Washington State Long-Term Care
OMBUDSMAN PROGRAM

Ombudsman Reporting Tool (ORT)

Washington State Long-Term Care Ombudsman Program

LTC Ombudsman Annual Report

Federal Fiscal Year 2013

October 1, 2012 - September 30, 2013

Rev 5.8.14

Agency or organization which sponsors the State Ombudsman Program: Multi-Service Center

Part I - Cases, Complainants and Complaints

A. Cases Opened

Provide the total number of cases opened during reporting period.	2,991

Case: Each inquiry brought to, or initiated by, the ombudsman on behalf of a resident or group of residents involving one or more complaints which requires opening a case and includes ombudsman investigation, strategy to resolve, and follow-up.

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Part I - Cases, Complainants and Complaints

B. Cases Closed, by Type of Facility

Provide the number of cases closed, by type of facility/setting, which were received from the types of complainants listed below.

Closed Case: A case where none of the complaints within the case require any further action on the part of the ombudsman and every complaint has been assigned the appropriate disposition code.

Complainants:	Nursing Facility	B&C, ALF, RCF, etc.*	Other Settings
1. Resident	1,136	736	17
2. Relative/friend of resident	250	308	0
3. Non-relative guardian, legal representative	11	18	0
4. Ombudsman/ombudsman volunteer	71	94	0
5. Facility administrator/staff or former staff	126	149	0
6. Other medical: physician/staff	8	16	0
7. Representative of other health or social service agency or program	24	47	1
8. Unknown/anonymous	61	65	1
9. Other: Bankers, Clergy, Law Enforcement, Public Officials, etc.	3	7	0

Total number of cases closed during the reporting period: 3,149

* Board and care, assisted living, residential care and similar long-term care facilities, both regulated and unregulated

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Part I - Cases, Complainants and Complaints

C. Complaints Received

For cases which were closed during the reporting period (those counted in B above), provide the total number of complaints received:	4,835

Complaint: A concern brought to, or initiated by, the ombudsman for investigation and action by or on behalf of one or more residents of a long-term care facility relating to health, safety, welfare or rights of a resident. One or more complaints constitute a case.

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Part I - Cases, Complainants and Complaints

D. Types of Complaints, by Type of Facility

Below and on the following pages provide the total number of complaints for each specific complaint category, for nursing facilities and board and care or similar type of adult care facility. The first four major headings are for complaints involving action or inaction by staff or management of the facility. The last major heading is for complaints against others outside the facility. See Instructions for additional clarification and definitions of types of facilities and selected complaint categories.

Residents' Rights	Nursing Facility	B&C, ALF, RCF, etc.
A. Abuse, Gross Neglect, Exploitation		
1. Abuse, physical (including corporal punishment)	4	13
2. Abuse, sexual	5	4
3. Abuse, verbal/psychological (including punishment, seclusion)	11	31
4. Financial exploitation (use categories in section E for less severe financial complaints)	8	21
5. Gross neglect (use categories under Care, Sections F & G for non-willful forms of neglect)	12	14
6. Resident-to-resident physical or sexual abuse	10	18
7. Not Used		
B. Access to Information by Resident or Resident's Representative		
8. Access to own records	13	6
9. Access by or to ombudsman/visitors	7	14
10. Access to facility survey/staffing reports/license	1	0
11. Information regarding advance directive	0	2
12. Information regarding medical condition, treatment and any changes	24	10
13. Information regarding rights, benefits, services, the resident's right to complain	20	28
14. Information communicated in understandable language	3	1
15. Not Used		
C. Admission, Transfer, Discharge, Eviction		
16. Admission contract and/or procedure	6	18
17. Appeal process - absent, not followed	5	0
18. Bed hold - written notice, refusal to readmit	9	6
19. Discharge/eviction - planning, notice, procedure, implementation, inc. abandonme	227	183
20. Discrimination in admission due to condition, disability	3	2
21. Discrimination in admission due to Medicaid status	3	3
22. Room assignment/room change/intrafacility transfer	26	11
23. Not Used		
D. Autonomy, Choice, Preference, Exercise of Rights, Privacy		
24. Choose personal physician, pharmacy/hospice/other health care provider	7	4
25. Confinement in facility against will (illegally)	23	18
26. Dignity, respect - staff attitudes	120	116
27. Exercise preference/choice and/or civil/religious rights, individual's right to smoke	78	99
28. Exercise right to refuse care/treatment	16	15
29. Language barrier in daily routine	7	6
30. Participate in care planning by resident and/or designated surrogate	17	18
31. Privacy - telephone, visitors, couples, mail	12	26
32. Privacy in treatment, confidentiality	10	8
33. Response to complaints	22	15
34. Reprisal, retaliation	11	19
35. Not Used		

