# State data for WA for FFY 2021



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# Case and Complaints Summary

**Total number of cases closed:** **1386**

**Totals Cases per Complainant by Facility Setting**

| Complainant | Nursing Facility | Residential Care Community | Other | Total per complainant |
|---|---|---|---|---|
| Resident | 305 | 334 | 0 | 639 |
| Resident representative, friend, family | 293 | 238 | 2 | 533 |
| Ombudsman program | 14 | 16 | 0 | 30 |
| Facility staff | 41 | 42 | 0 | 83 |
| Representative of other agency or program | 20 | 32 | 1 | 53 |
| Concerned person | 1 | 8 | 0 | 9 |
| Resident or family council | 2 | 6 | 0 | 8 |
| Unknown | 10 | 21 | 0 | 31 |
| **Total per facility type** | **686** | **697** | **3** | **1386** |

**Total number of complaints:** **3028**

**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 | 77 | 71 | 0 | 148 |
| B. Access to Information | 57 | 30 | 0 | 87 |
| C. Admission, transfer, discharge, eviction | 110 | 137 | 3 | 250 |
| D. Autonomy, choice, rights | 325 | 349 | 3 | 677 |
| E. Financial, property | 76 | 104 | 0 | 180 |
| F. Care | 573 | 301 | 0 | 874 |
| G. Activities and community integration and social services | 53 | 70 | 0 | 123 |
| H. Dietary | 93 | 93 | 1 | 187 |
| I. Environment | 74 | 107 | 0 | 181 |
| J. Facility policies, procedures and practices | 102 | 102 | 1 | 205 |
| K. Complaints about an outside agency (non-facility) | 26 | 16 | 0 | 42 |
| L. System and others (non-facility) | 20 | 54 | 0 | 74 |

**Complaint Verifications**

| Verification Status | Nursing Facility | Residential Care Community | Other | Total |
|---|---|---|---|---|
| Verified | 1435 | 1242 | 2 | 2679 |
| Not Verified | 151 | 192 | 6 | 349 |

**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 | 1246 | 1070 | 2 | 2318 |
| Withdrawn or no action needed by the resident, resident representative or complainant | 133 | 173 | 0 | 306 |
| Not resolved to the satisfaction of the resident, resident representative or complainant | 207 | 191 | 6 | 404 |

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## Complaint Types by Type of Facility

| Complaint Category/Type | Nursing Facility | Residential Care Community | Other | Total by Complaint Type |
|---|---|---|---|---|
| A. Abuse, gross neglect, exploitation | 77 | 71 | 0 | 148 |
| A01. Abuse: physical | 8 | 9 | 0 | 17 |
| A02. Abuse: sexual | 5 | 3 | 0 | 8 |
| A03. Abuse: psychological | 12 | 25 | 0 | 37 |
| A04. Financial exploitation | 6 | 20 | 0 | 26 |
| A05. Gross neglect | 46 | 14 | 0 | 60 |
| B. Access to Information | 57 | 30 | 0 | 87 |
| B01. Access to information and records | 38 | 21 | 0 | 59 |
| B02. Language and communication barrier | 13 | 4 | 0 | 17 |
| B03. Willful interference | 6 | 5 | 0 | 11 |
| C. Admission, transfer, discharge, eviction | 110 | 137 | 3 | 250 |
| C01. Admission | 9 | 10 | 1 | 20 |
| C02. Appeal process | 6 | 4 | 0 | 10 |
| C03. Discharge or eviction | 81 | 112 | 2 | 195 |
| C04. Room issues | 14 | 11 | 0 | 25 |
| D. Autonomy, choice, rights | 325 | 349 | 3 | 677 |
| D01. Choice in health care | 16 | 22 | 0 | 38 |
| D02. Live in less restrictive setting | 40 | 47 | 0 | 87 |
| D03. Dignity and respect | 93 | 99 | 1 | 193 |
| D04. Privacy | 22 | 20 | 1 | 43 |
| D05. Response to complaints | 58 | 64 | 0 | 122 |
| D06. Retaliation | 5 | 17 | 0 | 22 |
| D07. Visitors | 59 | 34 | 0 | 93 |
| D08. Resident or family council | 3 | 4 | 0 | 7 |
| D09. Other rights and preferences | 29 | 42 | 1 | 72 |
| E. Financial, property | 76 | 104 | 0 | 180 |
| E01. Billing and charges | 22 | 58 | 0 | 80 |
| E02. Personal property | 54 | 46 | 0 | 100 |

