Maryland
DEPARTMENT OF AGING

Larry Hogan | Governor Boyd K. Rutherford | Lt. Governor Rona E. Kramer | Secretary

August 3, 2022

The Honorable Larry Hogan
State House
100 State Circle
Annapolis, Maryland 21401

The Honorable Bill Ferguson
President
Senate of Maryland
State House, H-107
Annapolis, Maryland 21401

The Honorable Adrienne A. Jones
Speaker
Maryland House of Delegates
State House, H-101
Annapolis, Maryland 21401

RE: Report required Human Services § 10-909 HB 536/Ch. 155, 2010; FY2019 The State Long–Term Care Ombudsman Annual Report

Dear Governor Hogan, President Ferguson, and Speaker Jones:

Please find attached the Maryland Department of Aging's The State Long–Term Care Ombudsman Annual Report for fiscal year 2019 pursuant to Human Services § 10-909 HB 536/Ch. 155, 2010.

Do not hesitate to contact Alexandra Baldi, Legislative Liaison, at alexandra.baldi@maryland.gov or (410) 767-1102 with any questions.

Very truly yours,

Rona E. Kramer
Secretary

cc: Sarah Albert, Department of Legislative Services

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Long-Term Care Ombudsman Program
FACT SHEET June 2020

Authority: Annotated Code of Maryland, Human Services Article, Title 10, Subtitle 9; Older Americans Act, including 42 U.S.C. § 3058g

Protecting the rights and promoting the wellbeing of residents of long-term care facilities

The Ombudsman Program serves 53,000+ people in 227 Nursing Homes and 1,628 Assisted Living Facilities through:

- The Office of the State Long-Term Care Ombudsman at the Maryland Department of Aging with a State Ombudsman and an Ombudsman Specialist
- 19 Local Offices (39 FTEs) located in Area Agencies on Aging
- 137 Volunteers (82 designated)

In FY19, the Long-Term Care Ombudsman Program provided:

- 3444 Quarterly facility visits
- 5474 Consultations to individuals
- 142 Community Ed. Sessions
- 650 Meetings with resident councils
- 4948 Complaints addressed
- 1826 Consultations to facilities
- 77 Meetings with family councils
- 157 Participation in facility surveys

Sources of complaints:

- Residents – 42%
- Relative/Friend – 36%
- Other – Non relative guardian, bankers, clergy, public officials, other agencies
- Anonymous – 1%
- Facility/Staff – 10%

Most frequent complaints handled in Nursing Homes:

1. Discharge/eviction – planning, notice, procedures, abandonment
2. Failure to respond to requests for assistance – call bells, etc.
3. Medications – administration, organization
4. Care plan/resident assessment – inadequate, failure to follow plan or physician's orders
5. Personal Hygiene – includes nail care and oral hygiene, dressing and grooming
6. Dignity, respect – staff attitudes
7. Accidental or injury of unknown origin, falls, improper handling
8. Toileting, incontinent care
9. Food service – quantity, quality, variation, choice, condiments, utensils, menu
10. Assistive Devices, equipment

Most frequent complaints handled in Assisted Living Facilities:

1. Discharge/ Eviction Discharge/eviction – planning, notice, procedures, abandonment
2. Medications- administration, organization
3. Food service – quantity, quality, variation, choice, condiments, utensils, menu
4. Accidental or injury of unknown origin, falls, improper handling
5. Failure to respond to requests for assistance – call bells, etc
6. Dignity, respect – staff attitudes
7. Exercise preference/choice and/or civil/religious rights, individual's right to smoke
8. Abuse, physical (including corporal punishment) and Privacy – telephone, visitors, couples
9. Personal Hygiene – includes nail care and oral hygiene, dressing and grooming
10. Failure to respond to requests for assistance – call bells, etc.

Program Information:
The Long-Term Care Ombudsman Program provides individual and systemic advocacy for those who live in nursing home and assisted living facilities. Federal and State laws guide the Program and give it its authority.

