ANNUAL REPORT

Federal Fiscal Year 2020

Office of the State Long Term Care Ombudsman

Aging and Disability Services Division

Nevada Long Term Care
Ombudsman
Program

Nevada Long Term Care Ombudsman Program

Annual Report
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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 2019 through September 2020

Long Term Care Ombudsmen

- Closed 1,435 cases and investigated 2,534 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- Resolved, or partially resolved, 59% of nursing facility complaints (35% complaints were withdrawn or no action was needed) and 61% of residential care community complaints (36% complaints were withdrawn or no action was needed).

Ombudsmen Activities

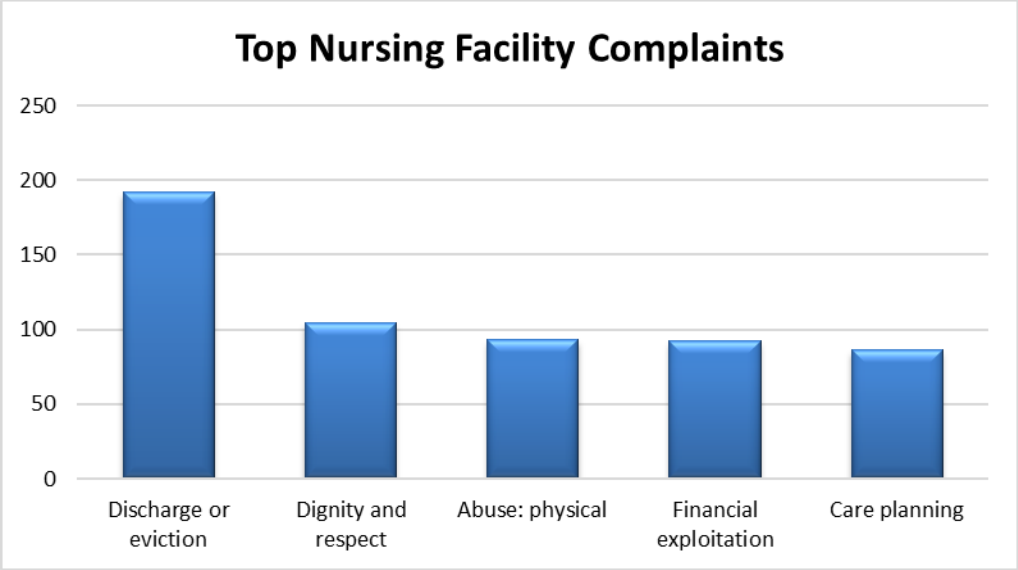
- Facility Visits – 1,582 visits;
- Information and assistance to facility residents and family –8,980
- Information and assistance to facility staff – 5,398

Statistics

- Average of 12 Full-Time Equivalent (FTE) Ombudsman staff;
- 616 Licensed Long-Term Care Facilities;
- 16,531 licensed beds = 1,378 beds per Ombudsman

The Long Term Care Ombudsman Program used CARES Act funding to purchase a Kindle Fire tablet for every facility in the state and a visitation booth for each skilled nursing facility. The ombudsman program sub-granted the funds to a local organization who assisted with the purchase of the tablets and accessories. Accessories included a screen protector and tablet case to provide additional protection for the tablet. The tablets provide the families and residents with an additional form of communication. Additionally, the ombudsman program can schedule virtual visits with residents to increase access to the ombudsman program as the pandemic and limitations on visitation ensue. Ombudsmen can also use the tablets to connect with family and resident councils and attend care plan meetings virtually. The visitation booths provide a safer way for residents to visit with family members, friends, and the ombudsman program. The visitation booths are made of plexiglass and were purchased through a company called SuperColor Digital, which has a production warehouse in Las Vegas. All skilled nursing facilities in the state received a visitation booth. The ombudsman program provided a press release and the State Long Term Care Ombudsman provided information, through interviews, to media outlets statewide. Facilities were surprised by and appreciative of the purchase of the tablets and visitation booths.

