STATE OF CONNECTICUT

OFFICE OF THE
STATE LONG TERM CARE
OMBUDSMAN

RESIDENT ADVOCATE
TRAINING AND RESOURCE MANUAL

Connecticut
LTCOP
Long Term Care Ombudsman Program

1-866-388-1888

Resident Advocate Program
Department of Aging and Disability Services (ADS)

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Welcome

- Your name
- Where you are from
- Name the “aha” moment that brought you here today
- What you hope to gain from this training

Federal Training Requirements

- A minimum of 36 hours of initial certification includes:
  - up to 7 hours of independent study
  - at least 10 hours in the field
  - 16-20 hours of classroom style training

Annual In-Service Training hours required for maintaining designation of a minimum 18 hours per year is required

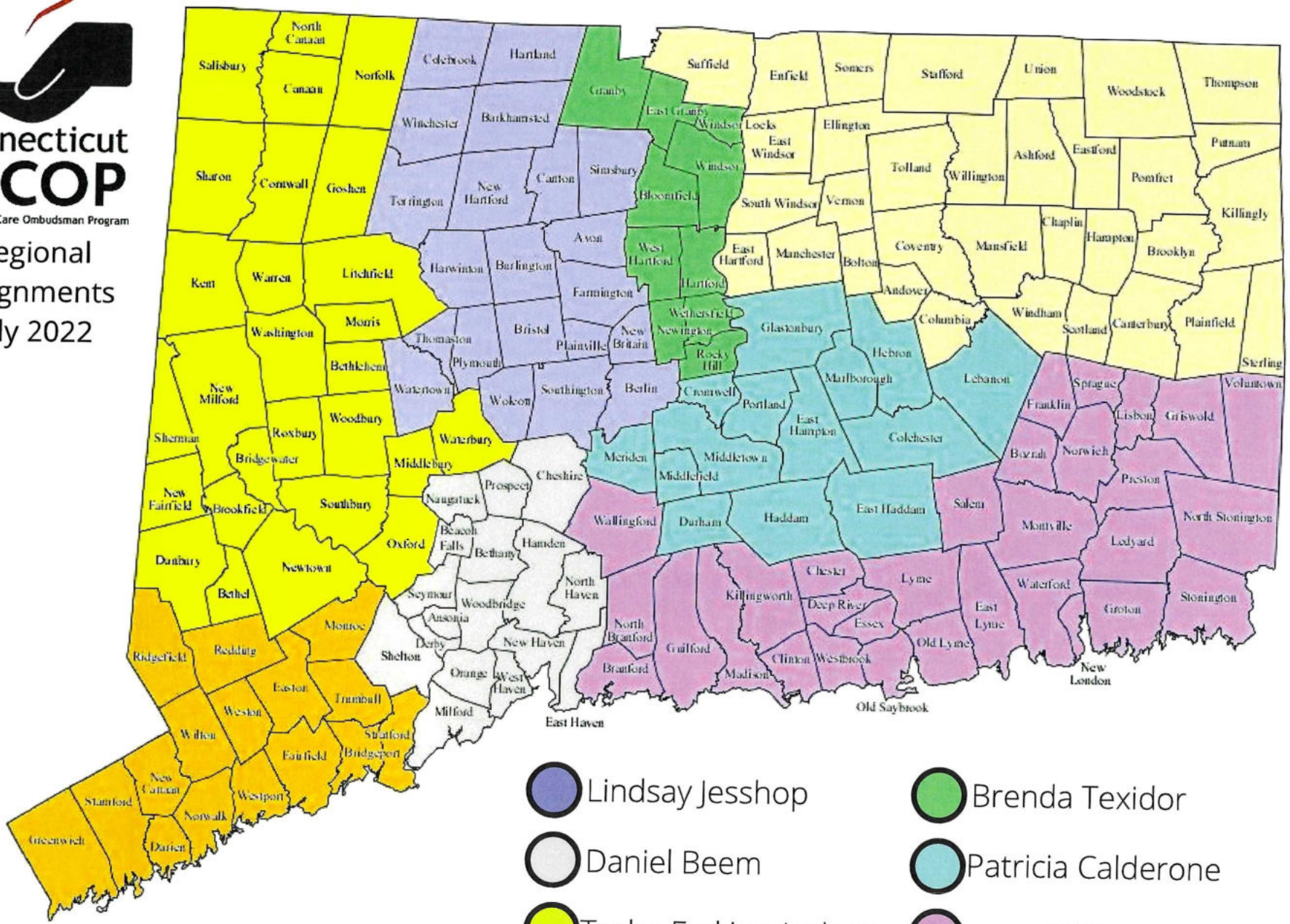
Methods include:

- Attend monthly meetings
- Attend LTCOP forums, RA Wrap-up
- Attend community presentations, or educational webinars

Contact The CT Long Term Care Ombudsman Program Toll Free 1-866-388-1888

Connecticut LTCOP
Long Term Care Ombudsman Program

Regional Assignments July 2022



- Lindsay Jesshop
- Brenda Texidor
- Daniel Beem
- Patricia Calderone
- Tasha Erskine-Jackson
- TBD
- Sylvia Crespo
- TBD

Connecticut Long-Term Care Ombudsman Program

State Ombudsman

Mairead Painter
Mairead.painter@ct.gov
860-424-5238

Regional Ombudsman

Sylvia Crespo - South Western Region

Phone: **(866) 388-1888**
Email: **sylvia.crespo@ct.gov**

Towns Covered:

BRIDGEPORT	DARIEN	EASTON	FAIRFIELD
GREENWICH	NEW CANAAN	NORWALK	REDDING
RIDGEFIELD	SOUTHPORT	STAMFORD	STRATFORD
TRUMBULL	WEST REDDING	WESTON	WESTPORT
WILTON			

Tasha Erskine-Jackson - North Western Region

Phone: **(866) 388-1888**
Email: **tasha.erskine@ct.gov**

Towns Covered:

BETHEL	BETHLEHEM	BRIDGEWATER	BROOKFIELD
CANAAN	CORNWALL	DANBURY	GOSHEN
KENT	LITCHFIELD	MIDDLEBURY	MORRIS
NAUGATUCK	NEW FAIRFIELD	NEW MILFORD	NEWTOWN
WILTON	NORFOLK	NORTH CANAAN	OXFORD
ROXBURY	SALISBURY	SHARON	SHELTON
SOUTHBURY	WARREN	WASHINGTON	WATERBURY
WOODBURY			

Vacant Regional Ombudsman - North Eastern Region

Phone: **(866) 388-1888**
Email:

Towns Covered:

ANDOVER	ASHFORD	BOLTON	CHAPLIN
COLCHESTER	COLUMBIA	EAST HARTFORD	EAST WINDSOR
EASTFROD	ELLINGTON	ENFIELD	GLASTONBURY
HEBRON	MANCHESTER	MANSFIELD	MARLBOROUGH
ROCKVILLE	SOMERS	SOUTH WINDSOR	STAFFORD
STAFFORD SPRINGS	SUFFIELD	TOLLAND	UNION
VERNON	WILLIMANTIC	WILLINGTON	WINDHAM
WINDSOR LOCKS			

Brenda Texidor - Northern Region

Phone: **(866) 388-1888**
Email: **brenda.texidor@ct.gov**

Towns Covered:

BLOOMFIELD	EAST GRANBY	GRANBY	HARTFORD
NEWINGTON	ROCKY HILL,	WEST HARTFORD	WETHERSFIELD
WINDSOR			

Dan Drew - South Central Region

Phone: **(866) 388-1888**
Email: **dan.** Drew**@ct.gov**

Towns Covered:

ANSONIA	BEACON FALLS	BETHANY	BRANFORD
CHESHIRE	DERBY	EAST HAVEN	HAMDEN
MILFORD	NEW HAVEN	NORTH BRANFORD	NORTH HAVEN
ORANGE	PROSPECT	SEYMOUR	WEST HAVEN
WOODBRIDGE			

Daniel Beem - Eastern Region

Phone: **(866) 388-1888**
Email: **@ct.gov**

Towns Covered:

BROOKLYN	BOZRAH	BROOKLYN	CANTERBURY
DANIELSON	DAYVILLE	EAST LYME	ESSEX
FRANKLIN	GRISWOLD	GROTON	HAMPTON
KILLINGLY	LEBANON	LEDYARD	LISBON
LYME	MONTVILLE	MYSTIC	NEW LONDON
NIANTIC	NORTH STONINGTON	NORWICH	OLD LYME
OLD SAYBROOK	PLAINFIELD	POMFRET	PRESTON
PUTNAM	SALEM	SPRAGUE	STONINGTON
STOTLAND	THOMPSON	UNCASVILLE	VOLUNTOWN
WATERFORD	WOODSTOCK		

Patricia Calderone - Central Region

Phone: **(866) 388-1888**
Email: **patricia.calderone@ct.gov**

Towns Covered:

CHESHIRE	CHESTER	CLINTON	COBALT
CROMWELL	DEEP RIVER	DURHAM	EAST HADDAM
EAST HAMPTON	GUILFORD	HADDAM	KILLINGWORTH
MADISON	MERIDEN	MIDDLEFIELD	MIDDLETOWN
MOODUS	PORTLAND	WESTBROOK	WALLINGFORD

Lindsay Jesshop - North Central Region

Phone: **(866) 388-1888**
Email: **lindsay.jesshop@ct.gov**

Towns Covered:

AVON	BARKHAMSTED	BERLIN	BRISTOL
BURLINGTON	CANTON	COLEBROOK	COLLINSVILLE
FARMINGTON	FORESTVILLE	HARTLAND	HARWINGTON
KENSINGTON	NEW BRITAIN	NEW HARTFORD	PLAINVILLE
PLANTSVILLE	PLYMOUTH	PROSPECT	SIMSBURY
SOUTHINGTON	THOMASTON	TORRINGTON	WATERTOWN
WINCHESTER	WOLCOTT		

MODULE 1

INTRODUCTION TO THE LONG TERM CARE OMBUDSMAN PROGRAM

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Annual Report, VRA Booklet, Regional Map

THE LONG TERM CARE OMBUDSMAN PROGRAM

I. HISTORY OF THE LONG TERM CARE OMBUDSMAN PROGRAM

(Source: Sections A-H Excerpted from the Virginia Ombudsman Curriculum)

A. Social Security Act Of 1935-1965

The Social Security Act is indirectly responsible for the nursing home industry, as it exists today. Social Security's original and sole purpose was to provide a supplemental retirement for working people and their dependents. It also provided Old Age Assistance (OAA) to needy people aged 65 and older who lived in the community.[1]

The Social Security Act prohibited Old Age Assistance money going directly to residents in public institutions. This signaled a beginning of the end for the public poor houses and provided a need for new alternatives for the aged without families who could care for them. Between 1935-1960, private rooming houses, private institutions, church-sponsored and other nonprofit institutions, and homes flourished and were paid for by the resident's Social Security money. Many of the homes began employing nurses and physicians to care for the aged and chronically ill.[2]

The most important factor in the development of nursing homes today was the creation of the federal Medicare and Medicaid programs in 1965. Medicare is a federal insurance program for persons over age 65. Medicare will pay for skilled nursing home care on a limited basis. Medicaid is a medical assistance program for the poor, including individuals over age 65, the blind, the disabled and members of families with dependent children. It is financed by a federal-state partnership. The purpose of this legislation was to provide financial assistance to the poor and the aged so that they would receive adequate medical care, both in and out of an institutional setting. Due to the availability of federal funds to help pay for nursing home services, demand for these services increased dramatically.

B. Growth of Nursing Home Industry

While the proportion of elderly residing in nursing homes increased continually throughout the first half of this century, the advent of Medicare in the 1960's followed by Medicaid brought an even greater growth to the

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[1] Davis, W.E., Ibid.

[2] Adapted from Training Materials from the State of Ohio

nursing home industry. The outlay of federal dollars to support eligible seniors in participating homes far exceeded even the most liberal projections.

A look at statistics reveals the size of this industry:

- The Bureau of Census did one of the initial inventories of the nursing home industry in 1939. It counted 1,200 facilities with 25,000 beds.
- By 1960, there were 9,600 homes with 330,000 beds.
- In 1970, there were 23,000 facilities with 1.1 million beds.
- By 1980, there were 30,000 facilities with 1.5 million beds.
- In 2000, it is estimated that there are 2.8 million nursing home beds.

C. Questions of Quality of Care

The nursing home industry in this environment grew dramatically with little direction or regulation. Many operators were well meaning but misinformed; some unscrupulous homes did indeed fleece their residents and poor care resulted in some deaths. Unfortunately, the opportunists and some of the more aggressive, dishonest operators gave the industry a bad reputation. A climate of mistrust and misunderstanding that is still prevalent developed between industry and consumers.

In the late 1960's and early 1970's, there were many publications written about abuse, neglect and substandard conditions in nursing homes. Several Congressional committees convened to hear testimony, compile data, and propose reforms for the nursing home industry.

Excerpts of testimony presented included the following two items:

Hearings before the United States Senate on February 26, 1970, brought out the fact that it was the carpeting in a Marietta, Ohio, nursing home that speared the flames in a fire on January 9th. That fire resulted in the deaths of 32 of 46 patients from asphyxiation from the acrid, deadly smoke.

After delays, by the facility, in seeking medical help, twenty-five residents of a commercial Baltimore nursing home died in a salmonella food poisoning epidemic in August 1970. When twelve patients had died, the Washington Post stated "in a telephone interview, Gould (the owner) complained about the focus of the news media on the 12 deaths over the weekend, saying "is it really that big?" [3]

Ample publicity attesting to poor care and personal profit for owners created an environment in which more rigid federal regulations for standards of care were enacted in the early 1970's.

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[3] Butler, R.N. Why Survive? Being Old in America, NY: Harper&Row, 1975

D. President Nixon's Eight Point Directive

In 1971, President Nixon formulated an eight-point nursing home program that consisted of:

1. Training of 2,000 state nursing-home inspectors
2. Complete (100 percent) federal support of state inspections under Medicaid
3. Consolidation of enforcement activities
4. Strengthening of federal enforcement of standards
5. Short-term training for 41,000 professional and paraprofessional nursing home personnel
6. Assistance for state investigative "Ombudsman" units
7. Comprehensive review of long term care
8. Crackdown on substandard nursing homes: cut-off of federal funds to them.[4]

In summary, the rapid growth of nursing homes and a concern for the quality of life experienced by the residents of these facilities were in part responsible for the creation of the nursing home ombudsman programs that exist today.

E. The Ombudsman Program History

In the Supplemental Appropriations Act of December 1971, Congress made funds available for the establishment of nursing home ombudsman demonstration projects.

In May of 1975 former Commissioner on Aging, Dr. Arthur S. Flemming, invited all State Agencies on Aging to submit proposals for grants to create Ombudsman Programs. The purpose was to enable the State Agencies to develop the capabilities of the Area Agencies on Aging to promote, coordinate, monitor and assess nursing home ombudsman activities within their service areas."

F. The Ombudsman Program under The Older Americans Act

The 1978 Amendments to the Older Americans Act, passed in October 1978, considerably strengthened the Ombudsman Program. Title III, Section 307(a) (12) required every State to have a program and specifically defined ombudsman functions and responsibilities. The

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[4] Ibid

organizational structure of each program is individual to the state in which it operates.

G. Vision and Philosophy of The Connecticut Long Term Care Ombudsman Program

Regardless of an ombudsman's level(s) of advocacy, effort, or the complexity of the issue/problem that is being addressed, there is a basic set of principles that guide an ombudsman's decisions.

(1) The Ombudsman provides services with respect for human dignity and the individuality of the client unrestricted by considerations of age, social or economic status, personal characteristics, or lifestyle choices.

(2) The Ombudsman respects and promotes the client's right to self-determination.

(3) The Ombudsman makes every reasonable effort to ascertain and act in accordance with the client's wishes.

(4) The Ombudsman acts to protect vulnerable individuals from abuse and neglect.

(5) The Ombudsman safeguards the client's right to privacy by protecting confidential information.

(6) The Ombudsman remains knowledgeable in areas relevant to the long-term care system, especially regulatory and legislative information and long-term care service options.

(7) The Ombudsman acts in accordance with the standards and practices of the Long-Term Care Ombudsman Program, and with respect for the policies of the sponsoring (contract) organization.

(8) The Ombudsman will provide professional advocacy services unrestricted by his/her personal belief or opinion.

(9) The Ombudsman participates in efforts to promote a quality long-term care system.

(10) The Ombudsman participates in efforts to maintain and promote the integrity of the Long-Term Care Ombudsman Program.

(11) The Ombudsman supports a strict conflict of interest standard, which prohibits any financial interest in the delivery or provision of nursing home, board and care services, or other long-term care services that are within their scope of involvement.

(12) The Ombudsman staff conduct him/herself in a manner, which will strengthen the statewide and national Ombudsman network.

The Long-Term Care Ombudsman Program is a resident-centered advocacy program. The Regional Ombudsman always considers the resident (or potential resident) the client regardless of who contacts the agency. The Ombudsman will assist, represent, and intervene on behalf of the resident only as mutually agreed upon between the Ombudsman and the client, legal representative or interested party. The Ombudsman will uphold her/his legal and professional responsibility to act in situations on behalf of vulnerable individuals. The Ombudsman acknowledges that it may not be possible to represent every client as requested if the client's desired outcome is contrary to existing law or regulation.

The Ombudsman is committed to and works to promote:

(1) The client's right to self-determination.

(2) The optimal level of individual and group functioning and independence.

(3) Informed participation in decision-making by all members of the long-term care community.

(4) The protection of vulnerable individuals.

The Ombudsman carries out her/his advocacy role through the activities of providing information, assisting in problem solving, and promoting individual and group self-advocacy skills. The Ombudsman has a responsibility to respond to all requests for assistance related to long-term care services, either through direct assistance or appropriate referral.

Therefore, Advocacy is work that is resident focused and that resolves an issue by providing mediation and access to particular systems and leaves the door open for future action. Whereas, Regulatory Enforcement is work that is government focused and punitive. Consequently, the enforcer applies actions to issues of non-compliance based on legal interpretation.

THE CONNECTICUT LONG TERM CARE OMBUDSMAN PROGRAM

The Connecticut Long-Term Care Ombudsman Program (LTCOP) protects and promotes the rights and quality of life for residents of skilled nursing facilities, residential care homes and managed residential care communities, also known as assisted living facilities. This is a program that is mandated by the Federal Older Americans Act and Connecticut General Statutes Sec. 17a-405 (Formerly Sec. 17b-400). The program consists of one State Ombudsman, eight Regional Ombudsmen, one Administrative Assistant, two Clerical/Intake Staff, and a group of volunteers known as Resident Advocates (RA's).

The State Ombudsman works with state agencies, advocacy organizations, policy makers, legislators, and stakeholders to improve systems that strengthen protections at the state and federal level.

The Regional Ombudsmen (RO's) provide a voice to residents' concerns. Equally important, RO's empower residents to exercise their rights. This is achieved through direct consultation and complaint resolution with the individual at their home. The Regional Ombudsmen respond to residents' concerns and act based on the resident's direction. Regional Ombudsmen are a highly professional, expert group of advocates who work tirelessly to assist residents to achieve their desired outcome for their complaint. Regional Ombudsmen explore all avenues to fully understand an issue and reach a satisfactory resolution. Receiving complaints and working to find a resolution is the largest part of the Regional Ombudsman's work, but they also engage in many other advocacy activities. The Regional Ombudsmen promote Resident Councils by providing support and facilitating the needs of the Resident Councils as they arise. They also support the work of the Executive Board of Presidents of Resident Councils and provide outreach to the public. Regional Ombudsmen attend senior fairs throughout the state, providing presentations to various groups. During nursing home closures, Regional Ombudsmen maintain an active role to inform and support resident choice about where they will move. During facility bankruptcy reorganizations and receiverships, the Regional Ombudsmen also increase their presence in the homes to support residents and ensure their rights are honored in what can be a difficult and anxious time.

Resident Advocates are trained by Ombudsman staff in residents' rights and problem solving. Resident Advocates spend four hours per week in one assigned nursing home and help residents solve problems or address concerns with facility administration.

In partnership with residents, resident representatives, community partners, and other support stakeholders, the LTCOP celebrates collaborative achievements of many individuals and partners. The Connecticut Long-Term Care Ombudsman Program is dedicated to providing residents with opportunities to give voice to their concerns.

The Ombudsman Program has an operating budget of $ 1,830,896, plus an additional $64,279.24 in CARES Act funding.

- Federal Funds: $ 349,040 ($ 191,271 from Title VII, Chapter 2 of the Older Americans Act, and $ 157,769 from Title IIIB of the Older Americans Act)
- State Funds: $ 1,481,856
- COVID-19 related funds $64,279.24 Activities Carried Out by the Office

The Mission of the Connecticut Long-Term Care Ombudsman Program is to protect the health, safety, welfare, and rights of long-term care residents by:

In 2020 and 2021, the staff of the Ombudsman program fulfilled their mission and requirements by:

❖ Bringing residents to the forefront to voice their concerns directly to public officials on issues affecting their lives.

The Office of the State Ombudsman developed materials for residents that focused on recovery and the support needed as we all begin to heal after the pandemic. The theme of the Annual Voices Forum was "Connection Matters - Our Voices LOUDER than EVER" and the residents were given tools and participated in a trauma and recovery training. Doctor Sheri Gibson presented, "Trauma During COVID-19: Healing Through Relationships." Dr. Gibson received her Ph.D. in Clinical Psychology with an emphasis in Geropsychology from the University of Colorado, Colorado Springs (UCCS). She is an instructor for the Psychology Department at UCCS and a faculty affiliate with the UCCS. 4 This annual event provides an opportunity for Presidents of Resident Councils in nursing homes to speak directly to public officials and agency heads in attendance, letting them know important issues they are dealing with and how these issues impact their quality of life. This year the event was held virtually due to the pandemic, but these important connections were still made. We found that some people preferred the virtual access and were able to attend, when otherwise they would not have been able to participate.

❖ Supporting residents in their quest to shape their own legislative agenda and to represent the residents' interests before governmental agencies: ➢ The Executive Board of Presidents of Resident Councils, a smaller regional representation of residents who are the Presidents of the Resident Councils at their nursing home, actively engaged in legislative advocacy at the General Assembly throughout the 2021 legislative session, reaching out to legislators, meeting with them, and providing testimony at public hearings when able. Some of their areas of outreach and advocacy included the Personal Needs Allowance legislation and increased staffing. The Personal Needs allowance and increased in staffing was passed.

❖ Investigating complaints and concerns made by or on behalf of residents in a timely and prompt manner.

➢ 4,499 complaints received

➢ 3,378 cases were closed

➢ 790 consultations were provided to individuals

➢ 873 consultations were provided for information and assistance to staff

➢ LTCOP testified to the key Aging, Human Services, and Public Health Committees.

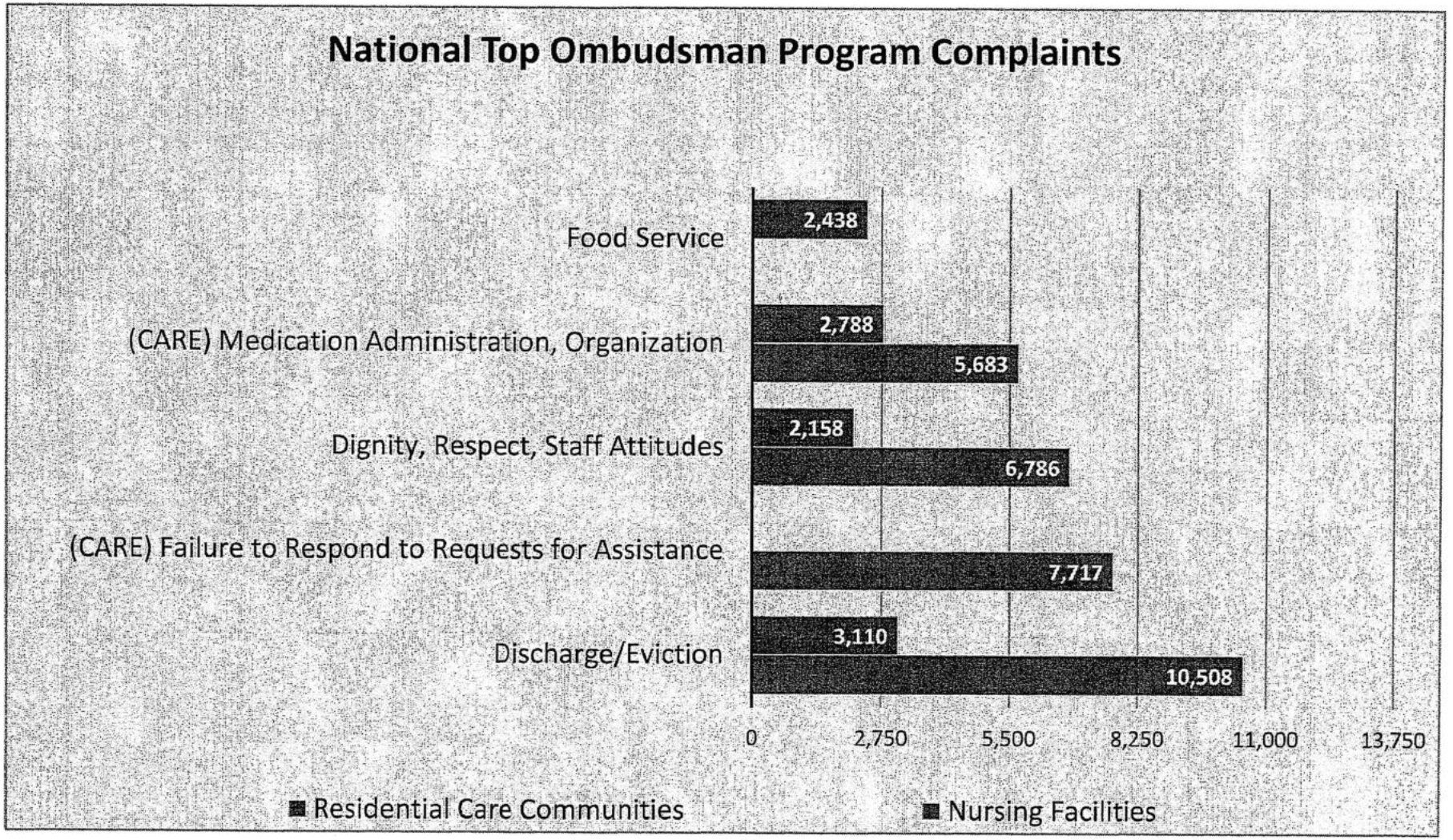
Connecticut
LTCOP
Long Term Care Ombudsman Program

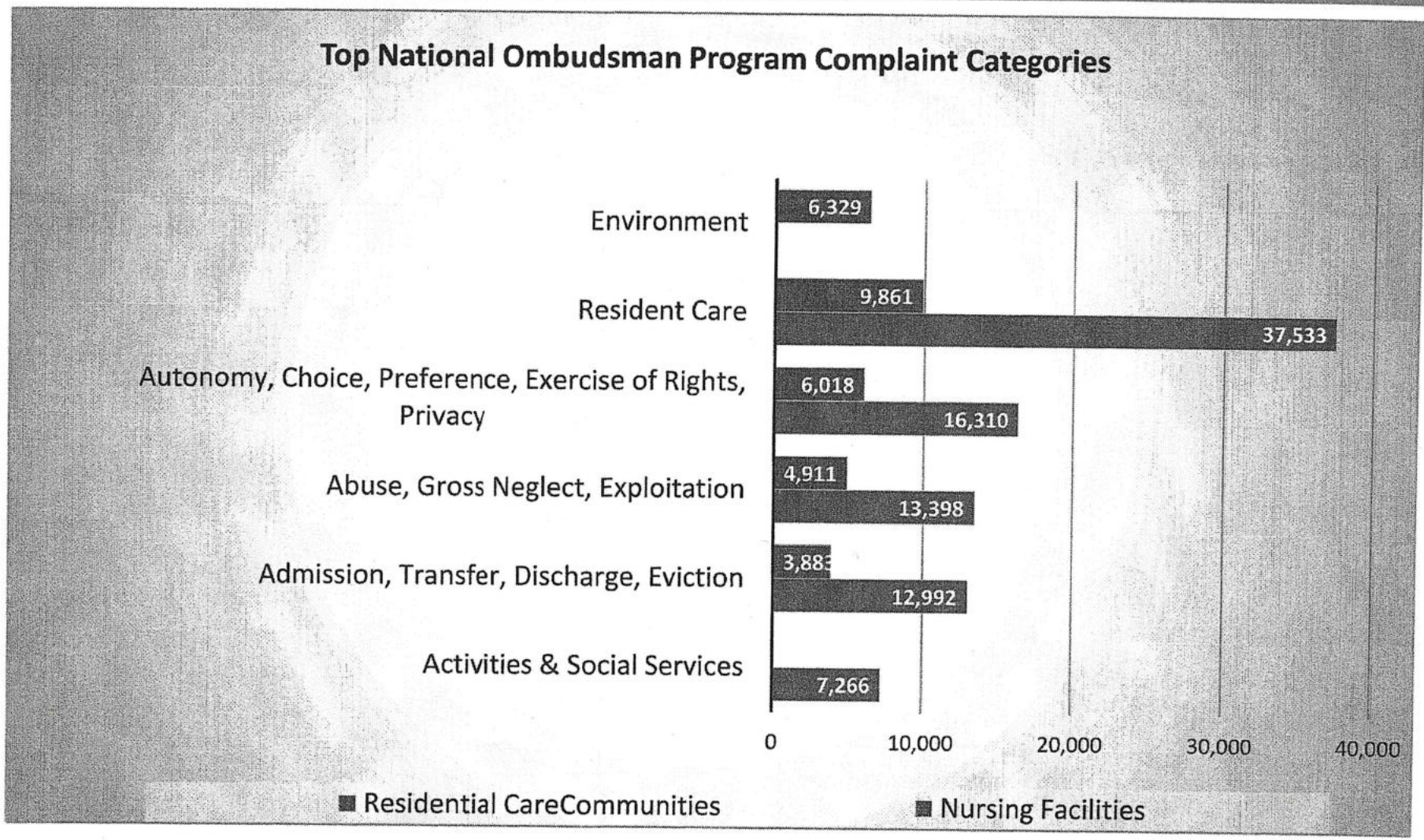
Complaints Received by the CT LTCOP

The LTCOP received a total of 4,499 Complaints in 2021

Below are the Top Five Categories of complaints in descending numerical order

- Care (848 Complaints)
- Residents Rights (727 Complaints)
- Admission, Transfer, and Discharge (465 Complaints)
- Environment (234 Complaints)
- Financial, property (274 Complaints)


National Top Ombudsman Program Complaints
Food Service
2,438
(CARE) Medication Administration, Organization
2,788
5,683
Dignity, Respect, Staff Attitudes
2,158
6,786
(CARE) Failure to Respond to Requests for Assistance
7,717
Discharge/Eviction
3,110
10,508
0
2,750
5,500
8,250
11,000
13,750
Residential Care Communities
Nursing Facilities


Top National Ombudsman Program Complaint Categories
Environment
6,329
Resident Care
9,861
37,533
Autonomy, Choice, Preference, Exercise of Rights, Privacy
6,018
16,310
Abuse, Gross Neglect, Exploitation
4,911
13,398
Admission, Transfer, Discharge, Eviction
3,883
12,992
Activities & Social Services
7,266
0
10,000
20,000
30,000
40,000
Residential CareCommunities
Nursing Facilities

Fundamentals of the Long-Term Care Ombudsman Program

Empower

Represent the Interests of Residents

Provide Resident-Directed Advocacy

Ensure Confidentiality

Educate

Comply with Federal & State Laws, Regulations, and Policies

Document

II. FUNCTIONS/ROLES OF THE RESIDENT ADVOCATE

A. Introduction to the Resident Advocate Role

The following is an outline of different roles a Resident Advocate will use to resolve substantiated problems:

ADVOCATE - This is often used as a generic term for what Resident Advocates do, but in looking at roles, it has a very different meaning and function from other roles. The Resident Advocate as an advocate, works on behalf of a resident in resolving complaints that have been substantiated and need specific strategies developed to alleviate the problem that was identified. Advocacy may take the form of negotiating with an administrator or other staff; filing a complaint on behalf of the resident; working with a resident council; or getting a group of residents who have similar concerns together and working to resolve the problem as a group.

EDUCATOR - Resident Advocates work to educate residents, families, friends, or potential consumers about their rights and responsibilities in a facility. Resident Advocates need to have a working knowledge of current federal and state residents' rights in order to answer questions. Resident Advocates also provide information to concerned individuals who wish to advocate for themselves, but do not know how to go about it. Handouts (e.g., "How to Select a Nursing Home" or "Resident Rights Pamphlet") can be used to provide supplementary information.

MEDIATOR - Resident Advocates act as a mediator between resident and staff, resident and other residents, or resident and family. In this role, the Resident Advocate is a spokesperson for the resident, communicating the concerns to the appropriate staff, or family member in an effort to see the grievance or problem resolved. At times, the response may be immediate and satisfactory. The facility or individual may be unaware of the problem until it surfaces through the efforts of the Resident Advocate, and the resolution may be relatively simple. A large percent of problems result from misunderstandings or breakdowns in communication. Clarification by the Resident Advocate may be all that is necessary.

BROKER – Resident Advocates, in their role as brokers, investigate problems and find other agencies that could better resolve them or are essential to the problem solving process. A referral by the Resident Advocate is made to the Regional Ombudsman for further action.

B. Advocacy Issues

Advocacy has been described as:

- Acting on behalf of another;
- Assisting another to represent himself/herself;
- A willingness to study, to learn, to gather information necessary to support a cause;[5]
- Advocacy is pleading the cause of another.[6]

C. The Do's and Don'ts Of Advocacy

The **DO'S** of Advocacy

1. Respect the confidentiality of all complaints made to you.
2. Be a good listener.
3. Assure the residents that you are there to listen to their problems.
4. Speak clearly and slowly so the resident can understand you.
5. Try to talk to the resident in a quiet, private area.
6. Explain things in a few words, rather than in long paragraphs.
7. Be objective, yet understanding.
8. Try to provide an accurate picture to the residents of what they can expect.
9. Attempt to make the residents feel you care and are there to help them.
10. Work with residents, the staff and the administration in solving problems.
11. Keep accurate records of problems as requested for evaluation of the program.
12. Remember that it may take some questions and perseverance to get to the real problem.
13. Attempt to understand the total situation or problem by seeking out as many sources of information as possible.

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[5] Adapted from training materials from the State of Florida
[6] Adapted from training materials from the State of Vermont

14. Remember that the resident may tire easily, have a short attention span, digress during conversations, or simply become confused.

The **DON'TS** of Advocacy

1. Do not provide physical or nursing care. This is the responsibility of the trained nursing staff in the facility and is for the residents' protection as well as the advocate's.
2. Do not bring unauthorized articles into the home such as food, drugs, prescriptions, tobacco, matches, alcoholic beverages, or gifts.
3. Do not make promises that may be impossible to keep.
4. Do not advise residents on business or legal matters.
5. Do not be critical of the residents or the nursing home.
6. Do not engage in arguments, but rather, stick to the question or problem at hand.
7. You are not an inspector of the facility. You are there to listen to individual complaints and try to resolve them.

D. Services Offered by the Program

DIRECT SERVICES The program receives, investigates, and resolves complaints made by or on behalf of persons who are residents of long term care facilities. The complaints are limited to those relating to action, inaction or decisions of providers, or their representatives, of long term care services, of public agencies, or of social services agencies, which may adversely affect the health, safety, welfare or rights of such residents. A complaint is defined as a problem, concern or issue reported to or observed by an Ombudsman or Resident Advocate on which action is taken on behalf of the resident(s) to intervene in or alter the outcome of the situation or solve the problem.

SYSTEMS ADVOCACY The Ombudsman Program provides information and public education to assist individual residents, or individuals requesting the information on behalf of a resident, concerning the long term care system, the rights of residents of long term care facilities, and services available to residents including the activities of the Ombudsman Program. Public education activities include public speaking engagements, sponsoring or conducting workshops, participation in community elderly networks, developing and distributing written materials, and promoting media coverage of long term care issues.

SYSTEMIC ADVOCACY In accordance with federal law, the Long Term Care Ombudsman Program monitors the development and

→ History of the Program

- **1970s**
  - The program officially began in 1972 with implementation of President Nixon's 1971 Eight Point Initiative to improve nursing home care.
  - The program started as a demonstration program to test its effectiveness. By the late 1970s, all states were required to have an Ombudsman program as a requirement of the Older Americans Act (OAA).

- **1980s**
  - The program expanded to include board and care as well as other similar adult care facilities.
  - Clarifying language was added to the OAA to ensure the program's access to long-term care facilities, residents, and records.

- **1990s**
  - Title VII, the Vulnerable Elder Rights Protection Program, was created in the 1992 amendments to the OAA.
  - The 1992 OAA amendments also included the creation of an Office of the State Long-Term Care Ombudsman and clarified some conflicts of interest.

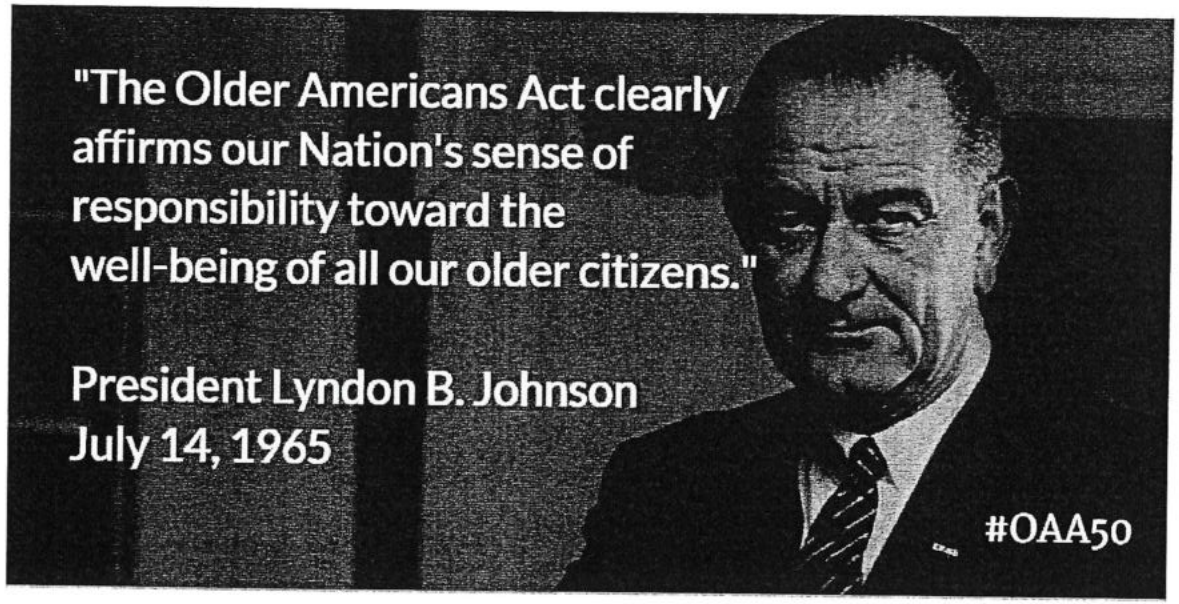
- **2000s**
  - The 2000 OAA amendments included specific language that prohibited Ombudsmen entities and representatives of the Office from financial gain through an action or potential action brought on behalf of individuals they served.

- **2006**
  - Reauthorization added "Assisted Living Facilities" to the definition of "Long-term Care Facility" thereby requiring the LTCOP to provide services to residents of Assisted Living Facilities.

- **2015**
  - The State Long-Term Care Ombudsman Programs Rule was published in February 2015 with an effective date of July 1, 2016. The LTCOP Rule adds clarity to many of the program responsibilities and provisions in the OAA.

- **2016**
  - The 2016 OAA amendments added clarity and additional authority to the LTCOP in several areas.

- **2020**
  - OAA reauthorization clarified that the LTCOP is allowed to provide, and financially support, recognition for individuals designated as volunteer representatives.



Ombudsman and Volunteer Resident Advocate (VRA) Selected Background Information

Sec. 17b-400. (Formerly Sec. 17a-405). Office of the Long-Term Care Ombudsman. Regional ombudsmen. Appointments. Inclusion in classified service. Definitions. (a) As used in this chapter:

(5) "Representative" includes a regional ombudsman, a residents' advocate or an employee of the Office of the Long-Term Care Ombudsman who is individually designated by the ombudsman.

Sec. 17b-401. (Formerly Sec. 17a-406). Residents' advocates. Appointment, expenses, removal. Use of trained volunteers. (a) Residents' advocates shall be appointed by the State Ombudsman, in consultation with the regional ombudsmen, for each region in sufficient number to serve the long-term care facilities within such region. Such residents' advocates shall, if possible, be residents of the region in which they will serve, and shall have demonstrated an interest in the care of the elderly.

Sec. 17b-402. (Formerly Sec. 17a-407). **Residents' advocates. Training. Regulations.** No person may perform any functions as a residents' advocate until the person has successfully completed a course of training required by the State Ombudsman.

Sec. 17b-406. (Formerly Sec. 17a-411). **Duties of residents' advocates.** Posting by nursing home facilities. Funding. (a) Residents' advocates, under supervision of the regional ombudsmen, shall assist the regional ombudsmen in the performance of all duties and responsibilities of the regional ombudsmen as described in section 17b-405.

(b) **All long-term care facilities shall post or cause to be posted in a conspicuous place therein a list of the names of the appropriate residents' advocates** and the names, addresses, and telephone numbers of the appropriate ombudsmen.

Advocates for Residents' Rights:

The Older Americans Act Long Term Care Ombudsman Program

After watching the video, Advocates for Residents' Rights: The Older Americans Act Long Term Care Ombudsman Program, use your own words to briefly describe what you learned regarding the following points.

