

MODULE 3

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THE COMMUNICATION PROCESS

I. SETTING THE STAGE FOR COMMUNICATION

Certain factors can prepare the way for your interaction with another person. These, if properly attended to can increase the chances that your communication will go the way you would like. This is especially true when working with nursing facility residents.

- Always introduce yourself, name, and role/affiliation, unless the resident knows you by name or recognition. Do not ask the resident, "You remember my name don't you?" or a similar question. That type of question puts the resident on the spot and calls upon the resident to utilize short term memory which normally is more difficult to use as a person ages.
- Greet the resident by Mr., Mrs., Miss, or Dr., and given name unless the resident asks you to use another name.
- Always knock on the door to a resident's room before entering, even if the resident can't verbally respond or if the resident is watching you approach. Knocking acknowledges that the room is their "space" and home. It also conveys a sense of respect for their privacy and dignity.
- Choose an appropriate place for the type of conversation or visit you plan to have with the resident. If you are just greeting people, a day room or porch setting is appropriate if that is where the residents are sitting. If you need to discuss personal information, find a setting with privacy and quiet. The setting in which communication occurs directly influences the nature of the interaction.
- Cultivating friendly, trusting relationships takes time. Be patient in visiting. Allow residents to get to know you while you are learning about them. Rarely does a person divulge their innermost thoughts or problems until a trusting relationship has been established.
- Be dependable. Visit or check back when you said you would. Promise only what you can deliver/control.
- Be honest. Avoid giving false hope or stating platitude. It's OK to admit, "I don't know".

A. Verbal Communication

The use of spoken words to send a message is called verbal communication. There are three essential components of this type of communication: Voice tone and language usage and the content of the message.

Voice tone can add meaning to the words that are uttered. The tone of one's voice often holds significant cues as to the underlying meaning of a statement. Voice tones certainly place emphasis where the speaker intends. Consider, for example, how the word "yes" can assume different meanings by varying the tone of expression.

If it is said:

- Softly, it can mean friendliness,
- Loudly, it can mean anger,
- Sharply, it can mean annoyance,
- Rising, it can mean a question.

Words are unique to humans. Depending on how it is used, conversation can create understanding or complete misunderstanding. Carefully chosen words bridge gaps and can be used to mend fences. Be sure that the words you use have the same meaning for the person with whom you are speaking as they do for you.

For example: If you told an administrator that Mrs. Jones lost her purse, would the administrator think that the resident forgot where she placed her purse? Would he think that Mrs. Jones purse was stolen?

For example: If you asked Mr. Green how he spends his time, would he laugh at you and say, "I can't spend time! I can only spend money and I don't have any of that!"

B. Nonverbal Communication

Nonverbal communication involves the sending of messages without the use of words. It is a continuous process and is the principal means by which feelings and attitudes are conveyed. Awareness of nonverbal cues is necessary to assure that a mixed message is not sent.

1. Facial Expressions

Seldom are we expressionless. Our faces portray a wide range of emotions and reactions, such as caring, disgust, inattention, or doubt. Facial expressions can be used to show that we understand or are in agreement (smiling or nodding) or can show that we do not understand and need clarification (a quizzical look, eyebrow tightened).

2. Eye Contact

The eyes themselves can send several kinds of messages. Meeting someone's glance indicates a sign of involvement or of confidence. Looking away signals a desire to avoid contact. Establishing eye contact indicates an interest in what someone is communicating. Eye contact should be spontaneous, where the listener looks at the speaker but also lets the eye drift occasionally. That individual's culture and background influence a person's comfort level with direct or sustained eye contact.

3. Distance/Personal Space

The way people use space is also part of nonverbal communication. Each of us has a variable size of personal space. Personal space refers to the distance that we put between others and ourselves.

We use four distances, depending on how we feel toward the person with whom we are communicating.

Intimate distance is usually reserved for people with whom we feel emotionally close. The zone begins with skin contact and ranges out to about 18 inches.

Personal distance can range from 18 inches to about 4 feet. Here again, the contact is rather close, but less personal than the intimate distance.

Social distance, the third zone, ranges from 4 feet to 12 feet. This is the distance that most business situations occur or Ombudsmen deal with residents.

Public distance runs outward from twelve feet. The closer range of public distance is the one most teachers use in the classroom.

As you seek to communicate effectively with others, you must be aware of their personal space. If you are trying to establish rapport, you will respect their comfort with the various degrees of physical closeness. There may be other times when you will purposefully "invade" someone's personal space.

4. Gestures and Movement

Two other methods of conveying feeling and attitudes are gestures and movements. Gestures can be used to punctuate a statement; for example, pointing to emphasize or signaling to get attention. Movements all too often indicate tension or boredom.

Shifting in one's seat, foot tapping, or finger drumming, all point up inattentiveness and should be restricted. By paying attention to these, you can tell when a resident is nervous, exhausted, ready to end your visit, or any one of a number of other messages. Gestures and movements do have meanings. To be skilled as a communicator, you need to be able to reach their meanings and effectively use gestures and movements to convey your messages.

5. Silence

Sometimes the absence of words is the most effective form of communication. Words or movements are not always necessary to express a message. Silence has a number of uses.

It can:

- Mean hostility, anger, and depression;
- Be soothing, showing empathy;
- Express concern and caring;

Provide time to organize:

- One's thoughts;
- Defuse tensions;
- Provoke a response from the other person.

Silence is a very powerful communication technique. Visitors should be comfortable with silence while visiting with residents. At times, the physical presence of another person is all the reassurance and comfort that a resident needs.

6. Communicating with Care Providers

Much of a Resident Advocate's work is spent communicating with residents of nursing facilities. A Resident Advocate also needs to communicate effectively with care providers. When communicating with care providers, remember the tips that follow:

- Clearly explain the nature of your role: why you are there, what you will be doing, what they can expect from you.
- Be sure to acknowledge the good work that providers do.

- Remember that care providers are very busy. Be respectful of the demands on their time. Be concise with your communication.

C. Listening

What is verbalized in communication is only one side of the coin. The other side is listening. Concentrate on improving your listening skills as you become an experienced Resident Advocate. You will experience many rewards from developing this skill as well as obtain better information on which to judge a situation.

Active listening is the act of hearing and responding both to the content and to the feeling of what is being said. Words are often a cover up of what people feel. Most of us have learned to use words to protect ourselves. Learn to listen for the feelings that are behind the words.

For example, in the statement: "I don't want my dinner". The content is simply the information stated about the speaker not wanting dinner. The feeling could be that the speaker is not happy about something, dislikes the food, or wishes to register a protest about something by not eating dinner.

Employing an active listening strategy, one would respond to the emotional content of the message. For example, one could respond to the feeling behind what was said by saying something like, "It sounds as if you're not happy with the food here," or "You must be upset about something".

A second aspect of active listening is feedback. Within this listening strategy, one is making statements that confirm that you are listening and encouraging the speaker to go on. Feedback is an excellent way to confirm that the information you are receiving is an accurate representation of what the sender of the information is intending for you to receive.

Some useful phrases for building understanding and receiving feedback are:

- "You seem really..." (identify the feeling);
- "From your point of view";
- "If I understand what you're saying";
- "I'm not sure I understood you, you mean...?"
- "How do you feel about...?"
- "Do you mean...?"

Active listening is a very effective communication tool. Using this listening strategy is helpful when you wish to convey that you are interested in what is being said, show that you understand what the other person is saying and feeling (not necessarily that you agree but that you hear and understand), help

the speaker explore all angles and come up with her/his own answers, and encourage the other person to keep talking.

However, active listening is not always appropriate. For instance, you would not use it when you do not have time to listen or when seeking specific information. If the speaker is only imparting or asking for information, there is no need for active listening.

II. THE COMPLAINT PROCESS

Responding to and resolving complaints is a primary part of an Ombudsman's/Resident Advocate's job and one that can at times be difficult. Complaint handling is really nothing more than a process you follow from receipt of a complaint through investigation and resolution. As you handle more and more complaints, you will adapt this process to your own style. Eventually it will become second nature to you.

A. What Is A Complaint?

This basic question is a confusing one for many Ombudsmen. Are complaints only those problems you report to the state, only those you refer to a regulatory agency, or anything a resident voices concern about?

In its simplest definition, a complaint is any expression of dissatisfaction or concern. This does not mean, however, that you should launch a full-scale investigation every time someone says today's lunch tasted bad. Many people express dissatisfaction just to let off steam or to have some way of expressing themselves about things over which they have little control. They may not expect or want you to intervene on their behalf. Some residents may be disoriented as to time and express complaints that relate to the past. Your task is to get to know residents individually and to perfect the skills we will discuss well enough to be able to determine when such expressions are actual requests for assistance.

On the other hand, problems sometimes exist in a facility about which no complaints are voiced. An absence of complaints may not mean that all the residents are receiving quality care or experiencing an acceptable quality of life. There are many reasons why residents are reluctant to voice complaints. Fear of being branded a "complainer", living in isolation, feeling hopeless, fear of retaliation, simple lack of awareness that they have a legal right to complain or lack of knowledge of rights and benefits -- are factors that prevent persons in institutions from voicing grievances.

A lack of reported complaints should be taken as an indication of the need to reach out to the residents. An on-going presence within facilities will make you a familiar figure to the residents. Once you have established trust, nursing home residents and their families may begin to assert their rights and voice complaints. Your ability to detect concerns of residents, which are only hinted at, and to observe situations, which require action, is as important as your ability to respond to a direct request for assistance.

Many people who make complaints need help focusing on the actual problem. They may contact you about a complaint that involves several problems. You will need to sort out the problems and determine which are most important. Many people will not complain until a problem has persisted for a long time. When they do complain, there may be a lengthy history of events and circumstances to consider.

Complainants may be highly emotional about a complaint. Consequently, problems are often stated in sweeping terms ("the food there is terrible"). You will need to work with the complainant to pinpoint what it is about the food that makes it unacceptable.

B. Confidentiality of Complaints

Explain the confidentiality policy to the complainant at the outset of the complaint handling process. If people insist on having their names kept secret, they should be told that, while you will do everything possible to protect their identity, there is the possibility that the facility may be able to determine who made a complaint. You should also explain clearly that some complaints are virtually impossible to investigate without revealing the identity of the resident. For example, a complaint regarding a resident's finances may not be properly checked out unless financial records were reviewed, which would immediately indicate who had filed a complaint.

If the use of a complainant's name is initially denied and it is needed to proceed further with a complaint investigation, you should speak with the person again to explain the situation and to request use of the name. You should explain that the investigation cannot move forward without identifying the complainant. You should discuss with the complainant the risks involved in being identified. A guarantee that retaliation will not occur should never be offered to obtain the complainant's permission to use their name.

Sometimes a resident will insist that nothing be done or said, despite your appeals. In such cases, you have little choice. You can do no more than what the resident gives you approval to do. There is only one exception to this rule: When you observe a condition or incident yourself, you have the right to initiate a complaint investigation on your own.

You will inevitably find yourself in a number of complaint situations that will pose ethical dilemmas or call for special handling. The key to knowing how to respond to many of these situations is to remember that you represent the resident. If you have questions as to how to proceed, contact the Regional Ombudsman office for direction.

C. Ethical Dilemmas

You will inevitably find yourself in a number of complaint situations, which will pose ethical dilemmas or call for special handling. The key to knowing how to respond to many of these situations is to remember that you represent the resident. Some specific suggestions for a few of these situations are discussed below. The resources previously mentioned will also be helpful to consult when faced with these dilemmas.

- A family member may complain about a resident's care. When you talk to the resident, however, he/she says everything is fine and/or asks you not to proceed. Your primary responsibility is to the resident. If pursuing the investigation would identify the resident, you must discontinue it unless the resident grants permission to proceed. As an alternative, if you feel there is a problem with the care in the facility, you might be able to pursue a more general investigation, taking care not to do anything which would reveal the resident's identity.
- The reverse situation may also occur. The resident may complain, but the family member will urge you not to "rock the boat". This case is clearer cut; the resident has asked for assistance and you should honor that request. You should explain to the family that you are obligated to assist residents in resolving problems.
- Some complaints will come from relatives who want you to investigate, but do not want the resident to know what you are doing. For example, two relatives may be involved in a dispute over who is to provide for the resident's expenses. On the other hand, relatives may fear that the resident will be upset or alarmed by a problem.

This is a particularly sensitive situation. In such cases, it may be advisable to have a general conversation with the resident to ascertain whether or not he/she is concerned about the same problem mentioned by the complainant. You will have to judge whether or not there is a problem concerning the resident. If the resident is being victimized, you have a responsibility to correct the problem. However, you should not become involved in family disputes that are not affecting the resident's well being.

- Special problems can arise when dealing with a resident who is unable to make decisions for himself/herself, but has not been legally adjudicated incompetent. If you receive a complaint from a resident who appears to be extremely confused, how should you consider it?
Even though the resident may be confused, you should check into the complaint. If it appears to be valid, it cannot be dismissed as invalid just because it comes from someone who is confused. The resident's condition should, however, be considered as one factor in determining whether the complaint is legitimate.
- Other cases may involve a resident for who Conservator of Person (COP) or a guardian has been appointed. Generally, when cases arise involving such residents you should work through the conservator. Exceptions to this rule would be:
 - The complaint is about the COP, legal guardian, or some action of the COP or legal guardian.
 - The complaint is about the issue of whether a COP or legal guardian is needed.
 - The Conservatorship or guardianship is a limited one in which the resident retains the right to make some decisions.
 With these types of cases, it may be advisable to seek advice through the Ombudsman's Office.
- In some cases, the interest of one resident will run counter to the well being of a group of residents. For example, a complaint about a resident being denied the right to smoke may reveal that the resident has almost set the facility on fire by smoking in non-smoking areas. In such cases, you should always try to determine the facts and help the parties arrive at a solution which, as far as possible protects the rights of the individual and the group. Your role is to assist in addressing the rights of all residents, not up holding one resident's rights to the detriment of other residents.
- In some cases, complainants other than residents will insist on remaining anonymous. As in the case of residents who do not wish their names used, such persons should not be forced to reveal their identity. The complaint, if specific enough, can still be investigated using some of the techniques below:
 - Use observation to look for supporting evidence during the course of your regular visits;
 - Engage in casual conversation to see how residents feel about an issue;

- Review recent complaints or survey reports to see if similar problems have been noted; and
- If all else fails, file the complaint for future reference in case similar problems arise.

The complaint is what is expressed to you. Before you resolve most complaints, you will need to gather additional information about the situation. As a Volunteer Resident Advocate, you are expected to attempt to verify the complaint, then move to resolution based upon factual information. Therefore, part of the *RECEIVE THE COMPLAINT* step of the problem solving process is collecting information from a variety of sources. This process is frequently referred to as *INVESTIGATION*.

III. COMPLAINT INVESTIGATION

A. Gathering Information

The purpose of investigation is to determine whether the complaint is valid and to gather the information necessary to resolve it. The successful resolution of a complaint often depends upon the quality of the investigation. A poor investigation can lead to a valid complaint being dismissed as invalid or unverifiable.

An investigation is, in essence, merely a search for information. You must seek to find information that will either prove or disprove the allegations made by the complainant. It is important that you be objective in gathering information. You must not make assumptions about the validity of a given complaint, although you believe there are problems in a facility. However, being an objective investigator does not mean that you lessen your efforts to improve the care and quality of life for long-term care residents.

You have a responsibility not to jeopardize the complainant after you have received a complaint in which a resident or complainant does not want his/her identity revealed. However, if the problem is a general one, there are techniques you can use to investigate:

- Personally observe the problem;
- Find other people to voice the same complaint;
- Have the complaint channeled through a group, such as a resident council, or;
- Handle as an anonymous complaint.

Information can be gathered in many ways. Among the most common are:

- Interviewing;
- Observation.

B. Building Trust

DO'S

- Let the individual do the explaining;
- Listen attentively and with understanding;
- Hear exactly what is being said;
- Be sensitive to sensory losses, memory lapses;
- Restate to clarify and assure understanding;
- Encourage the speaker to elaborate;
- Concentrate on physically demonstrating your attention -- use posture, facial expression, eye contact, gestures and voice quality;
- Be comfortable with silence;
- Keep conversation moving with open-ended questions;
- Repeat what has been said without adding or changing;
- Empathize.

DON'TS

- Make the complainant feel defensive;
- Evaluate, make value judgments, accuse, correct, or indoctrinate;
- Appear judgmental in your posture or facial expressions;
- Take control of the conversation. If you control, intimidate, or threaten, you will lose credibility;
- Create an impression of superiority. If you do, your usefulness will end;
- Seem detached or disinterested. Neutrality is not the same as lack of concern.

How you handle the problem-solving process directly impacts:

- Your relationship with residents and staff
- Your ability to achieve the desired outcome
- Future relationships with residents, families, and staff
- The reputation of the Ombudsman program

Long-Term Care Ombudsman Program Approach

Respectful

Persistent

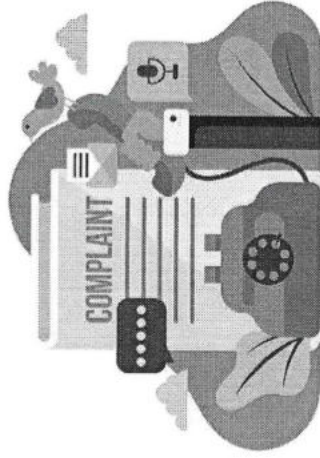
Assertive


Professional

Where do Complaints come from?

- Facility visits
- Phone calls
- Emails
- Resident council meetings
- Family council meetings

CONTACT US



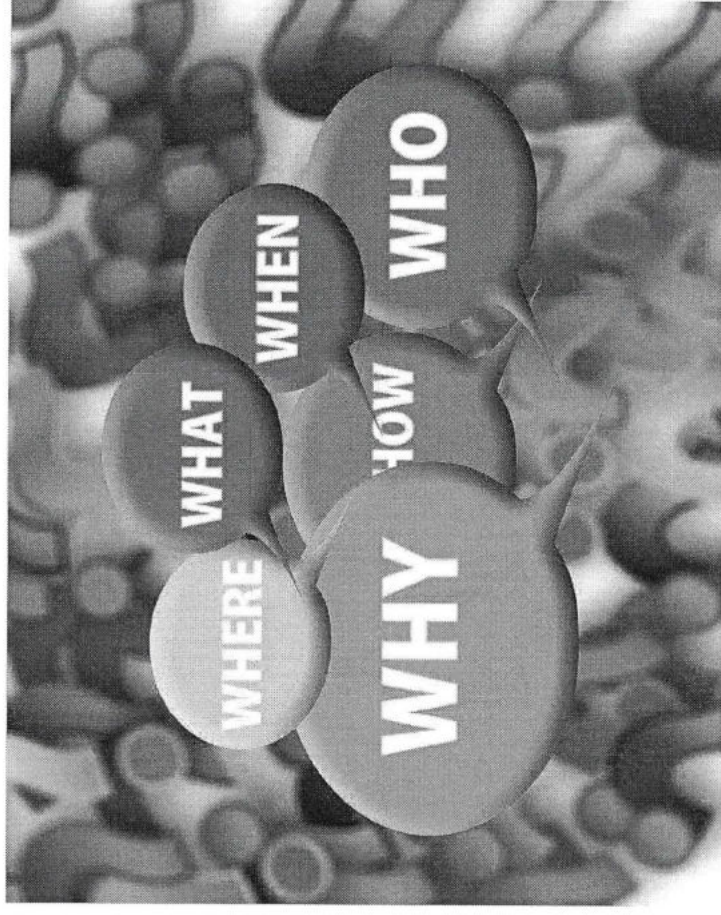
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Who are the Complainants?

- Residents
- Family members/friends of residents
- Facility staff
- Hospital staff
- Community members
- Clergy
- Legislators
- Representatives of the Office
- Anonymous
- Anyone

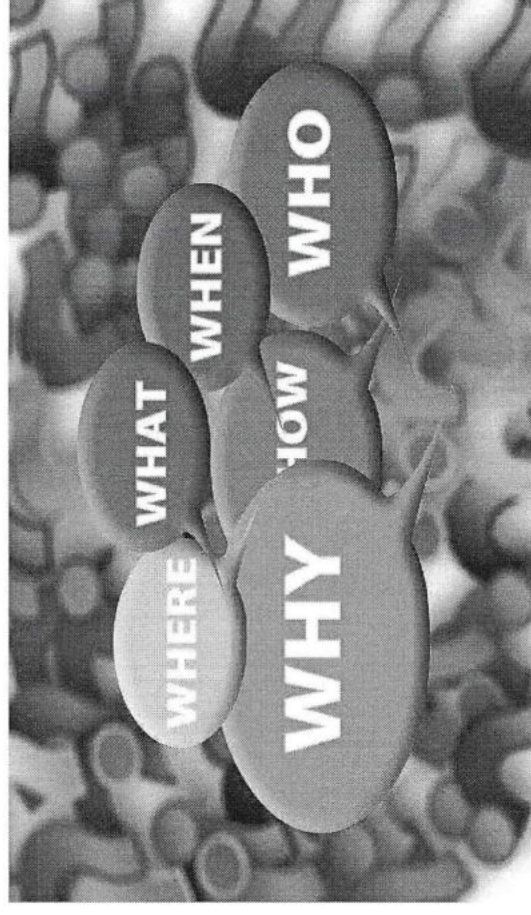
→ **Complaint Intake Process**

- **What** is occurring or has occurred?
- **When** the problem occurred and whether it is ongoing.
- **Where** the problem occurs or occurred.
- **Who** was or is involved?
- **How** resident(s) are affected.

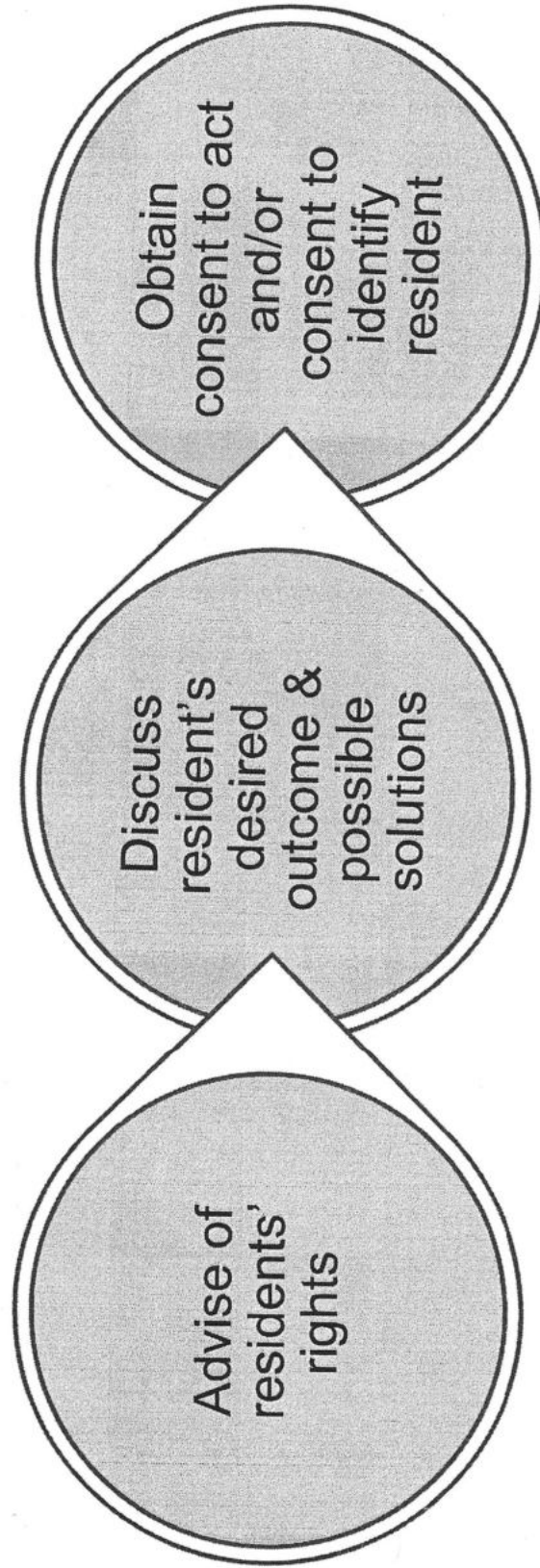


- **Why** the problem is occurring or has occurred.
- **What** steps have been taken to resolve the problem?
- **Who** has been contacted about the concern?
- **What** the facility has done in response to the problem.

- **What** is the resident's perspective of the problem?
- **What** the resident's wishes are regarding complaint resolution.



Initial Plan Development



Identify all steps already taken

5.

Clarify the outcome the resident is seeking

6.

Identify all relevant agencies

7.

1. Separate the problems

2. Categorize the complaint and identify laws or regulations

3. Consider potential cause(s)

4. Identify all participants

Resident Consent

What if the resident refuses to consent?

- Determine why.
- Explain the resident's options for addressing the complaint.
- Do not proceed with opening a complaint investigation.
- Provide your contact information.
- Determine if the concern is systemic.

What if the resident withdraws consent?

- Determine why.
- If the problem is recurring, provide other options for the resident to consider.
- Stop all advocacy efforts.
- Provide your contact information.
- Determine if the concern is systemic.

Complaint

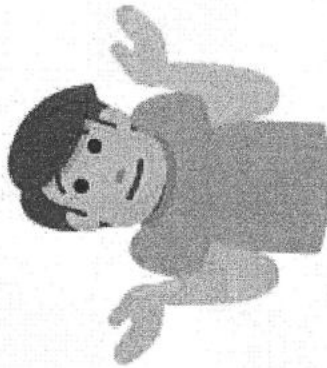
- Will you help me get more therapy?
- The facility is going to kick me out, can you do something about it?
- I want to be able to use the phone in private, is there anyone you can talk to about it for me?