Ombudsmen in Nursing Facilities



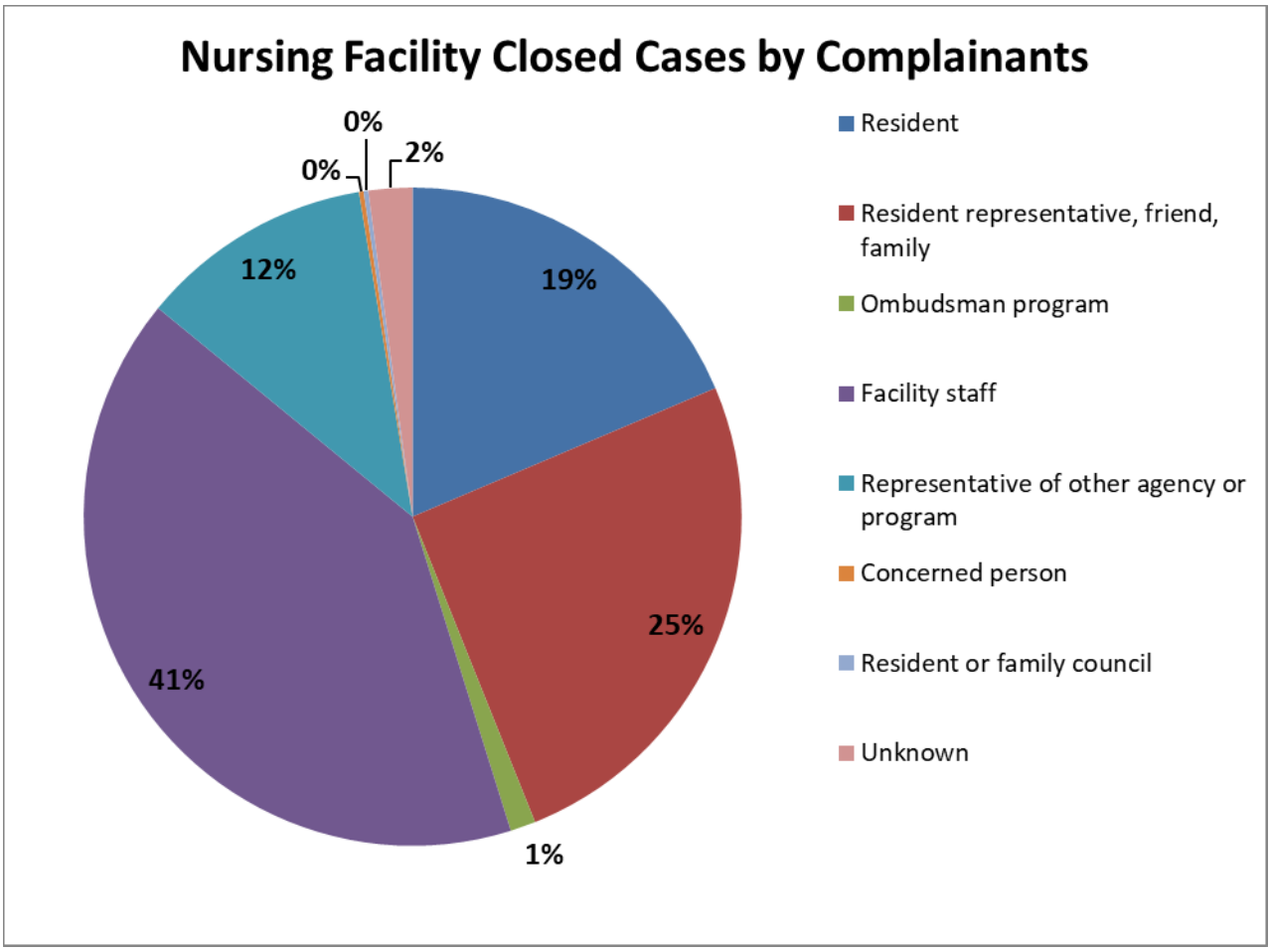
Discussion:

Ombudsmen investigated a total of 1,542 complaints regarding nursing facility residents during FFY 2020.

