LTCCC LONG TERM CARE COMMUNITY COALITION
Working to improve long term care through research, education & advocacy

Using Law and Regulation to Protect Nursing Home Residents When Their Government Fails Them

> If the tenets of our national nursing home reform law are learned, understood, appreciated and practiced, a nursing facility can and will offer a high quality, supportive and nurturing culture for its residents and also its staff…. We are proud of this law for it speaks to and for everyone living in a nursing facility and for those of us… who are, according to statistics, potential residents…. We have a clear direction and a strong foundation for good care in nursing homes. But, alas, it is not that simple…
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> *- Elma Holder, founder of the National Citizens' Coalition for Nursing Home Reform, speaking about the Nursing Home Reform Law of 1987 at a conference in April 2005.*

by Richard J. Mollot, Esq.

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About The Long Term Care Community Coalition

The Long Term Care Community Coalition (LTCCC) is a non-profit policy and advocacy organization that works to improve the lives of long term care consumers by strengthening regulation and enforcement and by educating consumers, policy makers & the news media. LTCCC functions as a coalition of over two dozen organizations joining together to protect the rights and welfare of long term care consumers in all settings, including nursing homes, assisted living facilities and managed long term care. For more news and information, or to make a tax-deductible donation to support our work, please visit www.ltccc.org.

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Executive Summary

In 1987 Congress passed the Nursing Home Reform Law as part of the Omnibus Reconciliation Act of 1987 (OBRA 87). Passage of this law was a watershed event in our country's approach to nursing home standards. Following an Institute of Medicine report to Congress which identified widespread problems of abuse, neglect and inadequate care, the law was promulgated to protect nursing home residents and to put an end to widespread, unnecessary suffering.

OBRA 87 established national standards for care and residents' rights for people in nursing homes. At its heart is the requirement that each resident be provided with services sufficient to attain and maintain his or her highest practicable physical, mental, and psycho-social well-being. To realize this mandate, many new federal requirements were established, including: a resident assessment process leading to development of an individualized service plan, the right to organize and participate in family or resident councils, the right to be free of unnecessary restraints (physical or chemical), and specific requirements for those most responsible for resident dignity and care - nursing home inspectors (surveyors), long term care ombudsmen and direct care workers.

The impetus for the present study lies in the failure to achieve so many of the promises codified in OBRA 87. As we approach the 20th anniversary of the law, why are so many nursing home residents still suffering because of inadequate care and abuse? Why are so many residents neglected or treated without dignity every day? Rather than focus on how things have gone wrong, however, the goal of this report is to help nursing home residents, family members, advocates, ombudsmen and like-minded policy makers make the promise of OBRA 87 a reality. It is not meant to be a comprehensive manual; if a simple "blueprint" for achieving OBRA 87's goals were possible, then those goals would probably not have eluded our society for so long. Rather, the report, with special sections focusing on legal remedies and state innovations, ombudsman activities, and in-depth interviews with individuals who are innovators in the fight to improve care and quality of life for nursing home residents, is meant to serve as a starting point for understanding fundamental rights, identifying some potential solutions to overcoming obstacles and, most importantly, encouraging individual and systemic advocacy.

PART I: BACKGROUND AND BASIS IN THE LAW FOR NURSING HOME RESIDENT PROTECTIONS

OBRA 87: The Key Legal Protection for Nursing Home Residents

The Nursing Home Reform Act, which became federal law as part of the Omnibus Reconciliation Act of 1987 (OBRA 87), is the foundation for most of the legal rights and protections for nursing home residents in the United States. Though the law pertains only to nursing homes that receive federal funding through Medicaid or Medicare, because the vast majority of facilities are certified to receive reimbursement for Medicaid or Medicare services, the law has served as a de facto industry-wide standard.

OBRA 87 came about as a result of Democratic congressional members' reaction to the Reagan Administration's proposal to reduce nursing home regulation in 1982. "Among the rules being considered for repeal were basic requirements that nursing homes maintain a safe and sanitary environment and respect the privacy and dignity of residents. The Administration's proposed rule also would have reduced the frequency of nursing home inspections, weakened the requirements for corrections of deficiencies, and relinquished responsibility for inspections to a private organization."[1]

Ultimately, the Administration agreed to postpone implementation of the proposed changes until the Institute of Medicine completed a study on the adequacy of nursing home regulation and reported their findings to Congress. The Institute of Medicine report[2] told of widespread misuse of physical and chemical restraints, horrendous failures in care, which was sometimes so deficient that it "is likely to hasten the deterioration of their [nursing home residents'] physical, mental, and emotional health."

OBRA 87 codified many of the recommendations made in the Institute of Medicine report. It contains specific provisions for the three key "players" responsible for resident care and protection: the nursing home staff who provide direct care, the state surveyors (inspectors) who are responsible for ensuring compliance with laws and regulations, and the long term care ombudsmen who advocate for residents individually as well as systemically.

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[1] *Overview of Representative Henry A. Waxman's Efforts To Improve Nursing Home Conditions* (available at http://www.house.gov/waxman/issues/health/issues_health_nursing_homes.htm).

[2] *Improving the Quality of Care in Nursing Homes* (Institute of Medicine, 1986).

Staffing

The Institute of Medicine report called for an increase in staffing standards to improve nursing home care, which led to the implementation of OBRA 87's staffing standards. OBRA 87 required an RN director of nursing, an RN on duty for eight hours a day, seven days a week, and a licensed nurse (either an RN, LPN or both) on duty around the clock for nursing facilities. The law established minimum standards for nurse aides, who provide approximately 90% of the direct care to residents: they must undergo a state-approved training curriculum of a minimum of 75 hours, pass a certification exam and undergo continuing education for the duration of their careers. Many states, recognizing that need for additional training to meet the arduous demands of nurse aides, have instituted higher training requirements.[3]

The law also requires that there be "sufficient" nursing staff to provide enough nursing and related services for residents to attain or maintain the "highest practicable" physical, emotional and psycho-social well-being. It is important to note that the law does not specify a numerical standard for minimum hours, but rather a standard that focuses on expected outcomes for nursing home residents. This distinction has been a decisive issue ever since, for while it mandates a level of staffing that will seemingly ensure resident well-being and dignified treatment, the lack of an easily measurable, quantitative requirement has proven disastrous for nursing home residents because, in effect, it has meant that there is no staffing level requirement whatsoever.

Survey System

As a result of OBRA 87, the nursing home survey system (the backbone of government oversight efforts) was markedly improved, with an increased focus on outcomes for residents and tougher enforcement mechanisms, including monetary sanctions for substandard care. The functional success of these changes, however, has depended on the political will and priorities of state and federal policy makers, the power of provider groups to weaken enforcement and regulatory interpretation and the ability of consumers and consumer advocates to "make the case" for strong enforcement.

[3] For more on nurse aide training requirements around the country, see our report, *Nurse Aide Training in New York: An Overview of Programs and Their Regulation by the State, with Recommendations for Improvement* (Available at www.ltccc.org/publications).

Long Term Care Ombudsman Program

Prior to the events leading up to promulgation of OBRA 87, concerns with the quality of care in nursing homes in the 1970s led to the formation of the ombudsman program. Since that time, the program has been greatly expanded. Under the Older Americans Act,[4] every state is required to have a Long Term Care Ombudsman Program. The responsibilities of the ombudsman program include advocating for residents of nursing homes and other long term care facilities, helping with resident complaints, and ensuring resident and family participation in the survey process. The advent of OBRA 87 resulted in a significant expansion of the ombudsman program's scope of activities and bolstered its focus on resident-centered care. However, similar to the situation with the survey system, the ability of an ombudsman program to function independently and fulfill its role (as defined in the Older Americans Act and OBRA 87) is dependent on the political will of the state policy makers on whom the ombudsman program rely.

After OBRA

As the culmination of the fight to stop deregulation of the nursing home industry, OBRA 87 had a significant and immediate impact. Not only did the law prevent the drastic diminishment in standards proposed by the Reagan Administration, it also led to numerous tangible changes such as more rigorous requirements for direct care staff (in terms of both staffing levels and training requirements), the parameters for conducting nursing home inspections (surveys), and the use of physical and chemical restraints.

Though it raised the bar for nursing home standards significantly, nursing homes continue to be, for good reason, the option of last resort. While not every nursing home is terrible, and there is a small but growing provider movement dedicated to resident-centered care[5], resident neglect and abuse are system wide problems. Study after study[6] has confirmed that

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[4] US Code Title 42, Chapter 35(A)(ii) Sec. 3058(g) (Available at http://www.ltcombudsman.org/uploads/OAASLTCOP.pdf).

[5] For more information on culture change in nursing homes, see examples like the Pioneer Network (www.pioneernetwork.net) and the Eden Alternative (www.edenalt.com).

[6] See, for examples, *Nursing Facilities, Staffing, Residents, and Facility Deficiencies*, 1998 Through 2004, Charlene Harrington, Ph.D., et al. (available at http://www.nccnhr.org/public/245_1267_11874.cfm), *Malnutrition and Dehydration in Nursing Homes: Key Issues in Prevention and Treatment*, Sarah Greene Burger, et al. (available at http://www.nccnhr.org/pdf/burger_mal_386.pdf), *Nursing Home Quality: Prevalence of Serious Problems, While Declining, Reinforces Importance of Enhanced*

nursing homes are commonly understaffed and that malnourishment, dehydration and pressure sores are commonplace (though all three are generally preventable with adequate care). These and the many other problems that nursing home residents and caregivers face every day, lead to the fundamental question: why are the protections of OBRA 87 and other laws not effectively safeguarding nursing home residents today?

As with most attempts to institute requirements on a profitable and powerful business sector, there have been ongoing, formidable activities to diminish the OBRA 87 mandates by weakening interpretation and enforcement of the law (and of subsequent laws and regulations). Given the industry's influence on both federal and states' governments, these activities have met with considerable success. As a result, lax enforcement and lenient interpretations of regulations have resulted in a nursing home care system that still fails to fulfill the promise of OBRA 87 for many, many consumers.

There are many studies and reports – by foundations, research groups and even the government itself[7] – which have identified and addressed the myriad of problems relating to the ability of federal and state governments to ensure that nursing home residents receive the care they need and are treated with dignity. As mentioned earlier, there is a vigorous movement in the private sector (and among likeminded public officials) to incapacitate regulatory enforcement and weaken interpretations of both laws and regulations.

Our purpose in this work, however, is not to join in that debate, but rather to help the non-expert identify what OBRA 87 and other laws require and, contrasting that with the hard reality for many nursing home residents, think about new and innovative ways to tackle the problems facing nursing home residents. In short, when legal mandates are ignored, and residents are harmed or are suffering as a result, what can be done to make things better?

