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Case and Complaints Summary

Total number of cases closed: **1268**

Totals Cases per Complainant by Facility Setting

Complainant	Nursing Facility	Residential Care Community	Other	Total per complainant
Resident	303	357	0	660
Resident representative, friend, family	173	206	2	381
Ombudsman program	28	12	0	40
Facility staff	38	44	0	82
Representative of other agency or program	22	37	2	61
Concerned person	3	8	0	11
Resident or family council	7	2	0	9
Unknown	9	15	0	24
Total per facility type	**583**	**681**	**4**	**1268**

Total number of complaints: **2626**

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	28	54	0	82
B. Access to Information	28	28	0	56
C. Admission, transfer, discharge, eviction	122	118	0	240
D. Autonomy, choice, rights	275	355	1	631
E. Financial, property	69	103	0	172
F. Care	445	296	2	743
G. Activities and community integration and social services	47	58	0	105
H. Dietary	66	109	0	175
I. Environment	58	107	0	165
J. Facility policies, procedures and practices	60	93	0	153
K. Complaints about an outside agency (non-facility)	14	12	1	27
L. System and others (non-facility)	22	54	1	77

Complaint Verifications

Verification Status	Nursing Facility	Residential Care Community	Other	Total
Verified	1103	1207	5	2315
Not Verified	131	180	0	311

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	986	955	5	1946
Withdrawn or no action needed by the resident, resident representative or complainant	116	191	0	307
Not resolved to the satisfaction of the resident, resident representative or complainant	132	241	0	373

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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	28	54	0	82
A01. Abuse: physical	4	10	0	14
A02. Abuse: sexual	2	5	0	7
A03. Abuse: psychological	4	21	0	25
A04. Financial exploitation	7	9	0	16
A05. Gross neglect	11	9	0	20
B. Access to Information	28	28	0	56
B01. Access to information and records	20	20	0	40
B02. Language and communication barrier	2	3	0	5
B03. Willful interference	6	5	0	11
C. Admission, transfer, discharge, eviction	122	118	0	240
C01. Admission	4	9	0	13
C02. Appeal process	9	3	0	12
C03. Discharge or eviction	94	91	0	185
C04. Room issues	15	15	0	30
D. Autonomy, choice, rights	275	355	1	631
D01. Choice in health care	13	16	1	30
D02. Live in less restrictive setting	31	33	0	64
D03. Dignity and respect	90	102	0	192
D04. Privacy	13	17	0	30
D05. Response to complaints	48	68	0	116
D06. Retaliation	4	14	0	18
D07. Visitors	38	42	0	80
D08. Resident or family council	2	3	0	5
D09. Other rights and preferences	36	60	0	96
E. Financial, property	69	103	0	172
E01. Billing and charges	24	65	0	89
E02. Personal property	45	38	0	83

Complaint Category/Type	Nursing Facility	Residential Care Community	Other	Total by Complaint Type
F. Care	445	296	2	743
F01. Accidents and falls	16	11	0	27
F02. Response to requests for assistance	91	54	0	145
F03. Care planning	42	36	2	80
F04. Medications	52	68	0	120
F05. Personal hygiene	59	41	0	100
F06. Access to health related services	31	16	0	47
F07. Symptoms unattended	48	20	0	68
F08. Incontinence care	16	14	0	30
F09. Assistive devices or equipment	44	24	0	68
F10. Rehabilitation services	45	6	0	51
F11. Physical restraint	0	1	0	1
F12. Chemical restraint	0	0	0	0
F13. Infection control	1	5	0	6
G. Activities and community integration and social services	47	58	0	105
G01. Activities	16	24	0	40
G02. Transportation	2	12	0	14
G03. Conflict resolution	7	16	0	23
G04. Social services	22	6	0	28
H. Dietary	66	109	0	175
H01. Food services	37	58	0	95
H02. Dining and hydration	11	17	0	28
H03. Therapeutic or special diet	18	34	0	52
I. Environment	58	107	0	165
I01. Environment	17	34	0	51
I02. Building structure	0	13	0	13
I03. Supplies, storage and furnishings	8	9	0	17
I04. Accessibility	7	6	0	13
I05. Housekeeping, laundry and pest abatement	26	45	0	71
J. Facility policies, procedures and practices	60	93	0	153
J01. Administrative oversight	30	45	0	75
J02. Fiscal management	0	7	0	7
J03. Staffing	30	41	0	71

