

AGING AND DISABILITY SERVICES DIVISION

ANNUAL REPORT

Federal Fiscal Year 2014



OFFICE OF THE STATE LONG TERM CARE OMBUDSMAN

Nevada Long Term Care Ombudsman Program

Annual Report

Heather Korbolic

State Long Term Care Ombudsman

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The mission of the Nevada Long Term Care Ombudsman Program is to advocate for and on behalf of the residents we serve to improve the quality of life and quality of care in long term care settings.

Long Term Care Ombudsman

- ❖ **Advocates** for increased consumer protections in state and federal laws and regulations.
- ❖ **Educates** residents about their rights.
- ❖ **Empowers and supports** residents and families to discuss concerns with facility staff.
- ❖ **Identifies and seeks to remedy** gaps in facility, government, or community services.
- ❖ **Protects** the health, safety, welfare, and rights of individuals living in nursing homes and assisted living facilities.
- ❖ **Provides information and assistance** regarding long-term services and supports.
- ❖ **Receives and investigates complaints**, and assists residents to resolve problems.
- ❖ **Represents** residents' interests before governmental agencies.
- ❖ **Respects** the privacy and confidentiality of residents and complainants

Highlights

October 2013 through September 2014

Long Term Care Ombudsmen

- Opened 936 cases and investigated 1,623 complaints on behalf of Nevada's Long Term Care residents;
- Responded to complaints from concerns about exercising preference and civil rights to involuntary discharges;
- Resolved, or partially resolved, 85% of nursing home complaints and 82% of group home/assisted living complaints.

