

**Memorandum**

Date NOV 26 1997

From June Gibbs Brown
Inspector General *June G Brown*

Subject State of Maryland's Ombudsman Program for Processing Elder Abuse and Neglect
Complaints and Accuracy of Geriatric Nurse Aide Registry (A-12-96-00016)

To Jeanette C. Takamura
Assistant Secretary for Aging

This memorandum is to alert you to the issuance on Friday, November 28, 1997, of our final audit report. A copy is attached.

Our objective was to evaluate Maryland's Ombudsman program to identify, investigate, and resolve complaints of elder abuse, neglect, and exploitation. We expanded our review to include a determination of whether findings or convictions of abuse by nursing home employees were appropriately annotated ("flagged") by Maryland's Department of Health and Mental Hygiene, Division of Licensing and Certification, on the Geriatric Nurse Aide (GNA) Registry to indicate that a prior abuse was committed.

The Ombudsman plays an important role in helping to ensure that the elderly are properly cared for and protected from abuse in long term care facilities. We found, in our sample, that the review and reporting network in Montgomery County's Ombudsman program did not provide reasonable assurance that instances of abuse occurring in long term care facilities were properly reported and resolved. Similar deficiencies were found in other counties but to a lesser degree. We also found that the State Ombudsman has not conducted annual monitoring reviews of all local Ombudsman programs.

The Ombudsman program is a featured part of the elder abuse avoidance system in Maryland that needs to work together with the police and various other offices, to provide services which protect residents' health, safety, welfare, and rights. However, we noted that: (1) the local Ombudsmen, who are principally responsible for investigating complaints which include abuse and neglect, were not always following established review procedures and resolving complaints; (2) all long term care facilities, particularly board and care facilities, are not being overseen by the Ombudsman; and (3) for 1993, 1994, and 1995, only 26 of the 57 local Ombudsman programs were reviewed annually as required by the State Ombudsman.

Page 2 - Ms. Jeanette C. Takamura

We also found that the State GNA Registry which is intended to record the history of nurse aide abuses, did not always include such information on individuals who were found to have abused residents of nursing homes. This information is important to nursing homes in hiring employees.

In Maryland's Office of Aging (OoA) response to our draft report, they did not agree with some of the findings and the conclusion in the report, but they agreed with all of the recommendations. Subsequent to the issuance of the draft report, the OoA provided additional information on monitoring visits, specific cases included in the report and interpretation of Maryland's criminal law. The report was adjusted, where appropriate, to reflect this new information.

Any questions or comments on any aspect of this memorandum are welcomed. Please call me or have your staff contact John A. Ferris, Assistant Inspector General for Administrations of Children, Family, and Aging Audits at (202) 619-1175. To facilitate identification, please cite Common Identification No. A-12-96-00016 in all correspondence relating to this report.

Attachment

cc:

Helene Fredeking, HCFA

Tim Hock, HCFA Region III

Department of Health and Human Services

**OFFICE OF
INSPECTOR GENERAL**

**STATE OF MARYLAND'S OMBUDSMAN
PROGRAM FOR PROCESSING OF ELDER
ABUSE AND NEGLECT COMPLAINTS
AND ACCURACY OF GERIATRIC
NURSE AIDE REGISTRY**



**JUNE GIBBS BROWN
Inspector General**

**NOVEMBER 1997
A-12-96-00016**



NOV 28 1997

Our Reference: Common Identification Number A-12-96-00016

Sue F. Ward, Director
Maryland Department of Aging
301 West Preston Street, Room 1007
Baltimore, Maryland 21201

Dear Ms. Ward:

Enclosed for your information and use are two copies of final Office of Inspector General (OIG) audit report entitled, "State of Maryland's Ombudsman Program for Processing Elder Abuse and Neglect Complaints and Accuracy of Geriatric Nurse Aide Registry."

Final determination as to actions to be taken on all matters reported will be made by the Department of Health and Human Services (HHS) action official. We request that you respond to the HHS action official within 30 days from the date of this letter. Your response should present any comments or additional information that you believe may have a bearing on the final determination.

In accordance with the principles of the Freedom of Information Act (Public Law 90-23), OIG audit reports issued to the Department's grantees and contractors are made available, if requested, to members of the press and general public, to the extent information contained therein is not subject to exemptions in the Act, which the Department chooses to exercise (see 45 CFR Part 5).

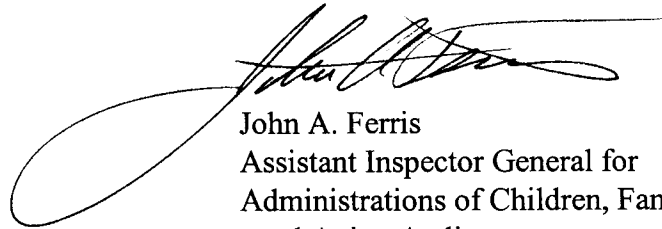
A copy of this final report has been furnished to representatives of the Maryland Department of Health and Mental Hygiene; Administration on Aging; Health Care Financing Administration; Division of Licensing and Certification; and the Medicaid Fraud Control Unit, Maryland Office of Attorney General.

We will be very happy to meet with you to discuss any matters in the report and the specific areas you mentioned which include: risk assessment system, volunteer program, and coordination with the police in their investigation of alleged abuse. Please call me at (202) 619-1175 or Peter Koenig at (202) 619-3191.

Page 2 - Ms. Ward

You may also contact both Sue W. Wheaton in the Administration on Aging at (202) 619-7585 and Lori Smetanke, Coordinator with the National Long Term Care Ombudsman Resource Center, at (202) 332-2275. They are available to provide technical assistance as may be needed in the specific areas. Ms. Wheaton indicated there are numerous models in other States that may assist you with your program. To facilitate identification, please cite Common Identification No. A-12-96-00016 in all correspondence relating to this report.

Sincerely yours,

A handwritten signature in black ink, appearing to read "John A. Ferris", with a large, sweeping flourish extending to the left.

John A. Ferris
Assistant Inspector General for
Administrations of Children, Family,
and Aging Audits

Enclosures

cc:

Lawrence P. Triplett, DHMH
Carol Benner, DHMH
Sharon Matthews, AoA
Sue Wheaton, AoA
Ed Glatzel, HCFA
Helene Fredeking, HCFA
Tim Hock, HCFA Region III
Timothy Sharpe, MFCU

EXECUTIVE SUMMARY

The Ombudsman plays an important role in helping to ensure that the elderly are properly cared for and protected from abuse in Long Term Care (LTC) facilities. We found, in our sample, that the review and reporting network in Montgomery County's Ombudsman program did not provide reasonable assurance that instances of abuse occurring in long term care facilities were properly reported and resolved. Similar deficiencies were found in other counties but they were not statistically significant. We found that the State Ombudsman has not conducted annual monitoring visits of all local Ombudsman programs. The Ombudsman program is a featured part of the elder abuse avoidance system in Maryland that needs to work together with the police and various other offices, to provide services which protect residents' health, safety, welfare, and rights. However, we noted that:

- the local Ombudsmen, who are principally responsible for investigating complaints, were not always following established review procedures and resolving complaints;
- all LTC facilities, particularly board and care facilities, are not being overseen by the Ombudsmen; and
- for 1993, 1994, and 1995, only 26 of the 57 local Ombudsmen programs received their required annual monitoring visits by the State Ombudsman.

We also found that the State Geriatric Nursing Assistant Registry, which is intended to flag abuses by nurse aides, did not always include such information on individuals who were found to have abused residents of nursing homes.

Subsequent to the issuance of the draft report, the Maryland Office of Aging (OoA) provided additional information on monitoring visits, specific cases included in the report and interpretation of Maryland's criminal law. The report was adjusted, where appropriate, to reflect this new information.

The OoA did not agree with some findings and the conclusions in the report. However, they agreed with all of the recommendations. The OoA comments and the Office of Inspector General's responses are summarized after each section in the body of the report. The complete text of OoA's comments is included in Appendix D.