Oversight (and numerous other Government Accountability Office studies of nursing home conditions, staffing and oversight available at www.gao.gov).

[7] In addition to the references mentioned above see, *inter alia*, The Commonwealth Fund (http://www.cmwf.org/topics/topics.htm?attrib_id=11990), The Kaiser Family Foundation (http://www.kff.org/) and the Institute of Medicine (http://www.iom.edu/CMS/3718.aspx).

The Short List: What Are the Basic Tenets of OBRA 87[8] That Residents and Their Advocates Can Rely on?

- "Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care."
- Nursing homes are required to 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… (i) Bathe, dress, and groom; (ii) Transfer and ambulate; (iii) Toilet; (iv) Eat; and (v) Use speech, language, or other functional communication systems."
    - Every resident receives "appropriate treatment and services to maintain or improve his or her abilities specified [above]."
    - "A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene."
    - "A resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that they were unavoidable and any resident with "pressure sores receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing."
    - Similarly, the law requires that a resident's urinary continence, mental and psychosocial functioning, range of motion and ability to eat are maintained, unless the individual's clinical condition demonstrates that the change is unavoidable.
    - "Each resident's drug regimen must be free from unnecessary drugs."
- "A facility must care for its residents in a manner and in an environment that promotes maintenance or enhancement of each resident's quality of life."
- "The facility must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality."

[8] Title 42 of Federal Regulations, Part 483, Requirements for States and Long Term Care Facilities (42CFR483) (available at http://www.access.gpo.gov/nara/cfr/waisidx_01/42cfr483_01.html).

- "When a resident or family group exists, the facility must listen to the views and act upon the grievances and recommendations of residents and families concerning proposed policy and operational decisions affecting resident care and life in the facility."
- Every nursing home "must have sufficient nursing staff to provide nursing and related services to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident…"
- "The facility must be designed, constructed, equipped, and maintained to protect the health and safety of residents, personnel and the public."

Older Americans Act: Title VII Vulnerable Elder Rights Protection[9]

The federal Older Americans Act (42 U.S.C. 3001 et seq., as amended) provides definitions of elder abuse and authorizes the use of federal funds for the National Center on Elder Abuse and for certain elder abuse awareness, training, and coordination activities in states and local communities, but does not fund adult protective services or shelters for abused older persons.

When the Act was reauthorized in 1992, Congress created and funded a new Title VII, Chapter 3 for prevention of abuse, neglect and exploitation. Title VII Vulnerable Elder Rights Protection is designed to serve as an advocacy tool and includes provisions for long term care ombudsman programs and state legal assistance development.

In the most recent amendments of 2000, Congress called on states to foster greater coordination with law enforcement and the courts. Title VII Vulnerable Elder Rights Protection has proven instrumental in promoting public education and interagency coordination to address elder abuse.

In the area of legal rights, Title VII includes a provision for a legal assistance developer in each state to serve as a focal point at the highest state level for all aspects relating to legal services for the elderly. Unfortunately, since 1992, no funds have been appropriated for this chapter. Since the early 1990s, elder abuse prevention funding has remained relatively constant at slightly over $5 million. Funds are divided on the basis of the 60 and older population of each state.

[9] http://www4.law.cornell.edu/uscode/html/uscode42/usc_sec_42_00003058---i000-.html.

PART II: FACING THE CHALLENGE: INTERVIEWS WITH INDIVIDUALS WHO HAVE BEEN LEADERS OR INNOVATORS IN THE FIGHT TO PROTECT RESIDENTS

When the Omnibus Reconciliation Act of 1987 (OBRA 87) was signed into law, the legal expectations of nursing home care changed. The Nursing Home Reform Law, which was part of OBRA 87, required that every resident receive care sufficient to enable them to attain and maintain their highest practicable physical, mental, and psycho-social well-being. While OBRA 87 did result in many significant changes for nursing home residents, the problems of nursing home neglect and abuse persist, and too many nursing home residents suffer because neither the word nor the spirit of the law are adequately enforced.

The following interviews were conducted with people who we identified as key leaders in the field of nursing home consumer protection. The purpose is to provide insights into the activities of people whose work has been particularly innovative. Each has made a significant impact in the field of long term care either in their state or nationally, and their work ranges from legal advocacy to policy advocacy to citizen education. We believe that they provide insights that can help others who are working to make the promise of OBRA 87 a reality.

NAME: Eric Carlson
GROUP/FIRM NAME: National Senior Citizens Law Center, www.nsclc.org

Eric Carlson is an attorney in the Los Angeles office of the National Senior Citizens Law Center (NSCLC). Mr. Carlson specializes in the law governing long term care facilities, including nursing homes and assisted living facilities. He counsels attorneys from across the country in issues relating to long term care, and also participates in litigation on residents' behalf. He was co-counsel in *Podolsky v. First Healthcare Corp.,* 50 Cal. App. 4th 632, 58 Cal. Rptr. 2d 89 1996 (which established that "guarantee agreements" - requiring a financial guarantee of payment as a condition of admission to the nursing home - that had been used routinely by facilities were illegal and unenforceable).

Mr. Carlson is the author of numerous publications and articles, including "Long Term Care Advocacy," the leading legal treatise on long term care issues. He is the principal author of NSCLC's Nursing Home Law Letter, a comprehensive bimonthly summary of developments in long term care. Mr. Carlson received his B.A. from the University of Minnesota in 1982, and

his J.D. from Boalt Hall School of Law at the University of California at Berkeley in 1988.

Questions

What was your most important activity that resulted in protection of a nursing home resident(s)? I would like to think that it is the consumer guide we put out a couple of months ago called "20 common nursing home problems and how to resolve them." I was able to use all the problems I've handled over the years and put them in a 40 page book that can be read by everybody; made to understand what the law is in long term care settings. That is the most effective thing I've done because it allows me to reach thousands of people.

What is the background/history preceding your action/activity? I've been doing this kind of work since 1990 and spent 10+ years working with individuals in a legal aid clinic for nursing home issues. I learned many things going through these advocacy battles and noticed that it's the same situation over and over again. There are only so many I can help individually and thought this [a book] would be the best way to reach a large number of people.

What was the specific incident (if any) that instigated activity? A few months into my job (the Nursing Home Reform Law was still very new it had been effective for only a few months) and a woman came in because her husband was about to be booted out of his nursing home. I thought to make some kind of appeal, and the nursing facility immediately backed down with a letter from the corporate council. I found that I can actually do something positive about this; where nursing facilities are not doing what they should be doing. There is an element of instinct in this kind of regulation.

What are the top things that you would want to tell or advise others who would want to replicate your success? Since I'm a lawyer, I would say you have to understand what the law is and you have to go out and reach people. I would tell them that if you just sit in your office and wait for your phone to ring, that your phone is not going to. You need to do something to get out there to do promotion and education; and so people have belief that there is room for improvement. Especially among LTC residents, it's easy to let things slide and accept the status quo.

Are you aware of other exceptional instances where an individual or organization was able to improve nursing home resident care/quality of life in a unique or innovative way? Obviously all sorts of good work are

being done, but someone that really stands out from everything else is Allison Hershel. She heads a citizens group in Michigan that strikes me as extremely active. And Michigan has always seemed to have an energized advocacy committee. I attribute a lot of it to Allison.

Are there any specific resources you would recommend? This summer I coauthor a book called "Baby-boomer guide to nursing home care" and among some subjects it will cover is Medicare with a focus on problem resolution. This will come out in June. And for advocates I have written a large volume "Long Term Care Advocacy" published by Matthew Bender. Another great resource is the NCCNHR publication "Getting Good Care There." In addition Robert Kane's book is an excellent resource and is based on his consumer experiences trying to find help for his mom. He and his wife have tried to organize an advocacy organization for family members of the LTC community.

NAME: Jeff Crollard
GROUP/FIRM NAME: Washington State Long Term Care Ombudsman Program

Jeff Crollard's law practice focuses primarily on elder rights and long term care issues. Since 1990, Mr. Crollard has been the attorney for the Washington State Long Term Care Ombudsman Program. The ombudsman program, with approximately 450 ombudsmen, advocates on behalf of residents living in nursing homes, boarding homes, assisted living facilities, veterans' homes, and adult family homes. In addition, Mr. Crollard represents residents and elders who have been injured, abused, neglected, or exploited.

Jeff Crollard is a frequent speaker and trainer of other advocates, care providers, residents, attorneys, and state licensors and investigators. He serves as an expert witness, is an active member of the elder law section of the state bar association, and participates extensively in state policy, regulatory and legislative issues concerning vulnerable adults and residents of long term care facilities. Mr. Crollard is a 1979 graduate of the University of Washington, and in 1985 received a joint law degree and masters in public policy from the University of California, Berkeley.

In his interview, Mr. Crollard highlights the importance of taking the time to thoroughly examine each complaint, where in most cases damning evidence is recorded and used for a provider's defense. For example, Mr. Crollard recounts a case of a man in an assisted facility who was being evicted on the grounds that careless use of his wheelchair was putting

other residents at risk. On closer examination it was the wheelchair's joystick that malfunctioned and to boot the resident's eyeglass prescription was far overdue. Obviously the facility was not performing its task of periodic healthcare management. But most importantly the resident was made to sign a waiver taking responsibility irrespective of any underlying reasons for damages. Mr. Crollard emphasizes a substantive law passed in Washington 1994 that includes a provision prohibiting waivers of potential liability by consumers. He calls this the protector of all other rights because it ensures that providers complete whole care planning. However, Mr. Crollard warns that such provisions are useless unless there is proper enforcement measures put into place.

Questions

What was your most important activity that resulted in protection of a nursing home resident(s)? The most important thing really involved assisted living and adult family homes, or in some places board and care with a spin off effect on nursing home enforcement. Many years ago, in 1994, we essentially cloned a lot of federal laws and passed a statewide resident rights law for assisted living including some protection from discharges transfers. This established a substantive law. For those concerned, non-nursing homes can usually provide care a little less expensively than nursing homes. And at the time, there were egregious examples of people living in these facilities who weren't extended even elementary rights such as receiving mail! Many states have piecemeal laws and confer a lot of discretion on facilities about whom they will take and who they will take out.