The top five complaints were as follows:

1) Discharge and Eviction
2) Dignity and Respect
3) Physical Abuse
4) Financial exploitation
5) Care Planning

Of the top five complaints reported to the Long-Term Care Ombudsman Program in FFY 2020, four of the complaints are in the Resident Care category specific to facility staff. It is essential for nursing facilities to have well-trained, and well-supervised staff is critical to quality care in a nursing facility. The Long Term Care Ombudsman Program has continued to focus on providing person-centered care training to facility staff members, including administrators. Additional training is needed for facility staff regarding discharge notices.



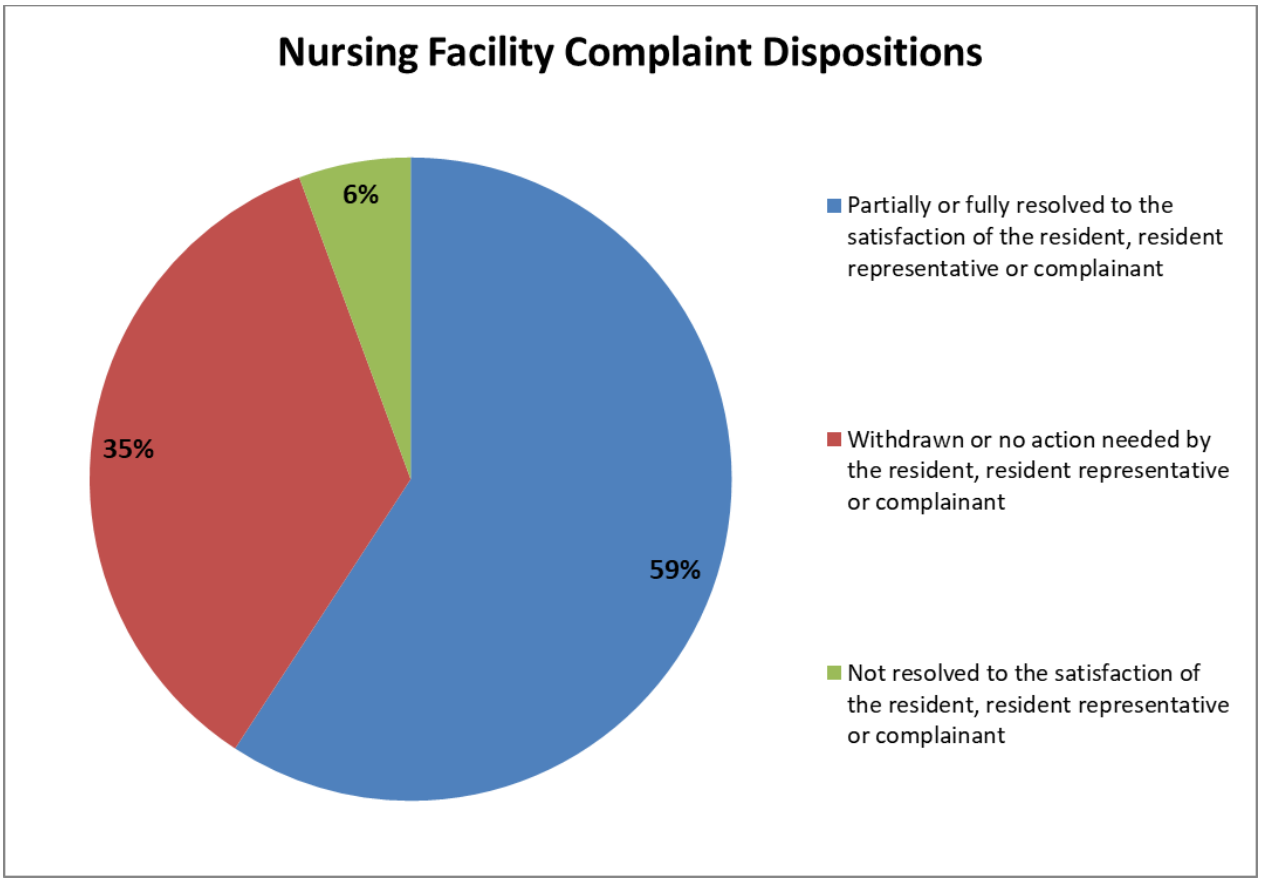
Complainants

Complainants to the Ombudsman Program vary in relationship to the resident.

In FFY 2020, the top three complainants in Nursing Facilities were as follows,

1) Facility staff
2) Resident representative, friend, family
