

**LONG TERM CARE OMBUDSMAN 10A  
POLICIES AND PROCEDURES**

<b>POLICY: OBTAINING CONSENT</b> <b>POLICY#: 800</b> <b>PAGE: 1 OF 4</b>	<b>DATE CREATED: 06/02</b> <b>DATE REVIEWED: 09/30/08, 10/12/04; 11/2010</b> <b>DATE REVISED: 10/27/05</b> <b>RULE: OAC 173-14-16(H)</b>
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**POLICY:**

Consent to investigate complaints; reveal the identity of a complainant, client or individual providing information about a complaint, resolve a complaint and to review records will be obtained by the Ombudsman in accordance with OAC 173-14-16(H).

**PROCEDURES:**

- I. Certified Ombudsman staff (or staff participating in Professional Development) and Ombudsman Associates Level II shall conduct investigations in a manner that protects the identity of the client, complainant, or individual providing information about a complaint, unless the client, complainant, or individual providing information about a complaint has provided consent to reveal their identity.
- II. With respect to clients and complainants, consent may be given:
  - A. In writing by the complainant, for the complainant, or the client, for client. Certified Ombudsman staff (or staff participating in Professional Development) and Ombudsman Associates Level II shall use written consent forms approved by the SLTCO.
  - B. Orally when the urgency of the complaint results in a situation where receiving written consent prior to an investigation is not practicable. Oral consent shall be documented in the case record.
  - C. When the complainant or client is unable to give consent due to diminished capacity or death, consent may be given:
    1. In writing by the legal representative of the complainant or client;
    2. Orally, when receiving written consent from the appropriate person is not practicable. Oral consent shall be documented in the case record.
    3. When there is no legal representative, when the legal representative is unknown to the representative or the provider, when the legal representative cannot be reached within three working days of the date upon which a complaint was received, or when the estate of a deceased client has no legal representative, consent may be given by the sponsor.
    4. If there is no sponsor, the Certified Ombudsman staff (or staff participating in Professional Development) may proceed with the approval of the SLTCO.
    5. In the event that the legal representative or the sponsor refuses to authorize an investigation and the Certified Ombudsman staff (or staff participating in Professional Development) has reasonable cause to believe the legal representative or the sponsor is not acting in the best interest of the client, the

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Certified Ombudsman staff (or staff participating in Professional Development) may proceed with the investigation, if approved by the SLTCO

.III. All consents requested and provided by the complainant and/or client shall be documented in ODIS.

IV. Certified Ombudsman staff (or staff participating in Professional Development) and Ombudsman Associates Level II with supervision shall make direct contact with the client, sponsor, and/or legal representative to obtain consent in order to investigate a complaint, reveal the identity of the client and/or complainant, resolve a complaint, or review records.

V. When authorized, the Certified Ombudsman staff (or staff participating in Professional Development) and Ombudsman Associates Level II with supervision may investigate a complaint, reveal identity of a client/complainant, or resolve a complaint.

A. Authorization to investigate is given by consent:

1. In writing by the complainant for her/himself or the client, for her/himself. Ombudsmen shall use written consent forms that have been reviewed by the SLTCO.
2. Written consent may also be obtained by faxed copy to the LTCO or mailed copy when the client, their representatives and/or the complainant have been interviewed by phone.
3. The signed authorization form to investigate a complaint, reveal identity of a client/complainant, or resolve a complaint is valid for one year from the date signed or until it is withdrawn.
4. A copy of the written consent will be placed in the case record.
5. Orally, when receiving written consent from the appropriate person is not practicable.
6. Oral and written consent shall be documented in the case record.
7. Any consent that was denied/declined shall be documented in the case record.
8. Consent shall be obtained PRIOR to revealing the client's/complainant's identity or taking any action to investigate and/or resolve the complaint.

B. When the complainant or client is unable to provide consent due to diminished capacity or death, consent may be given:

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1. In writing by the legal representative of the complainant or client.
2. Orally, when receiving written consent from the appropriate person is not practicable. Oral consent will be documented in the case record.

3. When there is no legal representative, the legal representative is unknown to the representative or the provider, the legal representative cannot be reached within three days of the date upon which a complaint was received, or when the estate of a deceased client has no legal representative, consent may be given by the sponsor. If there is no sponsor, the representative may proceed with the approval of the SLTCO.

4. In the event that the legal representative or the sponsor refuses to authorize an investigation and the representative of the office has reasonable cause to believe the legal representative or the sponsor is not acting in the best interest of the client, the representative may proceed with the investigation if approved by the SLTCO.

IV. In order to review client records, certified Ombudsman staff (or staff participating in Professional Development) and Ombudsman Associates Level II with supervision shall obtain consent from the appropriate person.

A. Consent may be given in any of the following ways:

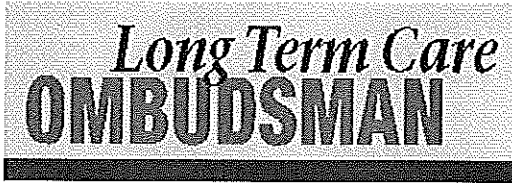
1. In writing by the resident or recipient;
2. Orally by the resident or recipient, witnessed in writing at the time it is given by one other person, and, if the records involved are being maintained by a long-term care provider, also by an employee of the long-term care provider designated under paragraph (E)(1) of section 173.20 of the Revised Code;
3. In writing by the guardian of the resident or recipient;
4. In writing by the attorney-in-fact of the resident or recipient, if the resident or recipient has authorized the attorney-in-fact to give such consent;
5. In writing by the executor or administrator of the estate of a deceased resident or recipient;
6. The signed authorization form to review records is good for 120 days, or/unless withdrawn, or until the complaint is closed.
7. The signed authorization form becomes a permanent part of the hard copy case record.

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B. If consent to access to records is not refused by a resident or recipient or the resident's or recipient's legal representative, but cannot be obtained and any of the following circumstances exist, a representative of the office of the state long-term care ombudsman program, on approval of the SLTCO, may inspect the records of a resident or a recipient, including medical records, that are reasonably necessary for investigation of a complaint:

1. The resident or recipient is unable to express written or oral consent and there is no guardian or attorney-in-fact;
2. There is a guardian or attorney-in-fact, but he the guardian or attorney-in-fact cannot be contacted within three working days;
3. There is a guardianship or durable power of attorney, but its existence is unknown by the long-term care provider and the representative of the office at the time of the investigation; or,
4. There is no executor or administrator of the estate of a deceased resident or recipient.



**AUTHORIZATION FOR RELEASE OF INFORMATION**

I, \_\_\_\_\_  
(Circle all applicable: Self, Power of Attorney, Legal Guardian, Durable  
Power of Attorney, other: \_\_\_\_\_)

request \_\_\_\_\_  
(Name of provider: facility, agency, other)

or its officers or employees, to furnish the Long Term Care Ombudsman  
with medical, financial, other written reports and any or all information  
pertaining to

\_\_\_\_\_  
(Name of resident/consumer).

