Appendix D

Ombudsman Work on Individual Complaints
Descriptions from the FY 1998 State Reports

(The names of residents have been changed to protect their confidentiality.)

Colorado

1 Improper use of restraint

Over a period of several months, the ombudsman had several multiple contacts with the wife of a male resident in nursing home due to care concerns. The resident is a 55 year old man, who has lived in the facility for over a year due to a severe brain injury. Due to his injury, he exhibits aggressive behaviors which may be directed towards other residents and staff. On two occasions, the ombudsman and wife of resident met with the staff to discuss care concerns and his ongoing care plan needs. On both occasions the facility stated that the only restraint used would be a quick-release seat belt in wheelchair. There had been a soft-waist restraint used in his recliner, but this was no longer considered safe and appropriate.

The facility continued to use the soft-waist restraint, and about 12 days after the resident's care plan meeting, the resident was found in his recliner during the night with the restraint around his neck. The resident's neck was reddened from the incident. Both the Director of Nursing and Administrator stated that they did not know how this had occurred since they had eliminated this type of restraint from the facility and their own policy prohibits restraint use during the night

The ombudsman made a referral to the state health department for investigation. The incident with the restraint occurred about a week before their annual survey for this facility. The survey team included this resident in their "sample". After reviewing his situation, the survey team did write a deficiency regarding resident assessment and use of appropriate restraints. The facility is attempting to assure this resident's safety, however, there doesn't seem to be any good solutions. At the present time the resident spends his time either laying in a bean bag chair, laying in bed (which is a mattress on the floor), or in his wheelchair with a restraint. His room is entirely covered with mats.

#2 Improper Notice of Involuntary Discharge

At a meeting with the wife of a resident, ombudsman and administrator - the wife was given a letter stating that it was to serve as a five day notice that the facility was discharging her husband. The reason stated for discharge was to ensure the safety of other residents and staff since the resident had been physically aggressive on numerous occasions. The regulations require that a 30 day notice be given, unless in an emergency, " as soon as practicable before the discharge or transfer."

The wife of the resident did appeal the discharge. The facility requested that the appeal go directly to the state health department. The first two steps of an appeal process involve staff from the facility, and they stated that since staff had been involved in the original discharge decision, they would be unable to be objective in evaluating the appeal. The State Health Department did investigate. The state health department determined that the facility could not involuntary discharge the resident. They stated several concerns from their investigation: (1) the actual written notice was incomplete, (2) the facility was considering it an "emergency" and only giving 5 days notice, (3) the facility failed to go through the proper steps of an appeal, (4) there wasn't enough evidence in the documentation that thorough assessments and interventions were attempted to address the resident's behavioral needs, and (5) the resident's physical condition had changed significantly and the reasons for discharge were no longer valid.

District of Columbia — Inadequate Personal Needs Allowance

The ombudsman received complaints from residents of board and care homes that they simply did not have enough money to buy necessities such as clothing, stamps, bus fare and soap to pay their share of the Medicaid co-payment for their medication and their medical care. Over 1800 residents living in board and care homes were experiencing the same problem. The majority are elderly, have chronic mental illness or developmental disabilities. Most of these residents receive only Supplemental Security Income. After taking out the cost of room and board, each resident was left with only $55 a month to purchase needed items and services. Residents were forced to choose what they would purchase and what they would do without. They were often reduced to begging, borrowing and living without. What started as an individual complaint became a systemic complaint. Residents, board and care home providers, case managers and day program staff were organized to support an increase in the monthly personal needs allowance for residents of board and care homes. Legislation was drafted, hearings were held, testimony was presented. The monthly personal needs allowance was increased to $70.00 a month. This represented a $15 per month increase.

Georgia

#1 Angry Mr. Jones

Mr. Jones, an 85 year old man from the mountains of north Georgia, had been a resident of the nursing home for only a few months but his behavior was becoming increasingly difficult for staff to deal with. After Mr. Jones struck a staff person, the nursing home asked the ombudsman for help. After investigation, the ombudsman discovered that Mr. Jones was miserable and angry about being in the nursing home; the only thing he wanted in life was to return to his home where he could be fishing by a mountain pond. The ombudsman got to work to help Mr. Jones determine whether, with appropriate supports for his medical needs, he could indeed move back home. Today, Mr. Jones receives in-home services, often sits by the pond — and occasionally hooks a bass!

