2006 Annual Report

State of New Jersey Office of the Ombudsman for the Institutionalized Elderly

Jon S. Corzine, *Governor*
Ronald K. Chen, J.D., *Public Advocate*
William P. Isele, M.A., J.D., *Ombudsman*

State of New Jersey
DEPARTMENT OF THE PUBLIC ADVOCATE
240 WEST STATE ST.
P.O. BOX 851
TRENTON, NJ 08625-0851
PHONE: (609) 826-5090 FAX: (609) 984-4747

JON S. CORZINE
Governor

RONALD K. CHEN
Public Advocate

October 23, 2006

To: The Honorable Jon S. Corzine, Governor
Members of the Legislature and
Fellow New Jerseyans

I am pleased to submit this Report of Accountability of the Office of the Ombudsman for the Institutionalized Elderly, covering Federal Fiscal Year 2005. This Report will provide you with a comprehensive picture of New Jersey's Long-Term Care Ombudsman Program, as we continue to strive together to improve the quality of care and quality of life of the residents of our long-term care facilities: the people who call these places "Home."

There have been several significant initiatives begun or continued in the Ombudsman's office over the past year, which have enhanced our ability to be of service to New Jersey's most vulnerable citizens, at minimal cost to the taxpayers:

- We continue to train and retain volunteer advocates. Our small army of volunteers maintains a personal presence of the Ombudsman in the majority of New Jersey's nursing facilities.
- We also continue our leadership role in the area of biomedical ethics. Fourteen regional long-term care ethics committees are now operating throughout the State, and every long-term care facility now has access to one of these committees.
- Finally, we are assisting long-term care administrators to effect a cultural change in their facilities – a project that can lead to improvement in the quality of life experienced by our most vulnerable elderly.

I look forward to working with you to improve the quality of life for some of New Jersey's most vulnerable citizens.

Respectfully yours,

Ronald K. Chen
Public Advocate

I. History and Background

In 1977, the New Jersey Legislature created the Office of the Ombudsman for the Institutionalized Elderly to investigate and respond to complaints of abuse, neglect, and exploitation of individuals sixty years of age and older, residing in licensed facilities (both public and private) within the State. *N.J.S.A.* 52:27G - 1 to 16.[1]

While the Office was initially located in the Department of Community Affairs, in 1996 it was moved to the Department of Health and Senior Services.. On July 13, 2005, Governor Richard Codey signed into law Chapter 155 (A-1424), which restored the Public Advocate as a principal department in the executive branch, and moved the Office of the Ombudsman into the Division of Elder Advocacy of the Department of the Public Advocate. That Law became effective January 17, 2006. On March 13, 2006, Ronald K. Chen was sworn in as the Public Advocate, and on September 11, 2006, Alice Dueker became Director of the Division of Elder Advocacy. The Office of the Ombudsman for the Institutionalized Elderly is proud to be a part of this new era of advocacy for New Jersey citizens.

In 1978, Congress reauthorized The Federal Older Americans Act of 1965, designating Long Term Care Ombudsman services as part of Title VII of that Act. As a result, all 50 States, the District of Columbia, Puerto Rico, and Guam now have Long-Term Care Ombudsman programs, although many are differently structured than New Jersey's. The advocacy and services for the older person offered by this Office, along with others encompassed by the federal Act, are empowering the elderly and their caregivers to have a greater voice in decisions regarding their quality of life.

Today, many of the "baby boom" generation are dealing with the realities of having a loved one in a nursing home or assisted living facility, or are, themselves, residents of such facilities. The Office of the Ombudsman for the Institutionalized Elderly (OOIE) exists to promote, advocate for and, ultimately, to ensure the adequacy of care received, and the quality of life experienced, by elderly residents of these facilities to ensure their voices are heard.

---

[1] **"Ombudsman"** derives from a Swedish word, meaning "people's advocate." King Charles XII of Sweden, who ruled as an absolute monarch, first created the office of the King's Ombudsman in 1713. The King at that time was residing in Turkey after having been abroad for 13 years. As a result of his long absence from Sweden, disorder had arisen in the Swedish government. In order to restore order, the King ordained that a new office should be created in Sweden to be headed by a person with the title of The Highest Ombudsman, i.e. the King's foremost representative. His duty was to ensure that public officials obeyed the law and otherwise fulfilled their obligations. The weapon of the Ombudsman was the right to prosecute those officials that were found at fault. This office, later known as the office of the Chancellor of Justice (Justitiekansler), still exists.
In 1809, the Swedish parliament adopted a new constitution, which prescribed a division of powers between the King and Parliament. As part of the Constitution of 1809 the Office of "Justitie-ombudsman," the first parliamentary Ombudsman, was formally created. One reason for the creation of the new office was that the Parliament wanted to have a supervisory institution of its own that was entirely independent of the King. Another important difference between the King's Ombudsman and the Parliamentary Ombudsman was that the former acted in the King's interest, whereas the supervisory activities of the latter had as their aim the protection of the rights of the individual citizen.