The Ombudsman Program works throughout the state and country to protect the rights and promote the wellbeing of residents who are oftentimes medically fragile, vulnerable, and isolated.

All ombudsmen must complete orientation and training, and be free of any conflict of interest. Volunteer ombudsmen are mentored by an experienced ombudsman to conduct facility visits and receive additional training to resolve complaints before becoming designated.

Ombudsmen throughout the state respond to grievances with the goal to resolve them at the lowest possible level based on the wishes/needs of the resident. Ombudsmen seek to empower residents, their family members, and resident representatives to better understand the long-term care system and address their issues using a variety of strategies. Ombudsmen may act with or on behalf of residents. Actions taken by ombudsmen are guided by the resident or resident representative.

Confidentiality is central to ombudsman work. No names or identifying information are released without permission.

Ombudsmen are proactive, working to prevent neglect, abuse and to promote residents' rights. They provide staff training, educational forums, work with resident and family councils, and are involved in local, county, and statewide discussions that address policies related to long-term care.

State Ombudsman Goals:

1. Provide the resources needed to ensure that the Maryland Long-Term Care Ombudsman Program is operated consistently with Older American's Act provisions and operating consistently within and between the local ombudsman programs.
2. Advocate with and on behalf of Maryland residents who live in long-term care facilities.
3. Promote quality of care and quality of life for residents including those with dementia through training, consultations, highlighting successful practices, and public policies that support person-centered care.

This Fact Sheet summarizes the FY19 (October 1, 2018 – September 30, 2019) data submitted to the Administration for Community Living. For more information, contact Stevanne Ellis, State Long-Term Care Ombudsman, stevanne.ellis@maryland.gov, or 1-800-243-3425 (toll free in Maryland) or 410-767-1100.

	A	B
1	**Part I - Cases, Complainants and Complaints**	
2	**A. Cases Opened**	
3		
4	Provide the total number of cases opened during reporting period.	2,270
5		
6	*Case: Each inquiry brought to, or initiated by, the ombudsman on behalf of a resident or group of residents involving one or more complaints which requires opening a case and includes ombudsman investigation, strategy to resolve, and follow-up.*	

	A	B	C	D
1	**Part I - Cases, Complainants and Complaints**			
2	**B. Cases Closed, by Type of Facility**			
3				
4	Provide the number of cases closed, by type of facility/setting, which were received from the types of complainants listed below.			
5	*Closed Case: A case where none of the complaints within the case require any further action on the part of the ombudsman and every complaint has been assigned the appropriate disposition code.*			
6				
7	**Complainants:**	**Nursing Facility**	**B&C, ALF, RCF, etc.***	**Other Settings**
8				
9	1. Resident	818	160	
10	2. Relative/friend of resident	707	129	
11	3. Non-relative guardian, legal representative	30	7	
12	4. Ombudsman/ombudsman volunteer	16	31	
13	5. Facility administrator/staff or former staff	182	55	
14	6. Other medical: physician/staff	17	6	
15	7. Representative of other health or social service agency or program	26	20	
16	8. Unknown/anonymous	6	11	
17	9. Other: Bankers, Clergy, Law Enforcement, Public Officials, etc.	89	39	
18				
19	Total number of cases closed during the reporting period:		2,349	
20				
21	* Board and care, assisted living, residential care and similar long-term care facilities, both regulated and unregulated			

	A	B
1	**Part I - Cases, Complainants and Complaints**	
2	**C. Complaints Received**	
3		
4	For cases which were closed during the reporting period (those counted in B above), provide the total number of complaints received:	4,948
5		
6		
7	*Complaint: A concern brought to, or initiated by, the ombudsman for investigation and action by or on behalf of one or more residents of a long-term care facility relating to health, safety, welfare or rights of a resident. One or more complaints constitute a case.*	