#2 Resident Abuse

When the ombudsman was contacted, Jim was already in the emergency room. A resident of a personal care home with mental retardation, Jim was unable to communicate verbally. Through gestures, Jim communicated that the bruises on wrists were caused by handcuffs and the ones on his head were from being slammed against a wall. Hospital lab tests revealed that Jim had been given a toxic level of antidepressants. Upon visiting the personal care home where Jim was a resident, the ombudsman found Perry, another resident, with his hands tied behind his back with a leather belt. The ombudsman was concerned for the safety of the residents remaining in this home. The resources of several agencies— including the licensing agency, law enforcement, and adult protective services— were brought in to address the care of these residents, who were quickly relocated to other personal care homes. Since then, the licensing agency has taken legal action to revoke the home provider's permit.

#3 Unlicensed Personal Care Home

Ms. Smith claimed to be a personal care home provider in order to receive referrals of individuals released from the hospital. But when a hospital worker thought it was odd that Ms. Smith's two residents missed their outpatient appointments, she asked for the ombudsman's help. The ombudsman went to Ms. Smith's home to investigate, where she discovered an unlicensed home with deplorable conditions--no one present to provide services to the residents, no food in the cupboards, only coffee creamer in the refrigerator. Roaches were crawling in a paper bag full of medicines, on the stove and on kitchen walls. The ombudsman spotted a disconnect notice from the gas company on the dining room table. Then the ombudsman talked to the two residents. Both told her they were hungry— they had eaten no breakfast that morning. Both requested help moving to a better home. Ms. Brown was too weak to get out of bed and had vomited on herself. The ombudsman contacted an ambulance for her. Unfortunately, Ms. Brown died in the hospital a few days later. Today, the other resident lives in another home. And the police have charged Ms. Smith for running her business without a license.

#4 Non-Payment Due to Guardianship Mismanagement

Mrs. Gonzalez was on the verge of discharge from the personal care home. Her bills had not been paid for months, and she asked the ombudsman for help. Mrs. Gonzalez' daughter, her guardian, had been ignoring the bills sent by the personal care home and had refused to cooperate with the home to work out a payment plan. At Mrs. Gonzalez' direction, the ombudsman brought the situation to the attention of the probate judge who determined that the guardianship should be terminated. Today, Mrs. Gonzalez manages her own finances and continues to live in the personal care home of her choice.

Indiana — Resident Behavior Issue

A 68 year old male resident had struck 3 other residents. The facility had made numerous attempts to solve the problem, but after the third incident they issued a 30-day discharge notice. Copies of the notice were not sent to the Ombudsman or to the responsible party, so the notice was invalid and the facility had to issue a second notice. The resident said he would kill himself if he had to leave the facility. While interviewing the resident, family, former employer, medical

doctor and psychiatrist, the Ombudsman found the resident had only completed third grade when he was forced to go to work in a saw mill. He always had a bad temper. He had once been shot by his ex-wife. He later became an underground miner and a farmer. At work he had showed his anger by hitting or kicking a truck, or other pieces of equipment. He had no formal training or social skills. Except for a 13-year period when he was married, he had always lived alone.

Between the 1st and 2nd notices, the facility agreed to role-play with him to introduce him to appropriate ways to express anger and frustration. His understanding of the process was very limited; however, after some discussion, he agreed that he had been treating other residents like he had treated the objects of his anger when he was working. "Hit it and yell or cuss!" Then he felt better.

The facility found a place away from the building where he could be alone, shell walnuts and watch nature regardless of the weather. He was provided with horse shoes that he could go outside to throw. When he felt anger, he was encouraged to go to an administrative office and "take it out on them." Facility staff now take more time explaining to him and they allow him much more time alone. He is receiving psychotherapy and is on a mild antidepressant to address the suicide threates. The facility dropped the discharge plans. There have been no incidents since December of 1997

Massachusetts — Threatened Nursing Home Closure

A facility that had two jeopardy findings in a 9 month period was threatening to close the doors over a weekend with less than 48 hours notice to residents and families. The owner was planning to abandon the residents. A court order was obtained delaying the closure and any transfer of residents. A receiver was placed. Residents and families were provided the time needed to select other facilities that were to their liking. The ombudsman assisted with information and support throughout the process. Ombudsman staff followed-up on every resident transferred in their new facility. What could have been a disastrous weekend for residents and families was averted. The closure was accomplished in an orderly manner, residents were afforded the chance to see and select new homes of their choosing.

