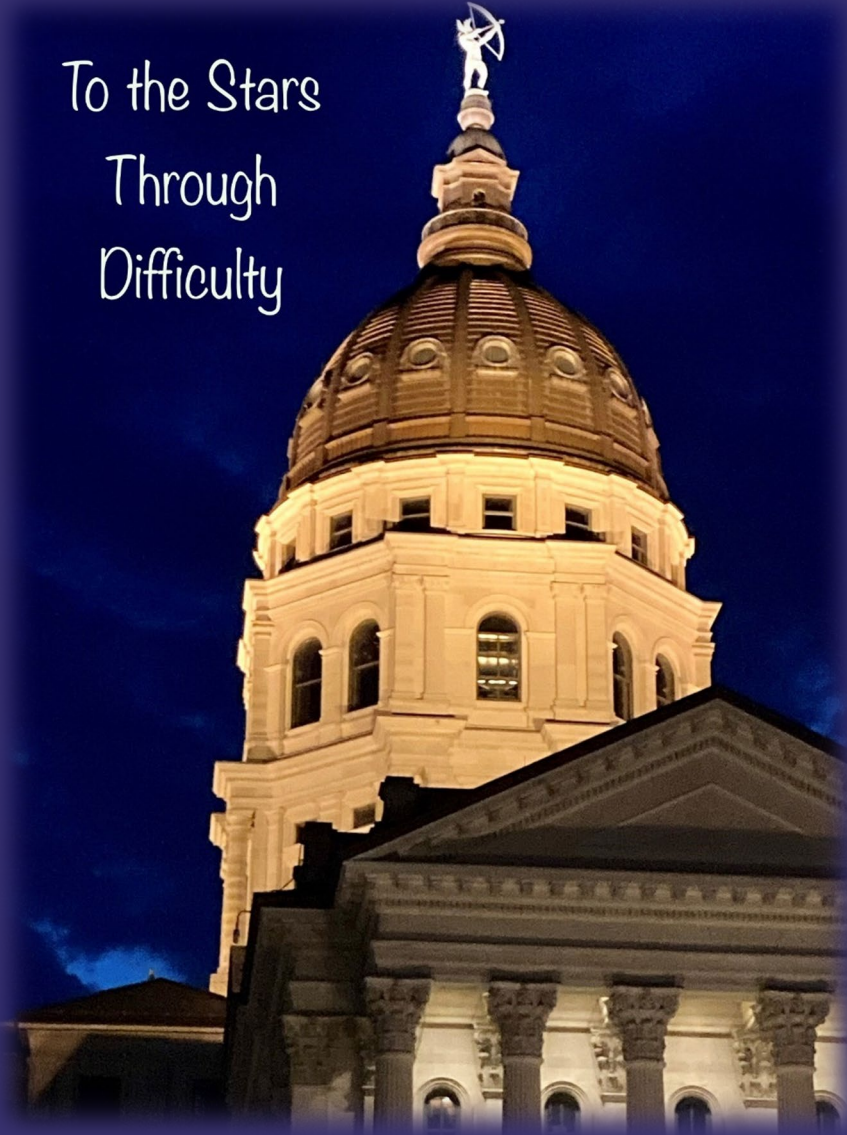


KANSAS LONG-TERM CARE OMBUDSMAN

2023 ANNUAL REPORT

Oct. 1, 2022 - Sept. 30, 2023

To the Stars
Through
Difficulty



Advocacy

Education

Empowerment



Dear Fellow Kansans,

I am humbled and honored to serve in the role of your State of Kansas Long-Term Care Ombudsman.

States' Long-Term Care (LTC) Ombudsman programs work to resolve problems related to the health, safety, welfare, and rights of individuals who live in LTC facilities, such as nursing homes, board and care, assisted living facilities and other residential care communities. Ombudsman programs promote policies and consumer protections to improve long-term services and supports at the facility, local, state, and national levels.

Our Kansas program is currently resourced with a small number of staff, while being tasked with a massive amount of work. Regional ombudsmen are stationed to attempt most efficiently to cover 105 counties and provide advocacy in approximately 780 licensed settings. The aging population is growing, the work is more complex and the number of ombudsmen, historically under resourced, is at nearly every direction too few. Ombudsmen are dedicated advocates who diligently work to serve Kansans. For residents, the only meaningful access to an Ombudsman requires an in-person visit and additional staff are needed to have that occur consistently.

The unique nature of the program requires an ombudsman to provide for confidential communication and action based on the residents' direction. Residents typically trust ombudsmen, and sometimes even share information they may not have shared with anyone else. Building trust and providing information to empower residents often allows them to address their own concerns.

This vast amount of work directly with residents within the adult care homes place ombudsmen in a unique position to be knowledgeable of widespread or systemic issues negatively impacting Kansans living in the homes. When adverse conditions overall are discovered, an ombudsman can work to resolve issues on behalf of all residents. When administrators and operators are committed to their responsibility of promoting and protecting residents' rights it can be a very productive and positive way to resolve issues before they escalate.

Another role of the Ombudsman is to analyze and monitor the development and implementation of federal, state, and local government laws, rules and regulations, resolutions, ordinances, and policies with respect to long-term care facilities and services provided in this state, and recommend any changes in such laws, regulations, resolutions, ordinances and policies. Additionally, the Ombudsman provides information to public and private agencies, the media, legislators, and others, as deemed necessary by the office regarding the problems and concerns of residents in facilities, including recommendations related thereto.

In the following pages you will find data, findings, and outcomes regarding the types of problems experienced and complaints received from, or on behalf of, residents. Also included in this report are policy, regulatory, and legislative recommendations to provide solutions for common problems and complaints with the goal of improving the quality of care and quality of life in facilities.

Respectfully,

Camille K. Russell

Camille K. Russell
Kansas State Long-Term Care Ombudsman

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What is an Ombudsman?