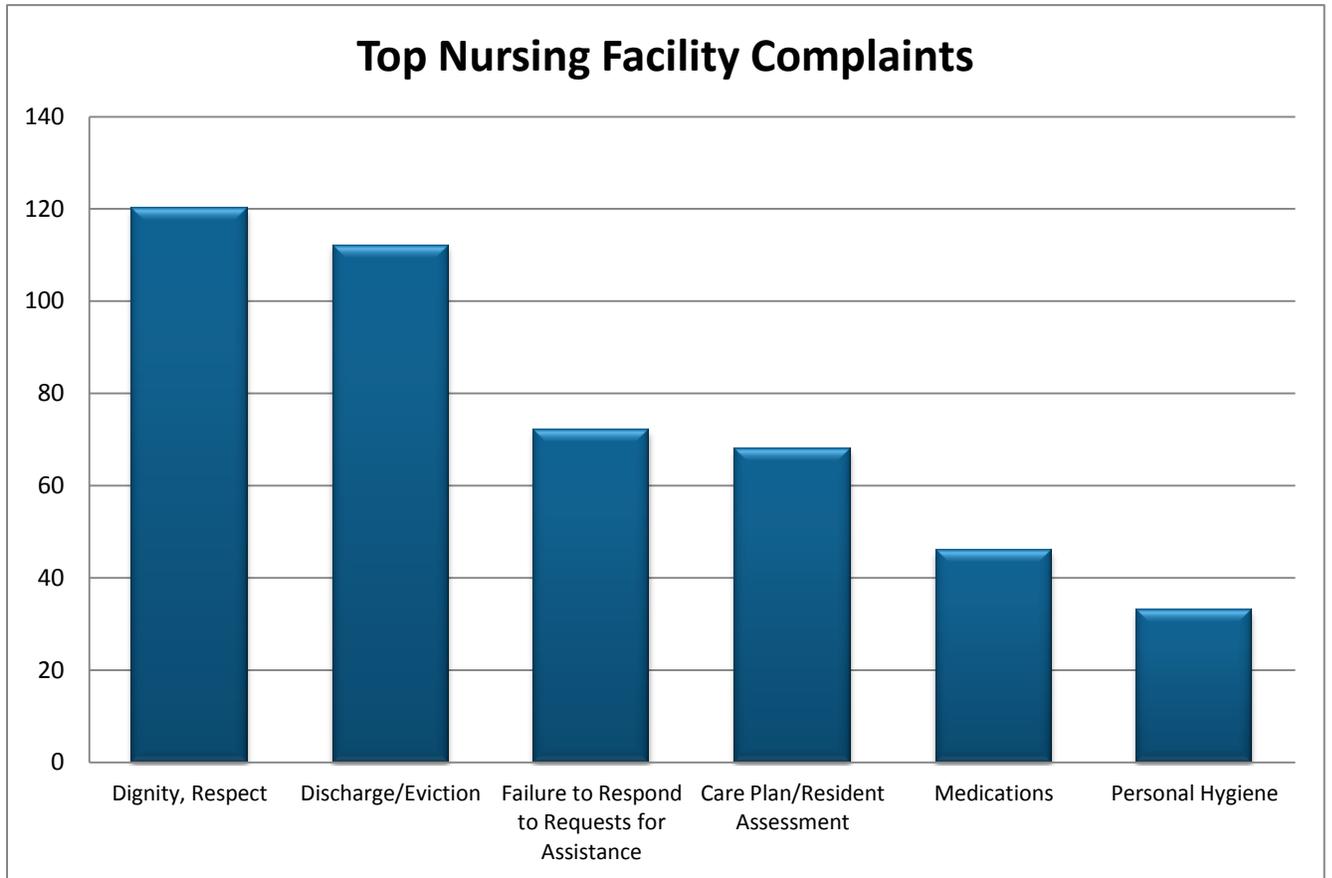
Ombudsmen Activities

- Facility Visits – 2,017 visits;
- Information and assistance to facility residents and family –18,583 consultations;
- Consultation to facility providers – 4,868 consultations;
- Council Support – attended 202 resident council meetings and 14 family council meetings.

Statistics

- 9.5 Full-Time Equivalent (FTE) Ombudsman staff;
- 15 Volunteers at the close of Federal Fiscal Year (FFY) 2014– who provide residents with education about the Long Term Care Ombudsman program and resident rights;
- 548 Licensed Long Term Care Facilities;
- 13,727 licensed beds = 1,445 beds per Ombudsman.

Ombudsmen in Nursing Facilities

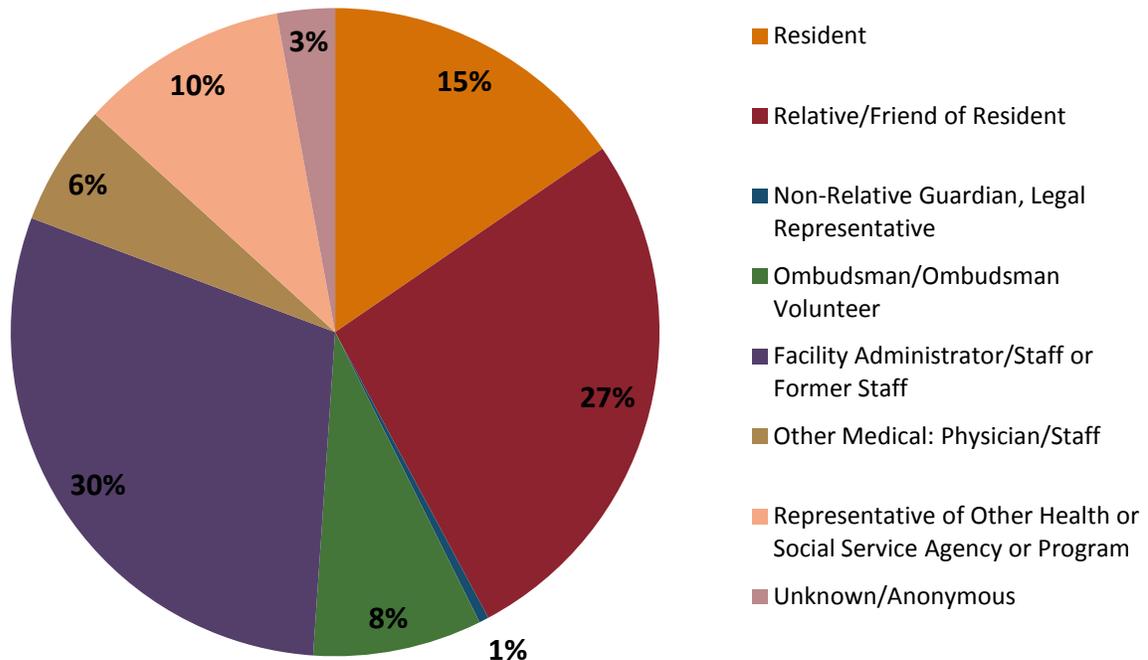


Discussion:

Ombudsmen investigated a total of 847 complaints regarding nursing facility residents during FFY 2014. The top six complaints were as follows; 1) Dignity and Respect concerns; 2) Discharge and Eviction concerns; 3) Failure to Respond to Requests for Assistance; 4) Care Plan/ Resident Assessment; 5) Medications; 6) Personal Hygiene.

Of the top six complaints reported to the Long Term Care Ombudsman Program in FFY 2014, four of the complaints are in the Resident Care category specific to facility staff. **Sufficient, well-trained, and well-supervised staff is critical to quality care in a nursing facility.**

Nursing Facility Closed Cases by Complainants

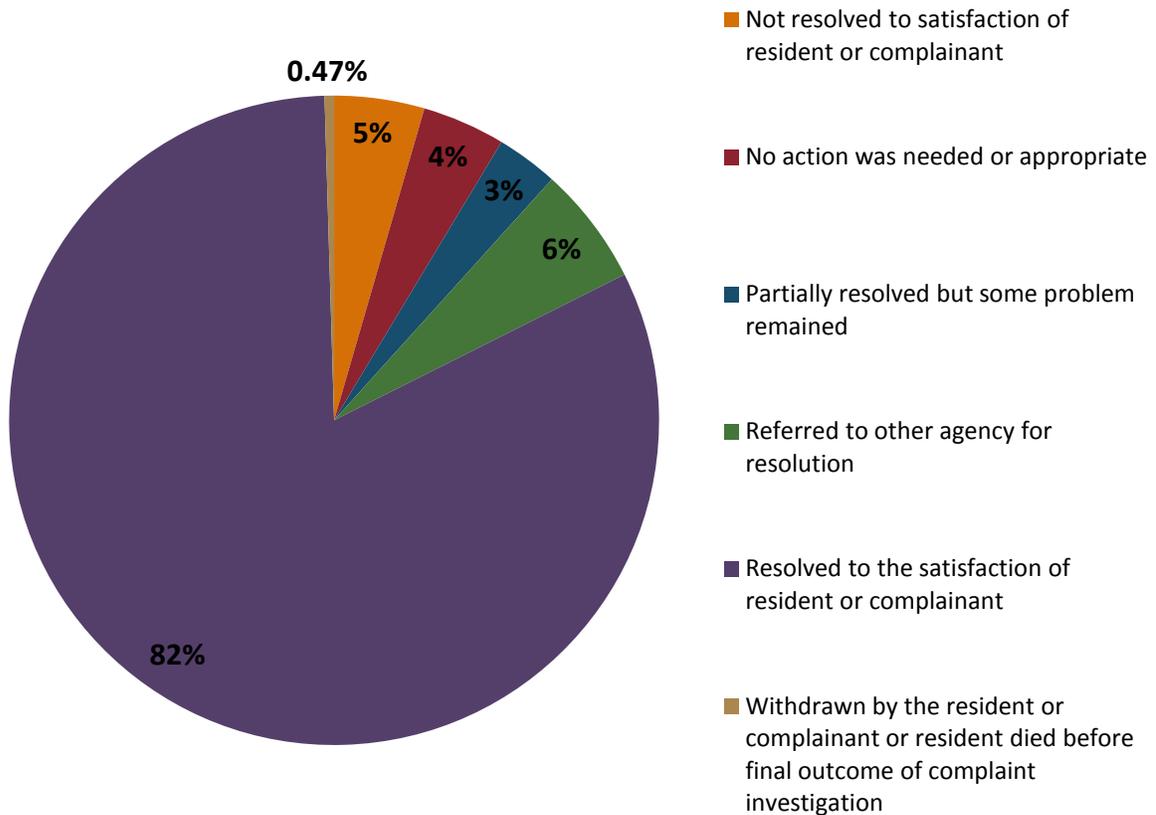


Complainants

Complainants to the Ombudsman Program vary in relationship to the resident. In FFY 2014, the top three complainants in Nursing Facilities were as follows, 1) Facility Administrator/Staff or Former Staff; 2) Relative/Friend of the Resident; 3) Resident.

The Ombudsman Program will make every reasonable effort to assist, advocate and intervene on behalf of the resident. When investigating complaints, the program will respect the resident and the complainant's confidentiality and will focus complaint resolution on the resident's wishes.

