Washington State Long-Term Care
OMBUDSMAN PROGRAM

Ombudsman Reporting Tool (ORT)

Washington State Long-Term Care Ombudsman Program

Long-Term Care Ombuds Annual Report

Federal Fiscal Year 2014

October 1, 2013 - September 30, 2014

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.	2,598

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	1,010	532	7
2. Relative/friend of resident	245	260	5
3. Non-relative guardian, legal representative	8	9	0
4. Ombudsman/ombudsman volunteer	74	92	0
5. Facility administrator/staff or former staff	120	117	2
6. Other medical: physician/staff	8	12	0
7. Representative of other health or social service agency or program	21	29	0
8. Unknown/anonymous	38	47	0
9. Other: Bankers, Clergy, Law Enforcement, Public Officials, etc.	0	4	0

Total number of cases closed during the reporting period: 2,640

* 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:	4,070

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)	9	8
2. Abuse, sexual	3	7
3. Abuse, verbal/psychological (including punishment, seclusion)	8	22
4. Financial exploitation (use categories in section E for less severe financial complaints)	6	18
5. Gross neglect (use categories under Care, Sections F & G for non-willful forms of neglect)	8	7
6. Resident-to-resident physical or sexual abuse	7	14
7. Not Used		
B. Access to Information by Resident or Resident's Representative		
8. Access to own records	6	3
9. Access by or to ombudsman/visitors	4	6
10. Access to facility survey/staffing reports/license	0	2
11. Information regarding advance directive	0	0
12. Information regarding medical condition, treatment and any changes	19	10
13. Information regarding rights, benefits, services, the resident's right to complain	22	32
14. Information communicated in understandable language	1	2
15. Not Used		
C. Admission, Transfer, Discharge, Eviction		
16. Admission contract and/or procedure	5	13
17. Appeal process - absent, not followed	1	1
18. Bed hold - written notice, refusal to readmit	5	6
19. Discharge/eviction - planning, notice, procedure, implementation, inc. abandonment	184	181
20. Discrimination in admission due to condition, disability	8	3
21. Discrimination in admission due to Medicaid status	3	2
22. Room assignment/room change/intrafacility transfer	17	6
23. Not Used		
D. Autonomy, Choice, Preference, Exercise of Rights, Privacy		
24. Choose personal physician, pharmacy/hospice/other health care provider	11	4
25. Confinement in facility against will (illegally)	18	22
26. Dignity, respect - staff attitudes	81	76
27. Exercise preference/choice and/or civil/religious rights, individual's right to smoke	56	53
28. Exercise right to refuse care/treatment	14	6
29. Language barrier in daily routine	1	4
30. Participate in care planning by resident and/or designated surrogate	16	6
31. Privacy - telephone, visitors, couples, mail	15	21
32. Privacy in treatment, confidentiality	7	7
33. Response to complaints	16	10
34. Reprisal, retaliation	5	13

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35. Not Used		
E. Financial, Property (Except for Financial Exploitation)		
36. Billing/charges - notice, approval, questionable, accounting wrong or denied (includes overcharge of private pay residents)	32	77
37. Personal funds - mismanaged, access/information denied, deposits and other money not returned (report criminal-level misuse of personal funds under A.4)	19	30
38. Personal property lost, stolen, used by others, destroyed, withheld from resident	63	33
39. Not Used		
Resident Care		
F. Care		
40. Accidental or injury of unknown origin, falls, improper handling	29	13
41. Failure to respond to requests for assistance	183	38
42. Care plan/resident assessment - inadequate, failure to follow plan or physician orders (put lack of resident/surrogate involvement under D.30)	109	74
43. Contracture	0	0
44. Medications - administration, organization	124	81
45. Personal hygiene (includes nail care & oral hygiene) and adequacy of dressing & grooming	82	23
46. Physician services, including podiatrist	59	9
47. Pressure sores, not turned	19	5
48. Symptoms unattended, including pain, pain not managed, no notice to others of changes in condition	54	10
49. Toileting, incontinent care	33	7
50. Tubes - neglect of catheter, gastric, NG tube (use D.28 for inappropriate/forced use)	12	3
51. Wandering, failure to accommodate/monitor exit seeking behavior	6	4
52. Not Used		
G. Rehabilitation or Maintenance of Function		
53. Assistive devices or equipment	89	41
54. Bowel and bladder training	2	1
55. Dental services	21	2
56. Mental health, psychosocial services	7	8
57. Range of motion/ambulation	15	4
58. Therapies - physical, occupational, speech	70	6
59. Vision and hearing	17	4
60. Not Used		
H. Restraints - Chemical and Physical		
61. Physical restraint - assessment, use, monitoring	3	1
62. Psychoactive drugs - assessment, use, evaluation	12	11
63. Not Used		
Quality of Life		
I. Activities and Social Services		
64. Activities - choice and appropriateness	46	38
65. Community interaction, transportation	17	22
66. Resident conflict, including roommates	53	33
67. Social services - availability/appropriateness/ (use G.56 for mental health, psychosocial counseling/service)	14	1
68. Not Used		
J. Dietary		
69. Assistance in eating or assistive devices	17	6