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E. Financial, Property (Except for Financial Exploitation)		
36. Billing/charges - notice, approval, questionable, accounting wrong or denied (includes overcharge of private pay residents)	46	90
37. Personal funds - mismanaged, access/information denied, deposits and other money not returned (report criminal-level misuse of personal funds under A.4)	26	44
38. Personal property lost, stolen, used by others, destroyed, withheld from resident	88	68
39. Not Used		
Resident Care		
F. Care		
40. Accidental or injury of unknown origin, falls, improper handling	35	27
41. Failure to respond to requests for assistance	180	63
42. Care plan/resident assessment - inadequate, failure to follow plan or physician orders (put lack of resident/surrogate involvement under D.30)	113	93
43. Contracture	3	0
44. Medications - administration, organization	102	87
45. Personal hygiene (includes nail care & oral hygiene) and adequacy of dressing & grooming	53	38
46. Physician services, including podiatrist	44	8
47. Pressure sores, not turned	12	7
48. Symptoms unattended, including pain, pain not managed, no notice to others of changes in condition	53	23
49. Toileting, incontinent care	53	11
50. Tubes - neglect of catheter, gastric, NG tube (use D.28 for inappropriate/forced us	14	4
51. Wandering, failure to accommodate/monitor exit seeking behavior	9	11
52. Not Used		
G. Rehabilitation or Maintenance of Function		
53. Assistive devices or equipment	81	35
54. Bowel and bladder training	1	0
55. Dental services	12	2
56. Mental health, psychosocial services	9	7
57. Range of motion/ambulation	11	6
58. Therapies - physical, occupational, speech	48	7
59. Vision and hearing	11	11
60. Not Used		
H. Restraints - Chemical and Physical		
61. Physical restraint - assessment, use, monitoring	3	6
62. Psychoactive drugs - assessment, use, evaluation	4	8
63. Not Used		
Quality of Life		
I. Activities and Social Services		
64. Activities - choice and appropriateness	49	64
65. Community interaction, transportation	21	34
66. Resident conflict, including roommates	59	28
67. Social services - availability/appropriateness/ (use G.56 for mental health, psychosocial counseling/service)	13	10
68. Not Used		
J. Dietary		
69. Assistance in eating or assistive devices	20	10
70. Fluid availability/hydration	14	7

