



The Office of the State Long-term Care Ombudsman is a resident-directed program that is staffed with caring and competent ombudsmen who are trained and supervised to support their work on behalf of residents. The office is fully compliant with federal rule and operates under the following principles:

- **Independent:** The Older Americans Act establishes the long-term care ombudsman program as an independent organization. This means that we must have independence from host agencies at state and local levels and remain free of any conflicts of interest. An ombudsman must be independent in order to effectively advocate for residents.
- **Resident-directed:** The Older Americans Act requires that an ombudsman is always resident-directed. This means that an ombudsman respects and honors resident choice by seeking a resolution the resident wants. Ombudsmen advocate for residents' desired outcomes without judgment.
- **Confidential:** All ombudsman interactions are confidential. Ombudsmen foster relationships with residents based on trust and respect, and maintaining confidentiality is a crucial part of building resident trust.
- **Responsive:** The Office of the Long-term Care Ombudsman promptly responds to the needs of residents. Ombudsmen deserve training and support that is equally responsive.

## 2015 PROGRAM HIGHLIGHTS

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- 83 local ombudsman full-time equivalent staff, 7 state office
- 540 certified volunteer ombudsmen; donated 44,000 hours
- 1,200 nursing homes and 1,826 assisted living facilities served
- Responded to 16,905 complaints
- Of the complaints worked, 14,838 were nursing homes; 2,018 were assisted living (36% increase from FY14); and 49 were about other agencies or problems outside the facility
- 73% of complaints were completely resolved; 19% were partially resolved
- Advocated for a resident in 46 state fair hearings and guardianship hearings
- Trained facilities in 246 sessions; gave 4,428 consultations
- Gave 12,201 consults to residents, family members, and friends
- Visited 1,093 nursing homes at least each quarter (91% of all homes, and an increase of 6% from FY14)
- Visited 1,406 assisted livings at least each quarter (77% of all homes, and an increase of 42% from FY14)
- Participated in 814 DADS Regulatory Services surveys
- Attended 1,343 resident councils and 166 family councils
- Gave 280 education sessions to community members
- Gave 17 interviews to the media
- Statewide budget is \$5.3 million



Lucinda Mata, MLO of the AAA of South Plains

In January 2015, a nursing facility social worker reported that 15 residents were unable to contact their private, professional guardian. The facility's attempts to reach the guardian were also unsuccessful. Due to payments owed to the facility, some residents were at risk of discharge. Resident needs were also unmet, including not having shoes, no access to their personal needs allowance, and the guardian not participating in the residents' care plans. The guardian had moved from Lubbock County, where the residents reside, to Travis County. The distance from Lubbock to Austin is 340 miles, which is a six and one-half hour drive. Calls from the ombudsman to the guardian were not returned.

At the facility, the ombudsman visited all residents with a guardian. Several were interviewable and granted the ombudsman permission to take action, describing their complaints about the guardian not visiting, communicating, or providing them with their personal needs.

On a routine visit to another nursing home, the ombudsman discovered that the same guardian was guardian of several residents. The ombudsman visited each resident and interviewed and received consent to act on complaints that were similar to those of residents in the other facility. During the course of the investigation and resolution steps, residents with this guardian became at risk of losing their Medicaid eligibility due to renewal paperwork not being completed and submitted.

#### Resolution Steps

The ombudsman researched options to resolve complaints about a guardian. In Texas, a private, professional guardian must register with the state and be certified with the Texas Judicial Branch Certification Commission (JBCC). Guardians are publicly listed on the site with their certification status, and JBCC receives and investigates complaints about Texas certified guardians. After consulting with local and state resources, the ombudsman filed two complaints on behalf of residents living at two facilities.

A JBCC compliance investigator was assigned to review the complaints against the guardian and make a recommendation to the JBCC regarding the guardian's certification status. The ombudsman maintained contact with the investigator, and provided evidence to support her complaints and new evidence as it was discovered. The ombudsman's follow-up ensured the investigation did not slip through the cracks as the investigation changed hands when the compliance investigator changed. She reminded the JBCC that she would continue to follow the case until their decision was reached.