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70. Fluid availability/hydration	9	4
71. Food service - quantity, quality, variation, choice, condiments, utensils, menu	103	72
72. Snacks, time span between meals, late/missed meals	15	6
73. Temperature	13	2
74. Therapeutic diet	22	14
75. Weight loss due to inadequate nutrition	6	3
76. Not Used		
K. Environment		
77. Air/environment: temperature and quality (heating, cooling, ventilation, water, noise	52	27
78. Cleanliness, pests, general housekeeping	31	42
79. Equipment/building - disrepair, hazard, poor lighting, fire safety, not secure	36	32
80. Furnishings, storage for residents	14	3
81. Infection control	11	7
82. Laundry - lost, condition	44	9
83. Odors	14	9
84. Space for activities, dining	3	2
85. Supplies and linens	7	3
86. Americans with Disabilities Act (ADA) accessibility	0	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	3
88. Administrator(s) unresponsive, unavailable	5	6
89. Grievance procedure (use C for transfer, discharge appeals)	3	4
90. Inappropriate or illegal policies, practices, record-keeping	6	13
91. Insufficient funds to operate	0	1
92. Operator inadequately trained	0	2
93. Offering inappropriate level of care (for B&C/similar)	3	4
94. Resident or family council/committee interfered with, not supported	4	2
95. Not Used		
M. Staffing		
96. Communication, language barrier (use D.29 if problem involves resident inability to communicate)	4	3
97. Shortage of staff	17	15
98. Staff training	8	9
99. Staff turn-over, over-use of nursing pools	7	3
100. Staff unresponsive, unavailable	23	15
101. Supervision	3	4
102. Eating Assistants	2	0
Not Against Facility		
N. Certification/Licensing Agency		
103. Access to information (including survey)	0	0
104. Complaint, response to	1	0
105. Decertification/closure	11	0
106. Sanction, including Intermediate	0	1
107. Survey process	0	0
108. Survey process - Ombudsman participation	0	0

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109. Transfer or eviction hearing	2	1
110. Not Used		
O. State Medicaid Agency		
111. Access to information, application	5	2
112. Denial of eligibility	7	4
113. Non-covered services	1	2
114. Personal Needs Allowance	4	6
115. Services	18	6
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	7	2
118. Bed shortage - placement	1	0
119. Facilities operating without a license	0	1
120. Family conflict; interference	24	30
121. Financial exploitation or neglect by family or other not affiliated with facility	20	30
122. Legal - guardianship, conservatorship, power of attorney, wills	35	60
123. Medicare	13	4
124. Mental health, developmental disabilities, including PASRR	0	5
125. Problems with resident's physician/assistant	3	4
126. Protective Service Agency	2	0
127. SSA, SSI, VA, Other Benefits/Agencies	7	11
128. Request for less restrictive placement	13	4
Total, categories A through P	2,403	1,646

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	2
131. Public or other congregate housing not providing personal care	1
132. Services from outside provider (see instructions)	16
133. Not Used	
Total, Heading Q.	21

Total Complaints* 4,070

* (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:	2,133	1,320	21

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)	2	7	0
b. Which were not resolved* to satisfaction of resident or complainant	182	76	0
c. Which were withdrawn by the resident or complainant or resident died before final outcome of complaint investigation	69	74	1
d. Which were referred to other agency for resolution and:			
1) report of final disposition was not obtained	54	77	0
2) other agency failed to act on complaint	0	3	0
3) agency did not substantiate complaint	59	51	0
e. For which no action was needed or appropriate	224	241	5
f. Which were partially resolved* but some problem remained	446	286	2
g. Which were resolved* to the satisfaction of resident or complainant	1,367	831	13
Total, by type of facility or setting	2,403	1,646	21

Grand Total (Same number as that for total complaints on pages 1 and 7 4,070

** 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=1, c=0 and d=0
Facility Type BC: a=0, b=3, 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.