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71. Food service - quantity, quality, variation, choice, condiments, utensils, menu	115	108
72. Snacks, time span between meals, late/missed meals	16	14
73. Temperature	26	6
74. Therapeutic diet	28	14
75. Weight loss due to inadequate nutrition	8	2
76. Not Used		
K. Environment		
77. Air/environment: temperature and quality (heating, cooling, ventilation, water, noi	46	44
78. Cleanliness, pests, general housekeeping	20	48
79. Equipment/building - disrepair, hazard, poor lighting, fire safety, not secure	32	53
80. Furnishings, storage for residents	18	13
81. Infection control	11	4
82. Laundry - lost, condition	25	10
83. Odors	7	9
84. Space for activities, dining	1	3
85. Supplies and linens	9	7
86. Americans with Disabilities Act (ADA) accessibility	2	4
Administration		
L. Policies, Procedures, Attitudes, Resources (See other complaint headings, of above, for policies on advance directives, due process, billing, management residents' funds)		
87. Abuse investigation/reporting, including failure to report	1	2
88. Administrator(s) unresponsive, unavailable	11	6
89. Grievance procedure (use C for transfer, discharge appeals)	6	5
90. Inappropriate or illegal policies, practices, record-keeping	13	25
91. Insufficient funds to operate	0	1
92. Operator inadequately trained	2	8
93. Offering inappropriate level of care (for B&C/similar)	4	7
94. Resident or family council/committee interfered with, not supported	3	4
95. Not Used		
M. Staffing		
96. Communication, language barrier (use D.29 if problem involves resident inability to communicate)	5	4
97. Shortage of staff	21	22
98. Staff training	13	18
99. Staff turn-over, over-use of nursing pools	1	7
100. Staff unresponsive, unavailable	21	36
101. Supervision	6	6
102. Eating Assistants	2	2
Not Against Facility		
N. Certification/Licensing Agency		
103. Access to information (including survey)	2	0
104. Complaint, response to	2	6
105. Decertification/closure	0	2
106. Sanction, including Intermediate	0	0
107. Survey process	0	0
108. Survey process - Ombudsman participation	0	0
109. Transfer or eviction hearing	2	0

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110. Not Used		
O. State Medicaid Agency		
111. Access to information, application	7	3
112. Denial of eligibility	6	8
113. Non-covered services	4	3
114. Personal Needs Allowance	1	6
115. Services	7	13
116. Not Used		
P. System/Others		
117. Abuse/neglect/abandonment by family member/friend/guardian or, while on visit out of facility, any other person	6	8
118. Bed shortage - placement	1	0
119. Facilities operating without a license	0	0
120. Family conflict; interference	33	32
121. Financial exploitation or neglect by family or other not affiliated with facility	26	30
122. Legal - guardianship, conservatorship, power of attorney, wills	52	57
123. Medicare	7	3
124. Mental health, developmental disabilities, including PASRR	4	5
125. Problems with resident's physician/assistant	2	2
126. Protective Service Agency	3	4
127. SSA, SSI, VA, Other Benefits/Agencies	10	10
128. Request for less restrictive placement	16	13
Total, categories A through P	2,571	2,235

Q. Complaints About Services in Settings Other Than Long-Term Care Facilities or By Outside Provider in Long-Term Care Facilities (see instructions)	
129. Home care	2
130. Hospital or hospice	7
131. Public or other congregate housing not providing personal care	2
132. Services from outside provider (see instructions)	18
133. Not Used	
Total, Heading Q.	29
Total Complaints*	4,835

* (Add total of nursing facility complaints; B&C, ALF, RCF, similar complaints and complaints in Q, above. Place this number in Part I, C on page 1.)

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Part I - Cases, Complainants and Complaints

E. Action on Complaints

Provide for cases closed during the reporting period the total number of complaints, by type of facility or other setting, for each item listed below.

	Nursing Facility	B&C, ALF, RCF, etc.	Other Settings
1. Complaints which were verified:	2,233	1,767	22

Verified: It is determined after work [interviews, record inspection, observation, etc.] that the circumstances described in the complaint are generally accurate.

2. Disposition: Provide for all complaints reported in C and D, whether verified or not, the number:

a. For which government policy or regulatory change or legislative action is required to resolve (this may be addressed in the issues section)	7	8	0
b. Which were not resolved* to satisfaction of resident or complainant	150	130	3
c. Which were withdrawn by the resident or complainant or resident died before final outcome of complaint investigation	75	92	0
d. Which were referred to other agency for resolution and:			
1) report of final disposition was not obtained	110	159	0
2) other agency failed to act on complaint	0	6	0
3) agency did not substantiate complaint	65	60	0
e. For which no action was needed or appropriate	230	262	2
f. Which were partially resolved* but some problem remained	586	384	6
g. Which were resolved* to the satisfaction of resident or complainant	1,348	1,134	18
Total, by type of facility or setting	2,571	2,235	29