Not a Complaint

- One aide is rude to me, but I don't want you to say anything.
- I don't want to get up so early in the morning, but it takes me so long to get ready. I've learned to accept it.
- My kids put me in this home, and I wish I didn't have to live here.

Concern or Complaint?

Lunch tastes
terrible!



Is there anyone I can talk
with about your concerns?

Is there anything I can help
you with today?

Is this something you
would like my help with?

Is there anything I can do
to help your situation?

Accessing Records

Resident is Able to Communicate
Informed Consent



Exercise good judgement on
resident's ability to provide informed
consent



Obtain and document consent from
the resident
Written, verbal or through another
means



Document consent according to
policies and procedures.

Resident is Unable to
Communicate Informed Consent
and has a resident representative



Confirm resident representative has
authority to grant access



Obtain and document consent from
the resident representative
Written, verbal or through another
means



Document consent according to
policies and procedures

Resident is unable to communicate informed consent, and the resident representative refuses to consent to the access and the resident representative is not acting in the best interests of the resident or the resident representative cannot be located despite a reasonable effort.



Notify your supervisor.



Document why you believe the resident cannot communicate informed consent.



Follow program policies and procedures regarding consent from the State Ombudsman to access records and document the permission.

Resident is not able to communicate informed consent and does not have a resident representative



Notify your supervisor



Document why you believe the resident cannot communicate informed consent.



Follow program policies and procedures regarding consent from the State Ombudsman to access records and document the permission.

Connecticut Long Term Care Ombudsman policy and procedure on complaint process.

- (1) The Long-Term Care Ombudsman's Office shall identify, investigate and resolve complaints made by, or on behalf of, residents that relate to an action, inaction or a decision of a provider, long-term care facility, a public agency or a health and social service agency, that may adversely affect the health, safety, welfare or rights of residents.
- (2) The Office of the Ombudsman shall respond to complaints promptly and prioritize those complaints involving abuse, neglect, exploitation, or complaints that are time sensitive. In determining the priority of response, the Office shall consider the severity of the risk to the resident, the imminence of the threat or harm to the resident, and the opportunity for mitigating harm to the resident through provision of Ombudsman program services.
- (3) The Regional Ombudsmen shall ensure access to Ombudsman services and timely response to requests and complaints by providing office coverage and visiting facilities. Office coverage may include a Regional Ombudsman or other Office representative providing telephone coverage, frequent checks of voicemail, or use of mobile devices.
- (4) A representative of the Office shall initiate a response to a complaint within two business days or sooner when the circumstances appear urgent. A case with the resident as the complainant takes priority over other cases. Initiation includes contact with the resident or complainant and other sources of investigative information; it does not require a facility visit within two business days. There is no required period for final disposition of a case.
- (5) The Office does not serve as an emergency responder. Complainants reporting emergencies should be urged to call 911 for immediate attention.
- (6) With respect to identifying, investigating, and resolving complaints, and regardless of the source of the complaint, the Ombudsman and the representatives of the Office serve the resident of a long-term care facility. The Ombudsman or representative of the Office shall investigate a complaint, including but not limited to a complaint related to abuse, neglect, or exploitation, for the purposes of resolving the complaint to the resident's satisfaction and of protecting the health, welfare, and rights of the resident. An investigation may be undertaken only with the resident's consent. The Ombudsman or representative of the Office may identify, investigate, and resolve a complaint impacting multiple residents or all residents of a facility.
- (7) Regardless of the source of the complaint, including when the source is the Ombudsman or representative of the Office, the Ombudsman or representative of the Office will support and maximize resident participation in the process of resolving the complaint as follows:
 - (a) The Ombudsman or representative of Office shall offer privacy to the resident for the purpose of confidentially providing information and hearing, investigating, and resolving complaints.

(b) The Ombudsman or representative of the Office shall personally discuss the complaint with the resident (and, if the resident is unable to communicate informed consent, the resident's representative) in order to:

(i) Determine the perspective of the resident (or resident representative, where applicable) of the complaint;

(ii) Request the resident (or resident representative, where applicable) to communicate informed consent in order to investigate the complaint;

(iii) Determine the wishes of the resident (or resident representative, where applicable) with respect to resolution of the complaint, including whether the allegations are to be reported and, if so, whether Ombudsman or representative of the Office may disclose resident identifying information or other relevant information to the facility and/or appropriate agencies.

(iv) Advise the resident (and resident representative, where applicable) of the resident's rights;

(v) Work with the resident (or resident representative, where applicable) to develop a plan of action for resolution of the complaint;

(vi) Investigate the complaint to determine whether the complaint can be verified; and

(vii) Determine whether the complaint is resolved to the satisfaction of the resident (or resident representative, where applicable). If a resident is unable to communicate his or her informed consent, or perspective on the extent to which the matter has been satisfactorily resolved, the Ombudsman or representative of the Office may rely on the communication of informed consent and/or perspective regarding the resolution of the complaint of a resident representative so long as the Ombudsman or representative of the Office has no reasonable cause to believe that the resident representative is not acting in the best interests of the resident.

(c) Where the resident is unable to communicate informed consent, and has no resident representative, the Ombudsman or representative of the Office shall:

(i) Take appropriate steps to investigate and work to resolve the complaint in order to protect the health, safety, welfare and rights of the resident; and

(ii) Determine whether the complaint was resolved to the satisfaction of the complainant.

(d) In determining whether to rely upon a resident representative to communicate or make determinations on behalf of the resident related to complaint processing, the Ombudsman or representative of the Office shall ascertain the extent of the authority that has been granted to the resident representative under court order (in the case of a guardian or conservator), by power of attorney or other document by which the resident has granted authority to the representative, or under other applicable State or Federal law.

(8) Any complaint filed with the Long-Term Care Ombudsman's Office shall contain the name and address of the long-term care facility, the name of the involved resident or residents or the statement that all the residents are affected, information regarding the nature and extent of the

complaint and any other information which the reporter believes might be helpful in the investigation of the complaint.

(9) A complaint may be filed with the Long-Term Care Ombudsman's Office, or the RA assigned to the resident's facility in person, by mail, facsimile, electronic mail or by telephone.

(10) For information or for filing of complaints with the State Ombudsman, persons may contact the Long-Term Care Ombudsman's Office. A toll-free number shall be available, and the number shall be conspicuously posted in each facility.

(11) A complaint filed by an individual who chooses not to disclose his or her identity shall be considered an anonymous complaint. Anonymous complaints shall be reviewed by the Ombudsman or the Ombudsman's designee. An investigation shall be done only if the State Ombudsman or the State Ombudsman's designee considers the nature of the complaint to be of such seriousness as to warrant follow-up.

(12) The State Ombudsman shall maintain a registry of all complaints.

(13) A complaint filed by a resident with the Long-Term Care Ombudsman's Office may be withdrawn by the resident at any time. Any request for withdrawal of a complaint, where the complainant is an individual other than the resident, may be granted only after consultation with the resident. If the resident wishes to proceed with an investigation, the Long-Term Care Ombudsman's Office shall proceed with the investigation on behalf of the resident. Requests for withdrawals shall be documented in the resident's case record. The complainant shall be advised, at the time the withdrawal, of the consequences of the withdrawal and that a complaint may be reopened if requested.

(14) If there is reason to believe, based on the information contained in the complaint received, that the resident is potentially at risk for immediate physical or emotional harm the evaluation shall be done immediately. Examples of immediate risk of physical or emotional harm include, but are not limited to, allegations of physical endangerment or withholding of medication, nutrition, or hydration. In cases where the complaint is received directly by the Ombudsman or there is a question regarding whether the resident is potentially at risk for immediate physical or emotional harm, the evaluation may be done by the Ombudsman.

(15) A representative of the Long-Term Care Ombudsman's Office shall initiate a full investigation of the complaint within ten business days after the determination is made that an investigation is warranted. A copy of the investigation report shall be sent to the State Ombudsman who shall maintain a registry of investigation reports. A copy of the investigation report may be sent to the resident or the resident's legal representative upon request. The State Ombudsman shall not disclose the identity or identifying information regarding another resident or the complainant if the complainant is someone other than the resident.

(16) If an investigation is completed and the Long-Term Care Ombudsman's Office has taken actions to attempt to resolve the complaint, but the complaint is not resolved to the satisfaction of the resident, the State Ombudsman may, with the authorization of the resident, request the advice or recommendations of the Executive Board. The State Ombudsman may, considering the advice

or recommendations of the Executive Board, take any recommended actions or close the case. The State Ombudsman shall provide, upon request, a written explanation to the individual regarding the decision to close a case. If a representative of the office is not able to substantiate the complaint with the resident and is unable to reach or make contact with the complainant after 3 separate attempts on subsequent days, the Representative of the program may close the case at that time.

(17) The appropriate representative of the Long-Term Care Ombudsman's Office shall conduct an impartial investigation of the complaint. The representative may, with the permission of the resident or the resident's legal representative, speak with the administrator of the facility and any other persons who may be a source of information. Other persons may include, but are not limited to, the friends and family of the resident involved, and if there is a specific resident involved, the staff of the facility, representatives from involved or relevant public and private agencies, or the legal representative of the resident. The representatives of the Long-Term Care Ombudsman's Office shall make written recordings of all statements by all persons being interviewed.

(18) In the course of an investigation any representative of the Long-Term Care Ombudsman's Office may observe the functioning of the entire facility and may interview residents at random. Except when the facts warrant immediate action, investigations shall be carried out at reasonable times and without interference with resident care.

(19) A long-term care facility, a representative of the Long-Term Care Ombudsman's Office, or any other person may not interfere with the proper medical treatment of any resident.

| | | |
|---|--|---|
| <p style="text-align: center;">NORS CODES</p> <p style="text-align: center;">Certified Ombudsman Volunteer Representative Guide</p> | | |
| Volunteer can manage independently | Volunteer must consult with OLTCO staff prior to involvement | Volunteer must notify OLTCO staff - Regional Ombudsman Only |
| B. ACCESS TO INFORMATION | B. ACCESS TO INFORMATION | B. ACCESS TO INFORMATION |
| Access to own records Access to facility survey/staffing reports/license Information communicated in understandable language | Access to Ombudsman/visitors Information regarding medical condition, treatment and any changes Information regarding rights/benefits/services | Information regarding advance directives |
| C. ADMISSION, TRANSFER, DISCHARGES, EVICTION | C. ADMISSION, TRANSFER, DISCHARGES, EVICTION | C. ADMISSION, TRANSFER, DISCHARGES, EVICTION |
| | Room assignment/room change/intrafacility transfer | Admission contract and/or procedure Appeal process - absent, not followed Bed hold- written notice, refusal to readmit Discharge/eviction - planning, notice, procedure, implementation, abandonment Discrimination in admission due to condition, disability Discrimination on admission due to Medicaid status |

| | | |
|---|---|--|
| | NORS CODES Certified Ombudsman Volunteer Representative Guide | |
| Volunteer can manage independently | Volunteer must consult with OLTCO staff prior to involvement | Volunteer must notify OLTCO staff - Regional Ombudsman Only |
| D. Autonomy, Choice, Exercise of Rights, Privacy | D. Autonomy, Choice, Exercise of Rights, Privacy | D. Autonomy, Choice, Exercise of Rights, Privacy |
| Choose personal physician Dignity, respect Exercise preference, choice and/or civil, religious rights (includes right to smoke) Language barrier in daily routine Privacy - telephone, visitors, couples, mail Privacy in treatment, confidentiality Response to complaints | Choose other health care provider, hospice Staff attitudes Exercise right to refuse treatment (guardians) Participate in care planning by resident and/or designated surrogate | Confinement to facility against will Reprisal, retaliation |
| E. Financial, Property (Except for Exploitation) | E. Financial, Property (Except for Exploitation) | E. Financial, Property (Except for Exploitation) |
| Personal property lost, stolen, used by others, destroyed, withheld from resident | | Billing/charges - notice, approval questionable, accounting wrong or denied Personal funds: mismanaged, access denied, deposits and other monies not returned |

| NORS CODES | | |
|---|---|--|
| Certified Ombudsman Volunteer Representative Guide | | |
| Volunteer can manage independently | Volunteer must consult with OLTCO staff prior to involvement | Volunteer must notify OLTCO staff - Regional Ombudsman Only |
| F. Care | F. Care | F. Care |
| Failure to respond to requests for assistance | Accident or injury of unknown origin, falls, improper handling Care plan/resident assessment - inadequate, lack of patient/family involvement, failure to follow plan of physician orders Contracture | Medications - administration, organization |
| Personal hygiene (includes nail care and oral hygiene) and adequacy of dressing and grooming Toileting, incontinent care Wandering, failure to accommodate/monitor | Physician services, including podiatrist Pressure sores, not turned Symptoms unattended, including pain, pain not managed, no notice to others of changes in condition Tubes - neglect of catheter, gastric, NG tube | |
| G. Rehabilitation or Maintenance of Function | G. Rehabilitation or Maintenance of Function | G. Rehabilitation or Maintenance of Function |
| | Assistive devices or equipment Bowel and bladder training Dental services mental health, psychosocial services range of motion, ambulation Therapies, physical, occupational, speech Vision and hearing | |
| H. Restraints - Chemical and Physical | H. Restraints - Chemical and Physical | H. Restraints - Chemical and Physical |
| | | Physical restraint - assessment, use, monitoring Psychoactive drugs - assessment, use, evaluation |
| I. Activities and Social Services | I. Activities and Social Services | I. Activities and Social Services |
| Activities - choice Community interaction , transportation Social services - availability | Activities - appropriateness of choice Resident conflict, including room mates Social services - appropriateness | |

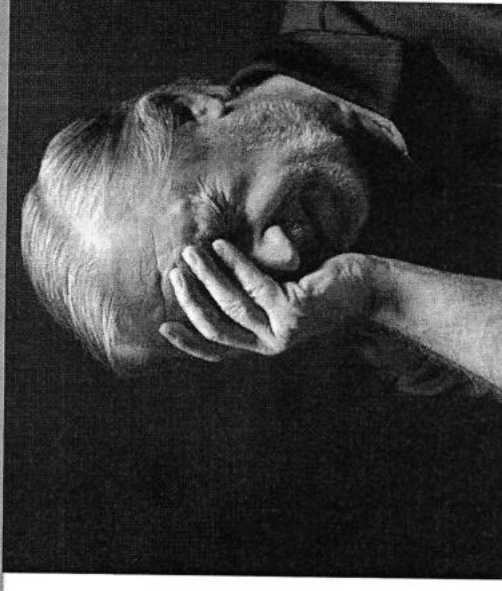
| NORS CODES | | |
|--|--|---|
| Certified Ombudsman Volunteer Representative Guide | | |
| Volunteer can manage independently | Volunteer must consult with OLTCO staff prior to involvement | Volunteer must notify OLTCO staff - Regional Ombudsman Only |
| J. Dietary | J. Dietary | J. Dietary |
| Fluid availability and hydration Food service - quantity, quality, variation, choice, utensils, menu Snacks, time span between meals, late/missed meals Temperature | Assistance with eating or assistive device eyes Therapeutic diet Weight loss due to inadequate nutrition | |
| K. Environment/Safety | K. Environment/Safety | K. Environment/Safety |
| Air/environment: temperature and quality (heating, cooling, ventilation, water), noise Cleanliness, pests, general housekeeping Equipment/buildings - disrepair, hazard, poor lighting, fire safety, not secure Furnishings, storage for residents Laundry - lost, condition Odors Space for activities, dining Supplies and linens | Infection control Americans with Disabilities Act (ADA) accessibility | |
| L. Policies, Procedures, Attitudes, Resources | L. Policies, Procedures, Attitudes, Resources | L. Policies, Procedures, Attitudes, Resources |
| Grievance procedure (not transfer/discharge) Resident or family Council/committee interfered with, not supported | Administrator unresponsive, unavailable offering in appropriate level of care (for B&C/similar) | Abuse investigation/reporting, including failure to report Inadequate or illegal practices, record keeping Insufficient funds to operate Operator inadequately trained |

Case Study: Mr. Richards

Mr. Richards has been in a nursing facility for several months when his wife starts to notice a change in his health.

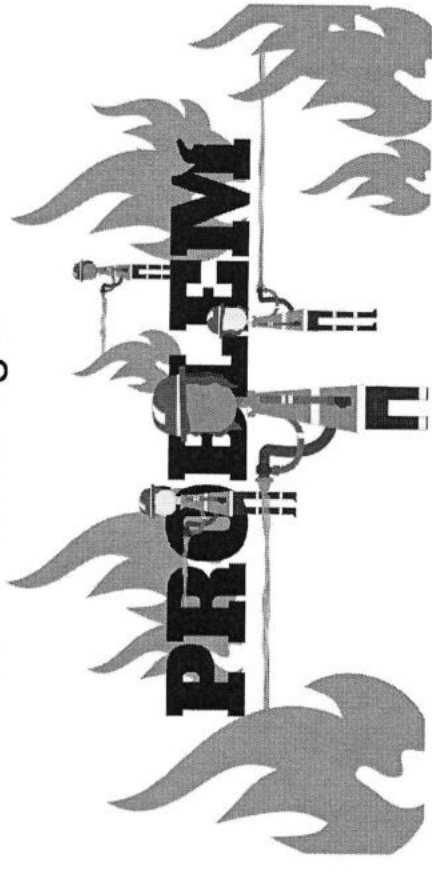
During a visit, Mrs. Richards tells you, "He became chronically sleepy, started losing weight, and the facility has done nothing about it." She believes that her husband was placed on an improper diet. "How could he be given an appropriate diet when the doctor never sees him? He loves milk, but it's always warm. I am still trying to get them to replace the hearing aid they lost two months ago! Can you help me?"

Every time you attempt to visit Mr. Richards, you observe that he is sleeping. Mrs. Richards is his agent under a power of attorney. You ask additional questions to determine the facts of the complaint.



Separate the problems

- Mr. Richards became chronically sleepy about one week ago.
- Mr. Richards lost 10 pounds in three weeks.
- The facility did not address the sleepiness or the weight loss in the care plan.
- The last time Mr. Richards was seen by a doctor was three months ago.
- Mr. Richards' hearing aid is missing.
- Mr. Richards' milk is always warm at all meals.



2. Categorize the complaint and identify laws or regulations

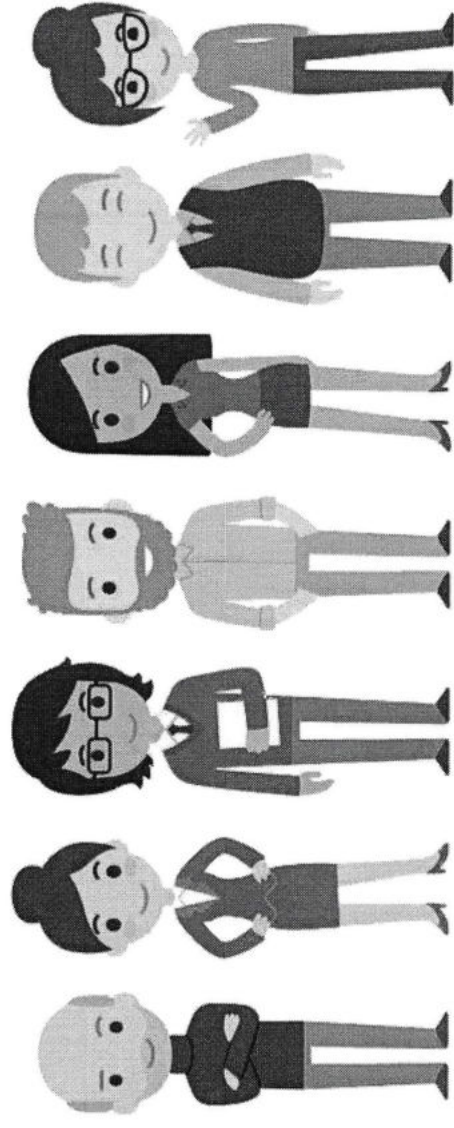
Care Planning. The facility is required to assess Mr. Richards and modify his care plan based on his current symptoms.

IMPLIED RULES
CRIMINAL
REGULATIONS
POLICIES
GOVERNMENT
ENFORCE
STATUTES
COURT
PERMITS
FOLLOW
SAFETY
LAWMAKERS
AUTHORITY
PENALTIES
PHILOSOPHY
LOCAL
STANDARDS
SOCIAL
REFORM
ENVIRONMENTAL
FEDERAL
CODE
WRITTEN

3. Consider potential cause(s)

- The facility is not aware of the new medical conditions.
- Some staff are aware of the concerns but have not communicated the concerns.
- The facility does not regularly weigh Mr. Richards.
- The facility does not have consistent staff assignments.
- Mr. and Mrs. Richards are not aware of his right to request a care plan and do not understand the purpose of a care plan.
- The facility views Mrs. Richards as a frequent complainer and ignores her concerns.
- An assessment was completed, and a care plan conference was held but the Richards were not informed.

4. Identify all participants



- Mr. Richards
- Mrs. Richards
- Care Plan Coordinator
- Director of Nursing
- Charge Nurse
- Certified Nursing Assistants (CNAs) who cared for Mr. Richards two months ago
- CNAs who currently care for Mr. Richards
- Mr. Richards' physician

5.

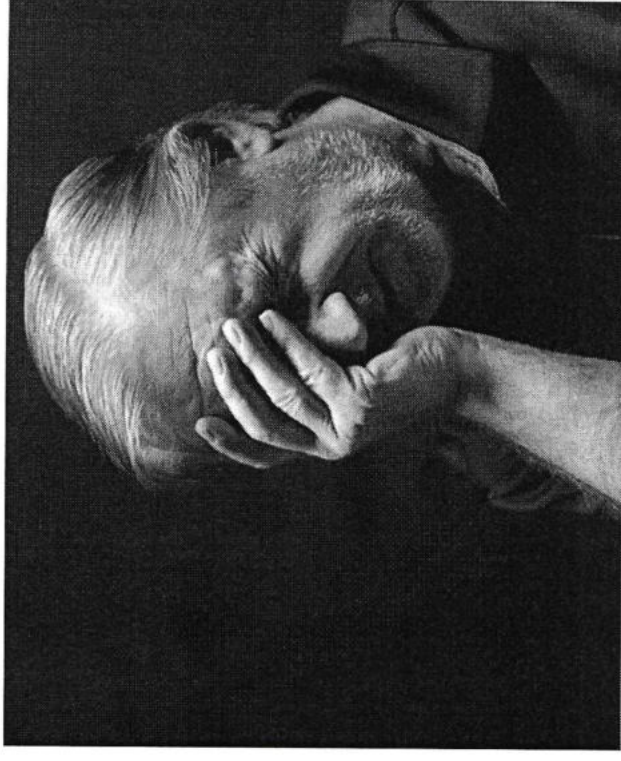
Identify steps already taken

- Who did she talk to at the facility? - What was their response?
- Has Mrs. Richards spoken with Mr. Richards' physician? - What was their response?
- When was the last care plan conference held?
- Is the facility following the current care plan?
- What changes does she believe need to be made to the care plan?

Clarify the outcome the resident is seeking

6.

- A comprehensive assessment
- A care plan meeting that includes Mr. Richard's physician
- Consistent staffing for Mr. Richards
- To be listened to when expressing concerns

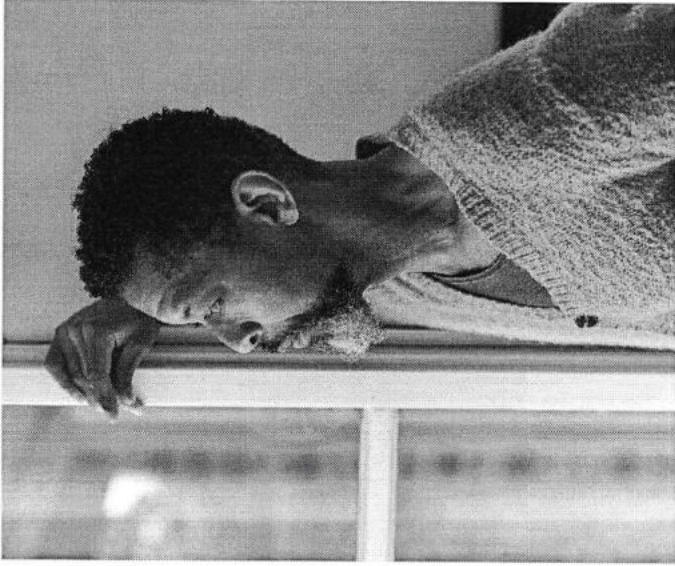


7. Identify all relevant agencies

- The regulatory agency may be called to investigate the facility's compliance with state and federal regulations.



Facility Initiated Discharge



Receives a discharge notice and does not want to leave

Is discharged without notice or due process

Is transferred to the hospital and not advised of the facility's bed hold policy

Is not readmitted post hospitalization

Is discharged to an unsuitable setting

Other Challenges

- The facility fails to provide a written notice of discharge
- The notice is incomplete or incorrect
- The reason for the discharge is not in compliance with federal and/or state regulations



The National

CONSUMER VOICE

for Quality Long-Term Care
formerly NCCNHR

FACT SHEET

INVOLUNTARY TRANSFER AND DISCHARGE

The threat of transfer or discharge from a nursing home can be both frightening and stressful for residents and their families. Too often, a facility may respond to a resident's difficulties, increasing need for care, or repeated questions or complaints from family members by attempting to transfer or discharge the resident. The Nursing Home Reform Law of 1987 protects residents from involuntary transfer and discharge. Contact the Long Term Care Ombudsman in your area for more information about legal rights and protections and for assistance in working with the facility.

TRANSFER and DISCHARGE

Transfer is movement from a certified institution to another institutional setting that assumes legal responsibility for the resident's care. **Discharge** is movement from a certified institutional setting to a non-institutional setting. After discharge, the facility is no longer legally responsible for the resident's care.