| Complaint Category/Type | Nursing Facility | Residential Care Community | Other | Total by Complaint Type |
|---|---|---|---|---|
| F. Care | 573 | 301 | 0 | 874 |
| F01. Accidents and falls | 21 | 16 | 0 | 37 |
| F02. Response to requests for assistance | 111 | 46 | 0 | 157 |
| F03. Care planning | 48 | 45 | 0 | 93 |
| F04. Medications | 72 | 64 | 0 | 136 |
| F05. Personal hygiene | 88 | 38 | 0 | 126 |
| F06. Access to health related services | 25 | 24 | 0 | 49 |
| F07. Symptoms unattended | 58 | 34 | 0 | 92 |
| F08. Incontinence care | 32 | 8 | 0 | 40 |
| F09. Assistive devices or equipment | 60 | 21 | 0 | 81 |
| F10. Rehabilitation services | 57 | 3 | 0 | 60 |
| F11. Physical restraint | 0 | 2 | 0 | 2 |
| F12. Chemical restraint | 1 | 0 | 0 | 1 |
| F13. Infection control | 0 | 0 | 0 | 0 |
| G. Activities and community integration and social services | 53 | 70 | 0 | 123 |
| G01. Activities | 21 | 27 | 0 | 48 |
| G02. Transportation | 4 | 15 | 0 | 19 |
| G03. Conflict resolution | 14 | 20 | 0 | 34 |
| G04. Social services | 14 | 8 | 0 | 22 |
| H. Dietary | 93 | 93 | 1 | 187 |
| H01. Food services | 49 | 60 | 0 | 109 |
| H02. Dining and hydration | 29 | 7 | 0 | 36 |
| H03. Therapeutic or special diet | 15 | 26 | 1 | 42 |
| I. Environment | 74 | 107 | 0 | 181 |
| I01. Environment | 15 | 24 | 0 | 39 |
| I02. Building structure | 2 | 11 | 0 | 13 |
| I03. Supplies, storage and furnishings | 12 | 2 | 0 | 14 |
| I04. Accessibility | 6 | 13 | 0 | 19 |
| I05. Housekeeping, laundry and pest abatement | 39 | 57 | 0 | 96 |
| J. Facility policies, procedures and practices | 102 | 102 | 1 | 205 |
| J01. Administrative oversight | 59 | 61 | 0 | 120 |
| J02. Fiscal management | 8 | 9 | 0 | 17 |
| J03. Staffing | 35 | 32 | 1 | 68 |

| Complaint Category/Type | Nursing Facility | Residential Care Community | Other | Total by Complaint Type |
|---|---|---|---|---|
| K. Complaints about an outside agency (non-facility) | 26 | 16 | 0 | 42 |
| K01. Regulatory system | 2 | 4 | 0 | 6 |
| K02. Medicaid | 15 | 8 | 0 | 23 |
| K03. Managed care | 0 | 2 | 0 | 2 |
| K04. Medicare | 6 | 0 | 0 | 6 |
| K05. Veterans Affairs | 1 | 2 | 0 | 3 |
| K06. Private Insurance | 2 | 0 | 0 | 2 |
| L. System and others (non-facility) | 20 | 54 | 0 | 74 |
| L01. Resident representative or family conflict | 11 | 37 | 0 | 48 |
| L02. Services from outside provider | 4 | 15 | 0 | 19 |
| L03. Request to transition to community setting | 5 | 2 | 0 | 7 |