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INTRODUCTION

BACKGROUND

Ombudsman programs exist to benefit and protect the Nation's approximately 2.4 million residents of nursing and board and care homes, and similar adult care facilities. These residents are among the most frail and vulnerable group in the Long Term Care (LTC) system. The State Ombudsman is responsible for training the local Ombudsmen, providing specialized technical assistance related to the care and treatment of residents, and the overall oversight and direction of the Ombudsman program. The Maryland LTC Ombudsman Program is administered through the Maryland Office on Aging by the State Ombudsman. The local Ombudsmen staff and volunteers at all 19 Area Agencies on Aging receive complaints, perform investigations, and work to resolve the complaints. The local Ombudsmen work through mediation and negotiation to resolve complaints. When appropriate, the Ombudsmen refer complaints to the police and the Maryland's Department of Health and Mental Hygiene (DHMH), Division of Licensing and Certification (L&C).

Title 42, Code of Federal Regulations (CFR) §483.156 provides the requirement for States to establish and maintain a registry of nurse aides that includes information on "any finding by the State survey agency [L&C] of abuse, neglect, or misappropriation of property by the individual." According to program officials, a finding of abuse means that sufficient evidence exists to support the conclusion that an abuse occurred.

In 1995, there were approximately 746,000 Marylanders over the age of 60. Over 35,000 of these individuals reside in nursing homes or other similar long term care institutions.

SCOPE AND METHODOLOGY

Our audit was conducted in accordance with generally accepted government auditing standards. Our objective was to evaluate Maryland's Ombudsman program to identify, investigate, and resolve complaints of elder abuse, neglect, and exploitation.

To accomplish this objective, we interviewed State and local Ombudsmen, officials from the DHMH/L&C, Maryland Department of Human Resources' Adult Protective Services (APS) and Women's Services Program. We also met with officials from the Maryland Office of Attorney General's Medicaid Fraud Control Unit (MFCU).

We reviewed applicable Federal and State laws and regulations regarding elder abuse and policies and procedures of the State and local Ombudsmen. We reviewed applicable records,

including the Maryland LTC Ombudsman program - Quarterly Reports (Quarterly Reports) submitted by the local Ombudsmen to the State Ombudsman and by the State Ombudsman to the Administration on Aging (AoA).

We randomly selected and reviewed 100 cases from the 2,130 (adjusted for duplicates) cases closed by the Ombudsmen for Fiscal Year (FY) 1995. A closed case is one in which the problem/ complaint has been resolved and no further action is needed or will be taken by the Ombudsman or the problem/complaint has been withdrawn. The population of cases was stratified and cases were selected as follows:

- 30 cases from Montgomery County;
- 40 cases from the combined counties of Baltimore City and Baltimore County; and
- 30 cases from the remaining counties in Maryland.

We met with 14 of the 19 local Ombudsmen, covering 18 of the 23 counties in Maryland, to obtain an understanding of how these offices investigate and resolve complaints. We also asked the local Ombudsmen what they believe were other issues, both positive and negative ones, related to performing their function.

We expanded our review to include a determination of whether findings or convictions of abuse by nursing home employees were appropriately annotated ("flagged") by L&C on the Geriatric Nursing Assistant (GNA) Registry to indicate that a prior abuse was committed.

Our review did not include an evaluation of: how cases were handled by other State offices (L&C, APS, etc.), allowability of expenditures made by the State or local Ombudsmen, or a determination of the extent of unreported cases.

The period covered by our review was: 1995 for sampling closed cases; 1993 through 1995 for reviewing monitoring visits; and 1990 through May 1996 for determining if aides convicted of abuse were flagged on the GNA Registry. The field work was performed between May 1996 and September 1996 at the Maryland Office on Aging in Baltimore, Maryland, and local Ombudsmen offices throughout Maryland. Additional information was obtained and field work was performed in May 1997.

In the Office of Aging (OoA) response to our draft report they did not agree with some of the findings and the conclusion in the report, but they agreed with all of the recommendations. The OoA's comments are appended in their entirety to this report (see Appendix D).

RESULTS OF REVIEW

GERIATRIC NURSING ASSISTANT REGISTRY

The GNA Registry, maintained by the DHMH's L&C, does not include all the pertinent information that would be needed by nursing homes in screening individuals during its hiring process. The Registry is a critical tool which should provide accurate information on abuse history for aides to nursing homes which must determine if hiring an aide places nursing home residents at risk. Specifically, the Registry officials were not making findings of abuse independent of the court system. Consequently, individuals that were found to have committed abuse in a nursing home were not flagged on the Registry. We found that 7 aides who had findings of abuse substantiated by the nursing home were not flagged on the Registry as well as 12 other nurse aides who were convicted of abuse, or had the finding of guilt deferred in a court of law. According to L&C, a nurse aide's record must be flagged on the GNA Registry only when convicted of a crime that occurs in a nursing home. This position is inconsistent with Federal and State requirements in that findings of abuse should be flagged on the Registry independent of the court system.

The Health Care Financing Administration (HCFA) regulation on Resident behavior and facility practices, 42 CFR § 483.13, states that a nursing facility must: (1) not use verbal, mental, sexual, or physical abuse, corporal punishment, or involuntary seclusion; (2) not employ individuals who have been found guilty of abusing, neglecting, or mistreating residents by a court of law or have had a finding entered into the State GNA Registry concerning abuse, neglect, mistreatment of residents or misappropriation of their property; and (3) report any knowledge it has of actions by a court of law against an employee, which would indicate unfitness for service as a nurse aide or other facility staff to the State GNA Registry or licensing authorities.

The Code of Maryland Regulations (COMAR) Title 10, Subtitle 7 Chapter 2 establishes the Geriatric Nursing Assistant Program in Maryland. The COMAR, which is consistent with HCFA regulation, requires the Registry to include, among other information, "*(h) Any findings documented by the Department [L&C] of resident neglect or abuse, or misappropriation of resident property involving an individual listed in the registry; and (I) A brief statement disputing the finding in §B(4)(h), by an individual, if the individual makes a statement.*" Accordingly, a "finding" flagged on the Registry is not limited to a conviction.

In our review of 100 case files, there were 8 cases in which an abuse to a resident occurred (see Appendix A). Seven cases occurred in a nursing home and one case occurred in a domiciliary care facility. We eliminated the one case in which the resident assistant was terminated by the domiciliary facility since the Registry only includes aides working in nursing homes. In six of

the seven cases, the GNA was terminated, and in one case the GNA was suspended for 3 days because the nursing homes felt they had sufficient evidence to take action on the GNA's abusive behavior. These seven cases were not prosecuted and consequently not flagged on the GNA Registry. In Maryland, the Office of Attorney General initially interpreted the regulations to mean that a "finding" only occurs when a conviction is obtained, which is in opposition to Federal and State requirements. The GNAs were therefore flagged only after being convicted of a crime in a nursing home. Subsequent to our audit results, the Office of Attorney General revised their interpretation of HCFA regulations and L&C will now include independent findings on the Registry.

We reviewed the Registry for the seven GNAs who were terminated or suspended and found that:

- Three individuals are listed on the GNA Registry but no reference is made about the finding of abuse and their termination for future reference.
- Two individuals were removed from the GNA Registry because their licenses expired. If they had been flagged, which they should have been, their names would have remained on the Registry indefinitely.
- For two individuals we were unable to determine if they were on the Registry because the Ombudsman case file did not include the GNAs' name or other identifying factors.

We expanded our review to determine whether convictions contained in the Attorney General's MFCU files were also recorded on the GNA register. The MFCU identified 24 GNAs that were found guilty (convicted) or declared their guilt in a court of law. Only 10 of the GNAs were flagged on the Registry. Two other ones were found guilty prior to establishment of the Registry and there was no retroactive provision to include them. The remaining 12 aides should have been flagged but were not: nine aides who were convicted and three aides who received the disposition of Probation Before Judgment (PBJ)¹. The Registry officials did not consider PBJ dispositions as convictions, and were not flagged on the Registry. Under Maryland law, PBJ is not a conviction. However, PBJs meet the requirements for a finding and should be included on the Registry.

The GNA Registry should include information on any finding by the State survey agency of abuse, neglect, or misappropriation of property by the individual. This would help protect residents of other facilities in which the GNAs may be later employed. The State Ombudsman's

1. Probation Before Judgment means whenever a person accused of a crime pleads guilty or nolo contendere or is found guilty of an offense, a court may stay the entering of judgement, defer further proceedings, and place the person on probation subject to reasonable terms and conditions as appropriate, such as pay a fine or pecuniary penalty to the State, or to make restitution, and any type of rehabilitation program or clinic.

office should work with the DHMH and the Office of Attorney General to improve the GNA Registry.