1. The role of the Long Term Care Ombudsman (LTCO)

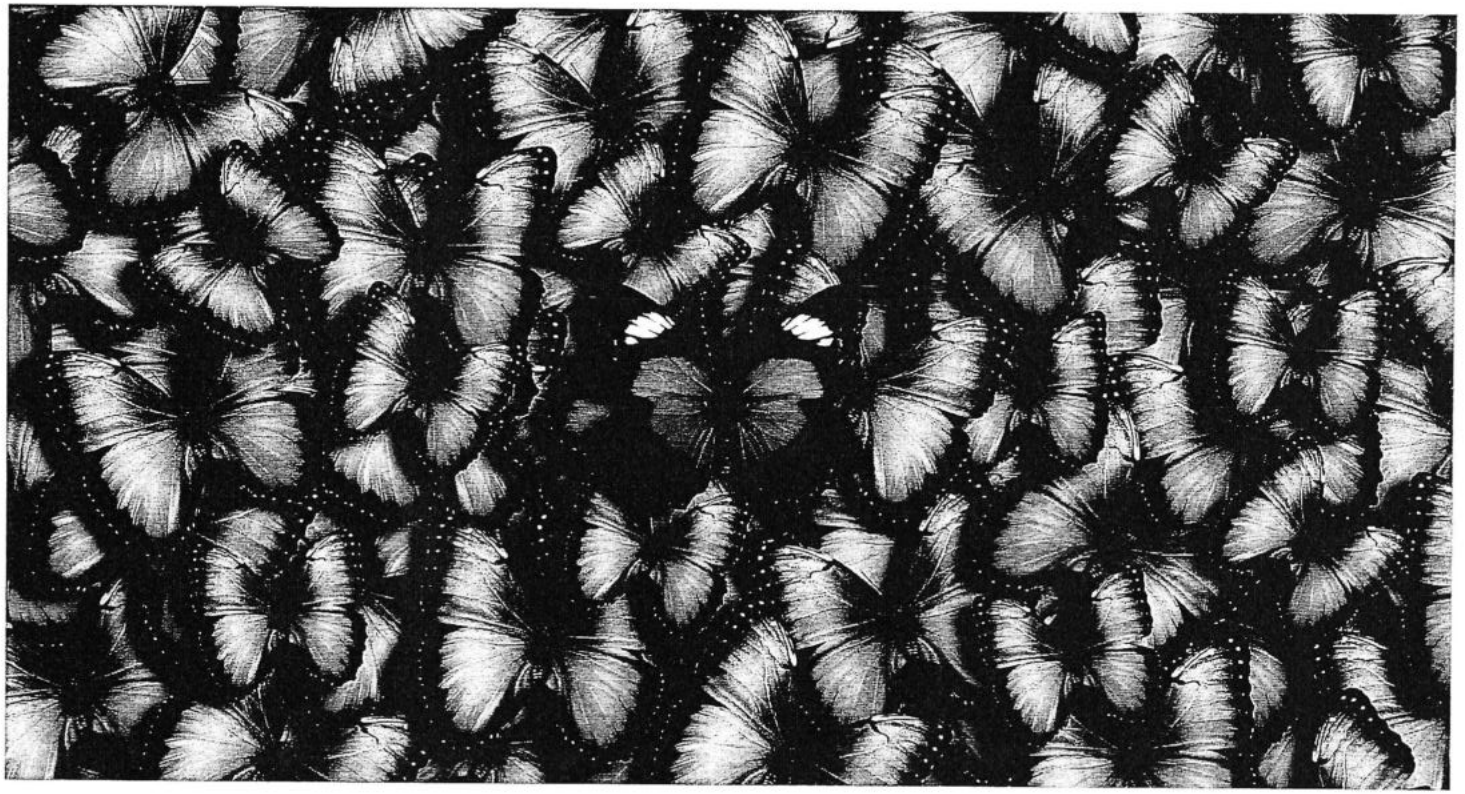
2. The purpose of the Long Term Care Ombudsman Program (LTCOP)

3. Five skills ombudsman need
    1.
    2.
    3.
    4.
    5

4. Characteristics of LTCO

5. Your questions about being an advocate

What Makes the LTCOP Unique?



Unique Elements of the LTCOP

While many types of ombudsman programs wrestle with ethical issues, confidentiality issues and other issues similar to those of the LTCOP, this program has a few unique elements.

• Jurisdiction: The jurisdiction of the LTCOP is the interest of the resident.

• Resolution Standard: At the end of the investigation and resolution process, the key question for a LTCO is, Has this complaint/issue been resolved to the satisfaction of the resident?

• Works on Issues Apart from Specific Complaint: The LTCOP has a mandate to advocate on behalf of the needs of a resident, or residents, separate from individual complaints. Therefore, the LTCOP is to be involved in broader long-term care issues. The LTCOP is expected to be involved in public policy work affecting residents in general.

• Promotes Development of Groups: The LTCOP promotes the development of citizen organizations to participate in the program and provides technical support for the development of resident and family councils to protect the well-being and rights of residents.

Based on a conversation with Becky Kurtz, Georgia State LTCO, and NASOP representative to the ABA Ombudsman Standards Committee, October 2002

Conflict of Interest

Many agencies, particularly governmental agencies, have conflict of interest provisions. Some also have ethical guidelines that extend to post-employment services for a period of time. In its early days, the conflict of interest provisions of the LTCOP were typically defined as having a financial or spousal conflict of interest. These concepts are commonly accepted among other programs and agencies. With the growth in long-term care services and the maturing of the LTCOP, *conflict of interest* has encompassed some additional dimensions.

The Institute of Medicine's study of the program devoted Chapter 4 to this topic.[9] It identifies three dimensions of conflict of interest: loyalty, commitment, and control.

- ***Loyalty***: These involve issues of judgment and objectivity. These are the typical situations almost everyone understands—financial and employment considerations. An ombudsman's ability to be fair and a resident advocate might be questioned if the ombudsman also is a consultant to a facility, a board member of a facility or management company, or works as a case manager with responsibility for assisting individuals with moving into long-term care facilities. Loyalty might also be an issue if the individual is an ombudsman in a facility which was the ombudsman's previous employer.

- ***Commitment***: These are issues of time and attention. Which goals are being addressed? Who establishes the goals and work priorities of the "full-time" State Ombudsman? If local ombudsmen are part time, where is their greater commitment in terms of time and loyalty?

  The LTCO, whether state or local, is required to be a voice for residents. This mandate takes precedence over being a voice for the positions of the employer. As ombudsmen fulfill their role to be loyal to carrying the *resident's* message, their loyalty to their employer may be questioned. Thus, the commitment called for in the LTCOP is not the typical view of commitment expected by most employers.

- ***Control***: These are issues of independence. Do other interests, priorities, or obligations of the agency that houses the ombudsman materially interfere with the LTCOP's advocacy on behalf of residents? Do administrative or political forces materially interfere with the professional judgment of the ombudsman? Is the ombudsman able to act responsibly without fear of retaliation by superiors?

The credibility of the LTCOP rests upon fulfilling its primary responsibility—acting on behalf of residents. If the program acts without being grounded in what residents want, its credibility and effectiveness will be lost.

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[9] Institute of Medicine. op. cit.

V. CONFLICTS OF INTEREST

A. Conflicts of Interest Prohibited

Policy: The State Agency Head and the Office will monitor and take appropriate steps to adequately remove or remedy the identified conflict of interest as defined in federal and state regulation.

Purpose: To ensure the Office is free from organizational and individual conflict of interest.

Goal: The Office will be free from conflict of interest at both the organizational level and the individual level.

Procedure:

(1) The employment or appointment of an Ombudsman or representative of the Office with a conflict of interest that cannot be adequately removed or remedied is prohibited.

(2) The Ombudsman will take steps to refuse, suspend or remove designation of an individual who has a conflict of interest, or who has a member of the immediate family with a conflict of interest, which cannot be adequately removed or remedied.

(3) The Ombudsman shall consider both the organizational and the individual conflicts of interest that may impact the effectiveness and credibility of the work of the Office. In so doing, the Ombudsman shall identify actual and potential conflicts and, where a conflict has been identified, will take action to remove or remedy that conflict. Where a conflict cannot otherwise be removed or remedied, the Ombudsman and/or the State Agency, and their respective and independent legal counsel, shall identify another arrangement with a public agency or non-profit organization with which to carry out the responsibilities of the Office.

B. Identification of Organizational Conflicts

(1) In identifying conflicts of interest, the Ombudsman shall consider the organizational conflicts that may impact the effectiveness and credibility of the work of the Office. Organizational conflicts of interest include, but are not limited to, placement of the Office, or requiring that an Ombudsman or representative of the Office perform conflicting activities, in an organization that:

(a) Is responsible for licensing, surveying, or certifying long-term care facilities;

(b) Is an association (or an affiliate of such an association) of long-term care facilities, or of any other residential facilities for older individuals or individuals with disabilities;

(c) Has any ownership or investment interest (represented by equity, debt, or other financial relationship) in, or receives grants or donations from, a long-term care facility;

(d) Has governing board members with any ownership, investment or employment interest in long-term care facilities;

(e) Provides long-term care to residents of long-term care facilities, including the provision of personnel for long-term care facilities or the operation of programs which control access to or services for long-term care facilities;

(f) Provides long-term care coordination or case management for residents of long-term care facilities;

(g) Sets reimbursement rates for long- term care facilities;

(h) Provides adult protective services; (i) Is responsible for eligibility determinations regarding Medicaid or other public benefits for residents of long-term care facilities;

(j) Conducts preadmission screening for long-term care facility placements;

(k) Makes decisions regarding admission or discharge of individuals to or from long-term care facilities;

or (l) Provides guardianship, conservatorship or other fiduciary or surrogate decision-making services for residents of long-term care facilities

(2) The Ombudsman will evaluate the Office for organizational conflicts on an annual basis.

C. Removing or Remedying Organizational Conflicts

(1) The Ombudsman shall identify organizational conflicts of interest in the Ombudsman program and describe steps taken to remove or remedy conflicts in the annual report submitted to the Assistant Secretary through the National Ombudsman Reporting System.

(2) In most cases, the removal or remedying of organizational conflicts will require changes to the organizational structure of the Office so that conflicts no longer exist.

D. Identifying Individual Conflicts of Interest.

(1) In identifying conflicts of interest, the Ombudsman shall consider individual conflicts that may impact the effectiveness and credibility of the work of the Office.

(2) Individual conflicts of interest for an Ombudsman, representatives of the Office, and members of their immediate families include, but are not limited to:

(a) Direct involvement in the licensing or certification of a long-term care facility;

(b) Ownership, operational, or investment interest (represented by equity, debt, or other financial relationship) in an existing or proposed long-term care facility;

(c) Employment of an individual by, or participation in the management of, a long-term care facility in the service area or by the owner or operator of any long-term care facility in the service area;

(d) Receipt of, or 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;

(e) Accepting 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 the Ombudsman or representative of the Office provides services (except where there is a personal relationship with a resident or resident representative which is separate from the individual's role as Ombudsman or representative of the Office);

(f) Accepting 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 the duties of the Ombudsman or the representatives of the Office without Ombudsman approval;

(g) Serving as guardian, conservator or in another fiduciary or surrogate decision-making capacity for a resident of a long-term care facility in which the Ombudsman or representative of the Office provides services; and

(h) Serving residents of a facility in which an immediate family member resides.

(3) To be eligible for appointment or continued employment, an Ombudsman or representative of the Office cannot have been employed by, or participated in the management of, a long-term care facility within the previous twelve months.

E. Removing or Remedying Individual Conflicts

(1) The Ombudsman will:

(a) Decline to employ or appoint an individual who has an unremedied conflict of interest or who has a member of the immediate family with an unremedied conflict of interest;

(b) Avoid assigning an individual to perform duties that would constitute an unremedied conflict of interest.

(2) The Ombudsman and the State Agency will use a screening tool to identify and remedy individual conflicts of interest. The screening tool will be used when an individual is initially designated an Ombudsman, a Regional Ombudsman, or a RA, and at least annually thereafter. The screening tool shall be used by:

(a) The State Agency to screen the Ombudsman or any applicant for appointment as Ombudsman for potential conflicts of interest.

(b) The Ombudsman to screen for potential conflicts of interest for any acting or prospective Regional Ombudsman or RA.

(3) Whenever a conflict of interest involving an Ombudsman is identified by or reported to the Commissioner of the State Agency, the following rules shall apply:

(a) An Ombudsman who has knowledge of a conflict of interest shall immediately disclose the conflict of interest to the Commissioner of the State Agency.

(b) The Commissioner and the Ombudsman shall determine and agree, in writing, on the method and deadline for removing or otherwise resolving the conflict of interest.

(c) Failure of the Ombudsman and the Commissioner to arrive at a written agreement shall be a reason to terminate the appointment of the Ombudsman.

(d) Failure of the Ombudsman to comply with the terms of the written agreement shall result in termination of the appointment of the State Ombudsman.

(e) An applicant for appointment as Ombudsman who fails to comply with the terms of the written agreement shall not be appointed.

(4) Whenever a conflict of interest involving a Regional Ombudsman or a RA is identified by or reported to the Ombudsman, the following rules shall apply:

(a) A Regional Ombudsman or a RA who has knowledge of a conflict of interest shall immediately disclose the conflict of interest to the State Ombudsman.

(b) The State Ombudsman, Regional Ombudsman, or RA shall agree, in writing, on the method and deadline for resolving the conflict of interest.

(c) Failure to arrive at a written agreement shall be grounds for the State Ombudsman to deny designation or re-designation as a Regional Ombudsman or RA.

(d) A Regional Ombudsman or RA shall lose their designation if the individual fails to comply with the terms of the agreement within the timeframe specified in the agreement. An applicant for designation as a Regional Ombudsman or RA who fails to comply with the agreed upon terms before the anticipated date of designation shall not be designated.

(e) Any individual applying for designation has the duty to disclose any known conflicts of interest at the time of application for designation

Name: **Date:**
Address: 55 Farmington Avenue HTFD,CT **Phone**
Email Address:

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

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.

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.

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.

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

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

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.

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: _____

My step-mother resides in the facility where I am assigned, but we haven't talked in years, so I don't think it is a conflict of interest.

I worked in the facility where I am assigned for only 2 months and it was 2 years ago. I left on good terms, so I don't see a conflict of interest.

I own a licensed group home and would like to become a representative of the Office.

I license and inspect assisted living facilities, but would like to volunteer as a representative of the Office in my spare time.

Stay in Your Lane

LTCOP Lane

- ❑ Getting help
- ❑ Coordinating
- ❑ Facilitating
- ❑ Changing laws
- ❑ Changing polices
- ❑ Providing training
- ❑ Pointing out problems

Not Your Lane

- ❑ Providing care
- ❑ Feeding residents
- ❑ Pushing residents in their wheelchairs
- ❑ Telling facility staff how to do their jobs
- ❑ Policing

Ethical Dilemmas

- June
- Jack
- Billie

June

June asks you to pour her a glass of water because her throat is dry. The water pitcher and cup are on her bed-side table, but out of her reach.

She's thirsty and can't reach her water but who is responsible to get the water for her? Does she have fluid restrictions? Does she have difficulty swallowing?

Jack

You are talking to Jack in a public area, but he wants to talk in private. He uses a wheelchair and cannot push himself down to his room. He asks you to do so.

He needs help with his wheelchair and wants to talk privately with a representative, which is his right to do so. Who is responsible for taking him to his room?

Billie

During a visit in Billie's room, she tells you she's chilly and asks you to get her sweater out of her closet and help her put it on.

She is uncomfortable and wants her sweater but is it okay for the representative go through her closet even at her request? Who is responsible for assisting her with dressing?

Determine if the following requests to the LTCOP are appropriate or inappropriate:

A. Mr. Lopez has uncontrolled diabetes and is morbidly obese. Against the doctor's recommended diet, he wants to eat the desserts that the other residents without diabetes are served. He asks you to talk to the dietary manager about getting the same desserts as everyone else.

B. The facility social worker contacts the LTCOP and asks for help finding a facility for a resident who is causing "problems."

C. Mrs. Thompson complains that she is lonely and asks you to stay longer to keep her company and look through her photo albums with her.

D. Mrs. Cohen tells the LTCOP she would like to go to Temple every week. Mrs. Cohen states that she heard "The Ride" program takes two fellow residents, but she needs assistance to fill out the application and submit it. With Mrs. Cohen's permission, the LTCOP asks the social worker to help the resident complete the application.

E. Mr. Clark wants your help to convince the facility staff that he should be allowed to take a shower every morning. The facility says they are concerned they don't have enough staff to allow for Mr. Clark or anyone else to shower daily and asked "what would happen if all of the residents wanted to take a shower every morning?" The staff member asks you to talk Mr. Clark out of his request.

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The National Long-Term Care Ombudsman Resource Center

The National Long-Term Care Ombudsman Resource Center (NORC)

www.ltcombudsman.org

This project was supported, in part, by grant number 90OMRC0001-01-00, from the U.S. Administration for Community Living, Department of Health and Human Services, Washington, D.C. 20201. Grantees undertaking projects under government sponsorship are encouraged to express freely their findings and conclusions. Points of view or opinions do not, therefore, necessarily represent official Administration for Community Living policy.

MODULE 2

RESIDENT RIGHTS

I. THE AGING PROCESS

II. WHY RESIDENTS NEED ADVOCACY
Fear of Retaliation Video and Exercise

III. NURSING HOME RESIDENTS' RIGHTS

A. Purpose

B. Reasons Why Residents Do Not Routinely Exercise Their Rights

IV. EMPOWERMENT

A. The Role of the Resident Advocate

B. Resident Participation

V. NURSING HOME REFORM ACT OF 1987

A. Provisions of the Law

B. Specific Rights

C. Care Planning

D. Use of Restraints

VI. CONNECTICUT PATIENT BILL OF RIGHTS

VII. RIGHTS AND LEGAL MATTERS

MODULE 2 Appendix and Topics
Video "Look At Me", Fear of Retaliation Video
Connecticut General Statutes, Chapter 319aa
Older Americans Act, Ombudsman Program

TABLE OF CONTENTS

PREFACE

OBJECTIVE

This document provides basic information about the processes that occur throughout life, and particularly in the later years, that are considered normal aging. It also discusses common illnesses in later life and the effects of medications. Ombudsmen must be able to work with older individuals and avoid stereotypes. Ombudsmen should be alert to the difference between the effects of normal aging and the results of diseases that afflict some elderly persons.

INTENDED USE

This document supplements the interactive module, *Aging*, developed and shared by the Louisiana Long Term Care Ombudsman Program, Governor's Office of Elderly Affairs. Long-Term Care Ombudsman Programs are encouraged to use that interactive module and this document as part of basic training for ombudsmen. However, this aging process resource document can be used independently.

SUGGESTIONS FOR USING WITH THE CURRICULUM

There are several ways to use these materials.

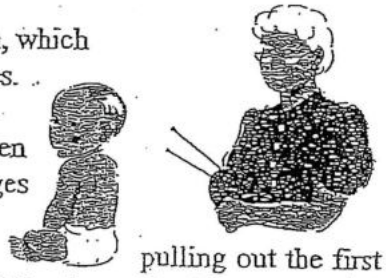
- One recommendation is to use them for individual self-study prior to attending class room training on other topics of the Basic Curriculum for Long-Term Care Ombudsmen. An understanding of the information on aging can be demonstrated via approaches to case studies and class room discussion on related topics.
- Another option is for students to read the resource materials prior to class, then project the inter-active module for use as a review and discussion prompt in class.
- If someone has a background in gerontology or long-term care, working through the interactive module could provide a review of relevant information. If any items are missed or spark curiosity, the person can read the related section of this resource material for further information.
- This document can also be used as a stand alone tool. It can be shared in electronic or hard copy versions for individual reading, assignments or to supplement a lecture. To facilitate learning and emphasize important points, programs could develop application questions to accompany this document.

Whatever method is used, the emphasis in training needs to be: What does this content mean to residents? What can caregivers do to support resident abilities and functioning? What is an appropriate ombudsman action?

I. The Aging Process

A. What is Aging

What is aging? Aging is a continuous process from birth to death, which encompasses physical, social, psychological, and spiritual changes.



Although aging is an ongoing process, the value of aging is seen differently at different points in the process. Some of the changes are anticipated with joy, such as a baby's first tooth or first step. Other changes are greeted with a less positive response, such as pulling out the first gray hairs that appear. Youth is valued in American culture; while signs of aging are masked with face-lifts, wrinkle creams, and hair dyes. The process of physical maturation that is so eagerly anticipated in the first stages of life is viewed very negatively when the youthful attractiveness begins to change.

These prevailing attitudes lead to a denial of the signs of aging. Some individuals quit celebrating birthdays after a certain age. The stereotypical perceptions of aging as a period of deterioration and decline are therefore perpetuated. The positive aspects of aging are ignored. Each stage of life has its own pluses and minuses. Sometimes in old age, the balance may seem to tip to more negatives than positives, but this is not due to the *natural aging process*.

There are many positive aspects of aging. After 70 or 80 years of living, individuals tend to have a clear sense of their values and priorities. Older persons can make definite choices about how to use their time and energy. Their priorities may be very different from what caregivers, family, or friends want them to be. Older people have learned ways to adapt to changes; they have managed to survive. Advanced age can bring a freedom to speak one's opinion. Because of retirement, many older individuals have greater freedom to pursue interests, to use time to think and to reflect. To paraphrase Jung, as we age, we become more ourselves.

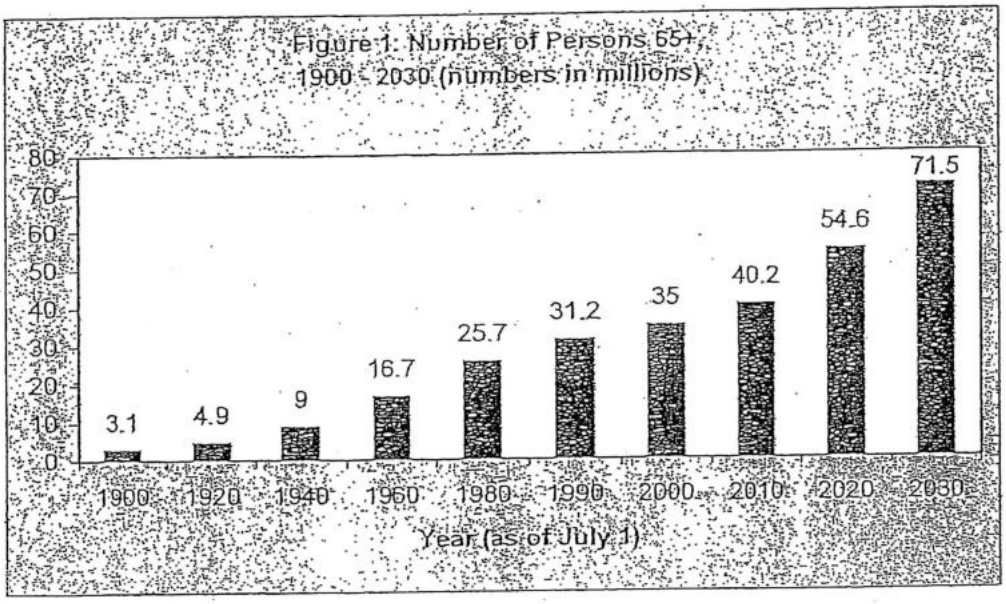
The advanced stages of aging are a normal, natural part of physical maturation. Instead of placing such a high value on youthfulness, it may be more productive to accept the changes throughout life without fear or denial.

B. Profile of Older People

As a long-term care ombudsman (LTCO), you will be working with older adults, their families, and their caregivers. To better understand the population of long term care residents who are your primary focus, you need to understand the "big picture" of the senior population, defined here as persons 65 years of age or older.

So who are aged people? At what age does a person become old? When a 64-year-old goes to bed and wakes up the next morning as a 65-year-old, has that person changed? Chronological age does not always correspond to a person's feelings. Although a person may be eighty years

old, the person may feel like he/she is forty. The age a person feels may vary with the time of day, the day of the week, and/or activities or stresses present in that person's life. A person may be very energetic on Saturday, but very tired and slow moving on Monday morning. Knowing a person's chronological age tells you almost nothing about that individual's feelings or abilities. Nevertheless, in this country, we categorize individuals by chronological age. Some key statistics[1] follow describing the population of seniors, persons 65 years or older.



Numbers and Growth

The older population—persons 65 years or older—numbered 35.6 million in 2002 (the most recent year for which data are available). They represented 12.3% of the U.S. population, about one in every eight Americans. The number of older Americans increased by 3.3 million or 10.2% since 1992, compared to an increase of 13.5% for the under-65 population. However, the number of Americans aged 45-64 – who will reach 65 over the next two decades – increased by 38% during this period.

The most rapid increase is expected between the years 2010 and 2030 when the "baby boom" generation reaches age 65. By 2030, there will be about 71.5 million older persons, more than twice their number in 2000. People 65+ represented 12.4% of the population in the year 2000 but are expected to be 20% of the population by 2030.

Minority Populations

Minority populations are projected to represent 26.4% of the elderly population in 2030, up from 17.2% in 2002. Between 2000 and 2030, the white** population 65+ is projected to increase by 77% compared with 223% for older minorities, including Hispanics, African-Americans,** American Indians, Eskimos, and Aleuts,** and Asians and Pacific Islanders.**

[1] The statistics and narrative information in this section come from: *A Profile of Older Americans 2003*, the Program Resources Department, American Association of Retired persons and the Administration on Aging, US Department of Health and Human Services, Washington, DC. http://www.aoa.dhhs.gov/aoa/stats/profile/ The data is based on information from the US Bureau of the Census and the National Center for Health Statistics.

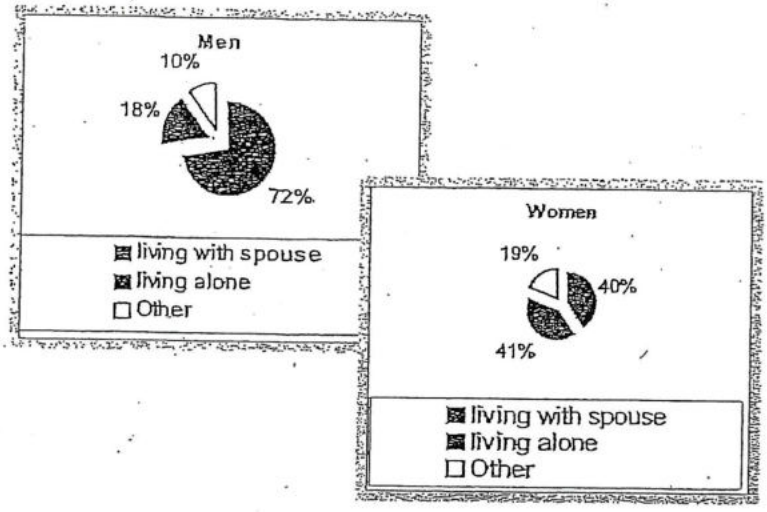
Age

The older population itself is getting older. In 2002, the 65-74 age group (18.3 million) was eight times larger than in 1900, but the 75-84 group (12.7 million) was more than 16 times larger and the 85+ group (4.6 million) was almost 38 times larger.

Living Arrangements

Over half of noninstitutionalized older persons lived with their spouse in 2002 (Figure 2). The proportion of individuals living with their spouse decreased with age, especially for women. **** About 30% of all older persons lived alone. The proportion living alone increases with advanced age. Among women aged 75 and over, for example, half lived alone (in 2000).

Figure 2: Living Arrangements of Persons 65+: 2002



Health and Health Care

In 2003, 38.6% of noninstitutionalized older persons assessed their heath as excellent or very good, compared to 66.6% for persons aged 18-64. There was little difference between the sexes on this measure, but older African-Americans (57.7%) and older Hispanics (60.5%) were less likely to rate their health as excellent or good than were older Whites (75.4%).***** Most older persons have at least one chronic condition and many have multiple conditions. Among the most frequently occurring conditions of the elderly in 2000-2001 were: hypertension (49.2%), arthritic symptoms (36.1%), all types of heart disease (31.1%), any cancer (20.0), sinusitis (15.1%), and diabetes (15.0).

Nursing Homes

While a small number (1.56 million) and percentage (4.5%) of the 65+ population lived in nursing homes in 2000 the percentage increases dramatically with age, ranging from 1% for persons 65-74 years to 5% for persons 75-84 years and 18% for persons 85+.

II. Biological Aspects of Aging[2]

A. Introduction

Aging brings some changes in all people. These changes are continuous throughout life, from losing baby teeth to the loss of taste buds. The normal changes with advanced age have only recently been studied and are beginning to be understood. Some changes are obvious in the way they alter physical appearance or in their visible effect upon body systems. Other changes are less apparent, in that they affect internal body systems, such as the circulatory systems. These changes vary in degree and rate from individual to individual.

B. Structural

MUSCLES	Muscles lose mass and tone. While exercise helps to maintain strength and tone, it does not prevent some loss. This change is observable in the looseness of underarm skin, sagging breast, and thinner legs and arms reflecting the changes in musculature.
SKELETON	Another change affecting appearance is the flattening of the spongy "cushion" between the vertebrae. Over the years, this material loses its resiliency. Older people may be shorter than they were in younger years and have a stooped posture.
SKIN	There are several changes that affect the skin. • The skin loses some elasticity, which results in wrinkles. The skin does not stretch and conform to its original shape as it once did. • There is a loss in the natural oils in the skin, which may lead to dryness and scratchiness. Individuals may need to use moisturizer to replace the loss in oils. • The skin becomes thinner and thus more susceptible to being broken or cut. • Older people may become more sensitive to temperature changes. • Some individuals may develop "aging" spots, which are dark areas of pigmentation. The presence of such spots does not indicate a problem with the function of the liver. The spots are simple changes in the pigmentation of the skin. Creams do not remove the spots although they may temporarily camouflage them. Spots on the skin of older people should be closely observed for sudden growth or changes in appearance. Such changes should be reported to a physician.

[2] Excerpted from The New Mexico Ombudsman Curriculum developed by Sara S. Hunt.

C. Sensory

MOUTH	The bone structure of the jaws may change, which can alter the way dentures fit. It is possible for an individual to develop problems with a set of dentures that he/she has had for years. Problems with dentures may have a negative impact on a person's nutritional intake.
TASTE	The sensitivity of taste buds decreases with age, especially with men. The tastes that decline first are sweet and salty, with bitter and sour decreasing more slowly. Those changes mean that foods may not taste like they used to older people. The elderly may over season food or may accuse others of omitting all seasonings in food preparation. Changes in taste may lead to a loss of appetite, which can lead to nutritional deficiencies.
SMELL	Sensitivity to smell decreases as individuals age. Older individuals may be less aware of certain odors, even body odors, than younger people. The decreased sensitivity to smell may also adversely affect appetite.
VISION	There are several eye disorders that occur more often in the aged, such as glaucoma and cataracts. In the fourth decade of life, visual capacity begins to decline.
DISTANCE	The lens of the eye may lose some of its ability to accommodate changes in distance vision. That means that it may take a person a few seconds longer to recognize someone who is across the room when the older person has been reading or doing handwork.
LIGHT	The pupil of the eye tends to become smaller with age, permitting less light to enter the eye. This means eyes have a decreasing ability to adjust to changing amounts of light, and glare becomes a problem. Older people need more light than younger people do.[3] If an older person has been sitting in a semi-dark room and opens a door to find a visitor standing in bright sunlight, the older person may not immediately recognize the visitor. That does not indicate a problem with mental alertness, but it may indicate a longer than usual period of time required to adjust to differences in light.
COLOR	Other changes in the lens of the eyes may make it difficult to distinguish blues and greens or pinks and yellows. An elderly person may comment on her green dress when it is actually blue. That kind of mistake does not necessarily indicate declining mental abilities; it may indicate changes in color identification. Colors that are very similar in shade like beige and brown may be difficult for older individuals to distinguish. Contrasting colors such as black and white may be more readily identified. Clothing can be tagged so those older individuals know which colors are complimentary.
DEPTH	Changes in the eyes may affect an older person's mobility. The floor may appear to be rolling so that older people may shuffle along to ensure stable footing. Changes in depth perception can make it difficult to judge the height of curbs or steps. A person may take a large step and receive a jolt. It is helpful to edge steps or curbs in a bright, contrasting color to facilitate the elderly person's ability to judge depth. Baseboards that contrast with the walls and floor make it easier to

[3] Stuen, C., & Faye, E.E. "Visipn Loss: Normal and Not Normal Changes among Older Adults." *Generations*. XXVIII(1), p. 8.

distinguish distances and surface areas.

PRINT The lens of the eyes also loses some of its ability to focus on small print, such as the body of a newspaper. Headlines are more readily discernible. That means many of the forms that have instructions in small print are very difficult for older people to complete. The same is true of reading the statements of benefits, an activity schedule, a list of resident rights, or learning to operate the control knobs on a piece of equipment.

The cumulative effect of these vision changes can alter a person's sense of independence and self-confidence. If vision changes make it difficult for senior citizens to negotiate a "strange" or unfamiliar environment, that person may limit shopping or take trips less often. An elderly person may appear to be two different people. One who is very efficient, steady, and independent may be observed in her own environment. In an unfamiliar environment, the same individual may appear confused, disoriented, and slow. That kind of difference may be due to vision changes. In the familiarity of a home environment, the person may function very well because he/she knows where everything is and how to operate the appliances.

It is important to allow older people the extra seconds needed for their eyes to accommodate to changes in light or distance. Eye examinations are also important to ensure that eye diseases or impairments are detected and promptly treated. Vision rehabilitation services such as the Lighthouse can be helpful in detecting problems and in offering tips to increase independent functioning.

HEARING Changes in hearing are multiple and can have a profound effect upon the life of an older person. Hearing loss can cause depression and social isolation. Because it can lead to paranoia and suspicion, hearing loss is potentially the most problematic of perceptual losses. Individuals who have some degree of hearing loss may not realize that they have a loss.

When an individual with a hearing loss is in a group, the person with the hearing loss may begin to think that others are talking about him/her, or are deliberately excluding that person from the conversation. In reality, group members may not realize the need to face the person and to speak so that he/she follows the conversation. Individuals with hearing losses may hear part of what is said and not know they have heard only part of the statement or question.

The mind may automatically compensate for unintelligible conversation by inserting information, which seems to make sense. The person may then give an inappropriate response and not realize that the communication has been misunderstood.

There are three major types of hearing loss.

- High frequency loss: low, deep sounds are more readily heard than higher sounds.
- Conductive hearing loss: sound waves are not properly conducted to the inner ear making sounds become muffled and difficult to understand.
- Central hearing loss: allows speech to be heard but not understood. Signals from the ear either do not reach the brain or the brain misinterprets them.

D. Systems

CIRCULATORY SYSTEM	The heart, like other muscles, weakens and loses pumping capacity. Arteries or veins may become rigid or blocked, which restricts blood flow and circulation. Under routine circumstances, these changes do not greatly alter the daily functioning of an individual. These changes may be observed when an aged person who has been sitting for a while suddenly stands and walks across the room. Unless a few extra seconds are allowed for the heart to supply sufficient blood to all the body extremities, the person may stumble, fall, or seem confused. After the heart has had sufficient time to pump the blood throughout the body, the unsteadiness or confusion disappears.
DIGESTIVE SYSTEM	One of the systems least affected by aging is the digestive system. As in earlier years, diet and exercise are extremely important to maintain proper functioning. Teeth become more brittle. Saliva, necessary to swallow food, decreases; the thirst response decreases. Peristalsis (the movement of the intestines) is slower, decreasing speed and effectiveness of digestion and elimination. Choking on food is a greater risk because of a decreased gag reflex.
URINARY SYSTEM	The urinary system experiences several changes. • A general weakening of the bladder muscles means that the impulse to urinate cannot be delayed as long as in earlier years. When an older person says, "I have to go to the bathroom," that usually means now. • The bladder doesn't stretch to hold as much as it used to, so urination may be more frequent. • With weakened muscles the bladder may not empty completely which increases susceptibility to urinary infections. • The kidneys filter the blood more slowly than in younger years. As a result, medications remain in the bloodstream longer than they do in younger people. That change in functioning compounds the danger of over-medication. Dosages of medicine need to be closely and continuously monitored. Interaction effects between prescribed medicine and over-the-counter drugs, even aspirin or Bufferin, are more likely to occur.
REPRODUCTIVE SYSTEM	In the reproductive system there is little change. Vaginal secretions diminish; erections may require more stimulation. In men, the prostate may become enlarged. Regular check-ups are particularly important for men. Prostate trouble may go untreated until it requires radical treatment.

E. Summary

The cumulative effect of these changes is minimal in everyday functioning. These changes occur gradually, which allows individuals to adapt to the changes. Normal, daily functioning continues. The impact of these changes is more apparent when an older person is in an unfamiliar environment or when an older person is subjected to physical or psychological stress. Exercise and diet significantly impact the rate of these changes by slowing down the processes. In spite of the normal, age-related changes, older people function well enough to maintain daily functioning.

III. Psychological Aspects of Aging

A. Memory

Short-term memory seems to decrease. It becomes more difficult to remember events in the immediate past, like what a person ate for breakfast, who came to visit yesterday, or the date and time of an appointment. There are ways to compensate for any decreases in short-term memory function. A person may write notes, which serve as reminders if they are kept in a specific place. Freedom from distractions or too much stimulation may also help with remembering immediate events or information. Long-term memory seems to improve with increasing age. Events, which occurred forty or fifty years ago, may become easier to remember. As events are remembered and retold, they become more vivid and detailed.

B. Adaptation To Change

Everyone throughout their lives experiences change. When a person acquires senior citizen status, he/she has lived through numerous changes. They have gone from the early days of automobiles to multi-lanes of traffic on interstates to airplanes to space ships. Individuals who have witnessed those changes have established patterns of adjusting to change. They know better what they can and can't tolerate and what is important to them.

Reactions to change vary from person to person. Change, whether positive or negative, is stressful. All individuals need time to adjust. Sometimes older people are seen as resistant to change, or "set in their ways." It may be that their refusal to accept change is a way of maintaining control. To say, "No," is to keep one area of their lives stable. At other times, change may be refused because it may not be understood. They may need more information or a clearer explanation, even if it is about a service being offered. Older people may need more time to consider the proposed change—to think it through, to decide. They may need assurance that the change can be tried on a temporary basis and then reevaluated. They may need reassurance about the terms of a service, information about other people who have utilized the service, and that the service can be easily terminated, before he/she accepts the service. There may be a very good reason for saying, "No." They need to be listened to in order to understand their needs. Sometimes it is tough to find a balance between trusting their own priorities and understanding the enabling supports that they need

C. Reminiscence

One method of coping with change is through reminiscence. There are several positive benefits of engaging in reminiscence. The present may be depressing or very unsatisfactory. By recalling a happier time, an older person may derive some contentment or the ability to endure the present. The strength to adjust to change may be derived from remembering previous successful adjustments.

Furthermore, reminiscence may provide an emotional outlet. Everyone reminisces. When something good happens, most people share the event with two or three friends. When friends meet,

they sometimes recall previous shared experiences and relive them at that moment. Some older people may not have several different people with whom to share an experience. If only one or two people are around that older person, those individuals may hear the same story several times.

Some of the common psychological purposes that reminiscence may serve are listed below.

IDENTITY	Through story telling, an older person can reveal personal achievements and characteristics. Indirectly, the older person may be saying, *"This is how I was before I became old."* It serves as an introduction to that person prior to any limitations on energy or functioning. Personal characteristics are often revealed; a new acquaintance can begin to understand what the older person has been throughout his/her life by listening to reminiscences.
SELF-ASSESSMENT	In recalling the past, an older person may engage in self-assessment, deciding what kind of life one has lived. A review of the totality of one's life imparts a sense of integration of self. Allowing an older person to give advice, wisdom, or history to others through reminiscence can reinforce self-esteem. It may reinforce a person's feeling that his/her life has been worthwhile.
GRIEVING	Reminiscence can be a productive method of dealing with loss and grief. In verbally sharing the loss, an individual may come to accept it. In grief, there is a need to remember and to relive past experiences. Reminiscence provides that opportunity. There may be conflicts in the past that are unresolved or need to be re-evaluated. By remembering past events, a person may decide to make amends with someone; to be forgiving or to seek forgiveness. Losses, which were suppressed, may surface. Grieving may need to be completed.

D. Intelligence

Intelligence does not decline with normal aging. When tested, older people scored lower on timed tests than do younger people. On tests without time limits, older people score better than younger individuals.

IV. Sociological Aspects of Aging

A. Introduction

As with individuals of any age, familial relationships are important to older people. With increasing age, family composition often undergoes some changes. Older men are much more likely to be married than older women. Almost half of all older women are widows. Divorced and separated older persons represent only 10% of all older persons. However, this percentage has increased since 1980.[4]

Family connections extend into later life as reflected by living arrangements. Almost 60% of older women and 78% of older men live with a spouse or with another relative.[5]

Relationship patterns which were established in earlier years prevail into later life. If a parent and child have always had personality clashes, they will continue to unless they learn new ways of dealing with each other. The parent who listened primarily to one child or turned to a child for advice will continue that pattern unless something intervenes.

B. Role Reversal

While it is true that an elderly person may become more dependent in some capacities, the person is still an adult. Sometimes individuals may appear to act like children because they feel they are being treated as children especially when living in an institution.

Dependencies in one area do not mean a person is dependent in all areas or is dependent all of the time.

An individual may need transportation and assistance in completing forms. That does not mean that person needs someone to make financial decisions for him/her. An aged individual may require temporary assistance in managing personal affairs until that person recovers from an illness or stress and is able to resume total responsibility. Sometimes families decide an elderly person is incapable of independence because the person makes a decision that disregards their advice.

Older people need to be encouraged to do as much for themselves as possible. Caregivers need to patiently allow sufficient time for persons to respond to questions or accomplish tasks. The emphasis should not be on perfection but on personal accomplishment. Ombudsmen should reinforce the decision-making ability of elders and expect and support as much independence in as many areas as possible.

[4] *Profile of Older Americans 2003*, op.cit.

[5] *Older Americans 2000: Key Indicators of Well-Being*. Appendix A: Detailed Tables. Indicator 5, Living Arrangements. Federal Interagency Forum on Aging-Related Statistics. http://agingstats.gov

C. Crisis

In families, it is helpful to anticipate potential crises. Before a stressful situation develops, consider the possibility that it may occur, and explore the alternatives. Areas to discuss include living arrangements, finances, wills, and funeral arrangements. It may be helpful to mention the subject and then discuss it more fully at a later date. Prior discussion helps prepare mental strategies for resolving crisis situations. It is easier to make decisions when everyone's wishes are known.

D. Limitations

There are limitations to familial support, both financially and emotionally. Resources are limited and families may be pulled in more than one direction. It is not uncommon for a middle-aged couple to have dependent children in the home and increasing responsibility for elderly parents. A retired couple trying to adjust to less financial flexibility, may be caring for aged parents. There may be little time to spend with older relatives or to provide assistance. Priorities must be established, limitations acknowledged, and expectations discussed.