In the Lubbock area, there was no volunteer guardianship program and finding people to serve as a guardian was very challenging. While the complaints were being investigated, the ombudsman contacted the judge presiding over the guardianship cases who had appointed the professional guardian to serve. The judge was responsive, notifying the guardian of her duties and setting a 30 day timeline to resolve the complaints or be called to a Show Cause Hearing to determine if the guardian should remain in this role. The judge also suspended appointment of this guardian to any new incapacitated individuals in his jurisdiction. The judge assigned an Attorney Ad Litem to represent the residents' interests. The Ad Litem was charged with a report to the judge on findings regarding the residents who were wards of the guardian. The judge requested the ombudsman report all additional complaints to him for consideration in the case, and routinely forwarded communications from the ombudsman to the guardian to illustrate the concerns and source.

The guardian retained an attorney and challenged the ombudsman's complaints and findings. The attorney requested the judge to reconsider the moratorium on appointing the person as a guardian in new cases, but the request was denied. During the investigation, it was determined that the guardian had 51 wards that she was court appointed to serve, which exceeds the state limit of 50.

Regarding the risk of losing Medicaid, the ombudsman communicated with the facility administrators and corporate offices of the facilities where the residents with guardians lived in order to ensure that residents were not at risk of discharge under these circumstances. Assuring the corporate and facility management that the ombudsman was tracking the case was essential to protecting the residents from discharge, for which the facilities had a valid reason to give 30 day notice. The ombudsman also explored options for valid signatures on Medicaid applications and arranged for the facility social workers to sign off on the applications on behalf of residents.

## Outcome

The ombudsman managed communications on many levels, including with the guardian, the guardian's attorney, probate judges, the facility that initiated the concerns, and the residents. She worked with the JBCC, adult protective services, and county services to explore options for replacement guardians for any residents who would continue to need one. She also provided testimony to the court on residents that appeared to be capable of limited guardianship and residents whose capacity might be eligible for full restoration of their capacity to make decisions.

The court investigator confirmed the ombudsman's complaints on behalf of the wards, including not paying the facilities on time, withholding personal needs allowances, and not visiting as required by court order. The investigator used the ombudsman's testimony, written reports of resident complaints, and other evidence gathered by the ombudsman to recommend removal of the guardian from all of the residents' cases.

Further, the JBCC compliance investigator used the evidence brought forth by the ombudsman to recommend removal of the guardian's certification and making her ineligible to serve as a private professional guardian in Texas. Authorized to issue sanctions, JBCC imposed a \$25,500 fine (51 violations at \$500 each) and did not renew her guardianship certification that lapsed in July 2015.

Due to the ombudsman's advocacy, two counties and their judges with probate jurisdiction recognized the gravity of the situation. The loss of this professional guardian left the far west Texas counties with no options other than family members, and each case where the guardian was removed required a case review and determination of capacity. In July 2015, the county judge in the larger of the two counties asked the ombudsman to pull together the key decision-makers and subject matter experts to meet in his chambers. She agreed, inviting the neighboring judge, adult protective services, regulatory services, the local dispute resolution office, and the state agency with limited guardianship authority. Working with the nursing facilities for some residents, the Social Security Administration made the facilities representative payees for residents unable to manage their own funds. The ombudsman provided documentation of the JBCC decisions, which the judges had not received, and this served as the impetus for the judges to sign orders removing the guardian from all cases. At the close of the meeting, the ombudsman requested that the residents receive written communication explaining what had happened and how and who they could ask for help with their Medicaid and other immediate concerns. The judges agreed to local individual attorneys in their jurisdiction to appoint as guardian in only the cases that were still necessary.