Our jurisdiction gives us the power to oversee and protect, when necessary. However, our long-term goal is to promote and advocate for the empowerment of individuals and their families so they can achieve greater self-determination.

Office of the Ombudsman for the Institutionalized Elderly
Chief Executive Officers
1978-2004

1. John J. Fay, Jr.	1978-1985
2. Jack R. D'Ambrosio, Jr.	1985-1988
3. Hector Rodriguez	1988-1989
William R. Abrams (Acting)	*1989-1990*
4. Harold W. George	1990-1991
Thomas P. Brown (Acting)	*1991-1993*
Goldie Torres Colonna (Acting)	*1993-1994*
Jacques O. Lebel (Acting)	*1994*
Bonnie Kelly (Acting)	*1994-1996*
5. Bonnie Kelly	1996-1999
William P. Isele (Acting)	*1999-2000*
6. William P. Isele	2000-present

Over the past several years, our volume of complaints had been increasing. This was attributed to many factors: the population living longer, families being scattered, and people working longer and being unable to care for their family members at home. Certainly, all of these factors played a role. But the increase of complaints being investigated by this office far exceeded the growth in the number of individuals residing in long-term care facilities. More and more of our complaints centered in areas of what should be routine care, rather than outright abuse. Our professional investigative staff, comprised of Registered Nurses, retired law enforcement officers, and social work professionals, draw upon their expertise to recognize the signs of abuse, the trauma felt by family members and the subtleties of the numerous problems that present themselves in the institutional setting. Each complaint is addressed individually and resolved or referred to the proper authorities for further action.

Our staff is not only investigating and responding to reports of abuse and neglect in the State's 415 nursing homes. Our jurisdiction also includes 216 Assisted Living Residences and Programs and Comprehensive Personal Care Homes (CPCHs), 166 Residential Care Facilities (RHCF's), 145 Adult Day Care facilities, 191 "Class C" Boarding Homes, and 9 Adult Family Care providers,[2] along with State-operated veterans' homes, mental hospitals and developmental facilities. This variety of levels of care requires more specialized knowledge and assessment on the part of our investigators. In this regard, it has become a necessity to provide ongoing training to stay abreast of the changing climate in long term care.

[2] Adult Family Care was added to our jurisdiction by Public Law 2001, Chapter 304, *N.J.S.A.* 26:2Y-7(f).

Office of the Ombudsman Staff
2005-2006

Lisa Adinolfi, R.N.	Field Investigator, Nursing Care
Audrey Anderson, J.D.	Supervisor of Investigations
Benjamin Bruno	Field Investigator
Joann Cancel	Coordinator of Volunteers
Maryanne Chamberlain	Customer Service Representative
Jennifer Linz Cooper, M.S.W.	Medical Social Work Consultant
Edward Corrales	Field Investigator
JoAnne Ivory Gibson, Esq.	Supervising Research Analyst (retired 3/1/06)
Frederick Golz, R.N.	Field Investigator, Nursing Care
William E. Hill	Field Investigator
William P. Isele, M.A., J.D.	Ombudsman
Michael Karwacki*	Field Investigator*
Richard Kitson	Field Investigator
V. Gail Meszaros	Field Investigator
Paul Plumeri	Field Investigator
James Plastine	Nursing Consultant
Terrie Raychel*	Clerk Typist*
Anita Scheckter	Program Development Specialist
Patricia Sharkey	Secretarial Assistant
Sharon Sniderman	Secretarial Assistant
Nalini Sundaresan, R.N.	Field Investigator, Nursing Care
Stanley Szot	Field Investigator
Steve Tassie	Field Investigator
Rita Victor	Principal Clerk Typist
Nora Vista-Shuda	Secretarial Assistant
Joseph Wattai*	Field Investigator*
Rachael Wise*	Volunteer Services Specialist*
Frederick Zeilsdorff	Field Investigator
Doris Ziefle, R.N.	Field Investigator, Nursing Care

* Part Time, Special Services Employee

II. Hotline Services

For many institutionalized elderly, their families and caregivers, the initial contact with the Office is through the complaint hotline (**1-877-582-6995**). The vast majority of complaints to which we respond are received through the hotline. Other sources of complaints are correspondence and/or referrals from other agencies.

State legislation (*N.J.S.A.* 52:27G-7.1) requires caretakers and licensed professionals to report alleged incidents of abuse to the Office. We can, and do, assess fines up to $5,000.00 for failure to report allegations of abuse.

A. Receiving complaints

On average, the hotline receives about 60 calls per day.