Grand Total (Same number as that for total complaints on pages 1 and 7 4,835

** Resolved: The complaint/problem was addressed to the satisfaction of the resident or complainant.*

3. Legal Assistance/Remedies (Optional) - For each type of facility, list the number of legal assistance remedies for each of the following categories that were used in helping to resolve a complaint: a) legal consultation was needed and/or used; b) regulatory endorsement action was needed and/or used; c) an administrative appeal or adjudication was needed and/or used; and d) civil legal action was needed and/or used.

Facility Type NF: a=1, b=3, c=0 and d=0
Facility Type BC: a=1, b=5, c=0 and d=0
Facility Type OT: a=0, b=0, c=0 and d=0

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Part I - Cases, Complainants and Complaints

F. Complaint Description (Optional):

Provide in the space indicated a concise description of the most interesting and/or significant individual complaint your program handled during the reporting period. State the problem, how the problem was resolved and the outcome.

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Case Example: The implications for the use of Vulnerable Adult Protection Orders upon residents' rights, care providers and the Long-Term Care Ombudsman Program.

Background

Complaint: The State LTCO Program received a complaint call from a woman who expressed dissatisfaction with a response from a local regional ombudsman program.

The caller described herself as a caregiver and former teacher of an elderly man stated that she and the elder had formed a close relationship to include living together. The relationship between the two individuals began at an exercise class designed for individuals who have a movement disorder. The complainant was the instructor and the student became LTCOP's client as a long-term care resident. The complainant believed that the resident was being held somewhere in a Washington long-term care facility against the resident's will. She disclosed that she had been alleged to have financially exploited the resident and that an investigation by the state's Adult Protective Services was underway. Her stated concern was the well-being of the resident as he was isolated from her, as well as other friends from their neighborhood.

Upon further investigation with the Regional Ombuds further background information was provided to the State LTCOP. According to the elder resident, the regional ombuds and the complainant, an old friend of the resident (someone that he saw a few times a year) raised some questions about possible financial exploitation by the caregiver. The friend became concerned about the resident's safety and suspicious of the teacher's motives. The friend accused the teacher/caregiver of overcharging the elder resident for care. The friend and couple invited the couple to come stay with them in a neighboring county and at that time, the resident signed a durable power of attorney and a draft of his will, of which he left his estate to his long time friend, his friend's wife and their children, and to the caregiver.

A few days later the couple asked the teacher to leave the resident to be in their care, subsequently obtaining a Vulnerable Adult Protection Order (VAPO) from the Courts. The VAPO was used to restrict the teacher from visiting or contacting the resident. The older adult was then placed in an assisted living facility near the home of the now Durable Power of Attorney (DPOA) which was a long distance from the resident's home and long-time neighborhood. The resident objected to not being allowed to see his former housemate, the restrained teacher, nor could he talk with her on the phone. Other visitors were also restricted from communicating with the resident and many did not know his whereabouts. Private phone calls were also pre-screened by the facility or listened into as a way to protect the elder from the alleged perpetrator. The old friend was appointed legal guardian of the Resident's person and finances.

The local program ombudsman knew the whereabouts of the resident and had visited the resident prior to the State LTCOP involvement. The resident had repeatedly asked to be able to see his former partner (caregiver) and to go to his home. The Regional LTCO and State LTCO worked together to assess the facts of the case in order to determine the course of action.

The State LTCOP utilized the LTCOP's attorney for guidance about the VAPO, court ordered guardianship and the Residents Rights. Working as a team, the local ombuds was directed to research the resident's wishes and to inform him and his guardian of LTCOP's actions. The guardian was informed that the resident requested LTCOP's services and wished to return to his community of choice, and specifically to his own house. The guardian was informed by the Regional LTCO that it was the resident's right and the guardian's duty to move the resident back to his home in spite of his need for care.