Because some residents had funds that were unaccounted for when the guardian was still responsible, the case was referred for criminal investigation to the district attorney. This action is still pending.

The ombudsman notified the facilities where the residents reside of the decision to remove the guardian in all cases.

After 10 months of intensive work, the ombudsman determined the residents' financial and personal situations were stabilized. Residents had their basic needs met and were able to access their own money; and the facilities were being paid, resolving the risk of discharge. The case was closed.

## OMBUDSMAN REFERENCES IN FEDERAL NURSING HOME REQUIREMENTS

TOPIC	SUMMARY	SOURCE
<b>Acronyms:</b> CFR: Code of Federal Regulations CMP: Civil Monetary Penalties LTCOP: Long-term Care Ombudsman Program RN: Registered Nurse		SA: State Survey Agency SLTCOP: State Long-term Care Ombudsman Program SLTCO: State Long-term Care Ombudsman SOM: State Operations Manual USC: United States Code
<b>Access</b>	Facilities must provide the LTCOP with immediate access to residents	42 CFR 483.10 42 USC 1395i-3 (c)(3)(A) 42 USC 1396r (c)(3)(A) SOM Appendix PP pg. 36-38
	Access to resident medical records with permission from the resident or legal representative	42 CFR 483.10 42 USC 1395i-3 (c)(3)(E) 42 USC 1396r (c)(3)(E) SOM Appendix PP pg. 36-38
	The location of the pharmacist's findings are part of the resident's clinical records and should be kept in a consistent location in order to facilitate communication between the resident, staff and LTCOP	SOM Appendix PP pg. 543-544
<b>Complaint Investigation</b>	General complaint intake process and other public entities that should receive information from the SA and/or perform investigations including the LTCOP	5010 SOM Chapter 5
	To assist the SA in the investigation planning process they should consult with the LTCOP	5070 SOM Chapter 5
	When the SA refers a complaint to another agency such as the LTCOP the SA must request a written report on the results of the investigation as the SA has the responsibility to assess compliance with Federal regulations and requirements	5075.6 SOM Chapter 5

<b>Consultation/Coordination with Ombudsman Program</b>	In order to review the accuracy of Nursing Home Compare the Secretary of the U.S. Department of Health and Human Services must consult with the SLTCOP	42 USC 1395i-3 (i)(2)(B)(i) 42 USC 1396r (i)(2)(B)(i)
	The SA should share information and consult with the LTCOP	3000B SOM Chapter 3
	States are encouraged to include at least one person in the decision making process in the information dispute resolution process that was not directly involved in the survey such as an ombudsman	7212.3.9 SOM Chapter 7
	Facilities utilize the LTCOP to provide in-service training regarding quality of life and residents' rights	7502.3 Chapter 7
	The SA should consult the LTCOP when investigating eligible candidates for placement as a temporary facility manager	7550.4 SOM Chapter 7
	The SA should ask residents if they are able to retain and use personal possessions	SOM Appendix PP pg. 39
	The SA should ask the LTCOP if he/she has been involved in a care plan meeting as the resident advocate and about the process	SOM Appendix PP pg. 137-139
	To ensure the facility has an appropriate Quality Assessment and Assurance process and committee gather available information from the LTCOP	SOM Appendix PP pg. 657
<b>Information to resident regarding rights and services</b>	Facilities must furnish a written description of legal rights which includes the posting of contact information for the LTCOP	42 CFR 483.10

