Older American Acts Performance System (OAAPS)

National Ombudsman Report (NORS)

Washington State Long-Term Care Ombudsman Program

Federal Fiscal Year 2020

October 1, 2019 – September 30, 2020

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State data for WA for FFY 2020

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State data for WA for FFY 2020

Case and Complaints Summary

Total number of cases closed: **1610**

Totals Cases per Complainant by Facility Setting

Complainant	Nursing Facility	Residential Care Community	Other	Total per complainant
Resident	452	371	0	823
Resident representative, friend, family	263	235	0	498
Ombudsman program	27	22	0	49
Facility staff	47	62	0	109
Representative of other agency or program	28	31	0	59
Concerned person	15	18	0	33
Resident or family council	3	6	0	9
Unknown	9	21	0	30
Total per facility type	**844**	**766**	**0**	**1610**

Total number of complaints: **3660**

Major Complaint Groups by Type of Facility

Complaint Category/Type	Nursing Facility	Residential Care Community	Other	Total by Complaint Type
A. Abuse, gross neglect, exploitation	75	105	0	180
B. Access to Information	45	45	0	90
C. Admission, transfer, discharge, eviction	203	168	0	371
D. Autonomy, choice, rights	467	446	0	913
E. Financial, property	110	127	0	237
F. Care	604	382	0	986
G. Activities and community integration and social services	58	77	0	135
H. Dietary	99	82	0	181
I. Environment	96	85	0	181
J. Facility policies, procedures and practices	79	132	0	211
K. Complaints about an outside agency (non-facility)	34	24	0	58
L. System and others (non-facility)	44	73	0	117

Complaint Verifications

Verification Status	Nursing Facility	Residential Care Community	Other	Total
Verified	1777	1522	0	3299
Not Verified	137	224	0	361

Complaint Dispositions

Disposition Status	Nursing Facility	Residential Care Community	Other	Total
Partially or fully resolved to the satisfaction of the resident, resident representative or complainant	1531	1303	0	2834
Withdrawn or no action needed by the resident, resident representative or complainant	185	227	0	412
Not resolved to the satisfaction of the resident, resident representative or complainant	198	216	0	414

State data for WA for FFY 2020

Complaint Types by Type of Facility

Complaint Category/Type	Nursing Facility	Residential Care Community	Other	Total by Complaint Type
A. Abuse, gross neglect, exploitation	75	105	0	180
A01. Abuse: physical	9	18	0	27
A02. Abuse: sexual	4	5	0	9
A03. Abuse: psychological	12	31	0	43
A04. Financial exploitation	18	29	0	47
A05. Gross neglect	32	22	0	54
B. Access to Information	45	45	0	90
B01. Access to information and records	36	31	0	67
B02. Language and communication barrier	5	5	0	10
B03. Willful interference	4	9	0	13
C. Admission, transfer, discharge, eviction	203	168	0	371
C01. Admission	23	15	0	38
C02. Appeal process	10	7	0	17
C03. Discharge or eviction	134	134	0	268
C04. Room issues	36	12	0	48
D. Autonomy, choice, rights	467	446	0	913
D01. Choice in health care	45	32	0	77
D02. Live in less restrictive setting	48	34	0	82
D03. Dignity and respect	152	144	0	296
D04. Privacy	29	23	0	52
D05. Response to complaints	75	81	0	156
D06. Retaliation	13	36	0	49
D07. Visitors	39	36	0	75
D08. Resident or family council	2	1	0	3
D09. Other rights and preferences	64	59	0	123
E. Financial, property	110	127	0	237
E01. Billing and charges	39	68	0	107
E02. Personal property	71	59	0	130

