developmental Disabilities

An intellectual or developmental disability, also called IDD, includes many chronic conditions. IDD's are differences that are sometimes present at birth and that affect the individual's physical, intellectual, and/or emotional development. However, IDD can begin at any time, up to 22 years of age. It usually lasts

throughout a person's lifetime. In the United States, about 2.3% of people have IDD.

Individuals with developmental disabilities may have difficulties with things such as speaking, learning, caring for themselves, moving around, making decisions, living independently, and making and managing money. Difficulties continue throughout their lives and are severe enough that the person needs ongoing supports.

Individuals with intellectual disabilities have trouble learning and solving problems, with practical skills such as dressing and shopping, and with social skills such as making and keeping friends.

Long-Term Care Residents with IDD

Nursing and assisted living facilities are home to individuals with a variety of abilities, including individuals with an IDD diagnosis. It is important to treat adults with IDD as adults and adjust your method of communication as necessary depending on the individual's responses to you. Review communication tips in Chapter 3 for ideas on how to connect with and serve residents with all abilities.

SOURCES: National Alliance on Mental Health (NAMI) <https://namica.org/resources/mental-illness/types-mental-illness/>; Mental Health First Aid USA 2013. Accessed January 2020.

Mental Health Association of Maryland, Missouri Department of Mental Health, and National Council for Behavioral Health; and National Institute of Mental Health (NIMH) <https://www.nimh.nih.gov/health/statistics/mental-illness.shtml>. Accessed January 2020,

The National Long-Term Care Ombudsman Resource Center, Module Two, Pages 17-19, Trainer Guide, Initial Certification Training Curriculum for Long-Term Care Ombudsman Programs. <https://ltcombudsman.org/uploads/files/support/module-2-trainer-guide.pdf>. Accessed January 2022.

Texas Health and Human Services and National Institutes of Health. <https://www.hhs.texas.gov/services/disability/intellectual-or-developmental-disabilities-idd-long-term-care>. Accessed November 2020.

On Your Own – Computer-Based Training (CBT) & Quiz – CMS Hand in Hand Dementia Training – Modules 1-4

Link to CBT: <https://qsep.cms.gov/welcome.aspx>

Complete the QSEP CBT training by (date): _____

Hand in Hand Module Titles

- Module 1 – Understanding the World of Dementia: The Person and the Disease
- Module 2 – Being with a Person with Dementia: Listening and Speaking
- Module 3 – Being with a Person with Dementia: Actions and Reactions
- Module 4 – Being with a Person with Dementia: Making a Difference

Introduction to QSEP CBT Training

CMS Hand in Hand Dementia Training was created by the Centers for Medicare and Medicaid Services (CMS) to provide long-term care providers training. This training demonstrates how facility staff can use person-centered care approaches to provide care for residents with dementia and how to prevent and report abuse.

Ombudsmen should keep in mind *Hand in Hand* was 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 the State Long-Term Care Ombudsman Certification Training Manual.

Time to Complete Training

Modules 1-4 may take up to four hours to complete.

It is recommended you complete this training when you will not have any interruptions to prevent having to start a lesson over. Before logging into QSEP, review the tips that follow.

Instructions to Access QSEP Hand in Hand CBT

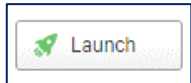
This training is mandatory for staff ombudsmen, volunteer ombudsmen, and Managing Local Ombudsmen (MLOs). It is required per [Texas Human Resources Code, Title 2, Subtitle D, Chapter 40, Subchapter A, §40.036](#).

There are five Modules within the *Hand in Hand* CBT. Hand in Hand Modules 1-4 are assigned in Chapter 2. Module 5 is assigned in Chapter 5.

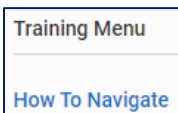
Click on the QSEP link above (found on page 44) or in the training companion document with hyperlinks provided by the local ombudsman program.

Steps to Access the CBT:

-  Log into [QSEP](#) training using the link found on Page 44 by clicking on "sign up." Select "Providers & Other Learners." Fill out your name and email address. Under "Select Your Organization Type," choose "Other." For the "Type", enter "Texas Ombudsman Program." Confirm your email address and log into QSEP. If you are unable to sign in using "sign up," log into QSEP using the Public Access option in the top right of your display.
- On the Training Catalog page, you should see the letters A-Z.



- Click the letter "H." Locate *Hand in Hand – A Training Series for Nursing Homes Toolkit*. Click on the launch button (rocket ship icon labeled "launch").



- Under the Training Menu heading found on the right half of the screen, click on "How to Navigate." Watch the demonstration.
- Start the *Hand in Hand* training by clicking on Module 1: Understanding the World of Dementia – The Person and the Disease. Complete Module 1 Introduction and Lessons 1-3.
- Watch all lessons found in Modules 1-4 then complete the quiz below.
- If you *signed up* for QSEP, after you complete Modules 1-5, you have the option to download a certificate of completion.

Take the Quiz

Module 1 – Understanding the World of Dementia: The Person and the Disease

1) Mark each statement below that is true about dementia.

- ☐ Dementia is not a specific disease. It is an umbrella term.
- ☐ Dementia is a term that describes a group of symptoms related to loss of memory, judgement, language, complex motor skills, and other intellectual function.
- ☐ Dementia affects people differently.
- ☐ There are other conditions with symptoms that can look like dementia.

2) According to Dr. Allen Power, the typical approach to dementia care is flawed. Mark each statement below that represents what Dr. Power said about how we should view and provide care for people with dementia.

- ☐ We need to understand what each person needs to succeed.
- ☐ We need to educate all who partner in care in a more individualized, person-centered approach to dementia.
- ☐ Caregivers do not need to learn each resident's retained strengths. Clinical staff decide what residents need.
- ☐ Nursing and assisted living facilities need to shift operations to support person-centered care.

3) Choose all the statements below that are true about who gets dementia.

- ☐ Everyone ends up with dementia at some point because it is a normal part of aging.
- ☐ More women than men have dementia.
- ☐ As many as half of people aged 85 or older have dementia.
- ☐ Dementia symptoms are most common after the age of 65.
- ☐ Young people never get dementia.

4) Choose each symptom below that is NOT a typical symptom of dementia.

- ☐ Memory loss
- ☐ Coughing
- ☐ Problems with orientation of time, place, and person
- ☐ Difficulty with speech such as inability to find the word

5) ☐ True ☐ False

Alzheimer's disease is the most common type of irreversible dementia, accounting for 60-80% of cases.

Module 2 - Being with a Person with Dementia: Listening and Speaking

6) ☐ True ☐ False

Being with a person with dementia means trying to see things from the person's perspective and trying to understand what they are communicating to you.

7) ☐ True ☐ False

People with dementia rarely have trouble answering questions or get overwhelmed by too many choices.

Module 3 – Being with a Person with Dementia: Actions and Reactions

8) In Module 3 - Lesson 1: I Want to Go Home: Video, Mrs. Caputo says she wants to go home, and it is time to pick up her children. What do these "clues" tell you about Mrs. Caputo's actions and reactions? Write your answer below.

9) Which of the following may contribute to unexplained or difficult actions (behaviors) of a resident with dementia? Select all that apply.

☐ Medication

☐ The environment

☐ Health conditions like pain or a urinary tract infection

☐ The caregiver

☐ None of the above

10) ☐ True ☐ False

What staff sometimes refer to as resident "difficult behavior" is a form of communication. Staff and others should try and understand what a resident is communicating.

11) Choose the three words that correspond with "the three Ps" taught in Hand in Hand. These three words relate to caregivers getting ready to care for persons with dementia.

☐ Prepare

☐ Propose

☐ Prevent

☐ Present (as in "be present")

☐ Perspective

12) Mark each statement that applies. Think about the I Want to Go Home: Preventing video in Module 3. How did the aide, Maria, respond to Mrs. Caputo?

- ☐ Maria knew Mrs. Caputo enjoys cooking and was prepared to redirect her.
- ☐ Maria invited Mrs. Caputo to the cooking class before she decided she wanted to go home.
- ☐ Maria did not know what Mrs. Caputo enjoys and was not prepared to redirect her.
- ☐ Maria insisted Mrs. Caputo come with her. She told her "No" and "You can't."
- ☐ Maria validated Mrs. Caputo's needs and distracted her.

Module 4 - Being with a Person with Dementia: Making a Difference

13) What does it mean to meet persons with dementia where they are? Mark all that apply.

- ☐ Accept their reality.
- ☐ Know who each person is as an individual.
- ☐ Treat each resident as the child they have become.
- ☐ Know where each person is in their dementia to identify their needs.
- ☐ Know and honor each person's strengths.

14) Mark the correct answer.

Mrs. Johnson has dementia. Gloria, the aide, recognizes where Mrs. Johnson is in her dementia. How did the care that Gloria provided for Mrs. Johnson change as Mrs. Johnson's dementia progressed?

- ☐ Nothing changed.
- ☐ Gloria provided more cues, modeling, and then assistance as Mrs. Johnson's dementia progressed.

People with Dementia Experience Life Differently

Dr. Allen Power, MD, is a board-certified internist and geriatrician. He provides education on models of care for older adults, particularly those who live with dementia and changing cognitive abilities. According to Dr. Power, too much

focus is put on the deficits and losses of individuals who have dementia and not enough focus is placed on their strengths and abilities.

Perspectives on Behavioral and Psychological Symptoms of Dementia (BPSD)

Per Dr. Power, long-term care staff and others may disregard a resident's method of expression because they believe the actions are part of the person's brain disease. They may:

- Ignore relational, environmental, and historical factors;
- Pathologize the resident's normal method of communication (labeling behaviors as symptoms of mental illness or brain disease); or
- Promote paths to prescribing drugs.

Below are some examples of descriptors used to describe individuals without dementia versus descriptors used to describe similar self-expressions by individuals with dementia.

Example 1

- A person without dementia: Walks, explores, gets bored, and leaves.
- A person with dementia: Wanders, elopes, exhibits frustration, or exit seeks.

Example 2

- A person without dementia: Gets angry, sad, anxious, or frustrated.
- A person with dementia: Exhibits challenging or difficult behaviors or is combative.

Watch the following YouTube video for a fun demonstration by Dr. Power for Dementia Alliance International.

On Your Own – Video – BPSD Demonstration by Dr. Allen Power, MD

Link to video: <https://youtu.be/eiolJQ4Kgws>

Video length: 3 minutes.

SOURCE: Allen Power MD, FACP | Research Institute for Aging (the-ria.ca) 2021, <https://the-ria.ca/research/meet-our-researchers/allen-power/>. Accessed September 2021.

Supplement 2-A: Eight Myths About Aging and Their Realities

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.

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 may try to do things for an older person because they lack patience to wait for the older adult to do it by themselves. Older adults can gradually become dependent on others if they receive unnecessary assistance.

Myth 5: Older adults are unproductive.

Reality: Most 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.

Myth 6: 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 7: Pressure ulcers are an unfortunate part of normal aging for nursing facility 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 facility 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.

Myth 8: Older adults and individuals with disabilities need protection.

Environmental risks must be minimized. Restraints can keep nursing 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 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."

SOURCES: University of Missouri – Kansas City. Consortium for Aging in Community. Breytspraak, L. & Badura, L. (2015). Facts on Aging Quiz (revised; based on Palmore (1977; 1981)). <http://info.umkc.edu/aging/quiz/>. Accessed August 2019.

Plassman BL, Langa KM, Fisher GG, Heeringa SG, Weir DR, Ofstedal MB, Burke JR, Hurd MD, Potter GG, Rodgers WL, Steffens DC, Willis RJ, Wallace RB. Prevalence of dementia in the United States: the aging, demographics, and memory study. *Neuroepidemiology*. 2007;29(1-2):125-32. doi: 10.1159/000109998. Epub 2007 Oct 29. PMID: 17975326; PMCID: PMC2705925. <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC2705925/>. Accessed 2021.

Supplement 2-B: Types of Serious Mental Illness and Dementia

Types of Mental Illness

Depressive Disorder

Depressive disorder is a serious emotional and biological disease that affects a person's thoughts, feelings, behavior, mood, and physical health. It can present different symptoms depending on the person. Symptoms include fatigue, trouble concentrating, difficulty making decisions, loss of interest in activities, and sleep disturbances. All age groups and all racial, ethnic, and socioeconomic groups can experience major depression. It is estimated 25 million American adults are affected by major depression each year, but only one-half ever receive treatment.

Bipolar Disorder

Bipolar disorder is a mental illness that causes changes in a person's mood, energy, and ability to think clearly. People with bipolar experience high and low moods known as mania and depression. These are not typical mood variations most people experience. Symptoms and their severity can vary. Although the illness can occur at any point in life, more than 50% of all cases begin between ages 15 to 25. Median age onset is 25 years of age. Bipolar disorder affects men and women equally.

Anxiety Disorders

Anxiety disorders are a group of mental illnesses that cause people to feel frightened, anxious, distressed, or uneasy during situations in which most other people would not experience these feelings. These disorders can make typical daily activities like shopping or going outside difficult. Anxiety disorders are the most common mental illnesses in America. Common anxiety disorders include generalized anxiety disorder, panic disorder, obsessive-compulsive disorder, and posttraumatic stress disorder (PTSD).

Post-Traumatic Stress Disorder (PTSD)

PTSD is an anxiety disorder that typically stems from a traumatizing event or threatening incident that happened in the past. People with PTSD typically

experience the event recurrently as a real-time incident that invades their daily activities or in reoccurring nightmares.

Psychosis

Psychosis is a condition where a person has lost some contact with reality. Disorders in which psychosis may occur are less common than other mental disorders. Bipolar disorder, schizophrenia, schizoaffective disorder, and delirium are some of the disorders in which psychosis may occur.

Schizophrenia

Schizophrenia interferes with a person's ability to think clearly, manage emotions, make decisions, and relate to others. Schizophrenia is a complex, long-term medical illness that affects each person differently. Symptoms may include delusions and hallucinations that last longer than six months.

The exact prevalence of schizophrenia is difficult to measure but estimates range from 0.25% to 0.64% of U.S. adults. Schizophrenia affects men and women with equal frequency. Although schizophrenia can occur at any age, it most often appears in men in their late teens or early twenties, while it appears in women in their late twenties or early thirties. It is uncommon for schizophrenia to be diagnosed in a person younger than 12 or older than 40.

Schizoaffective Disorder

Schizoaffective disorder is a chronic mental health condition characterized primarily by symptoms of schizophrenia, such as hallucinations or delusions, and symptoms of a mood disorder, such as mania and depression. Schizoaffective is relatively rare, with a lifetime prevalence of only 0.3%. People experience schizoaffective disorder at the same rate, but men often develop the illness at an earlier age.

Many people with schizoaffective disorder are often incorrectly diagnosed at first with bipolar disorder or schizophrenia.

Types of Dementia

Alzheimer's Disease

Alzheimer's disease is a degenerative brain disease and the most common form of dementia. It is a type of dementia that causes problems with memory,

thinking, and behavior. Symptoms usually develop slowly and get worse over time, becoming severe enough to interfere with daily tasks. Alzheimer's is not a normal part of aging. Alzheimer's disease accounts for 60 percent to 80 percent of dementia cases.

Alzheimer's is the sixth leading cause of death in the United States. On average, a person with Alzheimer's lives four to eight years after diagnosis, but can live up to 20 years, depending on other factors.

Alzheimer's worsens over time. Alzheimer's disease typically progresses slowly in three general stages — mild (early stage), moderate (middle stage), and severe (late stage). In its early stages, memory loss is mild, but with late-stage Alzheimer's, individuals lose the ability to carry on a conversation and respond to their environment. Since Alzheimer's affects people in different ways, the timing and severity of dementia symptoms vary as each person progresses through the stages of Alzheimer's differently.

Vascular Dementia

Vascular dementia is a general term that describes issues with reasoning, planning, judgment, memory, and other thought processes caused by brain damage from impaired blood flow to your brain. It is also known as multi-infarct dementia and is the second most common cause of dementia in older people.

Vascular dementia can develop if a stroke blocks an artery in your brain. Strokes do not always cause vascular dementia. Whether a stroke affects your thinking and reasoning depends on your stroke's severity and location. Vascular dementia can also result from other conditions that damage blood vessels and reduce circulation, depriving your brain of vital oxygen and nutrients.

Lewy Body Dementia (LBD)

LBD refers to a type of progressive dementia that leads to a decline in thinking, reasoning, and independent function because of abnormal microscopic deposits that damage brain cells over time. Most experts estimate that Lewy body dementia is the third most common cause of dementia after Alzheimer's disease and vascular dementia, accounting for 5 to 10 percent of cases. Alpha-synuclein protein, the chief component of Lewy bodies, is found widely in the brain, but its normal function is not known.

Lewy bodies are also found in other brain disorders, including Alzheimer's disease and Parkinson's dementia. Many people with Parkinson's eventually

develop problems with thinking and reasoning, and many people with Lewy body dementia experience movement symptoms, such as hunched posture, rigid muscles, a shuffling walk, and trouble initiating movement.

Symptoms of Lewy Body Dementia

- Changes in thinking and reasoning
- Confusion and alertness that varies significantly from one time of day to another or from one day to the next
- Sleep disturbances
- Slowness, gait imbalance and other Parkinsonian movement features
- Well-formed visual hallucinations
- Trouble interpreting visual information
- Delusions

Frontotemporal Dementia (FTD)

FTD refers to a group of uncommon disorders caused by progressive nerve cell loss in the brain's frontal lobes (the areas behind your forehead) or its temporal lobes (the regions behind your ears). Some people with frontotemporal dementia undergo dramatic changes in their personality and become socially inappropriate, impulsive or emotionally indifferent, while others lose the ability to use language.

Key Differences Between FTD and Alzheimer's

Age at diagnosis. Most people with FTD are diagnosed in their 40s to early 60s. Alzheimer's grows more common with increasing age.

Memory loss tends to be a more prominent symptom in early Alzheimer's than in early FTD. Advanced FTD frequently causes memory loss in addition to its more characteristic effects on behavior and language.

Behavior changes are often the first noticeable symptoms in with FTD. Behavior changes are also common as Alzheimer's progresses, but they tend to occur later in the disease.

Problems with spatial orientation – for example, getting lost in familiar places – are more common in Alzheimer's than in FTD.

Although people with Alzheimer's may have trouble thinking of the right word or remembering names, they tend to have less difficulty making sense when they speak, understanding the speech of others, or reading than those with FTD.

Hallucinations and delusions are relatively common as Alzheimer's progresses, but relatively uncommon in FTD.

Creutzfeldt-Jakob disease causes a type of dementia that gets worse unusually fast. More common causes of dementia, such as Alzheimer's, LBD, and FTD, typically progress more slowly. Creutzfeldt-Jakob disease is rare, occurring in about one in 1 million people annually worldwide.

SOURCES: National Alliance on Mental Health (NAMI) <https://namica.org/resources/mental-illness/types-mental-illness/>; Mental Health First Aid USA 2013. Accessed January 2020.

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Chapter 3: Person-Centered Communication

Chapter 3 is about person-centered communication. It introduces foundational principles of person-centered thinking and care approaches. It has tips for communicating with people who have disabilities and provides a structured approach to communicate effectively with people who live in nursing and assisted living facilities.

Learning Objectives

- Learn the foundational principle of person-centered thinking
- Understand the impact words have on others
- Learn to reframe negative terms to more positive terms
- 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 during a facility visit

Contents

- Person-Centered Communication
- Communication Basics
- Communication with Residents
- Communication with Facility Staff
- Communication During a Facility Visit

Video(s), Supplements, Forms

- YouTube Video: Person-Centered Care: Person-Centered Language
- YouTube Video: RSA Short: The Power of Empathy with Brené Brown

Person-Centered Communication

Person-Centered Thinking

Person-centered is a way of thinking and doing things that recognizes residents are partners in planning, developing, and monitoring their care. It promotes individualization of services and emphasizes quality of life, well-being, and informed choice.

Person-centered thinking:

- Puts residents at the center of decision-making.
- Recognizes residents as experts about their lives.
- Acknowledges residents are people who have individual interests, needs, and abilities.
- Identifies residents' strengths, goals, and preferences.
- Impact of Language and Words

Language plays an important role in shaping long-term care culture. The words we use when we talk to or about people can shape who they are and whether each person is shown value. Words convey meaning and they can be positive or negative. They can create filters through which we view the world around us.

Person-First Language

Generally, refer to the person first and a diagnosis or disability second. Residents are not their diagnosis. They are first, people. For example, say:

- "A resident with dementia" instead of "a demented resident."
- "A resident who uses a wheelchair" instead of "a wheelchair-bound resident."

Identity-First Language

Some people see their disability as a part of who they are and prefer to be identified with their disability first. This is called identity-first language. Identity-first language can validate a person's identity related to a disability.

For example:

- "A Deaf person" instead of "a person who is deaf."
- "An Autistic person" instead of a "person with autism."

Labeling

Labels are words or phrases that describe people instead of using their name. Labels can be positive or negative and can shape others' perceptions. Examples are: "idiot," "genius," "combative," or "sweetie."

Neutral Language

Use neutral language. Do not use words that paint a person as lacking or defective. Examples of language that are not neutral include "victim of" or "suffers from."

- Not neutral: Mr. Smith is a stroke victim.
- Neutral: Mr. Smith had a stroke.
- Neutral: Mr. Smith is recovering from a stroke.

Do not mention residents' disabilities unless the disability is vital to a request or comment. The fact that a resident has a bipolar diagnosis may not be relevant to a resident's request to see a doctor. The fact that a group of residents watching television all have a diagnosis of dementia may not be relevant to a conversation about providing care to those residents.

Person-Centered Care – Nursing Facility Definition

The nursing facility Code of Federal Regulations (CFR) defines person-centered care as care provided in a manner that places the resident as the "locus of control" and that supports the residents in making choices and having control over their life.

Psychology Today explains locus of control as, "... the degree to which an individual feels a sense of agency in regard to his or her life. Someone with an internal locus of control will believe that the things that happen to them are greatly influenced by their own abilities, actions, or mistakes. A person with an external locus of control will tend to feel that other forces—such as random chance, environmental factors, or the actions of others—are more responsible for the events that occur in the individual's life."

SOURCES: Hyams, K., Prater, N., Rohovit, J., & Meyer-Kalos, P. (2018, April). Center for Practice Transformation, University of Minnesota. Person-Centered Language, Clinical Tip No. 8. <https://practicetransformation.umn.edu/clinical-tools/person-centeredlanguage/>. Accessed February 15, 2020.

Ladau, E. (2015, July 20). Think Inclusive. Why Person-first Language Doesn't Always Put the Person First. <https://www.thinkinclusive.us/why-person-first-language-doesnt-always-putthe-person-first/>. Accessed February 15, 2020.

NCAPPS. (n.d.). National Center on Advancing Person-Centered Practices and Systems (NCAPPS). <https://ncapps.acl.gov/>. Accessed February 15, 2020,

On Your Own – Video & Quiz – Person-Centered Care – Person-Centered Language

Link to video: <https://youtu.be/zP2FfqHD6Lc>

Video length: 2 minutes.

Take the Quiz

- 1) Which of the following is an example of person-first language? Choose the best answer.
 - ☐ Mr. Davis has dementia.
 - ☐ Dementia Davis
 - ☐ The demented dude.
- 2) Using words that paint residents as lacking or defective should be replaced with neutral language. Which of the following statements is an example of neutral language? Choose the best answer.
 - ☐ Mr. Davis is a victim of dementia.
 - ☐ Mr. Davis suffers from memory loss.
 - ☐ Mr. Davis needs extra time to find the right words.
 - ☐ Mr. Davis is afflicted by memory loss.
- 3) What does the video mean when it says Sara does not label residents or give them nicknames?

- 4) List a couple of outcomes for residents who are discussed using negative labels or nicknames?

- 5) In the video, the narrator said, "By building relationships and thinking 'people first,' staff treat residents with the respect they deserve. Think 'people first.'" What does "people-first" or "person-centered" thinking mean?
-

Reframing the Language of Long-Term Care

Reframing requires seeing something in a new way, in a context that allows us to recognize and appreciate positive aspects versus negative aspects. Words can affect our ability and willingness to change by influencing how we see the people and places around us. Words can have influence, such as calling a child difficult rather than high-spirited, or the grocery store clerk slow instead of careful.



Exercise – Reframing the Language of Long-Term Care

Suggest how traditional long-term care words could be replaced with words that emphasize the person. Refer to the chart that follows for assistance.

- 1) Nursing facility _____
- 2) Staff _____
- 3) Resident _____
- 4) Hallway/unit _____
- 5) Nourishment _____
- 6) Activities room _____
- 7) Resident council _____
- 8) Therapy room _____
- 9) Meal tray _____
- 10) Diapers _____

The Language of Long-Term Care Reframed

People

Old Words

Grandma, sweetie

New Words

Resident's name

Elderly	Elders, older adults
Patient	Resident, neighbor, friend
Wanderer	Someone who likes to walk
Toilet resident	Needs help to the bathroom
New admit	New neighbor
Feeder	Someone who needs help to eat

Places

Old Words

Facility, nursing facility
Lobby, common area
Ward, unit
100-bed facility

New Words

Community, home, living center
Living room, foyer
Neighborhood, village
100 people live in this home

Things

Old Words

Activities
Mechanical soft food
Nourishment
Diaper

New Words

Meaningful things to do
Chopped food
Snack
Brief, Brand name (Attends)

Actions

Old Words

Admit, place
Discharge
Ambulate, wander
Elope, escape
Toileting
Allow
Claims

New Words

Move in
Move out
Walk
Left the building, unescorted exit
Using the bathroom
Help, facilitate, encourage
States, says

Attitudes

Old Words

A two-person assist

Problem

"You need to..."

"Sit. You will fall."

"We're already doing that."

"We tried that."

New Words

Requires two helpers

Challenge, opportunity

"Would you like to..."

"Let's walk."

"We really need to do that."

"Let's try again."

SOURCE : Culture Change Language, Pioneer Network, Karen Schoeneman, Senior Policy Analyst, Centers for Medicare and Medicaid Services

Communication Basics

It is important to evaluate how you communicate and the impact your messages have on others, including what you say, the words you use, and how you say it. It is also crucial to evaluate how well you listen to and understand others.

Communication Involves Four Actions

- 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 themselves 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.

Message is Sent

Verbal communication includes:

- Tone of voice
- Word choice

Nonverbal communication (Examples)

- Facial expressions
- Body language
- Gestures
- Eye contact

- Touch
- Spatial distance
- Silence
- Head nodding

Message is Received

Listening means comprehending what the other person is saying. 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.

To listen actively:

- Give the person your full attention.
- Be patient.
- Focus your energy on the conversation. Do not 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.

Sender Gets Feedback – Another Message is Sent

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.



Fill in the blank in the following statement.

- 1) 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.

 YouTube On Your Own – Video & Quiz - RSA Short - The Power of Empathy - Brené Brown on Empathy

Link to video: https://youtu.be/RZWf2_2L2v8

Video length: 3 minutes.

Instructions

Watch RSA Short – The Power of Empathy and complete the quiz.

Take the Quiz

1) Mark all that apply. Which of the following statements are accurate about empathy and sympathy?

- ☐ There is no difference between empathy and sympathy.
- ☐ Empathy fuels connection.
- ☐ Sympathy drives disconnection.

2) Mark three qualities of empathy.

- ☐ Judge others.
- ☐ Recognize and acknowledge a person's perspective as their own.
- ☐ Feel with people.
- ☐ Feel sorry for others.
- ☐ Recognize emotions in other people and communicating them.

3) ☐ True ☐ False

In this video, the narrator said, 'Rarely, if ever, does an empathic response begin with "at least."'

4) ☐ True ☐ False

While it is important for ombudsmen to show empathy, it is equally important for ombudsmen to set and enforce professional boundaries while working with residents, complainants, and facility staff.

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 that follows.



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 – Often 5 – Frequently

- ☐ Talk too much, not giving the other person a chance to talk.
- ☐ Interrupt others when they are talking.
- ☐ Do not look at the person talking.
- ☐ Fidget with pencil and paper, tap your legs, etc. when someone is talking.
- ☐ Have a “poker face,” blank look, or manner which makes it difficult for another to know if you are listening.
- ☐ Try to do other things while another is talking.
- ☐ Let emotional-laden words arouse personal ill feelings.
- ☐ Daydream or thinking about other things while another is talking.
- ☐ Blame the speaking habits or mannerisms of another.
- ☐ Finish the other person's statements.
- ☐ Draw conclusions about the subject before listening to it.
- ☐ Clean fingernails, glasses, etc. while the other person is talking.
- ☐ Listen only to the facts being said, not to emotional aspects.

- ___ Sit too close, being in another's personal space.
- ___ Look frequently at your watch or clock while another is talking.
- ___ Let your feelings get in the way while listening.
- ___ Ask many questions while another is talking.
- ___ **TOTAL SCORE**

Assessment Results

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.

Communication with Residents

Everyone who lives in a nursing or assisted living facility 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 their disability or diagnosis.
- Treat adults as adults.

- Assume the person has ability to understand.
- 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. Do not 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 help to complete forms or understand written instructions. Provide extra time for decision-making. Wait for the individual to accept the offer of assistance; do not "over-assist."

Approach - The Power of Attitude

- 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 cultural background, as you respond to verbal and nonverbal communication.

Tips for Communicating with a Resident Who...

Appears Nonresponsive

- Assume the individual can hear and understand.
- Explain who you are and what an ombudsman is.
- Try to include the resident who appears nonresponsive 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 them if you touch them unexpectedly or approach them 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.



Fill in the blank in the statement and answer the question about the scenario.

- 1) It is always a good idea to approach any resident from the _____.
- 2) During a facility visit, you sit and talk with a resident who has dementia. When you gather your things to leave the facility, the resident becomes agitated. How will you respond?

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.



Ombudsman Tip - Aphasia

Aphasia is a communication disorder that results from damage or injury to language parts of the brain. It is 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.
- 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.
- 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.
- Do not interrupt or appear impatient.
- Help end the conversation if needed.



Ombudsman Tip – Speaking Volume

Visitors to nursing facilities tend to speak loudly when it is not needed. Ombudsmen should use a regular volume.

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.

Has Memory Loss

- Assume the person is able 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.
- Do not correct mistakes made by the person. Be sensitive to the resident’s reality and allow it to be what it is.



Fill in the blank in the following statement.

- 1) In general, let a resident tell you if they need assistance. Respect assistive devices as _____ property.



Ombudsman Tip – Dementia Versus Delirium

Dementia is a progressive decline in memory and at least one cognitive area such as abstract thinking, attention, personality, and judgment. Brain damage resulting from 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 resulting from 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.

Speaks a Language Other Than a Language the Ombudsman Speaks

- 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 i-Translate.
- Have Spanish ombudsman cards and brochures available and provide them to residents whose preferred language is Spanish.
- Ask if the facility has a handheld translation device; request to use it.
- When using a translator, direct questions to the resident. Make eye contact with the resident, observe the resident's nonverbal communication, and listen.

Ombudsman Policies and Procedures Related to Translation Services

If an ombudsman needs to communicate with a person but is unable to because the ombudsman is not proficient in the language the person speaks, the ombudsman must:

- Ensure that an ombudsman who is proficient in the person's language, communicates with the person;
- Use a translation service provided by the host agency* to communicate with the person; or
- Obtain direction from the State Office regarding the ombudsman's inability to communicate with the person.

* A host agency is a governmental entity or nonprofit organization that contracts with Texas Health and Human Services (HHS) to ensure that the local ombudsman program implements the Ombudsman Program in a specific area of service.

SOURCE: OPPM, Section 570

Has a History of Trauma

- Be transparent. Communicate with honesty, openness, and authenticity.
- Maintain a respectful tone of voice since it can significantly impact how people receive and respond to messages.
- Keep the resident involved and informed.

- Be flexible. Watch for signs the discussion is too much for the resident on that day or at that time.

Communication Methods That Build Trusting Relationships

The following communication methods help build trusting relationships with residents:

- 1) Always respect the rights and dignity of each resident.
- 2) Remember residents' rooms are their homes.
 - 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 am an advocate."
- 5) Request permission to talk.
 - "Is now a good time to talk?"
 - "Do you feel like talking?"
- 6) Keep an open body posture. Open posture is often perceived as communicating with a friendly and positive attitude (uncrossed arms and legs, head upright). Establish a level of verbal warmth and trust. Be attentive and let them know you are interested.
- 7) 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?"

- 8) Allow the conversation, whenever possible, to go where the resident wishes. Gently look for openings to address potential issues. Do not rush!
- Let residents set the pace of the conversations.
 - Resist the impulse to talk rather than listen.
 - 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.
- 9) Discover residents' support systems.
- 10) Ask about contacts with family, friends, and other visitors.
- 11) Explore their personal history.
- Without prying, discover residents' personal interests and life history.
 - Mention interests you have in common to build rapport.
- 12) Discuss the history of their stay.
- After developing rapport, talk about their feelings about living in the nursing or assisted living facility. (Gather information through conversation to find out what it is 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.
 - Pursue concerns; do not ignore concerns that residents share.
- 13) Observe residents. Are they nervous or shaking? Do they cry easily or get angry? Do they appear fearful of being overheard by staff?
- 14) 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.
- 15) 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.
- 16) Respect confidentiality: protect resident identity if asked. Complaints can be investigated and resolved without using a resident's name. Some complaints affect several people in the facility.
- 17) 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.
- 18) Be honest and direct about your intentions. Explain any risks involved in any course of action.
- 19) 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.
- 20) Avoid making promises in general about what you will accomplish.
- 21) Be patient, dependable, and honest.



Ombudsman Tip – Resident Council

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



Exercise – The 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 questions that follow.

1) How did the instructor 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.



Exercise – Role Play - Communicating with Residents and Residents' Families - Call Lights

Objectives

- Model ways of making sure an ombudsman communicates with the resident even though family members are present.
- Gain ideas for alternative ways to solve problems.

Characters

- Narrator
- Georgia or George (Resident's daughter or son)
- Mr. (or Ms.) Bond (Resident)
- Ombudsman

Role Play

NARRATOR: The ombudsman knocks on Mr. Bond's door. Mr. Bond's daughter (or son) Georgia (or George) says, "Come in." Mr. Bond has some speech problems but can talk if given enough time. He can easily answer yes and no questions.

OMBUDSMAN: Hello Mr. Bond, Georgia. How are you today?

GEORGIA: Fine.

OMBUDSMAN: (Looks at Mr. Bond) - How are you Mr. Bond?

MR. BOND: (Gives a thumb up)

GEORGIA: Dad told me the CNAs are taking a long time to respond to his call light when he needs to go to the bathroom.

OMBUDSMAN: I am sorry to hear about that. Mr. Bond, is there a time of day when this is a problem?

MR. BOND (Nods his head, saying "yes.")

OMBUDSMAN: (Ombudsman looks at Mr. Bond) - I would like to hear more about this.

GEORGIA: I spoke to the afternoon Certified Nurse Aide (CNA), and she claims that all call lights are answered as soon as possible. What can we do?

OMBUDSMAN: (Ombudsman looks at Mr. Bond): Mr. Bond, I would like to hear more about your concerns.

MR. BOND: (Long pause and then Mr. Bond answers) - My daughter can tell you.



Ask the Instructor – Hold a Discussion

1) Is there anything else the ombudsman should ask Georgia (George) or Mr. Bond?

2) What are some alternative courses of action you might suggest for this ombudsman? Keep in mind empowering the resident and including the daughter in accordance with Mr. Bond's wishes.

SOURCE: Based on Missouri State Long-Term Care Ombudsman Program, Role Plays, National Long-Term Care Ombudsman Resource Center.
<https://ltcombudsman.org/uploads/files/support/mo-scripted-roleplays.pdf>. Accessed March 2016.

Communication with Facility Staff

Good relationships help ombudsmen succeed in promoting residents' rights, quality of life, and quality of care. Many resident concerns can be resolved, with resident consent, by speaking with a facility staff member, supervisor, or moving up the chain of command.

Determine the best staff to consult about a problem. Know what you want to achieve in your initial discussion. It is helpful to build rapport before you start to ask questions or problem solve. Sometimes rapport happens naturally. Building rapport is the process of establishing a connection. It can also be developed by finding common ground and by being empathic.

When starting a complaint discussion, try to reduce tension before getting to the complaint. Start out with non-threatening safe topics for small talk. Listen to what the other person is saying and look for shared experiences. Show empathy and demonstrate you can see the other person's point of view.

Here are some staff communication tips:

- When listening, nod and smile.
- Use the other person's name early in the conversation.
- Try to ask the staff questions that require more than a yes or no answer.
- Talk about things that reference what the other person said.
- Try to show empathy.



Exercise - Role Play - Communicating and Working with Facility Staff

Objectives

- Practice ways of being assertive with facility staff.
- Gain ideas for alternative ways to solve problems with staff.

Characters

- Narrator
- Ombudsman
- Executive Director

Role Play

NARRATOR: During today's facility visit, the ombudsman received dietary complaints from four residents. All four residents said that turnips are served too often. They said they were served three times in the last week. They request more variety.

OMBUDSMAN (to the executive director): I need to tell you about some food concerns reported to me. Several people told me turnips were served three times in the past week. They want more variety.

EXECUTIVE DIRECTOR: Our corporate dietician creates our menus and follows the guidelines provided by the State. I do not think you are qualified to criticize the menus. I wish you would stay within the scope of your job.

OMBUDSMAN: While I am not a dietician, I have heard these concerns from residents. This is important to them. Do you have a food committee here for residents? This kind of committee can help ensure residents' right to have their food preferences respected and improve satisfaction with dietary services.

EXECUTIVE DIRECTOR: Who are these people that are complaining? Let me talk to them. Lots of residents complain no matter what you serve them. They just want a gourmet meal. We are following doctors' orders because a lot of residents have specialized diets their physician prescribed, and I cannot change that.

SOURCE: Based on Missouri State Long-Term Care Ombudsman Program, Role Plays, National Long-Term Care Ombudsman Resource Center. <https://ltcombudsman.org/uploads/files/support/mo-scripted-roleplays.pdf>. Accessed March 2016.



Ask the Instructor – Hold a Discussion

1) How would you respond to leadership who isn't open to change or questions?

2) How would you verify the residents' complaint? How would you verify whether turnips were served three times in the past week?

3) What are some responses to the executive director that sound fair, firm, and friendly?

- 4) How would you avoid getting sidetracked with comments like “some people complain all the time,” “we are following doctors’ orders,” “we use corporate prepared menus,” etc.?
-

- 5) Name a pitfall an ombudsman should watch for during a conversation like this.
-

Communication During a Facility Visit

When You Enter a Facility...

- Wear your ombudsman badge and lanyard so that residents, residents’ family, and staff can easily identify you as an ombudsman.
- Let staff know you are in the building, and you are there to visit residents. Never identify which residents you are visiting.
- Introduce yourself to new staff but keep your visit resident focused.
- If the facility requests you to sign in, provide your name and write “ombudsman” as the name of the person you are visiting. You are not required to disclose your Protected Health Information (PHI). If photo identification is requested, you must show your state-issued ombudsman badge to verify your identity. See Chapter 6 for detail about an ombudsman’s access to facilities and residents.
- During a public health emergency, follow facility policy and Ombudsman Policies and Procedures as required for health screening.
- Request the facility census (resident roster). Requesting a facility census is optional. This is a confidential document that becomes an ombudsman record and must be safeguarded from release. Ombudsmen may:
 - Request a list of residents by room number or by name.
 - Ask if there are any new residents.
 - Place a check next to each resident’s name on the census with whom you have meaningful conversation to track how many resident contacts were made.

Maintain Privacy and Confidentiality

Knock & Get Permission to Enter

Ombudsmen and interns visit with residents in their rooms and in common areas. Knock and receive permission before entering a resident's room.

Offer Privacy Options for Confidential Conversations.

When in a resident's room, ask if you may close the door during private conversations. If an ombudsman visits with a resident in a public area, the ombudsman must, as much as the resident will allow, discuss confidential information in a way the discussion is not within the hearing of others.

Visit with Multiple Residents to Protect Identities

Visit multiple residents during a facility visit to help protect the identity of complainants.

If you are assigned a large facility with many residents, visit as many residents as time allows. Vary the residents you visit to ensure all residents have access to the ombudsman. Try to meet with new residents and families to share information concerning the Ombudsman Program and residents' rights.

Facility Visit Guides

See the Facility Visit Guide and Memory Care and Alzheimer's Certified Facility Visit Guide in Chapter 6 for more information on facility visits.

Chapter 4: Confidentiality, Disclosure, and Consent

Chapter 4 addresses important long-term care ombudsman confidentiality, disclosure, and consent requirements.

Learning Objectives

- Understand access, confidentiality, disclosure, and consent requirements for ombudsmen.
- Define confidentiality and how it applies to your work.
- Understand how to find and use ombudsman disclosure policies and procedures.

Contents

- Confidentiality
- Disclosure
- Consent
- Situations Where Consent is Not Required to Take an Action
- Frequently Asked Questions - Consent
- Resident Representatives
- Legally Authorized Representatives
- Other Types of Resident Representatives
- Frequently Asked Questions – Resident Representatives

Video(s), Supplements, Forms

- YouTube Video: How to Obtain Consent – Part 1 – Long-Term Care Ombudsmen
- Supplement 4-A: Ward Bill of Rights
- Supplement 4-B: Ombudsman Consent and Authority Flow Chart

Confidentiality

What is Confidential Information?

Confidential information is information that identifies a resident or complainant. It may be oral or written and includes any information received while performing ombudsman duties. An ombudsman is prohibited from disclosing confidential information unless consent and disclosure requirements are met as outlined in the OPPM.

Confidential information includes, but is not limited to:

- The name of the resident or complainant.
- Information about the resident's medical condition or medical history.
- The resident's social history, including occupation, residences, and information about a resident's family and personal life.
- The resident's source of payment.
- Whether a person has filed a complaint with the Ombudsman Program.
- Whether the Ombudsman Program records exist about a particular person or situation.
- Information from a communication between a resident and an ombudsman.

Written confidential information includes:

- Facility censuses (resident rosters) – A facility census is a list of residents living in a nursing or assisted living facility and typically their room or apartment number. An ombudsman may request a resident roster from the facility to use during a facility visit. Once received by the ombudsman, it is an Ombudsman Program confidential record and may not be shared outside the program;
- Medical, financial, and social notes created while identifying, investigating, or attempting to resolve a complaint by, or on behalf of, residents or complainants;
- Copies of any portion of a resident's long-term care facility records;
- Records collected during an investigation of a complaint;
- Administrative records, policies, and other documents of nursing or assisted living facilities;
- Notes made by an ombudsman; and

- Other records compiled and maintained by ombudsmen in carrying out their responsibilities. This includes notes, activity reports, phone logs, visit tracking forms, and emails.

Source: Chapter 600, Section 610 Confidentiality

Maintain Confidentiality While Visiting a Long-Term Care Facility

An ombudsman:

- Knocks and receives permission to enter before entering a resident's room.
- Visits multiple residents during a facility visit to help ensure that the identity of a complainant is not easily discernable.
- Discusses confidential information with a resident in such a way that the discussion is not within audible range of other persons, as much as the resident will allow - especially when in public areas.
- Views confidential records privately with the resident or separately.

Confidentiality Is Important

Confidentiality is of the highest importance in the Ombudsman Program. The resident has the right to say what information can be released and to whom.

The ombudsman must not disclose (outside of the Ombudsman Program) any information about a resident unless the ombudsman has resident consent. Treat the information in a written record with the same confidentiality as information provided orally from a resident, medical professional, or other caregiver. Everything you read and hear about a resident should be carefully guarded to protect the identity and privacy of a resident.



Fill in the blanks in the following statements.

- 1) Confidential information is information that _____ a resident or complainant. It may be oral or written and includes any information received while _____ ombudsman duties.

Disclosure

Disclosure means to make known or public.

Disclosure of Confidential Information

Disclosure of confidential information means releasing confidential information to anyone outside of the Ombudsman Program by communicating face-to-face, by telephone, by email or other electronic means, or by paper document.

Ombudsmen are prohibited from disclosing confidential information unless consent and disclosure requirements are met as outlined in Chapter 600, Sections 630 and 640 of the OPPM.

Ombudsman Program records may only be disclosed at the discretion of the State Ombudsman or designee. Refer to the OPPM for more information about disclosure.

Consent

Ombudsmen have a duty to support and maximize resident participation in the process of resolving complaints. They also have an obligation to obtain consent from the resident before taking any actions. Consent is required from a resident or complainant to:

- Work on the complainant's behalf.
- Work on the resident's behalf if the complainant is not the resident.
- Reveal a resident's or complainant's name or identifying characteristics.
- Access a resident's record or other confidential information.

Ombudsmen:

- Offer privacy options to the resident for conversations involving complaints.
- Discuss the complaint with the resident to determine the resident's perspective and wishes regarding resolution.
- Obtain informed consent from the resident, or when applicable the resident's legally authorized representative (LAR), before taking any action. More information about LARs may be found later in this chapter.



Ombudsman Tip

Regardless of the source of a complaint, an ombudsman serves the resident.



On Your Own – Video – How to Obtain Consent - Part 1

Instructions

Watch the video by The National Consumer Voice describing how ombudsmen obtain consent.

Link to video - Part 1: <https://www.youtube.com/watch?v=enjd8qQ5bjk>

Video length: 2 minutes.

Consent to Work on a Resident's or Complainant's Behalf

Complainants must provide consent for an ombudsman to work on their behalf. Additionally, if the complainant is not a resident, an ombudsman must seek agreement from the resident to work on the issue. If the resident declines to give the ombudsman consent, the resident's wishes supersede the complainant's request for ombudsman assistance. The ombudsman may:

- Advise the complainant of alternate avenues they may choose to pursue. Options may include providing consultation to the complainant for self-advocacy with facility management, having the complainant work through a family council, or explaining the facility's grievance policy. If the complainant's concern involves a regulatory violation, the ombudsman provides information on how to file a complaint with Regulatory Services.
- Determine if the concern impacts a significant number of residents. If it does, 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, the ombudsman must notify the resident of this decision and inform them that their identity will not be revealed.

Consent to Reveal Identity or Identifying Information

For each case in which identity cannot be protected, the resident and other complainants must provide consent to disclose their name or identifying information. If residents or other complainants request anonymity, the ombudsman must clearly identify themselves 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 might speculate about the identity of a resident or complainant. Without consent of the resident or complainant, the ombudsman must not confirm such speculation. Instead, the ombudsman can redirect the conversation to information that is relevant and not confidential. If necessary, the ombudsman informs facility staff of the Ombudsman Program's confidentiality law or informs staff that the question arises from the ombudsman, rather than from a resident or other complainant.

Consent to Access Confidential Information

Access to records and the information within a resident's record is all confidential. Ombudsmen must obtain resident consent to access the resident's confidential records. Facility staff members have an obligation to protect each resident's record from inappropriate access. Not only do laws pertaining to nursing 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, HIPAA does not prevent releasing resident clinical records to an ombudsman. 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 a facility staff person denies access, consult your supervising staff ombudsman or MLO. Chapter 12 describes the process for obtaining consent to access a resident record. Consent to access confidential information must be documented. For more information, see Chapter 12.



Question. Fill in the blanks in the following statements.

- 1) Information acquired within a record or disclosed orally is essentially the same. It is _____.

- 2) HIPAA applies to _____.
- 3) Older Americans Act applies to _____.
- 4) ___True ___ False

If the complainant is not a resident, an ombudsman must seek to obtain consent from the resident.

SOURCES: [26 TAC §88.201\(c\)-\(d\)](#) and [26 TAC §88.305](#)

Communication of Consent

Consent may be given in writing, orally, visually, or using auxiliary aids and services such as an interpreter or electronic communication device. For example, to communicate consent, a resident may:

- Nod their head "yes."
- Give a "thumbs up" sign.
- Use an electronic communication board to say "yes."
- Write the word "yes."
- Say the word "yes."

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?

Communication of informed consent, from a resident or others, means an ombudsman:

- Explains the ombudsman's role in investigating the complaint.
- Clarifies the ombudsman's understanding of the resident's problem or request.
- Explains the resident's rights and other law(s) related to the complaint.
- Describes what actions can be taken to resolve the complaint.
- Discusses possible outcomes or consequences, as needed.
- Gets direction from the resident on how to proceed.
- Receives voluntary communication of consent.



Ombudsman Tip – Complainants Who are NOT the Resident

Sometimes staff or a family member will call the ombudsman to ask for help on behalf of a resident. They may tell the ombudsman that the resident is unable to consent. It is important that the ombudsman makes an independent determination and does not rely solely upon information provided by a complainant's opinion.

Limitation of Consent

Consent given by a resident or resident's legally authorized representative (LAR), when applicable, is limited to the specific situation and activities for which it was given.

Withdrawal of Consent

A resident or resident's LAR, when applicable, may withdraw consent at any given time. This stops the ombudsman's actions.

Ability to Consent

The goal of the Ombudsman Program is to focus on the resident and their wishes even if the resident is not able to make all their decisions. The general presumption is residents have the ability to consent unless there is clear evidence to the contrary. The "ability to consent" means an individual can understand and appreciate the nature and consequences of decisions they are making and to reach and communicate an informed decision in the matter.

Ombudsmen must use their judgment to determine whether a resident has the ability to consent for a specific situation. To determine if a resident has the ability to consent, determine if the resident understands information relevant to the situation and appreciates the outcome(s) of consenting (or not consenting) regarding the situation.

To make this determination, it may be necessary to visit the resident in person, visit with the resident on multiple occasions, or inquire with the resident's LAR, facility staff, or other persons familiar with the resident about the resident's ability to consent.

It is important to acknowledge that facility staff and residents' families and friends may call an ombudsman to request ombudsman assistance on behalf of the resident. However, if an ombudsman is not familiar with the resident and the resident's abilities, the ombudsman needs to determine if the resident wants the ombudsman's assistance and if the resident is able to consent. Sometimes facility staff or family members tell the ombudsman that the resident is unable to consent. When the ombudsman visits the resident, occasionally the ombudsman finds the description of the resident's ability to consent is inaccurate. Ombudsmen do not base the ability to consent on a resident's diagnosis.

For example, a resident may determine their daily routine, go out and visit with friends, or spend "pocket money," but leave major financial and complex medical decisions up to an individual acting as their representative (such as an agent on a financial or medical power of attorney).

SOURCE: The National Long-Term Care Ombudsman Resource Center, Trainee Manual, Initial Certification Training Curriculum for Long-Term Care Ombudsman Programs. https://ltcombudsman.org/omb_support/training/norc-curriculum. Accessed January 2022.

Ability to Consent Is Dependent on the Nature of a Situation

Ability to consent is decision-specific and varies with the complexity and consequences of the decision in question. For example, an ombudsman may determine that a resident is able to consent to the investigation of a complaint about meal choices but is not able to consent to an investigation about medication dosage.

Ability to Consent May Fluctuate

Ability to consent is variable as to time and place; it may wax and wane. A person's ability to consent is not defined by their clinical status or cognitive ability. Therefore, the ability of a resident to consent to a situation may change from one time to another.

Relevant questions to determine a resident's ability to make decisions or to provide informed consent:

- Can the resident make and express choices about their life?
- Can the resident provide reasons for their choices?
- Are the resident's reasons rational (grounded in fact and reality)?

- Does the resident understand and appreciate possible outcomes of their decision?

For example, an ombudsman may determine on one occasion that a resident is able to consent to the complaint investigation about the cleanliness of the facility. A month later, the ombudsman may determine that the resident is not able to consent to a complaint about the quality of the food at the facility.



Ombudsman Tips – Ombudsman Concerns or Uncertainty

As an ombudsman, if you have concerns or are uncertain about how much help you should give someone, consult your supervising staff ombudsman or MLO.

Frequently Asked Questions – Consent

Question: How do I advocate for a resident who is unable to consent?

Answer: *The ombudsman must determine if the resident has an LAR. If the resident has an LAR, determine what authority the LAR has been granted.*

Question: Are there any exceptions to the requirement for ombudsmen to get consent?

Answer: *Yes, there are several circumstances where an ombudsman does not need consent to investigate. These exceptions are discussed in the next section and addressed in the OPPI, Chapter 700.*

Situations Where Consent Is Not Required to Take an Action

There are some circumstances when an ombudsman does not need consent from a resident or the resident's LAR to take an action.

Unable to Consent and No LAR

If an ombudsman determines that a resident is unable to consent and that the resident does not have an LAR, the ombudsman must protect the health, safety, welfare, and rights of the resident and investigate the complaint.

Unable to Consent and LAR Does Not Have Authority

If an ombudsman determines that a resident is unable to consent, and that the resident has an LAR, but the complaint is not within the scope of the authority granted the LAR, the ombudsman must protect the health, safety, welfare, and rights of the resident and investigate the complaint.

Unable to Consent and Resident Needs Immediate Assistance

Ombudsman Observes a Care Need

An ombudsman may request staff assist a resident without seeking evidence of an LAR or obtaining consent from an LAR if:

- The ombudsman observes a resident who needs immediate assistance from staff; and
- The ombudsman determines that the resident is unable to consent to investigation of a complaint.

Examples

A resident who is *unable* to consent:

- Appears to have fallen on the floor and cannot stand up.
- Has a soiled brief and needs incontinence care.

Consent Is Required if Additional Actions Are Required

If, in addition to requesting immediate assistance for a resident from facility staff, the ombudsman needs to take additional actions, the ombudsman must obtain consent.

Example

You observe a resident unsuccessfully trying to get out of bed. The resident has an immediate need and is unable to consent. You ask a nurse aide to help the resident and observe the aide go into the resident's room. An hour later, you see the same resident having difficulty getting out of bed again. You ask the nurse aide to help the resident again. The nurse aide states, "The resident needs to get out of bed to use the restroom all the time and we don't have enough staff available to assist the resident as often as needed." You realize this resident needs additional assistance beyond the immediate need.

You ask the nurse aide whether the resident has an LAR. The nurse aide tells you that the resident has a full guardianship of the person (a person who makes decisions on behalf of the resident). According to the OPPM, you are required to call the guardian to ask for consent to further investigate the complaint. You get a copy of the guardianship paperwork on file with the facility and verify the guardian's authority. You contact the guardian.

The resident's guardian tells you the resident is on a new medication and asks for your help to set up a care plan meeting to discuss incontinence care with the facility. You receive consent and guidance and contact staff to set up the meeting.

SOURCE: OPPM Section 740(c).

A Complaint Affects a Substantial Number of Residents

If an ombudsman identifies a complaint that affects a substantial number of residents, the ombudsman may investigate and work to resolve the complaint without obtaining consent from the residents or residents' LARs to investigate the complaint.

The following are examples of situations affecting a substantial number of residents.

- There is inadequate housekeeping throughout the facility.
- There are unpleasant odors in the communal areas of the facility.
- Pests are observed throughout a facility.
- A roof leak is seen in the dining room at the facility.



Fill in the blanks in the statement below and answer the questions.

- 1) 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.
- 2) While visiting residents, an intern (a volunteer ombudsman in training who is NOT certified) passes a resident who has soiled briefs that need to be changed. The resident has advanced dementia and is not able to talk to the intern.

- Does an intern need consent to ask staff to help the resident with an immediate care need? ___Yes ___No
 - What is appropriate for the intern to say and do?
-

3) During a facility visit, the ombudsman observes the air conditioning is not working in the dining room, activity room, foyer, and two out of four hallways where residents reside. The temperature outside has been over 90° for three days.

- Does this problem affect a substantial number of residents? ___Yes ___No
- Does the ombudsman need to seek consent? ___Yes ___No
- If yes, from whom? _____

4) Check the box for each statement that is an example of a circumstance where an ombudsman does not need a resident's or resident's LAR's consent to act.

___ There is inadequate housekeeping throughout a facility.

___ A resident reports the facility served her green beans today and she hates green beans. She requests the ombudsman's help.

___ An ombudsman observes a resident who appears to have fallen on the floor and is struggling to stand up. The ombudsman determines the resident is unable to give the ombudsman permission to act.

___ There is a strong, unpleasant odor in the dining room.

___ A resident's brief is soiled, and the ombudsman determines that the resident is able to consent.

___ A resident says he is not getting his PRN (as needed) medications when he requests them. The ombudsman determines that the resident is able to consent.

Resident Representatives

A resident representative is a person chosen by a resident to:

- support the resident in decision-making;
- access medical, social, or other personal information of the resident;
- manage financial matters; or
- receive notifications.

SOURCE: [42 CFR 483.5](#). Accessed December 2019.

Seek Consent from the Appropriate Resident Representative

Before taking any action on behalf of a resident, an ombudsman must seek consent from the resident. If the ombudsman determines the resident does not have the ability to consent, the ombudsman seeks consent from the resident's representative.

When seeking consent from the resident's representative, an ombudsman must not extend a resident representative the right to make decisions on behalf of the resident beyond the extent granted to the resident's representative under applicable state or federal law.

When investigating complaints, federal program regulations require ombudsmen to determine and verify the authority of a decision maker.



"...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."

SOURCE: Published in the Federal Register, 02/11/2015, Vol. 80, No. 28. LTCOP Final Rule. 1324.19 (b)(2)(iv) – National Consumer Voice, Initial Certification Training Curriculum for Long-Term Care Ombudsman Programs.

https://ltcombudsman.org/omb_support/training/norc-curriculum. Accessed Sept. 2023.

Legally Authorized Representatives (LAR)

An LAR is a person authorized by law to act on behalf of another person. The LAR authority may be assigned by the resident or by a court and includes:

- A parent, guardian, or managing conservator of a minor;
- The guardian of an adult; or
- An agent to whom authority to make healthcare or financial decisions (or both) is delegated under a medical power of attorney or durable power of attorney in accordance with state law.

SOURCES: OPPM, Definitions; [26 TAC §553.3\(41\)](#); [26 TAC §554.805\(a\)\(5\)](#); [26 TAC §554.2703\(a\)\(20\)](#). Accessed April 2025.

