Office of the State Long-Term Care Ombudsman Report

STATE FISCAL YEARS 2017-2018

Patty Ducayet | State Long-Term Care Ombudsman | November 2018

A Report to the Texas Governor, Lieutenant Governor
and Speaker of the House of Representatives

Contents

Overview

The Office of the State Long-Term Care Ombudsman is independent within the Texas Health and Human Services Commission (HHSC). Long-term care ombudsmen regularly visit nursing and assisted living facilities to advocate for residents. This report describes ombudsman services in nursing and assisted living facilities in state fiscal years 2017-18, including recommendations to ensure the highest quality of life and care for residents.

Mission

The mission of the Texas Long-Term Care Ombudsman Program is to improve the quality of life and care for residents of nursing and assisted living facilities by providing prompt, informal complaint resolution and promoting systemic change on behalf of residents' interests.

Highlights September 2016 – August 2018

Accomplishment	2017	2018
Nursing Facility Complaints Investigated	15,607	13,524
Nursing Facility Visits	23,708	21,339
Assisted Living Facility Complaints Investigated	3,376	3,210
Assisted Living Facility Visits	14,001	13,669
Consultations to Residents and Family Members	21,443	20,362
Consultations to Facility Staff	5,065	4,401
Family and Resident Councils Attended	1,145	984
Care Plan Meetings Attended	878	870
Input Provided to HHSC Long-Term Care (LTC) Regulatory	1,929	1,781
Volunteers	451	411
Hours Donated by Volunteers	24,751	20,551

Ombudsmen in Nursing Facilities

Story: Improper Discharge

An ombudsman learned that a facility planned to discharge a resident. The resident was upset and scared about having to leave the home. He complained about how facility staff were treating him.

Upon investigation, the ombudsman learned that the resident had a traumatic brain injury (TBI) and determined that the facility was not adequately caring for him. This included the facility admitting the resident for services without training any staff on caring for a person with a TBI. The ombudsman interviewed facility staff who reported serious concerns about the treatment of this resident by the administrator and director of nursing. Some staff reported that facility staff were intentionally provoking the resident so he would leave the facility, which the ombudsman observed while onsite at the facility. The resident reported feeling angry and depressed about his situation.

The ombudsman reported concerns about resident mistreatment by facility staff to HHSC LTC Regulatory Services and advised the facility about its responsibility to have staff with appropriate skills and training to care for each resident. While awaiting the outcome of the HHSC LTC Regulatory Services investigation, the ombudsman was in frequent contact with the resident to ensure he was being treated properly and that staff received needed training. Despite intervention by the ombudsman and involvement of HHSC LTC Regulatory, the facility still sought to discharge the resident.

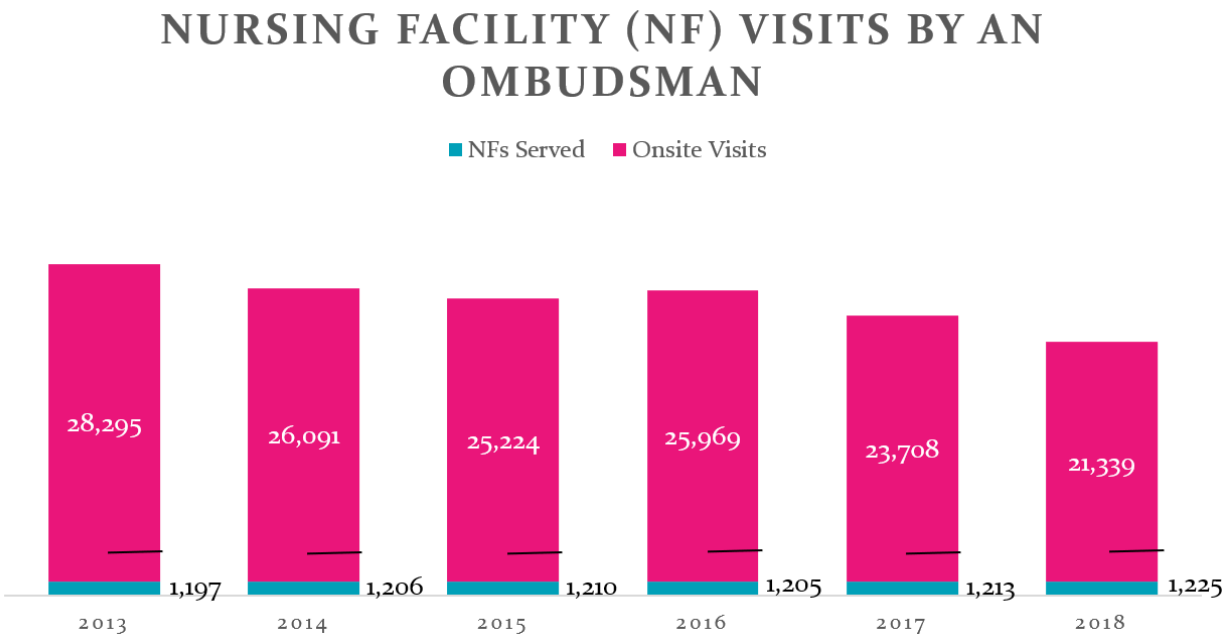
The ombudsman reviewed the facility's discharge documentation and determined that the facility did not have a valid reason for discharge. The ombudsman helped the resident file and prepare his appeal, including explaining why he was entitled to remain in the facility and why it was harmful to his welfare to be discharged.

Because of the resident's disability, we advocated for an accommodation so the hearing would be held in person at the facility. The ombudsman represented the resident during the hearing and helped him explain his case to the hearing officer. The hearing officer agreed with the resident and instructed the facility administrator that the resident must be allowed to stay.

The resident is happy he did not have to move. The ombudsman continues to visit the resident regularly to ensure he is receiving the care he needs and to monitor for any further mistreatment by facility staff.

Nursing Facility Visits

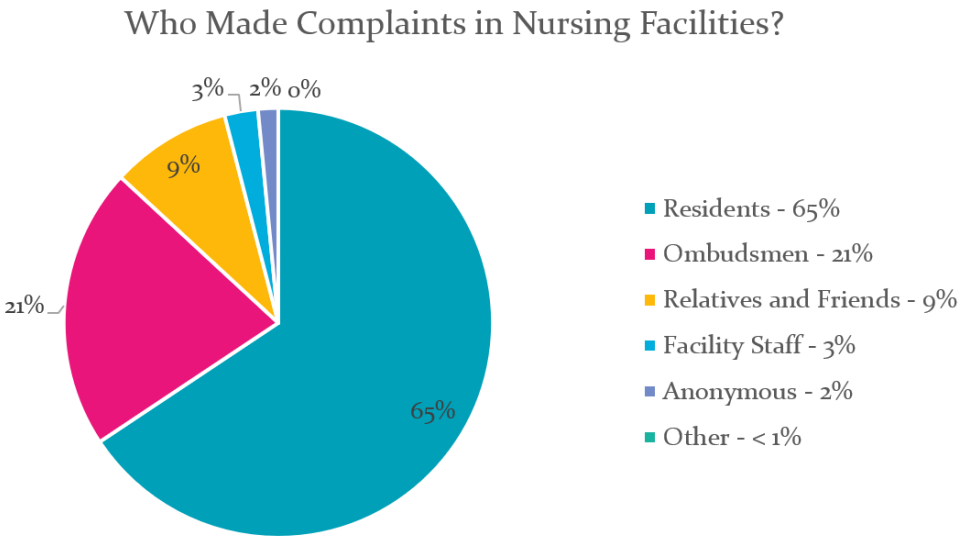
Ombudsmen visited over 1,200 nursing facilities at least once every three months, and typically volunteers visit two to four times a month in their assigned facilities. As identified in the chart below, ombudsman visits have declined to nursing facilities over the last six years. This decline is due to three reasons: fewer volunteers are volunteering with the program, staff ombudsman turnover, and the number of ALFs in operation has shifted demand for the program's attention to residents in ALF settings.



Most Frequent Nursing Facility Complaints

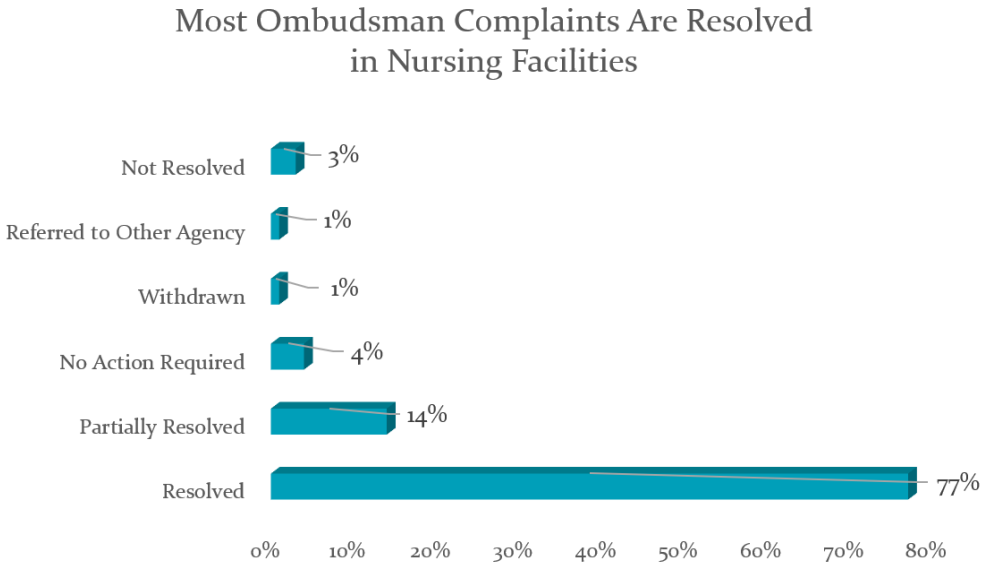
Rank	Complaint Description	2017	2018	Total
1.	Care: Failure to respond to requests for help, including call light	1,716	1,544	3,260
2.	Environment and Safety: Building cleanliness, pests, or housekeeping	1,032	828	1,860
3.	Dietary: Food quantity, quality, variation, or choice	929	811	1,740
4.	Autonomy and Choice: Dignity, respect, or poor staff attitudes	681	681	1,362
5.	Care: Bathing, nail and oral care, dressing, or grooming	634	535	1,169
6.	Care: Symptoms unattended or unnoticed, including pain not managed	672	493	1,165

Rank	Complaint Description	2017	2018	Total
7.	Environment and Safety: Equipment or building in disrepair, hazard, or fire safety	598	506	1,104
8.	Care: Medication administration or organization	567	529	1,096
9.	Admission and Discharge Rights: Discharge planning, notice, or procedure	499	545	1,044
10.	Environment and Safety: Odors	496	349	845
11.	Autonomy and Choice: Resident unable to exercise choice, rights, or preference	441	338	779
12.	Rehabilitation: Assistive devices or equipment	396	345	741
13.	Care: Help using the bathroom or with incontinent care	369	323	692
14.	Financial: Personal property lost, stolen, used by others, or destroyed	377	294	671
15.	Staffing: Staff are unresponsive or unavailable	300	287	587
16.	Activities: Availability, choice, or appropriateness	345	238	583
17.	Environment and Safety: Air temperature, water temperature, or noise	264	215	479
18.	Dietary: Fluid availability or hydration	210	251	461
19.	Social Services: Resident conflict	219	208	427
20.	Care: Physician services	197	200	397
Subtotal	Of 20 most frequent complaints	10,942	9,520	20,462
Total	**Of all complaints received**	**15,607**	**13,524**	**29,125**



Nursing Facility Investigations: Verification and Outcomes

Ombudsmen verify complaints through observation, interviews, and record review. Verification indicates that the circumstances described in the complaint existed or were generally accurate. In 2017 and 2018, 93 percent of nursing facility complaints were verified. On average, ombudsmen closed nursing facility cases in 31 days.



Nursing Facility Complaint Themes

The most frequent complaints involved resident care (30 percent of all complaints were in this category), environmental and safety concerns (19 percent), dietary issues (11 percent), autonomy and choice (10 percent), and admission and discharge rights (over five percent).

Complaints regarding rehabilitation, which are more than five percent of all complaints received, take the longest time to investigate and close at an average of 43 days. These complaints are less likely to be resolved, compared with other complaint categories, at a 72 percent rate of resolution.

Among the most difficult complaints to resolve by ombudsmen are complaints regarding discharge rights. These complaints are closed with a 69 percent rate of resolution. Although clear regulations exist to protect a resident from discharge, if a facility chooses to ignore regulations and an ombudsman refers the complaint to HHSC LTC Regulatory Services, the complaint is not typically investigated before the resident is discharged and few violations are written. See a program recommendation related to nursing facility discharge on page 18 of this report.

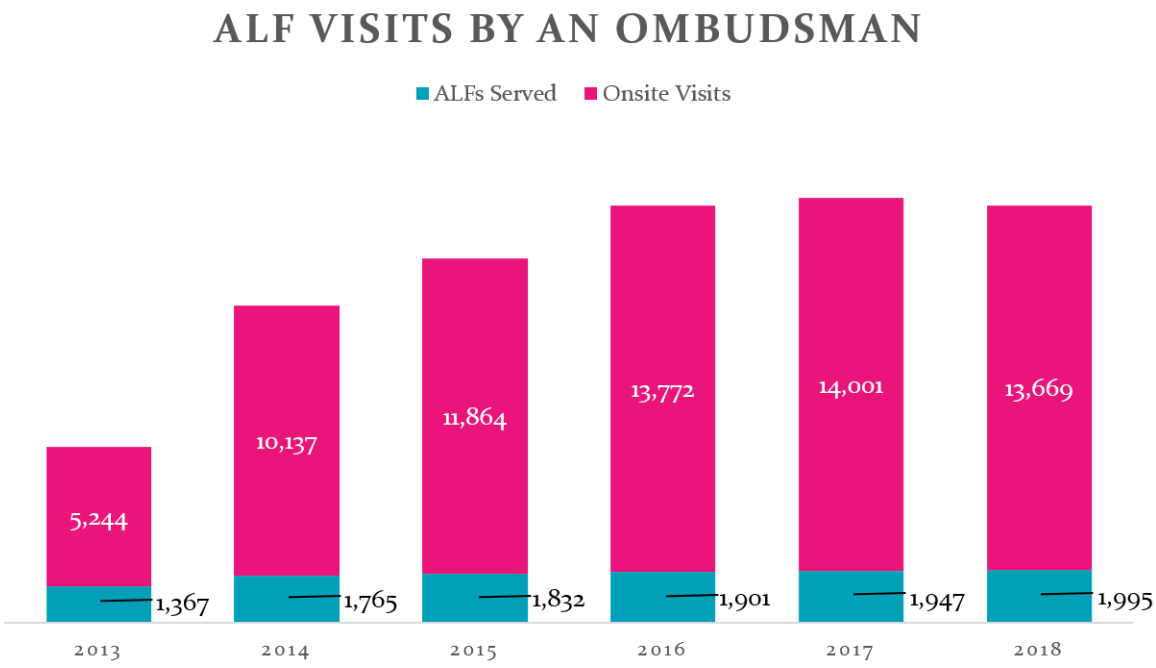
On average, resident care complaints are addressed in 22 days, and at an 80 percent rate of resolution. Environmental complaints are among the most likely complaints to be resolved at an 88 percent rate of resolution. Complaints about resident care or the facility environment may have a higher resolution rate because there are clear regulations that an ombudsman can use to address the situation.

Ombudsmen in Assisted Living Facilities

Beginning with the 83rd Texas legislative session, state funding was approved for the Texas Long-Term Care Ombudsman Program to serve residents of assisted living facilities. This funding makes it possible for local ombudsman offices to hire ombudsmen and regularly visit ALF residents in over 1,900 facilities across the state. In 2017-18, ombudsmen visited most ALFs at least once every three months of the year.

Because some ALFs use adult day services to provide daytime services to residents, ombudsmen made 1,475 visits to residents in day activity and health services settings in FY 17-18.

Assisted Living Facility Visits



Story: The Largest ALF in Texas Closes

An ombudsman was contacted by HHSC LTC Regulatory Services because an ALF was closing. The facility operated as an ALF for nineteen years and with a licensed capacity of 300 was the largest in Texas. At the time of closing, it had 117 residents and almost all residents paid for their care with Medicaid. Statewide availability of a Medicaid room in an ALF is limited; only about seven percent of ALF beds are paid with Medicaid.

The facility planned to notify residents 30 days before closing. The ombudsman notified the Office of the State Long-Term Care Ombudsman of the impending closure and requested help coordinating with the two managed care organizations (MCOs) that provided services in the area. With support from HHS Medical and Social Services, MCOs were onsite the day after residents were notified of the closure. Staff ombudsmen attended the MCO meeting with residents and followed up for the remaining weeks with residents about where they wanted to move.

With frequent onsite monitoring, staff ombudsmen coordinated with HHSC LTC Regulatory Services to help ensure residents' services continued and their transition to a new facility went smoothly. Residents were in disbelief that their home would no longer operate. Many residents lived there for several years and didn't want to move. Ombudsmen provided emotional support and helped residents find a new home. Neighboring ombudsman offices helped with alternative facilities that might offer a similar setting or amenities in a different county.

> ***"Ombudsmen provided emotional support and helped residents find a new home."***

Ombudsmen visited residents multiple times a week to help with their move. The facility owners announced they had no resources to help residents move, including packing residents' belongings and arranging for transportation. Staff ombudsmen worked with United Way to find volunteers and donations to help. Many residents didn't have the physical ability or the financial resources to move their belongings from one facility to another. With the help of donations, moving companies moved residents' belongings at no cost to residents, and eventually, all residents found a new facility before the facility closed. It was an emotional move for many residents with little time to adjust to losing their long-time home.

For news stories related to the facility closing see:

Fort Worth Star-Telegram, July 12, 2017, "After years of problems, Westchester Plaza is closing next month" (http://www.star-telegram.com/news/local/community/fort-worth/article161041089.html)

Fort Worth Star-Telegram, July 18, 2017, "Westchester Plaza resident found dead Monday night outside facility" (http://www.star-telegram.com/news/local/community/fort-worth/article162256483.html)

Trends to Watch: ALF Admission Policies

During the course of their work, ombudsmen have noticed problems with some written admission agreements that ALFs require residents to sign when they move in. These agreements outline ALF policies and expectations for the residents, but ombudsmen have discovered that some of these documents contain provisions that infringe on residents' rights. Below are a few examples.

Waiving liability: Residents are required to sign an agreement not to hold a facility responsible for injury sustained while in the facility, such as if a resident falls or is otherwise injured in the building. Sometimes these waivers are called "negotiated risk agreements" and used as a condition of the resident's stay.

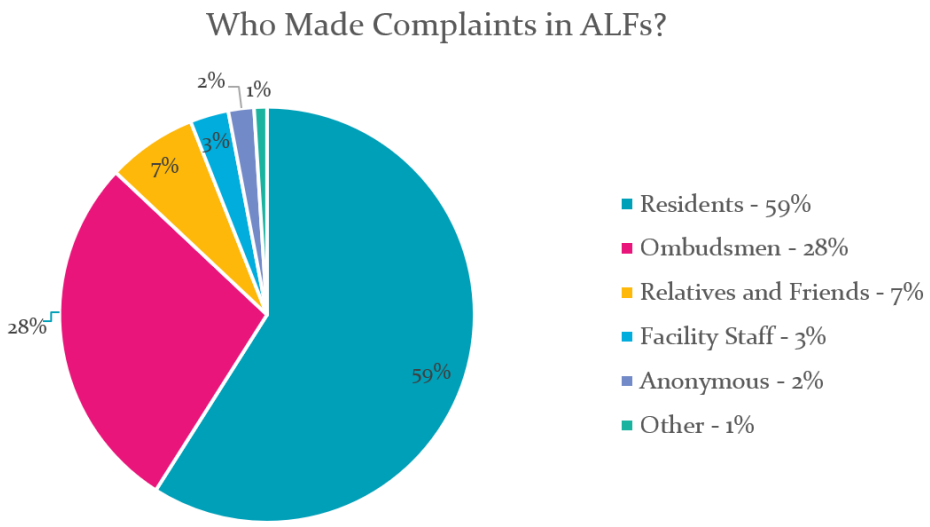
Residents charged for move: Due to renovations in one area of a facility, residents are relocated while their original room is remodeled. After the remodel, residents are expected to pay moving costs and a higher rate to return to their original room.

Limiting use of medical equipment: Residents are restricted from using their own electric wheelchair or scooter, unless a large deposit or fee is paid.

Most Frequent Assisted Living Facility Complaints

Rank	Complaint Description	2017	2018	Total
1.	Dietary: Food quantity, quality, variety, or choice	271	263	534
2.	Environment and Safety: Equipment or building in disrepair, hazard, or fire safety	242	228	470
3.	Environment and Safety: Building cleanliness, pests, or housekeeping	242	217	459
4.	Care: Medication administration or organization	170	156	326
5.	Autonomy and Choice: Information not provided about rights, benefits, services, or complaints	192	123	315

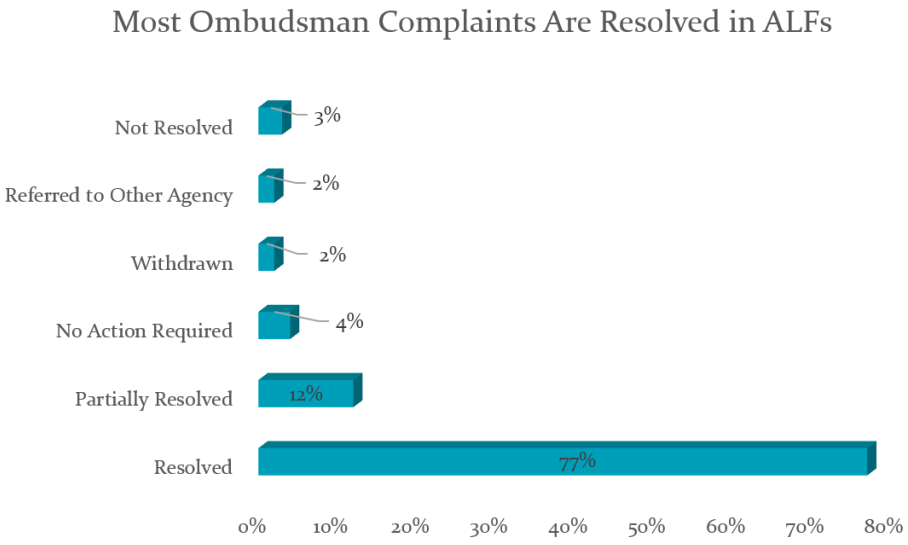
Rank	Complaint Description	2017	2018	Total
6.	Autonomy and Choice: Dignity, respect, or poor staff attitudes	149	146	295
7.	Care: Failure to respond to requests for help, including call light	129	136	265
8.	Environment and Safety: Air or water temperature, or noise	127	116	243
9.	Environment and Safety: Odors	100	99	199
10.	Activities: Availability, choice, or appropriateness	89	82	171
11.	Staffing: Staff are unresponsive or unavailable	86	75	161
12.	Care: Symptoms unattended or unnoticed, including pain not managed	67	90	157
13.	Social Services: Resident conflict	53	96	149
14.	Staffing: Shortage of staff	65	49	114
15.	Autonomy and Choice: Resident unable to exercise choice, rights, or preference	67	44	111
16.	Admission and Discharge Rights: Discharge planning, notification, or procedure	60	53	113
17.	Environment and Safety: Infection control	50	56	106
18.	Care: Bathing, nail and oral care, dressing, or grooming	57	48	105
19.	Rehabilitation: Assistive devices or equipment	60	43	103
20.	Dietary: Improper food temperature	48	52	100
Subtotal	of 20 most frequent complaints	2,324	2,172	4,496
Total	**of all complaints received**	**3,376**	**3,210**	**6,586**



Assisted Living Investigations: Verification and Outcomes

Ombudsmen verify complaints through observation, interviews, and record review. Verification indicates that the circumstances described in the complaint existed or were generally accurate. In 2017 and 2018, 88 percent of ALF complaints were verified.

On average, ombudsmen closed ALF cases in 40 days, which is nine days longer than an average nursing facility case was closed, and six days longer to resolve assisted living facility complaints than in 2016. This signals that ALF complaints are growing more complicated and require more time for an ombudsman to resolve.



Assisted Living Facility Complaint Themes

The most frequent complaints involved environmental and safety concerns (25 percent of all complaints were in this category), resident care (18 percent), dietary issues (12 percent), autonomy and choice (10 percent), and access to information (seven percent).

Complaints regarding dietary issues take on average 41 days to investigate and determine an outcome. These complaints are less likely to be resolved, compared with other complaint categories, at a 68 percent rate of resolution.

Similar to complaints in nursing facilities, complaints about discharge rights are among the most difficult complaints to resolve by ombudsmen. These complaints are closed with a 62 percent rate of resolution, which is seven percentage points lower than in nursing facilities. One of the reasons for difficulties in resolving these complaints is that ALF residents do not have appeal rights and a fair hearing to evaluate the merits of a facility's decision to discharge a resident. See a program recommendation related to this problem on page 17 of this report.

On average, complaints about access to information are addressed in 39 days, and are among the most likely complaints to be resolved at a 92 percent rate of resolution. Environmental complaints are addressed on average in 24 days and are resolved at an 88 percent rate of resolution. Complaints about access to information and the facility environment may have a higher resolution rate because there are clear regulations that an ombudsman can use to address the situation.

Work with Resident and Family Councils

Ombudsmen attended 1,939 resident council and 190 family council meetings in nursing and assisted living facilities.

Ombudsmen may attend meetings only at the invitation of the group and are often asked to provide information to councils about residents' rights, the role of an ombudsman, problem-solving techniques, and facility rules and regulations.

Consultation to Residents, Family Members, and Facilities

In addition to resolving complaints, ombudsmen work with residents, family members, and friends to respond to questions. Requests are most frequently related to the role of the ombudsman, residents' rights, resident care, how to select a facility, and how to pay for care. Ombudsmen provided a total of 41,805 consultations to residents and their families and friends.

Another way ombudsmen provide support to a resident is by attending their care or service plan meeting. This meeting includes members of a resident's interdisciplinary care team and a review of the resident's total plan of care. Ombudsmen work to bring the resident's interests to the heart of the discussion and empower residents and families to participate in the process. Ombudsmen attended 1,100 care or service plan meetings at the request of a resident or legal representative and an additional 648 meetings for the purpose of resolving a complaint on behalf of a resident.

Ombudsmen may also attend HHSC fair hearings to represent a resident in an appeal. Ombudsmen participated in 185 fair hearings to help nursing facility residents facing discharge from a nursing facility or denial of Medicaid benefits.

Ombudsmen are a resource to facility staff who encounter complex problems as care and services are provided. Consultation is available on any subject that affects a resident's life in a facility. Common consultation subjects include the ombudsman role, residents' rights, and discharge. Ombudsmen provided a total of 9,466 consultations to facility staff.

Training to Facility Staff

Most nursing and assisted living facility staff receive in-service education where they work. Twelve hours of continuing education is required for most nursing facility staff and six hours is required for most ALF staff. Upon request, ombudsmen provide training onsite to facility staff. Frequent topics include residents' rights, improving quality of life and care, person-centered dementia care, and the role of the ombudsman.

Ombudsmen provided facility staff 222 training sessions. A total of 5,213 employees received training from an ombudsman.

Training and Retention of Ombudsmen

Five hundred and fifty volunteers served in the Texas Long-Term Care Ombudsman Program and contributed 47,913 hours in 2017-18. Local staff ombudsmen recruited, trained and supervised volunteers, while state office staff approved training and issued certification for each ombudsman. A total of 387 new volunteer ombudsmen completed a three-month internship and were certified from Sept. 1, 2016 – Aug. 31, 2018.

The Office of the State Long-Term Care Ombudsman trained 115 staff ombudsmen, including 34 new staff ombudsmen. Training included statewide in-person and webinar training, and smaller intensive sessions provided by the state office for new managing local ombudsmen who lead the local ombudsman offices.

Twelve hours of annual continuing education is required for all staff and volunteers to maintain their certification status as an ombudsman.

Program Funding

Source of Funds	*2017*	*2018*
Older Americans Act Title III	2,587,909	2,787,165
Older Americans Act Title VII	1,220,068	1,303,986
State General Revenue	2,331,285	2,269,882
Other federal funds*	31,493	25,538
Local cash	132,745	125,695
Total	*6,303,500*	*6,516,979*

* Other federal funds were made up of funds to support residents relocating from a nursing facility to an ALF or a community setting, and Centers for Medicare and Medicaid Services Civil Money Penalty funds for approved grant projects to support nursing facility residents.

Recommendations

As directed by §712(a)(3)(G) of the Older Americans Act and §101A.260(a) of the Texas Human Resources Code, a long-term care ombudsman recommends improvements in the long-term care system to improve the lives of nursing and assisted living facility residents. The recommendations that follow are made by the Texas Office of the State Long-Term Care Ombudsman (Office).

Recommendations Regarding Disaster Preparedness and Response

Hurricane Harvey: Lessons Learned

Hurricane Harvey made landfall in Texas August 25, 2017. It brought flooding, strong winds, and threatened the safety of many nursing and assisted living facility residents. Ombudsmen connected with facilities and residents, to confirm the safety of residents and offer support to all involved. In addition, ombudsmen determined that changes are needed to safeguard residents and provide the highest level of care during emergencies like a hurricane. The following are recommendations to improve facilities' preparedness and response to future natural disasters.

All geographic factors need to be addressed in an evacuation plan

Heavy rains flooded streets, bayous, reservoirs, and rivers. Facility evacuation plans need to address more than flood plains and storm surge.

Evacuation plans need to include procedures for volunteer rescuers.

In some parts of the state, volunteer rescuers, like the Louisiana Cajun Navy, evacuated residents. Evacuation plans need to address how the facility will respond to volunteers and ensure the safety of residents evacuated by volunteer rescuers.

Resident safety concerns don't end with the storm

Residents who were evacuated returned to their facilities when the flood waters receded. However, many facilities were flood damaged, which raised concerns of mold, contamination, construction debris, and other hazards. HHSC LTC Regulatory Services inspections need to occur in damaged facilities prior to residents returning, or as soon as practicable when residents shelter in place.

Residents and their families must be informed of evacuation plans

Residents were evacuated to other facilities and families were unable to find them. Evacuation plans must include how evacuation details will be communicated in accordance with privacy laws. These details must be reviewed with residents and their families when they move into the facility, and followed in the event of an emergency.

Recommendations Regarding ALFs

Conduct a Comprehensive Quality Review of ALFs

The State of Texas does not have adequate information about the quality of ALF care in Texas. ALFs are the fastest growing type of long-term care and outnumber nursing facilities by over 700 facilities. ALF residents have diverse and sometimes complex care needs. However, there is no review of quality measures, adverse outcomes, or preventable occurrences, including medication errors, misuse of antipsychotic drugs, falls with injury, inappropriate placement in a locked unit, and restraint use. This lack of information leaves consumers unable to make informed choices and limits HHSC's policy decisions about the long-term care system. A comprehensive quality review of ALFs will study residents' quality of care and quality of life; report on costs, services provided, and violations; and assess the scope of RN delegation and who administers medications. The Office recommends that the 86th Texas Legislature allocate $140,000 in general revenue for HHSC Quality Monitoring Program to oversee the study.

Fund HHCS Exceptional Item – Protect Assisted Living Facility Residents with Ombudsman Services

The number of ALFs and residents is steadily increasing, including a net growth rate of 3 percent in 2018. Long-term care ombudsman funding is insufficient to sustain regular visits and services to all vulnerable ALF residents. ALFs tend to open and close more rapidly than nursing facilities, and this volatility places residents at risk of sudden relocation and without access to the protection of an ombudsman. This HHSC exceptional item requests a modest increase of $364,000 each year of the biennium to support the costs of the State Long-Term Care Ombudsman Program as it seeks to maintain regular onsite visits and prompt complaint responses to all residents in long-term care facilities. The Office recommends that the 86th Texas Legislature approve the exceptional item titled "Protect Assisted Living Facility Residents with Ombudsman Services", which requests $728,000 in general revenue in the HHSC legislative appropriations request.

Strengthen Protections for ALF Residents Facing Discharge

Unlike nursing facility residents who live in a Medicaid certified facility, ALF residents on STAR+PLUS have no right to appeal their discharge to a state agency. This leaves approximately 4,000 residents in the STAR+PLUS program without access to due process in situations in which they might have been retaliated or discriminated against. This issue would be addressed by adding language in Health and Safety Code (HSC) §247.064(b), providing residents the right to a state fair hearing if they wish to appeal a facility's decision to discharge the resident.

While ALFs can be fined for discharging residents without proper reason or notice, the penalty for doing so is not a strong deterrent. In fact, a discharge violation if "corrected" within 45 days, results in no penalty. To create a stronger deterrent, increase the administrative penalty for violations of discharge procedures to no less than $1,000 and remove the right to correct, as described in the recommendation below.

Remove the Right to Correct to Avoid Penalty on Rights Violations

Most ALF violations can be corrected by a facility, which results in no administrative penalty being assessed. Nursing facility state law excludes a violation of a resident's right from the right to correct, which protects resident's interests and holds nursing facilities accountable for rights violations. No such exclusion exists to protect an ALF resident. This problem can be remedied by excluding such violations by amending HSC §247.0452(b) to include "a violation described in §247.064".

Recommendations Regarding Nursing Facilities

Expand the Nursing Facility Direct Care Staff Enhancement Program

Even the best caregivers cannot do their job without enough staff to care for residents. The Institute of Medicine recommends that nursing facility residents receive 4.1 hours of direct care from a licensed nurse or certified nurse aide per day. Based on the most recent payroll data, Texas averages just 2.8 hours per resident per day. In 2000, Texas implemented the Nursing Facility Direct Care Staff Enhancement program to improve direct care staffing in nursing facilities, but due to limited funds not all facilities can participate. Nursing facility providers continue to say they cannot increase staffing at current Medicaid reimbursement rates. The Office recommends that the 86th Texas Legislature fully fund the enhancement program to raise Texas' staffing to national standards and give residents the level of care they need.

Stop Unnecessary Nursing Facility Discharge

A resident's right to not be improperly discharged is protected by federal law. Administrative penalties for a violation are set by the State. Ombudsman investigations of many discharge cases reveal there is no clinical or legal basis for discharge, making them improper and illegal. Additionally, citations are subject to the right to correct, which results in no fine. If penalties for illegal discharge were increased, and the citation were not subject to the right to correct, nursing facility residents would be protected from unnecessary discharge. Penalties in HSC §242.066 should be increased to $2,000 and violations related to transfer or discharge procedures must be considered a violation of a resident's right as described in HSC §242.501, making the violation ineligible for the right to correct in HSC §242.0665(b).

Require Nursing Facilities with Locked Units to Be Alzheimer's Certified

In 2014, ombudsmen identified over 200 nursing facilities with locked units that are not Alzheimer's certified, yet market themselves to care for residents with Alzheimer's disease and other forms of dementia. Alzheimer's certification ensures adequate staffing, staff training, and person-centered activities that are appropriate for people with dementia, but there are only 38 nursing facilities in the State that obtain the certification. This problem would be addressed by amending HSC §242.040(b) to require nursing facilities to be certified if they use a locked door to restrict residents' exit from a distinct part or all of the building.

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