Complaint Category/Type	Nursing Facility	Residential Care Community	Other	Total by Complaint Type
F. Care	604	382	0	986
F01. Accidents and falls	34	33	0	67
F02. Response to requests for assistance	110	65	0	175
F03. Care planning	65	54	0	119
F04. Medications	75	73	0	148
F05. Personal hygiene	74	41	0	115
F06. Access to health related services	42	24	0	66
F07. Symptoms unattended	63	39	0	102
F08. Incontinence care	25	21	0	46
F09. Assistive devices or equipment	59	20	0	79
F10. Rehabilitation services	47	10	0	57
F11. Physical restraint	2	1	0	3
F12. Chemical restraint	8	1	0	9
G. Activities and community integration and social services	58	77	0	135
G01. Activities	24	30	0	54
G02. Transportation	7	18	0	25
G03. Conflict resolution	16	15	0	31
G04. Social services	11	14	0	25
H. Dietary	99	82	0	181
H01. Food services	58	44	0	102
H02. Dining and hydration	21	16	0	37
H03. Therapeutic or special diet	20	22	0	42
I. Environment	96	85	0	181
I01. Environment	20	20	0	40
I02. Building structure	8	3	0	11
I03. Supplies, storage and furnishings	17	10	0	27
I04. Accessibility	6	9	0	15
I05. Housekeeping, laundry and pest abatement	45	43	0	88
J. Facility policies, procedures and practices	79	132	0	211
J01. Administrative oversight	37	69	0	106
J02. Fiscal management	2	8	0	10
J03. Staffing	40	55	0	95

Complaint Category/Type	Nursing Facility	Residential Care Community	Other	Total by Complaint Type
K. Complaints about an outside agency (non-facility)	34	24	0	58
K01. Regulatory system	2	3	0	5
K02. Medicaid	19	12	0	31
K03. Managed care	5	3	0	8
K04. Medicare	6	2	0	8
K05. Veterans Affairs	1	2	0	3
K06. Private Insurance	1	2	0	3
L. System and others (non-facility)	44	73	0	117
L01. Resident representative or family conflict	24	51	0	75
L02. Services from outside provider	11	18	0	29
L03. Request to transition to community setting	9	4	0	13

State data for WA for FFY 2020

Complaint Examples

	Nursing Facility Example	Residential Care Community Example	Optional Complaint Example
Facility type	Nursing Facility	Residential Care Community	N/A
Description	As a younger man, Resident suffered a brain tumor, and after surgery, was left with a significant brain injury. After several years receiving care from his loving family and caregivers at home, he entered a nearby nursing home chosen specifically so that his mother could walk to those visits. Resident's family visited daily, sometimes more than once. He also received hospice support from a nurse, speech therapist, and social worker once a week at the nursing home. Early in COVID times, the facility administrator made the unilateral decision to shut down all access to every resident in the facility without notice. Families and friends discovered that they were unable to reach residents by phone due to an inadequate phone system and understaffing. Even more alarming, access to the one cordless phone in the building was even worse for residents and many just gave up, becoming more isolated and depressed as the days turned into months. Families were not allowed to visit outside windows. For the case of Resident and his family was completely cut off from one another. The facility administrator denied Resident access to in-person hospice services. He also denied the volunteer certified LTC Ombuds for the building visitation and access to all residents. The ombuds was not able to investigate complaints in person and sought out guidance from his supervisor.	