Determine Whether a Resident Has an LAR

If an ombudsman determines that a resident is unable to consent to the investigation of a complaint and the ombudsman does not know if the resident has an LAR, the ombudsman must seek evidence of whether the resident has an LAR by asking facility staff and verifying that person's authority by reviewing the associated record.

SOURCE: OPPM, Chapter 700.

Determine the Authority of a Resident's LAR

If an ombudsman determines that the resident is unable to consent to investigation of a complaint and that the resident has an LAR, the ombudsman must determine if the complaint is related to the authority granted to the LAR based on:

- Documentation authorizing the power of attorney agent;
- Letters of guardianship or the court order appointing the guardian; or
- A court order appointing the managing conservator.

SOURCE: OPPM, Section 740(4)(A).

LARs Assigned by the Resident

Agent - Power of Attorney (POA)

A POA is a legal document giving one person the power to act for another person. The "principal" is the person who signed a POA. An "agent" is a person authorized to make decisions about another person's property, finances, medical care, or other matters in accordance with a power of attorney. It is important to review a power of attorney to determine when it gives the agent authority and for what.

Medical Power of Attorney (MPoA)

A MPoA is a type of advance directive that provides a way for residents to name an agent to speak to their health care providers. An MPoA agent cannot make medical decisions for a resident unless the resident is unable to make health care decisions for themselves. The agent may only make medical decisions for the resident until the resident is able to do so again.

If a resident requests assistance or files a complaint, consider the resident as the complainant. Coordination or consultation with the agent named in the MPoA is not required except as defined in the OPPM; for most circumstances, follow the resident's direction.

Residents can revoke (cancel) their Medical Power of Attorney at any time. More information on ombudsman referrals related to revocation of Powers of Attorney may be found in the OPPM Section 740(j).

SOURCES: Texas Law Help, Texas Legal Service Center. <https://texaslawhelp.org/>.

Texas Health and Safety Code, Title 2, Chapter 166, Advance Directives. <https://statutes.capitol.texas.gov/Docs/HS/htm/HS.166.htm#166.001>. Accessed 3/1/2023.

Durable Power of Attorney (DPoA)

A 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 a resident's incapacity may be established in the language of the DPoA, but not always. A DPoA can be for business and financial decisions.

If a resident wants to revoke a power of attorney, assist the resident in contacting a non-profit legal services organization in accordance with OPPM Section 770(c)(2). Refer to OPPM Chapter 700, Section 740(j).

SOURCES: OPPM Chapter 700; Texas Estates Code, Title 2, Chapter 751. <https://statutes.capitol.texas.gov/Docs/ES/htm/ES.751.htm#751.00201>.

Frequently Asked Questions – Agent on a Power of Attorney

Question: What should an ombudsman do if a resident tells them to contact their POA agent to get consent?

Answer: *If an ombudsman determines that a resident is able to consent to the investigation of a complaint, but the resident tells the ombudsman to seek consent from the resident's POA agent, the ombudsman must seek consent from the POA agent following the requirements established in the OPPM (Chapter 700, Section 740(d)). If consent is declined by the POA agent, the ombudsman does not investigate.*

Question: What should an ombudsman do if they believe a resident's POA agent's decision to decline to give or the agent's decision to withdraw consent may adversely affect a resident?

Answer: *The ombudsman should read and comply with OPPM, Section 740, subsections (h) and (i) related to referring a complaint or reporting the misconduct of an LAR. To report the misconduct of an LAR, the State Ombudsman's approval is required prior to taking any action.*



Fill in the blanks in the following statements.

- 1) The _____ is the person who signed a POA.
- 2) The _____ is the person given authority through a POA.

LARs Assigned by a Court

Guardian

A guardian is a person who has the legal authority to make decisions for a person or about the property interests of a person who is considered by a court to be incapable of administering their own affairs. A resident's need for a guardian is decided in a court of law, and a judge appoints a guardian. Sometimes individuals confuse their role as an agent on a resident's POA with serving as the resident's guardian.

A guardianship is established by a court of law and is a relationship between the person who needs help (called a ward) and the person or entity named by the court to help the incapacitated person (called a guardian). In Texas, a person does not have a guardian until an application to appoint one is filed with a court, a hearing is held, and a judge appoints a guardian. When the court appointment is made, the person the guardian cares for becomes a "ward of the court." See the Ward Bill of Rights in Supplement 4-A.

Individuals, Entities, or Guardianship Programs Can Be Appointed Guardians.

Guardians have legal responsibilities and are required to perform certain tasks when helping their wards. The court decides whether to place limitations on a guardian's authority. The court also establishes how much freedom wards have to make their own decisions. Guardianships can grant limited or full authority

but are created with the intention to promote and protect the well-being of the ward.

Types of Guardianships

Limited Guardian of the Person

As a limited guardian of the person, the guardian does not make all the ward's decisions. In a limited guardianship, the judge says what decisions the ward can make and states the ward's rights in the written guardianship orders. For example, the court may make the guardian responsible for deciding what medical care the ward will receive or where the ward will live, but the court may let the ward make their own decisions about getting married or driving.

Full Guardian of the Person

As a full guardian of the person, the guardian has the legal right to make personal decisions for the ward including where the ward will live, where the ward can go, or whether to limit the ward's contact with family or friends.

Limited Guardian of the Estate

As a limited guardian of the estate the court may allow the ward to make some of their own decisions. For example, the guardian may be required to pay the ward's bills, but the ward may decide whether to keep or sell property.

Full Guardian of the Estate

A person granted full guardianship of the estate has authority over all aspects of the ward's estate.

Guardian of the Person and Estate

A court may appoint someone to be both guardian of the person and of the estate. In a guardianship of the person and the estate, the guardian has authority over all aspects of the ward's care and estate.

SOURCES: "A Texas Guide to Adult Guardianship." Texas Health and Human Services. <https://hhs.texas.gov/sites/default/files/documents/laws-regulations/legal-information/guardianship/pub395-guardianship.pdf>. Accessed December 2019.

Texas Estates Code, Title 3. Guardianship and Related Procedures. <https://statutes.capitol.texas.gov/Docs/ES/htm/ES.1001.htm>. Accessed May 2025.

The Resident Has a Guardian and Is Able to Consent

If an ombudsman determines that a resident is able to consent and knows that the resident has a guardian, the ombudsman must determine if the complaint relates to a power granted to the guardian based on the court order or the letters of guardianship.

Frequently Asked Questions – Guardianship

Question: What if an ombudsman does not initially know that a resident has a guardian and finds this out while investigating a complaint?

Answer: *The ombudsman must stop the investigation and review documents (letters of guardianship or court order) to determine whether the complaint is within the scope of the authority granted to the guardian.*

If a complaint relates to matters within the scope of the authority of the guardian based on review of the court order or the letters of guardianship, the ombudsman must seek consent from the guardian as outlined in the OPPM.

If a complaint does not relate to matters within the scope of the authority of the guardian based upon review of the court order or letters of guardianship and the ombudsman determines the resident is able to consent to the investigation of a complaint, the ombudsman must seek consent from the resident as outlined in the OPPM.

SOURCE: [OPPM, Section 740](#).

Question: What is a letter of guardianship?

Answer: *It is a "certificate under seal of the clerk" issued by a court clerk that states the fact of the appointment and qualifications of the appointed guardian; the date of the appointment; and the date the "letters of guardianship" expire.*

Question: Where can I find a copy of the letters of guardianship or court order?

Answer: Nursing and assisted living facilities are required to request a copy of any current court order appointing a guardian and letters of guardianship for a resident or a resident's estate and keep them in the resident's clinical record.

SOURCES: [26 TAC §554.1936\(e\)](#); [26 TAC §553.265\(a\)\(2\)\(H\)](#).

Other Types of Resident Representatives

If an ombudsman determines a resident is unable to consent, the ombudsman asks staff if the resident has a representative. If one of the following types of resident representatives is identified, the ombudsman must determine if the person is also the resident's LAR since their legal authority may apply to Ombudsman Program consent policies.

Responsible Party (RP)

Facility staff, particularly in nursing facilities, might use the term "responsible party" or "RP" when referring to one type of resident representative. Sometimes the RP is the person the facility asked to sign the admission agreement or admission contract on behalf of the resident or that receives notifications about a resident.

Nursing facility regulations define responsible party as an individual authorized by the resident to act for the resident as an official delegate or agent. A responsible party is usually a family member or relative but may be a legal guardian or other individual. Authorization may be in writing or may be given orally.

Responsible party is not defined in assisted living facility regulations.

SOURCE: [26 TAC §554.101\(127\)](#).

Representative Payee

"A representative payee is a person, or an organization, appointed to receive Social Security or Supplemental Security Income (SSI) benefits for individuals who cannot manage, or direct the management of, their benefits." SSI is designed to help people who are aged, blind, or have disabilities, and who have little or no income.

"A payee's main duties are to use the benefits to pay for the current and future needs of the beneficiary, and properly save any benefits not needed to meet

current needs. A payee must also keep records of expenses... When [the Social Security Administration requests] a report, a payee must provide an accounting to [the Social Security Administration] of how he or she used or saved the benefits.”

SOURCE: Social Security. <https://www.ssa.gov/payee/>. Accessed July/2023.

Nursing facility regulations define a representative payee as “a person designated by the Social Security Administration to receive and disburse benefits, act in the best interest of the beneficiary, and ensure that benefits will be used according to the beneficiary’s needs.” Representative payee is not defined in assisted living facility requirements.

SOURCE: [26 TAC §554.101\(123\)](#).

Supported Decision Making Supporter

In 2015, legislators passed new laws that made Texas the first state to have laws recognizing supported decision-making agreements as an alternative to guardianship. Supported decision-making allows individuals to make their own decisions and stay in charge of their lives, while receiving the help and assistance they need to do so.

Under a supported decision-making agreement, the supporter can help a person with a disability:

- Understand the options, responsibilities, and consequences of their decisions.
- Obtain and understand information relevant to their decisions.
- Communicate their decisions to the appropriate people.

The supporter cannot make decisions for a person with a disability. The supported decision-making agreement does not assign the supporter as the resident’s LAR.

Though “decision-making supporter” is not explicitly defined in nursing or assisted living facility rules, the document (agreement) should be considered a formal expression of a resident’s wishes.

SOURCES: “Supported Decision-Making - Disability Rights Texas,” Disability Rights Texas. <https://disabilityrightstx.org/en/home/> and [26 TAC §554.101\(126\)](#). Accessed 04/2025.



Ask the Instructor – Hold a Discussion

Discuss the following situations with your instructor. Use Supplement 4-B, Ombudsman Consent and Authority Flow Chart (page 113) and Chapter 700 of the OPPM (found in Chapter 14) to answer the following questions.

- 1) A resident with advanced Alzheimer's disease has no LAR and no known family. She is unable to consent to ombudsman assistance. Some of the resident's 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 this resident? _____
- 2) A facility staff person asks the ombudsman how they may appropriately discharge a resident they want to discharge.
 - How does the facility's request for help with a discharge affect the ombudsman's actions?

 - What should the ombudsman *avoid* saying or doing? _____

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

 - Will the ombudsman instill trust in other residents if he or she helps facility staff in discharging the resident? ____Yes ____No
- 3) Resident Q tells the ombudsman that his breakfast is always served with coffee instead of hot tea which he reports he has requested multiple times. The ombudsman sees the dietary manager and visits with him about the resident's breakfast drink preference. The ombudsman watches meal service three times during the next month.
 - Based on this example, did this ombudsman seek consent from the resident to work the complaint? ____Yes ____No
 - If you answered yes, how did the ombudsman seek consent from the resident? _____

- 4) The ombudsman receives a call from Ms. Friend, the friend of a resident who lives in an assisted living facility that specializes in Alzheimer's and dementia care. The resident's friend says facility staff refuse to allow her to visit the resident or to take her out for their weekly coffee date. She says staff told her the resident's guardian said that no visitors are allowed and there is a letter in the resident's medical record. She is adamant her friend is alert and oriented and does not have a guardian.

Until one month ago, Ms. Friend states she visited her friend at the facility regularly. She states, "My friend moved into the assisted living facility with her husband who had advanced Alzheimer's disease. Once my friend's husband passed away - about a month ago - the rules for visiting my friend changed. I'm pretty sure my friend's daughter is an agent on her powers of attorney and not a guardian."

The complainant (Ms. Friend) gives the ombudsman consent to help, identify her by name, and discuss the complaint with the resident and others as needed.

What are the ombudsman's next steps?

- 5) Resident X can no longer communicate in any form. He needs new clothing. The facility calls the ombudsman to ask which resident representative they should notify about the resident's clothing needs so the representative can approve staff purchasing the resident some new clothes. The ombudsman asks staff what facility policies say and then explains the ombudsman's understanding of who can make financial decisions on behalf of residents.

Mark each representative below who is authorized to manage and / or spend a resident's money on behalf of the resident. Select all that apply.

- ☐ Agent on Financial Power of Attorney
- ☐ Medical Power of Attorney
- ☐ Representative Payee
- ☐ Guardian of the Person, Not Estate
- ☐ Responsible Party
- ☐ Guardian of the Estate
- ☐ Supporter

Supplement 4-A: Ward Bill of Rights

Senate Bill 1882 in the 84th Texas Legislature established a Bill of Rights for Wards under guardianship. It contains 26 specific rights.

ESTATES CODE

TITLE 3. GUARDIANSHIP AND RELATED PROCEDURES

SUBTITLE E. ADMINISTRATION OF GUARDIANSHIP

CHAPTER 1151. RIGHTS, POWERS, AND DUTIES UNDER GUARDIANSHIP

SUBCHAPTER H. RIGHTS OF WARDS

Sec. 1151.351. BILL OF RIGHTS FOR WARDS. (a) A ward has all the rights, benefits, responsibilities, and privileges granted by the constitution and laws of this state and the United States, except where specifically limited by a court-ordered guardianship or where otherwise lawfully restricted.

(b) Unless limited by a court or otherwise restricted by law, a ward is authorized to the following:

(1) to have a copy of the guardianship order and letters of guardianship and contact information for the probate court that issued the order and letters;

(2) to have a guardianship that encourages the development or maintenance of maximum self-reliance and independence in the ward with the eventual goal, if possible, of self-sufficiency;

(3) to be treated with respect, consideration, and recognition of the ward's dignity and individuality;

(4) to reside and receive support services in the most integrated setting, including home-based or other community-based settings, as required by Title II of the Americans with Disabilities Act (42 U.S.C. Section 12131 et seq.);

(5) to consideration of the ward's current and previously stated personal preferences, desires, medical and psychiatric treatment preferences, religious beliefs, living arrangements, and other preferences and opinions;

(6) to financial self-determination for all public benefits after essential living expenses and health needs are met and to have access to a monthly personal allowance;

(7) to receive timely and appropriate health care and medical treatment that does not violate the ward's rights granted by the constitution and laws of this state and the United States;

- (8) to exercise full control of all aspects of life not specifically granted by the court to the guardian;
- (9) to control the ward's personal environment based on the ward's preferences;
- (10) to complain or raise concerns regarding the guardian or guardianship to the court, including living arrangements, retaliation by the guardian, conflicts of interest between the guardian and service providers, or a violation of any rights under this section;
- (11) to receive notice in the ward's native language, or preferred mode of communication, and in a manner accessible to the ward, of a court proceeding to continue, modify, or terminate the guardianship and the opportunity to appear before the court to express the ward's preferences and concerns regarding whether the guardianship should be continued, modified, or terminated;
- (12) to have a court investigator or guardian ad litem appointed by the court to investigate a complaint received by the court from the ward or any person about the guardianship;
- (13) to participate in social, religious, and recreational activities, training, employment, education, habilitation, and rehabilitation of the ward's choice in the most integrated setting;
- (14) to self-determination in the substantial maintenance, disposition, and management of real and personal property after essential living expenses and health needs are met, including the right to receive notice and object about the substantial maintenance, disposition, or management of clothing, furniture, vehicles, and other personal effects;
- (15) to personal privacy and confidentiality in personal matters, subject to state and federal law;
- (16) to unimpeded, private, and uncensored communication and visitation with persons of the ward's choice, except that if the guardian determines that certain communication or visitation causes substantial harm to the ward:
 - (A) the guardian may limit, supervise, or restrict communication or visitation, but only to the extent necessary to protect the ward from substantial harm; and

(B) the ward may request a hearing to remove any restrictions on communication or visitation imposed by the guardian under Paragraph (A);

(17) to petition the court and retain counsel of the ward's choice who holds a certificate required by Subchapter E, Chapter 1054, to represent the ward's interest for capacity restoration, modification of the guardianship, the appointment of a different guardian, or for other appropriate relief under this subchapter, including a transition to a supported decision-making agreement, except as limited by Section 1054.006;

(18) to vote in a public election, marry, and retain a license to operate a motor vehicle, unless restricted by the court;

(19) to personal visits from the guardian or the guardian's designee at least once every three months, but more often, if necessary, unless the court orders otherwise;

(20) to be informed of the name, address, phone number, and purpose of Disability Rights Texas, an organization whose mission is to protect the rights of, and advocate for, persons with disabilities, and to communicate and meet with representatives of that organization;

(21) to be informed of the name, address, phone number, and purpose of an independent living center, an area agency on aging, an aging and disability resource center, and the local mental health and intellectual and developmental disability center, and to communicate and meet with representatives from these agencies and organizations;

(22) to be informed of the name, address, phone number, and purpose of the Judicial Branch Certification Commission and the procedure for filing a complaint against a certified guardian;

(23) to contact the Department of Family and Protective Services to report abuse, neglect, exploitation, or violation of personal rights without fear of punishment, interference, coercion, or retaliation;

(24) to have the guardian, on appointment and on annual renewal of the guardianship, explain the rights delineated in this subsection in the ward's native language, or preferred mode of communication, and in a manner accessible to the ward; and

(25) to make decisions related to sexual assault crisis services, including consenting to a forensic medical examination

and treatment, authorizing the collection of forensic evidence, consenting to the release of evidence contained in an evidence collection kit and disclosure of related confidential information, and receiving counseling and other support services; and

(26) to have private communications with the ward's physicians or other medical professionals, unless the court, after a hearing requested by the ward's guardian, orders the private communications to be limited due to:

(A) the risk of substantial harm to the ward; or

(B) the communications being unduly burdensome to the physician or medical professional.

(c) This section does not supersede or abrogate other remedies existing in law.

SOURCE: Texas Estates Code in Subchapter H, Section 1151.351 at: <https://statutes.capitol.texas.gov/Docs/ES/htm/ES.1151.htm>. Accessed 3/7/2024.



State Long-Term Care Ombudsman Program



State Long-Term Care Ombudsman Program

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The Ombudsman Consent and Authority Flow Chart is based on the State Long-Term Care Ombudsman Program [Ombudsman Policies and Procedures Manual, Chapter 700](#).

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Chapter 5: Residents' Rights

Chapter 5 is about understanding residents' rights and the ombudsman role to support residents in exercising their rights. Residents have the right to be free of abuse, neglect, and exploitation (ANE). It is important for ombudsmen to be able to recognize ANE and to understand their role in ANE allegations.

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.
- 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

- Overview of Residents' Rights
- Residents' Rights Under Law
- The Ombudsman Role
- Residents' Rights Themes
- Right to Be Free of Abuse, Neglect, and Exploitation
- Consent Requirements Related to Abuse, Neglect, and Exploitation
- Frequently Asked Questions - ANE
- Enforcement of Residents' Rights
- Rights of Families and Legal Representatives

Video(s), Supplements, Forms

- Infection Control Advocate & Resident Education (ICARE), Computer-Based Training (CBT): Lesson 1 -Common Infections in Nursing Home Communities
- ICARE, CBT: Lesson 2 - Preventing Infections in Nursing Home Communities
- NORC Video: Nursing Home Transfer and Discharge Procedures

- QSEP Hand in Hand, Module 5: Preventing and Responding to Abuse
- Supplement 5-A: Summary of Nursing Facility Resident Rights
- Supplement 5-B: Summary of Assisted Living Facility Resident Bill of Rights

Overview of Residents' Rights

Long-term care ombudsmen have a responsibility to provide information about residents' rights and help residents exercise their rights. Understanding rights and an ombudsman's role to support residents in exercising their rights are essential. The ombudsman process and approach are much the same regardless of whether an individual resides in a nursing or assisted living facility.

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

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?



Answer the following question.

1) How might individual routines impact residents' rights?

Residents' Rights Under Law

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

facility residents. In addition, state law protects rights specific to assisted living facility residents.

Federal Law and Regulations - Nursing Facility Residents

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

State Law and Regulations - Nursing and Assisted Living Facility Residents

- 1) Health & Safety Code
 - a) [Chapter 242](#) Convalescent and Nursing Homes
 - b) [Chapter 247](#) Assisted Living Facilities (see also Chapter 102 of the Texas Human Resources Code, Rights of the Elderly)
- 2) Texas Administrative Code, Title 26, Part 1
 - a) [Chapter 553](#) Licensing Standards for Assisted Living Facilities
 - b) [Chapter 554](#) Nursing Facility Requirements
 - c) [Chapter 320](#) Subchapter A – Rights of Persons Receiving Mental Health Services

The Ombudsman Role

Educate

The role of an ombudsman is to educate individuals on residents' rights and to advocate for those rights to be honored and respected. Ombudsmen need to understand residents' rights, laws, and regulations and use them as advocacy tools. However, it is the role of Texas Health and Human Services, Long-Term Care Regulatory Services (aka surveyors) to enforce regulations.

Empower

Empowerment means to give power to another or to take it for oneself. The dictionary definition is "to give authority to, to authorize." This concept includes an advocate's conscious decision to enable a disadvantaged person or group to become capable of self-advocacy. Ombudsmen encourage residents to:

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

Living in a facility can diminish a person's sense of self and their capabilities, which may disempower residents. Residents are moved into an unfamiliar environment with new rules and new social standards. They often do not know how things work in the facility. They may not want to upset caregivers or may not have the health, mobility, or energy to figure out how to get help. Residents strengthen their sense of self and identify when they have interactions and conversations with people they know.

SOURCE: Hunt, S. May 2005. "Equipping Long-Term Care Ombudsmen for Effective Advocacy: A Basic Curriculum, Residents' Rights." National Long-Term Care Ombudsman Resource Center. <https://ltombudsman.org/uploads/files/support/Local-Investigation-Curri-cResource-Material.pdf>. Accessed December 2021.

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

- Individual's history, culture, and life experience, including a history of trauma.
- Current health.
- Current support system.
- Facility size, culture, and physical environment.

Generational and ethnic differences can affect a person's sense of empowerment. Individuals may:

- Use indirect or direct approaches to work out problems;
- Depend traditionally on others to speak for them; or
- Accept the status quo.

Stay 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.

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 feeling empowered.



Answer the following questions.

- 1) Why is it important for ombudsmen to obtain consent and direction from residents?

- 2) How can short staffing at a facility 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.

- Communication
- Choice
- Decision making
- 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 or 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.
- 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 factors 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 Instructor – Hold a Discussion

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 getting the younger residents to change their behavior.

- How does the ombudsman decide who to represent?

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

2) A facility changed breakfast time from 8:00 a.m. to 7:00 a.m., but a group of residents do not want to get up that early.

- Do residents have a say in this policy? ____Yes ____No
- 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 their personal rights. To exercise the right to make decisions, 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 facilities, they participate in making decisions about the transition (move). Medicaid-eligible residents can work with the Money Follows the Person (MFP) program or through their Medicaid managed care (MCO) service coordinator. More details about this program are in Chapter 13, Regulators and Resources.

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.

Possible Obstacles to Implementing Residents' 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 and may cause other problems.
- 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 perceive 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



On Your Own - Infection Control Advocate & Resident Education (ICARE), Computer-Based Training (CBT) - Lesson 1 - Common Infections in Nursing Home Communities

Related Residents' Rights: Be Informed and Participate

Time to Complete Lesson: 10 minutes.

TIP: Locate ICARE: Introduction for Ombudsmen and download information sheets regarding the ICARE program and how ombudsmen can use it.

Instructions

- 1) Log into the ICARE computer-based training for ombudsmen at this link:
<https://www.unthsc.edu/center-for-geriatrics/education-programs/icare/>
- 2) Click on the link labeled *Ombudsmen & Other Advocates*.
- 3) Click on the dropdown arrow on the option titled, ICARE Lessons & Resources. Click open the link ICARE Lessons & Resources.
- 4) Click on the ICARE lessons dropdown arrow.
- 5) Click to open, [Lesson 1](#): Common Infections in Nursing Home Communities, or
- 6) In the first option, Video Lesson, select Common Infections in Nursing Homes.



Ask the Instructor - Late Night Television

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

- 1) Whose rights need to be protected, the complainant or those who go to bed at 8:00 p.m.? _____
- 2) What are the differences in resident rights in an assisted living facility and a similar situation in a nursing facility?

Specific Rights

Resident rights safeguard and promote dignity, choice, and self-determination. Nursing facilities 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 and assisted living facility residents. When a right applies only in a nursing facility, the right starts with, “In a nursing facility...”

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.
- In a nursing facility, access money and property deposited with the facility and have an accounting of that money and property and of all financial transactions made.
- 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.

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.

SOURCES: [26 TAC §553.267](#); [26 TAC §554.407](#).



Mark whether the following statements about residents' rights are true or false.

1) ___True ___False

Residents may leave their nursing facility for visits and can stay away overnight.

2) ___True ___False

Residents have the right to determine their personal care schedule, such as activities, bathing, and bedtime.

3) ___True ___False

Residents have the right to keep money in their room.

4) ___True ___False

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

5) ___True ___False

Facility staff may monitor resident visits with a long-term care ombudsman.

6) ___True ___False

Residents do not have the right to communicate in their native language to get or receive treatment, care, or services.

7) ___ True ___ False

Residents have the right to refuse food, medicine, therapy, and other services.



Ask the Instructor - Love and Marriage

A nursing facility administrator told marriage-bound residents, "You can get married, as long as your children give permission. I am not sure you'll be able to share a room."

- 1) Do residents need permission to marry? ___Yes ___No
- 2) Is a married couple entitled to their own room? ___Yes ___No
- 3) What if a couple is not married, can they room together? ___Yes ___No



On Your Own ICARE, CBT - Lesson 2 - Preventing Infections in Nursing Home Communities

Related Residents' Rights: Communication and Choice

Time to Completed Lesson: 13 minutes.

Instructions

- 1) Log into the ICARE computer-based training for ombudsmen at this link:
<https://www.unthsc.edu/center-for-geriatrics/education-programs/icare/>
- 2) Click on the link labeled, *Ombudsmen & Other Advocates*
- 3) Click on the dropdown arrow on the option titled, *ICARE Lessons & Resources* and click the blue ICARE LESSONS & RESOURCES link.
- 4) Click on the ICARE Lessons dropdown arrow.
- 5) Click to open and select [Lesson 2](#): Preventing Infections in Nursing Home Communities.
- 6) Select the first option, Video Lesson, Preventing Infections in Nursing Homes.

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.
- In a nursing facility, 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.

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 the resident and the resident representative.
- Notice of immediate discharge in the event the resident becomes a threat to the health and safety of self or others.
- In a Medicaid nursing facility, appeal a discharge before the discharge date in order to stay in the facility until an appeal decision is made or otherwise, up to 90 days to file an appeal.
- In a nursing facility, be readmitted to the facility as provided by regulations.
- In a nursing facility, receive notice of the bed-hold policy.

SOURCES: [26 TAC §553.267](#) and [26 TAC §554.502](#).



Fill in the blanks below.

- 1) Nursing facility residents should receive a ____-day notice of a facility's intent to discharge them.
- 2) The discharge notice must be in _____.

- 3) The resident must appeal the discharge before the discharge _____ to stay in the facility until an appeal decision is made but has up to 90 days to appeal.

On Your Own – Video & Quiz – Nursing Home Discharge

Watch the Nursing Home Discharge recorded webinar on the National Long-Term Care Ombudsman Resource Center website. More information about Transfer and Discharge can be found on the Consumer Voice website. Watch the following brief video.

Link to video: [Nursing Home Transfer and Discharge Procedures](#)

Video length: 15 minutes.

Instructions

Answer the following questions about nursing facility discharges, according to the video.

Take the Quiz

- 1) Mark each statement below that is **true** about nursing facility discharges. Select all that apply.

- ☐ Discharge notices must be communicated in writing.
- ☐ Residents have the right to appeal the discharge and must do so before their discharge date in order to stay in the facility until an appeal decision is made but have up to 90 days to appeal.
- ☐ Nursing facilities are businesses and nursing facility administrators get to decide who stays and who goes.
- ☐ If residents receive a discharge notice, they should contact their ombudsman if they need help.
- ☐ Federal law provides residents with rights and protections against discharge.
- ☐ Most notices must be given 30 days before the discharge date.

- 2) There are six reasons why a facility can transfer or discharge a resident against their will. Name two of the six reasons in the space below.

3) ___True ___False

A resident's doctor must document the reason for discharge in the resident's medical record.

4) ___True ___False

A facility cannot discharge a resident for failure to pay if their application for third-party payments (such as Medicaid) is pending.

5) ___True ___False

If the discharge notice says the reason for the discharge is that the facility "cannot meet the resident's needs," the facility must document in the resident's record the specific needs that cannot be met, what the facility has done to meet those needs, and the services available in the new facility that will meet the resident's needs.

A Resource for You

"25 Common Nursing Home Problems & How to Resolve Them" by Justice in Aging. Click on "Get the Guide" to download a PDF copy. This resource includes more information about problems with nursing home evictions. <https://justiceinaging.org/25-common-nursing-home-problems/>

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.

SOURCES: [26 TAC §553.267](#); [26 TAC §553.259](#); [26 TAC §554.403](#).

Complaints

Residents have the right to:

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

SOURCES: [26 TAC §553.267\(a\)\(3\)\(H\)](#); [26 TAC §554.408](#).

Optional Video: *Voices Speak Out Against Retaliation* (14 minutes) on CTLTCOP YouTube (Connecticut Ombudsman Program) - Link to Video: https://youtu.be/feoQjIW3_bc?si=PVDnprkRQWQB9f5S



Exercise - Residents Have Rights

Instructions

Mark whether the statements below are true or false.

1) ___ True ___ False

Residents have a right to complain only about situations that directly affect them.

2) ___ True ___ False

Only approved residents have the right to attend and participate in resident council meetings.

Use Supplements 5-A and 5-B, found at the end of this chapter, to choose the nursing and assisted living facility resident right to help resolve the complaint. Write the answer in the space provided.

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

4) No one will tell me why I must take so many pills every day.

- 5) Tomorrow facility staff are moving me to another hallway. I don't want to move.
-
- 6) My mother is very frail, and I don't want her to fall. Facility staff won't put side rails up on her bed at night.
-
- 7) My friend is critical of facility staff when she comes. The administrator says if she doesn't stop, she cannot visit me anymore.
-
- 8) The staff person who feeds my dad shoves food into his mouth without care or attention.
-
- 9) 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.
-
- 10) The activities are boring here ... TV, bingo, or playing with paint like children!
-
- 11) Someone is spying on me. My mail is opened before I get it.
-
- 12) I told the nurse last week there is a sore on my leg. No one has checked it yet.
-
- 13) This place is like a prison. I want to go home, and they won't let me.
-
- 14) The housekeeping staff always barges in when I'm undressed. No one ever knocks before they come into my room.
-

SOURCE: Based on Missouri State Long-Term Care Ombudsman Role Plays.

The Right to Be Free from Abuse, Neglect, and Exploitation (ANE)

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. However, ombudsmen are NOT mandatory reporters.

What is ANE?

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 insulted and ridiculed a resident calling her "the wicked witch."
- An aide forced a resident to bathe.
- Staff hovered over a resident to intimidate him.
- A charge nurse told a resident he will never see his family again if he does not comply with treatment.
- A staff person humiliated and reprimanded a resident who did not make it to the restroom in time.
- Staff posted a sexually explicit photo of a resident on social media.
- 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 of the facility, its employees, or its service providers to care for a person in a manner which would avoid physical or emotional harm or pain, emotional distress, or the failure to react to a situation which may be harmful. Neglect may or may not be intentional.

Examples of neglect may include:

- Failure to provide sufficient, qualified, competent staff, to meet resident's needs.
- 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.
- Failure to provide staff training on new equipment, new procedures, or medications.
- Failure to provide resident interventions as identified in the care plan.
- Ignoring call lights or cries for help.



Fill in the blank in the following statement.

- 1) 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.

Examples of Exploitation

- 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.

- Someone charges a resident an excessive fee for goods or services rendered.
- A person charges excessive rent or unreasonable fees for basic care services such as transportation, food, or medicine.
- A person obtains 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 using manipulation, intimidation, or threats.
- An individual, staff, or family member improperly uses a resident's POA or other fiduciary authority to alter a will, borrow money using the victim's name, or dispose of assets or income.

SOURCES: [26 TAC §553.267](#); [26 TAC §554.601](#); [26 TAC §554.602](#).



Fill in the blanks in the following statement.

- 1) 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.

Ombudsmen Are Not Mandatory Reporters

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.

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 Investigate Whether ANE Occurred

Ombudsmen do not determine whether ANE occurred but act as an advocate for the resident by following the resident's guidance. Ombudsmen are not the "finders of fact."

Ombudsmen Are Required to Investigate Complaints Related to ANE

Ombudsmen must investigate a complaint related to an allegation or suspicion of ANE and follow the guidance outlined in the OPPM. The following are examples of complaints related to ANE:

- An assisted living facility failed to report an allegation of ANE as required by state and federal law.
- A nursing facility failed to protect a resident from an alleged perpetrator during the investigation of ANE as required by state and federal law.
- A nursing facility retaliated against a resident for reporting an allegation of ANE.

SOURCE: OPPM, Chapter 800.



Very important 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.

Consent Requirements Related to Allegations of ANE

Able to Consent

If the resident is able to consent to the ombudsman reporting the allegation or suspicion and the resident gives consent for the ombudsman to report, the ombudsman must report an allegation or suspicion of ANE to the facility, the

appropriate authority, or both. If the resident does not consent, the ombudsman does not report the allegation of ANE.



Very important information!

Appropriate authorities to investigate whether ANE occurred include HHS Regulatory Services (LTCR), Adult Protective Services (APS), and law enforcement. See the OPPM, Section 820 for more information about authorities that investigate allegations of ANE.

Unable to Consent and Has an LAR

If the resident is unable to consent to an ombudsman reporting an allegation or suspicion of ANE, the ombudsman must determine if the resident has an LAR. If the resident has an LAR, the ombudsman must obtain consent from the LAR to report the allegation or suspicion of ANE to the appropriate authority (HHS Regulatory Services, APS, law enforcement). If the LAR consents to the ombudsman reporting the allegation of ANE, the ombudsman must report the allegation of ANE to the facility, appropriate authority, or both.

If the LAR declines to consent to reporting the allegation of ANE or does not respond, request approval from the State Ombudsman to refer the complaint. Review OPPM Section 740 (h) and (i) for more information about referring a complaint.

Unable to Consent and Does Not Have an LAR

If the ombudsman determines the resident is unable to consent and has no LAR, the ombudsman must report the allegation of ANE to the facility, appropriate authority, or both.

When a Complainant Is Not the Resident...

If the complainant is not the resident who is the alleged victim of ANE, a long-term care facility staff person, or a licensed professional with mandatory ANE reporting requirements, encourage the complainant to report the allegation to the facility or other appropriate authority as described in the OPPM Chapter 800.

To report the allegation to the facility or other appropriate authority, an ombudsman must obtain consent from the resident, or the resident's LAR, if the

resident is unable to consent, or have the authority to report without consent as detailed by OPPM Section 830.

If consent is obtained, report the allegation to the facility, appropriate authority, or both.

Notify the MLO that an ANE Report Was Made

Within 24 hours after making the report of an allegation or suspicion of ANE, the certified ombudsman must inform the MLO, if the ombudsman is not the MLO.

If the Ombudsman Personally Witnesses ANE...

Ombudsman consent requirements apply. An ombudsman must follow the ANE consent requirements related to allegations of ANE above and as outlined in the OPPM Chapter 800 even if the ombudsman personally witnessed ANE.

Frequently Asked Questions – ANE

Question: I hold a professional license issued by the State of Texas. My licensure requires me to report ANE. What are my responsibilities for reporting allegations of or witnessing ANE while serving as a long-term care ombudsman? See OPPM Section 820 (b).

Answer: *Even if an ombudsman carries a professional license (for example, a licensed social worker, teacher, lawyer, or nurse), you 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.*

Question: What should I do if a resident says they are going to commit suicide or harm others?

Answer: *Even though this is a very rare occurrence, be prepared.*

Request information from the resident including:

- *Who the resident is threatening to harm;*
- *Why the resident is threatening harm;*
- *When and how the resident intends to carry out the threat of harm;*
- *Whether the resident has the means and ability to carry out the threat of harm; and*

- *Whether the resident consents to the ombudsman taking action, such as reporting the threat to the facility or calling 9-1-1 or a mental health crisis center;*

Request the resident not act on the threat.

If the resident consents and you believe the threat may be credible, report the threat to:

- *The long-term care facility;*
- *Law enforcement by calling 9-1-1; or*
- *A mental health crisis center; and*

If the resident does not consent and you believe the threat may be credible and possible:

- *If you believe there is time without risking the safety of any person, immediately contact the MLO or the state office and follow guidance provided; or*
- *If the MLO or staff office staff are not immediately available, or you believe taking time to contact either will risk the safety of someone, immediately report the threat to the facility administrator or 9-1-1.*

Question: What should I do if I receive a credible communication from a person, other than a resident, that the person is threatening to harm self or others?

Answer: *Even though this is a very rare occurrence, be prepared. If the person being threatened is a resident or staff person of a facility, report the threat to the facility administrator or manager on duty, or law enforcement by calling 911. If the person being threatened is not a resident or staff person in the facility, report the threat to law enforcement by calling 9-1-1.*

Notify the MLO within two hours of reporting the threat to law enforcement or the long-term care facility administrator. Source: OPPM 840 (a).

Facility Responsibilities Related to ANE

Every facility has a responsibility to protect residents.

Employee Screening & Training

Before a nursing facility 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. This action is one method of deterrent from hiring a person with any known history of mistreating a resident.

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.

Additional Nursing Facility Requirements Related to ANE

Per TAC, nursing facilities must have sufficient staff with the appropriate competencies and skill sets to provide nursing and related services to assure resident safety and attain, or maintain, the highest practicable physical, mental, and psychosocial wellbeing of each resident. This includes hiring staff with the appropriate competencies and skill sets to provide care for residents with mental and psychosocial disorders, as well as residents with a history of trauma or post-traumatic stress disorder. This is determined by resident assessments and individual comprehensive care plans and considering the number, acuity, and diagnoses of the facility's resident population in accordance with the facility assessment.

SOURCES: [26 TAC §554.904\(1\)-\(2\)](#); [26 TAC §554.1001](#); [26 TAC §554.1931](#).

Resident Screening

Before admitting the resident to live in a facility, the facility should assess the potential resident's needs and determine if their facility can meet those needs. 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 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:

- Theft or misuse of resident funds or property;
- Death of a resident that involves unusual circumstances;
- 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;
- Drug theft (aka drug diversion) – 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;
- Fires – State provider letters specify reportable fire related incidents for nursing and assisted living facilities;
- Nursing facilities must report emergency situations that pose a threat to resident health and safety – Examples include bomb threats, floods, failure of the sprinkler system or fire alarm, failure of the heat or air-conditioning systems, a widespread nonfunctioning call system, and others; and
- Injuries of unknown source – In nursing facilities, 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.

In assisted living facilities, encourage the facility to self-report injuries that are suspicious (possible ANE), or that are from an unknown source.

SOURCES: Texas HHS [PL 2024-14 \(NF\)](#); [PL 19-23 \(ALF\)](#); [26 TAC §553.267](#); [26 TAC §554.601](#); [26 TAC §554.602](#).

On Your Own – CBT & Quiz – Hand in Hand Dementia Training - Module 5 – Preventing and Responding to Abuse by CMS

Reminder! For ombudsmen, special considerations apply to allegations of abuse, neglect, and exploitation and these are addressed in the State Long-Term Care Ombudsman Policies and Procedures Manual, Chapters 700 and 800.

Link to Video: <https://qsep.cms.gov/welcome.aspx>

Length of time to complete Module 5

Up to 1 hour. **WARNING** – Videos in this module contain abuse scenes.

This training takes up to 1 hour to complete. If you exit the CBT, you may have to start the section you are watching (when you exit) over. It is recommended you complete this training when you will not have any interruptions. There is an introduction and six lessons in Module 5.

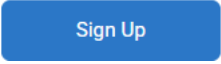
It may be helpful to read questions before watching the video-based Hand in Hand training.

Instructions to Access QSEP Hand in Hand CBT

There are five Modules within the CMS Hand in Hand computer-based training (CBT). Each module may take up to one hour to complete. This training is mandatory for staff ombudsmen, volunteer ombudsmen, and MLOs. It is required per Human Resources Code, Title 2, Subtitle D, Chapter 40, Subchapter A, §40.036. Watch Hand in Hand Module 5. Modules 1-4 are assigned in Chapter 2.

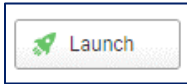
To complete the mandatory CMS Hand in Hand CBT, click on the [QSEP](#) link above or in the document provided by the local ombudsman program.

Steps to Access the CBT:

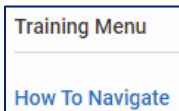
- 1)  Log into QSEP training by clicking on "Sign Up." Select "Providers & Other Learners." Fill out your name and email address. Under "Select Your Organization Type," choose "Other." For the "Type," enter "Texas Ombudsman Program." Confirm your email address and log into

QSEP. If you are unable to sign in using "Sign Up," log into QSEP using the "Public Access" option in the top right of your screen.

- 2) On the Training Catalog page, you should see the letters A-Z.



- 3) Click the letter "H." Locate *Hand in Hand – A Training Series for Nursing Homes Toolkit*. Click on the launch button (rocket ship icon labeled "launch").



- 4) Under the Training Menu heading found on the right half of the screen, click on "How to Navigate." Watch the demonstration.
- 5) Watch all lessons found in Module 5. Complete the quiz that follows.
- 6) If you signed up for QSEP and completed Modules 1-5, you can download and save your certificate of completion. Email the certificate to your trainer. You cannot download a certificate if you used Public Access and did not sign up for QSEP. Document the completion of Module 5 on the HHS Form 8618 to document completion.

Instructions

Mark the best answer for CMS Hand in Hand, Module 5 questions. Questions are separated into lessons.

Take the Quiz - Hand in Hand Module 5

Lesson 1: What is abuse?

- 1) ___True ___False

CMS' definition of abuse is the following: "Abuse is the willful infliction of injury, unreasonable confinement, intimidation, or punishment with resulting physical harm, pain, or mental anguish. Abuse also includes the deprivation by an individual, including a caretaker, of goods or services that are necessary to attain or maintain physical, mental, and psychosocial well-being. Instances of abuse of all residents, irrespective of any mental or physical condition, cause physical harm, pain or mental anguish."

- 2) What type of abuse is the following example? "You are an idiot and you're just playing at being a victim. Shut up and stop whining or I'm going to make you stop!" Mark the best answer.
- ☐ Verbal ☐ Physical ☐ Sexual
- 3) Degradation and humiliation are what type of abuse? Mark the best answer.
- ☐ Verbal
- ☐ Mental
- ☐ Physical
- 4) Slapping a resident's hand or squeezing a resident's arm hard enough to leave fingerprint bruises are two examples of which type of abuse? Mark the best answer.
- ☐ Verbal
- ☐ Mental
- ☐ Physical
- 5) What type of abuse is the following example? Staff in an assisted living facility post a video on social media of a staff person taunting and humiliating a resident. Select the best answer.
- ☐ Mental
- ☐ Physical
- ☐ Sexual
- 6) Two staff in a nursing facility take a picture of a resident that is sexually explicit and post it on social media. What type of abuse is this? Choose the best answer.
- ☐ Verbal ☐ Physical ☐ Sexual
- 7) A caregiver in a small residential assisted living coerces the residents to watch pornography with her. What type of abuse is this? Select the best answer.
- ☐ Verbal ☐ Physical ☐ Sexual

8) An assisted living staff member persuades a resident to give her sterling silver flatware to her. She said, "You have no family. If you give me your silverware, I will cherish it forever, pass it on to my daughter as a family heirloom, and we will always have loving memories of you." What type of abuse is this? Mark the best answer.

- ☐ Verbal
- ☐ Misappropriation of resident property (theft)
- ☐ Deprivation of goods and / or services (neglect)

Lesson 2: Recognizing Abuse

9) Video 1 - What does abuse look like? - A daughter and her mom are overheard discussing the mother's watch by a staff person. What type of abuse or neglect did you witness in this video? Choose the best answer.

- ☐ Verbal
- ☐ Mental
- ☐ Misappropriation of resident property (theft)

10) Video 2 - What does abuse look like? In this video, the resident is in bed and asks the aide to take her to the restroom. What type of abuse or neglect did you witness? Mark all that apply.

- ☐ Mental
- ☐ Physical
- ☐ Sexual
- ☐ Deprivation of goods and/or service (neglect)

11) Video 3 - What does abuse look like? In this video, an aide came to take a resident to shower her while the resident was watching her game show on television. What type of abuse or neglect did you witness? Mark all that apply.

- ☐ Verbal
- ☐ Mental
- ☐ Physical
- ☐ Sexual

12) Video 4 - What does abuse look like? - In this video, a staff person is shown leaving a resident's room and putting on his name tag. What type of suspected abuse or neglect did you witness? Select the best answer.

- ☐ Verbal
- ☐ Physical
- ☐ Sexual

Lesson 3: Signs of Abuse

13) Video 1 - Signs of Abuse – What signs did the aide see that concerned her and that could be a sign of abuse?

☐ Mrs. Caputo winced when the aide touched her	☐ Mrs. Caputo said she wants to go home.
☐ Mrs. Caputo was jumpy and unable to report how she injured her arm.	☐ Mrs. Caputo's arm was bruised and bleeding.

Lesson 4: Actions and Reactions: Understanding How Abuse Happens

14) ☐ True ☐ False?

Actions are what we do, and reactions are how we respond to something someone has done or how we respond to a situation.

15) ☐ True ☐ False

Abuse is sometimes the result of a series of actions and reactions that might be preventable.

Lesson 5: Preventing Abuse

16) Mark all that apply. According to CMS Hand in Hand, the best approach for staff to prevent abuse is for staff to...

- ☐ Know the resident.
- ☐ Know the resident's rights.
- ☐ Put themselves "in the shoes of the resident."

Lesson 6: Responding to and Reporting Abuse

17) ___True ___False

All facility staff are mandatory reporters of suspected, alleged, or witnessed abuse, neglect, or exploitation.

18) ___True ___False

Long-Term Care Ombudsmen are not mandatory reporters of ANE; they must follow guidelines established in the OPPM.

CMS Hand in Hand Module 5 was created for long-term care staff training. Ombudsmen follow consent requirements as outlined in the OPPPM.

A Resource for You

Visit “Publications” on the Office of the Long-Term Care Ombudsman website at this link:

https://apps.hhs.texas.gov/news_info/ombudsman/publications.html

- Assisted Living Facility Residents’ Rights book;
- Nursing Facility Residents’ Rights book; and
- Important Information about Discharge from a Nursing Facility.

Enforcement of Residents’ 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. 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 main method used 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 residents (who consented) as sources for more information.

How Facilities Can Promote Rights

- Educate residents and their families about rights (beyond the minimum requirement when a resident is admitted).

- 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.
- Incorporate resident participation and self-determination into every aspect of services, such as resident advisory committees for food services, activities, and housekeeping.
- Provide support to workers, such as sufficient staffing, training, supervision, mentoring, and increased salaries and benefits.
- Take time to introduce staff to the residents with whom they will work.
- Promote relationships between management and direct care staff.
- Use the information and wisdom of residents and their representatives to help develop and conduct training programs for staff.
- Help staff, residents, and families focus on empowerment. Residents need assistance, but the help received should strive to increase their ability to help themselves.
- Establish a grievance committee comprised of residents, family, staff, and management.
- Encourage and promote an open exchange of ideas, recommendations, and concerns throughout the facility.
- Build more private rooms for individual residents and public rooms for private use by residents.
- Promote a sense of community within the facility. Organize activities in different areas and design activities that promote interaction and intellectual stimulation.

SOURCE: National Consumer Voice, Nursing Home Resident Rights Project



Exercise - Role Play - Residents' Right to Participate in Activities

Objectives

- Model ways to empower a resident to solve their own problems;
- Suggest ways of helping a resident speak for themselves;
- Remind ombudsmen of the resident's right to choose activities; and
- Help ombudsmen understand the care plan process and how to use it to advocate for a resident.

Characters

- Narrator
- Ombudsman
- Ms. (or Mr.) Hay

Role Play

NARRATOR: The ombudsman knocks on a resident door.

OMBUDSMAN: May I come in?

MS. HAY: Please. How are you?

OMBUDSMAN: Wonderful. How are things going for you?

MS. HAY: Fine I guess since there isn't much to do around here.

OMBUDSMAN: I saw on the activity calendar they are having bingo later today.

MS. HAY: I hate bingo!

OMBUDSMAN: What would you rather do?

MS. HAY: I don't know, nothing offered here.

OMBUDSMAN: How did you spend most days before you moved here?

MS. HAY: I didn't do much. I worked on my farm.

OMBUDSMAN: You know, you have the right to have activities that are interesting to you. Have you spoken to the activities director about what interests you?

MS. HAY: No. He's too busy doing all that other stuff.

OMBUDSMAN: He probably is busy, but this is important. It might be good to talk to him in your care plan meeting. Have you been to one of those?

MS. HAY: I don't think so.

OMBUDSMAN: Staff here hold a care plan meeting every three months and more often if needed. You and any family members you invite can discuss your care with staff. You can also talk about what you want or what you need. It's a good time to talk about activities you like.

MS. HAY: Staff said something to me about a meeting a couple of times, but I didn't know what it was, so I didn't go.

OMBUDSMAN: Would you like to ask for a care plan meeting or talk to the activity director?

MS. HAY: I think I can talk to the activity director. Can you set that up?

OMBUDSMAN: Sure, I can. How about we make a list of things you want to talk to him about? I can help you with that. If you want, I can also help you practice how to ask him about activities and let him know what you want to do to stay active.



Ask the Instructor - Hold a Discussion About the Role Play

1) How would you help Ms. Hay create her list?

2) What would be your next steps, including follow-up on this case?

Rights of Nursing Facility Families and Legal Representatives

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

To Be Notified

A facility must immediately inform the resident; consult with the resident's physician; and notify, consistent with the representative's authority, the resident representative when there is:

- an accident involving the resident that results in injury and has the potential for requiring physician intervention;

- a significant change in the resident's physical, mental, or psychosocial status (a deterioration in health, mental, or psychosocial status in either life-threatening conditions or clinical complications);
- a need to alter treatment significantly (that is, a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or
- a decision to transfer or discharge the resident from the facility.

SOURCES: [26 TAC §554.403](#); [26 TAC §554.502](#).

To Participate

- In the care planning process;
- 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 family council.

SOURCES: [26 TAC §554.706](#); [26 TAC §554.802](#).

To 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.

SOURCE: [42 CFR §483.10](#).

Access to the Resident

Have immediate access to the resident (subject to the resident's rights to deny or withdraw consent at any time).

SOURCE: [26 TAC §554.413](#).

Rights of Assisted Living Facility Families and Legal Representatives

To Be Notified

- The facility must obtain the names and contact information for a resident's family, other persons named by the resident, and physician for emergency notification at the time of admission;

- Simple financial records on all charges billed to the resident for care must be available to residents and their legally authorized representative.
- The facility must keep a simple financial record on all charges billed to the resident for care and these records must be available to HHSC;
- A person who a resident, or a resident's legally authorized representative, identified in writing for the facility to contact in the event of a disaster or emergency;
- No later than 24 hours after the use of a restraint, the facility must notify one of the following persons, if there is such a person, that the resident has been restrained:
 - The resident's legally authorized representative; or
 - An individual actively involved in the resident's care unless the release of this information violates other law.

SOURCES: [26 TAC §553.259](#); [26 TAC §553.265](#); [26 TAC §553.275](#).

To Participate

The service plan must be approved and signed by the resident or a person responsible for the resident's health care decisions. In an Alzheimer's Assisted Living facility, facility staff get input from the family, if available, to develop an individualized service plan for each resident.

A facility may allow personal care staff to perform a health maintenance activity (HMA) for the resident, without being delegated by an RN, if certain requirements are met (as defined in TAC) and the resident, the resident's legally authorized representative, or other adult chosen by the resident, as applicable, is willing and able, and has agreed in writing, to participate in directing the personal care staff's actions in carrying out the HMA(s) for the resident.

SOURCES: [26 TAC §553.263](#); [26 TAC §553.307](#); [26 TAC §553.259](#).

To Make Concerns Known to the Facility

- Complaints can be made about the resident's care or treatment, and they may be made anonymously or communicated by a person designated by the resident.
- The provider must promptly respond to resolve the complaint.
- The provider must not discriminate or take other punitive action against a resident who makes a complaint.

SOURCE: [26 TAC §553.267\(3\)\(H\)](#).

Access to the Resident

Any person of the resident's choice, including family members, have access to the resident at any reasonable hour, subject to the resident's rights to deny or withdraw consent at any time.

SOURCE: [26 TAC §553.267\(a\)\(3\)\(J\)](#).



Fill in the blanks in the statement below.

- 1) For a resident in a nursing facility, family has a right to be notified within 24 hours of an _____ that results in injury or has potential for requiring physician intervention, or a significant change in the resident's physical, mental, or _____ status.
- 2) Family also has a right to participate in the _____ planning process.



Ask the Instructor - Determine the Ombudsman Response.

Instructions

Read the following policies related to abuse, neglect, and exploitation in Chapter 700 in the OPPM found in Chapter 14 and consult *Supplement 4-B: Ombudsman Consent and Authority Flow Chart*.

Describe how you think the ombudsman should respond to each of the following scenarios. Use the following sections of the OPPM to respond.

- 730 (d) (1-4) Responding to a Complaint
- 740 (a-j) Consent to Investigate a Complaint
- 750 (a-d) Situations for Which Consent is Not Required to take an Action

Scenario 1

Example: A resident tells you he was injured by someone who works at the assisted living facility where he lives. He tells you he did not want to shower, and the shower aide tried to force him. He states he has bruises where the aide squeezed his upper arms. He does not give you consent to report the ANE nor to disclose any identifying information.

What should you (as the ombudsman) do?

If consent is withheld, the ombudsman does not report the ANE allegation. Determine if other residents may be affected. Consider other advocacy options.

Scenario 2

A facility staff person pulls you aside during your facility visit and alleges physical abuse of a specific resident by a specific aide.

What should you (as the ombudsman) do?

Scenario 3

A resident tells you that she has been sexually abused by an aide on the night shift. She has the ability to consent but directs you not to report her allegation to the facility or to Regulatory Services.

What should you (as the ombudsman) do?

Scenario 4

You personally witness verbal abuse.

What should you (as the ombudsman) do?

Scenario 5

During a facility visit, you see and hear an altercation between a nurse and a resident during a birthday party held in the dining room. The resident is crying and holding his arms up in front of his face as if to protect himself. Four

residents and two aides are also in the dining room where the verbal confrontation is occurring.

What should you (as the ombudsman) do?

Scenario 6

A resident tells you that the facility's manager has verbally and mentally abused her. She is able to consent but directs you not to report the allegation to Regulatory Services for investigation. She tells you to seek consent from her daughter who is the agent named her medical and financial powers of attorney.

What should you (as the ombudsman) do?

Supplement 5-A: Summary of Nursing Facility Residents' Rights

As a resident of a Texas nursing facility, you have all the rights, benefits, responsibilities, and privileges granted by the Constitution and laws of this state and the United States. You 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; and
- 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](#); and
- 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; and
- 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; and
- 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 before the discharge date to remain in the facility or otherwise appeal within 90 days of receiving notice in a Medicaid facility; and
- 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; and
- 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; and
- 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, [26 TAC Subchapter E](#).

Supplement 5-B: Summary of Assisted Living Facility Resident Rights

As resident of an assisted living facility, you have all the rights, benefits, responsibilities, and privileges granted by the constitution and laws of this state and the United States, except where lawfully restricted. You have 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, sex, 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, 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 26 TAC §553.267.

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; and
- 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 your [resident's] finances, you [the resident] must be given, upon request and at least quarterly, an accounting of financial transactions made on your [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 your [individual] preference; you [the resident] are 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; and
- 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; and
- 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 you [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; and

- Be fully informed in advance about treatment or care that may affect your [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 your [the resident's] welfare, and your [the resident's] needs cannot be met by the facility;
 - your [the resident's] health is improved sufficiently so that services are no longer needed;
 - your [the resident's] health and safety or the health and safety of another resident would be endangered if the transfer or discharge is not made;
 - the provider ceases to operate or to participate in the program that reimburses for your [the resident's] treatment or care; or
 - you [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 you [the resident], your [the resident's] legal representative, or a member of your [the resident's] family, stating:
 - the facility intends to transfer or discharge you [the resident];
 - the reason for the transfer or discharge;
 - the effective date of the transfer or discharge;
 - the location to which you [the resident] will be transferred; and
 - any appeal rights available to you [the resident].

SOURCE: This list of rights is based on the Licensing Standards for Assisted Living Facilities, Residents Bill of Rights [26 TAC §553.267](#)

Chapter 6: Ombudsman Program Access and Long-Term Care Facility Operations

Chapter 6 is about nursing and assisted living facilities. People who live in either type of facility have a right to Ombudsman Program services. Nursing and assisted living facilities 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.
- Understand how most residents pay for nursing and assisted living facility care.
- Become familiar with long-term care management, operations, and staffing.
- Identify alternatives to nursing facility care.
- Understand your role as a resident advocate and how to maintain healthy boundaries.