	A	B	C	D
1	**Part I - Cases, Complainants and Complaints**			
2	**D. Types of Complaints, by Type of Facility**			
3				
4	Below and on the following pages provide the total number of complaints for each specific complaint category, for nursing facilities and board and care or similar type of adult care facility. The first four major headings are for complaints involving action or inaction by staff or management of the facility. The last major heading is for complaints against others outside the facility. See Instructions for additional clarification and definitions of types of facilities and selected complaint categories.			
5			**Nursing Facility**	**B&C, ALF, RCF, etc.**
6	**Residents' Rights**			
7	**A. Abuse, Gross Neglect, Exploitation**			
8		1. Abuse, physical (including corporal punishment)	93	24
9		2. Abuse, sexual	22	7
10		3. Abuse, verbal/psychological (including punishment, seclusion)	48	20
11		4. Financial exploitation (use categories in section E for less severe financial complaints)	20	13
12		5. Gross neglect (use categories under Care, Sections F & G for non-willful forms of neglect)	35	12
13		6. Resident-to-resident physical or sexual abuse	34	4
14		7. Not Used		
15	**B. Access to Information by Resident or Resident's Representative**			
16		8. Access to own records	27	2
17		9. Access by or to ombudsman/visitors	2	5
18		10. Access to facility survey/staffing reports/license		2
19		11. Information regarding advance directive	3	2
20		12. Information regarding medical condition, treatment and any changes	80	9
21		13. Information regarding rights, benefits, services, the resident's right to complain	73	12
22		14. Information communicated in understandable language	14	
23		15. Not Used		
24	**C. Admission, Transfer, Discharge, Eviction**			
25		16. Admission contract and/or procedure	6	4
26		17. Appeal process - absent, not followed	11	
27		18. Bed hold - written notice, refusal to readmit	7	1
28		19. Discharge/eviction - planning, notice, procedure, implementation, inc. abandonment	550	88
29		20. Discrimination in admission due to condition, disability	2	
30		21. Discrimination in admission due to Medicaid status	1	1
31		22. Room assignment/room change/intrafacility transfer	56	8
32		23. Not Used		
33	**D. Autonomy, Choice, Preference, Exercise of Rights, Privacy**			
34		24. Choose personal physician, pharmacy/hospice/other health care provider	11	
35		25. Confinement in facility against will (illegally)	10	3
36		26. Dignity, respect - staff attitudes	142	29
37		27. Exercise preference/choice and/or civil/religious rights, individual's right to smoke	105	28
38		28. Exercise right to refuse care/treatment	15	2
39		29. Language barrier in daily routine	1	1
40		30. Participate in care planning by resident and/or designated surrogate	13	2
41		31. Privacy - telephone, visitors, couples, mail	32	24
42		32. Privacy in treatment, confidentiality	5	1

	A	B	C	D
5			**Nursing Facility**	**B&C, ALF, RCF, etc.**
43		33. Response to complaints	27	5
44		34. Reprisal, retaliation	10	5
45		35. Not Used		
46	**E. Financial, Property (Except for Financial Exploitation)**			
47		36. Billing/charges - notice, approval, questionable, accounting wrong or denied (includes overcharge of private pay residents)	33	14
48		37. Personal funds - mismanaged, access/information denied, deposits and other money not returned (report criminal-level misuse of personal funds under A.4)	41	17
49		38. Personal property lost, stolen, used by others, destroyed, withheld from resident	89	22
50		39. Not Used		
51				
52	**Resident Care**			
53	**F. Care**			
54		40. Accidental or injury of unknown origin, falls, improper handling	141	32
55		41. Failure to respond to requests for assistance	186	30
56		42. Care plan/resident assessment - inadequate, failure to follow plan or physician orders (put lack of resident/surrogate involvement under D.30)	173	22
57		43. Contracture	2	
58		44. Medications - administration, organization	177	49
59		45. Personal hygiene (includes nail care & oral hygiene) and adequacy of dressing & grooming	161	23
60		46. Physician services, including podiatrist	64	10
61		47. Pressure sores, not turned	79	5
62		48. Symptoms unattended, including pain, pain not managed, no notice to others of changes in condition	84	11
63		49. Toileting, incontinent care	121	10
64		50. Tubes - neglect of catheter, gastric, NG tube (use D.28 for inappropriate/forced use)	35	
65		51. Wandering, failure to accommodate/monitor exit seeking behavior	15	9
66		52. Not Used		
67	**G. Rehabilitation or Maintenance of Function**			
68		53. Assistive devices or equipment	106	11
69		54. Bowel and bladder training	2	
70		55. Dental services	22	
71		56. Mental health, psychosocial services	6	1
72		57. Range of motion/ambulation	31	1
73		58. Therapies - physical, occupational, speech	88	7
74		59. Vision and hearing	12	2
75		60. Not Used		
76	**H. Restraints - Chemical and Physical**			
77		61. Physical restraint - assessment, use, monitoring	3	2
78		62. Psychoactive drugs - assessment, use, evaluation	9	1
79		63. Not Used		
80				
81	**Quality of Life**			
82	**I. Activities and Social Services**			
83		64. Activities - choice and appropriateness	38	10
84		65. Community interaction, transportation	37	8