An equipment malfunction and subsequent accident 20+ years ago sent resident to the hospital where he lived in a coma for over a year with a profoundly serious closed head injury. Rehabilitation in a nursing home for another year prepared him for his life in an assisted living facility where he had lived for 15+ years. Resident's head injury required accommodations for his mercurial personality and sensitivity to any questioning of his integrity and independence. He relished his almost daily contact with members of the small size city where he has many family members and friends and where he had his accident. He was often asked to assist with feeding local livestock which he enjoyed and was an important part of his daily activities. His life changed when COVID struck Washington State although his ALF had no active cases. Facility staff asked Resident to stop his trips to assist with livestock. The facility staff worried that Resident would bring COVID 19 into the facility. The assigned ombuds assisted Resident in proposing to the facility that he enter and leave through the sliding glass door in his apartment unit, which was on street level, but the facility administration rejected the idea. Resident claimed wearing a mask really "bothered" him and would not commit to wearing it consistently. Without notice, Resident returned to the ALF after completing his work with livestock only to find the front door of the facility was locked. He rang the doorbell and was told he was being "evicted". He panicked and called the police. His cat was in his apartment and he had nowhere to go which caused him great concern. The facility gave him a "discharge notice" and told him he was being discharged to the hospital, although he had no acute medical need for care. Police did not intervene. The resident did not know that he could appeal the discharge.	N/A
Complaint topic	Autonomy, Choice, Rights	Admission, Transfer, Discharge, Eviction	N/A
Complaint type	Visitors	Discharge or eviction	N/A
Verification	Verified	Verified	N/A
Disposition	Partially or fully resolved to the satisfaction of the resident, resident representative or complainant	Not resolved to the satisfaction of the resident, resident representative or complainant	N/A
Disposition narrative	After several weeks, only after the ombuds advocated on behalf of the resident, the window visits were accommodated but windows had to remain closed and residents needed to speak into phones. Resident was not able to operate a phone independently, requiring significant assistance. Resident's family became very concerned as his care was now devoid of the individualized care he received from hospice. The hospice social worker would assist the resident in making calls to his family with a tablet, an integral part of Resident's independence and psychosocial health. Now that the hospice worker was not allowed to enter the building by the administrator's decision, it was up to the facility staff to assist the resident in staying connected with his family. This help was not consistently available and calls did not take place between the resident and his mother. The Ombuds was asked to intervene and after several skilled attempts to advocate for Resident's individual needs, the issue escalated to the State Office and ultimately to the regulatory system. Hospice services were then allowed in the building and window visits accommodated by early June 2020.	Next step for the LTCOP: challenging the facilities that have failed to admit him based on "not a good fit" relative to Fair Housing and ADA regulations. The current plan also includes a plan to work with Washington State Labor & Industries that administers the settlement received because of Resident's injury and encourage their case management system to also assist Resident in locating a facility in his community.	N/A