E. Guilt

Family relationships may involve some guilt. The guilt may be unjustified or due to unreasonable expectations. A personal re-assessment with realistic goals may be needed. If family members or an older relative makes excessive demands, a family conference or a one-on-one discussion may be in order. Problems, limitations, expectations, and responsibilities must be discussed. The aged relative should be involved in the discussion and in problem solving. A workable solution must be found.

F. Losses

Anger and grief are two primary reactions to loss.

We experience losses throughout our lives. Some losses are more difficult to overcome than others. Common losses include the loss of friends, relatives, objects, and opportunities. Objects that are representative of special relationships or of personal achievement may be particularly important to an older person. Physical abilities may be lost: the use of an arm or leg, eyesight may diminish, and/or manual dexterity may decrease. These losses are usually accompanied by losses in roles and activities. The activities or functions which once gave meaning to one's life may have been dramatically altered. Opportunities to make new friends, acquire new skills, or accomplish life long goals, may be gone or greatly restricted. Recovery from losses may not be as quick in late life as it is in younger years.

There are two primary reactions to loss: anger and grief. Both are natural and may be expressed in various ways, depending on the individual. Talking about the loss is a therapeutic way to come to terms with it, to grieve, and accept the loss.

G. Death

Although death and dying may trigger strong feelings, it is a natural part of the life cycle. *There are five major reactions to death or dying, which have been identified by researchers: denial, anger, bargaining, depression, and acceptance.* Individuals do not always experience every stage, nor do they always experience the stages in the order listed. Stages may be repeated or skipped. Families or friends of a dying individual may also experience these reactions, and may do so at different times than the individual.

Ombudsman Visits With Residents Who Are Dying[6]

Responses of a Dying Person		Role of Ombudsman and Caregiver
When the awareness of a serious or fatal illness comes, persons react with shock and denial: *"No, not me! It can't be me!"* "This is not really happening. Someone has made a mistake."	DENIAL	Listening is very important. The dying person may not talk much and should not be pushed. Daydreaming about happier things, regardless of how improbable things may seem, should be encouraged and supported.
When denial can no longer be maintained, anger takes over. The question becomes *"Why me?"* or *"Why did God let this happen to me?"* The person feels angry, bitter, and envious of others who won't die.	ANGER	Family and friends usually find this stage difficult and mistake the anger as a personal attack. Be careful not to shorten or avoid visits or to react with anger. The resident needs an opportunity to ventilate his/her feelings. If the person feels respected and understood and is given attention by those important to him/her, she/he may soon begin to reduce the angry demands.
The person hopes that if she/he carries out promises, she/he will be rewarded with a longer life. This postponement is expressed in the hope that she/he will live to see some special event. *"Yes me, but..."* Many of these bargains are made with God and may be kept secret from family or friends.	BARGAINING	The resident needs someone to listen to him/her and to recognize his/her feelings. Expressing fears often helps to relieve the resident's feeling of guilt and enables the person to work through this stage in a more satisfying manner.
Faced with the reality of such a great loss, the person is profoundly sad.	DEPRESSION	Our initial reaction to depression is to try to encourage the person to look at the bright side. This approach, however, can be an expression of our own needs and is not generally helpful in working through this stage. In dealing with reactive depression, the individual may have much to share. Listening is very important. The resident experiencing depression will often express his/her sorrow through silence. In these instances, a touch of a hand or just silently sitting together is usually more meaningful than words.
If the person has had sufficient time and the support and care of those around him/her, he/she will pass into a stage of acceptance of impending death: a calm, peaceful and comfortable readiness to face death. The person is not happy, but not terribly sad either.	ACCEPTANCE	The family may need more support than the dying person, who has already found some peace. It is a silent time in which the resident wishes to be left alone. He/she often prefers that visits be short and relatively silent. Our presence confirms that we will be around until the end and reassures him/her that he/she is not alone

[6] Adapted from Elisabeth Kubler-Ross

V. Myths and Stereotypes

A. Myths and Stereotypes about Senior Adults

Within American society, there are some common generalizations that are thought to be truths about older people. Many elderly people, who may expect these behaviors of themselves, believe these stereotypes. The myths, stereotypes, and negative attitudes greatly influence interactions with older people. Expectations about the later years are formed very early and are reinforced throughout life.

The truth is that there is great variety among individuals in later life. Individuals are what they have always been. There is as much diversity in personalities among older adults as there is among younger individuals. Problems arise when people act on their assumptions about the older person. Family members may unconsciously "watch" their elderly relatives to see when they will begin to exhibit these characteristics. Some major myths and stereotypes are listed below.

MYTH	REALITY
Older people are disengaged – they live by themselves or with other older people; they lose interest in life and become more introspective and withdrawn; older people do not want to associate with other people.	Opportunities for older people to associate with other people may be very limited. Physical handicaps, lack of transportation, lack of alternatives, and the death of a spouse or close friends may cause an older person to appear disengaged. Other people may have disassociated from the elderly person. Older people do prefer to stay involved in life as much as possible.
Older people are sick – disease and disabilities are automatic with advancing age; older people are not expected to feel well.	Chronic conditions such as arthritis or diabetes usually begin in middle age and may worsen with advancing age. Disabilities previously assumed to be automatic effects of aging, have been shown to have other causes, and can be influenced by diet, exercise, and life style. The elderly did not suddenly become sick when they became aged. Sometimes the elderly may use this myth to get out of activities or commitments. The older person may need or want some encouragement to participate in activity.
Once a man, twice a child – they become childish, return to a second childhood, and must be treated like children.	Adults remain adults and function as adults. If any person is expected by others to act like a child, that person may conform to those expectations over time.

MYTH	REALITY
Older people are dependent – they need someone to take care of them.	Most older people are independent, living in the community, and are taking care of themselves. Many times, "help" is given to older people because others are too impatient to wait long enough for the elderly to do the tasks themselves. While others may think they are helping older people by doing shopping or running errands, they may actually be denying the older person opportunities to go out, maintain control and independence in decision-making, and receive stimulation and mental and physical exercise. Older people may gradually become dependent on others for unnecessary assistance.
The old are unproductive – they have already made their contribution to society.	The majority of older people remain actively and productively involved in life. However, opportunities for meaningful work, education, or leisure activities may be less available. When incapacity develops, it can be more directly traced to a variety of losses, diseases, or circumstances rather than aging. Productivity may have to be redefined to include sharing reminiscences or knowledge as well as producing tangible products or results.
The aged are asexual – Sexual desire is "only in their heads", sexual function ceases in old age.	In reality, sexual desire continues throughout life. With advancing age, sexual function may change, but it does not automatically cease. If a person has remained sexually active throughout adulthood, there is no reason that should change in the later years.
Grandparents are always eager to be with their grandchildren – All grandmothers love to bake cookies, and all grandfathers love to tell stories to their grandchildren; grandparents are always glad to keep their grandchildren.	All grandparents are entitled to their own lives and schedules. Most grandparents do enjoy time with their grandchildren but within limits. Sometimes grandparents prefer visits that are planned in advance. Grandparents may be expected to keep grandchildren and will feel guilty if they must say "No." Out of necessity, a growing number of grandparents have become surrogate parents for their grandchildren.

MYTH	REALITY
Old people become senile— Eventually all older people become forgetful, confused, and have reduced attention spans.	"Senility" is one of the most misused words; it has come to be a catch-all term with little specific meaning. Similarly, "Alzheimer's" has become a general term used to describe all types of behavioral symptoms or memory loss that may have very different causes and therefore very different strategies for intervention. (See the discussion of dementia later in this material for more information.) The expectation of senility puts many elderly on guard against actions that may be viewed as indicative of mental loss. When an older person becomes distracted and lets cooking food burn, she may try to camouflage the odors to prevent family members from realizing the food was burned. Otherwise, they may begin to wonder if she is safe alone.
All old people end up in nursing homes – if individuals live long enough, they will be institutionalized.	About five percent of the elderly are institutionalized at any one point in time. The majority live in community settings. Although, nursing home care is not inevitable, particularly as alternative services are developed, about forty percent of the total elderly population will spend some time in a nursing home.

B. Myths and Stereotypes about Care

Stereotyping and myths also affect the medical treatment older individuals receive and the way caregivers treat them. Clinical expertise is beginning to challenge many commonly held perceptions about inevitable age-related declines and appropriate interventions.

It is critically important that you, as an ombudsman, know the myths, ask questions, and offer information at opportune moments.

As an ombudsman, you need to know which conditions indicate a need for more assessment and/or consideration of different treatment interventions instead of assuming that the conditions are simply manifestations of the aging process.

Since your job will be working with individuals in long term care facilities, this section will focus on applications in that environment. The same principles are applicable to individuals in home settings or other residences.

The Imperative for Good Care

In addition to challenging some of the long-held perceptions about the causes of decline and appropriate treatment, there is a solid legal basis for rethinking stereotypical responses.[7] The Nursing Home Reform Law (OBRA '87) challenges the mindset that *"this is the way we've always done it,"* or *"we don't have the staff to do it."*

OBRA challenges everyone to re-examine assumptions and practices: *that old people are hopelessly depressed; bedsores and incontinence are unavoidable, and residents must be restraints help residents.* There are practitioners[8] who have blazed the trail: finding that time spent on thorough assessment and care planning saves time in the long run; accommodating individual needs is possible and is more efficient; and eliminating restraints results in better care. Their experience shows the law's potential.

One of the principle provisions of OBRA, Quality of Care, says, *"A nursing facility must provide services and activities to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident in accordance with a written plan of care."*

The requirements for long term care facilities explains what Quality of Care means:

> *"Based on a comprehensive assessment of a resident, the facility must ensure that a resident's abilities in activities of daily living do not diminish unless circumstances of the individual's clinical condition demonstrate that diminution was unavoidable. This includes the resident's ability to bathe, dress, and groom; transfer and ambulate; toilet; eat; and use speech language or other functional communication systems."*

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[7] Most of this section is from Frank, B., "The Promise of Nursing Home Reform Is In Your Hands . . . An Advocate's Message to Surveyors," *Survey and Certification Review*, June 1992. pp3-8, and the *Ombudsman Guide to The Nursing Home Reform Law*. National Long-Term Care Ombudsman Resource Center, National Citizens' Coalition for Nursing Home Reform. Washington, DC. 2004.

[8] The Pioneer Network serves as a national focal point for this type of activity, promoting "culture change," cultivating and sharing best practices. P.O. Box 18648, Rochester, NY 14618. (515)271-7570. www.pioneernetwork.net

The regulation applies to vision and hearing, pressure sores, urinary incontinence, range of motion, mental and psychosocial functioning, naso-gastric tubes, and other areas of care.

In short, this provision means that people should not get worse because of what the nursing home does to them. In fact, they should reach the highest level of functioning and well-being that they are capable of achieving. If a resident was able to walk, transfer, bathe himself/herself, move his/her arms, or maintain his/her skin condition when he/she entered the facility, he/she should still be able to do so after six months or a year; actually, for the rest of his/her stay in the facility, unless circumstances of his/her clinical condition demonstrate that diminution or decline was unavoidable. There are only three reasons that diminution is unavoidable:

- A new disease or condition is experienced by a resident (e.g. heart disease added to the Parkinson's)
- A resident's disease progresses (e.g. the parkinsonian medicine no longer works and the individual becomes so rigid he is rendered immobile)
- A resident refuses care.

The following is a description of some common myths and stereotypes that are being proved untrue. The Resident Assessment Protocols, part of the mandatory resident assessment process, contain excellent guidance to assist in changing perceptions and treatment approaches for all the conditions in this section. The knowledge basis and educational resources are available to alter *the way we've always done things.* As we change our way of thinking about conditions, there will be dramatic differences in what happens to individuals who enter nursing facilities.

Loss of Mobility

Myth or Stereotype

Given the frail condition of residents, movement is not as important for them as it is for other adults. They will experience a decline in mobility as an inevitable part of growing older.

Reality

"Movement, like other basic human needs, is lifelong and doesn't end with [old age and] institutionalization. The ability to meet these needs may fluctuate with physical and mental ability, but the drive that initiates the pursuit is forever. Frail, elderly persons who enter nursing facilities retain the drive to meet their need for movement, just as they do for the other basic needs. Institutions often fail to assist residents in meeting movement needs because they fail to recognize movement as a basic human need."[9]

All individuals need to move. "Impaired mobility can lead to a number of harmful physical and mental complications, which taken to their extreme, can be fatal."[10] Immobility negatively affects every body system. The effect of immobility, as well as ways to *maintain* mobility, is documented.

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[9] Tempkin, T., *Mobility: A Basic Human Need, Quality Care Advocate Special Section*, National Citizens' Coalition for Nursey Home Reform, Washing DC, 1993, p.1.

[10] Ibid.

In a limited study of nursing home residents, those who walked outdoors reported less fatigue than residents who did not.[11] Residents in the walking group slept better and reported better appetites than others in the study. Mobility is essential to life. It affects more aspects of life than just the physical ability to move.

Pressure Ulcers

Myth or Stereotype

Because of the age-related changes in the skin and the frailty of nursing facility residents, pressure ulcers/sores are inevitable for individuals who are not independently mobile. Pressure sores are an unfortunate part of normal aging for frail, elderly persons.

Reality[12]

A pressure ulcer is an injury caused primarily by unrelieved pressure that damages the skin and underlying tissue. An ulcer of this type is a serious problem that can lead to pain, longer hospital or nursing home stays, slower recovery from health problems, even death. Over 7% of residents in nursing facilities have pressure ulcers.[13] Sixty percent (60%) or more of residents will typically be at risk of pressure ulcer development.[14] Individuals who are at risk of developing pressure sores are those with limited mobility, incontinence, diabetes, decreased mental states, confusion, or apathy.[15] *Almost all pressure ulcers can be prevented.*

The assessment of risk factors is critical to prevention and/or early detection and intervention. The primary risk factors are:

- immobility or unrelieved pressure, including pressure from use of a restraint,
- laying in urine or feces,
- poor nutrition and hydration.

All of the major causes can be addressed by facility staff and relate to basic, daily care routines.[16]

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[11] Gueldner, S. H., and Spradler, J., "Outdoor Walking Lowers Fatigue," *Journal of Gerontological Nursing*, Vol. 14, No. 10, pp. 6-12.

[12] Most of this section is from: *Clinical Practice Guidelines No. 3: Pressure Ulcers in Adults: Predication and Prevention*, US Department of Health and Human Services, Public Health Service, Agency for Health Care Policy and Research, Rockville, MD, May 1992.

[13] Harrington C., Carillo, H., Wellin, C., et al, *Nursing Facilities, Staffing, Residents and Facility Deficiencies*. University of California, San Francisco. August 2003.

[14] Resident Assessment Protocol: Pressure Ulcers, Appendix C: HCFA's *RAI Version 2.0 Manual*. US Department of Health and Human Services, Health Care Financing Administration, Baltimore, MD. August 1999.

[15] DiDomenico, D.L., and Ziegler, W.Z., *Positioning and Skin Care, Practical Rehabilitation Techniques for Geriatric Aides*, Aspen Publishers, 1989, p. 73.

[16] *Ombudsman Guide to the Nursing Home Reform Law*, op.cit.

URINARY INCONTINENCE

MYTH OR STEREOTYPE

Urinary incontinence – the involuntary loss of urine – is to be expected, especially among residents in nursing facilities. It is another signal of advanced age and physical decline. Once it occurs, there is nothing that can be done except to keep individuals clean and dry.

Despite the high prevalence of urinary incontinence and the fact that it is associated with social and physical problems that impair general well being, nursing home staff often overlooks urinary incontinence as a potentially curable phenomenon.

REALITY

"Contrary to myth, incontinence is not a normal part of aging. It is actually easier to treat in the elderly than in the young. It is not inevitable, even in those with dementia (25% of the bedridden with dementia are continent), and is manageable in a third (33%) of those with dementia."[17]

It is estimated that more than one-half of all nursing home residents experience urinary incontinence. *Urinary incontinence is a symptom rather than a disease.*[18] In some cases, the disorder is temporary, secondary to an easily reversed cause such as a medication or an acute illness (e.g., urinary tract infection).[19] The most probable cause of urinary incontinence is immobility caused by chemical or physical restraints or lack of a toileting program. In 2002 only 5.8% of residents in facilities had bladder training programs.[20] Many cases are chronic, lasting indefinitely unless properly diagnosed and treated.[21]

"Despite the high prevalence of urinary incontinence and the fact that it is associated with social and physical problems that impair general well-being, nursing home staff often overlook urinary incontinence as a potentially curable phenomenon. Care plans that address incontinence often are custodial rather than rehabilitative in nature. In an attempt to keep residents dry, staff may diaper them, change clothing and linens frequently, toilet regularly, limit fluid intake, or use a catheter. Such approaches have their place under certain circumstances, but not until the resident has been evaluated properly to uncover the underlying cause of incontinence and treated when applicable."[22]

"Continence depends on many factors. Urinary tract factors include a bladder that can store and expel urine and a urethra that can close and open appropriately. Other factors include the resident's ability (with or without staff assistance) to reach the toilet on time (*locomotion*);

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[17] Siegal, D.L., "The Nursing Home Incontinence Project," prepared for *Living is for the Elderly*, January 1992.

[18] Harrington, C., op.cit.

[19] "Urinary Incontinence in Adults: Acute and Chronic Management." Agency for Health Care Policy and Research, Public Health Service, Department of Health and Human Services Clinical Practice Guideline #2. 1996 Update.

[20] Harrington, op.cit. 2003.

[21] Burger, S. G., National Citizens' Coalition for Nursing Home Reform, in a telephone conversation, January 14, 1994.

[22] *Long Term Care Letter: Special Report: Incontinence*, Vol. 3, No. 9, Brown University, May 8, 1991.

his/her ability to adjust clothing so as to toilet (*dexterity*); cognitive function and social awareness (*e.g., recognizing the need to void in time and in an appropriate place*); and the resident's motivation. Fluid balance and the integrity of the spinal cord and peripheral nerves will also have an effect on continence. Change in any one of these factors can result in incontinence, although alterations in several factors are common before incontinence develops."[23]

In summary, incontinence not only affects skin conditions and care routines, but also has a profound effect on an individual's dignity, self-esteem, and social relationships. Minimizing risk factors and a thorough assessment and appropriate interventions are essential to helping individuals maintain, or regain, urinary continence. Restorative care is also important.

DEPRESSION

MYTH OR STEREOTYPE

Older individuals tend to withdraw, slow down, and become depressed. Sadness is a natural response to loss of physical abilities and other life stage changes; therefore, depression is a normal part of living to an advanced age.

REALITY

"The ability to think, feel, interact with others, share a sense of purpose, work, love, experience gratification, care for others, and maintain self-responsibility are precious human attributes that elderly people strive to maintain. In only a few circumstances, are these elements of our experience and capacity so broadly and deeply challenged, as with depressive disease."[24]

Depression in the elderly is being diagnosed and treated.[25] A depressed mood may not be as noticeable a symptom among the elderly as are other symptoms such as loss of appetite, sleeplessness, lack of energy, and loss of interest and enjoyment of the normal pursuits of life. Depression affects many aspects of an individual's life. The risk of depression among women is over two times higher than that of elderly men.[26] One study suggests that a result of not treating depression in the elderly is a heightened risk of death.[27] White men over 80 are at greatest risk for suicide of all older people.[28] Treatment is effective, and depression can be alleviated in many cases. Proper assessment, detection, and intervention are critical.

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[23] Resident Assessment Protocol: Urinary Incontinence and Indwelling Catheter, Appendix C. HCFS's *RAI Version 2.0 Manual*. US Department of Health and Human Services, Health Care Financing Administration, Baltimore, MD August 1999.

[24] *Diagnosis and Treatment of Depression in Late Life, Consensus Statement*, Vol. 9, No. 3, National Institutes of Health, Bethesda, MD, November 4-6, 1991.

[25] Levenson, S., *Psychoactive Medications, Politics, The Unconventional "Wisdom" of LTC*, Caring for the Ages, February 2002. In fact, Dr. Levenson says antidepressants are being overused without regard to the adverse effects that may accrue.

[26] Haight, B. and Hendrix, S., (1999) *Suicidal Intent/Life Satisfaction: Comparing Life Stories of Older Women*, Suicide and Life Threatening Behavior, 28(3) 272-284.

[27] Golman, D., "High Death Risk is Found in Depressed Nursing Home Patients." New York Times, February 27, 1991.

[28] Cromwell, Y., *Suicide in the Elderly*, in Schneider, LS., Reynolds, BD., Leowitz, BD., et al Diagnosis and Treatment of Depression in Late Life: Results of a NIH Consensus Conference, American Psychiatric Association Press 1994.

Safety Concerns

Myth or Stereotype

As individuals become older and more physically frail, they need to be protected. Safety becomes very important; thus, minimizing risk is desirable. Using restraints is sometimes necessary to keep individuals from harming themselves by falling or other actions that may result in harm.

Reality

All of life has risks. It is impossible to create a totally risk-free, 100% safe environment. However, some of the care practices that have been justified on the basis of safety may need to be questioned. "Physical restraints do not make people safer. In fact, restraints are often harmful. Caregiver experience and medical research now show:

Physical restraints do not make people safer.

When a person stops using a body part, that part no longer works very well. The old saying, 'use it or you'll lose it' is true—people who are able to get up to try to walk and are restrained become weaker. Also, restrained residents often try to get out of restraints, sometimes resulting in serious injuries, such as broken bones, cuts requiring stitches, and concussions.

Some people also fall if they are not restrained. But research shows that these residents, when they do fall, have less serious injuries than those who are restrained."[29]

In talking with residents, families, and home staff, remember that individuals have the right to take risks and need enough information to allow them to make an informed decision. Advanced age does not remove an individual's ability to accept risks. More information on restraints can be found in *Nursing Homes: Getting Good Care There*[30] or in the fact sheets on the web site of the National Citizens' Coalition for Nursing Home Reform, www.nursinghomeaction.org.

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[29] Burger, S.G. *Avoiding Physical Restraint Use: New Standards in Care: A Guide for Residents, Families, and Friends.* National Citizens' Coalition for Nursing Home Reform. Washington, DC, 1993, p. 7.

[30] Burger, S.G., Fraser, V., Hunt, S., Frank, B., *Nursing Homes: Getting Good Care There.* Impact Publishers, Second edition, 2002. Available from the National Citizens' Coalition for Nursing Home Reform, Washington, DC. (202)332-2275. www.nursinghomeaction.org.

VI. Common Illnesses and Conditions Associated with Aging[31]

This section is included to provide *basic* information about selected conditions and illnesses that you might hear about as you visit residents. This information is not to be used as a medical guide. Do not advise residents about treatment or make a diagnosis based on the following information.

A. Hiatus Hernia

Sixty-nine percent (69%) of people 70 years and older have hiatus hernias.

Hiatus hernias:

- Are protrusions of the stomach upward through the esophageal opening of the diaphragm.
- Can be somewhat minimized if the resident is sitting up straight while eating.
- Are helped by smaller, more frequent meals as part of treatment.
- Require the staff to realize the importance of positioning a person correctly.

B. Constipation

The most common digestive problem among bedridden or inactive people is constipation.

Constipation can be caused by:

- Lack of fiber and fluid intake
- Decreased muscle tone
- Ignoring or being unable to heed the normal urge to defecate
- Laxative abuse
- Prolonged bed rest
- Insufficient food intake
- Tumors
- Certain medications, primarily tranquilizers, sedatives, pain medications, and antacids

Residents may complain about or have:

- Abdominal pain
- Distention of stomach
- Cramping

Many older people are dependent on laxatives. This dependency becomes counterproductive. If the person uses laxatives for any length of time, their digestive system will not function without them. Excessive use of laxatives impairs the absorption of fat and fat-soluble vitamins.

[31] Excerpted and adapted from the Illinois Ombudsman Curriculum.

Extreme constipation can become a medical emergency. It also can cause mental confusion as the system becomes poisoned by waste products that cannot be eliminated. However, a person who is dependent on laxatives needs to be taken off them slowly. A hearty breakfast, six or more glasses of liquid a day, and moderate exercise all are helpful in improving elimination.

C. Osteoporosis

Osteoporosis is:

- Loss of calcium from the bones
- Caused by insufficient calcium intake
- Lack of exercise
- Responsible for over 5 million spontaneous fractures every year; 55,000 people die annually from osteoporosis-related fractures. It is possible for bones to spontaneously break without being caused by a fall or applied pressure.
- Most prevalent in elderly white women

The vertebrae and other bones decrease in mass. This causes a gradual loss of height accompanied by a "dowager's hump" (curving of the upper spine). Inactivity increases calcium depletion. Upon admission to a nursing facility, the older resident is generally less active than they would be in their home, which further accelerates the problem. Facility staff must include restorative nursing practices in resident daily routines including range of motion, standing and walking.

D. Dementia

"Dementia is a loss of mental function in two or more areas such as language, memory, visual and spatial abilities, or judgment severe enough to interfere with daily life. Dementia itself is not a disease but a broader set of symptoms that accompanies certain diseases or physical conditions." [32]

"The two most common forms of dementia in older people are Alzheimer's disease and multi-infarct dementia (sometimes called vascular dementia). These types of dementia are irreversible, which means they cannot be cured. In Alzheimer's disease, nerve cell changes in certain parts of the brain result in the death of a large number of cells. Symptoms of Alzheimer's disease begin slowly and become steadily worse. As the disease progresses, symptoms range from mild forgetfulness to serious impairments in thinking, judgment, and the ability to perform daily activities. Eventually, patients may need total care.

In multi-infarct dementia, a series of small strokes or changes in the brain's blood supply may result in the death of brain tissue. The location in the brain where the small strokes occur determines the seriousness of the problem and the symptoms that arise. Symptoms that begin suddenly may be a sign of this kind of dementia. People with multi-infarct dementia are likely to show signs of improvement or remain stable for long periods of time, then quickly develop new symptoms if more strokes occur. In many people with multi-infarct dementia, high blood

[32] *Alzheimer's Disease and Related Dementias Fact Sheet.* The Alzheimer's Association. February 2004. (800)272-3900, www.alz.org

pressure is to blame. One of the most important reasons for controlling high blood pressure is to prevent strokes."[33]

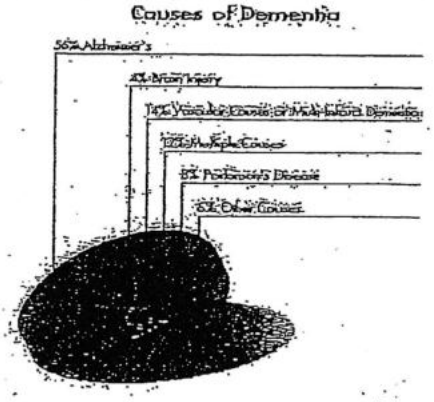
Before *dementia* became a common part of our vocabulary, the term *senility* was used. Senility and pre-senile dementia are still used as medical diagnoses. Regardless of the specific diagnosis, ombudsman approaches to residents with conditions that impair cognitive functioning are the same as described in this document.

Conditions that can cause reversible dementia, if detected early, are:

- Depression
- Drug interaction
- Problem with the thyroid gland
- High fever
- Minor head injury
- Poor nutrition
- Vitamin deficiency

Diseases that can cause irreversible dementia are:

- Alzheimer's Disease
- Multi-Infarct Dementia or vascular disease caused by multiple strokes in the brain (MID)
- Parkinson's Disease
- Creutzfeldt-Jakob Disease
- Huntington's Disease
- Pick's Disease
- Lewy Body Dementia



From *What is Alzheimer's Disease*[34]

[33] *Forgetfulness: It's Not Always What You Think.* Age Page. Alzheimer's Disease Education and Referral Center. National Institute on Aging. US Department of Health and Human Services. http://www.alzheimers.org/pubs/forgetfulness.html.

[34] *What is Alzheimer's,* The Alzheimer's Association. November 2003. op. cit.

E. Alzheimer's Disease[35]

Alzheimer's is:

- A disorder that destroys cells in the brain
- A degenerative, irreversible disease that usually begins gradually, causing a person to forget recent events or familiar tasks
- Variable in the rate with which it progresses from person to person
- Diagnosed as "probable Alzheimer's" based on a variety of tests. The diagnosis has an accuracy rate of 90%. Exact diagnosis can only be determined via a sample of brain tissues after death.

Residents have:

- Memory loss
- Confusion
- Personality and behavior changes
- Impaired judgment
- Difficulty communicating as the affected person struggles to find words, finish thoughts, or follow directions
- Inability to care for themselves as the disease progresses

Progression of Alzheimer's

Alzheimer's disease causes the formation of abnormal structures in the brain called plaques and tangles. As they accumulate in affected individuals, nerve cells connections are reduced. Areas of the brain that influence short-term memory tend to be affected first. Later, the disease works its way into sections that control other intellectual and physical functions.

Alzheimer's disease affects people in different ways, making it difficult for medical professionals to predict how an individual's disease will progress. Some experts classify the disease by stage (early, middle, and late). But specific behaviors and how long they last vary greatly, even within each stage of the disease.

As more is learned about the progression of the disease, new assessment scales are being developed to help physician's track, predict, and treat symptoms of Alzheimer's. New medications can slow the progression of memory loss in its early stages.

Statistics/Prevalence[36]

- Approximately 4.5 million Americans have Alzheimer's disease.
- 11 – 16 million Americans will have Alzheimer's by the middle of the next century unless a cure or prevention is found.

[35] *Facts About Understanding Alzheimer's Disease*. The Alzheimer's Association, January 2004, op.cit.
[36] *Fact Sheet Alzheimer's Disease Statistics*. The Alzheimer's Association, April 2004. op.cit.

- One in 10 persons over 65 and nearly half of those over 85 have Alzheimer's disease. A small percentage of people in their 30s and 40s develop the disease.
- A person with Alzheimer's lives an average of 8 years but can live as many as 20 years or more from the onset of symptoms.

Understanding Behavioral Symptoms

Damage to the brain from Alzheimer's disease can cause a person to act in different or unpredictable ways. Some individuals with Alzheimer's become anxious or appear aggressive, while others repeat certain questions or gestures. Often these behaviors occur in combination, making it difficult to distinguish one from another. Behavioral symptoms do not always become apparent immediately after the onset of disease and often change as the disease progresses. Challenging behaviors not only cause discomfort to individuals with the disease, but also can be frustrating and stressful for caregivers who cannot understand them.

When behavioral symptoms surface, the individual first needs to be evaluated by a physician for potential treatable underlying causes. Behavioral symptoms often result from a variety of unmet needs or treatable problems that the individual cannot communicate, such as:

- physical discomfort,
- medication side effects,
- chronic pain,
- infection,
- nutritional deficiencies,
- dehydration, or
- impaired vision or hearing.

When behavioral symptoms are brought on by causes other than physical problems, further evaluation should try to identify the unmet need and find ways to address it. Unmet needs include the basic human needs: need for toileting, sleeping, food, pain treatment, drink, warmth, companionship, and something useful to do. If a resident with dementia can no longer speak, behavior is the only form of communication.[37]

Non-Drug Treatments

Non-drug treatments of behavioral symptoms are recommended as a first option, since symptoms are best modified without the use of medication. Some suggestions for caregivers and families are:

- **Family education and counseling.** Learn what to expect when afflicted with or caring for someone with Alzheimer's. Family members who are familiar with the disease and know how to effectively communicate with their loved one may be able to better cope with behavioral symptoms. Counseling and support for individuals with the disease and their families is available through local chapters of the Alzheimer's Association.

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[37] *Ombudsman Guide to the Nursing Home Reform Law.* 2004. op.cit.

- **Modifying the environment.** Environmental factors such as lighting, color, and noise can greatly affect behavior. Dim lighting, for example, makes some individuals uneasy, while loud or erratic noise may cause confusion and frustration. The noise of a television set may be frightening. Modify the environment to reduce confusion, disorientation, and agitation. Keep familiar personal possessions visible to ensure comfort and feelings of warmth in your loved one's surroundings.

- **Planning activities.** The key to planning activities is in "knowing the details of a person's life." [38] Help individuals with Alzheimer's organize their time and know what to expect each day. Planned activities help individuals feel independent and needed by focusing their attention on pleasurable or useful tasks. Daily routines such as bathing, dressing, cooking, cleaning, and laundry can be turned into productive activities and may be pleasurable for a housewife. Working on a motor for a mechanic, walking and gardening for a farmer are other examples. Other more creative leisure activities can include singing, playing a musical instrument, painting, walking, playing with a pet, or reading. Planned activities may relieve depression, agitation, and wandering, as well as help affected loved ones enjoy the best quality of life.

Drug Treatments

Non-drug treatments are not always effective; therefore, severe behavioral symptoms may be best treated with medication. In some cases, drugs that are available for the treatment of cognitive symptoms [such as donepezil HCl (Aricept®), or tacrine HCl (Cognex®)] also may improve behavioral symptoms.[39]

Several drugs are available for treating behavioral symptoms, and many more are being studied for specific use in helping individuals who suffer from Alzheimer's. Drugs commonly used to treat behavioral symptoms such as agitation, aggression, paranoia, delusions, or depression associated with Alzheimer's include:

Anti-psychotics (neuroleptics)

- Haloperidol (Haldol)
- Olánzapine (Zyprexa)
- Quetiapine (Seroquel)
- Risperidone (Risperdal)

Anti-anxiety drugs

- Alprazolam (Xanax)
- Buspirone (Buspar)
- Diazepam (Valium)
- Lorazepam (Ativan)

[38] *Nursing Homes: Getting Good Care There*. 2002. op.cit.

[39] New drugs come on the market continually. While manufacturer's will claim they are safer than prior ones, that is rarely the case once the drug has been used in the general population for a time. Sarah G. Burger, April 2004.

Antidepressants

- Amitriptyline (Elavil or Endep)
- Bupropion (Wellbutrin)
- Desipramine (Norpramin or Pertofrane)
- Fluoxetine (Prozac)
- Fluvoxamine (Luvox)
- Nefazodone (Serzone)
- Nortriptyline (Pamelor or Aventyl)
- Paroxetine (Paxil)
- Sertraline (Zoloft)
- Trazodone (Desyrel)

Like any other drugs, these treatments can cause undesirable side effects. Because individuals with Alzheimer's may have difficulty identifying medication side effects, caregivers should ask the physician or pharmacist about what to expect and warning signs to watch for with any drug that is prescribed. Key questions to ask about any medication is, "Does it *enable* an individual to function more independently or at a higher level? Does it *improve* an individual's quality of life?"[40]

Resources

The Alzheimer's Association is the only national voluntary health organization dedicated to research for the causes, cures, treatments and prevention of Alzheimer's disease and to providing education and support services to affected individuals and those who provide their care.

The Alzheimer's Association
919 N. Michigan Avenue, Suite 1000
Chicago, IL 60611-1676
800-272-3900
www.alz.org

The Federal Government funds this service of the National Institute on Aging. It offers information and publications on diagnosis, treatment, patient care, caregiver needs, long term care, education and training, and research related to Alzheimer's disease. Staff responds to telephone and written requests and makes referrals to national- and State-level resources.

Alzheimer's Disease Education and Referral (ADEAR) Center
PO Box 8250
Silver Spring, MD 20907-8250
800-438-4380
www.alzheimers.org/adear

[40] Sarah G. Burger, consultant, April 2004.

F. Parkinson's Disease

Parkinson's is:

- A disease of the central nervous system
- Characterized by tremors in the extremities, rigidity, and slowness of movement
- An incurable, degenerative and progressive disease

Residents have:

- Tremor, which is a rhythmic shaking of a body part when it is at rest[41]
- Poor grasp
- Poor mouth-hand coordination; the resident may need special utensils, special diets, and extended time to eat
- Rigidity or stiffness of muscles that may cause difficulty in walking, moving, or using one's arms and hands such as an inability to suck or close their lips well and limited ability to bite, chew and swallow
- Loss of balance and slowness of movement, as well as handwriting that gets smaller and smaller; loss of arm swing while walking
- Impassive facial expression
- Decreased volume and clarity of the person's voice

Tips For Ombudsmen

Regardless of the cause of confusion, or whether it is reversible or irreversible, there are positive ways to respond to individuals. The expectation for improvement needs to be present. Individuals sometimes rise to meet our expectations, in spite of confusion. Voice tones as well as words and actions convey much meaning. As an ombudsman, you must be aware of all messages you are giving.

[41] Movement Disorder: Old Age or a Treatable Disease? *Board & Care Quality FORUM*. Titus, S. Vol2, No. 1. Reisacher Petro and Associates: Pittsburgh, PA, Jan/Feb 1999.

VII. Drugs and Their Side Effects in the Elderly[42]

Most nursing home residents are on five or more drugs at any time. Ombudsmen, in visiting in nursing homes, will notice the side effects these drugs can have on residents. This section familiarizes ombudsmen with common drugs in nursing homes and the side effects many residents experience. Ombudsmen should be familiar with this basic terminology of drugs so that when residents'/families' complaints involve drugs, ombudsmen recognize the terms. Ombudsmen can thus refer or investigate the complaint reliably.[43]

Over a four year period, two-thirds of nursing facility residents have adverse drug events (ADEs) and one out of seven of these results in hospitalization.[44] Ombudsman should be aware of the Beers Criteria that identify 48 commonly used individual drugs or classes of drugs to avoid in older adults and 20 diseases or conditions and medications to be avoided in older adults.[45]

The decision on prescribing appropriate drugs is the domain of the physician. Advance Practice Nurses (Nurse Practitioners and Clinical Nurse Specialists) in some states have prescriptive authority.[46] Pharmacists in nursing homes review the drug regime of residents on a monthly basis to ascertain if there are adverse drug reactions, allergies, contraindication, or ineffectiveness.

Remember: your role is not to second guess a medical decision regarding medications. You are to listen, observe, ask appropriate questions, and suggest that an individual ask his/her physician for additional review or more information. Ombudsman should know that all drugs given to the elderly should be started at a low dose and raised slowly. This is especially true for individuals who have a dementia.[47]

If more specific information related to medications is needed, call the State Long Term Care Ombudsman. You can also consult the following documents for excellent information about geriatric conditions, medications, and alternative treatments.

- F329: "Unnecessary drugs," Guidance to Surveyors. State Operations Manual, Appendix P, Survey Protocol for Long Term Care Facilities. Health Care Financing Administration, Baltimore, MD. PP-114+. Also available online: http://www.cms.hhs.gov/manuals
- "Psychotropic Drug Use," Resident Assessment Protocol. Resident Assessment Instrument Training Manual and Resource Guide. Health Care Financing Administration, Baltimore, MD.

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[42] Adapted from the Illinois Ombudsman Program Curriculum

[43] For more information see Nguyen, C., and Williams, B. *Reducing Medication Problems in the Elderly*, USC School of Pharmacy 1995.

[44] Cooper, JW. *Adverse Reaction Related Hospitalization of Nursing Facility Patients: A Four Year Study*, South Med Journal, 1999. 92:485-490.

[45] Fick, D, Cooper, J., Beers, M et al, *Updating the Beers Criteria for Potentially Inappropriate Medication Use in Older Adults*. Archives of Internal Medicine 2003. 163:2716-2724 (Google the Beers Criteria).

[46] *Ombudsman Guide to The Nursing Home Reform Law*, 2004, op. cit.

[47] *Resident Assessment Instrument for Long Term Care*, Centers for Medicare & Medicaid Services, Transmittal #8, Psychotropic /Drug RAP, 1999.

SUMMARY OF DATA ON MAJOR PSYCHOTROPIC MEDICATIONS[48]

A. Neuroleptics (Major Tranquilizers, Anti-psychotics)

Used for psychosis, which is a severe mental disorder in which thinking and emotion are so impaired that the individual is seriously out of contact with reality. Examples of psychotic disorders include:

SCHIZOPHRENIA – *A group of psychotic disorders characterized by major disturbances in thought, emotion, and behavior.*

- Ideas are not logically related.
- Perception and attention are faulty.
- Bizarre disturbances occur in motor activity.
- Emotions are flat, inappropriate, and ambivalent.
- There is reduced tolerance for the stress of interpersonal relationships, causing withdrawal from people and reality, often into delusions (a belief contrary to reality) and hallucinations (any sense perception without adequate external stimuli).

MANIA – *An emotional state characterized by intense and unrealistic feelings of elation.*

DEPRESSION WITH HALLUCINATIONS

TOXIC PSYCHOSIS–LSD, PCP

ORGANIC BRAIN SYNDROME – *Associated with psychotic behaviors or agitated behaviors that can be quantified. Organic problems caused by:*

- Infection such as encephalitis or neurosyphilis
- Trauma as in concussion, contusion, or laceration
- Nutritional deficiencies such as Korsakoff's psychosis, beriberi, or pellagra
- Cerebrovascular accident and brain tumors
- Degenerative diseases such as Alzheimer's, Pick's, Huntington's Chorea, and Parkinson's
- Cerebral arteriosclerosis
- Endocrine disturbances

Ombudsman should know that all drugs given to the elderly should be started at a low dose and raised slowly. This is especially true for individuals who have a dementia.[49]

Most common drugs used with these conditions:

- Haldol
- Loxitane
- Navene
- Moban
- Stelazine
- Prolixin
- Trilafon
- Thorazine

[48] From the Louisiana Ombudsman Program Manual.

[49] *Resident Assessment Instrument for Long Term Care*, Psychotropic /Drug RAP, op.cit.

Common side effects (stopping the medication will clear up symptoms in few days):

- Sedation (more common with low-potency drugs)
- Dry mouth, nausea, constipation, sweats, and/or blurred vision
- Tremor, muscle spasms, and restlessness
- Low blood pressure/dizziness (more common with low-potency drugs), causing falls
- Tardive dyskinesia: The involuntary movement of tongue and mouth, sometimes of arms, legs, torso. (Can become a permanent condition and needs to be watched very carefully.)
- High fever: Narcoleptic Malignant Syndrome, which is a medical emergency
- Acute Confusion and delirium

Summary

Generally safe medications; equally effective; the physician must weigh benefits versus side effects.

B. Minor Tranquilizers (Anti-Anxiety Agents)

Used for:

DISABLING ANXIETY: (Panic disorders, phobic disorders, post-traumatic stress disorder, and social phobia)

ALCOHOL WITHDRAWAL

STATUS EPILEPTICS

MUSCULAR SPASMS

Most common drugs used with these conditions are <u>all</u> listed <u>as potentially inappropriate</u> according to the Beers Criteria. Older persons are very sensitive to them. Avoid using the long acting ones. The drugs are grouped according to length of time it remains in a person's system:

- Long Life (18-36 Hr.), Valium, Paxipaim, Xanax (avoid these)
- Medium Life (10-12 Hr.), Tranxine, Ativan, Serax
- Short Life (4-12 Hr.), Librium, Centrax

Side effects:

- Common: Sedation
- Uncommon: Dry mouth, nausea, dizziness, confusion, withdrawal, tremor

Summary

All are potentially inappropriate for older persons, seldom habituating; usually used on short-term basis.