WHAT THE LAW SAYS ABOUT INVOLUNTARY TRANSFER/DISCHARGE:

The Nursing Home Reform Law of 1987 prohibits nursing homes from transferring or discharging a resident unless it can establish that one of the permissible reasons for transfer/discharge exist. Those reasons are:

- the nursing home cannot provide adequate care for the resident;
- the resident's health has improved to the point that he or she no longer needs nursing home care;
- safety of individuals in the facility is endangered;
- the health of others in the facility would otherwise be endangered;
- the resident has failed, after reasonable and appropriate notice, to pay for care (although the facility cannot evict a resident who is waiting for Medicaid eligibility and should work with other state agencies to obtain payment if the resident's money is being held by a family member or other individual); or
- the facility ceases to operate.

Before proposing a transfer/discharge, a facility must identify and try to meet the resident's individual medical, nursing, and psychosocial needs, by formulating and implementing an individualized care plan designed to meet those needs. Many of the permissible reasons for transfer or discharge can be addressed through assessment and care planning, making transfer or discharge unnecessary. Because most nursing homes provide fairly complex care for sick residents, it is rare that the facility cannot find a way to provide adequate care for the resident or to keep the resident and others safe with the use of a good assessment and care plan. Furthermore, universal health precautions should be in place in every nursing home that protect the health of residents and others and prevent the spread of infection. The nursing home assesses the care needs of prospective residents upon initial admission. Once a resident has been accepted by the nursing home, the nursing home should find ways to provide safe and appropriate care.

NOTIFICATION

If a resident is to be transferred or discharged, the facility must record the reason for transfer in the resident's clinical record, and notify the resident and the resident's family member, guardian, or legal representative in writing. The notice must include:

- the reason for the transfer or discharge,
- the location to which the resident will be moved,
- the date of transfer or discharge, and
- information about the resident's right to appeal to the state concerning the transfer or discharge,
- with the name, address, and telephone number of the state long term care ombudsman.

The location the resident will be moved to must be specific, appropriate, available, and agreeable to taking the resident.

TIME LIMITS

The law requires that a nursing home must inform the resident and the resident's family member, guardian or legal representative about a transfer or discharge at least thirty (30) days in advance.

PREPARATION BEFORE TRANSFER OR DISCHARGE

The nursing home must provide discharge planning and sufficient preparation and orientation to residents being transferred/discharged. The law guarantees the right of the resident (and/or family member) to participate in planning care and treatment, which should include choosing a new place to live. The nursing home should also prepare an orientation, such as a visit to the new home, and assure a safe arrival. The resident should know where he or she is going. The facility should also inform the new residence about the resident's needs, preferences and habits. Lastly, the nursing home should ensure possessions aren't lost in the moving process, and any personal funds are given to the resident or transferred to a new account.

BED HOLD AND READMISSION

The Nursing Home Reform Law gives Medicaid recipients the right to return to their facility after they have been out of the facility due to hospitalization or therapeutic leave. Some states will pay to hold a bed for Medicaid residents who are temporarily absent. If a Medicaid recipient loses a bed -- either because the state does not pay to hold the bed, or they have exceeded the state's bed hold period, readmission rights permit him or her to return to the next available bed in a semi-private room in the nursing home. Residents are entitled to notice about bed-hold and readmission rights twice-- upon admission and at the time of transfer. A facility's bed hold policy must be consistent with state regulations.

ADDITIONAL RIGHTS

The Nursing Home Resident Protection Amendment of 1999 requires that nursing homes continue to provide care for Medicaid residents already living in the facility even if the nursing home chooses to cease participation in Medicaid.

- A resident has the right to participate in planning care and treatment or changes in care and treatment.
- A resident and their family member or legal representative must receive notice before the resident's room or roommate in the facility is changed.
- A resident can refuse transfer from a portion of the nursing home that is certified at one level of care to another portion with different certification.

COMPLAINTS AND APPEALS

A resident has the right to appeal the facility's decision to transfer/discharge him or her. The transfer or discharge notice must include information about how to request a hearing, the resident's right to use legal counsel or other spokesman at the hearing, and the mailing address and telephone number of the State long-term care ombudsman. A complaint may also be filed with the state survey agency.

PROTECTION AGAINST INAPPROPRIATE TRANSFER OR DISCHARGE

Contact the Long Term Care Ombudsman program if you are concerned about plans for transfer or discharge from a nursing home. The ombudsman is empowered by law to advocate for nursing home residents. Also, find out if there is a family council at the nursing home. When families meet to share concerns and organize a consumer voice, this is a source of power for negotiation with the facility's administration.

Go to www.theconsumervoice.org/get_help to find an ombudsman in your area.

For more information and resources on transfer and discharge and residents' rights, go to www.theconsumervoice.org

National Consumer Voice for Quality Long-Term Care (formerly NCCNHR) is a nonprofit organization founded in 1975 by Elma L. Holder to protect the rights, safety and dignity of American's long-term care residents.

Verified

Confirmation that most or all facts alleged by the complainant are likely to be true.

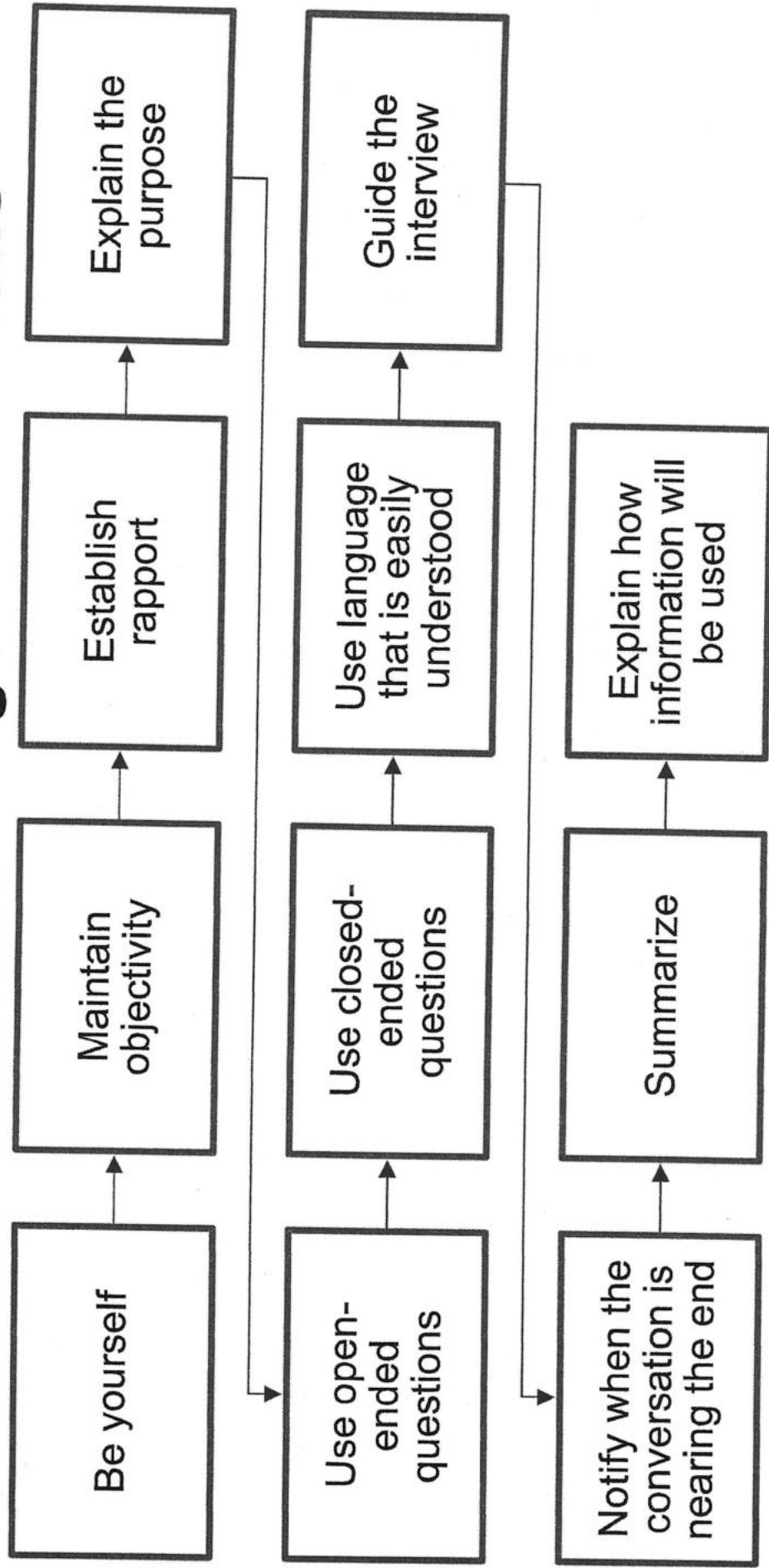
What if the complaint cannot be verified but the resident's perception of the problem still exists?

Not Verified

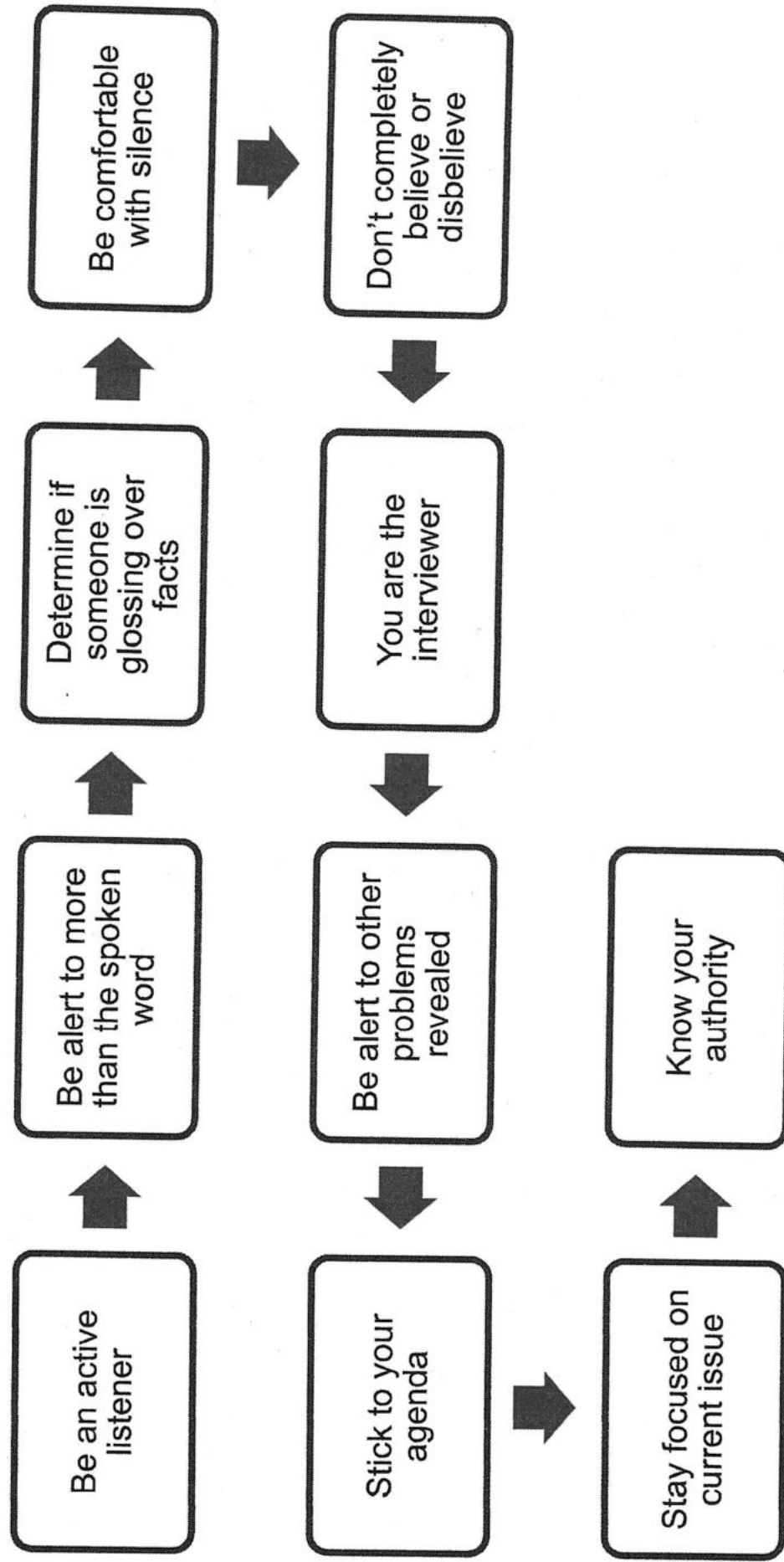
The circumstances of the complaint are found to be untrue.

What if a family member complains that the resident is not getting good care, but the resident is satisfied with the care received?

Guidelines for Investigative Interviews



Guidelines for Effective Listening During Interviews



MODULE 4

THE LONG TERM CARE SETTING

I. TYPES OF HOMES AND LEVELS OF CARE

- A. Skilled Nursing Homes
- B. Residential Care Home
- C. Assisted Living/MRC

II. STAFF AND DEPARTMENTS

III. LONG TERM CARE REIMBURSEMENT

IV. REGULATIONS GOVERNING LONG TERM CARE FACILITIES

- A. State Licensure
- B. Federal Certification
- C. Enforcement in Long Term Care Facilities
- D. Departments Involved In Inspection
- E. Ombudsman Intervention
- F. CMS Five Star Rating System/Sample Survey

V. VRA GUEST APPEARANCE/ARRANGE A SHADOWING VISIT

MODULE 4 Appendix
CMS - Five Star Rating
Sample DPH Survey

I. TYPES OF HOMES AND LEVELS OF CARE

A. Skilled Nursing Facility

A Skilled Nursing Facility is a nursing home that provides 24-hours skilled nursing care and related services, or rehabilitative services for the injured and disabled. These services cannot be provided in a facility other than a hospital. Medicare pays for residents with Medicare insurance for care only in SNF certified facility. Medicaid will pay for eligible residents in certified Nursing Facility (NF).

To illustrate, skilled care provides:

- 24-hour care including medical, nursing, dietary, pharmaceutical services, and an activity program.
- Emphasis on rehabilitation, attaining and maintaining the highest level of functioning such as gait training, and bowel and bladder training.
- Mandated staff to resident ratio.
- May include administration of intravenous medication or other treatments as ordered.

B. Residential Care Home

A residential care home is described as a facility with the capability of providing the necessary personnel to furnish food, shelter and laundry for two or more persons unrelated to the proprietor. The facility provides services of a personal nature, which do not require the training or skills of a licensed nurse. Additional services of a personal nature may include; assistance with bathing, help with dressing, preparation of special diets and supervision over medications which are self-administered. Other services may be provided through outside agencies. As of 2009, Connecticut has licensed 99 residential care homes with approximately 3,500 beds.

C. Assisted Living Facility (ALF)/Managed Residential Community (MRC)

An ALF or MRC is a housing and healthcare alternative which provides support such as housekeeping, emergency call system and meals and activities (specific services are disclosed in the contract). For individuals who may also require some healthcare supports most ALF/MRC's also have contracts with Assisted Living Services Agencies (ALSA's) which can provide nursing and home health services on a contracted basis separate from the ALF/MRC. Residents contract privately for housing however there are a number of demonstrations projects in Connecticut which may assist with costs.

While the ALF is not licensed by the state it is governed by the Connecticut Tenant Landlord Laws. The ALSA is licensed by the Department of Public Health and on site inspections are done every two years.

As of 2009 there are 84 ALSA's licensed by the State of Connecticut per the trade associations, the Connecticut Assisted Living Association, there are over 5,000 residents receiving assisted living services.

II. STAFF AND DEPARTMENTS OF LONG TERM CARE FACILITIES

- Administration

The administrative unit of a home may include the nursing home administrator, secretarial staff, accounting, and admissions.

Nursing Home Administrator -- responsible for overall (fiscal, legal, medical and social) management and operation of the facility.

Medical Director -- the physician who formulates and directs overall policy for medical care in a nursing home.

- Nursing Services

Director of Nursing -- a registered nurse that oversees the entire nursing staff.

Nursing Supervisor -- responsible for nursing care on a floor, section, or wing during a particular shift.

Certified Nurse Assistant (CNA) -- CNAs supply 80-90% of the "hands-on" patient care given in nursing homes. Certified Nurse Assistants are required to complete a training and competency program.

- Dietary Department

The dietary program is responsible for planning and preparing the food served in a nursing home in accordance with state licensure regulations (and federal certification requirements if it is a certified facility). Some nursing homes have a menu cycle, such as a four-week cycle or a seasonal cycle. A physician must order special diets.

Dietician -- expert in planning menus, diets and dietary procedures. The dietician is responsible for setting up special diets, as well as maintaining proper nutritional levels for residents.

Food Service Supervisor -- is responsible for the daily preparation of foods, and special diets.

- Activities Department

Most nursing homes have an activities program. An activities program is a requirement for certification of RHNS and CCNHSs. Activities should be planned to be appropriate to the needs and interests of the residents and to enhance the quality of life.

Recreational Therapist -- responsible for developing, scheduling and conducting programs to meet the social and diverse needs of residents.

- Social Services

The Social Services Department is responsible for identifying the medically related and emotional needs of the patient. An assessment of each resident's needs should be found in her/his record and needed services should be incorporated into the care plan. OBRA 1987 requires every nursing facility with more than 120 beds to employ a full-time professional social worker.

- Housekeeping

Members of the housekeeping staff are usually responsible for basic housekeeping chores such as sweeping floors, dusting, emptying waste cans, and cleaning furnishings.

Every nursing home has laundry facilities and is responsible for providing clean bed linens and towels. The home is also equipped to launder resident clothing.

- Ancillary Medical Staff

Medical staff is responsible for attending to the physical needs of the residents. Although nursing is the most visible of the medical staff, other medical personnel include attending physicians, physical therapists, occupational therapists, speech pathologists, and podiatrists.

III. LONG TERM CARE REIMBURSEMENT

Sources of payment include Medicaid, private pay, Medicare, and in a few cases private long-term care insurance. The vast majority of persons you encounter in nursing homes will be Medicaid recipients.

- Medicaid

Medicaid is a medical assistance program for low-income persons. It was established by Title XIX of the Social Security Act of 1965 and is often referred to as "TITLE XIX." It is a joint Federal-State program which reimburses providers for covered services to eligible persons.

The Department of Health and Human Services (HHS) administers the program through the Center for Medicare and Medicaid Services (CMS). CMS establishes general guidelines and monitors operation of the program by the states. Both state and federal funds are used in the program, based on a percentage determined by each state's per capita income. States are given some flexibility in deciding what services are covered and who is eligible, so there are differences in Medicaid from state to state.

Covered services

Certain services are required for nursing homes and are included in the payment made to the home. All services must be certified as medically necessary.

- Medicare

Medicare was established by Title XVIII of the Social Security Act and is sometimes referred to as "Title XVIII". Medicare, like Medicaid, is administered by a number of agencies. The Social Security Administration handles eligibility determinations. The Center for Medicare and Medicaid Services (CMS) and private insurance companies under contract with the government handle actual claims and payments. There are a number of benefit components to the Medicare program;

Part A - Covers hospitalization and related costs for skilled nursing, hospice, and home health following a hospital stay. Persons 65 or older who have paid Social Security or Railroad Retirement are eligible automatically. No premiums. Contrary to common belief, Medicare covers very little nursing home care. Medicare only pays for a maximum of 100 days in a skilled nursing facility and this is based on qualifying medical criteria. These days must be preceded by a hospitalization of at least three days.

Part B - which covers physicians and other medical expenses.

Part D - Medicare helps pay for certain prescription drugs under a new section of Medicare called Part D. Individuals sign up for a drug plan if they want prescription drug coverage under Part D and have to pay

premiums and co-payments. Not all drugs are covered and there are different plans to choose from.

- **Long term care insurance**

You may encounter a resident who has private long term care insurance. As the demand for long-term care services increases, insurance companies have begun to develop products, which provide coverage for nursing home and/or home health care. These policies are expected to account for an increasing percentage of long-term care financing, although most experts agree that they will never represent a major source of payment. These are individualized plans dependent and subject to contract. They do not always cover the entire cost of the nursing home care.

- **Private insurance**

Some private insurance policies offer nursing home coverage according to their established policies.

IV. REGULATIONS GOVERNING LONG TERM CARE FACILITIES

A. State Licensure

It is important for Resident Advocates to understand the standards, process, and agencies involved in licensing a nursing home. When complaints come to the Ombudsman Program the minimum standards contained in state law tell the consumer and the Ombudsman what kind of services, care, and physical surroundings to expect. If the Program needs to intervene because a home fails to meet those standards, the standards are a guide to the residents, Ombudsmen, and the home as to how to comply with the law.

In 1987 Congress passed a law called the Nursing Home Quality Reform Amendments of 1987, known in shorthand as OBRA '87, since it was a part of the Omnibus Budget Reconciliation Act of 1987. This law phased in many changes in the federal requirements for nursing homes.

B. Federal Certification

The federal requirements for Nursing Facilities (NF) are called Level A requirements and Level B requirements. Level B requirements are the standards that make up the more global level A requirements. These

requirements are set by the U.S. Department of Health and Human Services' Centers for Medicare & Medicaid Services (CMS) formerly known as The Health Care Financing Administration (HCFA).

Among the significant changes brought about by the 1987 amendments:

- The elevation of residents' rights to a more important requirement within the regulatory system.
- The new requirement for quality of care that shifts the focus of regulation to improving the quality of care for residents.
- Focus of rules on "attaining or maintaining the highest practicable physical, mental and psychosocial "well-being" instead of minimum standards.

C. Enforcement in Long Term Care Facilities

In Connecticut, the Department of Public Health (DPH) makes unannounced visits to facilities to conduct a federal and state survey of the facility. DPH contracts with the CMS to monitor that the facility complies with federal regulations. They are responsible within the state to monitor compliance with State of Connecticut regulations. Depending on the size of the home, they spend two or three days inspecting or surveying. In the past few years the federal survey process has changed from one that examined if a home had the proper type of personnel, and the appropriate policies and procedures in place to one that reviews the outcomes of resident care. New elements in the survey include interviewing residents about their care, observing meal service, and observing the nursing staff pass medications to the residents.

At the conclusion of the survey, an exit interview is held. Residents, administration, and staff are present. The Ombudsman and Resident Advocate can attend the exit interview also. The purpose of the meeting is for the survey team to give a summary of findings. Following the survey a "Statement of Deficiencies and Plan of Correction" is sent to the facility administrator, specifying any deficiencies and the corresponding statute or regulation in violation. The administration is responsible for replying with a written plan of correction for each listed deficiency. There is a time limit set for a response of the plan of correction (usually 30 days).

Although Connecticut has state laws for nursing homes, the federal government has had extensive laws for nursing homes since the 1970s because it finances resident care through the Medicare/Medicaid programs. The federal laws apply only to those facilities certified to accept Medicare/Medicaid payment for care. While the state has similar laws, the federal law takes precedence over state laws and can be used by Ombudsmen to resolve resident's problems.

D. Departments Involved in Certification Inspection

The Department of Public Health has the lead role in surveying and approving nursing homes certified to be providers under the Medicare and Medicaid programs. Once the facility is in substantial compliance with the federal requirements, the facility can sign its "Provider Agreement" with the Connecticut State Department of Social Services (DSS) and with the federal government for Medicare.

Federal Survey and Certification Process under Medicaid is the primary mechanism established for the enforcement of residents' rights. Having residents' rights as part of federal law may give new emphasis to the rights in enforcement.

Enforcement is hampered by a lack of understanding and sensitivity to residents' rights by surveyors. Even when surveyors are sensitive to residents' rights, they find them hard to quantify compared with other regulations. Violations are hard to document and hard to prove, and surveyors often fail to understand their seriousness. Correction is difficult to monitor.

The new long term care survey process, with its use of resident interviews, should sensitize surveyors to residents' rights issues and provide more opportunities for them to observe, learn about and document violations.

E. Advocacy/Ombudsman Intervention

While regulatory and legal mechanisms have an increasing role in assuring protection of resident's rights, the Ombudsman Program is the most effective mechanism for protecting residents' rights. It is by definition an intervention related to a specific situation. The Ombudsman is local, and the Resident Advocate's presence is regular and ongoing.

Corrective action in residents' rights violations most often takes the form of prevention. An insult or violation of dignity cannot be erased. However, it can be prevented from recurring through education and visitation. Ombudsmen can and do provide this sensitization to management and staff and often become involved in staff training activities as well as support to residents to assist in their assertion of their rights. Training may take the form of teaching residents, assisting residents' councils and educating families

MODULE 4 - APPENDIX

1. CMS - Five Star Rating
2. Sample DPH Survey

Information about The New Five-Star Quality Rating System for Nursing Homes

The Centers for Medicare & Medicaid Services (CMS) has improved information on the Nursing Home Compare website to help individuals, family members, caregivers, and the public find and compare the quality of nursing homes more easily. Visit www.medicare.gov/NHCompare for more information.

Overview of the Five-Star Nursing Home Quality Rating System

The Nursing Home Compare website now features a system that assigns each nursing home a rating between one and five stars. Nursing homes with five stars are considered to have above average quality compared to other nursing homes in that state. Nursing homes with one star have quality much below the average in that state (but the nursing home still meets Medicare's minimum requirements).

There is an overall five-star rating for each nursing home. This rating is based on the star ratings for three separate categories: 1) health inspections, 2) quality measures, and 3) staffing levels. These three categories are described below:

1) Health Inspections – The health inspection rating contains information from the last three years of onsite inspections, including both annual visits and any complaint investigation findings. Inspectors visit each nursing home and collect specific information to determine whether a nursing home meets Medicare's minimum requirements for safety and quality of care.

