Maryland
DEPARTMENT OF AGING

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

Long-Term Care Ombudsman Program
FACT SHEET FY 2021

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

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

The Ombudsman Program serves 53,000+ people in 227 Nursing Homes and 1,756 Assisted Living Facilities through:

- The Office of the State Long-Term Care Ombudsman at the Maryland Department of Aging with a State Ombudsman and Ombudsman Specialist
- 19 Local Programs (35 FTEs) located in Area Agencies on Aging
- 68 volunteers (49 designated)

In FY21, the Long-Term Care Ombudsman Program provided:

- 1670 Total facility visits
- 9232 Consultations to individuals
- 73 Community Ed. Sessions
- 128 Meetings with resident councils
- 3711 Complaints addressed
- 6834 Consultations to facilities
- 50 Meetings with family councils
- 175 Participation in facility surveys

Sources of complaints:

- Residents – 43%
- Relative/Friend – 45%
- Facility Staff – 4%
- Representative of other agency or program – 3%

Most frequent complaints handled in Nursing Homes by Complaint type:

1. Care
2. Autonomy, choice, rights
3. Admission, transfer, discharge, eviction
4. Access to information
5. Financial, property
6. Abuse, gross neglect, exploitation
7. Dietary
8. Environment
9. Facility policies, procedures, and practices
10. Activities, community integration & social services

Most frequent complaints handled in Assisted Living Facilities by Complaint type:

1. Care
2. Autonomy, choice, rights
3. Admission, transfer, discharge, eviction
4. Abuse, gross neglect, and exploitation
5. Access to information
6. Facility policies, procedures, practices
7. Financial, property
8. Dietary
9. System & others (non-facility)
10. Activities, community integration & social services

Program Information:

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

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

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

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

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

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

State Ombudsman Goals:

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

This Fact Sheet summarizes the FY21 (October 1, 2020 – September 30, 2021) data submitted to the Administration for Community Living. For more information contact Stevanne Ellis, State Long-Term Care Ombudsman, stevanne.ellis@maryland.gov, 1-800-243-3425 (toll free in Maryland) or 410-767-1100.

State data for MD for FFY 2021

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Case and Complaints Summary

Total number of cases closed: 1817

Totals Cases per Complainant by Facility Setting

Complainant	Nursing Facility	Residential Care Community	Other	Total per complainant
Resident	685	100	0	785
Resident representative, friend, family	692	128	0	820
Ombudsman program	18	17	0	35
Facility staff	56	24	0	80
Representative of other agency or program	44	18	0	62
Concerned person	9	11	0	20
Resident or family council	6	2	0	8
Unknown	4	3	0	7
Total per facility type	**1514**	**303**	**0**	**1817**

Total number of complaints: 3711

Major Complaint Groups by Type of Facility

Complaint Category/Type	Nursing Facility	Residential Care Community	Other	Total by Complaint Type
A. Abuse, gross neglect, exploitation	176	53	0	229
B. Access to Information	209	45	0	254
C. Admission, transfer, discharge, eviction	360	71	0	431
D. Autonomy, choice, rights	413	93	0	506
E. Financial, property	186	39	0	225
F. Care	1165	145	0	1310
G. Activities and community integration and social services	81	16	0	97
H. Dietary	164	24	0	188
I. Environment	145	39	0	184
J. Facility policies, procedures and practices	135	43	0	178
K. Complaints about an outside agency (non-facility)	24	6	0	30
L. System and others (non-facility)	62	17	0	79

Complaint Verifications

Verification Status	Nursing Facility	Residential Care Community	Other	Total
Verified	2582	452	0	3034
Not Verified	538	139	0	677

Complaint Dispositions

Disposition Status	Nursing Facility	Residential Care Community	Other	Total
Partially or fully resolved to the satisfaction of the resident, resident representative or complainant	2120	391	0	2511
Withdrawn or no action needed by the resident, resident representative or complainant	537	135	0	672
Not resolved to the satisfaction of the resident, resident representative or complainant	463	65	0	528

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Complaint Types by Type of Facility