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## Complaint Examples

| | Nursing Facility Example | Residential Care Community Example | Optional Complaint Example |
|---|---|---|---|
| Facility type | Nursing Facility | Residential Care Community | N/A |
| Description | Resident admitted for rehab from the hospital after hip surgery. After two weeks resident complained to family about unrelenting pain and contacted the Ombuds. Ombuds organized a care conference (the right of every resident to be informed of their car plan and their right to input into that plan). Attending: resident, family, Administrator, Director of Nursing, Director of Rehabilitation, Director of Social Services. Local Ombuds and Assistant State Long-Term Care Ombuds. Discussed: main discussion was about controlling pain and subsequently, the cessation of rehab services due to this problem. Approximately 3 weeks later the facility staff discovered a previously undiagnosed, massive infection deep in the surgical site and resident was readmitted to the hospital. Physician advised resident and family that once the infection was under control another surgery to clean out infection debris and only after that healed (several months) would the resident be eligible for rehabilitation via hip replacement. Resident with the support of his family elected to go home to die rather than trust the system that failed him. He died four weeks later at home under the care of his sons. Resident decided to go home to die rather than trust a system he and his family felt broken | Resident was a 13 year resident of an ALF where he once served as Resident Council President. His family is well known in the small community. At the beginning of the pandemic in early 2020 the resident was involved as he always had, in caring for a small number of cows with whom he shared ownership a few miles from the facility. He needed long term care as a result of a serious closed head injury nearly 2 decades ago. While his care needs had decreased he still needed medication management with support for activities of daily living. He was mask resistant but continued to care for his cows several times a week. At first the facility staff erroneously told him he could not leave the facility as facilities started to “lock down”. The Ombuds who had known Resident for years assisted him in a care conference where he was told he could not leave to manage his cows and asserted the resident’s right to leave the facility. Resident also did not wish to wear a mask as he felt it stifled his breathing, but the facility insisted that he come through the main entrance to the facility rather than directly enter his room which had an outside door. A few days without the legally required notice the facility locked him out of his assisted living apartment and called the police when he tried to reenter. He was not given a discharge notice nor was there a facility identified where he would receive continued care only a hotel room. He worried about his cat who was left in his room at the ALF and he was not provided with his medications which were vital in the treatment of his head injury. The only other Assisted Living Facility in the community refused his admission and his financial guardian located a motor home where he lived for 9 months and sustained a serious fall and jaw injury which required surgery. After more than a year another ALF more than 100 miles of the agreed to admit the resident. He misses his community and caring for his cows and feels justice has eluded him. | N/A |
| Complaint topic | Care | Admission, Transfer, Discharge, Eviction | N/A |
| Complaint type | Symptoms unattended | Discharge or eviction | N/A |
| Verification | Verified | Verified | N/A |
| Disposition | Not 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 | Substandard nursing home care after surgery and lack of prompt response by the regulatory system to a complaint regarding care made by the Office of the Washington State Long-Term Care Ombuds until after Resident died. | Assisted Living regulations in WA poorly regulated and rules that extend Resident Rights in the federal law to all long term care residents not fully enforced and especially evident during the pandemic…an example of how disaster preparedness exposed the need for regulatory reform to protect those most highly vulnerable among us. | N/A |