2) Quality Measures – This rating is based on ten different physical and clinical measures for nursing home residents, such as the percent of residents with pressure ulcers, the percent of residents with moderate to severe pain, or the percent of residents who have changes in their ability to move about. This information is collected by the nursing home on all residents and shows how well nursing homes care for their residents' physical and clinical needs.

3) Staffing Information – This rating includes information about the average number of hours of care given by nursing staff to each resident each day. This rating considers differences in the level of care residents in different nursing homes need. For example, a nursing home that has residents with more severe needs would be expected to have more nursing staff than a nursing home where the needs aren't as high.

Nursing Home Compare Has More Information

Alternatives to Nursing Home Care: If you or a family member need help with daily activities like eating, bathing or dressing, you may first want to consider community resources before looking into nursing home care. Many communities offer assistance with these types of activities in your own home. Visit Nursing Home Compare for more information about alternatives to nursing home care and a list of contacts.

Follow These Steps to Finding a Nursing Home:

Step 1: Visit Nursing Home Compare to find a nursing home in your area. Search by nursing home name, city, county, state or ZIP code.

Step 2: Use the information on Nursing Home Compare to compare the quality of the nursing homes you're considering. You may want to compare the Five-Star Quality ratings and other important quality information.

Step 3: Visit the nursing homes you're considering or have someone visit for you.

Step 4: Choose the nursing home that best meets your needs. Talk to your doctor or other healthcare practitioner, your family, friends, or others. Contact state agencies, such as the Long-Term Care Ombudsman or the State Survey Agency to get more information. Their phone numbers are listed on Nursing Home Compare.

Next Steps

CMS is interested in making additional changes the Nursing Home Compare website in several areas such as adding more quality measures, and including more information about nursing home characteristics and resident satisfaction.

We want to hear from you! To share your comments about the Five-Star ratings and ideas about how we can improve the Nursing Home Compare website, please e-mail us at BetterCare@cms.hhs.gov.

Additional Resources

To view or print Medicare's Guide to Choosing a Nursing Home, visit <http://www.medicare.gov/Publications/Pubs/pdf/02174.pdf>.

To view or print the Nursing Home Checklist (to take with you when you visit the nursing home) visit <http://www.medicare.gov/Nursing/Checklist.pdf>.

You can also call 1-800-MEDICARE (1-800-633-4227) to order a free copy. TTY users should call 1-877-486-2048.

December 2008

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

POC accepted 11-17-10 FAC

PRINTED: 10/21/2011
FORM APPROVE
OMB NO. 0938-039

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| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: [REDACTED] | (X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____ | (X3) DATE SURVEY COMPLETED 10/20/2011 |
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F 000 INITIAL COMMENTS

Abbreviations which may be used throughout this document include the following:

- ADL ("s) - activities of daily living
- ADNS - Assistant Director of Nursing
- APRN - Advanced Practice Registered Nurse
- BUN - Blood Urea Nitrogen
- COPD - chronic obstructive pulmonary disease
- CVA - cerebrovascular accident (stroke)
- DNS - Director of Nursing
- GI - gastrointestinal
- I&O - intake and output monitoring/measuring
- IV - intravenous
- LPN - Licensed Practical Nurse
- MD - Medical Doctor
- MDS - Minimum Data Set (interdisciplinary assessment tool)
- MI - myocardial infarction (heart attack)
- MRSA - Methicillin Resistant Staphylococcus Aureus
- NA - Nurse Aide
- OT - Occupational Therapist
- PT - Physical Therapist
- RCP - resident care plan
- RN - Registered Nurse
- SW - Social Worker
- VRE - Vancomycin Resistant Enterococcus

F 157 483.10(b)(11) NOTIFY OF CHANGES
SS=D (INJURY/DECLINE/ROOM, ETC)

F 157 F 157

A facility must immediately inform the resident, consult with the resident's physician, and if known, notify the resident's legal representative or an interested family member when there is an

- The facility will ensure that a resident's physician is notified when a skin tear occurs.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE TITLE (X5) DATE

[REDACTED SIGNATURE]

Executive Director

11/1/10

deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that the institution's safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

DEPARTMENT OF HEALTH AND HUMAN SERVICES
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| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: [REDACTED] | (X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____ | | (X3) DATE SURVEY COMPLETED 10/20/ |
| NAME OF PROVIDER OR SUPPLIER [REDACTED] | | | STREET ADDRESS, CITY, STATE, ZIP CODE [REDACTED] | | |
| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE | |
| F 157 | Continued From page 1 accident involving the resident which results in injury and has the potential for requiring physician intervention; a significant change in the resident's physical, mental, or psychosocial status (i.e., a deterioration in health, mental, or psychosocial status in either life threatening conditions or clinical complications); a need to alter treatment significantly (i.e., a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or a decision to transfer or discharge the resident from the facility as specified in §483.12(a). The facility must also promptly notify the resident and, if known, the resident's legal representative or interested family member when there is a change in room or roommate assignment as specified in §483.15(e)(2); or a change in resident rights under Federal or State law or regulations as specified in paragraph (b)(1) of this section. The facility must record and periodically update the address and phone number of the resident's legal representative or interested family member. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, review of the clinical record, and review of facility policy for the only sampled resident reviewed with a skin tear/wound (R #82), the facility failed to notify the physician when a skin tear/wound was identified. The findings include: Resident #82's diagnoses include congestive | F 157 | <ul style="list-style-type: none"> The physician for resident #82 was notified on 10/17/10. On 10/17/10, all residents on the nursing unit where Resident #82 resides were examined for skin tears. No skin tears were observed that required assessment, documentation and physician notification. On the nursing unit where Resident #82 resides weekly skin checks are completed. Assessment, documentation and physician notification will be completed for any skin tear found. Staff education of Skin Tear Policy. Random monthly observation audit of residents skin to ensure assessment, documentation and physician notification of skin tears for 3 months. <p>Responsible: Director of Nursing</p> | 10/17/10 10/17/10 ongoing | <p>PAE</p> <p>2/28/11</p> <p>700</p> <p>AV</p> |

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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|--------------------------|--|---------------------|--|----------------------------|
| F 157 | Continued From page 2 heart failure, and depression. A minimum data assessment dated 7/7/10 identified the resident with no cognitive deficits; independent with bed mobility, transfers, and toilet use, and requiring supervision with walking. A resident care plan dated 7/20/10 identified the risk for skin tears related to fragile skin. Interventions included close observation of skin during morning care. An observation on 10/17/10 at 12:30 PM with RN #1 noted a 1.8cm x 0.9cm open area on R #82's mid left shin with two steri-strips in place and a small amount of serosanguinous drainage present. Review of the clinical record on 10/17/10 at 12:45pm with RN #1 failed to provide documentation of when the open area was identified and/or that the physician was notified for a treatment order. At that time RN #1 indicated the area should have been assessed and documented in the clinical record and the physician notified for a treatment to the area. Review of a facility policy on physician notification indicated, in part, the physician should be notified of unexplained bruises or injuries. | F 157 | | |
| F 281 | 483.20(k)(3)(i) SERVICES PROVIDED MEET SS=D PROFESSIONAL STANDARDS The services provided or arranged by the facility must meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on observations, staff interviews, and | F 281 | <u>F281</u> The facility will ensure that medications are administered in accordance with physician orders and skin tears will be assessed per facility policy and standards of practice. | |

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| F281 | <p>Continued From page 3</p> <p>review of the clinical records for 1 of 10 residents reviewed for medication administration (R#218); and/or for one of two sampled residents reviewed with a skin tear (R#82), the facility failed to administer medications in accordance with physician orders and/or assess a wound according to professional standards of practice. The findings include:</p> <p>1. Resident #218's diagnoses include Parkinson's disease; and depression. An observation on 10/17/10 at 10:15 AM noted LPN #1 administering one scoop of Beneprotein powder into 240cc of house supplement and administering to R#218. At that time the Beneprotein powder container was noted to have an expiration date of October 2009.</p> <p>Review of physician orders dated 10/14/10 directed Benefiber one scoop mixed with 240cc of liquid or juice daily. No order for Beneprotein was noted in the orders.</p> <p>An interview and review of physician orders on 10/17/10 at 10:30 AM with LPN #1 indicated she was not aware the physician order was for Benefiber and was not aware the Beneprotein that was administered had expired.</p> <p>According to Basic Nursing Mosby, Third Edition, the five guidelines to ensure safe drug administration include the right drug, the right dose, the right client, the right route and the right time.</p> <p>2. Resident #82's diagnoses include congestive heart failure, and depression. A minimum data assessment dated 7/7/10 identified the resident with no cognitive deficits;</p> | <ul style="list-style-type: none"> Resident #218 had no adverse reaction related to receiving Beneprotein and the omission of Benefiber. Benefiber order was discontinued on 10/18/10. The expired Beneprotein was discarded on 10/17/10. LPN #1 was counseled regarding the medication error. A medication pass observation was conducted for LPN #1. A review of all Medication Administration Records indicate that no residents are on Benefiber. Staff Education on Medication Administration will be conducted. Random monthly medication pass observations for 3 months. Though the nurse failed to document the skin tear on Resident #82 she assessed the skin tear and implemented the treatment per the Skin Tear Policy on 10/16/10. | <p>10/18/10</p> <p>10/29/10</p> <p>10/25/10</p> <p>11/30/10</p> <p>2/28/11 RAC</p> |

DEPARTMENT OF HEALTH AND HUMAN SERVICES
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NAME OF PROVIDER OR SUPPLIER
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F 281 Continued From page 4

independent with bed mobility, transfers, and toilet use, and requiring supervision with walking.

A resident care plan dated 7/20/10 identified the risk for skin tears related to fragile skin. Interventions included close observation of skin during morning care.

An observation on 10/17/10 at 12:30 PM with RN #1 noted a 1.8cm x 0.9cm open area on R #82's mid left shin with two steri-strips in place and a small amount of serosanguinous drainage present.

Review of the clinical record on 10/17/10 at 12:45 pm with RN #1 failed to provide documentation of when the open area was identified, an assessment of the open area, physician notification and/or treatment orders for the open area. At that time RN #1 indicated the area should have been assessed and documented in the clinical record and the physician notified for an appropriate treatment to the area.

Review of a facility policy on skin tears indicated to implement protocol unless otherwise ordered by MD, complete a reportable event, and start tear, documentation form and continue documentation until healed.

According to AHRQ guidelines on preventing skin tears (2008), in part, a skin tear should always be assessed for size, document assessment and treatment findings, and continue to reassess.

F 309 483.25 PROVIDE CARE/SERVICES FOR
SS=D: HIGHEST WELL BEING

Each resident must receive and the facility must provide the necessary care and services to attain

F 281

- On 10/17/10, RN #1 assessed and documented the skin tear following the Skin Tear Policy. Both the physician and responsible party were notified. 10/17/10
- On 10/17/10, all residents on the nursing unit where Resident #82 resides were examined for skin tears. No skin tears/open areas were observed that required assessment, documentation and physician notification. 10/17/10
- On the nursing unit where Resident #82 resides, weekly skin checks are completed. Assessment, documentation and physician notification will be completed for any skin tears found. ongoing
- Staff Education of Skin Tear Policy. 11/30/10
- Random monthly observation audit of residents skin to ensure assessment, documentation and physician notification of skin tears for 3 months. 11/30/10

Responsible: Director of Nursing

F 309

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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FORM APPROVED
OMB NO. 0938-0001

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| F 309 | Continued From page 5 or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. This REQUIREMENT is not met as evidenced by: Based on observations, staff interviews, and review of the clinical records for 1 of 10 residents reviewed for medication administration (R#218), and/or for one of two sampled residents reviewed with a skin tear (R#82), the facility failed to administer medications in accordance with physician orders and/or document a wound assessment. The findings include: 1. Resident #218's diagnoses include Parkinson's disease, and depression. An observation on 10/17/10 at 10:15 AM noted LPN #1 administering one scoop of Beneprotein powder into 240cc of house supplement and administering to R#218. At that time the Beneprotein powder container was noted to have an expiration date of October 2009. Review of physician orders dated 10/14/10 directed Benefiber one scoop mixed with 240cc of liquid or juice daily. No order for Beneprotein was noted in the orders. An interview and review of physician orders on 10/17/10 at 10:30 AM with LPN #1 indicated she was not aware the physician order was for Benefiber and was not aware the Beneprotein that was administered had expired. | F 309 | F309 The facility will ensure that medications are administered in accordance with physicians orders and skin tears will be assessed per facility policy and standards of practice. <ul style="list-style-type: none"> Resident #218 had no adverse reaction related to receiving Beneprotein and the omission of Benefiber. Benefiber order was discontinued on 10/18/10. The expired Beneprotein was discarded on 10/17/10. 10/18/10 LPN #1 was counseled regarding the medication error. A medication pass observation was conducted for LPN #1. 10/25/10 A review of all Medication Administration Records indicated that no residents are on Benefiber. 10/25/10 Staff Education on Medication Administration will be conducted. 11/30/10 Random monthly medication pass observations for 3 months. 2/28/11 PAC | | |

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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NAME OF PROVIDER OR SUPPLIER
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F 309 Continued From page 6

According to Basic Nursing Mosby, Third Edition, the five guidelines to ensure safe drug administration include the right drug, the right dose, the right client, the right route and the right time.

2. Resident #82's diagnoses include congestive heart failure, and depression. A minimum data assessment dated 7/7/10 identified the resident with no cognitive deficits, independent with bed mobility, transfers, and toilet use, and requiring supervision with walking.

A resident care plan dated 7/20/10 identified the risk for skin tears related to fragile skin. Interventions included close observation of skin during morning care.

An observation on 10/17/10 at 12:30 PM with RN #1, noted a 1.8cm x 0.9cm open area on R #82's mid left shin with two steri-strips in place and a small amount of serosanguinous drainage present.

Review of the clinical record on 10/17/10 at 12:45 pm with RN #1 failed to provide documentation of when the open area was identified, an assessment of the open area, physician notification and/or treatment orders for the open area. At that time RN #1 indicated the area should have been assessed and documented in the clinical record and the physician notified for an appropriate treatment to the area.

Review of a facility policy on skin tears indicated to implement protocol unless otherwise ordered by MD, complete a reportable event, and start a skin tear documentation form and continue

F 309

- Though the nurse failed to document the skin tear on Resident #82, she assessed the skin tear and implemented the treatment per the Skin Tear Policy on 10/16/10.

- On 10/17/10, RN #1 assessed and documented the skin tear following the Skin Tear Policy. Both the physician and responsible party were notified.

10/17/10

- On 10/17/10, all residents on the nursing unit where Resident #82 resides were examined for skin tears. No skin tears/open areas were observed that required assessment, documentation and physician notification.

10/17/10

- On the nursing unit where Resident #82 resides weekly skin checks are completed. Assessment, documentation and physician notification will be completed for any skin tears found.

ongoing

- Staff Education Skin Tear Policy.

11/30/10

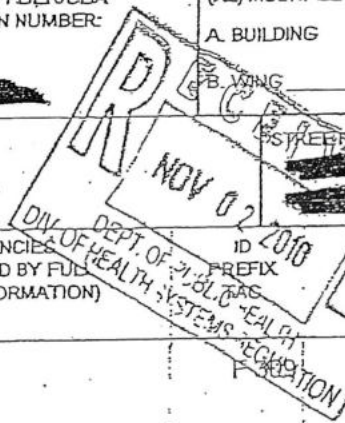
- Random monthly observations of residents skin to ensure assessment and documentation of skin tears for 3 months.

2/28/11
RAE

Responsible: Director of Nursing

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: [REDACTED] | (X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____ C. STREET ADDRESS, CITY, STATE, ZIP CODE [REDACTED] | (X3) DATE SURVEY COMPLETED 10/20/2010 |
| NAME OF PROVIDER OR SUPPLIER [REDACTED] | | | |
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| <p>F 309 Continued From page 7 documentation until healed.</p> | | | |



Resident Advocate (RA) Training - CT-Specific Data – Section 4: Long Term Care Settings, Who's Who In LTC Facilities, Residents' Rights in Nursing Facilities, Regulatory Process for Nursing Facilities, Residents' Rights in Residential Care Communities and Regulatory Process

Long Term Care Settings: In CT, the Long Term Care Ombudsman Program (LTCOP) has current jurisdiction to advocate for residents in skilled nursing facilities (SNFs), assisted living facilities (ALs), and residential care homes (RCHs). According to the CT Department of Public Health (DPH), there are approximately 205 SNFs, 116 ALs, and 93 RCHs licensed in CT. According to the CMS Nursing Home Compendium, 2015 (see resource reference below), the most recent version publicly available, the bed-size composition of CT SNFs is the following: 7% are less than 50 beds; 30% are 50-99 beds; 56% are 100-199 beds; and 7% are greater than 199 beds. In addition, 80% of SNFs are for-profit, 20% non-profit, and less than 1% government. 95% of CT SNFs are dually certified for Medicare and Medicaid, and only 5% of SNFs are Medicare only certified.

Prior to the Covid-19 pandemic start, CT SNF occupancy rates were about 88% in late 2019, the occupancy rates reached a pandemic low of 71% in July 2020, and the most recent May 2022 occupancy rate was 81%, an occupancy high since pandemic start, the CT Department of Social Services.

According to the CT Annual Nursing Facility Census Report, September 2021 (see resource reference below), "a total of 205 licensed nursing facilities were operating in Connecticut on September 30, 2021, six less than in 2020. With regards to nursing facility beds, the total number has declined by 18 percent (5,357) between September 30, 2004 and 2021, decreasing from 29,801 to 24,444 beds. In Connecticut, nursing facilities are licensed at two levels of care: Chronic and Convalescent Nursing Homes (CCNH), also known as Skilled Nursing Facilities, and Rest Homes with Nursing Supervision (RHNS), also called Intermediate Care Facilities. As of September 30, 2021, there were 23,812 CCNH beds and 632 RHNS beds, for a total of 24,444. Over time, nursing facilities have been either phasing out RHNS beds or converting them to CCNH beds. Between 2004 and 2021, the number of RHNS beds decreased from 1,547 to 632, or 59 percent. The number of facilities with non-profit status decreased from 63 in 2004 to 40 in 2021 and the number of facilities with for-profit status decreased from 183 to 165.

Of the 205 nursing facilities in Connecticut in 2021, 188 had a CCNH license, 16 had both a CCNH and RHNS license, and one facility provided care under an RHNS license only."

Resident Demographics – Who's Who in CT Nursing Homes:

According to the most recent CT Annual Nursing Facility Census Report, "as of September 30, 2021, there were 19,078 individuals residing in Connecticut nursing facilities. This represents 676 more residents than on the same date in 2020 and 8,718 fewer than in 2004.

In 2021, the majority of residents were white (79%), female (63%), and without a spouse (81%). This profile has remained consistent over the years. With regards to age, 16 percent were under 65 years of age, 46 percent were between 65 and 84, and 38 percent were age 85 or older. Since 2004, the percentage of younger nursing facility residents under age 55 decreased by 39% (565), the percentage of residents age 55 to 74 increased by 28% (1350), and the number of residents age 75 and older decreased by 44% (9,551).” Regarding resident payor source, 72% of CT nursing home residents are on Medicaid, Medicare was the payor source for 15% of residents, 9% of residents paid privately, and the balance was other insurance or other sources, per the report.

Residents’ Rights in Nursing Facilities

The following CT General Assembly state statutes provide resident rights protections for CT nursing home resident: 17a-405 to 17a-422 Protection of the Elderly Chapter and focus on Long Term Care Ombudsman Program role, responsibilities, and rights to advocate for residents; 19a-491c – Criminal History and Patient Abuse Background Search Program; 19a-490b – Furnishing of Health Records, Etc; 19a-527 – Classification of Violations By Nursing Home Facilities; 19a-533 – Discrimination Against Indigent Applicants; 19a-534 – Emergency Transfer of Patients; 19a-535 – Transfer or Discharge of Patients; 19a-535c – Nursing Facility Discharge – Caregiver Instructions and Training Requirements; 19a-537 – Reservation of Beds/Bed-Hold; 19a-551 - Management of Resident’s Personal Funds; 19a-560 – Disclosure Medicare and Medicaid and Advance Payment-Deposit Requirements; 19a-562 – Alzheimer’s Special Units or Programs Definitions and Disclosure Requirements; 19a-562a – Training Requirements for Nursing Home Facility and Alzheimer’s Special Unit or Program Staff; 19a-562f – Nursing Home Facility Staffing Levels – Definitions; 19a-562g – Calculation of Nurse and Nurse’s Aides Providing Direct Patient Care – Daily Posting and Public Information; 19a-562h – Failure To Comply With Nursing Home Facility Staffing Level Requirement; and many other CT state statutes outlining nursing home management operational responsibilities. In addition to the state statutes, there are DPH nursing home regulations.

Regulatory Process for Nursing Facilities

The CT Department of Public Health is the state regulatory and enforcement agency for nursing home regulations. The CT Department of Social Services is the state Medicaid payor and there are requirements for nursing homes to timely submit abuse, neglect, exploitation or abandonment reports to the state, and also to submit regular financial, cost report, and census reports to the state.

Residents’ Rights in Residential Care Communities and Regulatory Process

The following CT General Assembly state statutes provide resident rights protections for CT assisted living and residential care home residents: 17a-405 to 17a-422 Protection of the Elderly

Chapter and focus on Long Term Care Ombudsman Program role, responsibilities, and rights to advocate for residents; 19a-491c – Criminal History and Patient Abuse Background Search Program (for LTC facilities); 19a-490b – Furnishing of Health Records, Etc; 19a-495a – Unlicensed Assistive Personnel in RCHs and Medication Certification; 19a-495b – RCH Operational Requirements; 19a-534 – Emergency Transfer of Patients (for SNF and RCH residents); 19a –535 – RCH Transfer or Discharge of Patients; 19a-551 - Management of Resident's Personal Funds (for SNFs and RCHs); 19a-562 – Alzheimer's Special Units or Programs Definitions and Disclosure Requirements (for SNFs, AL and RCHs); 19a-562a – Training Requirements for Nursing Home Facility and Alzheimer's Special Unit or Program Staff (for SNF and ALs); 19a-562b – Staff Training and Education on Alzheimer's Disease and Dementia Symptoms and Care (for ALs and RCHs); 19a-563-19a-701 – Managed Residential Communities (MRC) statute requirements for the non-health care portion of assisted living and other senior living facilities.

The CT Department of Public Health is the state regulatory and enforcement agency for assisted living and RCH regulations. The CT Department of Social Services is the state Medicaid payor and there are requirements for assisted living facilities and RCHs to timely submit abuse, neglect, exploitation or abandonment reports to the state, and also to submit regular financial and other reports to the state, as appropriate to the RCH and AL if Medicaid or other DSS payment support provided. Most RCHs receive state DSS funding while most ALs are private-pay entities with some ALs participating in the DSS AL pilot program or are one of the few Medicaid-subsidized ALs across the state.

Resources: CT DPH; CT DSS; CT Annual Nursing Facility Census Report 9/30/21 - <https://data.ct.gov/stories/s/k7kn-cn6>; CT General Assembly; CMS Nursing Home Compendium, 2015.

Call lights not being answered

Residents are bored

Cold food

Sticky floors

Poor staff attitudes towards residents

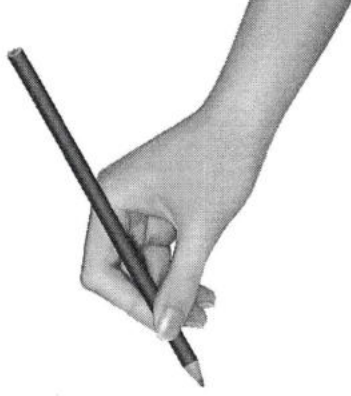
Broken sink

Soiled laundry in the resident's room

Not included on shopping trips

Resident's bill

CNAs waking residents at 4:00 AM



Administrator

DON

Charge nurse

Maintenance supervisor

Activities director

Housekeeping manager

CNA

Business office manager

Social service director

Dietary manager

MODULE 5

TRAINING WRAP-UP

- I. SHADOWING EXPERIENCE DISCUSSION
- II. STATE LONG TERM CARE OMBUDSMAN
- III. RESIDENT AND FAMILY COUNCIL
INCLUDING EXECUTIVE BOARD AND VOICES
FORUM
- IV. REPORTING FORMS AND ADMINISTRATIVE
RESPONSIBILITIES
MILEAGE
FACILITY CHECKLIST
- V. REVIEW OF APPENDIX
- VI. PROBATIONARY CERTIFICATION

Silver Panther
NCCNHR- Family/Resident Council - 1 page
Best Practices - 1 page
Probation Certificate
Mileage
VRA Check List
Websites
Acronyms

I. THE SHADOWING EXPERIENCE DISCUSSION

NOTES

THE STATEWIDE COALITION OF PRESIDENT OF RESIDENT COUNCILS EXECUTIVE BOARD

Resident councils are instrumental in resolving problems and effecting changes within individual facilities. Presidents of Resident Councils are a vital part of this process and serve as leaders in their nursing home communities. The Statewide Coalition of Presidents of Resident Councils (SCPRC) represents the collective voices of Resident Councils from every corner of the state. The Coalition, in partnership with the Ombudsman program, works to enhance the quality of life for all nursing home residents by developing best practices and advocating for legislative and policy changes.

The Executive Board of the SCPRC is made of nine (9) Councils Presidents, three from each of the three DSS regions within the state.