The Guardian was concerned about the protection of the resident and his ability to live independently in the home. LTCOP researched the court records and it was clear this resident, who was over 80 years of age, had the funds to pay for private caregivers at home. Guardian thought this was an irresponsible use of the resident's money because the resident could only afford it for about 3 years without divesting himself of assets. LTCOP pointed out that the resident had no heirs and he needed to plan for (except the guardian who was due to inherit the resident's money) and he had a right to go home. Furthermore, the resident testified to the courts that he wanted to live with his friend and wanted to take care of her. The resident continued to be adamant about wanting to live in his house.

After much encouragement by the Ombudsmen, the resident moved home after eight months in "captivity". As of this month he is doing fine with in-home services, to include a private case manager. The Guardianship is still in place. Adult Protective Services' report never became public. To our knowledge there have been no prosecutions of the former friend, but a 5-year restraining order was put into place by the courts at the Guardian's request.

Implications for LTCOP: This case serves as an example of small but recent trend in LTCOP cases where the use of a vulnerable protection order is used properly to protect the elder from a proven or alleged perpetrator. The complexity in resolving these cases involves higher than usual state and regional ombudsman time and the time of LTCOP's attorney.

A concern for residents is that VAPOs used inappropriately can over restrict an elder's legal rights, as a resident of a long-term care facility. For example VAPOs have been used to restrict visitations from family and friends who are not listed on the VAPO and limit resident's privacy by requiring all phone calls to the resident be screened by facility staff. VAPOs have also been incorrectly used as a reason to bar the ombudsman access to the resident. The role of the ombuds when confronted with a VAPO may not be clear. Good guidance from legal counsel is warranted, as the ombudsmen must work to ensure that residents' rights are being followed, without breaking a court order. In this case example, very limited information could be provided to the complainant because of the VAPO. A key consideration by an ombudsman in this case may be to determine if the protection of the resident as ordered by the courts is greater than the residents' expressed wishes and rights. A key question, can a VAPO be used to restrict a resident's right to make choices about where they live, such as being placed in a long-term care facility against their will?

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Part II - Major Long-Term Care Issues

A. Describe the priority long-term care issues which your program identified and/or worked on during the reporting period. For each issue, briefly state: a) the problem and barriers to resolution, and b) recommendations for system-wide changes needed to resolve the issue, or how the issue was resolved in your State. Examples of major long-term care issues may include facility closures, planning for alternatives to institutional care, transition of residents to less restrictive settings, etc.

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Part II Major Long-Term Care Issues

During the 2013 Legislative Session, The Washington SLTCOP continued to work on the recommendations from the Adult Family Home Quality Assurance Panel. The report was released in December 2012. Two member groups from the panel partnered with the SLTCOP to request from the legislature, action on several of the recommendations. SLTCOP attorney, in collaboration with AARP and the Washington State Residential Care Council (WSRCC), wrote draft legislation. WSRCC represents thousands of adult family home owners in collective bargaining with the State of Washington. Speaker Pro Tem, Rep. Jim Moeller agreed to be the prime sponsor of a bill. A companion bill SB5630, sponsored by Senator Barbara Bailey passed with unanimous votes in both the House and Senate. Summary of the bill can be found here http://apps.leg.wa.gov/billinfo/summary.aspx?bill=5630. Key elements of the bill include:

1.Creation of a consumer user-friendly website, with a feasibility study to include the addition of a vacancy search tool.

2.The website would include much of what is currently available through the state consumer website, but focused on using "plain" language, better navigation and enhanced information about selecting an AFH to include regulatory information and enforcement letters.

3.Website content to be kept current and old enforcement letter removed in a timely manner.

4.Direct the Department (DSHS) to when using such conditions on licensing such as "stop placements" to also impose a remedy. For example, repeated citations on medication errors leading to a stop placement must also include imposing a pharmacy consult or nurse consultant.