Nursing Facility Case Dispositions

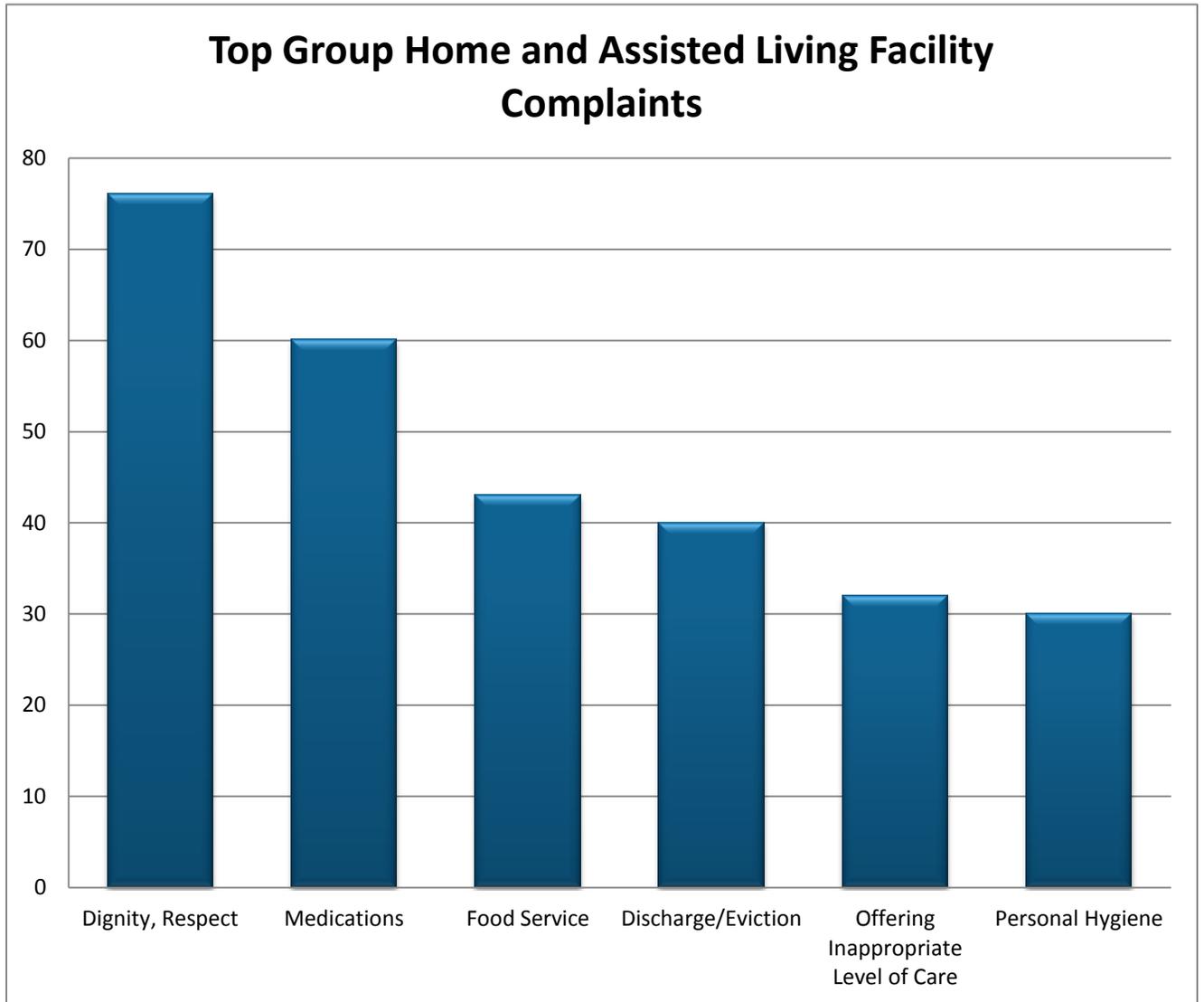


Verification of complaints

Verification is determined by an Ombudsman through observation, interviews, and/or record inspection. Verification signifies that the circumstances described in the complaint existed and were generally accurate.

In FFY 2014, the Long Term Care Ombudsman Program resolved 82 percent of Nursing Facility complaints to the resident's satisfaction. Not all complaints can be resolved to the satisfaction of a resident; for example, some complaints are referred to another agency for resolution and others do not require any action to be taken.