Contents

- Ombudsman Program Access
- The Ombudsman Role
- Long-Term Services and Supports
- Assisted Living Facilities
- Nursing Facilities
- Alternatives to Nursing Facility Care
- Consistent Staffing and Continuity of Care
- Emergency Preparedness
- Infection Prevention and Control
- Frequently Asked Questions – Infection Precautions and Ombudsman Visitation
- Good Relationships with Ombudsmen, Residents, and Facility Staff
- Volunteer Internship

- Facility Visit Guide
- Facility Visit Guide – Memory Care and Alzheimer’s Certified Facilities
- Review with Instructor: How to Fill Out a Volunteer Activity Report During Your Internship

Video(s), Supplements, Forms

- YouTube Video: Person-Centered Care – Consistent Staff Assignments
- YouTube Video: Ombudsman Program - PPE for Long-Term Care Ombudsman Facility Visits
- ICARE, CBT: Lesson 3 – Safeguarding the Nursing Home Environment
- ICARE, CBT: Lesson 4 – Hand Hygiene Heroes!
- ICARE, CBT: Lesson 5 – Gowns, Gloves, and Goggles – Precautions for Prevention

Ombudsman Program Access

In Texas, ombudsman services are available to people living in nursing and assisted living facilities that are licensed and regulated by Texas Health and Human Services. Ombudsmen do not provide oversight to Personal Care Homes, Day Activity and Health Services Centers (formerly called Adult Day Services), and Intermediate Care Facilities serving persons with intellectual or developmental disabilities.

Texas Administrative Code

- [26 TAC Chapter 88](#), Subchapter C - Access by the State Ombudsman and Representatives of the Office (26 TAC §88.201);
- [26 TAC Chapter 553](#), Subchapter E - Access to Residents and Records by the Long-Term Care Ombudsman Program (26 TAC §553.269); and
- [26 TAC Chapter 554](#), Subchapter E - Residents Rights, Access and Visitation Rights (26 TAC §554.413).

Access to Facilities

Ombudsmen make unannounced visits to nursing and assisted living facilities. Exceptions include scheduled meetings with management, resident council meetings, and care or service plan meetings. Ombudsmen have immediate, private, and unimpeded access to enter a long-term care facility.

- Interns (ombudsmen in training) must make facility visits only during a facility's regular visiting hours.
- Interns must wear their intern badge during a facility visit.
- Certified ombudsmen (volunteers and staff) must wear their ombudsman badge and lanyard during a facility visit.
- Certified ombudsmen may visit at times other than regular visiting hours *if* the ombudsman determines access may be required by the circumstance needing investigation.
 - A certified volunteer ombudsman must consult with their supervising staff ombudsman or MLO if they propose a visit to a facility at a time other than regular visiting hours.
- Visits with residents must not interrupt the provision of care such as physical therapy, wound care, bathing, or incontinence care.

Requirement to Attempt to Notify Staff

Upon entering a long-term care facility, a certified ombudsman and an intern must attempt to notify one of the following they are in the facility:

- A person at the front desk, the facility administrator, or a person working at the nurse's station; or
- If none of these persons are available at the facility, another staff person at the facility.

Access to Areas in Facilities Not Accessible to the Public

If a certified ombudsman needs to view an area of a facility that is not accessible to the public, such as a kitchen or medicine storage closet, the ombudsman must request that staff assist the ombudsman in accessing the area. An ombudsman must follow any facility procedures regarding health and safety precautions in viewing the area. Since interns do not investigate complaints, interns do not have access to areas in facilities not accessible to the public until that person is certified.

Access to Facility Information

Ombudsmen have access to the administrative records, policies, and documents of nursing and assisted living facilities to which residents or the public have access.

Examples of administrative records include but are not limited to:

- Facility policies and procedures;
- Admission agreements;
- Smoking policies;
- Resident handbooks;
- Emergency operation policies; and
- Facility grievance procedures.

Access to Residents

Ombudsmen have immediate, private, and unimpeded access to residents but must not interrupt the provision of care to a resident.

Access to Resident Representative Information

Ombudsmen have access to the name and contact information of a resident's representative when it is determined by the ombudsman that the information is needed to perform functions of the Ombudsman Program.

The Ombudsman Role

In a facility, an ombudsman:

- Visits residents.
- Provides residents with information about the Ombudsman Program.
- Provides information on how to get quality care.
- Promotes resident and family councils.
- Identifies problems in facilities and work to resolve them, following consent guidelines.
- Investigates and resolves complaints made by a resident, or by another complainant on behalf of a resident, following consent guidelines.
- Advocates for residents.

Long-Term Services and Supports (LTSS)

"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 facilities, and hospice.

How to Choose a Long-Term Care Facility

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

- How to Choose a Nursing Home by National Institute on Aging, <https://www.nia.nih.gov/health/how-choose-nursing-home>
- AARP, Assisted Living: Weighing the Options: <https://www.aarp.org/caregiving/basics/info-2017/assisted-living-options.html>
- Aging & Disability Resource Centers are part of the Texas "No Wrong Door" system designed to streamline public access to Long-Term Services and Supports (LTSS). Aging and Disability Resource Centers (ADRCs) are available in all 254 counties in Texas: <https://hhs.texas.gov/services/aging/long-term-care/aging-disability-resource-center/find-adrc>

Find and Compare Quality of Facilities

- [Care Compare](#) by Centers for Medicare and Medicaid Services (CMS) - Nursing Facilities Only
- [Long-Term Care Provider Search](#) by Texas HHS – Nursing and Assisted Living Facilities

Home Health and Hospice Services

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 facilities. Medicare, Medicaid, and other types of insurance may reimburse providers for services to eligible individuals.

Home health services include services such as:

- Nursing, including blood pressure monitoring, and diabetes treatment;
- Physical, occupational, speech, or respiratory therapy; and
- Medical equipment and supplies.

Hospice 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, seven days a week, during the final stages of illness, death, and bereavement.

Nursing Facilities and HCSSAs

Home health services are not provided in nursing facilities.

If a Medicaid certified nursing facility uses an outside hospice provider, state law requires a written contract between the facility and the hospice agency. The contract must say what services the facility will provide and what services the hospice agency will provide.

SOURCE: [26 TAC §554.1926](#).

Assisted Living Facilities and HCSSAs

Residents in assisted living facilities contract directly with home health and hospice agencies.

SOURCE: [26 TAC §553.259\(a\)\(3\)](#).

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 facility, but for whom independent living is no longer appropriate. Assisted living facilities are supposed to 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 with common areas or private residences with a few bedrooms. Assisted living facilities provide individualized health and personal care assistance. 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 owner;

- 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 facility 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.

- 1) Texas law – [Health and Safety Code, Title 4, Chapter 247](#), Assisted Living Facilities
- 2) Texas rule – [26 TAC §553](#), Licensing Standards for Assisted Living Facilities

Number of Assisted Living Facilities in Texas

As of January 2025, Texas had 2,013 assisted living facilities: 371 Type A, 1,631 Type B, and 11 Type C. Assisted living is further categorized as large or small as determined by the licensed bed capacity. If licensed for fewer than 17 beds, Type A and B facilities are designated as small; if licensed for 17 or more beds, facilities are designated as large.

SOURCE: January 2025. Texas HHS Regulatory Services Directory of all ALFs.
<https://www.hhs.texas.gov/providers/long-term-care-providers/assisted-living-facilities-alf>.
 Accessed January 2025.

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 or B. 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 nonambulatory, such as an individual who uses a wheelchair, a walker, or a powerchair, and has the capacity to transfer and evacuate independently 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 building's exit level (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 bedbound.

Type C Licenses - No Longer Issued

A Type C assisted living facility is a four-bed facility that was originally licensed by Texas HHS to provide adult foster care (AFC) services. Texas HHS no longer issues Type C licenses. A few facilities with a Type C license remain, but these numbers continue to decline. New AFC facilities that serve 4-8 individuals must obtain a Type A or Type B license. AFC provided in small group homes is subject to two sets of regulations: minimum standards for AFC and Licensing Standards for Assisted Living Facilities. The stricter requirements apply when requirements conflict; therefore, an enrolled AFC provider whose home is licensed as a small group home must comply with the requirement that an attendant be present at all times when residents are in the facility. This requirement applies regardless of the number of individuals currently residing in the facility.

SOURCE: Texas Health and Human Services, [26 TAC §553](#); [Texas HHSC Community Care Services Eligibility Handbook](#). Accessed May 2025.

Certified Alzheimer's Assisted Living Facilities

Assisted living facilities that advertise, market, or otherwise promote the facility as providing specialized care for persons with Alzheimer's disease or related disorders must be certified and meet additional requirements. A facility must be licensed as a Type B assisted living facility to be certified for Alzheimer's care.

Certification is not required for a facility to use advertising terms such as "medication reminders or assistance," "meal and activity reminders," "escort service," or "short-term memory loss, confusion, or forgetfulness."

A certified Alzheimer's assisted living facility or unit must employ enough staff to provide services for, and meet the needs of, its residents who have Alzheimer's and related disorders. All Type B assisted living facility night staff must be awake and immediately available, regardless of the number of licensed beds the facility has.

Activities programs in certified Alzheimer's assisted living facilities have additional requirements. They must provide opportunities for group and individual settings. On weekdays, each resident must be offered at least one cognitive activity, two recreational activities, and three activities of daily living (ADL) each day. The cognitive and recreational activities (structured activities) must be at least 30 minutes in duration, with a minimum of six and a half hours of structured activity for the entire week. At least an hour and a half of

structured activities must be provided during the weekend and must include at least one cognitive activity and one physical activity.

SOURCES: [26 TAC §553.3](#) (Subchapter A); [26 TAC §553.27](#) (Subchapter B); [26 TAC §553](#) (Subchapter F); [26 TAC §553.309\(c\)](#). Accessed September 2021.

Terms to Know

Activity of Daily Living

Activities of daily living (ADLs) is a term used to collectively describe self-care tasks. These tasks include eating, dressing, grooming, bathing, toileting, and moving (stand, sit, walk, lie down, etc.)

Functional Disability

A functional disability is a mental, cognitive, or physical disability that precludes the physical performance of self-care tasks, including Health Maintenance Activities (HMAs) and Activities of Daily Living (ADLs). It is defined in [26 TAC §553.3](#).

Nurse Delegated Tasks

In assisted living, a nurse delegated task is a nursing care task that can be delegated to a personal care staff (attendant) to perform. Nurse delegated tasks require documentation of the written authorization of a registered nurse (RN), where delegation criteria are met for the task.

The delegation of medication administration is governed by [22 TAC Part 11 §224](#). It describes RN delegation to unlicensed personnel. If attendants are performing RN delegated tasks, the facility must have an RN perform assessments, train, and evaluate and reevaluate attendants as required per rule.

The delegation process includes:

- Nursing assessment of a resident in a specific situation;
- Evaluation of the ability of the personal care staff;
- Teaching the task to the personal care staff;
- Ensuring supervision of the personal care staff in performing a delegated task; and
- Re-evaluating the task at regular intervals.

SOURCES; [22 TAC §224](#); [26 TAC §553.3\(20\)](#); [26 TAC §553.263](#).

Health Maintenance Activities (HMAs)

A facility may perform HMAs. If it provides HMAs, the facility must agree to offer HMAs as a service and add it to their facility disclosure statement and admission agreements. Some of the criteria that must be met include:

- The activity is performed for a resident with a functional disability, it addresses a condition that is stable and predictable, and it is an activity the resident could perform on their own if they did not have a functional disability;
- An RN working on behalf of the facility must conduct and document an assessment to determine if a task may be performed as an HMA;
- The facility does not have to have an RN on staff for this assessment;
- The resident, LAR, or designee is able to direct staff to perform the task without RN delegation; and
- The resident, LAR, or designee has agreed in writing to participate in directing care.

HMAs are tasks that are exempt from nurse delegation based on a Registered Nurse (RN) assessment. HMAs may require a higher level of skill to perform than personal care services. An HMA is not nurse delegation.

Examples of HMA tasks include:

- Administering oral medications.
- Topically applied medications.
- Administering unit dose medication administration.
- Administering of a bowel and bladder program.
- Routine preventive skin care and care of Stage 1 pressure ulcers.
- Feeding and irrigation through a permanently placed feeding tube.

May an assisted living facility stop offering HMAs?

Once a resident agrees to receive an HMA, and that service is identified on the resident's disclosure statement and admission agreement, the facility cannot stop providing that HMA for the resident unless the nursing assessment determines the service no longer meets criteria to be an HMA or the task can be provided via delegation. Refer to assisted living facility regulations for more information.

SOURCES: [22 TAC §225](#); [26 TAC §553.263](#).

Assisted Living Facility 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.

This section does not contain all requirements for assisted living.

Assisted Living Facility Policies and Procedures

Assisted living facilities must have written policies regarding the types of residents accepted, services provided, charges, refunds, responsibilities of facility and residents, privileges of residents, and other rules and regulations including:

- Implementation of advance directives;
- Restraint and seclusion;
- Infection prevention and control; and
- Emergency preparedness and response.

SOURCE: [26 TAC §553](#).

Admission Documents

When admitted, residents sign admission agreements that detail what residents pay and what the assisted living facility provides, such as room, board, and specific services. Costs vary based on level of care, setting, and location.

Upon admission, the facility must make available copies of the resident policies to residents or residents' responsible parties. They must provide residents with a copy of the Resident's Bill of Rights. They must provide the resident and the resident's LAR with a written copy of the facility's emergency preparedness plan or an evacuation summary.

SOURCE: [26 TAC §553.259](#).

Disclosure Statements

Each licensed assisted living facility must complete and provide to residents the Assisted Living Disclosure Statement ([HHS Form 3647](#)) according to the care and services the facility provides.

If the facility advertises, markets, or promotes that it provides services, including memory care services, to residents with Alzheimer's disease and related disorders, it must provide the Assisted Living Facility Memory Care Disclosure Statement ([HHS Form 3650](#)) to residents and disclose whether it is certified to provide specialized care to residents.

A facility that is Alzheimer's certified must also provide the Alzheimer's Assisted Living Facility Disclosure Statement to residents. ([HHS Form 3641](#)).

SOURCE: [26 TAC §553.259](#).

Disclosure statements provide information about the following:

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

SOURCES: [Texas HHS Forms](#) 3641, 3647, and 3650.



Ombudsman Tip – Assisted Living Facility Disclosure Statement

The assisted living facility disclosure statement, in addition to the agreement or contract signed at admission, is an important document for an ombudsman to be familiar with. Ombudsmen should encourage residents and families to refer to these documents.

Age 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 if the facility agrees, certain procedures are followed, and the resident's 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 their 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 about inappropriately placed residents are defined in the rules and may be found in the Licensing Standards for Assisted Living Facilities in 26 TAC §553.259(e), Admission Policies and Procedures - Inappropriate placement in Type A or Type B facilities.

SOURCES: [26 TAC §553.259](#); [26 TAC §553.307](#); [Texas HHS PL 2022-22](#).

Staffing Policies

An assisted living facility "must develop and implement staffing policies, which require staffing ratios based upon the needs of the residents, as identified in their service plans."

Assisted living facilities must have sufficient staff to:

- Maintain order, safety, and cleanliness.
- Assist with medication regimens.
- Prepare and serve meals.

- Assist with laundry;
- Assure residents receive the kind and amount of supervision and care required to meet basic needs.
- Ensure safe evacuation in the event of an emergency.

A certified Alzheimer's assisted living facility must employ sufficient staff to provide services for and meet the needs of its Alzheimer's residents. Large facilities or units with 17 or more residents must have two staff members immediately available when residents are present.

SOURCES: [26 TAC §553.253](#); [26 TAC §553.255](#); [26 TAC §553.305](#).

Management and Staff

Typical management and other assisted living staff positions are described below.

Manager

An assisted living manager may also be titled Executive Director or other similar titles. Facilities must designate, in writing, a manager to have authority over the operation. The following qualifications are required for managers.

In small facilities, the manager must have proof of graduation from an accredited high school or certification of equivalency of graduation.

In large facilities, a manager must have:

- an associate degree in nursing, health care management, or related field;
- a bachelor's degree; or
- proof of graduation from an accredited high school or certification of equivalency of graduation and at least one year of experience working in management or in health care management.

Managers must complete at least one course on the management of assisted living facilities which must be at least 24 hours in length. See TAC for details.

There are additional qualifications and training requirements for managers of certified Alzheimer's assisted living facilities. Managers for certified Alzheimer's facilities or a supervisor of a certified Alzheimer's unit must be 21 years of age, and have:

- an associate degree in nursing or health care management;
- a bachelor's degree in psychology, gerontology, nursing, or a related field; or

- proof of graduation from an accredited high school or certification of equivalency of graduation and at least one year of experience working with persons with dementia.

SOURCES: [26 TAC §553.253\(a\)](#); [26 TAC §553.301](#).

An assisted living facility manager must be on duty 40 hours per week and may manage only one facility, except for managers of small Type A facilities, who may have responsibility for no more than 16 residents in no more than four facilities. For small Type A facilities, the manager must be available by telephone or pager when conducting facility business off-site. In the manager's absence, an employee competent and authorized to act in the absence of the manager must be designated in writing.

SOURCE: [26 TAC §553.253\(a\)\(4\) and \(5\)](#).

Attendant

Full-time resident attendants must be at least 18 years old or be a high school graduate. To work in assisted living facilities, attendants are not required to be certified or licensed and must be trained according to assisted living regulations. Attendants may perform other functions as required by the facility such as activities, cook, housekeeper, or manager.

All assisted living facility staff must receive four hours of orientation prior to assuming any job responsibilities and pass a competency-based evaluation. Additionally, attendants must complete 16 hours of on-the-job supervision and training within the first 16 hours of employment following orientation.

Attendants in certified Alzheimer's assisted living facilities, or units, must additionally receive four hours of dementia-specific orientation prior to assuming any job and annually. They must complete 12 hours of education regarding Alzheimer's disease. See 26 TAC §553.254 for training requirements for staff of a facility that is not Alzheimer's certified and provides care to residents with Alzheimer's disease or related disorders.

SOURCES: [26 TAC §553.253](#); [26 TAC §553.303](#); [HHS PL 2025-01](#), and [26 TAC §553.305](#).

Activities Staff

Not all assisted living facilities have an activity director. Attendants may provide activities, or an activity director may be appointed by the facility. This position may be called life enrichment director or a similar title.

Regulations require assisted living facilities to provide an activity or social program at least weekly for residents. Regulations do not contain any staffing requirements.

Certified Alzheimer's assisted living facilities or units must have a designated employee responsible for leading activities. Facilities with 16 or fewer residents must designate an employee to plan, supply, implement, and record activities. Facilities with 17 or more residents must employ, at a minimum, a qualified professional who meets the criteria as detailed in regulations.

SOURCES: [26 TAC §553.261\(d\)](#); [26 TAC §553.309](#).

Business Office Staff

The business office handles the bookkeeping and billing for each resident. They may maintain demographic information of residents, including their payment source and location in the building (resident roster). Large assisted living facilities may have a business office staff on site while small assisted living facilities typically do not. A business office may help residents file a long-term care insurance claim.

Dietary Staff

A person must be designated by the facility to be responsible for the total food service. The facility may use "universal workers" who may perform other functions as required by the facility. Larger facilities may have a dietary supervisor who supervises cooks, helpers, and dishwashers.

SOURCE: [26 TAC §553.261\(e\)\(1\)](#).

Maintenance Staff

Maintenance staff or a maintenance director may be responsible for the interior and exterior of the facility 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. Not all facilities have onsite maintenance staff or directors.

Marketing and Admissions Staff

Some assisted living facilities may have someone in charge of marketing. A marketing director may be a resource for admissions materials.

Paying for Assisted Living Care

Personal

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

Long-Term Care Insurance

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 Benefits

Medicaid-Waiver Program

A facility may choose to accept residents who are eligible for Medicaid-waiver services. 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 provided through a managed care organization (MCO), the facility is contracted with the MCO who in turn pays the assisted living facility provider.

Block Grant Program

A facility may choose to accept residents eligible for Title XX block grant programs such as Residential Care and Adult Foster Care. These services require a contract and program application with the state. They provide for additional oversight and enforcement options as well. The resident pays the provider for room and board. The facility submits a claim to the state for all other services delivered.

U.S. Department of Veteran Affairs (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 aged 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 VA.

SOURCE: <https://www.tvc.texas.gov/claims/family-survivors/>. Accessed March 2024.

Medicare, Medicaid, or Other Insurance

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. In this arrangement, the assisted living facility staff maintains authority for the resident's total care, a home health agency provides medical care.



Fill in the blanks or mark whether the statements about assisted living facilities are true or false, as indicated.

- 1) Most assisted living staff are not _____ or _____.
- 2) Since residents can require help to evacuate, the highest level of care available is in a Type ____ assisted living facility.
- 3) ____ True ____ False
Assisted living can only be paid for with private funds (not Medicaid).
- 4) ____ True ____ False
Some assisted living facilities contract with the VA and accept VA Aid and Attendance benefits.
- 5) An assisted living facility must have _____ staff to meet the needs of residents as identified in their service plans.

Nursing Facilities

Nursing facilities are residences where people who are rehabilitating from illness or injury, or who have chronic illnesses or disabilities, and can receive services for their medical, social, and psychosocial needs live. Nursing facilities must be licensed. For Medicaid and Medicare to reimburse for care provided to eligible residents, nursing facilities must also be certified. This section does not include all requirements.

The State of Texas must license all nursing facilities. 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. Nursing facility businesses operate as either for-profit or not-for-profit. Building owners and operations managers may be different business entities.

Regulatory Services licenses, certifies, and monitors compliance of each of the license and certification types. Chapter 13 has more information about regulators and an ombudsman's relationship to their work.

Nursing Facility Laws and Rules

- 1) Federal: [Code of Federal Regulations, Title 42, Chapter IV, Part 483](#)
Requirements for States and Long-Term Care Facilities
- 2) State: [Health and Safety Code, Title 4, Chapter 242](#), Convalescent and Facilities Homes and Related Institutions
- 3) State: [Texas Administrative Code, Title 26, Chapter 554](#), Nursing Facility Requirements for Licensure and Medicaid Certification

Types of Nursing Facility Licenses

- If facilities participate in the Medicaid program, they are nursing facilities (NFs).
- If facilities participate in Medicare, they are skilled nursing facilities (SNFs). SNFs may be free standing, or hospital based.
 - Medicare certification allows the facility to bill for "skilled nursing" services.
 - SNFs are used for short-term rehabilitative stays after an individual has a qualifying hospital stay.
- If the facility chooses not to participate in government reimbursement (Medicaid or Medicare), they are called licensed only (or private pay).

SOURCES: [26 TAC §554.1](#); [26 TAC §554.2204](#).

Certified Alzheimer's Nursing Facilities

Nursing facilities may voluntarily apply for certification to provide specialized care for Alzheimer's disease and related disorders either at the time of the initial application for a license or at any time after the license is issued. A nursing facility is not required to be certified to provide care for people with Alzheimer's disease and related disorders.

Facilities may not advertise or otherwise communicate that the facility is certified to provide specialized care for people with Alzheimer's disease or related disorders unless the facility is certified.

SOURCE: [26 TAC §554.2208](#).

Number of Nursing Facilities in Texas

As of January 2025, Texas had 1,181 nursing facilities. Most facilities are licensed and certified for Medicaid and Medicare reimbursement (1,116 facilities). Eighteen facilities are licensed for Medicaid only. Forty-one facilities are certified for Medicare reimbursement only. Six facilities are licensed-only which means they only accept private pay and private insurance to pay for services. There are six hospital-based skilled nursing facilities, usually rehabilitation units within a hospital where services are paid for by Medicare and private insurance.

SOURCE: Texas HHS. <https://www.hhs.texas.gov/providers/long-term-care-providers/nursing-facilities-nf>; [26 TAC §554.1](#). Accessed January 2025.

Nursing Facility Services

Residents of nursing facilities 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 facility must meet additional requirements if children live there. In a Medicare-certified facility, residents requiring skilled nursing services receive additional rehabilitative therapies to recover and regain functioning following an accident, injury, or illness.

Most people move to a nursing facility because their ability to care for themselves has deteriorated and they require 24-hour nursing care. Individual needs vary with a wide range of cognitive impairments, mental illnesses, and physical disabilities. 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. Some residents:

- Live for years in a nursing facility, while others may only live there for days or weeks.
- Are admitted for therapy following surgery. After rehabilitation, they return home.

- Are admitted for respite care and stay temporarily while caregivers rest or recover.

Nursing Facility Management and Operations

While meeting the physical, mental, and psychosocial needs of residents, the nursing facility also operates as a business. Typical management positions and direct care staff positions are described on the next few pages.

Nursing Facility Operating Policies and Procedures

Nursing facilities must have an administrative policy and procedure manual that outlines the general operating policies and procedures of the facility. The manual must include policies and procedures related to admission and admission agreements, resident care policies, refunds, transfers and discharges, termination from Medicaid or Medicare participation, receiving and responding to complaints and recommendations, and protection of a resident's personal property and civil rights. A copy of this manual must be made available for review upon request to each physician, staff member, resident and resident's next of kin or guardian, and to the public.

SOURCE: [26 TAC §554.1920](#).

Admission Documents

When admitted, residents or their representatives sign admission agreements that detail what residents pay and what nursing facilities 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, and a description of the Ombudsman Program.

SOURCE: [26 TAC §554.403\(b\)\(1\)](#); [26 TAC §554.501](#); [26 TAC §554.1920](#).



Ombudsman Tips – Admission Paperwork Review

When meeting new residents and families, an ombudsman should ask if they understood the information in their admission packet, including the bed-hold policy and the Medicaid application process.

Admission paperwork can be daunting; few people remember everything they sign and receive when admitted.

An ombudsman may 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 guarantee of payment to the facility” for a resident as a condition of admission. It is illegal for the facility to require such arrangement, and the family can seek legal advice about how to handle it. Source: 42 CFR §483.15(a)(3)

Preadmission Screening and Resident Review (PASRR)

Before admission to a nursing facility, residents are screened using the Preadmission Screening and Resident Review ([PASRR](#)) process. PASRR is a federal requirement to help ensure that individuals are not inappropriately placed in nursing facilities for long-term care. It requires that all applicants, prior to admission to Medicaid-certified nursing facilities, 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 and [26 TAC §554.2756](#).

Staffing and Staffing Qualifications

Management

Governing Body

Each facility must have a governing body, or designated persons, functioning as a governing body that is legally responsible for establishing and implementing policies regarding the management and operation of the facility. A board of directors typically governs most facilities, either as a for-profit or not-for-profit facility. In corporations, the board hires regional staff to ensure administrators and facility staff adheres to corporate policy. Regional managers are another level of management for an ombudsman to work with to resolve problems on behalf of residents.

SOURCE: [26 TAC §554.1902](#).

Administrator – Licensed Nursing Facility Administrator (LNFA)

The governing board appoints, and the facility operates under the supervision of a nursing facility administrator who is:

- Licensed by the Texas Board of Nursing Facility Administrators (26 TAC Chapter 555);
- Responsible for the management of the facility;
- Required to work at least 40 hours per week on administrative duties; and
- Accountable to and who reports to the governing body for the overall management of the facility.

Administrators are responsible for all operational and financial aspects. The administrator's responsibilities include:

- Ensuring state and federal regulations are met;
- Developing policies and procedures; and
- Hiring, training, and terminating staff.



Ombudsman Tip – Communication with Facility Staff About Complaints

An ombudsman should learn how the administrator wants you to communicate concerns, such as bringing complaints and concerns directly to him or her or giving the complaint to the appropriate department - for example: giving food complaints to dietary or nursing complaints to nursing. Facilities must have a process to receive written complaints, so an ombudsman may use the written grievance policy as a more formal method to bring attention to some concerns.

Medical Services

Medical Director

A medical director is a physician who is licensed by the Texas Medical Board and hired by the nursing facility to assist in and advise the facility 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. The medical director is responsible for implementation of resident care policies and the coordination of medical care in the facility.

SOURCES: [26 TAC §554.1907](#); [26 TAC §554.1922](#).

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.

SOURCES: [26 TAC §554.406](#); [26 TAC §554.1201](#); [§554.1202](#); [§554.1205](#).

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. The facility may employ a pharmacist or contract for services.

SOURCE: [26 TAC §554.1501](#).

Nursing Services

The facility must have sufficient staff with appropriate competencies and skill sets to provide nursing and related services to assure resident safety and attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident. This is determined by resident assessments and individual care plans and considering the number, acuity, and diagnoses of the facility's residents.

Director of Nursing (DON)

The DON must be a Registered Nurse (RN). A DON:

- Ensures nursing services are provided;
- Has administrative and personnel duties; and

Staffing Requirement for DON

- The DON may only serve one facility in this capacity. The facility must designate a RN to serve on a full-time basis, 40 hours per week unless a waiver is in place.
- The nursing facility must use the services of a RN for at least eight consecutive hours a day, seven days a week unless a waiver is in place.
- The DON may serve as a charge nurse only when the facility has an average daily occupancy of 60 or fewer residents.

SOURCES: [26 TAC §554.1001](#); [26 TAC §554.1004](#).

Licensed Vocational Nurse (LVN) / Charge Nurse

An LVN is a nurse who is currently licensed by the Texas Board of Nursing as a licensed vocational nurse. The facility must designate a licensed nurse to serve as a charge nurse on each shift unless a waiver is in place. See [26 TAC §554.1001\(a\)\(5\)](#) for more information about waiver of requirement to provide licensed nurses on a 24-hour basis.

SOURCE: 26 TAC §554.

Certified Nurse Aide (CNA, Aide, Nurse Aide)

A CNA is an individual who provides nursing or nursing-related services to residents under the supervision of a licensed nurse. They provide the majority of direct resident care. Neither federal nor state regulations impose a minimum education requirement (for example be a high school graduate or have a General Education Development credential ((GED) – A GED is a non-traditional high school diploma.)

SOURCE: [26 TAC §556](#).

Staffing Requirements for CNAs

The nursing facility must provide services by sufficient numbers of nursing personnel, including nurse aides, on a 24-hour basis to provide nursing care to all residents following resident care plans.

Medication Aide

A medication aide is an individual who is permitted by Texas HHS to administer medications to residents in long-term care facilities. They may administer drugs only under the supervision of registered nurse (nurse delegation). In nursing facilities, unlicensed personnel may administer medication and must be a

nursing student, a medication aide student, or a medication aide with a current permit issued by Texas HHS.

To be a medication aide in a licensed Texas facility, the individual must read, write, and understand English, be at least 18 years old, be a high school graduate or have a GED, and be free of communicable diseases.

SOURCE: Texas HHS Medication Aide FAQs. <https://www.hhs.texas.gov/business/licensing-credentialing-regulation/long-term-care-credentialing/medication-aide-program/medication-aide-program-faqs>. Accessed 01-02-2025.



Ombudsman Tip – Professional Working Relationships with Facility Nurses

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

Other Services

Activity Director

This position may also be called Life Enrichment Director or a similar title. The activity director:

- Provides an ongoing program of activities to meet the interests and abilities of each resident, and activities should include more than the “3 B’s” - birthday, Bible, and bingo.
- This area of nursing facility life should take its cue from resident direction and address each resident's individual needs.
- Is often a staff liaison to the resident council.

The activities program in a nursing facility must be directed by a qualified professional who is a qualified therapeutic recreation specialist or an activities professional who:

- Is eligible for certification as a therapeutic recreation specialist or as an activity professional by a recognized accrediting body;
- Has two years of experience in a social or recreational program within the last five years, one of which was full-time in a therapeutic activities program;
- Is a qualified occupational therapist or assistant; or

- Has completed an activity director training course approved by a recognized credentialing body.

SOURCE: [26 TAC §554.702](#).

Admissions Director

- This person oversees the admissions process in a nursing facility. Admission directors may be a resource for admissions materials.
- Sometimes the admissions director also serves as the facility social worker.

Business Office Manager (BOM)

- This person handles the bookkeeping and billing for each resident.
- BOMs maintain demographic information of residents, including their payment source and location in the building.
- BOMs may help residents complete their Medicaid applications or file long-term care insurance claims. Sometimes corporate staff help with applications.

SOURCE: Refer to [26 TAC §554.404](#) for information about facility management of resident personal funds.



Ombudsman Tip – Identify Residents Who Are New to the Facility

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. The resident roster (census) typically provides this information.

Dietary Staff

Dietitian or Director of Food and Nutrition Services

The nursing facility must employ sufficient staff with the appropriate competencies and skill sets to carry out the functions of the food and nutrition services, taking into consideration resident assessments, individual plans of care, the number, acuity, and diagnoses of the facility's residents. This includes a qualified dietitian on full-time, part-time, or on a consultant basis. See [26 TAC §554.1102](#) for required qualifications.

If a facility does not have a qualified dietitian employed full-time, the facility must designate a person to serve as the director of food and nutrition services who receives frequent scheduled consultations from a qualified dietitian. See [26 TAC §554.1102](#) for required qualifications.

If a director of food and nutrition services is not a qualified dietitian and does not meet the qualification detailed in regulations, the person may serve as the director of food and nutrition services if they meet the minimum qualifications as detailed in regulations.

If a dietary consultant is used, monthly dietary hours are required in regulations.

Dietary Supervisor and Support Staff

The facility must provide sufficient support personnel to carry out the functions of the food and nutrition service. The facility may employ a dietary supervisor who supervises cooks, helpers, and dishwashers.

SOURCE: [26 TAC §554.1102](#); [26 TAC §554.1104](#).

Paid Feeding Assistants

A nursing facility may use paid feeding assistants if the assistant successfully completed a state-approved training course before feeding a resident. They must work under the supervision of an RN or an LVN and can only feed a resident in the dining room. Additionally, they may only help residents who have no complicated feeding problems like difficulty swallowing or recurrent lung aspirations (something other than air being inhaled).

SOURCE: [Texas HHS PL18-17](#).

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 facility 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.

Social Worker - Social Services Director

Social services staff are often responsible for meeting the psychosocial needs of residents and responding to family issues related to residents. Social workers should be advocates for individualized resident needs. They may also be the admissions coordinator or marketing director. Social services staff may be an important link for an ombudsman between the facility and resident. 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.

A qualified social worker is an individual who is licensed, including a temporary or provisional license, by the Texas State Board of Social Worker Examiners and who has at least:

- A bachelor's degree in social work, or a bachelor's degree in a human services field; and
- One year of supervised social work experience in a health care setting working directly with individuals.

Staffing Requirements - Social Worker

- Facilities with more than 120 beds must employ a qualified full-time social worker.
- Facilities with 120 or fewer beds must employ or contract with a qualified social worker (or a person who meets the requirements outlined above) to provide social services for "a sufficient amount of time to meet the needs of the facility's residents."

SOURCE: [26 TAC §554.703](#).



Ombudsman Tip – The Nursing Facility Social Worker as a Resource

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

Contracted Services

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

- Dentist
- Hospice
- Managed Care Organizations
- Pest Control
- Pharmacist
- Podiatrist
- Psychologist
- Psychiatrist
- Ophthalmologist
- Therapist: Physical, Occupational, Speech



Exercise - Help! – Identify the Right Person

Identify the best person to help solve each problem. Assume you obtained consent from the resident to help, as applicable.

- Activities Director
- Administrator
- Business Office Staff
- Charge Nurse
- Certified Nurse Aide
- Director of Nursing
- Dietary Staff
- Family Member
- Housekeeping Staff
- Medical Director
- Social Worker
- LTC Ombudsman

1) You notice Mr. Smith's drinking water container is empty. _____

2) Mrs. McMillan reports that she lost a sweater. _____

3) Mr. Jones is uncharacteristically depressed. _____

4) There is something sticky on the floor of the main entrance.

5) Several call bells are answered slowly and some not at all. _____

6) Mr. Jenkins is worried about his bills. _____

7) A resident tells you the aide named "Mary" hit her. _____

8) Mrs. Nelson tells you she does not get her personal needs allowance.

9) Several residents tell you they have not seen the doctor this month.

10) After speaking several times with the Director of Food Services, you find that complaints are not getting resolved. _____

11) You notice a resident is sliding out of a chair. _____

12) Mr. Sims appears lonely and bored. _____

13) A resident who had a stroke cannot use his left hand.

14) Residents want a craft that is not on the monthly calendar.

15) Ms. Jones notices a roach climbing on her television.



Ombudsman Tip – Praise Facility Staff for Good Work

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.

Paying for Nursing Facility Care

Personal Funds

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 facilities 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 and some assisted living facilities. A policy may include skilled and

non-skilled care. Each policy is different, so nursing facilities must work with the insurance company to bill for reimbursement.

Government Benefits

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 facility admission. Pays 100% for 1-20 days, then 80% for 21-100 days; if the person is also Medicaid-eligible, Medicaid pays the remaining 20% of the cost.

A Resource for You

Acentra Health is the Medicare Quality Improvement Organization (QIO) that works to improve the quality of care for Medicare beneficiaries. Their website has brief, informative videos for beneficiaries. Visit the Acentra Health YouTube video library at this link: <https://acentraqio.com/videolibrary>. Helpful topics include videos on how to file an appeal, file a complaint about quality of care, and request immediate advocacy.

U.S. Department of Veteran Affairs (VA)

VA benefits vary by military branch, service-connected disability, and war-time service. The Texas Veterans Land Board General Land Office operates state veterans' facilities. VA contracts with other nursing facilities to provide services to veterans. Some spouses and former spouses of veterans are also eligible for benefits.

Medicaid

Medicaid provides health care and long-term services and supports (LTSS) to low-income individuals with disabilities and people aged 65 and older. As of

2022, 58% of nursing facility residents are on Medicaid. Medicaid has no monthly insurance fee except for the Medicaid Buy-In programs, and it is paid by state and federal taxes. Once a resident is on Medicaid, they choose a Managed Care Organization. To be eligible for Medicaid for the Elderly and People with Disabilities (MEPD), applicants:

- must have a social security number and be a US citizen or meet alien status requirements.
- must meet income and resource limits for the program.

In Texas, all people eligible for SSI are automatically eligible for Medicaid.

Medicaid Services

- **Nursing Facility Care** – meeting medical, nursing, and psychosocial needs of each resident, 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.

Resident Pays

Medicaid eligible residents pay the nursing facility each month with their monthly income, usually a social security check, which is called "applied income." Residents keep \$75 per month to pay for incidental items. The \$75 is called a Personal Needs Allowance (PNA).

Medicaid Pays

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.

Once a resident is eligible for Medicaid, a MCO is chosen. The MCO will handle Medicaid payments to the nursing facility. The MCO will also provide care authorizations and service coordination.

Nursing Facility Provides

Nursing facilities must provide equal access to quality care regardless of diagnosis, severity of condition, or payment source. A facility provides, under the terms of the contract, for the total medical, nursing, and psychosocial needs of each resident. The following items and services are included in the payment rate made to the nursing facility and therefore, the facility must provide the following which is an abbreviated list.

For the entire list, review [26 TAC §554.2601](#). Nursing facilities must provide:

- Nursing care.
- Social services.
- Regulator, special, and supplemental diets, including tube feeding.
- Non-legend drugs, with the exception of insulin, and alcoholic beverages unless prescribed for medicinal purposes.
- Alcoholic beverages not prescribed for medicinal purposes are the expense of the recipient of family.
- Regular laundry services, except dry cleaning.
- Basic hygiene items and services.
- If a resident prefers to use a specific type or brand of a personal hygiene item rather than the item / brand furnished by the facility, the resident may use their personal funds to purchase the item(s).
- Medical accessories and supplies, such as cannulas, tubes, masks, swabs, [...], equipment that can be used by more than one person such as wheelchairs, trapeze bars, or walkers.
- If a resident wants equipment for exclusive use, its purchase is the responsibility of the resident.

- If a resident owns a piece of equipment that is medically necessary, the facility must maintain and repair the equipment.
- Facilities are required to maintain, in good repair, equipment necessary to meet the needs of the recipient.

SOURCES: [26 TAC §554.504](#); [26 TAC §554.2601](#).

Medicaid Eligibility

A Medicaid eligibility worker at Texas Health and Human Services Commission (HHSC) determines financial eligibility. Financial eligibility is based on criteria set for a person's maximum allowed monthly income and resources. The MEPD Handbook provides details on financial eligibility determination. Texas Medicaid & Healthcare Partnership (TMHP) to evaluate assessment information determines medical eligibility. To be eligible, a resident must 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 facility each day it delivers care to that resident. The final eligibility determination is comprised of dual financial and medical assessments based on household income, resources, and medical necessity (MN).

SOURCE: Medicaid for the Elderly and People with Disabilities Handbook. <https://www.hhs.texas.gov/handbooks/medicaid-elderly-people-disabilities-handbook> 2025.

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 Managed Care Organization (MCO)

Managed care is an integrated service delivery system where HHSC contracts with MCOs to provide all covered, medically necessary services to people receiving Medicaid benefits. HHSC pays each MCO a monthly capitation rate for every member enrolled in their plan, and MCOs reimburse providers for services provided to their members. Residents have a right to choose which MCO they want, from the available MCOs in the area.

Some items that are not included in the facility rate are negotiated between the MCO and the facility. The MCO has the authority to approve or deny these items. If a resident is denied a service, they have the right to appeal to the MCO, Medicaid, or both to obtain or restore that service.

MCOs are contractually required to make quarterly visits to most residents residing in a nursing facility (with the exception that nursing facility residents receiving hospice or in a nursing facility outside of the MCO's service area receive two telephonic service coordination outreach contacts each year).

MCO Service Coordinator

A service coordinator is responsible for ensuring a resident has access to the care they need, whether in a nursing or assisted living facility. If a resident has been denied a service, is facing discharge, or needs additional care, contact the service coordinator to see if they can help.

An MCO service coordinator is responsible for working with the nursing facility resident to ensure all of their medically and functionally necessary needs are met. This includes, but is not limited to:

- referring and assisting the resident in obtaining appointments with specialists.
- participating in discharge planning for when leaving a hospital or nursing facility.
- referring residents to community organizations for services and assistance not covered by Medicaid.

SOURCE: [STAR+PLUS Expansion Contract](#), Section 8.1.34.1 "Service Coordinator Plan Requirements" for more information.

MCO Participation in Resident Care Plan Discussions and Activities

Facilities are contractually required to provide the MCO with reasonable notice of and the opportunity to participate in care plan discussions and activities. They are required to inform a resident's MCO service coordinator within one business day (of receiving the following information) if the resident:

- had a significant, adverse change in condition, including a positive COVID-19 diagnosis.
- had an admission or discharge from the nursing facility.

- had an emergency room visit.
- is requesting to return to the community.

SOURCE: <https://www.hhs.texas.gov/handbooks/starplus-handbook/1200-mco-service-coordination>. Accessed 03-06-2023.

The Ombudsman Role with MCO Service Coordinators

Ombudsmen should find out who the MCO service coordinators are for residents in a nursing facility and develop a rapport with them. Explain the ombudsman role and be sure each service coordinator understands our principles of advocacy, resident-direction, and confidentiality.

Medicaid-Medicare Relationship

Medicare beneficiaries who have low incomes and limited resources may also receive help from the Medicaid program. For persons who are eligible for full Medicaid coverage, Medicare health coverage is supplemented by services that are available under the Medicaid program, according to eligibility category. For persons enrolled in both programs, any services that are covered by Medicare are paid for by the Medicare program before any payments are made by the Medicaid program, since Medicaid is always the "payer of last resort." Certain other Medicare beneficiaries may receive help with Medicare premium and cost-sharing payments through the Medicaid program.

SOURCE: [MEPD Handbook](#).



Ombudsman Tip – Nursing Facility Residents' Therapeutic Visits

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

SOURCES: [26 TAC §554.503](#); [26 TAC §554.2603](#).

Nursing Facility Resident Trust Funds

Residents whose care is paid for with Medicaid by an MCO receive \$75 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 may not require a resident to deposit their personal funds with the facility. The facility must deposit funds:

- in excess of \$50 in an interest-bearing account that is separate from the facility's account.
- 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 incontinence supplies, unless the resident prefers to purchase a specific brand of supplies and authorizes the charge.

Access to Personal Funds

If the nursing 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 facility must return the full balance of their 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.

SOURCE: [SOM Appendix PP](#), Pages 35-36 RE: F567; [42 CFR §483.10\(f\)](#).

Alternatives to Nursing Facility Care

A range of options exist for long-term services and supports. Financing those options is critical to any decision. The federal government approves waivers to use the money that would be paid to nursing facilities to instead pay for services in other settings that 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 most people on waiver services 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 facility care are most easily accessed by moving into a nursing facility 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.



Fill in the blanks in the statements below.

- 1) A person using Medicaid to pay for nursing facility care keeps \$_____ each month. This is called a Personal Needs _____.
- 2) What is “applied income?” _____
- 3) The State of Texas contracts with TMHP to determine a resident’s _____ eligibility / necessity.

Consistent Staffing

Consistent staffing is when the same employees are primarily assigned to work with the same residents. It improves relationships between residents and caregivers. Staff know residents’ routines - which allows them to provide better care.

Consistent staffing improves resident satisfaction. It helps residents feel better cared for and it builds trust that staff know how to meet their needs. It affects facility staff by improving their satisfaction and reducing staff turnover.

On Your Own – Video & Quiz – Person-Centered Care: Consistent Staff Assignments

Link to video: <https://youtu.be/Ib3fUy9De-c?si=ro5iPhJFw9Mw-7sj>

Video length: 2 minutes.

Take the Quiz

- 1) How did Sara's consistent assignment to support Mr. Davis improve his quality of care or quality of life?
-

Emergency Preparedness and Response Plans

Related Regulations

- Assisted Living Facility - [26 TAC §553.275](#)
- Nursing Facility - [26 TAC §554.326](#); [26 TAC §554.1914](#); [42 CFR §483.73](#)

Risk Assessment and the Eight Core Functions

Regulations for both nursing and assisted living facilities require them to conduct a risk assessment. They must develop and implement a written emergency preparedness and response plan based on its risk assessment. The plan must address a minimum of eight specified core functions and their implementation to ensure an adequate response.

Eight Core Functions of Emergency Management

Direction and Control designates emergency coordinators, details contacts, plans, and procedures.

Warning identifies emergency coordinators and others and describes how they will be contacted.

Communication describes how facilities will obtain and distribute information; it identifies the facility's primary and alternate mode of communication to be used during power outages or during an emergency. This section lists contacts and contacts' information. It requires current contact information to be accessible and includes contact information for resident LARs and emergency

contacts, personal contact information for facility staff, receiving facility, and pre-arranged evacuation destinations.

Sheltering Arrangements describes the facility's procedures for sheltering, including a decision to shelter in place, and the procedures for access to medications, records, food, water, equipment, and supplies.

Evacuation specifies the facility's procedures for implementing evacuation; it identifies destination(s) with routes, and a map.

Transportation identifies the facility's transportation (vehicles) and procedures for evacuation of residents, staff, and supplies. It identifies designated drivers and procedures for safely transporting residents, facility staff and others during evacuation.

Health and Medical Needs details how the facility will provide continuity of services that current residents require and any special services that residents use, such as dialysis. It also identifies procedures to enable each resident to continue to receive required care.

Resource Management plans how the facility will identify, obtain, transport, and store records, medication, food, water, equipment, resources, and staff needed during an emergency situation.

A Resource for You

Texas Health and Human Services, Regulatory Services Facility Surveyors and Liaisons webpage has listed some emergency preparedness resources. View this webpage at the following link:
<https://www.hhs.texas.gov/providers/long-term-care-providers/long-term-care-provider-resources/regulatory-services-facility-surveyors-liaisons/emergency-preparedness>.

Emergency-Related Facility Self-Reporting

AlertMedia – Communication Tool

Texas HHS uses AlertMedia to send emergency and outreach notifications through email, phone, voice calls, text, and app push if available. Rules require certain facility staff to enroll in and respond to requests through the AlertMedia Emergency Communication System. In assisted living facilities, the manager and the manager's designee are required to sign up. In nursing facilities, the administrator and DON must sign up. The designee(s) should be someone who

is associated with the licensed building or someone who is responsible for communicating emergency communications. The facility must respond to requests for information received through AlertMedia in the format established by Texas HHS. (Source: [HHS PL-2025-01](#))

Assisted Living Facility

Assisted living facilities must self-report incidents related to a disaster or an emergency. A facility must report a fire to Texas HHS immediately after the fire or as soon as practicable during the course of an extended fire and submit a required report form.

They must also self-report a death or serious injury of a resident, or threat to resident health or safety, resulting from an emergency or disaster following the requirements in [26 TAC §553.275](#).

Nursing Facility

Nursing facilities are required to report emergency situations that pose a threat to resident health and safety. Examples of emergency situations that should be reported to Texas HHS include bomb threats, fires, floods, failure of the sprinkler system or fire alarm, failure of the heat or air-conditioning systems, or a widespread nonfunctioning call system.

A nursing facility must report an emergency situation that caused the death or serious injury of a resident following the requirements in TAC.

SOURCES: [26 TAC §553.275\(p\)](#); [26 TAC §554.1914\(f\)-\(g\)](#); Texas HHS Provider Letters [PL 19-17](#); [PL 19-23](#); [PL 2013-33](#), [PL 2022-32](#), [PL 2023-13](#).

Emergency Preparedness Training

Assisted Living Facility

Assisted living facilities must provide staff training on the emergency preparedness plan at least annually. They must train a staff member on the staff member's responsibilities under the emergency preparedness and response plan. They must also offer training to each resident, legally authorized representative (if any), and each designated emergency contact, on the procedures under the facility's plan that involve or impact each of them, respectively.

Assisted Living Facility Drills

Assisted living facilities must conduct at least one unannounced annual drill with facility staff for severe weather or another emergency identified by the facility as likely to occur, based on the results of the facility risk assessment.

Nursing Facility

The nursing facility's emergency preparedness training and testing program is based on the emergency plan. Initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected roles. The facility must provide emergency preparedness training at least annually.

A nursing facility must train a facility staff member on the staff member's responsibilities under the plan within 30 days of assuming job duties. They must also train a facility staff member on the staff's responsibilities under the plan at least annually and when their responsibilities under the plan change.

Nursing Facility Drills

Nursing facilities must conduct at least one unannounced drill with facility staff for severe weather and other emergency situations identified by the facility as likely to occur, based on the results of the facility's risk assessment. They must conduct exercises to test the emergency plan at least twice per year, including unannounced staff drills using the emergency procedures. Fire drills must be conducted on each work shift at least once per quarter, with at least one fire drill per month. For more information, review HHS [PL 2023-21](#) – Required Trainings for Nursing Facility Staff.

SOURCES: [26 TAC §553.275\(n\)\(1-5\)](#); [26 TAC §554.326\(v\)\(2\)](#); [26 TAC §554.1914\(e\)](#); [42 CFR §483.73\(d\)\(1\) and \(2\)](#).

Infection Prevention

Protect Yourself and Others

- Perform hand hygiene. Wash your hands often with soap and water for at least 20 seconds or use alcohol-based hand sanitizer with at least 60% alcohol.
- Avoid touching your eyes, nose, and mouth.
- Avoid close contact with people who are sick.

- Stay home when you are sick.
- Limit surfaces touched.
- Cover your cough or sneeze; wash hands afterward.
- Follow the CDC's recommendations for using a facemask.



On Your Own – Video – State Long-Term Care Ombudsman Program PPE for Long-Term Care Ombudsman Facility Visits

Link to video: <https://www.youtube.com/watch?v=EdppYVbaBkc>

Length: 10 minutes.



On Your Own – CBT – Infection Control – ICARE – Lesson 3 – Safeguarding the Nursing Home Environment

Related Residents' Rights: Be Informed and Involved

Time to complete Lesson 3: 23 minutes.

Instructions

- 1) Log into the ICARE computer-based training for ombudsmen at this link: <https://www.unthsc.edu/center-for-geriatrics/education-programs/icare/>
- 2) Click on the link labeled, Ombudsmen & Other Advocates
- 3) Click on the dropdown arrow on the option titled, ICARE Lessons
- 4) Click to open, [Lesson 3](#): Safeguarding the Nursing Home Environment
- 5) Select the first option, Safeguarding the Nursing Home Environment



On Your Own – CBT – Infection Control – ICARE – Lesson 4 – Hand Hygiene Heroes!

Related Residents' Rights: Plan and Participate

Time to complete Lesson 4: 17 minutes.

Instructions

- 1) Click to open, [Lesson 4](#): Hand Hygiene Heroes!
- 2) Select the first option, Video Lesson, Hand Hygiene Heroes!



On Your Own – CBT – Infection Control – ICARE – Lesson 5 – Gowns, Gloves, and Goggles: Precautions for Prevention

Related Residents' Rights: Plan and Participate

Time to complete Lesson 5: 19 minutes.

Instructions

- 1) Click to open, [Lesson 5](#): Gowns, Gloves, and Goggles: Precautions for Prevention
- 2) Select the first option, Video Lesson, Gowns, Gloves, and Goggles



Answer the following questions about ICARE, Lesson 5.

- 1) What are the three types of infection prevention precautions that may be used to prevent direct and indirect germ spread in a long-term care facility? Select three.

☐ Standard

☐ Spread-Based

☐ Transmission-Based

☐ Enhanced Barrier

- 2) How can communication and choice prevent and control infections while respecting residents' rights?

- 3) ☐ True ☐ False

Standard precautions are the minimum infection prevention practices that apply to all resident care, regardless of suspected or confirmed infection status of the resident.

4) ____ True ____ False

Standard precaution practices are designed to protect residents, their visitors, and healthcare workers and include hand hygiene, cough etiquette, and cleaning & disinfecting.

Frequently Asked Questions – Infection Precautions and Ombudsman Visitation

Question: How do I identify residents' rooms where droplet, airborne, or contact isolation precautions are in place?

Answer: Ask facility staff how to identify rooms that require infection precautions.

Generally, when a resident is placed on isolation precautions, there will be a sign at the door of their room, to remind visitors and healthcare workers that precautions are needed. There will be a cart at the door that contains PPE supplies.

Question: If a resident is under precautions, am I required to visit them?

Answer: It depends. Because some residents may need ongoing precautions and may need help from an ombudsman, you should provide in-person services by introducing yourself following precautions while visiting.

Recommended Contents for a PPE Kit for Use During a Public Health Emergency

- Masks: Surgical and N95 Respirator
- Hand sanitizer;
- Eye protection: Goggles or face shield;
- Protective clothing: Disposable gowns and shoe covers;
- Disposable gloves;
- Disposable wipes;
- Paper bags to store used N95 respirators and / or eye protection; and
- Trash bags for disposing of gloves, gowns, wipes, and surgical masks.

Good Relationships Between Ombudsmen, Residents, and Facility Staff

Good relationships help ombudsmen succeed in promoting residents' rights, quality of life, and quality of care. While ombudsmen must remain resident focused as they advocate, they must avoid crossing a line allowing the resident to become overly dependent. Ombudsmen must maintain appropriate boundaries with residents, be courteous, respectful, and keep information confidential.

Ombudsmen must walk a fine line as they develop appropriate staff relationships. Ombudsmen need good working relationships with staff to achieve results, but they should not appear to be pro-facility by taking sides with staff over residents. Listed below are some "dos and don'ts" with facility staff.

Do These Things

- Establish your role as ombudsman and as a resource.
- Represent the resident perspective to staff.
- Praise the facility when they do something well.
- Devote most of your time in a facility to visiting and interacting with residents, not visiting with staff.
- Remind staff you are available to attend care or service plan meetings with a resident's invitation and teach staff in-services.

Do Not Do These Things

- Do not hug staff or appear too friendly.
- Do not take the facility's side against the resident. Ombudsmen represent residents.



Answer the following questions.

- 1) How can an ombudsman help residents see an ombudsman as a resident advocate, but not cross the line and create a dependent relationship?
-

- 2) How can an ombudsman develop relationships with staff that improves quality of life and care for residents, without crossing a boundary with staff or appearing to be pro-facility?
-

- 3) Give one example of an ombudsman being pro-facility.
-

Volunteer Internship - Accompanied and Unaccompanied Facility Visits

Interns must complete Chapters 1-6 of the Initial Certification Training Manual, all required infection control and PPE training, 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 must wear their Ombudsman Program intern identification badge while in a facility.

As part of initial certification training, interns must make at least two facility visits accompanied by an experienced certified ombudsman for training. Interns must also make at least two unaccompanied facility visits and complete an activity report prior to certification. Two hours per visit is recommended. Intern facility visits reported on their activity report(s) are credited as certification training hours.

An accompanied visit gives interns an opportunity to observe an experienced ombudsman make a facility visit. This allows interns to see how an ombudsman approaches residents and staff, and what is involved in performing the tasks associated with ombudsman work. Later, the experienced ombudsman observes the intern as a facility visit is made.

During unaccompanied visits, an experienced ombudsman does not accompany interns. Interns get acquainted with residents and develop trusting relationships. Interns are prohibited from investigating complaints and are required to notify their supervising staff ombudsman or MLO of any complaints they receive. Interns may not access a resident's record. See Ombudsman Activities (Dos and Don'ts) for more information. A minimum of two accompanied and two unaccompanied facility visits are required before certification can be recommended to the State Ombudsman.

SOURCE: OPPM 4010(g).

Things to observe about the trainer during an accompanied facility visit include:

- The ombudsman's physical appearance.
- What items they carry into each facility.
- The first actions the ombudsman takes upon entering a facility.
- How the ombudsman takes notes.
- Communication between the ombudsman and staff.
- Obtaining consent from residents and other complainants.
- How the ombudsman takes direction from residents.
- Not taking an action as requested by a resident.

Things to ask the instructor 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?