RESIDENT COUNCILS

Residents have the right to organize and participate in resident groups in the facility. Most nursing homes have a Resident Council. Each Resident Council determines exactly how it will operate and function. Some Residents are more formal and follow guidelines they have developed by means of by-laws. Other Resident Councils are more informally organized. Most all Resident councils hold monthly meetings. While staff of the nursing home may attend a meeting by invitation, many Resident Councils find it helpful to utilize their Therapeutic Recreation Director and/or their Social Worker to help with the meeting. The Regional Ombudsman and Volunteer Resident Advocate also assist at the request of the Resident Council and may attend meetings when invited to do so.

Resident Councils are instrumental in identifying issues and concerns specific to their nursing home and the care and quality of services being provided. Often the Council develops best practices to resolve problems and effect change in their individual home. Many of these best practices are shared with other Resident Councils. The varied issues around Residents' Rights as well as care and services become a guide of "Best Practices" for residents to share with one another. Everything from posting the Volunteer Resident Advocate's visiting schedule to resolving food complaints, Certified Nurse Assistant assignment and physical plant improvements are topics discussed and problem-solved at Resident Council. The remedies are "best practices" that residents appreciate being able to share with their peers. Residents develop best practices, some of which are unique to their home others which are universal to life in a nursing home. Sometimes it is not even the solution itself, but the process that becomes the "best practice", the how to of the problem solving that is so beneficial for others to learn and use themselves.

FAMILY COUNCIL

A resident's family has the right to meet in the facility with the families of other residents in the facility. If a family group exists, the facility must provide a private meeting place. Others may attend at the group's invitation. And the facility must provide a designated staff person responsible for providing assistance and responding to written request that results from group meetings. The

LTCOP in collaboration with University of Connecticut, Organizational and Skill Development Unit at the Department of Social Services has developed a web-based training program to help families get started in organizing a Family Council. The Regional Ombudsman are also available to assist as requested and attend a meeting by invitation.

HISTORY OF THE VOICES FORUM

In September of 1996, nursing home resident and activist Carol Rosenwald, with assistance from the Ombudsman Program, began organizing residents across the state to advocate for improvements in the long term care system. Carol envisioned a time when the "VOICES" of nursing home residents could be heard "beyond the walls" of their facilities. She became the founder of the Statewide Coalition of Presidents of Resident Councils and the driving force behind the first "VOICES" Forum in 1997. As a large group of voting constituents, residents were able to speak directly with political leaders and public officials about important issues affecting their quality of life.

To the Program's knowledge, the VOICES Forum is the only such forum in the country, held annually and dedicated to education residents about current topics of interest to them. The primary focus is to provide residents the opportunity to voice their concerns and contribute to legislative and public policy agenda.

THE CAROL ROSENWALD "SPIRIT OF ADVOCACY" AWARD

Carol Rosenwald, Founder of the Statewide Coalition of Residents Councils (SCRC), advocated tirelessly for systems and legislative changes to improve the quality of life for all nursing home residents. She believed residents should be active participants in discussions about their welfare and "have a say in matters affecting them."

In honor of Carol's legacy, The Carol Rosenwald 'Spirit of Advocacy' Award, was established by the Statewide Coalition of Presidents of Resident Councils and the Long Term Care Ombudsman Program. Each year, the Award is presented at the VOICES Forum to individuals and organizations that work to improve the quality of care and quality of life for individuals residing in nursing homes.

Connecticut Long Term Care Ombudsman Program

[CT.gov Home](#) [\(/\)](#) [Long Term Care Ombudsman Program](#) [\(/LTCOP/\)](#) Executive Board (RCP)

Executive Board of Resident Council Presidents



What is the E-Board?

"The Executive Board of Resident Council Presidents is committed to reducing the sense of powerlessness and isolation often felt by nursing home residents, by raising awareness, and insisting that they be regarded as viable, valuable members of their communities at large."

The SCPRC is an organization of nursing home Resident Council Presidents who, with the assistance of the Long Term Care Ombudsman Program, work together to empower Connecticut's 30,000+ nursing home residents for stronger and more effective self-advocacy.

Currently the Coalition has an executive committee made up of residents from across the state who have served as presidents in their own resident councils and are interested in making change on a larger scale. This committee has developed the Coalition's mission and goals, and its bylaws. The Executive Committee is given support and technical assistance from selected Ombudsman Program Volunteers who have a special interest in strengthening resident councils.

When does the E-Board meet?

The Executive Committee meets every other month to determine the direction of its efforts. Regional Coalition meetings are also held every other month to encourage Resident Council Presidents, from specific service areas, to gather and discuss strategies for strengthening their councils and creating change in larger systems.

What does the E-board do?

The Coalition joins with the Ombudsman Program in producing a quarterly newsletter ([/LTCOP/Content/Publications/Silver-Panther-Newsletter/](#)) for nursing home residents, updating them on any legislative or regulatory issues which directly affect them, and providing information on resident rights and resident council strategies. The newsletter profiles Executive Committee members and the Ombudsman Program Volunteers who serve as Regional Advisors. Nursing home residents are encouraged to share ideas, articles, poetry, recipes, and printable artwork. The SCPRC helps to organize, and co-convenes, the annual VOICES Forum. This statewide event

sponsored by the Ombudsman Program attracts Resident Council Presidents, Legislators, and other public officials, and provides them with an opportunity to interact and determine the most pressing challenges facing the state's nursing home residents as a group. The VOICES Forum has helped the Coalition, the Department of Social Services, and the Ombudsman Program, to shape legislative and regulatory agendas on long term care issues.

The SCPRC plans to continue these initiatives with the ongoing goal of opening and activating communication channels between nursing home resident councils and larger systems such as: community elderly services networks, state and local governments, and the nursing home industry.

What are the E-Board By Laws?

[Here](#) are the most updated E-Board Bylaws.

For further information on the SCPRC please contact the [Ombudsman Program \(/LTCOP/Content/Contact-Us/Contact-Us-Page\)](#). We welcome your comments

Statewide Coalition of Presidents of Resident Councils

Executive Board

BYLAWS AS OF July 2022

Name

The name of this organization shall be "The Executive Board of the Statewide Coalition of Presidents of Resident Councils" (SCPRC, Executive Board, and E-Board).

Mission Statement

As members of the SCPRC Executive Board we are committed to be the VOICES and represent all of our fellow peers who receive their long-term services and supports in a nursing home. We will advocate at the State and Federal levels for quality of care for individuals living in Connecticut skilled nursing homes and for individuals who have transitioned to the community. We strive to be credible and informed advocates as we work with the Office of the State Ombudsman and develop and support legislation and public policy initiatives for the individuals we represent.

Purpose

The purpose of the Executive Board is to serve as a vehicle for the Statewide Coalition of Presidents of Resident Councils to exercise their rights and protect their interests in matters affecting all people living in CT's skilled nursing facilities and those individuals who have transitioned to community living. The Executive Board members will serve on a variety of statewide public policy and advocacy groups. The Executive Board serves in an advisory role to the State Long Term Care Ombudsman. The Executive Board will present ideas for and assist with the content of the Annual VOICES Forum. The Executive Board will provide suggestions for the annual Carol Rosenwald "Spirit of Advocacy" award and Brian Capshaw "Rockstar" Award.

Membership

For the Board: There will be a maximum of nine Presidents of Resident Councils – three from each of the three Long Term Care Ombudsman Program (LTCOP) regions of the state, and up to three individuals who have transitioned from the nursing home setting to community-based living serving on the Executive Board.

For the Committees: Committee members may be ex-officio board members or recommended either by the resident council president, E-Board and/or LTCOP.

Statewide Coalition of Presidents of Resident Councils

BYLAWS AS OF July 2021

Administration

All members of the Executive Board shall serve in equal fashion with equal voting privileges and decision-making. If there is a need for a tie to be broken, the President will be provided with two votes. The board will review the mission statement and voting procedures/protocols annually. The Board will revisit its role at least annually to ensure that it is meeting by-law responsibilities. A Board satisfaction survey will be conducted annually. New Board members will be provided orientation. There exist two administrative roles, President and Vice President, which will be voted on annually in the month of December.

Each E-Board member will be provided with a LTCOP issued tablet, which will be utilized throughout the duration of a member's service on the Board. Tablets will enhance the opportunity for E-Board members to connect and work together on independent E-Board priorities / projects. Once a member no longer serves as an Executive Board member the tablet shall be returned to the CT LTCOP.

Special Committees

The Executive Board may establish special committees as needed within their membership and may choose to invite other individuals to join. Special committees will be evaluated annually to determine the ongoing need and viability.

Amendments

The Executive Board may amend any part of these by-laws with a majority vote of the members present at a meeting of the Executive Board.

Statewide Coalition of Presidents of Resident Councils

Executive Board

BYLAWS AS OF July 2021

Appointment and Terms of Office

The State Ombudsman and/or the Regional Ombudsman will make recommendations of appointments and will also consider those individuals who may volunteer for appointment to the Executive Board. The term of office will be determined by the member's willingness to continue serving on the Executive Board and be limited to three two-year terms. A member's six year term will conclude at the end of the calendar year of his or her sixth year of membership. A member may opt at the end of those three terms to continue as an emeritus member for two additional years with voting privileges. Emeritus members may also serve on Board special committees. If for personal reasons a member chooses to take a leave of absence or resigns his or her position for any reason, that request will be honored without question by the Executive Board and the Long Term Care Ombudsman Program. In the event of such vacancy, the State and/or Regional Ombudsman will recommend a Resident Council President from the same general geographic region or, in the case of a resignation of an individual in the community another individual who has transitioned to community living, to fill the vacant position. If an E-Board member has 3 uncommunicated absences from monthly E-Board calls or meetings the Board can vote to relinquish E-Board membership of that person. If an E-Board member no longer serves as the Resident Council President at his or her nursing home then they will no longer be able to serve on the E-Board but can opt to become an Emeritus member and serve on one of the special committees. The Office of the State Ombudsman will be responsible for record-keeping and appointment terms of office.



RESIDENT COUNCIL RIGHTS IN NURSING HOMES

The Nursing Home Reform Law guarantees nursing home residents a number of important rights to enhance their nursing home experience and improve facility-wide services and conditions. Key among these rights is the right to form and hold regular private meetings of an organized group called a resident council.

Facilities certified for Medicare and Medicaid must provide a meeting space and respond to the council's concerns. Nursing facilities must appoint a council-approved staff advisor or liaison to the resident council, but staff and administrators have access to council meetings only by invitation of the resident council.

Specifically, the federal law includes the following requirements for resident councils:

- The facility must provide a resident council, if one exists, with a private space for meetings.
- The facility must take reasonable steps, with the approval of the resident council, to make residents and family members aware of upcoming meetings in a timely manner.
- The resident council meetings are closed to staff, visitors, and other guests. For staff, visitors, or other guests to attend, the resident council must invite them.
- The facility must provide a designated staff person who is approved by the resident council and the facility to provide assistance and respond to written requests from the resident council.
- The facility must consider the views of a resident council and act promptly upon grievances and recommendations of the resident council concerning issues of resident care and life in the facility.
 - The facility must be able to demonstrate their response and rationale for their response.
 - However, the right to a response does not mean facilities are required to implement every request of the resident council.

**For more information and resources on residents' rights
go to, www.theconsumervoice.org.**

National Consumer Voice for Quality Long-Term Care (formerly NCCNHR) is a nonprofit organization founded in 1975 by Elma L. Holder to protect the rights, safety and dignity of American's long-term care residents.

BEST PRACTICES

A Food Committee was formed and meets once a month with the Dietary Director to specifically discuss food-related issues. One Resident food committee member represents each unit at the nursing home and committee members bring up issues they find on their unit.

A Resident Council recently installed a food committee, which meets fifteen minutes before the regular Resident Council meeting. The group discusses with the Food Services Director any problems that exist between food service and the residents. Besides identifying and solving any food service problems this committee has brought more residents to the table. Residents who might not normally come to a Resident Council meeting are now staying because at the end of the Food Committee the Resident Council meeting begins. Having more residents involved brings fresh insight to their over all community living.

A Resident Council holds a separate monthly Food Committee meeting with the dietary manager. This facilitates communications and prompt correction of problems and issues.

A nursing home has music piped into the dining room and this makes the Residents dining experience more enjoyable.

A Resident Council offers any meal of your choice on your Birthday

At another nursing home all concerns expressed during the Resident Council meetings are written up, then copies of the Resident Council minutes are given to all department heads, with the concerns highlighted.

A facility suggests that staff could be asked to excuse themselves for a part of the meeting so Residents would feel more comfortable speaking out about any concerns or grievances they may have.

At one nursing home the staff reminds the Resident Council and its sub-committees not to wait when individual and personal issues arise but to come forward and let them know immediately if something needs correction.

A Resident Council President personally visits individual Residents to reinforce the importance of Resident Council and to collect Resident concerns and grievances.

A Resident Council notes that they have only two (trusted) staff at their Council meetings. The Council sends their issues in writing to department heads and gives them thirty days to respond.

A Resident Council President reports that they hold a closed-door, resident-only meeting. As a result, the residents are more open in voicing their concerns without fear of reprisal.

A Resident Council assigns a designee to each floor; this representative visits privately with individual residents. The designee then presents the issues anonymously at the Resident Council meeting.

At the monthly Resident Council meetings of one facility, a staff member is voted on and receives a certificate and posted "kudos" for that month. This is a special honor coming directly from the Residents.

A Resident Council invited the Staff Development Nurse to speak on health issues concerning residents. The "Resident Council In-services" are held 1 - 2 times a month. Topics that are discussed are "Dehydration - Importance of Fluid Intake", "Arthritis - The Many Types and Treatment", and "Incontinence - What you always wanted to know". The Residents enjoy this very much.

A Resident Council developed a Welcoming Center for all new Residents who enter the facility. The idea was needed to make new Residents feel welcome and at home in their new environment.

A Resident Council insisted that their officers be given volunteer badges to wear daily so as to help other residents to be able to identify them should they have an issue or concern they wish to have addressed.

A Resident Council created a newsletter called the "Resident Voice".

What is a family council?

Under federal law, family members in a long-term care facility can join together to form a united consumer voice which can communicate concerns to facility administrators and work for resolutions and improvements by forming an independent family council.

Family councils can play a crucial role in voicing concerns, requesting improvements, supporting new family members and residents and supporting facility efforts to work for high quality of care and life in the facility.

**Join and support the family council
at your loved one's facility!**

If no family council exists, join with other family members to form one. Learn more by visiting the Family Council Center at <http://theconsumervoice.org/issues/family/family-council-center>



The National Consumer Voice for Quality Long-Term Care was founded out of public concern for the quality of care in nursing homes by Elma L. Holder as the National Citizens' Coalition for Nursing Home Reform (NCCNHR). The Consumer Voice represents consumers and advocates for public policies that support quality care and quality of life in all long-term care settings. The Consumer Voice also advocates for a strong, sufficient direct-care workforce, and promotes best practices in delivering quality care. We accomplish these efforts through:

- **Advocating** for public policies that support quality of care and life;
- **Empowering and educating** consumers and families;
- **Training and supporting** individuals and groups to advocate for and empower consumers; and
- **Promoting** the critical role of direct-care workers and best practices in quality-care delivery.



Contact Us

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www.ltcombudsman.org

**Empowered, Effective,
and Independent**

FAMILY COUNCILS



The National

CONSUMER VOICE
for Quality Long-term Care
formerly NCCNHR

Family Council Rights

Under the 1987 Nursing Home Reform Act

- Families have the right to organize and participate in a family council.
- The facility must provide a family group with private space if a group exists.
- The facility must make residents and family members aware of upcoming meetings in a timely manner.
- Staff, residents, or visitors may attend meetings at the group's invitation.
- The facility must provide a designated staff person, who is approved by the family group, responsible for providing assistance and responding to written requests that result from group meetings.
- When a family group exists, the facility must listen to the views and act upon the grievances and recommendations concerning proposed policy and operational decisions affecting resident care and life in the facility. The facility must be able to demonstrate their response and rationale for such response.



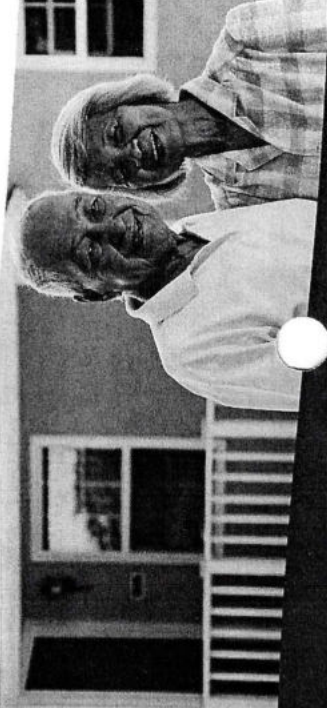
Resources

The Consumer Voice has resources, information, and opportunities for family councils. Visit <http://theconsumervoice.org/issues/family/family-council-center>

theconsumervoice.org/issues/family/family-council-center to learn more.

The Family Council Center contains information, tips, and tools such as

- Fact sheets
- Ways to take action
- Sample council materials
- Resources on family council rights and federal laws and regulations



Tips & Best Practices

- Collect contact information using a sign-in sheet at meetings.
- Plan for the long-term stability of the council by putting a structure in place, such as by-laws, and developing leadership.
- Brainstorm about how to address concerns in the facility.
- Communicate regularly with facility staff and management about council concerns and suggestions, actions to be taken, events that will be held, etc.
- Establish contact with the long-term care ombudsman.
- Focus on common council goals. Identify and continuously assess progress.
- Follow procedures for conducting effective meetings, such as using agendas, keeping minutes, starting and ending meetings on time, sticking to the topics scheduled for discussion and "assigning" tasks to be accomplished before the next meeting.
- Remember results may not be immediate, but family councils that persevere can be very effective.



Why *Family Led* Family Councils Benefit Families, Residents, and Facility Personnel

Open Communication

- Family members feel free to voice concerns without reservation in meetings where staff are not present.
- Gives facilities honest feedback to use for continuous quality improvement efforts.

Purpose

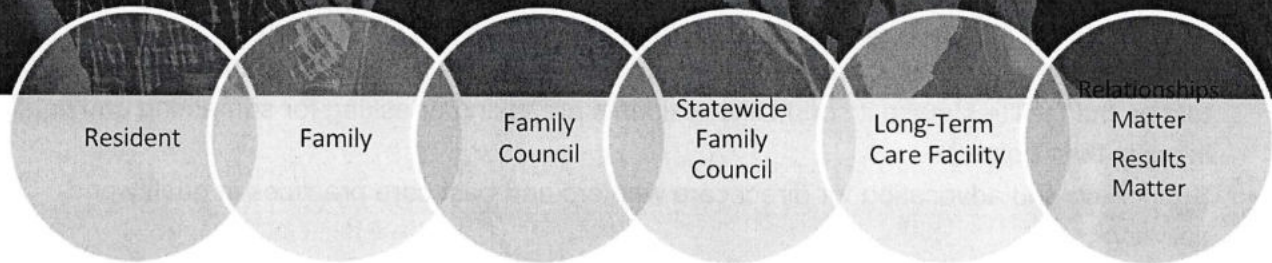
- Gives family members a place to constructively channel their anger and concerns within the nursing home as an alternative to filing complaints with outside agencies such as the ombudsman program or survey agency.
- The opportunity to meet privately with other families enables family members to discuss and consolidate common concerns, come up with ideas for how to address issues, and focus on collective goals.
- Keeps facility staff from being overwhelmed by a barrage of individual complaints all at once.
- Allows families and the facility to identify and focus on common facility-wide concerns and make improvements for all residents.

Empowerment

- Families can come up with creative ideas about how concerns can be addressed.
- Builds a trusting relationship between families and the facility.
- Federal regulations allow families to meet privately with facility staff attending *by invitation only*.

NCCNHR (formerly the National Citizens' Coalition for Nursing Home Reform) is a nonprofit membership organization founded in 1975 by Elma L. Holder to protect the rights, safety, and dignity of America's long-term care residents.

Connecticut Statewide Family Council



Organizational Statement:

The Connecticut Statewide Family Council (CTSFC) is associated with the State Long Term Care Ombudsman, under the authority of Public Acts 21-71 and 21-194. The CSFC provides a vital link between CTSFC, the Long-Term Care Ombudsman Office, and LTCF Family Councils and the LTCF.

The CSFC will serve as a communication vehicle for Family Council members (with a resident in a CT Long-Term Care Facility (LTCF)), and take an active role in improving the resident's experience. The CTSFC will focus on implementing programs, advocacy and best practices that successfully represent a positive resident and family experience in all facilities resulting in a high quality of life for residents and to ensure staff support. The CTSFC will share those best practices with LTCF Family Councils across the state

Vision:

All residents of LTCFs in Connecticut will have a positive resident and family experience, as they would enjoy if they were at home with their families.

Mission:

It is the mission of the CTSFC to:

- provide a communication vehicle for Family Council members with a resident in a CT Long-Term Care Facility (LTCF)
- take an active role in improving the resident's experience.
- focus on implementing programs, advocacy and best practices that successfully represent a positive resident and family experience in all facilities resulting in a high quality of life for residents and to ensure staff support.
- share best practices with LTCF Family Councils across the state

CONNECTICUT STATEWIDE FAMILY COUNCIL

Goals:

- The CSFC will work in an advisory role to the State Long Term Care Ombudsman office to enhance family-facility centered care initiatives and best practices.
- To ensure Resident's Rights, defined in Public Act 21-71
- Advocate for public policies that support quality of care and life for residents.
- Creating avenues for educating residents and **ensuring Resident's Rights** (older adults have told us the facilities make it sound like residents are taking or asking for something and not just living in their home.)
- Supporting and advocating for direct care workers and best care practices in quality and delivery.
- Support the LTCF in resident-family centered activities and initiatives.
- Participate as the voice of residents for patient safety, quality improvement, ethics and organization.

Officers and Committees, The Council Board Officers shall consist of a Chair/Co-Chair(s), Vice Chair and Secretary. The Chair/Co-Chair(s) shall preside over all meetings. In the event of his/her absence, the Vice-Chair shall preside, followed by the Secretary. The Secretary shall record the minutes of each meeting, post them on the website and distribute minutes and meeting agendas to members and interested people. The secretary shall maintain a listing of members. Committees are formed as needed to address topics relevant to the CTSFC.

Membership:

Anyone who has a family member, or friend in a CT Long-Term Care Facility and representing the diversity of the Connecticut LTCF community, can participate in CTSFC meetings and activities as a member. The structure and membership of the Council may change over time as determined by the council.

Elections: The term of officers shall be for a period of one-year and officers may be re-elected for an additional term at each January meeting, by those members in attendance.

Meetings: Will be held virtually, each month at a day and time that best accommodates members.

Voting is by majority of those present.

Rules of Order: Each Council meeting will follow the agenda prepared by the Chair/Co-Chair with items from Council members which must be received 10 days prior to the meeting.

The Chair may exercise time limits when necessary. During these meetings, Council members are asked to:

- Wait to be acknowledged before speaking.
- Be courteous to the person speaking even if you do not agree with them.
- Try to share at least one suggestion on how an issue can be resolved, if you raise an issue of concern.

CONNECTICUT STATEWIDE FAMILY COUNCIL

- Be specific and concise while communicating your point.
- Be constructive in criticizing and avoid personal attacks on individuals.

Participate in roll call for the minutes and regular attendance at meetings. Provide a report to LTCF Family Councils and/or LTCF

Orientation and Guidance:

Members of the CTSFC will receive information and guidance from the State Long Term Care Ombudsman and other agencies as appropriate.

Sample – Standing Agenda

1. Roll Call (establish a quorum)
2. Review & accept minutes from previous meeting
3. New Business
 - a. Introductions for new members
 - b. Open forum
 - c. New topics
4. Old Business
 - a. Committee reports
 - b. Pending legislation
 - c. Ongoing topics
5. Adjourn

CT Statewide Family Council Meeting

To let your voices be heard

Tuesday, July 26, 2022 - 7:00 pm

AGENDA

1. Role Call
2. Review and Approve 5/24/22 Minutes
3. New Business
 - a. Introduction of new members
 - b. Guest Speaker, Donna Gore
Re: New Transportation Fund
 - c. Mairead Painter, LTC Ombudsman
 - d. Open Forum
 - e. New Topics
4. Old Business
 - a. Care Plan Booklet
 - b. Pending Legislative Issues
5. Adjourn

To learn more, visit the CT Statewide Family Council
Tab by visiting the Long-term Care Ombudsman
Page at: <https://portal.ct.gov/LTCOP>

Join Zoom Meeting

[https://us02web.zoom.us/j/81042484370?](https://us02web.zoom.us/j/81042484370?pwd=WmtKN3ZwSjFzNXlyczNyazc0VDJxZz09)
[pwd=WmtKN3ZwSjFzNXlyczNyazc0VDJxZz09](https://us02web.zoom.us/j/81042484370?pwd=WmtKN3ZwSjFzNXlyczNyazc0VDJxZz09) copy
& paste link into web browser

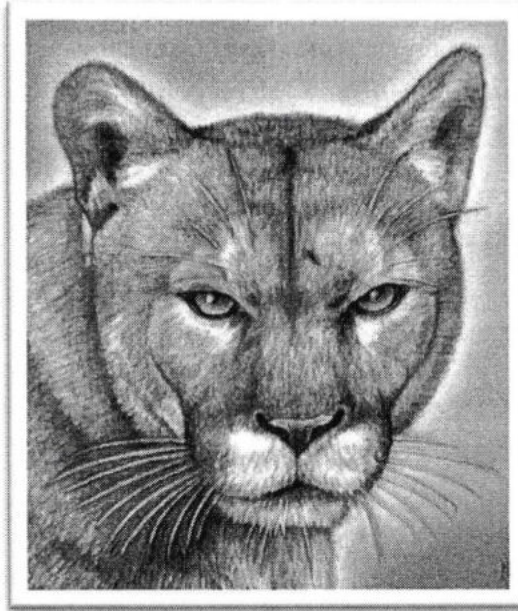
Dial: +1 929 205 6099

**Meeting ID: 810 4248 4370 Passcode:
093295**

For questions, contact:
Family Members & Co-Chairs
Cynthia Hadden, @
cindy6@comcast.net or
Amy Badini, @
abadini06870@gmail.com

Silver Panther Newsletter

FEBRUARY 2022 | Vol 13 Issue 1



Executive Board Members

Patty Bausch, David Peck, John Balisciano Jr., Martha Leland, Susan Bilansky, Anthony Gesnaldo, Jeanette Sullivan-Martinez,

IN THIS NEWSLETTER

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25th Annual Voices Forum
Page 9

Hello and thank you for taking the time to read this edition of the "Silver Panther", a newsletter brought to you by the Statewide Coalition of Presidents of Resident Councils (SCPRC) and The Long Term Care Ombudsman Program (LTCOP).