Complaint Category/Type	Nursing Facility	Residential Care Community	Other	Total by Complaint Type
K. Complaints about an outside agency (non-facility)	14	12	1	27
K01. Regulatory system	1	1	0	2
K02. Medicaid	4	7	1	12
K03. Managed care	2	2	0	4
K04. Medicare	5	0	0	5
K05. Veterans Affairs	1	0	0	1
K06. Private Insurance	1	2	0	3
L. System and others (non-facility)	22	54	1	77
L01. Resident representative or family conflict	11	38	0	49
L02. Services from outside provider	8	12	1	21
L03. Request to transition to community setting	3	4	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	This complaint centers on several complaints from a resident's family member who has durable power of attorney and expressed complaints about poor care and facility management. Her loved one was admitted into the nursing home early in the COVID pandemic. She alleges eight complaints related to deficits and concerns about care planning, choices in health care, therapeutic special diet (stomach feeding tube), Poor facility staffing, gross neglect, willful interference, unattended symptoms, and issues with administrative judgment and oversight. The ombudsman was able to investigate the complaints and verify some but not all of the allegations. Although he did not substantiate gross neglect, he found problems with poor communication between the facility provider and medical professionals. The resident was repeatedly sent to the ER for care with her feeding tube placing her at risk for transmitting COVID. The resident was sent to the ER for a clogged feeding tube and was hospitalized for pneumonia, and SEPSIS and placed on a ventilator. When she improved, she was able to breathe on her own but went into kidney failure requiring dialysis. The family complained that the facility failed to answer phone calls, and the facility's voicemail system remained full. They believed the facility had poor and inadequate staffing levels. The ombudsman provided education and information to the resident's family about nursing home oversight and complaint reporting. They agreed to have the ombudsman submit a complaint about poor communication to the oversight licensing entity.	This is a case of a complaint involving a patient in a hospital who was admitted from an adult family home and refused transfer back by the facility. The complaint comes from the hospital social worker/discharge planner to the long-term care ombudsman looking for assistance with advocacy to get the resident back to her home of four years. This is not an unusual occurrence where a facility has transferred a resident to an ER or acute care setting planned or not, and then refuse readmission for a variety of legal and illegal reasons. The majority of residents transferred to an acute care setting are readmitted or transferred back to their former home. Some are not transfered back because their care needs exceed the abilities of the facility. A change in condition such as a cardiovascular incident, or a fall resulting in injury may mean a temporary or permanent discharge from the facility, with a direct transfer from the acute care setting to a higher level of care- such as a nursing facility. However, there are too many incidents where a facility will not take the resident back for unlawful reasons- for instance, personality clashes between the provider, caregiver, resident, and resident family member. Or in this case where the facility requests more in Medicaid reimbursement and essentially withholds readmission until the State Medicaid Program agrees or negotiates terms. Seven days in the hospital to finally come to terms places the resident at risk for harm such as transmitting COVID and the stress it causes for fear of not being able to return to one's home. The provider is in a position of power where they might be able to get what they say they need to care for the person. The financial cost is high and a possible needed bed by the hospital is occupied. In this case, should the resident have been refused transfer back to their adult family home (a HCBS setting) the state oversight entity and State Unit on Aging does not believe the resident has right to an appeal to the State Medicaid Agency- Office of Administrative Hearings. However, for over a decade the OAH has been allowing discharge appeal hearings, and in cases where a judge denied a hearing, the higher review judge board has overturned the denial. The State lacks regulations on these hearing rights- a systems issue that the LTCOP, elderlaw attorneys and several aging organizations are trying to address through a petition process to the State Unit on Aging and the State Agency- Department of Health and Social Services.	N/A
Complaint topic	Care	Admission, Transfer, Discharge, Eviction	N/A
Complaint type	Care planning	Discharge or eviction	N/A
Verification	Verified	Verified	N/A
Disposition	Not resolved to the satisfaction of the resident, resident representative or complainant	Partially or fully resolved to the satisfaction of the resident, resident representative or complainant	N/A