Typical Ombudsman Activities

The ombudsman internship provides opportunity for interns to become acquainted with residents and form trusting relationships. Interns are restricted from certain activities while in training and limited to practicing the most fundamental skills of a resident advocate.

Ombudsmen:

- Attend ombudsman training.
- Are friendly and professional.
- Are dependable by visiting residents on a regular basis.
- Focus time and attention on residents.
- Wear their badge while making visits.

- Are good listeners and communicators.
- Respect confidentiality of all residents.
- Respect resident dignity, choice, and self-determination.
- Knock before entering each resident's room and introduce themselves.
- Learn about resident and family council activities.
- Visit all residents, including residents who cannot speak with them.
- Immediately report safety concerns to their supervising staff ombudsman.
- Consult with a staff ombudsman supervisor or MLO when needed.
- Follow guidelines established by the Ombudsman Program.
- Report facility visits and other Ombudsman Program work each month to the local office.

Ombudsmen DO NOT:

- Provide physical assistance or nursing care to residents.
- Act as an "inspector" in the facility.
- Make promises they are unable to keep.
- Treat residents as children or talk down to them.
- Advise residents on business or legal matters.
- Enter rooms where active treatment or personal care is being provided, such as rooms with the door closed.
- Solicit or accept any form of gift, loan, or gratuity from anyone in any capacity while associated with the Ombudsman Program.

Interns DO NOT:

- Visit or enter kitchens or medication rooms. *
- Investigate complaints: Interns must immediately refer complaints to their supervising staff ombudsman. **
- Access resident records. **

* This is only applicable to interns. Certified ombudsmen access areas where residents live and receive services. In general, areas restricted to residents are restricted to ombudsmen, 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. Interns must immediately refer complaints to their supervising staff ombudsman or MLO. Once certified, ombudsmen investigate and work to resolve complaints.

Facility Visit Guide

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.

Things to look for Residents...

Are residents...

- Clean and dressed?
- Participating in regular activities?
- Receiving meals and snacks?
- Asked about individual preferences?
- Inhibited by physical or chemical restraints*?
- Treated with kindness and respect?
- Are residents comfortable? Observe positioning in chairs, wheelchairs, and beds.
- Encouraged to personalize their living space?

* Read more about restraints in Chapter 5.

Things to look for Staff...

Do staff...

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

Things to look for Physical Environment...

- Are there odors in the rooms and halls?
- Do residents have outside spaces to enjoy?
- Are there private areas for conversations and phone calls?
- Are there safety features such as door alarms on exits, smoke alarms and detectors, and warning signs displaying wet floors?
- Do residents have ample access to water in their rooms and access to water, coffee, and other fluids in public areas?
- Does the facility have security that restricts residents' access to the outdoors?
- Are doors to hazardous areas properly secured?

Things to look for Management...

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

Facility Visit Guide - Memory Care and Alzheimer's Certified Facilities

In memory care, Alzheimer's certified, or locked units, it may be difficult to gain information from residents with advanced stages of dementia. However, ombudsman visits are greatly needed to give residents a voice.

If a resident can give consent to work a complaint, permission from the resident is required. If they are unable, get consent from the LAR or call your supervising staff ombudsman or MLO.

Visit Tips

- Strategically schedule visits to memory care facilities at a time when most residents are at their best. Ask staff.
- Acknowledge and talk with every resident you see.
- Ask staff to introduce you to new residents.
- Minimize environmental distractions like televisions or loud music.
- If there is an area where residents congregate, sit down with the group and be with them. Be okay with sitting together in silence.
- Smile. Show you are open and interested with a slight nod and smile.
- Validate feelings. Allow the person to express sadness, fear, or anger.
- Let the person talk even if it does not make sense or you believe something to be untrue.
- Do not rush the conversation. Give residents extra time to speak or answer questions.
- Do not argue, point out mistakes, assume the person does not remember anything, or talk about the person like they are not present.

Things to look for Meals and Snacks...

- Do residents eat the food offered?
- Do staff encourage residents who are uninterested in food to eat?
- Does the facility serve what is listed on the menu?

Things to look for Physical Environment...

- Are group spaces comfortable and inviting to residents? Are fluids available to residents?

- How do staff ensure residents stay hydrated?
- Is there a fenced outdoor area?
- Do residents use the outdoor space?
- Does the facility have an infection control policy specific to the facility's resident population?

Things to look for Activities...

- How many activities are scheduled daily?
- Do activities happen according to schedule?
- Which residents participate?
- Are activities tailored to each resident's abilities?
- Is the facility Music and Memory certified? If yes, do you observe residents receiving music therapy?

Things to look for Staff...

- Do staff know each resident's name, personality, and background?
- Are staff kind and attentive to resident's needs?
- Do staff use respectful language about residents and dementia care?
- What is the staff-to-resident ratio?
- Are staff numbers sufficient to meet the needs of residents?
- If the facility is Alzheimer's certified, is the minimum required staffing ratio met?
 - NF: 7 am – 3 pm ratio of 1 to 6
 - NF: 3 pm – 11 pm ratio of 1 to 10
 - NF: 11 pm – 7 am ratio of 1 to 18
 -
 - ALF: If 17+ residents must have 2 staff

Facility Contact Sheet

Facility Name _____

Facility ID# _____

Staff

Administrator or Manager _____

Medical Director _____

Director of Nursing / ALF Nurse _____

Social Worker (NF only) _____

Infection Preventionist (NF only) _____

Activity Director _____

Housekeeping / Laundry Manager _____

Resident Council Contact _____

Family Council Contact _____

Specialized Services _____

Community Involvement _____

Other: _____

Most Recent Survey (Inspection)

The most recent survey was conducted on: _____

Request Documents

Request a copy of the facility's admission packet (given to new admissions).

Ask if their resident handbook is part of the packet. If it is not part of the admission packet, request a copy and review it too. Check that information within the admission packet is easy to understand and includes required notices. Review your assigned facility's admission packet annually.

Locate and Review

Locate the following required postings:

- Resident rights;
- Current information about the Ombudsman Program; and
- Current policies about safety and resident responsibilities.

Change of Ownership

Be aware of changes in ownership or key personnel and keep your staff ombudsman updated through your monthly activity report. Notify your supervising staff ombudsman of any concerns you have at your assigned facility.

Ask the Instructor – How to Fill Out an Activity Report During a Volunteer Internship

Ombudsman: Your name – Ima Ombudsman				Facility: Name of facility you visited			Month/Year: May 2024	
Visits						Notes: 05/08/2024 – Ima Ombudsman (IO) visited facility from 3:30 to 5:00 pm. Many residents expressed excitement about menu for evening meal (enchiladas). ± 20 residents were listening to live music by Eddie Sharp. 05/22/2024 – IO visited from 9 am to 11:45 am. Activity director, Sam, said they are planning flag day and 4 th of July celebrations with a resident committee.		
Number of Contacts			Time – Hours : Minutes					
Visit Date	Resident	Family / Other	Staff	On Site	Travel (Optional)			Mileage (Optional)
05/08/2024	14	2	4	1h 30m	20m			
05/22/2024	21	1	2	2h 45m	20m			
Totals								
	35	3	6	4h 15m	0h 40m			
Activities								
Dates(s)		Activity Type		Resident Name(s): _____				
		Family Council Attended						
		Resident Council Attended						
		Survey Participation						
		Care Plan Attended						
Information and Assistance								
Dates(s)		Topic		Name and Role of Person(s) You Gave Information To				

Volunteers report ombudsman work on the [Long-Term Care Ombudsman Activity Report HHS Form 8620](#).

The activity report captures the ombudsman's name, the facility name where the work was completed, and the month and year the work was done.

It also captures the time spent in the facility and the number of contacts the ombudsman had (contacts are residents, resident's family, staff, or others with whom the ombudsman had meaningful conversations). See Chapter 11 for tips to complete the report.

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Chapter 7: Resident and Family Councils

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

Learning Objectives

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

Contents

- Resident and Family Councils
- Laws and Regulations Related to Resident and Family Groups (Councils)
- State and National Advocacy Organizations for Family Members

Video(s), Supplements, Forms

- Supplement 7-A: Agenda Template for Resident or Family Council Meetings
- Supplement 7-B: Sample Council Meeting Minutes
- Supplement 7-C: Sample Resident or Family Council Bylaws

Resident and Family Councils

Resident and family councils can impact quality of life and care for residents. It is a constitutional right for any private citizen to organize. In nursing facilities, laws and regulations support the residents' right to meet as a group and the families' right to form a council. A resident right to meet privately is supported by rules [26 TAC §554.706](#) (NF) and [26 TAC §553.267\(a\)\(3\)\(R\)\(i\)](#) (ALF).

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

Resident and family councils communicate and stay connected by traditional communication methods such as phone calls, newsletters, and mail but they may explore social networking such as email lists, Facebook, and Google groups.

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

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

What Is a Resident Council?

A resident council is a group of residents with a purpose. These residents, with or without the help of staff, identify a common need or request and act. The needs and desires of residents should drive council activity.

A resident council is a practical way to obtain resident input in a variety of services such as meal planning, social activities, and policies affecting residents. In management terms, a council might enhance a facility by offering to residents and staff the benefits of problem-solving; facility, resident, and staff

communications; and empowerment for residents through opportunities to make decisions.

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

Resident councils are about residents. Resident councils provide a forum for residents to:

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

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

- Broad participation.
- Agenda set by residents.
- Freely expressed concerns and suggestions.
- Staff who are responsive to residents' concerns.

SOURCE: Resident Councils of Washington, 2001



Ask the Instructor - Resident Councils

1) What is the key to success of a resident council?

2) How do I learn when the council meets in the facility where I am assigned?

The Ombudsman Role with Resident Councils

Ombudsmen only attend meetings and help with resident councils if invited by residents. An ombudsman can help find resources for meetings, advertise and recruit members, communicate with staff and family members, or give a presentation on a topic important to council members. Ombudsman presentation topics include residents' rights, individualized care or service plans, person-centered care, or the role of the ombudsman.

It is best for residents to do the work themselves. Ombudsmen support and advocate, but the council should be run by and for residents. Talk with residents about resident council meetings and encourage them to attend. Encourage residents to bring concerns to the council to determine if others have the same concerns. If they are reluctant, find out why. While protecting resident confidentiality, share feedback with the president of any identified barrier that should be addressed to help councils meet the needs of all residents who want to participate.



Ombudsman Tip – Residents Run the Resident Council

Watch for facility staff who control the council agenda or who limit resident input. Be an advocate for the group and discuss any concerns you have with your MLO or supervising staff ombudsman.

As a new ombudsman, seek out the following information:

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

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

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

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



Fill in the blanks in the statement below.

- 1) Ombudsmen attend council meetings if _____.
- 2) A facility must assign a staff person to _____ council needs.



Mark each statement below that is true.

- 1) Appropriate ways for an ombudsman to support councils include:
 - ___ Encouraging residents to attend council meetings.
 - ___ The Ombudsman attending the council meeting every month.
 - ___ Explaining the Ombudsman Program at a meeting.
 - ___ Creating and distributing minutes.



Ombudsman Tip – Attend a Resident Council Meeting

Be a source of information on specific laws, rights, services, and health issues. Search your community for resources to share. Ask your staff ombudsman for help if needed.

Remind residents that councils can be a means to solve problems. Tell residents you can attend with their permission. Some residents will welcome this support.

Come early. Arrive about 30 minutes before the meeting. Visit residents who said they would like to attend, as they may need a reminder. If staff has not helped residents get to the meeting, your presence can be a needed prompt.

Suggest writing concerns down. Some residents might write concerns and issues before the meeting. At the meeting, they have their concerns ready to share.

Offer information about residents' rights and regulations.

What Is a Family Council?

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

With the exception of laws and rules that are specific to resident groups, family councils serve similar purposes as resident groups and function similarly to them. The role of the ombudsman is also essentially the same.

Family Councils:

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

One barrier to an active family council is time. Family members and friends may not have time to visit the residents and attend a meeting. Family councils can provide needed validation for complaints and support and education to family and friends.

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



Ombudsman Tip – Attend a Family Council Meeting

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

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

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

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

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

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

Members will likely participate only if the council seems worthwhile. Councils may benefit from help to develop their organization and elect leadership. Ombudsmen can help members stay involved after the initial energy wanes and

encourage work on particular issues, so they see the value of their continued involvement.

The Ombudsman Role with Family Councils

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

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



Ombudsman Tip – Family Councils Problem Solve

Encourage family council participation to solve problems. For example, a family member is concerned facility staff is not meeting her relative's needs. Root causes may include under-staffing, lack of staff training, or insufficient management. Educate families about possible underlying causes to consider and help them recognize the benefit of working with the family council.

Ombudsmen Report Their Attendance at a Resident or Family Council Meeting

Volunteers report their attendance at a resident or family council meeting on their monthly report using the State Long-Term Care Ombudsman Program, Activity Report (Texas HHS Form 8620).

Staff ombudsmen report attendance at a resident or family council meeting in the ombudsman database.

More information about reporting may be found in Chapter 11.

Laws and Regulations Related to Resident and Family Councils (Groups)

Nursing and assisted living facilities are not legally required to have a resident council, but they must ensure there is no interference with council activities and that services and activities are based on the individual needs of residents.

Nursing Facilities

The 1987 Nursing Home Reform Law guarantees nursing facility residents the right to meet privately and regularly as a resident council.

Summary of Nursing Facility Residents' Rights and Resident and Family Councils

- The resident has the right to organize and participate in resident groups in a facility.
- The resident has a right to participate in family groups.
- The resident has a right to have family member(s) or other resident representative(s) meet in the facility with the families or resident representative(s) of other residents in the facility.
- Staff, visitors, or other guests may attend resident group or family group meetings only at the respective group's invitation.
- A facility must not limit the rights of a resident, a resident's family member, or a family council member to meet with an outside person, including:
 - An employee of the facility during the employee's nonworking hours if the employee agrees.
 - A member of a nonprofit or government organizations.
 - Another resident representative.

Summary of Nursing Facility Responsibilities

- A facility must assist a resident who requires assistance to attend resident group meetings.
- Facilities must provide a resident or family council, if one exists, with private space.

- Staff must take reasonable steps, with the approval of the council, to make residents and family members aware of upcoming meetings in a timely manner.
- Facilities must provide a designated staff person who is approved by the resident or family council and the facility.
- The designated facility staff person assists the council and is responsible to ensure written requests or complaints from councils are responded to by the facility.
- The facility must consider the views of councils and act promptly upon their grievances and recommendations concerning issues of resident care and life in the facility.
- The facility must be able to demonstrate their response and rationale for such response. This does not mean that the facility must implement every request of the resident or family council.
- A facility must not terminate an existing family council nor interfere with the formation, maintenance, or operation of a family council.

SOURCES: [26 TAC §554.706](#); [42 CFR §483.10](#).

Related Excerpts From the Nursing Facility Requirements for Licensure and Medicaid Certification

[26 TAC §554.706](#) (Subchapter H) – Nursing Facility

(a) A resident has the right to organize and participate in resident groups in a facility.

(b) A facility must assist a resident who requires assistance to attend resident group meetings.

(c) A resident has the right to have a family member or other resident representative meet in the facility with the family or resident representative of other residents in the facility and organize a family council. A family council may:

(1) make recommendations to the facility proposing policy and operational decisions affecting resident care and quality of life; and

(2) promote educational programs and projects intended to promote the health and happiness of residents.

(d) If a resident group or family council exists, a facility must:

(1) listen to and consider the views of a resident group or family council and act promptly upon the grievances and recommendations of residents and families concerning issues of resident care and life in the facility;

(2) be able to demonstrate responses to the grievances and recommendations of the resident group or family council and the rationale for such responses;

(3) provide a resident group or family council with private space and take reasonable steps with the approval of the group, to make residents and family members aware of upcoming meetings in a timely manner;

(4) provide a designated staff person who is approved by the resident or family group and the facility and who is responsible for providing assistance and responding to written requests that result from resident group and family council meetings; and

(5) allow staff or visitors to attend meetings only at the resident group's or family council's invitation.

(e) If a family council exists, a facility must:

(1) upon written request, allow the family council to meet in a common meeting room of the facility at least once a month during hours mutually agreed upon by the family council and the facility;

(2) provide the family council with adequate space on a prominent bulletin board to post notices and other information;

(3) designate a staff person to act as the family council's liaison to the facility;

(4) respond in writing to written requests by the family council within five working days;

(5) include information about the existence of the family council in a mailing that occurs at least semiannually;

(6) permit a representative of the family council to discuss concerns with an individual conducting an inspection or survey of the facility; and

(7) allow a resident to participate in a family council.

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

(g) A facility must not limit the rights of a resident, a resident's family member, or a family council member to meet with an outside person, including:

(1) an employee of the facility during the employee's nonworking hours if the employee agrees;

(2) a member of a nonprofit or government organization; or

(3) another resident representative.

(h) A facility must not:

(1) terminate an existing family council;

(2) prevent or interfere with the family council from receiving outside correspondence addressed to the family council or open family council mail; or

(3) willfully interfere with the formation, maintenance, or operation of a family council, including interfering by:

(A) denying a family council the opportunity to accept help from an outside person;

(B) discriminating or retaliating against a family council participant; or

(C) willfully scheduling events in conflict with previously scheduled family council meetings if the facility has other scheduling options.

Source Note: The provisions of this §554.706 adopted to be effective September 1, 2008, 33 TexReg 6151; amended to be effective March 24, 2020, 45 TexReg 2025; transferred effective January 15, 2021, as published in the Texas Register December 11, 2020, 45 TexReg 8871

Assisted Living Facilities

In assisted living facilities, residents' right to assemble and to access to resident councils is addressed in Texas Administrative Code (TAC). See related excerpts from below.

[26 TAC §553.267](#) (Subchapter E) - Assisted Living Facility

(a) Residents' bill of rights

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

(B) participate in activities of social, religious, or community groups unless the participation interferes with the rights of others; [...]

(H) complain about the resident's care or treatment. The complaint may be made anonymously or communicated by a person designated by the resident. The provider must promptly respond to resolve the complaint. The provider must not discriminate or take other punitive action against a resident who makes a complaint; [...]

(J) unrestricted communication, including personal visitation with any person of the resident's choice, including family members and representatives of advocacy groups and community service organizations, at any reasonable hour; [...]

(R) privacy, while attending to personal needs and a private place for receiving visitors or associating with other residents, unless providing privacy would infringe on the rights of other residents. This right applies to medical treatment, written communications, telephone conversations, meeting with family, and access to resident councils; [...]

Explore How Councils Work in Your Assigned Facility

Take time to explore when councils meeting in your assigned facility and how they interact with the facility staff.

- Does the council(s) meet on a regular basis?
- Does the facility help with arrangements for council meetings?
- Does the facility provide refreshments?
- Where do councils meet?
- Is there enough space for everyone who wants to attend?

- Does the meeting location offer privacy?
- Can council(s) meet without staff present if they desire?
- Do council attendees think the facility considers their views?
- Do they know how to file a grievance and understand the grievance process?
- Does the facility act promptly upon grievances and recommendations?
- Do they feel they can complain about care without worrying about retaliation?
- Are they familiar with the Ombudsman Program and how certified ombudsmen may help with concerns?

An Advocacy Organization

The National Consumer Voice for Quality Long-Term Care / The National Long-Term Care Ombudsman Resource Center

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

A Resource for You

Resident Council Toolkit <https://ltco.texas.gov/residents>

Supplement 7-A: Agenda Template for Resident or Family Council Meetings

Date

Time (beginning and ending)

Location

I. Welcome and Introductions

- a. Members
- b. Guests (facility staff, ombudsman, other)

II. Minutes and Correspondence

- a. Review minutes from the previous meeting.
- b. Review any correspondence from or to the council since the last meeting.

III. Officer or Committee Reports (as applicable)

IV. Report from Facility Support Staff or Administrator

V. Old Business

VI. New Business

VII. Guest Speaker / Program

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

IX. Adjourn

- a. Announce date, time, and location of next meeting.
- b. Remind attendees of other upcoming council events.

X. Social Time

SOURCE: Adapted from the Resident Council Handbook, Resident Councils of Washington and Nursing Home Family Council Manual, Texas Advocates for Nursing Home Resident

Supplement 7-B: Sample Council Meeting Minutes

Name of Council

Date:

Time:

Location of meeting:

Welcome and Introductions

The meeting was called to order by [name and time].

Present: [list the names of attendees; identify titles of officers and guests]

Minutes and Correspondence

[Example] The December minutes were approved as distributed.

Correspondence included a letter from Happy Elementary thanking the resident council for their donation of decorations for the school's annual carnival and a letter inviting our resident council to participate in Senior Days in our community.

Officer and Committee Reports

- [Example] President Davis reported she was invited to participate in Happy Elementary board of directors meeting scheduled February 5th to provide ideas on how the school and nursing facility can plan meaningful activities for the residents and students. The list of ideas was discussed, additional ideas were included, and all ideas were prioritized by the council.
- Treasurer Smith: Reported the barbeque fundraiser earned \$211 for the activities department.
- Welcoming Committee: Reported we have six new residents since the last meeting. There will be a write-up in our newsletter next month about them. They were introduced to the council board.
- Dietary Committee: Reported they are pleased to announce the Dietitian will be a guest speaker at our next meeting and we have made progress with residents choosing when they prefer to eat breakfast with more menu options.

- Sunshine Committee: Announced that Mr. Sound is better and returned from the hospital. Mrs. Valley is still in the hospital and a card is being sent.
- Facility Support Staff or Administrator: Reported...

Old Business

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

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

New Business

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

Guest Speaker / Program

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

Concerns

[Example] Concerns included:

People on Bluebonnet hallway were not given enough notice about being relocated. Staff told them Friday that they would be moved to other rooms on Monday.

Weekend access to management staff. If a serious problem occurred on the weekend, we are unsure how to reach the administrator and regional director. President Davis agreed to speak with the administrator about this concern and get everyone access to phone numbers for emergencies.

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

Respectfully submitted,

[Name], title

Supplement 7-C: Sample Resident or Family Council Bylaws

Name

The name of our council shall be _____.

Purpose

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

Membership

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

Officers and Their Duties

Officers of the council shall be:

- President (Chair) – The president presides over all meetings.
- Vice President (Vice Chair) – The vice president presides in the absence of the president.
- Secretary – The secretary takes minutes and writes correspondence as directed by the council.
- Treasurer – The treasurer is responsible for all financial business of the council.

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

Committees

The council shall have the following committees as needed:

- Executive (officers and committee chairs)
 - Purpose: to give direction and organization to the council

- Food
 - Purpose: to serve as a liaison between dietary services and the residents for suggestions and improvements.
- Grievance
 - Purpose: to serve as a sounding board for grievances and to follow up on complaints with administrator or ombudsman
- Program
 - Purpose: to coordinate guest speakers and refreshments for meetings
- Sunshine
 - Purpose: to prepare cards for residents in the hospital, for birthdays and other important events
- Volunteer
 - Purpose: to enlist members to organize and volunteer for special projects in the community and to improve quality of life in the facility
- Welcoming
 - Purpose: to greet new members, orient them to the facility, and encourage participation in the council

Elections

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

Meetings

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

Amendments

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

Rules of Order

- Each meeting will be conducted according to a written agenda [Rules could also follow Robert's Rules of Order].

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Chapter 8: Person-Centered Care and Service Planning

Chapter 8 explains resident-directed care, the care or service planning process, and residents' rights about advance care planning. An overview is provided on individual care planning, which includes resident assessments, care or service plan meetings, and care or service plan documents. Advance care planning involves discussing and preparing for future decisions about medical care if a person becomes seriously ill or unable to communicate their wishes.

Learning Objectives

- Distinguish between person-directed and traditional care practices.
- Increase knowledge of individualized care as directed by the resident.
- Understand the care and service planning process.
- Know the advance care planning concept and documents to communicate future health care wishes.
- Understand who may serve as a surrogate decision maker and under what circumstances.
- Apply state or federal regulations to person-directed, trauma-informed care planning.

Contents

- Person-Directed Care
- Resident-Directed Care
- Care and Service Plans
- Basics of Individualized Care
- Trauma-Informed and Culturally Appropriate Care
- The Ombudsman Role in Care Planning
- Advance Care Planning
- Ombudsman Role in Advance Care Planning
- Frequently Asked Questions – Serving as a Decision-Maker
- Regulations Related to Resident-Directed Care
- Connect Regulatory Compliance to Resident-Directed Care
- Discharge Planning

Video(s), Supplements, Forms

- YouTube Video: Person-Centered Care – Health Care Schedules
- YouTube Video: Person-Centered Care – Care Plans

Person-Centered Care

Residents have the right to be fully informed and to participate in the development and implementation of their person-centered care plan. Person-centered care means long-term care staff include residents in planning their care and schedules. They support the resident in making their own choices and having control over their daily lives.

Nursing Facilities

In 2016, the Centers for Medicare & Medicaid Services (CMS) released revised nursing facility regulations which emphasize person-centered care planning. Person-centered care is defined in federal nursing facility regulations as care that ensures the “focus is on the resident as the locus of control and supports the resident in making their own choices and having control over their daily lives.”

SOURCE: [CMS SOM Appendix PP](#). Accessed 9/14/2020,

Assisted Living Facilities

Like a nursing facility, an assisted living facility is responsible for all care provided to residents. Residents should receive the kind and amount of supervision and care they require to meet their basic needs. No federal regulations exist for assisted living facilities, but in Texas, facilities must comply with Licensing Standards for Assisted Living Facilities which requires a comprehensive assessment and an individual service plan for providing care. While residents who live in assisted living facilities tend to be more independent, the facilities still risk becoming institutionalized. Using person-centered principles when developing service plans can transform assisted living facilities in the same ways as nursing facilities.

Resident-Directed Care

Resident-directed care means a resident is actively involved in determining the course of their life in daily activities, care, and choices. When a resident cannot fully direct personal care, caregivers and advocates look to the person's expressed wishes for clues to provide person-centered care. Clues can come from advance care planning documents, known or previously expressed wishes, lifelong preferences, and input from family and friends. Resident-directed care requires regular communication with the resident to learn the resident's wishes and to create opportunity for the person to exercise choice and control over their life. Ombudsmen are trained to follow this same principle as we work to protect resident rights and resolve complaints.

Resident-Directed Care Practices

The resident-directed care model involves three interconnected areas: environment, care, and work. Changes can range from simple and inexpensive to complex and costly.

Environmental

- Create a "home" with a sense of community and safety for residents and staff.
- Shift toward neighborhoods and communities within a building.
- Reduce noise from overhead paging with pagers or wireless phones.
- Change centralized nursing stations to several nursing areas.
- Exchange medication carts for locked medication storage in resident rooms.
- Remove institutional signage.
- Serve meals from a buffet or use table service rather than trays.
- Construct private rooms and private baths.

Resident-Centered

Resident preferences or past patterns form the basis of decision making about some routines.

Staff begin to organize routines to accommodate expressed or observed resident preferences.

Resident-Directed

Residents make daily decisions about individual routine. When a resident is not capable of stating needs, staff honor habits and observed preferences. Staff organize their hours, patterns, and assignments to meet resident preferences.

SOURCE: Pioneer Network.
<https://www.pioneernetwork.net/wp-content/uploads/2021/09/Continuum-of-Person-Directed-Culture-21.pdf>

- Build smaller houses where 10-12 residents live together with a caregiver.

Care

- Have flexible waking and sleeping times.
- Make dining more personal and pleasant.
- Accommodate resident bathing preferences.
- Create and honor rituals and celebrations.
- Design social activities based on individual and group preferences.
- Staff promotes individuality and gives residents as much choice and control as possible.

Workplace

- Establish relationships as the number one organizational priority.
- Promote high quality leadership.
- Value and respect caregivers and their needs.
- Develop leadership opportunities for direct care staff.
- Assign direct care staff consistently to the same residents (consistent staff assignments).

Regulations and Resident-Directed Care

Facility staff may find it challenging to connect resident-directed principles and regulatory compliance. Considering resident-directed principles of respect, choice, empowerment, relationships, and community, ombudsmen help influence how facilities can change. When reviewing the following pages think about how nursing and assisted living facilities can comply with regulations and be resident directed.

When questions arise about resident choice or self-determination, remember that unless a resident has been declared mentally incompetent, the general presumption is residents have the ability to consent unless there is clear evidence to the contrary. Ability to consent means a resident understands and appreciates the nature and consequences of decisions and is able to reach and communicate an informed decision in the matter. Refer to consent in the OPPM found in Chapter 14 of this manual for more information.

Rights Are Retained

Nursing Facility

“The resident has a right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility. A facility must protect and promote the rights of each resident.”

Nursing facility residents have the right to exercise their rights as a resident at the facility and as a citizen or resident of the United States. Residents have the right to be free of interference, coercion, discrimination, or reprisal from the facility in exercising their rights.

SOURCES: [26 TAC §554.401\(a\)](#); [26 TAC §554.402\(a\) and \(b\)](#)

Assisted Living Facility

Assisted living residents have all the rights, benefits, responsibilities, and privileges granted by the constitution and laws of this State and the United States, except where lawfully restricted. They also have the right to be free of interference, coercion, discrimination, and reprisal in exercising these civil rights.

SOURCE: [26 TAC §553.267\(a\)\(2\)](#).

Care and Service Plans

A care or service plan outlines how staff will help residents, lists what each staff member will do, and when it will happen. Residents are partners in the care or service planning process.

Comprehensive Assessment (Resident Assessment)

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

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

Assessments should pay attention to strengths. In both nursing and assisted living facilities, comprehensive assessments must be completed within 14 days of admission. In nursing facilities, assessments must be reviewed at least annually with reviews every three months (quarterly), and when there is a significant change in a resident's physical or mental condition. In assisted living, the service plan must be updated annually or upon a significant change in condition, based upon an assessment of the resident.

SOURCE: [26 TAC §553.259](#); [26 TAC §554.801](#).

Nursing Facility - Care Plan

Baseline Care Plan

A nursing facility is required to develop and implement a baseline care plan within 48 hours of a resident's admission. This plan must set out initial goals for the resident, and include physician and dietary orders, plus any necessary therapy services or social services. The facility must give a summary of the plan to the resident and any resident representative. Baseline care plans must include:

- Initial goals based on admission orders;
- Physician orders;
- Dietary orders;
- Therapy services;
- Social services; and
- PASRR recommendation, if applicable.

SOURCE: [26 TAC §554.802](#); [CMS SOM Appendix PP, Pages 245-236](#); [42 CFR §483.20\(b\)\(1\)](#).

Comprehensive Care Plan

Federal law requires nursing facilities to develop resident-specific care plans for all residents, consistent with the resident's rights. State regulations specify care plans should include "measurable short-term and long-term objectives and timeframes to meet a resident's medical, nursing, mental, and psychosocial needs that are identified in the comprehensive assessment." They must be individualized and embrace a resident's needs and choices. A resident's social and emotional life are just as important as physical health.

For newly admitted residents, the comprehensive care plan must be completed within seven days of the completion of the comprehensive assessment and no

more than 21 days after admission. The care plan describes a strategy for how staff will help a resident and what each staff will do and when it will happen. For example, “The nurse aide will help me walk to each meal to build my strength.” Staff should be familiar with all care plans, document services provided according to them, and revise as needed.

Who develops the comprehensive care plan in a nursing facility?

An interdisciplinary team (IDT) develops the comprehensive care plan. The IDT must, at a minimum, consist of the resident’s attending physician, a registered nurse, and nurse aide with responsibility for the resident. The IDT can meet in person, by teleconference, or through written communication. If the attending physician is unable to participate in the development of the care plan, they may delegate participation to a nonphysician practitioner who is involved in the resident’s care, to the extent permitted by state law, or arrange alternative methods of providing input in the development and revision of the care plan, such as one-on-one discussions, videoconferencing, and conference calls with the IDT. Each resident has the right to participate in choosing treatment options and must be given the opportunity to participate in the development, review, and revision of his/her care plan. Facility staff have a responsibility to help residents engage in the care planning process.

“The determination of other appropriate staff or professionals’ participation in the IDT should be based on the physical, mental, and psychosocial condition of each resident. This includes an appropriate level of involvement of physicians, nurses, rehabilitation therapists, activities professionals, social workers, and other professionals, such as developmental disabilities specialists, or spiritual advisor. Involvement of other individuals is dependent upon resident request and/or needs. Each resident has the right to participate in choosing treatment options and must be given the opportunity to participate in the development, review and revision of his/her care plan. Residents also have the right to refuse treatment.”

As used in the CMS SOM Appendix PP, interdisciplinary means that professional disciplines, as appropriate, will work together to provide the greatest benefit to the resident. It does not mean that every goal must have an interdisciplinary approach. The mechanics of how the interdisciplinary team (IDT) meets its responsibilities in developing an interdisciplinary care plan (a face-to-face

meeting, teleconference, written communication) is at the discretion of the facility.

SOURCE: CMS SOM Appendix PP, Pages 237-247; [42 CFR §483.21\(b\)\(2\)](#); [26 TAC §554.802](#).

Assisted Living Facility - Service Plan

Care plans are called service plans in assisted living facilities. According to state licensing standards, a written plan of care in an assisted living facility (ALF) is the basis for providing services required to meet the needs of the resident.

Within 14 days of admission to an assisted living facility, a resident comprehensive assessment and an individual service plan must be developed. The service plan must be approved and signed by the resident or a person responsible for the resident's health care decisions. The facility must provide care according to the service plan. In assisted living, the service plan must be updated annually or upon a significant change in condition, based upon an assessment of the resident.

SOURCE: [26 TAC §553.259\(b\)](#).

Care or Service Plan Meeting

Both nursing and assisted living facilities should develop person-centered care or service plans using a person-centered planning process. There are four main steps in a person-centered plan process.

- 1) Assess the Resident
- 2) Hold a Care or Service Plan Meeting
- 3) Write the Plan
- 4) Review the Plan

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

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

If a facility staff or resident family member invites an ombudsman to attend a care or service plan meeting, the ombudsman must ask the resident, or resident's LAR when applicable, for consent to attend.

When attending a care or service plan meeting, observe and note how the meeting is conducted.

- Did staff encourage the resident and resident representative to participate?
- Did they set specific, measurable, achievable, and realistic goals?
- Was the plan agreed upon by all parties, including the resident?



Ombudsman Tip – Care and Service Plan Meetings

An ombudsman may attend care meetings at the invitation of a resident or the resident's LAR when applicable. An ombudsman can help residents and family prepare for a meeting by giving information on how a meeting typically works and helping them practice discussing specific comments, questions, or concerns. Staff lead the care or service plan meeting, but residents, family, and an ombudsman can direct discussion of issues most important to the resident. An ombudsman may also suggest a care or service plan meeting as a strategy for resolving a problem.

Resident Participation

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

- Tell staff their concerns, needs, and goals.
- Ask the doctor or staff who know about their condition, care, and treatment.

- Ask to meet when family can come if they want them there.
- During the meeting, residents can:
 - Discuss options for treatment and for meeting needs and preferences.
 - Ask for terms and procedures to be explained if needed.
 - Decide if they agree with the plan and feel it meets their needs.
 - Ask for a copy of the updated care plan.
 - Get the name of a person to talk to if they want changes.
- After the meeting, residents can:
 - Monitor how the plan is followed.
 - Talk with nurse aides, other staff, or their doctor about it.

Good care or service plans:

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

SOURCE: National Consumer Voice. <https://theconsumervoice.org/>.

A care or service plan may include:

- What kind of services are needed.
- What type of health care professional should provide the services.
- How often the services are needed.
- What kind of equipment or supplies are needed (for example, a wheelchair or feeding tube).
- What the resident's preferred schedule is for waking up and going to bed.
- If a special diet is required and dietary preferences.
- Health goal(s) and how the care plan will help the resident reach this goal.

SOURCE: CMS-Medicare. <https://www.medicare.gov/what-medicare-covers/part-a/care-plan-in-snf.html>.

Nursing Facility Regulations Related to Care Plans

- [26 TAC §554.406\(a\)\(1\)-\(3\); 42 CFR §483.10\(b\)\(7\)\(iii\) and \(c\)](#) - Right to Participate in Care Planning Process
- [26 TAC §554.801; 42 CFR §483.20](#) - Resident Assessment
- [26 TAC §554.802; 42 CFR §483.21](#) - Comprehensive Person-Centered Care Planning
- [26 TAC §554.803; 42 CFR §483.21\(c\)](#) - Discharge Planning
- [26 TAC §554.901; 42 CFR §483.25](#) - Quality of Care

Assisted Living Facility Regulations Related to Service Plans

- [26 TAC §553.259\(b\); 26 TAC §553.307](#) - Resident Assessment, Service Plan
- [26 TAC §553.267 \(a\)\(3\)\(O\)](#) - Right to Participate in Developing Service Plan

Basics of Individualized Quality Care

Traditionally, care and service plans were written from a staff perspective rather than a resident perspective. Individualized care and service plans provide care and service that support quality of life for each resident and their goals and preferences.

Example: Fred is an 84-year-old man with osteoarthritis. He is very pleasant and social, frequently visiting staff and residents. He ambulates with minimal assistance or moves independently in a wheelchair. Fred and his wife were happily married for 61 years and did not have children. They shared a room until she died six months ago.

Fred is now in a private room. Recently he attempted to fondle a female staff and resident. He is alert and aware of his surroundings, has minimal cognitive impairment, and is hearing impaired.

Need	Goal	Approaches
I need companionship.	I will choose a roommate by my next care plan meeting.	I prefer a roommate. When I am in my room, I like to watch action movies. I like to read books. I look up words in my dictionary. I enjoy wild birds. I have a bird feeder outside my window. Leave the shades open and ensure I have birdseed so I can fill the feeder. When I am out of my room, I enjoy eating in the dining room. Offer opportunities to be around staff and other residents. I may not talk a lot, but I like company. Speak clearly and directly to me. I have difficulty hearing. Introduce me to single women who are seeking companionship and friendship.

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

On Your Own – Video & Quiz – Person-Centered Care – Health Care Schedules

Link to video: https://youtu.be/TQe1cj2_ObI?si=3RdRqDfMjszr59UD

Length of video: 2 minutes.

Take the Quiz

1) What problem did Sara identify when she went to get Ms. Durham for her scheduled shower?

2) Why did Sara decide to let Ms. Durham sleep?

3) How does adapting residents' schedules and care plans to their wants or needs improve residents' lives?

4) If a resident tells the ombudsman they want to change their shower schedule, what should the ombudsman do? Check all that apply.

☐ Call the resident's daughter to see what she thinks about the resident's schedule.

☐ Ask the resident for consent to help.

☐ Listen to the resident's concerns and confirm the ombudsman's understanding of the resident's concerns is correct. Resolve any misunderstanding.

☐ If the resident wants ombudsman assistance, discuss strategies with the resident.

☐ Explain the resident's rights related to "choice" to the resident.

On Your Own – Video & Quiz – Person-Centered Care – Care Plans

Link to video: https://youtu.be/JGgCJp2XQpY?si=A590wAza_0WxSNSw

Length of video: 2 minutes.

Take the Quiz

1) What happened at Ms. Durham's next care plan meeting? Mark all that apply.

☐ Ms. Durham attended the meeting alone with several staff.

☐ Ms. Durham attended the meeting along with a facility nurse and Ms. Durham's CNA, Sara.

☐ An agreement about Ms. Durham's showering issue was not reached.

☐ Ms. Durham, facility staff, and Ms. Durham's daughter were able to find a solution.

- 2) Why is it important for direct care staff, like Sara, to be involved in resident care planning?
-

- 3) ____ True ____ False

A resident's care plan must be individualized, embracing a resident's needs and choices.

- 4) ____ True ____ False

Residents are partners in the care planning process.

- 5) ____ True ____ False

Problem solving is not a key part of care plan meetings.

Trauma-Informed Care

Trauma-informed care is a resident care approach based on knowledge of the impact of trauma. It encourages increased sensitivity with environments and services that are welcoming and engaging for residents.

Terms to Know

Culture, self, and world view are the "lenses" through which we interpret our life. Individual and community experiences typically shape our lenses early in life. An individual's lenses can be altered later in life if they experience significant emotional events or trauma.

Cultural responsiveness refers to the ability to understand and work with different kinds of people from various backgrounds. It includes learning about customs, traditions, and ways of thinking and then applying this knowledge in everyday life.

A trauma trigger is a stimulus that prompts or evokes the recall of a previous traumatic event, even if the stimulus itself is not traumatic or frightening. Triggers are highly individualized and may include sight, smell, sound, and touch. For instance, the triggers for a survivor of abuse may be an object, perfume, body odor, tone of voice, or physical touch.

Trauma

In a March 2022 publication on the *Caring for the Ages* website, Samantha Koury, LMSW, and Susan Green, LCSE, authors of “Creating Trauma-Informed Long-Term Care Organizations,” explain trauma.



“When individuals have experienced trauma, especially when it was prolonged, the brain learns that it needs to remain in survival mode – also referred to as the fight, flight, or freeze response. The over activation of the survival response in the brain combined with a self-view that reflects ideas such as “I’m not good enough,” “People will hurt me,” and “I can’t trust anyone,” causes individuals to be more likely to experience threats in the present, whether they are real or perceived. We cannot change what has happened to someone in the past, but potential activation of the survival response is something we do have control over in our roles when we respond in ways that “neutralize the environment” or prevent re-traumatization. Things that can cause re-traumatization include, but are not limited to, facility procedures, the physical environment, or even current events. Interactions may replicate a resident’s history of trauma literally or symbolically and may unknowingly result in the activation of a resident’s survival response.”

Types of Traumas

Life Experiences

- Domestic and sexual violence
- Childhood abuse
- Natural disasters
- Refugee
- Medical trauma
- Violent crime
- Car, train, or airplane crash

Witness of Violence

- Bias and discrimination
- Childhood neglect or abandonment
- Homelessness
- Robbery
- Family member with a mental health or substance use disorder
- Poverty and systemic discrimination
- Military combat

Aging Process Experiences

- Loss of loved ones
- Loss of own capacities
- Loss of roles, identity, home
- Increased dependence

Principles of Trauma-Informed Care

Substance Abuse and Mental Health Services Administration (SAMHSA) issued guidelines for trauma-informed care in 2014 that outlined six key principles for trauma-informed care. Below are five of the six principles. The sixth principle is peer support.

1-Safety

Staff:

- Monitor noise levels.
- Monitor who is coming in and out of the building.
- Recognize and address aspects of the facility's physical environment that may be re-traumatizing.

2-Trustworthiness and Transparency

- Staff-Resident-Resident Representatives maintain communication that is consistent, open, respectful, and compassionate.

3- Collaboration and Mutuality

- Residents are the experts on their lives.

4-Empowerment, Voice, and Choice

- Residents' voices are heard and used in care plans.
- Residents are given options and choices.
- Residents are kept informed.
- Residents are invited to their care plans and participate in the care planning process.
- Residents' hopes, capacities, interests, preferences, and needs are identified and addressed in care plans, as appropriate.

5-Assessment

- Thorough resident assessments and personal histories are taken.

SOURCES:

Koury, S.P., and S.A. Green. "Creating Trauma-Informed Long-Term Care Organizations." Caring for the Ages, [https://www.caringfortheages.com/article/S1526-4114\(22\)00003-8/fulltext.2022.01.003](https://www.caringfortheages.com/article/S1526-4114(22)00003-8/fulltext.2022.01.003). Accessed 06-29-2023.

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Fill in the blank in the statement below.

- 1) A trauma _____ is a stimulus that evokes the recall of a previous traumatic event.

Examples of Resident Re-Traumatization

In the following examples, assume each resident experienced severe trauma during their lifetime.

- A resident says she must continually retell a personal traumatic story to receive the care she needs. According to the resident, she has repeated

her story to five staff and outside care providers. She says she relives her trauma every time her story is repeated. She also says she has no voice; she feels unheard.

- A resident says that he feels like he is “being treated as a number by staff.” He believes staff are not transparent when communicating with him and “manage” him using “veiled threats, truths, or lies.”
- According to a resident, staff labeled him as difficult. Additionally, the resident reports that his care, and other things, are done for the resident rather than with him. The resident believes staff are exerting power or control over him.
- Per a resident, no choices are offered to them for services or treatment. The resident complains. “I am never invited to my care plan meeting. Staff do not involve me in planning my care, services, or treatment.” The resident frequently complains that staff use coercive practices.

Nursing Facility Regulations Related to Culturally-Competent and Trauma-Informed Care

Federal

- [42 CFR §483.21\(b\)\(3\)\(iii\)](#) – Services must be culturally-competent and trauma-informed.
- [42 CFR §483.25\(m\)](#) – Quality of care – Trauma-informed care.
- [42 CFR §483.40\(a\)\(1\) and \(b\)](#) – Behavioral health services – Care for residents with a history of trauma or post-traumatic stress disorder.

State

- [26 TAC §554.402](#) – Exercise of Rights
- [26 TAC §554.403](#) – Notice of Rights and Services
- [26 TAC §554.801](#) – Resident Assessment.
- [26 TAC §554.802](#) – Comprehensive person-centered care planning.
- [26 TAC §554.802\(h\)\(3\)](#) – Culturally competent and trauma informed.
- [26 TAC §554.901](#) – Quality of care.
- [26 TAC §554.901\(12\)](#) – Trauma-informed care and culturally-competent care
- [26 TAC §554.904\(a\)\(1\)\(A\)-\(B\)](#) – Behavioral health services.
- [26 TAC §554.1101](#) – Food and nutrition services.

- [26 TAC §554.1107](#) – Menus, nutritional adequacy, and meal service.
- [26 TAC §554.1108](#) – Food and drink – Allergies, Intolerances, Preferences
- [26 TAC §554.1116](#) – Therapeutic Diets
- [26 TAC §554.1931](#) – Facility assessment

Federal nursing facility federal regulations require facilities to provide care to trauma survivors that meets professional standards and is culturally competent. In addition, it must account for experiences and preferences of the residents and the needs of trauma survivors. According to the National Council for Community and Behavioral Health, an estimated 70% of adults in the United States have experienced some type of traumatic event.

After the facility identifies which residents are trauma survivors, staff identify triggers that can prompt recall of the previous traumatic events. They must ensure that each resident's comprehensive care plan includes approaches to address the resident's cultural preferences and reflects trauma-informed care when appropriate.

Examples of what may be addressed in a resident's care plan include:

- Communication and communication preferences.
- Food preparation.
- Clothing preferences.
- Physical contact or provision of care by a person of a different sex.
- Cultural etiquette (voice volume, eye contact).

SOURCE: The National Consumer Voice; [42 CFR §483.25\(m\)](#).

The demographics of Texas nursing facilities are changing. In addition to racial and ethnic diversity, facilities must also accommodate cultural and religious preferences. If culture or trauma is a concern for a resident, consider the following four elements. These tips are found in the CMS State Operations Manual, Appendix PP. Did facility staff:

- Identify the resident's history of trauma?
- Identify triggers which cause re-traumatization?
- Identify cultural preferences of a resident who is a trauma survivor?
- Use approaches that are culturally competent and are trauma informed?

Assisted Living Facility Regulations Related to Culturally-Competent and Trauma-Informed Care

Assisted living facility regulations do not currently use the terms culturally-competent care or trauma-informed care in TAC. For related regulations, review the following requirements.

State

- [26 TAC §553.253\(b\)\(1\)](#) and §553.253(d)(3) – Employee qualifications and training.
- [26 TAC §553.259\(b\)\(1\)\(A\)-\(J\)](#) – Admission policies and procedures.
- [26 TAC §553.267\(a\)\(3\)\(B\)](#), (C), (E), (G), and (O) – Residents' rights.
- [26 TAC §553.307\(d\)](#) – Additional requirements for certified Alzheimer's assisted living facilities for admission procedures, resident assessment, and service plans
- [26 TAC §553.303](#) – Certified Alzheimer's assisted living facilities and staff training.

Training Needs Related to Trauma-Informed Care

Residents

Facilities should make sure residents have access to mental health services. Staff should make sure residents who have a history of trauma are trained in trigger awareness along with techniques to reduce the effects of those triggers. This may help residents self-regulate in their daily lives. Self-regulation techniques include:

- Relaxation exercises like deep breathing, progressive muscle relaxation, guided imagery, or meditation.
- Self-soothing techniques like changing their environment, soothing music, tapping on acupressure points, or the "[butterfly hug](#)."

Facility Staff

Facilities need to ensure staff receive training on how common trauma is and that they should assume a resident has a history of trauma and act accordingly. Trauma comes in many forms; therefore, staff need to learn to respond with empathy and understanding to all residents. Staff need to know:

- How to establish and maintain a trusting relationship by listening.
- What empathy is and how to show it.
- Techniques to remain calm and non-threatening when they work with residents who have high levels of anxiety.
- Techniques to deescalate and reduce anxiety.
- The needs and how to meet the needs of residents who experienced trauma: safety, transparency, choice, reassurance, and comfort.

SOURCES: Koury, S.P., and S.A. Green. "Creating Trauma-Informed Long-Term Care Organizations." *Caring for the Ages*. [https://www.caringfortheages.com/article/S1526-4114\(22\)00003-8/fulltext](https://www.caringfortheages.com/article/S1526-4114(22)00003-8/fulltext). Accessed 06-29-2023.

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The Ombudsman Role in Care or Service Planning

An ombudsman is not responsible for creating a resident's care or service plan; however, an ombudsman may use the care planning process to solve problems.

Ombudsmen must be knowledgeable about resident-directed care practices in order to incorporate this in their conversations with residents, families, and providers and in their advocacy.

Ombudsmen only attend a care or service plan when invited by the resident or resident's LAR if the resident is unable to make the request. If facility staff invite an ombudsman to a resident's care plan meeting, the ombudsman must obtain consent from the resident (or the resident's LAR if the resident is unable to consent) to attend.

A Resource for You

“Honoring Preferences When the Choice Involves Risk: A Process for Shared Decision Making and Care Planning”

This resource published by Preference Based Living provides information about care planning when a resident’s choice involves risk. TIP: If you are short on reading time, start on page 17.

Link to resource: <https://www.preferencebasedliving.com/for-practitioners/practitioner/care-integration/honoring-preferences-when-the-choice-involves-risk/>.

Discharge Planning

Nursing Facility - Discharge Planning

Discharge planning is the process of creating an individualized discharge care plan, which is part of the resident’s comprehensive care plan. It involves the interdisciplinary team working with the resident and resident representative, if applicable, to develop goals and treatments to meet the resident’s discharge goals and needs to ensure a smooth and safe transition from the facility to the post-discharge setting. Discharge planning begins at admission and is based on the resident’s assessment and goals for care, desire to be discharged, and the resident’s capacity for discharge.

The discharge care plan is part of the comprehensive care plan and must:

- Be developed by the interdisciplinary team and involve direct communication with the resident and if applicable, the resident representative.
- Address the resident’s goals for care and treatment preferences.
- Identify needs that must be addressed before the resident can be discharged, such as resident education, rehabilitation, and caregiver support and education.
- Be re-evaluated regularly and updated when the resident’s needs or goals change.

- Document the resident's interest in, and any referrals made to the local contact agency.
- Identify post-discharge needs such as nursing and therapy services, medical equipment or modifications to the home, or ADL assistance.

Assisted Living Facility - Discharge Planning

Facility disclosure statements contain information about the facility's discharge process. Before admitting a resident, assisted living facility staff must explain and provide a copy of the disclosure statement to the resident, family, or responsible party ([26 TAC §553.259\(a\)\(3\) and \(c\)\(1\)](#)). Although a facility may establish their own policies and procedures for discharging residents, "discharge planning" is not addressed in the Licensing Standards for Assisted Living Facilities (TAC). For information about why a resident may be transferred or discharged, refer to [26 TAC §553.267\(a\)\(3\)\(X\)](#). If the discharge is related to an inappropriately placed resident, refer to [26 TAC §553.259\(e\)](#).

Advanced Care Planning

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

Advance care planning requires an individual to:

- Determine what wishes would need to be shared.
- Direct choices about care if staying home, in a nursing facility, or in a hospital.
- Talk with family and doctors about what treatment is desired and what is not.
- Document treatment wishes in the event of a serious accident, illness, or terminal condition.
- Tell others what is decided.

If help is needed to understand advance care planning forms, facility staff can explain them. Some benefits counselors at area agencies on aging are trained

to help complete Medical Powers of Attorney. The Texas Legal Services Center can provide information about legal forms and under some circumstances attorneys to assist in the completion of these documents.

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

Regulations and Statutes Pertaining to Advance Care Planning

- Federal: Code of Federal Regulations, Requirements for Long Term Care Facilities (Nursing Facility) - [42 CFR §483.10\(c\)\(6\), \(c\)\(8\), and \(g\)\(12\)](#) and [42 CFR 489.102\(a\)\(3\)](#)
- State - Advance Directives. [Health and Safety Code, Title 2, Chapter 166.](#)
- State - Nursing Facility Requirements - [26 TAC §554.419](#)
- State - Licensing Standards for Assisted Living Facilities - [26 TAC §553.259\(d\)](#)

Common Advance Directives Forms

Medical Power of Attorney

Authorizes, except to the extent a person states otherwise, a named agent to make all health care decisions in accordance with the person's wishes, including religious and moral beliefs, when a person is no longer capable to make them.

Directive to Physicians

A Directive to Physicians or Medical Power of Attorney may include a person's written wishes about specific medical procedures.

Directive to Physicians and Family or Surrogates

Communicates wishes to doctor(s), family, and others about medical treatment at some time in the future when a person is unable to make wishes known because of illness or injury.

Out-of-Hospital Do Not Resuscitate

Instructs emergency medical personnel and health care professionals to not attempt resuscitation and to allow natural death; it does not affect receiving other emergency care and treatment including comfort care.

SOURCE: [Texas Health and Safety Code, Title 2, Subtitle H, Chapter 166](#).

Statutory Durable Power of Attorney

A statutory durable POA designates an agent who is empowered to take certain actions regarding property and finances; it does not typically authorize anyone to make medical and other healthcare decisions. See the Texas Estates Code, Chapter 752 for more information.

Other Advance Care Planning Forms

Declaration for Mental Health Treatment

This form allows a person to make decisions in advance about mental health treatment and specifically three types of mental health treatment: psychoactive medication, convulsive therapy, and emergency mental health treatment.

The instructions in this declaration will be followed only if a court believes a person is incapacitated to make treatment decisions. Otherwise, a person is considered able to give or withhold consent for the treatments.

SOURCE: Civil Practice and Remedies Code, Title 6. Chapter 137
<https://statutes.capitol.texas.gov/Docs/CP/htm/CP.137.htm>. Accessed December 2015.

Consent to Medical Treatment

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

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

Texas Health and Safety Code §313.004, Consent for Medical Treatment sets situations under which others make medical decisions for people unable to decide on their own.

After two physicians certify in writing the person's incapacity to make medical decisions, the law allows the following people in order of priority to be surrogate decision makers:

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

Surrogates can give informed consent for all medical decisions needed, except:

- Voluntary inpatient mental health services;
- Electroconvulsive treatment; and
- Appointment of another surrogate decision maker.

Surrogates try to make decisions based on what people would want by considering:

- Current diagnosis;
- Prognosis;
- Any preference expressed about the treatment;
- Religious or personal beliefs;
- Feeling about similar treatment for other people; and
- Expressed concerns about effects of illness and treatment on family or friends.

If surrogates have no information about a person's wishes, they use the standard of best interest. They look at the benefits and burdens of treating and not treating, such as:

- Effects of treatment on the physical, emotional, and mental functions.
- Pain suffered from the treatment.
- Pain suffered without treatment.
- Humiliation, loss of dignity, and dependency suffering because of the condition or would suffer because of the treatment.

- Effect of the treatment on life expectancy.
- Potential for recovery, with and without the treatment.
- Risks, side effects, and benefits of the treatment.
- Religious beliefs and values.

SOURCE: Texas Health and Safety Code, Title 4, Subtitle F, Chapter 313, §313.004
<https://statutes.capitol.texas.gov/Docs/HS/htm/HS.313.htm>. Accessed December 2018.



Answer the following question.

- 1) Name one person who can be a surrogate decision maker.



Ask the Instructor - Family Members Disagree

- 1) The doctor tells a resident that there are no more treatments to improve his health and she recommends hospice care. Her son agrees but the resident's daughter wants treatment to continue.
- 2) Whose wishes do you advocate for? _____
- 3) What should an ombudsman do when family members disagree?

The Ombudsman Role in Advance Care Planning

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

Creation or Revocation of Advance Directives

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

Revocation of Powers of Attorney

If a resident asks questions about limits placed on their ability to exercise rights, an ombudsman's role is to educate, help the resident explore why those limitations exist, and work to overcome unnecessary limitations at the direction of the resident.

According to the OPPM Section 740 (j)(1), "If a resident requests assistance from a certified ombudsman to revoke a power of attorney, the certified ombudsman must:

Assist the resident in contacting a non-profit legal services organization in accordance with Section 770(c)(2) of this chapter, to revoke the power of attorney and, if desired, to execute a new power of attorney; and

If necessary, request that a person chosen by the resident, such as an LTC facility staff person, assist the resident with activities related to revocation of the power of attorney including:

- obtaining notarization of the resident's signature on the written revocation; and
- submitting the written revocation to the LTC facility and other entities that rely on the power of attorney."

Frequently Asked Question – Serving as a Decision Maker

Question: Is it a conflict of interest to serve as a resident decision maker for residents residing in an ombudsman's assigned facility?

Answer: *Yes. It is a conflict of interest for an ombudsman or intern to serve as a resident decision maker, such as a guardian or agent in a Medical Power of Attorney, in facilities where they are assigned to provide ombudsman services.*

Decline any such requests and explain your role as an advocate. This limit does not apply to an ombudsman serving as a decision maker for a family member in a facility where the ombudsman does not serve residents.

If you ever have any questions, speak with your supervising staff ombudsman, MLO, or the state office.



Read the statement below and indicate whether it is True or False.