<b>Notice and disclosure to the Ombudsman Program</b>	Notification when a penalty, assessment or exclusion becomes final	42 CFR 402.11 42 USC 1395i-3 (g)(5)(B) 42 USC 1396r (g)(5)(B) 3024 SOM Chapter 3 42 CFR 1003.129
	Notice of a waiver for nurse staffing requirements (i.e. 24-hour licensed nursing, provide an RN for 8 consecutive hours a day, 7 days a week and an RN designated as Director of Nursing on a full-time basis)	42 CFR 483.30 42 USC 1395i-3 (b)(4)(C)(ii)(IV) 42 USC 1396r (b)(4)(C)(ii)(IV) 7014.1 SOM Chapter 7 SOM Appendix PP pg. 451-455
	Disclosure of results of inspections (including form CMS-2567), investigation activities, proposed remedies, the facilities' request for informal dispute resolution, appeal and results of the appeal	42 CFR 488.325 42 USC 1395i-3 (g)(5)(B) 42 USC 1396r (g)(5)(B) 7212.3 SOM Chapter 7 7904.1 SOM Chapter 7
	Proposal to exclude from Medicare and Medicaid programs	42 CFR 1003.105
	Waiver for requirements for nurse aide training and competency evaluation programs	42 USC 1395i-3 (f)(2)(C)(iii) 42 USC 1396r (f)(2)(C)(iii) 4132.1E SOM Chapter 4
	The Monthly Quality Indicator Comparison report were designed for family members of a resident, potential residents and their families and state Ombudsman	3319E SOM Chapter 3
	<b>Survey Preparation and Process</b>	During offsite preparation for complaint investigation the SA should contact the LTCOP to discuss the nature of the complaints and potential history of similar complaints
The State should notify the LTCOP of the survey according to the protocol determined by the State and the SLTCO		7207.2 SOM Chapter 7 SOM Appendix P pg. 14-15
CMS will contact the SA regarding a Federal survey and the SA should notify the LTCOP of the Federal survey on behalf of CMS		7904.2 SOM Chapter 7
During the survey, the SA should invite the Ombudsman to the resident group interview (after securing resident permission), discuss observations with the Ombudsman (as appropriate), interview the Ombudsman and share resident concerns with the Ombudsman (after gaining resident permission)		SOM Appendix P pg. 23 and 40

<b>Survey Preparation and Process (continued)</b>	The SA should conduct resident interviews in private unless the resident wants to include a family member, staff person or Ombudsman	SOM Appendix P pg. 66
	The SA should invite the Ombudsman to the exit conference	SOM Appendix P pg. 86
<b>Transfer, Discharge, Readmission and Admission of residents</b>	Facilities must include contact information for the LTCOP in transfer or discharge notices	42 CFR 483.12 42 USC 1395i-3 (c)(2)(B)(iii)(II) 42 USC 1396r (c)(2)(B)(iii)(II) SOM Appendix PP pg. 47-48
	The SA should ask the LTCOP about facility compliance with transfer requirements	SOM Appendix PP pg. 41-42, 45-46
	The SA should ask the LTCOP if there are any problems with residents being readmitted to the facility after hospitalization	SOM Appendix PP pg. 50-51
	The SA should ask the LTCOP if the facility treats residents differently in transfer, discharge and covered services based on source of payment	SOM Appendix PP pg. 52-53
	If resident/family interviews reveal possible problems with admission contracts the SA should review the contracts for potential violations of requirements and refer to outside agencies if necessary, i.e. LTCOP or Office for Civil Rights	SOM Appendix PP pg. 614-615

**Sources:**

- 42 CFR: [http://ecfr.gpoaccess.gov/cgi/t/text/text-idx?c=ecfr&tpl=/ecfrbrowse/Title42/42tab\\_02.tpl](http://ecfr.gpoaccess.gov/cgi/t/text/text-idx?c=ecfr&tpl=/ecfrbrowse/Title42/42tab_02.tpl)
- 42 USC 1395i-3: [http://www.ssa.gov/OP\\_Home/ssact/title18/1819.htm](http://www.ssa.gov/OP_Home/ssact/title18/1819.htm)
- 42 USC 1396r: [http://www.ssa.gov/OP\\_Home/ssact/title19/1919.htm](http://www.ssa.gov/OP_Home/ssact/title19/1919.htm)
- SOM: <http://www.cms.gov/manuals/iom/itemdetail.asp?itemid=CMS1201984>