5.In the case of di minus citations, where there is no or very low risk for harm, the State can issue a consultation rather than a citation, the first time the violation occurs. No sanction will be imposed unless the AFH commits a repeat violation of the same law/regulation and it such a case the sanction will be harsher. A similar law has been in existence with assisted living facilities in Washington State without much problem. This provision is very similar.

6.SB 5630 requires the creation and use of a standardized disclosure form for all AFHs. The disclosure form should include a list of the AFH's scope of services and charges, to be made available to all consumers prior to admission into an AFH. The disclosure forms are to be posted on the new consumer website.

7.Last, the panels recommended review of the AFH licensing specialty designations requirements, curricula/training for staff and consider the identification of new specialty designation types. Currently there are three designations, dementia, mental health and developmental disabilities. New designations to consider may be traumatic head injury and bariatric care. The new law requires the Department to convene a stakeholder group to implement the new law.

In the fall of 2013, the Department with SLTCOP and other stakeholders began work on the creation of the DSHS AFH disclosure form.

Vulnerable Adult Abuse and Neglect Taskforce

In November of 2012, Disability Rights Washington also known as DRW, the Protection and Advocacy agency in Washington, issued a report, "Too Little, Too Late" (http://www.disabilityrightswa.org/reports#too_little_too_late) which described the inadequate abuse response by the Department in Supported Living (SL). In Washington individuals with intellectual disabilities and developmental disabilities can live in the community under a federal waiver, in settings known as "supported living". This report prompted the formation of a subcommittee focusing on the adult abuse response system.

Washington State LTCOP participated as a member of the subcommittee for approximately 7 months during which stakeholders and the Department met to assess the system and make recommendations for improvement, in time for the new legislative session, in January 2014. Recommendations included trauma informed practice and training for state licensors and case managers; intensive case management services for clients who required longer interventions; 24 hour complaint hotline; and a response system that was less bifurcated and focused upon the consumer victim rather than only on facility compliance.

At the end of the FFY 2013, DRW and a coalition of aging services advocates/organizations, to include the SLTCOP, worked to move forward some of the recommendations.

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Part III - Program Information and Activities

A. Facilities and Beds:

ALERT: AoA recommends that your program regularly enter into your data collection system all licensed facilities and beds in your state covered by your program and keep this information updated. In the event this is not being done in your program, the totals for Part III.A should be obtained from an outside source, such as the state licensing agency, and entered into the ORT manually.

1. How many nursing facilities are licensed in your State?	252
2. How many beds are there in these facilities?	23,704

3. Provide the type-name(s) and definition(s) of the types of board and care, assisted living, residential care facilities and any other similar adult care home for which your ombudsman program provides services, as authorized under Section 102(18) and (32), 711(6) and 712(a)(3)(A)(i) of the Older Americans Act. If no change from previous year, type "no change" at space indicated.

No Change

a) How many of the board and care and similar adult care facilities described above are regulated in your State?	3,286
b) How many beds are there in these facilities?	45,334

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Part III - Program Information and Activities

B. Program Coverage

Statewide Coverage means that residents of both nursing homes and board and care homes (and similar adult care facilities) and their friends and families throughout the state have access to knowledge of the ombudsman program, how to contact it, complaints received from any part of the State are investigated and documented, and steps are taken to resolve problems in a timely manner, in accordance with federal and state requirements.

B.1. Designated Local Entities

Provide for each type of host organization the number of local or regional ombudsman entities (programs) designated by the State Ombudsman to participate in the statewide ombudsman program that are geographically located outside of the State Office:

Local entities hosted by:

Area agency on aging	7
Other local government entity	0
Legal services provider	0
Social services non-profit agency	4
Free-standing ombudsman program	0
Regional office of State ombudsman program	2
Other; specify:	0

Total Designated Local Ombudsman Entities: 13

B.2. Staff and Volunteers

Provide numbers of staff and volunteers, as requested, at state and local levels.