An ombudsman is an independent resident advocate. Ombudsmen investigate complaints concerning the health, safety, welfare and rights of long-term care residents, and work to resolve these complaints **to the satisfaction of the resident** of long-term care services.

Ombudsmen also offer information and assistance about the rights of residents and the regulations pertaining to nursing homes, assisted living, home plus, residential health care facilities and boarding care homes. Additionally, ombudsmen work with providers of long-term care services to promote a culture of person-centered living and respect for resident rights.

The word “ombudsman” is Swedish and means “one who speaks on behalf of another. The Ombudsman advocate for residents of long-term care facilities.

Authority and Structure

The Kansas Long-Term Care Ombudsman Program is empowered by the Older Americans Act (OAA), Title VII, Chapter 2, Sections 711/712 and K.S.A. 75-7301 *et seq.*

The Kansas Long-Term Care Ombudsman program is responsible for advocating for residents of long-term care facilities including nursing homes, assisted living facilities, home pluses, residential care facilities, and boarding care homes. The Office strives to fulfill this responsibility every day by working to resolve complaints that impact the health, safety, and welfare of residents, as well as informing residents of their rights.

Appointed by the Governor, the State Ombudsman coordinates ombudsman services provided by the Office across the state.

The **Office of the State Long-Term Care Ombudsman** is attached to the Department of Administration and is provided technical assistance and advice to function as **an independent state agency** within the Office of Public Advocates. The Secretary of Administration and the Department of Administration have no authority over the state long-term care ombudsman, any regional long-term care ombudsman, any other ombudsman, including any volunteer ombudsman, or any other officer, employee or volunteer of the Office of the State Long-Term Care Ombudsman with respect to the performance of any power, duty or function of the office or the exercise of any other authority of the Office or the State Long-Term Care Ombudsman.

Functions and Responsibilities

The State Long-Care Ombudsman, as head of the Office, has the responsibility for the leadership and management of the Office.

The Older Americans Act calls upon the Ombudsman to be responsible for the management, including the fiscal management, of the Office of the Ombudsman and to personally or through representatives of the Office:

- Identify, investigate and resolve complaints made by or on behalf of residents.
- Provide information to residents about Long-Term Services and Supports (LTSS).
- Ensure that residents have regular and timely access to Ombudsman program 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.
- Promote the development of and assist citizen advocacy groups who want to protect the well-being and rights of residents.
- Provide technical support for the development of resident and family councils to protect the wellbeing and rights of residents.

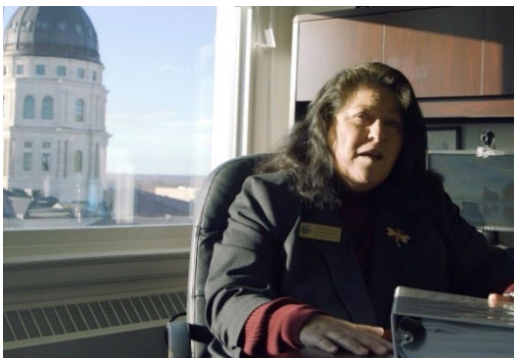
In addition to the complaint investigation and systems advocacy previously described, the Ombudsman, as head of a unified statewide program, is responsible for a variety of programmatic functions. The Ombudsman must:

- Require representatives of the Office to fulfill the duties in accordance with Ombudsman program policies and procedures.
- Determine the use of the fiscal resources appropriated or otherwise available for the operation of the Office.
- Designate staff and volunteer representatives of the Office.
- Establish certification training requirements for purposes of designation.

Overview of the Program's Service to Kansans

Between October 1st, 2022 – September 30th, 2023, the Kansas Long-Term Care Ombudsman Program:

- Investigated 1,599 complaints made by, or on behalf of, long-term care facility residents.
- Resolved, or partially resolved, 67 percent of these complaints to the satisfaction of the resident.
- Made 1,797 facility visits to adult care homes to meet with residents and to be available to assist residents.
- Assisted 98 individuals subjected to involuntary discharges/eviction actions.
- Supported resident and family self-advocacy by attending and providing support to 81 resident and family council meetings.
- Provided information and assistance to 2,132 individuals on topics such as residents' rights, resident care, infection control guidance, and regulations.
- Provided information and assistance to 1,197 facility staff on topics such as residents' rights, resident care, family conflict, power of attorney, and the role and responsibilities of the Ombudsman program.
- Provided 46 community education sessions on long-term care issues: with a focus on person centered practices.
- Completed 3 facility staff training sessions.
- Completed certification training for 5 Ombudsman.
- Provided information and advocated for residents with surveyors 289 times during facility surveys conducted by the state licensing agency (Kansas Department for Aging and Disability Services).



Camille Russell, State Long-Term Care Ombudsman

How Should We Care?

"It's considered one of life's toughest decisions: Is it better for an elderly loved one to age in place or be cared for in a nursing home? What would you do? It's called the nursing home dilemma for a reason, and the already emotionally-charged decision has just become a lot more difficult. Filmmaker Michael Price exposes widening cracks in an already stressed and fractured elder care system." – Kansas City PBS, KCPT, Kansas City

<https://www.pbs.org/video/how-should-we-care-zzprye/>

Complaint Investigation

Ombudsmen across Kansas investigate complaints about violations of resident rights or quality of care on behalf of residents in adult care homes. Ombudsmen work directly with the resident to identify solutions and implement needed changes for their care, rights, or quality of life.

The goal of the ombudsman's work is to resolve the concern to the satisfaction of the resident. Ombudsmen protect the confidentiality of the resident's information and do not act on behalf of the resident without permission from the resident. Ombudsmen investigation focuses on fully identifying the problem and developing potential solutions. Following program consent protocols, the ombudsman may review medical records, gather information from all parties, and observe the long-term care environment.