Agency Comments

Regarding PBJ as a finding, the Registry officials stated that "Under Maryland law, this finding is not a 'conviction' and therefore cannot be reported as such on the Registry. Many of the cases... were cases in which courts made PBJ findings.... Thus, it is L&C's belief that all 'convictions' (as that term is defined by Maryland law) that occurred after the adoption of necessary State regulations were appropriately 'flagged' on the registry." The Registry officials also stated that: "In 1990, L&C was advised, by the Office of the Attorney General, that it could not place 'independent findings' on the Registry without a change in the Maryland statute. Although legislative proposals were submitted by the Department [L&C] two years in a row to make such a change, these bills were defeated by the Legislature. Recently, the Office of the Attorney General reviewed its previous advice and has clarified it as follows: L&C may use a PBJ finding as a basis for making an 'independent finding' for purposes of the Registry without a statutory change. However, until recently only convictions were placed on the Registry because of the prior interpretation of the law. After receiving the new legal advice, L&C began making 'independent findings'...."

OIG Responses

As noted in their comments, L&C has acknowledged they have not been making and recording independent **findings** of abuse on the Registry during the 7-year period. We agree that recording a PBJ finding is appropriate and believe that using HCFA and State criteria, court findings of PBJ, even though they were deferred in a court of law, is sufficient evidence for inclusion on the Registry and should have been reported since 1990. The HCFA regulation and statute, as well as the State COMAR, clearly state that findings of abuse, neglect, or misappropriation of property are to be included on the Registry. The HCFA regulation further states that the nursing facility must report any knowledge it [the facility] has of actions by a court of law against an employee, which would indicate unfitness for service as a nurse aide or other facility staff to the State nurse aide registry or licensing authorities.

Information we have differs from L&C's stated understanding that all nurse aides who were convicted after the Registry had been established were appropriately "flagged" on the registry. At the time of our review, the Registry did not flag nine aides who were convicted and who received a probationary sentence. In addition, Registry officials were not consistently using their own criteria for reporting aides on the Registry, because eight aides with PBJs were flagged. We recognize that L&C has reviewed and updated the Registry recently, but these other GNAs should also be flagged. In addition to the nine convicted aides that were not flagged on the Registry, the remaining three aides who received a PBJ should have been flagged because they meet the criteria of a finding.

Agency Comments

Regarding the eight cases where an employee was terminated or suspended, "L&C did not agree with the auditors' conclusions in each of these cases...One of the eight cases occurred in a facility that was not a nursing home and therefore was not even subject to the Registry requirements.... However, even if L&C did agree, these cases would not have gone on the Registry unless there had been a criminal prosecution and a conviction because all eight of these cases occurred before L&C was making 'independent findings' of abuse."

OIG Responses

Concerning the eight cases where an employee was terminated or suspended, it is true that one of the eight cases occurred in a domiciliary care facility for the elderly and not a nursing home. As the Registry is currently structured, nurse aides in a domiciliary care facility are not subject to the Registry requirements. We adjusted the number of cases terminated or suspended to reflect this change. The L&C stated the remaining terminated or suspended cases would not have gone on the Registry unless there had been a criminal prosecution and a conviction because all eight of these cases occurred before L&C was making "independent findings" of abuse. As we discussed above, these cases were not classified as a finding by L&C, but should have been declared a finding and reported on the Registry.

PROCEDURES FOR RESOLVING CASES

The local Ombudsmen did not always follow the procedures established to investigate cases. Our review of 100 cases identified 16 cases in which the police and/or L&C were not notified to conduct an investigation, the Ombudsmen either did not investigate the case, did not conduct a timely investigation, or could not locate a case file for our review.

Title 42 CFR, section 483.13(c)(2) states that:

The facility must ensure that all alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source, and misappropriation of resident property are reported immediately to the administrator of the facility and to other officials in accordance with State law through established procedures (including to the State survey and certification agency).

The Maryland Office on Aging's LTC Ombudsman Program Procedures Manual (Procedures Manual) establishes the reporting requirements for the local Ombudsmen. The local Ombudsmen are to immediately report abuse or alleged abuse of residents to the police, L&C and the administrator of the facility, provided that the administrator is not the one accused. The Ombudsmen may assist with or conduct independently an investigation of alleged abuse. The investigation shall include but is not limited to: personal contact with the resident who has made the complaint or on whose behalf the complaint was made, interviewing officials and staff, visits

with other residents to verify complaint, working with the facility to protect the safety and well-being of the resident.

The problems we noted with the 16 cases (summarized in Appendix B) included:

Note: Several of the cases were found to have more than one problem.

- ✓ 9 cases had no documentation that the police were notified.

In one case, the resident's family had concerns about injuries to the resident. These included broken fingers, broken rib, and black eyes. While the facility could not pinpoint when injuries occurred, the nursing home fired the GNA who had responsibility for the resident. The same resident had an incident 2 weeks earlier. In this case, a nurse aide was heard yelling at the resident followed by a clapping sound. The aide was seen grabbing the resident while walking the resident back to the room. This aide was subsequently terminated and the case was closed.

- ✓ 8 cases had no documentation that L&C was notified.

For example, there was no evidence of L&C notification when a social worker was told by several nurses at a hospital that a resident had bruises on her arms, underarms, and torso. The facility indicated that an aide had handled her roughly while transferring her.

- ✓ 5 cases had no documentation that the police and L&C were notified.

In one case, a resident was found with an ankle fracture. The facility did not know what happened.

- ✓ 10 cases had no documentation that the local Ombudsman had investigated on-site the respective complaints; in 8 of these cases only telephone inquiries were documented. The remaining 2 cases did not show evidence that anything was done.

For example, a resident in a nursing home was difficult to contain. He had cancer and was continually begging the nurses for Valium. The resident also would leave the facility between 3 am - 4 am and had left one night but did not return. The nursing home official indicated that the facility did not want him back. About 4 months after the complaint was received, the Ombudsman contacted the nursing home. Upon learning that the resident

was discharged to a nursing home in Virginia, the case was closed. Earlier contact should have been made to discuss measures to restrain the resident and avoid further risk.

- ✓ 2 cases showed the response time exceeded the requirement in the Ombudsman Procedures Manual.

In one case, a resident was admitted to Bethesda Naval Hospital from the emergency room. The hospital was concerned because the patient was severely dehydrated, had a swollen scrotum, and reddened buttocks. According to the case file, the Ombudsman called the facility Administrator approximately 3 weeks after admittance to the hospital even though the Ombudsman was aware of the complaint 2 and one-half weeks earlier. During the discussion, the Ombudsman was informed that the patient had died. The case was closed.

In addition to the 16 cases discussed above, we identified:

- ✓ 1 case which showed that the Ombudsman and L&C were not able to respond timely to the potential abuse.

The resident sustained a small scratch in the middle of her forehead and a bruised right eye after falling. The nurse in charge neglected to file an incident report and was suspended for 1 day. The resident's son contacted the police charging abuse because of the bruised right eye. The police report was received by the Ombudsman 20 days after the incident. The Ombudsman then contacted a nursing home official who indicated that it was an oversight that the Ombudsman was not notified. The police report indicated that a copy was sent to L&C. About 1 month after the incident, the Ombudsman visited the resident at the nursing home and found no signs of abuse. The Ombudsman closed the case because of the length of time when their staff was informed of the incident and that it was unable to validate abuse.

The Procedures Manual sets the response time standards that are to be followed by the local Ombudsmen. These are: (1) cases of suspected/alleged abuse shall be responded to immediately upon receipt of the complaint; (2) serious complaints shall be responded to immediately whenever possible or within 24 hours of receipt of the complaint; and (3) non-emergency complaints shall be responded to within 5 working days.

The local Ombudsmen indicated that required procedures were not always followed because:

- The police are often not called unless the situation is serious. Various local Ombudsmen believe that if the police were called for every minor problem, credibility would be lost when a serious situation occurs.
- The Ombudsmen, when they believed the cases were appropriately handled by themselves, would not notify L&C. In these instances, L&C would not be aware of whether abusive actions or neglect did or did not take place, and whether nurse aides should be flagged on the Registry.
- Volunteer assistants did not investigate all assigned cases.

In one case in which a complaint was never investigated by the volunteer, the resident had black eyes and a scratch on the nose. The complaint intake form indicated that the resident was confused and disoriented and could not give an account of what happened.