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. If a resident does not appear alert and oriented and does not have a supported decision maker, the ombudsman can advocate in the resident's best interest.



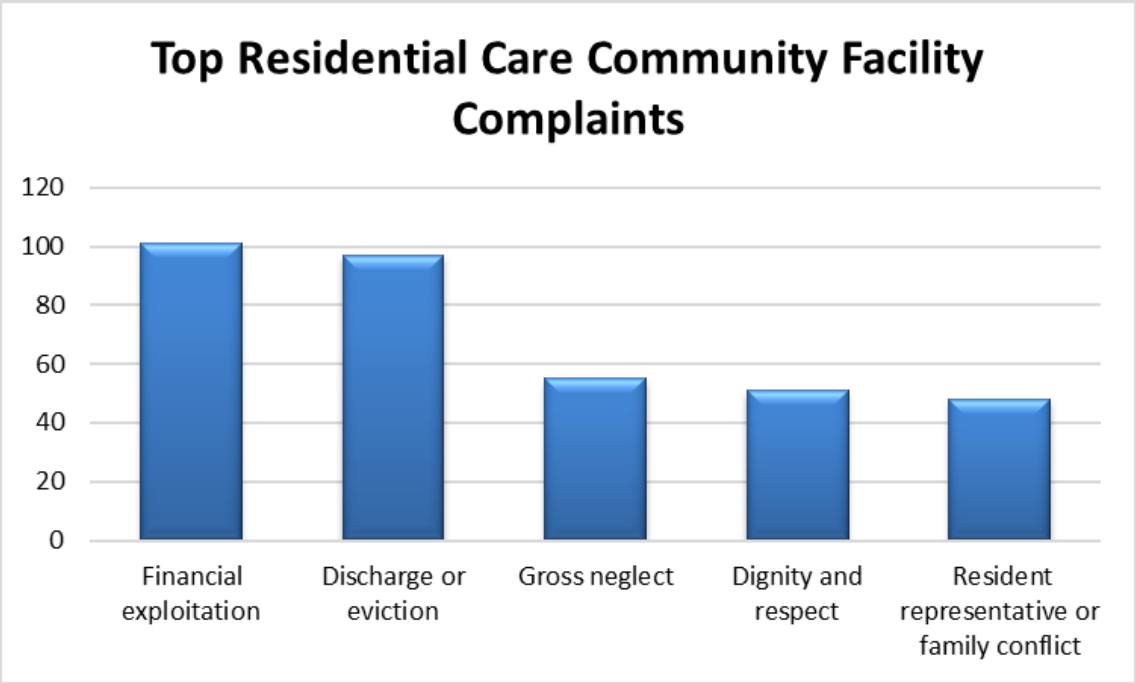
Verification of complaints

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

In FFY 2020, the Long-Term Care Ombudsman Program resolved **59%** of Nursing Facility complaints to the resident's satisfaction. However, 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. Additionally, there are instances in which the complaint is regarding resident preference versus a service or item not provided by the facility, such as a request for a specific food or drink item.

There are instances in which a family member or friend has a concern, and the resident does not agree there is a concern. This results in the complaint being withdrawn and no action is needed by the ombudsman. In these cases, the residents are provided the opportunity to share feedback on their care and the facility. Additional cases may be opened based on the feedback from the resident.