Approximately 58% of the complainants that called our hotline this year are representatives from Long Term Care facilities (comparable to 59% last year). Typically, these include the Director of Nursing, Social Worker, or Administrator

Approximately 26% of the complainants are family members or friends of the resident (comparable to 24% last year).

Approximately 3% of the complainants are from other agencies, such as the Department of Health, hospital representatives, or County boards of social services.

Approximately 3.5% of the complainants are residents.

Approximately 4.5% of the complaints we receive are from anonymous sources, compared to 6% last year.

B. Some examples of complaints, by type

Abuse:

We investigate many forms of abuse: physical, verbal, emotional and sexual.
Physical abuse is defined as the use of physical force that may result in bodily injury, physical pain, or impairment. Physical abuse may include but is not limited to such acts of violence as striking (with or without an object), hitting, beating, pushing, shoving, shaking, slapping, kicking, pinching, and burning. In addition, inappropriate use of drugs and physical restraints, force-feeding, and physical punishment of any kind also are examples of physical abuse.

The factors that contribute to physical abuse are many. Unfortunately, there has been only minimal scientific research on the causes of abuse and neglect in long-term care settings. However, it is generally agreed across diverse studies and surveys of stakeholders that there are

three (3) factors which are generally viewed as causing or significantly contributing to abuse and neglect in nursing homes. They are:

- Staffing shortages that cause neglect and create stressful working conditions in which abuse is more likely to occur.
- Staff burn-out, often a product of staffing shortages, mandatory overtime, and the fact that many staff must work two jobs to survive financially; and
- Poor staff training, particularly about the impact of dementia and how to interpret and manage challenging behaviors among residents.

We have encountered a few cases involving predators, those who seek out the weak and frail so that they can exert power over them. These individuals are criminals, and can best be dealt with by the criminal justice system. When we encounter such cases, we promptly refer them for prosecution. Apart from the violent predator, abuse in the long-term care setting usually occurs when a caregiver loses patience with a resident. A cognitively-impaired resident might strike out at an aide, and the aide might reflexively strike back. A "simple assault" committed by a person employed by a facility against an institutionalized elderly person is deemed to be a crime of the fourth degree, under N.J.S.A. 2C:12-1(d). In such cases, this office will refer the alleged abuser to the appropriate County Prosecutor for criminal prosecution, and to the appropriate licensing agency (State Board of Nursing or Nurse Aide Abuse Registry) for disciplinary action.

Incidents of verbal or emotional abuse are far more common than physical or sexual abuse. On a regular basis, we encounter caregivers who lash out verbally at residents, or cause them to feel threatened and insecure in the long-term care environment. In FFY 2005, we investigated 321 claims of verbal/emotional abuse. Physical abuse, as serious as it is, may leave a mark or a bruise that will fade in a few days, but verbal or emotional abuse can leave an internal scar that remains with the elderly resident for life. In most cases, the elderly we serve have no other home and no safe place where they can go. They are often dependent on the staff of the facility for even the most basic needs of bathing, toileting and eating. Even if a verbally abusive aide is removed, the resident can live in perpetual fear of further verbal abuse.

There is no law that makes verbal or emotional abuse of institutionalized elderly persons a crime. Nevertheless, we can, and do, refer our findings regarding such abusers to the appropriate enforcement agencies for disciplinary action.

Financial exploitation:

Financial exploitation by facility staff is rare. Perhaps this is because so many of the elderly we serve have spent-down all their assets, or do not exercise control over their own assets and have designated trusted family or friends to do so.

That is not to say that we never encounter misappropriation by facility staff. Even those residents who do not have assets receive a monthly personal needs allowance (PNA) of $35 from their Social Security income. In the past year, we have uncovered instances of misuse and misappropriation of PNA (personal needs allowance) funds by facilities, involving diversion of PNA funds or inability to account for such funds. We have referred these findings to the Medicaid Fraud Section of the Attorney General's Office, which is vigorously pursuing criminal

charges against the perpetrators. Our investigators continue to work closely and cooperatively with the Attorney General's staff on these cases.

By far, however, the greatest number of financial exploitation cases we have encountered are those involving trusted family members or friends who have misappropriated the assets and life savings of institutionalized elderly persons. This form of financial abuse continues to increase. We investigated 269 such cases in FFY 2005 (as compared to 237 in FFY 2004), and referred our findings to County Prosecutors under *N.J.S.A.* 2C:20-2. In this regard, we have noted that certain banks are taking a much more supportive and cooperative approach. This year, a few cases were even reported to us by bank officers who suspected that individuals were exercising undue influence over institutionalized elderly persons. Such reports have been non-existent in the past, and we are encouraged by this trend. Most complaints of financial exploitation come to us when a resident stops paying the facility, and discharge is being threatened. Sadly, by that time, the residents' assets have already been depleted. By notifying us earlier, bank officers have made it possible for us to stop the exploitation before all the funds are gone.