Because investigations of abuse are time sensitive, it is important for procedures to be followed and investigations adequately documented. If the local Ombudsman is the recipient of a report of alleged abuse, they are to immediately notify the appropriate law enforcement authorities and L&C. We found that the local Ombudsmen did not always follow procedures established to investigate cases and notify the proper authorities. We identified 16 cases in which the police and L&C should have been involved but were not.

Agency Comments

Although the OoA disagreed with some findings and the conclusion in the report, it “plans to reemphasize to all staff, including all local Ombudsmen, that they must strictly comply with the mandated reporting requirements.”

The OoA stated that: “We can certainly agree that 19² out of 100 is an unacceptable rate of noncompliance and could indicate a statewide problem. However, this would only be the case if the 100 cases were a representative sample of the State and if the 19 cases actually contained deficiencies. Neither is the case in this matter.

The 100 cases are not a representative sample of Maryland Ombudsman cases because 30 percent of the cases were taken from Montgomery County, although that county only has approximately 15 percent of the State's nursing home beds. Thus, Montgomery County's cases were

²Based on the State comments to our draft report, we adjusted this number to 16.

overweighted in the analysis. This is significant because problems of one county (Montgomery) have been used to indict the entire State of Maryland.”

OIG Responses

Our statewide sample was statistically selected using various strata from the 2,130 cases of complaints, ranging from abuse, neglect, and theft, to serving dinner without a cup or glass. Of the 100 cases we selected, 45 cases involved abuse and neglect. The number and kind of problems with abuse and neglect we identified were even more significant when related to the 45 sampled cases. Further, Montgomery County may only represent 15 percent of the State’s nursing home beds, but it constituted 27 percent of the 2,130 cases that were closed statewide. We randomly selected 30 cases from this county which represented 30 percent of the sample.

Agency Comments

The OoA stated that “Of the 19 cases identified” in the Proposed Report, 8 were cases from the local Ombudsman programs outside of the Montgomery County Ombudsman. In four cases: “... (1) the police notified ‘L&C’ and the Ombudsman at the same time in case number 12 making it unnecessary for the Ombudsman to contact L&C...The Ombudsman is to notify the police and L&C if it is the initial recipient of a suspected abuse report; (2) case number 15 was not an abuse case; and (3) cases numbered 16 and 17 did not involve facilities licensed by L&C. Thus, section 19-347 of the Health General Article of the Maryland Annotated Code did not require the Ombudsman to contact L&C and the police in any of these four cases. (Section 19-347 creates the standard that the Proposed Report contends was repeatedly violated.)”

OIG Responses

Included in the scope of our statewide review, we identified eight cases which were outside of the local Ombudsman program for Montgomery county in which either the reporting or investigation were not handled properly. Of these cases, four were from Baltimore City and Baltimore County Ombudsmen programs; and four were from the remainder of the local Ombudsmen programs for the State.

- For cases 16 and 17, we agree that both facilities were not licensed by L&C and they were eliminated from the report.
- For case number 12, reporting the abuse to L&C is an arguable issue. We recognize that the investigative report may have been sent to L&C by enforcement officials. However, there was no record to show that the Ombudsman contacted L&C to ensure that they were aware of the reported abuse and that appropriate action was being taken timely to resolve the charge. Also important, the Ombudsman was not notified of the abuse until 22 days after the police became aware of the incident.
- For case number 15, a family member complained that while the resident was in a nursing home for respite care, the resident developed decubitus ulcers (bed sores). The Ombudsman did not consider this an abuse case, and therefore did not conduct an investigation to determine whether the situation was an abuse or neglect. It is

recognized that these bed sores are often attributed to neglect and that the infections they cause can be life threatening. Neglect as well as abuse is a criminal law violation in Maryland. The likelihood of neglect should have been sufficient to conduct a thorough investigation.

Agency Comments

For the four remaining cases outside of Montgomery County, the OoA stated that “the bottom line is...there were only four cases that could in any way give support to the conclusion,...In all four cases the local Ombudsman had conducted a thorough investigation and concluded either that there was no abuse or no evidence to prove abuse.”

OIG Responses

We believe that procedures in these four cases which were included in our statewide review were not followed. We noted that in these cases the procedures were not followed when there was an alleged abuse. The L&C was not notified in each case, and for one case, the police was not notified of the abuse. Notification to L&C provides them an opportunity to investigate the alleged abuse and if substantiated, to flag the Registry.

- For case number 13, the family complaint was coded as an abuse case and the Ombudsman made a site visit the day the call was received. The family was concerned that a skin tear on the resident’s arm was a potential abuse. Although the Ombudsman treated it as an abuse case and investigated the case, L&C was not notified.
- For case number 14, the Ombudsman treated the complaint from a social worker at the nursing home’s hospital as an abuse case, but did not notify L&C. The social worker was told that several nurses observed bruises on the resident’s arms, underarms, and upper torso approximately 1 week before the complaint was received by the Ombudsman.
- For case number 18, when the resident’s daughter complained the resident had bruises on her leg, the Ombudsman treated it as an abuse case, but did not call the law enforcement agency and L&C.
- For case number 19, a registered nurse at the nursing home filed the complaint of alleged abuse on this case, but the Ombudsman did not notify L&C.

Agency Comments

For the 11 cases in Montgomery County, the OoA stated that “four were not even potential abuse cases...Case 7 concerned complaints of inadequate hygiene, inadequate supervision, dehydration, and inadequate care plan, Case 9 concerned a complaint of inadequate supervision of residents; Case 10 concerned a request to assist in determining a resident's competency, and Case 11 concerned a resident's rights issue.”

OIG Responses

Although the OoA agreed that seven cases in Montgomery County Ombudsman program did not follow procedures, we believe that the other four cases do represent an abuse situation.

- Regarding case number 7, the patient's condition--"severe dehydration, swollen scrotum, and reddened buttocks"--was of such a significant concern to the hospital emergency room staff that they formally complained to the Ombudsman noting the serious condition of the patient. The complaint should have been treated as an abuse or neglect case and the law enforcement agency should have been immediately notified. Although the Ombudsman had been notified, they did not take action to investigate and resolve the complaint until 3 weeks after receipt of the complaint. The extent of the investigation was a telephone call to the facility without any further action or resolution of the potential abuse or neglect complaint because the resident had died.
- For case number 9, the complaint was made and categorized as a patient to patient abuse, contrary to OoA's contention that no abuse was reported. The nursing home's Director of Nursing complained that one resident with Alzheimer's hit another resident on the head with his fist and that resident was "unable to see." The Ombudsman did not visit the facility to determine whether the facility was adequately protecting the safety and well being of the residents.
- For case number 10, the Administrator of the nursing facility asked the Ombudsman to assess a resident's competency because she alleged aggressive sexual behavior by another resident, but was unable to identify the person who kissed her. In this case the Ombudsman intended to visit the facility as annotated in the case file. However, the file did not contain any documentation regarding a visit, only telephone calls between the Ombudsman and the facility were documented. According to the case file, no assessment had been done during the 10-month time period while the case was opened. The case was closed when the complainant died. Again, we believe that the Ombudsman should have visited the facility to document the possible sexual abuse situation and to initiate, as requested, an assessment of competency.
- For case number 11, the nursing home's social worker reported to the Ombudsman that they were having difficulty controlling a resident. The complaint was coded by the Ombudsman as a resident rights issue. However, we believe that it was a possible neglect case. The resident continually begged for Valium and would leave the facility between 3 am to 4 am. When the social worker filed the complaint, the resident left the night before and had not returned. A nursing home official said the resident "was competent but was depressed" and that the nursing home "did not want to take him back" because of his behavior. In reviewing the case file, we found that the Ombudsman had taken no action to determine whether the resident was adequately controlled and safeguarded by the facility and treatment was initiated for his behavior during the 4-month period when the case was received until the time the case was closed--the resident was transferred to another nursing home. There also was no

documentation in the case file to show that the Ombudsman contacted the local Ombudsman where the resident was transferred to seek assistance for the resident. During this time, the resident could have been severely injured while absent from the nursing home. An onsite visit should have been made to interview staff, work with the facility to protect the safety and well-being of the resident, and secure the appropriate services needed by the resident.