	A	B	C	D
5			**Nursing Facility**	**B&C, ALF, RCF, etc.**
85		66. Resident conflict, including roommates	38	4
86		67. Social services - availability/appropriateness/ (use G.56 for mental health, psychosocial counseling/service)	38	2
87		68. Not Used		
88	**J. Dietary**			
89		69. Assistance in eating or assistive devices	35	6
90		70. Fluid availability/hydration	25	5
91		71. Food service - quantity, quality, variation, choice, condiments, utensils, menu	117	44
92		72. Snacks, time span between meals, late/missed meals	16	4
93		73. Temperature	20	2
94		74. Therapeutic diet	31	2
95		75. Weight loss due to inadequate nutrition	17	3
96		76. Not Used		
97	**K. Environment**			
98		77. Air/environment: temperature and quality (heating, cooling, ventilation, water, noise	38	27
99		78. Cleanliness, pests, general housekeeping	73	25
100		79. Equipment/building - disrepair, hazard, poor lighting, fire safety, not secure	28	26
101		80. Furnishings, storage for residents	10	2
102		81. Infection control	7	2
103		82. Laundry - lost, condition	40	5
104		83. Odors	5	1
105		84. Space for activities, dining		2
106		85. Supplies and linens	10	3
107		86. Americans with Disabilities Act (ADA) accessibility	3	3
108				
109	**Administration**			
110	**L. Policies, Procedures, Attitudes, Resources (See other complaint headings, of above, for policies on advance directives, due process, billing, management residents' funds)**			
111		87. Abuse investigation/reporting, including failure to report	5	1
112		88. Administrator(s) unresponsive, unavailable	29	8
113		89. Grievance procedure (use C for transfer, discharge appeals)	5	
114		90. Inappropriate or illegal policies, practices, record-keeping	14	16
115		91. Insufficient funds to operate		2
116		92. Operator inadequately trained	2	3
117		93. Offering inappropriate level of care (for B&C/similar)	1	1
118		94. Resident or family council/committee interfered with, not supported	1	1
119		95. Not Used		
120	**M. Staffing**			
121		96. Communication, language barrier (use D.29 if problem involves resident inability to communicate)	8	1
122		97. Shortage of staff	47	12
123		98. Staff training	7	11
124		99. Staff turn-over, over-use of nursing pools	5	
125		100. Staff unresponsive, unavailable	33	14
126		101. Supervision	4	1
127		102. Eating Assistants	1	