Ombudsmen in Group Homes/Assisted Living

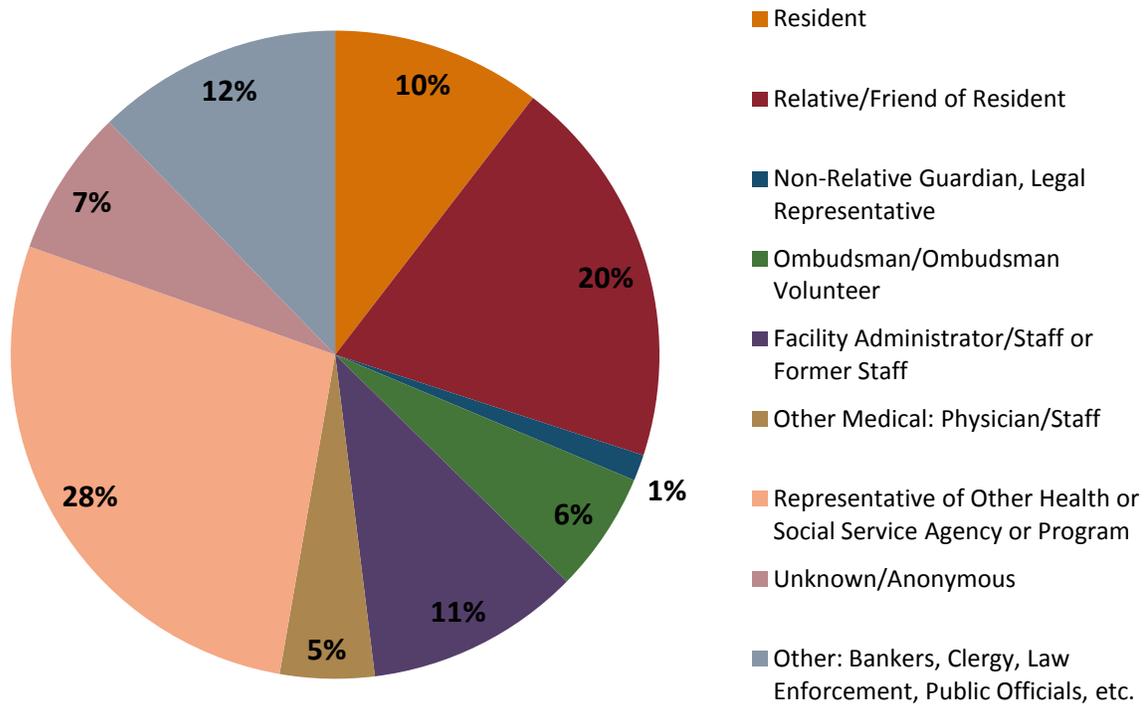


Discussion

The category of Group Home/Assisted Living includes Homes for Individual Residential Care (HIRCs) homes that are licensed to provide care to no more than two residents. Ombudsmen investigated a total of 773 complaints regarding Group Home residents, which was approximately half of the complaints received in FFY 2014. The top six complaints were as follows: 1) Dignity and Respect concerns; 2) Medication Issues; 3) Food Service; 4) Discharge/Eviction; 5) Offering Inappropriate Level of Care; and 6) Personal Hygiene.