Agency Comments

The OoA stated that "Montgomery County's Ombudsman Program has developed its own pragmatic way of dealing with various types of cases. In some situations the county's approach did not strictly comply with OoA's Ombudsman regulations or Maryland's law on reporting abuse in related institutions, §19-347 of the Health General Article. The OoA is instructing Montgomery County that it must comply with these legal requirements, even if Montgomery County thinks it is impractical to apply the requirements in all cases...This is not to excuse some of the Montgomery County cases where the reporting or investigation was inadequate by any standard. The Montgomery County Ombudsman has informed OoA that several of the cases resulted from the lack of follow-up by a volunteer who had to be 'terminated' for unsatisfactory performance."

The OoA further stated that "some of the local Ombudsman feel that they lose their credibility with the police and L&C if every questionable case is called in an abuse. Maryland's laws require the Ombudsman and the police to conduct their own investigation when they receive an abuse complaint. It is understandable that every questionable case was not reported because some people do not think that it is a good use of resources to have both agencies conduct an investigation into every case involving an unexplained injury...During the time frame in question, nursing homes felt compelled to report injuries of an unknown origin to the Ombudsman, even if there was no suspicion or belief that abuse had occurred...However, the nursing homes were not obligated to report such cases, and the Ombudsman was not legally required to report them to L&C or the police unless someone believed there had been abuse."

OIG Responses

Potential abuse, neglect or unexplained injury cases should be investigated because the resident's safety and well being is in question. Reporting these cases to L&C would give them an opportunity to assess the facility and/or staff. Being aware of the complaints and results of the investigation would be of value to L&C when it reviews the facility's application to renew its license or for flagging aides who have been found to abuse and neglect nursing home residents. We also believe that in order to stimulate better coordination of the investigations, the respective State agencies need to be aware of all complaints of alleged or possible resident abuse or neglect. Inquiry is needed to determine the nature of the allegation, completeness and documentation of the nursing home investigation, extent of the investigation to be performed, and the parties that will investigate the case. An informed State agency could rely upon the work of another State agency to prevent unnecessary work. Better coordination can also assist the respective State agency with the disposition of the case and determining whether action should be taken against the nursing home.

Agency Comments

In addition, the OoA stated that “the program was cited frequently for conducting investigations by telephone. The Proposed Report treated this as a violation of the regulation that requires that an investigation include ‘personal contact with the resident ... on whose behalf the complaint was made’....However, OoA has interpreted the phrase ‘personal contact’ to include a telephone conversation. The Proposed Report erroneously construed ‘personal contact’ to require a face to face encounter, which is not required in every single case. There are obviously cases where such personal contact would not be an efficient use of an Ombudsman's limited resources.”

OIG Response

When there is a potential abuse or neglect case which is a criminal offense, a visit to the facility is warranted to make a thorough inquiry and determine if abuse or neglect did occur, and to identify measures to protect residents more effectively.

COVERAGE OF OTHER LONG TERM CARE FACILITIES

The local Ombudsmen do not monitor all required types of licensed long term care facilities in Maryland. Visits of long term care facilities, other than nursing homes, are only made when informed of a complaint. There are over 120 board and care or other adult long term care facilities in Maryland.

The Older Americans Act of 1965, as amended (OAA), Title VII, Chapter 2, §712(a)(3) states that the function of the Ombudsman is to identify, investigate, and resolve complaints that are made by, or on behalf of, residents. The OAA further defines resident as meaning “an older individual who resides in a long term care facility.”

The Maryland Ombudsman's Procedures Manual states that the program's scope is to provide services to residents of licensed long term care facilities. These include: (1) skilled nursing facilities; (2) intermediate care facilities; (3) domiciliary care homes; (4) group sheltered housing for the elderly; and (5) other facilities as required by local law and providing personal, nursing, or custodial care for three or more unrelated individuals which is licensed or subject to licensure by the DHMH.

The Procedures Manual also establishes that the Ombudsman is to conduct facility visits of all nursing homes at least quarterly and visits of domiciliary care homes should be conducted quarterly when possible. In addition, facilities that DHMH or the Ombudsman have identified as having serious problems should be visited at least monthly until the situation improves and stabilizes.

In its Long Term Care Ombudsman Program Report for FY 1995 to AoA, the Maryland Ombudsman indicated that:

Designated Ombudsman representatives are not required to cover board and care and other similar facilities. The primary barrier is insufficient funding from the AoA. Some

programs do investigate complaints received from these types of facilities; however, routine monitoring of facilities in these areas is not performed. To overcome this barrier, we have indicated the need for increased Federal funding for the program from the AoA. Additionally, we work closely with the Housing Division staff within our agency to provide support and information about monitoring techniques, and to transmit reports that the local Ombudsman programs receive about their facilities.

To meet the objectives of the Ombudsman program, the local Ombudsmen need to ensure that: complaints from all types of long term care facilities are being identified, investigated, and resolved; and the Ombudsmen periodically visit all types of long term care facilities. We did not assess investigations and visits by the Division of Housing staff.

Agency Comments

The OoA agreed and will take action on our recommendations. The OoA stated that it “recognizes that the Ombudsman Program must work to serve residents in all kinds of long term care facilities” and that “resource problems make coverage of all types of long term care facilities quite difficult.”

REVIEW OF LOCAL OMBUDSMEN PROGRAMS

The State Ombudsman has not conducted monitoring reviews in over a year of all the local Ombudsman programs. The Procedures Manual of the Maryland Ombudsman states that one of the duties of the State Ombudsman is to “... *conduct an annual review of all local programs including the use of the monitoring instrument.*”

The State Ombudsman provided us with copies of the latest monitoring reports on file. Fifteen of the 1993 monitoring reports were provided after the draft audit report was issued. The State Ombudsman was only able to document 26 monitoring reports, covering a 3-year time span, for the 19 local Ombudsman programs. For the period 1993 through 1995, 57 reports of reviews should have been prepared and available. After 1993, there were no monitoring visits to 10 Ombudsman programs, notwithstanding that three of them were the largest programs in the State (Montgomery County, Baltimore City, and Baltimore County). Of the 26 monitoring reports provided: 17 were done in 1993; 7 were done in 1994; and 2 were done in 1995. Appendix C to this report provides a summary of when the last documented monitoring visit occurred.

Had monitoring visits of the local Ombudsmen been conducted, many of the problems noted throughout this report could have been identified and corrective actions taken. As discussed earlier and shown in Appendix B, there were 16 cases in which procedures were not followed, 14 of these cases were from 3 counties that did not have a monitoring visit in the 2-year period. In addition, all seven cases in Appendix A, in which aides were terminated or suspended for abuse, were from the same three counties.

To ensure that local programs comply with all applicable Federal and State statutes and regulations, the State Ombudsman should conduct monitoring visits with all local Ombudsman. Also, some local Ombudsman offices we visited indicated they successfully use volunteers to assist in their reviews. We encourage other offices to consider this alternative because of the limited funding.

Agency Comments

The OoA stated that “all 19 local programs were monitored in 1993.” The OoA provided 15 of the 1993 monitoring reports subsequent to the issuance of the Proposed Report. The OoA stated that “Monitoring was less than 100 percent in 1994 and 1995 for four main reasons: (1) the State Ombudsman resigned in January of 1994; (2) we were unable to hire a replacement until September of 1994; (3) the replacement was terminated while on probation in July of 1995 for unsatisfactory performance; (4) we were unable to hire a new replacement until 1996 because in 1995 the House of Representatives had approved, and the United States Senate was seriously considering approving, legislation that would have decimated the Ombudsman programs. When the Ombudsman Program was under stress because of staff turnover and under attack by the House of Representatives, OoA sensibly focused on the Program's core responsibilities.”

OIG Responses

The OoA stated that all 19 local programs were monitored in 1993, but did not provide the monitoring reports for two visits in 1993 to Anne Arundel and Calvert Counties. We adjusted the report to reflect the 15 monitoring reports for 1993 which were provided to us after issuance of the draft report. We believe that other methods could have been used by the OoA to conduct the required monitoring visits during 1994 and 1995; the OoA could have established a task force made of representatives from several of the local Ombudsman programs to conduct the monitoring visits and could have prioritized visits considering potential risks. Although it is true that the House of Representatives approved and the United States Senate was considering legislation to the elimination of the Ombudsman program, the program was continued. We do not believe that it was prudent for OoA to prematurely discontinue its monitoring efforts. The visits could have given the OoA a valuable insight into the local Ombudsman operations which could be used to strengthen the program as we identified in our report.

