

Appendix D

Descriptions of Individual Complaints From the 2000 and 2001 State Ombudsman Reports

(Individuals' Names Have Been Changed to Protect Their Confidentiality)

Alabama

Admission Agreement The admission agreement in a nursing home was not in compliance with standards for such agreements. The ombudsman program worked with the Medicaid agency to ensure that the agreement was changed to be compliant.

Arizona

Sex Offender in Nursing Home A convicted sex offender completed his prison sentence and was residing in a half way house. He was hospitalized with a mental illness and then transferred to a skilled nursing facility. He arrived in a debilitated condition. His parole officer wanted posting that the resident was a convicted sex offender. The resident objected. Legal counsel argued that due to the resident's medical condition, he posed no risk and could be considered a level one offender and also that he only resided with his roommate, not all of the residents. Other residents could be considered neighbors who would only need to be notified of a level two or three offense. The request for notification was withdrawn.

California

Abuse and Neglect When a frail older resident in a small personal care home was sent to the hospital, the ombudsman was able to visit privately with her and discuss an allegation of neglect at the personal care home. The resident said she was afraid of her caregiver and did not want to return to the facility after her hospitalization. Through investigation, the ombudsman found that the caregiver had been leaving the resident alone, withholding meals from her, and keeping her in fear of retaliation through verbal threats and abuse. In addition, the caregiver, who was licensed as a foster care provider, had been stealing from the resident and allowing the foster children to become verbally and physically violent toward her. The ombudsman contacted social services, Adult Protective Services (APS), the guardian and the state and served as an educator and advocate for the resident throughout the investigation process. Through the network of professionals contacted by the ombudsman, the resident was relocated to a more suitable environment and also was reunited with one of her guardians, from whom she had been separated for years. In the process, it was found that the caregiver had not renewed her license as a personal care boarding home provider and should not have been providing care for the resident. The caregiver was also under investigation for care given to the foster children in her home.

Colorado

Group Complaint and Intimidation A volunteer ombudsman was approached by a group of residents at a personal care boarding home shortly after a new director was put in charge of the facility. The residents alleged they had reported numerous problems regarding unsanitary environment, short-staffing, lack of security and lack of activities; and the new director did not respond to their concerns. They said that staff who raised the issues with the director were told "they could go work somewhere else."

Over the next two months, the volunteer and staff ombudsmen met with the director in an attempt to resolve the issues. Nevertheless, problems at the facility increased and the residents who had complained to the ombudsman were called in to the director's office individually and questioned about which residents had called the ombudsman. Residents then called the volunteer ombudsman and requested another meeting. Fifteen residents attended the meeting and voiced numerous complaints about sanitation, privacy, staffing, food, facility maintenance, lack of activities and resident rights. Residents again complained that they felt intimidated, manipulated and punished by the director for making complaints and voiced their fears of retaliation from the director. At this point the ombudsman filed a complaint to the licensing agency, accompanied by faxed documentation.

The licensing agency conducted an on-site investigation, which included sixteen resident interviews. Investigators followed up with phone interviews with sixteen families over the next month, as well as interviews with the director and the regional director. Subsequently, the licensing agency cited the facility with deficiencies in the areas of residents rights, environment, staff-to-resident ratio and fire safety. During a telephone exit conference with the regional director, the licensing agency investigators were told that the director had resigned her position. Residents of this facility expressed relief and gratitude to the volunteer ombudsman for the assistance provided them. This group of residents is now much more aware of their rights and the process available to protect those rights.

Thefts At one facility there were eight reported thefts within three months: five of residents' personal belongings and three of money. Two of these were reported to the ombudsman by residents and a family member. The facility reported the other six incidents and asked for suggestions on how to stop the thefts. The local police were called and did an in-service training session for the staff. All staff members were fingerprinted. More surveillance cameras were put up throughout the building. Two residents agreed to have cameras in their rooms. There were also cameras set up by the employee entrance/exit door (one employee had been reported leaving with a large trash bag). This report prompted the outside cameras to be set up. Of the eight thefts, one large sum of money (\$290) suddenly reappeared. The other money and personal belongings were not recovered; but there were no further reported thefts at the facility.

Connecticut

Transfer and Discharge A regional ombudsman received a frantic call from a woman who had been notified that her mother was being discharged immediately from a facility because her rehabilitation was complete. However, because she still needed long term care, she could not return home. The daughter explained that upon her mother's admission to the facility, they were told that "this was a short term facility" and if long term care was needed she would have to go elsewhere. The ombudsman informed the daughter that her mother was covered by Medicaid and had a right to remain in the facility for as long as she needed nursing home care. Numerous people in similar situations had transferred out of the facility; the ombudsman program had received sixteen complaints against the facility involving discharge and intra-facility transfers. With the approval of the complainant, the case was referred to the Department of Public Health. The facility was cited for inappropriate practices, waiting list law violation, inappropriate discharge planning and violation of resident rights. The case was referred to the Attorney General for further action against the facility.

Attention to Individual Needs A woman called the ombudsman regarding lack of care for her mother, who had been losing weight, had not been walked and had not participating in activities for fear of being left alone. The ombudsman arranged with the facility to address these issues. It was agreed that the resident's doctor would re-evaluate all medications (which numbered 27) and discontinue as many as possible; activities would be encouraged and the resident would be provided a hand bell to relieve her fear of being forgotten. A person was designated to spend time with her to relieve depression, and a volunteer was sought for companionship and to escort her to activities. A Sarah Lift was used to transfer her to the bathroom. Extras padding was placed on knee pads to alleviate discomfort. A fan was brought into her room to allow more circulation. When the ombudsman visited her in two weeks, the resident said her care had improved.

Georgia

Helping Residents and Families Through Complicated Bureaucracies Mrs. Brown, a nursing home resident in North Georgia, was financially eligible for nursing home Medicaid; but because she had given away some of her possessions as gifts, her family had to pay privately for several months before she could receive Medicaid benefits. During that time, Medicaid rules changed, making her eligible for Medicaid six months earlier. Both the county Medicaid eligibility office and the nursing home submitted requests for a correction to the state Department of Community Health, but months passed and the overpayment was still not corrected. Mrs. Brown passed away; and the family contacted the ombudsman, desperate because they thought the problem would never be corrected. The ombudsman contacted state-level officials who were finally able to find the problem and send the appropriate Medicaid funds to the facility. The facility promptly refunded Mrs. Brown's estate \$12,606.

Advocating for Better Care An ombudsman in South Georgia was making a routine visit to a personal care home when she noticed Mr. Jones, a 30-year old resident with developmental disabilities who was having severe trouble breathing. The six-foot tall man weighed only 72 pounds, was unable to communicate verbally, and had severely contracted legs and arms. Though the staff was trying to feed him, he was unable to eat much. The ombudsman thought the staff was unaware of how serious his condition appeared, and she urged them to contact Mr. Jones' physician immediately. Without the ombudsman's intervention and the immediate involvement of the physician, Mr. Jones' would almost certainly have died from respiratory arrest. The ombudsman followed up with frequent visits to monitor Mr. Jones' condition, which slowly improved, and advocated for more frequent monitoring of his weight by facility staff. In time, Mr. Jones' lungs cleared, he could breathe normally, and he began to gain weight.

Helping Residents Live in Safer Environments A hospital social worker in metropolitan Atlanta contacted the ombudsman to report that Ms. Woo had been allegedly abused in a personal care home. The ombudsman visited Ms. Woo in the hospital. She claimed that she had been physically and verbally abused and punished by her home provider. The provider had failed to follow doctor's orders for a pureed diet, so Ms. Woo was suffering from abdominal bleeding. Ms. Woo told the ombudsman she was afraid to return to the home. The ombudsman contacted law enforcement and regulators, who immediately began investigating the provider. The ombudsman retrieved the resident's possessions and funds from the home and assisted the hospital social worker to find Ms. Woo another personal care home. Today Ms. Woo is pleased with her new home. She tells the ombudsman she finally feels safe and protected.

Protecting Residents from Financial Exploitation Mr. Thomas and his wife had lived together in a South Georgia nursing home. When Mrs. Thomas died, their son urged Mr. Thomas to move home with him. After Mr. Thomas said he would rather stay in the nursing home, the son, who had financial power of attorney, stopped paying the nursing home bill. The social worker called the ombudsman to report that they didn't want to discharge Mr. Thomas but would have to if his bills weren't paid; the son had not paid in months and refused to return the nursing homes' calls. The ombudsman met with Mr. Thomas, who again expressed his desire to stay at the nursing home. After the son refused to return calls from the Ombudsman, she referred Mr. Thomas to the Elder Legal Assistance Program, which helped Mr. Thomas revoke his power of attorney and contacted the son by registered mail. Meanwhile, the nursing home filed for legal action against the son. The combination of strategies finally resulted in the son coming to a meeting at the nursing home, agreeing to pay the unpaid bills and giving up control of his father's funds. The resident continued living at the facility and said he was pleased that he was not forced to live with his son.

Protecting Residents' Rights (and Funds) A collection agency contacted the social worker in a South Georgia nursing home and asked to speak to Mrs. Miller. The social worker explained that Mrs. Miller was a nursing home resident and had no income from which the agency could collect. But the caller insisted on speaking to the resident. When he spoke to Mrs. Miller, he threatened that he would send a marshal to arrest her if she didn't pay her bill. This call caused Mrs. Miller, who had just returned from dialysis treatment, severe distress. Since Social Security

income is exempt from such collections, this threat was apparently intended solely to harass Mrs. Miller. The social worker called the ombudsman to request assistance. When the ombudsman arrived at the nursing home later that day, Mrs. Miller was still anxious from the call. The ombudsman assured her that she did not have to speak to anyone that she did not want to speak to, then referred the resident to the Elder Legal Assistance Program (ELAP). The ombudsman, social worker, and resident called the collection agency together, instructing them to call Mrs. Miller's attorney for any further contacts. Later an ELAP legal assistant called and advised the collection agency to not contact Mrs. Miller directly. From then until the time of her death a few months later, Mrs. Miller was not subject to any more illegal, harassing phone calls from the collection agency.

Recovering a Resident's Personal Funds An APS worker serving as legal guardian for Mrs. Lee contacted the Ombudsman to report a problem. Mrs. Lee had moved to a new nursing home but her personal funds had not been transferred from the nursing home where she had previously lived, and APS requests for information were being ignored. The ombudsman went to the facility to review Mrs. Lee's personal account. The ombudsman was told that there was nothing remaining in the account, but a review of the bookkeeping records indicated an over-billing error on the part of the facility. After several conversations with facility and corporate staff without resolution, the ombudsman pointed out that the facility, in refusing to correct the billing error and return the residents' funds, was violating the law. The ombudsman indicated her intention to contact the State Health Care Fraud Control Unit for further investigation. Immediately, the facility agreed to refund Mrs. Lee the nearly \$500 remaining in her account. Mrs. Lee and her guardian are now able to use these funds for Mrs. Lee's personal needs.

Enforcing the "No Deposit Needed" Rule An APS worker who was assisting Mrs. Diaz with admission to a nursing home, contacted the ombudsman, with a question: "may a nursing home require a deposit before admitting a resident?" Mrs. Diaz had been a Medicaid recipient previously in this same nursing home and had had no major changes in her financial situation. She and her family could not afford the large deposit required by the facility. The Ombudsman contacted the nursing home administrator and informed him of federal regulations prohibiting deposits as a condition of admission for Medicaid recipients. The administrator reluctantly agreed to admit Mrs. Diaz without a deposit. Mrs. Diaz received Medicaid benefits, as expected, and received the nursing care she needed.

Helping Residents Live More Independent Lives Mary, a 34-year-old mother of a small child, was placed in a nursing home after a serious auto accident. She awoke from a 9-month coma with total paralysis of her left side, little use of her right side, and unable to speak. Most of the nursing home staff avoided Mary because they could not understand what she was saying. The ombudsman persuaded the staff to spend more time and effort in communicating with the resident and urged staff to provide physical, occupational, and speech therapies. Mary was re-assessed by the facility, and limited therapies were started. The ombudsman then worked with the nursing home administrator to have the resident transferred to a more intensive rehabilitation program. For the first time in months, Mary dared to hope of living at home again with her child. Mary's family shared Mary's hope, and built an accessible room for her at their home.

Today, Mary lives with her grandmother and her child. Although her speech has not improved, she can communicate clearly in writing. She can transfer easily and can handle most of her physical needs independently. Most importantly, she is an active part of her family and again has a life worth living.

Helping Residents Participate in the Community Tom, a cheerful man with developmental disabilities who lived in the same personal care home and had participated in a sheltered workshop for more than two decades, started bagging groceries at a local store. Workshop staff notified the ombudsman that the personal care home staff had stopped Tom from working in the grocery store. Tom expressed to the ombudsman— in motions rather than words— his eagerness to return to work. The ombudsman discovered that, after Tom had suffered a seizure while at work, the personal care home staff had stopped his work out of concern for his safety. The ombudsman facilitated a meeting between staff of the personal care home, the workshop staff, Tom, and the grocery store manager to discuss Tom's safety and the need for better communication between all parties. At the ombudsman's suggestion, the store manager agreed to have the workshop staff train his employees in seizure response. As a result of the meeting, the personal care home and workshop had a more positive relationship that benefitted Tom, and Tom happily continued bagging groceries, enjoying the chance to be helpful to customers and actively participate in the community.

Working to Improve Conditions in Long-term Care Facilities On a routine personal care home visit, an ombudsman found Lucy, a frail resident, who told her that she had no bed and slept in a chair in the living room. The resident also reported that the personal care home owner had recently hit her on the head with a shoe. The ombudsman investigated further and found residents unattended during the nights and locked in their rooms without access to water or bathrooms. Residents sharing rooms were given pails for toilets. The ombudsman reported concerns to the Office of Regulatory Services (ORS). ORS investigated, found numerous serious violations of the personal care home regulations, and sanctioned the facility. The ombudsman provided in-service education sessions on residents' rights to facility staff. After this, Lucy and the other residents received better care from the facility.

Intra-facility Transfer; Preserving Resident Rights “My mother is very upset that she has suddenly been moved from the room she has lived in for many years,” the caller told the ombudsman, in reporting that her mother had been involuntary transferred to another room in the facility. The ombudsman found that the nursing home had failed to give the resident adequate notice of the move. Although the nursing home social worker insisted that the resident had agreed to the move, the resident clearly expressed that she had not wanted to move. The ombudsman discussed with nursing home staff their violation of the resident's right to notice of the transfer and the resident's right to appeal the decision. The ombudsman also emphasized the facility's responsibility to be aware of the stress for the resident in being suddenly uprooted. Eventually, the facility staff agreed to move the grateful resident back to the room which has been her “home” in the facility.

Hawaii

Guardian (and Heir) Didn't Want Dialysis for Sick Brother The ombudsman was notified by a concerned nursing home administrator that a resident's sister notified her brother's primary physician that she didn't want him to receive dialysis because he was going to die anyway, so why bother. The primary physician agreed with the sister (who is also the resident's guardian) that the treatment would only slow down the inevitable, so discontinued the order for dialysis. The resident had never married and had no family except his sister. The resident had substantial savings and property, which his sister would inherit after resident's death. The ombudsman met with the resident and was surprised that he had a guardian. He was alert and oriented but also very depressed. The depression was not being treated. This case had been transferred to a new physician when the resident was transferred from the hospital to the nursing home, and the new physician had never met the resident. The resident was first admitted to hospital for a condition where guardianship became necessary and the new physician was never made aware that resident had improved enough that he didn't really need a guardian anymore. The ombudsman spoke with the resident and discussed the consequences of not receiving dialysis and then asked him: "Do you want to die?" He said, "No, I want to live." The resident stated that he wanted the dialysis but was fearful that he would upset his sister. The ombudsman talked with him about his relationship with his sister and the importance of his speaking out regarding what he really wanted. They contacted the primary physician and arranged for him to meet with the resident to verify that guardianship was no longer necessary and that the physician should be discussing the resident's health status with resident. The sister was initially upset but eventually understood purpose of the ombudsman's involvement. The resident received regular dialysis and was treated for depression; and his sister visited him weekly. The social worker and administrator said they would continue monitoring situation and inform the ombudsman of any future problems.

Massachusetts

Out-of-state "Criminal Diversion Program" In a North Shore facility which had a significant number of younger residents with behavior problems, a male resident who was supposed to be on five minute visual checks eloped from the secure unit and made his way to an unattended activity room, where he attempted to sexually assault a female resident. When she resisted, a struggle ensued, during which the female resident's left eye was torn out of its socket. This incident, along with regulatory deficiencies in other facilities owned by the same corporation, led the ombudsman and other state officials to insist on monthly meetings with the corporate clinical services vice president. As more information was obtained, it was learned that 75% of the population with behavioral problems in these facilities were from out of state and were part a "criminal diversion program." Most had a history of violent behavior. Many were sex offenders. Further investigation revealed that employees in the "behavioral specialist' position," the staff position responsible for controlling and managing the behavioral residents, received only 8 hours of training and were not certified nurses assistants (CNAs). After several months of meetings, during which two additional facilities were found to be in jeopardy, the ombudsman and her colleagues were successful in getting the corporation to agree not to admit Level 1 and 2 sex offenders, persons who were diverted from the out of state criminal diversion program and several other groups of problem residents. In addition they insisted that all behavioral specialists

receive the basic CNA training in addition to specialized training.

Respecting Individual Preferences The State Office of the Ombudsman received a phone call from the son of a newly-admitted resident in a specialized dementia unit of a nursing home. He had received a phone call the previous evening that his mother had become extremely agitated and aggressive, striking out first at staff people and then at other residents. The facility informed him that they had 'pink slipped' her: involuntarily transferred her to a psychiatric facility. The son was told that her behavior was so difficult that it was unlikely they would readmit her. Ombudsman staff intervened and arranged for a family meeting at the facility. As the case developed, it was learned that the episode which led to the transfer was preceded by the staff's attempt to give the resident a shower. The son had told the facility on admission that the resident was frightened by the shower (not unusual for many dementia residents) and was more amendable to baths. As a result of ombudsman intervention, the woman was returned to the nursing home, where she was given baths as part of her regular care plan and there were no further lashing-out episodes.

Mississippi

Never Give up - Empowering Families to Advocate for Their Loved Ones The daughter of a resident called to file a complaint about her mother's lack of care during the New Year's holiday. She explained that her mother was left sitting in her rocking chair in her bra and Depends for four hours. The aide had said to the resident that she would return soon to complete dressing her. The resident tried to dress herself without much success, as she was unable move herself out of the rocker. She was still sitting in her rocker when the daughter came to visit her. Both the daughter and resident were very upset. The charge nurse took full responsibility for the incident. The aide on duty admitted that she had left the resident, explaining that she did not have time to check on this resident during the four hours due to staffing shortage. The nurse also told the daughter that afternoon medications were administered with night medications due to staffing shortage. The ombudsman documented the complaint and asked the regulatory agency to get involved. During the ombudsman complaint investigation follow-up, the regulatory agency said the complaint could not be validated. During this period, the resident died. The daughter (complainant) and ombudsman were unhappy with the outcome of the regulatory agency investigation. Similar complaints due to staffing shortage had been filed against this facility. The ombudsman worked diligently to try to get problems corrected but the problems continued. Once again, she felt that the regulatory agency had not properly investigated the complaint. She discussed her lack of satisfaction with the regulatory agency staff and advised them that she planned to report the complaint and their outcome to the federal Centers for Medicare and Medicaid Services (CMS). A few weeks later, both she and the complainant received another letter stating that the facility had been investigated again and that they were noncompliant with staffing requirements. They were understaffed 8 out of 14 days during the complaint time period. As a result of the findings, the complainant feels that other residents will receive better quality care.

Discharge Due to Unpaid Bills An ombudsman learned from one of her routine visits to a nursing home that Mrs. Brown had received a discharge notice and she had less than 10 days left

before the date of discharge. When the ombudsman spoke with Mrs. Brown, she said she wanted to stay in the nursing home, which had issued the discharge notice because Mrs. Brown had more than \$4,000 in unpaid bills. Her bill had not been paid because her son, the responsible party and representative payee, was using her retirement check for his own expenses. The ombudsman explained to Mrs. Brown that the check must come to the nursing home to help pay her bill. Mrs. Brown asked for the ombudsman's help in explaining this to her son. The ombudsman helped Mrs. Brown contact the Mississippi State Department of Health, Division of Licensure and Certification to appeal the involuntary discharge, thereby delaying the discharge. The ombudsman explained to the son that he did not have a right to Mrs. Brown's retirement check and could be liable for misuse of these funds. Upon the ombudsman's advice, Mrs. Brown gave the facility permission to receive her retirement check directly to avoid additional debt. Then the ombudsman set up a meeting between the son and the nursing facility staff to devise a payment plan, after which Mrs. Brown's bills were paid and Mrs. Brown remained in the nursing home and continued to receive the care she needed.