State data for WA for FFY 2020

System Issues

	System Issue 1	System Issue 2	System Issue 3 *(Optional)*
System issue topic	D - Autonomy, Choice, Rights	C - Admission, Transfer, Discharge, Eviction	N/A
Problem description	Due to COVID 19 restrictions are placed on residents' access to their communities due to concerns about transmission. Some residents are restricted from leaving their facilities even for medical concerns such as wound treatments. Even as the surrounding community opens up allowing for essential shopping, outdoor exercise and recreation, residents are kept in isolation within the long-term care facilities even as COVID 19 numbers are low in the community. Experts in public health, agencies and decision makers continue to restrict resident access to essential services, socialization and outdoor visits due to concerns over the risk of exposure in the community and bringing COVID 19 back into the facility. Decision makers including some providers restrict long-term care residents from exercising their right to leave the facility and return nearly a year into the pandemic. Some providers go as far as to discharge residents without notice for violating their rules, sending residents to hospitals without any signs or symptoms of COVID 19 or testing results. To date some residents are threatened discharge should they leave the facility because the "facility cannot guarantee that the resident practiced infection control precautions (social distancing, face masking, hand sanitizing. Residents are placed into "quarantine" if they leave and return to the facility regardless of their activity (dialysis, out to the parking lot, or to the grocery store). Residents are prevented from exercising their right to choose by threat of losing their home or threat of isolation in the home.	This year the office of the state long-term care ombudsman program continued to receive complaints about admission, transfer, discharge and eviction but with the added impacts of the COVID 19 crisis. During the pandemic guidelines and directives (proclamations) were issued by a variety of entities from state government agencies with oversight responsibilities, the Governor's office, the CDC, and the Centers for Medicaid and Medicare. The expertise of local public health entities also known as the local health jurisdictions (LHJs) play an increasing critical role as decision makers in the protection of the public, and long-term care residents. In Washington State, LHJ's have home rule and broad authority to impose rules to protect the public. Directives, guidelines and rules impacted the coming and going of long-term care residents including their admission into some long-term facilities or not, COVID-19 testing, data collection and reporting, determination of criteria and measures as part of the state's "reopening" plan for the greater community and for long-term care facilities by license setting type. The state's licensing an oversight were limited in their ability to act in their role as inspectors and investigators during COVID 19. Statutes and rules upon licensing were waived by CMS (nursing homes) and by the state's governor and legislator. This left a break in normal protections for consumers on admissions, transfers, discharges and evictions.	N/A
Barriers description	•Lack of clear nimble communication by state agencies with oversight responsibilities. The state department of health created a risk assessment about seven months into the pandemic. Some providers are not utilizing the risk assessment. •Lack of enforcement on residents right to leave the facility and return without threat of discharge or imposed quarantine. Complaints received and handled but there is no enforcement. This creates a piece meal approach to resolving a systemic issue. •Infection control issues and abuse are the only complaints or issues being investigated and take priority over other types of complaints. •Lack of knowledge by agencies and decision makers regarding resident rights. •Ageism and ableist attitudes (implicit and explicit bias). •Lack of workforce availability making a wholistic approach to infection control prevention and precautions difficult to impossible. The state office of the long-term ombuds (the Office) advocated for the formation of a stakeholder advisory group which began meeting approximately four months into the pandemic with the purpose of a coordinated collaborative approach to address current issues related to the pandemic and plan future strategies and goals. The advisory group is convened by the state unit on aging. The request was made in hopes to improve communication making it clearer and timely. Early on in the pandemic providers and advocates were not included in decision making due to the sudden and hard-hitting nature of COVID-19 in Washington state's nursing homes. The need for key stakeholders to come together was evident as providers, advocates and residents were often in the dark as to what was happening and how and who were making policy decision in long-term care. The advisory group meets weekly, tackling a variety of issues important to long-term care, such as workforce shortages and staffing issues, testing, lack of PPE and testing supplies, and most recently vaccination distribution. The group has also advised the Governor's office on issues such as visitations and group activities.	Of special concern during COVID was the handling of the eviction of long-term care residents from facilities due to COVID 19; charging the state attorney general's office of civil rights with the responsibility to investigate complaints about evictions from long-term care during COVID 19. The LTC Ombuds described complaints received regarding residents being locked out of their care homes because they left the home temporarily. Facilities lacked the tools to fairly manage residents who left the building and returned. In the first few months of the pandemic, some residents who went out to smoke a cigarette were "blocked" from re-entering and it took advocacy by the ombuds for their re-entry. We had several complaints regarding residents who were sent to the hospital emergency room or for admission, for evaluation and treatment and refused readmission. Rapid testing for COVID 19 was not yet available, and not all facilities at the time had access to testing. Facilities required two negative tests before they would admit a resident. Residents who wanted to return to their "step down" facility, for example a resident in a skilled nursing rehab ready to return to their assisted living facility were refused without two negative COVID tests. Residents found themselves "stuck" in a situation where they could not leave a nursing home because they could not find a less restrictive setting willing to take them because they had COVID (and recovered) or may have been exposed to COVID while in the nursing homes. Lastly, we saw situations where residents were discharged from care facilities do to non-payment. The governor's office issued a moratorium on evictions during COVID 19. There was confusion to if the moratorium applied to long-term care residents and settings. Normally, eviction law does not apply to long-term care facilities in Washington State. The moratorium also included a restriction on rent increases. The problem this presented to long-term care facilities was that given the nature of their business, rent increases were needed to meet their duty to care for vulnerable adults.	N/A
Issue status	Newly identified in this reporting year and not fully resolved.	Newly identified in this reporting year and not fully resolved.	N/A