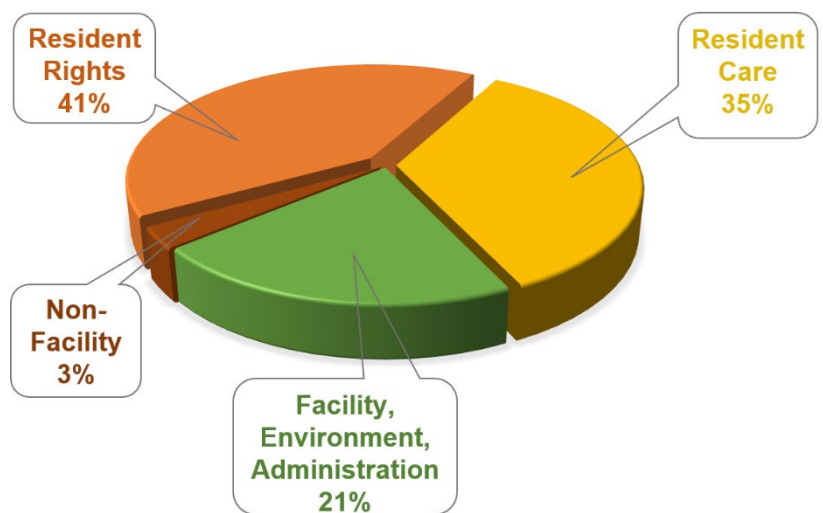
Following an investigation, the ombudsman meets with the resident to discuss the results of the investigation and to develop viable solutions to the resident's concerns. The ombudsman works with residents, family, and providers to reach a resolution, as an advocate for the resident at all times.

Between October 1, 2022 and September 30, 2023, the Kansas Office of the Long-Term Care Ombudsman received and handled 1,599 complaints. Ombudsmen are trained to handle many types of complaints in long-term care settings. The Ombudsman program defines 59 different complaints grouped into four categories: Resident Rights, Resident Care, Facility Environment & Administration, and Non-Facility.

The chart to the right shows the percentage breakdown of the total number of complaints investigated in each of these four categories in FY2023.

The largest number of complaints handled during this reporting year concerned resident rights at 41% and resident care at 35%.

The smallest number were non-facility complaints at 3%.

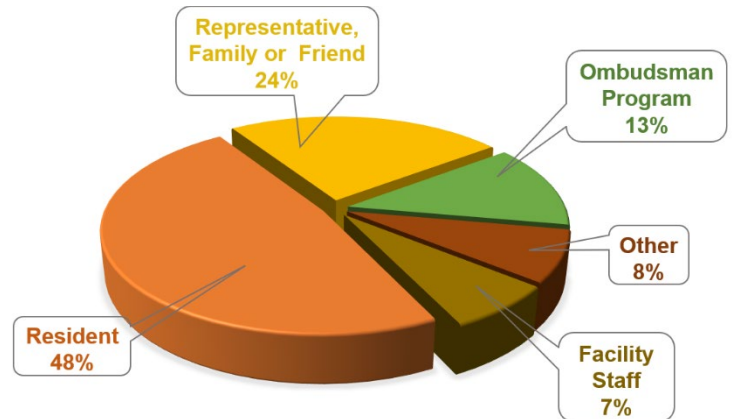


Complainants and Complaint Resolution

Who are the complainants?

Most complaints are made by residents themselves or their friends or relatives. However, many providers contact us because they recognize that residents need an independent advocate to make sure their concerns are heard and addressed. No matter who initiates the complaint, the program will respect the resident and the complainant's confidentiality, while focusing complaint resolution on the resident's wishes.

The chart to the right shows who made the complaints.

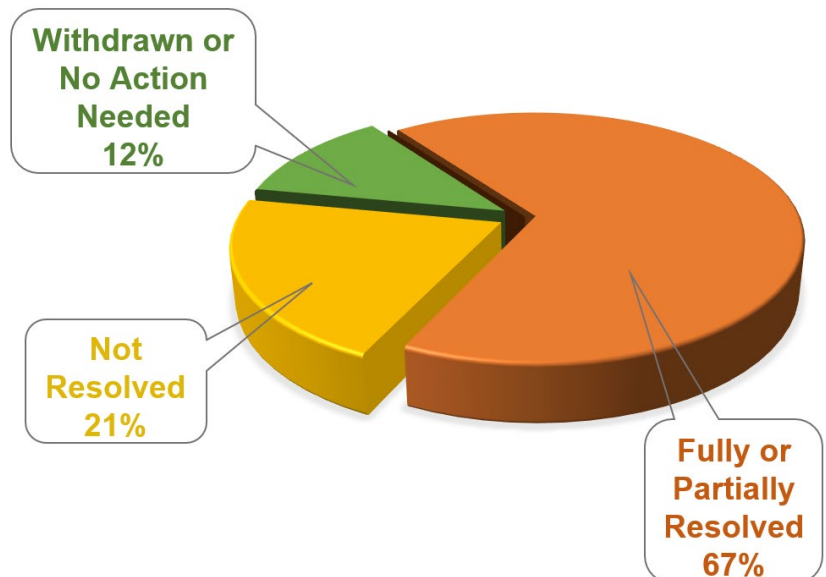


Complaint Resolution

A complaint is closed when there is no further action needed on the part of the ombudsman. Each complaint is then assigned a disposition. A complaint is resolved when the complaint/problem is addressed to the satisfaction of the resident, or if the resident is not able to make their wishes known, the resident's representative or the complainant.

In FY2023, the Long-Term Care Ombudsman Program resolved 67% of complaints to the resident's satisfaction. Not all complaints can be resolved to the satisfaction of a resident. For example, some complaints are referred to another agency for resolution and others do not require any action to be taken.

The chart to the right shows what types of disposition codes were assigned to closed complaints during the year.