Ombudsmen in Residential Care Community Facilities



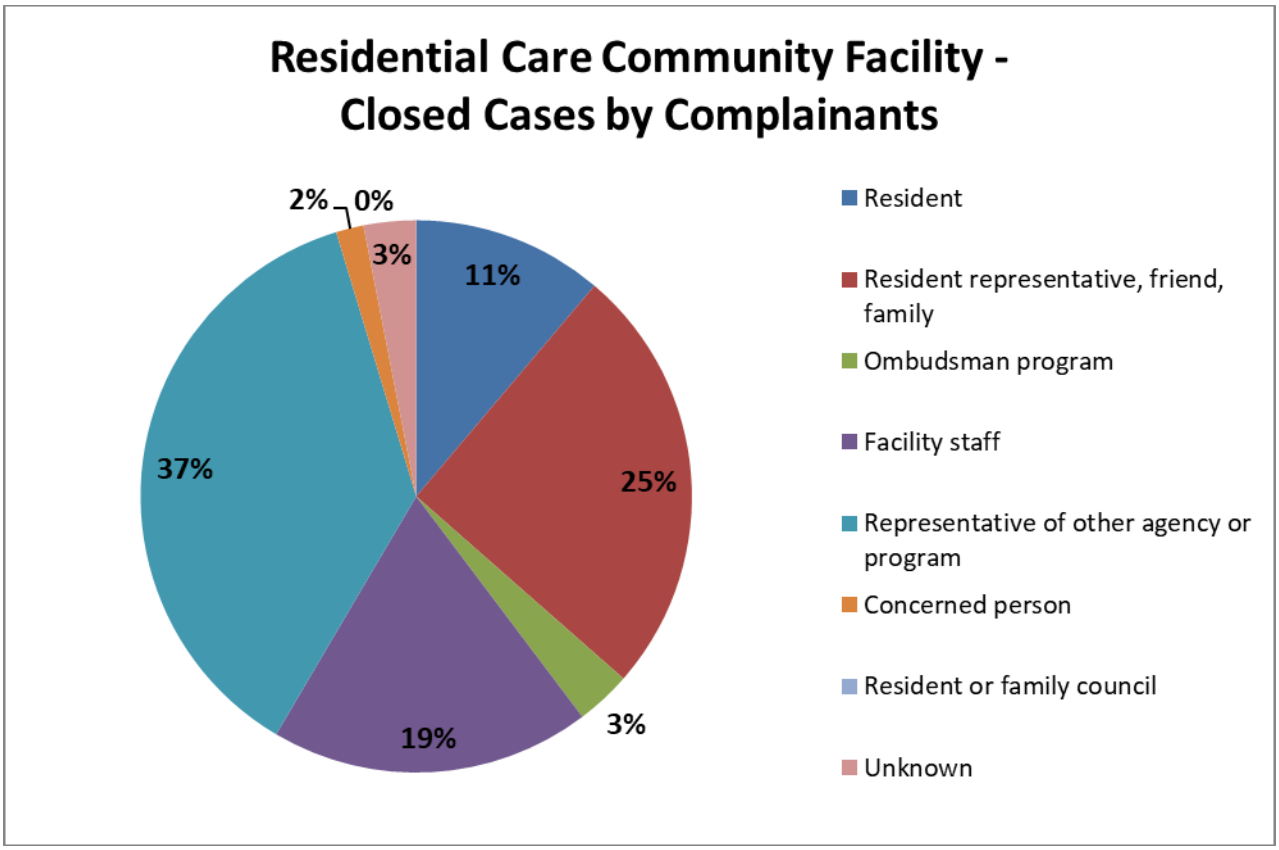
Discussion

The category of Residential Care Facilities includes Homes for Individual Residential Care (HIRCs) homes which are licensed to provide care to no more than two residents. Ombudsmen investigated a total of 992 complaints regarding Residential Care Community Facility residents.