	A	B	C	D
5			**Nursing Facility**	**B&C, ALF, RCF, etc.**
128				
129	**Not Against Facility**			
130	**N. Certification/Licensing Agency**			
131		103. Access to information (including survey)		
132		104. Complaint, response to	2	
133		105. Decertification/closure		2
134		106. Sanction, including Intermediate		
135		107. Survey process		
136		108. Survey process - Ombudsman participation		
137		109. Transfer or eviction hearing		
138		110. Not Used		
139	**O. State Medicaid Agency**			
140		111. Access to information, application	14	
141		112. Denial of eligibility	14	
142		113. Non-covered services	4	1
143		114. Personal Needs Allowance	2	
144		115. Services	4	
145		116. Not Used		
146	**P. System/Others**			
147		117. Abuse/neglect/abandonment by family member/friend/guardian or, while on visit out of facility, any other person	4	1
148		118. Bed shortage - placement		
149		119. Facilities operating without a license		5
150		120. Family conflict; interference	15	6
151		121. Financial exploitation or neglect by family or other not affiliated with facility	6	7
152		122. Legal - guardianship, conservatorship, power of attorney, wills	22	10
153		123. Medicare	4	
154		124. Mental health, developmental disabilities, including PASRR		
155		125. Problems with resident's physician/assistant	1	
156		126. Protective Service Agency	1	
157		127. SSA, SSI, VA, Other Benefits/Agencies	14	4
158		128. Request for less restrictive placement	15	3
159	**Total, categories A through P**		4,045	889
160				
161	**Q. Complaints About Services in Settings Other Than Long-Term Care Facilities or By Outside Provider in Long-Term Care Facilities (see instructions)**			
162		129. Home care		
163		130. Hospital or hospice	2	
164		131. Public or other congregate housing not providing personal care	1	
165		132. Services from outside provider (see instructions)	11	
166		133. Not Used		
167		**Total, Heading Q.**	14	
168				
169	**Total Complaints***		4,948	
170				

	A	B	C	D
5			**Nursing Facility**	**B&C, ALF, RCF, etc.**
171	* (Add total of nursing facility complaints; B&C, ALF, RCF, similar complaints and complaints in Q, above. Place this number in Part I, C on page 1.)			

	A	B	C	D	E	F
1	**Part I - Cases, Complainants and Complaints**					
2	**E. Action on Complaints**					
3						
4	Provide for cases closed during the reporting period the total number of complaints, by type of facility or other setting, for each item listed below.					
5				**Nursing Facility**	**B&C, ALF, RCF, etc.**	**Other Settings**
6	1. Complaints which were verified:			3,318	688	0
7						
8	*Verified: It is determined after work [interviews, record inspection, observation, etc.] that the circumstances described in the complaint are generally accurate.*					
9						
10	2. Disposition: Provide for all complaints reported in C and D, whether verified or not, the number:					
11		a. For which government policy or regulatory change or legislative action is required to resolve (this may be addressed in the issues section)□		1	1	
12		b. Which were not resolved* to satisfaction of resident or complainant□		400	70	2
13		c. Which were withdrawn by the resident or complainant or resident died before final outcome of complaint investigation□		275	75	
14		d. Which were referred to other agency for resolution and:□				
15			1) report of final disposition was not obtained	110	58	
16			2) other agency failed to act on complaint	1	2	
17			3) agency did not substantiate complaint	29	15	
18		e. For which no action was needed or appropriate□		457	101	
19		f. Which were partially resolved* but some problem remained□		1,165	224	12
20		g. Which were resolved* to the satisfaction of resident or complainant		1,607	343	
21						
22	**Total, by type of facility or setting**			4,045	889	14
23						
24	**Grand Total (Same number as that for total complaints on pages 1 and 7)**					4,948
25						
26	** Resolved: The complaint/problem was addressed to the satisfaction of the resident or complainant.*					
27						
28	3. Legal Assistance/Remedies (Optional) - For each type of facility, list the number of legal assistance remedies for each of the following categories that were used in helping to resolve a complaint: a) legal consultation was needed and/or used; b) regulatory endorsement action was needed and/or used; c) an administrative appeal or adjudication was needed and/or used; and d) civil legal action was needed and/or used.					
29						
30						