The single best provision in the law is a statute that says the facility cannot ask or require that a resident or their representative waive potential liability for any losses or injury or waive any of their rights. And that's a very important provision (the protector of all the other rights). This provision has helped in all sorts of ways; for example, I had a case where a person who used a power wheel chair and occasionally bumped into walls and into other residents facility was told they violated institution rules and had to drive safely. He was made to sign a waiver that basically said he would take responsibility for any damage made to the facility or other residents. Now what that does is that no matter whatever the underlying reasons might be, if I cause damage I waive your potential liability. We told the facility that they cannot have residents sign something like this. Essentially they need to figure out what the problem is, or why is the resident driving a wheelchair like this. It turned out that the joystick was malfunctioning, which caused the wheelchair to accelerate and stall. Furthermore, the resident's eyeglass prescription was out of date. Over time he had

developed contractures in his joints affecting his hands obviously making it more difficult to operate a wheelchair. But with physical therapy, eventually, the resident was able to safely use a wheelchair again.

What the facility should have done in the beginning was reassess the patient and do whole care planning. That is exactly the expected procedure of these facilities, set forth in licensing laws: for a facility to take appropriate interventions. Furthermore what the law does is it binds the caretaker to assessment and care planning. This provision is the most important component of our law and applies to all care facilities. So we have a protector provision but what really matters is how and whether it is enforced.

We always hear of bad cases and for a couple years we would go to the enforcement agency and say "do something about this." And depending on the state agency (they vary across the country), you could very easily get a response that says "you always have bad apples" and honestly it gets frustrating yet understandable if there are too few inspectors to thoroughly look into systemic problems. Part of the problem is that most people in a regulatory field do not see themselves as prosecutors but instead see themselves as policemen who get people to follow rules. So even if I had ten times the amount of inspectors, there still would not be enough to be out at different shifts, so there needs to be multiple pressures on the industry to do the right thing. Some areas include training and some are market pressures (i.e., deaths reported in the paper). But we also need watchdogs like ombudsmen and coalitions and an active state agency. So what we did (and this is the only time it's been done in the country) is we devoted time to looking at licensing and complaint investigation files. We opened agency files without anything blacked out and 20 of us read through them over the course of four or five months. We were able to see patterns; we were able to trace a complaint historically across systems. The reason we were able to do this was by a unique interpretation of the law: We convinced the state that the ombudsman has access to these otherwise confidential files under federal law (which was, therefore, applicable to the state). We were able to see names and phone numbers so would call family members and residents, only to find that we were the first to do so even in unsubstantiated cases. We found urgent cases, which hadn't been attended to in months. So we put together a massive report that gave examples of grim and incompetent investigations, terrible things that had happened repeatedly. We took it to the media and did press conferences around the state; eventually we were able to get good laws passed about pursuit of citations and complaints. Ongoing vigilance is a

necessary component, as is a government agency with greater enforcement authority.

What was the specific incident (if any) that instigated activity? One case that irked us was a group home for developmentally disabled guys. The home was a couple of stories high and had its roof collapsing on about a third of the facility. There was a plastic tarp over the roof, and remember this is in Seattle where it rains nonstop. The tarp was there for three years!!! Meanwhile the ceiling was falling in some rooms, there was mold, and it was cold with water dripping in. Residents were slipping and falling, yet there was no follow-up by the state. We went to the head of enforcement for the state agency and she said, "We're the DOH and we only have so many inspectors so don't come to me with something like this. If you have deaths or rapes, then I have time." This was a proud person whose attitude was we don't need any more help especially with quality of life things. I found that when you look closely at the facts for any specific case, there is some other explanation, mostly to do with bad enforcement.

For example, there was a resident with bad dementia. Her daughter visited at some point and was helping mom get out of bed to the walker and noticed she was wincing regarding one leg and found a bulge on her thigh. It turns out the woman had a fractured femur and it was obviously painful. She was then transferred to a hospital where it was discovered that the fracture had been there at least a week. Which means that in the intervening four or five days, the resident had obviously been showered and it should have been obvious to the bath aid, who had not taken appropriate steps. Now there may have been several causes: she either fell alone or while under supervision, but either way it should have been known to the facility before the daughter discovered it. Records however did show the woman complained of her leg hurting and it's possible that the aid was so incompetent she did not know what was there. On the other hand it could have been lack of staff training or a cover-up. What the DOH focused on was whether the facility took care of the problem when they became aware of it. The answer was yes; the resident was immediately transferred to the hospital, which meant there was no citation leading to an unsubstantiated complaint.

What are the top things that you would want to tell or advise others who would want to replicate your success? It is important to pick bullet proof examples because the people you are accusing are going to be defensive and if you overstate the case for rhetorical purposes, someone

will always find the two cases out of 10 that are exaggerated. Every example must be scrutinized for it to stand up against skepticism.

Are you aware of other exceptional instances where an individual or organization was able to improve nursing home resident care/quality of life in a unique or innovative way? One example that we've done here specific to nursing homes has to do with the issue of mental health services for nursing home residents. Between 20-35 residents have a diagnosable mental illness and nursing homes have an obligation to meet both the physical and mental health needs. For those with serious mental illness, inpatient psychiatric hospitalization becomes an exit from a nursing home. Historically what homes have done is provide little mental health service, with one social worker on staff referring people to community-wide public resources. If more sophisticated intervention is needed, there are limited resources and people go untreated, making them subject to discharge or involuntary commitment.

Every state has a system of mental health professionals that can involuntarily commit a patient. In that body of law, there is a parallel set of laws subject to interpretation, which is that you cannot commit someone if there is a less restrictive alternative. So what I did was I started to train the mental health professionals about what nursing homes' obligations are to provide services. Before you swoop in and take the person out, you should know the following about nursing homes: The obligations to do a reassessment and care planning. So if someone is acting violent suddenly, there may be a medical issue like impacted bowels, electrolyte imbalance or urinary tract infection. Of course, there are really difficult instances when a professional concludes that the nursing home has not completed an obligation and meanwhile this person is a threat to others; in this case, the mental health professional should remove the patient and file a complaint against the nursing home. I knew that the audience I had to reach was the mental health professionals with the power to enforce; it was a way to use the existing nursing home law and hold providers accountable to it. The audience I chose was receptive because these mental health institutions have few beds and each is expensive to occupy, so the training was a success. Advocates need to target key decision points. This system of removing residents to psychiatric units was used as an end run on discharge laws. Again, the approach is how we can use parallel systems to help with enforcement. Unfortunately the obligation to meet mental health needs is not as applicable for assisted living.

Are there any specific resources you would recommend? National senior citizens law center web site. Eric Carlson's paper on 10 or 20 most common problems in care facilities and how to deal with them from around the country. NCCNHR and also Alzheimer Association have resourceful websites. And one thing family members need to do is become as educated as they can about the condition the resident has and the more they understand the more they can serve as watchdogs. This requires families to be out there frequently because every facility I know will drop the ball on at least small things.

NAME: Toby Edelman
GROUP/FIRM NAME: Center for Medicare Advocacy, Inc.
Website: www.medicareadvocacy.org

Toby Edelman is an attorney at the Washington D.C. office of the Center for Medicare Advocacy. She has been an advocate for nursing home residents since 1977 and was a key author of the Nursing Home Reform Law. She represented plaintiffs in *Valdivia v. California Department of Health Services,* in which California refused to adopt the new Nursing Home Reform Law. She argued successfully that California's position would ultimately harm nursing home residents. This momentous victory prevented other states from doing the same. She is a member of the Board of Directors of the National Citizens Coalition for Nursing Home Reform, where she advocates to improve quality of life for nursing home residents. She received an A.B. from Barnard, an ED. M. from Harvard and a J.D from Georgetown University.

In her interview, Edelman points out that one of the biggest challenges facing advocates is finding residents and families who are willing to endure participation in the battle against providers. She felt the full force of the industry when trying *Valdivia* and remembers the extent of their influence on legislatures at both the national and state levels. She shares the effects of earning the media's sympathy and the impact advocates can have if they join together in one common strategy.

<u>Questions</u>

What was your most important activity that resulted in protection of a nursing home resident(s)?

I think the most important work I've done is on *Valdivia v. California Department of Health Services*. California would not implement the Nursing Home Reform Law. The state basically said, "We want federal dollars but we do not want to comply with the law." So we sued the state

and a preliminary injunction resulted. Our bottom line was that California's refusal would harm residents.

The case is extremely important because in 1990, if California had gotten away with it, other states would have followed. Their defense was that their law was a model for federal law, which was not true because no one state was the model. And they said it would be extra money to implement the law, but Congress said that the existing waiver authority was just as costly. The industry continued to strong arm legislators asserting that the reimbursement rate was too low. Ultimately California knew that they would either have to face providers or us in court and they chose us. The industry was so powerful everywhere and it was a very big deal at the time.

First media coverage was sympathetic to the state because the federal government said it would disallow reimbursement for surveying nursing homes since an adequate process was not implemented. In an administrative proceeding the night before the hearing, the secretary [of the Department of Health & Human Services] and the state came up with an agreement allowing California to dictate how the survey process would change. It was an amazing experience to go against such a powerful force; we continued to argue that nursing homes residents would suffer if the law was not implemented. Arguing at the injunction was pretty intense for me and the state claimed they were close to settling with the secretary and the secretary claimed the opposite, that they had reached an impasse. The argument that Mr. Valdivia would not get therapy anyway because he was not improving was disputed by our expert who said that even if Valdivia had reached a plateau, it did not mean he was not improving. I argued that therapy allowed him to walk and under California Medicaid law, therapy was revoked and his condition worsened.

What were the circumstances that impeded your action? Identifying the people who are willing to come forth publicly with any kind of case is difficult because families are worried about retaliation if there is attention brought to an issue. Advocates were really concerned about this in the summer of 1990; who would be willing to come forth? Out of 100,000 residents in California we only got two people. On the other side we were hit in so many different directions and there was so much press attention to this. What the secretary did was come in and conduct the surveys since California wouldn't do it. And the state appealed to the ideas of "state rights" and "big government"; making it extremely difficult to turn the press around. We painted the industry as being very greedy. There were

two substantive issues revolving around the case: 1) Valdavia and the lack of therapy and 2) The use of restraints. We were able to respond to the press by showing how this is about better care for people; and sympathy turned from the state to Medicare advocacy.

What are the top things that you would want to tell or advise others who would want to replicate your success? I hope others do not have to go through what I did; where a state is just not following protocol. We're treated as bleeding hearts and not understanding of reality. But it's important for advocates to come together in a common strategy; cooperation in one position really helps and we don't see that a lot in the legislative arena. It is very hard to fight the nursing home industry individually. We had huge numbers of depositions and the industry intervened as a plaintiff in the end. But we were never on the same side on anything.