Numbers of Complaints Investigated by Category and Type of Complaint

Category and type of complaint	Number of complaints
Resident Rights: Abuse, neglect, exploitation	120
Resident Rights: Access to information	33
Resident Rights: Admission, transfer, discharge, eviction	98
Resident Rights: Autonomy, choice, rights, privacy	332
Resident Rights: Financial, property	77
Total Resident Rights Complaints	660
Resident Care: Care	406
Resident Care: Activities, community integration, social services	49
Resident Care: Dietary	107
Total Resident Care Complaints	562
Environment/administration: Environment	110
Environment/administration: Policies, procedures and practices	222
Total Environment/administration Complaints	332
Non- Facility: Outside agencies	15
Non - Facility: Systems, Others	30
Total Non- Facility Complaints	45
Total Complaints all Categories	1,599

Common Complaint Issues

Care issues increased 41% - 406 in number

The root cause of most care issues is failure of the home to provide adequate nursing staff.

Common issues include:

- Accidents and falls caused by unattended or incorrectly addressed needs, over-medicated, inadequate care plans or improper environment.
- Medication errors or omissions. Medication administration not documented or incorrectly documented.
- Residents not provided baths or showers in a timely manner, or not at all.
- Residents remaining in soiled clothing or incontinent briefs; hands and face not washed; teeth or dentures not cleaned.
- Staff failure to identify and address or acknowledge reported symptoms such as pain, pressure sores, fevers, or infection. Failure to note and address behavioral or cognitive changes.
- Resident's health care provider was not notified of changes in resident condition.
- Resident representative was not notified of changes in resident condition.
- Not accessing needed healthcare services timely for the resident, or at all.
- Failure to create or follow a person-centered care plan.
- Care planning that did not include the resident or resident representative.

Common Complaint Issues (cont.)

Care issues increased 41% in the program year alone - 406 in number

- Specialized Services indicated by a PASRR Level II screen were not included in the care plan or being followed.
- Care plans not scheduled to include those parties desired by the resident, not scheduled with allowance of sufficient time or the resident not being given a copy of the current care plan.
- The facility not updating the care plan or refusing to hold a care plan to provide for changes as needed.
- Failure to provide access to assistive devices or to maintain adaptive equipment such as grab bars, wheelchairs, hearing aids, visual aids and other communication assistive equipment.
- Facility caused difficulties in accessing or keeping a service animal.
- Failure to provide or arrange for rehabilitation therapies or services to improve or maintain the residents function or is not assisted or encouraged to walk when appropriate.
- Physical and chemical restraints including reclining chairs and improper use of bed rails deliberately intended to prevent residents from having freedom in body movement and inappropriate use of antipsychotic medication involving the inappropriate assessment, use or monitoring of the medication.
- Failure to follow infection control procedures: Staff not wearing, or not properly wearing, necessary personal protective equipment (PPE); facility not providing necessary PPE; infections unreported or not treated appropriately.

Common Complaint Issues (cont.)

Resident Rights - 332 in number

- Residents denied the right to choose their own physician/pharmacy/hospice or other health care provider.
- Residents not offered or supported in transition planning to return to community or other less restrictive setting. Staff interfering with a residents' choice to move from a facility.
- Residents treated with rudeness, indifference, or insensitivity. Staff not knocking on the residents' doors before entering; leaving doors or curtains open while providing care, making statements to residents such as "hurry up", "be quiet", "quit turning on your call light" or "go to your room".
- Staff disclosing confidential information without permission; talking about resident care where others can hear, sharing resident information in a newsletter, on social media or other format without consent.
- Privacy in communication rights violations such as opening mail; monitoring visitor conversations, phone calls or e-mail. Searching rooms, drawers and other private spaces without consent.
- Facility staff ignored or trivialized resident complaints. Required grievance processes were absent; or denied. Inappropriate policies where residents were not to report abuse, neglect, exploitation, or other grievances, before telling administrators, operators or director of nursing.
- Retaliation for making complaints. Examples are verbal threats of eviction, room moves, withheld medications and/or bath and showers, call lights ignored and meals not served timely or at all.
- Staff place restrictions on or otherwise fail to support a resident's right and ability to choose who to associate with and when to visit with others, either in the facility or within the community.
- Facilities interfere with forming and/or function of resident and family councils. Staff did not assist in the promotion of councils and/or exerted too much control; did not respond or follow-up on council requests.
- Failure to protect or promote personal liberty or freedom of choice, right of assembly, speech, religious freedom or the right to vote. Common examples are choice of roommate, smoking/non-smoking, right to refuse care or treatment and other civil rights issues or preferences.

Common Complaint Issues (cont.)

Abuse, Neglect, Exploitation complaints - 120 in number

- Hitting, slapping, pinching or kicking a resident.
- Unwanted or inappropriate touching, sexual coercion, sexually explicit photographing, or sexual harassment.
- Verbal assaults, insults, threats, intimidation, humiliation, or harassment. Oral, written and gestured language that willfully included disparaging and derogatory terms used against residents regardless of their ability to comprehend. Humiliation; bullying; harassment; threats of punishment or deprivation; and separation of a resident from other residents or from their room against the resident's will.
- Improper use of an individual's funds, property, or assets for another person's profit or advantage.
- Deprivation of resident's rightful access to, information about, or use of personal benefits, resources, personal needs allowance, belongings or assets.
- Facility staff failed to protect residents from harm or failed to meet needs for essential medical care, nutrition, hydration, hygiene, clothing, basic activities of daily living or shelter, which resulted in a serious risk of compromised health and/or safety, relative to age, health status, and cultural norms.

Note: Resident often voice concerns to ombudsmen but deny permission to address the complaints directly on their behalf, stating they fear retaliation/revenge by facility staff.

Reports to the ANE hotline lack sufficient address. Residents are often not interviewed and if so, only to determine facility compliance. Protections are not put into place. Assessments and recommendations for actions or services for the victim are not occurring.