Affected setting	Nursing Facility Residential Care Community	Not specific to a setting	N/A
Resolution strategies	Provided information to public or private agency Provided Information to legislator or legislative staff Recommended changes to laws, regulations, policies or actions through written or oral testimony. Provided leadership or participated on a task force Provided information to the media Provided educational forums; facilitated public comment on laws, regulations, policies or actions Developed and disseminated information	Provided information to public or private agency Recommended changes to laws, regulations, policies or actions through written or oral testimony. Provided educational forums; facilitated public comment on laws, regulations, policies or actions	N/A
Resolution description	The Office was partially successful in introducing the concept of an essential support person for residents during all phases of the Governor's "safe start" (reopening) plans for long-term care facilities. The office worked with stakeholders in adopting the CMS definition of "compassionate care" allowing for visits for people who needed more support due to conditions such as dementia, mental illness or other conditions. The Governor's original proclamation limited compassionate visits to end of life situations only. Also brought to the attention of decision makers is the harmful effects of isolation upon residents and the need for social connection. Stakeholders understand the impacts and are trying to limit the isolation by policy but the Office continues to advocate for continued information sharing and stronger enforcement. The LTC Ombudsman Program continues to receive complaints about residents not being allowed to have window visits, or visits outside. The unreasonable restriction of compassionate visits by decision makers because the resident is not in the "active phase of dying". Additionally, the office receives complaints about facilities restricting outside services, including hospice care, wound care and special treatments post-surgery. The office has received complaints regarding a lack of communication with facility staff such as the facility phones not being answered during business hours or over the weekend, residents not being able to connect with their loved ones and friends and complaints from medical providers/vendors that the facility doesn't respond to their phones and email. These issues continue to be problematic with some facilities and not all. The office continues to inform key decision makers, advocate for long-term care residents, resolve complaints and make systemic recommendations for solutions. The Office worked with media throughout the state and nation offering information about the impacts of COVID 19 on long-term care residents with focus on the need for essential support person visitations, residents rights, the harm in isolation and the need for access to appropriate care in and out of the facility. When possible and appropriate, media were connected to residents and/or their families to share their personal stories. Local (Regional) long-term care ombudsmen were also interviewed at times. The state long-term care ombuds participated in print, online and radio interviews. The Office utilized resources created by the NORC and Consumer Voice to educate others. The Office also created its own educational materials to share with ombuds, consumers and the public.	The ombudsman program provided advocacy on individual discharges including assisting residents in their rights to file an appeal. During COVID 19 guidelines were issued allowing facilities to discharge or transfer residents without notice of written discharge. The ombuds program advocated for clarity on the rules on discharge and transfer notices. The ombuds worked to inform decision makers about the circumstances in which long-term care residents were discharged against their will, provided systems advocacy and recommendations for improvement. The ombuds was successful in keeping long-term care residents who cannot pay their facility bill as a protected group from evictions during the pandemic to prevent homelessness. However, the ombuds was not successful in preventing resident rent increases and the allowance of COVID 19 fees (a new fee that is related to the costs for preventing transmission of COVID such as PPE costs and infection control supplies). The ombuds was not successful in their request that all involuntary discharges be paused during the pandemic. With stakeholder work, including meetings with policy makers, the ombuds advocated for clear, person centered assessment and care planning, advocating for the right to residents to exercise their choice to living environment whenever possible. In the cases of discharge appeals during the pandemic. The hearings were delayed in some part of the state due to COVID 19. The ombudsman supported residents in their appeals by providing information, testimony and administrative supports. In some cases, the ombuds was not successful in helping the consumer "win" their appeals. In one notable case an ombuds was successful in helping the client win her case to re-enter a facility based on the failure of the facility to issue a written discharge, appeal notice and at the time, the ombuds was able to call the judge's attention to the eviction moratorium. In this particular case the skilled nursing home chose to appeal the decision appeal. At the time of this report the case is unresolved.	N/A

State data for WA for FFY 2020

Organizational Structure

Office of state LTCO location Within a private, non-profit agency

Local Ombudsman Entity Location	Number of Ombudsman
Area agency on aging (AAA) an area agency on aging designated under section 305(a)(2)(A) of the Older Americans Act or a State agency performing the functions of an area agency on aging under section 305(b)(5) of the OAA.	6
Social services non-profit agency, with 501(c)(3) status, other than AAA	3
Legal services provider	0
Stand-alone local Ombudsman entity - a non-profit agency with 501(c)(3) status – the only program is the local Ombudsman entity	0
Total number of entities	9