Are you aware of other exceptional instances where an individual or organization was able to improve nursing home resident care/quality of life in a unique or innovative way? I think people have had successes by all kinds of advocacy on the state level, particularly in Texas. The state regulator [in Texas] was being beaten up. A legislator admitted that they acted based on industry promptings, of course the industry denied this. A lot of advocacy groups had been working on legislation independently and AARP came in and made nursing home legislation a priority with the power to change legislation, to give authority to go after industry on a corporate wide basis. We need to take stronger action against corporations rather than individual nursing homes. When I went to Texas, it was tremendously important to have AARP working with other advocacy groups. We need to enlist powerful colleagues. There was one individual who was able to change the law based on a nursing home kicking out Medicaid beneficiaries. Federal law was changed and at the bill signing in the White House, Clinton turned to this man and said "When most people have a problem they walk away but you pursued it and made a difference."

NAME: Deborah Truhowsky
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Ms. Truhowsky attended New York University where she earned her B.A. degree. She remained on the East coast where, in 1988, she completed her J.D. degree at Hofstra University School of Law. Ms. Truhowsky then

completed a Masters of Law degree in Business and Taxation from the University of the Pacific, McGeorge School of Law. She is a pioneer in the field of elder abuse and chairs her law firm's Elder Abuse and Neglect Department.

In her interview, Ms. Truhowsky highlights nuances made in the law between abuse and neglect. She emphasizes the importance of public health law in the context of elder abuse; specifically New York's public health law Section 2801-D, which in addition to other causes of action for nursing home negligence, creates a private cause of action for nursing home abuse. Section 2801-d provides that any residential health care facility that injures a resident by virtue of violating any federal statute or code shall be liable to that resident in damages. Ms. Truhowsky spurns the idea that injuries such as bruises, falling and bedsores are unavoidable consequences of growing older or unavoidable conditions of long term care facilities.

Questions

What was your most important activity that resulted in protection of a nursing home resident(s)?

New York State has a fairly new law, Public Health Law (PHL) Section 2801-D, which provides grounds for suing a nursing home for neglect or abuse. It is an excellent piece of legislation; it puts the burden of proof on the facility and not the ones bringing the case.

We are pursuing cases, under PHL Section 2801-d, against nursing homes whose abuse or neglect results in serious injuries or death to a resident. Since this is a new area of law in the State of New York, only one case has gone to verdict holding a nursing home responsible under the PHL Section 2801-d as far as we know. We are currently handling tens of cases and expect several to go to trial this year.

Our goal and expectation is that once we begin to take verdicts against nursing homes that this will create an incentive for the facilities to improve their quality of care. Unfortunately we see over and over again that businesses perform "cost/benefit" analyses. If nursing homes feel that they will have to pay more in the form of jury verdicts or settlements if they continue to engage in poor care, then hopefully they will spend the appropriate money to improve care at their facility.

As this time our adversaries on these cases are using as many delay tactics as they can to prolong our litigation. We are responding to them aggressively each time they do this and will see to it that these cases are

tried. We correlate their desire to stall and delay us with their deep concern of these cases getting to a jury and how outraged a jury will be with their behavior. If a jury is outraged, then the jury will hold them financially responsible.

What is the background/history preceding your action/activity? (NB: This question might overlap with the next, depending on situation.)
In New York, there was little precedent for these types of cases. Therefore, we began to bring these types of cases to court [this has been happening over the last 3-4 years]. There is a sense of urgency because of an aging demographic. It is a much needed change, but there is so much more that needs to be done. We need to do more, use every tool in the arsenal.

What were the circumstances that impeded your action?
We are always dealing with opposition, i.e., defense firms, insurance companies. Nursing homes are afraid of us bringing these kinds of actions because they don't want a large verdict against them. It is sad to say but, for them, it is often more about the economic bottom line and not the altruistic. They are fighting us bringing these cases. They are trying to limit the use of the Public Health Law. They are also trying to limit what the defense is allowed to bring into court.

What facilitated success of your success?
It is too early to say if we are truly a success. We are certainly moving in the right direction, but still very much in the process. The difference or what has contributed to the success so far has been the strong Public Health Law and the determination [of those] to pursue it.

Is there anything that provided strong impetus or support for your action (such as a research study's findings, a court case, news report of abuse, etc…)?
There are few firms that have handled these cases as negligence and not elder abuse. By using the negligence statute, the burden of proof lies on me, and often I couldn't prove my case. By using the Public Health law, (elder abuse) it puts the burden of proof on the nursing homes.

What are the top things that you would want to tell or advise others who would want to replicate your success?
To other lawyers…well there are two things:
1. First, family/ residents don't always know when they are victims of abuse or neglect [it is up to us to help them realize that they are being wronged] and

2. For lawyers, these cases need to be litigated by someone that understands the complexities of the public health law and who is properly trained in identifying what type of wrong is being committed. They need to be able to make the determination of when a case is appropriate to be tried under the public health law and when it should be tried under a negligence statue.

Are there any specific resources you would recommend?
National Association of Trial Lawyers of America (www.atla.org): They have a division /subset called the Nursing Home Litigation Group. Very good resources, they keep a database of information.

PART III: LEGAL ADVOCACY

There are many reasons why it is rare for a nursing home case of neglect or abuse to wind up in court. The frailty of nursing home residents, who are, of course, the direct consumers of nursing home care, is a major impediment; unlike other consumer-provider relationships, most residents cannot walk out of a facility and hire an attorney from the safety of their home or another locale. Their lives, literally, depend on the people they would be accusing of wrongdoing. Indeed, the fear of retaliation is a major impediment to residents filing complaints within the system – to state overseers or ombudsmen – no matter to taking the more serious step of seeking help from an attorney and filing a lawsuit. Pragmatically, even if a resident or family were willing to sue, the odds of a substantive win have been remote. Under traditional legal conceptions of damages, monetary rewards for nursing home abuse and neglect are hard to prove.

Though, as a recent study found, "the legal system's traditional response to concerns about the quality of long term care has been regulation," our investigation turned up a number of examples of innovation in the use of the legal system to tackle nursing home problems.

Following is an overview of causes of action - bases for suing – which have been used successfully in legal advocacy, a review of some state level innovations (both laws and court cases), and a list references for further information and exploration.

Causes of Action

- **Negligence**: A claim of negligence is a logical cause of action in nursing home cases since it requires a duty; violation of that duty; proximate cause; and damages. In addition, "negligence *per se* is a very important cause of action in nursing home cases. The theory of negligence *per se* is based on the reasoning that the statute or regulation sets the standard of care. The unexcused violation of a legislative enactment or administrative regulation is therefore negligence in itself. "[10]
- **Wrongful death** (self-explanatory).
- **Intentional tort**: A deliberate act that causes harm to, for which the victim may sue the wrongdoer. Examples in a nursing home include

[10] *Nursing Home Litigation* (available at http://www.nursing-home-abuse-resource.com/care_center/nursinghome-litigation.pdf).

sexual assault, assault and battery. In this situation, the nursing home would likely be responsible for the actions of an employee.

1. **Negligent hiring and supervision**: "An ongoing problem in nursing home cases is that, despite specified regulations to the contrary, nursing homes remain understaffed as to all employees and particularly understaffed in the more expensive positions, such as Registered Nurses and LVN's. Nurse aides with poor salaries, too little training and little experience provide almost all of the care. Therefore, negligent hiring and supervision of personnel is an ongoing problem. An example of this type of claim in a hospital is found in *St. Paul Medical Center v. Cucil*, 842, S.W.2d 808 (Tex.App.-Dallas 1992, no writ)."[11]

- **Loss of consortium**: Loss of consortium involves a claim by a loved one of the resident – typically a spouse or child – for their suffering as a result of the resident's abuse, unnecessarily deteriorated condition, etc…
- **Third party responsibility claim**:
    - A nursing home can be found liable because of acts of a third party when the nursing home fails to protect residents from other residents or others in the home. A resident may be injured, assaulted or sexually assaulted by another resident.
    - In addition to suing the nursing home, other relevant parties can be sued, including the administrator, director of nursing, any direct care worker that could be responsible for the injury(for example, if there is a claim of failure to give medication, one might sue the medication aide).
- **Breach of statutory or regulatory rights, duties or responsibilities**: Suitable for injuries such as violations of residents' right to autonomy, dignity, or privacy.

[11] *Ibid*.

State Innovations

The following is a subjective review of noteworthy activities on the state level, a product of inquiries made to approximately 35 state attorneys general, discussions with advocates and state officials and research of case law, law journals and other relevant publications.

Alabama: Arbitration clauses in admission agreements
State court allowed class action complaint to be brought against nursing home chain that requires residents to sign admissions agreements with arbitration clause.[12]

California: Punitive damages for abuse or neglect/expansive definition of "elder abuse"
1. The California Supreme Court's decision in *Covenant Care, Inc. v. Superior Court* (86 P.3d 290) held that procedural requirements for alleging punitive damages in malpractice actions did not apply in claims asserted under the Elder Abuse and Dependent Adult Civil Protection Act. The Act provides prevailing plaintiffs with the possibility of noneconomic damages, punitive damages, and attorneys' fees where there is proof of physical abuse, neglect, or fiduciary abuse of elderly or dependent adults.[13]

2. Chapter 980, a state law passed in 1998, enhances protections for elders and dependent adults by expanding the categories of reportable types of elder abuse to include abandonment, isolation, neglect, and financial abuse. Prior to Chapter 980, existing law required mandated reporters to report only actual or apparent physical abuse, not isolation, financial abuse, or neglect. The definition of "mandated reporter" is also expanded by Chapter 980 to include any person who has assumed full or intermittent care for an elder or dependent adult. To streamline the process of reporting, investigating, and prosecuting elder abuse that occurs in long term care facilities, Chapter 980 requires that reports of

[12] *Cockrell v. HIS* (available at http://www.nsclc.org/news/03/06/Cockrell_IHS_arbagree.pdf).

[13] *See Expeditious Efforts for the Elderly: Covenant Care, Inc. v. Superior Court*, Bernadette Stafford, 39 U.C. Davis L. Rev. 699 and *Heart of Stone: What Is Revealed About the Attitude of Compassionate Conservatives Toward Nursing Home Practices, Tort Reform, and Noneconomic Damages*, Michael L. Rustad, 35 NMLR 337.

abuse or neglect in long term care facilities be forwarded immediately to the State Department of Health Services, and that reports of criminal abuse or neglect in long term care facilities be forwarded as well to the Bureau of Medi-Cal Fraud. Where the alleged abuse has occurred in a state mental hospital or developmental center, the incident must be reported to investigators of the State Department of Mental Health, the State Department of Developmental Services, or a local law enforcement agency, and reports of known or suspected criminal activity must be forwarded as soon as practicable to the Bureau of Medi-Cal Fraud. In addition, Chapter 980 declares that training regarding how and when to report suspected incidents of criminal elder abuse in a facility setting will be provided by the Bureau of Medi-Cal Fraud. Mandated reporters who violate Chapter 980 by willfully failing to report "physical abuse, abandonment, isolation, financial abuse or neglect of an elder or dependent adult" can be sentenced to up to one year in county jail, fined up to $ 5,000, or both. Furthermore, Chapter 980 emphasizes the confidential nature of abuse reports, and clarifies how and to whom reports of elder abuse may be disclosed.