Residents ever more frequently state they witness, or have been subjected to, verbal threats of eviction, room moves, withheld medications, call lights ignored, baths and showers withheld, meals not served, and more when complaints are voiced or otherwise asserting their rights.

Facility staff contact ombudsman to report they also have been intimidated with threats of job loss, or suffered job loss when they attempt to report ANE of residents to their director of nursing, or operators and administrators.

Several instances where nursing homes failed to report ANE incidents to state survey agencies or notify law enforcement despite federal and state laws requiring reports be made.

Common Complaint Issues (cont.)

Kansas Statute – Duty to address abuse, neglect or exploitation of residents

39-1404. Same; duties of Kansas department for aging and disability services and department of health and environment; personal visit; investigation and evaluation; information provided to certain persons. (a) The department of health and environment or the Kansas department for aging and disability services upon receiving a report that a resident is being, or has been, abused, neglected or exploited, or is in a condition which is the result of such abuse, neglect or exploitation or is in need of protective services shall:

(1) When a criminal act has occurred or has appeared to have occurred, immediately notify, in writing, the appropriate law enforcement agency;

(2) make a personal visit with the involved resident:

(A) Within 24 hours when the information from the reporter indicates imminent danger to the health or welfare of the involved resident;

(B) within three working days for all reports of suspected abuse, when the information from the reporter indicates no imminent danger; or

(C) within five working days for all reports of neglect or exploitation when the information from the reporter indicates no imminent danger.

(3) Complete, within 30 working days of receiving a report, a thorough investigation and evaluation to determine the situation relative to the condition of the involved resident and what action and services, if any, are required. The investigation shall include, but not be limited to, consultation with those individuals having knowledge of the facts of the particular case; and

(4) prepare, upon a completion of the evaluation of each case, a written assessment which shall include an analysis of whether there is or has been abuse, neglect or exploitation; recommended action; a determination of whether protective services are needed; and any follow up.

(b) The department which investigates the report shall inform the complainant, upon request of the complainant, that an investigation has been made and, if the allegations of abuse, neglect or exploitation have been substantiated, that corrective measures will be taken if required upon completion of the investigation or sooner if such measures do not jeopardize the investigation.

(c) The Kansas department for aging and disability services may inform the chief administrative officer of a facility as defined by K.S.A. 39-923, and amendments thereto, within 30 days of confirmed findings of resident abuse, neglect or exploitation.

History: L. 1980, ch. 124, § 4; L. 1983, ch. 149, § 4; L. 1990, ch. 153, § 4; L. 1997, ch. 161, § 5; L. 1998, ch. 200, § 6; L. 2003, ch. 91, § 5; L. 2003, ch. 149, § 27; L. 2014, ch. 115, § 159; July 1.

THREE YEARS IN A ROW WE HAVE ASSERTED THAT ANE INVESTIGATIONS, EVALUATION AND FINDINGS BY KANSAS DEPARTMENT FOR AGING AND DISABILITY SERVICES (KDADS) under K.S.A 39-1404 ARE ABSENT.

KDADS small number of surveyors are dedicated to investigating compliance for licensing and certification requirements of the adult care homes. However, KDADS does not have a structure in place to fulfill its mandate to address ANE under K.S.A 39-1404 or subsequently K.S.A 39-1411 register of reports. Absent a criminal conviction, there is no individual ANE address.

FY2022 - Only 6 individuals statewide are reported to have been substantiated by KDADS

A SERIOUS and URGENT NEED!!!

Common Complaint Issues (cont.)

Dietary Complaints Increased 87% - 107 in number

Residents suffer hunger, frustration, depression and a multitude of adverse health consequences when dietary concerns are not addressed.

Common complaints are:

- Food quantity
- Food quality
- Food improperly prepared
- Variation or choice
- Temperature - cold Long periods without food or missed meals
- Adaptive equipment not available for resident to eat independently
- Staff failure to assist residents opening lids, packages etc.
- Staff placing food out of the residents reach
- Residents who require conversation and prompting to take a bite, drink, or even swallow are left unattended.
- Trays picked up with food uneaten. (Charting by staff reflecting the resident refused, when in reality, the resident went without needed assistance.)
- Shortages of other dining supplies

BLT



Bean Burrito



Burnt Rolls



Common Complaints (cont.)

Admission, Transfer, Discharge, Eviction - 98 in number

Common **complaints** involved one or more of the following scenarios:

- Resident was transferred or discharged without notice or due process.
- Resident was transferred to the hospital and not advised of bed hold policy.
- Facility refused to readmit resident post hospitalization.
- Facility failed to provide written discharge notice as required.
- Notice was incomplete or incorrect.
- Transfer or discharge lacked appropriate reason or rational.
- Transfer or discharge lacked appropriate location.

=====
Notably:

Facilities threats of discharge are occurring at much higher numbers than complaint numbers reflect. Resident and family members ever more frequently express fear of retaliation and will not provide consent for complaint address of these threats, or other concerns.

Retaliation is a violation of regulation, and a crime in Kansas. Unfortunately, there is not meaningful enforcement on either front leaving residents at significant risk. This often impedes the ability of ombudsmen to expediently resolve these issues.

Under the Kansas Residential Landlord & Tenant Act, a renter has certain rights including the right to due process before evictions. Individuals living in nursing homes have appeal rights when provided notice of eviction. While it may seem unbelievable and certainly unconscionable, residents in *state licensed* adult care homes, such as assisted living and other board and care type homes in Kansas have less due process rights that any other Kansan under landlord tenant law. Currently, vulnerable Kansans living in a *state licensed* adult care home have no due process, or appeal rights; thus, little recourse when notice is not properly provided or is based on incorrect claims.

Involuntary Discharges are traumatic to residents and to their families.

36% of all residents died within 30 days of nursing facility discharge.