1) ____ True ____ False

It is a conflict of interest for ombudsmen to serve as a resident's Medical Power of Attorney at the facility where they provide ombudsman services.

Connect Regulatory Compliance with Resident-Directed Care



Exercise - Practice Applying Regulations to Resident-Directed Care

Instructions

Review the regulations for nursing and assisted living facilities that follow. Answer the correlating questions to practice promoting resident-directed care.

In some sections, information from the SOM (CMS State Operations Manual Appendix PP – Guidance to Surveyors for Long Term Care Facilities) is provided.

In the SOM, a F-tag number is assigned to the corresponding regulatory provision. F-tags ("F" for "federal") create the system through which federal nursing facility regulations are identified in the nursing facility survey process. Generally, each regulatory provision is assigned a corresponding F-tag number and surveyors use these numbers to indicate, on the Statement of Deficiencies, when a facility has failed to meet (or exceed) a given standard.

General Rights

Nursing Facility

"The resident has a right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility. A facility must protect and promote the rights of each resident."

A nursing facility resident has the right to exercise the resident's rights as a resident at the facility and as a citizen or resident of the United States; and has

the right to be free of interference, coercion, discrimination, or reprisal from the facility in exercising the resident's rights.

SOURCES: [26 TAC §554.401\(a\)](#); [26 TAC §554.402\(a\) and \(b\)](#); [42 CFR §483.10\(a\),\(b\)and \(f\)\(1\)-\(2\)](#).

Assisted Living Facility

Assisted living residents have all the rights, benefits, responsibilities, and privileges granted by the constitution and laws of this State and the United States, except where lawfully restricted. They also have the right to be free of interference, coercion, discrimination, and reprisal in exercising these civil rights.

SOURCE: [26 TAC §553.267\(a\)\(2\)](#).

Choice

Nursing Facility

The resident has a right to:

- Self-determination through support of resident choice;
- Participate in planning care and treatment or changes in care and treatment, to the extent practicable;
- Choose activities, schedules (including sleeping and waking times), health care and providers of health care services consistent with their interests, assessments; and
- Make choices about aspects of their life in the facility that are significant to the resident.

Assisted Living Facility

Residents in the assisted living facility have a right to make their own choices regarding personal affairs, care, benefits, and services.

SOURCE: [26 TAC §553.267\(a\)\(3\)\(E\)\(i\)](#).

Voice Grievances

Nursing Facilities

[26 TAC §554.408\(a\)\(1\)-\(3\)](#)

(a) A resident has the right to:

(1) voice grievances without discrimination or reprisal including grievances regarding treatment that has been furnished as well as treatment that has not been furnished;

(2) prompt efforts by the facility to resolve grievances the resident may have, including those with respect to the behavior of other residents; and

(3) notify state agencies of complaints against a facility...

Assisted Living Facilities

26 TAC §553.267(a)(3)(H)

(a) Resident's bill of rights.

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

(H) complain about the resident's care or treatment. The complaint may be made anonymously or communicated by a person designated by the resident. The provider must promptly respond to resolve the complaint. The provider must not discriminate or take punitive action against the resident who makes a complaint.

Access to Long-Term Care Ombudsmen

Nursing Facilities

26 TAC §554.413(a)(4)-(5)

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

(4) the State Ombudsman;

(5) a certified ombudsman; ...

(c) In accordance with the Older Americans Act, §712 (b) (1) (A) and 45 CFR §1324.11 (e) (2), a facility must allow:

(1) the State Ombudsman, a certified ombudsman, and an ombudsman intern to have:

(A) immediate, private, and unimpeded access to enter the facility at any time during the facility's regular business hours or regular visiting hours;

(B) immediate, private, and unimpeded access to a resident; and

(C) immediate and unimpeded access to the name and contact information of a resident representative if the State Ombudsman, a certified ombudsman, or an ombudsman intern determines the information is needed to perform a function of the Ombudsman Program; and

(2) the State Ombudsman and a certified ombudsman to have immediate, private, and unimpeded access to enter the facility at a time other than regular business hours or visiting hours, if the State Ombudsman or a certified ombudsman determines access may be required by the circumstances to be investigated.

Assisted Living Facilities

26 TAC §553.269(a) and (b)

(a) A resident has the right to be visited by the State Ombudsman, a certified ombudsman, or an ombudsman intern.

(b) In accordance with the Older Americans Act, §712(b)(1)(A), and 45 CFR §1324.11(e)(2), a facility must allow:

(1) the State Ombudsman, a certified ombudsman, and an ombudsman intern to have:

(A) immediate, private, and unimpeded access to enter the facility at any time during the facility's regular business hours or regular visiting hours;

(B) immediate, private, and unimpeded access to a resident; and

(C) immediate and unimpeded access to the name and contact information of the resident's legally authorized representative, if the State Ombudsman, a certified ombudsman, or an ombudsman intern determines the information is needed to perform a function of the Ombudsman Program; and

(2) the State Ombudsman and a certified ombudsman to have immediate, private, and unimpeded access to enter the facility at a time other than regular business hours or visiting hours, if the State Ombudsman or a certified ombudsman determines access may be required by the circumstances to be investigated.

Activities

Nursing Facilities

26 TAC §554.702

(a) The facility must provide, based on the comprehensive assessment and care plan and the preferences of each resident, an ongoing program to support a resident in the resident's choice of activities, both facility-sponsored group and individual activities and independent activities, designed to meet the interests of and support the physical, mental, and psychosocial well-being of each resident, encouraging both independence and interaction in the community.

Assisted Living

26 TAC §553.261(d)

(d) Activities program. The facility must provide an activity or social program at least weekly for the residents.

26 TAC §553.309, Subchapter F (Certified Alzheimer's)

(a) A facility must encourage socialization, cognitive awareness, self-expression, and physical activity in a planned and structured activities program. Activities must be individualized, based upon the resident assessment, and appropriate for each resident's abilities.

(b) The activity program must contain a balanced mixture of activities addressing cognitive, recreational, and activity of daily living (ADL) needs.

(1) Cognitive activities include arts, crafts, storytelling, poetry readings, writing, music, reading, discussion, reminiscences, and reviews of current events.

(2) Recreational activities include all socially interactive activities, such as board games and cards, and physical exercise. Care of pets is encouraged.

(3) Self-care ADLs include grooming, bathing, dressing, oral care, and eating. Occupational ADLs include cleaning, dusting, cooking, gardening, and yard work. Residents must be allowed to perform self-care ADLs as long as they are able, to promote independence and self-worth.



Mark whether the statement is true or false, fill in the blank, or answer the question.

- 1) ____ True ____ False

Assisted living and nursing facility residents have the right to complain about their care or treatment.

- 2) What do nursing and assisted living facility regulations say about the facility response? The provider (facility) must respond _____.

- 3) If you received a complaint from a resident stating staff retaliated against her after she filed a complaint against them with Regulatory, what actions do you think you might take?

- 4) ____ True ____ False

A facility must allow the State Ombudsman, a certified ombudsman, and an ombudsman intern to have immediate, private, and unimpeded access to enter the facility at any time during the facility's regular business hours or regular visiting hours.

You (as an ombudsman) make a visit to an assisted living facility. In every room where you are invited to come in and visit with a resident, the same resident assistant (aide) comes in to empty the trash or ask how the resident is, or if they need anything. It becomes obvious to you that they are checking to see what you are doing.

What action(s) will you take first?

- 5) ____ True ____ False

Based on a resident's comprehensive assessment, a nursing facility must plan an ongoing program to support a resident in the resident's choice of activities designed to meet the interests of residents.

- 6) ____ True ____ False

An assisted living facility that is NOT Alzheimer's certified must provide an activity or social program at least weekly for residents.

- 7) List several things you think an activity director should consider when planning activities for residents.



Exercise - Apply Nursing Facility Regulations to Resident Food Concerns – Hold a Group Discussion

Instructions

Food complaints are common in both nursing and assisted living facilities.

Review the following regulations related to food and nutrition services for nursing facilities. After some of the following nursing facility federal regulations, there will be an excerpt from the CMS 3State Operations Manual (SOM) Appendix PP. The SOM provides guidance to Regulatory Services surveyors on the interpretation of federal requirements. Finally, read the scenario and answer the questions that follow it.

Nursing Facility Regulations

[42 CFR §483.60](#) Food and nutrition services (26 TAC §554.1101)

The facility must provide each resident with a nourishing, palatable, well-balanced diet that meets his or her daily nutritional and special dietary needs, taking into consideration the preferences of each resident.

Excerpt from SOM – 42 CFR §483.60 Food and nutrition services F-800. Note: F-800 is referred to as an "F-Tag" which is a Federal Regulatory Tag.

"This requirement expects that there is ongoing communication and coordination among and between staff within all departments to ensure that the resident assessment, care plan and actual food and nutrition services meet each resident's daily nutritional and dietary needs and choices.

While it may be challenging to meet every resident's individual preference, incorporating a residents' preferences and dietary needs will ensure residents are offered meaningful choices in meals/diets that are nutritionally adequate

and satisfying to the individual. Reasonable efforts to accommodate these choices and preferences must be addressed by facility staff." [SOM]

[42 CFR §483.60\(c\)](#) Food and nutrition services. (26 TAC §554.1107)

(c) Menus and nutritional adequacy. Menus must—

(1) Meet the nutritional needs of residents in accordance with established national guidelines;

(2) Be prepared in advance;

(3) Be followed;

(4) Reflect, based on a facility's reasonable efforts, the religious, cultural, and ethnic needs of the resident population, as well as input received from residents and resident groups;

(5) Be updated periodically;

(6) Be reviewed by the facility's dietitian or other clinically qualified nutrition professional for nutritional adequacy; and

(7) Nothing in this paragraph should be construed to limit the resident's right to make personal dietary choices.

Excerpt from SOM - 42 CFR §483.60 (c) Menus and nutritional adequacy-F803 (p. 626)

"The facility must make reasonable efforts to provide food that is appetizing to and culturally appropriate for residents. This means learning the resident's needs and preferences and responding to them. For residents with dementia or other barriers or challenges to expressing their preferences, facility staff should document the steps taken to learn what those preferences are.

It is not required that there be individualized menus for all residents; however, alternatives aligned with individual needs and preferences should be available if the primary menu or immediate selections for a particular meal are not to a resident's liking. Facilities must make reasonable and good faith efforts to develop a menu based on resident requests and resident groups' feedback." [SOM]

[42 CFR §483.60\(c\)-\(d\)](#) Food and nutrition services. (26 TAC §554.1108)

(c) Menus and nutritional adequacy. Menus must—

(1) Meet the nutritional needs of residents in accordance with established national guidelines.;

(2) Be prepared in advance;

(3) Be followed;

(4) Reflect, based on a facility's reasonable efforts, the religious, cultural, and ethnic needs of the resident population, as well as input received from residents and resident groups;

(5) Be updated periodically;

(6) Be reviewed by the facility's dietitian or other clinically qualified nutrition professional for nutritional adequacy; and

(7) Nothing in this paragraph should be construed to limit the resident's right to make personal dietary choices.

(d) Food and drink. Each resident receives and the facility provides—

(1) Food prepared by methods that conserve nutritive value, flavor, and appearance;

(2) Food and drink that is palatable, attractive, and at a safe and appetizing temperature;

(3) Food prepared in a form designed to meet individual needs;

(4) Food that accommodates resident allergies, intolerances, and preferences;

(5) Appealing options of similar nutritive value to residents who choose not to eat food that is initially served or who request a different meal choice; and

(6) Drinks, including water and other liquids consistent with resident needs and preferences and sufficient to maintain resident hydration.

Excerpts from SOM – 42 CFR §483.60 (d) Food and drink. F571 (pages 40-41), F656 (page 241), F804, F805, F806, F807 (pages 630-635)

F571 - "(L) Except as provided in (e)(11)(ii)(L)(1) and (2) of this section, specially prepared or alternative food requested instead of the food and meals generally prepared by the facility, as required by §483.60.

... (2) In accordance with §483.60(c) through (f), when preparing foods and meals, a facility must take into consideration residents' needs and

preferences and the overall cultural and religious make-up of the facility's population."

F656 - "Culturally Competent Care Cultural competency, (also known as cultural responsiveness, cultural awareness, and cultural sensitivity) refers to a person's ability to interact effectively with persons of cultures different from his/her own. it means being respectful and responsive to the health beliefs, practices, and cultural and linguistic needs of diverse population groups, such as racial, ethnic, religious, or social groups

(<https://www.samhsa.gov/capt/applying-strategic-prevention/culturalcompetence>).

The interventions in the resident's care plan must reflect the individual resident's needs and preferences and align with the resident's cultural identity. [SOM]

[26 TAC §554.402](#) Exercise of Rights

(e) The facility must allow the resident the right to observe the resident's religious beliefs. The facility must respect the religious beliefs of the resident in accordance with 42 United States Code §1396f.



The Scenario - Nursing Facility Menus, Food, and Frequency of Meals

A nursing facility resident tells the ombudsman he has questions and concerns about meals and meal service and what his facility is required to do. He says he is very unhappy with meals served at his facility. About 30% of the facility's 75 residents are first generation immigrants to the United States.

Ayoub Bennani immigrated to the United States 25 years ago. He worked as a chef most of his life. Mr. Bennani loves to tell people about his culture, spices, and foods. He says many residents, including himself, do not eat typical American foods like chicken fried steak or hot dogs. He gave the ombudsman two months of weekly menus. Many meals were pork or foods known to have pork byproducts.

Mr. Bennani and other Muslim residents report they eat mostly fresh vegetables and fruits because they are uncertain if the facility buys and serves certified Halal food. Halal means permitted. Halal foods are foods that are allowed under his religious dietary guidelines.

Mr. Bennani wants to know if the facility's cooks and dietary manager understand Halal food and food preparation. He also voiced concerns that vegetables are served overcooked and bland. He wants the vegetables seasoned with spices he is familiar with and prefers. He understands meals must be low sodium. He says the facility rarely adds any spices to vegetables other than a little salt and pepper or Italian spices.

Many residents tell the ombudsman that they submitted food complaints to their resident council food committee. The members of the food committee, interviewed by the ombudsman, say the facility dietary manager and the administrator told them that their corporate office creates the facility's menus. Mr. Bennani requests the facility adapt their menus to meet religious and cultural food preferences of residents. He reports the facility has not responded favorably to resident's food complaints.

Mr. Bennani agrees that a care plan meeting may be a good way to discuss his personal concerns, especially if the dietary manager and administrator come to it. He gives you consent to help, use his name, share his concerns, and to request the meeting.

Take the Quiz - Answer the Questions That Follow.

- 1) List Mr. Bennani's complaint(s) below.

- 2) Summarize what the federal nursing facility regulations (CFR) and SOM guidance say about incorporating individual food preferences and resident culture and religious beliefs.

- 3) What do the federal nursing facility regulations (CFR) and the SOM guidance say about food preparation and appearance?

- 4) Mr. Bennani decides the best place to resolve his issues is during his care plan meeting. Mr. Bennani asks the ombudsman to request, attend, and support him during the meeting. Who does Mr. Bennani need to consider inviting to his care plan meeting?

- 5) What else does the ombudsman and Mr. Bennani need to know before the meeting?

- 6) How can the ombudsman help Mr. Bennani prepare for the meeting?

- 7) If you were the ombudsman, what ideas do you have about how to resolve Mr. Bennani's concerns?



Exercise - Apply Regulations to Resident Concerns - Menus, Food, and Frequency of Meals – Assisted Living Facility – Hold a Group Discussion

Instructions

Read the following assisted living facility regulations related to food and residents' rights. Answer the questions that follow the regulations.

Assisted Living Facility Regulations

[26 TAC §553.261](#)

(e) Dietary services. [...]

(2) At least three meals or their equivalent must be served daily, at regular times, with no more than a 16-hour span between a substantial evening meal and breakfast the following morning. All exceptions must be specifically approved by HHSC.

(3) Menus must be planned one week in advance and must be followed. Variations from the posted menus must be documented. Menus must be prepared to provide a balanced and nutritious diet, such as that recommended by the National Food and Nutrition Board. Food must be palatable and varied. Records of menus as served must be filed and maintained for 30 days after the date of serving.

(4) Therapeutic diets as ordered by the resident's physician must be provided according to the service plan. Therapeutic diets that cannot customarily be prepared by a layperson must be calculated by a qualified dietician. Therapeutic diets that can customarily be prepared by a person in a family setting may be served by the assisted living facility.

(5) Supplies of staple foods for a minimum of a four-day period and perishable foods for a minimum of a one-day period must be maintained on the premises.

(6) Food must be obtained from sources that comply with all laws relating to food and food labeling. If food, subject to spoilage, is removed from its original container, it must be kept sealed, and labeled. Food subject to spoilage must also be dated [...]

(11) Facilities must prepare food in accordance with established food preparation practices and safety techniques...

[26 TAC §553.267](#)

(a) Resident's bill of rights

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

(B) participate in activities of social, religious, or community groups unless the participation interferes with the rights of others;

(C) practice the religion of the resident's choice; [...]

(E) be treated with respect, consideration, and recognition of his or her dignity and individuality, without regard to race, religion, national origin, sex, age, disability, marital status, or source of payment. This means that the resident:

(i) has the right to make his/her own choices regarding personal affairs, care, benefits, and services; [...]

Take the Quiz - Answer the Questions That Follow.

1) Summarize what assisted living facility regulations say about honoring resident food preferences, culture, preparation, and appearance.

2) Think about the nursing and assisted living facility regulations you just read. What is one notable observation you have about the difference between the two sets of rules (nursing facility rules versus assisted living facility rules)?

Two Resources for You

1 - Texas HHS Long-Term Care Regulatory Provider and Information Letters can be useful advocacy tools for ombudsmen. Add the following links to your favorites in your preferred search engine.

- ALF: <https://www.hhs.texas.gov/providers/long-term-care-providers/assisted-living-facilities-alf/alf-letters-memos>
- NF: <https://www.hhs.texas.gov/providers/long-term-care-providers/nursing-facilities-nf/nf-information-provider-letters>

For example, [PL 2022-23](#) provides guidance to large, assisted living providers (licensed for 17 or more residents) about the requirements a facility must develop, maintain, and enforce for dietary policies and procedures that address food preparation and service.

2 - The Texas HHS Quality Monitoring Program (QMP) helps address conditions in Texas nursing facilities (NFs) that could be detrimental to the health, safety and welfare of residents. QMP is not a regulatory program and quality monitors do not cite problems. Quality monitors prioritize visits to NFs that have a history of resident care deficiencies, or that have been identified as having a higher-than-average risk of being cited for significant deficiencies in future surveys conducted by Regulatory staff. QMP keeps many evidence-based, best-practice fact sheets on their website here:

- QMP: <https://www.hhs.texas.gov/providers/long-term-care-providers/nursing-facilities-nf/quality-monitoring-program/evidence-based-best-practices>

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Chapter 9: Identify, Receive, and Investigate Complaints

Chapter 9 describes an ombudsman's approach to recognizing, receiving, and investigating complaints on behalf of residents. To solve problems for residents, ombudsmen use investigation and problem-solving skills. More than anything else, ombudsmen use common sense and stay resident-directed throughout the process.

Learning Objectives

- Learn methods to recognize and receive complaints.
- Learn the timeframes to respond to complainants.
- Identify basic investigation methods.
- Learn how to collect evidence.
- Recognize and employ good interview approaches.

Contents

- Definition of a Complaint
- Intake: Identifying and Receiving Complaints
- Respond to Complaints
- Frequently Asked Question – Response to a Complainant
- Investigate Complaints
- Documentation
- Ombudsman Consent and Authority Flow Chart – Decision Tree

Videos, Supplements, Forms

- YouTube Video: LTCO Casework: Advocacy and Communication Skills
- YouTube Video: The Monkey Business Illusion

Definition of a Complaint

A complaint is a statement of dissatisfaction or concern made by, or on behalf of, a resident, which relates to action, inaction, or a decision by any person or entity who provides care or makes decisions related to a resident, which may adversely affect the health, safety, welfare, or rights of the resident (OPPM 720(a)).

Intake – Identify and Receive Complaints

Ombudsmen receive complaints from a variety of sources including residents, residents' family, facility staff, and others acting on behalf of residents. Individuals who voice the complaint are called complainants. Complaints are received in person, by phone, text, mail, and email.

Complaint identification stems from an ombudsman's senses: sight, sound, smell, taste, and touch. For example, while making a facility visit the ombudsman smells an unpleasant odor throughout the facility, witnesses a problem with food service, and notices many housekeeping issues. These observations are potential complaints and need further investigation. Follow consent guidelines established in the OPPI.

The following are examples of complaints and complainants (OPPI 720(a)).

- A resident tells an ombudsman that the facility does not offer him enough food choices and wants the ombudsman's help getting a wider variety. The resident is the complainant in this example.
- A resident tells an ombudsman that she does not like showering at 6 a.m. and she requests the ombudsman's help getting a later shower time. The resident is the complainant in this example.
- A resident's guardian tells an ombudsman she is concerned that facility staff are not properly administering medication to the resident (guardian's ward). She requests the ombudsman's help investigating the situation. The resident's guardian is the complainant in this example.
- An ombudsman observes that multiple call lights at a long-term care facility go unanswered for 20 or more minutes. The problem affects at least six residents. The ombudsman is the complainant in this example.

Respond to Complaints

Timeframes to Respond to Complainants

If the Complaint IS NOT an Allegation of ANE

An ombudsman must respond to a complainant within two business days after receipt of the complaint, unless it is time sensitive or there is risk to the health, safety, or welfare of the resident.

If the Complaint IS an Allegation of ANE

If an ombudsman receives a complaint of alleged ANE or suspects ANE has occurred, the ombudsman must respond within one business day of receiving the complaint. If an ombudsman receives a complaint of alleged ANE or suspects ANE has occurred, they ombudsmen must explain to the complainant that ombudsmen do not investigate whether ANE occurred and to whom the complainant should report the allegation of ANE.

See Sections 730, 810, or 6020 of the OPPM for more information or contact your supervising staff ombudsman for more guidance.

SOURCE: OPPM 730, 810, and 6020 (b)

Discuss the Complaint with the Resident

Involve the resident unless the resident is unable to participate.

Ombudsmen support and maximize the resident's participation in the complaint resolution process. Find a private place to meet with the resident to discuss the complaint and to determine the resident's perspective. If the complainant is not the resident, explain you are required to involve the resident and act according to the resident's wishes.

Regardless of who makes a complaint, an ombudsman must always act on behalf of the resident in investigating and resolving the complaint.

Gather Information

Listen more than talk. Stay neutral and allow the complainant to tell their story without responding positively or negatively. Remember you are hearing only

one side of the story. Do not make promises and avoid judgmental statements like "That's horrible" or "That should not have happened."

Direct the Conversation If Needed

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

Get Consent to Act or Share Confidential Information

Follow ombudsman consent requirements explained in Chapter 4 of this manual and in the OPPM.



Answer the following question.

1) ____ True ____ False

An ombudsman must respond to a complainant within two business days after receipt of the complaint, unless it is time sensitive or there is risk to the health, safety, or welfare of the resident.

Explain Confidentiality and the Option for Anonymity to Residents and Other Complainants

Many residents worry about retaliation if concerns are brought to staff's attention. Explain the Ombudsman Program policies about confidentiality and a complainant's right to anonymity if they request it. Ombudsmen must provide anonymity if requested. **The rules of confidentiality and anonymity apply to all complainants, not just residents.**

Explain the Resident's Right to File a Complaint with Regulatory Services, Complaint and Incident Intake (CII) At Texas HHS

When complaints relate to alleged regulatory violations, inform complainants they have the right to file a complaint with Texas HHS Regulatory Services, Complaint and Incident Intake (CII). Ombudsmen must help residents or residents' LARs, when appropriate, file a complaint with CII when requested. Some complaints are in the scope of both ombudsman and regulatory authority.

Explain how the Ombudsman Program response will differ from the Regulatory Services response and requirements.

Complaints can be made about the care, treatment, or services by people who live in or receive services from nursing and assisted living facilities.

Complainants report complaint(s) to CII by telephone at 1-800-458-9858.

Seek Guidance from MLO or State Office as Needed

If an ombudsman is uncertain whether a complaint is appropriate for investigation or is uncertain how to proceed with investigating the complaint, the ombudsman must seek direction from the supervising staff ombudsman or MLO.

Frequently Asked Question – Response to a Complainant

Question: What is considered a response to a complainant?

Answer: *A response to a complainant includes the following:*

Acknowledgement that the complaint was received and whether it is appropriate for investigation by an ombudsman.

A request for consent from the complainant to disclose the identity of the complainant.

If the complainant is not the resident who is the subject of the complaint, an explanation that the complaint will be investigated only if:

- *the resident who is the subject of the complaint or the resident's LAR, when applicable, consents to investigation of the complaint; or*
- *the resident is unable to consent to investigation of the complaint, has no LAR, and the ombudsman determines the ombudsman has authority to investigate.*

SOURCE: OPPM 730(d)(3).

Refer to OPPM Section 730 for information on how to determine whether a visit to a nursing or assisted living facility is necessary and the required timeframe.



Fill in the blank in the statement below.

Complainants have the right to request _____.



Exercise – Apply Ombudsman Consent Requirements to Casework

Instructions

Read each scenario that follows and answer the questions. Refer to the *Ombudsman Consent and Authority Flow Chart* found at the end of Chapter 4. If more information is needed, review the OPPM Chapters 700 and 800 found in Chapter 14.

Scenario 1

A 75-year-old resident complained to the ombudsman that he is having trouble getting the medication aides at his facility to give him pain medication that his physician prescribed PRN (PRN is a Latin term that stands for “pro re nata.” This means the medication is administered as needed and the resident may request it.). The resident described the problem in detail. He provided dates, times, and a description of the medication aides. He told the ombudsman he does not request the pain medication more often than it is prescribed and knows he can have the medication every 4-6 hours. He requests help with his problem and expressed a desired outcome. He told the ombudsman he does not have a guardian and his daughter is his MPoA (agent on a medical power of attorney).

- 1) Does the resident have a guardian? ____ Yes ____ No ____ Unknown
- 2) Does the resident have an POA? ____ Yes ____ No ____ Unknown
- 3) Does the ombudsman have enough information to determine the resident is able to consent? ____ Yes ____ No ____ Unknown
- 4) From whom should the ombudsman obtain consent?
____ Resident
____ Resident’s MPoA
____ Guardian
____ No consent needed

Scenario 2

The daughter of a resident is the resident's MPoA agent. She emails a scanned copy of her mother's MPoA that names her as her agent, along with her complaint, to the ombudsman. The daughter says she is her mother's decision maker. She complains to the ombudsman that she has asked her mother's assisted living facility not to allow phone calls from the resident's sister. She says her aunt upsets her mother. The facility staff have not complied with the daughter's request. The daughter wants the ombudsman to contact the facility administrator and get the facility to comply with her request to limit her mother's phone calls.

The ombudsman explains to the resident's daughter that ombudsmen work for residents and are required to visit the resident and determine their perspective. She is fine with the ombudsman discussing her complaint with her mother and consents to the ombudsman using her name and talking about her complaint. The ombudsman meets with the resident and determines that she is able to consent. The resident tells the ombudsman that she likes to get calls from her sister even though the phone calls upset her occasionally.

1) Does the resident have a guardian? ☐ Yes ☐ No ☐ Unknown

2) Does the resident have an MPoA? ☐ Yes ☐ No ☐ Unknown

3) Did the ombudsman determine the resident is able to consent?

☐ Yes

☐ No

4) From whom should the ombudsman obtain consent?

☐ Resident

☐ Resident's MPoA

☐ Guardian

☐ No consent needed

Scenario 3

An 80-year-old resident complains to an ombudsman that he wants the camera (electronic monitoring device) in his room removed. He gave the ombudsman consent to help and to share his name and his concern. The ombudsman

determines that the resident is able to consent and, therefore, relies on the consent of the resident to investigate the complaint.

While investigating the complaint, the ombudsman speaks with the administrator of the facility who tells the ombudsman that the resident has a guardianship.

1) Did the ombudsman *initially* determine the resident is able to consent?

☐ Yes ☐ No

2) What, if anything, should the ombudsman do next?

Scenario 4

An 18-year-old resident tells an ombudsman she does not like the choice of activities at the facility and requests assistance from the ombudsman. The resident requests the ombudsman's help advocating for different activity choices. The ombudsman determines that the resident is able to consent. The resident consents to the ombudsman using her name and discussing her concern with staff.

Three weeks ago, the ombudsman reviewed this resident's guardianship paperwork during the investigation of another complaint. The resident has a guardian which is limited to financial matters.

1) Is the resident under 18 years of age or does the resident have a managing conservator?

☐ Yes

☐ No

2) Does the resident have a guardian of the person?

☐ Yes

☐ No

☐ Unknown

3) If the resident has a guardian, what type of guardian does this resident have?

☐ Guardian of the Person

☐ Guardian of the Estate

4) Did the ombudsman review the resident's guardianship paperwork to confirm there is a guardian and what decisions the guardian exercises for the resident?

☐ Yes ☐ No

5) Did the ombudsman determine the resident is able to consent?

☐ Yes

☐ No

6) From whom does the ombudsman need to seek consent?

☐ Resident

☐ Resident's MPoA

☐ Guardian

☐ No consent needed

Scenario 5

An ombudsman visits an 80-year-old resident of an assisted living facility who is unable to communicate. During the visit, the resident's roommate tells the ombudsman that she recently witnessed a CNA "smack" the resident. The ombudsman observes bruising on the resident's arm. The ombudsman knows the resident's daughter is the resident's guardian of the person and estate. The ombudsman calls the guardian immediately about the allegation but does not hear back from the guardian within two hours.

1) Is the resident under 18 years of age or does the resident have a managing conservator?

☐ Yes ☐ No

2) Does the resident have a guardian of the person?

☐ Yes

☐ No

☐ Unknown

3) From whom does the ombudsman need to seek consent?

☐ Resident

☐ Guardian

☐ Resident's MPoA

☐ No consent needed

- 4) Are the criteria met to request approval from the State Ombudsmen to refer the allegation of abuse to Regulatory Services? (OPPM Chapter 700, Section 740, Subsection h, Paragraph 2)

___ Yes

___ No

___ Unsure

SOURCE: OPPM, Section 740(h)



Ombudsman Tip – The OPPM Explains the Investigative Process

Follow the investigative process outlined in the OPPM.



Exercise – Select Activities Ombudsmen Perform Before or During a Complaint Investigation

- 1) Mark each statement below that is an example of an activity that ombudsmen may conduct prior to or during a complaint investigation.
- ___ Determine whether the complaint is appropriate for ombudsman investigation.
 - ___ Determine if disclosure of confidential information is necessary to effectively investigate a complaint.
 - ___ Obtain consent from the complainant and the resident, if the complainant is not the resident.
 - ___ Determine what, if any, state or federal requirements apply.
 - ___ Encourage the resident to help develop a plan of action for resolution of the resident's complaint.
 - ___ Call the resident's children and discuss the complaint with them before taking any actions.
 - ___ Document the activities the ombudsman performed during investigation of a complaint.
 - ___ Explain to residents and other complainants the option to report the complaint to HHS Regulatory Services.
 - ___ Help file a complaint with Regulatory Services if requested and consent requirements are met.

SOURCE: OPPM, Section 760.

Investigate Complaints

Investigating is one step in the ombudsman problem-solving process. More information on the five-step problem-solving process is described in Chapter 10. Investigation is the process of gathering information to help explain what happened and to help those involved determine a suitable response. For the purpose of complaint investigation, ombudsmen make unannounced visits to facilities and follow the investigative process outlined in the OPPM.

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

Evaluate the complaint then determine what information is needed, what questions need to be answered, and the best way to obtain that information. Factors to consider include whether the complaint:

- Is a communication problem that can be resolved with explanation or discussion.
- Is an issue with facility policies, procedures, or practices.
- Involves conduct of individuals.
- Is one of a series of complaints which may indicate a pattern or a widespread problem (systemic).
- Is a significant issue for the complainant, resident, or the facility and how significant.
- Needs to be referred to other agencies such as Regulatory Services, Adult Protective Services, or law enforcement.

SOURCE: Accessed January 2015 from:
<http://www.ombudsman.wa.gov.au/Publications/Documents/guidelines/Binder-Conducting-Investigations.pdf>.

Gather Evidence

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



Very important information!

Examples of when an ombudsman does NOT investigate include:

- When the complaint is about personnel issues with facility staff that do not affect or involve residents.*
- When the ombudsman has is a conflict of interest, or there is the perception of a conflict of interest or impropriety.*
- When the resident or complainant declines their consent or tells the ombudsman they no longer want further action.*

Three Methods of Evidence Collection

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

Observation – Method 1 for Evidence Collection

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

Tips for Observation

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

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

On Your Own – Video & Quiz – The Monkey Business Illusion

Find and watch this video on YouTube.

Link to video: https://youtu.be/IGQmdoK_ZfY?si=pLJK-cfuYUv6yfZo

Video length: 2 minutes.

Instructions

Count the number of times the team in white shirts passes the basketball. Answer the question below.

Take the Quiz

Answer the following questions about The Monkey Business Illusion. In the video people are passing basketballs. One group is wearing white shirts; the other group is wearing black shirts.

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

The video demonstrates selective observation: when you look too hard for one thing, you can miss an important piece of evidence.

2) What did you see that was unusual?

3) If you did not see something unusual, watch the video again. Answer the question above.

Interview – Method 2 for Evidence Collection

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

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

- Whether you have permission to identify the resident, complainant, or other identifying information during the conversation.
- To whom you need to speak.

- What questions you need answered and what specific information you need.

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

Introduce yourself.

- Shake hands.
- Give your credentials.
- Explain confidentiality.
- Be clear about the purpose of the meeting.

Do not provide too much information about what you are investigating because you might reveal identifying information such as the names of other witnesses. Ombudsman policy requires you to protect confidentiality of any resident or complainant.

What details you ask about will differ depending on the person's role. For example, you need to find out if staff respond to resident call lights in a timely manner. If you are talking to a family member, you might ask what they observe about call lights when they visit. If you are talking to the administrator, you might ask whether there has been a recent turnover of staff and what expectations and training of those expectations is given on call light response practices.



Very important information!

Share very little information about yourself other than your role as an ombudsman. If your personal information is not consistent with the witness's value system, the witness might not want to develop rapport with you. Sharing your personal beliefs or personal experience with a similar situation is not appropriate.

Order of Interviews

The order of who you interview can be important. Who do you interview first when you investigate?

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

Interview Techniques

- Ask clear questions.
- If you are not receiving answers, rephrase, and re-ask.
- Ask your supervising ombudsman to help if you are uncomfortable asking a question.
- Be mindful of nonverbal cues; these can be observable evidence too.



An interview is like a funnel.

Start with “larger” open-ended questions then refine and channel information with close-ended questions. At the bottom of the funnel, you ask close-ended questions meant to pinpoint and clearly define some facts.

Open-Ended Questions

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

Start an interview with open-ended questions. They help define the big picture and elicit the interviewee to describe or explain. Open-ended questions increase

the chances of getting additional details and ensure a greater accuracy of the facts from the interviewee's perspective.

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

- How did the argument between you and Mr. Smith start?
- What have you done to correct the problem?
- What happened?



Very important information!

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

Close-Ended Questions

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

- Did you and Mr. Smith argue?
- Do you know if anyone reported the incident?
- Have you taken any action to correct the problem?



On Your Own – Video & Quiz –Long-Term Care Ombudsman Casework: Advocacy and Communication – Anne Walker

Link to video: https://youtu.be/8QwwlP8drCk?si=84BO42r_wGdrY7FZ

Video length: Scene 1 - Anne Walker, 22 minutes.

Instructions

Watch the video and answer the following questions. Be prepared to discuss your responses with your trainer.

Note: Some questions seek specific examples from the scenarios, so it may be helpful to review the questions before watching the video to understand what you will be asked to identify.

Take the Quiz

Mark each word that best fills in the blanks in the following statement. Choose the three best answers from the list that follows the statement.

1) An ombudsman investigation should be _____, _____, and _____.

___ Critical

___ Thorough

___ Objective

___ Subjective

___ Timely

2) How did Gloria use her senses to gather evidence?

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

4) Ms. Walker stated she did not want to be identified with this complaint. She also said residents have been discharged due to sharing their concerns. What else could Gloria say in response to Ms. Walker's statements?

5) Gloria visited the facility during the early morning to observe the facility routine. What is another way Gloria could approach the investigation of this complaint?

6) What can Gloria do to ensure Ms. Walker is not identified as the complainant?
Choose all that apply.

- ☐ Visit multiple residents at each visit.
- ☐ Interview other residents about their shower schedules and experiences with showering without revealing someone has a complaint.
- ☐ Do not review a record specific to the resident, like her medical record.
- ☐ If staff are questioned about showering schedules, tell staff which days and times the ombudsman has questions about.

7) Which of the following are concerns Ms. Walker expressed in this scenario?
Choose all that apply.

- ☐ The shower time is too early.
- ☐ The shower is too cold.
- ☐ Staff are too rough with her.
- ☐ Staff do not listen to her preferences.

8) Were all of Ms. Walker's concerns addressed to her satisfaction?

- ☐ Yes
- ☐ No
- ☐ Some, but not all, concerns were addressed to her satisfaction.

9) Why didn't Gloria review Ms. Walker's care plan to check her preferences about showers? Select all that apply.

- ☐ She used other strategies such as interviewing other residents.
- ☐ Reviewing Ms. Walker's record might identify her as a complainant.
- ☐ She did not have Ms. Walker's consent to review her records.

10) List one example of an open-ended question Gloria asked and explain what information was gained.

- 11) List one example of a close-ended question Gloria asked and explain what information was gained.
-

The Emotional or Uncooperative Witness

An emotional or uncooperative witness can impede a successful interview. Empathic listening is important and gives the person undivided attention which can make the interview more productive. Try to be nonjudgmental and acknowledge the person's feelings, not just the facts. Think about potential emotional responses from witnesses and plan your response before it is needed. This can prepare you to de-escalate an emotional or uncooperative witness.



Ask the Instructor - Brainstorm appropriate responses to an emotional or uncooperative witness.

Instructions

List an approach for each emotional or uncooperative response.

Crying: _____

Pacing: _____

Slamming things: _____

Eye rolling: _____

Screaming or yelling: _____

Sarcasm: _____

Blaming: _____

Record Review – Method 3 for Evidence Collection

Review of relevant documentation may be necessary to thoroughly investigate a problem. Accessing a confidential resident record requires the resident's consent and is described in Chapter 12. Facility policies and admissions paperwork that does not contain a specific resident's name is public and available for review by an ombudsman when requested.

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

- Resident care or service plans
- Nursing notes about a resident
- Powers of attorney
- Advanced directives
- Admission agreements, or contracts
- Facility transfer sheets
- Facility policies and procedures
- Resident council meeting minutes
- Grievance reports
- Incident reports regarding a specific resident

Records not created by the facility could include:

- Police reports;
- Regulatory Services survey records;
- Ombudsman reports;
- Care records created by an outside service provider; and
- Resident or family journals or notes, paid companion (sitter) journals or notes.

In general, review of a resident's medical records can help you learn:

- The condition of a resident before and after an incident.
- Whether staff have assessed, care planned, implemented care, and evaluated the outcome of the care as specified by regulatory requirements.
- How the facility documented care delivered to a resident.

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

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Chapter 10: Complaint Resolution Skills

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

Learning Objectives

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

Contents

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

Video(s), Supplements, Forms

- YouTube Video: Long-Term Care Ombudsman Casework: Advocacy and Communication Skills – Brian Brashear
- Supplement 10-A: Basic Guidelines for Ombudsman Documentation

Complaint Resolution Skills

Conflict Resolution

Conflict arises from differences. It occurs when people disagree over their principles, views, or choices. Small conflicts can produce strong feelings. An ombudsman can help residents feel safe and secure, to feel respected and valued, and to know their voice is heard.

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

Healthy responses to conflict are characterized by:

- The ability to recognize and respond to important matters.
- A willingness to move forward.
- The ability to seek resolution (and avoid punishing).
- A belief that resolution can support the interests and needs of those involved.

SOURCE <https://www.edmonds.edu/student-services/counseling-and-wellness/counseling-center/documents/conflict.pdf>. Accessed January 2025.

Self-Advocacy

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

Residents who self-advocate are able to ask for what they need and want and tell people about their thoughts and feelings. Self-advocacy is the goal because it means they know their rights and responsibilities, they speak-up for their rights, and they are able to make choices and decisions that affect their lives.

Strategies to promote self-advocacy include:

- Educate a resident on residents' rights.
- Support a resident's participation in their care or service plan.
- Coach a resident in ways to negotiate with facility staff.

- Encourage a resident to bring their complaint to the resident council.
- Bring residents with similar concerns together to work on the problem.
- Encourage a resident to use the facility grievance process.

Mediation

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

Ombudsman work is on behalf of residents. Although impartial in investigation, ombudsmen are resident advocates when resolving a problem.

Parties are not usually equal in power. Mediation can be appropriate when two residents or two family members are the parties in conflict.



Very important information!

For ombudsmen to resolve conflicts, the problem and the parties need to fall within the scope of the Ombudsman Program.

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

Negotiation

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

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

Focus on Interests, Not Positions

- Explore interests.
- Each side may have multiple interests; try to find similar interests to form the basis of a win-win solution.
- Avoid having a bottom line.

For example, “We agree residents need the best care possible. Let’s discuss what Mr. Tanaka needs to feel safe and secure in his home.”

Negotiate on the Merits

- Recognize people are problem solvers.
- Concentrate on achieving a wise outcome, reached efficiently and agreeably.
 - Focus on solving the problem.
 - Do not try to score debate points or outsmart the other party.

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

Separate the People from the Problem

- Avoid personalizing statements or focusing on personality conflicts.
- Be soft on the people and hard on the problem.
- Be aware the other person may see the situation differently.
- Do not react to emotional outbursts; allow the other side to let off steam.
- Phrase ideas in terms you think will solve a problem, not in terms of what someone should do.

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



Answer the following question.

1) The difference between a position and an interest is:

Look for Options with Mutual Gain

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

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

Insist on Using Objective Criteria

Objective criteria are factual pieces of information, independent of the people involved in the problem or negotiation, which are relevant to what should or should not be agreed upon. Using objective criteria requires preparation.

- Turn the discussion into a rational one: apply logic; establish and verify facts; and hear new or existing information.
- Yield to principle, not pressure.

Example

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

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



Fill in the blank in the following statement.

- 1) When negotiating with management, separate the _____ from the problem.

Negotiation Styles

There are many ways to resolve a complaint. Each situation may require a different negotiation style, and some may involve multiple ones over time.

Review the appropriateness of your strategy and ask, “Is this the best method to resolve this problem with this person?” Negotiation styles include collaboration, competition, accommodation, compromise, and avoidance.



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

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



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

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

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

SOURCE: <http://www.mediate.com/articles/eilermanD5.cfm> and <http://www.dousguides.com/>. Accessed January 2015.

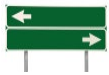


Accommodation

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

Use this style when the issue is something of minimal importance to the resident but important to the facility. This technique can backfire if the ombudsman uses it frequently as it can earn the reputation of “not standing your ground.” If residents feel their concerns are not acknowledged or their opinions are ignored, then the ombudsman may be too accommodating.

SOURCE: <http://www.dougsguides.com/>. Accessed January 2015.



Compromise

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

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

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

SOURCE: <http://www.dougsguides.com/>. Accessed January 2015.



Avoidance

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

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

SOURCES <http://www.dougsguides.com/>; [Thomas-Kilmann Conflict Mode Instrument](http://www.themyersbriggs.com/); <https://www.themyersbriggs.com/>. Accessed January 2015.

Potential Barriers to Resolving Conflict

Response to Authority Figures

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

Common Responses

Intimidation

Feeling intimidated by a person in authority is common. Sometimes the professional title, expertise, or social status associated with a person can lead to feeling intimidated about personal training or capabilities.

Anger or Fear

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

Avoidance

It is common for people to avoid directly confronting a problem. It can feel safer to avoid face-to-face communication to solve a problem, especially if an experience was negative.

Strategies to Work Effectively with Authority Figures

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

- Make an objective assessment of the person. Authority figures can be potential allies or opponents.
- Evaluate perceived prejudices, preferences, and decision-making patterns shown by authority figures. Study their personalities and adjust your

responses to communicate better. For example, knowing four personality types known by terms such as controller, promoter, feeler, and thinker, you can build better relationships. If they are thinkers, give them facts; if they are feelers, share personal stories. If they are controllers, show them respect for their authority; if they are promoters, talk about how a good outcome can positively affect their reputation.

- Know the lines of communication. If a person in authority makes an unfavorable decision, find out who has higher authority, appeal rights, or opportunities.
- Be aware of policies, guidelines, rules, regulations, and laws that govern the authority figure. Know which ones the person has authority to control.
- Use residents' rights and other laws when they apply. Laws are powerful tools that ombudsmen must know and use. Refer to nursing and assisted living facility rules cited in Chapter 11, *Supplement 11-F: State and Federal Regulations, Statutes, and Guidance* (p. 424).

Other Barriers to Resolving Conflict

Personal Values and Beliefs

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

Emotional Involvement

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

- Ask your supervising staff ombudsman for help or ask your staff ombudsman to take the case.

Friendly with Facility Staff

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

On Your Own – Video & Quiz –Long-Term Care Ombudsman Casework: Advocacy and Communication Skills – Brian Brashear

Link to video: https://youtu.be/-3cpAaXyU1c?si=XvaY_4zeFRc4Sw_G

Video length: Scene 2 - Brian Brashear, 13 minutes.

Instructions

Watch the video and answer the following questions. Be prepared to discuss your responses with your trainer.

Note: Some questions seek specific written examples from the video. It may be helpful to review the questions before watching the video to understand what you will be asked to identify.

- 1) Mr. Brashear's complaint reoccurred. In nursing and assisted living facilities, why do you think a complaint may reoccur?

- 2) Which of the following concerns did you hear Mr. Brashear express during the video scenario? Choose all that apply.

☐ He needs a bigger room to accommodate multiple visitors.

☐ Staff are unfriendly with his church friends.

☐ Staff told him his friends cannot visit him after 8 pm and that he can only have one visitor at a time.

___ The administrator told him he should consider moving and he is afraid the facility is discharging him.

___ The facility will not let his friends have tea or coffee.

___ The night nurse is ignoring him.

- 3) When talking to the administrator, Gloria used the PEP method. Choose the three terms below that create the PEP method acronym.

___ Point

___ Penalize

___ Evidence

___ Repeat Point

- 4) How did Gloria address Mr. Brashear's concerns in relation to his rights and the other residents' rights when speaking with Mr. Cook?

- 5) Explain why you think Gloria's method of working with Mr. Cook, the administrator, was or was not effective. Is there anything you may have done differently?

- 6) How did Gloria ensure her complaint investigation was resident directed while reminding Mr. Cook of the need for resident-directed care and quality of life?

- 7) Ombudsmen need to remain "calm, objective, and in control" always, especially when a situation has escalated. When speaking with Mr. Cook what techniques did Gloria use, both verbal and nonverbal, to maintain her professionalism and remain calm, but assertive.

___ Gloria kept her hands in her lap and looked relaxed.

___ Gloria was professional and courteous while directly stating Mr. Brashear's concerns.

____ Gloria leaned forward and raised her voice so that both Mr. Cook and Mr. Brashear knew she meant business.

____ Gloria was professional while stating Mr. Brashear's rights and her concerns with the facility's response.

____ Gloria ignored Mr. Cook's comment that he faces lots of challenges in running a nursing facility.

8) The administrator, Mr. Cook, told Gloria that he and his staff worry about Mr. Brashear's friends asking questions about his health and his care. How did Gloria respond to Mr. Cook's concern?

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

The Five-Step Problem-Solving Process

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

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

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

Ombudsmen use observation, interviews, and record review to collect facts or evidence during an investigation. See Chapter 9 for more information about investigation skills.

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



Answer the question below.

1) Resident-directed advocacy means the ombudsman should:

STEP 2: Consider underlying causes and determine scope of the problem.

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

Factors for ombudsmen to consider are:

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

Responsibility may rest with one or more of the following:

- Facility staff failed to perform their duties properly.
- Unclear regulations about the issue.
- Services cannot be reimbursed.
- Outside professionals gave unclear instructions.
- Resident or family contributed to the problem.

Example

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



Ombudsman Tip – Problem-Solving for Lasting Solutions

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

STEP 3: Explore ways to resolve and take action.

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

To identify possible solutions, ask yourself:

- What will resolve the problem?
- What will it take to keep the problem from reoccurring?
- What obstacles might be encountered with each solution?
- What are the resident's options regarding their medical and physical needs?

Sometimes there are several ways to resolve a problem. Options help ombudsmen be prepared with ideas for possible solutions, anticipate potential obstacles, and have suggestions ready to overcome obstacles to resolution.



Ombudsman Tip – Complaints Can Be Resolved in Several Ways

Sometimes, ombudsmen develop a solution and suggest it to all parties. At other times, they bring people together to discover the best solution. Complaints can be resolved in several ways.

Ombudsmen should try to find a solution that addresses the root cause and supports the resident's wishes.

Exploring Solutions

A resident complains, "I pay a lot to live here but I can't even get a baked potato for lunch." She asks the ombudsman for help.

Possible Solution: Changing Menu Options

Potential Obstacles:

- Cost or supply issues
- No other similar requests have been made
- Resident preferences have not determined menu decisions in the past

Suggestions to Overcome Obstacles:

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

Possible Solution: Updating the Resident's Food Preferences

Potential Obstacles:

- Dietary manager unavailable
- Dietary manager unwilling
- Decision making is delegated to a family member

Suggestions to Overcome Obstacles:

- Speak with manager with authority over dietary manager
- Educate on resident rights

Possible Solution: Changing Dietary Orders

Potential Obstacles:

- There is a medical reason that potatoes are not provided
- The resident has an order for mechanically softened foods

Suggestions to Overcome Obstacles:

- Facilitate communication between resident and dietary staff
- Explore options with physician or dietitian

Possible Solution: Staff Training

Potential Obstacles:

- Time lag to next training

- Not all staff in attendance
- Staff turnover

Suggestions to Overcome Obstacles:

- Request interim training, ongoing training, and training across all shifts



Exercise – Brainstorm Solutions

Instructions

Brainstorm possible solutions, potential obstacles, and suggestions to overcome obstacles below.

Ms. Garcia wants to stay up late at night. An evening charge nurse knows her preference and will accommodate her. This nurse does not work every night.

1) How can a lasting solution be reached?

a) Possible Solution: _____

b) Potential Obstacles: _____

c) Suggestion to Overcome Obstacles: _____

d) Possible Solution: _____

e) Potential Obstacles: _____

f) Suggestion to Overcome Obstacles: _____

Check with the Resident

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

- Share with the resident what the ombudsman learned;
- Be sure the resident wants you to continue trying to resolve the problem;
- Confirm the outcome the resident seeks;
- Discuss ideas regarding how to resolve the problem;
- Encourage the resident to participate in the resolution process;
- Discuss potential consequences to the resident, if any;

- Discuss possible outcomes; and
- Determine what will satisfy the resident.

Take Action

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



Fill in the blank in the statement below.

- 1) Before taking action to resolve a complaint, be sure you know what the _____ wants.

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

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

- Trust your gut.
- Call or email all parties the day before to confirm.



Ombudsman Tip – Meeting for Success

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

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

- Care planning to focus attention on resident needs, routines, strengths, and preferences.
- Resident and family councils.
- Laws and rules that support the resident, especially residents' rights.
- Regulatory agencies which oversee health care facilities and use investigations, citations, and penalties to enforce laws and rules.

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



Ombudsman Tip – Use Care Plan Meetings to Problem Solve

Individual care or service plans should be updated to meet a resident's needs. Ombudsmen can suggest a care or service plan meeting to resolve a variety of problems.

Other Resolution Strategies

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

These strategies might include:

- Legal services – advice, litigation.
- Courts – judgments, enforcement, recovery, damages.
- Elected officials – add, edit, or delete laws and rules.
- Local media – publicity, news, opinions.

STEP 4: Check on progress and outcomes.

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

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

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

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

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

STEP 5: Determine resident or complainant satisfaction with outcome.

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

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



Fill in the blank in the statement below.

1) Close a case when you have done all the _____ you can do.

Case Example - The Five-Step Problem-Solving Process

- Complainant – Mr. Smith, Administrator of Golden Oaks Retirement
- Resident - Mr. Flynn
- Complaint - Mr. Smith (administrator) tells you (ombudsman) that Mr. Flynn (resident) will not bathe, and he wears the same clothes every day. His body odor is unpleasant for his roommate, caregivers, and other residents. Mr. Smith says that the facility is concerned they cannot meet Mr. Flynn's needs. Mr. Smith, the administrator, agrees you can use his name and discuss his concerns with the resident, Mr. Flynn.

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

You consult with Mr. Flynn. Mr. Flynn acknowledges there is a problem and gives you permission to take action, talk to any staff necessary to resolve his problem, talk to his roommate, and to use his name and other identifying information. You open a case and begin to collect information.

Mr. Flynn tells you he prefers to wear overalls. The overalls he wears everyday fit well, but he does not trust the facility laundry to wash them because they lost or damaged several pairs in the past.

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

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

Statutory support for this case that is applicable:

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

STEP 2: Consider underlying causes and determine scope of the problem.

Issues Mr. Flynn shared with you:

- The bathing environment is unpleasant.
- He needs some new clothes that are clearly labeled.
- Laundry sorting process does not ensure residents get their laundry returned.

Things that need further exploration by you:

- Is Mr. Flynn embarrassed by some part of the bathing process?
- Do the bathing times match his preferences?
- Do the caregivers know or respect Mr. Flynn's bathing preferences?

- Do the caregivers need additional training?
- Scope: the problem primarily affects Mr. Flynn

STEP 3: Explore ways to resolve and take action.

Mr. Flynn identifies he wants to bathe in the afternoons and to have all the time he wants in the shower. He agrees to allow a CNA to check on him at regular intervals and to pull the call light when he is finished or if he needs help.

Mr. Flynn agrees to the purchase of new overalls and shirts of the same brand and size, using his trust fund. He will allow the activity director to label his clothing. Laundry bags will be used to distinguish his clothes.

You and Mr. Flynn meet with the social worker in Mr. Flynn's room. Mr. Flynn takes the lead with his requests. The social worker says the facility may need to set a limit on the shower time and Mr. Flynn agrees to 20 minutes.

The social worker confirms the nursing facility should replace any items lost in the laundry.

STEP 4: Check on progress and outcomes.

- The administrator brings Mr. Flynn his new clothes to approve.
- Mr. Flynn signs the receipts for the new overalls. He is satisfied.
- The overalls are clearly labeled with Mr. Flynn's name.

The first day of Mr. Flynn's requested scheduled bath is successful. He must persuade staff to allow him to bring his soiled clothes back to his room for the laundry, but this is also successful.

The social worker writes down a procedure for bathing with his input and gives him a copy. She places a copy in his medical records and updates his care plan. His direct caregivers are briefed on the procedures.

STEP 5: Determine resident or complainant satisfaction with outcome.

Mr. Flynn reports he is very satisfied with the outcome. If he encounters problems, he plans to speak with the social worker or administrator first, then the ombudsman if needed.



Exercise – Three Case Discussions

Case 1 Discussion: “Show Me the Money.”

Mrs. James’ sister, Ms. Martin, visits her often at the nursing facility where she resides. Ms. Martin contacts you (the ombudsman). According to the resident’s sister, Mrs. James lost several items of clothing recently. Ms. Martin said that at her last visit with Mrs. James, her sister was wearing clothes that did not belong to her. Mrs. James told her sister some clothes had been taken out of her dresser. Ms. Martin searched her sister’s room and didn’t find the clothing. She reports that housekeeping said they don’t have the items either. Ms. Martin tells you that she asked the administrator about this yesterday, and the administrator said, “Your sister is confused.”

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

Other residents report their funds are not accounted for. The administrator reports:

- Because of theft, resident personal needs allowance (PNA) is given on an as-needed basis.
- At admission, every resident signs a form authorizing the facility to administer funds for security purposes. For residents who have a diagnosis of dementia, a family member is asked to agree to this procedure by signing the form.

Step 1: Identify the problem and research statutory support.

Step 2: Consider causes and scope.

Step 3: Explore ways to resolve the problem(s) and take action.

The process continues in real cases...

- *Step 4: Check on progress and outcomes.*
- *Step 5: Determine satisfaction.*

Case 2 Discussion: “Discharge – Unable to Meet Needs”

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

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

Step 1: Identify the problem and research statutory support.

Step 2: Consider causes and scope.

Step 3: Explore ways to resolve and take action.

The process continues in real cases...

- *Step 4: Check on progress and outcomes.*
- *Step 5: Determine satisfaction.*

Case 3 Discussion: “No Appropriate Food Choices”

Jerry Smith lives in Happy Hills assisted living facility. He recently shared his concern about the facility’s lack of food choices appropriate for a person with diabetes. Mr. Smith states he inquired about appropriate meal options for diabetes before moving into Happy Hills. At that time, the executive director told Mr. Smith they always have two entrée choices at each meal and that he can choose the best option that serves his dietary needs.

Mr. Smith showed the monthly menu to you (the ombudsman). He highlighted the entrée choices which did not meet his dietary needs. Many lunches and dinners listed two high carbohydrate options such as chicken spaghetti and tuna noodle casserole. No sugar free desserts were indicated.

Mr. Smith said he recently told the executive director and the nurse about his dietary concerns. He shows you a copy of the facility disclosure statement which indicates no special diets are offered by his assisted living facility. He feels that meeting his needs requires a specialized diet and that the facility promised they would do so before he moved in. Mr. Smith and you review sections C and section D of Happy Hill Assisted Living Facility’s Texas HHS Form 3647 Assisted Living Disclosure Statement. The disclosure form indicates special diets are not offered.