This Newsletter is designed to keep you abreast of the current issues that affect you, the residents of Connecticut nursing facilities.

We invite you to contact us with suggestions of articles you would like to see in future issues, or best practices your facility is using. You may contact us through Email at LTCOP@CT.GOV or by telephone at [1-866-388-1888](tel:1-866-388-1888).



Letter from the State Ombudsman

Hello Residents,

Change is in the air and life as we know it is getting back to a more normal pace. This time last year there was a more ominous feeling of WINTER IS COMING! However, this year I am looking forward to brighter days and the sun glistening off any snow we may get. Most individuals in our long-term care communities have been vaccinated and even received boosters of the vaccination. My Office is strongly suggesting that you speak to your medical provider about your vaccination needs and access to booster.

With the overwhelming response to the vaccine and boosters, on November 11, 2021, CMS (Centers for Medicare and Medicaid Services) released revised guidance that allows for visitation for ALL residents at ALL times. There are still infection prevention measures in place to help support residents living in long term care, but we see this as a move in the direction of fully restoring residents' rights.

I also wanted to have an opportunity to give you all an update on what is happening at a state and federal level. Since the beginning of the pandemic there has been an increased level of energy and attention regarding nursing homes throughout the country. I believe this is one of the tarnished "silver linings" of the pandemic. Previously, many of the issues and concerns that we advocated for did not get the attention we feel they deserved. We now have that attention and the opportunity to move forward with some incredibly important initiatives.

My legislative focus this year will be on the Federal Essential Caregivers bill, staffing, quality care, transparency, and accountability. I believe that focusing our legislative agenda on these items will improve the overall quality of life for the individuals we serve. My hope is that you will take an opportunity to reach out and let us know about your individual experience and why it is necessary that we see improvements in these areas. We will be working to connect you with your local legislative members so that they can hear directly from you about issues and concerns.

I look forward to what we can continue to accomplish together. You have all been so incredibly strong through this very challenging time and I applaud you for work tenacity.

Wishing you all the best for a happy and healthy 2022!

Sincerely,

Mairead Painter, State Long-Term Care Ombudsman



THE LONG-TERM CARE OMBUDSMAN PROGRAM WOULD LIKE TO WELCOME THE FOLLOWING INDIVIDUALS WHO JOINED THE TEAM IN 2021

Andre Pope joined the Ombudsman team as an administrative secretary to the State Ombudsman. Subsequent, to the Ombudsman program, Andre was at the Bureau Rehabilitation Services for seven years. The department helps individuals with disabilities prepare for, obtain, maintain or with advance employment. He came to the program eager to learn and jump right into the advocacy world. He has been a great addition to the program.

Anthony Gesnaldo joined The Executive Board of the Statewide Coalition of the President of Resident Councils (SCPRC). He's a former state senator and president of the Resident Council at Glastonbury Healthcare Center. He brings a great deal of experience that will help with the advocacy in his home and statewide.

The program trained seven volunteer advocates that wanted to give their time to help the residents. The advocates were placed in nursing homes where they will assist residents with conflict resolution, educate the residents on their rights and advocate to improve the resident's quality of life. The program is delighted to be working with each of these volunteers:

- Jennifer Glick
- Margaret (Meg) Dee
- Auline Kong
- Margit Rosenberger
- Colleen McDermott
- Sarah Caratasios
- Deb Ciofi
- Lorrie Seely



LETTER FROM THE NEW E-BOARD PRESIDENT

Statewide Coalition of Presidents of Resident Councils also known as the Executive Board or "E-Board"

January 10, 2022

Dear Silver Panther Members:

Hello. My name is David Peck. I am the newly elected president of the Statewide Coalition of Presidents of Resident Councils. We are more easily known as the E-Board or Executive Board. As of now, we are a Board of seven members. We are all currently, or in the past, have been a President of the Resident Council in a skilled nursing facility. Five members are living in a skilled nursing home, one is living independently in the community, and our past president, Jeanette Sullivan-Martinez is a member emeritus. Jeanette has been with the Coalition for the past seven years. She has spread the word of our mission and led us into many victories. She has been more than generous with her time, is always positive and her eloquent speaking is an attribute. I am personally very grateful that she has decided to stay on as an emeritus member.

One of the goals of the E-Board is to support specific legislation by giving oral and written testimony and sharing our personal views as residents as to how proposed laws can and will change our lives for the better.

We are open to answer any questions anyone may have and if we can be of assistance, we are always willing to listen. Please feel free to contact me, my Vice President, Patty Bausch, or Jeanette Martinez, our esteemed member emeritus. You can direct e-mails at this time to LTCOP@ct.gov.

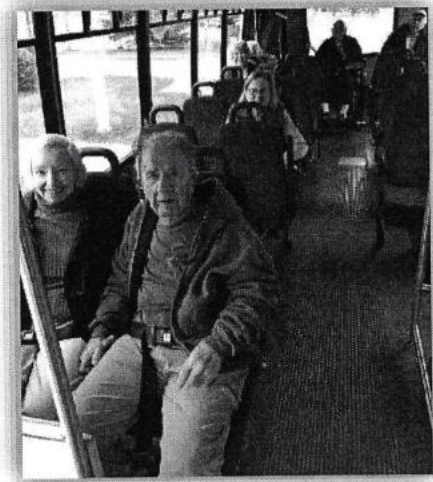
Very truly yours,

David Peck
President,
Statewide Coalition of Presidents of Resident Councils

BEST PRACTICES

Avalon at Stoneridge Best Practices

The fantastic holiday season was celebrated all month long at Avalon health Center at Stoneridge in Mystic, CT. We have enjoyed many great programs beginning with a performance by the Coast Guard band. Our bus trips included selecting the facility resident Christmas tree and a tour of holiday lights. Residents hosted a popup store for our community shoppers along with volunteer gift wrappers. The culinary club baked cookies and our creative arts group painted cork keychains for the Stonington Lobster Trap Tree lighting. The volunteer council has been working hard to help the Humane society this season with the Pet Paper Program. To celebrate the close of 2021 they celebrated with a party on the 31st complete with a live band, hors d'oeuvres and champagne.



The Connecticut Long Term Care Ombudsman Program is now on Facebook!



www.Facebook.com/ctltcop

Please visit our page and click "Like"

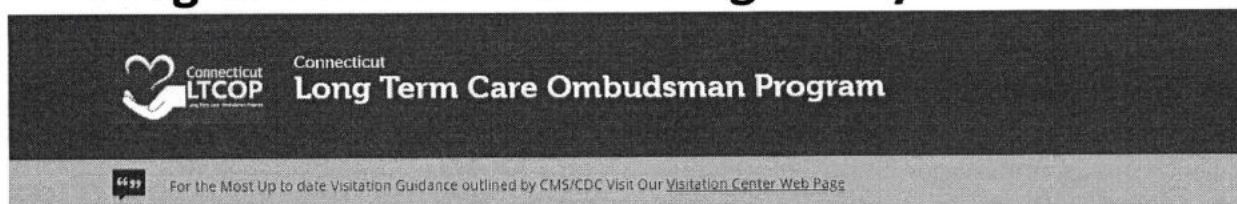


**** Facebook Live Schedule Update****

The Long Term Care Ombudsman Program has updated it's frequency for live events and they will now take place on the third Wednesday of every month at 5:30 pm. Please tune in to have your questions answered in real time!

www.Facebook.com/ctltcop/live

Get Updates from Long Term Care Ombudsman Program and E-Board straight to your inbox!



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<https://portal.ct.gov/LTCOP>

Please visit the CTLTCOP web page and click “Subscribe” to stay informed on topics that you care about most:

- Legislative News
- Local and State Wide Resident Council Resources
 - Silver Panther Newsletter
- Local and State Wide Family Council Resources
 - Visitation / COVID-19 Updates
 - Educational Opportunities / Webinars

The Resident Volunteer Advocates Annual Training Wrap-up

The resident advocates had a meet and greet with Commissioner, Amy Porter, in person. She thanked them for their invaluable work and for being a voice for residents in nursing homes in our state. The state ombudsman, Mairead Painter, also thanked the volunteer advocates for their time and commitment to the program and the residents. She is committed to growing the advocate program through outreach. The volunteer advocates shared part of this educational day with the Commissioner, State Ombudsman, and the Regional Ombudsman staff.

As part of the federal requirement annual in-service trainings are required to maintain certification as a representative of the Long Term Care Ombudsman Program.

This year's training was provided by Laurene Gomez, Behavior Health Program Manager from Department of Mental Health and Addiction Services (DMHAS) with Kathy O'Connor and Tom Shane nurses from the Nursing Home Diversion and Transition Program on December 14, 2021. The topic was on Staying Calm in a Crisis: How to De-Escalate the Escalating Resident. They talked about strategies of What to Do and What not to Do if encountered with an agitated resident and safety steps to take. This training will help the volunteers on how to manage a crisis situation with a resident during a nursing home visit.

The Nursing Home Diversion and Transition Program provides interventions that include:

- Diverting individuals from emergency rooms and avoiding unnecessary acute care hospitalizations for psychiatric reasons
- Transitioning individuals living in nursing facilities back into the community
- Providing outreach, education, and engagement regarding community-based options to individuals residing in nursing facilities with serious and persistent mental illness
- Providing consultation to professional staff regarding Behavioral Health options to nursing facility discharge teams
- Liaison support to DMHAS LMHAs and individuals who are in the process of diversion/transition as well with DSS Money Follows the Person and Mental Health Waiver staff
- Assessment for Level of care needs and determining the most appropriate community-based option i.e. skilled nursing facility or State Hospital bed

- Maintaining an updated, working knowledge of community-based resources for individuals living with mental illness and substance use issues
- Diabetes education regarding self-administration and healthy lifestyle choices
- Crisis intervention and consultation with other providers and local police
- Education regarding Mindfulness-Based alternative interventions to reduce psychiatric symptoms and cravings for substances
- Substance abuse counseling and resource education and connection
- Assistance with linkage and support for MAT

DMHAS also offers the COACH Program that provide individuals with ongoing support with connection to mental health community resources and supportive services.

For additional information or a referral, you can contact:

Laurene Gomez, Clinical Manager Diversion Nurse Program, (860) 262-6953 Laurene.Gomez@ct.gov

Mary Ives, Administrative Assistant, (860) 262-6957, Mary.ives@ct.gov

The 25th Annual Voices Forum

Your Care, Your Rights, Your Voice

The annual Voices Forum was held as virtual event on October 8, 2021.

The State Ombudsman, Mairead Painter, thanked the volunteer resident advocates for their continual support to the program and the work that they do to help the residents. She would like to increase the advocates in the program and their work will also be to educate new advocates coming into the program. She remembered long time advocate, Bob Raynor, that served the program for 20 years. According to his family, being an advocate for the program meant a great deal to him.

Today's program was to continue to find ways to connect virtually and in person and ways to still be involved through Podcasts and resident councils. Mairead has been working on Podcast's and recently released a Podcast on Medicare and long term care with more releases to come on topics on how to talk to your doctor, special guests and covering many other different topics. These can be heard through different devices such as Spotify, EcoDocs and Amazon among other devices of choice. The program is promoting the statewide family council to support the resident councils and work with the facilities to improve quality of life.

The Commissioner of the Department of Aging and Disability Services, Amy Porter, made opening remarks. She highlighted the work of the Ombudsman program in the past year on Resident Rights and the need for people to get connected in different ways and find new ways even through this forum that connections still happen until we can meet again in person to continue the critical conversations. That this year's theme keeps the focus on the acknowledgement of individual care, celebration of resident's voice and the recognition of resident rights.

Representative, Michelle Cook, presented on how to reach out and connect with your legislative representatives by telling your personal story. She shared her family story and how this story helped her in understanding the need for individuals to advocate for what's important to them.

The executive board of the Statewide Coalition of the President of Resident Councils also submitted questions to Governor Lamont. The questions submitted were on:

- The development of the work force in Connecticut.
- What can be done in developing an interest as a profession to work in nursing homes.
- Is there a plan to hold the nursing homes accountable to ensure that the pandemic funds went to the staff for wage increase.
- Any ideas on how to fix the problem of isolation and depression.
- How to fix problems with low staffing that affect the quality of life of residents.
- The nursing homes hiring pool staff from agencies that don't know the residents and the impact of this practice.

The recipient of this year's program award, Carol Rosenwald was given to Mairead Painter the State Ombudsman. The Executive Board of Resident Council nominated her for the award for her hard work in the spirit of advocacy. The national recognition award of Brian Capshaw nominee was Liz Stern. She's been advocating at a state and federal level for the Essential Caregiver Bill. It passed at a state level but not at a federal level which she continues to push as well for residents to have two essential support caregivers of their choosing. She's also working on the statewide family council which is on a Zoom platform providing monthly information to nursing homes.

Ingraham Manor in Bristol was watching Voices live. 😊

You can watch the Voices Forum at <https://portal.ct.gov/LTCOP/Voices2021>



Statewide Coalition of Presidents of Resident Councils (SCPRC)



Executive Board Members

| <u>E-Board Member</u> | <u>Location</u> |
|--|--|
| <i>John Balisciano Jr.</i> | <i>Hewitt Health and Rehab</i> |
| <i>Patty Bausch</i> Vice President | <i>Newtown Rehabilitation and Health Care Center</i> |
| <i>Susan Bilansky</i> | <i>Hebrew Home</i> |
| <i>Anthony Gesnaldo</i> | <i>Glastonbury Health Care Center</i> |
| <i>Martha Leland</i> | <i>Touchpoints of Manchester</i> |
| <i>Jeanette Sullivan-Martinez</i> Emeritus Member | <i>Pendleton Healthcare</i> |
| <i>David Peck</i> President | <i>Community Setting - Hamden</i> |



The Long Term Care Ombudsman Program

TOLL FREE NUMBER

1-866-388-1888

Email: ltcop@ct.gov

Facebook: www.facebook.com/CTLTCOP

State Website: https://portal.ct.gov/ltcop

MAIREAD PAINTER

STATE LONG TERM CARE OMBUDSMAN

860- 424-5200

Andre Pope - Administrative Assistant

860-424-5239

| REGIONAL ASSIGNMENTS |
|--|
| <p><u>WESTERN REGION</u></p> <p>INTAKE NUMBER 203-597-4181</p> <p>Deborah Robinson - Intake Coordinator</p> <p>Regional Ombudsmen</p> <p>Sylvia Crespo, Tasha Erskine-Jackson</p> |
| <p><u>SOUTHERN REGION</u></p> <p>INTAKE NUMBER 860-823-3366</p> <p>Stephanie Booth/Andre Pope - Intake Coordinator</p> <p>Regional Ombudsmen</p> <p>Dan Lerman, Patricia Calderone, Daniel Beem</p> |
| <p><u>NORTHERN REGION</u></p> <p>INTAKE NUMBER 860-424-5221</p> <p>Stephanie Booth/Andre Pope - Intake Coordinator</p> <p>Regional Ombudsmen</p> <p>Brenda Texidor, Brenda Foreman, Lindsay Jesshop</p> |



MedicareAdvocacy.org

The Center for Medicare Advocacy

The Center for Medicare Advocacy, Inc. is a private, non-profit organization which provides education, advocacy, and legal assistance to help elders and people with disabilities obtain necessary healthcare. We focus on the needs of Medicare beneficiaries, people with chronic conditions, and those in need of long-term care. The organization is involved in education, training and litigation activities of importance to Medicare beneficiaries nationwide.

TOLL FREE NUMBER

Telephone: 860-456-7790 | **Toll Free:** 1-800-262-4414

Email: info@medicareadvocacy.org

Facebook: <https://www.facebook.com/MedicareAdvocacy.org>

Website: <https://medicareadvocacy.org/>

Winter Wonderland

This monster word search includes more than 50 winter words going in every possible direction. Can you find them all?



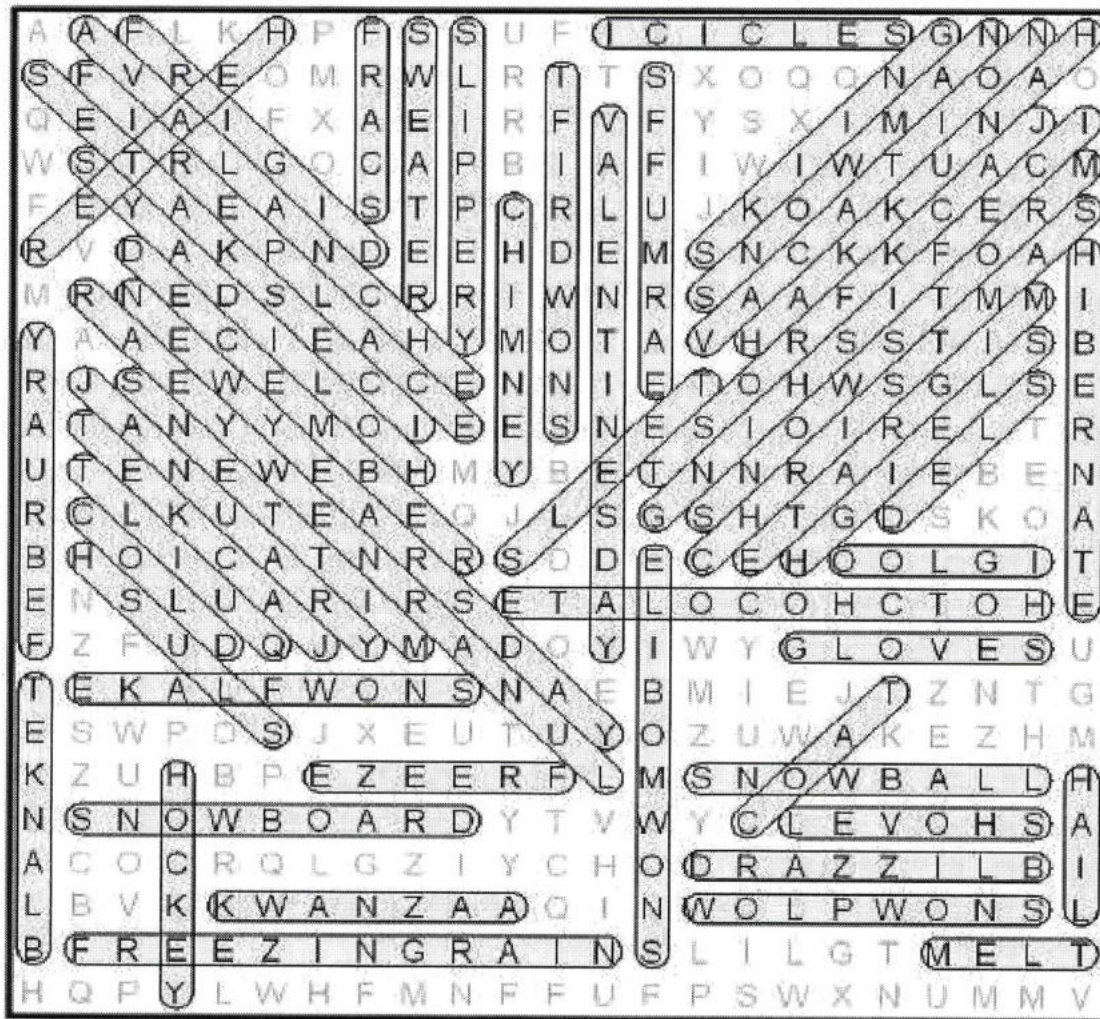
avalanche
blanket
blizzard
chimney
Christmas
coat
cold
December
earmuffs
February
fireplace
freeze
freezing rain
frigid

gloves
hail
Hanukkah
heater
hibernate
hockey
holidays
hot chocolate
ice fishing
ice skates
icicles
igloo
Jack Frost
jacket

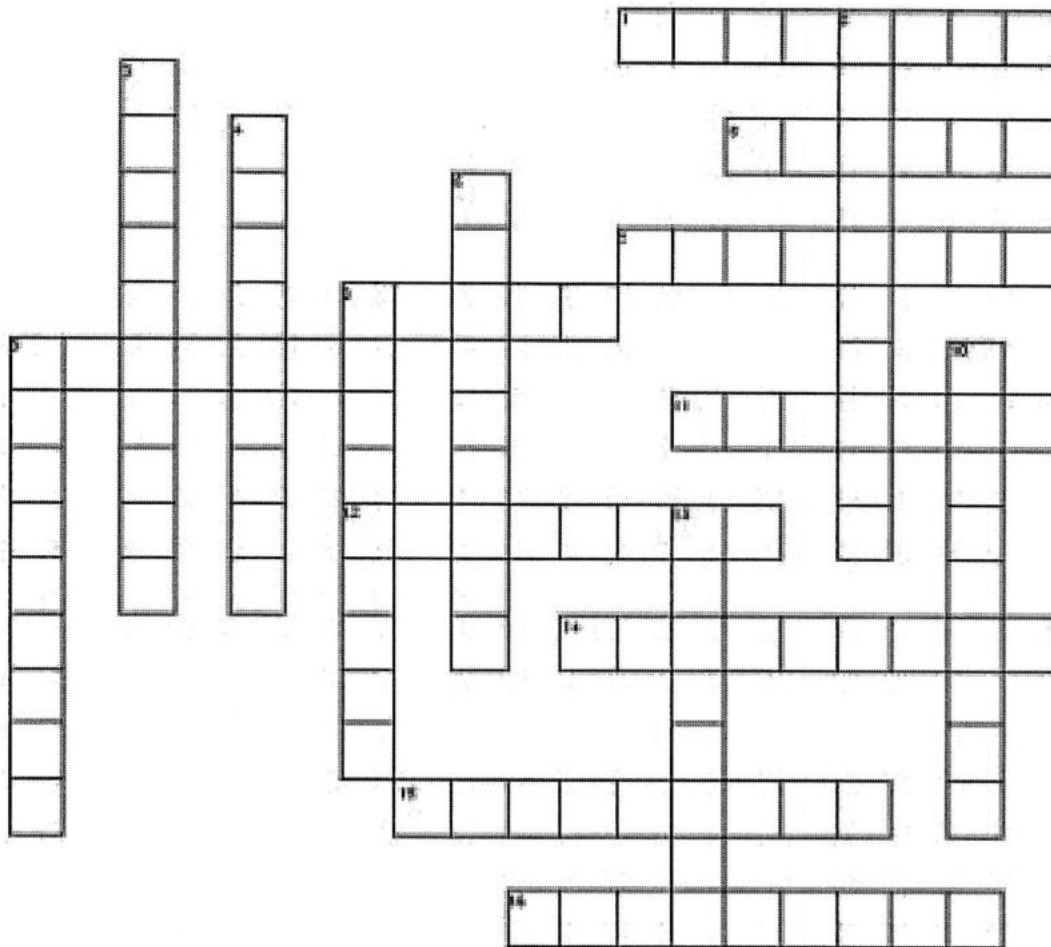
January
Kwanzaa
lunar new year
melt
migrate
mittens
New Year's Day
quilt
scarf
shovel
skiing
sled
sleet
sleigh

slippery
slush
snowball
snowboard
snowdrift
snowflake
snowman
snowmobile
snowplow
snowstorm
sweater
vacation
Valentine's Day

Answer Key



Snow, Snow, Snow



ACROSS

1. A piece of winter clothing that keeps children warm and dry as they play in the snow.

5. It _____ last night.

7. A rounded handful of snow that may be thrown.

8. The adjective form of snow (as in "Stopping by the Woods on a _____ Evening")

9. A person made of snow.

11. Look outside! It's _____.

12. The absence of snow. ("It's been a _____ winter.")

14. A flat object that people use to travel in surf-like position down hills of snow.

15. A single piece of snow.

16. A type of winter storm.

DOWN

2. A tool people use to remove snow from sidewalks.

3. A vehicle that may be driven across snow.

4. A machine that creates artificial snow.

6. Something people use to help them walk across snow.

8. A landscape covered with snow.

9. An avalanche of snow.

10. A large bank of snow.

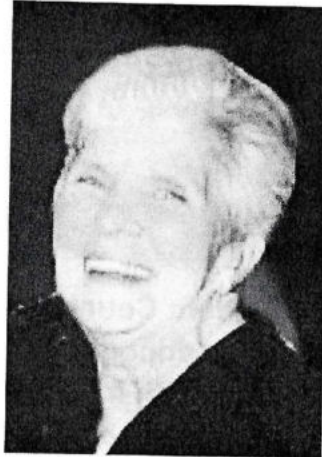
13. A machine used to remove snow from roads.



Y.B. 1111



Carol Rosenwald Spirit Of Advocacy Award
You Must Hold Onto Your Ideals and Always Have the
Courage To Speak Your Mind” ~ Carol Rosenwald



History of the VOICES Forum

In September of 1996, nursing home resident and activist Carol Rosenwald, with assistance from the Ombudsman Program, began organizing residents across the state to advocate for improvements in the long term care system. Carol envisioned a time when the “VOICES” of nursing home residents could be heard “beyond the walls” of their facilities. She became the founder of the Statewide Coalition of Resident Councils and the driving force behind the first “VOICES” Forum in 1997. As a large group of voting constituents, residents were able to speak directly with political leaders and public officials about important issues affecting their quality of life.