Disposition narrative	The long-term care ombuds referred the case to an outside agency- state licensing- to investigate the complaint of poor communication. The facility was alleged to not respond to medical professional phone calls about treatment causing the serious illness of the resident. Unfortunately, the resident passed away before these issues were resolved. The family stated that they would pursue legal counsel about a private lawsuit.	The long-term care ombudsman was contacted by the hospital social worker about the resident's wishes to return to her home- a six-resident private home licensed as an adult family home. The ombudsman was informed that upon placing the call to the LTCOP, the AFH provider had "rolled back" their position. The resident is a Medicaid recipient. The facility did not issue a written discharge notice as required under state Resident's Rights laws and adult family home licensing requirements. The basis of the refusal for transfer/readmission is the AFH provider states that they need more Medicaid reimbursement to hire more staff to care for the resident. The home is required to have at least one direct care staff for six residents and is required to meet the needs according to each resident's negotiated care plan and comport with licensing laws. The resident is bariatric and requires a Hoyer lift. The state agency that assesses and approves care levels (reimbursement rates) refuses to adjust the payment rate. The facility has previously requested $300 more per day and been refused by the state per the hospital social worker. State licensing oversight entity was called because the facility failed to provide written notice of discharge. The resident has been growing weaker over time and the AFH states that they are not able to meet her needs in a safe manner. The resident was reassessed while in the hospital and the state, Medicaid evaluator recognized the resident had more needs, and agree to an increase in reimbursement to the home of an additional $60 per day. The resident was returned to the home on the 7th day in the hospital.	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	D - Autonomy, Choice, Rights	L - System and Others (non-facility)
Problem description	No discharge appeal rights are promulgated through rules for residents receiving care services in residential care communities (HCBS settings). Washington State offers robust community-based options for Medicaid beneficiaries but does not offer Medicaid residents discharge appeal rights. They do offer some discharge rights similar to those given to nursing home residents such as reasonable accommodation prior to discharge, a 30-day notice in writing with a few exceptions, and six lawful reasons to discharge. The rule also requires the facility to name a "location" as to where the resident will move to. Location does not mean a specific name of a facility or address, but it is defined as a "type" of settings or location. This means a resident could be discharged to an assisted living facility, but at the time of discharge notice not know which assisted living or the geographic location. No rules have been established in Washington's administrative code addressing HCBS setting about discharge appeals. For the past decade, Washington's Medicaid agency has ruled allowing assisted living and adult family residents hearing rights to hear their appeals, and in some cases ruled in favor of residents. Without discharge appeal rules, some residents are receiving hearings, but most others are not aware that they can file an appeal. The same for licensed providers- some know that residents are filing appeals and the courts are accepting the appeals, and others do not. Consumers and providers are not knowledgeable about appeals. This has an unfair impact on residents on their families who are already dealing with systemic racial and financial disparities in health and long-term care. It might be an equity issue as well. Those who have access to an attorney, or an ombudsman may receive the support and knowledge needed to appeal a discharge. But many others do not have this information or access to legal or advocacy resources. There is also uncertainty about if the state's unlawful detainer process (similar to an eviction) process is being used by providers as there's a lack of awareness of this court process. In Washington State, long-term care residents are not covered under Landlord Tenant Laws but landlords can use the unlawful detainer court process to remove long-term care residents.	During the pandemic, the restriction of visitation was a common practice to prevent the transmission of COVID-19. By late spring/early summer of 2021, vaccinations were available to all age groups and some of the policies about quarantine and isolation were changing as well as some infection control protocols and restrictions. This caused residents distress, including mental health and behavioral health issues, loneliness, changes in cognition, and declines in functional abilities. As the infection changed, transmission decreased and more and more residents were vaccinated, visitations were still being restricted. The prior fiscal year the LTCOP worked with state legislators and stakeholders to establish a law allowing residents to have an essential support person of their choosing during emergency situations where residents were restricted access to visitors. The law though enacted was new and needed time to be implemented including the creation of rules.	CARES ACT FUNDS: Due to COVID, there were multiple impacts on the program and long-term care system including communication, access to residents and facilities, and impacts upon volunteers and staff especially around infection control and prevention. COVID funds were needed to respond to new problems and changes to systems due to the pandemic.