C. Antidepressants

Used for depression (when depression lasts more than two weeks):

NOREPINEPHRINE TYPE DEPRESSION – *characterized by:*

- Sleepiness
- Overeating
- Weight gain

SEROTONIN TYPE DEPRESSION – *characterized by:*

- Restlessness
- Anxiety
- Loss of appetite/weight

PANIC ATTACKS

OBSESSIVE COMPULSIVE DISORDERS: *Where the mind is flooded with persistent and uncontrollable thoughts or is compelled to repeat an act again and again*

Most common drugs used with these conditions:

- Asendin
- Desyrel
- Elavil
- Impipramine
- Ludiomil
- Norpramin
- Pamelor
- Prozac
- Paxil
- Sinequan
- Surmontil
- Tofranil
- Vivactil
- Zoloft

Common side effects:

- Sedation (more common with serotonergic)
- Dry mouth, nausea, constipation, sweats, and/or blurred vision

Summary

Very effective in endogenous depression; adverse reaction in people with cardiac problems and epilepsy; often requires two or three different medications before one is found that is effective and has the fewest side effects.

> **IMPORTANT:** *These medications are toxic in overdoses. They can be quite dangerous. A small "mg" dosage is given for this reason.*

D. Lithium Therapy

Used for:

BIPOLAR DISORDERS: Manic/depressive, manic, depression

ALCOHOLISM

Medication used:

- Lithium

Side effects:

- Common – Tremor, nausea, diarrhea
- Less common – Muscle weakness, muscle cramps, abdominal cramps, convulsions, acne, confusion

> IMPORTANT: *Can be toxic when too much Lithium is in a person's system or sodium levels drop. Effects when one of these occurs: tremor, nausea, diarrhea, loss of coordination, confusion, and coma. Blood levels must be checked regularly by a physician.*

Summary

Most people take this medication without side effects. Therapy is long term (five years without a relapse). The patient is checked for blood levels and vital functions regularly.

E. Miscellaneous

NASAL DECONGESTANT SPRAYS

- Used for the relief of nasal congestion

Adverse Effects

- "Rebound congestion"
- Burning/stinging
- Sneezing

Examples:

- Dristan
- Neo-Synephrine
- Sinex

CAFFEINE

- Used as an aid in staying awake
- Found in several beverages like coffee, tea, colas, and cocoa

Adverse Effects of Caffeine

- Insomnia
- Excitement
- Increased Urination
- Nausea/Vomiting
- Nervousness
- Ringing in the ears
- Restlessness

The Aging Process

* Required

Enter your name (last name first; for example: Smith, John) *

Your answer

1. Depression in the elderly is under diagnosed and under treated. *

- True
- False

2. Medications prescribed for a medical problem may have an unintended effect on behavior. *

- True
- False

3. It is possible for bones to break spontaneously. *

- True
- False

4. Chronological age is an accurate indicator of an individual's feelings and abilities. *

- True
- False

5. There are a range of non-drug interventions and treatments that may be effective in meeting a resident's needs when behavioral symptoms occur. *

- True
- False

6. The possibility that a person will live in a nursing home increases with age until age 78 when it remains the same no matter how long the person lives. *

- ○ True
- ○ False

7. It is important to allow older people the extra seconds needed for their eyes to accommodate to changes in light or distance. *

- ○ True
- ○ False

8. Individuals who have some degree of hearing loss may not realize that they have a loss. *

- ○ True
- ○ False

9. One method of coping with change is through reminiscence. *

- ○ True
- ○ False

10. Intelligence declines with the normal aging process. *

- ○ True
- ○ False

11. "Once a man, twice a child," remains one of the great truths about the elderly. *

- ○ True
- ○ False

12. Sensitivity to smells decreases with aging. *

- ○ True
- ○ False

13. Sexual desire ceases in old age. *

- ○ True
- ○ False

14. Movement is not important for individuals who are confined to bed. *

- ○ True
- ○ False

15. Pressure sores are an unfortunate part of normal aging for frail, elderly persons. *

- ○ True
- ○ False

16. Physical restraints prevent falls and injuries for individuals who are confused or have balance problems. *

- ○ True
- ○ False

17. In spite of age related changes, individuals living in nursing homes are to be assisted in maintaining or improving their abilities unless a decline is unavoidable. *

- ○ True
- ○ False

18. Inactivity increases calcium depletion which may contribute to osteoporosis. *

- ○ True
- ○ False

19. Alzheimer's Disease affects areas of the brain that control long term memory first. *

- ○ True
- ○ False

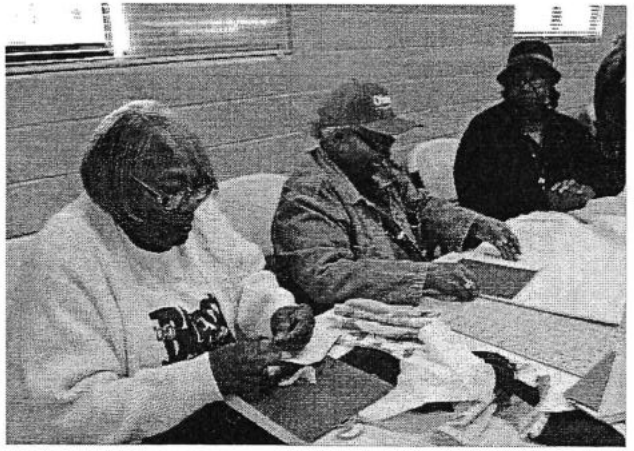
20. Incontinence is a normal part of aging. *

- ○ True
- ○ False

SUBMIT

Never submit passwords through Google Forms.

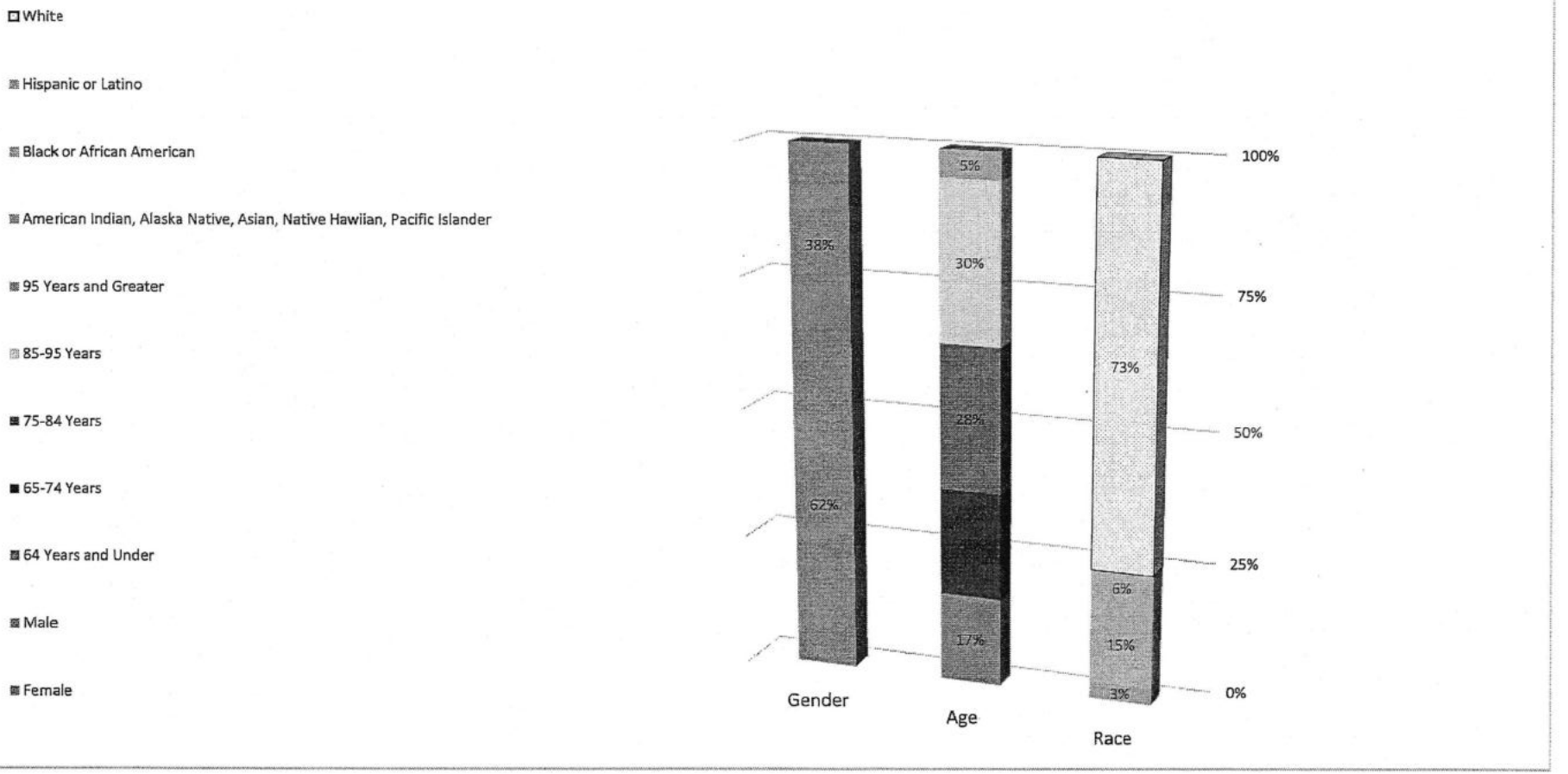
Who Lives in Nursing Facilities and Why?



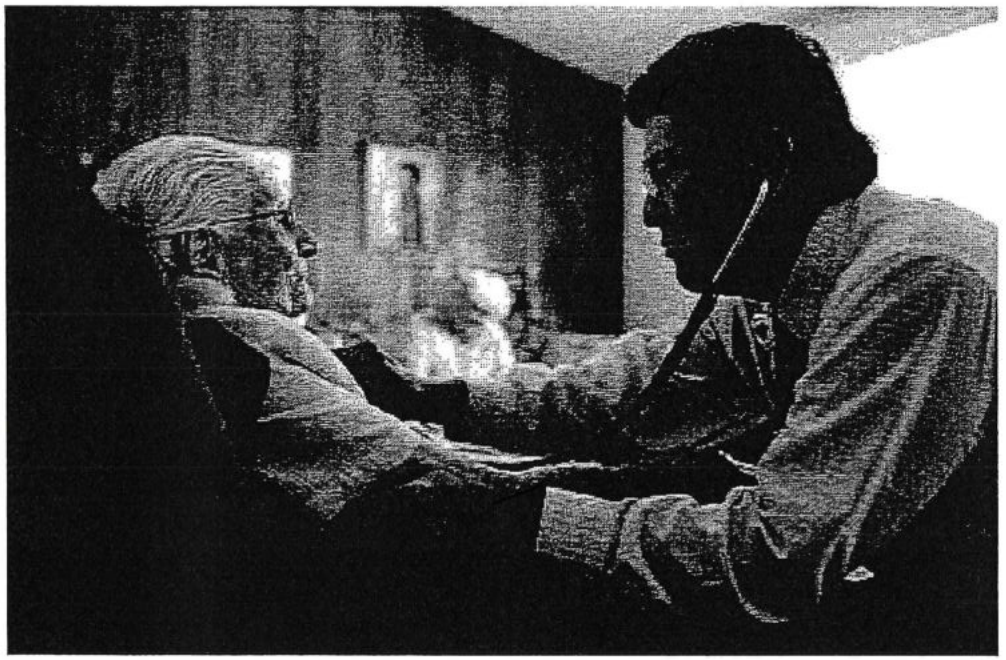
→ Where do persons with disabilities live?

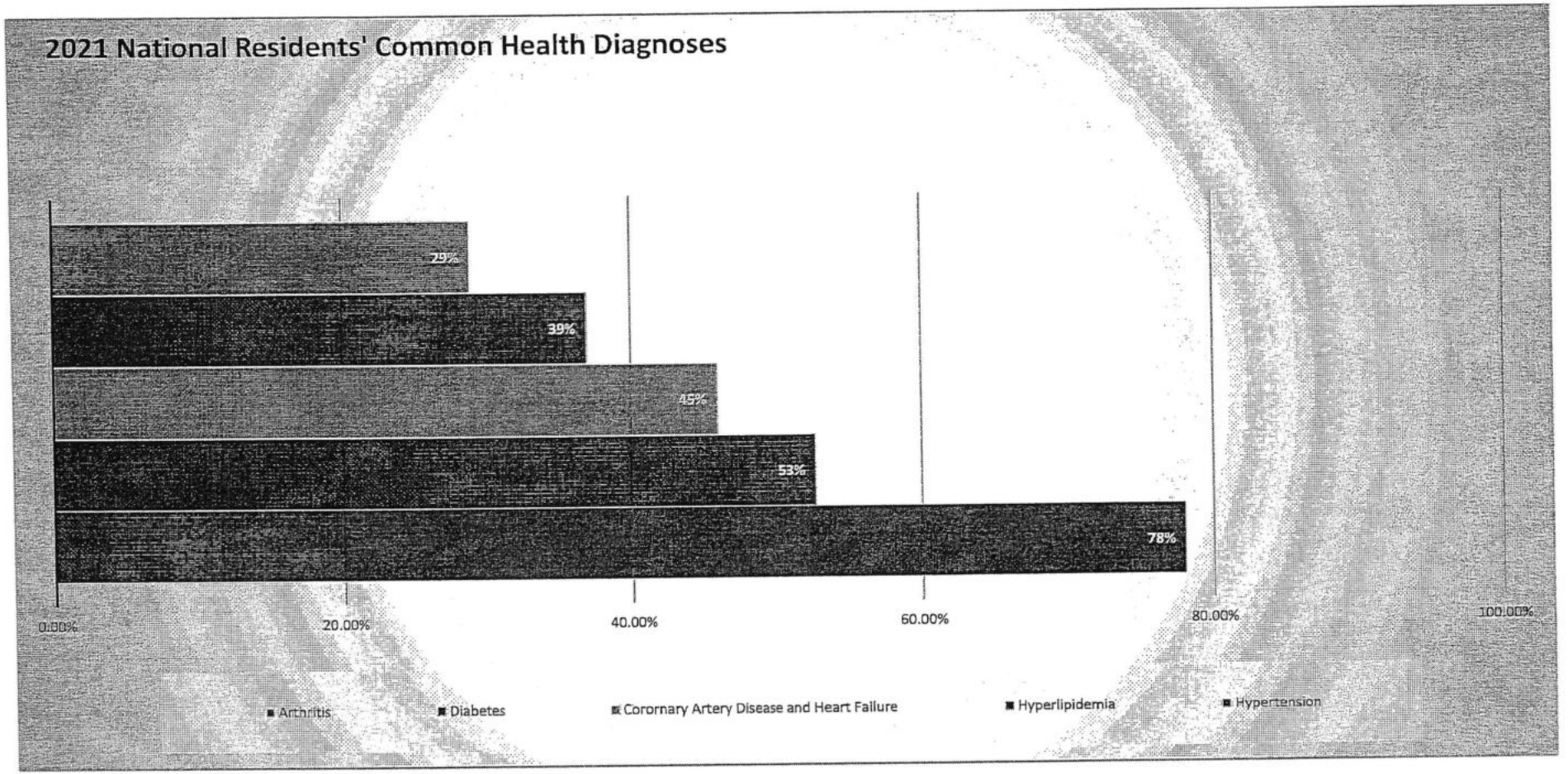
- With their families in the community
- Group homes
- Intermediate Care Facilities for the Intellectually Disabled (ICF/IID)
- Residential care communities (RCCs)
- Nursing facilities

2021 National Nursing Facility Population



Common Physical Diagnoses and Their Importance to the Ombudsman Program



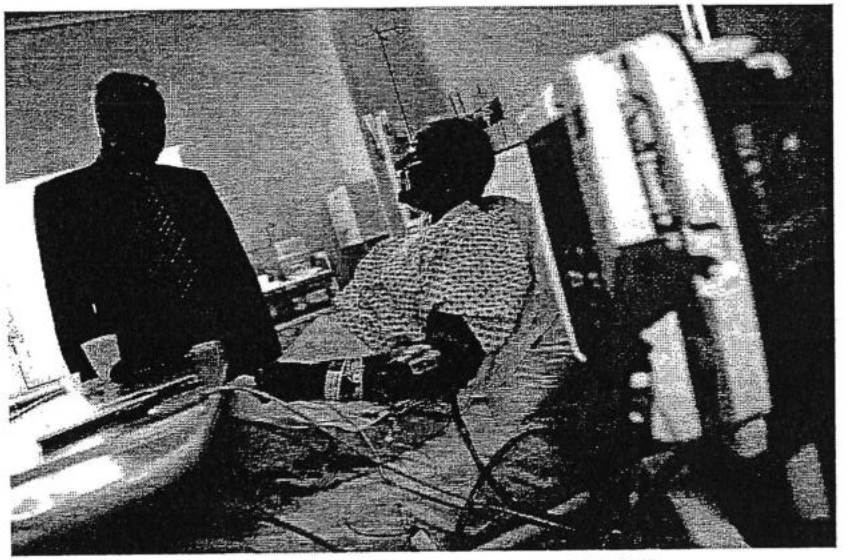

2021 National Residents' Common Health Diagnoses
29%
39%
45%
53%
78%
0.00%
20.00%
40.00%
60.00%
80.00%
100.00%
Arthritis
Diabetes
Coronary Artery Disease and Heart Failure
Hyperlipidemia
Hypertension

Hypertension

- Why is this important information for the LTCOP?
  - Residents may have concerns related to:
    - Medication
    - Diet
    - Exercise
    - Stress
  - Residents may want to go against doctor's orders and ask the LTCOP to advocate on their behalf.

Heart Disease & High Cholesterol

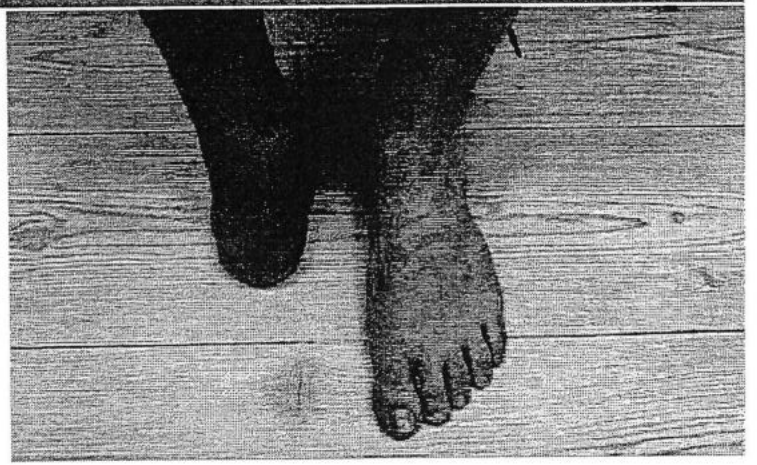
- Why is this important information for the LTCOP?
  - Residents may have concerns such as:
    - Fear
    - Anxiety
    - Medication distribution
    - Diet



Diabetes

- Type 1 diabetes occurs when the body does not make insulin.
- Type 2 diabetes is more common and occurs when the body does not make or use insulin well.
- The term “brittle diabetes” may be used to describe uncontrolled diabetes with drastic swings between too high or too low blood sugar.

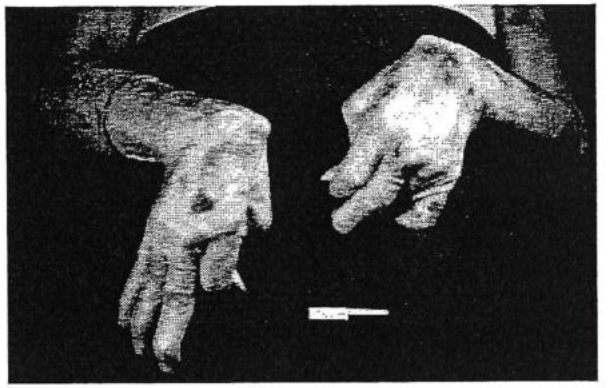
Diabetes



- Why is this important information for the LTCOP?
  - Residents may have concerns such as:
    - Uncontrolled blood sugar levels
    - Insulin not being checked per doctor's order
    - A diet served that is not appropriate for people with diabetes
    - The facility not allowing the resident's right to decline dietary restrictions set by the physician or the facility
    - Possible amputation

Arthritis

- Why is this important information for the LTCOP?
  - Residents may have concerns related to:
    - Pain
    - Quality of life
    - Anxiety
    - Depression



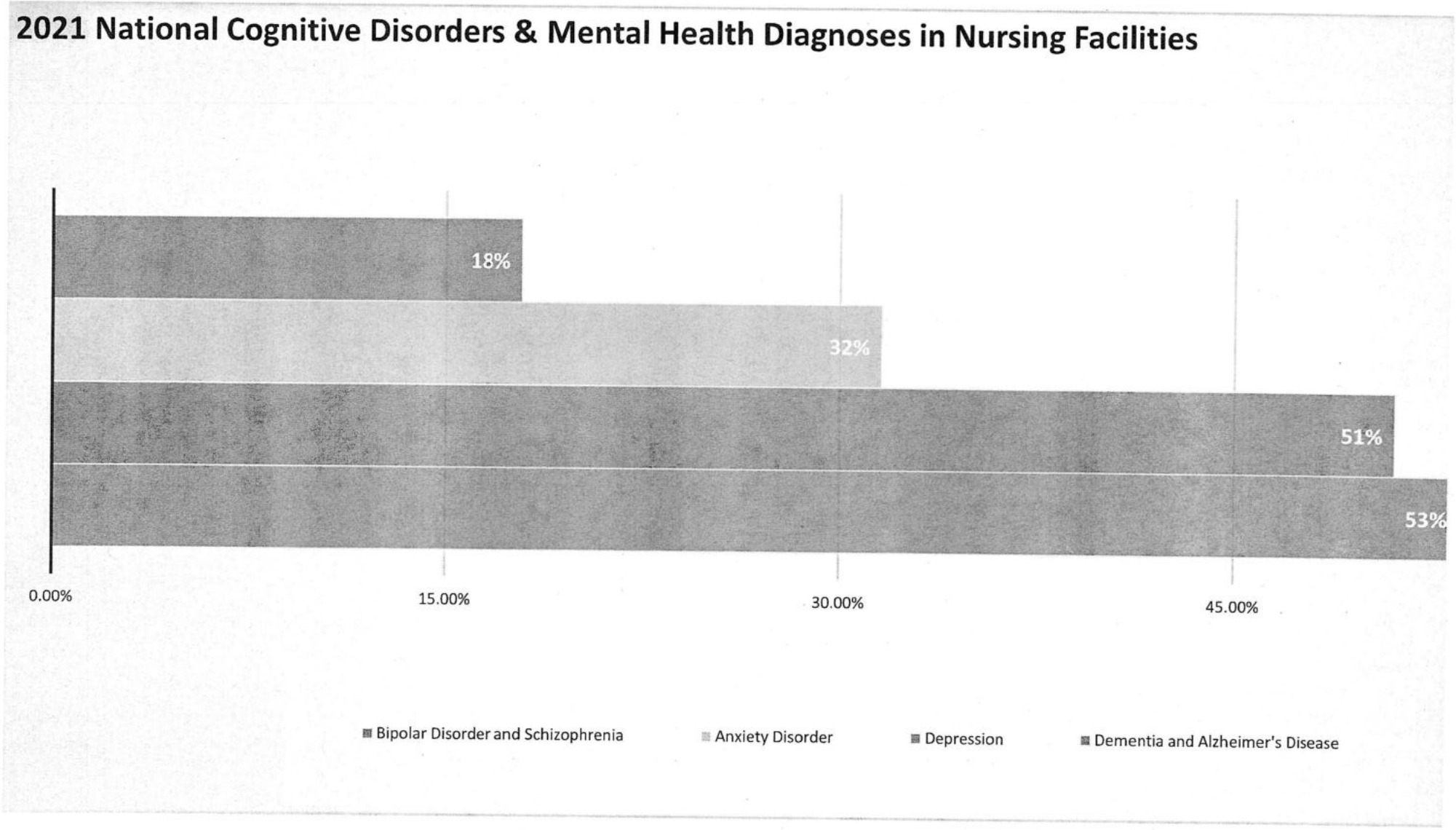
Cogn

Important:

The Ombudsman program does not serve as a source of medical advice or expertise (even if a representative has such expertise) but serves to represent resident concerns and ensure that the resident has access to medical information and their health care providers.

Serious Mental Illness (SMI)

- Why is this information important for the LTCOP?
  - Working with individuals who have a diagnosis of a serious mental illness may challenging due to barriers in communication
  - Facility staff are often not properly trained
  - Residents with SMI are at greater risk for facility-initiated discharge


2021 National Cognitive Disorders & Mental Health Diagnoses in Nursing Facilities
18%
32%
51%
53%
0.00%
15.00%
30.00%
45.00%
Bipolar Disorder and Schizophrenia
Anxiety Disorder
Depression
Dementia and Alzheimer's Disease

Bipolar Disorder

Causes dramatic shifts in a person's:

- Mood
- Energy
- Ability to think clearly

Individuals with this disorder experience extreme high and low mood as mania and depression.

Anxiety Disorders

Emotional Symptoms	Physical Symptom
Feelings of apprehension or dread	Pounding or racing heart and shortn of breath
Feeling tense or jumpy	Sweating, tremors and twitches
Restlessness or irritability	Headaches, fatigue and insomnia
Anticipating the worst and being watchful for signs of danger	Upset stomach, frequent urination o or diarrhea

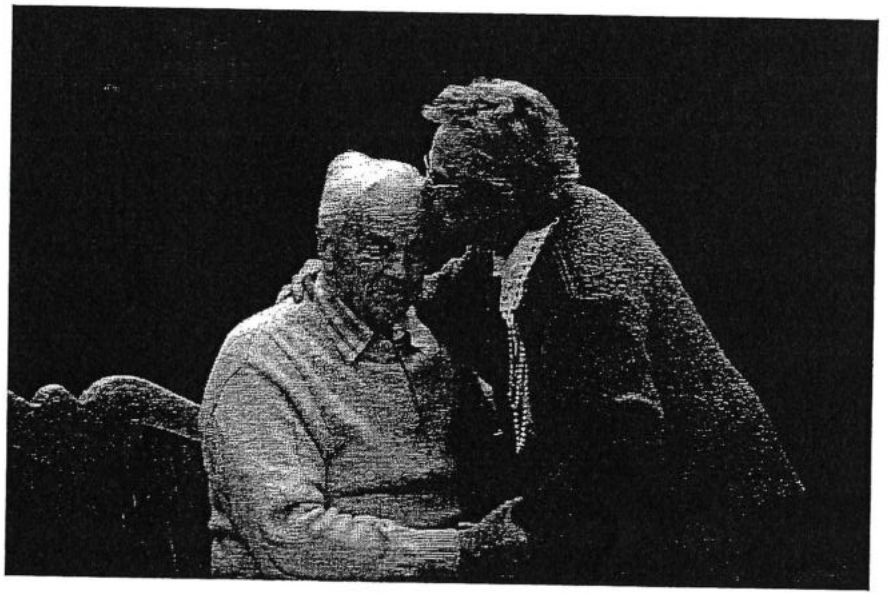
Major Depressive Disorder (MDD)

- One of the most common mental disorders

- Symptoms vary, but may include:
  - Sadness
  - Hopelessness
  - Anxiety
  - Pessimism
  - Irritability
  - Worthlessness
  - Fatigue

Dementia

- Decline in memory, reasoning or other thinking skills that interferes with daily life. Affects the ability to:
  - Communicate
  - Remember
  - Reason
  - Think



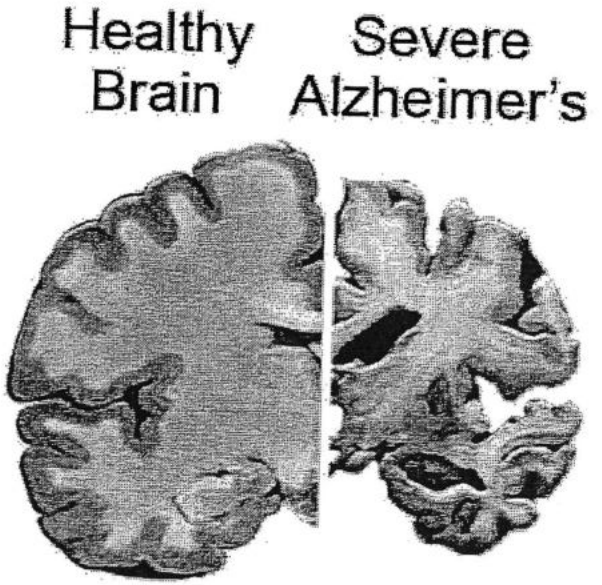
Dementia

- Why is this information important to the LTCOP?
  - Residents may have concerns about:
    - Anxiety
    - Medication
    - Others respecting their rights
    - Their care plan
  - Facilities and other residents may have concerns about:
    - Wandering
    - Combativeness
    - Anxiety

Alzheimer's Disease

- Memory loss
- Disorientation
- Confusion
- Behavior changes
- Weight loss
- Incontinence
- Delusions or hallucinations

- Difficulty:
  - Speaking
  - Eating or swallowing

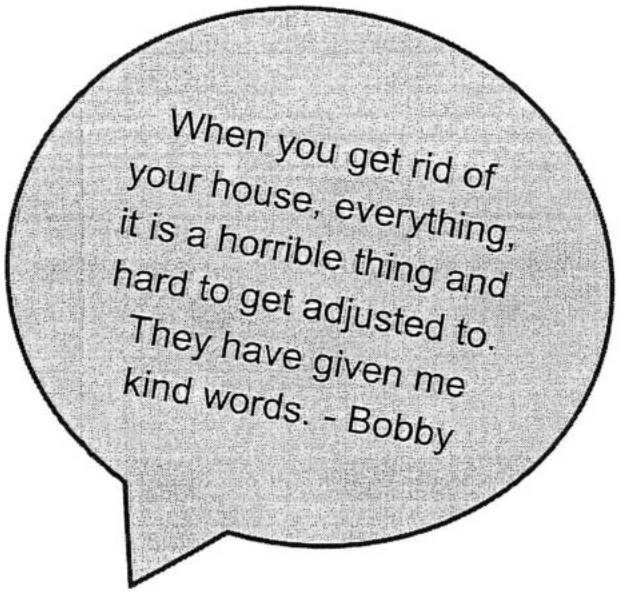


Why do People Stay in Long-Term Care?

- Nursing facilities:
  - The resident's health did not improve enough to go home
  - The resident does not have available supports and services in order to successfully live home alone
  - The resident does not have a home to go to

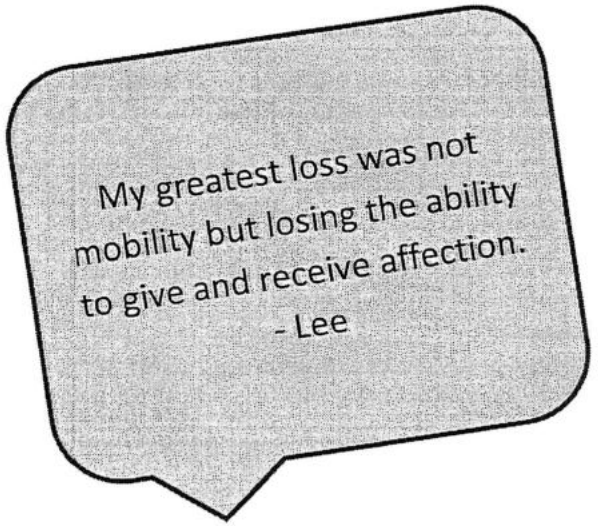
- RCCs
  - Their needs are being met
  - Socialization
  - Fills the gap between living independently and living in a nursing home

Experiences of Loss



Loss	New Circumstances	Possible Effects
Health	Coming to terms with managing a new or worsening illness and/or disability	Feeling anxiety, fear, frustration, anger, despair
Home	Removed (voluntarily or involuntarily) from a familiar home or setting to an unknown, unfamiliar place	Having a sense of uneasiness, anxiousness, uncomfortableness, confusion as to whereabouts
Family, Friends, Neighbors	Separated from loved ones with whom you lived or visited often - perhaps the resident's partner or caregiver passed away.	Feeling sad, lonely, forgotten, isolated, missing loved ones

Experiences of Loss



Loss	New Circumstances	Possible Effects
Freedom	Adjusting to new routines, scheduled activities, and the confines of the facility; understanding a new system with rules and guidelines	Feeling frustrated, angry, hopeless, loss of control over daily life; having no autonomy, feeling like a child again
Privacy	Sharing a room with a stranger, staff walking in and out, people asking personal questions, people washing and dressing you and taking you to the bathroom	Feeling humiliated, embarrassed, loss of dignity, frustration, anger
Personal Property	Loss of personal belongings with special meaning or memories	Feeling disconnected

2. Name some reasons people enter long-term care facilities.

3. Name some of the losses that residents may experience when they enter a long-term care facility and how those losses affect residents?

4. Name some of the common diagnoses and other health concerns of residents.

5. Why is it important for representatives to understand resident experiences?

II. WHY RESIDENTS NEED ADVOCACY

In any group situation differences of opinion and preference occur. In an institutional setting, certain methods of operation develop for convenience and efficiency, which may conflict with the needs of individual residents. Yet, residents may be unable to express their particular needs without assistance from others. Barriers to self-advocacy are manifold.

Individual Problems Which May Surface in Nursing Homes

- Loneliness - need of someone to talk with
- Boredom - not enough social or personal activities
- Problem with roommate(s)
- Lack of privacy
- Poor food service or quality
- Inability to get services, care or attention because of physical or communication problems
- Physical or drug restraints
- Use, accounting and safe keeping of personal funds and personal possessions
- Desire to go outside the facility for community activities
- Insufficient medical or nursing care
- No rehabilitative care
- Neglect
- Resident abused physically or mentally
- Loss of dignity and feeling of respect based on general treatment in facility
- Additional or high charges for "extra" services
- Transfer from one room to another without notice
- Transfer to another facility because of change from private pay to Medicaid

III. NURSING HOME RESIDENTS' RIGHTS

A. Purpose

The purpose of residents' rights is to safeguard and promote dignity, choice and self-determination of residents in nursing homes and to protect civil, personal and privacy rights, the right to information, rights related to health care, due process and life in the nursing home, transfer and discharge rights, the handling of personal finances and the right to be free from abuse and restraints.

B. Reasons Why Residents Do Not Routinely Exercise Their Rights

- Residents are intimidated by the idea of appearing in any way to criticize the nursing home.
- Most residents do not know that they have specified rights and do not know what their rights are in a nursing home.
- Even residents who are aware of their rights must choose their "battles" and often put up with daily violations of their individuality and dignity because; a) it requires too much strength to challenge each encounter; b) they are easily labeled troublemakers; c) they are dependent for their care on those very people and they are, therefore, hesitant to criticize, and often d) they experience a sense of defeatism.
- Residents' autonomy is undermined from the start by the very fact that most residents would rather not be in a nursing home; many did not have much of a role or choice in the decision to be there, and most have no other options.
- Residents face physical, emotional, psychological, social and mental disabilities that make it difficult for them to voice their concerns.

IV. EMPOWERMENT

Empower means to give power to another or to take it for oneself. The dictionary definition is "to give authority to, to authorize". This concept includes an advocate's conscious decision to enable a disadvantaged person or group to become capable of self-advocacy.

A. The Role of the Resident Advocate

As a Resident Advocate, you will be an advocate acting on behalf of residents. In some cases, you will be able to educate, support, and encourage residents to

engage in self-advocacy, to represent themselves. In other situations, you will be representing the resident(s). There is a basic complaint process, a problem solving process that Ombudsmen use to analyze and resolve problems.

Resident Advocates are in a unique position to empower residents to exercise their rights. They can help residents and facilities overcome the obstacles to the exercising of residents' rights by:

- Educating residents, facility personnel, and family members about residents' rights
- Encouraging residents to exercise their rights in very specific ways
- Supporting residents in the exercising of their rights
- Modeling/demonstrating a respect for residents' rights; and
- Maintaining a continuous awareness of, and sensitivity to, residents' rights

Resident Advocates can serve as a counterbalance to some of the barriers that inhibit the implementation of residents' rights. They have an obligation not only to provide information about residents' rights, but also to assist residents in exercising those rights: resident empowerment.

B. Resident Participation

The 1987 Nursing Home Reform Amendments (OBRA '87) provide the following to support resident self-determination:

FREE CHOICE: The right to choose a personal attending physician, to be fully informed in advance about care and treatment, to be fully informed in advance of any changes in care or treatment that may affect the resident's well-being, and (except with respect to a resident adjudged incompetent) to participate in planning care and treatment or changes in care and treatment.

ACCOMODATION OF NEEDS: The right to reside and receive services with reasonable accommodations of individual needs and preferences, except where the health or safety of the individual or other residents would be endangered. The right to receive notice before the room or roommate of the resident in the facility is changed.

GRIEVANCES: The right to voice grievances with respect to treatment or care that, is or fails to be, furnished, without discrimination or reprisal for voicing the grievances and the right to prompt efforts by the facility to resolve grievances the resident may have, including those with respect to the behavior of other residents.

PARTICIPATION IN RESIDENT AND FAMILY GROUPS: The right of the resident to organize and participate in residents groups in the facility and the right of the resident's family to meet in the facility with the families of other residents in the facility.

V. THE NURSING HOME REFORM ACT OF 1987

A. Provisions of the Law

The Nursing Home Reform Amendments of OBRA '87 require that nursing facilities "promote and protect the rights of each resident..." Several important provisions of the law set the stage for protection of these rights.

1. **Quality of Life:** The new law requires each nursing facility to "care for its residents in such a manner and in such an environment as will promote maintenance or enhancement of the quality of life of each resident". A new emphasis is placed on dignity, choice, and self-determination for nursing home residents.
2. **Provision of Services and Activities:** The new law requires each nursing facility to "provide services and activities to attain or maintain the highest practicable physical, mental and psychosocial well-being of each resident in accordance with a written plan of care which is initially prepared, with the participation to the extent practicable of the resident or the resident's family or legal representative."
3. **Participation in Facility Administration:** The new law makes "resident and advocate participation" a criteria for assessing a facility's compliance with administration requirements.
4. **Assuring Access to the Ombudsman Program:** The new law; (a) grants immediate access by Ombudsmen to residents and reasonable access, in accordance to state law, by the Ombudsmen to records; (b) requires facilities to inform residents how to contact Regional Ombudsman to voice complaints or in the event of a transfer or discharge from the facility; (c) requires state agencies to share inspection results with the Ombudsman Program.

Before the enactment of The Nursing Home Reform Act of '87, several residents' rights could be limited or denied because the resident's physician documented that the exercise of that right was "medically contra-indicated".

This provision gave the physician the power to restrict a resident's rights. The Nursing Home Reform Act of '87 removed this provision.

B. Specific Rights

Under the law (The Nursing Home Reform Act of '87), each nursing facility must "protect and promote the rights of each resident" including:

1. **Rights to self-determination:** Nursing home residents have the right:
   - To choose their personal physician;
   - To full information, in advance, and participation in planning and making any changes in their care and treatment;
   - To reside and receive services with reasonable accommodation by the facility of individual needs and preferences;
   - To voice grievances about care or treatment they do or do not receive without discrimination or reprisal, and to receive prompt response from the facility; and
   - To organize and participate in resident groups (and their families have the right to organize family groups) in the facility

2. **Personal and Privacy Rights:** Nursing home residents have the right:
   - To participate in social, religious, and community activities as they choose;
   - To privacy in medical treatment, accommodations, personal visits, written and telephone communications, and meetings of resident and family groups; and
   - To confidentiality of personal and clinical records.

3. **Rights Regarding Abuse and Restraints:** Residents have the right:
   - To be free from physical or mental abuse, corporal punishment, involuntary seclusion, or disciplinary use of restraints
   - To be free of restraints used for the convenience of staff rather than the well-being of residents;
   - To have restraints used only under written physician's orders to treat a resident's medical symptoms and ensure the resident's safety and the safety of others; and
   - To be given psychopharmacologic medication only as ordered by a physician as part of a written plan of care for a specific medical

symptom, with annual review for appropriateness by an independent, external expert.

4. **Rights to Information:** Nursing homes must:
   - Upon request provide residents with the latest inspection results and any plan of correction submitted by the facility
   - Notify residents in advance of any plans to change their room or roommate;
   - Inform residents of their rights upon admission and provide a written copy of the rights, including their rights regarding personal funds and their right to file a complaint with the state survey agency;
   - Inform residents in writing, at admission and throughout their stay, of the services available under the basic rate and any extra charges for extra services including, for Medicaid residents, a list of services covered by Medicaid and those for which there is an extra charge; and
   - Prominently display and provide written and oral information for residents about how to apply for and use Medicaid benefits and how to receive a refund for previous private payments that Medicaid will pay retroactively.

5. **Rights to Visits:** The nursing home must:
   - Permit immediate visits by a resident's personal physician and by representatives from the licensing agency and the Ombudsman Program;
   - Permit immediate visits by a resident's relatives, with the resident's consent;
   - Permit visits "subject to reasonable restriction" for others who visit with the resident's consent; and
   - Permit Ombudsmen to review resident's clinical records if a resident grants permission.

6. **Transfer and Discharge Rights:** Nursing homes "must permit each resident to remain in the facility and must not transfer or discharge the resident unless":
   - The transfer or discharge is necessary to meet the resident's welfare and the resident's needs which cannot be met by the facility;

- Resident's health has improved such that the resident no longer needs nursing home care;
- The health or safety of other residents is endangered; or
- The resident is more than 15 days in arrears of payment, when privately paying for care;
- The facility ceases to operate.
  - **Notice**: must be given to residents and their representatives before transfer:
  - **Timing:** at least 30 days in advance, or as soon as possible if more immediate changes in health require more immediate transfer:
  - **Content:** reason for transfer, the resident's right to appeal the transfer, and the name address and phone number of the ombudsman program and protection and advocacy programs for mentally ill and developmentally disabled; and
  - **Returning to the Facility:** the right to request that a resident's bed be held, including information about how many days Medicaid will pay for the bed to be held and the facility's bed-hold policies, and the right to return to the next available bed if Medicaid bed-holding coverage lapses.
  - **Orientation:** A facility must prepare and orient residents to ensure safe and orderly transfer or discharge from the facility.