OTHER MATTERS

The various local Ombudsman offices we visited were asked what they considered helpful techniques in managing the program. The responses they provided were similar. The one most often mentioned by the local Ombudsman dealt with the importance of developing a close relationship with the nursing homes and other organizations like L&C, the police, and the State Ombudsman.

Others included:

- The ability to use good communication skills working with all interested parties to obtain a full understanding of the nature of the complaint and to resolve them.
- Encouraging residents to become knowledgeable about their rights and avenues for reporting complaints by providing education to the seniors and instructing them to be more vocal about their own situation.

- The program must never miss the focus that the resident is paramount. For example, it is easy to get trapped into thinking about what the family or facility wants when the Ombudsman Program should be about what is best for the resident.
- Frequent visits to nursing homes. Having a regular presence serves as a motivation to the nursing home to be more attentive to resident rights knowing that you are an active and involved Ombudsman.
- Baseline educational qualifications and skills should be established for Ombudsman because they need to have a background and knowledge of many areas, including nursing and psychology.

Also, while many of the local Ombudsmen use volunteers and cited this as a good technique, some were not enthusiastic and do not use them. Often, the local Ombudsmen indicated they do not have the time available to recruit, train, and supervise the volunteers; the volunteers are not accountable for any problems that may occur; volunteers often do not have a professional background which is helpful, such as a nurse or social worker; and volunteers are hard to keep.

The problems which most of the Ombudsmen offered usually dealt with the lack of funding and staffing for the program. The local Ombudsmen believe others view the services they provide as being a “nice thing” rather than a “necessary thing” and they feel this results in the program being underfunded. Although the AoA has requested increases in funding for the nationwide Ombudsman program, the actual funding has been flat lined for several years at approximately \$4.4 million. The AoA reported that although there is a “sizeable Ombudsman network nationwide, the numbers of local programs, staff, and volunteers are insufficient to meet the demand for Ombudsman assistance with the myriad of questions and problems residents and their loved ones have regarding long term care facilities. As the population ages, the number of older people living in long term care facilities continues to increase, and so the need for Ombudsman services.”

Other concerns the Ombudsmen mentioned included:

- The difficulty in keeping track of nursing home employees who have had problems at one facility and move on to another facility. One Ombudsman indicated that she had seen nurse aides working in facilities she knew had problems at other facilities, but had no mechanism to pass this information on to the facilities.
- The lack of enforcement power. The Ombudsmen feel that the program’s major tool is its power of persuasion. The Ombudsmen say they cannot enforce penalties on the facilities. If L&C determines during its survey of a nursing home that problems noted in the investigation are not appropriately followed-up, penalties can range from civil monetary penalties to termination of Medicare/Medicaid payments to the nursing home. We were also informed that the Ombudsmen can not review resident charts or incident reports to look for unreported abuse cases. This is in contrast to the L&C office which has such authority.

- The Ombudsmen indicated that, because of staff shortage, they should reduce coverage in other program activities such as housing and guardianship for elders.
- The difficulty in evaluating the program's effectiveness and how outcomes are measured.
- Problems in delineating the significance of the issues which warrant police attention. Procedures do not allow for judgment in determining whether or not to call for police assistance. In one Ombudsman program, there is an unwritten policy with the nursing homes that if there is some ambiguity of the cause of injury or a direct accusation against an employee, the police and the Ombudsman will be called.
- Better communication over roles and responsibilities between the family and the facility is needed.

CONCLUSION AND RECOMMENDATIONS

The Ombudsman program plays an important role in the detection, investigation, and resolution of cases of abuse in long term care facilities. However, this is only one part of the "elder abuse system" in Maryland. Working together with the police and various other offices, the Ombudsman can provide services to assist the residents of long term care facilities in protecting their health, safety, welfare, and rights. This is not always occurring in Maryland. Getting these other authoritative offices involved also alleviates the burden of investigating alleged abuses to just the Ombudsman office. The GNA registry does not include all the information that would be useful to the Ombudsmen and long term care facilities. The local Ombudsmen did not always follow established procedures in investigating cases, visiting facilities, and conducting annual evaluations of all local Ombudsmen.

RECOMMENDATIONS

We recommend that the Maryland Office on Aging:

1. Work with the DHMH and the Maryland's Office of Attorney General to improve the GNA registry to include information on any finding of abuse, neglect, or misappropriation of property by a GNA regardless if a conviction has been obtained.
2. Review the procedures used to receive, investigate and resolve complaints timely, and ensure that:
 - a. these procedures are being followed by the local Ombudsmen;
 - b. the local Ombudsmen are identifying, investigating, and resolving complaints from all types of long term care facilities; and
 - c. annual monitoring visits of the local Ombudsmen are performed.

3. Instruct its local Ombudsmen to routinely visit all required types of long term care facilities or, in absence of necessary staff resources, devise a risk assessment system to visit the facilities and consider expanding the use of volunteers.
4. Work with the AoA and the local Ombudsmen to eliminate the barriers identified to achieve a more successful program.

Agency Comments

The OoA stated that they “agreed with all of the recommendations” and “plan to work diligently to implement them.”

SEVEN CASES OF ABUSE, WITH GNA NOT FLAGGED IN REGISTRY

Case No.	Description	Ombudsman Program
1	This case was eliminated because the facility was not licensed by L&C.	Eliminated
2	The resident family had concerns about injuries to the resident. These included broken fingers, broken rib, and black eyes. While the facility could not pinpoint when injuries occurred, the nursing home fired the GNA who had responsibility for resident.	Montgomery County
3	A resident indicated to a GNA that he was applying the wrong lotion. The GNA shoved the bottle in resident's face. The resident tried to push him away. The GNA hit the residents hand. The GNA was suspended for 3 days pending further investigation. No other information was included in the case file.	Montgomery County
4	A resident was physically abused by staff. The police were notified and prepared a police report. The Ombudsman was notified through a police report over a month after the incident occurred. The resident's guardian did not press charges because he was satisfied that the employee was terminated from employment.	Baltimore City
5	A GNA grabbed a resident by her wrist and shoved her into a wheelchair. The GNA was terminated from employment.	Baltimore City
6	A resident was scratched by a GNA. The GNA was terminated. A police report was filed, but the resident did not wish to press charges since he no longer felt threatened.	Baltimore City
7	A nursing assistant, using his hat, hit a resident and then poured cold water on the resident. The assistant was suspended then terminated from employment. A police report was filed. The resident was glad the assistant was no longer taking care of him.	Baltimore City
8	A resident was found with a black left eye. An investigation did not determine if this was an accidental injury or not, but Ombudsman notes indicate that GNA was responsible because she was assigned to the resident and did not report anything. After the Ombudsman reported her conclusions to the administrator, the GNA was terminated from employment.	Baltimore County

SUMMARY OF 16 CASES WHERE PROCEDURES WERE NOT FOLLOWED

Case No.	Description	Type of Procedure Not Followed			Ombudsman Program
		Police Not Notified	L&C Not Notified	No Indication Ombudsman Investigated	
1	A GNA hit a resident twice on the back. The incident was witnessed by the Assistant Administrator of the nursing home. The GNA stated that the resident had stepped on her foot. The GNA was terminated. There was no indication that the police were notified. There was no indication that Ombudsman investigated, only telephone calls were documented.	✓		✓	Montgomery County
2	The resident's family had concerns about injuries to the resident. These included broken fingers, broken rib, and black eyes. While the facility could not pinpoint when injuries occurred, the nursing home fired the GNA who had responsibility for resident. There was no indication that the police and L&C were notified. There was no indication that Ombudsman investigated, only telephone calls were documented.	✓	✓	✓	Montgomery County
3	A resident indicated to a GNA that he was applying the wrong lotion. The GNA shoved the bottle in resident's face. The resident tried to push him away. The GNA hit the residents hand. The GNA was suspended for 3 days pending further investigation. No other information was included in the case file. There was no indication that the police were notified. There was no indication that Ombudsman investigated, only telephone calls were documented.	✓		✓	Montgomery County
4	A resident had a bruise on the right eye. The cause of the bruise was not determined. There was no indication that the police and L&C were notified.	✓	✓		Montgomery County