State data for WA for FFY 2020

Organizational Conflicts of Interest

Conflict of Interest Type	Location	Remedy
Provides LTC services, including Medicaid/Waivers	Local	Steps were taken to remedy the conflicts of interests (COIs) : 1.The LOE has in place remedies such as separate branding and image from the LOE, separate programmatic policies and procedures, separate and secure LTCOP database from the host agency, and job functions are handled by a separate unit than the LTCOP. 2.Subcontracting agreements between the State LTCOP and the LOE require the LOE to follow the state and federal laws and regulations regarding “independence” between the LOE and the local program and the Office of the State LTCO providing program leadership and direction, setting policies and procedures and all other responsibilities by the State LTCO separate from the “employer” responsibilities of the LOE. The subcontracting agreements require that the LOE identify organizational and individual conflicts of interests and a remedy to COIs or removal of the COIs. 3.The LOE will remove LTCOP staff access to the “CARE” case management database. Volunteer LTCOP do not have access to the “CARE” database. When a certified ombuds seeks case management records, the ombuds will follow LTCOP standards, which require the resident’s informed consent to view the records. Once permission is obtained, the ombuds will directly contact the appropriate case manager for the records and will document the request in ombudsman records. 4.Certified ombudsmen will seek supervision from their immediate supervisor. Regional LTC Ombuds will seek information and support, when needed, from the Office of the State LTC Ombuds. Should the ombuds need immediate consultation or assistance, and the State LTCO or her designees not be available, the certified ombuds can seek consult from the Executive Director of the LOE. If the Executive Director is not available, the ombudsman will go to the LOE supervisor. If the issue involves a former case management client, the LOE supervisor will recuse himself due to conflicts of interest.

State data for WA for FFY 2020

Staff and Volunteers

Office of State Ombudsman Staff

Total staff	15	
Total full-time equivalent (FTE)	14	
Total state volunteer representatives	47	
Total hours donated by state volunteers representatives	3,999	Hours
Total other volunteers (not representatives)	26	

Local Ombudsman Entity Staff

Total staff	18	
Total full-time equivalent (FTE)	11	
Total local volunteer representatives	154	
Total hours donated by local volunteer representatives	13,721	Hours
Total local volunteers (not representatives)	78	

State data for WA for FFY 2020

Funds Expended

Funds Expended from OAA Sources

Federal - OAA Title VII, Chapter 2, Ombudsman	$340,257
Federal - OAA Title VII, Chapter 3	$74,361
OAA Title III - State level	$145,266
OAA Title III - AAA level	$64,187
Other Federal Sources	
There are no other Federal sources	
Total other Federal funds expended	$0
Other State Sources	
There are no other State sources	
Total other State funds expended	$1,761,380
Other Local Sources	
There are no other Local sources	
Total other Local funds expended	$240,112

State data for WA for FFY 2020

Facility - Number and Capacity

Licensed Nursing Facilities

Total number	209
Total resident capacity	20073

Residential Care Communities

Total number	3504
Total resident capacity	54738

State data for WA for FFY 2020

Facility - Residential Care Community Information

RCC type	RCC type definition	Minimum RCC capacity	Maximum RCC capacity
Assisted Living Facilities	These facilities in a community setting are licensed to care for seven or more residents. The assisted living facility (ALF) provides room and board and help with activities of daily living. Some ALFs provide limited nursing services; others may specialize in serving people with mental health problems, developmental disabilities, or dementia (Alzheimer's disease). •The assisted living facility must provide housing and assume general responsibility for the safety and well-being of each resident, as defined in this chapter, consistent with the resident's assessed needs and negotiated service agreement. •The assisted living facility must provide each resident with the following basic services, consistent with the resident's assessed needs and negotiated service agreement: (a) Activities - Arranging for activities in accordance with Washington State WAC 388-78A-2180; (b) Housekeeping - Providing a safe, clean and comfortable environment for each resident, including personal living quarters and all other resident accessible areas of the building; (c) Laundry - Keeping the resident's clothing clean and in good repair, and laundering towels, washcloths, bed linens on a weekly basis or more often as necessary to maintain cleanliness; (d) Meals - Providing meals in accordance with Washington State WAC 388-78A-2300; and (e) Nutritious snacks - Providing nutritious snack items on a scheduled and nonscheduled basis, and providing nutritious snacks in accordance with Washington State WAC 388-78A-2300. (3) The assisted living facility must: (a) Provide care and services to each resident by staff persons who are able to communicate with the resident in a language the resident understands; or (b) Make provisions for communications between staff persons and residents to ensure an accurate exchange of information. (4) The assisted living facility must ensure each resident is able to obtain individually preferred personal care items when: (a) The preferred personal care items are reasonably available; and (b) The resident is willing and able to pay for obtaining the preferred items. •An assisted living facility means any home or other institution, however named, which is advertised, announced, or maintained for the express or implied purpose of providing housing, basic services, and assuming general responsibility for the safety and well-being of the residents, and may also provide domiciliary care, consistent with Chapter 388-78A WAC to seven or more residents after July 1, 2000. An assisted living facility that is licensed for three to six residents prior to or on July 1, 2000, may maintain its assisted living facility license as long as it is continually licensed as an assisted living facility.	7	