7. **Protection of Personal Funds:** A nursing facility must:
   - Not require residents to deposit their personal funds with the facility; and
   - If it accepts written responsibility for resident's funds;
   - Keep funds over $50 in an interest bearing account, separate from the facility account;
   - Keep other funds available in a separate account or petty cash fund;
   - Keep a complete and separate accounting of each resident's funds, with a written record of all transactions, available for review by residents and their representatives;
   - Notify Medicaid residents when their balance comes within $200 of the Medicaid limit and the effect of this on their eligibility;

- Upon a resident's death, turn funds over to the resident's trustee;
- Purchase a surety bond to secure resident's funds in its keeping; and
- Do not charge a resident for any item or service covered by Medicaid, specifically including routine personal hygiene items and services.

8. **Protection Against Medicaid Discrimination:** Nursing homes must:
   - Establish and maintain identical policies and practices regarding transfer, discharge and the provision of services required under Medicaid for all individuals regardless of source of payment;
   - Not require residents to waive their rights to Medicaid, and must provide information about how to apply for Medicaid;
   - Not require a third party to guarantee payment as a condition of admission or continued stay; and
   - Not "charge, solicit, accept or receive" gifts, money, donations, or "other consideration" as a precondition for admission or for continued stay for persons eligible for Medicaid.

RESIDENTS' RIGHTS PERTAINING TO FEAR OF RETALIATION

&

THE BEST PRACTICES THAT SUPPORT THEM

Resident Rights	Best Practices that Support Resident Rights
The resident has a right to a dignified existence, self determination, and communication with and access to persons and services inside and outside the facility. A facility must protect the rights of each resident	• Facilities are encouraged to have discussions of resident rights more frequently. • Have your roommate advocate for you. • A designated resident on each wing to advocate at the Resident council meeting on their behalf. • Review a section of the Residents Rights each month in the resident council meeting and conduct a Q & A.
The resident has the right to exercise his or her rights as a resident of the facility and as a citizen or resident of the United States.	• The Registrar of voters [Democrat, Republican & Independent] assists this process by coming in to assist one-on-one with our residents who need help filling out the absentee ballot. • The Residents watch the elections on TV and it is discussed the next day at a coffee/newspaper hour. • Facility will educate residents on admission of rights within the facility. Residents will also be provided with opportunities to participate in current events through discussions, newspapers, internet access, voting, and correspondence as a citizen of the United States.
The resident has the right to be free of interference, coercion, discrimination, and reprisal from the facility in exercising his or her rights.	• If staff members are present at the resident council meeting, the residents have the right to ask the staff members to step out of the meeting in order for them to meet privately.

Resident Rights	Best Practices that Support Resident Rights
The resident or his or her legal representative has the right upon an oral or written request, to access all records pertaining to himself or herself including current clinical records within 24 hours excluding weekends and holidays; and after receipt of his or her records for inspection, to purchase at a cost not to exceed the community standard photocopies of the records or any portions of them upon request and 2 working days advance notice to the facility.	• Include the residents COP & COE if applicable. • Rate is not to exceed the going rate of .65 per page or free to residents who qualify for Medicaid - Title 19.
The resident has the right to be fully informed in language that he or she can understand of his or her total health status, including but not limited to, his or her medical condition.	• Residents Rights are available in English & Spanish, are posted on the bulletin boards in the hallways and are available in the resident council minutes to any resident. If the resident speaks in another language interpreters are used, including the Language Bank. • *Web site also available: www.babelfish.yahoo.com and www.translate.google.com*
The resident has the right to be fully informed in advance about care and treatment and of any changes in that care or treatment that may affect the resident's well being.	• Care plan meetings, when appropriate should be arranged at the bedside of the resident for their inclusion, with the full team. • Offer information in advance to residents and family members on frequent Q. & A. • Have the C.N.A. present • Whole team needs to be present; nurse, S.W., T.R.D., C.N.A., Dietician, P.T., O.T., S.T., MDS coordinator. • Offer phone conference for families unable to be present with the whole team; or offer alternate time for the whole team to meet with family & resident. • Written notice should be given to residents as well as reminding them the morning of the meeting. • Ambassador [staff member] to guard and assist with concerns or issues during the residents stay. • Copy of the care plan given to the resident or their responsible party member.

Resident Rights	Best Practices that Support Resident Rights
The resident has the right to refuse treatments, to refuse to participate in experimental research, and to formulate an advance directive. The facility must inform the resident both orally and in writing in a language that the resident understands of his or her rights and all rules and regulations governing resident conduct and responsibilities during their stay in the facility.	• Advanced Directives and consents are explained and signed upon admission. • Don't start the conversation with Advanced Directives but instead offer the resident and family time to make choices and to be fully informed of medical outcomes. • Residents Rights are available in English & Spanish, are posted on the bulletin boards in the hallways and are available in the resident council minutes to any resident. If the resident speaks in another language interpreters are used, including the Language Bank. • Residents should have access to a communication board
The resident has the right to voice grievances without discrimination or reprisal.	• Facilities are encouraged to adopt policies regarding fear of retaliation, including a "no tolerance" policy. • Form an internal committee to provide meaningful and an interactive in-service to staff and residents specific to this issue.
The resident has the right to prompt efforts by the facility to resolve grievances the resident may have, including those with respect to the behaviors of other residents.	• Contact trusted staff members, ombudsman, resident council president, etc. to voice your concerns anonymously. • Establish a "concerns box" so residents can submit a concern anonymously. Facilities should check this box on a regular basis to address the concerns. • All management including upper management and the administrator can be invited as needed to resident council meetings so residents can voice concerns.
The resident has the right to refuse to perform services for the facility.	• Residents will be educated on their rights pertaining to freedom of choice on admission and semi-annually thereafter. Residents who perform services for the facility are acknowledged through their care plan.

Resident Rights	Best Practices that Support Resident Rights
The resident has the right to have reasonable access to the use of a telephone where calls can be made without being overheard.	• Cordless phones are available on each resident's unit. If the resident wants to make a private call the Social Services Office phone may be used which is located in a secluded office.

Note: These rights cannot be violated by a conservator unless the conservator is given specific written authority to do so after a hearing in the Probate Court conducted according to the conservatorship statute.

This product was developed by the Fear of Retaliation Committee Members Membership included residents, the Connecticut Long Term Care Ombudsman and individuals from public agencies and industries affiliated with long term care.
2010

Resident Experiences

Video: Voices Speak out Against Retaliation

1. What reasons are given for not reporting poor treatment or problems within the facility?

2. What concerns or fears are brought up by the residents?

3. What examples of retaliation did you hear from the video?

4. What examples to overcome the fear of retaliation are discussed in the video?

The National CONSUMER VOICE for Quality Long-Term Care formerly NCCNHR

FACT SHEET

RESIDENTS' RIGHTS: AN OVERVIEW

Residents' Rights are guaranteed by the federal 1987 Nursing Home Reform Law. The law requires nursing homes to "promote and protect the rights of each resident" and places a strong emphasis on individual dignity and self-determination. Nursing homes must meet federal residents' rights requirements if they participate in Medicare or Medicaid. Some states have residents' rights in state law or regulation for nursing homes, licensed assisted living, adult care homes, and other board and care facilities. A person living in a long-term care facility maintains the same rights as an individual in the larger community.

RESIDENTS' RIGHTS GUARANTEE QUALITY OF LIFE

The 1987 Nursing Home Reform Law requires each nursing home to care for its residents in a manner that promotes and enhances the quality of life of each resident, ensuring ***dignity, choice, and self-determination.***

All nursing homes are required "to provide services and activities to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident in accordance with a written plan of care that… is initially prepared, with participation, to the extent practicable, of the resident, the resident's family, or legal representative." ***This means a resident should not decline in health or well-being as a result of the way a nursing facility provides care on a regular basis.***

The 1987 Nursing Home Reform Law protects the following rights of nursing home residents:

The Right to Be Fully Informed of

- Available services and the charges for each service
- Facility rules and regulations, including a written copy of resident rights
- Address and telephone number of the State Ombudsman and state survey agency
- State survey reports and the nursing home's plan of correction
- Advance plans of a change in rooms or roommates
- Assistance if a sensory impairment exists
- Residents have a right to receive information in a language they understand (Spanish, Braille, etc.)

Right to Complain

- Present grievances to staff or any other person without fear of reprisal and with prompt efforts by the facility to resolve those grievances
- To complain to the ombudsman program
- To file a complaint with the state survey and certification agency

Right to Participate in One's Own Care

- Receive adequate and appropriate care
- Be informed of all changes in medical condition
- Participate in their own assessment, care planning, treatment, and discharge
- Refuse medication and treatment
- Refuse chemical and physical restraints
- Review one's medical record
- Be free from charge for services covered by Medicaid or Medicare

Right to Privacy and Confidentiality

- Private and unrestricted communication with a person of their choice
- During treatment and care of one's personal needs
- Regarding medical, personal, or financial affairs

Rights During Transfers and Discharges

- Remain in the nursing facility unless a transfer or discharge:
    - is necessary to meet the resident's welfare;
    - is appropriate because the resident's health has improved and s/he no longer requires nursing home care;
    - is needed to protect the health and safety of other residents or staff;
    - is required because the resident has failed, after reasonable notice, to pay the facility charge for an item or service provided at the resident's request

- Receive thirty-day notice of transfer or discharge which includes the reason, effective date, location to which the resident is transferred or discharged, the right to appeal, and the name, address, and telephone number of the state long-term care ombudsman
- Safe transfer or discharge through sufficient preparation by the nursing home

Right to Dignity, Respect, and Freedom

- To be treated with consideration, respect, and dignity
- To be free from mental and physical abuse, corporal punishment, involuntary seclusion, and physical and chemical restraints
- To self-determination
- Security of possessions

Right to Visits

- By a resident's personal physician and representatives from the state survey agency and ombudsman programs
- By relatives, friends, and others of the residents' choosing
- By organizations or individuals providing health, social, legal, or other services
- Residents have the right to refuse visitors

Right to Make Independent Choices

- Make personal decisions, such as what to wear and how to spend free time
- Reasonable accommodation of one's needs and preferences
- Choose a physician
- Participate in community activities, both inside and outside the nursing home
- Organize and participate in a Resident Council
- Manage one's own financial affairs

Advocates for Residents Rights

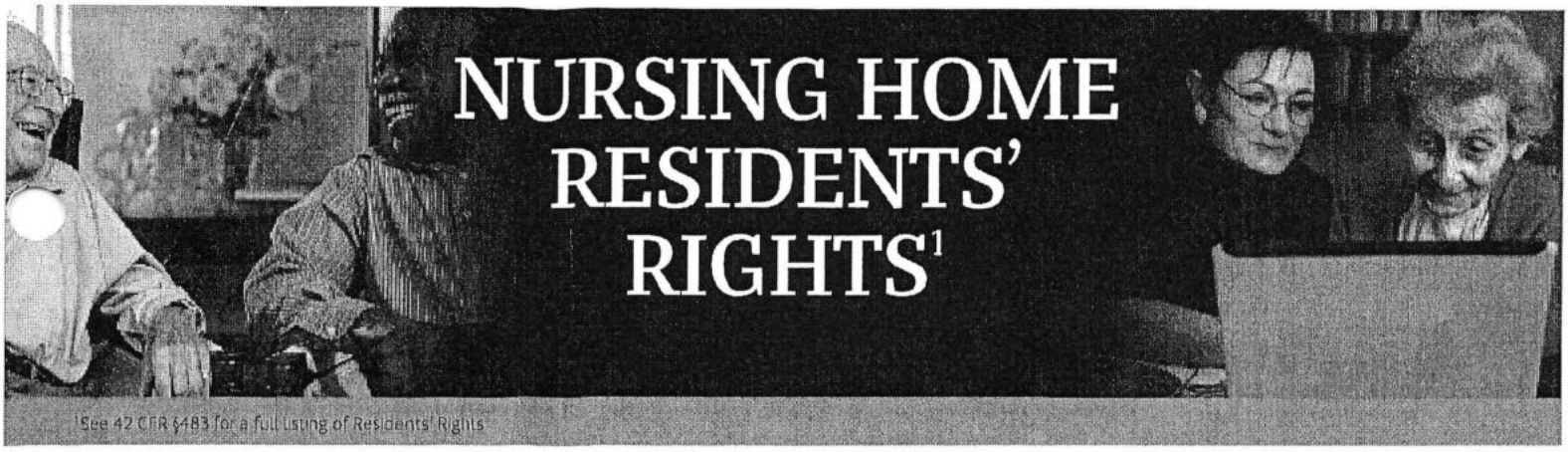
Where do you go for help if you're concerned a facility is not guaranteeing the rights of residents? Contact your local or state long-term care ombudsman or, if one exists, your state's citizen advocacy group. The Long-Term Care Ombudsman Program is required by federal law to promote and protect the rights of residents in licensed long-term care facilities. The Consumer Voice can help you locate advocates and ombudsmen in your area. Visit our website:

www.theconsumervoice.org to view a map listing ombudsmen and citizen advocacy groups nationwide.

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.

Tel. 202. 332.2275, email: info@theconsumervoice.org, website: www.theconsumervoice.org



NURSING HOME RESIDENTS' RIGHTS[1]

[1] See 42 CFR §483 for a full listing of Residents' Rights

Residents of nursing homes have rights that are guaranteed by the federal Nursing Home Reform Law. The law requires nursing homes to "promote and protect the rights of each resident" and stresses individual dignity and self-determination. Many states also include residents' rights in state law or regulation.

Right to a Dignified Existence

- Be treated with consideration, respect, and dignity, recognizing each resident's individuality
- Freedom from abuse, neglect, exploitation, and misappropriation of property
- Freedom from physical or chemical restraints
- Quality of life is maintained or improved
- Exercise rights without interference, coercion, discrimination, or reprisal
- A homelike environment, and use of personal belongings when possible
- Equal access to quality care
- Security of possessions

Right to Self-Determination

- Choice of activities, schedules, health care, and providers, including attending physician
- Reasonable accommodation of needs and preferences
- Participate in developing and implementing a person-centered plan of care that incorporates personal and cultural preferences
- Choice about designating a representative to exercise his or her rights
- Organize and participate in resident and family groups
- Request, refuse, and/or discontinue treatment

Right to be Fully Informed of

- The type of care to be provided, and risks and benefits of proposed treatments
- Changes to the plan of care, or in medical or health status
- Rules and regulations, including a written copy of residents' rights
- Contact information for the long-term care ombudsman program and the state survey agency
- State survey reports and the nursing facility's plan of correction
- Written notice before a change in room or roommate
- Notices and information in a language or manner he or she understands (Spanish, Braille, etc.)

Right to Raise Grievances

- Present grievances without discrimination or retaliation, or the fear of it
- Prompt efforts by the facility to resolve grievances, and provide a written decision upon request
- To file a complaint with the long-term care ombudsman program or the state survey agency

Right of Access to

- Individuals, services, community members, and activities inside and outside the facility
- Visitors of his or her choosing, at any time, and the right to refuse visitors
- Personal and medical records
- His or her personal physician and representatives from the state survey agency and long-term care ombudsman program
- Assistance if sensory impairments exist
- Participate in social, religious, and community activities

Rights Regarding Financial Affairs

- Manage his or her financial affairs
- Information about available services and the charges for each service
- Personal funds of more than $100 ($50 for residents whose care is funded by Medicaid) deposited by the facility in a separate interest-bearing account, and financial statements quarterly or upon request
- Not be charged for services covered by Medicaid or Medicare

Right to Privacy

- Regarding personal, financial, and medical affairs
- Private and unrestricted communication with any person of their choice
- During treatment and care of personal needs

Rights During Discharge/Transfer

- Right to appeal the proposed transfer or discharge and not be discharged while an appeal is pending
- Receive 30-day written notice of discharge or transfer that includes: the reason; the effective date; the location going to; appeal rights and process for filing an appeal; and the name and contact information for the long-term care ombudsman
- Preparation and orientation to ensure safe and orderly transfer or discharge
- Notice of the right to return to the facility after hospitalization or therapeutic leave

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GET HELP

The National CONSUMER VOICE for Quality Long-Term Care formerly NCCNHR

For more information about Residents' Rights, or questions or concerns, contact your Long-Term Care Ombudsman Program. The Long-Term Care Ombudsman Program promotes and protects the rights of residents in licensed long-term care facilities. Visit **www.theconsumervoice.org** for more information.

1001 Connecticut Ave, NW, Suite 632, Washington, DC 20036 ■ 202-332-2275
info@theconsumervoice.org ■ www.theconsumervoice.org

The Ombudsman Program Under The Older Americans Act

The 1978 Amendments to the Older Americans Act, passed in October 1978, considerably strengthened the Ombudsman Program. Title III, Section 307(a)(12) required all state agencies on aging to establish an Ombudsman program that would carry out the following activities:

- Investigate and resolve long term care facility residents' complaints;
- Promote the development of citizens' organizations and train volunteers;
- Identify significant problems by establishing a statewide reporting system for complaints, and work to resolve these problems by bringing them to the attention of appropriate public agencies;
- Monitor the development and implementation of federal, state, and local long term care laws and policies;
- Gain access to long term care facilities and to residents' records;
- Protect the confidentiality of residents' records, complainants' identities, and Ombudsman files.

These regulatory provisions set the framework for development of State programs that encompassed both the sub-state program focus of the early nationwide program and the complaint investigation focus of the demonstration projects. Thus, States were able to build on their early Ombudsman initiatives as they began implementing the legislative requirements. Many States developed and worked for enactment of State Ombudsman legislation. Such legislation is sometimes necessary to comply with the requirement in the Act to secure access to facilities and to residents' records.

The 1981 reauthorization of the Older Americans Act resulted in a further expansion of Ombudsman duties. In addition to nursing homes, board and care homes were included in the Ombudsman realm of responsibilities. The name was changed from Nursing Home Ombudsman Program to Long Term Care Ombudsman Program(LTCOP) to reflect this change. Other duties remained substantially the same.

No major changes were made to the LTCOP's duties in the 1984 reauthorization of the OAA.

The 1987 Amendments to the OAA made substantial changes related to the Long Term Care Ombudsman Program resulting in a significant improvement in the ability of program to advocate on behalf of residents of Long Term Care facilities. The changes required States to provide for:

- Ombudsman access to residents and residents' records.
- Immunity to Ombudsman for the good faith performance of their duties.
- Prohibitions against willful interference with the official duties of an Ombudsman and/ or retaliation against an Ombudsman, resident, or other individual for assisting the Ombudsman program in the performance of their duties.

The 1992 reauthorization made other changes to the OAA and to the Long Term Care Ombudsman Program. These changes included:

- The establishment of the Office of Long Term Care Ombudsman Programs in the Administration on Aging;
- The Office to be headed by an Associate Commissioner for the Ombudsman Programs.

During 2000, the Older Americans Act was re-authorized, with no changes made to the Titles pertaining to the Long Term Care Ombudsman Program.

During January of 2001, a final report prepared by the Administration on Aging evaluating the Long Term Care Ombudsman Program was released. "Residents of nursing homes, board and care homes, and adult care facilities and their families have strong advocates in the nation's long-term care ombudsmen", according to the report. The evaluation confirms that Ombudsman Programs under the Older Americans Act are empowering long-term care residents and their families to be informed long-term care consumers and to facilitating the resolution of problems regarding care and conditions in long-term care facilities.

In Connecticut, PUBLIC ACT 99-176 further strengthens the independence and mandate of the Office of the State Long Term Care Ombudsman.

residents of a nursing home facility;

(3) "Transfer trauma" means the medical and psychological reactions to physical transfer that increase the risk of death, or grave illness, or both, in elderly persons; and

(4) "Substantial violation" means a violation of law which presents a reasonable likelihood of serious physical or mental harm to residents of a nursing home facility.

Sec. 19a-550. (Formerly Sec. 19-622). Patients' bill of rights. (a)(1) As used in this section, (A) "nursing home facility" shall have the same meaning as provided in section 19a-521, and (B) "chronic disease hospital" means a long-term hospital having facilities, medical staff and all necessary personnel for the diagnosis, care and treatment of chronic diseases; and (2) for the purposes of subsections (c) and (d) of this section, and subsection (b) of section 19a-537, "medically contraindicated" means a comprehensive evaluation of the impact of a potential room transfer on the patient's physical, mental and psychosocial well-being, which determines that the transfer would cause new symptoms or exacerbate present symptoms beyond a reasonable adjustment period resulting in a prolonged or significant negative outcome that could not be ameliorated through care plan intervention, as documented by a physician in a patient's medical record.

(b) There is established a patients' bill of rights for any person admitted as a patient to any nursing home facility or chronic disease hospital. The patients' bill of rights shall be implemented in accordance with the provisions of Sections 1919(b), 1919(c), 1919(c)(2), 1919(c)(2)(D) and 1919(c)(2)(E) of the Social Security Act. The patients' bill of rights shall provide that each such patient: (1) Is fully informed, as evidenced by the patient's written acknowledgment, prior to or at the time of admission and during the patient's stay, of the rights set forth in this section and of all rules and regulations governing patient conduct and responsibilities; (2) is fully informed, prior to or at the time of admission and during the patient's stay, of services available in the facility, and of related charges including any charges for services not covered under Titles XVIII or XIX of the Social Security Act, or not covered by basic per diem rate; (3) is entitled to choose the patient's own physician and is fully informed, by a physician, of the patient's medical condition unless medically contraindicated, as documented by the physician in the patient's medical record, and is afforded the opportunity to participate in the planning of the patient's medical treatment and to refuse to participate in experimental research; (4) in a residential care home or a chronic disease hospital is transferred from one room to another within the facility only for medical reasons, or for the patient's welfare or that of other patients, as documented in the patient's medical record and such record shall include documentation of action taken to minimize any disruptive effects of such transfer, except a patient who is a Medicaid recipient may be transferred from a private room to a nonprivate room, provided no patient may be involuntarily transferred from one room to another within the facility if (A) it is medically established that the move will subject the patient to a reasonable likelihood of serious physical injury or harm, or (B) the patient has a prior established medical history of psychiatric problems and there is psychiatric testimony that as a consequence of the proposed move there will be exacerbation of the psychiatric problem which would last over a significant period of time and require psychiatric intervention; and in the case of an involuntary transfer

from one room to another within the facility, the patient and, if known, the patient's legally liable relative, guardian or conservator or a person designated by the patient in accordance with section 1-56r, is given at least thirty days' and no more than sixty days' written notice to ensure orderly transfer from one room to another within the facility, except where the health, safety or welfare of other patients is endangered or where immediate transfer from one room to another within the facility is necessitated by urgent medical need of the patient or where a patient has resided in the facility for less than thirty days, in which case notice shall be given as many days before the transfer as practicable; (5) is encouraged and assisted, throughout the patient's period of stay, to exercise the patient's rights as a patient and as a citizen, and to this end, has the right to be fully informed about patients' rights by state or federally funded patient advocacy programs, and may voice grievances and recommend changes in policies and services to facility staff or to outside representatives of the patient's choice, free from restraint, interference, coercion, discrimination or reprisal; (6) shall have prompt efforts made by the facility to resolve grievances the patient may have, including those with respect to the behavior of other patients; (7) may manage the patient's personal financial affairs, and is given a quarterly accounting of financial transactions made on the patient's behalf; (8) is free from mental and physical abuse, corporal punishment, involuntary seclusion and any physical or chemical restraints imposed for purposes of discipline or convenience and not required to treat the patient's medical symptoms. Physical or chemical restraints may be imposed only to ensure the physical safety of the patient or other patients and only upon the written order of a physician that specifies the type of restraint and the duration and circumstances under which the restraints are to be used, except in emergencies until a specific order can be obtained; (9) is assured confidential treatment of the patient's personal and medical records, and may approve or refuse their release to any individual outside the facility, except in case of the patient's transfer to another health care institution or as required by law or third-party payment contract; (10) receives quality care and services with reasonable accommodation of individual needs and preferences, except where the health or safety of the individual would be endangered, and is treated with consideration, respect, and full recognition of the patient's dignity and individuality, including privacy in treatment and in care for the patient's personal needs; (11) is not required to perform services for the facility that are not included for therapeutic purposes in the patient's plan of care; (12) may associate and communicate privately with persons of the patient's choice, including other patients, send and receive the patient's personal mail unopened and make and receive telephone calls privately, unless medically contraindicated, as documented by the patient's physician in the patient's medical record, and receives adequate notice before the patient's room or roommate in the facility is changed; (13) is entitled to organize and participate in patient groups in the facility and to participate in social, religious and community activities that do not interfere with the rights of other patients, unless medically contraindicated, as documented by the patient's physician in the patient's medical records; (14) may retain and use the patient's personal clothing and possessions unless to do so would infringe upon rights of other patients or unless medically contraindicated, as documented by the patient's physician in the patient's medical record; (15) is assured privacy for visits by the patient's spouse or a person designated by the patient in accordance with section 1-56r and, if the patient is married and both the patient and the patient's spouse are inpatients in the facility, they are permitted to share a room, unless medically contraindicated, as documented by the attending physician in the medical record; (16) is fully informed of the availability of and may examine all current state, local and federal inspection reports and plans of correction; (17) may organize, maintain and participate in a patient-run resident council, as a means of fostering communication

among residents and between residents and staff, encouraging resident independence and addressing the basic rights of nursing home and chronic disease hospital patients and residents, free from administrative interference or reprisal; (18) is entitled to the opinion of two physicians concerning the need for surgery, except in an emergency situation, prior to such surgery being performed; (19) is entitled to have the patient's family or a person designated by the patient in accordance with section 1-56r meet in the facility with the families of other patients in the facility to the extent the facility has existing meeting space available which meets applicable building and fire codes; (20) is entitled to file a complaint with the Department of Social Services and the Department of Public Health regarding patient abuse, neglect or misappropriation of patient property; (21) is entitled to have psychopharmacologic drugs administered only on orders of a physician and only as part of a written plan of care developed in accordance with Section 1919(b)(2) of the Social Security Act and designed to eliminate or modify the symptoms for which the drugs are prescribed and only if, at least annually, an independent external consultant reviews the appropriateness of the drug plan; (22) is entitled to be transferred or discharged from the facility only pursuant to section 19a-535 or section 19a-535b, as applicable; (23) is entitled to be treated equally with other patients with regard to transfer, discharge and the provision of all services regardless of the source of payment; (24) shall not be required to waive any rights to benefits under Medicare or Medicaid or to give oral or written assurance that the patient is not eligible for, or will not apply for benefits under Medicare or Medicaid; (25) is entitled to be provided information by the facility as to how to apply for Medicare or Medicaid benefits and how to receive refunds for previous payments covered by such benefits; (26) on or after October 1, 1990, shall not be required to give a third party guarantee of payment to the facility as a condition of admission to, or continued stay in, the facility; (27) in the case of an individual who is entitled to medical assistance, is entitled to have the facility not charge, solicit, accept or receive, in addition to any amount otherwise required to be paid under Medicaid, any gift, money, donation or other consideration as a precondition of admission or expediting the admission of the individual to the facility or as a requirement for the individual's continued stay in the facility; and (28) shall not be required to deposit the patient's personal funds in the facility.

(c) The patients' bill of rights shall provide that a patient in a rest home with nursing supervision or a chronic and convalescent nursing home may be transferred from one room to another within a facility only for the purpose of promoting the patient's well-being, except as provided pursuant to subparagraph (C) or (D) of this subsection or subsection (d) of this section. Whenever a patient is to be transferred, the facility shall effect the transfer with the least disruption to the patient and shall assess, monitor and adjust care as needed subsequent to the transfer in accordance with subdivision (10) of subsection (b) of this section. When a transfer is initiated by the facility and the patient does not consent to the transfer, the facility shall establish a consultative process that includes the participation of the attending physician, a registered nurse with responsibility for the patient and other appropriate staff in disciplines as determined by the patient's needs, and the participation of the patient, the patient's family, a person designated by the patient in accordance with section 1-56r or other representative. The consultative process shall determine: (1) What caused consideration of the transfer; (2) whether the cause can be removed; and (3) if not, whether the facility has attempted alternatives to transfer. The patient shall be informed of the risks and benefits of the transfer and of any alternatives. If subsequent to the completion of the consultative process a patient still does not wish to be transferred, the

Person-Centered Care Based in Law

- Nursing Home Reform Act (OBRA) Omnibus Budget Reconciliation Act of 1987
- Federal Requirements for States and Long-Term Care Facilities

Who decides?

The resident!

NCCNHR
The National Consumer Voice For Quality Long-Term Care

Federal Nursing Home Reform Act from the Omnibus Budget Reconciliation Act of 1987 or simply

OBRA '87 SUMMARY

Developed by Hollis Turnham, Esquire

In 1987, President Ronald Reagan signed into law the first major revision of the federal standards for nursing home care since the 1965 creation of both Medicare and Medicaid 42 U.S.C1396r, 42 U.S.C. 1395i-3, 42 CFR 483. The landmark legislation changed forever society's legal expectations of nursing homes and their care. Long term care facilities wanting Medicare or Medicaid funding are to provide services so that each resident can "attain and maintain her highest practicable physical, mental, and psycho-social well-being."

Medicaid Provision: 42 U.S.C. 1396r(b)(4)
http://www4.law.cornell.edu/uscode/42/1396r.html

Medicare Provision: 42 U.S.C. 1395i-3(b)(4)
http://www4.law.cornell.edu/uscode/42/1395i-3.html

Federal Regulations: 42 CFR 483.25
http://www.access.gpo.gov/nara/cfr/waisidx_02/42cfr483_02.html
(Scroll down to retrieve a specific title part and section as text or pdf file.)

WHAT IS OBRA '87?

The Federal Nursing Home Reform Act or OBRA '87 creates a set of national minimum set of standards of care and rights for people living in certified nursing facilities. This landmark federal legislation comes by its common name "OBRA" through the legislative process. Congress, then and now, usually completes a huge measure of its budgetary and substantive work in one large bill. The bill accomplishing that function in 1987 was entitled the Omnibus Budget Reconciliation Act of 1987 or "OBRA '87." The separate Federal Nursing

Home Reform Act along with many other separate bills was "rolled into"one bill to insure final passage of all the elements.

These minimum federal health and care requirements for nursing homes are to be delivered through variety of established protocols within nursing homes and regulatory agencies. And as minimum standards, Long-Term Care Ombudsmen should view OBRA as a baseline that should be built upon to reach not only resident "well-being" but also happiness and fulfillment.

OBRA also recognized the unique and important role performed by the LTCOP for nursing home residents. The federal Medicaid and Medicaid legislation included those distinct advocacy roles and subsequent regulations and other guidance has given LTCOPs additional tools to serve resident interests.

The changes OBRA brought to nursing home care are enormous. Some of the most important resident provisions include:

- Emphasis on a resident's quality of life as well as the quality of care;
- New expectations that each resident's ability to walk, bathe, and perform other activities of daily living will be maintained or improved absent medical reasons;
- A resident assessment process leading to development of an individualized care plan 75 hours of training and testing of paraprofessional staff;
- Rights to remain in the nursing home absent non-payment, dangerous resident behaviors, or significant changes in a resident's medical condition;
- New opportunities for potential and current residents with mental retardation or mental illnesses for services inside and outside a nursing home;
- A right to safely maintain or bank personal funds with the nursing home; Rights to return to the nursing home after a hospital stay or an overnight visit with family and friends The right to choose a personal physician and to access medical records;
- The right to organize and participate in a resident or family council;
- The right to be free of unnecessary and inappropriate physical and chemical restraints;
- Uniform certification standards for Medicare and Medicaid homes;
- Prohibitions on turning to family members to pay for Medicare and Medicaid services;

- and New remedies to be applied to certified nursing homes that fail to meet minimum federal standards.

OBRA set in motion forces that changed the way state inspectors approached all their visits to nursing homes. Inspectors no longer spend their time exclusively with staff or with facility records. Conversations with residents and families are a prime time survey event. Observing dining and medications administration are a focal point of every annual inspection.

Under OBRA, Long Term Care Ombudsman Programs have defined roles to fulfill and tools to use in the annual inspection process to nurture the conversations between residents/families and inspectors and life in the nursing home.

HOW DID OBRA '87 COME ABOUT?

The federal Nursing Home Reform Act became law with growing public concern with the poor quality of care in too many nursing homes and the concerted advocacy of advocates, consumers, provider associations, and health care professionals. Congress asked the Institute of Medicine (IoM) to study how to better regulate the quality of care in the nation's Medicaid and Medicare certified nursing homes.

In its 1986 report Improving the Quality of Care in Nursing Homes, the expert panel recommended:

- A stronger federal role in improving quality;
- Revisions in performance standards, the inspection process, and the remedies to improve nursing home services;
- Better training of nursing home staff;
- Improved assessment of resident needs; and
- A dynamic and evolutionary regulatory process.
- Information can be found at: http://www.nap.edu/catalog.php?record_id=646

In order to assure implementation of the IoM recommendations from the "blue ribbon panel," the National Citizens' Coalition for Nursing Home Reform organized the "Campaign for Quality Care" to support the federal reforms. National organizations representing consumers, nursing homes, and health care professionals worked together, and continue to work, to create consensus positions on major nursing home issues. Their consensus positions on the IoM report laid the foundation for the federal law.

OBRA has changed the care and lives of nursing home residents across America. There have been significant improvements in the

comprehensiveness of care planning. Anti-psychotic drug use declined by 28-36% and physical restraint use was reduced by approximately 40%.

Several states have taken all or parts of OBRA '87 and made them state law for their licensed nursing homes or other kinds of long term care facilities. For example, the state of Washington has extended the rights that nursing home residents have to residents of all Washington long term care facilities.

And, Michigan has incorporated many of the OBRA prohibitions on Medicaid discrimination into state law.

Online Research: *The links to federal laws and regulations in this document have been made to the most reliable sources known to the Ombudsman Resource Center. Links to the Medicaid and Medicare laws are made to the Legal Information Institute maintained by Cornell University. The federal code of regulations is accessed here through the United States Government Printing Office.* If these resources do not meet your needs or you find better resources for federal legal research, please contact Center staff at ombudcenter@nccnhr.org

Resident Assessments and Care Plans

The National CONSUMER VOICE for Quality Long-Term Care formerly NCCNHR

FACT SHEET

ASSESSMENT AND CARE PLANNING: THE KEY TO QUALITY CARE

Every person in a nursing home has a right to good care, under the law. The law says the home must help people "attain or maintain" their highest level of well-being - physically, mentally and emotionally. To give good care staff must assess each resident and plan care to support each person's life-long patterns, and current interests, strengths and needs. Resident and family involvement in care planning gives staff information they need to make sure residents get good care and the care they deserve.

WHAT IS A RESIDENT ASSESSMENT?

Assessments gather information about how well residents can take care of yourselves and when you need help in "functional abilities" -- how well you can walk, talk, eat, dress, bathe, see, hear, communicate, understand and remember. Staff also ask about residents' habits, activities and relationships so they can help residents live more comfortably and feel more at home. The assessment helps staff look for what is causing a problem. For instance, poor balance could be caused by medications, sitting too much, weak muscles, poor-fitting shoes, a urinary infection or an ear ache. Staff must know the cause in order to give treatment.

WHAT IS A PLAN OF CARE?

A plan of care is a strategy for how the staff will help a resident. It says what each staff person will do and when it will happen (for instance—The nursing assistant will help Mrs. Jones walk to each meal to build her strength). Care plans must be reviewed regularly to make sure they work and must be revised as needed. For care plans to work, residents must feel like they meet your needs and must be comfortable with them. Care plans can address any medical or non-medical problem (example: incompatibility with a roommate).

WHAT IS A CARE PLANNING CONFERENCE?

A care planning conference is a meeting where staff and residents/families talk about life in the facility--meals, activities, therapies, personal schedule, medical and nursing care, and emotional needs. Residents/families can bring up problems, ask questions, or offer information to help staff provide care. All staff who work with a resident should be involved--nursing assistants, nurse, physician, social worker, activities staff, dietician, occupational and physical therapists.

WHEN ARE CARE PLANNING CONFERENCES HELD?

Care planning meetings must occur every three months, and whenever there is a big change in a resident's physical or mental health that might require a change in care. The care plan must be completed within 7 days after an assessment. Assessments must be completed within 14 days of admission and at least once a year, with reviews every three months and when a resident's condition changes.

WHAT SHOULD YOU TALK ABOUT AT THE MEETING?

Talk about what you need, how you feel; ask questions about care and the daily routine, about food, activities, interests, staff, personal care, medications, and how well you get around. Staff must talk to you about treatment decisions, such as medications and restraints, and can only do what you agree to. You may have to be persistent about your concerns and choices. For help with problems, contact your local ombudsman, advocacy group or others listed on the next page.

HOW RESIDENTS AND THEIR FAMILIES CAN PARTICIPATE IN CARE PLANNING

Residents have the right to make choices about care, services, daily schedule and life in the facility, and to be involved in the care planning meeting. Participating is the only way to be heard.

Before the meeting:

- Tell staff how you feel, your concerns, what help you need or questions you have; plan your agenda of questions, needs, problems and goals for yourself and your care.
- Know, or ask your doctor or the staff, about your condition, care and treatment.
- Ask staff to hold the meeting when your family can come, if you want them there.

During the meeting:

- Discuss options for treatment and for meeting your needs and preferences. Ask questions if you need terms or procedures explained to you.
- Be sure you understand and agree with the care plan and feel it meets your needs. Ask for a copy of your care plan.
- Ask with whom to talk if you need changes in it.

After the meeting:

See how your care plan is followed; talk with nurse aides, other staff or the doctor about it.

Families:

- Support your relative's agenda, choices and participation in the meeting.
- Even if your relative has dementia, involve her/him in care planning as much as possible. Always assume that s/he may understand and communicate at some level. Help the staff find ways to communicate with and work with your relative.
- Help watch how the care plan is working and talk with staff if questions arise.

A Good Plan Should:

- Be specific, individualized and written in common language that everyone can understand;
- Reflect residents' concerns and support residents' well-being, functioning and rights; Not label residents' choices or needs as "problem behaviors;"
- Use a multi-disciplinary team approach and use outside referrals as needed;
- Be re-evaluated and revised routinely - Watch for care plans that never change.

For more information and resources on assessment and care planning, go to www.theconsumervoice.org

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

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Assessments

All nursing facilities are required by federal regulations to provide supports and services necessary to help residents reach or maintain their highest practicable level of well-being. Nursing facilities are required to conduct initial and periodic comprehensive and accurate assessments. An initial assessment evaluates functional capacity and helps staff learn about the resident and their needs. The Resident Assessment Instrument-Minimum Data Set, often referred to as the "MDS" is the required assessment tool used in nursing facilities. It is designed to collect the minimum amount of data to guide care planning and monitoring for residents. It is from this assessment that care plans are developed.

The most important tools for assuring that residents receive adequate care are through resident assessment, care plan development, and the care plan meeting.

When Does the Nursing Facility Assess the Resident?

- At the time of admission (details below)
- When readmitted following hospitalization
- Quarterly
- Annually
- After a significant change in condition
- When a significant change to a prior assessment needs to be made
- At the time of discharge

When Medicare is paying for the resident's stay, the facility must complete an assessment at the following specific intervals, different from the list above: 5-day, 14-day, 30-day, and 90-day mark.

What is the Ombudsman Program's Role in an Assessment?

The Ombudsman program can help residents participate in the assessment process to the greatest extent possible by:

- Suggesting that residents prepare for the assessment by thinking about daily routines, activity preferences, and goals before staff begin interviews
- Reminding residents that they can request activities or daily routines that are not included in the list provided on the MDS assessment
- Helping residents work with facility staff to resolve any issues related to assessment interview procedures

Baseline Care Plan

Within 48 hours of admission, nursing facilities are required to develop a baseline care plan for each resident. It must include the instructions needed to provide effective and person-centered care of the resident and meet professional standards of quality care.

The nursing facility is required to provide the resident and their decision maker with a summary of the baseline care plan including but not limited to the following information:

- The initial goals of the resident
- A summary of the resident's medications and dietary instructions
- Any services and treatments to be administered by the facility

The Care Plan

The care plan must include resident-specific, measurable objectives, and timeframes to meet the resident's medical, physical, mental, and psychosocial needs identified in their MDS. The care plan must also describe services that will be used to help the resident attain or maintain their highest practicable physical, mental, and psychosocial well-being. Care plans must include the resident's preferences, including the right to refuse treatment, and potential for discharge.

A thorough care plan is:

- Individualized
- Specific
- Comprehensive
- Written in a language everyone can understand
- Reflective of the resident's concerns, preferences, and goals
- Supportive of the resident's well-being, abilities, and rights

Federal regulations require facilities to develop and implement a comprehensive person-centered care plan within seven days after completion of the MDS assessment, but not more than 21 days after admission.

Residents' rights to participate in the development and implementation of their person-centered care plan are clear. The mere existence of the regulations, however, does not guarantee that these planning processes will operate in a person-centered way. Some nursing facilities may be inclined to treat the planning regulations as a bothersome requirement, which makes it essential that residents effectively assert both their right to participate and their preferences for care and discharge. This is where the Ombudsman program can provide an extra voice of knowledge and support to help the resident achieve their goals.

Residents' Rights Related to Care Planning[44]

- ✓ The right to participate in the planning process, including the right to identify individuals or roles to be included in the planning process, the right to request meetings, and the right to request revisions to the person-centered plan of care.

- ✓ The right to participate in establishing the expected goals and outcomes of care, the type, amount, frequency, and duration of care, and any other factors related to the effectiveness of the plan of care.

- ✓ The right to be informed, in advance, of changes to the plan of care.

- ✓ The right to receive the services and/or items included in the plan of care.

- ✓ The right to see the care plan, including the right to sign it after significant changes to the plan of care are made.

The nursing facility is required to inform the resident of their right to participate in their treatment plan and support them in doing so. The planning process is required to include the resident and/or the resident's representative, an assessment of the resident's strengths and needs, and to incorporate the resident's personal and cultural preferences in developing goals of care.

Once the MDS assessment is complete and a care plan is written, a care plan meeting is held no later than 21 days after admission, every three months, or after a significant change in condition. The care plan meeting is supposed to be scheduled to accommodate the resident and/or the resident's representative.