Type of Staff	Measure	State Office	Local Programs
Paid program staff	FTEs	3.00	14.56
	Number people working full-time on ombudsman program	2	9
Paid clerical staff	FTEs	0.50	0.75
Volunteer ombudsmen certified to address complaints at close of reporting period	Number volunteers	0	347
Number of Volunteer hours donated	Total number of hours donated by certified volunteer	0	48,545
Certified Volunteer: An individual who has completed a training course prescribed by the State Ombudsman and is approved by the State Ombudsman to participate in the statewide Ombudsman Program.			
Other volunteers (i.e., not certified) at close of reporting period	Number of volunteers	11	100

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Part III - Program Information and Activities

C. Program Funding

Provide the amount of funds expended during the fiscal year from each source for your statewide program:

Federal - Older Americans Act (OAA) Title VII, Chapter 2, Ombudsman	$333,158
Federal - Older Americans Act (OAA) Title VII, Chapter 3, Elder Abuse Preventior	$0
Federal - OAA Title III provided at State level	$49,449
Federal - OAA Title III provided at AAA level	$78,703
Other Federal; specify:	$0
State funds	$1,043,064
Local; specify:	$291,530
Attorney General Grant, Roads to Community Living-DSHS, County general revenue, State Senior Citizens Services Act, Private Donations, Community Services Block Grant, Private foundation grants	
Total Program Funding	$1,795,904

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Part III - Program Information and Activities

D. Other Ombudsman Activities

Provide below and on the next page information on ombudsman program activities other than work on complaints.

Activity	Measure	State	Local
1. Training for ombudsman staff and volunteers	Number sessions	50	194
	Number hours	148	1,302
	Total number of trainees that attended any of the training sessions above (duplicated count)	445	6,467
	3 most frequent topics for training	Reducing misuse of atypical antipsychotics	Omb. Services
		Roads to Comm Living	Community Services
		Advocacy	Mental Health
2. Technical assistance to local ombudsmen and/or volunteers	Estimated percentage of total staff time	30	80
3. Training for facility staff	Number sessions	0	24
	3 most frequent topics for training		Resident Rights
			Reducing misuse of atypical antipsychotics
			Omb. Services
4. Consultation to facilities (Consultation: providing information and technical assistance, often by telephone)	3 most frequent areas of consultation	F - Care	Z - Omb. Services
		Z - Omb. Services	F - Care
		C - Admission, Transfer, Discharge Eviction	C - Admission, Transfer, Discharge, Eviction
	Number of consultations	998	6,461

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5. Information and consultation to individuals (usually by telephone)	3 most frequent requests/needs	Z - Omb. Services	Z - Omb. Services
		J - Dietary	F - Care
		M - Staffing	C - Admission, Transfer, Discharge, Eviction
	Number of consultations	3,100	35,629
6. Facility Coverage (other than in response to complaint) *	Number Nursing Facilities visited (unduplicated)	0	184
	Number Board and Care (or similar) facilities visited (unduplicated)	0	1,827
7. Participation in Facility Surveys	Number of surveys	110	779
8. Work with resident councils	Number of meetings attended	10	788
9. Work with family councils	Number of meetings attended	0	67
10. Community Education	Number of sessions	16	161
11. Work with media	3 most frequent topics	Reducing misuse of atypical antipsychotics	Z - Omb. Services
		Z - Omb. Services	F - Care
			J - Dietary
	Number of interviews/ discussions	1	16
	Number of press releases	4	0
12. Monitoring/work on laws, regulations, government policies and actions	Estimated percentage of total paid staff time (Note: the total of the percentage at each level in this item and item 2 should not add to more than 100%.)	30	10

* The number is for facilities receiving at least one visit per quarter, not in response to a complaint. It is not for the number of visits. States which do not have a regular visitation program should enter "0" in lieu of "NA," as this numeric field cannot accept "NA."