Complaint Category/Type	Nursing Facility	Residential Care Community	Other	Total by Complaint Type
A. Abuse, gross neglect, exploitation	176	53	0	229
A01. Abuse: physical	47	20	0	67
A02. Abuse: sexual	11	5	0	16
A03. Abuse: psychological	36	4	0	40
A04. Financial exploitation	22	13	0	35
A05. Gross neglect	60	11	0	71
B. Access to Information	209	45	0	254
B01. Access to information and records	170	36	0	206
B02. Language and communication barrier	39	8	0	47
B03. Willful interference	0	1	0	1
C. Admission, transfer, discharge, eviction	360	71	0	431
C01. Admission	11	5	0	16
C02. Appeal process	11	0	0	11
C03. Discharge or eviction	312	63	0	375
C04. Room issues	26	3	0	29
D. Autonomy, choice, rights	413	93	0	506
D01. Choice in health care	25	6	0	31
D02. Live in less restrictive setting	45	13	0	58
D03. Dignity and respect	96	19	0	115
D04. Privacy	21	8	0	29
D05. Response to complaints	36	3	0	39
D06. Retaliation	12	5	0	17
D07. Visitors	84	13	0	97
D08. Resident or family council	5	1	0	6
D09. Other rights and preferences	89	25	0	114
E. Financial, property	186	39	0	225
E01. Billing and charges	56	22	0	78
E02. Personal property	130	17	0	147

Complaint Category/Type	Nursing Facility	Residential Care Community	Other	Total by Complaint Type
F. Care	1165	145	0	1310
F01. Accidents and falls	60	10	0	70
F02. Response to requests for assistance	176	17	0	193
F03. Care planning	163	12	0	175
F04. Medications	131	29	0	160
F05. Personal hygiene	157	17	0	174
F06. Access to health related services	99	17	0	116
F07. Symptoms unattended	132	13	0	145
F08. Incontinence care	73	7	0	80
F09. Assistive devices or equipment	84	16	0	100
F10. Rehabilitation services	90	6	0	96
F11. Physical restraint	0	1	0	1
F12. Chemical restraint	0	0	0	0
F13. Infection control	0	0	0	0
G. Activities and community integration and social services	81	16	0	97
G01. Activities	27	5	0	32
G02. Transportation	8	1	0	9
G03. Conflict resolution	19	5	0	24
G04. Social services	27	5	0	32
H. Dietary	164	24	0	188
H01. Food services	89	18	0	107
H02. Dining and hydration	48	3	0	51
H03. Therapeutic or special diet	27	3	0	30
I. Environment	145	39	0	184
I01. Environment	35	15	0	50
I02. Building structure	5	8	0	13
I03. Supplies, storage and furnishings	27	3	0	30
I04. Accessibility	10	1	0	11
I05. Housekeeping, laundry and pest abatement	68	12	0	80
J. Facility policies, procedures and practices	135	43	0	178
J01. Administrative oversight	39	20	0	59
J02. Fiscal management	7	5	0	12
J03. Staffing	89	18	0	107

Complaint Category/Type	Nursing Facility	Residential Care Community	Other	Total by Complaint Type
K. Complaints about an outside agency (non-facility)	24	6	0	30
K01. Regulatory system	0	2	0	2
K02. Medicaid	12	4	0	16
K03. Managed care	1	0	0	1
K04. Medicare	8	0	0	8
K05. Veterans Affairs	1	0	0	1
K06. Private Insurance	2	0	0	2
L. System and others (non-facility)	62	17	0	79
L01. Resident representative or family conflict	16	8	0	24
L02. Services from outside provider	21	7	0	28
L03. Request to transition to community setting	25	2	0	27