To address this and other weaknesses in traditional civil actions against elder- abusers, the California Legislature enacted the Elder Abuse and Dependent Adult Civil Protection Act (EADACPA). This Act provides for the reporting of actual or suspected abuse of an elder, delineates special requirements for mandated reporters, and authorizes APS to conduct investigations and provide other services in response to elder abuse reports. As discussed in Part IV.D, supra, implementation of Chapter 980 into the EADACPA should dramatically impact the reporting aspect of elder abuse law, both in the civil and criminal arenas.

EADACPA applies generally to cases involving elderly victims of abuse, regardless of whether the victim is living at home in the community or in a long term care setting. However, California's elderly victims have faced judicial obstacles blocking achievement of full recovery under the EADACPA where the abusive act arose in the context of provision of medical services in long term care facilities. Achieving full EADACPA recovery for victims abused in long- term care settings is particularly important, in light of well-documented reports of extensive abuse and neglect of elderly persons residing in skilled nursing facilities.

Louisiana: Resident bill of rights

Louisiana has a Nursing Home Patient's Bill of Rights which allowed for damages and attorney fees against homes who violated the rights of residents who required extra protection because of their infirmity and

isolation from the community. **Unfortunately** in 2003 the state legislature did away with the right to seek damages or attorney fees for these violations. [14] The example in Louisiana serves as a reminder to consumer advocates and pro-senior policy makers that vigilance is required even after a fight appears to have been won.

Massachusetts: Combating elder abuse

In September 2003, Attorney General Reilly's office sent a letter to the administrators of all nursing home facilities located in Massachusetts reminding them of the requirements they must meet before moving a resident to a different room within the same nursing home facility against the resident's wishes.

The Attorney General's Elder Abuse Project is a training grant to help professionals across the state to address the growing issue of elder abuse. The project is funded by the Office on Violence Against Women at the United States Department of Justice. This project seeks to improve the capacity of law enforcement, including police, prosecutors, victim-witness advocates, probation officers, and elder services professionals to more effectively recognize, investigate and prosecute a wide range of abuse perpetrated against older individuals.

A multidisciplinary steering committee meets at six to eight week intervals to plan and develop training conferences, materials and resources to address the needs of vulnerable elders in our state. Committee

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[14] The following came from one Louisiana attorney we spoke to:

> The nursing home lobby in Louisiana successfully stripped away these citizens rights and now only injunctive relief is available. In addition, the nursing homes now fall under the protection of Louisiana's "medical malpractice act" by joining as a "qualified health care provider" to be a member of the Louisiana Patient's Compensation Fund which allows protection and a cap on damages of $100,000 by the provider and $ 400,000 from the PCF.
>
> The nursing home lobby ALSO included their management companies, their owners, corporations now as "qualified health care providers" to receive protections under the cap of only $100,000. We need HELP in Louisiana. The nursing home lobby has over 90% of our Medicaid funds, controls our legislature and continues to strip away any rights they may have. The event of Katrina victims dying in nursing homes in Louisiana captured a brief moment of attention from some in our nation. However, the happenings of what occurs daily throughout our state in long term care facilities is more appalling. Any exposure, assistance that can be given is so desperately needed. We don't have multimillion dollar verdicts because we have no punitives, we have caps, and no penalties left. However, we have a state full of victims who need help from capable attorneys who are willing to do so.

representatives include the Massachusetts District Attorneys Association, Massachusetts Chiefs of Police Association, Executive Office of Health and Human Services, Executive Office of Elder Affairs, Massachusetts Department of Public Health, Jane Doe Inc., UMASS-Boston: Gerontology Institute, Municipal Police Training Committee, Massachusetts Senior Centers & Councils on Aging, and the Office of the Attorney General.

Five statewide training conferences were held between March 2004 and September 2005 covering an overview of elder abuse including forensic markers, financial exploitation, elder domestic violence and sexual assault and abuse in institutional settings. In addition, a police roll call video was produced to aid in the education of police on the issue of elder domestic violence and sexual assault. Model Elder Abuse Roundtable sessions have been held since early Spring 2005. These meetings continue to allow primary community stakeholders to explore new approaches, share information, and advance dialogue concerning elder abuse issues.

Minnesota: Consumer tools to compare nursing homes

Minnesota has enabled consumers to compare nursing homes in the state, giving them access to valuable information in a format that is easily accessible. This enables Minnesota consumers to better select a nursing facility best suited for their needs, by prioritizing the type of care they are seeking.. The Minnesota Nursing Home Report Card[15] is the first of its kind in the nation (generated by a state rather than a private group) to provide consumers with information on quality of life and resident satisfaction with respect to individual nursing homes, in addition to such objective data as hours of direct care, staff turnover, proportion of single rooms and state inspection results. Additionally, consumers can search for nursing homes according to their preferences in a particular geographic location.

South Carolina: Resident bill of rights

South Carolina has created measures to protect long term care residents by codifying in state law rights for residents, providing them with greater independence and heightened standard of care. South Carolina has enacted the "Bill of Rights for Residents of Long term Care Facilities." S.C. Code Ann. § 44-81-10, *et seq.* (2001). Essentially, this statute provides that "each resident must be treated with respect and dignity..." and specifically protects, among other things, a resident's right to choose a personal physician, to be free from physical and chemical restraints and a right to privacy. S.C. Code Ann. § 44-81-40 (2001).

[15] http://www.health.state.mn.us/nhreportcard/.

Nonetheless, this statute does not provide for any private right of action. Accordingly, almost all of the litigation regarding nursing home abuse and neglect in South Carolina involves traditional common law remedies for negligence, gross negligence and breach of contract.[16] Advocates and others wishing to replicate this idea in their own states are advised to make sure that there are effective means of enforcing these rights.

Texas: Video monitoring of resident care

1. "Granny Cams"

Texas has allowed consumers and their families to have a strong role in monitoring the care provided to nursing home residents. In 2001, Texas became the first state to enact a law dealing with granny cams. Under the statute, a nursing home or related institution "shall permit a resident or the resident's guardian…to monitor the room of the resident through the use of electronic monitoring devices." Residents are allowed to choose where in the room the cameras can be put. The statute requires express written consent of the resident or her guardian as well as the consent of any roommates.[17]

2. State law addressing abuse of the elderly

"A nursing home assumes the care, custody and control of the resident who is an elderly person. The nursing home assumes responsibility for protection, food, shelter and medical care of the resident. The nursing home violates Texas Penal Code Section 22.04 if, by omission, the nursing home intentionally, recklessly, or negligently causes bodily injury to the resident. Section 22.04 bases liability, among other things, on the fact that the nursing home assumed the care of the resident. It provides:

> (a) A person commits an offense if he intentionally, knowingly, recklessly, or with criminal negligence, by act or intentionally, knowingly, or recklessly by omission, causes to a child, elderly individual, or disabled individual:
>
> (1) serious bodily injury;
>
> (2) serious mental deficiency, impairment, or injury; or
>
> (3) bodily injury.
>
> (b) An omission that causes a condition described by Subsections (a)(1) through (a)(3) is conduct constituting an offense under this section… [under certain circumstances]."[18]

[16] See article by W. Andrew Arnold and Brian E. Arnold in *South Carolina Lawyer* magazine (14 S. Carolina Lawyer 28).

[17] See article by Tracey Kohl in *Fordham Urban Law Journal* (30 Fordham Urb. L.J. 2083).

[18] http://www.capitol.state.tx.us/statutes/docs/PE/content/htm/pe.005.00.000022.00.htm.

Utah: Collaborating resources to combat and improve problems within the system of nursing home care

Utah has a joint task force of groups to advocate for resident rights and improve problems of abuse and neglect. Through this collaboration, a greater breadth of issues can be addressed. The Utah Multidisciplinary Task Force (UMTF) is an effort to bring together private and public agencies that investigate, prosecute, or enforce sanctions against the abuse/neglect of people with disabilities. According to an advocate we spoke to in Utah, "Our goal is to identify systemic problems that hinder our abilities to effectively reduce abuse/neglect of people with disabilities and find ways to resolve those problems. Our current roster of members include the following agencies: Attorney General's Office- Medicaid Fraud Control Unit APS DCFS Dept. of Health- License, Certification, and Resident Assessment Dept. of Human Services- License and Certification Salt Lake County District Attorney's Office, Special Victims Unit Salt Lake City Police Salt Lake County Police Long Term Care Ombudsman Office of Public Guardian."

The advocate reported that two major projects have come out of UMTF collaboration:

> 1) A training curriculum developed to train family members who are looking for long term care options or who currently have a loved one residing in a long term care facility. Topics are geared toward increasing family involvement and presence at the facility and include identifying/reporting abuse/neglect and advocating for resident needs in care plan meetings. The trainings are conducted by APS, the Ombudsman, and the Disability Law Center.
>
> 2) An identification of the problem that when long term care facility residents pass away at a hospital, the death is reported to the health department with no information that ties the individual's care to the facility from which they were transferred. Therefore, the problem for investigative agencies is the potential that negligent or abusive care is not accounted for in the reporting of the death. We were unable to get legislation to resolve this issue but have embarked on a pilot project with a local hospital, the Utah Hospital association, and our Vital Statistics department to have this information reported on a monthly basis and analyze the collected data for trends/need to establish this reporting in statute.

Legal References

Organizations/Websites Of Interest:

1. National Senior Citizens Law Center (www.nsclc.org).
2. Legal Services Corporation (www.lsc.gov).
3. American Bar Association Commission on Law and Aging (www.abanet.org/aging).
4. National Academy of Elder Law Attorneys (www.naela.com).
5. AARP (www.aarp.org/research/longtermcare/nursinghomes/).
6. Nursing Home Law Outline (www.mcguffey.net/NHlawoutline.html#top), one of many online resources provided by attorneys and law firms, this site provides a well-rounded and easy-to-use listing of articles, news stories, statutes, etc….