Barriers description	The State Unit of Aging believes it lacks rulemaking authority and requires the state legislature to give them statutory authority to write them. Advocates and other legal experts believe the state agency has the authority to write rules for discharge appeal rights. However, the state's Medicaid agency review board has found in favor of assisted living and adult family home residents having appeal rights. When there is opposition to this right to hearing, this is an exhaustive and expensive exercise.	Barriers to implementing the essential person law and opening up visitations are fear of transmission of COVID 19.	The inability to reach residents, staff/providers, and resident families during COVID due to visitation restrictions and safety concerns caused the program to lose connection to some residents. We also saw a significant loss in volunteerism as many volunteers are age 60 plus and have health conditions placing them at higher risk for serious illness or hospitalization related to COVID. We had to develop new ways to reach residents, support staff, and program volunteers, switching priorities and strategies to deal with the limitations and impacts in multiple systems. At the same time supply shortages, the slowdown in the economy, inflation, and workforce issues also have significant impacts on the program. Some of the things we did with the funding: 1. Hired a communications consultant to handle mostly external communications with media and others who wanted to speak to the State LTCOP, to educate the public, reports, and decision-makers about the impact of the pandemic from testing, prevalence in long-term care, challenges, care issues, restrictions on visitation, negative impacts upon residents in isolation. Communications consultant trained State staff, long-term care ombudsmen staff and volunteers about how to share public messages, and working with media. The consultant continues to assist us with media focusing during the last 18 months on promoting the program increasing awareness about LTCOP because much information about resident rights and the LTCOP have been lost during the pandemic. The consultant met with our resident advisory council (residents from longterm care) to the State LTCOP, providing skills training to resident members. She answered their questions about advocacy and how to speak to media resulting in written stories and opinion pieces highlighting the impacts of the pandemic upon residents and their families. 2. We also hired an education/communications coordinated who focused on internal and external training and information sharing for the benefit of ombudsmen and residents. Examples such as paid speakers focusing on trauma-informed care, self-care, resilience during recovery, quarterly state-run training, and meetings statewide. The coordinator set up statewide Zoom meetings about infection control/COVID, training and information about COVID vaccinations, testing, treatments, and infection prevention for staff and volunteers. The coordinator was also responsible for updating our website and doing a major renovation of our ten-year-old website. We also started a podcast focusing on topics of interest to residents, families, and the public title "Please Knock Before Entering". This podcast still exists today and we are still utilizing the coordinator person at a reduced number of hours per week (20 hours now versus full time last report). This position helped to create the Resident Advisory Council which included recruitment, screening applicants through interviews, setting up technology meetings, providing training and information to members, and helping members organize and set up meeting agendas. The coordinator facilitated meetings held one to three times a month, responded to member questions, and helped to keep members moving forward in their goals. She provided ongoing support to them and still does today. 3. Some of the local regionals used CARES ACT funding to purchase technology to support staff and volunteers' work. Because visitations were limited at varying levels throughout the pandemic, local ombuds purchased "grand pads" "I pad" and other handheld devices to hold meetings with residents, providers, and their families. 4. CARES ACT funding was used to purchase rapid antigen test kits that were sent to local programs. We also used the funding to replenish our PPE and cleaning supplies inventories at the state and local levels- medical masks, face shields, and sanitation wipes.
Issue status	Ongoing issue from last fiscal year	Ongoing issue from last fiscal year	Fully or Partially Resolved including issues that are newly reported or an ongoing issue from last year.
Affected setting	Nursing Facility Residential Care Community	Nursing Facility Residential Care Community	Not specific to a setting