	A
1	**Part I - Cases, Complainants and Complaints**
2	**F. Complaint Description (Optional):**
3	
4	Provide in the space indicated a concise description of the most interesting and/or significant individual complaint your program handled during the reporting period. State the problem, how the problem was resolved and the outcome.
5	
6	The ombudsman met with a resident who shared his desire to move to a place where he could have more independence. This resident was able to ambulate and complete most activities of daily living independently. Because the resident had a diagnosis of depression, his sibling insisted that he stay in the nursing home. The resident stated that the social worker deferred to his sibling, rather than respecting his wishes, and told him that the sister was his guardian. After receiving permission from the resident to investigate his complaints, it was found that the sibling did not have guardianship, and that the attending physician's assessment indicated that the resident was capable of making his own decisions. The ombudsman was able to arrange multiple meetings with the resident, social worker and the sibling to assist the resident in expressing his desire to move to a less restrictive setting. The sibling shared that these settings had not worked before but that she was willing to help her brother try again. With assistance of the facility social worker, the resident applied for the Medicaid Waiver. Although he was not financially eligible for the waiver, the resident had sufficient income to move to a local assisted living facility. The assisted living managed his medications, and arranged his medical and mental health appointments, The resident was able to use public transportation to enjoy community activities. The resident told the ombudsman that he was happy in the assisted living facility.

	A
1	**Part II - Major Long-Term Care Issues**
2	A. Describe the priority long-term care issues which your program identified and/or worked on during the reporting period. For each issue, briefly state: a) the problem and barriers to resolution, and b) recommendations for system-wide changes needed to resolve the issue, or how the issue was resolved in your State. Examples of major long-term care issues may include facility closures, planning for alternatives to institutional care, transition of residents to less restrictive settings, etc.
3	
4	Issue: Safe discharges to assisted living facilities [ALF] from nursing homes and hospitals during a time period of the proliferation of licensed and unlicensed ALFS and the significant needs of older, mentally and physically disabled adults. This problem will only increase as the state's population continues to age as well as the number of older Marylanders who are wholly reliant on social security benefits, making the vast majority of assisted living facilities in their community unaffordable. In the past year, the LTCO program has received numerous complaints of abuse and neglect from residents of licensed and unlicensed facilities. Residents and/or their responsible parties are extremely fearful of retaliation, many are just seeking guidance, as they have already been told that if they complain, the resident "will be put on the streets." Most of these same residents are not from the area where the facility is located and are not familiar with options and have little or no support or resources. The path to these assisted living facilities usually starts at the time of discharge from the hospital. The resident no longer has a funding source to remain at the hospital and the hospital staff has determined that going home is not a safe discharge as the resident requires supervision. The resident may also have been living with family who can no longer care for the resident. Hospital staff understood that the resident's fixed income makes placing the resident difficult and contacts a "placement" service. The placement service, using their contacts, identifies an assisted living facility who will accept the resident. Sometimes the new provider meets the resident, but just as often the resident is picked up and moved to the facility with little or no input. The resident from that point has lost control and the provider now is making all the decisions by; retaining the resident's bank card, deciding which day care the resident will attend, which doctor they will see and the timing of the move to an unlicensed facility to free beds for the next hospital discharge. The provider may also be working with or operate a transportation company, which will transport the resident to day care, unlicensed facilities and doctor appointments, thereby making taking control of the resident's life seamless. The barriers to ensuring the safe discharge of residents to assisted living are; the continued use of unlicensed placement agencies by heath care facilities, no or poor assessments of resident prior to admission to these facilities, no oversight of unlicensed facilities by the regulatory agency, and little or no consequences for the operator of the unlicensed facility or those who discharge the resident to an unlicensed facility. The recommendations to address the problem of these unsafe discharges are: • Require placement agencies to be licensed and to hold them accountable for unsafe discharges with stiff penalties • Hold hospital and nursing home staff accountable by enforcing existing regulations and implementing stronger regulations regarding proper medical assessments prior to admission to an ALF • Give the regulatory agency more authority to penalize and close unlicensed facilities in real time so residents can be safely moved • Build stronger partnerships with law enforcement as many of the violations by assisted living operators are criminal • Partner with the 2020 Census program to ensure proper count of residents of licensed and unlicensed ALFs • Fund safe housing for residents who need assistance.