U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES Office of the Assistant Secretary for Planning and Evaluation
RESIDENT AND FACILITY FACTORS ASSOCIATED WITH HIGH RISK OF DISCHARGE FROM NURSING FACILITIES, 2012-2017

Ombudsman Activities

Information and Assistance/Consultation

The Long-Term Care Ombudsman's Office provides information to residents, facilities, and providers. Requests for information are most frequently related to resident rights; choosing a nursing home; interpreting regulations; the abuse, neglect or exploitation of a resident; and admission and discharge procedures. Consultation does not involve investigating or working to resolve a complaint.

PY 2023

Representatives of the Office consulted with 2,132 residents and 1,197 facilities or providers about long-term care issues.

Resident and Family Councils

The Long-Term Care Ombudsman's Office assist resident and family councils by attending meetings upon request and providing assistance in the development and continuation of resident and family councils. Resident and family councils are meetings that give residents and their families opportunities to discuss issues, care needs, frustrations, and to receive support and encouragement.

PY 2023

Representatives of the Office worked with 81 resident councils and family councils across the state.

Community Outreach and Education

The Long-Term Care Ombudsman's Office conducts community outreach education in person and virtually. Ombudsmen provide education related to the rights of residents, how to advocate on behalf of or empower residents, the services of the ombudsman program, person-centered care practices, and elder abuse.

PY 2023

Representatives of the Office provided 46 community education sessions about issues pertaining to long-term care across the state.

Survey Participation

The Long-Term Care Ombudsman's Office participates in survey activities conducted by the Department for Aging and Disability Services, which serves as the regulatory agency for long-term care facilities in Kansas to ensure their compliance with federal and state laws. The role of the Office is to provide comment, share concerns on behalf of residents and family members and ensure the residents' voices are heard. Participation by the Office may include pre-survey briefings, attending resident interviews or the exit interview.

PY 2023

Representatives of the Office provided information and advocated for residents with surveyors 289 times during facility surveys conducted by KDADS.

Ombudsman Capacity - Volunteers and Paid Staff

Long-term care ombudsman programs rely on volunteer representatives to supplement all program activities. Every ombudsman, paid or volunteer encourages self-advocacy and interaction among residents, staff and community. Certified ombudsmen work to ensure that resident rights are being honored, requested information is provided and receives, investigates, and resolves concerns made by, or on behalf of, residents.

Volunteers initially receive a minimum of 36 hours classroom and on-site training. The training includes subject matter to include elder rights, the regulatory process, care plans, advocacy, the aging process, communication, problem-solving and facility staff structure. Annually, volunteers must complete 18 hours of approved training to remain certified. *This is 6 more hours of training a year than a certified nurse aid providing direct care to residents is required to complete.*

Unfortunately, ombudsman programs across the country have seen reduced numbers of volunteers. The extraordinary conditions during and post pandemic were devastating to ombudsman volunteer numbers in many states, Kansas included. The increased complexity of cases, the less collaborative environment in the homes because of understaffing and a “corporate culture” usurping administrators’ authority, place undue stress on paid staff and volunteers. Volunteers require additional support, recruiting and training is more problematic and paid ombudsman required to do so are already stretched far too thin.

Even using one-time Covid funds to increase staffing, our paid ombudsman staff are assigned at a rate of approximately 1 staff to 3400 residents when the advised ratio is 1 to 2000. With regular funding resuming *and our aging population increasing*, there is risk of dire decisions in operations that will impact Kansas having a fully functional program. Projections would have the program at a 1 to 4200 ration by fiscal year 2026.

Funding needed for an additional 5-7 ombudsman, a volunteer coordinator, and a deputy ombudsman at an *additional* estimated cost of \$600,000 -\$770,000 annually by 2026 is a realistic possibility.

The Older Americans Act requires the State agency (KDADS)-provide for adequate legal counsel for the program (LTCO) that has competencies relevant to the legal needs of the program and of residents and is without conflict of interest. The program continues to lack adequate and conflict-free legal counsel. This program year the program was imposed to contract independently to assure the full ability to carry out the duties and the functions of the office.

Systemic Issue: Insufficient Staffing

Despite extensive efforts, there are barriers that exist when attempting to protect the rights, health, safety and welfare of persons residing in long-term care. The following are some of the systemic issues of particular concern.

Insufficient staffing is a root cause of many concerns.

Ombudsman programs are receiving ever-increasing concerns of abuse and neglect of residents. Residents not getting medications, receiving the wrong medications, lacking assistance to bathe, change clothes or use the bathroom, not having their room or bedding cleaned, care plans not done timely, rehabilitation not happening, unaddressed pain, wound care absent, being isolated, weight loss, transportation not scheduled, medical appointments canceled, refusals to access acute care treatment, frequent verbal abuse and more ongoing.

Sores, soiled items, inedible food, pests, bruises and death are often brought forth with a direct correlation to insufficient staffing. Residents and family members often express fear of retaliation or that addressing issues will only cause the already too few staff to get in trouble and be let go, leaving even greater gaps in care.

Often, individuals are not living in the home of their choosing but rather in an adult care home provided under the premise of safety. The home is promising care and accepting full payment, but the reality is they are not staffing to a level that can make good on promises made. Residents often voice they choose to not drink anything with their evening meal, knowing help to use the bathroom may not be available for hours on end. They are told to soil themselves in bed and lay for hours waiting for relief and care. They share they have stared at the same calendar page for months because asking an aid to turn the page would take critical time from necessary care they desperately need.

Facilities often acknowledge they are short on staff; nevertheless, they continue to accept new admissions.

More and more administrators voice they have no authority to hire or are offered incentives by owners or other management NOT to hire staff.

Residents frequently tell ombudsmen they are ready to die rather than live with the loss of dignity, the loss of autonomy, and the physical and emotional suffering they endure.

Sufficient staffing is lacking to provide care.

Providers are billing for services NOT rendered.