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Complaint Examples

	Nursing Facility Example	Residential Care Community Example	Optional Complaint Example
Facility type	Nursing Facility	Residential Care Community	Other
Description	The ombudsman program worked with a resident with with impaired hand mobility and pain issues related to a neurologic condition. The resident was in need of solutions to enhance the ability to use the call bell, have adequate fluid intake, and to relieve pain issues considering non-medication approaches. Approach to resolution: The problem was resolved via an inter-disciplinary approach involving nursing and therapy staff to procure adaptive equipment to allow the resident to use a call bell and to control their own fluid intake without needing staff assistance. The resident's hand mobility was impaired to the degree that the resident was unable to hold and drink from a glass/cup or to press a traditional call button. The therapy department needed to research and procure specific items just for this resident and the resident was provided a call bell activated by breath and an appropriate drinking vessel and straw to allow for independent fluid intake. Pain management services were requested for this resident. A massage therapist was contacted and was able to provide specific tissue manipulation targeted at resident's pain issues.	An assisted living facility (ALF) did not follow the proper procedures when they relocated residents to another one of their facilities because of staffing shortages. In addition the residents and families were not given adequate notification of the impending move and the licensing agency was not notified. The local ombudsman contacted the manager of the facility to get an update on the facility. The assisted living manager informed the ombudsman that the facility had temporarily closed one of their locations and moved two residents to another location owned by the facility. The local ombudsman spoke with the licensing agency who advised the ombudsman that the facility would lose their license if the facility was not operational and that the facility needed to contact the licensing agency immediately to report this situation. In addition, the licensing agency stated that the facility had failed to adequately notify them and follow procedures of notifying resident representatives.	A younger nursing home resident with a mental illness diagnosis had been in a small assisted living facility (ALF) in another county under that county's Intensive Adult Foster Care Program. The resident did well in that environment for about 4 years. When the pandemic struck and the resident's day program closed, the resident began to exhibit disruptive behaviors that caused the ALF owner to issue the resident an involuntary discharge notice. The resident's elderly parents and guardians were not able to find similar residential placement. The parents attempted to care for the resident in their home, but a series of unfortunate events unfolded which resulted in the resident living in several different facilities including a crisis center and several nursing homes for a few months. The resident also was hospitalized more than once. This was very destabilizing for the resident. The resident was placed in the dementia unit of a nursing home. Within about two months of that placement, the resident was issued an involuntary discharge notice due to aggressive behaviors that the facility endangered other residents.
Complaint topic	Care	Admission, Transfer, Discharge, Eviction	Admission, Transfer, Discharge, Eviction
Complaint type	Care planning	Discharge or eviction	Discharge or eviction
Verification	Verified	Verified	Verified
Disposition	Partially or fully resolved to the satisfaction of the resident, resident representative or complainant	Not resolved to the satisfaction of the resident, resident representative or complainant	Partially or fully resolved to the satisfaction of the resident, resident representative or complainant

Disposition narrative	Outcome: This plan was implemented and the resident gained independence and reduced pain levels. The resident's mood and outlook were improved by these small measures which were sustained until the resident was able to transition on the Home and Community-Based Options Waiver to a community setting.	The local ombudsman spoke with the manager of the ALF to inform him about what steps needed to be taken according to the licensing agency. The Manager argued that he had spoken with a surveyor from the licensing agency, and that he had been advised that the actions taken by the facility were acceptable because it was considered an emergency. The manager stated that residents' families had been contacted by phone and were fine with the move. The local ombudsman contacted licensing agency to follow up, and the licensing agency staff said that the facility needed to contact them as soon as possible when there is a relocation or closure. The local ombudsman provided the COMAR regulation (10.07.14.08 B Voluntary Closure) and sent it to the manager with the information given by OHCQ. The local ombudsman visited the residents at the facility, and explained the ombudsman's role. At the time of the visit, there were not any concerns noted by the residents. In addition, the local ombudsman contacted the families of the residents that were affected by the move. Fortunately, the families were not upset about this relocation, and verified that they were notified by phone and not in writing. The local ombudsman made a complaint to the licensing agency and attempted to verify that the facility had contacted them about this matter. The local ombudsman did not receive the results for the licensing agency's investigation.	What made this case unique and ultimately successfully resolved was the effective collaboration among a range of parties including: Maryland Legal Aid Bureau -Legal Aid attorneys represented the resident and guardians in a mediation that resulted in the nursing home agreeing to develop and execute a person-centered care plan that would address the resident's needs until the guardians could identify alternative placement in a more residential setting. The Nursing Home – The nursing home temporarily did not assign a roommate to this resident, allowing the resident to have more personal space. The facility also provided psychiatric services that included medication adjustments and weekly therapy sessions. Activities staff also arranged for the resident to have outdoor time and appropriate engagement opportunities. All of this contributed to improvements in the resident's behavior. The Local Health Department and Community Partners: The local health department deployed its Multi- Disciplinary Team, which included the local hospital, local non-profit leaders, AAA program managers and the manager of the local Assertive Community Treatment (ACT) Team to explore options for this resident. Through this collaboration, resident was able to be placed on a wait list for an intensive residential rehab program (RRP). Ombudsman and Medicaid Waiver Programs: The local ombudsman consulted with ombudsmen in neighboring counties to identify Medicaid waiver participating ALFs experienced in serving individuals with a mental health diagnosis. The local Home and Community Based Services Program Manager contacted these facilities and worked with the resident's guardians to identify viable placement options. Within several months of the local LTCOPs participation, the resident was able to find placement in a waiver- participating ALF that was close to the resident's family and where the resident would have their own bedroom and bathroom. Community-based mental health services were identified, and resident had access to engagement opportunities both within the ALF and at adult day programs. The resident's behaviors stabilized as a result of an effective combination of environmental, behavioral, and pharmacological interventions. The resident was able to transition to a less restrictive setting and enjoy the quality of life that they desired and deserved.