Case No.	Description	Type of Procedure Not Followed			Ombudsman Program
		Police Not Notified	L&C Not Notified	No Indication Ombudsman Investigated	
5	It was noted that resident had hematomas to both eyes and a scratch on the nose. The resident was confused and disoriented and could not give an account of what happened. There was no indication that the police and L&C were notified. There was no indication that Ombudsman investigated.	✓	✓	✓	Montgomery County
6	A resident had a skin tear on back of the left hand. There was no indication that the police were notified. There was no indication that Ombudsman investigated, only telephone calls were documented.	✓		✓	Montgomery County
7	A resident was admitted to Bethesda Naval Hospital from the emergency room. The hospital was concerned because the patient was severely dehydrated, had a swollen scrotum, and reddened buttocks. Noted in file that patient died. There was no indication that the police were notified. There was no indication that Ombudsman investigated, only a telephone call to the Hospital was documented. The response time for Ombudsman's telephone call was approximately 3 weeks after in-take date.	✓		✓	Montgomery County
8	A resident was found with an ankle fracture. The facility did not know what happened. There was no indication that the police and L&C were notified. Response time for Ombudsman to visit facility was approximately 2 weeks after the incident.	✓	✓		Montgomery County
9	A resident hit another resident. There was no indication that Ombudsman visited the facility.			✓	Montgomery County

Case No.	Description	Type of Procedure Not Followed			Ombudsman Program
		Police Not Notified	L&C Not Notified	No Indication Ombudsman Investigated	
10	The Ombudsman was asked to assess competency of resident. The resident and another resident had been sexually aggressive. The nursing home felt that this was consensual, but when asked, the resident did not know who had kissed her. There was no indication that the Ombudsman performed the assessment. The case was closed approximately 10 months after it was opened because the resident had passed away months prior.			✓	Montgomery County
11	A resident was a management problem. He had cancer and was continually begging the nurses for Valium. The resident also would leave the facility at between 3 am - 4 am. The resident was competent but depressed. The resident had left the night before and did not return. The facility did not want him back. There was no indication that anything was done with this case from the time it was received to the time it was closed -- 4 months later -- when the Ombudsman was informed that the resident was discharged to a nursing home in Virginia.			✓	Montgomery County
12	This case was eliminated from this chart because there was some record to indicated that L&C was notified.				Eliminated
13	A resident had a skin tear on arm. The family was concerned about potential abuse. There was no indication that L&C was notified.		✓		Baltimore City
14	A Social Worker was told by nurses at a hospital that a resident had bruises on her arms, underarms, and torso. The facility indicated that an aide had handled her roughly while being transferred. When the Ombudsman saw the resident, he indicated that she had not been abused. There was no indication that L&C was notified.		✓		Baltimore City

Case No.	Description	Type of Procedure Not Followed			Ombudsman Program
		Police Not Notified	L&C Not Notified	No Indication Ombudsman Investigated	
15	A resident was in a nursing home for respite care and developed decubitus ulcers (bed sores). It does not appear that the Ombudsman visited the facility, only telephone calls were documented.			✓	Baltimore County
16	This case was eliminated because the facility was not licensed by L&C.				Eliminated
17	This case was eliminated because the facility was not licensed by L&C.				Eliminated
18	A daughter of resident called to report bruises located on the resident's legs. Also indicated that there had been bruises on the resident's arm. The Ombudsman felt that the cause of the bruise was from handling patient during care. The Ombudsman was not able to determine if it was intentional abused. There was no indication that the police and L&C were notified.	✓	✓		Washington County
19	A resident had an unexplained injury --fractured finger. There was no indication that L&C was notified.		✓		Allegany County

**LATEST DOCUMENTED MONITORING VISIT
AS OF DECEMBER 1995**

Local Ombudsman Program	Date of Visit
Allegany	October 5, 1994
Anne Arundel	June 7, 1995
Baltimore City	April 21, 1993
Baltimore County	June 18, 1993
Calvert	December 15, 1994
Carroll	May 13, 1993
Cecil	April 5, 1993
Charles	August 9, 1993
Frederick	May 28, 1993
Garrett	October 5, 1994
Harford	May 12, 1993
Howard	April 11, 1995
Lower Shore	November 18, 1994
Montgomery	May 17, 1993
Prince George	May 24, 1993
Queen Anne	June 28, 1993
St. Mary	December 15, 1994
Upper Shore	November 18, 1994
Washington	October 4, 1994

Agency Comments



August 19, 1997

Via Telefacsimile and Federal Express

Mr. John A. Ferris
Department of Health & Human Services
Office of the Inspector General
Assistant Inspector General for Administrations
of Children, Family, and Aging Audits
330 Independence Avenue, Room 5759
Washington, D.C. 20201

Re: Proposed Audit Report A-12-96-00016

Dear Mr. Ferris:

Thank you for providing the opportunity to (and extending the time to) respond to the proposed audit report entitled "Review of the State of Maryland Long Term Care Ombudsman Program's Receipt, Investigation and Resolution of Complaints of Elder Abuse, Neglect, and Exploitation." The Maryland Office on Aging ("OoA") and Department of Health and Mental Hygiene ("DHMH") have been working diligently to gather together all of the facts needed to provide a complete picture of the issues addressed in the proposed audit report ("Proposed Report") because the Proposed Report does not convey an accurate depiction of Maryland's Ombudsman Program or Geriatric Nurse Aide Registry.¹

The second sentence of the Proposed Report states, "We found that the review and reporting network within the State did not provide reliable assurance that instances of abuse were properly reported and resolved and that the Ombudsman program was adequately monitored."

¹ Please note that the title of the Proposed Report is not accurate because your audit covered more than the Ombudsman Program. For example, the Geriatric Nurse Aide Registry is independent of the Ombudsman Program. We suggest an addition such as: "and Review of the Department of Health and Mental Hygiene's Geriatric Nurse Aide Registry."

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While no programs are perfect, this sweeping condemnation is not supported by the facts. Unfortunately, the Proposed Report was written when certain information was unavailable or had not been obtained. This unfortunate situation, in conjunction with various assumptions that were apparently made from the incomplete facts, led to the erroneous condemnation. The remainder of this letter sets forth the full facts and explains why many of the Proposed Report's conclusions are in error. The information set forth below follows the format of the Proposed Report.

Geriatric Nurse Aide Registry

The Proposed Report sharply criticizes the State's GNA Registry based on the State's alleged failure to "flag" all GNA abuse on the Registry. Unfortunately, the auditors were unaware of some crucial facts when making its criticisms, including constraints placed on the Licensing and Certification Administration ("L&C") by Maryland law.

Convictions

Although the federal regulations require the State to place convictions on the Registry, many cases of abuse, especially for first-time offenders, result in a finding by Maryland courts of "Probation before Judgment" ("PBJ"). Under Maryland law, this finding is not a "conviction" and therefore cannot be reported as such on the Registry. Many of the cases reviewed by the auditors were cases in which courts made PBJ findings. The auditors incorrectly assumed that such could be considered "convictions" for purposes of the Registry. In addition, some of the cases reviewed by the auditors included "convictions" that occurred prior to the State's adoption of regulations establishing the Registry. For these cases, there was no legal authority for L&C to "flag" these convictions. Thus, it is L&C's belief that all "convictions" (as that term is defined by Maryland law) that occurred after the adoption of necessary State regulations were appropriately "flagged" on the registry.

Independent Findings

In 1990, L&C was advised, by the Office of the Attorney General, that it could not place "independent findings" on the Registry without a change in the Maryland statute. Although legislative proposals were submitted by the Department two years in a row to make such a change, these bills were defeated by the Legislature. Recently, the Office of the Attorney General reviewed its previous advice and has clarified it as follows: L&C may use a PBJ finding as a basis for making an "independent finding" for purposes of the Registry without a statutory change. However, until recently only convictions were placed on the Registry because of the

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prior interpretation of the law. After receiving the new legal advice, L&C began making "independent findings" and defending them before an Administrative Law Judge when challenged.

L&C has reviewed the eight cases reviewed by the auditors. L&C does not agree with the auditors' conclusions in each of these cases.² However, even if it did agree, these cases would not have gone on the Registry unless there had been a criminal prosecution and a conviction because all eight of these cases occurred before L&C was making "independent findings" of abuse. However, as you are aware, L&C never had control over the prosecution of criminal cases or the outcomes of the prosecutions.

Procedure for Resolving Cases

The Proposed Report states on page five, "The local Ombudsman did not always follow the procedures established to investigate cases" (emphasis added). Undoubtedly this statement is true of every state ombudsman program in the country, as no one is perfect. The real issue is whether the Ombudsman Program is performing well. If any program that did not always follow the procedures was deemed guilty of not providing "reliable assurance that instances of abuse were properly reported and resolved" (the charge made against the Maryland program), then every Ombudsman program would be condemned.

The Proposed Report claims to have found deficiencies in 19 of the 100 files reviewed. We can certainly agree that 19 out of 100 is an unacceptable rate of noncompliance and could indicate a statewide problem. However, this would only be the case if the 100 cases were a representative sample of the state and if the 19 cases actually contained deficiencies. Neither is the case in this matter.

The 100 cases are not a representative sample of Maryland Ombudsman cases because 30 percent of the cases were taken from Montgomery County, although that county only has approximately 15 percent of the State's nursing home beds. Thus, Montgomery County's cases were overweighted in the analysis. This is significant because problems of one county (Montgomery) have been used to indict the entire state of Maryland.

² One of the eight cases occurred in a facility that was not a nursing home and therefore was not even subject to the Registry requirements.

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Of the 19 cases identified in the Proposed Report, 11 are from Montgomery County, whose situation is addressed below in a separate section of this letter. Thus, the entire remainder of the state only had eight cases flagged by the auditors. Of those eight cases, at least four were flagged erroneously by the auditors: (1) the police notified "L&C" and the Ombudsman at the same time in case number 12 making it unnecessary for the Ombudsman to contact L&C³; (2) case number 15 was not an abuse case; and (3) cases numbered 16 and 17 did not involve facilities licensed by L&C. Thus, §19-347 of the Health General Article of the Maryland Annotated Code did not require the Ombudsman to contact L&C and the police in any of these four cases. (Section 19-347 creates the standard that the Proposed Report contends was repeatedly violated.)

The bottom line is (that outside of Montgomery County) there were only four cases that could in any way give support to your conclusion that "the State did not provide reliable assurance that instances of abuse were properly reported and resolved." While we strive for 100 percent perfection, we do not think four questionable cases out of 70 is a sufficient basis for the disparaging conclusion in the Proposed Report.

This point becomes even more apparent if you examine the four "questionable" cases at issue. In all four cases the local Ombudsman had conducted a thorough investigation and concluded either that there was no abuse or no evidence to prove abuse. As you mentioned in the Proposed Report, some of the local Ombudsman feel that they lose their credibility with the police and L&C if every questionable case is called in as abuse. Maryland's laws require the Ombudsman and the police to conduct their own investigation when they receive an abuse complaint. It is understandable that every questionable case was not reported because some people do not think that it is a good use of resources to have both agencies conduct an investigation into every case involving an unexplained injury.⁴ OoA plans to reemphasize to all staff, including all local Ombudsman, that they must strictly comply with the mandated reporting requirements. In the meantime, it is unwarranted to conclude from four out of 70 cases that "the

³ The Ombudsman is to notify the police and L&C if it is the initial recipient of a suspected abuse report.

⁴ During the time frame in question, nursing homes felt compelled to report injuries of an unknown origin to the Ombudsman, even if there was no suspicion or belief that abuse had occurred. The Ombudsman Program for lack of a better category coded such reports as "A-12 - Physical Abuse." However, the nursing homes were not obligated to report such cases, and the Ombudsman was not legally required to report them to L&C or the police unless someone believed there had been abuse.

State did not provide reliable assurance that instances of abuse were properly reported and resolved." The conclusion is especially unwarranted when each of those four cases were investigated by a local Ombudsman who concluded there was no evidence to support a finding of abuse.

Montgomery County

Montgomery County's Ombudsman Program has developed its own pragmatic way of dealing with various types of cases. In some situations the county's approach did not strictly comply with OoA's Ombudsman regulations or Maryland's law on reporting abuse in related institutions, §19-347 of the Health General Article. OoA is instructing Montgomery County that it must comply with these legal requirements, even if Montgomery County thinks it is impractical to apply the requirements in all cases.⁵

Before addressing the specifics of some of the Montgomery County cases, you should know that the Montgomery County Ombudsman, Vivian Omagbemi, is more than just one of our most respected local Ombudsmen. She is considered an expert on Ombudsman issues nationwide. Ms. Omagbemi was a member of the Committee to Evaluate the State Long-Term Care Ombudsman Programs commissioned by the Administration on Aging. The Committee's study resulted in the publication of a substantial book entitled "Real People Real Problems: An Evaluation of the Long-Term Case Ombudsman Programs of the Older Americans Act." It was published by the Institute of Medicine in 1995. The book is an excellent resource for anyone reviewing the effectiveness of Ombudsman Programs.

Of the 11 Montgomery County cases flagged by the auditors, four were not even potential abuse cases.⁶ In addition, the program was cited frequently for conducting investigations by telephone. The Proposed Report treated this as a violation of the regulation that requires that an

⁵ This is not to excuse some of the Montgomery County cases where the reporting or investigation was inadequate by any standard. The Montgomery County Ombudsman has informed OoA that several of the cases resulted from the lack of follow-up by a volunteer who had to be "terminated" for unsatisfactory performance.

⁶ Case 7 concerned complaints of inadequate hygiene, inadequate supervision, dehydration, and inadequate care plan; Case 9 concerned a complaint of inadequate supervision of residents; Case 10 concerned a request to assist in determining a resident's competency; and Case 11 concerned a resident's rights issue.

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investigation include "personal contact with the resident ... on whose behalf the complaint was made...." COMAR 14.11.05.04.B. However, OoA has interpreted the phrase "personal contact" to include a telephone conversation. The Proposed Report erroneously construed "personal contact" to require a face to face encounter, which is not required in every single case. There are obviously cases where such personal contact would not be an efficient use of an Ombudsman's limited resources.⁷

Coverage of Other Long-Term Care Facilities

The OoA recognizes that the Ombudsman Program must work to serve residents in all kinds of long-term care facilities. We appreciate your recognition in Recommendation three on page 12 of the Proposed Report that resource problems make coverage of all types of long-term care facilities quite difficult.

Review of Local Ombudsmen

The monitoring of local programs has not been as scant as suggested in the Proposed Report. The Proposed Report is based on only two monitoring reports being conducted in 1993. However, this is mistaken. All 19 local programs were monitored in 1993. The auditors only examined two 1993 monitoring reports because those were not archived. Had the importance been communicated, we would have worked to retrieve all of the old monitoring reports from our archives. We provided a number of additional reports to Mr. Rubbo during our meeting on July 23, 1997. Attached to the original of this letter are copies of seven additional monitoring reports for 1993.

Monitoring was less than 100 percent in 1994 and 1995 for four main reasons: (1) the State Ombudsman resigned in January of 1994; (2) we were unable to hire a replacement until September of 1994; (3) the replacement was terminated while on probation in July of 1995 for unsatisfactory performance; (4) we were unable to hire a new replacement until 1996 because in 1995 the House of Representatives had approved, and the United States Senate was seriously considering approving, legislation that would have decimated the Ombudsman programs. When the Ombudsman Program was under stress because of staff turnover and under attack by the House of Representatives, OoA sensibly focused on the Program's core responsibilities.

⁷ See "Real People Real Problems" pages 82-83 (Institute of Medicine 1995).

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Conclusion

We agree with all of the Recommendations on pages 12 and 13 of the Proposed Report. We plan to work diligently to implement them. However, we do not agree with some of the sweeping conclusions in the Proposed Report, especially the unwarranted conclusion that "the State did not provide reliable assurance that instances of abuse were properly reported and resolved and that the Ombudsman Program was adequately monitored." The Report would be much more helpful if it offered more detailed recommendations on things such as: (1) how to devise a risk assessment system; (2) how to create a volunteer program when the staff who would have to oversee the volunteers are too overwhelmed to get such a program started; or (3) how to avoid the duplication of effort that occurs when both the Ombudsman and police investigate the same case of alleged abuse. We appreciate all the hard work your staff has performed and would welcome any ideas they have on these three knotty issues.

Sincerely,



Sue F. Ward
Director, Office on Aging

SFW:cas

Enclosure

cc: Judy Santine, AoA (w/o enc.)
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