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## System Issues

| | System Issue 1 | System Issue 2 | System Issue 3 *(Optional)* |
|---|---|---|---|
| System issue topic | C - Admission, Transfer, Discharge, Eviction | B - Access to Information | N/A |
| Problem description | During the first year of the pandemic Residents Rights were waived and compliance weakened in licensed long-term care settings. Some of the waivers were granted by federal entities and others by state executive leadership. The purpose of the waivers were to give health and long-term care providers greater ability to respond to the rapidly changing environment and challenges derived from the covid crisis. The intention was to protect the public, residents, staff and utilize well limited resource. One specific waiver for nursing homes (federal guidance) and for residential care (state oversight) was notification of discharges and transfers and notifications of discharges and transfer related to COVID.<br><br>Washington State law for Admission, Transfer and Discharge comports with federal residents rights and CMS laws for discharges in nursing homes. Over two decades ago, the Washington State legislature extended residents rights to residential care settings i.e. adult family homes and assisted living facilities. However, the right to appeal a discharge was not extended to assisted living and adult family homes. Without the right to appeal, residential care residents under Medicaid waiver for nursing home care, were denied the right to appeal their discharge to an administrative law judge (ALJ). Whereas nursing home residents were given appeal rights to a hearing with an ALJ. Coupled with the pandemic, and the lack of eviction protections, residents of HCBS settings were left to rely on the state's unlawful detainer law to address evictions by residential care providers.<br><br>The problem for residents who live in assisted living and similar settings is that the unlawful detainer process is not well understood. It requires the resident to appear in court before a judge within 10 days of being served a notice. For a vulnerable adult this requirement is a significant burden on them. At least a quarter of residential care residents and as high as half of all adult family home residents are Medicaid beneficiaries in this state. They have little to no financial resources to hire a lawyer. Legal aid services are also very limited and difficult to access in a timely manner. Nursing home residents are given the ability to appeal and participate in a hearing by telephone in the comfort of their home. They do not need to hire an attorney as the hearing is much less formal than the unlawful detainer process. There is less burden placed on the vulnerable adult. In an ALJ hearing the resident is often given at least 30 days to appeal and more time for the hearing date. This allows the resident to gather information to present to the official, and seek assistance from legal aid, the long-term care ombudsman program and/or the state protection and advocacy agency. We have found that providers also do not well understand the "Eviction" process or unlawful detainer process and they skip the process all together. Going to court is an expensive process for the provider as well. | The pandemic has interrupted operations in long-term care facility by requiring staff to focus on infection control issues. Policies that waived residents to all facilities to operate quickly and responsively to COVID put the rights of residents on the back burner. As time progressed during the pandemic, licensed long term found increasing difficult to adequately staff and meet residents' needs. One of the most common complaints received during the pandemic was the lack of connection between facilities and residents and resident family members. A specific complaint we received from residents, residents' family and friends, state agencies and medical providers was that many long-term care facilities would not answer their telephones, or respond to voice mail messages and email. We received numerous complaints from residents that they were not allowed to use the phone in the building, phone hand sets were not working or missing, or the phone was never provided to residents when requested. Medical providers complained that they were not able to reach clinical staff in the facilities causing delays in medication changes, failed coordinated care, and a lack of follow up or monitoring on doctor ordered therapies and treatments. Ombudsmen also expressed concern that they were not able to reach facility staff or administrators for complaint investigation and resolution. It was understandable that in the earliest days of the pandemic that response to calls and emails would be delayed. But nearly a year into the pandemic, the number of complaints on communication were higher than expected. | N/A |
| Barriers description | The overarching barrier to resolving the issue of lack of discharge appeal process for residential care residents is the willingness and cooperation of three key entities: 1) licensed long term care providers 2)the state unit on aging and the 3)state court system (The Office of Administrative Hearings (OAH). | During the pandemic the communication concerns and failures had real outcomes. Lack of information heightened anxiety for residents and their families. Visitation was restricted leaving residents feeling "alone and isolated". Families and friends lost contact with their loved one leaving them to speculate what was happening in the care facility and if their loved one was safe. In one complaint, the family attribute the inability to see and talk to their loved one who as admitted during the pandemic into a nursing home to their death. Attempts to reach staff were many, yet very little information was shared with them. Another family complained that the facility would not take the time to facilitate the use of a phone or iPad for their loved one who had series mobility and communication limitations. The facility would not allow hospice services in the building and it was the hospice social worker and nurse who would often help the resident with the telephone and facilitate using the iPad twice a week. Once the hospice service was "kicked out" (illegally) all communication stopped and the resident was left without their family's monitoring, and real functional daily assistance. The facility expressed that they didn't have enough staff to help with these needs. The issue was the demands of the pandemic and the willingness of some providers and owners to make the investments in facilitating communication. For some providers the explanation that problem is lack of Medicaid funding reimbursement. For others they attributed the problem to staff were needed to attend to residents and dealing with COVID. | N/A |
| Issue status | Fully or Partially Resolved including issues that are newly reported or an ongoing issue from last year. | Newly identified in this reporting year and not fully resolved. | N/A |
| Affected setting | Residential Care Community | Nursing Facility<br>Residential Care Community | N/A |
| Resolution strategies | Recommended changes to laws, regulations, policies or actions through written or oral testimony.<br>Provided leadership or participated on a task force<br>Provided information to the media<br>Developed and disseminated information<br>Legal action where an Ombudsman program initiates legal action | Provided information to public or private agency<br>Provided Information to legislator or legislative staff<br>Provided information to the media | N/A |
| Resolution description | We approached a well-respected elder law professor in the community who operates a legal studies clinic at local private law school. Together with the LTCOP attorney, the professor, her law students, two assisted living residents and the State LTCO developed analysis of existing laws on residents' rights and appeals, complaints about involuntary discharges and the state response system to these discharges. The first year of work focused on understanding the laws, and why there were no appeal rights for residential care residents. A strategy was developed based on the law students' research and recommendations. Over several years, draft petitions for rulemaking for full discharge rights were prepared by the students and their professor. LTCOP provided further analysis, review and feedback on the petition, and participated in communicating the issue to others. Strategies were modified as information was sought from policymakers at the state level, from other elder law attorneys, OAH administrative law judges, and from provider membership organizations. This activity took several years and partially delayed because of the pandemic. But towards the end of FFY 2021, it was clear given the pandemic we need to get this project completed. At the time of this report, the final petition has been drafted and key decision makers are aware that the petition will be submitted soon. We will report on the conclusion in FFY 2022. | State LTCOP worked with a state legislator on a comprehensive state bill to address some of the more immediate concerns brought on by the pandemic. Our focus was eliminating isolation of residents, address violations in some resident rights and better prepare for the next pandemic while addressing some emergency concerns sooner than later through review of existing response and planning. The bill passed during the 2021 state legislative session. HB 1218 included a provision to require long-term care facilities to assist residents with communications, provide an adequate number of functional telephone equipment for resident use, and respond to email messages and phone calls in a timely reasonable manner. Rules for this new statute have yet to be written for licensing inspectors and complaint investigators. We have yet to understand the impact of the new law. Recently we did see a citation issued on a facility's lack of responsiveness to phone calls issued by the state licensing entity.<br><br>There are other parts of this new law that address isolation. Implementation of a new state Resident Right which is the right for a resident to designate someone to be their essential support person.<br><br>At this time, we believe the new law addresses only part of the presenting problem. Education about the new law, rule-making and implementation are parts of a systemic solution yet to be addressed and fully actualized. A decrease in Covid transmission and cases in and out of licensed long term is also part of the solution to remedy the problem of poor communication in long-term care facilities. | N/A |