Minnesota — Bed Side Rails

The most frustrating type of complaint this year was the issue of side rails as a physical restraint. The complaints were particularly difficult because in many cases, ombudsman staff were in conflict with family members over the use of side rails. This situation was created because too many residents suffered injuries due to facility removal of all side rails. In too many cases the side rails came down all in one day instead of gradually. There was no bedside assessment and no acceptable alternative implemented to keep residents safe. The large number of falls and injuries led to a family backlash against restraint reduction. The issue became so controversial that many family members contacted legislators and pushed for an amendment to the resident's bill of rights to allow a family member to request and consent to the use of a physical restraint on behalf of a resident.

Mississippi — Transforming Nursing Home Life Through Creativity

Beating the Odds Creatively: For the past two years, Mrs. Doe, a resident of Greentree Nursing Home, had called the district ombudsman with many complaints regarding her experiences in the nursing home, which had left her traumatized. An extensive investigation was conducted by the district ombudsman and the state ombudsman. We looked at records and policies and conducted interviews with other residents and family members, Mrs. Doe and staff. After the review and investigation, it was determined that: 1) there had been inadequate and untimely response to the call light; 2) her right to take her medications independently had been denied and, 3) she had not been treated with dignity and individuality by a certified nurses' aide. The ombudsmen recommended detailed in-service training for all staff in these areas.

Mrs.Doe, in her early 60's, had been diagnosed with rheumatoid arthritis almost forty years ago. Unable to care for herself any longer, she landed at the Greentree Nursing Home in 1992. Faced with this dreadful disease, she persevered. She recently painted and completed decorations on a doll house. Today, she is creating many wonderful pieces of art with watercolors, paints, charcoal, and ink. Through the efforts of the State Long-Term Care Ombudsman and the district ombudsman, Mrs Doe's complaints have become almost non-existent. To help assure that she had a outlet for all her emotional and creative energy and talent, we suggested that she display her art and allow us to profile her story in the biannual newsletter, *Aging in Mississippi*, published by the Mississippi Department of Human Services, Division of Aging. This resulted in an immediate change in Mrs. Doe, which has enhanced her life in the nursing home.

New Mexico — Exploitation of a Resident by Caregivers

The resident is deaf and has a diagnosis of depression. A checking account was opened by the facility for this resident two days after his admission. A case manager from the hospital became involved when this resident eloped from the facility to look for his girlfriend, who also resided at the facility. The case manager happened to see his checkbook and reported the case to APS as possible exploitation. The case was investigated jointly by APS (adult protective services), L&C (licensing and certification), and the ombudsman with the permission of the resident. Joint interviews were conducted, all information shared, and follow-up assignments were divided among the agencies.

A volunteer ombudsman organized the checks on computer and identified where the money was spent and who the checks were made out to. The ombudsman program tracked down receipts and itemized statements for all questionable purchases. The ombudsman obtained information on the resident's bank account, PIN number, and phone access to bank balances. Someone had checked the resident's balance frequently (not the resident, who is deaf). L&C continued to look at regulatory issues for citations which culminated in a license revocation. APS obtained copies of the checks and check ledgers. The facility appealed the license revocation, all parties testified at the hearing, the license revocation was upheld.

New York — Threatened Nursing Home Closure

In the latter part of 1999 the City of New York suddenly closed the Neponset Health Care Center in Queens, New York. The stated reason for this closure was that the ocean-side complex needed $47 million in repairs to the building structure. The New York City Ombudsman Program acted quickly to assist residents with individual and group advocacy to protect resident rights in the transfer process. They also became active with the NYS Department of Health which had approved the closure plan. Many people in the community believed that the closure was done for political reasons without regard for the well-being of the individual residents. When adequate information was not forthcoming from DOH on the closure, the LTCOP contacted the Healthcare Financing Administration (HCFA) in New York City for assistance. HCFA is currently fining the city approximately $3,000 per day for the inappropriate closure of this facility. This care is currently pending in court with numerous charges concerning inadequate discharge planning and other violations.

North Carolina — Licensing and Certifiction Agency Not Responsive to Complaints

Multiple family members from one nursing home were very concerned that the licening and certification section of the Division of Facility Services were not handling their complaints appropriately. They cited inappropriate follow-up from DFS, lack of citation for all deficiencies that were noted, not using all of the documentation provided for use in the survey process, lack of communication between the sections of DFS, and the feeling that DFS sided with the facility over the residents because of a fear of lawsuit from the facility. Interestingly, one of these families had a settled lawsuit against the facility, and videotapes from a hidden camera were given to DFS for use in their investigation.