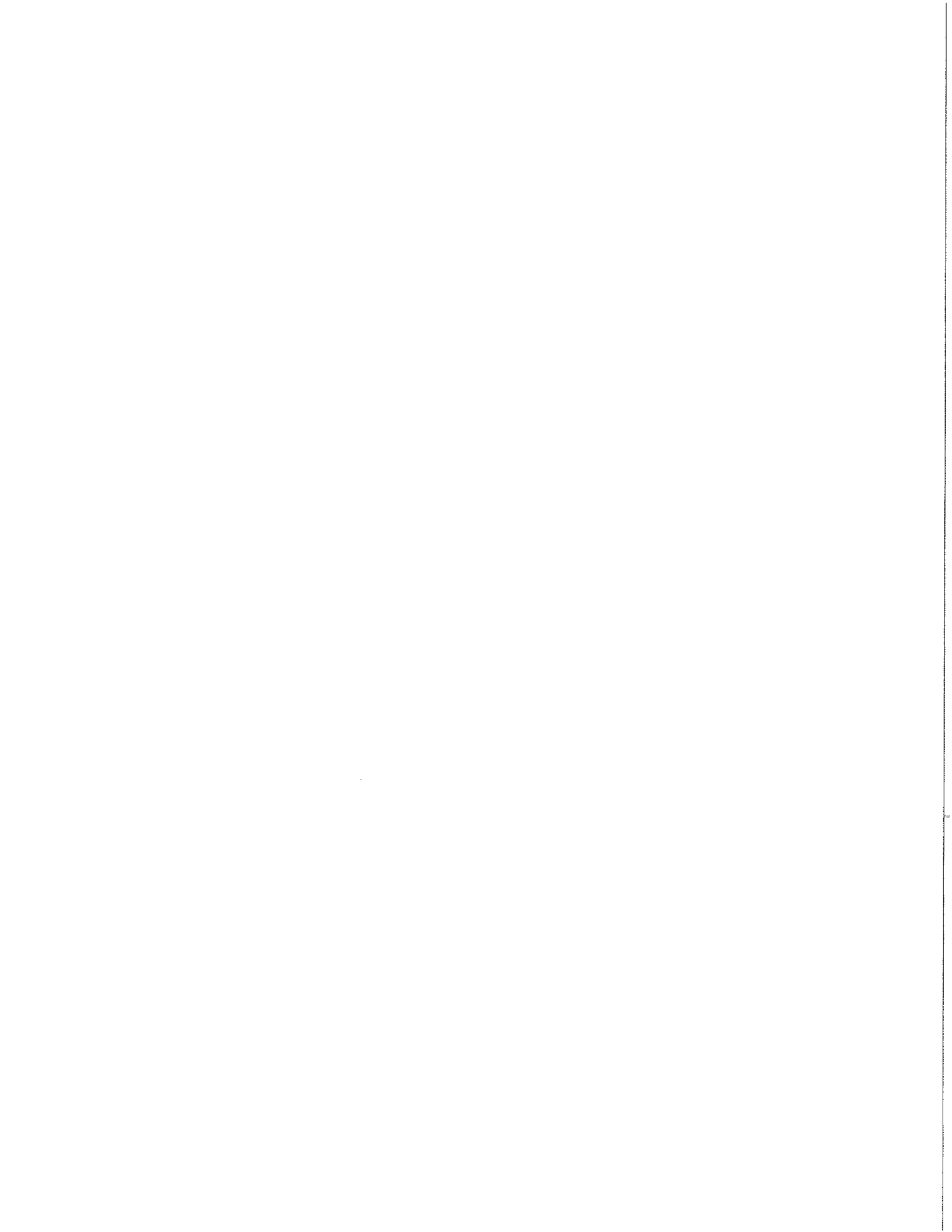
I further authorize and request you to provide the Long Term Care  
Ombudsman access to review and copy all aforementioned records.

A copy of this authorization shall have the same effect as the original.  
This authorization shall be valid for **one year** from dated signed or until  
withdrawn.

\_\_\_\_\_  
(Signature) Date: \_\_\_\_\_

\_\_\_\_\_  
(Address)

Long Term Care Ombudsman  
2800 Euclid Avenue, Suite 200 • Cleveland, Ohio 44115  
Phone: 216.696.2719 Toll-free: 1.800.365.3112  
Fax: 216.696.6216 • [www.ltco.org](http://www.ltco.org) • [info@ltco.org](mailto:info@ltco.org)  
Serving Cuyahoga, Geauga, Lake, Lorain, and Medina



**Office of the State Long-Term Care Ombudsman  
Policy and Procedure**

**103.00 Request for Records and/or Testimony**

**POLICY:** It is the policy of the Office of the State Long-Term Care Ombudsman Program to maintain the confidentiality of all investigative files. Information contained in the investigative files maintained by the state and regional offices of the Program shall be released only at the discretion of the State Ombudsman, or if disclosure is required by court order. Identities of clients, witnesses, and complainants shall not be released absent a court order.

**PROCEDURE A. Submission of request to the State and/or Regional Long-Term Care Ombudsman Program**

When an investigative file, either in whole or in part, or a request to submit to deposition or to testify in an administrative or judicial proceeding is requested by a party outside of the Office of the State Long-Term Care Ombudsman, the request must be submitted upon receipt to the State or Regional Long-Term Care Ombudsman Program in writing for consideration.

**B. Submission to Office of State Long-Term Care Ombudsman**

1. When any regional ombudsman or representative of the state office receives a request for an investigative file, either in whole or in part, or a request to submit to deposition or to testify in an administrative or judicial proceeding, they shall notify the State Long-Term Care Ombudsman (SLTCO) immediately by telephone, in the case of a regional ombudsman receiving the request. Ombudsmen may not release any part of an investigative file in the absence of a court order and/or agreement of the State Long-Term Care Ombudsman.
2. Within one business day after notification, the ombudsman shall submit the written request and complete and submit the attached form to the SLTCO or designee by facsimile transmission (in the case of a regional ombudsman receiving the request) describing the case involved, the circumstance for the request, and other required information in a format prescribed by the State Long-Term Care Ombudsman.

### **C. Decision by State Long-Term Care Ombudsman**

1. The SLTCO or designee will review the records requested and discuss the circumstance with the ombudsman in making a determination as to the release or withholding of records.
2. As appropriate, the SLTCO or designee will seek permission from the resident or complainant to release identity. Names and identifying information about clients, complainants, and/or witnesses will not be released without written consent of the affected individuals or their legally authorized representatives who have the proper scope of authority to provide such consent, unless required by court order. The SLTCO may request that the regional ombudsman seek the required consent.
3. The SLTCO or designee will consult Ohio Department of Aging internal legal counsel or the Ohio Attorney General as needed.
4. As necessary and as requested by the SLTCO, the role of the SLTCO's legal counsel will include:
  - a. negotiating with the party issuing the request in order to implement the SLTCO determination;
  - b. explaining the confidentiality restrictions;
  - c. advising the SLTCO on the risks and benefits of disclosure;
  - d. taking action to quash the request; and/or
  - e. being present during deposition or testimony.

### **D. Ombudsman Representation in Administrative Hearings**

1. When an ombudsman represents a client at an administrative hearing (e.g. discharge hearing, Medicare/Medicaid appeal hearing) in accordance with an established action plan, the ombudsman may present copies of client medical records obtained during the course of the investigation with client consent as determined necessary to represent the client and in accordance with ombudsman laws, rules, and policies to protect confidentiality.

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**Effective date: April 1, 2004**

**Revision date: April 1, 2004**

**Authority/Basis:** 712(42 U.S.C. 3058g) Older Americans Act of 1965; 173.22 Ohio Revised Code

**Office of the State Long-Term Care Ombudsman  
Notification of Request for Investigative File**

<b>Ombudsman Name</b>		<b>Regional Program</b>	
<b>Case Number, if applicable</b>			
<b>Date Request Received</b>		<b>Requested Date of Response</b>	
<b>Description of Request</b>	<b>Narrative</b>		
<input type="checkbox"/> Request from attorney <input type="checkbox"/> Subpoena <input type="checkbox"/> Request from client or representative <input type="checkbox"/> Request from provider			
<b>Was the subpoena accompanied by funds for costs of compliance?</b>			
<b>County of jurisdiction issuing subpoena</b>		<b>County of ombudsman residence</b>	
<b>Description of Ombudsman Contact with party making the request</b>			
<b>Ombudsman Disposition – pros and cons of compliance with request, potential benefit or detriment to client, etc.</b>			

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<b>POLICY: COMPLAINT INVESTIGATION</b> <b>POLICY#: 801</b> <b>PAGE: 1 OF 2</b>	<b>DATE CREATED: 06/02</b> <b>DATE REVIEWED:</b> <b>09/20/0810/12/04; 11/2010</b> <b>DATE REVISED: 10/27/05</b> <b>RULE: OAC 173-14-16(B)(2)</b>
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**POLICY:**

The LTCO will initiate and conduct investigations of complaints as part of the complaint handling protocol to determine if the complaints are verified.