VOICES 2016 marks the twenty anniversary of Carol’s vision and of this historic event. Our heartfelt thanks to the many courageous residents who have attended VOICES over the years and to all of you attending today who inspire systems change in long term care. You have our deepest admiration and respect.

~The Long Term Care Ombudsman Program

Brian Capshaw Rock Star Award



The Coalition of Presidents of Resident Councils and the Long-Term Care Ombudsman Program are pleased to announce that Brian will be honored annually for his incredible advocacy both in Connecticut and at the national level. In 2012, Brian participated in the Consumer Voice Conference in Washington, DC. He represented Connecticut nursing home residents with a strong voice and with the incredible advocacy that only one who has "walked the walk" can bring to the conversation. From that first moment on Brian catapulted into the advocacy world like a meteor lighting up the sky! He became the resident representative on the Long-Term Care Advisory Council, he testified at countless hearings and he went door to door at the capitol talking with legislators about all the issues so important to quality care and services for nursing home residents: improved staffing levels, video monitoring, personal needs allowance, to name just a few. Brian continued his national advocacy: he was appointed to be the Chair of the Leadership Council of the Consumer Voice, he was interviewed numerous times by the national media and participated in a wide variety of state and national workgroups. Brian was invited to the White House to participate in the 2015 White House Conference on Aging, the only nursing home resident invited. And last year, at the 2015 VOICES Forum, we honored Brian for being our very own Rock Star, with a rock of course!

Personally, Brian loved sports, loved his family and friends, loved getting into his van to meet friends for concerts and various activities. And he thoroughly enjoyed his rock music! Brian, in every fashion, was an inspiration and a joy to all who knew and admired him. We miss him dearly. This year we honor Brian Capshaw, his spirit and advocacy both in Connecticut and at the national level. We are so pleased to award the First Annual Brian Capshaw Rock Star Award to his dear friend and colleague, Lisa Tripp. Together, Lisa and Brian worked on issues of importance especially related to nursing home enforcement issues, a passion of Brian's. Our sincere congratulations to Lisa, the first recipient of Brian's Rock Star Award. We are honored and Brian would be so plea

Fill-in Forms Information for the SP-26NB and W-9 Forms

Overview

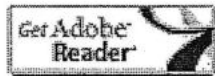
There is no verification of the information you enter. You are responsible for entering all information. Some information must be handwritten on the form.

Software Requirements

To view, complete and print the following fill-in PDF forms, you will need the freely available Adobe Reader software installed on your computer.

Adobe Reader


Adobe PDF files are a means to distribute publications and other information. To fill-in, download and print a PDF file, you will need to have the Adobe Reader software installed. You can download the latest version of Adobe Reader FREE from the Adobe Reader download page on Adobe's Web site.



Completing the form on your PC

When positioning the cursor on a fill-in area, the cursor will change appearance.

The **I-beam pointer**  allows you to type text.

The **hand pointer**  allows you to select a check box or button.
Enter the appropriate data in each box or field.

To move from one field to the next, press the Tab key.

You can also use your mouse to move your cursor from field to field. Place your cursor in the field you want to fill in, then left-click.

Some fields limit the maximum number of characters you can enter and may automatically advance to the next field.

For additional help with fill-in forms, see the Adobe Reader's on-line help information at:
<http://www.adobe.com/support/reader/>

Saving a Form

When saving a file, be sure to use the Save function of Adobe Reader rather than the web browser's save.

Printing a Form


When printing Adobe PDF files from within your web browser, whether you are printing a blank form or printing a form after filling it in from your PC, use the print button at the left end of the special Adobe Acrobat tool bar, which appears immediately above the viewing window.

THIS PAGE IS FOR INFORMATION ONLY AND DOES NOT NEED TO BE PRINTED NOR SUBMITTED WITH THE FOLLOWING FORMS.

STATE OF CONNECTICUT - AGENCY VENDOR FORM
IMPORTANT: ALL parts of this form must be completed, signed and returned by the vendor.

READ & COMPLETE CAREFULLY

SP-26NB-IPDF Rev. 4/

| | | | |
|---|--|---|------------------------|
| COMPLETE VENDOR LEGAL BUSINESS NAME | | Taxpayer ID # (TIN): <input type="checkbox"/> SSN <input type="checkbox"/> FEIN | |
| WRITE/TYPE SSN/FEIN NUMBER ABOVE | | | |
| BUSINESS NAME, TRADE NAME, DOING BUSINESS AS (IF DIFFERENT FROM ABOVE) | | | |
| BUSINESS ENTITY: <input type="checkbox"/> CORPORATION <input type="checkbox"/> LLC CORPORATION <input type="checkbox"/> LLC PARTNERSHIP <input type="checkbox"/> LLC SINGLE MEMBER ENTITY <input type="checkbox"/> NON-PROFIT <input type="checkbox"/> PARTNERSHIP <input type="checkbox"/> INDIVIDUAL/SOLE PROPRIETOR <input type="checkbox"/> GOVERNMENT | | | |
| NOTE: IF INDIVIDUAL/SOLE PROPRIETOR, INDIVIDUAL'S NAME (AS OWNER) MUST APPEAR IN THE LEGAL BUSINESS NAME BLOCK ABOVE. | | | |
| BUSINESS TYPE: A. SALE OF COMMODITIES B. MEDICAL SERVICES C. ATTORNEY FEES D. RENTAL OF PROPERTY (REAL ESTATE & EQUIPMENT) | | | |
| E. OTHER (DESCRIBE IN DETAIL) | | | |
| UNDER THIS TIN, WHAT IS THE PRIMARY TYPE OF BUSINESS YOU PROVIDE TO THE STATE? (ENTER LETTER FROM ABOVE) → | | | |
| UNDER THIS TIN, WHAT OTHER TYPES OF BUSINESS MIGHT YOU PROVIDE TO THE STATE? (ENTER LETTER FROM ABOVE) → | | | |
| NOTE: IF YOUR BUSINESS IS A PARTNERSHIP, YOU MUST ATTACH THE NAMES AND TITLES OF ALL PARTNERS TO YOUR BID SUBMISSION. | | | |
| NOTE: IF YOUR BUSINESS IS A CORPORATION, IN WHICH STATE ARE YOU INCORPORATED? | | | |
| VENDOR ADDRESS | | STREET | CITY STATE ZIP CODE |
| Add Additional Business Address & Contact information on back of this form. | | | |
| VENDOR E-MAIL ADDRESS | | VENDOR WEB SITE | |
| REMITTANCE INFORMATION: INDICATE BELOW THE REMITTANCE ADDRESS OF YOUR BUSINESS. <input type="checkbox"/> SAME AS VENDOR ADDRESS ABOVE. | | | |
| REMIT ADDRESS | | STREET | CITY STATE ZIP CODE |
| CONTACT INFORMATION: NAME (TYPE OR PRINT) | | | |
| 1 ST BUSINESS PHONE: | | Ext. # | HOME PHONE: |
| 2 ND BUSINESS PHONE: | | Ext. # | 1 ST PAGER: |
| CELLULAR: | | 2 ND PAGER: | |
| 1 ST FAX NUMBER: | | TOLL FREE PHONE: | |
| 2 ND FAX NUMBER: | | TELEX: | |
| WRITTEN SIGNATURE OF PERSON AUTHORIZED TO SIGN PROPOSALS ON BEHALF OF THE ABOVE NAMED VENDOR | | | DATE EXECUTED |
|  SIGN HERE | | | |
| TYPE OR PRINT NAME OF AUTHORIZED PERSON | | TITLE OF AUTHORIZED PERSON | |
| IS YOUR BUSINESS CURRENTLY A DAS CERTIFIED SMALL BUSINESS ENTERPRISE? <input type="checkbox"/> YES (ATTACH COPY OF CERTIFICATE) <input type="checkbox"/> NO | | | |
| IS YOUR BUSINESS CURRENTLY A CT DOT CERTIFIED DISADVANTAGED BUSINESS ENTERPRISE (DBE)? <input type="checkbox"/> YES <input type="checkbox"/> NO | | | |
| IF YOU ARE A STATE EMPLOYEE, INDICATE YOUR POSITION, AGENCY & AGENCY ADDRESS | | | |
| PURCHASE ORDER DISTRIBUTION: (E-MAIL ADDRESS) | | | |
| NOTE: THE E-MAIL ADDRESS INDICATED IMMEDIATELY ABOVE WILL BE USED TO FORWARD PURCHASE ORDERS TO YOUR BUSINESS. | | | |

ADD FURTHER BUSINESS ADDRESS, E-MAIL & CONTACT INFORMATION ON SEPARATE SHEET IF REQUIRED

Request for Taxpayer Identification Number and Certification

Give form to the
requester. Do not
send to the IRS.

Print or type
See Specific instructions on page 2.

Name (as shown on your income tax return)

Business name, if different from above

Check appropriate box: ☐ Individual/Sole proprietor ☐ Corporation ☐ Partnership
☐ Limited liability company. Enter the tax classification (D=disregarded entity, C=corporation, P=partnership) ▶
☐ Other (see instructions) ▶

☐ Exempt
payee

Address (number, street, and apt. or suite no.)

Requester's name and address (optional)

City, state, and ZIP code

List account number(s) here (optional)

Part I Taxpayer Identification Number (TIN)

Enter your TIN in the appropriate box. The TIN provided must match the name given on Line 1 to avoid backup withholding. For individuals, this is your social security number (SSN). However, for a resident alien, sole proprietor, or disregarded entity, see the Part I instructions on page 3. For other entities, it is your employer identification number (EIN). If you do not have a number, see *How to get a TIN* on page 3.

Social security number

or

Employer identification number

Note. If the account is in more than one name, see the chart on page 4 for guidelines on whose number to enter.

Part II Certification

Under penalties of perjury, I certify that:

1. The number shown on this form is my correct taxpayer identification number (or I am waiting for a number to be issued to me), and
2. I am not subject to backup withholding because: (a) I am exempt from backup withholding, or (b) I have not been notified by the Internal Revenue Service (IRS) that I am subject to backup withholding as a result of a failure to report all interest or dividends, or (c) the IRS has notified me that I am no longer subject to backup withholding, and
3. I am a U.S. citizen or other U.S. person (defined below).

Certification instructions. You must cross out item 2 above if you have been notified by the IRS that you are currently subject to backup withholding because you have failed to report all interest and dividends on your tax return. For real estate transactions, item 2 does not apply. For mortgage interest paid, acquisition or abandonment of secured property, cancellation of debt, contributions to an individual retirement arrangement (IRA), and generally, payments other than interest and dividends, you are not required to sign the Certification, but you must provide your correct TIN. See the instructions on page 4.

Sign
Here

Signature of
U.S. person ▶

Date ▶

General Instructions

Section references are to the Internal Revenue Code unless otherwise noted.

Purpose of Form

A person who is required to file an information return with the IRS must obtain your correct taxpayer identification number (TIN) to report, for example, income paid to you, real estate transactions, mortgage interest you paid, acquisition or abandonment of secured property, cancellation of debt, or contributions you made to an IRA.

Use Form W-9 only if you are a U.S. person (including a resident alien), to provide your correct TIN to the person requesting it (the requester) and, when applicable, to:

1. Certify that the TIN you are giving is correct (or you are waiting for a number to be issued),
2. Certify that you are not subject to backup withholding, or
3. Claim exemption from backup withholding if you are a U.S. exempt payee. If applicable, you are also certifying that as a U.S. person, your allocable share of any partnership income from a U.S. trade or business is not subject to the withholding tax on foreign partners' share of effectively connected income.

Note. If a requester gives you a form other than Form W-9 to request your TIN, you must use the requester's form if it is substantially similar to this Form W-9.

Definition of a U.S. person. For federal tax purposes, you are considered a U.S. person if you are:

- An individual who is a U.S. citizen or U.S. resident alien,
- A partnership, corporation, company, or association created or organized in the United States or under the laws of the United States,
- An estate (other than a foreign estate), or
- A domestic trust (as defined in Regulations section 301.7701-7).

Special rules for partnerships. Partnerships that conduct a trade or business in the United States are generally required to pay a withholding tax on any foreign partners' share of income from such business. Further, in certain cases where a Form W-9 has not been received, a partnership is required to presume that a partner is a foreign person, and pay the withholding tax. Therefore, if you are a U.S. person that is a partner in a partnership conducting a trade or business in the United States, provide Form W-9 to the partnership to establish your U.S. status and avoid withholding on your share of partnership income.

The person who gives Form W-9 to the partnership for purposes of establishing its U.S. status and avoiding withholding on its allocable share of net income from the partnership conducting a trade or business in the United States is in the following cases:

- The U.S. owner of a disregarded entity and not the entity,

- The U.S. grantor or other owner of a grantor trust and not the trust, and
- The U.S. trust (other than a grantor trust) and not the beneficiaries of the trust.

Foreign person. If you are a foreign person, do not use Form W-9. Instead, use the appropriate Form W-8 (see Publication 515, Withholding of Tax on Nonresident Aliens and Foreign Entities).

Nonresident alien who becomes a resident alien. Generally, only a nonresident alien individual may use the terms of a tax treaty to reduce or eliminate U.S. tax on certain types of income. However, most tax treaties contain a provision known as a "saving clause." Exceptions specified in the saving clause may permit an exemption from tax to continue for certain types of income even after the payee has otherwise become a U.S. resident alien for tax purposes.

If you are a U.S. resident alien who is relying on an exception contained in the saving clause of a tax treaty to claim an exemption from U.S. tax on certain types of income, you must attach a statement to Form W-9 that specifies the following five items:

1. The treaty country. Generally, this must be the same treaty under which you claimed exemption from tax as a nonresident alien.
2. The treaty article addressing the income.
3. The article number (or location) in the tax treaty that contains the saving clause and its exceptions.
4. The type and amount of income that qualifies for the exemption from tax.
5. Sufficient facts to justify the exemption from tax under the terms of the treaty article.

Example. Article 20 of the U.S.-China income tax treaty allows an exemption from tax for scholarship income received by a Chinese student temporarily present in the United States. Under U.S. law, this student will become a resident alien for tax purposes if his or her stay in the United States exceeds 5 calendar years. However, paragraph 2 of the first Protocol to the U.S.-China treaty (dated April 30, 1984) allows the provisions of Article 20 to continue to apply even after the Chinese student becomes a resident alien of the United States. A Chinese student who qualifies for this exception (under paragraph 2 of the first protocol) and is relying on this exception to claim an exemption from tax on his or her scholarship or fellowship income would attach to Form W-9 a statement that includes the information described above to support that exemption.

If you are a nonresident alien or a foreign entity not subject to backup withholding, give the requester the appropriate completed Form W-8.

What is backup withholding? Persons making certain payments to you must under certain conditions withhold and pay to the IRS 28% of such payments. This is called "backup withholding." Payments that may be subject to backup withholding include interest, tax-exempt interest, dividends, broker and barter exchange transactions, rents, royalties, nonemployee pay, and certain payments from fishing boat operators. Real estate transactions are not subject to backup withholding.

You will not be subject to backup withholding on payments you receive if you give the requester your correct TIN, make the proper certifications, and report all your taxable interest and dividends on your tax return.

Payments you receive will be subject to backup withholding if:

1. You do not furnish your TIN to the requester,
2. You do not certify your TIN when required (see the Part II instructions on page 3 for details),
3. The IRS tells the requester that you furnished an incorrect TIN,

4. The IRS tells you that you are subject to backup withholding because you did not report all your interest and dividends on your tax return (for reportable interest and dividends only), or

5. You do not certify to the requester that you are not subject to backup withholding under 4 above (for reportable interest and dividend accounts opened after 1983 only).

Certain payees and payments are exempt from backup withholding. See the instructions below and the separate Instructions for the Requester of Form W-9.

Also see *Special rules for partnerships* on page 1.

Penalties

Failure to furnish TIN. If you fail to furnish your correct TIN to a requester, you are subject to a penalty of \$50 for each such failure unless your failure is due to reasonable cause and not to willful neglect.

Civil penalty for false information with respect to withholding. If you make a false statement with no reasonable basis that results in no backup withholding, you are subject to a \$500 penalty.

Criminal penalty for falsifying information. Willfully falsifying certifications or affirmations may subject you to criminal penalties including fines and/or imprisonment.

Misuse of TINs. If the requester discloses or uses TINs in violation of federal law, the requester may be subject to civil and criminal penalties.

Specific Instructions

Name

If you are an individual, you must generally enter the name shown on your income tax return. However, if you have changed your last name, for instance, due to marriage without informing the Social Security Administration of the name change, enter your first name, the last name shown on your social security card, and your new last name.

If the account is in joint names, list first, and then circle, the name of the person or entity whose number you entered in Part I of the form.

Sole proprietor. Enter your individual name as shown on your income tax return on the "Name" line. You may enter your business, trade, or "doing business as (DBA)" name on the "Business name" line.

Limited liability company (LLC). Check the "Limited liability company" box only and enter the appropriate code for the tax classification ("D" for disregarded entity, "C" for corporation, "P" for partnership) in the space provided.

For a single-member LLC (including a foreign LLC with a domestic owner) that is disregarded as an entity separate from its owner under Regulations section 301.7701-3, enter the owner's name on the "Name" line. Enter the LLC's name on the "Business name" line.

For an LLC classified as a partnership or a corporation, enter the LLC's name on the "Name" line and any business, trade, or DBA name on the "Business name" line.

Other entities. Enter your business name as shown on required federal tax documents on the "Name" line. This name should match the name shown on the charter or other legal document creating the entity. You may enter any business, trade, or DBA name on the "Business name" line.

Note. You are requested to check the appropriate box for your status (individual/sole proprietor, corporation, etc.).

Exempt Payee

If you are exempt from backup withholding, enter your name as described above and check the appropriate box for your status, then check the "Exempt payee" box in the line following the business name, sign and date the form.

Generally, individuals (including sole proprietors) are not exempt from backup withholding. Corporations are exempt from backup withholding for certain payments, such as interest and dividends.

Note. If you are exempt from backup withholding, you should still complete this form to avoid possible erroneous backup withholding.

The following payees are exempt from backup withholding:

1. An organization exempt from tax under section 501(a), any IRA, or a custodial account under section 403(b)(7) if the account satisfies the requirements of section 401(f)(2),

2. The United States or any of its agencies or instrumentalities,

3. A state, the District of Columbia, a possession of the United States, or any of their political subdivisions or instrumentalities,

4. A foreign government or any of its political subdivisions, agencies, or instrumentalities, or

5. An international organization or any of its agencies or instrumentalities.

Other payees that may be exempt from backup withholding include:

6. A corporation,

7. A foreign central bank of issue,

8. A dealer in securities or commodities required to register in the United States, the District of Columbia, or a possession of the United States,

9. A futures commission merchant registered with the Commodity Futures Trading Commission,

10. A real estate investment trust,

11. An entity registered at all times during the tax year under the Investment Company Act of 1940,

12. A common trust fund operated by a bank under section 584(a),

13. A financial institution,

14. A middleman known in the investment community as a nominee or custodian, or

15. A trust exempt from tax under section 664 or described in section 4947.

The chart below shows types of payments that may be exempt from backup withholding. The chart applies to the exempt payees listed above, 1 through 15.

| IF the payment is for . . . | THEN the payment is exempt for . . . |
|--|--|
| Interest and dividend payments | All exempt payees except for 9 |
| Broker transactions | Exempt payees 1 through 13. Also, a person registered under the Investment Advisers Act of 1940 who regularly acts as a broker |
| Barter exchange transactions and patronage dividends | Exempt payees 1 through 5 |
| Payments over \$600 required to be reported and direct sales over \$5,000 ¹ | Generally, exempt payees 1 through 7 ² |

¹ See Form 1099-MISC, Miscellaneous Income, and its instructions.

² However, the following payments made to a corporation (including gross proceeds paid to an attorney under section 6045(f), even if the attorney is a corporation) and reportable on Form 1099-MISC are not exempt from backup withholding: medical and health care payments, attorneys' fees, and payments for services paid by a federal executive agency.

Part I. Taxpayer Identification Number (TIN)

Enter your TIN in the appropriate box. If you are a resident alien and you do not have and are not eligible to get an SSN, your TIN is your IRS individual taxpayer identification number (ITIN). Enter it in the social security number box. If you do not have an ITIN, see *How to get a TIN* below.

If you are a sole proprietor and you have an EIN, you may enter either your SSN or EIN. However, the IRS prefers that you use your SSN.

If you are a single-member LLC that is disregarded as an entity separate from its owner (see *Limited liability company (LLC)* on page 2), enter the owner's SSN (or EIN, if the owner has one). Do not enter the disregarded entity's EIN. If the LLC is classified as a corporation or partnership, enter the entity's EIN.

Note. See the chart on page 4 for further clarification of name and TIN combinations.

How to get a TIN. If you do not have a TIN, apply for one immediately. To apply for an SSN, get Form SS-5, Application for a Social Security Card, from your local Social Security Administration office or get this form online at www.ssa.gov. You may also get this form by calling 1-800-772-1213. Use Form W-7, Application for IRS Individual Taxpayer Identification Number, to apply for an ITIN, or Form SS-4, Application for Employer Identification Number, to apply for an EIN. You can apply for an EIN online by accessing the IRS website at www.irs.gov/businesses and clicking on Employer Identification Number (EIN) under Starting a Business. You can get Forms W-7 and SS-4 from the IRS by visiting www.irs.gov or by calling 1-800-TAX-FORM (1-800-829-3676).

If you are asked to complete Form W-9 but do not have a TIN, write "Applied For" in the space for the TIN, sign and date the form, and give it to the requester. For interest and dividend payments, and certain payments made with respect to readily tradable instruments, generally you will have 60 days to get a TIN and give it to the requester before you are subject to backup withholding on payments. The 60-day rule does not apply to other types of payments. You will be subject to backup withholding on all such payments until you provide your TIN to the requester.

Note. Entering "Applied For" means that you have already applied for a TIN or that you intend to apply for one soon.

Caution: A disregarded domestic entity that has a foreign owner must use the appropriate Form W-8.

Part II. Certification

To establish to the withholding agent that you are a U.S. person, or resident alien, sign Form W-9. You may be requested to sign by the withholding agent even if items 1, 4, and 5 below indicate otherwise.

For a joint account, only the person whose TIN is shown in Part I should sign (when required). Exempt payees, see *Exempt Payee* on page 2.

Signature requirements. Complete the certification as indicated in 1 through 5 below.

1. Interest, dividend, and barter exchange accounts opened before 1984 and broker accounts considered active during 1983. You must give your correct TIN, but you do not have to sign the certification.

2. Interest, dividend, broker, and barter exchange accounts opened after 1983 and broker accounts considered inactive during 1983. You must sign the certification or backup withholding will apply. If you are subject to backup withholding and you are merely providing your correct TIN to the requester, you must cross out item 2 in the certification before signing the form.

3. Real estate transactions. You must sign the certification. You may cross out item 2 of the certification.

4. Other payments. You must give your correct TIN, but you do not have to sign the certification unless you have been notified that you have previously given an incorrect TIN. "Other payments" include payments made in the course of the requester's trade or business for rents, royalties, goods (other than bills for merchandise), medical and health care services (including payments to corporations), payments to a nonemployee for services, payments to certain fishing boat crew members and fishermen, and gross proceeds paid to attorneys (including payments to corporations).

5. Mortgage interest paid by you, acquisition or abandonment of secured property, cancellation of debt, qualified tuition program payments (under section 529), IRA, Coverdell ESA, Archer MSA or HSA contributions or distributions, and pension distributions. You must give your correct TIN, but you do not have to sign the certification.

What Name and Number To Give the Requester

| For this type of account: | Give name and SSN of: |
|---|---|
| 1. Individual | The individual |
| 2. Two or more individuals (joint account) | The actual owner of the account or, if combined funds, the first individual on the account ¹ |
| 3. Custodian account of a minor (Uniform Gift to Minors Act) | The minor ² |
| 4. a. The usual revocable savings trust (grantor is also trustee) | The grantor-trustee ³ |
| b. So-called trust account that is not a legal or valid trust under state law | The actual owner ¹ |
| 5. Sole proprietorship or disregarded entity owned by an individual | The owner ³ |
| For this type of account: | Give name and EIN of: |
| 6. Disregarded entity not owned by an individual | The owner |
| 7. A valid trust, estate, or pension trust | Legal entity ⁴ |
| 8. Corporate or LLC electing corporate status on Form 8832 | The corporation |
| 9. Association, club, religious, charitable, educational, or other tax-exempt organization | The organization |
| 10. Partnership or multi-member LLC | The partnership |
| 11. A broker or registered nominee | The broker or nominee |
| 12. Account with the Department of Agriculture in the name of a public entity (such as a state or local government, school district, or prison) that receives agricultural program payments | The public entity |

¹ List first and circle the name of the person whose number you furnish. If only one person on a joint account has an SSN, that person's number must be furnished.

² Circle the minor's name and furnish the minor's SSN.

³ You must show your individual name and you may also enter your business or "DBA" name on the second name line. You may use either your SSN or EIN (if you have one), but the IRS encourages you to use your SSN.

⁴ List first and circle the name of the trust, estate, or pension trust. (Do not furnish the TIN of the personal representative or trustee unless the legal entity itself is not designated in the account title.) Also see *Special rules for partnerships* on page 1.

Note. If no name is circled when more than one name is listed, the number will be considered to be that of the first name listed.

Secure Your Tax Records from Identity Theft

Identity theft occurs when someone uses your personal information such as your name, social security number (SSN), or other identifying information, without your permission, to commit fraud or other crimes. An identity thief may use your SSN to get a job or may file a tax return using your SSN to receive a refund.