The Care Plan Meeting

The care plan meeting is a conference where staff, the resident, and persons of the resident's choice go over the care plan. Care plans are a great tool to use when resolving a complaint. Representatives of the Office can participate in a care plan meeting with permission of the resident. It is a good idea to request a copy of the current care plan as well as the proposed care plan (if available) prior to the meeting. Review both care plans with the resident and talk about the resident's concerns and goals and expectations of the representative's role during the care plan meeting.

While an effective care plan requires the involvement of several individuals, all members of the care plan team may not actually attend the meeting.

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[44] 42 CFR Part 483 Requirements for Long-Term Care Facilities, § 483.21 Comprehensive person-centered care planning. https://www.govinfo.gov/content/pkg/FR-2016-10-04/pdf/2016-23503.pdf

The National CONSUMER VOICE for Quality Long-Term Care formerly NCCNHR

FACT SHEET

BASICS OF INDIVIDUALIZED QUALITY CARE

Individualized care is the right of every nursing home resident. The Nursing Home Reform Law of 1987 requires that residents receive services and activities to "attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident in accordance with a written plan of care..." Quality of care means what care is provided. The law also requires nursing facilities to "care for its residents in such a manner and in such an environment as will promote maintenance or enhancement of the quality of life of each resident." An emphasis is placed on dignity, choice, and self determination for residents. Quality of life means how care is provided.

The law requires nursing facilities to provide quality of care in a way that supports quality of life for each resident. When facilities do this, they achieve individualized care for each resident. Residents and family members should expect the facility to provide individualized care based on Quality of Care Basics.

Read a real resident's experience in one nursing home and follow how an Individualized Plan of Care should be developed. For this example, four areas of care will be used: (1) the assessment and care plan process (the basis for individualized care), (2) toileting, (3) hydration, and (4) mobility. (For more information, see Burger et al "Nursing Homes: Getting Good Care There," Chapters 4 and 5, available from the Consumer Voice).

HOW ONE NURSING HOME RESIDENT AND HER DAUGHTER CAN ACHIEVE THE BASICS OF INDIVIDUALIZED CARE

Your mother lived independently until she suffered a stroke two months ago. Your need to work prevents you from bringing her to your home for care. Together you made the decision that she would go to a nursing home for rehabilitation. The stroke left her with right-sided weakness (she is also right-handed) and some inability to make herself understood. Based on your mother's excellent response to rehab in the hospital, her physician thinks she should continue to make progress and return home in eight to twelve weeks.

The nursing home staff welcomed your mom. You both felt confident about your decision. Your mom's roommate was glad for the company and was patient with her slow speech. Your mom asked you to attend the first care planning conference with her. The staff said your mom would receive physical therapy three times a week, and speech and occupational therapy once a week.

You're both pleased with the therapy program, but your mother complained that the nursing staff will not take her to the toilet except as part of the therapy sessions. A fastidious woman, your mother knows when she has to go the bathroom and was determined to use the toilet, not a brief (diaper), bedpan, or commode. At the end of her second month in the facility, you noticed that you had difficulty opening your mother's right hand for the manicure she loved to get. Her skin looked very dry and flaky. Your mom's spirits seemed to be sinking. In fact, recently she seemed to be getting worse, not better.

When you mentioned these concerns to the staff, you were told that this happens to all frail, old people. The nursing staff then suggested speaking with the doctor to obtain an order for an antidepressant. You became really concerned.

ASSESSMENT AND CARE PLANNING

The Resident Assessment and Care Plan Process: In order to know what care and services to provide and how to provide them, the law requires a careful and thorough assessment of your mom. Staff need to learn your mom's strengths and needs. A list of assessment items relating to your mom includes:

- Her life history, daily routines, strengths, interests, food likes and dislikes, and other personal information. (Think of this information as the important details about your mother that reflects who she is as an individual, and which will form the basis for planning her care.)

- Her ability to function including walking, dressing, using the toilet, and eating. (The stroke has affected your mom's right and dominant side, so she will need assistance to regain independence.)

- Physical or mental conditions that may affect her ability to recover. (Except for the stroke, she is quite healthy mentally and physically.)
- Her potential for improvement. (Her physician expects her to recover and go home.)
- Communication abilities. (Her speech is slowed.)
- Nutritional status and medications. (She must relearn to feed herself and manage her own medications.)

The assessment is completed by day 7 in a skilled unit (your mother's situation at first); by the 14th day in a nursing facility (long term chronic care); and once a year thereafter, or whenever a resident's condition changes. The assessment is done by the interdisciplinary team (IDT) that includes: the resident, direct caregiver(s), nurse, physician, physical therapist, occupational therapist, speech therapist, activity therapist, dietitian, and social worker. The assessment information is the foundation for the care planning process.

DEVELOPING AN INDIVIDUALIZED CARE PLAN

The Care Plan, by law, is initially prepared with participation to the extent practicable of the resident or the resident's family or legal representative. The initial care plan must be complete by the 21st day of her stay, and subsequent care plan reviews are repeated quarterly, or whenever there is a major change in a resident's condition. The initial care plan process begins during the assessment. It is called an Individualized Care Plan because each resident's conditions, abilities, needs, routines, and goals are unique, requiring a plan of care (road map for care) that reflects who this individual is. The overarching goal is for your mother to return home and live as independently as possible. There are many little goals along the way. Care plan goals are all measurable, time limited, and the team member responsible for each is identified. This simply means that each goal will be clearly identified and stated. Each goal will also list an estimated time for accomplishment, as well as the specific team member(s) responsible in assisting to achieve that goal.

Physical Therapy will help your mother to regain the ability to walk. Occupational Therapy will assist her in attaining independence in dressing, eating, and toileting. Speech Therapy will help to improve her slow speech pattern. But therapy only takes up a few hours each day. The IDT must plan what happens for the rest of the 24-hour period. This plan must support your mother's goal for independence and prevent any harm from occurring. The Plan of Care must then be relayed to each staff member, including the Certified Nursing Assistants (CNAs), so that everyone is consistent in helping your mom reach her stated goals.

Traditionally, nursing homes have used nursing/medical model care plans. That type of plan is not suited to individualized nursing home care. It is written from the staff perspective rather than each resident's perspective.

Here is an example of what you may find:
Problem
Incontinence

Goal
Will become independent in toileting

Approaches
Assist to bedpan at 6 am, 9am, 12 noon, 4pm, 9pm (or when requests) (CNA). Assess ability to stand and pivot on left leg in one week to transfer to commode or toilet, 2/14/16 (N/PT*).

Here is an example of an individualized care plan written from a resident's perspective:

Need
I need assistance with using the bathroom.

Goal
I want to regain my independence in using the toilet so that I may go home.

Approaches
I know when I have to go to the bathroom and will tell you. Please assist me to the bed pan on my usual schedule from home at 6am, 9am, 12 noon, 4pm, 9pm (and when I request) (CNA). Assess my ability to stand and pivot on left leg in one week. Then help me to the commode or toilet, 2/14/16 (N/PT*).

*CNA=Certified Nursing Assistant, N=Nursing; PT=Physical Therapy; OT=Occupational Therapy; ST=Speech Therapy; D=Dietary

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FACT SHEET

PHYSICAL RESTRAINT-FREE CARE

EVERYONE DESERVES DIGNITY AND FREEDOM

Restraint-free individuals can eat, dress and move independently, maintain their muscle and strength, interact with others, and maintain their freedom and dignity.

Physical Restraints

What are Physical Restraints?

A physical restraint is any object or device that the individual cannot remove easily which restricts freedom of movement or normal access to one's body. Examples include vest restraints, waist belts, geri-chairs, hand mitts, lap trays, and side rails.

Poor outcomes of restraints:

- Accidents involving restraints which may cause serious injury: bruises, cuts, entrapment, side rail deaths by strangulation, and suffocation.
- Changes in body systems which may include: poor circulation, constipation, incontinence, weak muscles and bone structure, pressure sores, agitation, depressed appetite, infections, or death.
- Changes in quality of life which may include: reduced social contact, withdrawal, loss of autonomy, depression, disrupted sleep, agitation, or loss of mobility.

Physical restraints are used in place of good care because:

- Facilities or family members mistakenly believe that they ensure safety;
- Facilities fear liability;
- Facilities may use them in place of adequate staff.

Restraints are most often used on:

- Frail elderly residents who have fallen or may fall.
- Residents with a dementing illness who wander unsafely or have severe behavioral symptoms

PHYSICAL RESTRAINT USE IN THE U.S.

Nationally, over 6% of nursing home residents are restrained. The Advancing Excellence in America's Nursing Homes Campaign has set a goal of 5% or less for all nursing homes in the country. In many nursing homes across the country, residents are restraint-free without any increase in serious injuries. It is unrealistic to expect that all falls and injuries can be prevented.

Federal Law and Regulations

The Nursing Home Reform Act of 1987 (OBRA '87) states the resident has the right to be free from physical or chemical restraints imposed for purposes of discipline or convenience and if restraint is not required to treat the resident's medical symptoms.

This law also includes provisions requiring:

- quality of care—to prevent poor outcomes;
- assessment and care planning—for each resident to attain and maintain her/his highest level of functioning;
- residents be treated in such a manner and environment to enhance quality of life.

RESTRAINT REDUCTION STRATEGIES

Twenty years of experience provide many strategies for safe restraint reduction and elimination. Restraint reduction involves the whole facility, including administrators, nursing directors, physical and recreational therapists, nursing assistants, and housekeeping personnel. Family members and advocates can encourage the facility's efforts, and expect and insist that the facility:

- Complete a **comprehensive resident assessment** that identifies strengths and weaknesses, self care abilities and help needed, plus lifelong habits and daily routines.
- Develop an **individualized care plan** for how staff will meet a resident's assessed needs. It describes the care goals (e.g. safe walking), and when and what each staff person will do to reach the goal. The care team includes staff, residents and families (if the resident wants), and devises the plan at the quality care plan conference. The resident may also invite an ombudsman to attend. Care plans change as the resident's needs change.
- Train staff to assess and meet an individual resident's needs—hunger, toileting, sleep, thirst, exercise, etc.—according to the **resident's routine rather than the facility's routine.**
- Make permanent and consistent staff assignments and promote staff flexibility to meet residents' individualized needs.
- Treat medical conditions, such as **pain**, that may cause residents to be restless or agitated.
- Support and encourage care giving staff to **think creatively** of new ways to identify and meet residents' needs. For example, a "night owl" resident could visit the day room and watch TV if unable to sleep at night.
- Provide a **program of activities** such as exercise, outdoor time, or small jobs agreed to and enjoyed by the resident.
- Provide **companionship**, including volunteers, family, and friends by making the facility welcoming.
- Create a **safe environment** with good lighting, pads on the floor to cushion falls out of bed, a variety of individualized comfortable seats, beds and mattresses, door alarms, and clear and safe walking paths inside and outside the building.

NURSING HOMES CAN IMPLEMENT SPECIFIC PROGRAMS FOR REDUCING PHYSICAL RESTRAINTS, INCLUDING:

Restorative care, including walking, dressing, independent eating, and bathing programs, as well as:

- Wheelchair management program—including correct size and good condition for seat cushions.
- Individualized seating program—chairs, wheelchairs, tailored to individual needs.
- Specialized programs for residents with dementia, designed to increase their quality of life.
- Videotaped family visits for distant families.
- Wandering program—to promote safe wandering while preserving the rights of others.
- Preventive program based on knowing the resident—to prevent triggering of behavioral symptoms of distress.
- Toileting of residents based on their schedules rather than on staff schedules.

For more information and resources on physical restraint free care, go to www.theconsumervoice.org.

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ADVANCED PLANNING AND THIRD-PARTY DECISION-MAKERS

Section 4

Third-Party Decision-Makers

Assigned ***by*** the Resident

- Power of Attorney (POA)
  - Appointed by the individual
  - Does not remove rights
  - Different types of POAs

Assigned ***for*** the Resident

- Guardianship
- Conservatorship
  - Appointed by the court
  - Removes the individual's rights
  - Deems the individual incapable of administering their own affairs

Power of Attorney (POA)

"Power of Attorney" is the document.

"Principal" is the person appointing the decision-maker (agent).

"Agent" is the person who is appointed by the principal.

Agents are required to act with the highest degree of good faith.

An agent's authority can be revoked by the principle.

Your Rights To Make Health Care Decisions

A Summary of Connecticut Law

prepared by the Office of the Attorney General
for the Department of Social Services and
Department of Public Health

Your Rights to Make Health Care Decisions

You have the right to make health care decisions about the medical care you receive. If you do not want certain treatments, you have the right to tell your physician you do not want them and have your wishes followed.

You also have the right to receive information from your physician to assist you in reaching a decision about what medical care is to be provided to you.

There may come a time when you are unable to actively participate in determining your treatment due to serious illness, injury or other disability.

This booklet discusses the options available in Connecticut to help you to provide written instructions to guide your physician, family and others as to what treatment choices you desire to be made if you can not express your wishes. It also shows you how to appoint someone to make decisions on your behalf.

Frequently Asked Questions

Do I have the right to make health care decisions?

Yes. Adult patients in Connecticut have the right to determine what, if any, medical treatment they will receive. If you can understand the nature and consequences of the health care decisions that you are being asked to make, you may agree to treatment that may help you or you may refuse treatment even if the treatment might keep you alive longer.

Do I have the right to information needed to make a health care decision?

Yes. Physicians have the responsibility to provide patients with information that can help them to make a decision. Your physician will explain:

- what treatments may help you;
- how each treatment may affect you, that is, how it can help you and what, if any, serious problems or side effects the treatment is likely to cause;
- what may happen if you decide not to receive treatment.

Your physician may also recommend what, if any, treatment is medically appropriate, but the final decision is yours to make. All of this information is provided so you can exercise your right to decide your treatment wisely.

What is an advance directive?

An advance directive is a legal document through which you may provide your directions or express your preferences concerning your medical care and/or to appoint someone to act on your behalf. Physicians and others use them when you are unable to make or communicate your decisions about your medical treatment.

Advance directives are prepared before any condition or circumstance occurs that causes you to be unable to actively make a decision about your medical care.

In Connecticut, there are two types of advance directives:

- the living will or health care instructions
- the appointment of a health care representative

Must I have an advance directive?

No. You do not have to make a living will or other type of advance directive to receive medical care or to be admitted to a hospital, nursing home or other health care facility. No person can be denied medical care or admission based on whether they have signed a living will or other type of advance directive.

If someone refuses to provide you medical care or admit you unless you sign a living will or other type of advance directive, contact the Department of Public Health in Hartford, Connecticut at 860-509-7400.

What is a living will?

A living will is a document that states your wishes regarding any kind of health care you may receive. Should you be in a terminal condition or permanently unconscious, the living will can also tell your physician whether you want "life support systems" to keep you alive or whether you do not want to receive such treatment, even if the result is your death. A living will goes into effect only when you are unable to make or communicate your decisions about your medical care.

What does terminal condition and permanently unconscious mean?

A patient is in a "terminal condition" when the physician finds that the patient has a condition which is (1) incurable or irreversible and (2) will result in death within a relatively short time if life support systems are not provided. "Permanently unconscious" means a permanent coma or persistent vegetative state where the patient is not aware of himself or his surroundings and is unresponsive.

What is a life support system?

A "life support system" is a form of treatment that only delays the time of your death or maintains you in a state of permanent unconsciousness. Life support systems may include among other things:

- devices such as respirators and dialysis;
- cardiopulmonary resuscitation (CPR);
- food and fluids supplied by artificial means, such as feeding tubes and intravenous fluids.

It does not include

- normal means of eating and drinking, such as eating with assistance of another person or through a straw;
- medications that help manage pain;

Will I receive medication for pain if I have a living will?

Yes. A living will does not affect the requirement that your doctor provide you with pain medication or care designed solely to maintain your physical comfort (for example, care designed to maintain your circulation or the health of your skin and muscles). This type of care must be provided whenever appropriate.

What is a health care representative?

A health care representative is a person whom you authorize in writing to make any and all health care decisions on your behalf including the decision whether to withhold or withdraw life support systems. A health care representative does not act unless you are unable to make or communicate your decisions about your medical care. The health care representative will make decisions on your behalf based on your wishes, as stated in a living will or as otherwise known to your health care representative. In the event your wishes are not clear or a situation arises that you did not anticipate, your health care representative will make a decision in your best interests, based upon what is known of your wishes.

What kind of treatment decisions can be made by a health care representative?

A health care representative can make any and all health care decisions for you, including the decision to accept or refuse any treatment, service or procedure used to diagnose or treat any physical or mental condition. The health care representative can also make the decision to provide, withhold or withdraw life support systems. The health care representative cannot make decisions for certain specific treatments which by law have special requirements.

How will my health care representative know when to get involved in making decisions for me?

At any time after you appoint your health care representative, your health care representative can ask your attending physician to provide written notice if your physician finds that you are unable to make or communicate your decisions about your medical care. Even if your health care representative does not do so, your health care providers will usually seek out your health care representative once they determine that you are unable to make or communicate your decisions about your medical care.

What is a conservator?

A "conservator of the person" is someone appointed by the Probate Court when the Court finds that a person is incapable of caring for himself/herself including the inability to make decisions about his or her medical care. A person who is conserved by a court is known as a "ward".

The conservator of the person is responsible for making sure that the ward's health and safety needs are taken care of and generally also has the power to give consent for the ward's medical care, treatment and services.

You can name in advance the person you want the Court to appoint as your conservator if you become incapable of making your own decisions. If you have a conservator, he or she will be consulted in all medical care decisions. If you have a living will, however, the conservator's consent is not required to carry out your wishes as expressed in the living will.

If a conservator is later appointed for you, he or she must follow your health care instructions, either as expressed in a living will, or as otherwise known to your conservator made while you were able to make and communicate health care decisions. Further, a conservator cannot revoke your advance directives without a probate court order.

How are decisions made if I have both a health care representative and a conservator?

Generally, the decision of a health care representative will be followed if the conservator and health care representative disagree unless the probate court orders otherwise. This rule may not apply when the conservator has been appointed in some particular situations.

What advance directives should I have?

If you want to be sure that your wishes about your medical care are known if you cannot express them yourself, you should have a living will and you should

also appoint a health care representative. Each of these advance directives has a special importance.

If you are unable to make or communicate your preferences as to your medical care, your physician will likely look first to your living will as the source of your wishes. Your health care representative can make decisions on your behalf according to what is stated in your living will. In situations that are not addressed by your living will, your health care representative can make a decision in your best interests consistent with what is known of your wishes.

Who can I name as my health care representative or as my conservator?

If you wish to you can name the same person to be your health care representative and to be your conservator. The following persons cannot be named your health care representative:

- your physician;
- if you are a patient at a hospital or nursing home or if you have applied for admission, the operators, administrators, and employees of the facility;
- an administrator or employee of a government agency responsible for paying for your medical care.

Other than these restrictions, you can name anyone you feel is appropriate to serve as your health care representative. Of course, you should speak to the person whom you intend to name and be sure of his or her willingness to serve and to act on your wishes.

Do I need a lawyer to create an advance directive?

No. You do not need a lawyer to create an advance directive. You can use the forms in this booklet.

Do I need a notary to create an advance directive?

Except for optional forms, the forms do not require the use of a notary. An additional optional form called a witnesses' affidavit that is included among the forms in this booklet requires a notary public or a lawyer to verify the signature of the witnesses. This form is discussed in more detail in the next section. If you have legal questions, you should consult a lawyer.

Do I have to sign my advance directives in front of witnesses?

Yes. You must sign the document in the presence of two witnesses in order for the advance directives to be valid. The witnesses then sign the form.

For the living will and the appointment of health care representative, an optional form is provided in this booklet. It is called a witnesses' affidavit. It is the witnesses' sworn statement that they saw you sign the living will or appointment form, that you were of sound mind and it was your free choice to do so. In the event that there is a dispute regarding your living will or appointment of a health care representative, the witnesses' affidavits support its validity. This affidavit requires the use of an attorney or notary public. No other form requires the use of a notary or an attorney.

Who can witness my signature on an advance directive?

In general, Connecticut law does not state who may or may not be a witness to your advance directive. An important exception is that the person who you appoint to be your health care representative or as your conservator cannot be a witness to your signature of the appointment form.

Once I complete an advance directive what should I do?

You should tell the following persons that you have completed an advance directive and give them copies of the directives you have made:

- your physician;
- the person(s) you have named as a health care representative;
- anyone who will make the existence of your advance directives known if you cannot do so yourself, such as family members, close friends, your clergy or lawyer.

You should also bring copies with you when you are admitted to a hospital, nursing home or other health care facility. The copies will be made part of your medical record.

After I complete an advance directive, can I revoke it?

Yes. You can revoke your living will or appointment of a health care representative at any time. A living will can be revoked either orally or in writing. If you sign a new living will, it may revoke any prior living will you made.

However, to revoke your appointment of a health care representative, you must do so in writing that is observed and signed by two witnesses in order for the revocation to be valid.

Remember whenever you revoke an advance directive to tell your physician and others who have copies of your advance directive.

To revoke your designation of a conservator, you can do so either in writing or by making a new designation which states that earlier designations are revoked. It is advisable to put any revocation in writing. However, once a court has appointed a conservator, it cannot be revoked without a court order.

If I already have a living will or appointed someone to make health care decisions, do I need a new one?

No. Connecticut's living will statutes were revised effective October 1, 2006. If your living will and other advance directives, such as a health care agent or power of attorney for health care, were completed prior to this date, they are still valid, although they are slightly different than the new advance directives.

On October 1, 2006, the health care representative replaced the appointment of a health care agent and power of attorney for health care. The health care representative is, in effect, a combination of these two types of advance directives. The new living will makes clear that the living will can be used to provide your instructions regarding any type of health care, not just life support systems.

If I don't have an advance directive, how will my wishes be considered if I am unable to speak for myself?

If you are unable to make and communicate your decision concerning your medical care and you do not have a living will, your physician can consult with other persons to determine what your wishes are regarding the withholding or withdrawal of life support systems. If you have discussed your wishes with your physician, he or she will, of course, know your stated wishes. Your physician may also ask your health care representative, your next of kin or close relatives and your conservator, if one has been appointed, what you have told them about your wishes regarding withholding or withdrawing life support systems. If your wishes are unknown, then decisions will be made based upon what is in your best interests.

It is not recommended that you rely on oral instructions to these individuals to make your wishes known. If there is no living will, such instructions are required to be specific and may need to be proven in a court. You are better advised to complete a living will or appoint a health care representative if you want to be sure that your wishes will be understood and known in the event you are unable to state them yourself.

What is a document of anatomical gift?

It is a document in which you make a gift of all or any part of your body to take effect upon death. Any adult may make an anatomical gift in writing, including through a will, a donor card or by a statement imprinted or attached to a motor

vehicle operator's license. An anatomical gift may be made for the purpose of transplants, therapy, research, medical or dental education, or the advancement of medical or dental science. If you do not limit the gift's purpose to one or some of these uses, the gift can be used for any of these purposes. You may select who receives the gift - a hospital, physician, college, or an organ procurement group. You may also specify that the gift be used for transplant or therapy for a particular person. If no one is named to receive the gift, any hospital may do so.

Can I revoke an anatomical gift?

Yes. An anatomical gift may be revoked or changed only by (1) a signed statement; (2) an oral statement in the presence of two witnesses; (3) or by informing your physician if you are in a terminal condition. An anatomical gift may not be revoked after the donor's death.

What if I have more questions?

If you have additional questions about advance directives, discuss them with your physician and family. A social worker, patient representative or chaplain may be able to assist you, but they cannot provide legal advice. If you have legal questions, you should speak with a lawyer.

ADVANCE DIRECTIVE FORMS

Three sets of forms are contained in this booklet.

1. A **combined advance directive** form includes all of the advance directives- appointment of health care representative, living will, appointment of conservator and organ donation into one form. In the combined form, there is a place where you can choose to not make or use each kind of directive by signing your initials.
2. An **appointment of health care representative** form if you wish to only appoint a health care representative.
3. A **living will or health care instructions** if you wish to only make your wishes known but not appoint anyone to act on your behalf.

Each form includes the optional witness affidavit form.

COMBINED ADVANCE DIRECTIVES

FORM

ADVANCE DIRECTIVES OF _____

To Any Physician Who Is Treating Me, this document contains the following:

1. My Appointment of A Health Care Representative
2. My Living Will or Health Care Instructions
3. My Document of Anatomical Gift
4. The Designation of My Conservator Of The Person For My Future Incapacity

As my physician, you may rely on these health care instructions and decisions made by my health care representative or conservator of my person, if I am unable to make a decision for myself.

I choose not to appoint a health care representative, please go to the next page. _____ (Initial here)

APPOINTMENT OF HEALTH CARE REPRESENTATIVE

I appoint _____ to be my health care representative. If my attending physician determines that I am unable to understand and appreciate the nature and consequences of health care decisions and unable to reach and communicate an informed decision regarding treatment, **my health care representative is authorized to (1) accept or refuse any treatment, service or procedure used to diagnose or treat my physical or mental condition, except as otherwise provided by law, such as psychosurgery or shock therapy as defined in Conn. Gen. Stat. § 17a-540, and (2) make the decision to provide, withhold or withdraw life support systems**.

I direct my health care representative to make decisions on my behalf in accordance with my wishes, as stated in this document or as otherwise known to my health care representative. In the event my wishes are not clear or a situation arises that I did not anticipate, my health care representative may make a decision in my best interests, based upon what is known of my wishes.

If _____ is unwilling or unable to serve as my health care representative, I appoint _____ to be my alternative health care representative.

I further instruct that as required by law my attending physician disclose to my health care representative protected health information regarding my ability to understand and appreciate the nature and consequences of health care decisions and to reach and communicate an informed decision regarding treatment at the representative's request made at anytime after I sign this form.

I choose not to provide Health Care Instructions, please go to the next page. _____ (Initial here)

LIVING WILL or HEALTH CARE INSTRUCTIONS

If the time comes when I am incapacitated to the point when I can no longer actively take part in decisions for my own life, and am unable to direct my physician as to my own medical care, I wish this statement to stand as a statement of my wishes.

I, _____, the author of this document, request that, if my condition is deemed terminal or if I am determined to be permanently unconscious, I be allowed to die and not be kept alive through life support systems.

By terminal condition, I mean that I have an incurable or irreversible medical condition which, without the administration of life support systems, will, in the opinion of my attending physician, result in death within a relatively short time. By permanently unconscious I mean that I am in a permanent coma or persistent vegetative state which is an irreversible condition in which I am at no time aware of myself or the environment and show no behavioral response to the environment.

Specific Instructions

Listed below are my instructions regarding particular types of life support systems. This list is not all-inclusive. My general statement that I not be kept alive through life support systems provided to me is limited only where I have indicated that I desire a particular treatment to be provided.

	Provide	Withhold
Cardiopulmonary Resuscitation		
Artificial Respiration (including a respirator)		
Artificial means of providing nutrition and hydration		
_____		
_____		

Other specific requests: _____

_____

_____

_____

_____

_____

_____

_____

_____

I do want sufficient pain medication to maintain my physical comfort. I do not intend any direct taking of my life, but only that my dying not be unreasonably prolonged.

DOCUMENT OF ANATOMICAL GIFT

I make no anatomical gift at this time. _____ (Initial here)

I hereby make this anatomical gift, if medically acceptable, to take effect upon my death _____ (Initial here)

I give: (check one) _____ (1) any needed organs or parts

_____ (2) only the following organs or parts:

_____

_____

to be donated for: (check one)

___ (1) any of the purposes stated in subsection (a) of section 19a-279f of the general statutes

___ (2) these limited purposes _____.

DESIGNATION OF A CONSERVATOR OF THE PERSON

I choose not to designate a person to be appointed as my conservator. _____ (Initial here)

If a conservator of my person should need to be appointed, I designate _____, be appointed my conservator.

If this person is unwilling or unable to serve as my conservator of my person, I designate _____ be appointed my conservator.

No bond shall be required of either of them in any jurisdiction.

These requests, appointments, and designations are made after careful reflection, while I am of sound mind. Any party receiving a duly executed copy or facsimile of this document may rely upon it unless such party has received actual notice of my revocation of it.

x_____L.S. Date _____, 20____

WITNESSES' STATEMENTS

This document was signed in our presence by _____ the author of this document, who appeared to be eighteen years of age or older, of sound mind and able to understand the nature and consequences of health care decisions at the time this document was signed. The author appeared to be under no improper influence. We have subscribed this document in the author's presence and at the author's request and in the presence of each other.

x_____
(Witness)
x_____
(Number and Street)
x_____
(City, State and Zip Code)

x_____
(Witness)
x_____
(Number and Street)
x_____
(City, State and Zip Code)

OPTIONAL FORM

WITNESSES' AFFIDAVITS

STATE OF CONNECTICUT)
)
) :ss._____
) (Town)
COUNTY OF _____)

We, the subscribing witnesses, being duly sworn, say that we witnessed the execution of these health care instructions, the appointment of a health care representative, the designation of a conservator for future incapacity and a document of anatomical gift by the author of this document; that the author subscribed, published and declared the same to be the author's instructions, appointments and designation in our presence; that we thereafter subscribed the document as witnesses in the author's presence, at the author's request and in the presence of each other; that at the time of the execution of said document the author appeared to us to be eighteen years of age or older, of sound mind, able to understand the nature and consequences of said document, and under no improper influence, and we make this affidavit at the author's request this _____ day of _____, 20____.

x_____
(Witness)
x_____
(Number and Street)
x_____
(City, State and Zip Code)

x_____
(Witness)
x_____
(Number and Street)
x_____
(City, State and Zip Code)

Subscribed and sworn to before me by _____and _____, the signing witnesses to the foregoing affidavit this _____ day of _____, 20____.

_____

Commissioner of the Superior Court
Notary Public
My Commission expires: _____

(Print or type name of all persons signing under all signatures)

APPOINTMENT OF HEALTH CARE REPRESENTATIVE FORM

APPOINTMENT OF HEALTH CARE REPRESENTATIVE

I understand that, as a competent adult, I have the right to make decisions about my health care. There may come a time when I am unable, due to incapacity, to make my own health care decisions. In these circumstances, those caring for me will need direction and will turn to someone who knows my values and health care wishes. By signing this appointment of health care representative, I appoint a health care representative with legal authority to make health care decisions on my behalf in such case or at such time.

I appoint _____ to be my health care representative. If my attending physician determines that I am unable to understand and appreciate the nature and consequences of health care decisions and to reach and communicate an informed decision regarding treatment **my health care representative is authorized to (1) accept or refuse any treatment, service or procedure used to diagnose or treat my physical or mental condition, except as otherwise provided by law, such as psychosurgery or shock therapy as defined in Conn. Gen. Stat. § 17a-540, and (2) make the decision to provide, withhold or withdraw life support systems.**

I direct my health care representative to make decisions on my behalf in accordance with my wishes as stated in a living will, or as otherwise known to my health care representative. In the event my wishes are not clear or a situation arises that I did not anticipate, my health care representative may make a decision in my best interests, based upon what is known of my wishes.

If _____ is unwilling or unable to serve as my health care representative, I appoint _____ to be my alternative health care representative.

This request is made, after careful reflection, while I am of sound mind.

_____ / _____ / _____ (Date) X_____

WITNESSES' STATEMENTS

This document was signed in our presence by _____ the author of this document, who appeared to be eighteen years of age or older, of sound mind and able to understand the nature and consequences of health care decisions at the time this document was signed. The author appeared to be under no improper influence. We have subscribed this document in the author's presence and at the author's request and in the presence of each other.

x_____
(Witness)
x_____
(Number and Street)
x_____
(City, State and Zip Code)

x_____
(Witness)
x_____
(Number and Street)
x_____
(City, State and Zip Code)

OPTIONAL FORM

WITNESSES' AFFIDAVITS

STATE OF CONNECTICUT)
)
) :ss._____
) (Town)
COUNTY OF _____)

We, the subscribing witnesses, being duly sworn, say that we witnessed the execution of this appointment of a health care representative by the author of this document; that the author subscribed, published and declared the same to be the author's instructions, appointments and designation in our presence; that we thereafter subscribed the document as witnesses in the author's presence, at the author's request and in the presence of each other; that at the time of the execution of said document the author appeared to us to be eighteen years of age or older, of sound mind, able to understand the nature and consequences of said document, and under no improper influence, and we make this affidavit at the author's request this _____ day of _____, 20____.

x_____
(Witness)
x_____
(Number and Street)
x_____
(City, State and Zip Code)

x_____
(Witness)
x_____
(Number and Street)
x_____
(City, State and Zip Code)

Subscribed and sworn to before me by _____and _____, the signing witnesses to the foregoing affidavit this _____ day of _____, 20____.

_____

Commissioner of the Superior Court
Notary Public
My Commission expires: _____

(Print or type name of all persons signing under all signatures)

LIVING WILL OR HEALTH CARE INSTRUCTIONS FORM

LIVING WILL or HEALTH CARE INSTRUCTIONS

If the time comes when I am incapacitated to the point when I can no longer actively take part in decisions for my own life, and am unable to direct my physician as to my own medical care, I wish this statement to stand as a statement of my wishes.

I, _____, the author of this document, request that, if my condition is deemed terminal or if I am determined to be permanently unconscious, I be allowed to die and not be kept alive through life support systems.

By terminal condition, I mean that I have an incurable or irreversible medical condition which, without the administration of life support systems, will, in the opinion of my attending physician, result in death within a relatively short time. By permanently unconscious I mean that I am in a permanent coma or persistent vegetative state which is an irreversible condition in which I am at no time aware of myself or the environment and show no behavioral response to the environment.

Specific Instructions

Listed below are my instructions regarding particular types of life support systems. This list is not all-inclusive. My general statement that I not be kept alive through life support systems provided to me is limited only where I have indicated that I desire a particular treatment to be provided.

	Provide	Withhold
Cardiopulmonary Resuscitation		
Artificial Respiration (including a respirator)		
Artificial means of providing nutrition and hydration		
_____		
_____		

Other specific requests: _____

_____

_____

_____

_____

_____

_____

_____

I do want sufficient pain medication to maintain my physical comfort. I do not intend any direct taking of my life, but only that my dying not be unreasonably prolonged.

This request is made, after careful reflection, while I am of sound mind.

_____ / _____ / _____ (Date) X_____

WITNESSES' STATEMENTS

This document was signed in our presence by _____ the author of this document, who appeared to be eighteen years of age or older, of sound mind and able to understand the nature and consequences of health care decisions at the time this document was signed. The author appeared to be under no improper influence. We have subscribed this document in the author's presence and at the author's request and in the presence of each other.

x_____
(Witness)
x_____
(Number and Street)
x_____
(City, State and Zip Code)

x_____
(Witness)
x_____
(Number and Street)
x_____
(City, State and Zip Code)

OPTIONAL FORM

WITNESSES' AFFIDAVITS

STATE OF CONNECTICUT)
)
) :ss._____
) (Town)
COUNTY OF _____)

We, the subscribing witnesses, being duly sworn, say that we witnessed the execution of this living will or health care instructions by the author of this document; that the author subscribed, published and declared the same to be the author's instructions, appointments and designation in our presence; that we thereafter subscribed the document as witnesses in the author's presence, at the author's request and in the presence of each other; that at the time of the execution of said document the author appeared to us to be eighteen years of age or older, of sound mind, able to understand the nature and consequences of said document, and under no improper influence, and we make this affidavit at the author's request this _____ day of _____, 20____.

x_____
(Witness)
x_____
(Number and Street)
x_____
(City, State and Zip Code)

x_____
(Witness)
x_____
(Number and Street)
x_____
(City, State and Zip Code)

Subscribed and sworn to before me by _____and _____, the signing witnesses to the foregoing affidavit this _____ day of _____, 20____.

_____

Commissioner of the Superior Court
Notary Public
My Commission expires: _____

(Print or type name of all persons signing under all signatures)

Connecticut Long Term Care Ombudsman Program

Your Legal Rights As an Individual Receiving Long Term Services and Supports

We are all protected by certain legal rights that seek to provide each of us with fair treatment and quality care, safe from discrimination, fear or abuse. Understanding your legal rights, benefits and obligations is crucial to maximizing the use of the long term services and supports you receive.

The Connecticut Long Term Care Ombudsman Program has created this page to provide you with links and pertinent information to help you to do just that.

Learning About Your Legal Rights

One centralized resource that the state of Connecticut offers regarding your legal rights is My Place CT. My Place CT is a free web based resource center created specifically for individuals in Connecticut. Once on the My Place CT Legal Rights Web Page, you can use the menus to find subjects that best match your needs.

- The Legal Matters section addresses issues, such as living wills, powers of attorney, conservators and other legal matters that are important to understand when planning for your future.
- The Consumer Rights section will help you recognize and understand your rights within the system of services and supports for older adults and persons with disabilities.
- The Legal Resources section will point you to organizations that can provide additional information and help.

Another General Resource for Connecticut Residents is CT Law Help. **CTLawHelp.org** was created by several nonprofit legal services organizations whose shared mission is to improve the lives of Connecticut's poorest citizens by providing free legal services to people with low income. The website is funded by the Connecticut Bar Foundation and the Legal Services Corporation, and seeks to further the goal of equal access to justice by providing information and self-help materials on legal issues affecting people with low income.

Legal Resources - Where to Get Help

- For concerns over your care, or if you feel your rights have been violated, you should contact the nursing home administrator or a staff member in charge.
- You can also **contact us** at the CT Long-Term Care Ombudsman Program by calling us at 1-866-388-1888 (Toll-Free) or by Email at LTCOP@CT.GOV.
- You can also file a complaint with the Department of Public Health.

For additional information on the legal rights and benefits available to older adults and people with disabilities, review the resources below:

Obtaining Legal Assistance

Connecticut Network for Legal Aid

This network of several nonprofit legal services organizations has a shared mission to improve the lives of Connecticut's low-income residents by providing free legal services. Their goal is to offer equal access to justice by providing information and self-help materials on a variety of legal issues.

Explore the Connecticut Network for Legal Aid website for contact and eligibility information as well as extensive legal self-help information and tools. Services are free.

Consumer Law Project for Elders (CLPE)

The CLPE Hotline provides free legal assistance, including advice, representation and referrals to people aged 60 and over who have consumer problems or questions about their rights as consumers. Call 1-800-296-1467 (Toll-Free) to be connected with a legal specialist.

Need a Lawyer?

Local and county bar associations offer lawyer referral services to help you find a private attorney in your county. There may be a fee for the referral and for services from private attorneys.

Area | Telephone
Hartford, Litchfield, Middlesex, Tolland and Windam 1-860-525-6052
Fairfield 1-203-335-4116
New Haven 1-203-562-5750
New London 1-860-889-9384

Other Legal Service Resources

There are also a number of legal services organizations that provide free legal help to those who qualify. One of the organizations listed below may be able to help. Contact them directly for information about their services and eligibility requirements.

- Connecticut Legal Services: A nonprofit law firm dedicated to representing, advising and educating low-income individuals and families in matters relating principally to civil law and thereby helping them secure the protections, privileges, benefits, rights and opportunities these laws provides.
- Greater Hartford Legal Aid: A not-for-profit law firm whose staff helps clients with civil (not criminal) legal issues. They are advocates, primarily lawyers and paralegals, who know how to serve people who have little money.
- New Haven Legal Assistance: Provides high-quality legal services to individuals, families and groups in the greater New Haven area, including the lower Naugatuck Valley, who are unable to obtain legal services because of limited income, age, disability, discrimination, and other barriers.
- Statewide Legal Services of Connecticut (SLS): A private, nonprofit corporation dedicated to helping as many low-income people possible to understand their civil (non-criminal) legal problems. They cooperate with other nonprofit law firms and volunteer attorneys to provide a broad range of legal services to Connecticut's poor.

- Disability Rights Connecticut (DRCT): In addition to conducting investigations, educating policy makers, and challenging discriminatory barriers in court, we can help individuals with disabilities understand and exercise their rights. When you contact DRCT, you will be given information about disability rights, referred to experts and resources, empowered in your advocacy efforts and provided representation consistent with DRCT's mandates, priorities and resources. The agency also provides public education and training and informs policymakers about issues affecting people with disabilities.

(DRCT Programs and Services English) (DRCT Programs and Services Spanish)

(DRCT Poster English) (DRCT Poster Spanish)

National Law Advocacy Groups

The National Center on Law & Elder Rights (NCLER): The National Center on Law and Elder Rights (NCLER) provides the legal services and aging and disability communities with the tools and resources they need to serve older adults with the greatest economic and social needs. A centralized, one-stop shop for legal assistance, NCLER provides Legal Training, Case Consultations, and Technical Assistance on Legal Systems Development. Justice in Aging administers NCLER through a contract with the Administration for Community Living's Administration on Aging.

The National Academy of Elder Law Attorneys (NAELA): Members of the NAELA are attorneys who are experienced and trained in working with the legal problems of older Americans with disabilities. Elder and special needs law includes helping such persons and their families with planning for incapacity and long-term care, Medicaid and Medicare coverage (including coverage of nursing home and home care), health and long-term care insurance, and healthcare decision making. It also includes drafting of supplemental needs and other trusts, the selection of long-term care providers, home care and nursing home problems solving, retiree health and income benefits, retirement housing, and fiduciary services or representation. Established in 1987, NAELA is a non-profit association that assists lawyers, bar organizations, and others. NAELA's mission is educate, inspire, serve and provide community to attorneys with practices in elder and special needs law. NAELA currently has members across the United States, Canada, Australia and the United Kingdom.

Return to LTCOP Home Page

Frequently Asked Questions About Powers of Attorney

April 2019 by CLS

What is a Power of Attorney?

A Power of Attorney is a legal document you use to allow another person to act for you. You create a legal relationship in which you are the principal and the person you appoint is the agent. A Power of Attorney specifies the powers you give to your agent. The powers can be limited or broad. For example, if you are selling your house, but unable to attend the closing, you can give someone the power just to sign the deed in your absence. Most durable powers of attorney, however, give your agent the power to do almost anything you could do.

Banks, brokerage firms, and other financial institutions may require you to sign one of their own forms. The CT law requires that these third parties accept the power of attorney if it's acknowledged. The law provides for a process for verification if there are still questions.

What does "durable" mean?

All Powers of Attorney executed in Connecticut are presumed to be 'durable' unless stated otherwise. The word 'durable' means the Power of Attorney will still be effective if the principal becomes mentally incapacitated. A Power of Attorney in Connecticut no longer needs to state that "this Power of Attorney shall not be affected by the subsequent disability or incompetence of the principal" or similar words. The powers you give to your agent will remain effective when you are unable to give your agent instructions. Older power of attorneys and out of state powers of attorney may still have these words, and remain effective. You or your attorney may still choose to include those words, or the word 'durable' in the new Connecticut powers of attorney. But if not, your power of attorney is durable unless otherwise stated.