**PROCEDURES:**

- I. Investigation
  - A. Where appropriate, all investigations shall include:
    1. A face-to-face interview with the client;
    2. An on-site visit to where the services that are the subject of the complaint were provided, and,
    3. Direct contact, be it by face-to-face contact, a telephone call, email, or by letter with the complainant if different from the client;
    4. LTCO staff and volunteers shall not use tape recorders, photographs, videos or other electronic devices of clients, complainants, provider staff, and any others during a complaint investigation or at any time without authorization of the Clinical Manager or the Executive Director.
  - B. The principal steps in an investigation shall include, but are not limited to the following:
    1. Obtaining consent from the client;
    2. Obtaining a clear statement of the problem(s);
    3. Informing the client of the ombudsman process and possible steps in the investigation;
    4. Revealing known conflicts of interest to the client, if any;
    5. Obtaining a statement of the client's goals;
    6. Identifying the participants;
    7. Identifying the relevant agencies;
    8. Identify any steps already taken to handle or resolve the complaint.
    9. Determining gaps in the information;
    10. Gathering factual information through interviews with those persons with potential knowledge including, but not limited to, the complainant, the client, other agencies, and the provider's staff, management or owners;
    11. Observing in a facility, in a location where services are delivered, or in a client's own home;
    12. Researching regulations and laws;
    13. Reviewing relevant client, provider, or government records;

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14. The investigating Ombudsman need not exhaust one principal step before starting another, need use only those principal steps necessary, and need not follow them in the order listed above.
- C. Ombudsman shall document a clear chronology in the case record of:
1. The contacts made regarding the complaint and to affect resolution of the problem, including the type of contact, the date, and who made the contact.
  2. Copies of all correspondence sent or received.
  3. Copies of all documents gathered as part of the complaint handling process.
  4. Copies of release of information forms.
  5. Documentation shall be made contemporaneously or at the latest within five (5) business days of each activity in the case. Staff shall within this time frame.
  6. Ombudsman shall document any deviations from established case handling protocol, practice, or policy.

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<b>POLICY: COMPLAINT INTAKE</b> <b>POLICY#: 802</b> <b>PAGE: 1 OF 2</b>	<b>DATE CREATED: 07/02</b> <b>DATE REVIEWED: 09/29/08,</b> <b>10/12/04; 11/2010</b> <b>DATE REVISED: 10/27/05</b> <b>Rule: OAC 173-14-16 - 173-14-19</b>
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**POLICY:**

All complaints will be reviewed and responded to by an Ombudsman. All complaint activity will be reported in the Ohio Documentation and Information System (ODIS) contemporaneously, and in accordance with OAC173-14-16, to OAC173-14-19, and ODIS reporting instructions.

**PROCEDURES:**

I. Intake

- A. Certified Program Directors, Ombudsman Specialists, Ombudsman Specialists in training, Ombudsman Associate Level I and Associate Level I staff or volunteers shall conduct initial complaint intake screening.
  1. A case will be opened in ODIS regarding complaints that are made by, or on behalf of, consumers and relate to the action, inaction, or decisions of providers or representatives of providers of long-term care services, public agencies, or health and social services agencies that may adversely affect the health, safety, welfare, or rights of consumers including the welfare and rights of consumers with respect to the appointment and activities of guardians and representative payees whenever appropriate.
- B. An Ombudsman shall respond to all complaints received over the telephone, by electronic mail, in person, via the LTCO website, or through postal mail.
  1. The representative shall confirm that a complainant utilizing electronic mail that the electronic mail may be a mode of communication through which confidential information is shared between the agency, provider, party, and person involved.
    - a. The electronic transmission shall be kept to a minimum.
    - b. As appropriate, the representative shall obtain the consent of the client or complainant to communicate personal information via email.
    - c. The representative shall refer to case activity by case number and/or the provider involved in the complaint.
  2. A complaint generated by the program itself shall be considered a complaint received.
  3. The Ombudsman shall document all attempts to respond to the complainant or client contemporaneously.
- C. Certified Ombudsman staff (or staff participating in Professional Development) and Ombudsman Associate Level I or II with supervision staff or volunteers with supervision shall:

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**POLICY: COMPLAINT INTAKE**  
**POLICY#: 802**  
**PAGE: 2 OF 2**

**DATE CREATED: 07/02**  
**DATE REVIEWED: 9/29/08,**  
**10/12/04**  
**DATE REVISED: 10/27/05**  
**Rule: OAC 173-14-16(A)**

1. explain the role of the ombudsman program, and
  2. gather information needed to determine response time, and
  3. determine if there is any conflict of interest, and
  4. advise regarding options for handling the complaint that are available to the client or the program, including, but not limited to, encouraging and empowering the client to handle the complaint directly with the agency, provider, party, or person involved, if possible.
- D. In determining the response time for initiating an investigation, certified Ombudsman staff (or staff participating in Professional Development) and Ombudsman Associate Level II staff or volunteers with supervision shall analyze the urgency of the complaint based upon the information received at the time of intake.
- E. The response time shall be commensurate with the potential harm posted to the client.
1. If there is probable physical harm to the client, the certified Ombudsman staff (or staff participating in Professional Development) and Ombudsman Associate Level II staff or volunteer with supervision shall respond by the end of the next working day after receiving the complaint.
  2. In all other cases, the certified Ombudsman staff (or staff participating in Professional Development) Ombudsmen Associate Level I and Level II staff or volunteer with supervision shall respond as appropriate to the complaint or no longer than within 10 business days.
- F. The Ombudsman shall follow the Complaints Declined for Investigation Policy, to identify those complaints that s/he will decline to investigate.
- G. The Ombudsman shall refer to an appropriate resource any person whose concerns do not fall within the scope of the mission or authority of the LTCO.
- H. The Ombudsman shall apply the probable harm screen following the Complaint Probable Harm Screen Policy to determine response time.
- I. The Ombudsman shall gather the following information from the complainant whose stated complaint is within the scope of the mission or authority of the LTCO. The ombudsman shall complete the initial intake screen with the following information:
1. First and last name
  2. Source of complaint
    - a. "Anonymous" indicates the Ombudsman doesn't know identity of caller and/or doesn't know relationship of the caller to the

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client. Sources who wish to remain confidential should not be reported as anonymous.

<b>POLICY: COMPLAINT INTAKE</b> <b>POLICY#: 1001</b> <b>PAGE: 3 OF 3</b>	<b>DATE CREATED: 07/02</b> <b>REVIEWED: 09/29/08, 10/12/04</b> <b>REVISED: 10/27/05</b> <b>Rule: OAC 173-14-16(A)</b>
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- b. Staff will advise complainant that remaining anonymous may limit the ability of the LTCO to investigate and resolve the complaint.
    - c. Staff will review confidentiality requirements with complainants and encourage provision of contact information so that follow up can occur.
  3. Relationship
  4. Address, City, State, Zip
  5. Home and work telephone.
  6. Problem as presented by client/complainant and goal.
    - a. Problem shall contain a clear, concise statement of each of the complaints received from client/complainant.
    - b. Problem shall include a clear, concise statement as to client/complainant's desired outcome or goal(s)
    - c. Documentation in the summary should reflect all complaints of the client/complainant.
    - d. Each complaint shall be listed but some complaints can be combined into one complaint code as appropriate.
  7. Prior action already taken by complainant/client to handle or resolve the complaint.
  8. Identification of other participants and relevant agencies
  9. Indication what strategies were offered to client/complainant for handling the complaint.
  10. Indication whether written consent and verbal consent of the client and/or complainant were obtained and how.
- J. The complaint shall be provided to the assigned Ombudsman. The assigned Ombudsman shall attempt to contact the client/complainant as appropriate to the complaint and the probable harm screen as stated in the Probable Harm Screen policy.