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System Issues

	System Issue 1	System Issue 2	System Issue 3 *(Optional)*
System issue topic	B - Access to Information	L - System and Others (non-facility)	L - System and Others (non-facility)
Problem description	Given that the pandemic limited families ability to visit residents in-person, it became clear that communication practices were not equal in each facility. There were many facilities that chose not to communicate regularly. When families families called the facility at times they would not get a response or would leave a voice mail and not receive a return phone call. In addition, staffing shortages impacted a family's ability to speak with or get a return call from the appropriate staff member or to even be able to speak with their loved ones on the phone or via a virtual meeting. Specifically, the areas impacted by poor communication were: Families were not getting consistent information about outbreak status in facilities Families were not getting contacted about medical changes or information about their loved ones Families having to reach out to facilities for most information rather than the facility staff keeping the family members up to date. Families had less contact with their loved ones which led to residents being even more isolated.	Problem: Hospitals discharging residents with mental illness and/or history of addictions issues to skilled nursing facilities far away from family and support systems. Newly admitted residents to nursing homes were telling the ombudsmen, "I don't know how I got here." Too many residents are admitted to skilled nursing facilities [SNF] far away from family and support systems. The residents expressed fear and experienced depression because they "don't belong here." Family members who wanted to visit could not because of lack of transportation resources, distance from their home to the facilities, lack of time, and finances. Often the SNF staff complained that the resident was uncooperative and had "behavioral issues," while not considering that the resident was unhappy for not only living at a SNF, but also living far away from home. The facility staff would write care plans for these "behaviors" and decide to give the residents medication rather than looking at the reason for what the resident was experiencing. The ombudsman would advocate for the resident to be transferred to a SNF closer to their home.	Problem description: During the pandemic, in federal guidance and state transmittals, orders and directives the main focus has been on nursing homes. In the guidance for nursing homes, it is usually written that the nursing home must do this or follow the guidance from CMS, CDC, and the Maryland Department of Health. The state guidance for assisted living facilities has been less clear, and in one transmittal it is written: MDH Order No. 2020-10-01-03 ("Amended Directive and Order Regarding Assisted Living Program Matters") All assisted living programs should follow all applicable federal guidance from CDC and CMS. The word should is not a mandate. It is a judgment call of the provider of services. There are over 1700, assisted living facilities in Maryland and there are few if any that do not provide healthcare services. The assisted living facility staff, by state definition, assist with activities of daily living. Residents that need assistance have a medical diagnosis or disability that leads to deficits that require the need for assistance . As a result, the staff provide assistance to residents with a vast range of healthcare needs and services. In contrast, retirement communities many residents live in independent living environments rather than assisted living settings. In many cases, retirement communities and senior apartment do not provide assistance to their residents at all.

Barriers description	See above - Staff shortages resulting in the staff's lack of time to communicate regularly with families or to arrange phone calls, virtual or in-person visits with residents. Some facilities lacked technology, and did not purchase tablets or other devises to provide another avenue of communication. Staff also had "pandemic fatigue" and were at times reluctant or unwilling to facilitate communication or return calls from family members and others	With repeated requests from the ombudsman program, the SNF staff contacted nursing homes near the resident or family member's home, but often would run into the same barriers the hospital probably did at the time of discharge; the SNFs in the resident's county would not admit them. It seems that the SNFs in other jurisdictions did not often admit residents with chronic mental illness and/or a history of addiction issues or the facility lacked services and staff with the appropriate professional expertise to provide services to these populations of residents. In addition, there are some nursing homes that have large percentage of their population of residents with mental illness and addictions issues. That does not mean the facility is focused and trained to treat this population, it only illustrates their willingness to admit them. These facilities are admitting residents often that are ill, angry, depressed and without a local and available support system.	- There are currently no federal regulations or a federal definition for assisted living facilities. The only federal information about assisted living is in the HCBS guidance, and it does not cover the state of emergency related to the pandemic. -The language in state guidance is "should" not must. - The statement in the problem description: All assisted living programs should follow all applicable federal guidance from CDC and CMS, but it is not written which guidance to follow. Which guidance from the CDC and CMS is applicable? Since assisted living facility is not a term defined consistently by the federal government, it is left to the assisted living provider to determine which guidance from the CDC and CMS to use as a guide. Are assisted living facilities health care settings or retirement communities or some type of other congregate setting? -Because the guidance for assisted living facilities is not a must, it makes it difficult for the Department of Health at the state and local level as well as other agencies, including the survey agency, to give consistent guidance. -Many assisted living providers do not have legal counsel to help them to interpret the guidance and then follow it. -The federal and state guidance that is designed for retirement communities and other congregate settings often does not apply to assisted living facility residents.
Issue status	Ongoing issue from last fiscal year	Ongoing issue from last fiscal year	Ongoing issue from last fiscal year
Affected setting	Nursing Facility Residential Care Community	Nursing Facility	Residential Care Community