Quality of care:

Neglect remains the most frequent type of complaint we investigate. The daily misery, indignity, preventable decline, and premature death caused by neglect in nursing homes remains the most serious challenge confronting us both in New Jersey and in our nation. In our experience, neglect is far more widespread than abuse. Neglect can be defined as the refusal or failure to fulfill any part of a person's obligations or duties to an institutionalized elderly person. Neglect in the long-term care setting typically involves the refusal or failure to provide an elderly person with such life necessities as food, water, personal hygiene, medicine, comfort, personal safety, and other essentials which the facility and its staff have a responsibility to provide.

The kinds of neglect we see most frequently include residents being left wet or soiled with feces; residents not being turned and positioned, which can lead to pressure ulcers; staff shutting off call lights without helping the resident who sought assistance; residents not receiving enough help at mealtimes; staff failing to perform prescribed range of motion exercises to prevent residents from developing contractures[3]; and staff failure to respond to residents' requests or need for something to drink, leading to dehydration.

Most experts agree that the chief causes of neglect in long-term care facilities are low staffing levels and inadequate staff training. We make our staff available to present in-service educational programs on a variety of care-related topics to both administrators and facility staff.

[3] An abnormal, often permanent shortening, as of muscle or scar tissue, that results in distortion or deformity, especially of a joint of the body

III. Investigations

In 1977, the New Jersey Legislature found and declared that "[T]here should be established as an agency of the State Government the Office of the Ombudsman for the Institutionalized Elderly, to receive, investigate and resolve complaints concerning certain healthcare facilities serving the elderly...." *N.J.S.A.* 52:27G-1. Thus, for 27 years, the receipt, investigation and resolution of complaints has been our first responsibility.

New **cases** opened by the Office showed a slight decrease from 3,302 in Federal Fiscal Year (FFY) 2004 to 3,112 in FFY 2005. This follows several years of steady increases in the number of new cases opened. We identify as **cases** any matters that are entered into the Office's data base and assigned to a member of our field investigative staff for investigation. Each case consists of one or more **complaints**.

"Number of cases opened," however, only tells part of the story. In FFY 1997, this Office opened 2,111 new cases, representing 2,373 individual complaints. By comparison, in FFY 2004, our 3,112 new cases represented 6,319 individual complaints. These numbers indicate that the cases we are seeing continue to be more complex in nature, although during the past five years the number of complaints has plateaued at approximately 7,000 per year.

The *National Ombudsman Reporting System* (NORS), developed by the Federal Administration on Aging, requires us to compile complaints in 17 different broad categories which are, in turn, divided into a total of 132 more specific categories. Attached to this report is that portion of our FFY 2005 NORS Report, which illustrates the distribution of complaints over these categories.

Abuse complaints have continued their downward trend this year, from 1068 in FFY 2004 to 981 in FFY 2005. Complaints of neglect and poor care remain a serious concern, and increased from 2298 complaints in FFY 2003 to 2620 complaints in FFY 2004, an increase of 14%. This number fell to 2105 in FFY 2005. In this category, the most common complaint by far relates to the individual care plan and allegations that the care plan is either inadequate or staff fails to follow the care plan or a physician's orders. We investigated 805 such complaints in FFY 2005, down from 968 in FFY 2004.

Staffing Shortages. Staffing problems in New Jersey's long-term care facilities continue to be severe. This fact has resulted in increased concerns regarding the quality of care, and increased verification by our investigators of neglect and careless handling of elderly residents of institutional facilities.. In FFY 1997, we received 83 complaints related to staffing and 764 complaints of care neglect. By FFY 2002, these figures had multiplied to 239 complaints related to staffing, and 3,329 complaints of care neglect. It is significant that the number of staffing complaints we received *decreased* to 118 in FFY 2003 and the number of care complaints dropped to 2,298. Complaints about staffing levels and care neglect appear to have stabilized at about this level, and in FFY 2005 we received 128 complaints related to staffing and 2,105 complaints related to care neglect.

These figures indicate to us that, while there are still insufficient numbers of caregivers to provide the care that our elders need, facilities have found ways to use the staff that they have

more efficiently and more productively. As a result, complaints of improper handling have decreased, and residents' requests for assistance are not going unanswered for as long as they were in the recent past. We have observed that care plans are more carefully followed, medications are being administered more carefully, personal hygiene and grooming are not neglected as frequently, and residents who are prone to wander are more closely monitored or accommodated. While each of these concerns may not strictly rise to the level of abuse, when such concerns are properly addressed it has a powerful impact on the quality of life experienced by the vulnerable elderly living in the facilities where they occur, and we are greatly encouraged by the decrease in these complaints in recent years.