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<b>POLICY: CASE-COMPLAINT ASSIGNMENT</b> <b>POLICY#: 803</b> <b>PAGE: 1 OF 1</b>	<b>DATE CREATED: 06/02</b> <b>DATE REVIEWED: 10/12/04;</b> <b>11/2010</b> <b>DATE REVISED: 10/27/05</b>
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**POLICY:**

The Clinical Manager (CM) of Long Term Care Ombudsman (LTCO) shall be responsible for assigning long term care facilities and community-based long-term care providers and complaints to the staff Ombudsman. The CM and/or the Executive Director will review assignments at least annually, or more often as necessary, and modify assignments as needed to assure adequate LTCO coverage and timely response.

**PROCEDURES:**

- I. Assignment of Long Term Care Facilities
  - A. Nursing Homes, Residential Care Facilities, Unlicensed assisted living facilities, Adult Care Facilities and Adult Foster Homes.
    1. Staff Ombudsman who handle complaints will be assigned to specific long term care facilities.
    2. Ombudsman are responsible for all activity in their assigned facilities (including complaint-handling and regular presence activities) however; ombudsman are expected to assist each other to maintain coverage during vacations, sick leave, etc., and/or in emergency situations.
      - a. The Clinical Manager will develop a schedule for backup of ombudsman positions that includes vacations, unplanned leaves (sick leave, jury duty, etc.) and holiday coverage. (See Policy #.... Schedule of backup....)
    3. Assignments may be made based on experience and availability of staff.
- II. Assignment of Community-Based Long Term Care Service Providers
  - A. Complaints concerning community-based long-term care providers shall be assigned by zip code to a specific Ombudsman.
  - B. Assignments may also be made based on experience and availability of staff.
- III. Complaints/Case Assignment
  - A. Complaints/Cases shall be given to the Ombudsman assigned to that facility taking into consideration the following factors:
    - Number of recent probable harm complaints
    - Distribution of cases within the past two weeks
    - Active caseload size
  - B. As needed, the Clinical Manager may assign complaints to any certified Ombudsman or staff participating in Professional Development in any location within the five-county area.

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<b>POLICY: COMPLAINT PROBABLE HARM SCREEN</b> <b>POLICY#: 804</b> <b>PAGE: 1 OF 1</b>	<b>DATE CREATED: 06/02</b> <b>DATE REVIEWED: 10/12/04;</b> <b>11/2010</b> <b>DATE REVISED: 10/27/05</b> <b>Rule: OAC 173-14-16(A)(4);</b> <b>OAC 173-14-16(B)(1)</b>
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**POLICY:**

LTCO will respond to complainants and clients commensurate to the probable harm posed to the client in accordance with OAC 173-14-16.

**PROCEDURES:**

- I. Certified staff (or staff participating in Professional Development) and the Program Director will analyze the urgency of the complaint based upon the information received at the time of intake.
- II. Complaints shall be identified as those that pose or do not pose probable harm to the client and other consumers by one of the following categories:
  - A. Complaints that pose probable harm (it is more likely than not (probable) that there is physical harm posed to the client) to the client.
    1. If it is more likely than not that there is probable physical harm to the client, the Ombudsman shall respond to the complaint by the end of the next business day.
    2. Probable harm applies to physical harm that has already occurred, is occurring or that might occur.
    3. Probable harm to other consumers shall also be considered upon intake of the complaint.
  - B. Complaints that do not pose probable harm to the client. .
    1. Response time shall be appropriate to the complaint but not more than ten (10) business days from the initial contact, unless the Ombudsman has prior authorization of the Clinical Manager or Program Director.
    2. The response time will be commensurate with the potential harm posed to the client.
    3. Staff will seek technical assistance as appropriate to determine response time.
    4. Staff will provide the client/complainant an anticipated response time.
- III. Certified staff (or staff participating in Professional Development), the Program Director or Ombudsman Associate Level II volunteers with supervision shall document receipt of a probable harm complaint and immediately notify the assigned Ombudsman.

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<b>POLICY: COMPLAINTS DECLINED FOR INVESTIGATION</b> <b>POLICY#: 805</b> <b>PAGE: 1 of 2</b>	<b>DATE CREATED: 06/02</b> <b>DATE REVIEWED: 10/12/04, 11/2010</b> <b>DATE REVISED: 10/27/05</b> <b>RULE: OAC 173-14-16(A)(3);</b>
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**POLICY:**

Certified staff ( or staff participating in Professional Development), the Program Director or Ombudsman Associate Level II volunteers shall apply a screen to identify those complaints that will be declined for investigation. The Clinical Manager or the Program Director will review all complaints that Ombudsmen recommend to decline for investigation.

**PROCEDURES:**

- I. Certified staff ( or staff participating in Professional Development), the Program Director or Ombudsman Associate Level II volunteers may decline to investigate a complaint under the following circumstances:
  - A. The complaint is frivolous, vexatious, or not made in good faith;
  - B. The complaint was made so long after the occurrence of the incident on which it is based that it is no longer reasonable to conduct an investigation;
  - C. The information requested does not fall within the mission or purview of the LTCO. In that case, a referral shall be made to the appropriate entity and the activity shall be accurately reported in ODIS under Advocacy and General Information;
  - D. An investigation would create a real or apparent conflict of interest;
  - E. An adequate investigation cannot be conducted because of insufficient funds, insufficient staff, lack of staff expertise, or any other reasonable factor that would result in an inadequate investigation despite a good faith effort.
  
- II. Certified staff ( or staff participating in Professional Development) or Ombudsman Associate Level II volunteers shall advise the Clinical Manager or the Program Director of any complaint that is recommended to be declined for investigation.
  
- III. The Clinical Manager or the Program Director shall review all complaints that certified staff (or staff participating in Professional Development), the Program Director or Ombudsman Associate Level II volunteers recommend to be declined for investigation.
  - A. The Clinical Manager or Program Director shall review the facts to determine if the complaint meets the conditions in Section 1.
  - B. The Clinical Manager or Program Director shall approve or disapprove the recommendation to refer the complaint to the State Long Term Care Ombudsman (SLTCO).

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POLICIES AND PROCEDURES**

<b>POLICY: COMPLAINTS DECLINED FOR INVESTIGATION</b> <b>POLICY#: 1805</b> <b>PAGE: 2 of 2</b>	<b>DATE CREATED: 06/02</b> <b>DATE REVIEWED: 10/12/04,</b> <b>09/20/08, 11/2010</b> <b>DATE REVISED: 10/27/05</b> <b>RULE: OAC 173-14-16(A)(3);</b>
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- C. The certified staff (or staff participating in Professional Development), the Program Director or Ombudsman Associate Level II volunteers, or Clinical Manager shall inform the client/complainant of the referral to the SLTCO.

**LONG TERM CARE OMBUDSMAN 10A  
POLICIES AND PROCEDURES**

<b>POLICY: DETERMINATION OF COMPLAINT STATUS AND CLOSING COMPLAINTS</b> <b>POLICY#: 806</b> <b>PAGE: 1 OF 5</b>	<b>DATE CREATED: 06/02</b> <b>DATE REVIEWED: 9/27/08, 10/12/04</b> <b>DATE REVISED: 10/27/05; 11/2010</b> <b>RULE: OAC173-14-16(E);</b> <b>ODIS INSTRUCTIONS: STATUS AND CLOSING DETAILS</b>
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**POLICY:**

Ombudsmen will determine the reason/s for closing a complaint. Complaints will be assigned codes to indicate whether they are active or closed. A status is required for each closed complaint in the case. Complaints on which the Ombudsman is working or in which follow-up activity is planned will remain in the "active" status. Resolution is determined by the satisfaction of the client. If the client lacks capacity, the resolution is determined by the satisfaction of the person who directed the Ombudsman's investigation.