Systemic Issue: Overuse and Abuse of Guardianship or Conservatorship

Common complaints from people subject to guardianship include:

- Not initially being served notice; not advised of hearings, or right to attend; and not being properly represented.
- Guardians' failure to follow court orders.
- Loss of home or other property sold or disposed of by guardian without notice or communication.
- Guardian preventing a less restrictive setting or return to a community setting.
- Inappropriate restriction of visitors by the guardian.
- Preventing communication with others; taking or turning off cell phone.
- Restricting the ability to leave the premises and access the larger community (imprisoned).
- The guardian does not know the person, never visits, and makes choices without including the person in the process.
- Guardianships sought for the convenience of hospitals to facilitate discharge plans contrary to the person's choice or necessity.
- Deprivation of personal property, ID's and interference with mail or access to financial information.
- Lack of clothing or other personal needs items.

"There are challenges, overuse and abuse of adult guardianship or conservatorship, and it is essential that we recognize the scope of the issue, and take action to improve the laws, practice, oversight, and accountability. The first step in change is acknowledging the need. It is time to stand up and say, we can do better, we must do better, we are the agents of change."

Challenges in Guardianship and Guardianship Abuse (americanbar.org)

GUARDIAN EDUCATION and OVERSIGHT IS LACKING

Systemic Issue: Misuse of Antipsychotic Medications

Facility staff frequently ask physicians to prescribe drugs to manage agitation and other behaviors before attempting nonpharmacological alternatives to antipsychotic medications.

When prescribed for residents with dementia, antipsychotic drugs may have serious implications including over-sedation, loss of independence, confusion, falls, or even death.

These drugs are often being administered without the required informed consent. Other times the resident, and their representatives, are inappropriately pressured to consent to these medications.

Kansas lacks staffing standards for memory care, or specific dementia training for staff. Person centered practices improve communication between caregivers and individuals living with dementia, for a reduction in dementia-related behaviors and an increase in job satisfaction for staff. Too few facilities are investing in staff training to give them the tools they need to be successful supporting residents expressing their difficulties through behavior.



“Difficult” is not a diagnosis and it is inappropriate to label any resident this way. Actions and behaviors are a form of communication by which residents are expressing an unmet need.

[HTTP://THECONSUMERVOICERWORK.ORG/UPLOADED/FILES/GENERAL/CV_DIFFICULTDIAGNOSIS_ADVOCATEFS_WEB.PDF](http://theconsumervoicework.org/uploads/files/general/cv_difficultdiagnosis_advocatefs_web.pdf)

Action: Person Centered Practices Training

Person Centered Approaches Skills Building Core Concept

March 22nd OR March 28th
2pm to 3pm CST

Person-Centered Care, as defined by the Centers for Medicare & Medicaid Services, is "to focus on the resident as the locus of control and support the resident in making their own choices and having control over their lives." (CMS §483.5)



Person Centered Approaches Rituals & Routines

Aug 7th or Aug 24th, 2023
2 p.m. to 3 p.m. CST

Person-Centered Care, as defined by the Centers for Medicare & Medicaid Services, is "to focus on the resident as the locus of control and support the resident in making their own choices and having control over their lives." (CMS §483.5)



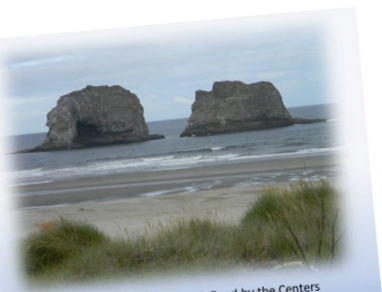
Person Centered Care is a requirement for nursing homes. Systemically, there continues to be a lack of understanding and implementation even though significant improvements in both agitation and quality of life occur in people supported by staff offered person-centered training interventions.

In 2022, and again in 2023, the Office of the State Long-Term Care Ombudsman utilized one-time Older American Act grant funding to provide information and education on Person Centered Practices. The Center for Medicare and Medicaid (CMS) Final Rule for Nursing Facilities provide definition of and requirements for nursing facilities to provide residents with person centered care. Person Centered Care is defined as: "to focus on the resident as the locus of control and support the resident in making their own choices and having control over their daily lives." Person Centered Practices and Care not only increase and support resident choice and control, it decreases the likelihood of abuse and neglect.

Virtual training sessions were offered to residents, family members, ombudsmen, Adult Protective Service staff, nursing home staff and other interested parties for the purpose of introducing the foundational concepts and skills of Person-Centered Practices. A total 21 sessions in 2023 included 601 participants* confirmed in attendance for these virtual education events.

* Some events were viewed by teams using one device; this only counted as one participant.

Person Centered Approaches Skills Building "Matching" September 26th 2:00 PM CST



Person-Centered Care, as defined by the Centers for Medicare & Medicaid Services, is "to focus on the resident as the locus of control and support the resident in making their own choices and having control over their lives." (CFR §483.5)

Person Centered Approaches Skills Building Communication Chart June 27th 2pm to 3pm CST

Person-Centered Care, as defined by the Centers for Medicare & Medicaid Services, is "to focus on the resident as the locus of control and support the resident in making their own choices and having control over their lives." (CFR §483.5)



Action: Coordination and Systems Advocacy

As Ombudsmen made visits to adult care homes across the state, we also distributed Kansas Attorney General Elder and Dependent Adult Abuse Prevention Council magnets and bookmarks to provide valuable phone numbers for people to call if they suspect abuse, neglect, exploitation or fraud regarding elder and dependent adults.



Our state is fortunate to have a strong citizens advocacy organization in Kansas Advocates for Better Care (KABC). The Office of the State Long-Term Care Ombudsman is committed to promoting the work of KABC to protect the well-being and rights of residents. When and where appropriate the two entities have formed solid alliances to advocate for better care and quality of life.