The top five complaints were as follows:

1) Financial exploitation
2) Discharge/Eviction
3) Gross neglect
4) Dignity and Respect
5) Resident representative or family conflict

The complaints in this setting contain concerns about financial exploitation, discharge/eviction, gross neglect, dignity and respect, and resident representative or family conflict. As compared to the Nursing Facility setting, the Residential Care Community facilities have fewer training requirements for staff. The Long-Term Care Ombudsman Program will continue to provide training to facility staff regarding person-centered care and discharge/eviction issues.



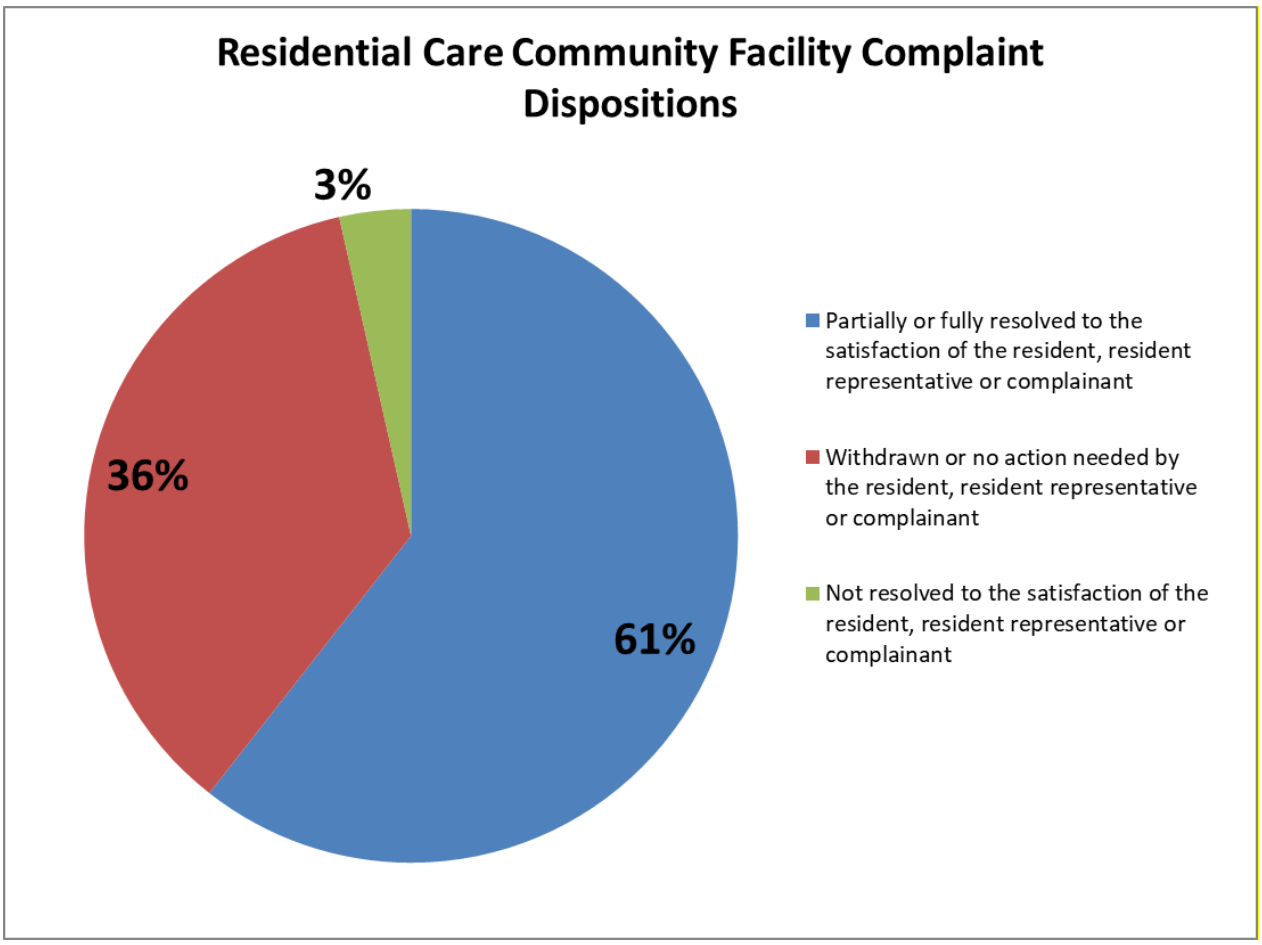
Complainants

Complainants to the Ombudsman Program vary in relationship to the resident.

In FFY 2020, the top three complainants for Residential Care Community Facilities were as follows:

1) Representative of other agency or program
2) Resident representative, friend, family
3) Facility staff

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.



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 2020, the Long-Term Care Ombudsman Program resolved **61%** of Residential Care Community 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. As previously mentioned, there are instances in which the resident does not agree with the concerns expressed in the intake and the case is closed because the complaint is withdrawn, or no action is needed.

Information and Assistance and Training

Information and Assistance 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 Residential Care Community Facility. In FFY 2020, the Ombudsman Program had 8,980 instances of information and assistance 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 Residents Rights, Role of Ombudsman and Medicaid outreach. Due to the COVID-19 pandemic, Ombudsmen access to the facilities was limited, resulting in a decrease in training provided to facility staff. Only one presentation was provided to facility staff in 2020.

Information and Assistance 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. The Ombudsmen provide information and assistance to facility staff on a variety of topics including care planning, resident rights, appropriate discharge procedures and planning, person-centered care, power of attorney, guardianship authority, and family conflict. Ombudsmen provided a total of 5,398 consultations to facility staff in FFY 2020.

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) investigated autonomy, choice, rights and privacy, and care issues which are amongst the top three complaints. Issues related to these complaints range from dignity and respect, resident choice and concerns with overall care.