Adult Family Homes	Adult Family Homes (AFH) must be license before provider can provide personal care, special care, room and meals for two to six adults, unrelated to provider, in their home. •An AFH is a residential home licensed to care for two to six adults not related by blood or marriage to the person or persons providing the services. •The AFH provides room and meals, laundry, supervision, assistance with activities of daily living and personal care. Some homes provide nursing or other special care. •A licensed AFH is generally at a residential home address. •An adult family home is a single family residence, a duplex unit, or other type of dwelling for one or two families [per IRC #R101]. Each unit must have: oSeparate staffing; oSeparate call systems; oSeparate living quarters; oSeparate addresses; oEither a fire wall or floor separating the two units; and oNo internal door in common. The following is a partial list of some things the provider must do. •Know and comply with all AFH applicable laws and rules; •Meet the assessed care needs and preferences for each resident which may include, but is not limited to: oAssisting with personal hygiene, dressing, bathing, toileting, body care, walking and moving from one spot to another, oProviding nutritious meals, oOffering activities other than television, oProviding medication assistance or administration, and oProviding supervision to residents with challenging behaviors or at risk of falls; •Be responsible for the care and services provided to residents 24 hours a day whether the provider is on site or not; •Screen and hire responsible, dependable and qualified staff members; •Ensure that staffing is adequate to meet all resident needs at all times (24 hours a day, seven days a week); •Provide staff orientation and ongoing staff support and training; •Maintain adult family home records such as individual resident records, staffing records, accounting, income tax and payroll records; and •Ensure that each resident is protected from oabandonment, overbal, sexual, physical, and mental abuse, oexploitation and financial exploitation, oneglect, and oinvoluntary seclusion.

Enhanced Services Facilities	Enhanced Services Facilities (ESF): Licensed residential facility will provide a community placement option for individuals whose complicated personal care and behavioral challenges do not rise to a level that requires an institutional setting. Individuals are referred to an ESF if they are coming out of state and community psychiatric hospitals or have no other placement option due to their complex behavior, medical, chemical dependency and/or mental health needs. ESFs use high staffing ratios, with a strong focus on behavioral interventions, to offer effective services to their residents. These facilities offer behavioral health, personal care services and nursing, at a level of intensity that is not generally provided in other licensed long-term care settings. In order to serve ESF residents, provider must be a licensed ESF provider and be contracted with the Home and Community Services (HCS) Division. Successful ESF applicants will have experience providing personal care to Medicaid clients with highly complex personal care and behavioral challenges • The Contractor must have a current Enhanced Services Facility (ESF) license. • The Contractor must have demonstrated experience and ability providing services and supports in a community based setting to adults with complex behavioral and personal care needs. • The Contractor must have a demonstrated ability to provide (or arrange) for all required staff trainings •One toilet and handwashing sink for every four residents; •At least one bathing unit for every four residents; •Access to at least one bathing device for immersion; and •Access to at least one roll-in shower on each resident care unit.

State data for WA for FFY 2020

Back to Index

Program Activities

Certifications and Training

Certification training hours	32	Hours
Training hours required to maintain certification	31	Hours
Number of new individuals completing certification training	64	

Ombudsman Program Activities

Information and assistance to individuals	26548
Community education	287

Ombudsman Program Activities - Facilities

Activity	Nursing Facility	Residential Care Community
Training sessions for facility staff	5	4
Information and assistance to staff	1697	2796
Number of facilities that received one or more visits	164	1230
Number of visits for all facilities	1969	4810
Number of facilities that received routine access	0	0
Total participation in facility survey	70	89
Resident council participation	143	208
Family council participation	1	7

State and Local Level Coordination Activities

Area agency on aging programs, Aging and disability resource centers, Adult protective services programs, Protection and advocacy systems, Facility and long-term care provider licensure and certification programs, The State Medicaid fraud control unit, The State legal assistance developer and legal assistance programs

Other Coordination Activities

Describe any state or local level coordination and leadership activities with the entities listed, as applicable.