	A	B	C	D
1	**Part III - Program Information and Activities**			
2	**A. Facilities and Beds:**			
3			ALERT: AoA recommends that your program regularly enter into your data collection system all licensed facilities and beds in your state covered by your program and keep this information updated. In the event this is not being done in your program, the totals for Part III.A should be obtained from an outside source, such as the state licensing agency, and entered into the ORT manually.	
4			1. How many nursing facilities are licensed in your State?	227
5			2. How many beds are there in these facilities?	28,645
6			3. Provide the type-name(s) and definition(s) of the types of board and care, assisted living, residential care facilities and any other similar adult care home for which your ombudsman program provides services, as authorized under Section 102(18) and (32), 711(6) and 712(a)(3)(A)(i) of the Older Americans Act. If no change from previous year, type "no change" at space indicated.	
7			no change	
8				
9			a) How many of the board and care and similar adult care facilities described above are regulated in your State?	1,628
10			b) How many beds are there in these facilities?	24,443

	A	B	C	D	E
1	**Part III - Program Information and Activities**				
2	**B. Program Coverage**				
3					
4	*Statewide Coverage means that residents of both nursing homes and board and care homes (and similar adult care facilities) and their friends and families throughout the state have access to knowledge of the ombudsman program, how to contact it, complaints received from any part of the State are investigated and documented, and steps are taken to resolve problems in a timely manner, in accordance with federal and state requirements.*				
5					
6	**B.1. Designated Local Entities**				
7					
8	Provide for each type of host organization the number of local or regional ombudsman entities (programs) designated by the State Ombudsman to participate in the statewide ombudsman program that are geographically located outside of the State Office:				
9					
10	**Local entities hosted by:**				
11		Area agency on aging		19	
12		Other local government entity		0	
13		Legal services provider		0	
14		Social services non-profit agency		0	
15		Free-standing ombudsman program		0	
16		Regional office of State ombudsman program		0	
17		Other; specify:		0	
18					
19					
20	Total Designated Local Ombudsman Entities			19	
21					
22	**B.2. Staff and Volunteers**				
23					
24	Provide numbers of staff and volunteers, as requested, at state and local levels.				
25		**Type of Staff**	**Measure**	**State Office**	**Local Programs**
26		Paid program staff	FTEs	2.00	39.50
27			Number people working full-time on ombudsman program	2	26
28		Paid clerical staff	FTEs	0.30	2.00
29		Volunteer ombudsmen certified to address complaints at close of reporting period	Number volunteers	1	82
30		Number of Volunteer hours donated	Total number of hours donated by certified volunteer Ombudsmen	350	8,420
31		*Certified Volunteer: An individual who has completed a training course prescribed by the State Ombudsman and is approved by the State Ombudsman to participate in the statewide Ombudsman Program.*			
32		Other volunteers (i.e., not certified) at close of reporting period	Number of volunteers	0	55
33					
34	**B.3. Organizational Conflict of Interest**				
35					

	A	B	C	D	E
36	Provide a description of any organizational conflicts of interest identified and steps taken by the State agency and the Ombudsman to remedy or remove identified conflicts; indicate (a) the type of conflict as described in 45 CFR §1324.21and Section 712 (f)(2)of the Older Americans Act; or a brief description of other conflicts of interest that may impact the effectiveness and credibility of the work of the Office (b) indicate if the conflict was at the State Office or at a local Ombudsman entity or both (c) provide a description of steps taken to remedy or remove each conflict of interest. If no conflicts were identified among the state Office or local Ombudsman entitie s, where applicable, write that none were identified.				
37					
38	Location of Conflict Identified at:		State & Local		
39					
40		no change			
41					
42	For subsequent reporting years:				
43	No	I certify that I have reviewed the organization conflicts of interest in my state Ombudsman program and report no changes in organization conflicts or the remedies previously implemented			