Step 1: Identify the problem and research statutory support.

Step 2: Consider causes and scope.

Step 3: Explore ways to resolve and take action.

The process continues in real cases...

- *Step 4: Check on progress and outcomes.*
- *Step 5: Determine satisfaction.*

Supplement 10-A: Basic Guidelines for Ombudsman Documentation

Volunteer Ombudsmen document their monthly activities on HHS Form 8620, Long-Term Care Ombudsman Activity Report and may optionally use Form 8619 Long-Term Care Ombudsman Case Record to better capture casework information. Volunteers report monthly.

Staff Ombudsmen document cases in the statewide confidential database within 14 days of completing the activity or casework.

Documentation should:

- Describe consent obtained (to whom the ombudsman can speak, what information can be shared, and what actions the ombudsman may take).
 - If a resident is determined unable to consent, explain why. If an LAR provided consent, explain how the LAR's authority was verified.
- Indicate the date when each action was taken.
- Record documentation in chronological order.
- Use quotes when useful, especially to capture the speaker's attitude, opinions, or statements.
- Use each person's name and title or name and relationship to the resident, to identify the people involved. Avoid using "he," "she," or "they."
- Use objective language to describe behavior and observations.

Write with Clarity

A well-written complaint follows the basic rules of grammar, spelling, and punctuation. Proofread it, especially if it will be submitted to Complaint and Incident Intake (CII). Poor spelling and grammar can reflect carelessness on behalf of the writer and may generate doubt about the complaint's accuracy or the complainant's credibility.

General Rules about Acronyms

An ombudsman may use any acronym defined in the Initial Certification Training Manual or OPPM without defining the acronym first. Acronym lists are provided in both manuals for quick reference. Examples include OPPM (Ombudsman Policies and Procedures Manual), MLO (Managing Local Ombudsman), and SOM

(CMS State Operations Manual Appendix PP – Guidance to Surveyors for Long Term Care Facilities).

An ombudsman may establish an acronym other than the acronyms listed in these manuals if the ombudsman initially spells out the full word or words in the record. For example, in a case intake summary: "Beatrice Potter, Corporate Compliance Officer (CCO) called me about a problem with Medicaid application renewals for Health Seniors corporation. CCO said there is an issue."

In addition, because a case record establishes the ombudsman's initials as an abbreviation in each case, the ombudsman can use those initials to refer to themselves throughout a case record without having to separately establish their initials in a case record.

Stick to Facts - Be Specific and Organized

Facts explain who, what, when, where, and how. Describe facts without making assumptions about intentions, motivations, or emotions. Objective words describe behavior. Subjective words label behavior. For example, do not assign an emotion you assume a person exhibited. Instead, describe what you witnessed. Do not include commentary about your personal feelings or assumptions you have about why you think the problem exists.

Relevant Facts Organized and Itemized

List only facts relevant to the problem. Facts should be organized in a chronological and logical order. The organization of the facts should clearly communicate the sequential order of events to the reader.

Tips

- Answer the questions: who, what, where, when, and how. The answers should illustrate the situation, and, when applicable, describe the facility's noncompliance with a requirement.
- Provide dates and times for observations.
- Describe who and what was observed.
- Identify any record(s) reviewed and the date(s) on which they were reviewed.
- Provide the names and title of people interviewed, the dates interviews were conducted, and contact information.

Reminder About Submitting Complaints to CII

Prior to submitting a complaint to CII, the ombudsman must obtain consent from the resident. If the resident is unable to give consent, document the reason and state who provided consent and how their authority was verified.

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Chapter 11: Stay Connected and Report Ombudsman Work

Chapter 11 is about an ombudsman's communication with the Long-Term Care Ombudsman Program and ways volunteers, local program staff, and the state office stay connected.

Learning Objectives

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

Contents

- Stay Connected with the Ombudsman Program
- Consultations with Ombudsman Program Staff
- Report Ombudsman Work
- What is an Information and Assistance Activity?
- Casework
- Complaint Code Categories
- Perpetrator Roles and Codes
- Frequently Asked Questions – Complaint Codes
- Complaint Verification
- Referral Agency
- Disposition
- Close the Case
- Frequently Asked Questions – Casework Documentation
- Form 8620 – Activity Report

Video(s), Supplements, Forms

- YouTube Video: How to Obtain Consent (and the Importance of Documentation), Part 2
- Supplement 11-A – Ombudsman Complaint Codes
- Supplement 11-B – Complaint Codes and Descriptions
- Supplement 11-C – Exercise: Researching Statutory Support – Nursing Facilities Complaints
- Supplement 11-D – Exercise: Researching Statutory Support – Assisted Living Facilities Complaints
- Supplement 11-E – Training and Advocacy Resources
- Supplement 11-F – State and Federal Regulations, Statutes, and Guidance Used in Ombudsman Work

Stay Connected with the Ombudsman Program

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

Program communications are vital for effective advocacy. Ombudsmen stay connected in a variety of ways.

Consultations with Staff Ombudsmen*

Ombudsmen should never feel alone. Volunteers can call their supervising staff ombudsman for problem-solving ideas and for guidance about ombudsman procedures. Staff can contact their MLO or the State Office for guidance. Request a joint visit when needed.

*Consultation as referenced in this section is not reported as an “Information and Assistance” activity.

Joint Visit(s)

A staff ombudsman makes periodic visits with a volunteer. Joint visits allow ombudsmen to learn from one another. Take advantage of these visits to ask

questions, make observations, and exercise critical thinking skills while observing another ombudsman in action.

Continuing Education

In addition to training received for certification, every ombudsman must earn 18 hours of continuing education each year. Continuing education keeps ombudsmen informed of changes in the long-term care system and builds upon the foundation of initial training. Training in person with other ombudsmen is critical to staying connected.

Report Work

As a federally- and state-funded program, reporting is required. To maintain certification, a volunteer ombudsman must report their activities monthly. Staff ombudsmen report activities and cases as soon as possible and no later than 14 days after a reportable action is taken, in accordance with Sections 7050 and 7060 of the OPPM.

Date volunteer report is due: _____

Evaluation

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

Other

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



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Fill in the blanks in the following statements.

- 1) Every ombudsman is required to earn ____ hours of continuing education each year.

2) Staff ombudsmen report daily, and volunteers report _____.

Consultations with Ombudsman Program Staff

Consultations with staff ombudsmen or MLOs provide all ombudsmen the support they need while ensuring ombudsmen follow procedures to protect residents' rights and the integrity of the Ombudsman Program. In some circumstances, consultation is advised. At other times, it is required.

Consultation is encouraged for many situations, including when ombudsmen:

- Need information about possible resources.
- Are unsure about laws and rules that may apply to a problem.
- Have questions about ombudsman procedures.
- Feel stuck on a case or problem.
- Suspect facility staff are not taking a complaint seriously.



Ombudsmen must consult their supervising staff ombudsman or MLO when they:

- Feel uncomfortable helping a resident or have a personal belief that may interfere with their ability to assist a resident with a problem.
- Have a conflict of interest related to any person associated with the facility where they serve.
- Believe a person is interfering with an ombudsman's official duties.
- Are asked to disclose confidential information and consent from the resident, resident's LAR, or complainant cannot be obtained.
- Need the State Ombudsman's approval to take further action because it is suspected a resident's LAR is not acting in a resident's best interest.
- Do not have consent to report ANE but suspect other residents are at risk.
- Feel a serious risk to resident health and safety exists in the facility where the ombudsman serves.
- Are directed to consult with their supervising staff ombudsman as described in this training manual or in other written policies and procedures or other documents promulgated by the Office.



State Ombudsman Approval Required – Contact MLO

Contact the MLO to get state ombudsman approval to:

- Take further action in a case where the resident is unable to consent, and the ombudsman believes the resident's LAR may not be acting in the resident's best interest.
- Report ANE without resident consent.
- Remedy a conflict of interest.



Fill in the blanks in the following statements.

- 1) Consultations provide ombudsmen the support they need while ensuring they follow procedures to protect residents' rights and the _____ of the Ombudsman Program.
- 2) Consultation is required when ombudsmen are asked to disclose confidential _____ and _____ from the resident, resident's LAR, or complainant cannot be obtained.



On Your Own – Video – How to Obtain Consent and the Importance of Documentation, Part 2

Link to video: <https://youtu.be/9swvBWqj52M?si=IquKmIEIiwPuwkoB>

Video length: 2 minutes.

Report Ombudsman Work

It is important for ombudsmen to report ombudsman work since it builds a picture of what happens in long-term care facilities across Texas.

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

local programs to analyze and report work to meet federal and state requirements.

Volunteers report their work monthly using the Long-Term Care Ombudsman Activity Report (Form 8620). Starting with the first month of visiting residents in a facility as an ombudsman intern, volunteers fill out this report to describe activities completed on behalf of residents. Once an intern is certified, these reports are part of state and federal reporting of program work.

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

Ombudsman Reportable Activities

There are multiple activities ombudsmen conduct or may attend at their assigned facility. These activities are reported on the monthly activity report or, if staff, in the ombudsman database. Remember, certain ombudsman activities require an invitation prior to attending including care or service plan meetings, resident council, and family council meetings. Ombudsman reportable activities include the following:

- Facility visits, Facility visits for complaint only, Facility visits to a DAHS facility.
- Resident or family council attended.
- Care or service plans attended or attended for complaint resolution.
- Fair hearing or MCO appeals attended.
- Information and assistance to facilities (facility staff, owner).
- Information and assistance to individuals (anyone who is not facility staff or owner).
- Public education conducted.
- Survey participation.
- Systems advocacy.
- Training given to facility staff.

Volunteers report activities, including their facility visits, on their monthly activity report.

Staff ombudsmen, including MLOs, report their reportable activities in the ombudsman database within 14 days after completion, in accordance with OPPM Section 7060.



Ombudsman Tip – Ombudsman Program Reports

The State Ombudsman creates a report of program accomplishments for the Texas Legislature and Governor and reports annual program accomplishments. Reports are available on the Texas Long-Term Care Ombudsman Program website. Find a copy of these reports at: <https://ltco.texas.gov/reports>.

Report Information and Assistance Activities (I&A)

An I&A activity is conducted when an ombudsman provides information to an individual or facility staff or owner about issues impacting residents. To qualify as an I&A activity, the ombudsman must be providing information to someone (not receiving information). I&A topics include but are not limited to:

- Residents' rights
- How to pay for long-term care.
- Ombudsman role.
- How to access services or benefits.
- Care issues.
- Facility regulations.
- Finding a nursing or assisted living facility.

An I&A may be provided by telephone, written correspondence such as email, or in person. There are two types of I&A activities:

- 1) Information and assistance to an individual (residents and anyone who is not facility staff or a facility owner).
- 2) Information and assistance to facilities (facility staff, owners, operators).

Volunteers report I&A activities on their monthly activity report. Staff ombudsmen, including MLOs, report their I&A activities in the ombudsman

database within 14 days after completion of the I&A activity (OPPM Section 7060).

When reporting an I&A activity, the contact's name and role must be documented as well as the topic of the consultation. If you provide I&A to a facility staff person, document the staff's first and last name and title.

Examples

- Information and assistance to individual: Jose Alvarado, resident's son. Topic: How to pay for long-term care.
- Information and assistance to facilities: Administrator, Jay Fry. Topic: Residents' rights related to discharge notices.

Basic Principle of I&A Activities

Ombudsmen provide advice and expertise or resources to another person. The ombudsman does not reveal confidential information or take action to solve a problem.

Examples of I&A to Individuals

An ombudsman provides information:

- About the role of an ombudsman to a newly admitted resident.
- To a resident's family member about nursing or assisted living facility laws and regulations.
- About managed care to someone who called you and asked about long-term care Medicaid and Managed Care Organizations (MCOs).
- To a resident about the resident council.
- To a member of the public, who is not a facility staff person, about resources or services outside the scope of the Ombudsman Program.

Examples of I&A to Facilities

An ombudsman provides information:

- About laws and regulations, survey protocols, or provider letters to a facility staff person.
- On how to promote residents' rights, individual choice, and resident-centered care to a facility administrator.

- On the interpretation of laws and regulations governing nursing or assisted living facilities to a staff person at a corporate office.

SOURCE: The National Long-Term Care Ombudsman Resource Center (NORC). National Ombudsman Reporting System (NORS) Training Part I. <https://ltcombudsman.org>; OPPM Chapter 900. Accessed 11/24/2020.

Report Casework

Volunteers report casework on their monthly activity report. Staff ombudsmen, including MLOs, must create a record, in accordance with OPPM Section 7050, in the ombudsman database regarding the investigation of a complaint within 14 days after receipt of the complaint.

Components of a Case

A case must have at least one complaint and is comprised of the following components:

- Date case was opened (also referred to as date received, intake date).
- Date first action was taken.
- Complainant name & role.
- Name of resident.
- Documentation of whether consent was obtained and for what it was given.
- Documentation of whether the resident or other complainant requests anonymity.
- Intake summary; one or more complaints.
- Best complaint code for each complaint.
- Name of nursing or assisted living facility.
- Documentation of whether each complaint was verified or not.
- Information regarding whether a complaint was referred to another agency.
- Alleged perpetrator if the complaint involved an allegation of ANE.
- A brief description of actions taken to resolve the complaint.
- Disposition code for each complaint.
- Date each complaint was closed.
- Date case was closed (all complaints are closed within a case).

SOURCE: NORC. NORS Training Part I. <https://ltcombudsman.org>. Accessed 11/24/2020.

Date Received / Date Opened

This is the date the ombudsman received or identified the complaint by telephone, email, mail, fax, or in person.

First Action Date

The date on which the first action is taken to investigate the complaint by the ombudsman. For more information, review OPPM Section 730(d).

Complainant Name

A complainant is the person who contacts the ombudsman and requests complaint investigation services regarding one or more complaints. When ombudsmen report their casework, they identify the complainant role for each case. When the resident is not the complainant, the resident's name, who is the subject of the complaint, must also be identified in the case record.

Complainant Role

When ombudsmen report complainants name, they assign one of the following complainant roles.

- Facility staff
- Ombudsman staff or volunteer
- Other person – neighbor, family of another resident, religious counselor
- Representative of medical or social service agency / program
- Resident
- Resident or family council
- Resident representative, friend, family
- Unknown

Complaint

A complaint is an expression of dissatisfaction brought to, or initiated by, the Ombudsman Program which requires ombudsman investigation and resolution on behalf of one or more residents of a long-term care facility.

Identify Complainants and the Number of Complaints Received

Example 1

A woman calls and relays specific concerns regarding her mother's care and care plan. She states she witnessed lengthy call light response times, and her mother is unhappy with her current shower schedule. The resident's daughter, Ima Family, asks the ombudsman for help, gave consent to use her name, and to discuss her concern with anyone, including her mother or staff. The ombudsman explained the program's requirement to get her mother's consent to help.

The ombudsman visited the resident during his next facility visit. He discussed the problems reported to him with the resident. He listened to the resident's perspective, and she described how she and her daughter had previously attempted to resolve the problems. He asked the resident what she wanted.

The resident said staff frequently take over 30 minutes to respond to her call light and sometimes she urgently needs to use the restroom. Staff wake her up at 6:00 a.m. on her shower days and she does not like this shower schedule. The resident gave the ombudsman consent to help, use her name, discuss her concerns, review her care plan and other records as needed, and to talk to staff on her behalf. She does not want to participate in resolving her concerns.

- 1) Complainant: Ima Family
- 2) Complainant Role: Resident representative, friend, family
- 3) Number of Complaints: 2 complaints (call light response times and shower schedule)
- 4) Was consent obtained? ☒ Yes ☐ No ☐ Not required.
- 5) From whom? Select all that apply.
 - ☒ Resident
 - ☒ Complainant (Daughter)
 - ☐ Resident's LAR
 - ☐ Consent Not Required

Example 2

During a facility visit, two residents told the ombudsman they would like to have water available, but staff do not bring it when asked. They are afraid to ask again and said it must be an oversight because staff are always rushed. They do not want to complain anymore. As the ombudsman continued her visit, the ombudsman observed eight residents who cannot get out of bed and did not have water at their bedside tables. Some of the residents could not communicate with her. She did not observe any staff filling containers or distributing water while she was visiting. Before speaking to the charge nurse, the ombudsman let the two residents who did not want to complain know she was investigating the issue because a significant number of residents are affected. She explains she will not identify them. The ombudsman addresses the issue with the charge nurse without identifying any residents.

- 1) Complainant: Ombudsman
- 2) Complainant Role: Ombudsman Program / the ombudsman
- 3) Number of Complaints: 1 complaint - no water / hydration
- 4) Was consent obtained? ___ Yes ___ No X Consent Not Required (A substantial number of residents are affected.)

Example 3

Yesterday, the ombudsman received five notices (letters) of resident involuntary discharge from four different nursing facilities. The facilities were complying with the federal requirement to send copies of these notices to the Ombudsman Program and each notice contained all required elements.

The Ombudsman Program is not yet actively involved in investigating and working to resolve the discharges since no residents or resident representatives asked for advice or assistance. The Ombudsman Program received the notices as required. Nursing facilities are required to send copies of involuntary discharge notices to the Ombudsman Program.

Receipt of these notices is neither a case nor an I&A activity. To report a case related to the discharge notices, the ombudsman must obtain consent and take an action.

If the resident or their representative asks the ombudsman for information or suggestions on how to proceed with the discharge or with an appeal, without ombudsman help, this would be reported as an I&A activity.

If the resident or their representative asks the ombudsman to investigate, identify options, and help them either stay in the facility or find another solution, it would be a case with one complaint, or more if other problems are identified.

NOTE: It is important for staff to read each discharge notice to determine if any errors exist. When discharge notices do not include all required elements, ombudsmen contact residents to see if they need ombudsman assistance.



Exercise - Is it a case or an I&A activity?

Instructions

For each scenario, indicate the following:

- 1) Is it a case, an I&A activity, or neither?
- 2) If it is a case, how many complaints are there?
- 3) If it is a case, who is the complainant?

NOTE: For cases, assume you have the consent of the complainant. If the complainant is not the resident, assume you have the resident's (or resident's LAR if applicable) consent.

Tips:

- A case must have one or more complaints.
- Complaints must be made by, or on behalf of, one or more residents.
- Complaints must be related to the health, safety, welfare, or rights of residents.
- Complaints require ombudsmen to follow OPPM consent requirements.
- Complaints require investigation and other actions by the ombudsman.

Example

You visit Mrs. Jones during your facility visit. Mrs. Jones tells you staff still bring her pureed food even though her doctor said she could start eating regular food. You notice the resident's call bell is broken. Mrs. Jones requests your

assistance in resolving these problems. You spoke to the Director of Nursing (DON) about the call bell, and she promptly fixed the bell. You attempted to talk to the dietician about the pureed food, but she is not available until the next morning. You tell Mrs. Jones that you will check back with the dietician and agree to follow-up with her on the results.

- 1) Is this a case, an I&A activity, or neither? Case
- 2) If this is a case: How many complaints are there? 2 (pureed food, call light)
- 3) What is the complainant role? Resident – Mrs. Jones

Answer the questions that follow each of the scenarios.

- 1) A certified nurse aide (CNA) approaches you about the new Director of Nursing (DON). She says that the DON does not listen to staff and is very patronizing when she gives instructions. Staff do not like working with the DON, several of them are looking for jobs somewhere else. She asks you to intervene with management on behalf of the staff.
 - a) Is this a case, an I&A activity, or neither? _____
 - b) If this is a case: How many complaints are there? _____
 - c) What is the complainant role? _____
- 2) A facility staff person tells you that Mrs. Smith's son, who is the agent named in his mother's power of attorney, is verbally abusing Mrs. Smith, using her income for his own purposes, and has not paid her bill for three months. The staff person requests your involvement.
 - a) Is this a case, an I&A activity, or neither? _____
 - b) If this is a case: How many complaints are there? _____
 - c) What is the complainant role? _____
- 3) Mr. Brown's daughter, Alice, calls you concerned that her father is eating all his meals in his room instead of in the dining room. She says she is her father's guardian of the person and estate; she emails you a copy of Mr. Brown's guardianship papers. You visit Mr. Brown, who is unable to express his wishes. Per guidance given to you from Alice, you speak with the Director of Nursing (DON) about Alice's concern. The DON says staff should be taking Mr. Brown to the dining room and that she will discuss the problem with two new CNAs assigned to Mr. Brown. She put a note in Mr. Brown's chart. The

following week you call Alice. Alice says the CNAs are taking her father to the dining room now and he appears much happier.

- a. Is this a case, an I&A activity, or neither? _____
- b. If this is a case: How many complaints are there? _____
- c. What is the complainant role? _____

4) Ms. Miller, a resident of Sunny Valley Assisted Living Facility, stops you in the hall and tells you she has a problem: her son, who lives at home, has just lost his Medicaid benefits and she is concerned he will not be able to pay for his medication. As she rolls away in her wheelchair, you notice that the wheelchair keeps veering to the left and hitting the wall. You ask if she would like your assistance in getting it fixed, or in getting a new chair. She replies, "Yes."

- a. Is this a case, an I&A activity, or neither? _____
- b. If this is a case: How many complaints are there? _____
- c. What is the complainant role? _____

5) A facility administrator calls you to complain that the volunteer ombudsman assigned to his facility is not doing her job. He explains that he informed her about a problem the facility was having with a resident's behavior, but she refused to address the facility's concern. Instead, she visited privately with the resident and refused to tell the administrator or the corporate regional manager about her visit.

- a. Is this a case, an I&A activity, or neither? _____
- b. If this is a case: How many complaints are there? _____
- c. What is the complainant role? _____

6) Resident Sara Lee's daughter, Ms. Pam Child, called you to complain that her mother would like to take a bath more often than once a week. You go to Hilltop Haven to visit the resident, Mrs. Lee.

On your way to Mrs. Lee's room, you notice there is dirty laundry on the floor in the hall and that the hall is dark because several lights are not working. When you visit Mrs. Lee, she says her daughter is correct and that she wants to have a bath more often than once a week.

After you visit Mrs. Lee, you visit Mrs. James, another resident. She tells you that they stopped her physical therapy (PT), and she does not know why. She complains that the sliding track for the privacy curtain is broken, so it does not close all the way. She also tells you that she just received a notice from the facility saying that she will have to switch to the facility pharmacy even though it may cost more than the pharmacy she has been using for the past three years.

- a. How many total complaints did you receive? _____
- b. Identify the complainants' names and roles. Identify the number of complaints per complainant.

Complainant Name / Role: _____/_____

Number of Complaints: ____

Complainant Name / Role: _____/_____

Number of Complaints: ____

Complainant Name / Role: _____/_____

Number of Complaints: ____

Complainant Name / Role: _____/_____

Number of Complaints: ____

SOURCE: NORC. NORS Training Part I Case, Complaint, Complainant and I&A.
https://ltcombudsman.org/uploads/files/support/NORS_Training_Part_I_Quiz_2021.pdf

Complaint Code Categories

The next step in reporting ombudsman work is to get familiar with complaint categories and codes. A list of codes is provided in this chapter and is followed by a list with detailed descriptions of each. *Supplement 11-B - Complaint Codes and Descriptions* begins on page 399. To categorize each complaint, codes are organized into separate headings.

Major Categories of Complaints

A Codes – Willful mistreatment of residents. Headings include:

- Abuse, Gross Neglect, Exploitation

B – J Codes - Complaints against the facility. Headings include:

- Access to Information
- Admission, Transfer, Discharge, Eviction
- Autonomy, Choice, Rights
- Financial, Property
- Care Arranged by the Facility, Including PASRR Services
- Activities, Community Integration and Social Services
- Dietary
- Environmental
- Facility Policies, Procedures and Practices

K - L Codes - Complaints that are not against the facility. Headings include:

- Complaints about an Outside Agency (Non-facility)
- System: others (non-facility)



Exercise - Find the Best Complaint Code

Instructions

Use **Supplement 11-B - Complaint Codes and Descriptions** found at the back of this chapter (starts on page 399) to assign the best code to describe a complaint. This supplement provides a detailed description of each complaint code.

Complaint categories are identified in the exercise to help you locate the correct complaint code.

Example

An ombudsman observed a resident with fingernails and hair that appeared dirty. From the Complaint Codes and Descriptions, the following complaint category and code are selected.

- The best complaint category is “F – Care.”
- The best complaint code is F05 Personal hygiene, including teeth.

Category C. Admission, Transfer, Discharge, Eviction

- ____ 1. A nursing facility forces a resident to change rooms and roommates without telling her in advance.

- _____ 2. An assisted living facility dropped off a resident at the local emergency room (ER); the ER could find no acute medical illness and wanted the resident to return to the facility. Staff at the resident's assisted living facility told the hospital they must find another facility for the resident and refuses to pick up the resident.
- _____ 3. A nursing facility sent a resident to another nursing facility while she awaited her discharge appeal hearing.
- _____ 4. An assisted living facility told a resident she needs to move out immediately since her daughter is unhappy with the facility and filed a complaint with CII (Regulatory Services, Complaint and Incident Intake).

Category D. Autonomy, Choice, Rights

- _____ 5. The assistant administrator of an assisted living facility threatened a resident with discharge from the facility if he brought concerns to the ombudsman's attention.
- _____ 6. Staff give residents showers in the shower room without the curtains being drawn while other residents are brought in and out of the room.
- _____ 7. Staff do not knock on residents' doors before entering their rooms, including closed doors.
- _____ 8. A resident continues to tell the staff that he does not want to take a shower, but they say that he is required to shower at least once a week.
- _____ 9. Residents are not allowed to smoke after 5:00 pm because a staff member is not available to monitor them on the front porch.
- _____ 10. Residents made several reports to the nursing facility administrator that there are ants in residents' bedrooms, but nothing appears to have been done about it. They are unhappy that the administrator is unresponsive.
- _____ 11. An assisted living facility tells a resident's friends they are a bad influence and cannot visit the resident again in the facility. Staff tell the resident that he cannot meet those friends outside of the facility.

Category E. Financial, Property

- _____ 12. The facility will not give a resident his personal needs allowance when he wants some money because they say he spends it all in the first week of the month.
- _____ 13. The assisted living facility manager informed a resident that the cost for care will increase, but he did not provide written information as to how much and when the new charges will take effect.

Category F. Care

- _____ 14. Several male residents are observed to be unshaven, female residents have long facial hair, and numerous residents have dirty, jagged fingernails.
- _____ 15. Nursing assistants do not help a resident walk with a walker four times a day as directed in the care plan, based on the physician's order.
- _____ 16. A resident has two bruises on the side of her face, but the nursing staff do not seem to know what caused them.
- _____ 17. Staff do not respond to residents' call lights unless they yell for help.
- _____ 18. The assisted living facility did not keep track of when medications were administered to the resident and the resident believes that he is not receiving all his medications as prescribed by his physician.
- _____ 19. The nursing facility always smells like urine and family members have complained to the Ombudsman that their relatives are often found to be in a urine-soaked incontinence brief.
- _____ 20. A resident has not been able to straighten out his legs ever since the nursing facility staff stopped assisting him into his wheelchair each day.
- _____ 21. A section of the nursing facility's wall-mounted handrails is missing from the hallway near the dining room.
- _____ 22. The ombudsman observed the caregiver going from room to room to provide personal care without washing her hands in between care and not changing her gloves.

Category G. Activities, Community Integration, and Social Services

- _____ 23. A group of residents complain the assisted living facility staff will take residents to medical appointments but will not provide or arrange for transportation to church or other community events, unless it is an activity for the whole group.
- _____ 24. A resident complains that there is nothing to do at the facility except play Bingo; he has talked to the Activity Director (AD) about offering other activities, but the AD is not following through.
- _____ 25. A resident's daughter died. The resident asks the Ombudsman to help him because the social worker refused to assist the resident to arrange a time and a room to meet with his family.

Category H. Dietary

- _____ 26. Several residents are observed in the dining room not being assisted with opening their food packaging, cutting their food, and seasoning their food.
- _____ 27. Residents report that they do not get snacks on the weekends and that they feel hungry between meals. Several ask the ombudsman for help.

Category I. Environment

- _____ 28. Several residents voiced concerns about staff smoking cigarettes in the nearby breakroom because the smell drifts into their rooms. They want to move to a different part of the facility.
- _____ 29. Flies are present in the facility because the back door to the laundry room is always propped open and there is no screen door.
- _____ 30. The main entrance has steps up to the porch and does not have a wheelchair ramp.
- _____ 31. There is no soap or toilet paper in the public bathrooms because the assisted living facility wants to control the number of supplies used.

Category J. Facility Policies, Procedures, and Practices

- _____ 32. Residents cannot go to bed when requested because the staff is busy assisting other residents.
- _____ 33. An assisted living facility's electricity has been cut off due to unpaid bills.

Category K. Complaints About an Outside Agency (non-facility)

- _____ 34. Families are upset and call the ombudsman to ask for help because the Medicaid agency deemed multiple residents are ineligible for Medicaid after incorrectly calculating part of their Veteran's pension in their monthly income.
- _____ 35. A veteran wants to change his assigned VA social worker because the social worker seems to side with the facility rather than him.

Category L. System: Others (non-facility)

- _____ 36. A nursing facility resident would like to revoke the guardianship ordered during his illness and asked the ombudsman for help.
- _____ 37. A nursing facility resident wants to move into his own apartment. He complains that the agency worker who met with him said that the services he needs would not be available. There is a long waiting list for those services.

Perpetrator Roles & Codes

When reporting a case where allegations of ANE are made, identify the role of the alleged perpetrator. The perpetrator is the person who is alleged to be the cause of the ANE. There can be multiple perpetrators for each complaint. Perpetrator roles are assigned a code for reporting purposes.

If a complaint is coded using the "A codes" (for complaints of ANE), identify the alleged perpetrator's role using the codes below.

Perpetrator Codes for Role

- 01 - Facility staff
- 02 - Another resident
- 03 - Family, Resident representative, friend
- 99 - Other



Exercise – Complaint Codes and Alleged Perpetrator Role Codes

Instructions

In 38-40, assign the best complaint code and assign an alleged perpetrator code to each statement. The first one is completed for you.

A. Abuse, Neglect, and Exploitation

38. A nursing facility resident reports to the ombudsman that his niece is making withdrawals of unusual amounts of funds that are not routine from his bank account. He requests ombudsman assistance.

Complaint Code: A-4 Financial exploitation

Perpetrator: Family, resident representative, friend Code: 03

39. A resident complains that resident Jeff Jay hit her on the head because she did not move out of the way fast enough for him. The resident requests ombudsman assistance.

Complaint Code: _____

Perpetrator: _____ Code: ____

40. A resident tells the ombudsman that staff took her photo when she was in the bathroom and said they would post it online if she doesn't quit pushing her call light button. The resident requests ombudsman assistance.

Complaint Code: _____

Perpetrator: _____ Code: ____

SOURCE: NORC, NORS Training Part II, Complaint Coding Quiz, Accessed May 2020.
https://ltcombudsman.org/uploads/files/support/NORS_Training_Part_II_Quiz_2021.pdf

Frequently Asked Questions - Complaint Codes

Question: When a complainant has two complaints that fall under that same complaint code, do I record the code once or twice?

Answer: *Record one complaint and work to resolve all issues raised: If a complainant has two complaints that fall under one code, such as*

code I-05 Housekeeping, Laundry and Pest Abatement, the ombudsman lists one complaint and one complaint code (I-05).

Question: If there is complaint that could be documented under two or more different complaint codes, do I choose one or code it under more than one code?

Answer: *Record one complaint and select the best complaint code. A complaint should not be assigned more than one complaint code.*

Question: When do you assign complaint codes? For example, when a family member contacts the ombudsman with a concern and requests action or is it coded after the ombudsman speaks with the resident and receives their consent to investigate the issue?

Answer: *Assign complaint code(s) upon receipt of the complaint based on the problem or problems initially identified by the complainant.*

For the example, this means the complaint the family member contacted the ombudsman about is the complaint reported and code assignment corresponds to the complaint. The ombudsman assigns complaint codes immediately based on the concerns shared by the family member.

If, when the ombudsman visits the resident for consent to take further action, the resident agrees with those concerns and gives the ombudsman consent, then the ombudsman leaves the family member as the complainant and works to resolve those complaints following resident's guidance.

If, when the ombudsman visits the resident for consent to take further action, the resident shares additional concerns, the ombudsman opens another case with the resident as the complainant and assigns complaint codes for the resident's additional concerns.

If the resident does not agree with the family member and asks the ombudsman not to proceed, the ombudsman closes the case as withdrawn or no action needed. The program still had a complaint, and it might be legitimate, but to honor the resident's direction did not act.

Complaint Verification

Ombudsmen always attempt to verify complaints, but they work to resolve a complaint whether it is verified or not. Each complaint must have a verification status, verified, or not verified.

Verified

A verified complaint means that most or all facts alleged by the complainant are found to be true (mostly accurate). A complaint is verified if the ombudsman finds that the problem, condition, or incident existed or has taken place.

Verification of Complaints of a Subjective Nature

Resident perception is a sufficient basis upon which to verify a complaint of a subjective nature. Here are two examples of complaints of a subjective nature:

- The food is poorly seasoned.
- Staff are mean to me.

Not Verified

A complaint is marked as “not verified” if most facts alleged by the complainant are found to be inaccurate or not enough evidence was found to demonstrate the condition or incident occurred.

Some complaints cannot be verified but still must be investigated. In such instances, the ombudsman cannot get enough information to prove that the condition or incident occurred, but the ombudsman also cannot determine that it did not occur.

Not verifying a complaint does not mean the ombudsman questions the sincerity or truthfulness of the complainant.

Process to Verify a Complaint

Take one or more of the following steps to verify a complaint:

- Research relevant laws, rules, regulations, and policies.
- Interview the resident or complainant.
- Interview staff, administration, other residents, and families.

- Observe the environment. Do not search a resident's body or room for evidence; however, if a resident or others willingly present evidence to you, document your observation.
- Identify relevant agencies and interview staff.
- Examine relevant records, if required.
- Refer the complaint to a more appropriate agency for investigation. Suspend the investigation if continuation could hinder investigation by the other agency.
- Consult with your supervisor.

Example of a Verified Complaint

A resident's son complains his father is unable to dine in the dining room because there are not enough chairs. He eats his meals in his room. You visit the resident who confirms this and gives the ombudsman consent to help. The ombudsman observes a meal service and determines there are no spare chairs. The ombudsman and resident speak to the administrator together. They find out there are plenty of dining chairs in storage. The administrator has staff move several chairs to the dining room. The resident starts having meals in the dining room. He is very pleased with the outcome.

Example of a Verified Complaint of a Subjective Nature

A resident complains that staff are disrespectful to her. The ombudsman does not need to independently observe staff acting disrespectfully to identify the complaint as "verified." However, an ombudsman must seek objective verification of the complaint whenever possible. In this example, an ombudsman may talk to other residents to see if anyone encountered disrespectful staff and may observe the staff person's interactions with other residents.

Example of a Complaint that is Not Verified

A nursing facility resident complains the facility is keeping her money. "They're ripping me off," she states. With consent, the ombudsman talks with the business office manager (BOM) who says the resident asked to have her own phone. The resident agreed to pay for the phone out of her Personal Needs Allowance (PNA). The BOM says the resident uses the balance of her PNA to have her hair done and purchase personal items. The facility provides sufficient documentation of these agreements and the facility's actions. In this example,

the alleged facts in the complaint are inaccurate; therefore, the complaint is not verified.

Referral Agency

A referral agency is the agency or agencies to which a complaint was referred as part of the plan of action for complaint resolution. If there was no referral made to another agency; use code "no referral was made." You may have more than one referral agency for a complaint.

Referral Agency Codes

- 01 – Licensing, regulatory, or certification agency (Regulatory Services)
- 02 – Adult protective services
- 03 – Law enforcement or prosecutor (Includes Office of Attorney General or the Medicaid Fraud Control Unit)
- 04 – Protection and advocacy (Disability Rights Texas)
- 05 – Legal services (Non-profit legal services organization)
- 06 – No referral was made
- 99 – Other

Disposition

A disposition is the final resolution or outcome of the complaint. When all work on a complaint is done, assign a disposition code. Check back with the resident to find out if the problem is solved and to determine the resident's perspective on the resolution.

A case remains open until all complaints within the case are closed. Do not assign a disposition code to a complaint while it is under investigation.

Principles of Assigning a Disposition Code

- A disposition code is required for each complaint, whether the complaint is verified.
- Each complaint has one disposition code. Choose the best one.
- When choosing a disposition code, always follow the direction of the resident. If the resident cannot communicate their satisfaction, the ombudsman may look to the resident's representative or to the complainant to determine if the resolution is consistent with the rights

and interests of the resident. If the ombudsman is the complainant and there is no resident or LAR related to the complaint, the ombudsman makes the determination of whether the case was resolved, not resolved, or withdrawn.

Disposition Codes

- 01 - Partially or fully resolved
- 02 - Withdrawn or no action needed
- 03 - Not resolved

Disposition Descriptions and Examples

01 – Partially or Fully Resolved

The disposition code of “partially or fully resolved to the satisfaction of the resident, resident representative, or complainant” is documented if the complaint is partially or fully resolved as determined by the resident, resident’s LAR, or complainant.

Example

An ombudsman receives a complaint from a resident that the LTC facility had not returned the resident’s clothing after it was collected to be laundered. With consent from the resident, the ombudsman investigates the complaint and speaks with the owner of the ALF about the unreturned clothing.

The owner explained that facility’s washing machine was broken, and the resident’s clothes were taken to a laundromat and would be returned to the resident that evening. The ALF owner further explains that a new washing machine would be installed in the facility the next day.

After being informed of the owner’s response by the ombudsman, the resident indicates that she is satisfied with the actions taken by the ALF. Further, the resident contacts the ombudsman that evening to inform him that she received her laundered clothes and that she is satisfied with the result of the ombudsman’s investigation.

The ombudsman documents the disposition code of “partially or fully resolved to the satisfaction of the resident, resident representative, or complainant.”

02 - Withdrawn or No Action Needed

The disposition code of “withdrawn or no action needed by the resident, resident representative, or complainant” is documented if:

- The resident who is the subject of the complaint or the resident’s LAR declines consent for the ombudsman to investigate the complaint;
- The complaint is withdrawn by the resident or complainant; or
- The resident died before the final outcome of the complaint investigation and the ombudsman determines that further investigation would not benefit other residents.

Example

A resident’s husband calls the ombudsman and says the facility is not providing his wife with adequate medication to relieve her anxiety. The ombudsman visits the resident and determines that she is able to consent. The resident explains that she does not have anxiety and does not need medication. The resident declines consent for the ombudsman to investigate the complaint.

The ombudsman documents the disposition code “withdrawn or no action needed by the resident, resident representative, or complainant.”

03 - Not Resolved

The disposition code of “not resolved” is documented if the problem identified in the complaint was not addressed to the satisfaction of the resident, resident’s LAR, or complainant.

Complaint Resolution Is Not Always Clear-Cut

Sometimes a complaint cannot be resolved even with thorough investigation, unquestionable verification, and wise and persistent efforts by the ombudsman. Sometimes:

- A problem may go away and then reappear.
- Part(s) of the problem will be resolved but not others.
- The complainant will not be completely convinced the situation is as good as it should be.
- The complainant may say everything has been solved even if the ombudsman would prefer to continue pursuing the matter.

Example

A resident tells the ombudsman that she wants to move in with her son. After contacting the resident's son, the son tells the ombudsman that he is unable to care for his mother and does not want her to live with him. The ombudsman explains to the son that his mother may be able to receive home health care assistance in the son's home. The son continues to state that he does not want his mother to live with him.

The ombudsman asks the resident if she would be interested in moving to another place in the community. The resident states that she is only interested in living with her son. The ombudsman determines that further complaint investigation by the ombudsman is unlikely to produce resident satisfaction and explains this to the resident. The ombudsman documents the disposition code "not resolved" to the satisfaction of the resident, resident's LAR, or complainant.

Close the Case

For each complaint in a case, an ombudsman must determine if all reasonable attempts to resolve the complaint have been made.

A case is closed when none of the complaints within the case require any further action on the part of the ombudsman and every complaint has been assigned the appropriate disposition code.

There is one "date closed" per case. Each complaint within a case may have different closed dates.

Example

During a facility visit on June 25th, nursing facility resident, Mrs. Q., complains the facility is keeping her money. "They're ripping me off," she states emphatically. With resident consent, you talk with the business office manager (BOM). The BOM tells you the resident asked to have her own phone. The resident agreed to pay for the phone out of her Personal Needs Allowance (PNA) and the BOM has the documentation to support this agreement. The BOM says, "The resident uses the balance of her PNA to have her hair done and purchase personal items."

You report back to the resident on July 1st. The resident forgot she was paying for her phone out of her PNA. She is glad you straightened things out. She likes

having the phone because she can stay connected with her children and her friends. The resident states, "I am very satisfied with the help you provided."

- 1) Date received? June 25
- 2) First Action Date: June 25
- 3) Who is the complainant? Mrs. Q, resident.
- 4) What is the referral code? 06 – No referral was made
- 5) Can this case be closed? X Yes
- 6) What is the closed date? July 1st
- 7) The case disposition is 01 – Partially / Fully resolved.
- 8) The case can be closed because there is nothing more for the ombudsman to do.
- 9) The resident expressed satisfaction.
- 10) No referral to another agency was necessary.

Frequently Asked Questions - Casework Documentation

Question: When should the ombudsman be the complainant?

Answer: The most common example is when an ombudsman makes general observations about the facility environment that need attention and it affects several or all residents. The problems identified may include circumstances where residents agree with the problem and want it addressed but do not want to be the complainant of record.

Also, the ombudsman may be the complainant when a resident needs assistance but is unable to communicate informed consent and has no resident representative available.

Question: The ombudsman receives a complaint from someone other than the resident. Upon an initial investigation, the ombudsman speaks to the resident who does not agree with the complaints and does not want assistance from the ombudsman. Is this a case?

Answer: Yes, this is a complaint, and it must be reported. See the next question and answer for more explanation.

Question: After speaking with the resident, the ombudsman determines the resident does not want assistance with complaints made on his behalf. What disposition code should be used?

Answer: *The ombudsman selects complaint disposition code "02 – no action needed or withdrawn" since the resident did not want ombudsman assistance.*

Question: How do I determine the disposition code if the resident dies during the investigation?

Answer: *Ombudsmen determine complaint disposition in the following order: the resident, the resident representative, complainant, the ombudsman. At the time of the resident's death, consider if progress was made that meets the disposition of partially resolved or not resolved.*

Question: When a nursing facility sends the local ombudsman program copies of resident discharge notices, should the program open a case at the time of receipt of the notice?

Answer: *No. The nursing facility is not asking the Ombudsman Program to establish a case and investigate. At the point of receipt of the notice, there is no complainant for which to establish a case.*

Discharge notices sent to the local program are Ombudsman Program records and must be retained according to the OPPM.

Question: If the ombudsman contacts a resident to follow up about the discharge notice received, is this a case?

Answer: *It depends on the actions taken by the ombudsman. The ombudsman opens a case if the resident requests and consents to ombudsman assistance. The ombudsman documents an I&A activity if the resident does not want further assistance but asks the ombudsman to explain the notice and related rights.*

Question: What is the first action date?

Answer: *The date on which the first action is taken to investigate the complaint. For example, a caller leaves a voicemail for you*

expressing a concern. The first action date is the date you return the phone call.

SOURCE: The National Long-Term Care Ombudsman Resource Center, NORS FAQs, September 2023. Accessed 11-1-2023 from, https://ltcombudsman.org/uploads/files/support/NORS_FAQs_2021.pdf



Exercise - Practice Reporting Casework

Instructions

For each scenario, indicate the following:

- 1) Date Received (Also called Date Opened or Intake Date) - the date the ombudsman receives the complaint;
- 2) The first action date (the date the first action is taken to investigate the complaint);
- 3) The complainant in the case (for example, "resident," and the complainant code);
- 4) The complaint code(s);
- 5) Whether the complaint(s) is verified or not verified;
- 6) Whether the case can be closed or not;
- 7) The disposition;
- 8) The referral agency – if a referral was made; and
- 9) The date the complaint is closed.

Example

Mrs. Green's son calls you on August 1st of this year and you have a 15-minute conversation. The resident's son, John Green, tells you the nursing facility refuses to take his mother to the dining room for meals. You explain your requirement to discuss the complaint with the resident and determine if the resident is able to give you consent. The son understands the requirement and gives you consent to use his name and discuss his concern with his mother.

You visit Mrs. Green on August 5th and explain the call received from her son. She said she likes to eat lunch in her room because it is quiet, and it is the only time she gets to be alone. She says she prefers to eat dinner in the dining room but there are not enough dining chairs. She does not use a wheelchair and

requires a chair. She gives you consent to help, use her name, and discuss her concern with the administrator.

You visit the dining room. There are approximately 25 tables but there are only two chairs at each table for four people. There are no spare chairs in the dining room or in the hall. Dining room staff explain there is a shortage of dining room chairs. While visiting with other residents, you identify three more residents who have experienced occasional dining room seating issues.

You meet with the administrator and ask questions about the shortage of chairs in the dining room. The administrator says she is aware of the problem, and she will contact the facility's corporate office to get dining room chairs ordered.

The administrator emails you on August 8th and says the dining chairs were ordered. She expects the chairs to be delivered between August 18th and August 25th. On September 1st, you contact the administrator and confirm the chairs arrived and are set up in the dining room. During your next facility visit on September 10th, you observe more chairs in the dining room. You visit Mrs. Green. She confirms the problem is resolved and says she is satisfied with the outcome. You close your case.

- 1) What date did you open this case (date complaint received)? August 1st
- 2) What is your first action date (date you spoke to complainant, John Green)? August 1st
- 3) Complainant: Mr. Green / Family, Resident representative, friend (son)
- 4) Complaint code 1? I-03 (Environment, Furnishings)
- 5) Verified? ☒ Yes ☐ No
- 6) Can this case be closed? ☒ Yes ☐ No
- 7) Disposition: Partially/Fully resolved
- 8) Referral agency: No referral
- 9) What is the case closed date? September 10th

Answer the questions about each scenario.

Scenario 1: A resident's daughter, Ima Daughter, leaves you a voicemail on March 5th detailing a long-term care complaint. You return her call on March 6th

and speak with her for 20 minutes. Ms. Daughter complains that her mom, Mrs. Nguyen, is not allowed to have her cat in her apartment at her assisted living facility. She says her mother is very distraught. You explain your requirement to discuss the complaint with the resident and determine if the resident is able to give you consent. The resident's daughter gives you consent to help her with her complaint, use her name, and discuss her concerns with her mother and any facility staff necessary to solve the problem.

You visit with Mrs. Nguyen during your facility visit on March on 10th of this year. She says her daughter accurately reported her concern. She states she wants to keep her cat. Mrs. Nguyen gives you consent to help, to use her name, and to freely discuss her concern with staff. Mrs. Nguyen tells you her daughter is on her way to the facility with her admission paperwork and asks you to meet with them in approximately 30 minutes. You agree.

You review the facility admission agreement and policies with Mrs. Nguyen and her daughter and find no pet policy. With consent, you ask facility staff for a copy of the facility's pet policy. They are unable to find it. Mrs. Nguyen tells you staff knew she had a cat upon admission and that was nine months ago. With resident consent, you visit with Mrs. Nguyen's closest neighbors. The three residents you visit with state they do not have an issue with Mrs. Nguyen's cat.

You, Mrs. Nguyen, and Ima Daughter meet with the assisted living facility manager on March 17th to work out a solution. The manager says, "Other residents and staff report they are allergic to the cat even though the cat stays in Mrs. Nguyen's apartment." The manager states no pets are allowed in the building; the cat must go. The manager is still unable to produce a facility pet policy. The resident and her daughter are not satisfied with this outcome and the resident's daughter helps her mom fill out and submit a facility grievance form. Ima Daughter asks the manager to provide the name, phone number, and email address for the facility's corporate office. She requests that you conference in on their phone call to the corporate office. She will let you know the date and time. The resident requests you call a complaint into Regulatory Services, Complaint and Incident Intake (CII).

1) What date did you open this case (date complaint was received)?

2) What is your first action date (On what date did you speak to the complainant, Ima Daughter?)? _____

3) Complainant / Complainant role _____ / _____

- 4) Complaint code _____
- 5) Verified? ____ Yes ____ No
- 6) Can this case be closed? ____ Yes ____ No
- 7) Disposition _____
- 8) Referral agency _____
- 9) What is the case closed date? _____

Scenario 2: On January 31st, you visit resident Mr. Milanson during a facility visit. Mr. Milanson tells you an aide stole his family's Bible. With the resident's consent, you speak to the aide who was working the day it allegedly went missing. The aide says she put the Bible in the resident's top dresser drawer for safekeeping. It has a black and gold leather cover. You report back to Mr. Milanson that the Bible is in the dresser drawer. You wait while Mr. Milanson locates his Bible. He is very satisfied with the outcome.

- 1) What date did you open this case? _____
- 2) What is your first action date? _____
- 3) Complainant / Complainant Role _____ / _____
- 4) Complaint code _____
- 5) Verified? ____ Yes ____ No
- 6) Can this case be closed? ____ Yes ____ No
- 7) Disposition _____
- 8) Referral agency _____
- 9) What is the closed date? _____

Scenario 3: Mr. Soto calls you on March 6th and during your conversation, he complains that his friend, Ms. Reynosa, needs to be moved to a room closer to the nurse's station. Per Mr. Soto, Ms. Reynosa feels isolated at the end of the hall. You explain your requirement to discuss the complaint with the resident and determine if the resident is able to give you consent. Mr. Soto understands the requirement and gives you consent to use his name and discuss his concern with his friend.

You visit Ms. Reynosa in Sunnyside Nursing Facility on March 12th. She agrees she would feel less isolated in one of the two rooms near the nurses' station. You investigate and find there are no empty beds in either room; you report this

information to Ms. Reynosa. On March 16th, Mr. Soto reports to you and to his friend that he asked the facility to move one of the residents out of these two rooms to accommodate Ms. Reynosa. The facility refused.

You visit Ms. Reynosa on March 20th. The resident tells you that she wants to forget the whole thing. She says her current room is fine and “all the commotion about moving” is upsetting her.

- 1) What date did you open this case? _____
- 2) What is your first action date? _____
- 3) Complainant / Complainant Role _____ / _____
- 4) Complaint code _____
- 5) Verified? ____ Yes ____ No
- 6) Can this case be closed? ____ Yes ____ No
- 7) Disposition _____
- 8) Referral agency _____
- 9) What is the case closed date? _____

Scenario 4: During a visit at a nursing facility on June 1st of this year, several residents tell you that lunch is frequently served cold. You observe a noon meal service and note several residents arrived late because they came from an activity that ended 30 minutes after lunch service started. You visit some of the residents after they return to their rooms. Seven residents report the food was served cold and that it happens frequently. Three of the seven residents say the food was cold because activities and lunch overlap, and staff seem unable to keep the food warm. All seven residents say they do not care if activities and lunch overlap as long as they are served hot food. You open a case on behalf of the seven residents who request your assistance.

You meet with the food services director and the administrator by phone about the problem on June 3rd. They agree to serve hot food to residents who attend activities that overlap with the start of the lunch service. During your follow-up visit on June 14th, residents still complain the food is served cold. You continue to work on the case and request a scheduled conference call with the food services director and the administrator. During the phone call, the administrator tells you the facility ordered new food warming equipment on June 16th.

On June 27th, the food services director calls you and leaves a voicemail stating the kitchen is using the new food warming lamps and residents are happy. You check in with residents during your next facility visit on July 15th. All residents report the problem is solved and they are satisfied with the improvements made.

- 1) What date did you open this case? _____
- 2) What is your first action date? _____
- 3) Complainant / Complainant Role: _____/ _____
- 4) Complaint code _____
- 5) Verified? ____ Yes ____ No
- 6) Can this case be closed? ____ Yes ____ No
- 7) Disposition _____
- 8) Referral agency _____
- 9) What is the closed date? _____

Scenario 5: On May 5th, Ms. White, a resident living in an assisted living facility, calls you and complains that staff will not let her go to the day activity and health services (DAHS) center each day (Monday through Friday) as she has in the past. With Ms. White's consent, you investigate the complaint and discover the activity center reduced the number of days it is open each week; it is open on Monday, Wednesday, and Friday only. Ms. White says she was not aware the center's schedule changed. She now attends the center each day it is open. You suggest a meeting between Ms. White, the manager, and yourself to discuss strategies to help her remember her schedule. Mrs. White agrees and requests you schedule the meeting.

Ms. White, the assisted living facility manager, and you meet on May 20th and discuss techniques that might help Ms. White such as keeping a calendar in her room with her activity center schedule. The three of you discuss other services in the community that Ms. White may be able to utilize. You check back with Ms. White on June 10th, and she reports she is also attending a vocational program one day a week. She is happy with the new schedule.

- 1) What date did you open this case? _____
- 2) What is your first action date? _____
- 3) Complainant / Complainant Role _____/ _____

- 4) Complaint code _____
- 5) Verified? ____ Yes ____ No
- 6) Can this case be closed? ____ Yes ____ No
- 7) Disposition _____
- 8) Referral agency _____
- 9) What is the closed date? _____

Scenario 6: During a facility visit on August 1st, a nursing facility resident who is receiving hospice services, John Moreno, complains that he is in a lot of pain. He says the facility refused to contact his hospice agency about changing his pain medication. With resident consent, you ask the DON to consult with the hospice agency's pain management doctor per the resident's request. She agrees and calls you the next day to report a physician assistant made a visit and the doctor made a change in the pain medication dosage. The DON said she already reported the change to Mr. Moreno. You visit the resident again on August 5th, but he is asleep. Three days later you visit the facility to see the resident again. The DON tells you the resident died the night before.

- 1) What date did you open this case? _____
- 2) What is your first action date? _____
- 3) Complainant / Complainant Role _____ / _____
- 4) Complaint code _____
- 5) Verified ____ Yes ____ No
- 6) Can this case be closed? ____ Yes ____ No
- 7) Disposition _____
- 8) Referral agency: _____
- 9) What is the closed date? _____

Scenario 7: On May 1st, a daughter of a resident, Miss Maathai, calls you and complains that her mother is not bathed as often as she should be. She is also concerned that her mother must share a room at the assisted living facility (ALF). You explain your requirement to discuss the complaint with the resident and determine if the resident, Mrs. Kamau, is able to give you consent. Miss. Maathai requests your help and understands and encourages you to discuss her concerns with her mother. On May 7th, you visit Mrs. Kamau who reports that

she dislikes taking a shower more than a few times a month. She reports the facility offers her bathes as well as showers. She tells you she likes gardening and is outside in the garden when the weather is nice. She enjoys having a roommate. She is happy at the ALF and is aware her daughter is not satisfied with her care.

- 1) What date did you receive (open) this case? _____
- 2) What is your first action date? _____
- 3) Complainant / Complainant Role _____ / _____
- 4) Complaint code 1 _____ Complaint code 2 _____
- 5) Verified - 1 ____ Yes ____ No Verified - 2 ____ Yes ____ No
- 6) Can this case be closed? ____ Yes ____ No
- 7) Disposition - 1 _____ Disposition - 2 _____
- 8) Referral agency _____
- 9) What is the closed date? _____

Scenario 8: On September 25th, Bill Frye calls you and discusses concerns about his father's care with you. He is unhappy with his father's dining experience at the nursing facility, especially the lack of staff assistance. He is worried his father will lose weight. Bill Frye requests your assistance with his concerns and gives you consent to use his name and speak to anyone you need to. You explain your requirement to discuss the complaint with the resident and determine if the resident is able to give you consent. He states he is the agent on his father's medical power of attorney (MPoA). He insists his father is unable to converse with you and is not able to give you consent. He understands the requirement. He says his father's MPoA is on file at the facility and encourages you to review it. He offers to meet you at the facility after your visit with his father. He makes it clear he wants to be involved in negotiating a solution.

On a visit on October 3rd, you observe residents in the dining room eating and using plastic utensils. No staff help Bill's father, George Frye, cut his food or open his milk carton. The resident cannot give you consent or direction and is unable to call for staff assistance. You ask an aide to help Mr. Frye.

Two days later, you and Bill Frye meet with the administrator at the facility. Over the next two weeks, the facility purchases more flatware for residents and starts using it. Staff update the resident's care plan to include eating assistance.

The administrator and nurse schedule staff in-services in October and November that focus on how staff can improve a resident's dining experience, including assisting residents who need help.

You check back with Bill Frye on December 15th to see if the issue is resolved. Bill Frye reports the problem is resolved and that he is happy with the changes.

- 1) What date did you receive (open) this case? _____
- 2) What is your first action date? _____
- 3) Complainant / Complainant Role _____ / _____
- 4) Complaint code 1 _____ Complaint code 2 _____
- 5) Verified - 1 ___Yes ___ No Verified - 2 ___Yes ___ No
- 6) Can this case be closed? ___Yes ___ No
- 7) Disposition - 1 _____ Disposition - 2 _____
- 8) Referral agency _____
- 9) What is the closed date? _____

Scenario 9: During your facility visit on January 25th, a resident, Mr. Plum, complains to you that only one alternative meal is offered at dinner. He wants at least two options for alternative meals during the week. He also would like a big screen TV in the lounge closest to his room. You accompany Mr. Plum to help him share his concerns with the facility's administrator. The administrator refuses to purchase a TV with a larger screen. She says the lounge near Mr. Plum's room is too small for a larger screened TV. She says there is a big screen TV in another lounge area. The administrator agrees to have two alternative meals during the week but says the facility cannot offer two on weekends. You visit the resident several weeks later, on February 15th. Mr. Plum says he is satisfied with alternative meals during the week. He is not happy (not satisfied) about the TV.