**PROCEDURES:**

- I. Prior to closing a case, the representative shall inform the client and/or complainant that ombudsman activity will cease. A representative may cease activity when any of the following occurs:
  - A. The complaint has been resolved or explained to the client's satisfaction;
  - B. The representative of the office determines that no further activity by the representative will produce satisfaction for the client;
  - C. The complaint is not a complaint a representative of the office should be handling;
  - D. The complaint has been withdrawn;
- II. Upon completion of Ombudsman activity, a case shall be closed and a determination of status shall be reported for each complaint in the case.
  - A. Resolution is first determined by the client's satisfaction.
    1. If the client lacks capacity, the resolution is determined by the satisfaction of the person who represented the client during the investigation.
  - B. Resolved - The complaint/problem was addressed to the satisfaction of the client or complainant.
    1. The Ombudsman must have performed adequate follow-up to justify this choice.

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POLICIES AND PROCEDURES**

<b>POLICY: DETERMINATION OF COMPLAINT STATUS AND CLOSING COMPLAINTS</b> <b>POLICY#: 806</b> <b>PAGE: 2 OF 5</b>	<b>DATE CREATED: 06/02</b> <b>REVIEWED: 9/27/08,10/12/04; 11/2010</b> <b>REVISED: 10/27/05</b> <b>RULE: OAC 173-14-16(E);</b> <b>ODIS INSTRUCTIONS: STATUS AND CLOSING DETAILS</b>
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2. A complaint handled through empowerment of a client and/or complainant may be coded as resolved or partially resolved if there has been follow-up activity indicating resolution.
  3. If the client or complainant is satisfied with the outcome but in the Ombudsman's assessment, the problem remains the complaint may be coded as resolved. However, it may be appropriate for the Ombudsman to seek resolution on behalf of other residents or another specific client, if one is known. Ombudsmen should use their judgment in making this determination.
- C. Partially resolved - The complaint/problem was addressed to the satisfaction of the client or complainant but some problem(s) remain.
- D. Not resolved – The complaint was not resolved to the satisfaction of the client or and problems remain.
- E. Explained – The findings of the investigation did not indicate a need for change or warrant continued ombudsman intervention. The client/complainant received an explanation.
- F. Systemic – The complaint is verified but government policy or regulatory change or legislative action is required to resolve the complaint.
- G. Referred – The Ombudsman referred the complaint to another agency for resolution and the report of final disposition was not obtained.
1. The Ombudsman has investigated and attempted to resolve the complaint unsuccessfully and has determined that referral of the complaint for resolution is necessary.
  2. The Ombudsman should be deliberate in referrals to other agencies for resolution, not investigation. Referrals should be made to ODH using the form provided by the State Office.
  3. The Ombudsman should conduct follow-up to see if the referral was successful in resolving the complaint to the satisfaction of the client or complainant.
  4. If the referral was successful, the complaint status is "resolved."
  5. All follow-up activities shall be documented in the case record as appropriate.

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<b>POLICY: DETERMINATION OF COMPLAINT STATUS, AND CLOSING COMPLAINTS</b> <b>POLICY#: 806</b> <b>PAGE: 3 OF 5</b>	<b>DATE CREATED: 06/02</b> <b>REVIEWED: 9/27/08,10/12/04; 11/2010</b> <b>REVISED: 10/27/05</b> <b>RULE: 173-14-16(E);</b> <b>ODIS INSTRUCTIONS: STATUS AND CLOSING DETAILS</b>
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- H. Discontinued – The Ombudsman has discontinued all complaint handling activities. This may include but is not limited to, situations where the Ombudsman determines that the complaint is frivolous, vexatious or occurred so long ago that an investigation is no longer appropriate and in some other situations.
  
- I. Withdrawn by client/complainant – The client or complainant has withdrawn the complaint. The client or complainant has requested that the Ombudsman cease any further complaint handling activities.
  
- J. Client took action – The client was empowered and handled the complaint.
  - 1. This status should be used in the very few instances when the Ombudsman was not able to conduct follow-up activity to determine whether the complaint was resolved.
  - 2. If the Ombudsman empowered the client to contact the Ohio Department of Health (ODH), the Ombudsman should not contact ODH to determine if the complaint was received.
  - 3. If it is important for the Ombudsman to know if ODH received the complaint, the Ombudsman should refer the complaint independently.
  - 4. The Ombudsman should follow-up with the client to determine if contacting ODH resolved the complaint and if so, the status should be changed to resolved.
  - 5. The Ombudsman should let the client know that they intend to follow-up and in what time frame.
  
- K. Complainant (not client) took action – The complainant handled the complaint.
  - 1. This status should be used in the very few instances when the Ombudsman was not able to conduct follow-up activity to determine whether the complaint was resolved.
  - 2. If the Ombudsman empowered the complainant to contact ODH, the Ombudsman should not contact ODH to determine if the complaint was received.
  - 3. If it is important for the Ombudsman to know if ODH received the complaint, the Ombudsman should refer the complaint independently.

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4. The Ombudsman should follow-up with the complainant to determine if contacting ODH resolved the complaint and if so, the status should be changed to resolved.
  5. The Ombudsman should let the complainant know that they intend to follow-up and in what time frame.
- K. Active – Complaint handling activity that is ongoing including investigation, resolution, or follow-up conducted by the Ombudsman.
- VI. While most closing details must be completed for each complaint type included in the case, some only need to be completed when the final complaint code and the case are being closed: Following is a list of the closing details:
- A. Date closed – The date all Ombudsman activity on a complaint has ended and is required for each complaint.
    1. The date closed must be the same as or later than the date received.
    2. The date the complaint is closed is required for each complaint.
    3. In a case with multiple complaint codes, the date the individual complaint codes are closed must be entered as this activity occurs.
  - B. For each code closed in a multiple complaint case, the following are required
    1. Verification
    2. Status other than active
    3. Resolution strategy
    4. Note in the Case Activity Details including the code, the date and reason the code is being closed.
    5. Name - The name of ombudsman closing the case. This is required for each complaint.
    6. Reason for closing – The reason for closing must be indicated in the note field and the level to which the client/complainant's satisfaction was achieved. This is required for each complaint.
    7. Mail questionnaire to: (See Policy ..... ) –.
    8. Deviations in complaint handling practice/policy – Ombudsman should report deviations in complaint handling protocol as defined in Ombudsman rules. This is required at case closing.

**LONG TERM CARE OMBUDSMAN 10A  
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<b>POLICY: DETERMINATION OF COMPLAINT STATUS AND CLOSING COMPLAINTS</b> <b>POLICY#: 806</b> <b>PAGE: 5 OF 5</b>	<b>DATE CREATED: 06/02</b> <b>DATE REVIEWED:</b> <b>09/27/08,10/12/04; 11/2010</b> <b>REVISED:10/27/05</b> <b>RULE: OAC 173-14-16(E);</b> <b>ODIS INSTRUCTIONS: STATUS</b> <b>AND CLOSING DETAILS</b>
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10. Client advised of further LTCO involvement – The Ombudsman should indicate whether or not the client was advised of further LTCO involvement. This is required at case closing.
11. Advising of further LTCOP involvement includes, but is not limited to ensuring that the client/complainant knows how to reach the Ombudsman if the problem resurfaces or new problems occur, that the Ombudsmen will continue a regular presence to monitor the situation, and whether or not there is a volunteer in the facility who is also advocating for residents. This is required at case closing.
12. Client advised of outcome - The Ombudsman should indicate whether or not the client was advised of the outcome of the investigation. This is required at case closing.
13. Volunteer was advised of the outcome. The Ombudsman should indicate whether or not the volunteer was advised of the outcome of the investigation. This is required as appropriate at case closing.
14. Administrative or legal assistance remedies include:
  - a. Legal consultation was needed and/or used
  - b. Regulatory enforcement action was needed and/or used
  - c. An administrative appeal or injunction was needed and/or used
  - d. Civil legal action was needed or used. This is required for each complaint at case closing.
15. Closed case record and signature.
16. Upon final case closing, the Ombudsman handling the case will print and sign a copy of the ODIS case record. The signed case will be added to all other case documentation, and filed.

**LONG TERM CARE OMBUDSMAN 10A  
POLICIES AND PROCEDURES**

<b>POLICY: REFERRAL OF COMPLAINTS TO SLTCO</b> <b>POLICY#: 807</b> <b>PAGE: 1 OF 1</b>	<b>DATE CREATED: 06/02</b> <b>DATE REVIEWED: 09/26/08, 10/12/04; 11/2010</b> <b>DATE REVISED: 10/27/05</b> <b>RULE: OAC 173-14-17</b>
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**POLICY:**

Staff ombudsman shall refer complaints to the State Long Term Care Ombudsman (SLTCO), in accordance with OAC 173-14-17, after approval of the Clinical Manager or the Executive Director.

**PROCEDURES:**

- I. Upon approval of the Clinical Manager or Executive Director, staff Ombudsman shall refer any complaints:
  - A. That pose a conflict of interest to the Ombudsman or the program that cannot be remedied by reassigning the complaint to another representative;
  - B. That the client has chosen to have handled by the SLTCO;
  - C. That are frivolous, vexatious, or not made in good faith;
  - D. That were made so long after the occurrence of the incidence on which it is based that it is no longer reasonable to conduct an investigation;
  - E. For which an adequate investigation cannot be conducted because of insufficient funds, insufficient staff, lack of staff expertise, or any other factor that would result in an inadequate investigation despite a good faith effort;
  - F. For which an injunction is sought against a long term care facility for a violation of the Residents Bill of Rights pursuant to Sections 3721.10 to 3721.17 of the Revised Code.
- II. After approval of the Clinical Manager or Executive Director, the staff Ombudsman may refer complaints to the (SLTCO) that were not successfully resolved by the Ombudsman.
- III. The staff Ombudsman will document according to LTCO policy the following:
  - A. Updates provided by the SLTCO on the progress and disposition of the referral.
  - B. If the STLCO will not handle the referral, the reasons the complaint will not be handled.

**LONG TERM CARE OMBUDSMAN 10A  
POLICIES AND PROCEDURES**

<b>POLICY: COMPLAINT RESOLUTION</b> <b>POLICY #: 808</b> <b>PAGE: 1 OF 3</b>	<b>DATE CREATED: 06/02</b> <b>DATE REVIEWED: 9/28/08,</b> <b>10/12/04; 11/2010</b> <b>DATE REVISED: 10/27/05</b> <b>RULE: OAC 173-14-01; OAC 173-</b> <b>14-16(C); OAC 173-14-18,ODIS</b> <b>INSTRUCTIONS - COMPLAINT</b> <b>HANDLING: RESOLUTION</b> <b>STRATEGY</b>
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**POLICY:**

Ombudsmen will attempt to resolve all complaints in accordance with OAC 173-14-16. Ombudsmen will determine a resolution strategy each complaint.

**PROCEDURES:**

- I. The Ombudsman shall attempt to resolve all complaints.
- II. The Ombudsman shall advise the client, legal representatives, or sponsor of the options for resolving the complaint and the various strategies that could be used. Where appropriate, Ombudsman will encourage and empower the client to handle the complaint directly with the agency, provider, or person with whom the client has a problem.
- III. The Ombudsman shall select a resolution strategy. For documentation purposes in the Ohio Documentation and Information System, the final selection must reflect the primary resolution strategy, when there is more than one utilized strategy. The Ombudsman is required to select the appropriate code before closing the case. The following is a list of resolution strategies:
  - A. Negotiation – The ombudsman represents the views and interests of the client or complainant to bring about an agreement between the client and provider.
  - B. Mediation – The Ombudsman remains an objective third party between client or complainant and other parties in an attempt to resolve a complaint. Mediation is appropriate when the power between the parties is equal or can be equalized such as with a roommate conflict.
  - C. Client/Complainant Empowerment - The Ombudsman provides the client or complainant with advice, the purpose of which is to enable the consumer to take another step to resolve the complaint.
    1. The Ombudsman plans and conducts follow-up to determine if the information resulted in resolution of the complaint.
    2. Follow-up activities include but are not limited to site visits, phone calls, emails, letters or interviews completed by an Ombudsman.
    3. All follow-up activities will be documented in the case record as appropriate.
    4. The purpose of the follow up is to ensure that the resolution strategy remains effective.

**LONG TERM CARE OMBUDSMAN 10A  
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<b>POLICY: COMPLAINT RESOLUTION</b> <b>POLICY#: 808</b> <b>PAGE: 2 OF 3</b>	<b>DATE CREATED: 6/02</b> <b>REVIEWED: 09/217/08, 10/12/04;</b> <b>11/2010</b> <b>REVISED: 10/27/05</b> <b>Rule: OAC 173-14-01; OAC 173-14-</b> <b>16(C); OAC 173-14-18</b> <b>ODIS INSTRUCTIONS -</b> <b>COMPLAINT HANDLING:</b> <b>RESOLUTION STRATEGY</b>
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D. Education – The Ombudsman notifies the provider of a problem and upon receiving that information, the provider fixes the problem such as changing current facility practices to effect a change.

E. Brokering – The Ombudsman remains involved in the resolution of the complaint by collaborating with or facilitating the involvement of other agencies or resources.

1. All referrals made by representatives of the office shall contain the pertinent facts known to the representative and shall be subject to the confidentiality and consent requirements set forth in rule 173-14-16 of the Administrative Code.
  - a. Any confidential information transmitted in a written document shall be marked as confidential.
2. Representatives of the office may report any violation of provider licensing laws or standards, or Medicare/Medicaid certification laws or standards, discovered during the course of complaint-handling to the department of health.
3. Representatives of the office may report any violations of professional licensing laws or standards discovered during the course of complaint handling to the appropriate professional board or organization.
4. Representatives of the office may report any violation of the provider agreement, Medicaid discrimination laws, nursing home waiting list requirements, personal needs allowance laws, Medicaid covered services provisions, or facility transfer plans discovered during the course of complaint handling to the Ohio Department of Job and Family Services.
5. Representatives of the office may report any violations of laws or standards whose investigation or enforcement is under the jurisdiction of a federal, state, or local public agency, to the appropriate agencies.
6. Representatives of the office shall report any suspected criminal violation discovered during the course of complaint handling to the appropriate law enforcement agency.
7. Any public agency that receives a referral from a representative of the office is required to acknowledge receipt of the referral within thirty days from the date on which the agency received the referral and, except as otherwise provided by law, shall notify the representative of the results of its investigation within thirty days from the date on which the agency completes its investigation.

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<b>POLICY: COMPLAINT RESOLUTION</b> <b>POLICY#: 808</b> <b>PAGE: 3 OF 3</b>	<b>DATE CREATED: 6/02</b> <b>REVIEWED: 09/27/08, 10/12/04</b> <b>REVISED: 10/27/05</b> <b>Rule: OAC 173-14-01; OAC 173-14-16(C); OAC 173-14-18</b> <b>ODIS INSTRUCTIONS - COMPLAINT HANDLING: RESOLUTION STRATEGY</b>
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E. Developing an action plan in conjunction with the client after taking into consideration the scope of the problem, the history of the provider, and pertinent laws and regulations.

a. The plan shall include strategies and actions to be taken by the representative including target dates and a follow-up schedule.