Since 2011, the Nevada LTCOP has focused on person-centered care. In 2018, the Nevada LCTOP continued efforts to educate facility staff on the importance of implementing person centered care. In addition to the providing person-centered care training to facility providers, the ombudsman program has increased the focus on individuals with dementia by implementing the Positive Approach to Care (PAC) training. Just prior to the COVID-19 pandemic, all ombudsman staff members participated in training to become certified PAC trainers. The goal was to provide additional tools and resources to long term care facility staff members to help provide more person-centered care for residents, specifically for residents with dementia, in all long-term care settings.

The LTCOP has strived to ensure the program is consistent statewide and this has greatly improved with the collaborative efforts of the quality assurance team and the management analyst position. In 2020, the program met with the quality assurance and management analyst staff to brainstorm ideas to obtain data regarding the discharge letters. An excel spreadsheet was created to capture this data. Data was entered by quality assurance staff for a period based on the information from each discharge letter. From there, the data was reviewed, and a report was provided to the ombudsman program. The data provided some key findings to assist the ombudsman program with addressing issues with the discharge letters. Most importantly, a list of facilities who submitted or did not submit letters to the ombudsman program was established. The State Unit on Aging Manager and the State Long Term Care Ombudsman reached out to the survey and certification agency to begin monthly meetings to discuss the findings. Prior to the creation of the database, the ombudsman program only had anecdotal information to provide to the Survey and Certification Agency. With the data, the Survey and Certification Agency, had tangible evidence as to what the issues were with the discharge/transfer letters. The monthly meetings were helpful and meaningful ideas were shared. However, the COVID-19 pandemic struck, and the progress was halted. Additionally, an administrative assistant position was frozen due to budget constraints, due to impact of COVID-19 to the state economy. This position was intended to be used for the data entry of the discharge letter information for data collection. Currently, local ombudsmen continue to review discharge letters, but data entry into the excel sheet is not possible. If the Administrative Assistant position is unfrozen, this position will assume the intended role of working with discharge letters.