Resolution strategies	Provided information to public or private agency Recommended changes to laws, regulations, policies or actions through written or oral testimony. Provided leadership or participated on a task force 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 leadership or participated on a task force	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
Resolution description	The issue is not yet resolved. The LTCOP and the LTCOP attorney worked with legal experts on strategies and a petition to the state agency requesting rulemaking. At the time of this report, the petition was denied by the State Unit on Aging (DSHS) and the state LTCOP has filed an appeal with the Governor's office. The results of the appeal will be reported in FFY 2023.	This is an ongoing issue that will take time. It is not clear that rules were required but the state unit chose to create a workgroup to create rules for the ESP. LTCOP participated in stakeholder workgroup over the last year. LTCOP referred residents to participate in the workgroup to provide their perspectives and insights. The LTCOP will need to provide education and training to providers, consumers, and the public about the ESP right.	Hiring these two individuals (communications consultant and staff coordinator) was successful in addressing barriers caused by the pandemic. We have decreased the hours of the staff coordinator as of August 2022 from full-time to part-time. We were able to secure grant funding to help pay for a facilitator to support the Resident Advisory Council which continues to inform the State ombuds on issues in long-term care settings, and give voice to those we serve on a higher platform to impact policies and laws, and inform the public in general. The purchase of Ipads and handheld devices was not 100 percent successful during the "lockdown" period of the pandemic. The physical logistics and some staff (facility), residents, and volunteer ombuds had technology struggles. One example is in rural areas that don't have broadband, the use of some tablets reliant on an internet connection wouldn't work. Because we moved to a "virtual-based" communication for monthly training and meetings with staff and volunteers- it did help in that way. We also have kept on board our contracted communications consultant in helping us with recruiting volunteers, and helping with advocacy, and informing the public about long-term care issues in our state.