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## 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 |

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# 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) :<br>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.<br>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.<br>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.<br>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. |

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# Staff and Volunteers

**Office of State Ombudsman Staff**

| | |
|---|---|
| Total staff | 14 |
| Total full-time equivalent (FTE) | 14 |
| Total state volunteer representatives | 43 |
| Total hours donated by state volunteers representatives | 3,457 Hours |
| Total other volunteers (not representatives) | 26 |

**Local Ombudsman Entity Staff**

| | |
|---|---|
| Total staff | 18 |
| Total full-time equivalent (FTE) | 11 |
| Total local volunteer representatives | 120 |
| Total hours donated by local volunteer representatives | 9,593 Hours |
| Total local volunteers (not representatives) | 78 |

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# Funds Expended

**Funds Expended from OAA Sources**

| | |
|---|---|
| Federal - OAA Title VII, Chapter 2, Ombudsman | $473,039 |
| Federal - OAA Title VII, Chapter 3 | $59,800 |
| OAA Title III - State level | $157,306 |
| OAA Title III - AAA level | $73,430 |
| **Other Federal Sources** | |
| There are no other Federal sources | |
| Total other Federal funds expended | $346,567 |
| **Other State Sources** | |
| There are no other State sources | |
| Total other State funds expended | $1,867,566 |
| **Other Local Sources** | |
| There are no other Local sources | |
| Total other Local funds expended | $239,724 |

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# Facility - Number and Capacity