F. Legislative advocacy - planning, preparing, and conducting community education programs, training events, and legislative and other public relations contacts; influencing the outcome of the formation and implementation of public policy that affects consumers; representing consumers, both individually and collectively, to effect a positive change.

G. Public disclosure ????????????

I. Not applicable – The Ombudsman did not employ resolution strategies because the complaint was undetermined, explained, or not verified or for some other reason the Ombudsman didn't provide intervention of any kind. This option may be appropriate when the client/complainant reports a complaint they have already addressed or withdraws a complaint reported to the program.

J. Strategy unknown – The primary strategy has not been identified because it is too early to determine what action is needed. This must be changed prior to closing a case.

**POLICY: QUALITY ASSURANCE PROCESS**  
**POLICY #: 809**  
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**DATE CREATED: 12/01**  
**DATE REVIEWED: 10/01/08,**  
**01/06/05; 11/2010**  
**DATE REVISED: 06/27/02**  
**RULE: 173-14-15**

**POLICY:**

The policy of the Long-Term Care Ombudsman (LTCO) is to assure delivery of Ombudsman services of the highest quality through systematic evaluation and ongoing quality improvement.

**PROCEDURES:**

**I. Complaint Handling:**

**A. Utilization Review:** The Clinical Manager will review the adequacy and completeness of ombudsman intervention in relation to the consumer's needs and direction.

1. Every month, three open cases of each ombudsman who are handling complaints will be selected and shall include but not be limited to the following criteria:
  - cases which include physical and/or sexual abuse complaints
  - cases referred by the State Long Term Care Ombudsman Program
  - cases opened longer than 90 days
  - cases with no activity for the last 30 days
- a. The following areas for review include but are not limited to coding; conflict of interest; timely response; appropriate consents to handle the complaint, to reveal identity and release records; client direction; complaint statement and goals; plans of action; application of appropriate rules, laws or legislation.
- b. Deviation from protocol will receive particular attention.
- c. Individual Ombudsman staff shall receive written comments including positive findings, trends, issues and any recommendations for improvement.
- d. The Clinical Manager will document quality assurance in ODIS.
- e. The Clinical Manager shall report any outliers or issues of concern to the Executive Director as necessary on a monthly basis.

**B. Closed Record Review:** The Clinical Manager will review for structural compliance

1. Every month, three closed case records of each staff ombudsman who are handling complaints shall be reviewed. This review shall include but not be limited to the following criteria:
  - client/complainant empowered
  - complaints that were referred
  - complaints withdrawn by the client

- complaints withdrawn by the complainant

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- Unresolved complaints
  - Not verified complaints
  - Discontinued complaints
  - Cases with greater than average hours
  - Cases that were open longer than 90 days
  - Cases with volunteer involvement
2. The following areas of review shall include but not be limited to completeness and accuracy regarding coding, investigation, plan of action, complaint statements and goals, volunteer involvement and narrative notes.
  3. Individual ombudsman staff will receive written comments regarding each record review. Included will be positive feedback, other findings, trends, issues and recommendations for improvement.
  4. The Clinical Manager will document quality assurance in ODIS.
  5. The Supervisor shall report any outliers or issues of concern to the Executive Director as necessary and on a monthly basis.

**C. Quality Measures Review:**

1. Every quarter, a review of quarterly measures will include but not be limited to:
  - whether the consumer was the source of the complaint
  - response time
  - verification rate of individual ombudsmen as well as program
  - resolution rate of individual ombudsmen as well as program
  - status codes of cases targeting those that have been not verified, undetermined, discontinued, withdrawn by client/complainant or client/complainant took action, empowerment
  - time between received date and start date
  - time between open and closed dates
  - number of hours reported of each LTCO
2. Findings of this review will be shared with Ombudsman staff to identify area for improvement within our service delivery and to compile and analyze data relating to outcomes.
3. The Clinical Manager will document quality assurance in ODIS.
4. The Supervisor shall report any outliers or issues of concern to the Executive Director as necessary and on a monthly basis.

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#### **D. Caseloads Distribution**

Caseloads of the staff ombudsmen who are handling complaints will be reviewed quarterly to ensure even workload distribution consistent with satisfactory response to consumers.

- The Supervisor shall advise the Executive Director of any necessary change in case distribution on a quarterly basis or as needed.

#### **E. Consumer Satisfaction Survey/ Outcome Measurement Survey**

1. Names and addresses of all complainants, clients, and others as indicated in ODIS by the Ombudsman handling the case will be submitted to the SLTCOP, as requested. All closed cases will be checked for completeness of names and address information by the Supervisor or other designated staff.
2. As results of the Consumer Satisfaction Surveys are received, the staff member who handled the complaint, the Clinical Manager and the Executive Director will be provided a copy of the survey.
3. Persons who requested information and/or selection assistance will be sent a satisfaction survey on a monthly basis.
4. As results of the satisfaction surveys are received, the staff member who handled the request, the Clinical Manager and the Executive Director will be provided a copy of the survey.
5. The Supervisor shall report any issues of concern to the Executive Director as necessary and on a monthly basis.

### **II. General Information, Advocacy and Regular Presence**

#### **A. General Information and Advocacy Review**

1. Each month, at least five Advocacy/General Information (AGI) entries of each staff Ombudsman will be reviewed.
2. The review will focus on the appropriateness and thoroughness of Ombudsman response, and that documentation and time calculation of the ombudsman are accurate.
3. Each Ombudsman will receive written comments regarding the review, including positive feedback, other findings and recommendations.
4. The Clinical Manager will document quality assurance in ODIS.
5. The Supervisor shall report any outliers or issues of concern to the Executive Director as necessary and on a monthly basis.

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**RULE: 173-14-15**

**B. Selection Assistance Review**

1. Each month, at least four General Information entries for #15: Selection Assistance will be reviewed for the quality of the information provided including but not limited to the variety and relevance of options offered appropriate to the needs of the client, the type of information sent via mail or email and the timeliness of the response (date received to date of assistance).
2. The Clinical Manager shall report any issues of concern to the Executive Director as necessary and on a monthly basis.

**B. Review of Collection and Entry of Data for the Provider Data Base**

1. Each month, documentation of revisions and/or new providers/services entered into the PDB will be reviewed to determine accuracy as well as progress toward goals
2. Each month, five PDB entries will be reviewed for accuracy and completeness.
3. Review of data will include comparing paper questionnaire with a PDB entry, as well as checking of spelling, grammar and clarity of entries.

**C. Regular Presence Review**

1. Each quarter, the Clinical Manager will review regular presence indicators for each staff Ombudsman. This review includes visits to facilities, contact with volunteers, community presentations, work with resident and family councils.
2. Each quarter, the Clinical Manager will review AGI entries of each staff ombudsman indicating ongoing contact with volunteers (technical assistance, meetings, assistance with complaint handling).
3. The Clinical Manager will report on the findings of the regular presence review to the Executive Director on a quarterly basis.

**C. Presentations/In-service Review**

1. Evaluation of presentations/in-services shall be conducted to obtain feedback regarding the content and presentation of long-term care information with the intended purpose of quality improvement.
  - a. Each Ombudsman shall distribute an appropriate evaluation tool to each participant at the end of a presentation/in-service.
  - b. Evaluations shall be submitted to the Clinical Manager and the Executive Director.