*~ Camille Russell, State Long-Term Care Ombudsman
Recipient of the 2023 KABC Caring Award*

Ombudsmen also distributed vaccination materials to adult care homes across the state which were prepared by Health Quality Innovations under contract with Centers for Medicare and Medicaid Services.



Participation in development of Kansas Crisis Standards of Care: Long-Term Care Phase 2, facilitated by the Kansas Health Institute (KHI)

Promotion of Person-Centered Approach to Preparing for Time of Crisis

https://ombudsman.ks.gov/docs/default-source/default-document-library/kansas-long-term-care-ombudsman-healthcare-crisis-passport-revised-9-30-22.pdf?sfvrsn=86dc3007_4

The State Ombudsman participates as a Steering team member of The Kansas Adult Decision-Making Learning Collaborative.

The Learning Collaborative is comprised of interested parties and stakeholders connecting, learning together and making recommendations regarding a continuum of adult decision-making options for those adults in need of decision-making assistance. Using a person-centered approach, valuing autonomy, always considering the least restrictive options and informed by those with lived experience.

Action: Coordination and Systems Advocacy (cont.)

Presented at the Annual National Consumer Voice Conference



Ombudsmen served on two Judicial Council Committees

- Uniform Guardianship and Conservatorship Advisory
- Advisory Committee Adult Care Discharge

PEAK PERSON-CENTERED CARE Conference

In addition to having two ombudsmen serve on the PEAK advisory team, ombudsmen supported the person-centered care conference in Manhattan, KS, by providing two breakout sessions: “Raising the Residents Voice”, staffing an information table, assisting with registration and awarding a resident council tools kit, including a Resident Council Handbook, to one PEAK home winner.



Note: **Resident Council Handbooks** are a resource that can be accessed by any resident or facility wishing easy to use guidance and technical assistance to build stronger resident groups. Resident Council Presidents may request a paper copy from their Regional Ombudsman. Additional copies to support councils can be accessed for the facility to print by accessing the resource on our website.

https://ombudsman.ks.gov/docs/default-source/default-document-library/kansas-residents-council-handbook.pdf?sfvrsn=3a323f07_0

Recommendations

- Modernize laws, regulations and policies to incorporate current needs and rights of Kansas residing in assisted living and other board and care type adult homes.
- Create LEVELS of licensure for state licensed adult care homes.
- Create certification requirements, including minimum staffing and training, for licensure types advertising or charging increased fees for memory care services.
- Require transparency in ownership and tie further enhanced funding to specific outcomes, prioritizing staffing and other direct care costs.
- Increase surveyor capacity and legal support for regulatory compliance activities; require multidisciplinary survey teams.
- Increase long-term care ombudsman capacity for current settings and provide ombudsman funding and authority to serve nursing homes for mental health.
- Increase fines for serious or repeated regulatory violations in state licensed adult care homes.
- Update licensing requirements and continuing education for facility administrators-operators; enforce current regulations for notice of change of administrators-operators and limits on the number of homes a single administrator/operator may be assigned.
- Require written reasons for denial of admission made by adult care homes.
- Increase coordination and training between federal, state, and local government programs and services to serve the needs of older adults, their families, and other caregivers with a specific focus on person-centered practices.
- Modernize laws, regulations, and policies to promote capacity building in housing, transportation, long term care improvements, and caregiver support.
- Support or create opportunities to strengthen the direct care workforce.
- Support or create opportunities to better support cognitive and behavioral health for older adults.
- Support or create opportunities to improve the economic well-being of older adults.
- Increase access to justice for older adults to include addressing abuse, neglect, and exploitation.
- Promote a more age-integrated state to encourage intergenerational activities to decrease loneliness and isolation across generations.
- Require courts to report aggregate guardianship data be made readily available to the public.
- Adopt The Uniform Guardianship, Conservatorship and Other Protective Arrangements Act (UGCOPAA), a comprehensive guardianship statute drafted with extensive input from experienced guardianship judges and organizations that advocate for guardianship reform.
- Create Elder Death Review Teams

Program Staff

JUSTIN ERK

Region 1 Long-Term Care Ombudsman

Barton, Dickenson, Ellsworth, Harvey, Marion, McPherson, Ottawa, Reno, Rice & Saline Counties

JANETTE CORPSTEIN

Region 2 Long-Term Care Ombudsman

Atchison, Brown, Chase, Clay, Doniphan, Douglas, Geary, Jackson, Jefferson, Leavenworth, Lyon, Marshall, Morris, Nemaha, Osage, Pottawatomie, Riley, Shawnee, Wabaunsee & Washington Counties

HECTOR RODRIGUEZ

Region 3 Long-Term Care Ombudsman

Johnson & Wyandotte Counties

MARILYN RANDA

LOU ANNE WARD

Region 4 Long-Term Care Ombudsman

Butler, Cowley, Harper, Kingman, Sedgwick & Sumner Counties

KATIE ROSS

Region 5 Long-Term Care Ombudsman

Barber, Clark, Comanche, Edwards, Finney, Ford, Grant, Gray, Greeley, Hamilton, Haskell, Hodgeman, Kearney, Kiowa, Lane, Meade, Morton, Ness, Pawnee, Pratt, Scott, Seward, Stafford, Stanton, Stevens & Wichita Counties

VELVET UNREIN

Region 6 Long-Term Care Ombudsman

Cheyenne, Cloud, Decatur, Ellis, Gove, Graham, Jewell, Lincoln, Logan, Mitchell, Norton, Osborne, Phillips, Rawlings, Republic, Rooks, Rush, Russell, Sheridan, Sherman, Smith, Thomas, Trego & Wallace Counties

GINA ELLIOTT

Region 7 Long-Term Care Ombudsman

Allen, Anderson, Bourbon, Chautaugua, Cherokee, Coffey, Crawford, Elk, Franklin, Greenwood, Labette, Linn, Miami, Montgomery, Neosho, Wilson, & Woodson Counties

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