The Complaints in the Group Home and Assisted Living settings contain concerns about resident care, dietary, discharge and eviction, and resident rights. As compared to the Nursing Facility setting, the Group Homes and Assisted Living facilities have fewer training requirements for staff.

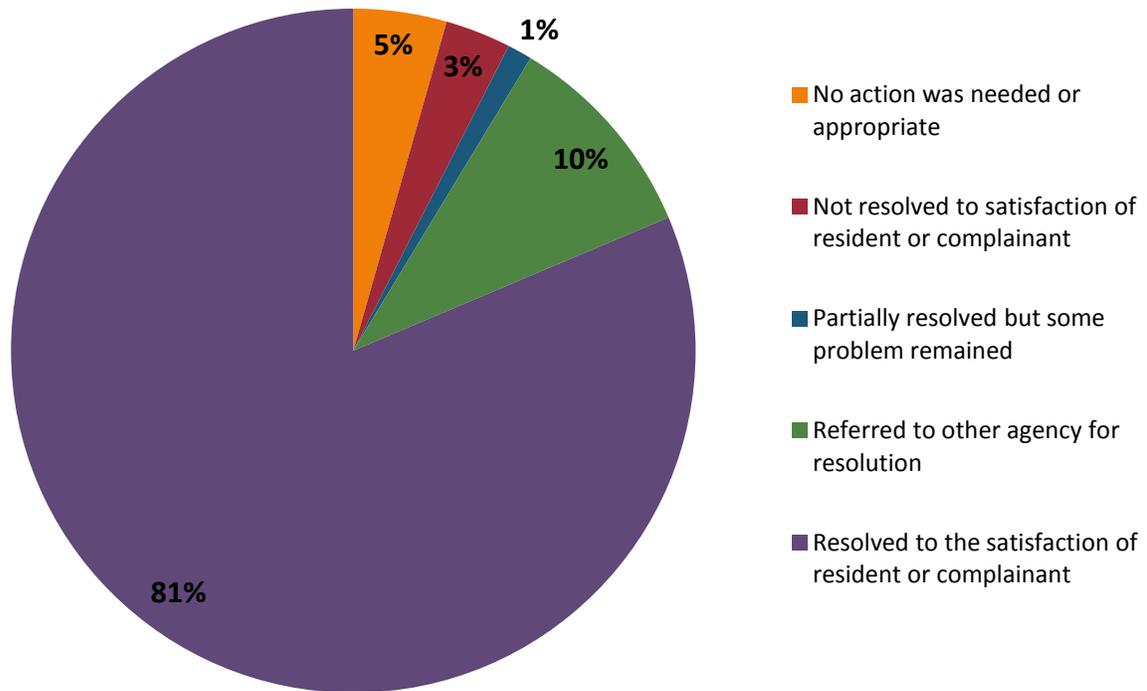
Group Home and Assisted Living Facility - Closed Cases by Complainants



Complainants

Complainants to the Ombudsman Program vary in relationship to the resident. In FFY 2014, the top three complainants for Group Homes and Assisted Living Facilities were as follows, 1) Representative of Other Health or Social Service Agency or Program; 2) Relative/Friend of Resident; 3) Other: Bankers, Clergy, Law Enforcement, Public Officials, etc. The Ombudsman Program will make every reasonable effort to assist, advocate and intervene on behalf of the resident. When investigating complaints, the program will respect the resident and the complainant's confidentiality and will focus complaint resolution on the resident's wishes.