Dementia Action Collaborative: A coalition made up of a number of individuals, representatives from government entities and organizations focused on improving and expanding dementia friendly services, communities and initiatives. The collaborative is convened by the State Unit on Aging. The State LTCO participates and coordinates a subcommittee on dementia standards in long-term care "Memory Care" units. The State LTCO attorney and Assistant State Ombuds serve on committees including leading subcommittees and responsible for components of the work. The subcommittee is creating a survey to determine standards in memory care.

Department of Commerce Proviso: The Office worked closely with the Department of Commerce (contracting agency for the LTCOP) and stakeholders on a budge proviso to determine funding model recommendation for the LTC Ombudsman Program. In 2020, the WA State Legislature included a proviso in the supplemental Operating Budget, SB 6168 Section 127(92) as follows:
$10,000 of the general fund—state appropriation for fiscal year 2021 is provided solely for the department to make recommendations on a sustainable, transparent, and reactive funding model for the operation of the LTCOP. (a)The department must recommend a plan that: (i)Serves all residents in long term care equally; (ii)Is reactive to changes in service costs; and (iii) Is reactive to changes in number of residents and types of facilities served. (b)The department shall convene not more than three stakeholder meetings that includes representatives from the department of social and health services, the department of commerce, the department of health, the office of financial management, the office of the governor, the long-term care ombuds program, representatives of long-term care facilities, representatives for the area agencies on aging, and other stakeholders as appropriate. The department must submit a report with recommendations to the governor & the appropriate fiscal and policy committees of the legislature by 12/1/2020. The Office lobbied legislators and policy makers for the inclusion of the proviso in the state budget. Commerce convened stakeholders in the summer of 2020. This required significant preplanning work and coordination between by Commerce and the Office. State LTCOP provided program research information, its data and funding history, technical support and presented information to stakeholders.

Stay Connected-Technology Campaign: The State LTCOP worked to establish a campaign to raise fund for Amazon tables for long-term care residents. The goal was to help residents remain socially connected to their families, friends & community during the pandemic. To manage the spread of COVID 19, long-term care residents were not allowed visitors by state authorities & the Governor's proclamation, resulting in very limited activities & socialization. The Office led fundraising efforts WA and collaborated with the State Adult Family Home (AFH) Councils, a member organization that's the collective bargaining unit for AFH providers, and a private placement agency which provided assistance in researching the need, types of devices and connections to possible resources. Approximately $5200 was raised through private donations. All accounting and management of the outreach campaign to solicit donations was managed by the Office and its host entity, the Multi-Service Center a private non-profit based in south King County. Next, the Office secured a technology fund grant through the WA State Department of Social & Health Services. Funds were sourced from the state's civil monetary penalties for adult family homes. The LTCOP secured just under $100,000 to purchase approximately 1000 Amazon Fire tablets and protective covers for AFH. The program began in April and ends July, 2021. The civil penalty grant was awarded in September of 2020. Thus far to date, the program has distributed just under 650 tablets.

Life Care Center of Kirkland Townhall: The first known outbreak of COVID 19 in a LTC setting happened in February 2020 at Life Care Centers of Kirkland a nursing home located in Washington state. The LTCOP led and coordinated an effort to bring local epidemiological and public health experts together with Life Care leadership for the benefit of informing resident family members about COVID 19, the impacts, infection control and take questions. The townhall was held on March 2020, three weeks into the outbreak crisis. The LTCO convened a panel of experts from the Seattle King County Public Health and the Washington State Department of Health. Lead epidemiologists from the county, the state's top medical officer, and Life Care leadership. The director of state 's licensing unit, Residential Care Services (RCS) was invited but RCS declined to attend due to conflicts of interest. They provided written responses to pre-submitted questions. There were 125 participants on the call.