The ombudsman program had been involved with these families from the time the original complaints were raised within the facility (1996). During 1997-98 the program tried unsuccessfully to mediate a resolution between the families and DFS. The families and ombudsmen worked through the entire system, ending up by meeting with the Governor. At this time, the situation is still unresolved and the families are currently working on a formal complaint to HCFA regarding their concerns.

Texas — Threatened Discharge: “Interfering” Relative

A complaint was received indicating that staff at the facility was mistreating the resident's wife when she came to visit. At the same time, the facility was calling to say that they just could not do anything with the resident's wife: she was interfering with care being given to her husband, threatening staff, causing nurse aids to quit, and not receptive to talking with the administrator. The local ombudsman arranged to have a care plan meeting to examine this issue. This was done, with problems shared and tentative agreements made for the resident's care that were pleasing to the wife.

Shortly thereafter, the resident's wife received a discharge notice that listed the reason as "not being able to meet the needs of the resident." During the care plan meeting, there was no indication that the facility was not able to meet the resident's needs. The ombudsman program supported the family in appealing the discharge.

The appeal hearing was scheduled. Both the regional ombudsman and the volunteer ombudsman attended the hearing. During the hearing, the vice president of the corporation quickly decided that there was no reason why the facility could not continue to care for "Mr. X."

The resident continues to reside in the facility and the family is satisfied with the level of care.

West Virginia — Representing Resident at Fair Hearing

Trying to select a "most interesting and/or significant individual complaint" handled by our program is not a particularly easy task. In trying to accomplish this goal we honed in on the word significant.

For a long time the ombudsman program has realized the importance of establishing credibility (and thus more influence) with the State Board of Review. The Board of Review is responsible for convening the fair hearing process and hears grievances regarding matters such as inappropriate discharge from a nursing home. Historically, the ombudsman has represented residents in this fair hearing process. Unfortunately, our win record has not been illustrious.

In an effort to obtain more favorable rulings for the resident, the ombudsman program has tried to do a better job of representing residents by becoming more knowledgeable of current nursing home regulations. The ombudsman program also met with all state hearing officers and their supervisors at the State Board of Review at a September meeting. During this meeting we tried to educate the hearing officers as to the role of an ombudsman in advocating for residents rights. We also discussed issues involving Alzheimer's residents and the fact that some nursing homes are too quick to want to discharge them without ensuring a safe and orderly discharge.

Recently, we found ourselves involved with an Alzheimer's resident whose legal representative lived out of state. Apparently, there had been a breakdown in communication between the nursing home and this legal representative which resulted in the resident incurring a rather large unpaid bill.

The nursing home notified the legal representative that the resident would be discharged to the representative's care. This could have been a disaster since no real discharge planning ever took place between the nursing home and the legal representative. Also, the discharge notice was improperly written and did not adequately explain the resident's rights.

The legal representative made a complaint to the ombudsman program. A regional ombudsman helped represent the resident at a fair hearing, and a state hearing officer reversed the nursing home's proposal to discharge the resident. The written decision noted that "no discharge plan was in place to insure a safe and orderly discharge". In addition, the state hearing officer noted that an adequate discharge notice advising the resident of her rights was not completed by the nursing home.

Now that we have received this ruling it is our intent to hold it up as a precedent for other cases - particularly those regarding discharge notices. We are optimistic that since residents are beginning to win hearings, nursing homes will be more sensitive to resident rights and perhaps there will not even be a need for a large number of thse hearings.

Washington

1 Helping a Resident Move to His Own Apartment

One resident who lived in a nursing home for over a year following an illness wished to leave. He was mentally alert and physically able to live independently despite chronic health problems. His desire was to live independently in his own apartment. The nursing home's idea of an independent setting was to move him to an assisted living facility. The nursing home social worker and administrator did not explore other options with him. The ombudsman was aware of a subsidized senior housing program located near a major shopping area and a senior center at which she thought he might do well. It was exactly what he wanted.

The nursing facility staffs were aware of this option and resident preference but continued to ignore his wishes. The ombudsman followed through on the resident's direction and helped him to apply for the housing program. Meanwhile the facility called in a mental health professional that diagnosed the resident as "at risk" to live independently, the Medicaid case manager was also opposed to this "risky move." Despite this assessment and lack of support by all the professionals, the ombudsman prevailed, and the resident moved into his new home. He is receiving meals on wheels and participates in programs at the nearby senior center. He is pleased with his new environment and with the dedication of the ombudsman.