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**RULE: 173-14-15**

**D. Volunteer Program Review**

1. On a quarterly basis, the Volunteer Coordinator (VC) will review:
  - a. The percent of complaints with the lead handled by ombudsmen staff and volunteers including follow-up activities.
  - b. The number of new volunteers recruited, trained, and certified.
2. Upon receipt, Ombudsman volunteer reports will be copied and given to the staff Ombudsman by the end of the next working day for assigned staff or a designee to determine if complaints are imbedded in the reports. The VC or a designee will review the reports as follow up on complaints and to ensure that the volunteer is acting within their certification level.
3. The VC will review forty ODIS entries for volunteer services for completeness and accuracy on a quarterly basis.
4. The VC will report on the findings of the volunteer program review to the Executive Director on a quarterly basis.
5. The VC shall report any issues of concern to the Executive Director as necessary and on a monthly basis.
6. Upon voluntarily separation from the program, the former volunteer will be sent an exit survey. The surveys will be evaluated for improvements in the program. The VC will provide the exit surveys to the Executive Director upon receipt.

**LONG TERM CARE OMBUDSMAN 10A  
POLICIES AND PROCEDURES**

<b>POLICY: MEDIA RELATIONS</b> <b>POLICY#: 900</b> <b>PAGE: 1 OF 1</b>	<b>DATE CREATED: 06/02</b> <b>DATE REVIEWED: 11/02/04,</b> <b>09/23/08; 11/2010</b> <b>DATE REVISED: 10/27/05</b>
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**POLICY:**

All communication with the media will be handled by the Executive Director of LTCO or his/her designee, or the President of the Board of Trustees. No staff should initiate or respond to contacts by the media without specific approval of the Executive Director of the LTCO or the President of the Board of Trustees.

**PROCEDURES:**

- I. The Executive Director of the LTCO will determine and/or approve contacts made to the media.
- II. Staff will notify the Executive Director immediately when contact is made from any media source. If the Executive Director is not available, staff receiving the contact will contact the President of the Board of Trustees, if the situation requires immediate attention.
- III. Staff may be given authority to address the media regarding a particular issue/topic, complaint and/or service by the Executive Director. .

**LONG TERM CARE OMBUDSMAN PROGRAM 10A  
POLICIES AND PROCEDURES**

<b>POLICY: PROVISION OF GENERAL INFORMATION</b> <b>POLICY :902</b> <b>PAGE: 1 OF 1</b>	<b>DATE CREATED: 06/02</b> <b>DATE REVIEWED: 09/26/08;</b> <b>11/2010</b> <b>DATE REVISED: 06/27/02</b> <b>LAW: OAC 173-14-01, ODIS AGI</b> <b>Reporting Instructions,</b> <b>Definitions &amp; Codes</b>
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**POLICY:**

The LTCO shall provide general information to consumers with regard to rights and regulations, entitlements, public benefit programs, access to services, selection of long term care services, and provider consultation. General information is defined as researching and providing information on the topics noted above, using verified and objective information and referrals to other sources of assistance in those situations where a case is not being opened for complaint handling.

**PROCEDURES:**

- I. Ombudsmen staff shall accept general information requests over the telephone, by mail, electronic transmission, or in-person.
  - A. Staff shall document information contemporaneously or as soon as practicable within three business days of receipt. Upon an approved request, by the Clinical Manager and/or Executive Director, the documentation timeline may be extended from three to five business days of receipt.
- II. Contacts requesting assistance regarding long-term care services and facilities will be referred to the staff conducting intake and/or selection assistance per the Selection Assistance Policy. Additional information shall be offered from the assigned Ombudsman.
- III. Persons seeking legal information not available in fact sheets or other written forms shall be referred to Legal Aid, the Cleveland Bar Association, the ProSenior Legal Hot-line, and any other list of LTCO approved attorneys.
- IV. Ombudsmen shall respond to requests from providers and offer consultation regarding long-term care issues or problems. Providers will be offered information on laws, rules and other pertinent materials. Ombudsmen will be diligent in determining if the consult should be considered a complaint with LTCO as the complainant.

**LONG TERM CARE OMBUDSMAN PSA 10A  
POLICIES AND PROCEDURES**

<b>POLICY: CLOSED RECORD FILING PROCESS</b> <b>POLICY#:</b> <b>PAGE: 1 OF 2</b>	<b>DATE CREATED: 2009</b> <b>DATE REVIEWED: 2/24/2011</b> <b>DATE REVISED:</b>
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- I. Ombudsman case record retention
  - A. Closed records are to be filed and maintained for a period of three years.
- II. Closed records
  - A. At the end of each month all ombudsmen are to submit their closed records to the Clinical Manager for review prior to filing.
    1. The assigned ombudsman signs his/her own closed records.
    2. The assigned ombudsman should enter basic information related to the guardian or designated contact so that computer-generated labels can be utilized for mailings.
    3. No information is to be added to records once they are closed.
  - B. A closed record has two sections
    1. Printed case record
    2. Attachments
      - a. Attachments provide documentation of the services/activities provided by the staff ombudsman, management personnel, and organizational staff, the long term care provider, consumer/guardian, complainant, and/or physician/other medical personnel.
      - b. A printed record without any attachments will be returned to the Clinical Manager before filing to verify that no attachments are warranted.
      - c. Attachments without an accompanying case record must have the Case # and Facility name written on them.
  - C. If two closed records are discovered (one in filing basket and another in record folder) both records are given to the Clinical Manager for review; the earliest print date determines the printed record to be used and the Clinical Manager confirms all documents are included with the record that is retained for filing.
  - D. The "date closed report" from ODIS is used to verify that the date of the last code closed is the same month in which filing is completed.

### III. Responsibilities of personnel assigned to filing case records:

A. Use the Closed Record Report (sorted alphabetically by facility first then by Case #) to confirm all closed case files have been submitted. Submit a report of any discrepancies, in writing, to the Clinical Manager.

1. The Clinical Manager informs the OS of which cases are needed for filing.

B. Highlight the case number and the name of the provider agency;

C. Remove all re-usable paper clips and file folders either at the time of original filing or at the time of the annual purge.

### IV. Purging

A. Records over three years are to be "purged" from stored records by the end of March each year.

B. Records over three years are to be removed from the file folder, placed in a shredding box/container, clearly marked as "PURGED RECORDS" on the box, and stored in the designated area for pick-up and shredding.

### V. Filing process

A. Closed case records should have the facility provider name either typed or printed on the tab of the folder.

B. Standard letter-size vanilla file folders are utilized with colored-label tabs to identify the type of provider facility as follows:

- |                                     |   |
|-------------------------------------|---|
| 1. ROYAL BLUE                       | Nursing Homes, Government, PASSPORT, McGregor PACE  |
| 2. GREEN                            | Medicare, Health Maintenance Organizations  |
| 3. WHITE                            | Adult Care Facilities: Group Homes, Foster Homes, Family Home, AGS  |
| 4. RED                              | Assisted Living aka Residential Care Facilities   |
| 5. YELLOW                           | Home Health Agencies, AGS, Ambulance  |
| 6. (new) PINK (currently any color) | Miscellaneous Agencies- Non government; Against Provider; Not Against Provider; Durable Equipment; Meals on Wheels; Hospice |

C. The color coding label scheme is helpful but may not always be accurate, so there are drawer content labels which are affixed outside of all drawers of the file cabinets with a listing of the contents of the drawer.

D. Cross-reference on facility name changes

1. When there is a name change for a facility/provider, two (or more) folders must be made for cross-reference, with appropriate color labels that are printed or hand written.

2. The record is filed under the changed (newest) facility name with the old/original name also listed (underneath). IS THIS CORRECT?
  3. Selection Assistance staff will provide a copy of changes in facility names to the Clinical Manager for the filing personnel as LTCO is made aware of them.
- VI. To confirm that LTCO is in compliance with all local, state, and federal records requirements and procedures, LTCO adheres to the SLTCO regulations.
- VII. All closed record file cabinets are locked at the conclusion of each work day by the Office Manager.