Neglect by Provider/Health Care Decision-Maker A hospital employee told the ombudsman that she was very concerned about the condition of Mrs. Taylor, a personal care home resident, who had been admitted to the hospital for the fourth time within a year. She had an elevated blood sugar level of more than 600 and lice infestation. Upon investigation, the ombudsman found that Mrs. Taylor was depressed and fearful of trying other, more appropriate living arrangements. The ombudsman discovered that the personal care home owner also had authority to make health care decisions for Mrs. Taylor if she became incapacitated. Mrs. Taylor did not know that under the law "neither a treating health care provider nor an employee of a treating health care provider may be named as her agent." The ombudsman explained to Mrs. Taylor that she had the right to revoke the agent's authority to make decisions for her. The ombudsman located an attorney through North Mississippi Rural Legal Services who was willing to help Mrs. Taylor. She then reported the personal care home owner to the regulatory agency and the Attorney General's office, as she had on numerous other occasions. The facility was cited. As a result, the owner closed the personal care home. Mrs. Taylor then moved into a nursing home, where she received the care she needed. Other residents of the home also received appropriate placement.

Montana

Protecting Individual Rights A woman was placed in a nursing home by her daughter, who had been caring for her at home and had Durable Power of Attorney (DPOA). The resident had a feeding tube that her daughter had used exclusively and wanted the nursing home to use also. The resident, who seemed competent, began requesting to eat orally, and the nursing home staff began to give her regular food. The ombudsman visited with the resident, thought she was competent, saw no medical reason for tube feeding, and had reason to believe the doctor had placed the feeding tube only because of pressure from the daughter. The ombudsman spoke with resident about her rights. The resident requested assistance in revoking the DPOA. The ombudsman and facility social worker assisted in this process, notifying the doctor and the daughter. Then the resident requested to have the feeding tube removed. The daughter became

threatening to her mother, secured a lawyer to file for guardianship and threatened the doctor with a lawsuit if the tube was removed. The ombudsman continued to provide the resident with support and encouragement. The doctor concurred that the resident had capacity to make these decisions, and the feeding tube was removed, after which time the resident ate well, lost no weight and felt good about making her own decision. The downside was that the daughter did not visit her mom for months following this occurrence.

New York

Advocating for Resident's Needs Being Met The daughter of a skilled nursing home resident who had suffered a stroke called the ombudsman, concerned because her father's rehabilitation therapy had been cut back to a half hour a day. She thought this was because his Medicare benefits had run out and Medicaid had not yet been approved, although quite some time had elapsed since the Medicaid application had been filed. She was also concerned because her father was depressed and had no interest in any activities in the facility; the family's request to a wedding anniversary celebration for her parents in the facility had not been answered; the facility was encouraging the family to take her father home; her father wanted to come home but he could not transfer from his wheelchair without assistance and her mother would not be unable to care for him due to her own health problems. The daughter also wanted to know if the facility didn't have to provide him with a motorized wheelchair since he couldn't operate a manual wheelchair.

The ombudsman determined that facility was not required to provide a motorized wheelchair and discovered from the Medicaid agency that some needed documentation concerning the resident's life insurance policies was missing. This information was relayed to the daughter, who assisted her mother in obtaining the documentation. An ombudsman visited the resident and found him very depressed and wanting to go home. The ombudsman talked to the facility's social worker, who thought the resident could go home if the family was willing to be trained in how to transfer and care for him. The daughter stated that she had been trained but developed tendinitis from trying to transfer him and besides lived in another county and could not be at the resident's home all the time to help her mother. The ombudsman also attempted to talk to the activities director about the anniversary celebration and other activities for the resident and was told the family would have to contact the activities director if they wished to discuss it. This was relayed to the daughter, who said she would contact the activities director. In talking to the interim administrator, the ombudsman learned that the facility was looking into providing more therapy for the resident, although they felt the resident could not stand the intensive therapy that would be required to get him to the point where he could transfer himself and be able to go home. The administrator said the staff was planning a surprise anniversary party for the couple and the resident had been taken to his granddaughter's high school concert, which the daughter was very pleased about.