Answers to staffing problems may lie in several areas. Certainly the pay and job satisfaction of the workers are important elements. Education is also key. We have encountered facility staff who viewed resident behaviors as intentional. In such cases, a resident who resisted care or struck out at a staff member was often viewed as intending to harm the staff member or as deliberately "being difficult." Given these views, some staff believed that treating such residents "roughly" was acceptable, particularly if, in their view, the resident might hurt the staff member. Addressing this situation is clearly complex and must involve vastly improved basic training and continuing education for CNAs. Some nursing homes are starting child day-care centers. This helps attract workers who might not otherwise be able to leave their homes. It provides the additional benefit of introducing youngsters into the environment of the seniors who reside there. Other facilities have embarked on a course of cultural change. The Eden Alternative[4] has been implemented in several New Jersey nursing homes, and other similar creative solutions are being pursued.

In furtherance of these efforts, the Office of the Ombudsman, in partnership with the University of Medicine and Dentistry of New Jersey, Center for Healthcare Ethics, developed a program of team-building workshops for long-term care administrators. The workshops focused on developing leadership skills in problem solving, team-building, cultural competency, decision making, conflict resolution and interpersonal communications. The intent of these workshops was to assist administrators in fulfilling their responsibilities to create and maintain the kind of institutional culture that leads to better outcomes for residents. This program continued in 2005-2006, at no cost to the Office, and attracted more than 100 administrators. Other similar efforts in effecting culture change in long-term care settings are being developed. The ultimate success of these programs remains to be seen in future years' statistics.

A third factor causes concern for the future: the rapid growth of **Assisted Living** facilities in New Jersey. In 1996, only 11 of these were in existence. Today, there are 216 Assisted Living Residences and Programs and Comprehensive Personal Care Homes in New Jersey. In 2002, concerns over conditions in one chain of Assisted Living residences, Alterra Healthcare Corporation, were so severe that new admissions were suspended by the Department of Health

[4] The Eden Alternative is a nationally-known approach to changing the culture in nursing homes. In 1994, *The Eden Alternative: Nature, Hope and Nursing Homes* by William H. Thomas MD described a program to eliminate what he called the three plagues of long-term institutional care – loneliness, helplessness, and boredom. The Eden mission uses companion animals, indoor plants, and gardens to give patients the opportunity to care for other living things and to alleviate boredom through the variety of experiences brought to each facility by the animals. Both staff and patients must embrace the program.

and Senior Services. In January 2003, Alterra filed for reorganization under Chapter 11 of the Federal Bankruptcy Act. In 2005, the Marriott hotel corporation, which operated more than a dozen Brighton Gardens assisted living residences in the State, withdrew from the business altogether, and sold its facilities to another corporation, Sunrise Senior Living, headquartered in McLean, Virginia.

Although the growth in construction of assisted living facilities has slowed, there is still a great deal of change occurring in this relatively young industry. Seniors, and families of seniors, often feel misled and deceived in their dealings with these organizations. Indeed, some of the most complicated and time-consuming cases we have handled this year arose out of such encounters with assisted living policies. Assisted Living facilities are high on our priority list for monitoring, as they are less strictly regulated than nursing facilities.

IV. Ethics and End-of-Life Care

As a result of the New Jersey Supreme Court's 1985 decision ***In the Matter of Claire C. Conroy*** (98 *N.J.* 321, 1985), the Office of the Ombudsman is the overseer of ethical decision making in New Jersey's long-term care facilities.

Regional Long-Term Care Ethics Committee Development and Training

In December, 1998, the Office of the Ombudsman for the Institutionalized Elderly, in cooperation with the Cooper Hospital University Medical Center, received a three-year grant from the Robert Wood Johnson Foundation to sponsor and encourage the development of a statewide network of Regional Long Term Care Ethics Committees. Our initial goal was twelve (12) such committees. We exceeded this goal. By the end of the grant period, fourteen (14) such committees had been created, and these regional committees are functioning as the only statewide network of regional long-term care ethics committees anywhere in the country. Nursing homes and other providers of long-term care are encouraged to tap this resource when confronted with issues of bio-medical ethics, or merely the day-to-day ethical issues that arise everywhere.

Consistency of approach and methodology was a concern in creating this network. As part of the Robert Wood Johnson Foundation grant, we developed a five-session educational program and curriculum. The introductory intensive session (1½ days) presents ethical theory and case methodology customized for long-term care. Follow-up sessions 1 and 2 address ethical issues relating to the law, decision-making capacity, and pain management. Follow-up sessions 3 and 4 address advance care planning, the role of culture and spirituality, and educating and utilizing ethics committees. During the grant period, this curriculum was offered eleven (11) times, in various locations throughout the State. More than 700 health care professionals, representing more than 200 long-term care facilities in the State, participated.