When does the Power of Attorney take effect?

The Power of Attorney is effective as soon as you sign it before two witnesses and have it notarized. You may give the Power of Attorney to your agent(s) and tell the person(s) not to use it unless you are unconscious or unable to act for yourself. However, the agent could use the Power of Attorney as soon as he or she receives it.

Some people may choose to use a "springing" Power of Attor specific triggering event happens, such your incapacity. Ther Powers of Attorney. First, the agent needs an affidavit showi the agent can use the Power of Attorney. Then, even though that accept the document with the affidavit are not liable, ba agent's power under a springing Power of Attorney. Finally, i would be accepted in other states.

If I give someone a Power of Attorney, does that r money any more?

No. When you give someone a Power of Attorney, you still have the right to control your money and property. However, you are giving your agent the ability to access your money. Your agent is not supposed to take or use your money without your permission, but there is a risk that a dishonest or unscrupulous agent might steal your money. It is therefore very important to choose an agent you trust. You should go over the agent's duties before you sign your power of attorney.

Can the Power of Attorney be used by the agent to take my money or property without my permission?

There is a risk that the agent you choose to give your Power of Attorney may abuse the power by taking or spending your money without your knowledge or permission. Because the agent can use the Power of Attorney to access your bank account and sell your property, do not give your Power of Attorney to anyone you do not trust with your money or property. It can be very difficult to get back money or property taken by the agent, because the agent usually has no money left to return. The agent may also sell your property, or mortgage it, making it worth less.

If I think someone is using my Power of Attorney to steal from me, what can I do?

First, you should **revoke the Power of Attorney**.

Second, notify all banks or other financial institutions in which you have money that you have revoked the Power of Attorney

Third, you can go to the probate court (by yourself or through an attorney) and demand that the agent you suspect of stealing from you **file an accounting** showing how the money was spent. You will need to pay a filing fee and possibly pay the agent for the cost of preparing the accounting. The court will hold a hearing at which time you can challenge the information given in the accounting. Ultimately, if the court finds the agent took your money without your permission, you can sue the agent or possibly press criminal charges.

How can I revoke my Power of Attorney?

If you have not given the Power of Attorney to anyone, you can revoke it by destroying the document. The Power of Attorney cannot be used unless the agent has it or it (or a copy) has already been given to banks, financial institutions or others so that they think you want the agent to act on your behalf.

If the Power of Attorney has been given to the agent, an institution, or has already been recorded, you should execute a document revoking the Power of Attorney that is witnessed and acknowledged in the same manner as the first Power of Attorney. A revocation is included on this website. Then you will need to give a copy of the Revocation to the banks or others so that they know the Power of Attorney is no longer good.

Connecticut law does *not* provide that a new Power of Attorr
possible to have more than one agent with your Power of At
with an attorney.

What is the difference between a "short form" an

The "statutory short form" Power of Attorney is the most common Power of Attorney form available on line and sold in Connecticut stores. The document lists only the powers given to the agent. It is "short" because it does not include the paragraph that describes each power in detail NOR DOES IT PROVIDE FOR ESTATE PLANNING POWERS. IMPORTANT: In the statutory short form, ALL the powers listed are included; you should initial the boxes only to DELETE certain powers. The SAMPLE short form Power of Attorney can be found here. The statute that describes the powers can be found here.

A "statutory long form" Power of Attorney is available if you wish to give your agent additional "hot powers" or ESTATE PLANNING POWERS. *IMPORTANT: In the long form the hot powers must be initialed IF YOU GRANT THEM TO YOUR AGENT. These powers are broad and sweeping and should only be granted after consultation with an attorney.* If you execute either a "statutory short form" or "statutory long form" Power of Attorney, it would be wise to keep a copy of the statute handy. You can read the statute here: **Power of Attorney Statute**.

I have a Power of Attorney I signed in another state. Can I use it in Connecticut?

Most Powers of Attorney signed in other states will be recognized in Connecticut. In general, a Power of Attorney used to convey title to real estate, must be signed, dated, witnessed by two people, and "acknowledged" or notarized by a notary public or court official. (State laws govern who is authorized to take "acknowledgments.") The practical question is not whether the Power of Attorney is valid, but whether a financial institution will honor it. Also, if the document refers to statutes from another state, you may have to provide a copy of those statutes.

The law may be different in the state where you signed your Power of Attorney. Even if the document lists the same or similar powers, they may have a different meaning when used in Connecticut. Also, many states have different statutory protections for people signing a Power of Attorney.

Do I need to get a new Power of Attorney if I move to a different state?

When you move to a different state, you should always consult a local attorney to see whether your Power of Attorney will be effective the way you intended.

In some states, a Power of Attorney is not "durable" unless it is "*recorded*," that is, filed with local government. In addition, there may be special rules about how it is revoked. Check with a local attorney.

Why do I need a Power of Attorney?

A Power of Attorney can be very helpful to you and your family. If you were unable to handle your own affairs as a result of illness, accident, or even absence, the Power of Attorney gives your agent the power to handle your affairs as you would handle them yourself. You might not be able to execute a Power of Attorney at a time when you are disabled due to an accident. If you are unable to handle your own affairs and have no Power of Attorney, your spouse or f
Court to appoint a Conservator of the Estate (COE) for you. T
file an inventory, and prepare accountings. Sometimes this i
prefer to avoid the expense of probate court by naming thei
Attorney.

Where should I keep my Power of Attorney?

Your Power of Attorney is an important legal document. Keep it in a safe and secure place. You may wish to give a copy to your agent(s) or inform them of a place where it can be easily found. Your agent may keep a copy in case yours is lost. Make sure your family knows where to find your Power of Attorney, or whom to ask when it is needed.

Do I need to update my Power of Attorney if nothing has changed?

Some banks and financial institutions will try to reject a Power of Attorney that is several years old because of the possibility that the Power of Attorney has been revoked. There are several options to prepare for this. If you remain competent, it is prudent to re-execute your Power of Attorney every five years or so.

It is always a good idea to review your Power of Attorney periodically to make sure you still agree with your choices.

If you are no longer competent, your agent can sign an affidavit that your power of attorney is in full force and affect and provide that to the financial institution.

CT law requires banks and other third parties to accept your power of attorney if it's properly acknowledged. If the bank has remaining questions there is a written procedure that they must follow before they can reject the power of attorney.

Do I need the original power of attorney?

CT law states, "unless a power of attorney otherwise provides, a photocopy or electronically transmitted copy of an original power of attorney has the same effect as the original."

Do powers of attorney cover digital assets?

A digital asset is defined by the CT Revised Uniform Fiduciary Access to Digital Assets Act, effective 1 OCT 2016, as "...an electronic record in which an individual has a right or interest." such as electronic records, emails, social media accounts, digital files, and virtual currency. The statutory SHORT FORM power of attorney forms do not automatically give this power to your agent. You must add this power in the statutory SHORT FORM power of attorney forms if you want your agent to have it.

Connecticut Judicial Branch
Law Libraries

SEARCH Ask a Librarian

Connecticut Law About Powers of Attorney

These links connect to resources available and are provided with the understanding that they represent only a starting point for research.

This web page has many external links to valuable resources. Please view our Linkage Policy for more information.

See Also: **Law About Living Wills**

Research Guides and Information

Information from the Connecticut Probate Courts:

- New Power of Attorney Law Takes Effect October 1st, 2016

Information from CTLawHelp.Org

- Powers of Attorney
  - Frequently Asked Questions about Powers of Attorney in Connecticut
  - Durable Statutory Power of Attorney - Short Form
  - Revocation of Power of Attorney Form

OLR Research Reports - Office of Legislative Research:

Office of Legislative Research reports summarize and analyze the law in effect on the date of each report's publication. Current law may be different from what is discussed in the reports.

- Power of Attorney "Hot Powers" - 2020-R-0285
  Summarize Connecticut's power of attorney "hot powers" statute.
- Durable Power of Attorney - 2007-R-0372
  You asked (1) whether there is any state oversight of people granted durable power of attorney and (2) what sanctions might apply if a person granted this power took advantage of the grantor, for example by misappropriating his property.
- Power of Attorney - Revocative - 2005-R-0669
  You asked how a person might revoke a power of attorney? Our office is not authorized to give legal opinions and

Recent Public Acts

- **Public Act 17-91** - *An Act Adopting The Connecticut Uniform Recognition of Substitute Decision-Making Documents Act and Revising The Connecticut Uniform Power of Attorney Act*
  - **Summary**
- **Public Act 16-40** - *An Act Concerning Revisions to the Connecticut Uniform Power of Attorney Act*
  - **Summary**
- **Public Act No. 15-240** - *An Act Concerning Adoption of the Connecticut Uniform Power of Attorney Act*
  - **Summary**

Connecticut General Statutes

Selected statutes:

- **Chapter 15C - Connecticut Uniform Power of Attorney Act**
  - **Sec. 1-350** *et seq.*

    Sec. 1-352 *Power of attorney short form, long form and optional information form.*

Click on the link below to search the full-text of the statutes:
https://search.cga.state.ct.us/r/statute/dtsearch_form.asp

Recent Case Law

Connecticut Appellate Court:

- *Kindred Nursing Centers East, LLC v. Morin*, 125 Conn. App. 165, 7 A. 3d 919 (2010). "Under our common law, a power of attorney creates a formal contract of agency between the grantor and his attorney in fact. *Long* v. *Schull*, 184 Conn. 252, 256, 439 A.2d 975 (1981). Under our statutory law, this agency relationship encompasses a variety of transactions that the grantor presumptively has authorized his attorney in fact

this report should not be considered one.

- Joint Power of Attorney - 2002-R-0758
  You asked if someone gives a power of attorney to two people in the same document, do both have to sign a deed on the principal's behalf.

- Power of Attorney - Mental Capacity - 2002-R-0094
  You asked about the mental capacity requirements for someone who wishes to execute a power of attorney.

Library Materials

- Connecticut Estates Practice: Incapacity, Powers of Attorney and Adoption in Connecticut, 4th edition, by Ralph H. Folsom, Laura Weintraub Beck & Daniel P. Fitzgerald
  - *Chapter 6: Powers of Attorney*
- Connecticut Estate Planning, Wills and Trusts Library, by Robert F. Cohn.
  - *Chapter 30: Durable Powers of Attorney for Financial Matters*
- Durable Powers of Attorney and Health Care Directives, by Michael L. M. Jordan

Search the online catalog for availability and locations.

to undertake on his behalf. General Statutes Sec. 1-42 et seq. The central issue in this case is whether, pursuant to these established legal principles, a person to whom a resident of a nursing home has given a power of attorney has a duty to assist the nursing home in securing the continuation of the resident's eligibility for medicaid financing."

MODULE 3

THE COMMUNICATION PROCESS

I. SETTING THE STAGE FOR COMMUNICATION
   - A. Verbal Communication
   - B. Nonverbal Communication
   - C. Listening

II. THE COMPLAINT PROCESS
   - A. What is a complaint
   - B. Confidentiality of complaints
   - C. Ethical dilemmas

III. COMPLAINT INVESTIGATION
   - A. Gathering Information
   - B. Building Trust

IV. CASE SCENARIOS

MODULE 3 Appendix
Video: "Home of the Brave" & NH Care Plans/Getting Good Care (AARP)
Care Planning Handouts:
NCCNHR - Care Planning; Nutrition/Hydration; Abuse/Neglect
Questions to Consider
Resident Rights to Individualized Care
Case Study Handouts

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 you 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 you 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?

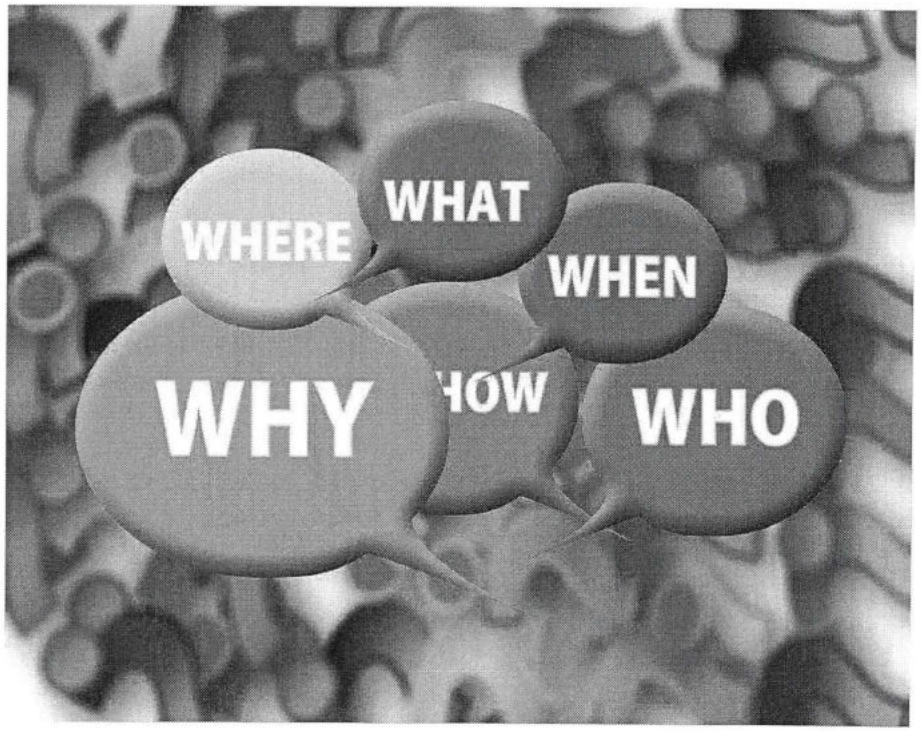
- Facility visits
- Phone calls
- Emails
- Resident council meetings
- Family council meetings

Who are the Complainants?

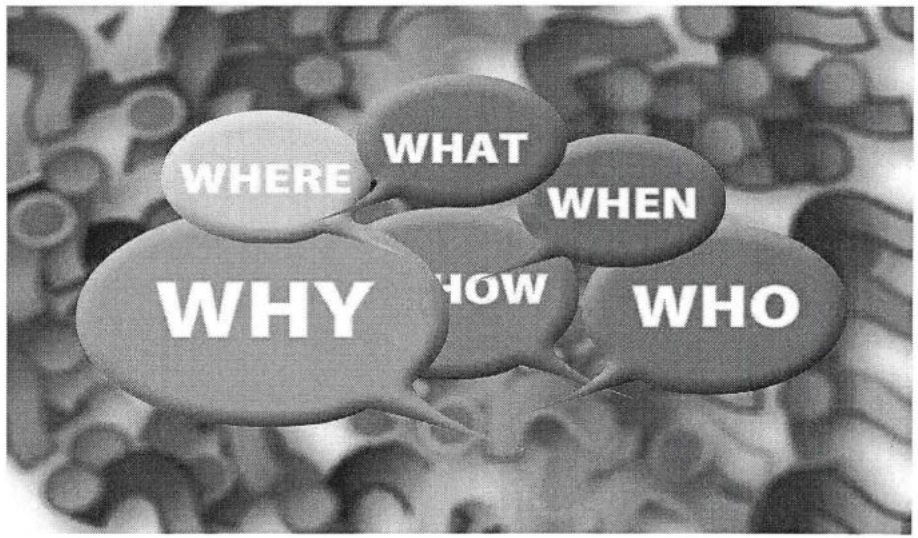
- Residents
- Family members/friends of residents
- Facility staff
- Hospital staff
- Community members
- Clergy
- Legislators
- Representatives of the Office
- Anonymous
- Anyone

→ Complaint Intake Process

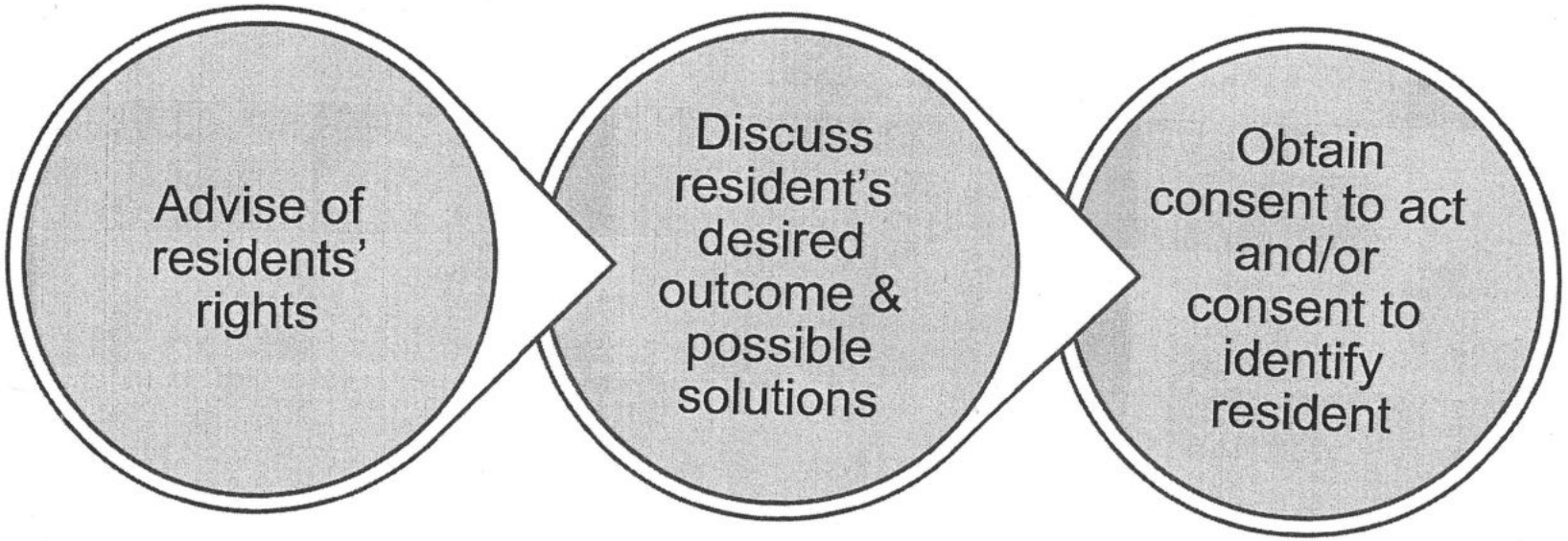
- **What** is occurring or has occurred?
- **When** the problem occurred and whether it is ongoing.
- **Where** the problem occurs or occurred.
- **Who** was or is involved?
- **How** resident(s) are affected.

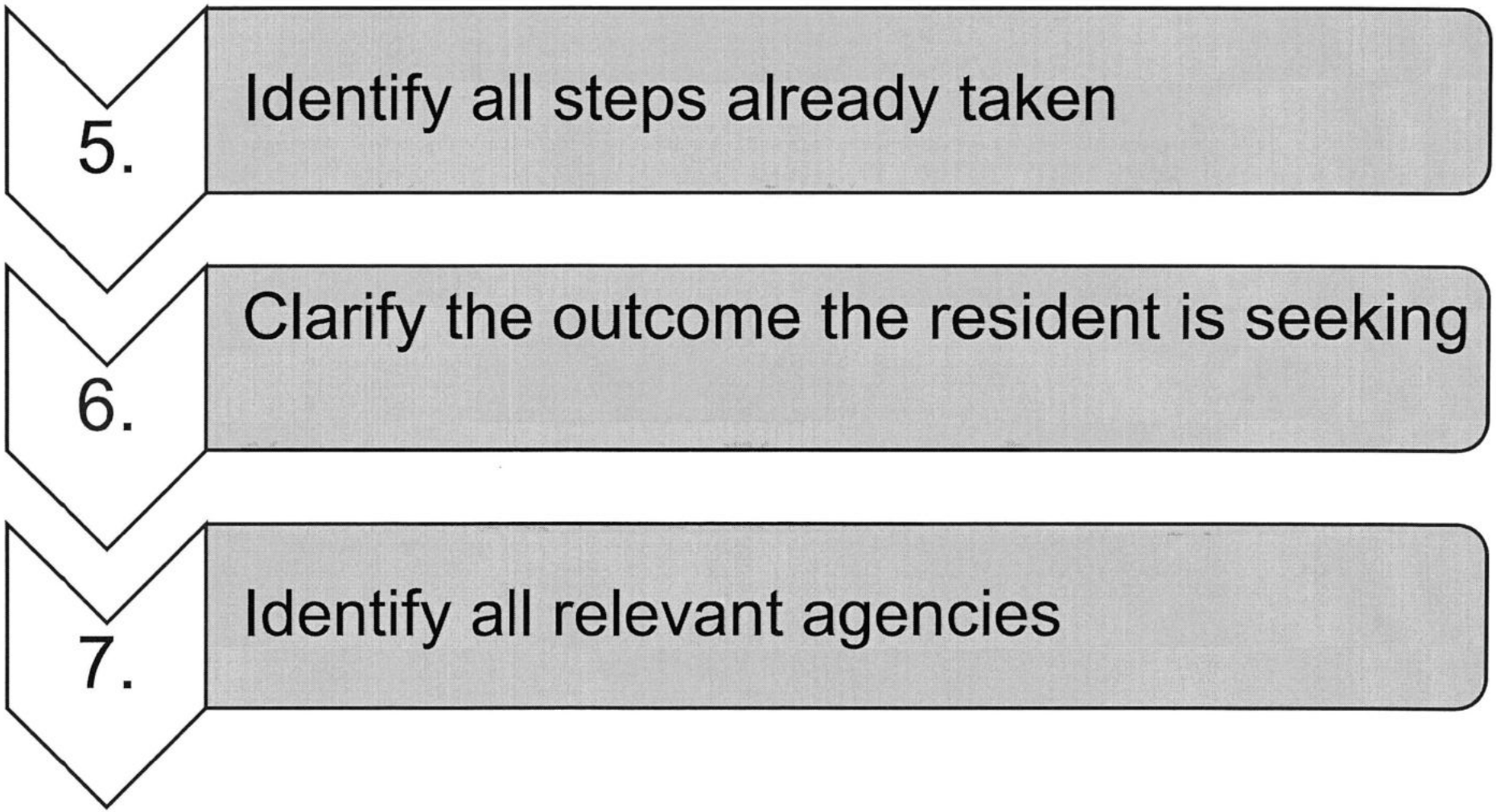


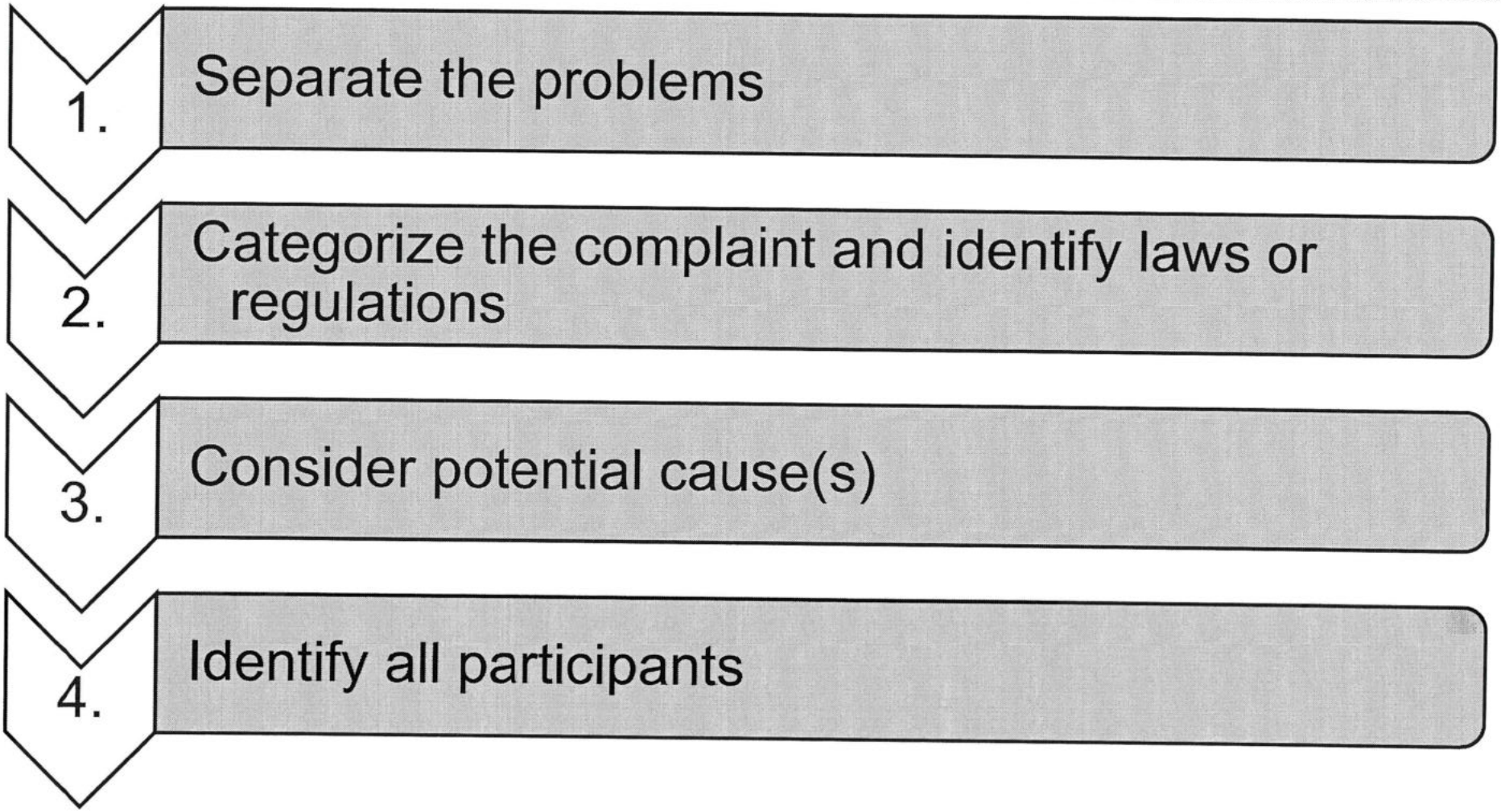
- **Why** the problem is occurring or has occurred.
- **What** steps have been taken to resolve the problem?
- **Who** has been contacted about the concern?
- **What** the facility has done in response to the problem.
- **What** is the resident's perspective of the problem?
- **What** the resident's wishes are regarding complaint resolution.



Initial Plan Development




5.
Identify all steps already taken
6.
Clarify the outcome the resident is seeking
7.
Identify all relevant agencies


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

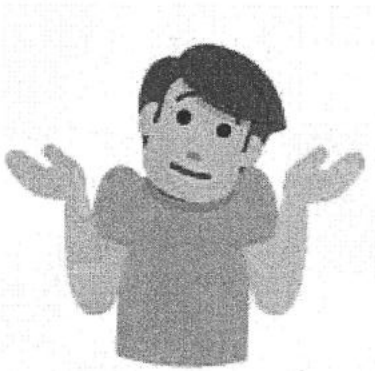
- Will you help me get more therapy?
- The facility is going to kick me out, can you do something about it?
- I want to be able to use the phone in private, is there anyone you can talk to about it for me?

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!



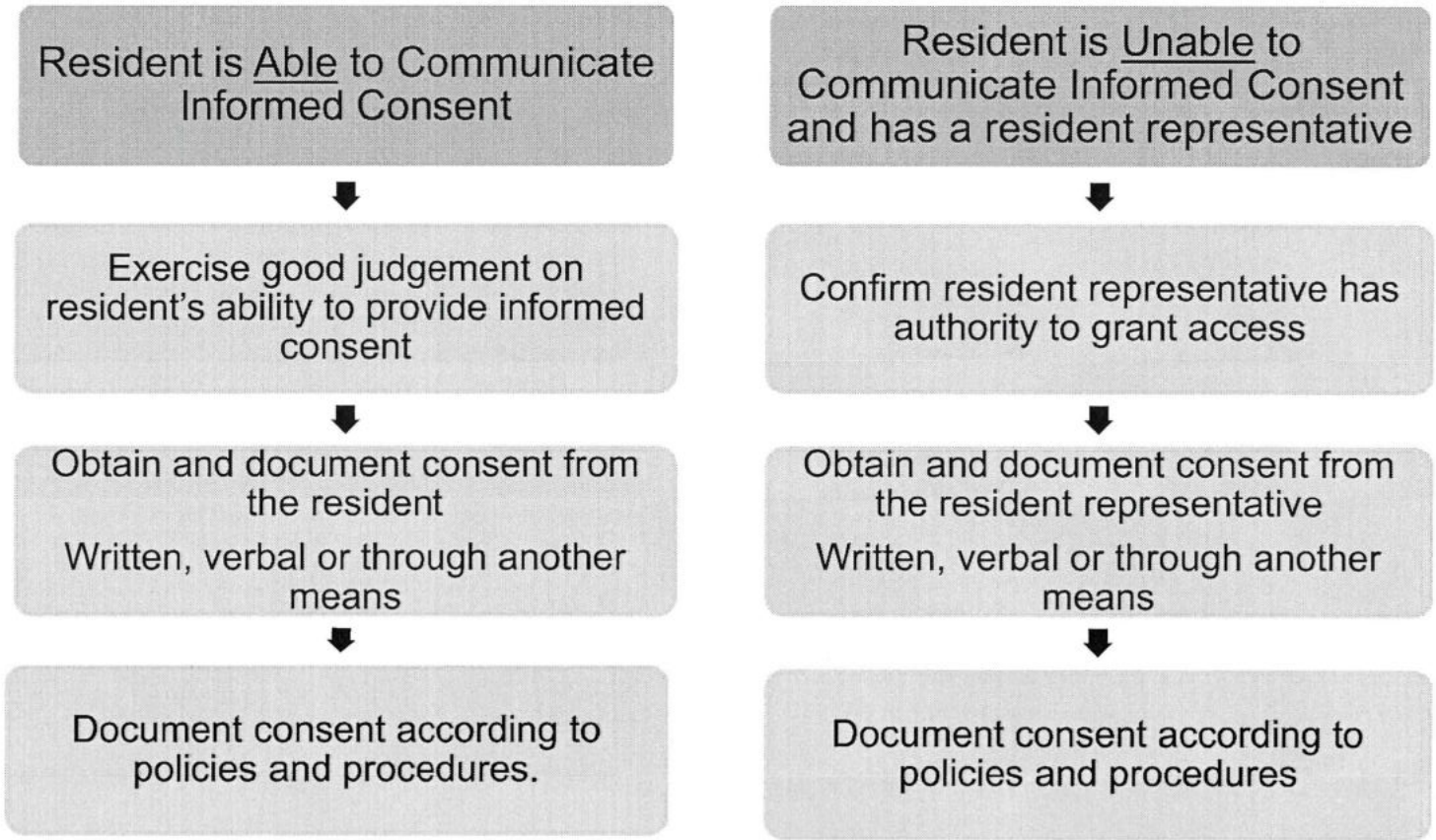
Is there anyone I can talk with about your concerns?

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

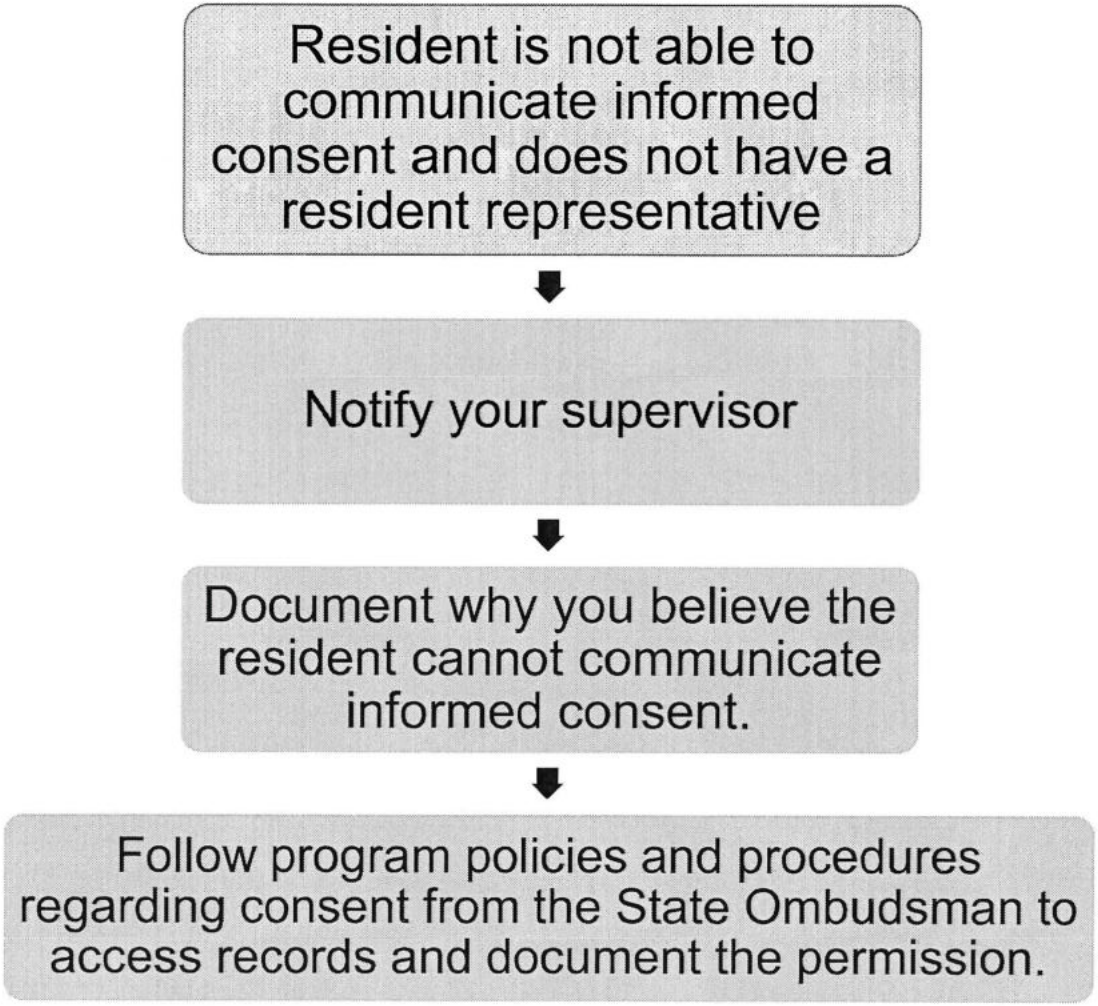


Resident is unable to communicate informed consent, and the resident representative refuses to consent to the access and the resident representative is not acting in the best interests of the resident or the resident representative cannot be located despite a reasonable effort.

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 ofthe 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.

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
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, with held 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

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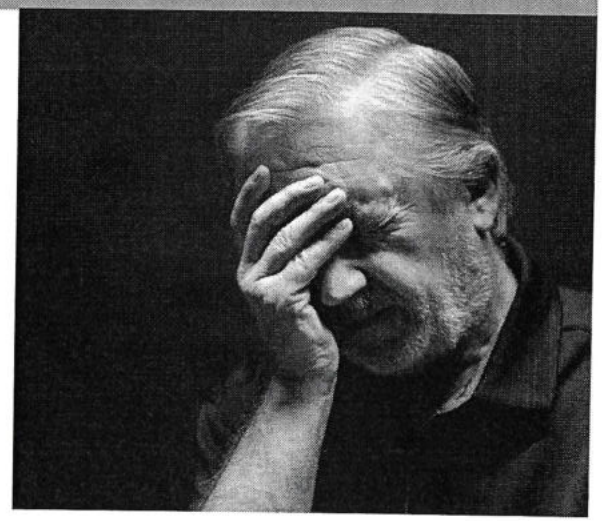
F. Care	F. Care	F. Care
Failure to respond to requests for assistance	Accident or injury of unknown origin, falls, improper handling Care plan/resident assessment - inadequate, lack of patient/family involvement, failure to follow plan of physician orders Contracture	Medications - administration, organization
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	Activities - appropriateness of choice Resident conflict, including room mates	
Social services - availability	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)	Administrator unresponsive, unavailable	Abuse investigation/reporting, including failure to report
Resident or family Council/committee interfered with, not supported	offering in appropriate level of care (for B&C/similar)	Inadequate or illegal practices, record keeping Insufficient funds to operate Operator inadequately trained

Case Study: Mr. Richards



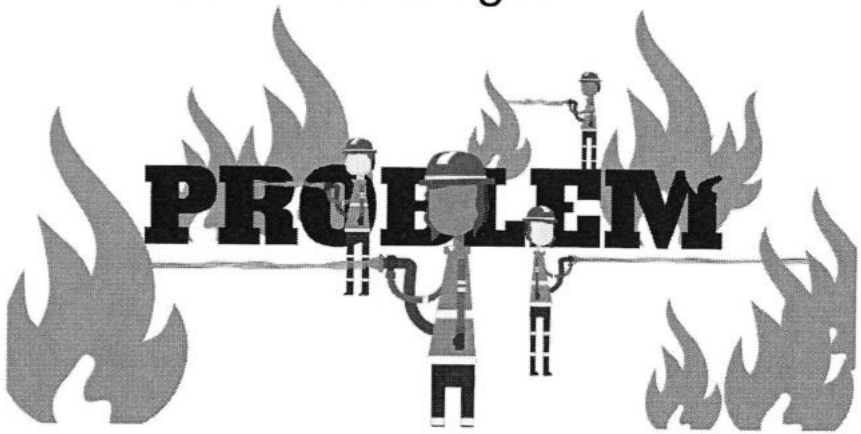
Mr. Richards has been in a nursing facility for several months when his wife starts to notice a change in his health.

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.

1. 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.



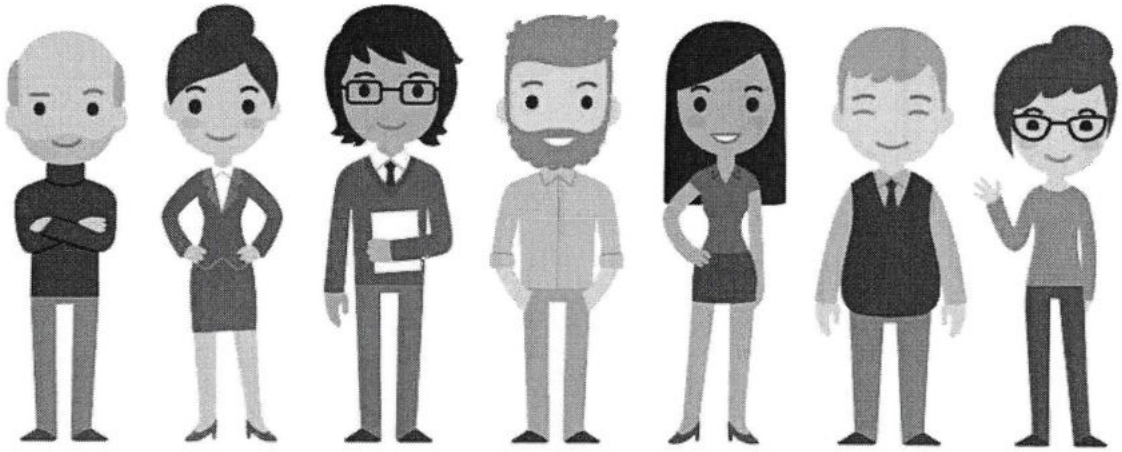
2. Categorize the complaint and identify laws or regulations

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

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



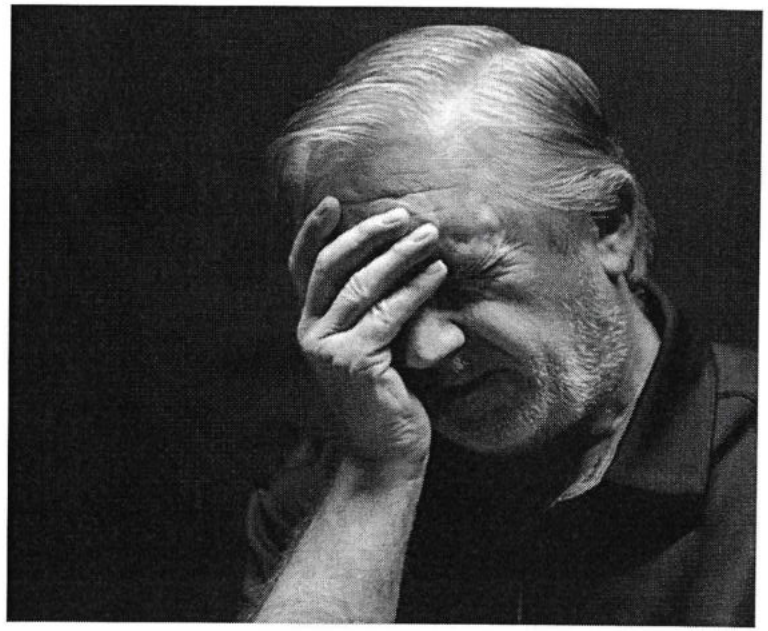
- Mr. Richards
- Mrs. Richards
- Care Plan Coordinator
- Director of Nursing
- Charge Nurse
- Certified Nursing Assistants (CNAs) who cared for Mr. Richards two months ago
- CNAs who currently care for Mr. Richards
- Mr. Richards' physician

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?

6. Clarify the outcome the resident is seeking

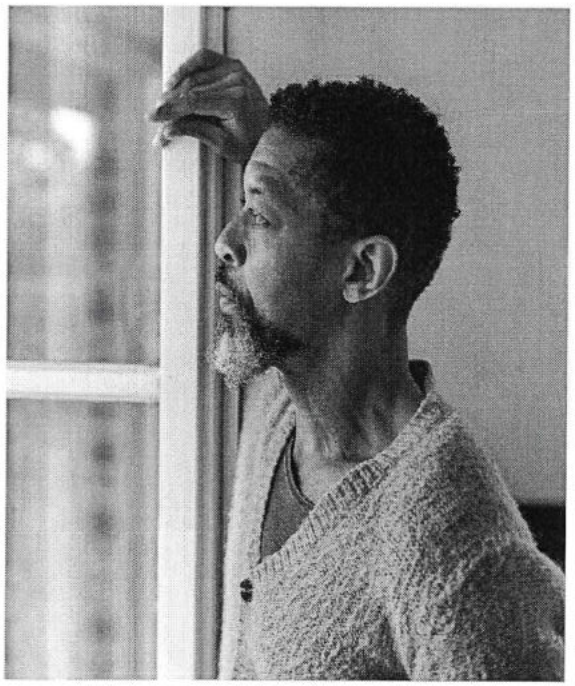
- A comprehensive assessment
- A care plan meeting that includes Mr. Richard's physician
- Consistent staffing for Mr. Richards
- To be listened to when expressing concerns



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.