A few days later, the daughter called to request a ride on the Office of Aging's handicap van for her father to attend his granddaughter's high school graduation which was arranged for him. She reported that the surprise anniversary party had been held at the facility and went very well. She

also said her father was looking forward to going to the war plane museum with the other veterans in the facility as part of the facility's Memorial Day activities honoring the veterans. She said she had had a meeting with various staff, including the social worker and the head of therapy, and it was agreed that the resident would be put back on restorative therapy for one week to see how he would do. However, after three days they called and told her they felt he had reached a plateau and probably wouldn't get any better from the therapy and wanted to put him back on maintenance therapy. She asked them to continue the restorative therapy until the end of the week, which they agreed to do; but she did not have much hope of continuing the therapy after that especially as her father did not seem interested in therapy. (The father's lack of interest in therapy had also been noted by the ombudsman on the first visit.). The daughter felt, however, that generally things were going better and that the ombudsman must have done something to "shake them up" at the home." The ombudsman also noted the resident seemed in a calmer and happier state on his next visit and more accepting of his situation.

Texas

Illegal Discharge From the Only Nursing Home in a Rural Community This is a common type of complaint: A resident was discharged from a rural Texas facility located in a small community where there is only one nursing facility and the closest neighboring facility is approximately 30 miles away. The facility was able to care for the resident but was discharging her due to actions on the part of family members who the facility perceived as being demanding and displeased with the care provided by the facility.

The ombudsman program supported the family in appealing the discharge notice, which was a very brief two-sentence statement that did not conform to state standards. Therefore the ombudsman program interpreted it as an illegal discharge notice. The local ombudsman program assisted the family in filing the petition for hearing and contacted the hearing examiner in an effort to allow the resident to remain in the facility.

The subsequent hearing resulted in a decision to overturn the discharge notice by the facility and to allow the resident to remain in the facility close to her family members. Had it not been for the ombudsman intervention, this resident, like many others in Texas, would have been discharged, and the family would have had to look elsewhere for care resources.

Washington

Appealing Medicaid Reimbursement Ruling Background: Washington State legislators and policy makers have long promoted community based care options by providing a Medicaid Waiver program to provide in-home, adult family home and assisted living options for nursing home eligible recipients. The ombudsman program has long maintained that community care is not necessarily cheaper than nursing home care when the needs of residents are similar. Unfortunately, the State Medicaid agency and State Aging and Adult Services Administration do not agree and have sold these programs to the legislature as a cost saving alternative in addition to a consumer preferred alternative to nursing home care. This problem has been further

exacerbated with the regulatory change in resident assessments and corresponding reimbursements. In the past, some Medicaid residents in community settings qualified for an "exceptional rate" which was higher than the typical three level reimbursement to accommodate special need services that were required to remain in the preferred community setting. Effective July 2000, this assessment and reimbursement system was changed and the "exceptional rate" was eliminated. As residents on this rate were re-assessed, their reimbursement to the provider was reduced, which led to discharges because the provider stated that they could not provide the necessary services at the lower reimbursement level. The ombudsman program attacked this problem in several ways: by commenting on the proposed rules; by asking providers to call into the state hotline to report when they turned away prospective Medicaid residents, and by assisting individuals to remain in their homes through the administrative appeals process.

In one instance, we represented a resident who had lived in an adult family home for over two years. She had dementia and other health problems that required additional staff time at night. Her "exceptional rate" allowed the provider to purchase additional staff and to assure that the staff were trained in dementia caregiving.. With a new assessment which triggered a lower reimbursement rate, the provider felt that he could not care for the resident, and he issued a discharge notice. With assistance from the local ombudsman, the resident filed for a fair hearing, with the argument that she was denied a Medicaid service. Ombudsman primary legal counsel represented the resident at an administrative fair hearing on both the right to have a fair hearing and on the denial of a Medicaid service. The resident won the right to a fair hearing and won on the right to an "exceptional" or "flex rate" at the initial hearing, but the State appealed the decision and on the appeal the resident lost. The ombudsman legal counsel asked for a reconsideration of the appeal. This was a lengthy and difficult case to present and argue but is representative of systemic work that the program has tackled in the past year. The program continued to work on this issue as more residents were re-assessed and the reimbursement system was changed.

Protecting Resident's Right to Make Independent Decisions Ombudsman support was requested for a resident with a developmental disability and whose guardian/stepmother did not respect her choices. Based on the guardian's beliefs about people with developmental disabilities, the resident was not allowed to continue high school, attend social functions, have her hair styled, attend religious meetings of her choice, shave her legs, wear nail polish or use deodorant. After meetings with the guardian, at which the ombudsman explained residents rights and copies of relevant regulations provided, the guardian still refused to accept the resident's right to make independent decisions. Working with facility owner, the case manager and APS, the guardianship was successfully challenged in court and a new guardian put in place.