The most interesting and significant case Washington LTCOP involved the separation of a husband and his wife of 63 years, by a family member who was their durable power of attorney. The case presented as a complaint by an assisted living specializing in Alzheimer's care, concerned about the well-being of their resident who wanted to revoke his nephew's DPOA. The facility was concerned that the resident was frequently attempting to "elope" from the facility and had been successful a couple of times. The elder gentleman was often angry, combative towards caregivers and experiencing increasing falls to the floor. The assisted living administrator did not know why the resident's nephew refused to allow the couple to speak by phone. They supported the nephew's decision to not allow, face –to- face visits between the couple because they feared their resident's safety as a "flight risk".

Upon further fact finding and investigation by an incredibly gifted and dedicated local volunteer Ombuds, it was discovered that the resident was being held against his will in a locked memory care unit, by his DPOA. But in collusion with the assisted living provider who had described themselves as being "extraction specialists". Following an inpatient stay in a local nursing home for the wife's rehab of a broken leg, both residents were tricked into touring the assisted living facility as a possible to place of residence. Once on the tour, the two residents were separated by staff and by the nephew. The wife was placed onto a cabulance, where she was silently whisked away to a different assisted living facility. Neither resident was told in advance of the plan to separate them, and neither were given the choice to go along with the plan concocted by the nephew and assisted living "extraction specialists".

It was clear that the elder gentleman was angry and combative because he wanted to find his wife. He also clearly articulated to all involved that he was worried about his wife, missed her and wanted to live with her and not alone in the assisted living facility. The wife, who was placed in different assisted living for people with Alzheimer's, was told that her husband was away on a business trip. She was more advanced in her memory problems, and didn't seem distressed by the news. But overtime she began to express a desire to see her husband, which went ignored by the facility and her family.

This case called for every resource available to the State LTC Ombudsman Program, as the legal issues and family dynamics complicated the residents' abilities to exercise their residents' rights. Because of cognitive impairments, the residents' complaints were ignored or downplayed by providers, health care professionals and especially by the durable power of attorney. It appeared to the volunteer ombuds that the resident was declining rapidly in function and cognition due to the physical and chemical restraints being used to against the husband. The LTCOP attorney became involved to help secure proper legal representation for the husband, correspond with the nephew's attorney and advise the State LTCO.

After many months of separation, the residents were finally reunited. The couple currently resides in the same assisted living facility (different than before) where they continued to be visited and monitored by the same local volunteer ombuds.

The State LTC Ombudsman Program submitted a formal complaint to the State licensing oversight agency. The state imposed conditions on licenses and daily civil fines for violations of Washington State statutes and/or regulations. Specifically for violating residents' rights, for restraining the resident in a memory care locked unit against his will and for using chemical restraints in attempt to subdue the resident's expressed will to leave the locked unit.

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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.

Misuse of antipsychotic drugs and ombuds access.

Several studies have shown that the off label use of atypical anti-psychotics can have serious long term negative effects. The Washington State LTCOP created and implemented a consumer awareness initiative, under the provision of grant funds awarded by the Attorney General's office of Washington State. The two- year grant for $521,000 was comprised of funds collected from settlement of a case against Janssen Pharmaceuticals, a division of Johnson and Johnson, for illegal marketing of the drugs Risperdal, Risperdal Consta, Risperdal M-Tab, and Invega.

Washington's LTCOP State and Regional LTCO Programs used the grant funding to develop training for ombudsmen related to the appropriate and inappropriate use of atypical antipsychotics, as well as outreach tools and consumer awareness activities. Regional programs trained community volunteers across the state. These volunteers conducted in-person outreach and education with residents who lived in nursing homes, assisted living and adult family homes settings. Staff Ombudsmen conducted group presentations consisting of residents, providers, and resident family members.

a) The Washington State LTCO Program encountered access issues to residents in mostly assisted living settings, but in all three major licensed long-term care settings. Residents were denied access to the "Reduce the Misuse" information as were their family members or responsible parties. Barriers consisted of refusal by facilities to allow presentations by the Ombuds when requested, refusal to provide contact information for residents family members/responsible parties, retaliatory complaints made against ombuds, and impediment of Ombuds work to include investigation of complaints or distribution of general information. The refusals were not widespread. In general most providers were open to the information, supported the campaign and assisted in helping ombuds distribute information to residents, families and/or providers.

b) Recommendations for system-wide change to resolve the issue were made and several approaches attempted. We continued training and monitored the implementation of the campaign, for quality and effectiveness. This included technical assistance provided to Regional Ombuds, onsite- training, web-based trainings and collaborations on work plans to ensure that all ombuds understood the purpose of the campaign and the LTC Ombudsman role. We educated the state licensing oversight agency (RCS) about ombuds access being restricted. We tracked incidents of unlawful restrictions to ombudsmen by facilities, and when needed involved RCS to investigate these incidents. Washington LTCOP brought to the attention of RCS, old RCS guidance (policy) memos regarding LTCOP access and use of antipsychotic drugs. As a result of our informing RCS of the issues we were finding, in particular the barriers we were encountering, RCS issued new memos to all providers on both topics. This was helpful to ombuds in the field who could point providers to the memos when questioned about Ombuds authority and work on the campaign.

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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?	237
2. How many beds are there in these facilities?	22,130

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?	3,932
b) How many beds are there in these facilities?	49,012

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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	14.23
	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	332
Number of Volunteer hours donated	Total number of hours donated by certified volunteer	0	38,067
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	$292,605
Federal - Older Americans Act (OAA) Title VII, Chapter 3, Elder Abuse Preventior	$0
Federal - OAA Title III provided at State level	$47,357
Federal - OAA Title III provided at AAA level	$69,407
Other Federal; specify:	$0
State funds	$948,440
Local; specify:	$234,411
County general revnues, State Senior Service Act, Community Services Block Grant, Private foundation grants, Private Donations	
Total Program Funding	$1,592,220

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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	48	237
	Number hours	328	1,166
	Total number of trainees that attended any of the training sessions above (duplicated count)	465	5,483
	3 most frequent topics for training	Atypicals Grant Education by State Office	Omb. Services
		Resident Rights	Atypicals Grant Education by Regional Office
		Omb. Services	Dementia
2. Technical assistance to local ombudsmen and/or volunteers	Estimated percentage of total staff time	30	80
3. Training for facility staff	Number sessions	2	185
	3 most frequent topics for training	Role of an Ombuds	Atypicals Grant Education by Regional Office
		Resident Rights	Omb. Services
			Resident Rights
4. Consultation to facilities (Consultation: providing information and technical assistance, often by telephone)	3 most frequent areas of consultation	Z - Omb. Services	Z - Omb. Services
		F - Care	F - Care
		C - Admission, Transfer, Discharge, Eviction	C - Admission, Transfer, Discharge, Eviction
	Number of consultations	454	7,057

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5. Information and consultation to individuals (usually by telephone)	3 most frequent requests/needs	Z - Omb. Services	Z - Omb. Services
		F - Care	F - Care
		C - Admission, Transfer, Discharge, Eviction	C - Admission, Transfer, Discharge, Eviction
	Number of consultations	2,472	35,521
6. Facility Coverage (other than in response to complaint) *	Number Nursing Facilities visited (unduplicated)	3	79
	Number Board and Care (or similar) facilities visited (unduplicated)	4	466
7. Participation in Facility Surveys	Number of surveys	1	789
8. Work with resident councils	Number of meetings attended	3	804
9. Work with family councils	Number of meetings attended	0	41
10. Community Education	Number of sessions	12	846
11. Work with media	3 most frequent topics	AG Grant	AG Grant
		Ombudsman Program	V - Role of Volunteer
		Resident Rights	V - Role of Volunteer
	Number of interviews/ discussions	2	7
	Number of press releases	4	11
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%.)	35	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."