Tel. 202. 332.2275, email: info@theconsumervoice.org, website: www.theconsumervoice.org

Verified

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

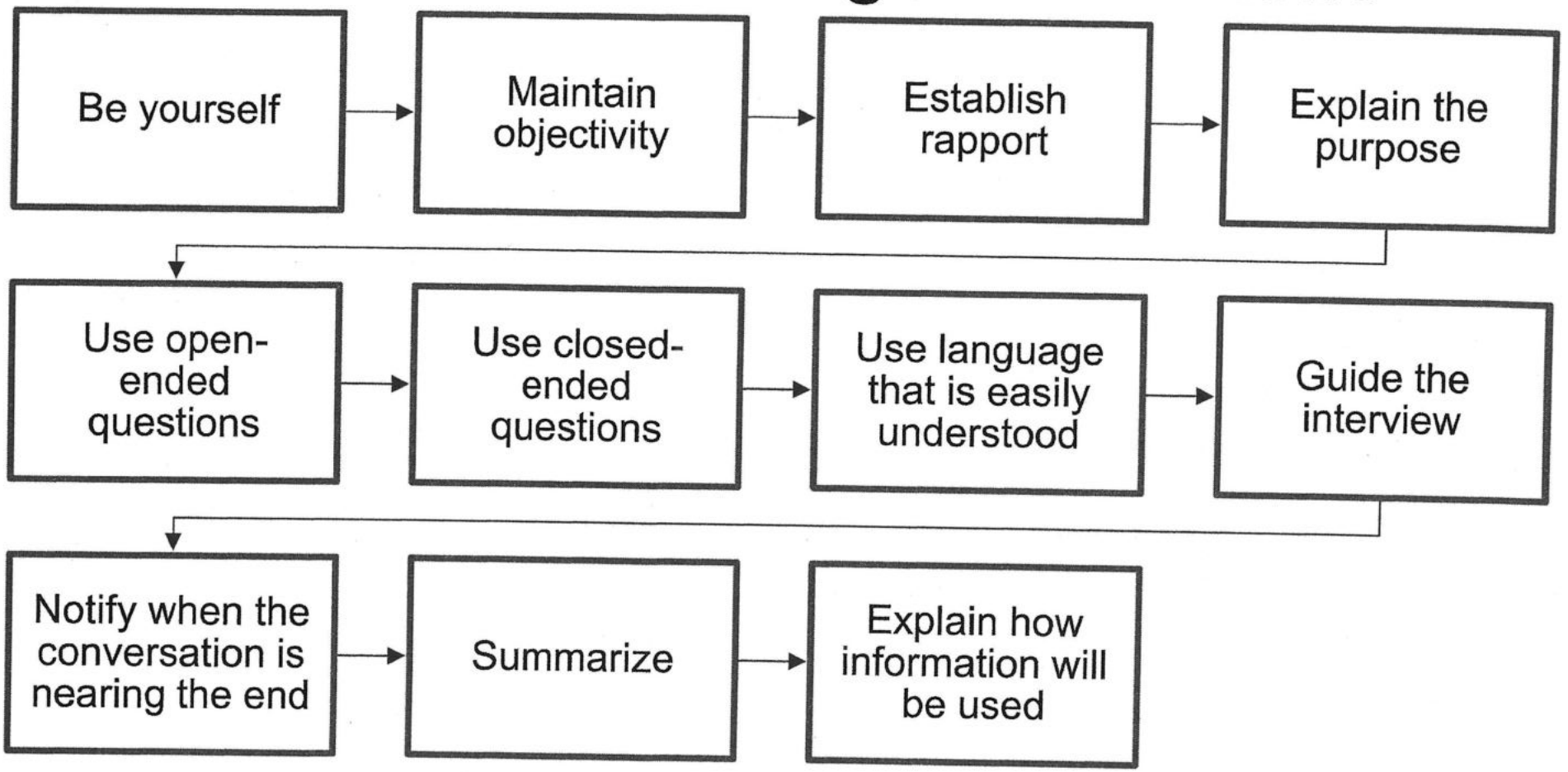
What if the complaint cannot be verified but the resident's perception of the problem still exists?

Not Verified

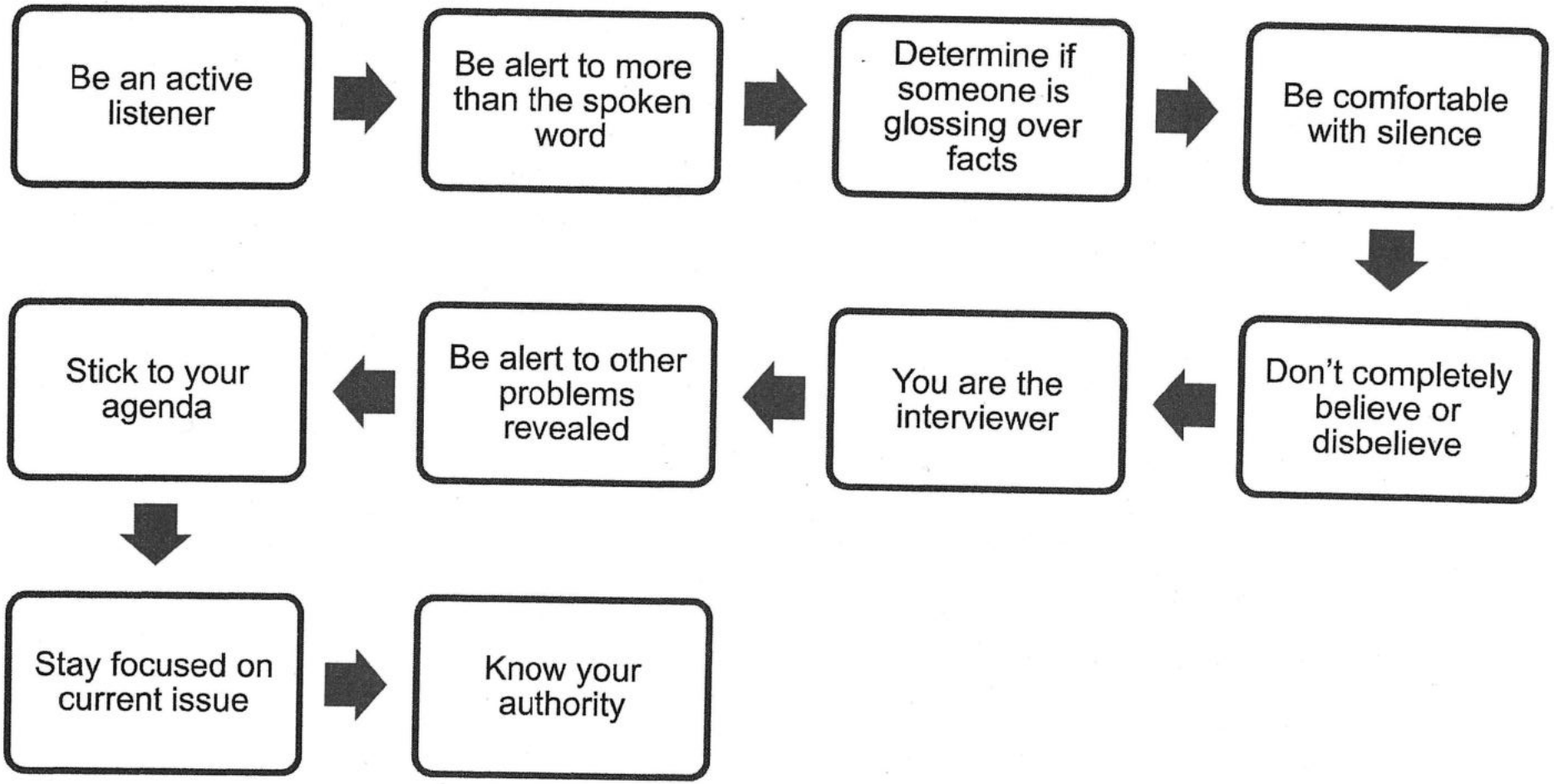
The circumstances of the complaint are found to be untrue.

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 livening 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

CMS
CENTERS for MEDICARE & MEDICAID SERVICES

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 PAC

PRINTED: 10/21/201
FORM APPROVE
OMB NO. 0938-039

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	[redacted]	A. BUILDING _____ B. WING _____	10/20/2010

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
[redacted]	[redacted]

RECEIVED NOV 02 2010 DIVISION OF HEALTH SYSTEMS REGULATION DEPT. OF PUBLIC HEALTH

(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 000	INITIAL COMMENTS	F 000		

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 SS=D	483.10(b)(11) NOTIFY OF CHANGES (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	(X6) DATE
[redacted]	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 safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 owing 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.

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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	• 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. Responsible: Director of Nursing	10/17/10 10/17/10 ongoing PA ~~2/28/11~~ too ar

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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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 SS=D	483.20(k)(3)(i) SERVICES PROVIDED MEET 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	F281 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.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 281	Continued From page 3 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: 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. 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 7/710 identified the resident with no cognitive deficits;		• 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.	10/18/10 10/29/10 10/25/10 11/30/10 2/28/11 RAC

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

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
[redacted]	[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 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 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. • 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. • 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. • 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. Responsible: Director of Nursing	10/17/10 10/17/10 ongoing 11/30/10 ~~12/8/10~~
F 309 SS=D	483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Each resident must receive and the facility must provide the necessary care and services to attain	F 309		

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

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
[redacted]	[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) COMPLETIC DATE
F 309	Continued From page 5	F 309		

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.

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.

- 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. — 1[illegible]0
- 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~~ [illegible]

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

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
[redacted]	[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 309	Continued From page 6	F 309		

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 7/710 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

- 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~~ RAC

Responsible: Director of Nursing

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

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

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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(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) COMPLETIO DATE
F 309	Continued From page 7 documentation until healed.	F 309		

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

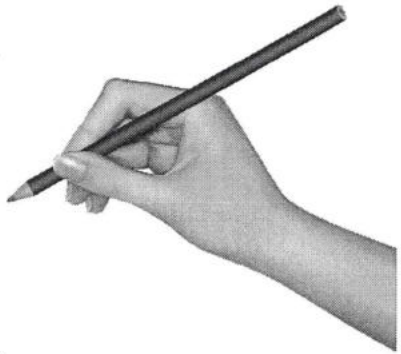
The following CT General Assembly state statutes provide resident rights protections for CT assisted living and residential care home residents: 17a-405 to 17a-422 Protection of the Elderly

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-cnb6; CT General Assembly; CMS Nursing Home Compendium, 2015.

Call lights not being answered	Administrator
Residents are bored	DON
Cold food	Charge nurse
Sticky floors	Maintenance supervisor
Poor staff attitudes towards residents	Activities director
Broken sink	Housekeeping manager
Soiled laundry in the resident's room	CNA
Not included on shopping trips	Business office manager
Resident's bill	Social service director
CNAs waking residents at 4:00 AM	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 hone 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 share 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 "SPRIIT 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

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 nurs 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.

The National CONSUMER VOICE for Quality Long-Term Care formerly NCCNHR

FACT SHEET

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.

Tel. 202. 332.2275, email: info@theconsumervoice.org, website: www.theconsumervoice.org

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 polices 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 work-force, and promotes best practices in delivering quality care. We accomplish these efforts through:

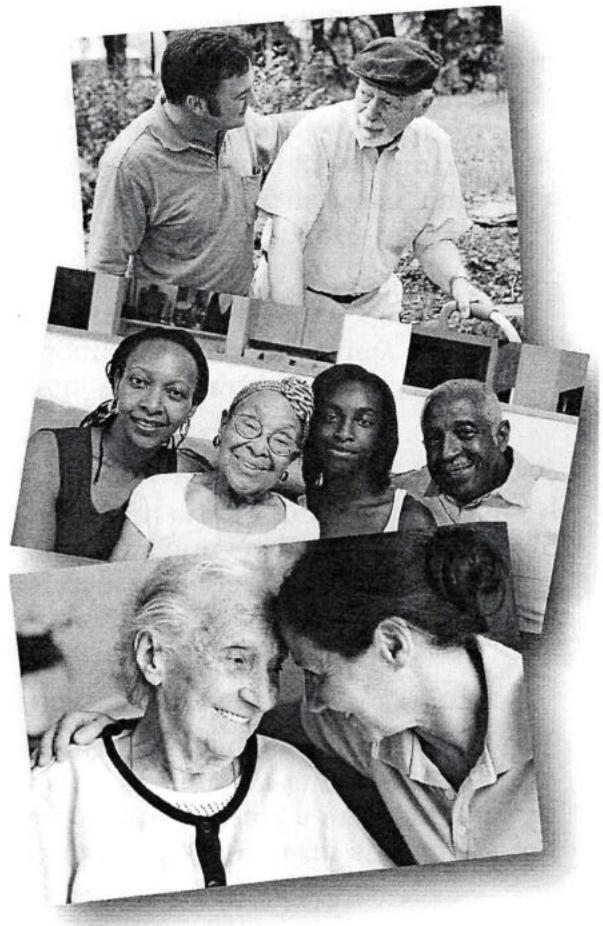
- **Advocating** for public policies that support quality of care and life;
- **Empowering** and **educating** consumers and families;
- **Training** and **supporting** individuals and groups to advocate for and empower consumers; and
- **Promoting** the critical role of direct-care workers and best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

Contact Us

P: 202-332-2275
E: info@theconsumervoice.org
www.theconsumervoice.org
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

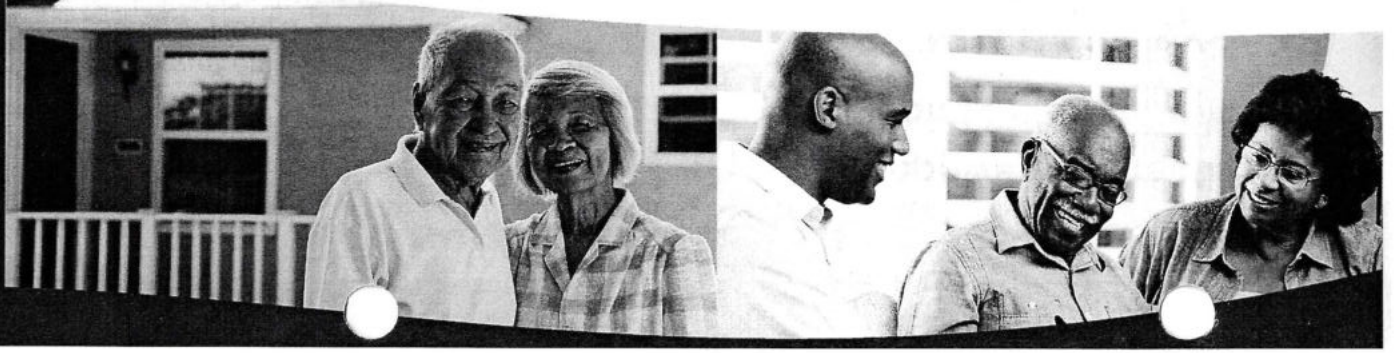
The Consumer Voice has resources, information, and opportunities for family councils. Visit **http://theconsumervoice.org/issues/family/family-council-center** to learn more.

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.



NCCNHR The National Consumer Voice for Quality Long-Term Care

Consumer Fact Sheet February 2008

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

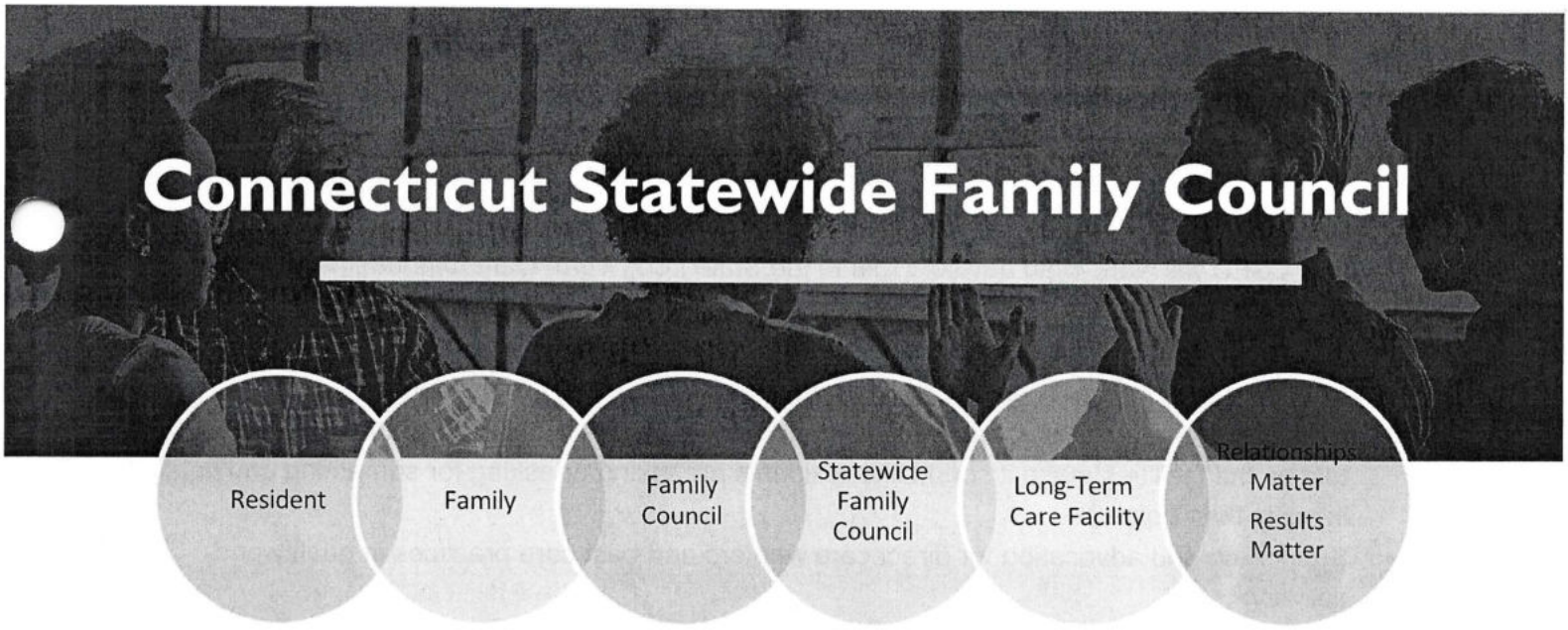
- Gives family members a place to constructively channel their anger and concerns within the nursing home as an alternative to filing complaints with outside agencies such as the ombudsman program or survey agency.
- The opportunity to meet privately with other families enables family members to discuss 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.

1828 L Street, NW, Suite 801, Washington, DC 20036.
Tel.: 202.332.2275 Fax: 202.332.2949 Email: nccnhr@nccnhr.org Website: www.nccnhr.org.



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.

- 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?pwd=WmtKN3ZwSjFzNXlyczNyazc0VDJxZz09 copy & paste link into web browser

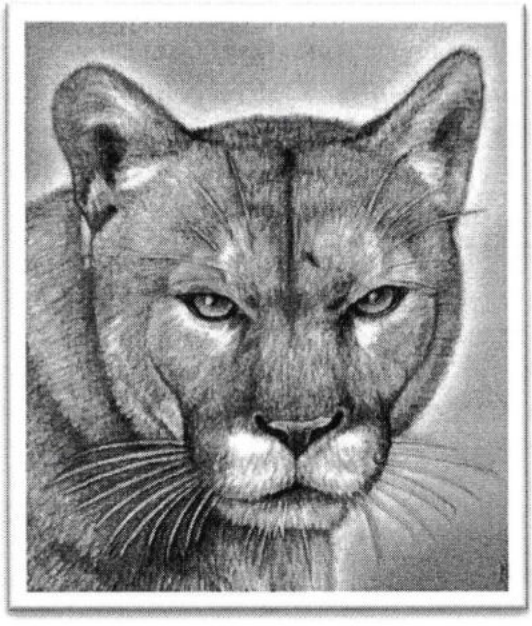
Dial: +1 929 205 6099

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,

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IN THIS NEWSLETTER

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.

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 is it 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 OMBUDMAN 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,

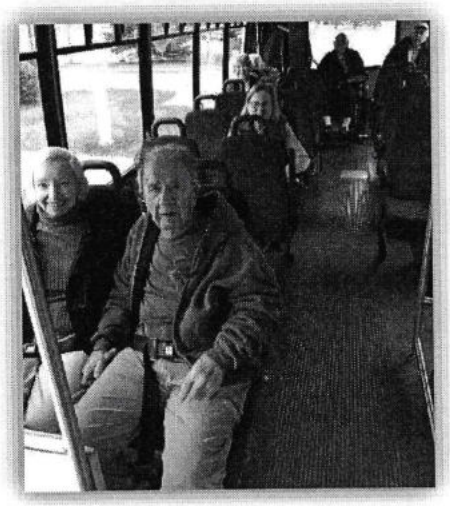
David E. Peck

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. Out 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

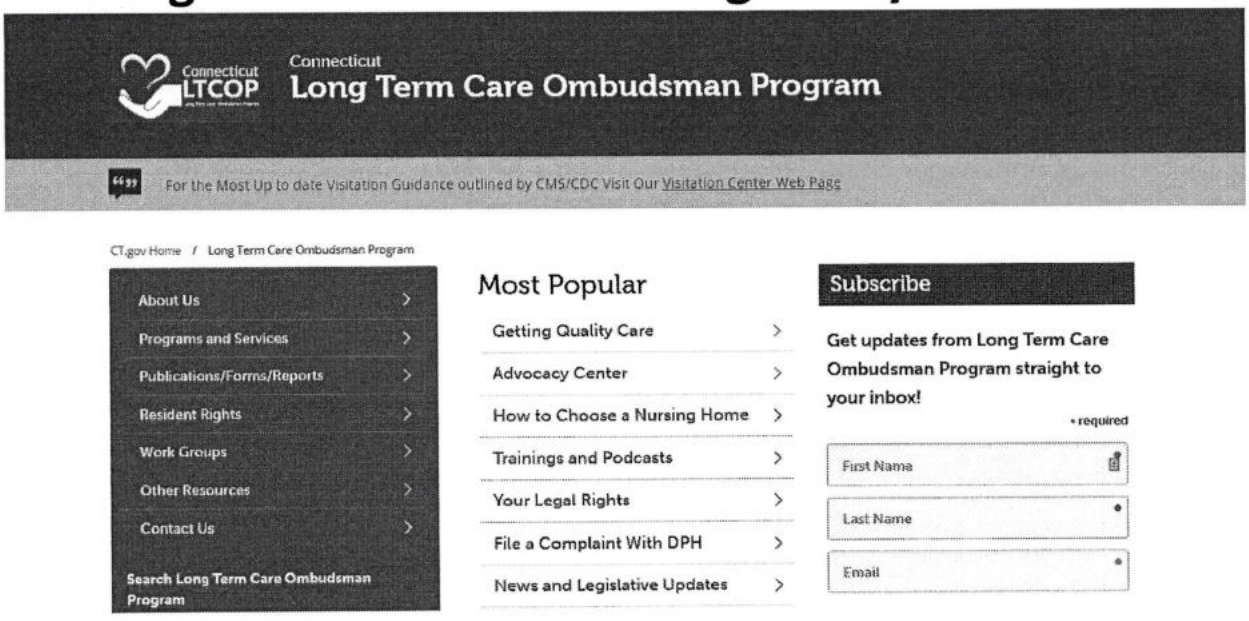
Please visit our page and click "Like"

**** 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!



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

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

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

WESTERN REGION

INTAKE NUMBER 203-597-4181
Deborah Robinson - Intake Coordinator
Regional Ombudsmen
Sylvia Crespo, Tasha Erskine-Jackson

SOUTHERN REGION

INTAKE NUMBER 860-823-3366
Stephanie Booth/Andre Pope - Intake Coordinator
Regional Ombudsmen
Dan Lerman, Patricia Calderone, Daniel Beem

NORTHERN REGION

INTAKE NUMBER 860-424-5221
Stephanie Booth/Andre Pope - Intake Coordinator
Regional Ombudsmen
Brenda Texidor, Brenda Foreman, Lindsay Jesshop

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

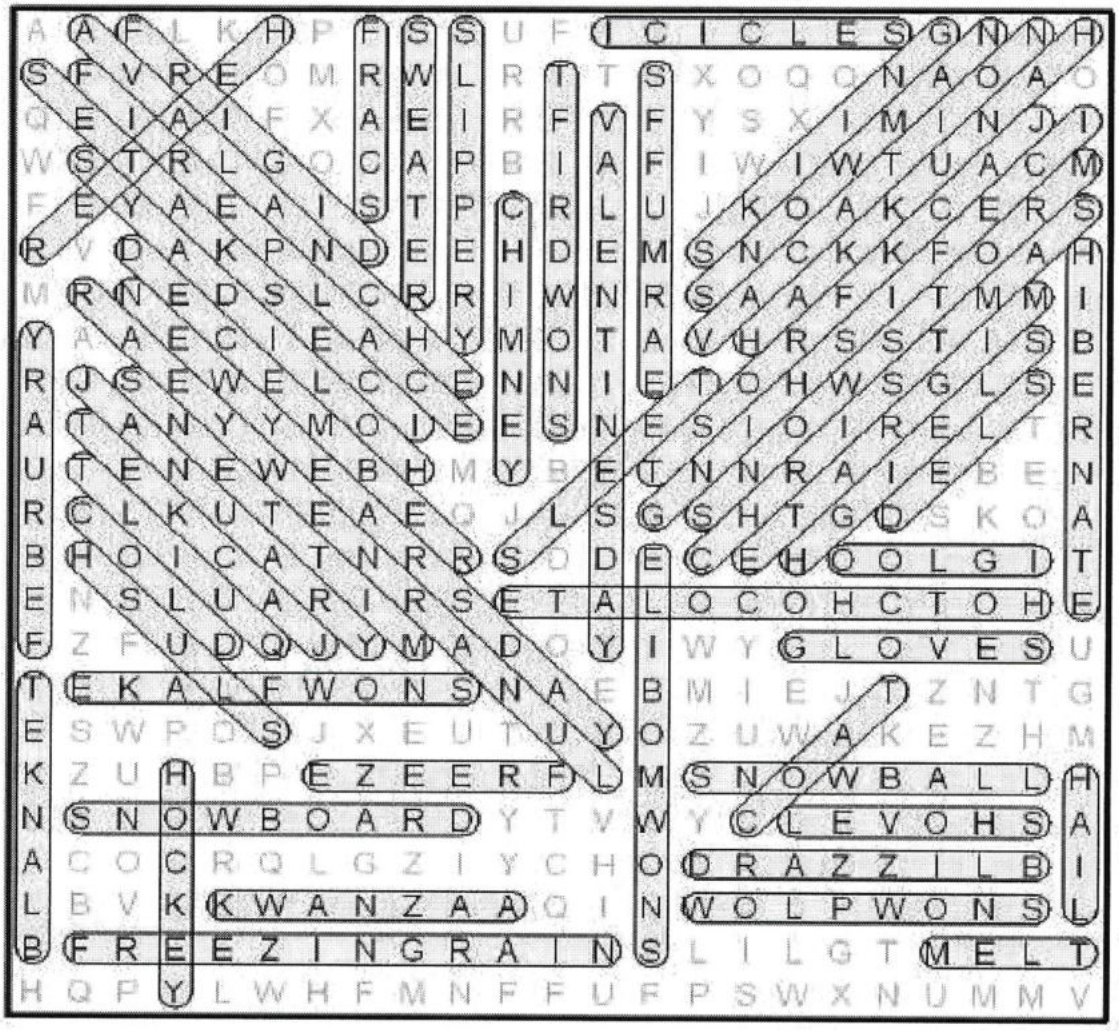
Website: https://medicareadvocacy.org/

Winter Wonderland

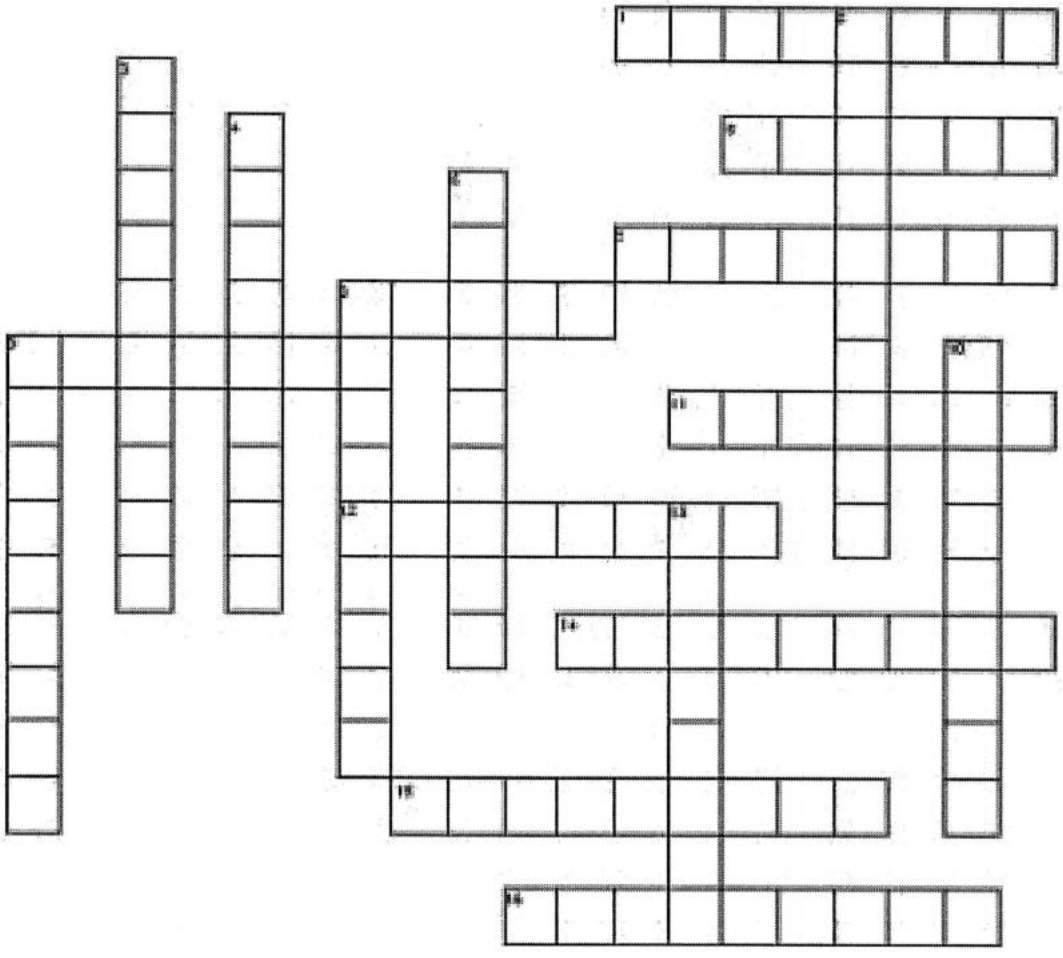
This monster word search includes more than 50 winter words going in every possible direction. Can you find them all?

avalanche	gloves	January	slippery
blanket	hail	Kwanzaa	slush
blizzard	Hanukkah	lunar new year	snowball
chimney	heater	melt	snowboard
Christmas	hibernate	migrate	snowdrift
coat	hockey	mittens	snowflake
cold	holidays	New Year's Day	snowman
December	hot chocolate	quilt	snowmobile
earmuffs	ice fishing	scarf	snowplow
February	ice skates	shovel	snowstorm
fireplace	icicles	skiing	sweater
freeze	igloo	sled	vacation
freezing rain	Jack Frost	sleet	Valentine's Day
frigid	jacket	sleigh	

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 articial snow.

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

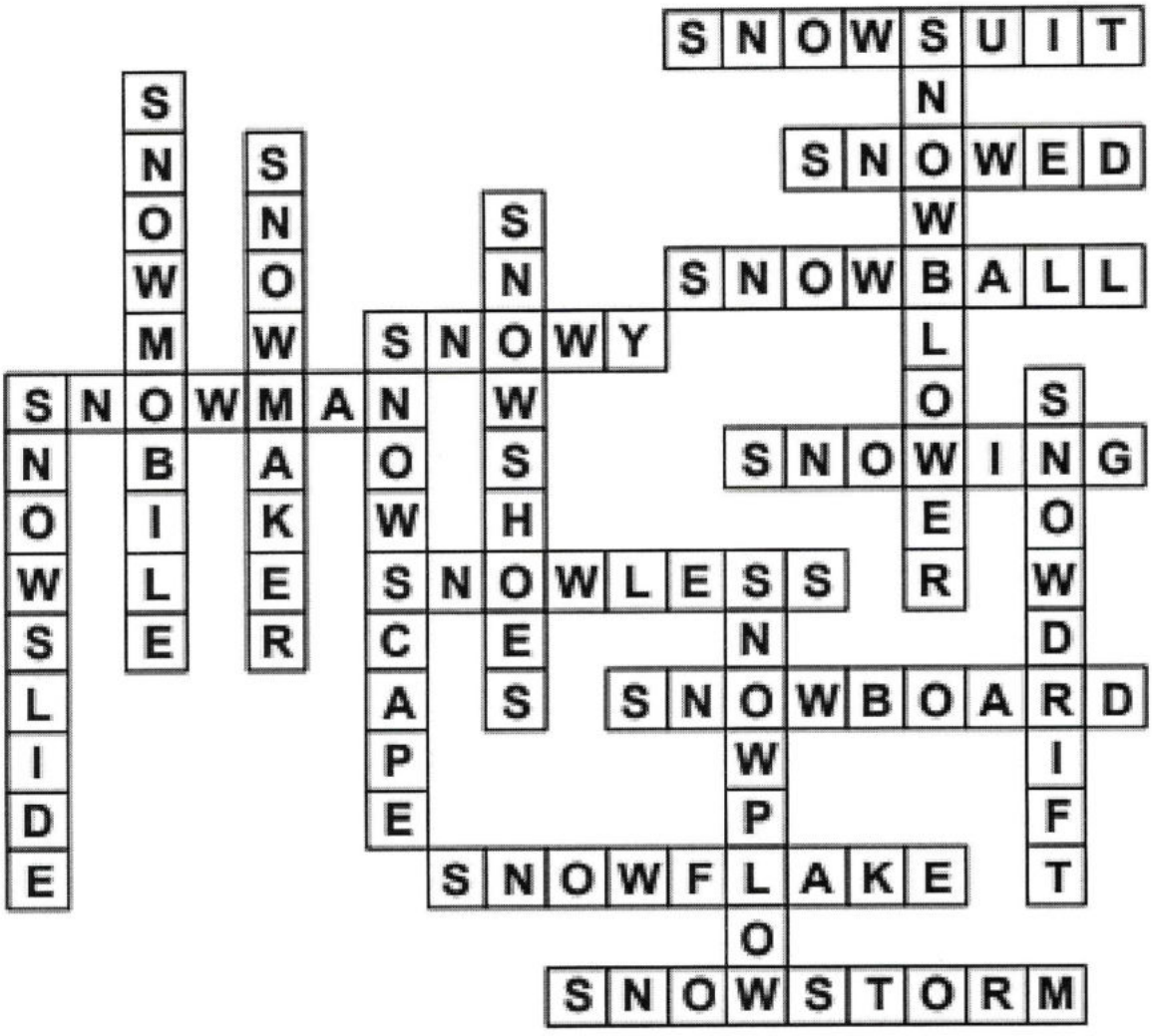
8. A landscape covered with snow.

9. An avalanche of snow.

10. A large bank of snow.

13. A machine used to remove snow from roads.

Answer Key



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

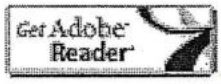
There is no verification of the information you enter. You are responsible for entering all information. Some information must be handwritten on the form.

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):** ☐ SSN ☐ FEIN WRITE/TYPE SSN/FEIN NUMBER ABOVE
BUSINESS NAME, TRADE NAME, DOING BUSINESS AS (IF DIFFERENT FROM ABOVE)	

BUSINESS ENTITY: ☐ CORPORATION ☐ LLC CORPORATION ☐ LLC PARTNERSHIP ☐ LLC SINGLE MEMBER ENTITY
☐ NON-PROFIT ☐ PARTNERSHIP ☐ INDIVIDUAL/SOLE PROPRIETOR ☐ 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.* ☐ *SAME AS VENDOR ADDRESS ABOVE.*

REMIT ADDRESS STREET CITY STATE ZIP CODE

CONTACT INFORMATION: NAME (TYPE OR PRINT)

1ST BUSINESS PHONE:	Ext. #	HOME PHONE:
2ND BUSINESS PHONE:	Ext. #	1ST PAGER:
CELLULAR:		2ND PAGER:
1ST FAX NUMBER:		TOLL FREE PHONE:
2ND FAX NUMBER:		TELEX:

WRITTEN SIGNATURE OF PERSON AUTHORIZED TO SIGN PROPOSALS ON BEHALF OF THE ABOVE NAMED VENDOR ⇐SIGN HERE	DATE EXECUTED
TYPE OR PRINT NAME OF AUTHORIZED PERSON	TITLE OF AUTHORIZED PERSON

IS YOUR BUSINESS **CURRENTLY** A DAS *CERTIFIED* SMALL BUSINESS ENTERPRISE? ☐ YES *(ATTACH COPY OF CERTIFICATE)* ☐ NO

IS YOUR BUSINESS **CURRENTLY** A CT DOT *CERTIFIED* DISADVANTAGED BUSINESS ENTERPRISE (DBE)? ☐ YES ☐ 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

Form **W-9**
(Rev. October 2007)
Department of the Treasury
Internal Revenue Service

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.

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

Social security number

or

Employer identification number

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 [1]
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.

VENDOR INVOICE FOR GOODS OR SERVICES RENDERED TO THE STATE OF CONNECTICUT
CO - 17 REV. 10/2010

STATE OF CONNECTICUT
OFFICE OF THE STATE COMPTROLLER
ACCOUNTS PAYABLE DIVISION

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

(1) BUSINESS UNIT NAME	(2) BUSINESS UNIT NO.	(3) INVOICE NO.	(4) INVOICE AMOUNT
ADS/LTCOP			

(5) DOCUMENT DATE	(6) INVOICE DATE	(7) ACCOUNTING DATE	(8) RPT. TYPE	(9) VENDOR FEIN/SSN ID / ADDRESS CODE

VENDOR / PAYEE: FIELDS 9,10,14 and 18 ARE MANDATORY FOR PAYMENT

(10)
PAYEE:
PAYEE:
ADDRESS:
ADDRESS:
ADDRESS:
CITY: STATE : CT COUNTRY: ZIP CODE :

(11) VOUCHER NO.

(12) VOUCHER DATE

PREPARED BY

(13) VENDOR COMMENTS

(14) GIVE FULL DESCRIPTION OF GOODS AND / OR SERVICES (TO BE COMPLETED BY VENDOR)	(15) QUANTITY	(16) UNITS	(17) UNIT PRICE	(18) AMOUNT
			.56	
			TOTAL	

VRA Signature: _____

RO Signature: _____

BUSINESS UNIT USE ONLY

(19) AMOUNT	(20) QUANTITY	(21) FUND	(22) DEPARTMENT	(23) SID	(24) PROGRAM	(25) ACCOUNT	(26) PROJECT/ GRANT	(27) CHARTFIELD 1	(28) CHARTFIELD 2	(29) BUDGET REFERENCE
		12060	62911	20835	52992	50800	30101	191010	-----	2021

(30) DEPARTMENT NAME AND ADDRESS

Department on Aging and Disability Services
55 Farmington Ave, 12th Floor
Hartford, CT 06105

(31) PO NO.

(32) COMMODITIES RECEIVED OR SERVICES RENDERED - SIGNATURE

(33) PO BUSINESS UNIT

(34) RECEIVING REPORT NO.

(35) DATE(S) OF RECEIPT(S)

SHIPPING INFORMATION

(36) DATE SHIPPED	(37) FROM - CITY / STATE	(38) VIA - CARRIER	(39) F.O.B.

VRA_____ Facility_____ Mo/Yr_____

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___ N___ If yes please document.

Other Observations, Notes, and Comments.

VRA________________ Facility________________ Mo/Yr________

Name ______________________________ Date ____________
Room Number __________ Ethnicity ____________ Age (approx) ______
Complaint: ______________________________
____
Intervention: ______________________________
____
Resolution: ______________________________
____
______________________________ Case Status: OPEN ☐ CLOSED ☐

Name ______________________________ Date ____________
Room Number __________ Ethnicity ____________ Age (approx) ______
Complaint: ______________________________
____
Intervention: ______________________________
____
Resolution: ______________________________
____
______________________________ Case Status: OPEN ☐ CLOSED ☐

Name ______________________________ Date ____________
Room Number __________ Ethnicity ____________ Age (approx) ______
Complaint: ______________________________
____
Intervention: ______________________________
____
Resolution: ______________________________
____
______________________________ Case Status: OPEN ☐ CLOSED ☐

Name ______________________________ Date ____________
Room Number __________ Ethnicity ____________ Age (approx) ______
Complaint: ______________________________
____
Intervention: ______________________________
____
Resolution: ______________________________
____
______________________________ Case Status: OPEN ☐ CLOSED ☐

Sheet 2 – Front

VRA ______________________ Facility ______________________ Mo/Yr ________

Name ______________________ Date ______________
Room Number ____________ Ethnicity ______________ Age (approx) ________
Complaint: ______________________
Intervention: ______________________
Resolution: ______________________
Case Status: OPEN ☐ CLOSED ☐

Name ______________________ Date ______________
Room Number ____________ Ethnicity ______________ Age (approx) ________
Complaint: ______________________
Intervention: ______________________
Resolution: ______________________
Case Status: OPEN ☐ CLOSED ☐

Name ______________________ Date ______________
Room Number ____________ Ethnicity ______________ Age (approx) ________
Complaint: ______________________
Intervention: ______________________
Resolution: ______________________
Case Status: OPEN ☐ CLOSED ☐

Name ______________________ Date ______________
Room Number ____________ Ethnicity ______________ Age (approx) ________
Complaint: ______________________
Intervention: ______________________
Resolution: ______________________
Case Status: OPEN ☐ CLOSED ☐

Sheet 2 - Rear

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 de-certification 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 **Date:**
Email Address: **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

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.

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.

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.

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

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

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.

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: _____

Selected Websites for Long Term Care Consumers

Consumer and Government Links

www.ct.gov/ltcop - 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/CertificationandComplianc/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=| 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 - 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 - 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/ - 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

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

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