- 1) What date did you open this case? _____
- 2) What is your first action date? _____
- 3) Complainant / Complainant Role _____ / _____
- 4) Complaint code 1 _____ Complaint code 2 _____
- 5) Verified - 1 ___Yes ___ No Verified - 2 ___Yes ___ No

- 6) Can this case be closed? ____ Yes ____ No
- 7) Disposition – 1 _____ Disposition – 2 _____
- 8) Referral agency _____
- 9) What is the closed date? _____

Scenario 10: On March 5th, you notice a bad smell when visiting an assisted living facility (ALF). The ALF had plumbing problems in the past and the owner was slow to resolve them. The owner is on the phone, so you cannot talk to him. A substantial number of residents are upset with the smell and tell you that a toilet may have backed up again. Since this complaint affects the entire facility and all residents, you work the problem. The staff person you talk with does not know what is causing the odor. You open a case.

Returning the next day, you learn that the city was repairing a gas line behind the facility and ruptured a sewage pipe. You do not smell any odors during your visit. After speaking with residents and staff, no one reports a problem with the plumbing and are relieved that the smell is gone. Residents are very satisfied. You conclude the broken sewer line was the cause of the problem and close the case.

- 1) What date did you open this case? _____
- 2) What is your first action date? _____
- 3) Complainant / Complainant Role _____ / _____
- 4) Complaint code _____
- 5) Verified ____Yes ____ No
- 6) Can this case be closed? ____Yes ____ No
- 7) Disposition _____
- 8) Referral agency _____
- 9) What is the closed date? _____

Scenario 11: On June 1st, during a facility visit, a resident, Scarlet Müller asks for your help in fighting a 30-day discharge notice she received. She says, "If I am forced to move, it will be my third nursing facility in two years." She wants to stay where she is and requests your help. With consent, you review the discharge notice, assist her in filing an appeal, and begin investigating the

issues. The facility is not willing to review the resident assessment, care plan, or to discuss any solutions.

The local legal aid has represented other residents from this nursing facility in the fair hearing (discharge appeal) process. The resident is eager to have you make a referral on her behalf when you tell her about this option. You contact legal aid, and an attorney agrees to take the case. On July 5th, the hearing officer rules that the resident can remain in the nursing facility. You visit with the resident later in July and she is happy with the outcome.

- 1) What date did you receive this case? _____
- 2) What is your first action date? _____
- 3) Complainant / Complainant Role _____ / _____
- 4) Complaint code _____
- 5) Verified ___Yes ___ No
- 6) Can this case be closed? ___Yes ___ No
- 7) Disposition _____
- 8) Referral agency _____
- 9) What is the closed date? _____

SOURCE: Modified from, The National Long-Term Care Ombudsman Resource Center, National Ombudsman Reporting System (NORS) Training, Part III Quiz, Verification, Disposition, Referral, and Closing Cases Quiz, Accessed May 2019.



Ombudsman Tip – Monthly Report

Volunteers start their monthly activity report after their first visit of the month and add to it each time they visit. As soon as the last visit of the month is completed, email or mail the activity report to your Ombudsman Program.

Staff enter activities into the confidential ombudsman following the requirements established in the OPPM.



Exercise - Practice Filling Out an Activity Report

Instructions

Find the activity report that follows (pages 391-392). Fill out the following information on the form.

- 1) In the space next to Ombudsman, write your first and last name.
- 2) In the space next to Facility, write *Golden Oaks*.
- 3) Next to Month/Year, write *September 2025*.
- 4) In the Visits section, enter the two facility visits and related information from your notes below.
 - a) 9-2-2025 – Contacts: *14 residents, 3 staff, 1 family member*.
 - i) Total time on site = *2 h 15 m (2 hours and 15 minutes)*
 - ii) If your program requests that you complete the travel time and mileage, it took you 15 minutes and 7 miles each way (from home to facility and facility to home = 14 miles).
 - b) 9-17-2025 – Contacts: *11 residents, 4 staff, 0 family or friends*.
 - i) Total time on site = *1 h 30 m*
 - ii) If your program requests that you complete the travel time and mileage, it took you 15 minutes and 7 miles each way (from home to facility and facility to home = 14 miles).
- 5) Locate the Notes section on the right half of the form. Under notes, write the following information:
 - a) A new social worker started last week per Janie Smith, Administrator. His name is Henry Potter, and he will work M-F from 7 am to 4 pm.
- 6) Locate the Activities section (mid-form). Under Activity Type, locate Resident Council Attended. Under Date (next to Resident Council Attended), write 9-17-2025.
- 7) Locate the Information & Assistance section.
 - a) On the first line in the Date column, write *9-2-2025*.
 - b) On the same line in the Topic column, write, *Omb Program / Role*.
 - c) In the Name & Role of Persons You Gave Information To column, write the residents' names from your notes below. You visited residents who

were new admissions to the facility since your last visit. You gave each person information about what you do and the Ombudsman Program. The number after each name is the resident's room number.

i) J. Smith-404, L. Haney --310. B. Lamsens-302 - Explained Omb Prog & Role

- 8) Locate Page 2 of the Activity Report. Find the section titled Cases and Complaints. Fill in the appropriate spaces using the case notes below.

Date Received: 09-02-2025.

Resident Name: Sam Goodwin

Complainant Name & Role: Sam Goodwin, Resident

Who Gave Consent? 1-Resident

Complaint Code: F4- Medication

Complaint: Medication for blood pressure is not administered with meals. Resident wants medication (med) as prescribed and believes his physician told him that Carvedilol is taken with meals. The resident asked the CNA about his medication twice. To date, no staff discussed his complaint with him. Resident's desired outcome is taking medication with each meal.

Consent: Resident gave ombudsman (omb) consent to get copy of medication administration record (MAR) and to review prescription for his blood pressure medicine (med) to determine how and when med is prescribed. Resident gave consent for omb to speak to any nursing staff necessary to get answers about med.

Investigation: On 9-2, Omb got copy of MAR and prescription and reviewed them with resident. Med is listed on MAR. Prescription does not require med to be taken with food or meal.

On 9-2, resident agreed omb can speak to LVN. Charge nurse said med does not have to be taken with food. She confirmed it is prescribed three times per day. Resident is fine with med administration as is.

Checked back with resident SG on 9-17. He is still satisfied. Closing case.

Verified: No

Date Closed: 9-17-2025.



State Long-Term Care Ombudsman Program
Long-Term Care Ombudsman Activity Report

Form 8620
 September 2019-E

Ombudsman:				Facility:			Month/Year:
Visits							Notes:
	No. of Contacts			Time – Hours : Minutes			
Visit Date	Resident	Family/Other	Staff	On Site	Travel (Optional)	Mileage (Optional)	
Totals							
Activities							
Date(s)	Activity Type	Resident Name(s):					
	Family Council Attended						
	Resident Council Attended						
	Survey Participation						
	Care Plan Attended						
Information and Assistance							
Date(s)	Topic	Name and Role of Person(s) You Gave Information To					

Cases and Complaints

Date Received	Resident Name	Complainant Name and Relationship to Resident	Who Gave Consent 1. Resident, 2. LAR* 3. Ombudsman	Complaint Code and Complaint Description Enter code A-1 to L-3 Describe the complaint What did the ombudsman do to resolve the complaint? If referred, to what agency?	Verified		Disposition 1. Resolved 2. Withdrawn 3. Not Resolved	Date Closed
					Y	N		
					☐	☐		
					☐	☐		
					☐	☐		
					☐	☐		

*legally authorized representative

Tips for Filling Out the HHS Form 8620 Long-Term Care Ombudsman Activity Report

Certified volunteer ombudsmen are required to submit Form 8620 Activity Report each month. The report can be submitted electronically or as a paper copy. Submit the report by the due date set by your local long-term care ombudsman program.

Download a Fillable PDF

HHS Form 8620 may be accessed and downloaded to a personal computer from this link: <https://www.hhs.texas.gov/regulations/forms>. Alternatively, in the browser search bar type "Texas HHS Forms" to find the website. HHS forms may not be compatible with smart phones.

Tips on Completing an Activity Report

In the spaces provided, enter your first and last name, the name of your assigned facility to which this report applies, and the month and year you conducted the activities in this report.

Facility Visits

Under the Visits section, enter the:

- Date – Enter each date you visited the facility.
- No. of Contacts – Enter the number of separate contacts for residents, family/others (non-relative visitors), and staff.
- Time on Site – Enter total time you spent at the facility making visits and resolving complaints. Enter time in hours and minutes (1h 30m). Do not use decimals.
- Total the number of contacts and time on site.



Ombudsman Tip – What is a contact?

For the Ombudsman Activity Report, a contact is defined as a meaningful interaction. TIP: Use the resident census or roster to track contacts during the facility visit.

Optional – Ask your supervisor if travel time and mileage are tracked using this form.

- Travel – Enter time spent traveling to and from the facility.
- Mileage – Enter miles traveled to and from the facility.

Activities

- Family Council Attended – Enter the date or dates you attended the family council meeting. TIP: Only attend if invited by a family council member.
- Resident Council Attended – Enter the date or dates you attended the resident council meeting. TIP: Only attend if invited by a resident council member.
- Survey Participation – Enter the date or dates of participation in any part of an HHS Regulatory Services annual survey or complaint investigation.
- Care Plan Meeting – Enter the date or dates you attended a care plan meeting. Enter the name of the resident who was the subject of the care plan meeting. TIP: Only attend if invited by the resident or the resident's legally authorized representative.

Information and Assistance

- Date(s) – Enter the date or dates you provided information and assistance.
- Topic – Enter the topic of the information and assistance you provided (such as resident rights or the role of the ombudsman).
- Name and Role (or title) of Person(s) You Gave Information To – Enter the name or names of the person or persons you gave information and assistance to on one topic. Enter the role or title of the person or persons you gave information and assistance to (such as a resident, a family member, administrator, or facility staff).

Cases and Complaints

- Date Opened – Enter the date you received or identified the complaint.
- Resident Name – Enter the name of the resident who is the subject of the complaint. If the complaint involves several residents, enter "several."
- Complainant Name and Relationship to Resident – Enter the name of the complainant and how the complainant is related to the resident (such as a

resident, friend, family member, legally authorized representative, or staff person).

- Who Gave Consent – Select the person who gave consent for the complaint investigation.
 - Resident – Select if the resident gave consent for the investigation.
 - LAR - Select if the resident's legally authorized representative gave consent to investigate the complaint.
 - Provide the name of the LAR.
 - Describe why the resident is determined unable to consent.
 - Document how the authority of the LAR was verified (for example, the POA document or letter of guardianship was reviewed).
 - Ombudsman - Select if the ombudsman is authorized to investigate the complaint without consent of the resident(s) or LAR (ombudsman determined means the resident is unable to communicate consent and has no LAR).
- Complaint Code and Complaint Description (Codes A-1 to L-3) – Enter one code that best matches the complaint. See the attached list of complaint codes. Enter a description of the complaint, including:
 - Details about the complaint.
 - What you did to investigate and resolve the complaint.
 - If, as part of the complaint investigation, the complaint is to another agency, the name of the agency.
 - If the complaint involves an allegation of abuse, neglect, or exploitation, the name of the alleged perpetrator.
- Verified – After investigation, mark "Y" if you verified the complaint (through investigation, you found that most or all the facts are true or likely to be true or the complaint is based on the subjective opinion of the resident) or mark "N" if you could not verify the complaint.
- Disposition – For each complaint, choose a disposition that best describes the outcome after completing the complaint investigation.
 - Resolved - Choose this disposition if the complaint is partially or fully resolved as determined by the resident, resident's LAR, or complainant.
 - Withdrawn - Choose this disposition if the resident who is the subject of the complaint or the resident's LAR declines consent for the ombudsman to investigate the complaint; the complaint is withdrawn

- by the resident or complainant; or the resident died before the resolution of the complaint, and you determine that further investigation would not benefit other residents.
- Not Resolved - Choose this disposition if the complaint was not addressed to the satisfaction of the resident, resident's LAR, or complainant.
 - Date Closed .

Supplement 11-A: Ombudsman Complaint Codes

Code	Description
A	Abuse, Gross Neglect, Exploitation
A-1	Abuse: physical
A-2	Abuse: sexual
A-3	Abuse: psychological
A-4	Financial exploitation
A-5	Gross neglect
B	Access to Information
B-1	Access to information and records
B-2	Language and communication barriers
B-3	Willful interference with ombudsman
C	Admission, Transfer, Discharge, Eviction
C-1	Admission
C-2	Appeal process
C-3	Discharge or eviction, and bed hold
C-4	Room issues (roommate choice, moves)
D	Autonomy, Choice, Rights
D-1	Choice in health care (refuse care, treatment schedule)
D-2	Live in less restrictive setting
D-3	Dignity and respect, staff attitudes
D-4	Privacy (phone, visitors, treatment, intimacy)
D-5	Response to complaints, grievances
D-6	Retaliation
D-7	Visitors (access to, when, whom)
D-8	Resident or family council
D-9	Other rights and preferences (smoke, vote)
E	Financial, Property
E-1	Billing and charges, refunds
E-2	Personal property/funds lost, stolen
F	Care Arranged by the Facility, Including PASRR Services
F-1	Accidents and falls
F-2	Response to requests for assistance
F-3	Care planning (participate, not followed)
F-4	Medications
F-5	Personal hygiene, including teeth
F-6	Access to and quality of health services (physician, hospice, dental, hearing)

Code	Description
F-7	Symptoms unattended (pain, change in condition)
F-8	Incontinence care
F-9	Assistive devices or equipment
F-10	Rehabilitation services (PT, OT, ST, restore)
F-11	Physical restraint
F-12	Chemical restraint
F-13	Infection control
G	Activities, Community Integration, Social Services
G-1	Activities
G-2	Transportation
G-3	Conflict resolution between residents
G-4	Social services, including appointments
H	Dietary
H-1	Food services (quality, quantity, temperature, snacks, utensils)
H-2	Dining and hydration, staff fails to assist
H-3	Therapeutic or special diet
I	Environment
I-1	Environment (air, water, noise, odors)
I-2	Building structure (security, hazards)
I-3	Supplies (linens, toiletries), storage and furnishings (poor condition, unavailable)
I-4	Accessibility (space for activities or dining, ADA, barriers or obstructions)
I-5	Housekeeping, laundry, pest abatement
J	Facility Policies, Procedures, Practices
J-1	Administrative oversight (unresponsive, policies, failure to report, unlicensed facility)
J-2	Fiscal management, insufficient funds
J-3	Staffing (shortage, training, turnover, unresponsive, supervision)
K	Complaints about an Outside Agency (Non-facility)
K-1	Regulatory system
K-2	Medicaid
K-3	Managed care
K-4	Medicare
K-5	Veterans Affairs
K-6	Private insurance
L	System: Others (Non-facility)
L-1	Resident representative or family conflict, including family interference w/ resident wishes
L-2	Services from outside provider, including PASRR services
L-3	Request to transition to community setting

Supplement 11-B: Complaint Codes and Descriptions

Administration for Community Living/Administration on Aging, Office of Long-Term Care Ombudsman Programs

Complaint: An expression of dissatisfaction or concern brought to, or initiated by, the Ombudsman program which requires Ombudsman program investigation and resolution on behalf of one or more residents of a long-term care facility.

Major Categories of Complaints

- A. Abuse, Gross Neglect, Exploitation
- B. Access to Information
- C. Admission, Transfer, Discharge, Eviction
- D. Autonomy, Choice, Rights
- E. Financial, Property
- F. Care Arranged by the Facility, Including PASRR Services
- G. Activities, Community Integration and Social Services
- H. Dietary
- I. Environmental
- J. Facility Policies, Procedures and Practices
- K. Complaints about an Outside Agency (Non-facility)
- L. System: others (non-facility)

A. Abuse, Gross Neglect, Exploitation

Use this section for serious complaints of willful mistreatment of residents by facility staff, resident representative/ family/friend, other residents or an outside individual. Indicate who appears to be the cause of the abuse, neglect or exploitation: (1) Facility staff, (2) another resident (3) resident representative, family, friend or (99) other.

1. Abuse: physical

The intentional use of physical force that results in acute or chronic illness, bodily injury, physical pain, functional impairment, distress, or death.

Examples and Reporting Tips: Includes hitting, slapping, pinching, kicking, etc. and/or controlling behavior through corporal punishment.

2. Abuse: sexual

Forced and/or unwanted sexual interaction (touching and non-touching acts) of any kind.

Examples and Reporting Tips: Includes, but not limited to unwanted or inappropriate touching, sexual coercion, sexually explicit photographing, and sexual harassment. Sexual harassment includes any form of unwanted sexual attention (e.g., sexual advances, suggestions, requests, or threats) that is deemed inappropriate, offensive, intimidating or humiliating. Harassment includes contact and non-contact acts.

3. Abuse: psychological

The infliction of anguish, pain, or distress through verbal or nonverbal acts. This includes but is not limited to verbal assaults, insults, threats, intimidation, humiliation, and harassment.

Examples and Reporting Tips: Includes, but is not limited to oral, written, or gestured language that willfully includes disparaging and derogatory terms used against residents regardless of their ability to comprehend; humiliation; bullying; harassment; threats of punishment or deprivation; and involuntary seclusion, which is the separation of a resident from other residents or from his/her room against the resident's will. It also includes abuse that is facilitated or caused by the taking or using photographs or recordings in any manner that would demean or humiliate a resident, posting these photos on social media networks or sending these photos through multimedia messages.

Use D03 (Dignity and respect) for less severe forms of staff rudeness or insensitivity.

Use F02 (Response to requests for assistance) if staff is unavailable, unresponsive to residents.

4. Financial exploitation

The illegal or improper use of an individual's funds, property, or assets for another person's profit or advantage.

Examples and Reporting Tips: Includes, but is not limited to, depriving a resident of rightful access to, information about, or use of personal benefits, resources, personal needs allowance, belongings, or assets.

5. Gross neglect

Failure to protect a resident from harm or the failure to meet needs for essential medical care, nutrition, hydration, hygiene, clothing, basic activities of daily living or shelter, which results in a serious risk of compromised health and/or safety, relative to age, health status, and cultural norms.

Examples and Reporting Tips: Use the appropriate categories under Resident Care (F) or, in some cases, Facility Policies, Practices and Procedures (J) and for similar complaints but gross neglect is not clearly indicated.

Perpetrator: Person(s) who appears (is alleged) to have caused the abuse, neglect, or exploitation.

Examples and Reporting Tips: Only used for Abuse, Gross Neglect, and Exploitation complaints A01 to A05. There can be multiple perpetrators for each complaint.

B. Access to Information

Use this category for complaints against the facility regarding access to information made by or on behalf of the resident. Use for willful interference with ombudsman duties.

1. Access to information and records

Access to information or access to resident records is denied or delayed.

Examples and Reporting Tips: Examples of records include medical, financial and similar documents. Access to information includes public benefits, residents' rights, or any information regarding medical condition, advance directives or treatment. Includes access to the administrative records, including public staffing reports, policies, and survey documents, to which the residents have, or the public has access, of long-term care facilities.

2. Language and communication barriers

Information (written, verbal or other formats) is not provided in a language or format that the resident can understand; facility does not provide an interpreter. Language barrier on the part of facility staff making it difficult for the resident to understand and communicate with a staff person, and similar complaints.

Examples and Reporting Tips: Use also when the resident is not provided with auxiliary aids and services.

3. Willful interference (with ombudsman)

Actions or inactions taken by an individual or entity in an attempt to intentionally prevent, interfere with, or attempt to impede a resident or complainant from accessing the Ombudsman program.

Examples and Reporting Tips: Includes when an employee or other representative of a facility interferes with the Ombudsman Program having immediate access to the facility, access to records, or to meet with a resident in person, in private, or by phone.

Use B01 (Access to information and records) when the resident is having difficulty accessing records and other information.

C. Admission, Transfer, Discharge, Eviction

Use this category for complaints against the facility involving issues regarding Admission, Transfer, Discharge and/or Eviction.

1. Admission

Resident is admitted to a facility or section of a facility against their wishes. The admission agreement or contract is missing or contains illegal provisions.

Examples and Reporting Tips: Use when the facility requires or requests waivers of rights as a condition of admission. Use for violation of Medicaid rules or other improper or illegal provisions such as discrimination in admission based on pay source.

2. Appeal process

Resident did not receive information on appeal rights, or assistance from facility staff to file an appeal. The facility failed to follow appeal ruling and similar problems.

Examples and Reporting Tips: Use when facility fails to inform resident of appeal rights under Medicaid, Medicare, managed care or other.

3. Discharge or eviction (includes bed hold)

Resident received a discharge notice and does not want to leave. Resident was transferred or discharged without notice or due process; resident was transferred to the hospital and not advised of bed hold policy or was not readmitted post hospitalization and similar problems.

Examples and Reporting Tips: Use when facility fails to provide a written discharge notice; notice is incomplete or incorrect; if the transfer or discharge is for inappropriate reasons; or to an inappropriate environment.

4. Room issues (roommate choice, moves)

Resident requests a room change, and the request is denied or resident objects to planned room or physical location change; there is no notice, or inadequate notice of change.

Examples and Reporting Tips: Use for issues with room assignments, forced room changes or intra-facility transfers; complaints involving roommate choice; and similar problems.

D. Autonomy, Choice, Rights

Use this category for complaints involving facility staff failure to honor and promote a resident's right or preferences.

1. Choice in health care (refuse care, treatment schedule)

Resident is denied the right to choose own physician/pharmacy/hospice or other health care provider.

Examples and Reporting Tips: Use when the resident's preferred care or treatment schedule is not accommodated. Use L02 (Services from outside

provider) if the resident is permitted to choose her personal physician but that physician is unavailable.

2. Live in less restrictive setting

Resident is not offered transition planning services to return to a less restrictive setting; request to return to community is denied, ignored, or inadequately addressed; facility staff prevents the resident from moving from the facility; and similar problems.

Examples and Reporting Tips: Use for nursing facility complaints about MDS Section Q (request for information to return to community) and when facility fails to refer resident to the Local Contact Agency for assistance.

3. Dignity and respect (and staff attitudes)

Resident is treated with rudeness, indifference or insensitivity.

Examples and Reporting Tips: Facility staff fails to knock before entering room, posts signs relating to individual's care and similar problems. Use when interactions are not age-appropriate or person-centered.

Use codes A02 (Abuse: sexual) or A03 (Abuse psychological) for inappropriate posts on social media.

4. Privacy (phone, visitors, treatment, intimacy)

Failure to ensure privacy during provision of care or treatment, or in other aspects of life.

Examples and Reporting Tips: Use when facility staff: discloses confidential information; shares resident information in a newsletter or other format without consent; opens resident mail; fails to close doors/privacy curtains when giving personal care; monitors phone calls or emails.

Use for lack of privacy when meeting with visitors and if couples denied privacy and similar problems.

Use code B03 (Willful interference) if a lack of privacy is related to visits from the Ombudsman program.

5. Response to complaints (and grievances)

Facility staff ignores or trivializes a resident complaint or there is no facility grievance process thereby limiting the resident's ability to resolve a problem directly with the administration.

Examples and Reporting Tips: Use if the grievance procedure is not followed or made known to residents.

6. Retaliation

Acts of retaliation/revenge by facility staff in response to a complaint to the facility, Ombudsman program, or state survey agency.

Examples and Reporting Tips: Use for threat of discharge, lack of care, requests ignored, call lights unanswered, rough handling, monitoring resident's phone, mail or visits without resident's permission.

Use for retaliation in response to actions taken by a resident, family, or another person acting on behalf of a resident.

May add additional complaints if resident feels abused or neglected due to the retaliation.

7. Visitors (access to, when, whom)

Restrictions on a resident's ability to choose who to associate with and when to visit, either in the facility or in the community.

8. Resident or family council

Interference with or prevention of the formation of a resident or family council. Staff does not assist in the promotion of councils or exerts too much control; does not respond or follow-up on council requests and similar problems.

9. Other rights and preferences (smoking, voting)

The deprivation of any right, not defined in D1-D8, such as personal liberty or freedom of choice, right of assembly, speech, religious freedom, the right to vote.

Examples and Reporting Tips: The deprivation of any right, not defined in D1-D8, such as personal liberty or freedom of choice, right of assembly, speech, religious freedom, the right to vote. Includes cohabitation, smoking/non-

smoking, right to refuse care or treatment and other civil rights issues or preferences.

Use D4 for complaints involving privacy.

E. Financial, Property

Use this category for complaints involving facility staff mismanagement of residents' funds and property or billing problems.

1. Billing and charges (and refunds)

Incorrect or improper billing such as overcharging, raising rates without notice, deposits not refunded, and billing for services or supplies that were not provided, and similar complaints.

Examples and Reporting Tips: Use for billing for items or services that should be covered by Medicaid, Medicare or other insurance.

2. Personal property (including funds lost, stolen)

Loss or mismanagement, by the facility, of resident property including resident's money or trust fund.

Examples and Reporting Tips: Use for lost personal items such as laundry, prostheses, dentures, hearing aid, glasses, radio, watch, and cigarettes. Use if the facility staff withholds or damages resident property and similar problems. Use for failing to reimburse resident for lost or damaged items.

Use A04 (Financial exploitation) if improper use of property or money is for the benefit of others.

F. Care Arranged by the Facility, Including PASRR Services

Use this category for any complaint involving facility staff failure to provide care including, poor quality care, planning, and delivery.

1. Accidents and falls

Any unexpected or unintended incident or injury of unknown origin, which may result in injury or illness to a resident.

Examples and Reporting Tips: Example: A resident who self-propels catches a finger in wheelchair spoke and fractures a finger; resident falls while getting out of bed; pinches hand in doorjamb and sustains a skin tear.

Use A05 (Gross neglect) if this is a repeated problem which facility staff fail to address.

2. Response to requests for assistance

Failure to promptly respond to call light or call bell or requests for assistance goes unanswered.

Examples and Reporting Tips: Such as, requests for returning to resident's room, transfers to chair or bed, and similar problems.

Use D06 (Retaliation) if slow response in reaction to a resident complaint or actions taken by the resident, family, or other person involved in the resident's care.

3. Care planning (participate, not followed)

Facility does not create or follow a person-centered care plan. Care planning does not include the resident or resident representative, or staff disregards or is not informed of the plan.

Examples and Reporting Tips: Use if the nursing facility resident's Specialized Services as indicated by a PASRR level II screen are not included in the care plan.

Use if care plans are not scheduled, not enough time allowed at the meeting, or a copy of plan is not provided to the resident, etc.

4. Medications

Medication given in error, or not given on time or at all. Medication administration not documented or incorrectly documented.

Examples and Reporting Tips: Medications not secured, incorrect medications including expired; not filled in a timely manner; incorrectly labeled and similar problems.

5. Personal hygiene (including teeth)

Failure to provide hygiene services such as: not bathed in a timely manner or at all or is allowed to remain in soiled clothing or incontinent briefs; hands and face not washed; teeth or dentures not cleaned.

Examples and Reporting Tips: Use for lack of nail care and grooming and similar problems.

Use A05 (Gross neglect) if there is failure to meet essential care.

6. Access to (and quality of) health services (physician, hospice, dental, hearing)

Failure to obtain or maintain healthcare services based upon a change in resident's condition, or at the residents' request, or if the service is not obtained in a timely manner and similar complaints.

Examples and Reporting Tips: Services such as physician, podiatry, dental, vision, hearing, mental health, hospice.

Use D01 (Choice in health care) if denied choice of medical provider.

7. Symptoms unattended (pain, change in condition)

Failure to accommodate, identify or provide services related to a change in resident's condition. Use if symptoms are not addressed and care is not provided.

Examples and Reporting Tips: Use for failure to identify and address symptoms such as pain, skin integrity, pressure sores, fever, and infection.

Use if resident's health care provider is not notified of changes in resident condition; resident representative is not notified of changes in resident condition. Use for lack of monitoring and care for individuals with nasal gastric tubes and similar. Includes changes in mental health or cognitive changes.

Use A05 (Gross neglect) if there is failure to meet essential care that threatens the health, safety or welfare of the resident.

8. Incontinence care

Failure to provide incontinence care or catheter care in a timely manner as requested, or as directed by the care plan. Not providing necessary bowel and bladder training.

Examples and Reporting Tips: Resident is not assisted to the bathroom or is provided with incontinence briefs or catheters rather than receiving assistance to go to the bathroom (for purposes of staff convenience.)

9. Assistive devices or equipment

Failure to provide access to assistive devices and similar equipment and supports. Failure to maintain adaptive equipment.

Examples and Reporting Tips: Use if the facility creates barriers in accessing or keeping a service animal. Equipment and devices can include but are not limited to: Hoyer lifts; handrails; grab bars; raised toilet seat; elevators; ambulation aids; wheelchairs; hearing or visual aids and communication devices.

10. Rehabilitation services (PT, OT, ST, restorative)

Failure to provide or arrange for rehabilitation therapies or services. The resident is not assisted or encouraged to improve or maintain his or her function or is not assisted or encouraged to ambulate when appropriate.

Examples and Reporting Tips: Services such as physical, occupational and speech therapy; range of motion and exercise programs and similar.

11. Physical restraint

Use of any device, material or equipment attached to or near the resident's body, which cannot be controlled or easily removed by the resident which deliberately prevent or are deliberately intended to prevent free body movement to a position of choice and/or a normal access to their body.

Examples and Reporting Tips: Physical restraints include but are not limited to: leg restraints; arm restraints; hand mitts; soft ties or vests; lap cushions, and lap trays the resident cannot remove easily. Physical restraints include any other device that a resident cannot control or remove without assistance including reclining chairs and improper use of bed rails. Use this code for issues involving the assessment, use and monitoring of physical restraints.

12. Chemical restraint

Use of any for discipline or convenience that is not required to treat medical symptoms.

Examples and Reporting Tips: Includes inappropriate use of antipsychotics, anti-anxiety or hypnotic medication. Use this code for issues involving the inappropriate assessment, use or monitoring of chemical restraints.

13. Infection control

Insufficient measures to prevent or control infection.

Includes failure to follow infection control procedures; staff not wearing, or not properly wearing, necessary personal protective equipment (PPE); facility not providing necessary PPE; spread of infection; infection unreported or not treated appropriately; and similar problems.

G. Activities, Community Integration and Social Services

Use this category for any complaint involving activities, community integration or social services.

1. Activities

Lack of choice and appropriate activities for each resident; facility fails to consider individualized preferences; variety of activities is limited or not offered; posted activities not conducted.

Examples and Reporting Tips: Use for any complaint related to activities either individual or group.

Use D07 (Visitors) if the complaint is about interaction with visitors.

2. Transportation

Failure to assist resident in obtaining transportation to participate in community, attend health care appointments, and similar complaints.

Examples and Reporting Tips: Use L02 (Services from outside provider) if complaint is about a transportation provider other than the facility.

3. Conflict resolution (between residents)

Disagreement between residents where the assistance of the Ombudsman is requested by the residents or facility staff to achieve a resolution.

Examples and Reporting Tips: Use for roommate disagreements regarding interpersonal relationships, the volume of the TV, visitors in the room, and conflict between residents about a resident council.

Use L01 (Resident representative or family conflict) for a resident conflict or disagreement with their resident representative, family or friend.

4. Social services (including appointments)

Social services are not available or appropriate. Facility staff fail to provide social services to help a resident achieve his or her goals; access supports, etc.

Examples and Reporting Tips: Includes problems with making medical appointments, arranging for escorts to appointments, family support, grief counseling and similar problems.

H. Dietary

Use this category for complaints regarding food service, assistance.

1. Food services (quality, quantity, temperature, snacks, utensils)

Food quantity, quality, variation, choice, temperature, and timing of meals, timing of snacks, substandard meals or snacks, or food that does not meet resident expectations.

Examples and Reporting Tips: Includes posted menu is not served; alternate selections not offered; servings too small; no variety; quality is poor; food has little nutritional value, presentation, utensils not provided and similar complaints.

Use I03 (Supplies, storage and furnishings) if there is a shortage of dining supplies.

2. Dining and hydration (and staff fail to assist)

Facility staff fails to assist with dining or ensuring adequate hydration and similar complaints.

Examples and Reporting Tips: Includes the facility staff has not provided adaptive equipment for resident to maintain independence in eating, meal set up, i.e., opening milk cartons, tray not within reach or staff do not provide direct assistance; including providing fluid and reminders or assistance to stay hydrated.

Use A01 (Abuse: physical) or A05 (Gross neglect) for willful instance of food deprivation.

3. Therapeutic or special diet

Therapeutic diet is not served as indicated in the care plan or a special request diet or food preferences are not accommodated and similar complaints.

Examples and Reporting Tips: Use when resident has specific dietary preferences, i.e., vegetarian, or dietary requirements based on religious practice or food allergies and similar problems.

I. Environment

Use this category for complaints involving the physical environment of the facility, including the resident's space.

1. Environment (air, water, noise, odors)

The building environment including the room or water temperature is too hot or cold or ventilation is inadequate.

Examples and Reporting Tips: Use for cigarette smoke or other unpleasant odors; noise; and similar problems.

2. Building structure (security, hazards)

Building interior or exterior is not maintained, or there are building hazards such as poor lighting, building not secure and similar complaints.

Examples and Reporting Tips: Use for complaints about elevator problems or malfunctioning automatic doors. Use for fire safety concerns such as inadequate or non-functioning or expired fire extinguishers, fire alarms, smoke detectors,

or other emergency equipment not available and any other building maintenance problem.

3. Supplies (linens, toiletries), storage and furnishings (poor condition, unavailable)

Furnishings in resident rooms or common areas are lacking or in disrepair; inadequate or inaccessible locked storage for valuables. Shortage of supplies such as bed linens, towels, toilet paper, etc.

Examples and Reporting Tips: Use if supplies such as linens or resident furniture are in poor condition.

Use H01 (Food services) if there is not enough food on hand in the facility.

4. Accessibility (space for activities or dining, ADA, barriers or obstructions)

Complaints regarding building and grounds accessibility.

Examples and Reporting Tips: Inappropriate door handles; electronic door openers not available; sinks and toilets are wrong height, lack grab bars, etc. inaccessible entrances/exits or hallways and similar complaints.

5. Housekeeping, laundry, pest abatement

Housekeeping services are inadequate or absent. Resident and common rooms not clean, and linens are not changed. Laundry is not washed. Residents lack clean clothes. Problems with pest control and similar problems.

Examples and Reporting Tips: Pests include: bedbugs; cockroaches; rodents etc.

Use E02 (Personal property) for lost laundry.

J. Facility Policies, Procedures and Practices

Use this category for acts of commission or omission by facility leadership/owners including: administrators, resident managers, etc.

1. Administrative oversight (unresponsive, policies, failure to report, unlicensed facility)

Mismanagement including but not limited to: administrator is absent, unresponsive, inadequately trained or not supervising staff; incomplete, missing or falsified record keeping: background screening not performed; illegal policies/practices and similar complaints.

Examples and Reporting Tips: Use for failure of facility to report or investigate suspected resident abuse, neglect or exploitation to the specified authority.

Includes problems with a facility planning and implementing an all-hazards approach to disaster preparedness and response.

2. Fiscal management (including insufficient funds)

Facility lacks fiscal resources that result in: staff shortages, staff alerts of not being paid, lack of food, or supplies, utilities cut off, etc.

Examples and Reporting Tips: Includes problems related to bankruptcy and general insufficient funds to operate. Includes complaints about health care fraud, waste, and abuse.

Use I 03 (Supplies, storage and furnishings) if there is a shortage of supplies not related to fiscal management problems.

Use A04 (Financial exploitation) if the facility is misusing resident funds.

3. Staffing (shortage, training, turnover, unresponsive, supervision)

Problems with shortage of staff, turn over, over-use of temporary agencies, etc. Use for complaints about the skills or training of staff and similar complaints.

Examples and Reporting Tips: Includes all staff, direct care, nursing housekeeping, etc.

Use J01 (Administrative oversight) if the administrator is absent or on site infrequently.

K. Complaints about an Outside Agency (Non-facility)

Use this category for complaints involving decisions, policies, actions or inactions by the programs and agencies listed below; including private and public benefits.

1. Regulatory system

Complaints specific to actions or inactions of the licensing and certification agency or similar regulatory agency.

Examples and Reporting Tips: Complaints regarding access to survey information; response to complaints and survey process; failure to enforce and or sanction facility; closure process, and other similar issues.

2. Medicaid

Complaints regarding Medicaid eligibility, coverage or other issues related to the Medicaid program.

Examples and Reporting Tips: Use for problems involving implementation of the Pre-Admission Screening and Resident Review (PASRR) requirements of the Nursing Home Reform Act related to individuals with a mental illness, intellectual, or a developmental disability seeking admission to a Medicaid-certified nursing facility. Use for denials of Medicaid services.

3. Managed care

Complaints regarding covered services, denial of services or other issues related to a managed care plan.

Examples and Reporting Tips: Includes problems with coverage areas, enrollment and dis-enrollment, and the grievance and appeals process.

4. Medicare

Complaints regarding Medicare eligibility, coverage or other issues related to the Medicare program.

Examples and Reporting Tips: Includes complaints about observation status.

5. Veterans Affairs

Complaints about eligibility, coverage or other issues related to the Department of Veterans Affairs (DVA.)

6. Private insurance

Complaints regarding any private insurance company, covered services, denial of payment, etc.

Examples and Reporting Tips: Includes Long-Term Care insurance, disability insurance, Medicare supplemental and similar types of private insurance.

L. System: Others (Non-facility)

1. Resident representative or family conflict (including family interference with resident wishes)

Resident representative, or family member interferes with the resident's decision making, and preferences related to health, welfare, safety, or rights but does not rise to the level of abuse, gross neglect or exploitation.

Examples and Reporting Tips: Includes complaints regarding resident decision making such as guardianship, conservatorship, durable power of attorney/power of attorney, wills and similar complaints.

Use codes A01-A05 for any form of abuse, gross neglect or financial exploitation and for the perpetrator, select code 03 (Family, Resident representative, Friend).

2. Services from outside provider (including PASRR services)

Problems with services provided to a resident from an individual or entity not associated with or arranged by the facility.

Examples and Reporting Tips: Use for complaints about services that are typically arranged by the resident or family independent of facility services and may include, companion services, hospice, therapies, transportation and similar problems.

Use F06 (Access to health-related services) if the facility fails to arrange for services as directed by care plan.

3. Request to transition to community setting

Barriers to transition to community, inadequate assistance with accessing housing, services and supports not related to facility action or inaction.

Examples and Reporting Tips: Use when the resident requests assistance to remove organizational barriers, including lack of housing, unresponsive local contact agency, and lack of personal care services that prevent or delay a move.

Use D02 (Live in less restrictive setting) if the facility is not providing assistance or discharge planning.

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Supplement 11-C: Exercise - Researching Statutory Support for Nursing Facility Complaints

This exercise may be completed either in class or as self-study as directed by your instructor. Use the provided links to find the rule. The first one has been completed for you. To shorten your search, use "Ctrl F" to complete a word search. To read some Subchapters in their entirety, you may need to select "Cont'd..." or "Next Page" if these options are available at the bottom of the page.

[Texas Administrative Code, Title 26, Part I, Chapter 554](#), Nursing Facility Requirements for Licensure and Medicaid Certification

Example

- 1) May medications be released to residents? Reference §554.1507(a)(b) [Hint: Find Subchapter P, Pharmacy Services, §554.507 Drug Release]
- 2) What is the maximum time period between meals? [Hint: Subchapter L]
Reference §554. _____
- 3) Must the facility provide physician-ordered medical transportation to medical services outside the facility? [Hint: Subchapter X]
Reference §554. _____
- 4) Where can you find information about appropriate reasons for a discharge?
Reference §554. _____
- 5) What types of information must be conspicuously and prominently posted in a licensed nursing facility?
Reference §554. _____
- 6) Does the resident have to be provided access to representatives of the Ombudsman Program?
Reference §554. _____
- 7) In §554.307 (Hint: Subchapter D, Division 2), what do regulations say about the accessibility of resident call cords (call button / call light cord)?

8) What is a "Therapeutic Home Visit"? [Hint: Subchapter AA]

Supplement 11-D: Exercise - Researching Statutory Support for Assisted Living Facility Complaints

This exercise may be completed either in class or as self-study as directed by your instructor. Use the provided links to find the rule. The first one has been completed for you. To shorten your search, use "Ctrl F" to complete a word search. To read some Subchapters in their entirety, you may need to select "Cont'd..." or "Next Page" if these options are available at the bottom of the page.

[Texas Administrative Code, Title 26, Part 1, Chapter 553](#): Licensing Standards for Assisted Living Facilities

- 1) What criteria are used to determine if a resident is placed appropriately in a Type A assisted living facility? [Hint: Subchapter A, Introduction, Types of ALFs]

Reference §553.3(b)_____

- 2) Does the resident service plan have to be approved and signed by the resident or resident's responsible party for making health care decisions? [Hint: Subchapter E Standards for Licensure, Admission Policies and Procedures]

Reference §553. _____

- 3) May a resident self-administer medications? [Hint: Subchapter E Coordination of Care, Medications, Self-Administration]

Reference §553. _____

- 4) Does the resident have to be provided access to representatives of the Ombudsman Program? [Hint: Subchapter Standards for Licensure, Access to Residents and Records by the State Long-Term Care Ombudsman Program]

Reference §553. _____

- 5) What required postings must an assisted living facility prominently and conspicuously post for display in a public area of the facility that is readily available to residents, employees, and visitors?

Reference §553. _____

- 6) May a facility discharge a resident because covert electronic monitoring is being conducted by or on behalf of a resident?

Reference §553. _____

- 7) Is a 30-day discharge notice required in assisted living?

Reference §553. _____

Supplement 11-E: Training and Advocacy Resources

Websites for Advocacy Tools, Resources, and Free Training

- Office of the Long-Term Care Ombudsman, Texas HHS - Annual Reports, Publications / Brochures, Training Resources:
<https://ltco.texas.gov/reports>
- The National Consumer Voice / The National Long-Term Care Ombudsman Resource Center: Webinars, Policy Updates, Fact Sheets, Training on Demand: <http://www.ltcombudsman.org/>
- Gov Delivery - Sign up to receive nursing and assisted living provider letters and other communications:
<https://public.govdelivery.com/accounts/TXHHSC/subscriber/new>
- Long Term Care Community Coalition <https://nursinghome411.org/about-ltccc/>
- Justice in Aging <https://justiceinaging.org/>

Other Resources

- CMS: Find and compare nursing facilities:
<https://www.medicare.gov/care-compare/>
- CMS Quality Safety & Oversight (QSO) Communications:
<https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/SurveyCertificationGenInfo/Policy-and-Memos-to-States-and-Regions>
- Texas Long-Term Care Provider Search:
<https://apps.hhs.texas.gov/LTCSearch/providersearch.cfm>
- Texas HHS Provider (PL) & Information Letters (IL):
<https://www.hhs.texas.gov/providers/long-term-care-providers>

Supplement 11-F: State and Federal Regulations, Statutes, and Guidance Used in Ombudsman Work

State Statutes for Long-Term Care Facilities

Assisted Living Facilities

Texas Health and Safety Code

Title 4. Health Facilities

Subtitle B. Licensing of Health Facilities

Chapter 247. Assisted Living Facilities

<https://statutes.capitol.texas.gov/Docs/HS/htm/HS.247.htm>

Nursing Facilities

Texas Health and Safety Code

Title 4. Health Facilities

Subtitle B. Licensing of Health Facilities

Chapter 242. Convalescent and Nursing Homes and Related Institutions

<https://statutes.capitol.texas.gov/docs/HS/htm/HS.242.htm>

State Regulations – Texas Administrative Code

Assisted Living Facilities

Licensing Standards for Assisted Living Facilities

Texas Administrative Code

Title 26. Health and Human Services

Part 1. Health and Human Services Commission

Chapter 553. Licensing Standards for Assisted Living Facilities

https://texas-sos.appianportalsgov.com/rules-and-meetings?chapter=553&interface=VIEW_TAC&part=1&title=26

Nursing Facilities

Nursing Facility Requirements for Licensure and Medicaid Certification

Texas Administrative Code

Title 26. Health and Human Services

Part 1. Health and Human Services Commission

Chapter 554. Nursing Facility Requirements for Licensure and Medicaid Certification

https://texas-sos.appianportalsgov.com/rules-and-meetings?chapter=554&interface=VIEW_TAC&part=1&title=26

Federal Regulations and CMS Surveyor Guidance

Federal Nursing Facility Regulations - [42 CFR §483](#)

CMS State Operations Manual Appendix PP

<https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/GuidanceforLawsAndRegulations/Downloads/Appendix-PP-State-Operations-Manual.pdf>

Other State Statutes Used in Ombudsman Work

Advanced Directives

Texas Health and Safety Code

Title 2. Health

Subtitle H. Public Health Provisions

Chapter 166. Advance Directives

Subchapter A. General Provisions

<https://statutes.capitol.texas.gov/Docs/HS/htm/HS.166.htm>

Guardianship

Texas Estates Code

Title 3. Guardianship And Related Procedures

Subtitle E. Administration Of Guardianship

Chapter 1151. Rights, Powers, And Duties Under Guardianship

Subchapter A. Rights, Powers, And Duties In General

Subchapter H. Rights Of Wards

<https://statutes.capitol.texas.gov/Docs/ES/htm/ES.1101.htm>

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Chapter 12: Resident Records

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

Learning Objectives

- Understand the requirement to get resident consent.
- Distinguish when reviewing resident records is necessary.
- Identify elements of medical records

Contents

- Resident or LAR Access
- Ombudsman Access
- Frequently Asked Question - Access
- Request, Review, and Use of a Record
- Medical Records
- Types of Resident Records
- Disclosure of Confidential Resident Records
- Ombudsman Program Records

Video(s), Supplements, Forms

- Supplement 12-A - Common Medical Chart Abbreviations

Resident and LAR Access to Resident Records

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

- Licensing Standards for Assisted Living Facilities [26 TAC §553.267\(a\)\(3\)\(M\)](#)
- Nursing Facility Requirements for Licensure and Medicaid Certification [26 TAC §554.403\(f\)](#)



Determine whether the following statement is True or False.

1) ____ True ____ False

Residents have the right to review all medical and financial records pertaining to them.

Ombudsman Access

An ombudsman has immediate access to all files, records, and other information concerning a resident, including an incident report involving the resident, IF:

- the ombudsman has the consent of the resident or resident's LAR, if applicable;
- the resident is unable to communicate consent to access and has no LAR; or
- such access is necessary to investigate a complaint and the following occurs:
 - the resident's LAR refuses to give consent to access to the records, files, and other information;
 - the ombudsman has reasonable cause to believe the LAR is not acting in the best interests of the resident; AND
 - if it is the ombudsman seeking access to the records, files, or other information, the ombudsman obtains the approval of the State Ombudsman to access the records, files, or other information without the LAR's consent.

Examples of a Resident Record

- Admission paperwork with resident signature;
- Bathing schedules;
- Care notes;
- Care plans;
- Dietary orders;
- Incident reports related to the resident;
- Grievances;
- Medication administration records; and
- Physician orders

Request, Review, and Use of a Record

Process for an Ombudsman to Access a Resident Record

To access a resident record, an ombudsman must request consent from the resident or LAR, as applicable, to access the record. Ombudsmen have authority to access resident records without consent if the resident is unable to communicate consent to access and has no LAR.

If a resident's LAR refuses to give consent to the ombudsman to access the records, files, or other information, and the ombudsman has reason to believe the LAR is not acting in the resident's best interests, the ombudsman must obtain the approval of the State Ombudsman to access the resident's records without the LAR's consent.

Process for an Ombudsman to Request a Record

An ombudsman may seek access to a record after a resident or LAR grants consent, or the ombudsman determines that the ombudsman has the authority to access a record without consent because the resident is unable to consent and does not have an LAR. The ombudsman must only request the records necessary to investigate the complaint.

The ombudsman may request a record with staff at the nurse's station or administrative office. If facility staff asks for proof of consent, the ombudsman must complete HHS Form "Acknowledgement of Ombudsman Access to Confidential Record" and provide the form to facility staff (OPPM Section 540(d)).

Copies of or Notes about a Resident Record

A note made or copy of a resident record is an Ombudsman Program record and needs to be protected in accordance with program disclosure requirements.

SOURCE: OPPM, Section 540(f).

HIPAA Does Not Prevent Release of Information to a Certified Ombudsman

The rules adopted under the Health Insurance Portability and Accountability Act do not prevent a nursing or assisted living facility from releasing protected health information or other identifying information regarding a resident to a certified ombudsman as long as the requirements established in the OPPM, Section 540 are met. A certified ombudsman is a “health oversight agency” as that phrase is defined in 45 CFR §164.501.

SOURCE: OPPM, Section 560.

Ombudsman Access to Resident Representative Information

An ombudsman has access to the name and contact information of a resident representative when the information is needed to perform functions of the Ombudsman Program.

SOURCE: OPPM, Section 530.

Frequently Asked Question – Ombudsman Access

Question: What should an ombudsman do if facility staff refuse to allow the ombudsman to review a resident record?

Answer: *If facility staff refuse to provide a resident record to an ombudsman who has obtained consent for the record or has authority to access without consent, the ombudsman, if not the MLO, must notify the MLO. Additionally, if staff refuse to allow an ombudsman privacy when reviewing the resident record, the ombudsman, if not the MLO, must notify the MLO.*

SOURCE: OPPM, Section 540.

Tips on Reviewing Resident Records

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

- When residents ask you to look at their records, you may assist immediately and involve them in the request to facility staff.
- If you decide that review of a record is necessary to investigate a complaint, your program may require volunteers to consult with their supervising staff ombudsman before proceeding. Check with your supervising staff ombudsman about their policy on volunteers reviewing records.
- Always get oral or written consent from the resident or legal representative.
- Always document that the resident or legal representative gave consent and provide documentation to your ombudsman office.
- Interns may not review resident records.
- Never pressure a resident for the consent. Respect their wish for privacy and act in accordance.

Consider the following before accessing a resident's confidential record:

- What is the issue or concern?
- Does the resident understand a request for records will identify him or her?
- Does the resident know they have the right to review personal records?
- What factors make review of a record necessary on this case?
- What specific facts are you looking for?
- Does the resident have a legally authorized representative?



Determine if the following statement True or False.

1) ____ True ____ False

A note made or copy of a resident record is an Ombudsman Program record.

Records Ombudsmen DO NOT Access

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

- Personnel; and
- Facility budget and accounting.



Ombudsman Tip – Quality Assurance

Facilities may state that a record is not releasable because it is a product of the facility's quality assurance committee. However, if the record names the resident who consented to the investigation and the document is pertinent to your investigation, it is likely subject to release to the ombudsman. In these cases, contact the State Ombudsman for assistance.

Medical Records

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

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

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

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



Ombudsman Tip – Resident Medical Records

Medical records in nursing facilities and assisted living facilities vary on how much and what resident information is included. Ask facility staff for help when needed to find specific information within the record.

Overview of Medical Record Organization

Staff organize content in resident medical records by sections that often include the following information. If you cannot find information, ask a charge nurse for help. Many care providers use electronic records, and an ombudsman has access to the same information in them as a written medical record.

Administration

- Admission paperwork (contracts, face sheet which has emergency contact information, major diagnoses, resident photo, date of birth, etc.).
- Advance care planning documents such as Directive to Physician, Medical Power of Attorney, Durable Power of Attorney, Out-of-Hospital Do Not Resuscitate, and Guardianship paperwork.

History and Physical

- Comprehensive medical history and physical exams done by the resident's physician.
- May include discharge summaries from hospitalizations.
- May include a medical overview of the patient.

Vital Signs

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

Progress Notes

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

Physician Orders

Instructions to support personnel for any service to be done for the resident.

- Medication
- Lab test or x-ray
- Therapy: speech, physical, occupational
- Activity level

Individual Assessment, Care and Service Plans

- See Chapter 8: Care Planning

Nurses Notes

- Dated reports on what happened during each shift
- This section will be extensive in a nursing facility
- Negotiated risk agreement(s)
 - Documentation of a risk a resident has been informed of and chooses to take. Examples include a resident refusing thickened liquids to prevent choking and a resident using a reposition device for bed mobility and transfer, like a bed rail.

Labs

- Reports of laboratory results, such as blood chemistry, urine cultures, sputum cultures, and feces tests.

Imaging

- Reports of any imaging study, such as x-rays, CT scans (computed tomography), MRIs (magnetic resonance imaging), and others.



Ombudsman Tip – Do NOT Provide Medical Advice

Do not make medical assumptions, interpretations, or provide medical advice to facility staffs, residents, or family.

Therapy

- Dated notes on physical therapy (PT), speech therapy (ST), and occupational therapy (OT).

Case Management

- Transfer or discharge plans including which location and expected timeframe.
- Dated and signed social service notes

Medications

The Medication Administration Record (MAR) or the electronic Medication Administration Records (e-MAR) is a list all medications prescribed for a resident and a record of when medications were given, missed, and refused.

Incident Reports

Facilities fill out incident reports in order to record details of an unusual event that occurs at the facility, such as an injury to a resident, staff member, or visitor.



Exercise: Name the Medical Record Section

Instructions

List the section of the medical record where you might find the following examples.

- 1) What care does the morning shift need to give following the night shift?

- 2) Who did the resident name as her Medical Power of Attorney?

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

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

5) When did the resident return from the hospital?

6) What is the resident's working diagnosis?

7) Did the physician prescribe Ativan?

8) When does the facility plan to discharge the resident?

Documentation of Consent to Access a Record

Ombudsmen document consent in case notes, the Long-Term Care Ombudsman Activity Report, Consent to Release Records to the Certified Ombudsman HHS Form 8624-O (oral), or Consent to Release Records to the Certified Ombudsman Form 8624-W (written). View the forms on the Texas HHS Forms Web page: <https://hhs.texas.gov/laws-regulations/forms>.

In preparation for some meetings, such as care or service plan meetings or fair hearings, an ombudsman may make copies from the resident's clinical record. These then become a confidential Ombudsman Program record and should be protected as such. Any copies of residents' records obtained by an ombudsman constitutes an Ombudsman Program record and ombudsman must follow disclosure requirements as outlined in the Ombudsman Policies and Procedures Manual.

A certified ombudsman must, at the request of a facility staff person, provide a completed HHS Form 8628, "Acknowledgement of Ombudsman Access to Confidential Record" to the facility at the time the certified ombudsman is requesting access to a confidential record concerning a resident from the facility staff person. Download Form 8628 from the HHS Forms Web page link above.



Answer the following question.

- 1) What should an ombudsman do if facility staff refuses to allow a certified ombudsman, who has resident consent, to review a resident's record?
-

Disclosure of Confidential Resident Records

Disclosure means releasing confidential information to anyone outside of the Ombudsman Program. The OPPM establishes guidelines ombudsmen must follow for disclosure of confidential information in response to complaints and record requests. These guidelines apply to the State Ombudsman, all certified ombudsmen (staff and volunteers), and when specified, ombudsman interns.

Request for Written Confidential Information

Notify the State Ombudsman

If ombudsmen receive a request for confidential written information, they must immediately notify the State Ombudsman and provide the State Ombudsman with any communication from the person making the request.

SOURCE: OPPM, Section 640

Ombudsman Program Records

Confidential Ombudsman Program records include:

- Notes created while identifying, investigating, or attempting to resolve a complaint by or on behalf of residents or complainants.
- Copies of any portion of a resident's record.
- Records collected during an investigation of a complaint.
- Administrative records, policies, resident census, and other documents of nursing or assisted living facilities.
- Data relating to complaints and conditions in nursing or assisted living facilities.
- Notes made by an ombudsman while performing the functions of a long-term care ombudsman.
- Other records compiled and maintained by ombudsmen in carrying out their responsibilities.

SOURCE: OPPM, Section 5040



Determine whether the following statement is True or False.

1) ____ True ____ False

If a resident's LAR requests a certified ombudsman's notes related to a resident, the ombudsman must immediately notify the State Ombudsman.