	A	B	C	D
1		**Part III - Program Information and Activities**		
2		**C. Program Funding**		
3				
4		Provide the amount of funds expended during the fiscal year from each source for your statewide program:		
5				
6		Federal - Older Americans Act (OAA) Title VII, Chapter 2, Ombudsman		$291,377
7		Federal - Older Americans Act (OAA) Title VII, Chapter 3, Elder Abuse Prevention		$78,087
8		Federal - OAA Title III provided at State level		$125,000
9		Federal - OAA Title III provided at AAA level		$107,930
10		Other Federal; specify:		$0
11				
12		State funds		$1,502,018
13		Local; specify:		$1,027,129
14		county funds		
15				
16		**Total Program Funding**		$3,131,541

	A	B	C	D
1	**Part III - Program Information and Activities**			
2	**D. Other Ombudsman Activities**			
3				
4	Provide below and on the next page information on ombudsman program activities other than work on complaints.			
5				
6	**Activity**	**Measure**	**State**	**Local**
7		Number sessions	20	123
8		Number hours	173	1,570
9		Total number of trainees that attended any of the training sessions above (duplicated count)	534	810
10	**1. Training for ombudsman staff and volunteers**		Ombudsman Services	Advocacy
11		3 most frequent topics for training	Ombudsman Program Orientation	Ombudsman Services
12			Ombudsman Training and Designation	Resident's Rights
13	**2. Technical assistance to local ombudsmen and/or volunteers**	Estimated percentage of total staff time	30	18
14		Number sessions	2	51
15			Ombudsman Services	Resident's Rights
16	**3. Training for facility staff**	3 most frequent topics for training	Resident's Rights	Elder Abuse/Adult Protections
17				Ombudsman Services
18			Care Planning/Service Plans	Discharge notices and Discharge Issues
19	**4. Consultation to facilities (Consultation: providing information and technical assistance, often by telephone)**	3 most frequent areas of consultation	Care Issues in LTC	Care Issues in LTC

	A	B	C	D
6	**Activity**	**Measure**	**State**	**Local**
20			Ombudsman Services	Behaviors
21		Number of consultations	35	1,791
22			Ombudsman Services	Care Issues in LTC
23	**5. Information and consultation to individuals (usually by telephone)**	3 most frequent requests/needs	Care Issues in LTC	Ombudsman Services
24				Assisted Living
25		Number of consultations	240	5,234
26	**6. Facility Coverage (other than in response to complaint) ***	Number Nursing Facilities visited (unduplicated)	0	217
27		Number Board and Care (or similar) facilities visited (unduplicated)	0	644
28	**7. Participation in Facility Surveys**	Number of surveys	2	157
29	**8. Work with resident councils**	Number of meetings attended	5	650
30	**9. Work with family councils**	Number of meetings attended	0	77
31	**10. Community Education**	Number of sessions	3	142
32				Elder Abuse/Financial Exploitation
33		3 most frequent topics		Ombudsman Services
34	**11. Work with media**			Resident's Rights
35		Number of interviews/ discussions	0	6
36		Number of press releases	0	15

	A	B	C	D
6	**Activity**	**Measure**	**State**	**Local**
37	**12. Monitoring/work on laws, regulations, government policies and actions**	Estimated percentage of total paid staff time (Note: the total of the percentage at each level in this item and item 2 should not add to more than 100%.)	35	5
38	* The number is for facilities receiving at least one visit per quarter, not in response to a complaint. It is not for the number of visits. States which do not have a regular visitation program should enter "0" in lieu of "NA," as this numeric field cannot accept "NA."			