To reduce your risk:

- Protect your SSN,
- Ensure your employer is protecting your SSN, and
- Be careful when choosing a tax preparer.

Call the IRS at 1-800-829-1040 if you think your identity has been used inappropriately for tax purposes.

Victims of identity theft who are experiencing economic harm or a system problem, or are seeking help in resolving tax problems that have not been resolved through normal channels, may be eligible for Taxpayer Advocate Service (TAS) assistance. You can reach TAS by calling the TAS toll-free case intake line at 1-877-777-4778 or TTY/TDD 1-800-829-4059.

Protect yourself from suspicious emails or phishing schemes.

Phishing is the creation and use of email and websites designed to mimic legitimate business emails and websites. The most common act is sending an email to a user falsely claiming to be an established legitimate enterprise in an attempt to scam the user into surrendering private information that will be used for identity theft.

The IRS does not initiate contacts with taxpayers via emails. Also, the IRS does not request personal detailed information through email or ask taxpayers for the PIN numbers, passwords, or similar secret access information for their credit card, bank, or other financial accounts.

If you receive an unsolicited email claiming to be from the IRS, forward this message to phishing@irs.gov. You may also report misuse of the IRS name, logo, or other IRS personal property to the Treasury Inspector General for Tax Administration at 1-800-366-4484. You can forward suspicious emails to the Federal Trade Commission at: spam@uce.gov or contact them at www.consumer.gov/idtheft or 1-877-IDTHEFT(438-4338).

Visit the IRS website at www.irs.gov to learn more about identity theft and how to reduce your risk.

Privacy Act Notice

Section 6109 of the Internal Revenue Code requires you to provide your correct TIN to persons who must file information returns with the IRS to report interest, dividends, and certain other income paid to you, mortgage interest you paid, the acquisition or abandonment of secured property, cancellation of debt, or contributions you made to an IRA, or Archer MSA or HSA. The IRS uses the numbers for identification purposes and to help verify the accuracy of your tax return. The IRS may also provide this information to the Department of Justice for civil and criminal litigation, and to cities, states, the District of Columbia, and U.S. possessions to carry out their tax laws. We may also disclose this information to other countries under a tax treaty, to federal and state agencies to enforce federal nontax criminal laws, or to federal law enforcement and intelligence agencies to combat terrorism.

You must provide your TIN whether or not you are required to file a tax return. Payers must generally withhold 28% of taxable interest, dividend, and certain other payments to a payee who does not give a TIN to a payer. Certain penalties may also apply.

CO - 17 REV. 10/2010

VENDOR: PLEASE COMPLETE THIS FORM AND SEND IT TO THE
DEPARTMENT **BILLING ADDRESS** SHOWN ON THE PURCHASE ORDER

(10) VENDOR RATE. FIELDS 9, 10, 14 and 18 ARE MANDATORY FOR PAYMENT

(13) **VENDOR COMMENTS**

RO Signature: _____

(30) DEPARTMENT NAME AND ADDRESS

(31) PO NO.

| | |
|--|--|
| (32) COMMODITIES RECEIVED OR SERVICES RENDERED - SIGNATURE | |
|--|--|

(33) PO BUSINESS UNIT

(34) RECEIVING REPORT NO.

| |
|----------------------------|
| (35) DATE(S) OF RECEIPT(S) |
|----------------------------|

(36) DATE SHIPPED

(37) FROM - CITY / STATE

(38) VIA - CARRIER

(39) F.O.B.

MONTHLY FACILITY VISIT CHECKLIST

BASIC FACILITY OBLIGATIONS (A comment is required for all items answered NO)

| | Y | N |
|---|---|---|
| 1. LTCOP posting visible | | |
| 2. Required postings: survey, menu, shift/staffing, activity calendar, bank hours | | |

LIVING SPACES/DINING EXPERIENCE

| | Y | N |
|--|---|---|
| 3. Facility clean, odor free, comfortable temperature, good lighting, furnishings and equipment in good repair | | |
| 4. Quiet visiting areas available, noise levels reasonable, P.A. system used minimally | | |
| 5. Hallways hazard free, exits clear | | |
| 6. Resident rooms are tidy, to residents' satisfaction | | |
| 7. Meals presented in appetizing manner | | |
| 8. Staff assisting residents as needed with feeding & meals | | |
| 9. Alternate food choices available on menu | | |
| 10. Fluids visible and available to residents | | |

STAFF

| | Y | N |
|---|---|---|
| 11. Staff are wearing name tags | | |
| 12. Staff knock before entering residents' rooms | | |
| 13. Staff overall pleasant and courteous to residents | | |
| 14. Staff are respectful of individual needs and preferences | | |
| 15. Staff speaking in language understood by residents when in resident rooms, common areas | | |
| 16. Staff attentive/responsive (not distracted with private conversations with other staff, using cell phones, etc) | | |

RESIDENTS

| | Y | N |
|--|---|---|
| 17. Residents appear clean, well-groomed and are appropriately dressed for the season | | |
| 18. Residents can reach call bells and there is timely response | | |
| 19. Resident council meeting notices posted, meeting minutes accurately reflect content, concerns addressed | | |
| 20. Residents/families satisfied with medical/dental care – Residents satisfied with daily schedule | | |
| 21. Residents have access to private telephone (if they do not have their own phone) | | |
| 22. Residents know how to contact administrative staff, social services and regional ombudsman | | |
| 23. Residents are invited to participate in meaningful care conferences/care plan meetings | | |
| 24. Activity calendar meets the residents' needs and preferences/ Residents satisfied with activity programs | | |
| 25. Residents satisfied with visitation policy | | |

Use "Other Observation" section for periodic notes such as:

- Significant changes in key personnel, administrative staff, census
- Observations during an emergency or unusual incident, for example a fire drill or a resident emergency such as a fall.
- Family council exists and meets regularly.
- Procedure to protect residents' belongings, e.g. labeling, updated inventories, locked storage, grievance procedure.
- VRA introduces self, Program, and brochure to newly admitted residents

| | | | | | | | | |
|-----------------------------|--|--|--|--|--|--|--|--|
| Dates Visited | | | | | | | | |
| Number of residents visited | | | | | | | | |
| Facility Census | | | | | | | | |
| Hours Spent | | | | | | | | |

VRA

Facility

Mo/Yr

Did you advocate for any residents this month? Y_____

Other Observations, Notes, and Comments.

Other Observations, Notes:

VRA _____ Facility _____ Mo/Yr _____

| | |
|--|-----------------|
| Name _____ | Date _____ |
| Room Number _____ | Ethnicity _____ |
| Age (approx) _____ | |
| Complaint: _____ | |
| Intervention: _____ | |
| Resolution: _____ | |
| Case Status: OPEN <input type="checkbox"/> CLOSED <input type="checkbox"/> | |

| | |
|--|-----------------|
| Name _____ | Date _____ |
| Room Number _____ | Ethnicity _____ |
| Age (approx) _____ | |
| Complaint: _____ | |
| Intervention: _____ | |
| Resolution: _____ | |
| Case Status: OPEN <input type="checkbox"/> CLOSED <input type="checkbox"/> | |

| | |
|--|-----------------|
| Name _____ | Date _____ |
| Room Number _____ | Ethnicity _____ |
| Age (approx) _____ | |
| Complaint: _____ | |
| Intervention: _____ | |
| Resolution: _____ | |
| Case Status: OPEN <input type="checkbox"/> CLOSED <input type="checkbox"/> | |

| | |
|--|-----------------|
| Name _____ | Date _____ |
| Room Number _____ | Ethnicity _____ |
| Age (approx) _____ | |
| Complaint: _____ | |
| Intervention: _____ | |
| Resolution: _____ | |
| Case Status: OPEN <input type="checkbox"/> CLOSED <input type="checkbox"/> | |

VRA _____ Facility _____ Mo/Yr _____

| | |
|--|-----------------|
| Name _____ | Date _____ |
| Room Number _____ | Ethnicity _____ |
| Age (approx) _____ | |
| Complaint: _____ | |
| Intervention: _____ | |
| Resolution: _____ | |
| Case Status: OPEN <input type="checkbox"/> CLOSED <input type="checkbox"/> | |

| | |
|--|-----------------|
| Name _____ | Date _____ |
| Room Number _____ | Ethnicity _____ |
| Age (approx) _____ | |
| Complaint: _____ | |
| Intervention: _____ | |
| Resolution: _____ | |
| Case Status: OPEN <input type="checkbox"/> CLOSED <input type="checkbox"/> | |

| | |
|--|-----------------|
| Name _____ | Date _____ |
| Room Number _____ | Ethnicity _____ |
| Age (approx) _____ | |
| Complaint: _____ | |
| Intervention: _____ | |
| Resolution: _____ | |
| Case Status: OPEN <input type="checkbox"/> CLOSED <input type="checkbox"/> | |

| | |
|--|-----------------|
| Name _____ | Date _____ |
| Room Number _____ | Ethnicity _____ |
| Age (approx) _____ | |
| Complaint: _____ | |
| Intervention: _____ | |
| Resolution: _____ | |
| Case Status: OPEN <input type="checkbox"/> CLOSED <input type="checkbox"/> | |

RESIDENT ADVOCATE CERTIFICATION AGREEMENT

AGREEMENT made this _____ day of _____, ("Agreement" hereinafter), by and between the State of Connecticut Ombudsman Program in the State Department of Aging and Disability Services, acting through its duly authorized representative _____ of _____.

WITNESSETH

WHEREAS, Resident Advocate wants to donate services in connection with the Ombudsman Program of the State, and Ombudsman Program willingly accepts such services.

Now, THEREFORE, in consideration of the premises Hereinafter set forth, the Ombudsman Program and Resident Advocate, hereby, agree as follows:

The Ombudsman Program agrees that, in the sole discretion of the State Ombudsman as to scope and appropriateness of services, it will train said Resident Advocate, and utilize Resident Advocate's services as a certified representative of the Connecticut Ombudsman Program.

IN WITNESS, WHEREOF, the parties, Hereto, have executed this AGREEMENT the day and year first above written.

Resident Advocate

Regional Ombudsman

Mairead Painter
State Long Term Care Ombudsman

CONFIDENTIALITY POLICY

1. Volunteer Resident Advocates, as representatives of the State Long Term Care Ombudsman, shall respect and preserve the privacy and confidentiality of resident and program information. Connecticut General Statutes Section 17b-414 specifically provides that only the State Ombudsman or her designee may disclose files and records maintained by the program. Further, the disclosure of the identity of any complainant or resident cited in such files or records is prohibited without appropriate consent or a court order.

2. Volunteer Resident Advocates shall not:

- Attempt to access information that is not within the scope of their responsibilities including medical records; or
- Misuse, disclose without proper authorization, or alter resident information.

Violation of this policy may constitute grounds for corrective action up to and including decertification and termination from the Long Term Care Ombudsman Program. Unauthorized release of confidential information may also have personal, civil and/or criminal liability and legal penalties attached.

I have read the foregoing confidentiality policy and agree to follow its terms in the performance of my duties as a Volunteer Resident Advocate.

Name (please print): _____

SS#: _____

Signature: _____ Date: _____

Witness: _____ Date: _____

Name:

Address: 55 Farmington Avenue HTFD,CT

Email Address:

Date:

Phone

Employment and Responsibilities

Have you or any members of your immediate family or household ever been employed by a long-term care provider (facility or by the owner or operator of a facility)? *Note: Immediate family member is defined as "a member of the household or a relative with whom there is a close personal or significant financial relationship" (§712 of the Older Americans Act, §1324.1, Definitions, LTCOP Rule.* ☐ Yes ☐ No

Do you, or any members of your immediate family or household, receive or have the right to receive, directly or indirectly remuneration (in cash or in kind) under a compensation arrangement with an owner or operator of a long-term care facility? ☐ Yes ☐ No

If Yes to either question, please list the following.

| Start/End dates of employment (MM/YY) | Name of person employed or compensated | Your relationship | Employer | Position/duties or Compensation Arrangement |
|---------------------------------------|--|-------------------|----------|---|
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Are you currently performing any of the responsibilities listed below? *Check all that apply.*

- ☐ Surveying or participating in the licensing or certification of long-term care facilities.
- ☐ Working for an association (or an affiliate of an association) of long-term care facilities or of any other residential facilities for older individuals or individuals with disabilities.
- ☐ Providing care to residents of long-term care facilities or involved in the provision of personnel for long-term care facilities.
- ☐ Providing long-term care coordination or case management for residents of long-term care facilities.
- ☐ Providing adult protective services.
- ☐ Participating in eligibility determinations regarding Medicaid or other public benefits for residents of long-term care facilities.
- ☐ Conducting pre-admission screening for long-term care facility placements.
- ☐ Making decisions regarding admission or discharge of individuals to or from long-term care facilities.
- ☐ Providing guardianship, conservatorship, or other fiduciary or surrogate decision-making services for residents of long-term care facilities.

For all responsibilities that were checked, describe your role and provide additional information.

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The National Long-Term Care
Ombudsman Resource Center

Are you, or a member of your immediate family, serving as an officer or board member of a long-term care facility or service provider? ☐ Yes ☐ No

If Yes, please provide additional information, e.g. position, length of service, responsibilities.

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Financial Interest

Do you or any member of your immediate family or household have an ownership or investment interest (represented by equity, debt, or other financial relationship) in an existing or proposed long-term care facility or service? ☐ Yes ☐ No

If Yes, please provide information regarding the financial interest including as applicable, the location of the facility and/or the area covered by the service.

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Relationships

Do you, or a member of your immediate family or household, have an immediate family member residing in a long-term care facility? ☐ Yes ☐ No

Do you or have you resided in a long-term care facility? ☐ Yes ☐ No

If Yes, to either of the questions, please list the following.

| Name of Facility | Location of Facility | Your relationship or Length of Time |
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Are you serving individuals who live in long-term care facilities in any capacity, such as a volunteer visitor, conducting pet therapy, providing entertainment, or any other services, paid or volunteer? ☐ Yes ☐ No

If Yes, provide additional information.

| Name of Facility | Location of Facility | Your Role | Frequency |
|------------------|----------------------|-----------|-----------|
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Additional Considerations

Do you, or a member of your immediate family or household, have any other relationships, activities, or responsibilities that may impact the effectiveness and credibility of the work of the Office of Long-Term Care Ombudsman (e.g., personal injury attorney, works for a pharmaceutical company or medical supply company)? ☐ Yes ☐ No

If Yes, please list them. If you are not sure about the potential impact on the Office, please list the relationship, activity, or responsibility, for discussion with a staff Ombudsman program representative.

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Agreements

As a representative of the Office of the State Ombudsman, I understand that I, and members of my immediate family and household, cannot:

- accept gifts or gratuities of significant value from a long-term care facility or its management, a resident or a resident representative of a long-term care facility in which I serve;
- accept money or any other consideration from anyone other than the Office, or an entity approved by the Ombudsman, for the performance of an act in the regular course of my duties as a representative of the Ombudsman program without Ombudsman approval.

If any circumstances in this document change or if I have questions or concerns regarding an actual or potential conflict of interest with my duties as a representative of the Ombudsman program, I will notify my direct Ombudsman program supervisor immediately.

If any circumstances or opportunities arise and I have questions or concerns regarding the potential impact on the effectiveness or credibility of the Ombudsman program, I will notify my direct Ombudsman program supervisor immediately.

I understand and agree with the preceding statements and verify that all the information I have provided is accurate.

Signature

Date

For Program use only

After reviewing this document and speaking with the applicant, it has been determined that the following conflict of interests can and will be remedied and supporting documentation is included with this application.

It has been determined (through conversation with the applicant) that the following conflicts of interests cannot be remedied, and the applicant has been notified (or will be notified). ☐ Yes ☐ No

Per our state policies and procedures, the pertinent information for designation by the State Ombudsman was forwarded to the State Office.

Staff name and signature: _____

Date: _____



**The National Long-Term Care
Ombudsman Resource Center**

Selected Websites for Long Term Care Consumers

Consumer and Government Links

www.ct.gov/lfcop - CT Long Term Care Ombudsman Program

www.nccnhr.org/ - National Consumer Voice for Quality Long Term Care

www.medicare.gov - Go to nursing home compare link to access the Five Star Rating System information on facility staffing, quality measures, health inspections, and overall rating

<http://www.cms.hhs.gov/> - Center for Medicare and Medicaid Service site – lots of links to press releases, surveyor information, data, etc.
http://www.cms.hhs.gov/CertificationandCompliance/13_FSQRS.asp - background information on and links to the Five Star Quality Rating Program

<http://www.ct.gov/longtermcare/site/default.asp> - State of CT website for a wealth of long term care information including Area Agencies on Aging, Centers for Independence, provider listings, etc

<http://www.ct.gov/agingservices/cwp/view.asp?a=2509&q=313010&agingServicesNav=1> - separate link for State of CT Aging Services information

www.ct.gov/dss - CT Department of Social Services general link – includes information on Medicaid eligibility, spend-down, home care program for elders, personal care assistance waiver programs, etc.

<http://www.ct.gov/dss/cwp/view.asp?a=2353&Q=428792&PM=1> - State of CT Department of Social Service information on Money Follows the Person Program

<http://www.cga.ct.gov/2009/ACT/PA/2009PA-00168-R00SB-00455-PA.htm> - An Act on Nursing Home Bill of Rights signed in 2009 by Governor Rell

http://www.ct.gov/dph/lib/dph/public_health_code/sections/19-13-d5_to_19-13-d13_long-term_hospitals.pdf - CT Department of Public Health "Nursing Home" Regulations

[http://www.ct.gov/dph/lib/dph/public health code/sections/19-13-d105 assisted living agency.pdf](http://www.ct.gov/dph/lib/dph/public%20health%20code/sections/19-13-d105%20assisted%20living%20agency.pdf) - CT Department of Public Health
Assisted Living
Regulations

<http://www.assistedlivingconsumers.org/> - Assisted Living Consumer Alliance -

[http://www.longtermcare.gov/LTC/Main Site/index.aspx](http://www.longtermcare.gov/LTC/Main_Site/index.aspx) - National Clearinghouse for Information on Long Term Care Information

Legal Resources

CT Legal Services – low-income and 60+ typical focus and links to Consumer Law Project for the Elderly
<http://www.connlegalservices.org/>

National Academy of Elder Law Attorneys – <http://www.naela.com/>

CT Bar Association Elder Law Section –
<http://www.ctbar.org/article/view/86/1/43>

Center for Medicare Advocacy – information on Medicare rights, benefits, etc - www.medicareadvocacy.org

Provider Resources

[http://www.myinnerview.com/resource_center/national report abstract/](http://www.myinnerview.com/resource_center/national_report_abstract/) - A National nursing home customer satisfaction study and survey results

www.aahsa.org - American Association of Homes and Services for the Aging – excellent link to wealth of LTC consumer information and data

www.ahca.org - American Health Care Association – for-profit LTC trade association – excellent links to data, consumer information, etc.

<http://www.ncal.org/> - National Center for Assisted Living provider group

<http://www.cahcf.org/> - CT Association of Health Care Facilities – CT's for-profit long term care trade association

www.canpfa.org - CT Association of Non-Profit Facilities for Aging – non-profit long term care trade association

<http://www.ctassistedliving.com/> - CT Assisted Living Association provider site – lists providers and offers consumer information

<http://www.cthomecare.org/associations/3390/files/medicare%20checklist.pdf> - CT Home Care Association checklist for choosing a home care agency

General Assembly and CT Television Network

<http://www.cga.ct.gov/> - CT General Assembly – follow the legislative process

<http://www.ctn.state.ct.us/> - CT Television Network – watch hearings, speeches, meetings, councils, etc

Legal Resources

<http://www.connlegalservices.org/> - CT Legal Services – low-income and 60+ typical focus and links to Consumer Law Project for the Elderly

National Academy of Elder Law Attorneys - <http://www.naela.com/>

CT Bar Association Elder Law Section -

<http://www.ctbar.org/article/view/86/1/43>

Aging and Disability Resources

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Community First Choice

Are you or a loved one living in the community and need assistance to remain there? The Affordable Care Act created an optional State Plan service which will allow eligible individuals to access Personal Attendant Care (PCA) and other services and supports through self-direction.

AGENCY: DEPARTMENT OF SOCIAL SERVICES

Connecticut Home Care Program for Elders (CHCPE)

This program provides services to help eligible residents live in the community. Eligible applicants must be 65 years of age or older, be at risk of nursing home placement and meet the program's financial eligibility criteria. To be at risk of nursing home placement means that the applicant needs assistance with critical needs such as bathing, dressing, eating, taking medications and toileting. CHCPE helps clients continue living at home instead of going to a nursing home. Each applicant's needs are reviewed to determine if he/she may remain at home with the help of home care services.

AGENCY: DEPARTMENT OF SOCIAL SERVICES

Connecticut Partnership for Long-Term Care

The state of Connecticut provides Connecticut residents with unbiased information about the need for long-term care; the ability to find and purchase quality, affordable long-term care insurance; and a way to get needed-care without depleting assets.

AGENCY: DEPARTMENT OF MENTAL HEALTH AND ADDICTION SERVICES

Living Services

The State of Connecticut offers a variety of services to help eligible individuals who need support to live at home or to return to community living. Many of the programs are administered under a Medicaid 'waiver,' meaning that Connecticut has received federal approval to waive certain Medicaid requirements to meet the service needs of older adults and adults with disabilities in the community.

AGENCY: DEPARTMENT OF SOCIAL SERVICES

Long-Term Services and Supports - LTSS

Governor Dannel P. Malloy, joined by Department of Social Services Commissioner Roderick L. Bremby and Office of Policy and Management Undersecretary Anne Foley, announced the release of Connecticut's Strategic Plan to Rebalance Long-Term Services and Supports, including a town-by-town projection of Connecticut's long-term care needs and strategies to meet those needs, on January 29, 2013.

AGENCY: DEPARTMENT OF SOCIAL SERVICES

Long-Term Support for Family Caregivers

Support to help family caregivers find services for their loved ones. Provides an array of services like information, referrals to support groups and short term respite in the home to help relieve caregiver stress.

AGENCY: STATE UNIT ON AGING

Medicare Fraud Prevention Information

Senior Medicare Patrol (SMP) Program - recruits and trains volunteers to educate seniors to protect themselves against health care fraud, consumer scams, detection of fraudulent activities and assists with reporting suspected health care fraud to appropriate entities.

AGENCY: STATE UNIT ON AGING

Medicare Savings Program

The State of Connecticut offers financial assistance to eligible Medicare enrollees through our 'Medicare Savings Programs.' These programs may help pay Medicare Part B premiums, deductibles and co-insurance.

AGENCY: DEPARTMENT OF SOCIAL SERVICES

Money Follows the Person

AGENCY: DEPARTMENT OF SOCIAL SERVICES

Money Follows the Person Program

Money Follows the Person is a Federal demonstration project dedicated to assuring Connecticut residents access to a full range of high quality, long-term care options that maximize autonomy, choice and dignity.

AGENCY: DEPARTMENT OF SOCIAL SERVICES

MyPlaceCT

My Place CT helps individuals understand how to access long-term care services and supports. The portal includes a website and call center, as well as career opportunities for caregivers. It asks consumers about their needs and shows how they can pay for care and also lists housing, long-term care insurance and transportation options.

AGENCY: DEPARTMENT OF SOCIAL SERVICES

Non-Emergency Medical Transportation (NEMT)

Medicaid Non-Emergency Medical Transportation (NEMT) is an important benefit for Medicaid members who need to get to and from Medicaid-covered medical services but have no means of transportation.

AGENCY: DEPARTMENT OF SOCIAL SERVICES

The CHOICES Program

Connecticut's program for Health insurance assistance, Outreach, Information and referral, Counseling, Eligibility Screening. This program provides information to persons age 60 and older as well as to people with disabilities, and is comprised of both staff, in-kind professionals from local service agencies and volunteers.

AGENCY: STATE UNIT ON AGING

Coronavirus Information

Find the latest data, health guidance, and resources on how to navigate the COVID-19 pandemic.

Coronavirus Testing

Testing is available in many locations throughout Connecticut. Anyone experiencing symptoms should contact their primary care provider.

Electronic Benefits Transfer

Access your EBT account to transfer benefits online such as SNAP, WIC, and Cash Payments.

Acronyms

| | |
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| APRN | Advanced Practice Registered Nurse |
| AAA | Area Agency on Aging |
| ADA | Americans with Disabilities Act |
| AARP | American Association of Retired Persons |
| AFLON | Advocates for Loved Ones in Nursing Homes Regional Citizen's Advocacy Group |
| ALF | Assisted Living Facility |
| ALSA | Assisted Living Services Agency |
| AOA | Administration on Aging |
| CCRC | Continuing Care Retirement Communities |
| CNA | Certified Nurses Assistant |
| CON | Certificate of Need |
| CMS | Centers for Medicare & Medicaid Services (formerly HCFA) |
| DPH | Department of Public Health |
| DSS | Department of Social Services |
| LOB | Legislative Office Building |
| LTC | Long Term Care |
| LTCOP | Long Term Care Ombudsman Program |
| MFP | Money Follows the Person |
| MRC | Managed Residential Care |
| NASOP | National Association of State Ombudsman Programs |
| NCCNHR | National Consumer Voice for Quality long Term Care |
| OAA | Older Americans Act |
| OBRA | Omnibus Budget Reconciliation Act of 1987 |
| OPM | Office of Policy and Management |
| OSD | Office of Organizational & Skilled Development |
| PA | Physician Assistant |
| PNA | Personal Needs Allowance |
| RCH | Residential Care Home |
| SALSA | Supervisor is Assisted Living Service Agency |
| SCPRC | Statewide Coalition of Presidents of Resident Councils |
| VRA | Volunteer Resident Advocate |