This program has received such widespread support and enthusiasm in the community, that, notwithstanding the conclusion of the three-year Robert Wood Johnson Foundation grant, we committed to continuing these training sessions as long as there are individuals desiring the training. Pursuant to this commitment, in December 2003, this Office teamed with the Office of Public Guardian (OPG) and the Bureau of Guardianship Services in the Division of Developmental Disabilities (BGS), to offer a twelfth intensive training session, which concluded in May 2004 after four follow-up sessions. In all, more than 125 individuals, including staff of the OPG and the BGS, participated.

In 2005-2006, we decided to take the training to the regions. Each Regional Long-Term Care Ethics Committee (LTEC) was given the opportunity to sponsor a training in its region. By July 2006, 12 of the 14 LTECs had taken advantage of this offer, and 191 individuals participated. In all, more than 1,000 individuals have now been trained in the Statewide Ethics Education and Development (SEED) methodology.

V. Volunteer Program

The Office's Volunteer Advocacy Program, first piloted in 1993, continues to thrive. We have trained more than 400 volunteers, of whom **230 are currently active and placed in 200 facilities throughout the State.** After completing 32 hours of training in communication, observation and trouble-shooting skills, the advocates visit nursing facilities near their homes a minimum of four hours each week, and address resident concerns on such issues as living conditions, daily activities, and quality of care. It is the philosophy of the Office that concerns of this nature are best resolved at the bedside, before they develop into complaints. In that regard, the corps of volunteers has become a valuable asset to the Office.

New Jersey has a very dedicated and caring corps of volunteers. Far too often, our volunteers are the only visitors a resident may have. Good quality care should not depend upon a resident having family members who monitor their care closely while others are neglected. Having an advocate to speak for all the residents, whether their families are near or far, or they have no families at all, is the best way to assure that **CARE** remains the key word in Long-term Care. Our advocates are in facilities, working pro-actively to make sure that minor concerns do not grow into major quality of care complaints.

The volunteer advocate program is administered regionally in the northern counties by Bergen Family Services, Inc., a non-profit service agency, with experience in nursing home advocacy and community-based volunteer programs. Three in-house staff members do the same for the central and southern counties.

Recognition of our volunteer program has been wide-spread and positive.

VII. Conclusion

The New Jersey Office of the Ombudsman for the Institutionalized Elderly remains a vital and effective presence in advocating for and protecting the rights of the more than 120,000 men and women who make their homes in long-term care facilities in this State. Whether their home happens to be a State-run Veteran's home, a non-profit or for-profit nursing facility, a residential health care facility, a "Class C" boarding home, or an Assisted Living facility, abuse, neglect or exploitation is simply unacceptable.

Our challenge, and our passion, is to assure all of these New Jersey citizens that they will receive good quality care and enjoy a good quality of life as long as they live.

~

"Life is no brief candle to me. It is a sort of splendid torch which I have got a hold of for the moment, and I want to make it burn as brightly as possible before handing it on to future generations."

- George Bernard Shaw

State Annual Ombudsman Report to the Administration on Aging

Agency or organization which sponsors the State Ombudsman Program: Ombudsman

Part I -- Cases, Complainants and Complaints

A. Provide the total number of cases opened during the period. 3,112

> **Case:** Each inquiry brought to, or initiated by, the ombudsman on behalf of a resident or group or residents involving one or more complaints or problems which requires opening a case file and includes ombudsman investigation, fact gathering, setting of objectives, and/or strategy to resolve, and follow-up.

B. Provide the number of cases closed, by type of facility/setting which were received from the types of complainants listed below.

> **Closed:** Ombudsman activity on as case has stopped for any of the following reasons: 1) resolution or partial resolution, 2) by request of the complainant, 3) complaint(s) unresolved, 4) complaint(s) not verified, 5) residents dies and no further investigation was requires or 6) complaint(s) referred to other agency for resolution and final disposition was not obtained and/or reported to ombudsman.

	Nursing Facility	Board and Care (or similar)	Other Settings
1. Resident	87	14	4
2. Relative/friend of resident	675	98	11
3. Non-relative guardian, legal representative	14	7	0
4. Ombudsmen/ombudsmen volunteer	38	3	0
5. Facility administrator/staff	1472	251	28
6. Other medical: physicial/staff	20	6	0
7. Rep. of other social service agency or program	49	24	0
8. Unknown/anonymous	111	22	3
9. Other; specify types	72	5	1
	2538	430	47

Total number of cases closed during the period: 3015

C. For cases which were closed during the reporting period (those counted in b above), provide the total number of complaints recieved: 6,319

> **Complaint:** A concern brought to, or initiated by, the ombudsmen for investigation and action by or on behalf of one or more residents of a long-term care facility relating to health, safety, welfare, or rights as a resident. One or more complaints constitute a case.

State: NJ **Fiscal Year:** 2006 September, 2006

Part I, Types of Complaints, cont.

D. Types of complaints, by Type of Facility (for cases closed)
Below and on the following pages provide the total number of complaints for each specific complaint category, for nursing facility and board and care or similar type of adult care facility.

Ombudsman Complaint Categories

	Nursing Facility	Board & Care
Residents Rights		
A. Abuse, Gross Neglect, Exploitation		
1. Abuse, physical (including corporal punishment)	366	53
2. Abuse, sexual	37	6
3. Abuse, verbal/mental (including involuntary seclusion)	290	31
4. Financial Exploitation - severe	40	9
5. Gross Neglect	55	7
6. Resident-to-resident physical or sexual abuse	64	23
7. Other; specify	0	0
Residents Rights		
B. Access to Information		
8. Access to own records	13	4
9. Access to ombudsman/visitors	22	2
10. Access to facility survey	0	0
11. Information regarding advance directive	0	0
12. Information regarding medical condition, treatment and any changes	64	12
13. Information regarding rights, benefits, services	4	0
14. Information communicated in understandable language	0	0
15. Other; specify	0	0
Residents Rights		
C. Admission, Transfer, Discharge, Eviction		
16. Admission contract and/or procedure	9	9
17. Appeal Process - absent, not followed	0	0
18. Bed hold - written notice, refusal to admit	18	1
19. Discharge/eviction - planning, notice, procedure	115	36
20. Discrimination in admission due to condition, disability	1	0
21. Discrimination in admission due to Medicaid status	1	3
22. Room assignment/room change	42	2
23. Other; specify	0	0

Part I, Types of Complaints, cont.

Residents Rights

D. Autonomy, Choice, Exercise, of Rights, Privacy

24. Choose personal physician/pharmacy	8	0
25. Confinement in facility against will (illegally)	24	5
26. Dignity, respect - staff attitudes	183	10
27. Exercise choice and/or civil rights (includes right to smoke)	89	7
28. Exercise right to refuse care/treatment	27	3
29. Language barrier in daily routine	41	3
30. Participate in care planning	11	0
31. Privacy - telephone, visitors, couples, mail	17	5
32. Privacy in treatment, confidentiality	20	0
33. Response to complaints	20	0
34. Reprisal, retaliation	5	0
35. Other; specify	0	0

Residents Rights

E. Financial, Property (Except for Financial Exploitation)

36. Billing/charges-notice,approval,questionable,accounting wrong or denied	54	4
37. Personal funds-mismanaged,access denied,deposits and other money not returned	21	7
38. Personal property lost, stolen, used by others, destroyed	91	24
39. Other; specify	0	0

Residents Rights

F. Care

40. Accidental or injury of unknown origin; falls; improper handling	305	25
41. Call lights, response to requests for assistance	153	5
42. Care plan/assessment inadequate, no pat./fam. involvement, failure to follow MD	706	99
43. Contracture	3	0
44. Medications - administration, organization	166	27
45. Personal hygiene (includes oral hygiene)	123	11
46. Physician services, including podiatrist	28	4
47. Pressure sores	76	2
48. Symptoms unattended, no notice to others of changes in condition	181	26
49. Toileting, incontinent care	70	5
50. Tubes-neglect of catheter,gastric,NG tube	30	0
51. Wandering, failure to accommodate/monitor	48	12
52. Other; specify	0	0

Residents Rights

G. Rehabilitation of Maintenance of Function

53. Assistive devices or equipment	50	2
54. Bowel and bladder training	0	0
55. Dental services	11	0
56. Mental health, psychosocial services	6	0
57. Range of motion/ambulation/exercise	7	1
58. Therapies, outside	34	1
59. Vision and hearing	4	0
60. Other; specify	0	0

Part I, Types of Complaints, cont.

Residents Rights

H. Restraints - Chemical and Physical

61. Physical restraint - assessment, use, monitoring	31	0
62. Psychoactive drugs - assessment, use, evaluation	21	4
63. Other; specify	0	0

Residents Rights

I. Activities and Social Services

64. Activities - choice and appropriations	60	1
65. Community interaction, transportation	4	1
66. Resident conflict, including roommates	16	4
67. Social services - availability, appropriateness	15	1
68. Other; specify	0	0

Residents Rights

J. Dietary

69. Assistance in eating or assistive devices	33	1
70. Fluid availability/hydration	48	5
71. Menu - quantity, quality, variation, choice, condiments, utensils	34	7
72. Snacks, time span between meals	6	4
73. Temperature	10	1
74. Therapeutic diet	22	4
75. Weight loss due to inadequate nutrition	33	1
76. Other; specify	0	0