Supplement 12-A: Common Medical Chart Abbreviations

Abbreviation	Term
AB	Antibody
ABD, ABDOM	Abdomen
ABN	Abnormal
ADENOCA	Adenocarcinoma
ADM	Admission
ADR	Adverse drug reaction
AK(A)	Above knee (amputation)
AKA	Also known as
BCC	Basal cell carcinoma
BE	Barium enema
B/F	Black female
BIL	Bilateral
BK(A)	Below knee (amputation)
BM	Bone marrow
BM	Bowel movement
B/M	Black male
BP	Blood pressure
BX	Biopsy
CC	Chief complaint
CHF	Congestive heart failure
CIS	Carcinoma-in situ

Abbreviation	Term
CRF	Chronic renal failure
CT SC	Computerized tomography scan
CVA	Cerebrovascular accident
CVA	Costovertebral angle
CXR	Chest x-ray
DC	Discharge
DC	Discontinued
DNR	Do not resuscitate
DO	Doctor of Osteopathic Medicine
DTR	Deep tendon reflex
DX	Diagnosis
ECF	Extended care facility
ECG, EKG	Electrocardiogram
EEG	Electroencephalogram
EENT	Eyes, ears, nose, & throat
EGD	Esophagogastroduodenoscopy
EMG	Electromyogram
ENL	Enlarged

Abbreviation	Term
ENT	Ear, nose & throat
FBS	Fasting blood sugar
FU	Follow up
FUO	Fever unknown origin
FX	Fracture
GB	Gallbladder
GI	Gastrointestinal
HB	Hemoglobin
HEENT	Head, eyes, ears, nose, throat
HGB	Hemoglobin
H&P	History and physical
IM	Intramuscular
IV	Intravenous
K	Potassium
L1-L5	Lumbar vertebrae
LE	Lower extremity
LFT	Liver function test
LLE	Left lower extremity
LLL	Left lower lobe (lung)
LLQ	Left lower quadrant (abdomen)
L-SPINE	Lumbar spine

Abbreviation	Term
LUE	Left upper extremity
LUL	Left upper lobe (lung)
LUQ	Left upper quadrant (abdomen)
MD	Doctor of Allopathic Medicine
MI	Myocardial infarction
MRI	Magnetic resonance imaging
NEURO	Neurology
N&V	Nausea and vomiting
OP	Operation
OP	Outpatient
OPHTH	Ophthalmology
OR	Operating room
OSTEO	Osteomyelitis
OT	Occupational therapy
OV	Office visit
PA	Posteroanterior
PA	Pulmonary artery
PA	Physician assistant
PALP	Palpable, palpated, palpation

Abbreviation	Term
PATH	Pathology
PDR	Physician's Desk Reference
PE	Physical examination
PEG	Percutaneous gastrostomy tube
PMD	Personal (primary) medical doctor
PMH	Past medical history
PND	Postnasal drip
POD	Postoperative day
PRN	As needed (pro re nata)
PT	Patient
PT	Physiotherapy
Q	Quadrant
q	every
QID	Four times a day
qd	Every day
RLE	Right lower extremity
RLL	Right lower lobe (lung)
RLQ	Right lower quadrant
RML	Right middle lobe (lung)
RO, R/O	Rule out

Abbreviation	Term
ROM	Range of motions
RT	Right
RUE	Right upper extremity
RUL	Right upper lobe
RUQ	Right upper quadrant
RX	Treatment
SCC	Squamous cell carcinoma
SNF	Skilled nursing facility
SOB	Shortness of breath
STAPH	Staphylococcus
STAT	Immediately (statim)
STREP	Streptococcus
SUB-Q, SUBQ	Subcutaneous
SX	Symptoms
T1-T12	Thoracic vertebra
TID	Three times a day
T-SPINE	Thoracic spine
UE	Upper extremity
UGI	Upper gastrointestinal

Abbreviation	Term
URI	Upper respiratory infection
UROL	Urology
UTI	Urinary tract infection
VS	Vital signs
W/	With
W/F	White female
WNL	Within normal limits
W/O	Without
WT	Weight
W/U	Work-up
XR	X-ray

Chapter 13: Regulators and Other Resources

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

Learning Objectives

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

Contents

- Regulators and Other Resources
- Ombudsman Role with Regulatory Services
- Other Resources
- Ombudsman Referrals to Outside Agencies

Video(s), Supplements, Forms

Regulators and Other Resources

With regulators and other agency resources, ombudsmen communicate professionally as advocates and work on behalf of residents with their consent. Ombudsmen maintain resident and complainant confidentiality and follow ombudsman consent guidelines as they coordinate with other agencies.

Regulators

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

- Federal – Centers for Medicare and Medicaid Services (CMS)
- State – Regulatory Services (Texas Health and Human Services)

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

Centers for Medicare & Medicaid Services (CMS)

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

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

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

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

Texas HHS Regulatory Services

Regulatory Services is the state survey agency of Texas. Regulatory Services main responsibilities are licensure and certification of facilities. This is accomplished through inspections of several facility types and services related to long-term services and supports. It monitors facilities for compliance with rules in the Nursing Facility Requirements and Licensing Standards for Assisted Living Facilities. Another major responsibility is to conduct investigations of complaints and incidents. Regulatory Services staff who conduct inspections are commonly referred to as “surveyors” and sometimes as “the state” or “state surveyors.”

Regulatory Services staff:

- Determine that regulated facilities comply with federal and state rules;
- Determine if providers are meeting the minimum standards and requirements for service, determine conditions that may jeopardize resident health and safety, and identify deficient practice areas;
- Monitor providers’ plans of correction to ensure that areas of inadequate care are corrected and comply with state and federal requirements; and
- Take enforcement actions if facilities are not in compliance with requirements.

By federal and state laws, both Regulatory Services and the Long-Term Care Ombudsman Program have mandates to receive and investigate complaints. To expedite investigations, a Program Agreement explains each entity’s joint and individual responsibilities.



Very important information!

Regulatory Services and the Long-Term Care Ombudsman Program are mandated to investigate complaints. To expedite investigations, a Program Agreement explains each entity’s joint and individual responsibilities.

The Long-Term Care Ombudsman Program does not determine whether alleged ANE happened. Regulatory Services determines if alleged ANE occurred in a facility.

Surveys and Licensures

Initial Licensure

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

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

Nursing Facilities

To become licensed, a nursing facility operator submits a license application, pays a fee, and the facility passes a health and life safety code inspection. Facilities choose to be private pay (licensed only), Medicaid- or Medicare-certified, or dually certified to be reimbursed for Medicaid and Medicare services. When receiving government reimbursement, the facility must comply with additional requirements.

Regulatory Services conducts surveys and licensing inspections of nursing facilities. The licensing inspection is usually conducted in conjunction with the annual recertification survey. These visits:

- Are unannounced;
- May take place on any day of the week at any time of day;
- Have results that are available to the public; and
- Are resident-directed and outcome-oriented.

Assisted Living Facilities

To become licensed, an applicant submits an application, completes Assisted Living Facility Pre-Licensure Computer-Based Training, pays a fee, and the facility passes a health and life safety code inspection. Under some circumstances, a facility can get licensed after a life safety inspection only.

For assisted living facilities, Regulatory Services conducts similar licensure inspections on average once every two years, to determine if the facility

complies with licensing standards. Standards are less rigorous than requirements of nursing facilities.



Very important information!

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

Purposes of a Survey

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



Ombudsman Tip – Find and Review the Facility Survey Inspection Report

Survey inspection reports and copies of other inspection reports must be made available to the ombudsman upon request to Regulatory Services.

Tasks Surveyors Complete During a Standard Survey.

Modifications of the tasks below, which are used in the nursing facility survey, are applied to the assisted living facility standard survey.

Offsite Preparation

Surveyors review the facility's history and identify any existing concerns. They may preselect potential residents for the sample. They determine if any features

of the facility require specialty surveyors, such as pharmacists and dieticians, to join the survey team. These surveyors may be onsite only for the portion of the survey relevant to their expertise.

Entrance Conference and Onsite Preparatory Activities

At the entrance conference, the team leader informs the administrator of the survey and introduces the team members. While the team leader requests additional information from the administrator, other team members may begin task three, the initial tour.

Initial Tour

Surveyors review the facility, staff, and residents, obtain an initial evaluation of the environment including the kitchen, confirm or invalidate any preselected concerns, and add concerns discovered during the tour.

Sample Selection

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

Information Gathering

Surveyors make observations of the facility, kitchen, residents, quality of life assessments, medication passes, quality assessment and assurance review, and abuse prohibition review.

Surveyors hold a *resident group interview* and ask standard questions about rights and care. Only selected residents attend. When a survey team runs the resident meeting, this is not a resident council meeting. An ombudsman who attends a resident group interview reports this as survey participation.

Information Analysis for Deficiency Determination

Surveyors review the collected information and determine whether or not the facility failed to meet one or more of the regulatory requirements.

Exit Conference

Surveyors inform the facility of their observations and the preliminary findings.



Fill in the blank in the following statement.

- 1) The purpose of a survey is to determine whether facilities meet licensing standards and whether the facility meets standards for _____ in Medicare or Medicaid.

Throughout the survey, the team discusses observations and information collected. Surveyors can extend a survey beyond the typical four days in a nursing facility and one day in an assisted living facility.

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

Complaint Investigations

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

Substandard Quality of Care (SQC)*

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

Immediate Jeopardy (IJ) or Immediate Threat (IT)

An IJ or IT is a situation in which the provider's noncompliance has caused, or is likely to cause, serious injury, harm, impairment, or death to a resident or several residents. If surveyors identify an IJ to residents' health and safety,

they notify the administration with specific details, including the individuals at risk, before the survey team leaves the facility. The facility must immediately implement corrective measures and faces daily fines until the problem is corrected. Only onsite confirmation by surveyors of the facility's corrective actions can remove IJ status.



Ombudsman Tip – Residents Have the Right to Examine Survey Results

Residents have the right to examine the results of the survey of a facility conducted by federal or state surveyors and any plan of correction. The facility must make the results available for examination in a place readily accessible to residents and must post notice of their availability.

Enforcement

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

- Suspension of a license;
- Revocation of a license;
- Emergency suspension and closing order;
- Referral to the Attorney General;
- Suspension of admissions; and
- Administrative penalties, which range from \$100 to \$10,000 based on severity.

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

arbitration, and appeal through CMS. Nursing facility Medicaid enforcement actions include:

- Imposition of civil money penalties; and
- Termination of the provider agreement (loss of its Medicaid contract).

The Enforcement section of Regulatory Services may take enforcement action on an assisted living facility when a facility is in violation of the sections of Title 26, Chapter 553, the Texas Health and Safety Code, Chapter 247; an order adopted under Texas Health and Safety Code, Chapter 247, or a license issued under Texas Health and Safety Code, Chapter 247.

SOURCES: 26 TAC §553. Subchapter H; 26 TAC §554, Subchapter V.

Administrative Penalties

Administrative penalties are created by state law and rule. Some administrative penalties allow a facility to correct the problem and remove the penalty. Other violations must be corrected but are not eligible for removing the financial penalty, including a violation that:

- Results in serious harm or death to a resident,
- Is a serious threat to the health or safety of a resident;
- Substantially limits the facility's capacity to provide care;
- Specific portions of the criteria for denying a license; or
- A violation of a resident right.

SOURCES: [26 TAC §554.2112](#); [26 TAC §553.751](#).

Amelioration

Amelioration is a term used in enforcement to describe the option to make facility improvements with money imposed as a penalty. Amelioration allows a facility to submit a plan for approval by the State of Texas. The plan must propose how part of the administrative penalty will be used to improve services in a nursing or assisted living facility. Rules apply.

SOURCES: [26 TAC §554.2115](#); [26 TAC §553.751](#).

Trustee Appointment

With assistance from the Office of the Attorney General, Regulatory Services may petition a Travis County court for the involuntary appointment of a trustee.

This enforcement action is rare as it is costly and likely results in the forced closure of the facility and relocation of all residents. Regulatory Services argues its case to the court and the facility has an opportunity to make counter arguments. If a trustee is appointed, the trustee controls all facility operations and serves as an officer of the court until dismissed by the court.

Another option of a trustee placement is by agreement between Regulatory Services and the facility operator. In the case of a trustee by agreement, the operator pays all costs for the trustee. In practice, operators are more likely to hire a consultant to serve this function and not formally agree to a trustee.

SOURCE: [26 TAC §554.2116](#); [26 TAC §553.651](#)- [§553.711](#).

Revocation of a Nursing Facility License

The executive commissioner may revoke a license if the facility has committed three violations, also known as “three strikes” (see Immediate Threat Violations - PL 18-03 NF) The violations:

- Constitute an immediate threat to health and safety related to abuse or neglect of a resident within a 24-month period at the same facility; and
- Each of the violations is reported in connection with a separate survey, inspection, or investigation visit that occurred on separate entrance and exit dates.
- For purposes of calculating the 24-month period, the date a violation occurs is the date of the initial exit conference for the survey inspection, or investigation visit in which the violation was cited.
- Facilities that change ownership after receiving one or two violations described above reset the facility’s strikes to zero.

SOURCE: [26 TAC §554.2107](#).

Revocation of an Assisted Living Facility License

Texas Health and Human Services Commission may revoke an assisted living facility license when the applicant, license holder, or a controlling person violates [26 TAC §553.751\(a\)\(2\)-\(9\)](#) related to Administrative Penalties, or violates the [Texas Health and Safety Code, Chapter 247](#) in a repeated or substantial manner, submits false or misleading statements on a license application or application attachments, uses subterfuge or other evasive means to obtain a license, conceals a material fact on a license application that would have been the basis for denying a license under [26 TAC §553.17](#), or violates the

[Texas Health and Safety Code §247.021](#). The facility may continue to operate during a revocation as long as the revocation is under appeal. If revoked, the license must be returned to HHSC.

SOURCE: [26 TAC §§553.451-553.483](#) and [26 TAC §553.751](#).



Ask the Instructor - Enforcement Actions

1) Which enforcement action occurs most often? _____

Credentialing

Many types of personnel work in nursing and assisted living facilities. Professional boards license physicians, nurses, pharmacists, social workers, and others are regulated by state agencies and boards.

Board of Nursing ([BON](#))

The BON issues licenses to graduates of approved nursing education programs seeking licensure by exam and to nurses licensed in other states seeking Texas licensure by endorsement. All nurses are required to renew their licenses on a biennial basis with evidence of required continuing nursing education.

Nursing Facility Administrator ([LNFA](#)) Licensing and Investigations Program

- Issues, renews, and revokes licenses, as well as provides continuing education;
- Investigates complaints or referrals resulting from findings of substandard quality of care and violations of the NFA standards of conduct;
- Imposes and monitors sanctions; and
- Provides quarterly training for administrators in training.

Nurse Aide Training and Competency Evaluation Program ([NATCEP](#))

HHS reviews and approves or disapproves nurse aide training and competency evaluation programs and nurse aide competency evaluation programs. Each NATCEP must provide a minimum of 100 clock hours of training and teach the HHS-established curriculum.

Nurse Aides ([CNA](#))

HHS maintains a registry of all nurse aides who are certified. Certified Nurse Aides are required to have:

- Participated in a state-approved nurse aide training and competency evaluation program: 60 classroom hours; 40 hours clinical training;
- Passed skills and written portions of the competency evaluation program test; and
- Review and investigate allegations of abuse, neglect, or misappropriation of resident property by nurse aides.

Medication Aides ([CMA](#))

- Issues and renews Medication Aide permits and review continuing education;
- Imposes sanctions;
- Approves and monitors medication aide training programs;
- Develops educational, training, and testing curriculum; and
- Coordinates and administers tests.

SOURCE: [PL-2023-14](#)

Employee Misconduct Registry ([EMR](#)) and Employability Status Search

HHS-regulated facilities and agencies are required to check the Employee Misconduct Registry and nurse and medication aide registries before hiring an individual to determine if the person is listed in either registry as having committed an act of abuse, neglect, exploitation, misappropriation, or misconduct against a resident or consumer and is, therefore, unemployable.



Answer the following question.

- 1) All nursing and assisted living facility employees must be determined employable. Operators must check what two registries?

Ombudsman Role with Regulatory Services

According to the OPPM Section 5080, ombudsmen are prohibited from disclosing information provided to the ombudsman by a surveyor regarding a survey or complaint investigation of a facility to a person who is not in the Ombudsman Program. Examples of such information are information:

- Regarding an upcoming survey of a facility;
- From a conversation with a surveyor about a survey; or
- Discussed during an exit conference or survey team meeting attended by the ombudsman.

Ombudsman Survey Participation

A member of the Regulatory Services survey team is required to contact the local ombudsman entity within two hours of entering a facility to ask about concerns and to say when the resident group interview is scheduled.

With resident and complainant permission, ombudsmen provide resident names to include in the survey sample or for record review, and family members for interviews.



Ombudsman Tip – Consent and Regulatory

Ombudsman consent and confidentiality policies apply to communications with the Regulatory Services survey team.

Ombudsmen may:

- Attend the resident group meeting if invited by residents;
- Attend the exit interview (between facility staff and the survey team);
- Participate in other activities as agreed upon;
- Describe systemic or serious concerns they have not been able to resolve.

Generally, ombudsmen do not report complaints they are currently working to resolve as it may trigger the surveyors to investigate the same issue.

If you arrive at a nursing or assisted living facility while Regulatory Services is conducting a survey, introduce yourself to the lead surveyor and provide relevant information about the facility. It is generally recommended that the ombudsman then leave unless they plan to attend the resident group interview.

This clarifies to residents and facility staff that surveyors are regulators and ombudsmen are advocates, keeping our roles distinct.

Other Resources

Within state government, agencies hold authorities and responsibilities that may impact people who live and work in nursing and assisted living facilities. Long-term care ombudsmen interact with agency staff on various levels. Ombudsmen most often work with staff in divisions of the following agencies:

- Texas Health and Human Services ([HHS](#)).
- Adult Protective Services ([APS](#)).
- Texas HHS Access and Eligibility Services ([AES](#)) or [Your Texas Benefits](#).

Staff who determine Medicaid eligibility are called eligibility workers and are often responsible for handling other benefit applications. Duties of these workers include verifying application information as well as helping clients to obtain necessary documentation. Authorizing approval for benefits, maintaining records, and investigating possible fraud are other required activities.

Complaint and Incident Intake (CII)

[CII](#) receives complaints about HHS licensed providers including nursing and assisted living facilities, state supported living centers, home health and hospice agencies, and day activity and health service agencies. The toll-free number is 1-800-458-9858. CII agents answer calls Monday through Friday from 7 a.m. to 7 p.m. If you call outside those hours, leave a message. Complaints may also be filed through email using this email address: ciicomplaints@hhs.texas.gov.

Ombudsmen must follow the guidelines established in the Ombudsman Policies and Procedures and this training manual.

Fair and Fraud Hearings

The [Fair and Fraud Hearings](#) section of the HHS Appeals Division receives appeal requests from applicants to contest actions taken regarding benefits and services. The programs include all Medicaid-funded services, the Supplemental Nutrition Assistance Program (formerly known as the Food Stamp Program), and other agency programs required by law or rule to provide the right to a fair hearing.

Fair and Fraud Hearings provide accessible, neutral forums to conduct administrative hearings while issuing just and impartial decisions with respect for the dignity of individuals and their due process rights. Hearings officers conduct the hearings, consider evidence, and issue decisions in accordance with rules, regulations, and laws.

State and federal laws require hearings officers to be impartial and to not have prior knowledge of any case. They may only consider evidence and testimony provided at the hearing to make a decision on a case.

Most hearings are held by phone but may be face-to-face if requested. The date, time, and call-in number are in the hearing notice. Once everyone is in attendance, the hearings officer explains what will happen and swears in everyone. The agency representative explains the action they took. Then appellants ask questions and explain why they disagree with the agency's action or inaction.

Hearings officers must issue a decision no later than 90 days from the date of the appeal request. Some circumstances could extend the time. Appellants have 30 days from the date on the decision to ask the hearings officer to reopen an appeal.

Nursing Facility Discharge Appeals

Federal and State law protect residents from improper discharge. Ombudsmen receive involuntary discharge notifications from nursing facilities and may receive a request for assistance from residents and resident representatives regarding discharge. Ombudsmen act to ensure the resident's rights are upheld. Because discharge is a time sensitive issue, ombudsmen must prioritize discharge cases accordingly.

Refer to the OPPM, Ombudsman Program Protocol 17-01: Notice of Discharge from a Medicaid Certified Nursing Facility for more information.

Ombudsman Role with Nursing Facility Discharge Appeals and Hearings

If invited by the resident or resident representative, attend the hearing. At the hearing, state your role as a long-term care ombudsman and witness for the resident.

If requested, submit an appeal request on behalf of the resident by using [HHS Form 8625](#), "Designation of a Long-Term Care Ombudsman as Representative and Request to Appeal a Nursing Facility Discharge." Keep a record that the request was submitted.

HHS Form 8625 must be used to designate, in writing, a long-term care ombudsman as the resident's representative. The resident or resident's LAR must sign the form. If the ombudsman signs for the resident, a witness must sign the form. If the resident does not have the ability to consent and has no LAR, the State Ombudsman will sign the form. It can be emailed to the State Ombudsman or faxed to (512) 438-3233.

Scan and email the signed form to oesfairhearings@hhsc.state.tx.us or fax it to 1(866) 559-9628. Include the following with the form:

- 1) A copy of the discharge notice;
- 2) The correct mailing address and contact information;
- 3) The reason the resident disagrees with the facility's decision to discharge;
- 4) Any request for accommodation at the hearing, including an interpreter; and
- 5) The names, addresses, and contact information of any witnesses the resident wants to attend the hearing.

The resident or representative may also call 211, option 3, to request the appeal or check the status of the appeal. Hearing staff will send a Hearing Packet to the resident or representative to acknowledge the hearing request and to set a time, date, and place for the hearing.

HHS Office of the Ombudsman

The [HHS Office of the Ombudsman](#) receives complaints from persons concerning services provided by HHS, such as Medicaid services provided through an MCO, support services provided through HHS, and medical transportation provided through HHS.

HHS managed care ombudsmen help people with Medicaid managed care resolve problems. Before calling a managed care ombudsman, residents should first try to talk with the MCO about their concern. If the problem is not resolved, the HHS Office of the Ombudsman may be able to help. HHS Ombudsmen can help residents:

- 1) Find their way through the managed care system;

- 2) Solve problems;
- 3) Answer questions;
- 4) Understand their Medicaid coverage; and
- 5) Know their rights.

Residents may call toll-free (866) 566-8989. Managed care ombudsmen are available Monday – Friday, 8 a.m. to 5 p.m.

SOURCE: <https://hhs.texas.gov/about-hhs/your-rights/hhs-office-ombudsman>.

Preadmission Screening and Resident Review (PASRR)

The Preadmission Screening and Resident Review ([PASRR](#)) is a federal requirement to ensure that people are not inappropriately placed in nursing facilities. It requires all applicants, prior to admission to a Medicaid-certified nursing facility, are assessed to determine whether they might have a diagnosis of a mental illness, an intellectual disability, or a developmental disability. The preadmission screening is called a "[PASRR Level I Screen](#)."

The [PL1](#) is completed for every individual seeking admission to a Medicaid certified nursing facility regardless of their funding source or diagnosis.

If the screening is negative — meaning the individual is not suspected of having a mental illness, an intellectual disability, or a developmental disability — the nursing facility enters the PL1 into the online portal, and the PASRR process ends for that individual.

If the screening is positive — meaning the individual is suspected of having a mental illness, an intellectual disability, or a developmental disability — the local IDD authority ([LIDDA](#)) will complete and submit a PASRR evaluation within seven to 14 days, depending on the type of admission and length of stay.

PASRR evaluations help determine the most appropriate setting and help to develop recommendations for specialized services for the person's plan of care.

SOURCE: 26 TAC Subchapter BB Nursing Facility Responsibilities Related to Preadmission Screening and Resident Review (PASRR); Texas HHS: <https://www.hhs.texas.gov/providers/long-term-care-providers/long-term-care-provider-resources/preadmission-screening-resident-review-pasrr>. Accessed 01-10-2023.

Promoting Independence

In January 2000, Texas embarked on a [Promoting Independence](#) Initiative in response to the U.S. Supreme Court ruling in [Olmstead v. Zimring](#). The Court ruled in June 1999 that states must provide community-based services for persons with disabilities who would otherwise be entitled to institutional services, when:

- the state's treatment professionals determine that such placement is appropriate;
- the affected persons do not oppose such treatment; and
- the placement can be reasonably accommodated, considering the resources available to the state and the needs of others who are receiving state supported disability services.

People with complex medical needs can choose to live and receive care in a home setting instead of a nursing facility.

Money Follows the Person (MFP) Demonstration Project

The Centers for Medicare and Medicaid (CMS) sponsors the [Money Follows the Person Demonstration](#) (MFPD) to support state efforts to rebalance their long-term services and supports system so that people have a choice of where they live and receive services. Since its inception, the program has helped over 44,000 Texans move from institutions to the community. MFPD helps Texas increase the use of home and community-based services ([HCBS](#)) and reduce the use of institutionally based services. HCBS helps people with self-care tasks such as bathing, eating, and dressing, and enables people to live safely in the community.

Over the past 11 years, Texas has reduced the portion of LTSS expenditures that support institutionally based services from 53 percent in 2009 to 35 percent in 2020. At the same time, Texas increased the portion of LTSS expenditures on HCBS from 47 percent in 2009, to 65 percent in 2020. Community-based services now account for the majority of the state's LTSS expenditures.

MFPD is part of the state's Promoting Independence Initiative, the state's response to the supreme court [Olmstead decision \(119 S.C.T. 2176\)](#). Promoting Independence uses state general revenue to provide community-based services in the most integrated setting, within certain limitations.

In calendar year 2021, HHSC received over \$28 million in federal funds to help people transition out of nursing facilities, state supported living centers, intermediate care facilities for individuals with intellectual disabilities, and other institutions. Funds also support behavioral health services that help people remain in the community, integrated employment that promotes greater self-sufficiency, and community-based supports to persons with intellectual and developmental disabilities who have complex medical and behavioral health needs.

Texas HHSC also collaborates with the Texas Department of Housing and Community Affairs ([TDHCA](#)) to provide affordable, accessible, and integrated housing for persons transitioning from institutional settings. The [Section 811 Project Rental Assistance \(PRA\) program](#) is a federally funded program that pays part of a tenant's rent, based on income, making their housing more affordable. The rental housing support is available in Section 811 PRA housing, located in eight regions of the state. The program has housed over 600 people since it began in 2016.

SOURCE: Texas HHS, Promoting Independence. <https://www.hhs.texas.gov/providers/long-term-care-providers/long-term-care-provider-resources/promoting-independence-pi>. Accessed 03-17-2023.

Relocation Service Coordination

In nursing facilities, social workers are responsible for discharge planning. If a resident indicates an interest in returning home or moving to a less restrictive environment, a social worker helps the resident explore their options. An MCO is required to participate in this process once it becomes aware of the resident's request. All STAR+PLUS MCOs must participate in the Promoting Independence (PI) initiative.

The MCO must designate a point of contact, if not the Nursing Facility Service Coordinator, to receive referrals for residents who want to return to the community using STAR+PLUS Home and Community Based Services (HCBS) waiver services. HCBS waiver is an authorization from Medicaid that allows a beneficiary to receive services at home or in a community setting, rather than a nursing facility. The MCO Service Coordinator, or point of contact, works with the resident and resident's family, the individual's primary care physician, the nursing facility discharge planner, and other community partners, as needed.

If the initial review does not support a return to the community, the Service Coordinator must conduct a second assessment 90 days after the initial

assessment, and quarterly thereafter, to evaluate if the individual's condition or circumstances changed and support a return to the community. If a return to the community is possible and appropriate, the Service Coordinator must develop and implement a transition plan with the individual and their supports.

Prior to the discharge date, the MCO must ensure all necessary services, including transition assistance services ([TAS](#)) items, as well as mental health or substance use disorder treatment, are in place on the discharge date. The MCO service coordinator or point of contact must be present at the relocation site on the day and time of the resident's transition.

Following discharge, the MCO must maintain contact with persons relocated from nursing facilities in the time intervals in the STAR+PLUS Handbook.

The MCO must maintain documentation of the assessments completed as part of this initiative and make them available for state review at any time.

STAR+PLUS Handbook <https://www.hhs.texas.gov/handbooks/starplus-handbook>. Accessed 2021.

Quality Monitoring Program (Nursing Facilities Only)

The Quality Monitoring Program ([QMP](#)) has a team of quality monitors comprised of nurses, pharmacists, and dietitians. Quality monitors use the Early Warning System (explained later in this chapter) scores to prioritize visits to nursing facilities and conduct initial and follow-up quality monitoring (QM) visits for higher risk facilities and facilities with a history of resident care deficiencies.

What do quality monitors do?

Quality monitors partner with nursing facility staff and provide educational and technical assistance to improve quality of care and resident outcomes. They perform the following types of in-person support and technical assistance to nursing facility staff:

- QM Visits: Initial and Follow Up;
- Rapid Response Team (RRT) Visits; and
- In-Service visits.

Quality Monitoring Visits

QMP visits *are not a regulatory activity*. During a QMP visit, the quality monitors may:

- Recommend changes to policies or procedures;
- Conduct staff or in-service training;
- Offer technical assistance; and
- Educate staff about evidence-based best practices.

Rapid Response Team Visit

The *HHS Early Warning System (EWS) identifies nursing facilities that are high risk. EWS scores are used to prioritize Rapid Response Team (RRT) visits. Nursing facilities that are identified as high risk. A facility must cooperate with a RRT to improve the quality of care provided at the facility. A RRT may visit a facility that requests assistance, but that visit may not occur until at least 60 days after the date of an exit interview following an inspection.

In-Service Visit

During in-service visits, quality monitors provide in-service education presentations to NF staff, offering evidence-based information in an interactive manner. The information provided supports quality improvement in multiple areas of long-term care, including fall prevention and reducing the use of anti-psychotic medications.

**Early Warning System*

[Chapter 255 of the Texas Health and Safety Code](#) requires the Texas Health and Human Services Commission to establish an Early Warning System (EWS) for long-term care facilities. The EWS was first implemented in 2003 and uses statistical data to predict which nursing facilities may have conditions that could be detrimental to the health, safety, and welfare of residents. The EWS is required to identify facilities as low or high risk. Every nursing facility is assigned an EWS score; the higher the EWS score, the higher the facility's risk of a poor outcome on its next regulatory inspection or survey.

SOURCE: Texas HHS March 2032 QMP Report; [26 TAC §554.910](#) - [§554.911](#).

Trust Fund Monitoring (Nursing Facilities Only)

Residents have the right to manage their financial affairs or designate other people to do so. Some residents deposit personal funds with the nursing facility. Families and guardians often want facilities to assume this responsibility. If residents deposit their funds, facility staff manage the residents' funds but must keep them separate from facility funds.

To safeguard Medicaid-eligible residents' money, nursing facilities use an accounting system for their incomes and expenses. Trust Fund Monitors audit facility systems that include:

- A collective bank account for all participating residents;
- Individual resident files showing all deposits and withdrawals;
- A petty cash fund to provide small amounts of money; and
- Receipt files for each resident of all purchases and payments made by and for that resident.

When residents move or pass away, facilities close their trust fund accounts. Details about nursing facility trust funds are found in [26 TAC §554.404](#) and [26 TAC §554.405](#) which are part of the resident rights section of nursing facility rules.

- If the resident moves, the facility releases the funds within five days.
- Within 30 days of a resident's death, the facility must release resident's funds to the individual or probate jurisdiction managing the resident's estate.

Assisted living facility licensing standards do not establish or address resident trust funds.

Federal Resource

Medicare Quality Improvement Organization (QIO)

Acentra Health

Acentra Health is a [QIO](#) that works under contract with CMS. It is a resource for residents who are Medicare recipients. Residents who are not satisfied with the quality of care received, the discontinuation of skilled nursing services, or Medicare discharge plans, can call the Acentra Health Medicare Beneficiary

Helpline at 1-888-315-0636. A complaint form can be downloaded from the company's website at <https://www.acentraqio.com/bene/helpline.aspx>.

More information about QIOs may be found on the CMS website at: <https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/QualityImprovementOrgs/index.html>.

Resources for Applying for Medicaid

To learn about options and to determine eligibility for benefits, refer individuals to their local Aging and Disability Resource Center or to 2-1-1. In Texas, there are several ways to apply for Texas Medicaid.

- Visit YourTexasBenefits.com and apply online.
- Call 2-1-1.
- Download and complete an application form and send it to your local HHS office by mail.
- Visit your local HHS office in person and request to complete a Medicaid application.

Ombudsman Referrals to Outside Agencies

While educating, advocating, or solving problems, ombudsmen may consider supports and services at agencies and programs. Before using outside resources, discuss the situation with your supervising staff ombudsman. By contacting these resources or referring others to them, staff with in-depth knowledge of their agency programs provide answers in the most effective and efficient manner. With consent from residents and complainants, ombudsmen provide detailed information to help reach resolution appropriately and quickly.

If you make referrals, follow up with the residents to see if they received answers to their questions, information about their issues, or resolution to their problems. If not, ask whether they want you to take further action or pursue a different approach.

SOURCE: OPPI Chapter 700, Section 740



Exercise - Help! Identify the right resource.

Write the program or the best person to help solve each problem. To act on a resident's behalf, you always need resident consent. For this exercise, assume you obtained consent from the resident.

- 1) Mrs. Cash moved to a new nursing facility. She asks for her personal funds deposited with the facility and is told no money is available.

- 2) When Mr. Rich moved into a long-term care facility, he was private pay. Now he has spent down to a total of \$2,000 in his accounts. Where does he apply for Medicaid?

- 3) You observe numerous residents restrained during a facility visit. Facility staff says they use physical restraints to prevent falls, but they want to learn best clinical practices to keep residents safe.

- 4) Mr. Brown's bill has not been paid for the past three months. His dementia got worse, and his son started paying. The business office manager believes the son is paying his own house payments out of his dad's money.

- 5) Each time you visit Ms. Morrow, she talks about moving out of the nursing facility because everyone is "old," and she believes she could live in an apartment.

- 6) The nursing facility sent Mr. Chang a 30-day discharge notice stating they cannot meet his needs. He does not understand because other residents are in the same condition. He wants to stay.

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Chapter 14: Get Acquainted with the Ombudsman Policies and Procedures Manual (OPPM)

Contents

- Exercise: Get Acquainted with the Ombudsman Policies and Procedures Manual
- Ombudsman Policies and Procedures Manual

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Get Acquainted with the OPPM



Exercise: Get Acquainted with the Ombudsman Policies and Procedures Manual

Chapters 200 – 400

Fill in the blank or answer the question.

- 1) What is the acronym for legally authorized representative? __ __ __
- 2) What is the acronym for managing local ombudsman? __ __ __
- 3) What is the acronym for abuse, neglect, and exploitation? __ __ __
- 4) List three functions of a certified ombudsman:

- 5) A _____ ombudsman must document his or her performance of Ombudsman Program functions using HHSC form “Long-Term Care Ombudsman Activity Report.”

Chapter 500

Answer true or false, fill in the blank, select the best answer, or answer the question.

- 6) A visit by a certified ombudsman must be _____, unless the visit includes a scheduled meeting with LTC facility staff, such as a care plan meeting.
- 7) An _____ visit is a visit for which a certified ombudsman does not, before the visit, notify LTC facility staff of the visit.
- 8) A certified ombudsman has immediate, private, and unimpeded access to enter an LTC facility:

- 9) To visit an LTC facility at a time other than during the facility's regular business or visiting hours, a volunteer ombudsman must
-

- 10) ___ True ___ False

Upon entering an LTC facility, a certified ombudsman must attempt to notify a facility staff person that the certified ombudsman is in the facility.

- 11) ___ True ___ False

A certified ombudsman may not request a list of resident names and room numbers.

- 12) ___ True ___ False

If a certified ombudsman needs to view an area of an LTC facility that is not accessible to the public, such as a medicine storage closet, the certified ombudsman must request that facility staff assist the ombudsman in accessing the area and follow facility procedures and precautions in viewing the area.

- 13) ___ True ___ False

A certified ombudsman does not have immediate, private, and unimpeded access to a resident.

- 14) ___ True ___ False

A certified ombudsman must not interfere with the provision of care to a resident, such as physical therapy, wound care, bathing, or incontinence care.

- 15) ___ True ___ False

A certified ombudsman must not visit an LTC facility when ill.

- 16) ___ True ___ False

A certified ombudsman has access to the name and contact information of a resident representative when the information is needed to perform functions of the Ombudsman Program.

17) List three examples of a resident record.

18) Describe the process for a certified ombudsman to access and review a resident record. _____

19) List three examples of LTC facility information that is accessible to residents or the public (including ombudsmen).

20) HIPAA does not prevent the release of information to a certified ombudsman. A certified ombudsman is a "health _____ agency."

21) List one thing a certified ombudsman must do if they need to communicate with a person and the ombudsman is not proficient in the language the person speaks.

Chapters 600-700

Answer true or false, fill in the blank, select the best answer, or answer the question.

22) Information identifying a resident or complainant is confidential. Confidential information may be oral or written. List four types of information that is confidential.

23) Check all that apply. Ombudsmen must:

- ☐ Knock before entering a resident's room.
- ☐ Visit with residents in a way that the discussion is not within audible range of other people, as much as the resident will allow.
- ☐ Visit multiple residents during a visit to help ensure the identify of a complainant is not easily identifiable.
- ☐ Wear their ombudsman badge during facility visits.
- ☐ Meet with each nurse aid on duty during a facility visit.

24) To determine if a resident has the ability to consent, the certified ombudsman must determine if the resident understands information relevant to the situation and appreciates the effects of consenting or not consenting regarding the situation. In making such a determination, a certified ombudsman may need to:

25) ☐ True ☐ False

The ability of a resident to consent to a situation may depend on the nature of the situation. (Meal choice vs. medication dosage)

26) ☐ True ☐ False

The ability of a resident to consent to a situation may change from one time to another.

27) ☐ True ☐ False

Consent given by a resident or LAR is limited to the specific situation and activities for which it was given.

28) ☐ True ☐ False

A resident or LAR may not withdraw consent at any time.

29) ☐ True ☐ False

If a certified ombudsman receives a request for written confidential information, the certified ombudsman must immediately notify the State Ombudsman of the request and provide the State Ombudsman with any communication from the requestor.

30) ☐ True ☐ False

Regardless of who makes a complaint, a certified ombudsman must always act on behalf of the resident in investigating and resolving the complaint.

31) ☐ True ☐ False

A "complaint" is a statement of dissatisfaction or concern made by or on behalf of a resident, which relates to action, inaction, or a decision by any person or entity who provides care or makes decisions related to a resident, which may adversely affect the health, safety, welfare, or rights of the resident.

32) ☐ True ☐ False

If a certified ombudsman receives a complaint, the certified ombudsman must document the nature of the complaint and determine whether the complaint is appropriate for the certified ombudsman.

33) ☐ True ☐ False

An LOE must respond to a complainant within two business days after receipt of the complaint, except when a complaint is an allegation of ANE of a resident. For ANE (Chapter 800), ombudsmen must respond within one business day.

34) ☐ True ☐ False

According to 730 (d)(4)(A), a certified ombudsman must determine whether a visit to an LTC facility is necessary to obtain consent from the resident to investigate the complaint.

Sections 740 and 750 are addressed in the Certification Training Manual.

Fill in the blank, select the best answer, or answer the question.

35) In accordance with OPPM Section 760(a)(1), list the criteria for complaint investigation if the complainant is the resident or LAR. A certified ombudsman must investigate the complaint if:

_____ ; and
_____.

36) Check all that apply. Which of the following are activities of complaint investigation according to OPPM Section 760 (a)(2)?

- ☐ Determine what, if any, state or federal requirements apply to the complaint.
- ☐ Observe the environment of the resident and situations in the LTC facility related to the complaint.
- ☐ Interview relevant witnesses.
- ☐ Accuse the facility.
- ☐ Encourage the resident or LAR to participate in the process to resolve the complaint.
- ☐ Inform the facility of the complainant's name and problem.
- ☐ Determine and document a disposition code for the complaint.

37) Per OPPM Section 770, list two entities or organizations from which certified ombudsmen frequently request assistance.

[Chapter 800 is addressed Certification Training Manual.](#)

Chapters 900-3000

38) Fill in the blank, select the best answer, or answer the question.

39) Check all that apply. Which of the following are examples of information and assistance to an individual or to a facility by a certified ombudsman?

_____ Explain the role of a certified ombudsman.

_____ Provide information about laws and regulations related to long-term care.

_____ Provide information about resident councils.

_____ Investigate a complaint on behalf of a resident.

_____ Answer a caller's questions about choosing a nursing or assisted living facility.

40) According to OPPM Section 930, if a certified ombudsman who is not an MLO receives a communication from a public official requiring a response that is not systems advocacy and that is not related to a complaint, the certified ombudsman must not provide information to the public official and must refer the communication to the _____.

41) According to OPPM Section 1020, a certified ombudsman must consult with and obtain approval from the _____ before commenting on or recommending changes to a public official, governmental entity, or the media regarding the development and implementation of laws, rules, regulations, and other policies and actions that pertain to the health, safety, welfare, and rights of residents with respect to the adequacy of LTC facilities and services.

42) What statement must a certified ombudsman include when they provide comments or recommend changes to a public official or governmental entity or information to a legislator or the media?

43) Give an example of willful interference.

44) According to OPPM Chapter 2000, what should a certified ombudsman do if he or she suspects that an LTC facility is retaliating against a representative of the Office?

45) List three prohibited activities for a representative of the Office while performing the functions of the Ombudsman Program.

Chapters 4000-5000

Answer true or false, fill in the blank, select the best answer, or answer the question.

46) List three examples of an individual conflict of interest.

47) If during an unaccompanied visit an ombudsman intern identifies a complaint, the ombudsman intern must not _____ the complaint and must inform a certified ombudsman about the complaint.

48) An ombudsman internship must be for ____ days, which begins on the day of the first accompanied visit.

49) According to OPPM Section 4020, a volunteer ombudsman must complete at least _____ hours of continuing education provided by the LOE during each SFY beginning the SFY after the SFY in which the volunteer ombudsman was initially certified.

50) If a volunteer ombudsman completes more than 18 hours of continuing education in one SFY, the volunteer ombudsman may apply the hours exceeding _____ hours to the next SFY, up to 18 hours.

51) An LOE must ensure that a certified ombudsman, other than an MLO, is evaluated _____ to determine if he or she demonstrates compliance with the Initial Certification Training manual and Ombudsman Policies and Procedures.

52) ___ True ___ False

The State Ombudsman may suspend or terminate certification for good cause, as determined by the State Ombudsman, in accordance with 26 TAC §88.103(c) and (d).

53) ___ True ___ False

If the State Ombudsman suspends an ombudsman's certification, they must not visit a long-term care facility or investigate a complaint during the period of suspension.

54) ___ True ___ False

A person may file a grievance regarding the suspension or termination of certification of a representative of the Office by the State Ombudsman in accordance 26 TAC §88.309(c).

55) ___ True ___ False

An MLO may allow a volunteer ombudsman to take a leave of absence from the Ombudsman Program.

56) ___ True ___ False

A volunteer ombudsman who returns from a leave of absence of less than six months may immediately resume performance of Ombudsman Program functions but must complete the continuing education hours required per Ombudsman Policies and Procedures.

57) ___ True ___ False

A certified ombudsman must not disclose information provided to the certified ombudsman by a surveyor regarding a survey or complaint investigation of an LTC facility to a person who is not a representative of the Office.

58) ___ True ___ False

OPPM Section 5090 states that a certified ombudsman may provide information to an HHS surveyor during an annual survey or complaint

investigation but must not disclose confidential information to the surveyor unless the certified ombudsman has obtained consent or has authority to disclose the information in accordance with Section 630 of the OPPM.

59) List three examples of Ombudsman Program records.

60) A certified ombudsman must not act as a first responder during an _____.

Chapters 6000-8000

Answer the questions.

61) What constitutes a required visit to a nursing facility?

_____;

_____; and

_____.

62) List one performance measure as described in Ombudsman Policies and Procedures.

63) List two things monitored when the Office conducts an onsite visit or a desk review of an LOE.

Answer True or False

64) ___ True ___ False

Volunteer ombudsmen and ombudsman interns are not permitted to access the ombudsman database.

65) ___ True ___ False

The ombudsman marks the resident's complaint as verified if a resident is the complainant and the certified ombudsman determines the complaint is subjective in nature (based on personal feelings or opinions).

Fill in the blanks or select the best answer.

66) According to OPPM Section 7050, the disposition code documented by a certified ombudsman is based on the _____ of the resident if the resident is able to communicate their satisfaction with a complaint investigation.

67) If the resident is unable to communicate their satisfaction with a complaint investigation and the resident has an LAR, the disposition code documented by a certified ombudsman is based on the satisfaction of the _____, unless the certified ombudsman determines the LAR is not acting in the best interest of the resident.

68) Regarding complaint verification, if a certified ombudsman investigates a complaint, the certified ombudsman determines that the complaint (circle one) is ___ verified or ___ is not verified - if most or all of the allegations of the complaint are not true or not likely to be true based on investigation activities.

Fill in the blanks for the complaint dispositions below. (7050 f)

69) Partially or _____ resolved to the satisfaction of the resident, resident representative, or complainant.

70) With _____ or no action needed by the resident, resident representative, or complainant.

71) Not _____

72) According to Chapter 8000, a representative of the Office must immediately notify the MLO and the State Ombudsman in any of the following circumstances. The representative:

a) receives a subpoena or court order related to a lawsuit or other legal action or a court order that pertains to the performance of Ombudsman Program functions;

b) is served with notice of a suit in relation to the performance of Ombudsman Program functions; is threatened with _____;

- c) or needs legal counsel for an issue related to the performance of Ombudsman Program functions.

72) List the names of two of the ombudsman protocols found in the Appendices.

Staff Ombudsmen Only (Questions 70-82)

Chapter 5000

Fill in the blanks.

- 73) An MLO is required to serve on a _____ - time basis unless the requirement is waived by the State Ombudsman.
- 74) An LOE must obtain approval from the _____ for materials to be distributed to persons other than representatives of the Office before the materials are distributed.
- 75) If an LOE uses a _____ on printed materials created by the LOE, the LOE must use a logo that is approved by the Office.

Chapter 6000

Fill in the blanks.

- 76) For a Type B assisted living facility with a licensed capacity of 150, what is the minimum number of required visits per FFY? _____
- 77) The Office conducts at least one onsite LOE visit every _____ years.
- 78) The Office may conduct a desk review at any time and will conduct at least one desk review of an LOE every _____ months.

Chapter 7000

Answer True or False or fill in the blank.

- 79) ___ True ___ False

Any staff ombudsman can enter or edit data regarding a representative of the Office's personal identifying information, contact information, or certification information in the ombudsman database.

80) ___ True ___ False

An LOE does not have to let the Office know that information is inaccurate or missing in a user profile in the ombudsman database.

81) ___ True ___ False

Only staff of the Office are permitted to create a record regarding each LTC facility in an LOE's service area.

82) ___ True ___ False

If an LOE identifies information that is inaccurate or missing in an LTC facility record created by the Office, the LOE must correct or add the information in the record.

83) ___ True ___ False

Staff ombudsmen must create a record in the ombudsman database regarding investigations of complaints.

84) A staff ombudsman must submit activities and casework to the Office by entering information into the ombudsman database within ___days in accordance with OPPM Sections 7050 and 7060.

85) List five reportable ombudsman reportable activities.

a) _____

b) _____

c) _____

d) _____

e) _____

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State Long-Term Care Ombudsman Program Policies and Procedures

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Appendix 1: Forms

Contents

- Initial Certification Training Tracking Form
- Debrief for Accompanied Facility Visits
- Evaluation of the State Long-Term Care Ombudsman Initial Certification Training

HHS Form 8618 – Download Instructions

HHS Form 8618 is used to log your training hours.

Download the State Long-Term Care Ombudsman Program, Initial Certification Training Log, HHS Form 8618, from the Texas HHS forms website. Use the link below.

FOLLOW THE INSTRUCTIONS.

Note: Texas HHS Forms may NOT be compatible with mobile phones.

- 1) Go to the HHS Forms Website: <https://www.hhs.texas.gov/regulations/forms>
- 2) Type 8618 in the space provided and click the blue "Go" button.
- 3) When you see the "Title" bar, click on the form title in the box: Form 8618, State Long-term Care Ombudsman Program, Initial Certification Training Log.
- 4) Once you are on the form page, right click on the "**8618.pdf**" (blue) link found under the title "Documents." This opens a dropdown box.
- 5) In the dropdown box, click on "**Save link as**" option.
- 6) **Save the training log on your computer or tablet.** Save the form using your last name and the form number. For example, Smith-8618.
 - a) **Do NOT** fill the form directly from the website.
 - b) **Do NOT** fill the form by opening the "Download" popup.
 - c) Close the HHS Forms website and close HHS Form 8618.
 - d) Open the form from your computer and fill out the form.
- 7) When you finish training:
 - a) Do not print the form to sign it. **Type you name in the space provided.**

- b) Save the form and close it.
- c) Attach the form to an email (after saving and closing it) and send it to your program contact.
- d) Do NOT save your form as read only. The MLO (Managing Local Ombudsman) reviews your form and signs it.



State Long-Term Care Ombudsman Program
Initial Certification Training Log

Form 8618
February 2024

Name of Individual:	Program Name:

Training Requirements

The following is required:

- 16 or more manual training hours must be provided in-person. Review definition of in-person training below.
- 10 or more training in-facility training hours, which includes time the trainee makes accompanied and unaccompanied visits.
- Three additional hours of in-person manual review, in-facility training, or a combination of manual review and in-facility training.
- Seven hours of self-study credit count toward the first 36 hours of training. All self-study hours count toward total training hours.

In-person training means live instruction and may occur in a physical or virtual classroom setting. This includes live in-person meetings, live video conferencing applications, and live phone calls.

Certification Training Manual

Chapter Number and Title	In-Person			Self-Study		
	Date	Hours	Minutes	Date	Hours	Minutes
Introduction						
YouTube: What Does a Long-Term Care Ombudsman Do? 3 minutes.						
Chapter 1: The Basics of Long-Term Care Ombudsman Programs						
Chapter 2: Aging and Residents						
QSEP: CMS Hand in Hand Dementia Training Module 1 Understanding the World of Dementia: The Person and the Disease. 1 hour.						
QSEP: CMS Hand in Hand Dementia Training Module 2 Being with a Person with Dementia: Listening and Speaking. 1 hour.						
QSEP: CMS Hand in Hand Dementia Training Module 3 Being with a Person with Dementia: Actions and Reactions. 1 hour.						
QSEP: CMS Hand in Hand Dementia Training Module 4 Being with a Person with Dementia: Making a Difference. 1 hour.						
YouTube: BPSD Demonstration by Dr. Allen Power. 3 minutes.						
Chapter 3: Person-Centered Communication						
YouTube: Person-Centered Care - Person-Centered Language. 3 minutes.						
YouTube: RSA Short - The Power of Empathy - Bréne Brown on Empathy. 3 minutes.						
Chapter 4: Confidentiality, Disclosure, and Consent						
YouTube: How to Obtain Consent, Part 1. 2 minutes.						
Chapter 5: Residents' Rights						
ICARE: Lesson 1 - Common Infections in Nursing Home Communities. 10 minutes.						
ICARE: Lesson 2 - Preventing Infection in Nursing Home Communities. 13 minutes.						
NORC: Video & Quiz - Nursing Home Discharge. 15 minutes.						

Chapter Number and Title	In-Person			Self-Study		
	Date	Hours	Minutes	Date	Hours	Minutes
QSEP: CMS Hand in Hand Dementia Training Module 5 Preventing and Responding to Abuse. 1 hour.						
Chapter 6: Ombudsman Program Access and Long-Term Care Facility Operations						
YouTube: Person-Centered Care: Consistent Staff Assignments. 2 minutes.						
YouTube: State Long-Term Care Ombudsman PPE for Long-Term Care Ombudsman Facility Visits. 10 minutes.						
ICARE: Lesson 3 - Safeguarding the Nursing Home Environment. 23 minutes.						
ICARE: Lesson 4 - Hand Hygiene Heroes! 17 minutes.						
ICARE: Lesson 5 - Gowns, Gloves, and Goggles: Precautions for Prevention. 19 minutes.						
Chapter 7: Resident and Family Councils						
Chapter 8: Person-Centered Care and Service Planning						
YouTube: Person-Centered Care - Health Care Schedules. 2 minutes.						
YouTube: Person-Centered Care - Care Plans. 2 minutes.						
Chapter 9: Identify, Receive, and Investigate Complaints						
YouTube: The Monkey Business Illusion. 2 minutes.						
YouTube: Long-Term Care Ombudsman Casework: Advocacy and Communication - Anne Walker. 22 minutes.						
Chapter 10: Resolving Complaints						
YouTube: Long-Term Care Ombudsman Casework: Advocacy and Communication Skills – Brian Brashear. 13 minutes.						
Chapter 11: Stay Connected and Report Ombudsman Work						
YouTube: How to Obtain Consent and the Importance of Documentation, Part 2. 2 minutes.						
Chapter 12: Resident Records						
Chapter 13: Regulators and Other Resources						
Chapter 14: Exercise – Getting Acquainted with the Ombudsman Policies and Procedures						
Subtotal Certification Training Manual:						

In-Facility Training				
Accompanied Training Visits	Date	Hours	Minutes	Name of Accompanying Certified Ombudsman
First Accompanied Visit				
Facility Name: Golden Oaks of Austin				
Second Accompanied Visit				
Facility Name: Golden Oaks of Austin				
Unaccompanied Training Visits				
First Unaccompanied Visit				
Facility Name: Golden Oaks of Austin				
Second Unaccompanied Visit				
Facility Name: Golden Oaks of Austin				
Other Training Visits				
☐ Accompanied ☐ Unaccompanied				
Facility Name: Golden Oaks of Austin				
☐ Accompanied ☐ Unaccompanied				
Facility Name:				
☐ Accompanied ☐ Unaccompanied				
Facility Name:				
☐ Accompanied ☐ Unaccompanied				
Facility Name:				
☐ Accompanied ☐ Unaccompanied				
Facility Name:				
Subtotal In-Facility Training:				
Grand Total Manual and Facility Training (total in minutes):				
Grand Total of Training (hours + minutes):				

Trainee	
I certify the documented dates and times for long-term care ombudsman certification training are accurate.	
Trainee Typed Name or Signature _____	Date _____
Managing Local Ombudsman (MLO) or State Ombudsman	
I certify the Initial Certification Tracking form was reviewed by me and determined to be accurate.	
MLO or State Ombudsman Typed Name or Signature _____	Date _____

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Debrief for Accompanied Facility Visits

Intern _____

Facility _____

Certified Ombudsman _____

Date: _____

Questions to Ask the Certified Ombudsman (in a private setting)

- 1) Do you need to vary your attire when visiting certain types of facilities? If so, why?
- 2) What support documents and materials do you keep with you or in your car?
- 3) Do you have a protocol at the start of each facility visit?
- 4) How many residents do you usually visit? How do you make sure all residents are visited over time?
- 5) How do you keep professional limits with facility staff?
- 6) How do you decide which staff to talk to about a complaint? How do you decide whether to “go up the chain of command” on a complaint?
- 7) What are the most important things to document in your notes?
- 8) What are some tips for staying resident-directed when you work on a case?
- 9) How do you get consent from a resident? What do you specifically ask?
- 10) I noticed you told _____ that you could not assist with a request about _____. Why is that something you did not take action on?
- 11) How do you keep ombudsman records secure, including print copies, email, and phone calls?
- 12) What strategies have you used with success in responding to clients who are:
 - Angry or attacking
 - Tearful
 - Unfocused (struggling to make or stay on point)
 - Suspicious

- Reluctant to talk
- Cognitively impaired
- Speech impaired

13) Other questions you have:

Things to Observe About the Ombudsman

- Physical appearance
- Items carried into each facility
- The first actions the ombudsman takes upon entering a facility
- Facial and verbal expressions to residents
- Facial and verbal expressions to facility staff
- Communication with which staff
- Note taking
- How the ombudsman takes direction from residents
- Obtaining consent from residents and other complainants

Reflective Questions

Answer these questions within one week of completing your facility visit. Discuss them with your supervising staff ombudsman. Answers do not have to be lengthy, but they should be substantive and reflect your insights into the experience.

- 1) What made the biggest impression on you?
- 2) What were some words or phrases you heard the ombudsman use that you will strive to use in your work?
- 3) Describe something you observed and how you might have handled it differently—explain why.
- 4) What are some questions the experience left you wondering? To whom do you need to direct those questions?

- 5) Follow-up with the staff ombudsman you are partnered with to hold a discussion about what you observed and to debrief about your accompanied facility visit.

Checklist

Mark each item completed during your visit.

Introduced to:

- ☐ the nursing facility administrator or assisted living facility manager.
- ☐ the Director of Nurses (DON) or assisted living facility nurse.
- ☐ the nursing facility social worker(s).
- ☐ the activity director.
- ☐ the resident council president.

I located the:

- ☐ residents' rights poster.
- ☐ facility's license.
- ☐ activity calendar.
- ☐ manager's or administrator's office
- ☐ social worker's office (nursing facility only)
- ☐ dining room.
- ☐ menu.
- ☐ activity room.
- ☐ Ombudsman Program poster or information on how to contact the program.

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Evaluation of State Long-Term Care Ombudsman Program Initial Certification Training

Rate Your Overall Training

On a scale of 1 to 5, please rate the following statements about your certification training experience.

1 = Disagree

4 = Mostly agree

2 = Mostly disagree

5 = Agree

3 = Neutral

- 1) ___ Prior to starting the certification training class, local staff explained training requirements and the path to certification.
- 2) ___ The instructor(s) was / were knowledgeable and prepared to teach each class.
- 3) ___ The instructor(s) frequently provided examples to explain concepts.
- 4) ___ Classes were organized.
- 5) ___ The training materials were organized and useful.
- 6) ___ The CMS Hand in Hand (QSEP) computer-based training provided important information for ombudsmen.
- 7) ___ ICARE (Infection Control) computer-based training provided important information for ombudsmen.

Instructions: Mark each statement with which you agree.

- 8) ___ I understand why residents need advocates.
- 9) ___ I know what I can and cannot do as an ombudsman intern.
- 10) ___ I know what I can and cannot do as a certified ombudsman.
- 11) ___ I will avoid any conflict of interest with my role as resident advocate and remain independent of any facility.
- 12) ___ I realize some beliefs about aging are actually myths and stereotypes.
- 13) ___ I will be aware of verbal and nonverbal messages.

- 14) ___ I understand what person-centered thinking is and will practice it.
- 15) ___ I understand the negative impact labeling can have.
- 16) ___ I understand ombudsman consent requirements.
- 17) ___ I understand ombudsman confidentiality and disclosure requirements.
- 18) ___ I believe I can explain an ombudsman's role related to the investigation of ANE.
- 19) ___ I believe I can recognize ANE.
- 20) ___ I understand ombudsman consent requirements related to ANE reporting.
- 21) ___ I understand intern and certified ombudsman access in nursing and assisted living facilities.
- 22) ___ Ombudsmen must receive an invitation from a resident to attend a resident council meeting.
- 23) ___ Ombudsmen must receive an invitation from a resident, or LAR when applicable, to attend a resident's care or service plan meeting.
- 24) ___ Volunteer: I understand how to fill out an HHS Form 8620 (Activity Report).
- 25) ___ My accompanied facility visits provided helpful training.
- 26) ___ My unaccompanied facility visits helped build my confidence.
- 27) ___ I know who to contact if I need help or if I have questions.

Comments:
