# Annual Report

**State Fiscal Year 2024**

**State Long-Term Care**
**Ombudsman Program**

**November 2024**

# Overview

The Office of the State Long-Term Care Ombudsman is independent within the Texas Health and Human Services (HHS) to ensure the office fulfills its advocacy function for residents of nursing facilities and assisted living facilities (ALFs). This report is required by Section 101A.262 of Title 6 of the Texas Human Resources Code, Chapter 101A, Subchapter F.[1] It is due on November 1 of each even-numbered year to inform the public of the work of the State Long-Term Care Ombudsman Program (Ombudsman Program) on behalf of residents. The report includes information and findings relating to the problems and concerns of residents and recommendations to solve the problems, resolve the concerns, and improve the quality of the residents' care and lives.

Federal law and regulation also require an annual report by the Ombudsman Program. Title 45 of the Code of Federal Regulations, Section 1324.13(g) requires that the report describe program activities and analyze program data; evaluate resident problems and complaints; identify problems or barriers to resolving complaints; make policy, regulatory, and legislative recommendations; analyze the success of the program; and describe barriers that prevent the optimal operation of the program.[2]

## Mission

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

## Functions

The purpose of the Ombudsman Program is to protect the health, safety, welfare, and rights of residents. Ombudsmen:

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

[1] Ombudsman Program State Statute (https://statutes.capitol.texas.gov/Docs/HR/htm/HR.101A.htm)

[2] Ombudsman Program Federal Regulation on Annual Report (https://www.ecfr.gov/current/title-45/part-1324#p-1324.13(g))

- Provide residents with information about the Ombudsman Program, their benefits, rights, and services;
- Make regular visits to residents in facilities and respond to requests received in person, and by telephone, mail, and email;
- Represent the interests of residents before governmental agencies, and pursue administrative, legal, and other remedies to protect residents;
- Advocate for system improvements to the media and state and federal decision-makers; and
- Coordinate with and promote citizen organizations and councils.

### Example: Ombudsman Complaint Function

> A resident of a Houston-Galveston Area nursing facility was experiencing issues with her personal hygiene and toileting assistance. The resident's daughter contacted the ombudsman who met with the resident and her daughter, documented their concerns, and conducted unannounced visits to observe staff interactions. The ombudsman interviewed other residents and met with facility administrator to address the issues. The ombudsman made an action plan with the resident, including additional staff training, regular checks, and a revised care plan. The ombudsman conducted follow-up visits to ensure the care plan was implemented as planned. After a month, the resident reported significant improvements, and a final review confirmed continued adherence to the care plan. The resident expressed high satisfaction, and her daughter appreciated the ombudsman's role in resolving the concerns.

## Facilities and Residents

In 2024, there were 2,004 ALFs with a licensed bed capacity of 82,268, including 21,435 Alzheimer's certified beds. At the same time, there were 1,186 freestanding nursing facilities with a licensed bed capacity of 136,433. Only 1,376 nursing facility beds are Alzheimer's certified.

Another 111 hospital-based skilled nursing facilities are licensed in the state.[3] In hospital-based settings, ombudsman contact information must be posted, and an ombudsman must respond to a complaint, but does not routinely visit these settings.

[3] Data as of Sept. 2024 from Long-Term Care Regulation

Ombudsmen serve people seeking to move into a facility and during and after their stay. They investigate complaints related to the health, safety, welfare, and rights of a resident of a long-term care facility.

# Ombudsman Rules and Training Updated

## Revised Program Rules

Revised Ombudsman Program rules in Title 26 of the Texas Administrative Code, Chapter 88, took effect in May 2024. Revisions include changes to ombudsman performance measures; adding a requirement for an ombudsman to provide documentation to facility staff after accessing a resident record; revising the funding formula for local ombudsman entities; and modifying the program's grievance procedures. Corresponding revisions to the Ombudsman Policies and Procedures Manual will be completed in 2025.

## Training and Education

A revised certification training manual was released in May 2024. New curriculum adds references to Code of Federal Regulations and Texas Administrative Code; iCARE infection control and prevention training for long-term care ombudsmen, developed by the University of North Texas Health Science Center;[4] and content on person-centered care and trauma-informed care.

### Example: Ombudsman Uses State and Federal Law to Solve a Complaint

> A resident in the Heart of Texas area contacted his ombudsman to explain that he was being kicked out of his nursing home and had nowhere else to go. The ombudsman learned that the resident had entered the facility for short-term therapy but had applied for services under Medicaid because he needed long-term care. After he applied for Medicaid, facility staff told him they were no longer accepting Medicaid-pending residents and he would have to leave immediately. The resident had run out of his Medicare therapy days to stay in the facility and was terrified of not having anyone to care for him. The ombudsman spoke with facility staff and the facility's corporate office to explain the resident's rights under state and federal law to not be discharged while a Medicaid application is pending. The ombudsman also explained that this would be an unsafe discharge for the resident.

[4] UNTHSC Center for Geriatrics ICARE for Ombudsmen

> The corporate office agreed to allow the resident to stay in the facility. His Medicaid application was approved, and he expressed gratitude for the ombudsman helping him to stay safe in the nursing home.

# Staff and Volunteer Ombudsmen

Staff and volunteer ombudsmen must complete at least 36 hours of initial certification training and 18 hours of annual continuing education. Last year, paid staff completed an average of 52 hours to achieve certification and volunteers completed an average of 46 training hours. Twenty-one new staff and 71 new volunteers were certified.

## Staff

The program is staffed with 105 paid ombudsmen, including nine full-time state office staff, 72 full-time local staff, and 24 part-time local staff. A staff ombudsman is assigned to ALFs and nursing facilities to visit, give information and assistance, attend care plans and resident councils, and investigate and resolve complaints.

A 1995 Institute of Medicine study on the State Long-Term Care Ombudsman Program recommended one full-time equivalent (FTE) staff per 2,000 licensed facility beds.[5] The study was conducted at a time when ombudsman work and the acuity level of residents was less complex than today. With 87 FTEs in local offices responsible for 3,190 facilities and 218,701 licensed beds, on average one FTE is responsible for 37 facilities. The FTE to licensed bed ratio in Texas is one staff to 2,514 licensed beds, and more when staff vacancies exist.

### Paid Staff Tenure and Turnover

On average, staff ombudsmen serve for 4.5 years. Staff tenure ranges from zero to 35 years in the position.

2024 matched the highest staff turnover in a decade with 27 staff leaving, which is a 25% turnover rate. Due to current funding levels, part-time positions are necessary to ease staff workloads and ensure residents have an ombudsman who regularly visits and promptly responds to a complaint. However, part-time positions are more difficult to fill and keep. In 2024, part-time ombudsman positions had a 44% turnover rate.

### Temporary State Office Staff

Two positions, the Discharge Rights Ombudsman and Quality Assurance Ombudsman, are funded with temporary federal funds that end in September 2025. Both functions have improved ombudsman services to residents, family members, and facilities.

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[5] Institute of Medicine. 1995. Real People Real Problems: An Evaluation of the Long-Term Care Ombudsman Programs of the Older Americans Act. Washington, DC: The National Academies Press (https://doi.org/10.17226/9059)

State funding to continue these positions is requested in the recommendation on page 21.

The Discharge Rights Ombudsman reviews every nursing facility discharge notice sent to an ombudsman.[6] The position analyzes trends, identifies common errors, trains ombudsmen, and advises facilities on proper discharge procedure. With nursing facility discharge continuing to top ombudsman complaints, the position improves our protection of residents experiencing discharge.

The Quality Assurance Ombudsman trains new managers in the 28 local offices regarding required investigation and documentation practices. Every three months, the position conducts quality assurance of ombudsman records. This oversight identifies and corrects documentation errors to ensure compliance with ombudsman policies and procedure and promotes best practices in ombudsman investigation and record-keeping. Due to staff turnover and the demands on staff to promptly respond to complaints and conduct frequent facility visits, the position ensures that ombudsmen perform their functions in accordance with program requirements.

# Volunteers

In 2024, volunteer ombudsmen donated 9,452 hours. Using the Independent Sector's value of a volunteer hour in Texas of $31.94, that equals $301,897 in donated time. [7] The number of volunteers at year end are shown in the table below.

| Year End | Number of Active Volunteers |
|---|---|
| **2019** | 386 |
| **2020** | 347 |
| **2021** | 268 |
| **2022** | 290 |
| **2023** | 290 |
| **2024** | 281 |

## Volunteer Tenure and Turnover

On average, volunteers serve for 4.4 years. Volunteer tenure ranges from zero to 32 years.

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[6] 42 CFR §483.15(c) requires a nursing facility to provide the ombudsman with a copy of each notice of transfer or discharge of a resident.

[7] Value of Volunteer Time Report | Independent Sector Resources

In 2024, the volunteer turnover rate was 22% with 63 volunteers leaving. Of the 63 who left, three were promoted to a paid staff ombudsman position. Others left for health, caregiving, and other personal reasons.

# Long-Term Care Landscape

This section includes comments related to the long-term care landscape. These conditions inform our work and relate to recommendations in the report.

## Nursing Facility Survey and Enforcement

According to Centers for Medicare and Medicaid Services (CMS) data on state survey agencies, Texas has the second most nursing facilities in the U.S., behind California.[8] It ranks first in the U.S. for numbers of serious deficiencies and federal fines.

In 2023, KFF reported on CMS data about nursing facilities and states' enforcement of federal regulations.[9] The report analyzes enforcement and other data by state to allow for comparison and ranking. In that context, Texas ranked 26th for its percent of facilities with serious deficiencies causing actual harm. It tied for 19th with five other states in the percent of facilities with any deficiency cited and tied for 25th with seven other states for the percent of facilities with no deficiency cited. Texas ranked 13th in the percent of facilities with a federal fine and 37th in the average number of deficiencies cited per facility. These data indicate that Texas survey and enforcement decisions are about average compared with other states.

However, there are 145 freestanding nursing facilities with more than 15 months since a recertification survey was completed. Delays in recertification surveys effect the timing of complaint investigations, especially complaints set for investigation at the next recertification survey. As time passes, evidence is lost and forgotten, degrading the quality of an investigation, and reducing the likelihood that a complaint will be substantiated.

## Facility Closures and Occupancy[10]

### Closures

Since 2003, an average of 32 ALFs close each year. The total number of ALFs peaked in 2020, and the number hovers at just over 2,000 facilities today. The number of ALF licensed beds increased to a peak of 82,268 in 2024.

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[8] CMS QCOR Survey Data; Retrieved Oct. 1, 2024.

[9] State Health Facts - Nursing Facilities | KFF Data as of Oct. 27, 2023; KFF is a nonprofit health policy research, polling, and news organization.

[10] Texas ALF and NF Closures directories at (ALF) | Texas Health and Human Services and Nursing Facilities (NF) | Texas Health and Human Services; retrieved October 2, 2024

Since 1994, an average of 10 nursing facilities close each year. The number of nursing facilities peaked at 1,250 facilities in 2018 and declined to 1,186 in 2024. The table below shows the number of ALF and NF closures by year.

| Year | Number of ALFs Closed | Number of Nursing Facilities Closed |
|---|---|---|
| **2019** | 27 | 11 |
| **2020** | 22 | 20 |
| **2021** | 75 | 13 |
| **2022** | 88 | 18 |
| **2023** | 28 | 17 |
| **2024** | 54 | 7 |

## Occupancy

ALF occupancy is not reliably measured, but ombudsmen observe ample number of facilities with unoccupied beds. However, assisted living care is unaffordable for many Texans and few ALFs contract with managed care organizations to provide HHS STAR+PLUS Home and Community Based Services. In 2023, only 3,693 Texans paid for ALF services with the HHS STAR+PLUS waiver.

With over 83,000 residents, Texas has the 3rd highest number of nursing facility residents in the country, behind California and New York.[11] In 2023, Texas HHS reported a nursing facility occupancy rate of 63%.[12]

[11] CMS QCOR Survey Data and
LTC Community Coalition Analysis of Nursing Home Staffing Data

[12] Reports and Presentations | Texas Health and Human Services Regulatory Services Annual Report

# Visits by an Ombudsman

The purpose of an ombudsman visit is to monitor residents' health, safety, welfare, and rights; communicate with residents, which may involve receiving, investigating, and resolving a complaint; and observe conditions of the facility. When conducting a visit, volunteer and staff ombudsmen must comply with facility requirements related to infection control.

Visits are typically unannounced to facility staff. Conversations between an ombudsman and a resident or complainant are confidential. While onsite, ombudsmen may attend care plan meetings when invited by a resident, attend resident and family council meetings when invited by a council, and train facility staff upon request of a facility. Numbers of ombudsman visits made by facility setting are shown in the table below.

| Type of Facility | Number of Licensed Facilities[13] | Facilities Visited by an Ombudsman Every 90 Days | Total Number of Ombudsman Visits |
|---|---|---|---|
| **Type A ALF** | 384 | 351 | 2,268 |
| **Type B ALF** | 1,620 | 1,350 | 9,816 |
| **Nursing Facility** | 1,186 | 1,102 | 14,630 |

A Type A ALF cares for residents who do not require routine care during sleeping hours, can leave the facility unassisted in an emergency, and can follow directions during an emergency.

A Type B ALF cares for residents who may require care from staff during sleeping hours; need help transferring to and from a wheelchair; need assistance to get out of the facility or are unable to follow directions during an emergency. A Type B facility can be Alzheimer's certified to provide specialized services to residents with Alzheimer's disease or a related condition.

A nursing facility must provide for the needs of each resident, including room and board, social services, over-the-counter medications, medical supplies and equipment, and personal needs items. A skilled nursing facility provides medical services from nurses, physical and occupational therapists, speech pathologists, and audiologists. Skilled nursing facilities provide round-the-clock assistance with healthcare and activities of daily living. Skilled nursing facilities can be used for short-term rehabilitative stays after a person is released from a hospital.

[13] Data as of Sept. 2024 from Long-Term Care Regulation

# Information and Assistance

Ombudsmen provide information and assistance (I&A) to residents and others who seek information about the Ombudsman Program, residents' rights, and facility requirements. In 2024, ombudsmen reported I&A to over 30,500 residents and family members of residents, and I&A to over 4,000 facilities.

## Example: Information Helps Resident with Brain Injury

> A nursing facility resident in the South East Texas area was in a coma due to a traumatic brain injury. His private insurance ended after a few months of moving to the facility. His family applied for Social Security Disability Insurance (SSDI) and Medicaid, but both take time to establish. While they waited, the family had to pay the facility. The family paid what they could but couldn't keep up with the $7,000 monthly bill and the resident was issued a discharge notice. The family asked the ombudsman to try and prevent his discharge because he needed extensive care that they could not provide at home. The ombudsman contacted the HHS Medicaid office and determined that his disability status could be established through a state program while he awaited a Federal SSDI determination. The ombudsman advised the family about information needed by Medicaid, which the family supplied. Within days, his disability status was approved by HHS. The facility rescinded its plan to discharge, and the resident was able to remain in the facility where his care needs could be met.

# Meetings, Hearings, Training, and Survey Participation

In 2024, ombudsmen:

- Attended 1,133 care and service plan meetings for residents.
- Attended 726 resident council meetings and 17 family council meetings.
- Participated in 163 fair hearings for appeal of a resident discharge or Medicaid denial.
- Trained 45 facilities.
- Participated in 1,259 HHS Long-Term Care Regulation facility surveys.

# Complaints

In 2024, ombudsmen investigated 1,181 complaints regarding ALFs and 6,384 complaints regarding nursing facilities. An ombudsman complaint investigation and resolution are typically completed within 67 days in an ALF and 62 days in a nursing facility.

## Who Makes Complaints

Anyone may make a complaint to an ombudsman if it relates to the health, safety, welfare, or rights of a resident. More than half of complaints received are voiced by a resident. A family member, guardian, or friend is the next source of a complaint, followed by an ombudsman. The table below shows the type of complainant and the percent of complaints made by them.

**Percent of Complainants by Type**

| Rank | Complainant | Percent |
|---|---|---|
| **1** | Resident | 66.6% |
| **2** | Family, Guardian, or Friend | 18.2% |
| **3** | Ombudsman | 8.5% |
| **4** | Facility Staff | 2.8% |
| **5** | Concerned Person or Group | 2.4% |
| **6** | Unknown | 1.5% |

## Example: Resident is Angry and Withdrawn

> The West Central Texas ombudsman met a resident that had just transferred to a nursing facility. She was bed bound due to a severe car accident. Each month when the ombudsman visited, the resident frequently denied the ombudsman entry into her room. Staff reported that she would scream and threaten them, often declined care, and was not involved in her own care planning. After seven months of regular visits by the ombudsman, trust was built with the resident who shared that she was depressed and felt "like a piece of furniture" with no future. They discussed what would make her feel more herself and the resident decided she wanted her freedom of mobility back. The

> ombudsman helped start the process of getting her an electric wheelchair. Once mobile in the chair, the resident was observed smiling, joining in activities, going on outings, and involved in her care. The resident now reports feeling excited about her future.

# Assisted Living Facilities

## Facility Staff

Type A facility staff must be on the property but may sleep at night. When a Type A facility has 17 or more residents, night staff must be awake.

Type B night staff must be on the property and always awake. If the Type B facility is also Alzheimer's certified, sometimes called a memory care facility, and has 17 or more residents, two staff members must be on the property when residents are present.

### Examples: Inadequate Staffing in Alzheimer's Certified Memory Care

> Residents Repeatedly Elope: Four residents left the building unaccompanied during a six-month period. They were found by staff and visitors.
>
> Heat Stroke: In August, a resident was last seen three hours before they were found lying on the ground of the enclosed outdoor courtyard of the facility and had to be treated for heat stroke.
>
> Found Outside in Cold: Outside temperature was 10 degrees when a staff ending their shift at 7:00 a.m. found a resident outdoors. The resident wore sleeping clothes and was lying on the ground in a fetal position. A door from the kitchen was left open and was accessible from the Memory Care unit. The resident was cold but vital signs appeared normal.
>
> Death: In July, a resident died after approximately 12 hours of outdoor heat exposure in the facility's enclosed outdoor courtyard.
>
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## 2024 ALF Complaints

Ombudsmen verified 91% of all complaints received and resolved 86% to the satisfaction of the complainant.[14] The table below describes the five most common complaints ombudsmen investigated about an ALF, including how many complaints were made, the percent of complaints verified, and percent of complaints resolved by ombudsman action. The top five complaints remain the same problems reported in 2023.

| Rank | Complaint Description | Number Received | Percent Verified | Percent Resolved |
|---|---|---|---|---|
| **1** | Food Services | 110 | 92% | 95% |
| **2** | Problems with Medications | 88 | 93% | 88% |
| **3** | Housekeeping, Laundry, Pest Control, and Infection Control | 69 | 94% | 94% |
| **4** | Unmet Requests for Help | 68 | 90% | 88% |
| **5** | Involuntary Discharge | 65 | 100% | 75% |

### Issue: Immediate Threats to Health and Safety

Our office is concerned about serious violations occurring in ALFs. We are aware of over 150 violations that occurred in ALFs in 2024 with the potential to cause harm to residents, including violations involving staffing and supervision of residents, abuse and neglect, and emergency response. More than half of these violations happened in a facility that is Alzheimer's certified.

Examples of these situations are described below, and a recommendation related to immediate threats is made on page 29.

[14] Verified means that after observation, interview, and record review, the ombudsman determines that circumstances described in the complaint are generally accurate.

### *Example: Bedfast Residents*

> A large Type B ALF had residents who were unable to leave their bed and others that required a geriatric chair to be out of bed, requiring two- and three-person lifts. Residents had pressure ulcers. Staff did not have access to resident assessments and care plans. Staff did not know the building evacuation procedures and were not trained how to report abuse and neglect.

### *Example: Facility Manager Abuses Residents*

> A resident in a small Type B ALF hid in their room out of fear of the manager of the building. Another resident reported fear of using a call light for toileting help after being moved forcefully, causing pain. The resident said if they had to stay in the facility they wanted to die. Another resident overheard the manager yelling at other residents when they asked for help. The owner was unaware how to report and investigate abuse by their staff.

### *Examples: Staff Not Trained for Emergencies*

> Code Status Not Documented or Known: Facility staff for 10 residents did not know any resident's status to be revived if their heart or breathing stopped. Records did not show the resident's or legal decision-maker's request for resuscitation. Staff were not certified to administer CPR-cardiopulmonary resuscitation. Care needs for the memory care residents were not known to staff who asked the residents with dementia or their visitors for information about the residents' care needs.
>
> Staff Failed to Seek Emergency Help: Staff found a resident unresponsive in bed and waited 20 minutes before calling 9-1-1. When paramedics arrived, a sheet was pulled up to the resident's neck and no one was in the room administering aid. There was no nurse on duty and no evidence that a nurse was called by staff. The resident's code status could not be determined from the records. Paramedics found the resident still warm to the touch and administered CPR, but the resident was pronounced dead 30 minutes later.

### *Examples: Medications Not Given*

> A resident was prescribed a fifteen-day course of antibiotics for a urinary tract infection but was only given two. Staff falsified

> documentation, writing that the full course of medicine was given. The resident had to be hospitalized with sepsis and was discharged to skilled nursing care due to loss of functioning.
>
> Morning and afternoon medications were not given at a large Type B ALF that is Alzheimer's certified. A medication technician administered medications later that day but did not have nurse delegation to do so. Insulin was not administered to a resident with dangerously high blood sugar levels. Staff were unaware of emergency evacuation procedures and had not been trained on them.

### *Example: Not Enough Staff to Meet Needs*

> Staff work alone to care for over 20 residents, more than half need assistance to get in and out of bed, including some who require two staff to help. Staff leave residents in bed due to a lack of staff.

### *Example: Falls Assessed, Not Monitored*

> In a large Type B ALF, a resident fell in their room and fractured their back. Three days passed with no staff checking on the resident. Four other residents had fall management plans that weren't followed by staff.

### *Example: Medications Administered Without Nurse Delegation*

> In a large Type B ALF, the medication technicians were administering medicine without the required nurse delegation. Physician orders were not followed, which included giving medication past the prescribed end date.

## Nursing Facilities

Ombudsmen verified 94% of all complaints received and resolved 88% to the satisfaction of the complainant. The table below describes the 10 most common complaints ombudsmen investigated about a nursing facility, including how many complaints were made, the percent of complaints verified, and percent of complaints resolved by ombudsman action. The top 10 complaints remain the same problems reported in 2023.

## 2024 Nursing Facility Complaints

| Rank | Complaint Description | Number Received | Percent Verified | Percent Resolved |
|---|---|---|---|---|
| **1** | Involuntary Discharge | 571 | 96% | 85% |
| **2** | Unmet Requests for Help | 515 | 95% | 88% |
| **3** | Food Services | 382 | 95% | 88% |
| **4** | Personal Property Lost, Damaged, or Stolen | 325 | 86% | 82% |
| **5** | Problems with Medications | 315 | 91% | 90% |
| **6** | Assistance with Personal Hygiene | 312 | 94% | 90% |
| **7** | Dignity and Respect | 274 | 90% | 92% |
| **8** | Assistive Devices and Equipment | 261 | 94% | 89% |
| **9** | Other Rights and Preferences, Including Choice, Religion, and Voting | 240 | 94% | 93% |
| **10** | Housekeeping, Laundry, Pest Abatement, and Infection Control | 213 | 97% | 94% |

### Staffing Is the Underlying Cause of Many Complaints

Of the 10 most frequent complaints received, complaints about unmet requests for help, food services, problems with medications, assistance with personal hygiene, dignity and respect, and housekeeping and infection control relate to an insufficient number of staff. Understaffing also leads to residents having more unmet behavioral health needs, which a facility may try to solve with involuntary discharge rather than meet its requirements.

### *Example: Resident Who Needs Two-Person Assist Misses Activities*

> A nursing facility resident in Harris County called her ombudsman to say she couldn't participate in religious services at the facility. The resident explained that she requires two people to transfer from her bed to wheelchair. The facility told her that they didn't always have enough staff to get her to activities. The ombudsman met with the director of nurses and the social worker where the ombudsman reinforced the resident's right to participate in activities and practice the religion of her choice. The facility staff agreed to send two caregivers to the room about an hour before an event to make sure she could get up and get ready to attend. On the ombudsman's follow up visit, the resident said staff had been coming to get her up and she is able to attend the services when she wishes to.

## Representing Residents in a Discharge Appeal

Many residents rely on an ombudsman to help when a facility notifies them of its plan to discharge the resident. Ombudsmen can represent residents in their discharge appeal, helping a resident explain how their needs can be met at the facility or how the facility failed to meet its legal requirements. Because discharge continues to be a top complaint, we recommend three actions to address the issue on pages 22-23.

### *Example: Resident Stuck in Hospital, Wins Hearing*

> In the Lower Rio Grande Valley area, a resident called his ombudsman to report he was in the hospital and ready to return to the nursing facility. The facility refused to take him back, saying it had been more than 30 days since the resident left. He was stuck at the hospital. The facility hadn't told the resident how to hold his room at the facility or about his discharge rights. The facility also didn't give a discharge letter to the resident or the ombudsman. The ombudsman helped the resident report the issues to HHS Long-Term Care Regulation and requested a fair hearing to appeal the discharge. The ombudsman represented the resident in the hearing and the resident won, but the facility refused to readmit the resident. After two months and involvement from the Ombudsman Program state office and HHS Long-Term Care Regulation, the nursing facility finally accepted the resident back.

# Recommendations

## Problem: More Staff Ombudsmen Are Needed

Long-term care ombudsman services are delivered through contracts between HHS and agencies housing area agencies on aging (AAAs). Ombudsmen and the agencies that employ them report insufficient funding to operate. Since 2018, $1.8 million annually in state revenue has been allocated for Ombudsman Program operations. The program receives less than $1.5 million annually in federal funds for ombudsman services. This results in AAAs dedicating an additional $2.6 million in other federal funding meant for serving older Texans in a variety of important ways. As described on page 6, the ratio of staff ombudsmen to licensed bed capacity exceeds by over 500 beds the recommended level of one staff ombudsman for every 2,000 licensed beds. This delays ombudsman action and means residents must wait for resolution to problems. It also contributes to turnover of paid staff and volunteer ombudsmen.

### Solution: Increase state funding for the Long-Term Care Ombudsman Program

Additional general revenue is needed to sustain high-quality ombudsman services. Estimating the cost of salaries, benefits, and travel expenses at $130,000 per full-time employee, an additional $2.8 million in general revenue each year would hire additional ombudsmen and increase hours of part-time ombudsmen to the equivalent of 22 full-time positions. These changes would mean more staff ombudsman eyes and ears in facilities, observing conditions, investigating complaints, and working to resolve complaints in lieu of regulatory action.

An additional $200,000 in general revenue and allocation of two FTEs is needed to fund the Quality Assurance Ombudsman and Discharge Rights Ombudsman at the Ombudsman Program state office. These positions are described on page 7. The Discharge Rights Ombudsman position is also a proposed solution to the problem of nursing facility discharges described below.

## Problem: Nursing Facilities Continue to Not Comply with Discharge Rules

Involuntary discharge from a nursing facility is the top complaint received in the Ombudsman Program. With federal funds available through Sept. 2025, the Discharge Rights Ombudsman position within the Office of the State Long-Term Care Ombudsman determined that facilities are inconsistently sending notices to

ombudsman office locations and use facility notice templates with errors. This means that residents are not receiving proper notice of their discharge and appeal rights.

A 2021 U.S. Office of Inspector General report about nursing facility-initiated discharges includes recommendations to CMS and state long-term care ombudsman programs to better understand the problem and address it.[15] Available national data show that discharge is the top national complaint received by state long-term care ombudsman programs for the past 12 years.

Facilities are willing to "take the hit," meaning accept the costs of a citation from HHS, for a violation of discharge requirements. A reason enforcement doesn't work is the violation often doesn't come with administrative penalties or other effective deterrents.

## Solution 1: Authorize an HHS portal where discharge notices must be filed.

In response to the prevalence of nursing facility discharge complaints in other states, state agencies developed a portal for facilities to upload or generate a discharge notice. Access to the portal is available to the Office of the State Long-Term Care Ombudsman, State Survey Agency, and Office of Fair Hearings to efficiently respond to the notice and process a fair hearing request. A portal implemented in Texas would help facilities provide accurate and standard notice to a resident, meet notice requirements to the ombudsman, and efficiently initiate a fair hearing request on behalf of a resident.

## Solution 2: Fund a Discharge Rights Ombudsman to help ombudsmen respond to discharge complaints.

We request that the Texas legislature authorize one full-time position and funding for an Ombudsman IV classification within the Office of the State Long-Term Care Ombudsman. With ongoing funding, we can leverage the work accomplished by this specialized ombudsman and continue our analysis, training, and direct advocacy by the Discharge Rights Ombudsman.

## Solution 3: Increase the penalty for discharge violations.

Modify Health and Safety Code §242.066 to establish a minimum daily fine for a discharge violation. If Long-Term Care Regulation determines that a violation of the

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[15] U.S. Office of Inspector General, "Facility-Initiated Discharges in Nursing Homes Require Further Attention", Nov. 2021, OEI-01-18-00250, https://oig.hhs.gov/oei/reports/OEI-01-18-00250.asp

discharge requirements occurred that resulted in the improper expulsion of a resident from the facility, require HHS to impose a minimum penalty of $5,000 per day that the resident is denied return to the facility.

## Problem: Understaffing of Nursing Facilities

CMS published its final rule on staffing requirements in May 2024 with the staffing assessment in effect as of June 2024 and minimum staffing requirements to take effect two to five years later. Lawsuits by representatives of the nursing home industry and state attorneys general followed. It is our position that a minimum staffing standard is necessary to improve care in nursing facilities. The final rule sets standards that are necessary and achievable, as evidenced by nearly 60% of facilities nationwide already staffing at the future total staffing standard of 3.48 hours per resident day (HPRD).[16] Texas, however, is understaffing its nursing homes with just over a quarter of facilities currently meeting future total staffing requirements and only about 15% meeting the future Registered Nurse (RN) requirement.[17]

Research and reporting show that facilities will understaff to increase profits, which results in residents going without needed care.[18] A 2023 study on nursing facility staffing found a strong relationship to quality and safety when nursing facilities are staffed with CNAs for 2.44 HPRD or higher. The report also found that nursing facilities with higher staffing perform better on facility-reported quality and safety measures and RN staffing had the strongest effect of quality and safety.[19] A 2016 study found that to avoid omitted care that exceeds 10% daily, CNAs should be staffed at 2.8 HPRD for residents with lower care needs and 3.6 HPRD for residents with high care needs.[20]

State policies that pay the same for poorly staffed facilities as well-staffed facilities encourages understaffing. On average, nursing facilities with lower staffing levels have

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[16] A Closer Look at the Final Nursing Facility Rule and Which Facilities Might Meet New Staffing Requirements | KFF

[17] Nursing Home Staffing Data - NursingHome411 Long-Term Care Community Coalition analysis of CMS data at Payroll Based Journal Daily Nurse Staffing | CMS Data

[18] Harrington C, Schnelle JF, McGregor M, Simmons SF. The Need for Higher Minimum Staffing Standards in U.S. Nursing Homes. Health Serv Insights 2016; Rau, Jordan, Care Suffers as More Nursing Homes Feed Money into Corporate Webs December 31, 2017; and Private Investment Homes Sometimes Differed from Others in Deficiencies, Staffing, and Financial Performance. Government Accountability Office (GAO-11-571): July 15, 2011.

[19] Abt Associates Nursing Home Staffing Study June 2023

[20] Schnelle, et al. Determining nurse aide staffing requirements to provide care based on resident workload: A discrete event simulation model. J. American Medical Directors Association November 2016.

lower costs because the facilities spend less on staff.[21] The CMS Care Compare site lists Texas's average total nurse staffing hours, which includes RNs, Licensed Vocational Nurses, and CNAs, is 3.25 HPRD, which is lower than reported last year.[22] In a 2022 issue brief, analysis of state staffing policies and reimbursement rates by MACPAC concluded that, "Even if a facility receives adequate overall payment from the state, it may not allocate that revenue to direct care staff if it does not have an incentive to do so. To counteract these incentives, several states have adopted minimum staffing standards that exceed the federal requirements and have designed Medicaid payment methods to incentivize greater spending on staffing."[23]

### Solution: Require a percentage of nursing facility Medicaid reimbursements to pay for direct care staff.

For nursing facilities that participate in the Texas direct care staff enhancement program, 85% of its add-on reimbursement must be spent on direct care staffing. We recommend that a comparable percentage is applied to the Medicaid daily rate reimbursements that all Medicaid-certified facilities receive, using the enhancement program definition of direct care staff. Outcomes should be measured by analysis of the CMS payroll-based journal dataset.

## Problem: ALF Alzheimer's Care Has Weak Staffing Standards

Because only 34 nursing facilities are Alzheimer's certified, ALFs serve as the primary setting offering Alzheimer's certified care in Texas. A total of 716 ALFs are Alzheimer's certified.[24] The only minimum staffing requirement in an Alzheimer's certified ALF requires two staff immediately available for a facility with 17 or more residents.[25] Licensed capacity of these facilities range from four to 96 beds with an average of 29 beds per facility.

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[21] MACPAC Issue Brief: Estimates of Medicaid Nursing Facility Payments Relative to Costs. January 2023 and MACPAC Report to Congress on Medicaid and CHIP, Principles for Assessing Medicaid Nursing Facility Payment Policies. March 2023.

[22] CMS Nursing Home Care Compare retrieved October 2024

[23] MACPAC Issue Brief: State Policy Levers to Address Nursing Facility Staffing Issues. March 2022

[24] Data as of Sept. 2024 from Long-Term Care Regulation

[25] Title 26 Texas Administrative Code, Chapter 553, Section 553.305

Residents with Alzheimer's disease and related dementias experience a variety of symptoms and require individualized interventions. Common care needs that are staff-intensive for residents with Alzheimer's disease include:

- supervision to avoid elopement or injury
- reminders to use a toilet
- encouragement or help eating
- frequent and personalized activities to avoid boredom
- redirecting distressing or negative behavior

As shown in the examples on page 15, inadequate staffing in Alzheimer's certified ALFs has harmed residents.

### Solution: Set a minimum direct care staffing ratio in Alzheimer's certified ALFs

Appropriate minimum staffing ratios provide residents the supervision, quality activities, and health care services they need. An Alzheimer's certified nursing facility must have one staff for every six residents during the daytime, one staff for every 10 residents in the afternoon to evening, and one staff for every 18 residents overnight. A staffing standard for Alzheimer's certified ALFs that is comparable to an Alzheimer's certified nursing facility would protect residents and ensure they get quality care and adequate supervision.[26]

## Problem: Emergency Response Plans Are Not Reviewed and Plans Are Not Known to the Public

Long-term care facilities regularly experience natural disasters like hurricanes, wildfires, and flooding and other emergencies like infectious disease outbreaks and active shooters. ALFs and nursing facilities are required to maintain an all-hazards emergency preparedness and response plan. These plans may be reviewed by HHS when a surveyor is onsite, but a comprehensive review of emergency preparedness plans by HHS is not routinely conducted. The only way for the public to know what a facility's emergency plan includes is to request it from the facility.

### Solution 1: Require ALFs and nursing facilities to report daily to HHS when an emergency or disaster occurs.

Like required reporting in Florida, require a facility to submit a daily report regarding the building's physical conditions, operations including HVAC and reliance on

[26] Title 26 Texas Administrative Code, Chapter 554, Subchapter W, Section 554.2208

generator power, medications, food supplies, food storage, and food preparation capability, and the condition of residents.

### Solution 2: Require ALFs and nursing facilities to annually submit emergency plans to HHS.

Providers are accustomed to submitting reports to HHS as a condition of licensure. Facilities should be required by statute to annually submit an emergency response plan to HHS for review. Having the plans at HHS will be useful for state emergency planning and response.

### Solution 3: Require annual Texas Department of Emergency Management (TDEM) approval and submission of approved facility plans to HHS Long-Term Care Regulation to publish results.

Require a facility to annually submit its emergency plan to TDEM for approval. Require facilities to submit the approved plan to HHS Long-Term Care Regulation to publish key details from each plan on the HHS website. Public information should include which facilities have an onsite generator and what systems the generator is capable of powering.

## Problem: Many Facilities Do Not Have Generators

Natural disasters and other emergencies present significant risk to long-term care residents. The ability to heat or cool a facility during an emergency saves lives in long-term care facilities. In August 2022, HHS released a report on generator availability and usage in ALFs and nursing facilities.[27] Based on a survey of providers, 99% of nursing facilities and 47% of ALFs reported having an onsite generator. Over half of nursing facilities reported the system could power air conditioning and heating. For ALFs with a generator, 63% reported the system could power air conditioning and 67% reported the system could power heating. Only 38% of small ALFs, which are licensed for fewer than 17 beds, reported having a generator.

[27] Generator Availability in Nursing Facilities and Assisted Living Facilities Aug. 2022, https://www.hhs.texas.gov/regulations/reports-presentations

### Solution 1: Require large ALFs and all nursing facilities to maintain safe temperatures during an emergency with backup power.

ALFs with a licensed capacity of 17 or greater and all nursing facilities should be required to maintain safe temperatures, as defined by rule, when power is lost. We recommend that these facilities have onsite capabilities to generate emergency power by:

- having enough fuel, or an alternative power source with sufficient capacity to operate, for 72 hours;
- maintain safe temperatures in an area in the facility of sufficient size to always maintain residents safely; and
- for a facility that maintains a separate area in the facility with a locking device as defined by commission rule to restrict a resident's ability to exit the facility, maintain a separately powered area within the locked area.

### Solution 2: Issue generator grants to Medicaid-certified and contracted facilities.

The 88th Texas Legislature passed S.B. 2627 to establish a backup power packages program to fund generators for businesses like ALFs and nursing facilities. To date, no funds have been issued to long-term care facilities. We recommend awards are prioritized for facilities with the greatest financial need serving residents eligible for Medicaid. We also recommend education and outreach to ensure eligible facilities are aware of the opportunity to apply.

## Problem: Behavioral Health Needs of Nursing Facility Residents with Dementia Are Not Met

When a facility admits a resident into their care, the facility agrees to meet the person's needs. Behavioral health needs too often go unmet with facility staff not giving personalized care and not knowing how to respond to a person's symptoms of dementia. If common and predictable behavioral symptoms associated with dementia are not managed by facility staff, they escalate. As the problem goes unaddressed, a resident's unmet needs can trigger a revolving door of discharge from facilities and transfers in and out of hospitals. A resident's family supports and cognitive strengths tend to decline as multiple discharges and transfers happen.

Nursing facility rules and regulations already require a facility to plan and provide individualized and trauma-informed care. In our experience, enforcement of these

requirements is not effective at curtailing the problem and happen too late to prevent harm.

Providing good care to a person with dementia requires ample staffing for supervision, activities, and healthcare delivery. Residents with dementia benefit from individualized care given by the same caregivers. Meeting the staffing requirements for Alzheimer's certification in rule has costs that providers say are not covered by standard Medicaid reimbursement because many residents with dementia are otherwise relatively healthy. Staffing requirements in the Alzheimer's certification rules ensure competent and enough staff deliver care but only 34 nursing facilities are Alzheimer's certified.

### Solution: Implement a rate enhancement for nursing facilities with Alzheimer's certification

We recommend that the Texas legislature authorize and fund a rate enhancement to incentivize more nursing facilities to achieve Alzheimer's certification. An enhanced reimbursement rate for Alzheimer's certified care will get more nursing facilities certified and require compliance with the staffing and training standards within these settings.

## Problem: The Public Is Not Aware of Serious Violations Cited by HHS Long-Term Care Regulation

### Existing nursing facility report

Certain serious violations that are cited in a nursing facility are classified as immediate jeopardy, or IJ, which means a situation where noncompliance has caused, or is likely to cause, serious injury, harm, impairment, or death to a resident. Every three months, HHS publishes an IJ report on its website called the Quarterly IJ Summary Report. The report is in PDF format that includes a list of violations cited, the frequency of each citation, and whether the violation was identified from a complaint, incident, or survey. It identifies the region where the facility is located, date, purpose of visit, and describes the citation, situation, and deficient practice.

The Quarterly IJ Summary Report is limited in its use because it does not identify the name of the nursing facility associated with the citation even though the citation is public information. This means the public cannot use this report to identify a problem at a specific location or evaluate care concerns with several facilities. Because each report is published as a PDF, analysis across time or by deficiency requires significant effort.

## No comparable ALF Report

The most serious violations in an ALF are called an immediate threat, or IT, which means a situation that causes, or is likely to cause, serious injury, harm, or impairment to or the death of a resident. ITs are cited by HHS Long-Term Care Regulation, but the only way to view this public information is by knowing where a problem occurred or searching each facility on the HHS website. Violations that are published on the HHS site are difficult to find and lack detail. An ALF IT Summary Report would give the public valuable information about facilities where serious problems occur, like those described on pages 16-18.

## Solution 1: Improve the nursing facility Quarterly IJ Summary Report.

HHS should revise its existing report to be useful for a larger segment of the public. We recommend the report is published, on an ongoing basis, in Excel format and updated at least every three months. We recommend that the facility name, address, and bed capacity is included on the report and that the report is available for download.

## Solution 2: Publish an ongoing report on ALF immediate threats.

We recommend that the Texas Legislature direct HHS Long-Term Care Regulation to publish an ALF Immediate Threat report with the requirements that follow.

- Publish in an Excel format on the HHS website.
- Update at least every three months.
- Identify the name and address of the facility.
- Include the facility type, licensed bed capacity, and whether the facility is Alzheimer's certified.
- Include details about the IT that are like those provided in the nursing facility Quarterly IJ Summary Report.
- Allow the document to be downloaded, like the facility list published on the HHS website.

# Problem: ALF Policies Can Undermine Residents' Rights

ALFs are regulated by state law and rules. HHS issued proposed ALF rules in 2024 but a final rule was delayed. This delay is one of several over the course of more than a

decade. Current ALF rules contain some ambiguous requirements and fail to protect resident interests.

For example, ALF rules require a facility to set and follow its own policies. When a person makes a complaint about an ALF policy to HHS, HHS usually finds the ALF in compliance if the ALF has a policy and follows it. However, ALF policies can be at the detriment of free choice and other rights. For instance, a resident who uses a motorized wheelchair can be charged significant non-refundable fees to use the wheelchair in the facility. Facility policies have also limited when a person is allowed visitors or use a telephone and set unreasonable notice requirements on residents who want to move out.

### Solution: Prohibit ALF policies that limit a resident's right.

HHS should implement rule changes that prohibit facility policies from conflicting with a resident right. Rules should require that any limit placed on a resident right must be time-limited and determined necessary to protect the health and safety of the resident.

## Problem: It Is Difficult to Know Who Owns Facilities

Knowing who owns and operates a facility licensed by the State should be easily accessible to residents, regulators, and others. Some ownership detail is collected on facility cost reporting, facility licensure applications, and change of ownership applications but HHS does not make the information available to the public. The information published on facility ownership does not show common ownership or provide the public with information about quality care provided by a particular owner.

When facility revenues are made up of mostly tax dollars, facility expenditures should be available to the public. Management services, rent, and related businesses like a staffing agency can be subsidiaries of the same parent company, each collecting fees. These investment strategies warrant greater attention to ensure government funding goes to resident care.

### Solution 1: Publish key elements of Medicaid cost reports.

Financial information reported to HHS about each Medicaid-certified nursing facility should be available to the public. HHS should analyze and report on its website key measures of financial health as part of the cost reporting process.

## Solution 2: Publish clear information on corporate ownership and quality.

HHS should publish more ownership information on nursing facilities and ALFs that includes the parent company, all related companies, and any management company associated with the business. Further, it should publish quality data by common ownership and management companies on the Long-Term Care Provider Search webpage.[28]

[28] HHS provider search

# Contact Information

## State Long-Term Care Ombudsman

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## Statewide Help

1-800-252-2412; enter the zip code of the area where help is needed.

Email: ltc.ombudsman@hhs.texas.gov

Facebook: facebook.com/texasltcombudsman/

Website: Texashhs.org/Itcombudsmantexashhs.org/ltcombudsman