Selected Resources On Elder Abuse

1. Safeguarding Our Seniors: Protecting the Elderly from Physical and Sexual Abuse in Nursing Homes: Hearing Before the Senate Spec. Comm. on Aging, 107th Cong. (2002).
2. *Protecting the Rights of Nursing Home Residents Through Litigation*, Steven M. Levin, *Ill. State Bar Journal* (January 1996).
3. *See generally* Nat'l Ctr. on Elder Abuse, *An Analysis of State Laws Addressing Elder Abuse, Neglect, and Exploitation* (1995) (listing prohibited behavior as defined by state laws covering elder abuse).
4. *The Nursing Home Reform Law: Issues for Litigation*, Toby S. Edelman, 24 Clearinghouse Rev. 545, 545-49 (1990).
5. *The Right to a Remedy: When Should an Abused Nursing Home Resident Sue?*, Susan J. Hemp, 2 Elder L.J. 195 (1994).
6. La. Rev. Stat. Ann. 14:93.3(A) (criminalizing mistreatment of elderly in nursing homes); Mass. Ann. Laws ch. 265, 38 (prohibiting by criminal penalty knowing and willful abuse, mistreatment, or neglect of a patient or resident of a nursing home); Tenn. Code Ann. 71-6-117 (1995) (stating, "It is unlawful for any person to willfully abuse, neglect or exploit any adult within the meaning of the provisions of this part. Any person who willfully abuses, neglects or exploits a person in violation of the provisions of this part commits a Class A misdemeanor."); Wyo. Stat. Ann. 35-20-109 (Michie 2001) (stating, "A person who abuses, neglects, exploits or abandons a disabled adult is guilty of a misdemeanor and upon conviction shall be fined not more than one thousand dollars.").
7. Definitions of abuse *See* Wash. Rev. Code Ann. 74.34.020(2) (West 2001) (The definition of abuse in Washington State is "the willful action or inaction that inflicts injury, unreasonable confinement,

intimidation or punishment on a vulnerable adult."); see also Ariz. Rev. Stat. Ann. 46-451(A)(1) (West 1997) (Arizona defines abuse as the: "(a) Intentional infliction of physical harm; (b) Injury caused by negligent acts or omissions; (c) Unreasonable confinement; or (d) Sexual abuse or sexual assault"); Cal. Welf. & Inst. Code 15610.07 (West 1998) (California law defines elder abuse as "physical abuse, neglect, fiduciary abuse, abandonment, isolation or other treatment with resulting physical harm or pain or mental suffering. The deprivation by a care custodian of goods or services that are necessary to avoid physical harm or mental suffering.").

8. *Legal Counsel for the Elderly, A Practical Guide to Nursing Home Advocacy* 88 (1990).

Resources On The Issue Of Pain Mismanagement As A Form Of Abuse

1. *Mack v. Soung*, 95 Cal. Rptr. 2d 830, 834 (Cal. Ct. App. 2000). The court in Mack defined recklessness as "more than inadvertence, incompetence, unskillfulness, or failure to take precautions, but rather rises to the level of a conscious choice of a course of action with knowledge of the serious danger to others involved in it."
2. In 1990, the estate of Henry James sued the Guardian Care nursing home in North Carolina for the inadequate pain control of the decedent Henry James, a terminally ill cancer patient. Tinker Ready, *Nursing Home Is Fined*, News & Observer (Raleigh, N.C.), Nov. 27, 1990, at 1B. In this case, although the physicians had ordered adequate doses of morphine to be given every three hours for Mr. James' pain control, the nursing home's staff regularly substituted less powerful narcotics. Unfortunately, Mr. James was in pain caused by his cancer for seven months before he died. Quietly and ahead of its time, a North Carolina jury found the Guardian Care nursing home liable for violations of state Division of Facility Services regulations concerning the inadequate pain control of a terminally ill cancer patient. The jury awarded $ 7.5 million in compensatory damages and $ 7.5 million in punitive damages to the estate of Henry James. While suits against nursing homes for poor care are not unique, this case may be the first of its kind where a nursing home was held liable for inadequate pain control.
   In *Bergman v. Chin*, No. H205732-1 (Cal. Super. Ct. June 13, 2001) the family of an eighty-five-year-old man sued the physician who failed to treat him adequately for the pain his cancer caused prior to his death, using elder abuse statutes and not the more conventional medical malpractice statutes. Natalie White, *Failure to*

Treat Pain, Novel Verdict Could Signal a New Brand of Med-Mal Suit, Lawyer's Wkly. USA, Aug. 6, 2001 (http://www.lawyersweeklyusa.com/subscriber/archives.cfm?page=/archives/usa/01/806 011.htm). Despite the fact that this case involved elder abuse laws, and not medical malpractice statutes, the trial judge reduced this $ 1.5 million award to $ 250,000 applying California's $ 250,000 medical malpractice damage "cap." Marino, supra note 29, at 341-42 (citing Cal. Civ. Code 3333 (West 1995)). This author suggests that the verdict and the precedent it establishes may be a "self-inflicted wound" by organized medicine. The Bergman case began as a complaint to the California Medical Board, "which agreed the patient should have had better palliative care but took no action against the doctor." If the California Medical Board had even sent Dr. Chin a letter of reprimand, this suit may not have been filed. The Bergman estate claimed that Dr. Chin was reckless in not prescribing enough medication to relieve the pain from Mr. Bergman's lung cancer complications. In May 2001, a California jury awarded $ 1.5 million to the Bergman estate.

PART III: THE LONG TERM CARE OMBUDSMAN PROGRAM

Ombudsman Responsibilities

According to the U.S. Administration on Aging, which administers the Long Term Care Ombudsman Program on the federal level, "Ombudsman responsibilities outlined in Title VII of the Older Americans Act include:

- identify, investigate and resolve complaints made by or on behalf of residents;
- provide information to residents about long term care services;
- represent the interests of residents before governmental agencies and seek administrative, legal and other remedies to protect residents;
- analyze, comment on and recommend changes in laws and regulations pertaining to the health, safety, welfare and rights of residents;
- educate and inform consumers and the general public regarding issues and concerns related to long term care and facilitate public comment on laws, regulations, policies and actions;
- promote the development of citizen organizations to participate in the program;
- provide technical support for the development of resident and family councils to protect the well-being and rights of residents; and
- advocate for changes to improve residents' quality of life and care."[19]

Challenges to Ombudsman Program Effectiveness

Unfortunately, political "realities" often prevent a state or local ombudsman program from fulfilling its mandate. A comprehensive study by the Institute of Medicine found:

> Although in some states and locales elements of the ombudsman programs are vigorously implemented, the ombudsman program as a whole has not been fully implemented with regard to the provisions of the OAA that call for ombudsman services to be available and accessible to residents of LTC facilities. The committee finds the following:

[19] http://www.aoa.gov/prof/aoaprog/elder_rights/LTCombudsman/ombudsman.pdf.

* Not all residents of LTC facilities in need of advocacy assistance have meaningful access to the services of an ombudsman.

* Given the lack of a frequent visitation pattern to LTC facilities by ombudsmen in many parts of the country and little, if any, evidence that other methods are used effectively to build an awareness in the community of the availability of ombudsman services, large numbers of residents of LTC facilities are unaware of, and thus would probably not be able to use, the ombudsman programs' services.

* For the most part, ombudsmen provide timely responses to complaints. However, serious problems exist in some locales. For example, some state programs serve a large proportion of their LTC residents largely through one central toll-free telephone service. In such cases, it is not unusual for ombudsmen to investigate complaints through telephone inquiries only. Those residents most in need of an ombudsman to assist in protecting their health, safety, welfare, and rights may be reluctant or simply unable to initiate complaints to the ombudsman by such means as telephone calls because they are too frail or cognitively impaired.

* Implementation of the ombudsman program for residents of nursing facilities has been uneven among and within states.

* Implementation of the ombudsman program for residents of board and care homes has not been achieved in any significant way except in a small number of states.

* The ombudsman program activities of too many states are piecemeal, fragmented, and focused primarily on responding to complaints that relate to individual residents of nursing facilities. These states are not in compliance with the spirit of the program provisions as stated in the OAA; the Offices of the State LTC Ombudsman programs do not function as a whole, statewide, unified, integrated program delivering a range of individual, systemic, and educational efforts.

* AoA has not mandated any level of implementation for the legislated LTC ombudsman program, nor has the agency monitored the states' efforts at implementation. Although

ombudsman programs vary in the amount of staff and volunteer resources being expended to serve the residents of LTC facilities, no agreed-upon level of effort exists to signify that an ombudsman program has been implemented at a minimum acceptable level in a state. States do not uniformly comply with the essential requirements for operating statewide ombudsman programs, and neither AoA nor any other federal agency employs mechanisms to require such compliance.

* AoA has not developed technical guidance materials that inform states of the federal government's operational definitions of a fully implemented Office of the State LTC Ombudsman program.

* Ombudsman programs need competent legal advice and backup, including, when the circumstances call for legal interventions, assistance to LTC facility residents in pursuing issues in the courts and in regulatory hearings. The availability of these services is extremely uneven across the country.

* Except in a very few states, state units on aging have not fulfilled their responsibility to ensure that adequate and independent legal counsel is available to the ombudsman programs for the purpose of providing advice and counsel related to LTC residents.[20]

Overcoming the Challenges: A Selection of Ombudsman Programs Which Have Undertaken Unusual or Innovative Activities

1. **Arizona: State Ombudsman – Robert Nixon: 602-542-6454**
   - Recommended in "*Good Guardianship: Promising Practice Ideas on Court Links for Agencies on Aging, Adult Protective Services, and Long term Care Ombudsman*"
   - Details:
     a) Homepage: http://www.de.state.az.us/aaa/programs/ombudsman/default.asp

[20] *Real People Real Problems: An Evaluation of the Long term Care Ombudsman Programs of the Older Americans Act*, Institute of Medicine (1995) (The homepage of the report is http://www.nap.edu/catalog/9059.html, and a summary (covering many substantial issues) can be found here: http://newton.nap.edu/html/rprp/summary.html).

b) Located in Aging and Adult Administration (under Dept of Economic Security).

- Innovative Practices:
  a) Alternatives to Guardianship Program: Maricopa County, Arizona
     i. Formed by area agency on aging, LTCOP, APS, the public fiduciary, the local probate court, and others to identify alternatives to guardianship and to protect vulnerable adults.
     ii. Contact: Dawn Savattone (savattone@aaaphx.org)

2. California: State Ombudsman – Joe Rodrigues: 916-323-6681

- Recommended by Mark C. Miller (2004 "Ombudsman Program Involvement in Nursing Home Transition Activities")
- Details:
  a) Homepage: http://www.aging.state.ca.us/html/programs/ombudsman.html
  b) Located in Dept of Aging.
- Innovative Practices:
  a) The Contra Costa County Ombudsman Program participates in "Providing Assistance to Caregivers in Transition" (PACT)
     i. 3-year pilot project funded by the AoA that supports, educates and empowers caregivers in moving their loved ones out of an institutional setting.

3. Colorado: State Ombudsman – Pat Tunnell: 800-288-1376

- Recommended by Sherer Murtiashaw (2001 "Ombudsman Initiatives Addressing Neglect and Abuse")
- Details:
  a) Homepage: http://www.thelegalcenter.org/services_older.html
  b) Administered by The Legal Center (private, nonprofit) under a contract with the Dept of Human Services, Division of Aging and Adult Services.
- Innovative Practices:
  a) Quality of Care Project: Denver metro area (Donna Singer, Program Coordinator)
     i. Implemented to help prevent abusive incidents from occurring in the first place by providing training on abuse prevention to CNAs working in nursing homes.

4. **Connecticut: State Ombudsman – Maggie Ewald: 860-424-5200 (ltcop@po.state.ct.us)**
    - Recommended by Barbara Frank (2000 "OMBUDSMAN BEST PRACTICES: Supporting Culture Change to Promote Individualized Care in Nursing Homes")
    - Details:
        a) Homepage: http://www.ltcop.state.ct.us/
        b) Located in Dept of Social Services, Elderly Services Division
    - Innovative Practices:
        a) Combination of direct services to NH residents, partnerships with the state's elderly services networks, and rigorous systemic and legislative advocacy
        b) Assists the Statewide Coalition of Presidents of Residents Councils (SCPRC), an organization of nursing home Resident Council Presidents who empower Connecticut's 30,000+ nursing home residents for stronger and more effective self-advocacy
            i. VOICES: a statewide annual conference sponsored by the LTCOP which "Provides an opportunity to members of the Coalition to hear speakers addressing advocacy topics, to receive training on relevant issues, and to participate in an open forum with legislators and public officials to raise the issues and concerns of nursing home residents."
            ii. www.ltcombudsman.org/ombpublic/49_352_3506.cfm
        c) CT Best Practice - Model Relocation:
            i. Facing the closure of an inner city nursing facility in Connecticut, LTCOP puts together a model relocation plan to ensure a smooth process in the relocation of residents and protects the health and safety of residents.
            ii. LTCOP represented residents in all court proceedings and decision making meetings involving the Medicaid Agency and the Office of the Attorney General.
            iii. http://www.ltcombudsman.org/ombpublic/49_352_1009.cfm
        d) 1994-1997 "Breaking the Bonds":
            i. Acted as partner and catalyst in a free-standing initiative & collaboration among key stake-holders in the state to improve care for NH residents and

provide educational programming for staff, surveyors, and ombudsmen to address the areas where providers encountered difficulties in eliminating restraint use.

ii. Impetus was the large percentage of cases of resident-to-resident abuse coming inappropriately to the SLTCOP

5. D.C.: State Ombudsman - Jerry Kasunic: 202-434-2140

- Recommended by national consumer advocate
- Details:
  a) Homepage: http://www.aarp.org/states/dc/dc-lce/a2003-05-08-lce_longtermcare.html
  b) Funded by DC Office on Aging & AARP Legal Counsel for the Elderly
  c) Ranked as 1 of the 2 best Ombudsman Programs in US by Inspector General of the U.S. Department of Health and Human Services
  d) Works on legal injunctions and has relationships with attorneys
- Innovative Practices:
  a) 2003 Model Transfer and Discharge Plan – Helped file lawsuit to impose plan
     i. 1986 Nursing Homes and Community Residence Facilities Residents' Protection Act: Never implemented
     ii. http://www.ltcombudsman.org/ombpublic/49_468_4552.cfm
  b) 2003 Broken Promises – AARP report on DC's DOH inaction
     i. DOH failed to use city regulations to hire additional monitors, issue violations or impose any fine against nursing homes 2 years after getting the authority
     ii. http://www.ltcombudsman.org/ombpublic/49_468_4604.cfm

6. Georgia: State Ombudsman - Becky A. Kurtz, Esq: 888-454-5826

- Recommended by Sara Hunt (2002 "Ombudsman Best Practices: Using Systems Advocacy to Improve Life for Residents")
- Details:
  a) Homepage: http://www.georgiaombudsman.org/
  b) Located in Dept of Human Resources, Division of Aging Services (Elder Rights and Advocacy Section)

c) The Director of the Division appoints the LTCO

- Innovative Practices:
  a) Contributions: http://www.georgiaombudsman.org/help.asp
  b) In-state ombudsman with own advisory board
     i. promotes broader community involvement in advocacy for long term care residents and in program support
  c) Participates in the Coalition of Advocates for Georgia's Elderly (2006 priorities):
     i. Legislative: Grandparents Raising Grandchildren, Criminal Neglect of Adults, Consumer Right to Participate Act, Cause of Death Reporting Requirements
     ii. Budget: Increase PNA for NH Medicaid Recipients, Funding for Community Care Services Program and non-Medicaid Home/Community Based Services Program
     iii. http://www.gcoa.org/
  d) 2000 Atlanta LTCOP released report on abuse in nursing homes (grant from ORC)
     i. Critical of complaint response of Office of Regulatory Services resulting in creation of a new complaint unit and a requirement that surveyors contact the LTCOP during most complaint investigations
     ii. Contact: Karen Boyles, Atlanta LTCOP (404-371-3800; kjboyles_alas@yahoo.com)
  e) Participates in *SALT*, Seniors and Lawmen Together (Gwinnett County):
     i. LTCOP and adult protective services provided training in elder abuse for police officers & engages in issues advocacy with legislation
     ii. Also joined Human Services Team: spin-off group to call with case referrals when an immediate response was necessary
     iii. Contact: Jennie Deese, Staff Ombudsman, Decatur, GA (404-371-3800; jddeese@yahoo.com)

7. **Kentucky: State Ombudsman - John Sammons: 1-800-372-2991 (JohnM.Sammons@mail.state.ky.us)**
    - Recommended by Sara Hunt (Independent Consultant for NCCNHR) & Mark C. Miller (2004 "Ombudsman Program Involvement in Nursing Home Transition Activities")
    - Details:
        a) Homepage: http://chfs.ky.gov/omb/
        b) Located in Cabinet for Health & Family Services, Office of the Ombudsman
    - Innovative Practices:
        a) 2002 Task Force on Quality Long term Care
            i. Recommended using money from CMPs to support upgrading the LTCOP to full-time status and provide a minimum of 1 full-time ombudsman position for every 2,000 nursing home residents
            ii. http://www.ltcombudsman.org/ombpublic/49_352_3507.cfm
        b) Nursing Home Transition Services: SLTCO serves on the state's Olmstead Advisory Committee & a workgroup developing a training curriculum for direct care workers under a Real Choice Systems Change Grant
            i. "It's Your Move" Contact: John Sammons (SLTCO, Office of Aging Services, Johnm.sammons@KY.gov, 502-564-6930)

8. **Maine: State Ombudsman - Brenda Gallant: 1-800-499-0229 (MLTCOP@MaineOmbudsman.org)**
    - Recommended by national advocate
    - Details:
        a) Homepage: http://www.maineombudsman.org/
        b) The Maine LTC Ombudsman Program - Independent from State Government
    - Innovative Practices:
        a) Facility Staff Training on:
            i. Residents' Rights
            ii. Quality of Life
            iii. Recognizing/Preventing Abuse & Neglect
        b) Provides assistance with starting Family Councils
        c) Advocates for Legislation:
            i. Criminal background checks & employment restrictions
            ii. Standard admission contract
            iii. Elimination of duplicate assessments

iv. Improve assessments and delivery of mental health services for the elderly

d) Testifies before state legislature's "Joint Standing Committee on Appropriations & Financial Affairs" – May 24, 2005

9. **Missouri: State Ombudsman - Carol Scott: 1-800-309-3282 (scotmwo@dssda.state.mo.us)**
   - Recommended by Sara Hunt (2002 "Ombudsman Best Practices: Using Systems Advocacy to Improve Life for Residents") and Sherer Murtiashaw (2001 "Ombudsman Initiatives Addressing Neglect and Abuse")
   - Details:
     a) Homepage: http://www.dhss.mo.gov/Ombudsman/
     b) Located in Dept of Health & Senior Services, Div of Senior Services and Regulation
   - Innovative Practices:
     a) Elderly Abuse & Neglect Hotline Evaluation
        i. Cooperative effort between the LTCOP and the Missouri Division of Aging's Institutional Services to evaluate public's satisfaction
        ii. LTCOP collects evaluation form every month
     b) 2003 Advance Directives booklet
        i. http://www.ltcombudsman.org/ombpublic/49_352_4368.cfm
     c) 1996 SERVE – Serving Elderly Residents who are Victims of Crime:
        i. Provides victim advocacy to the elder abuse victim residing in LTC facilities (Dorothy Erickson, Executive Director, dlerickson@msn.com)
     d) 2003 Training on residents' rights for staff and residents
        i. Defining & reacting to complaints
        ii. Preventing & diminishing complaints
        iii. Communicating with residents, families and staff
        iv. http://www.ltcombudsman.org/ombpublic/49_506_4380.cfm
     e) Educational publications and brochures (how to act during surveys, etc.)
        i. Not sure whether its state or local ombudsman
        ii. http://www.dhss.mo.gov/Ombudsman/Publications.html

10. **Nevada: State Ombudsman – Bruce McAnnany: 702-486-3545 (dasvegas@govmail.state.nv.us)**
    - Recommended by Sherer Murtiashaw (2001 "Ombudsman Initiatives Addressing Neglect and Abuse") & Mark C. Miller (2004 "Ombudsman Program Involvement in Nursing Home Transition Activities")
    - Details:
      a) Homepage: http://www.nvaging.net/ltc.htm
      b) Located in Dept of Human Resources, Div for Aging Services
    - Innovative Practices:
      a) 1998 Abuse Video Series:
         i. Series of 3 videos dealing w/ abuse, neglect and exploitation targeted for use in the police department's training program.
      b) Facilitated meetings between residents and facilities to reaffirm the resident's right to consider other care options and to address the barriers to discharge (Gilda Johnstone)

11. **New Mexico: State Ombudsman – Walter Lombardi: 505-222-4500 (walter.lombardi@state.nm.us)**
    - Recommended by Phillip O'Connor (*St. Louis Post-Dispatch* – "Ombudsmen often feel powerless in efforts to blow the whistle" 10/15/02)
    - Details:
      a) Located in Dept of Aging & LTC Services
    - Innovative Practices:
      a) LTCOP Undercover as Residents in Nursing Homes
         i. Contact: Michelle Grisham, director of the state agency on aging
         ii. Found problems, including neglect, verbal and emotional abuse, thefts, residents left sitting for hours in urine and feces, and records being falsified
         iii. NH industry complained about the visits, but the governor backed Grisham
         iv. Grisham now has the authority to conduct the undercover visits (written into the state law)

12. **New York: State Ombudsman - Martha Haase: 518-474-7329 or 1-800-342-9871 (m_haase@ofa.state.ny.us)**
    - Details:
      a) Homepage: http://www.ombudsman.state.ny.us/
      b) Located in Office for the Aging

c) Important to remember that the state is very big, and therefore needs a strong state ombudsman to organize the 56 local ombudsman programs.

- Innovative Practices:
  a) Operation Restore Trust (ORT or Senior Medicare Patrol Project) - coordinated state-federal effort to prevent fraud, waste and abuse in the Medicare/Medicaid programs. A collection of videos detailing the ORT initiative and educates the public on identifying and reporting Medicare/Medicaid fraud, waste and abuse.

13. North Carolina: State Ombudsman – Sharon Wilder: 919-733-8395

- Recommended by Sherer Murtiashaw (2001 "Ombudsman Initiatives Addressing Neglect and Abuse"), Sara Hunt (2001 "Joining Forces for Residents: Citizen Advocates and Long Term Care Ombudsman") & Mark C. Miller (2004 "Ombudsman Program Involvement in Nursing Home Transition Activities")
- Details:
  a) Homepage: http://www.dhhs.state.nc.us/aging/ombud.htm
  b) Located in Dept of Health & Human Services, Div of Aging & Adult Services
- Innovative Practices:
  a) Community Advisory Committees for nursing homes & assisted-living to work to maintain the Residents' Bill of Rights and promote community involvement and cooperation to ensure quality care
  b) SLTCOP staff participates in the Nursing Home Transition Work Group designed to assist Medicaid eligible nursing home residents who want to return to the community
     i. "Transitions" Contact: Denise Rogers (LTCO/Elder Rights Specialist, Division of Aging and Adult Services, Denise.Rogers@ncmail.net, 919-733-8395)
  c) First Responder's: A Guide to Abuse, Neglect & Exploitation of Disabled Adults:
     i. Training program targeted to first responders such as police, emergency room staff, home health, firemen, medics, meals on wheels staff, nutrition sites, LTC facilities, senior services employees, and council on aging.
     ii. Contact: Lottie M. Massey, Regional Ombudsman, lmassey@centralina.org

d) Works with Citizen Action Group, Friends of Residents in Long Term Care (FOR):
   i. Contact: Carol Teal (ED at FOR) or Wendy Sause (SLTCO, NC Div of Aging)
   ii. Policy and legislative advocacy

14. Oklahoma: State Ombudsman – Esther Houser: 405-521-6734

- Recommended by national advocate & Sara Hunt (2001 "Joining Forces for Residents: Citizen Advocates and Long Term Care Ombudsman")
- Details:
  a) Homepage: http://www.okdhs.org/aging/glance.htm
  b) Located in Dept of Human Services, Aging Services Division
- Innovative Practices:
  a) FBI honored SLTCO with a citation for their cooperation and assistance in the convictions of the former Oklahoma Deputy Commissioner of Health for bribery and Medicaid fraud and two nursing home owners for money laundering and Medicaid fraud.
  b) Engages in systemic advocacy
  c) Publications from Northern Oklahoma Development Authority (NODA) – Area on Aging, including "Know Your Rights": (http://www.noda-aaa.com/pages/publications.html)
  d) Works with Citizen Action Group, Oklahomans for the Improvement of Nursing Home Care (OK INCH)
     i. Contact: Jo Anna Deighton
     ii. All OK INCH members are family members of NH residents

15. Oregon: State Ombudsman – Meredith Cote: 503-378-6533 (LTCO.contact@state.or.us)

- Recommended by Barbara Frank (2000 "OMBUDSMAN BEST PRACTICES: Supporting Culture Change to Promote Individualized Care in Nursing Homes")
- Details:
  a) Homepage: http://www.oregon.gov/LTCO/index.shtml
  b) Located in independent state agency "Long Term Care Ombudsman"
  c) Monitored by the LTC Advisory Committee, appointed by the Governor and legislative leadership (w/in Medicaid)
- Innovative Practices:

a) 1995 Gerontologist article: "The relationship between volunteer long term care ombudsmen and regulatory nursing home actions" (Vol 35, Issue 4 509-514)
    i. Relationship between the presence of Oregon volunteer LTCO and externally handled abuse complaints, survey reports, and regulatory sanctions
b) Collaborative Restraint Free Care Initiative (RWJ grant):
    i. Joanne Rader (503-873-6748) and the Benedictine Institute in Mt. Angel, OR coordinated a statewide effort to reduce the use of restraints.
    ii. Trained providers, surveyors, ombudsmen, protective services workers, and any other parties whose actions could influence the use of restraints on individualized care to reduce restraints.

16. Pennsylvania: State Ombudsman – Laurie Sisak: 717-783-7247 (RA-Ombudsman@state.pa.us)

- Recommended by Barbara Frank (2000 "OMBUDSMAN BEST PRACTICES: Supporting Culture Change to Promote Individualized Care in Nursing Homes")
- Details:
    a) Homepage: http://www.aging.state.pa.us/aging/cwp/view.asp?a=283&q=252766
    b) Located in Dept of Aging
- Innovative Practices:
    a) 1990 "CARIE" (Philadelphia, PA) – Abuse Prevention Training:
        i. Center for Advocacy for the Rights and Interests of the Elderly (CARIE), which operates a local ombudsman program in Philadelphia, started an institutional abuse committee to identify the need to engage in abuse prevention and determined to develop a training program for nursing home staff. (Full-time project director, Beth Hudson Keller)

17. Texas: State Ombudsman – John Willis: 512-438-4356

- Recommended by Mark C. Miller (2004 "Ombudsman Program Involvement in Nursing Home Transition Activities")
- Details:
    a) Homepage: http://www.dads.state.tx.us/news_info/ombudsman/index.html

b) Located in Dept of Aging and Disability Services

- Innovative Practices:
  a) "Home by Choice"
     i. Contact: Margaret Matthews (Regional Ombudsman, Area Agency on Aging of Central Texas, Omb12@centexaaa.com, 254-939-1886)
     ii. LTCOP doesn't actively seek out residents with a potential to transition; however, they respond aggressively to residents' requests for assistance to return to the community, by providing information about options and making referrals, mainly to the independent living centers
  b) Quality Initiative: Resident-Centered Care
     i. http://www.ltcombudsman.org/ombpublic/49_352_3504.cfm
     ii. http://www.dads.state.tx.us/news_info/ombudsman/bestpractices/index.html
  c) Best Practice on Advocating for Residents in Nursing Home Closures
     i. http://www.ltcombudsman.org/ombpublic/49_352_4374.cfm
  d) Addressing Problems in Nursing Homes
     i. http://www.dads.state.tx.us/news_info/ombudsman/addressing_problems.html

18. Washington State: State Ombudsman – Kary Hyre: 800-422-1384 (karyh@skcmsc.com)

- Recommended by Sherer Murtiashaw (2001 "Ombudsman Initiatives Addressing Neglect and Abuse")
- Details:
  a) Homepage: http://www.aasa.dshs.wa.gov/Programs/ombudsmen.htm (and http://www.aasa.dshs.wa.gov/Programs/ombudsmen.htm)
  b) Located in Department of Social & Health Services, Aging & Disability Services Admin
- Innovative Practice:
  a) 1996 Criminal Mistreatment - Dependent Persons (legislation)
     i. Involved in promulgation of legislation that makes mistreatment of elderly a crime under the criminal statutes

ii. SLTCO lobbied and testified on legislation's behalf

19. Wisconsin: State Ombudsman - George Potaracke: 608-246-7014 (boaltc@ltc.state.wi.us)

- Recommended by national advocate
- Details:
  a) Homepage: http://longtermcare.state.wi.us/home/Ombudsman.htm or http://dhfs.wisconsin.gov/aging/BOALTC/LTCOMBUD.HTM
  b) Located in Board on Aging & Long Term Care (where Ombudsmen considered state employees in their own government unit)
- Innovative Practices:
  a) Provider Accountability Consortium interested in legal charges against Medicaid providers, specifically nursing homes, that provide substandard care:
     i. http://www.ltcombudsman.org/ombpublic/49_352_3508.cfm
     ii. Led by US Attorney's Office, 3rd District in cooperation w/ other US attorneys in state, LTCOP, Wis. Attorney General's Office, District Attorney's Association, Postmaster General's office, Medicare intermediaries, MA fiscal agent, State Licensing and Certification of MA providers, Dept of Regulation and Licensing, US and Wisconsin Veterans Affairs
     iii. Meets monthly to review provider citations & identifies cases for further investigation and possible prosecution under federal and/or state statutes in both civil and criminal litigation. Individuals are identified for regulatory action leading to professional licenses suspension and/or revocation. SLTCOP helps identify witnesses willing to be interviewed or deposed. Criminal prosecutions for abuse by caregivers is up by 29% since the DA's organization joined the consortium.

Ombudsman Resources

1. National Long Term Care Ombudsman Resource Center http://www.ltcombudsman.org/default.cfm (see, especially, page on systemic advocacy).
2. The National Association of State Long Term Care Ombudsman Programs www.nasop.org.
3. U.S. Administration on Aging, Elder Rights: LTC Ombudsman page http://www.aoa.dhhs.gov/prof/aoaprog/elder_rights/LTCombudsman/Legislation_Reg/legislation_reg.asp.
4. *The Long Term Care Ombudsman Program: Rethinking and Retooling for the Future* (also known as the *Bader Report*) (2003). Presents the proceedings, recommendations, and background materials from the 2002 retreat of the National Association of State Long Term Care Ombudsman Programs (available at http://longtermcare.state.wi.us/home/whitepaper03_FINAL.pdf).
5. *Enhancing the Performance of Local Long Term Care Ombudsman Programs* (Toolkit), Carol Estes, et al. (available at http://www.ltcombudsman.org/uploads/EstesToolkit06.pdf).
6. Experiences and Challenges of Local Long Term Care Ombudsman Programs in New York State & California: A Qualitative Inquiry (presentation January 16, 2005), Steven P. Lohrer, PhD, et al. (http://sswr.confex.com/sswr/2005/techprogram/P978.HTM).
7. *State Long Term Care Ombudsman Provisions. In the Older Americas Act, as Amended in 2000. By Topic, With Policy Interpretations* (available at www.aoa.gov/prof/aoaprog/elder_rights/LTCombudsman/Legislation_Reg/Omb.%20Prov.%20by%20topic.doc).