Group Home and Assisted Living Facility Case Dispositions



Verification of complaints

Verification is determined by an Ombudsman through observation, interviews, and/or record inspection. Verification signifies that the circumstances described in the complaint existed and were generally accurate.

In FFY 2014, the Long Term Care Ombudsman Program resolved 81 percent of Group Home/ Assisted Living Facility complaints to the resident's satisfaction. Not all complaints can be resolved to the satisfaction of a resident as some complaints are referred to another agency for resolution and others do not require any action to be taken.

Consultations and Training

Consultation to Residents and Family

Ombudsmen spend their time resolving complaints for residents and providing residents, their families and friends with information related to resident rights. Ombudsmen answer questions, research and interpret regulations, and provide empowerment tools to residents and their loved ones. Often the Ombudsmen advise families and friends on how to select a Skilled Nursing Facility or Group Home/Assisted Living Facility. In FFY 2014, the Ombudsman Program provided a total of 18,583 consultations to residents and families.

In-Service Training to Facility Staff

Most staff employed by long term care facilities receive required trainings where they work. Ombudsmen are asked to provide training on site on the topics of Dignity and Respect, Customer Service, Resident Rights, Elder Abuse and Mandated Reporting, and Culture Change. Ombudsmen provided 69 trainings to facility staff. The top three topics of these trainings were 1) Elder Abuse, 2) Resident Rights, and 3) Culture Change.

Consultation to Facility Staff

Ombudsmen have worked diligently to establish sound working relationships with facility staff. Ombudsmen are resources for facility staff, particularly management, when they encounter complex problems. Consultation involves any subject that affects a resident's life in a facility. Common consultation subjects include care planning, resident rights, appropriate discharge procedures and planning, culture change, power of attorney, guardianship authority, challenging resident behaviors, and family conflict. Ombudsmen provided a total of 4,868 consultations to facility staff in FFY 2014.



Program Outcomes

The data from the past five (5) National Ombudsman Reporting System (NORS) annual reports show that the Nevada State Long Term Care Ombudsman Program (LTCOP) has investigated discharge and eviction issues, which are amongst the top three complaints. Issues related to this type of investigation range in nature from inappropriate notification letters, timing of notification, reasons for discharge, to lack of discharge planning.

Nevada residents who live in Skilled Nursing Facilities (SNFs) are afforded discharge/transfer rights under the Code of Federal Regulations 483.12 and Nevada Administrative Code 449.74429. These rights allow a facility to transfer or discharge a resident only in the cases that the facility can no longer meet the resident's needs, the resident no longer requires SNF care, the safety of individuals in the facility is endangered, the health of individuals in the facility would be endangered, the resident has failed after reasonable and appropriate notice to pay for their stay, or the facility ceases to operate. The regulations also require that a resident be provided with a 30 day discharge notification and this notification must contain specific items which include: the address where the resident will be discharged to, information on how to appeal the discharge, and contact information for the LTCOP. Finally, facilities are required to provide sufficient preparation and orientation to residents in order to ensure a safe and orderly discharge.

The LTCOP recognizes that when a discharge is not done in accordance with state and federal regulations residents and their families can be harmed. It is also recognized that in order to correct the on-going problem with discharge issues LTCOP must collaborate with the State licensing agency to identify regulation violations.

As a result of the frequency of discharge complaints in Federal Fiscal Year 2014 (FFY 14), the LTCOP worked with the State's Protection and Advocacy Organization to identify their role in assisting with discharges for individuals who are developmentally disabled or who have mental illnesses. Through collaboration with the state licensing agency and the Protection and Advocacy Organization, the LTCOP developed a Technical Bulletin to provide SNFs with guidance and interpretation of discharge regulations and an example of an appropriate discharge notification letter. At the close of FFY14, the Technical Bulletin had not yet been approved through the state licensing agency for distribution, however the LTCOP has provided the bulletin to SNF Administrators.

As advocates of long term care residents, the LTCOP provides, and will continue to provide, routine and on-going training to SNF staff on the rights of residents to receive appropriate discharge notification, for allowable reasons, and planning to ensure resident safety and well-being.