**Licensed Nursing Facilities**

| | |
|---|---|
| Total number | 213 |
| Total resident capacity | 19986 |

**Residential Care Communities**

| | |
|---|---|
| Total number | 3756 |
| Total resident capacity | 54005 |

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## 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).<br>•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.<br>•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.<br><br>•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.<br>•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.<br>•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.<br>•A licensed AFH is generally at a residential home address.<br>•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:<br>oSeparate staffing;<br>oSeparate call systems;<br>oSeparate living quarters;<br>oSeparate addresses;<br>oEither a fire wall or floor separating the two units; and<br>oNo internal door in common.<br>The following is a partial list of some things the provider must do.<br>•Know and comply with all AFH applicable laws and rules;<br>•Meet the assessed care needs and preferences for each resident which may include, but is not limited to:<br>oAssisting with personal hygiene, dressing, bathing, toileting, body care, walking and moving from one spot to another,<br>oProviding nutritious meals,<br>oOffering activities other than television,<br>oProviding medication assistance or administration, and<br>oProviding supervision to residents with challenging behaviors or at risk of falls;<br>•Be responsible for the care and services provided to residents 24 hours a day whether the provider is on site or not;<br>•Screen and hire responsible, dependable and qualified staff members;<br>•Ensure that staffing is adequate to meet all resident needs at all times (24 hours a day, seven days a week);<br>•Provide staff orientation and ongoing staff support and training;<br>•Maintain adult family home records such as individual resident records, staffing records, accounting, income tax and payroll records; and<br>•Ensure that each resident is protected from abandonment, verbal, sexual, physical, and mental abuse, exploitation and financial exploitation, neglect, and involuntary 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.<br>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.<br>In order to serve ESF residents, provider must be a licensed ESF provider and be contracted with the Home and Community Services (HCS) Division.<br>Successful ESF applicants will have experience providing personal care to Medicaid clients with highly complex personal care and behavioral challenges<br>• The Contractor must have a current Enhanced Services Facility (ESF) license.<br>• 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.<br>• The Contractor must have a demonstrated ability to provide (or arrange) for all required staff trainings<br>•One toilet and handwashing sink for every four residents;<br>•At least one bathing unit for every four residents;<br>•Access to at least one bathing device for immersion; and<br>•Access to at least one roll-in shower on each resident care unit. | | |

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## 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 | 15094 |
| Community education | 50 |

**Ombudsman Program Activities - Facilities**

| Activity | Nursing Facility | Residential Care Community |
|---|---|---|
| Training sessions for facility staff | 4 | 30 |
| Information and assistance to staff | 1148 | 2987 |
| Number of facilities that received one or more visits | 135 | 961 |
| Number of visits for all facilities | 1096 | 4047 |
| Number of facilities that received routine access | 63 | 125 |
| Total participation in facility survey | 16 | 54 |
| Resident council participation | 88 | 143 |
| Family council participation | 4 | 19 |

**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.**

Stay Connected Technology Campaign- started October 30, 2020 and Completed October 1, 2021. Technology for adult family homes across Washington State. Campaign started last year and noted in last report. Partnership lead by State LTC Ombudsman Program. Purchased and delivered a little over 1060 Amazon tablets to adult family homes for resident use. Program funded by private donations and State civil monetary funds ($99,900 grant to LTCOP). Partners included the State Unit on Aging and the Adult Family Home Association of Washington and regional (local) LTC programs.

Dementia Action Collaborative- State subcommittee work on long-term reported in last annual report and continues. Ltc ombuds providing leadership in development of statewide survey focusing on consumers who currently use Alzheimer's specific facilities or seeking Alzheimer's specific facilities. Partners are many including: Provider Associations, Alzheimer's Association, State Unite on Aging, individual licensed care facility operators, community consultants and advocates. Meets quarterly and monthly.

Quarterly meetings with Elder Abuse prosecutors and the State of Washington Medicaid Fraud Unit (MFCU) to discuss trends in concerns for licensed long-term, updates on criminal and legal cases by MFCU or other regional prosecutors. Discussion about new cases. Purpose is to coordinate across the state. Not lead by the LTC Ombudsman. Convened by MFCU. Members also include county prosecutors, and the State Assistant Attorney General representing client for the State Unit on Aging facility oversight and licensing entity.