2 Threatened Dumping of Residents in Hospital Emergency Room

A couple who owned a small nursing home in the northwest corner of Washington decided that they could no longer afford to keep their home operating. Inexperienced managers, they were behind in paying their bills and decided that the solution to their financial problems was to try and send all of the residents to the local hospital emergency room. The local ombudsman was notified of this "discharge plan" and immediately went to the nursing home to help the residents stay calm and to support the staff members who had not left. The state survey agency set-up temporary management to keep the home open short-term to assure those residents could move in a safe manner. In a matter of a few weeks over 30 residents moved. During this difficult transition period, the volunteer and regional ombudsmen visited the residents and provided reassurance. Unfortunately, some residents had to be placed out of their community. This out-of-county placement resulted in other regional ombudsmen becoming involved in follow-up visits to the residents. The ombudsmen met with residents in their new homes to assure that the residents were happy with their placement. Those residents who were not satisfied had the assistance of the ombudsman to find new homes, usually back in their community, with the outcome being that all the residents are now satisfied with their final placement.

Wyoming — Helping Resident Return Home Against Wishes of Relative with Power of Attorney

A very frail 94 year-old widow was admitted to Life Care Center in Cheyenne, WY. She had an enlarged heart and was on oxygen. A great-niece who lived in Cheyenne for several years had had the resident's general power of attorney and durable power of attorney for medical care. A lady who had rented the resident's basement apartment for the nine years and had formed a close relationship with the resident contacted the regional ombudsman to let him know the resident's desire to return home. The great-niece not only objected, she accused the tenant of trouble-making, threatened to evict the tenant, told the clergyman that he could no longer store his car in the resident's garage and had the nursing home restrict visits of the resident's neighbors and tenant. Reports were received that the great-niece was selling the resident's household furnishings and getting ready to sell her property.

The assistant ombudsman visited the resident, who confirmed, in the presence of two of her visiting neighbors, that she wanted to go home. The assistant ombudsman met with the facility social worker and his assistant to inform them of the resident's desire. Relatives (nephew and family) arrived from Kentucky with intent to take resident to Kentucky with them, but resident was too frail. They retained an attorney in Cheyenne to revoke the great-niece's powers of attorney and pursue a guardianship for the resident.

Life Care Center refused to honor the revocation of the powers of attorney. After waiting in the resident's physician's office for 2 hours, 20 minutes on New Year's Eve, the assistant ombudsman discussed with the physician the feasibility of the resident's return home, provided there would be a suitable plan for her care. The assistant ombudsman informed the physician that a 64-year-old relative in Arizona confirmed to him that she was willing to come and provide 24 hour care. The physician approved the plan but advocated for a family conference. The husband of the great-niece called to postpone the conference for a "cooling off" period. Their attorney requested a letter advising him of the purpose of such a meeting, who the ombudsman represented and what the ombudsman did. The letter was sent.

Meeting was held in the administrator’s office. Ten people were present: administrator, director of nursing, great-niece and her husband, their attorney, the attorney representing the relatives in Kentucky, the resident (who said nothing), the assistant ombudsman, a great-great-nephew and another relative. The ombudsman facilitated the meeting. It started out pretty tense with sides pretty well drawn. The administrator sided with the resident staying put. The great-niece questioned the proposed care-givers' health and lack of care-giver training. The meeting almost ended in discord, disagreement, or whatever you could call it. The assistant ombudsman advocated avoiding a lawsuit and focused on the common concern for the resident's welfare and respecting her desire to live out the rest of her life at home. The resident's physician had examined her a few days earlier in private without interference from any of the parties involved. It was agreed to wait for the transcript of his interview.

The great-niece's attorney received the physician's transcript. The attorney's resistance started to

fade. He suggested he would feel better if the care-giver was paid for her services. The great-niece wanted to be sure Life Care Center would take the resident back if she left and needed to return. The great-niece wanted to talk to the proposed care-giver about the care-giver's health, and offered to help spell the care-giver. The Kentucky relatives were pressing their attorney for a decision. The great-niece droped her objections to the resident returning home under the care of the Arizona care-giver. She thanked the assistant ombudsman for his assistance. The resident returned home. Her wish comes true 40 days after entering the nursing home and 27 days after our involvement. She died at home in her own surrounding 14 days after returning home.