Residents Rights

K. Environment

77. Air/environment: temperature and quality	16	6
78. Cleanliness, pests	46	7
79. Equipment/Buildings - Disrepair, safety hazards, lack of handicapped access	44	13
80. Furnishings, storage for residents	5	0
81. Infection control	24	1
82. Laundry - lost, condition	4	0
83. Odors	14	2
84. Space for activities, dining	0	0
85. Supplies and linens	8	1
86. Other; specify	0	0

Residents Rights

L. Policies, Procedures, Attitudes, Resources

87. Abuse investigation/reporting	105	22
88. Administrator(s) unresponsive, unavailable	21	4
89. Grievance procedure (use C categories for transfer, discharge appeals)	0	0
90. Inadequate record-keeping	329	72
91. Insufficient funds to operate	2	1
92. Operator inadequately trained	0	0
93. Offering inappropriate level of care(for B&Cs,ALFs,RCFs,and similar facilities)	6	13
94. Resident or family council/committee interfered with, not supported	0	1
95. Other; specify	0	0

State: NJ **Fiscal Year:** 2006 September, 2006

Part I, Types of Complaints, cont.

Residents Rights

M. Staffing

96. Communication or language barrier	10	0
97. Shortage of staff	37	13
98. Staff training, lack of screening	21	3
99. Staff turn-over, over use of nursing pools	7	1
100. Staff unresponsive, unavailable	25	1
101. Supervision	10	0
102. Other; specify	0	0
134. sss	0	0

Residents Rights

N. Certification/Licensing Agency

103. Access to information (including survey)	0	0
104. Complaint, response to	0	0
105. Decertification/closure	0	0
106. Intermediate sanction	0	0
107. Survey process	0	0
108. Survey process - ombudsman participation	0	0
109. Transfer or eviction hearing	0	0
110. Other; specify	0	0

Residents Rights

O. State Medicaid Agency

111. Access to information, application	0	0
112. Denial of eligibility	2	0
113. Non-covered services	1	0
114. Personal Needs Allowance	0	0
115. Services	0	0
116. Other; specify	0	0

Residents Rights

P. System/Others

117. Abuse/neglect/abandonment by non-staff person, or while on outside visit	88	11
118. Bed shortage - placement; lack of alternative settings	0	0
119. Board and care licensing/similar facility licensing, regulation	0	0
120. Family conflict	152	22
121. Financial exploitation by family or other not affiliated with facility	214	55
122. Legal - guardianship, conservator ship, power of attorney, wills	115	31
123. Medicare	1	0
124. PASARR	0	0
125. Physician not available	4	1
126. Protective service agency	1	0
127. SSA, SSI, VA, Other Benefits	3	0
128. Other; specify	2	0
Total, categories A through P	5403	801

Part I, Types of Complaints, cont.

Q. Complaints in Other than Nursing Home or Board and Care/Similar Settings		
129.	Home care	0
130.	Hospital or Hospice	2
131.	Public or other congregate housing not providing personal care	0
132.	Services from outside provider	113
133.	Other, specify	0
Total, Heading Q		**115**
Total Complaints		**6319**

E. Action on Complaints: Provide for cases closed during the reporting period the total number of complaints, by type of facility or other setting, for each item listed below.

		Nursing Facility	Board & Care	Other Settings
1.	Complaints which were *verified*	2,749	437	58

Verified: It is determined after work [interview, record inspection, observation, etc.] that the circumstances described in complaints are substantiated or generally accurate.

2. *Disposition:* Provide for all complaints reported in C and D, whether verified or not, the number:

1.	For which government policy or regulatory change or legislative action is required to resolve (this may be addressed in the issues section.	1	2	0
2.	Which were not resolved* to the satisfaction of resident or complainant	87	16	4
3.	Which were withdrawn by the resident or complainant	73	9	0
d.	Which were referred to other agency for resolution and: 1) report of final disposition was not obtained	35	10	0
	2) other agency failed to act on complaint	0	0	0
6.	For which no action was needed or appropriate	39	6	0
7.	Which were partially resolved but some problem remained	739	172	18
8.	Which were resolved to the satisfaction of resident or complainant	4429	586	93
	Total	**5403**	**801**	**115**
	Grand Total (Same number as that for total complaints on pages 1 and 7)			**6319**

Resolved*: The complaint/problem was addressed to the satisfaction of the resident or complainant.

F. Legal Assistance/Remedies (Optional) Discuss on an attached sheet the types and percentages of total complaints for which a) legal consultation was needed an/or used; b regulatory enforcement action was needed and/or used; c) an administrative appeal or adjudication was needed and/or used; and d) civil legal action was needed and/or used.