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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	5
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	11

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Organizational Conflicts of Interest

Conflict of Interest Type	Location	Remedy
Other: The local host entity to the Eastern Washington LTCOP (Spokane Neighborhood Action Program or SNAP) provides small business loans to a licensed long-term care facility. Possible conflict or appearance of a conflict. The local entity is a community action program dedicated to ending poverty in communities. One of the new services they offer is loans for small businesses.	Local	The placement of the loan service is far removed from the local LTCOP in the organizational structure. The local entity with the State LCOP developed a policy to remedy the appearance of a conflict or real conflict. The supervisor of the LTCOP will be provided with a list of Adult Family Homes that have loans with SNAP. Should there be a complaint at a home, the state LTCOP will be notified to handle the complaint or assign a designee to avoid any potential conflicts or interference. The local entity, SNAP, will follow LTCOP policies and procedures.

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Staff and Volunteers

Office of State Ombudsman Staff

Total staff	4	
Total full-time equivalent (FTE)	4	
Total state volunteer representatives	0	
Total hours donated by state volunteers representatives	0	Hours
Total other volunteers (not representatives)	18	

Local Ombudsman Entity Staff

Total staff	22	
Total full-time equivalent (FTE)	19	
Total local volunteer representatives	141	
Total hours donated by local volunteer representatives	16,925	Hours
Total local volunteers (not representatives)	110	

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Funds Expended

Funds Expended from OAA Sources

Federal - OAA Title VII, Chapter 2, Ombudsman	$398,920
Federal - OAA Title VII, Chapter 3	$39,251
OAA Title III - State level	$39,003
OAA Title III - AAA level	$30,624
Other Federal Sources	
There are no other Federal sources	
Total other Federal funds expended	$271,091
Other State Sources	
There are no other State sources	
Total other State funds expended	$2,084,057
Other Local Sources	
There are no other Local sources	
Total other Local funds expended	$317,053

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Facility - Number and Capacity

Licensed Nursing Facilities

Total number	206
Total resident capacity	20236

Residential Care Communities

Total number	4028
Total resident capacity	59446

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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). •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 licensed 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.		

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Program Activities

Certifications and Training

Certification training hours	36	Hours
Training hours required to maintain certification	18	Hours
Number of new individuals completing certification training	73	

Ombudsman Program Activities

Information and assistance to individuals	18557
Community education	245

Ombudsman Program Activities - Facilities

Activity	Nursing Facility	Residential Care Community
Training sessions for facility staff	5	2
Information and assistance to staff	1420	3637
Number of facilities that received one or more visits	154	1017
Number of visits for all facilities	1884	5397
Number of facilities that received routine access	26	169
Total participation in facility survey	37	20
Resident council participation	126	174
Family council participation	1	9

State and Local Level Coordination Activities

Area agency on aging programs, Adult protective services programs, Protection and advocacy systems, Facility and long-term care provider licensure and certification programs, The State Medicaid fraud control unit, State and local law enforcement agencies, Courts of competent jurisdiction, The State legal assistance developer and legal assistance programs

Other Coordination Activities: Department of Health, Local Health Jurisdiction and Public Health entities, State Developmental Disabilities Ombudsman Program

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

The state LTCOP and regional or local LTCOPs met at least weekly with multiple stakeholders around COVID-19. The State LTCOP meets weekly with Long-term care stakeholders convened by the State Unit on Aging to coordinate COVID response and prevention- to share information and coordinate with providers, and infection control experts from state and local agencies. Vaccination and treatment distribution and outreach to the public were often coordinated through these meetings on state and local/county levels. Coordination and promotion of COVID-19 vaccinations. One example includes the LTCOP working with local health jurisdictions, the Department of Health, and adult family homes in several counties to inform providers about the availability of traveling vaccination teams.

State LTCOP staff served on two stakeholder workgroups related to HB 1218 law for essential support persons; information and training. State LTCOP meets quarterly with all MFCU attorneys, prosecutors, and state licensing entities for information sharing and communication relevant to the quality of care, life for residents, abuse/neglect response system, and issues or barriers. State LTCOP meets quarterly with the head of State MFCU and the head of state's licensing entity to coordinate, inform and collaborate on policy issues related to systems, abuse/neglect response, updates, and interpretations of laws. Regional programs meet quarterly with the head of regional licensing administrators to coordinate issues related to licensing, provide updates on LTCOP/State licensing and problem-solve any issues related to coordination, and quality of service to mutual clients.

Regional LTC Ombuds convene and lead local advisory council meetings (held monthly) that include a variety of LTCP stakeholders. Examples of members may be the local adult protective services office, consumers, specialists in dementia, mental health, and developmental disabilities, and long-term care facility representatives. The purpose of the meetings is to engage local stakeholders and constituents in the quality of LTCOP services by sharing information, providing feedback and suggestions for the local program and acting as a resource for the program such as providing expert subject matter training for volunteers.

The State LTCOP coordinated with the regional long-term care ombuds to recruit residents to volunteer on the state Resident advisory council. Meetings were led and convened by the State LTCOP and held at least once a month. Key leaders are invited to speak to the group to exchange information, and learn resident perspectives- one example is the Governor's Health Policy Advisor was invited to attend to hear from residents about their concerns regarding visitations, workforce shortages, and other quality of life issues in long-term care.