Resolution strategies	Provided information to public or private agency Provided Information to legislator or legislative staff Recommended changes to laws, regulations, policies or actions through written or oral testimony. Provided leadership or participated on a task force Provided information to the media Provided educational forums; facilitated public comment on laws, regulations, policies or actions Developed and disseminated information Recommended changes to laws, regulations, policies or actions through written or oral testimony.	Provided information to public or private agency Recommended changes to laws, regulations, policies or actions through written or oral testimony. Provided leadership or participated on a task force Provided educational forums; facilitated public comment on laws, regulations, policies or actions Recommended changes to laws, regulations, policies or actions through written or oral testimony.	Provided information to public or private agency Provided Information to legislator or legislative staff Recommended changes to laws, regulations, policies or actions through written or oral testimony. Provided leadership or participated on a task force Provided educational forums; facilitated public comment on laws, regulations, policies or actions Developed and disseminated information Recommended changes to laws, regulations, policies or actions through written or oral testimony.

Resolution description	The ombudsman program provided resources and assistance to facilities that were having communication issues. The staff in facilities were encouraged to email families on a regular basis, have increased family councils or town hall meetings, provide regular phone calls to provide families with updates (one facility has an automatic calling system that calls families on a regular basis), write newsletters, and update information on their website on a regular basis. The ombudsman program discussed these concerns with the providers, stakeholders, NORC, ACL and other agencies to identify other solutions and information that would be helpful to the residents, families, other visitors and facility staff.	This issues is still ongoing. Individual advocacy was provided to residents in this situation. Recommendations: Each county should have a least one nursing home that can treat mental illness and addiction issues. Staff in these facilities need to be properly trained to care for these residents. Medicaid payment for this care should be equivalent to the payment of care for other illnesses. More education should be provided in universities and in internships to professionals working with these populations. The ombudsman program will continue to work with stakeholders, the Maryland Hospital association and provider groups, state agencies, and others to address this issue. Additionally legal action should be taken at the State level against SNFs who are found to discriminate against this population.	This issue is still unresolved. The ombudsman program continues to advocate and educate at the federal, state, and local level for clearer guidance for assisted living facilities related to infection control, visitation rights, and other pandemic related issues. The ombudsman program has pushed for assisted living facilities to be defined at the state, local and federal level as a health care facility and requested that specific guidance be written and provided to assisted living facilities.

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Organizational Structure

Office of state LTCO location State Unit on Aging

Local Ombudsman Entity Location	Number of Ombudsman
Area agency on aging (AAA) an area agency on aging designated under section 305(a)(2)(A) of the Older Americans Act or a State agency performing the functions of an area agency on aging under section 305(b)(5) of the OAA.	19
Social services non-profit agency, with 501(c)(3) status, other than AAA	0
Legal services provider	0
Stand-alone local Ombudsman entity - a non-profit agency with 501(c)(3) status – the only program is the local Ombudsman entity	0
Total number of entities	19

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Organizational Conflicts of Interest

Conflict of Interest Type	Location	Remedy
Makes decisions on admissions or discharges	Both State and Local	When a AAA has a guardianship case, then this is a conflict. See the remedy for guardianship.
Has governing board, ownership, investment, or employment interest LTC facility	Local	In one county, one of the governing board members has indirect oversight of a nursing home. In this county, the governing board is a policy-making entity only. If an issue related to the ombudsman program or anything that could potential conflict comes up, this board member would recuse him or herself from a vote or decision that could be a potential conflict.
Provides LTC coordination or case management for residents	Both State and Local	See guardianship remedy - guardians can provide LTC coordination and case management In most counties in Maryland, the local Department of Aging is one of the supports planning agencies that residents can select when they are applying for services including the medicaid waiver. Supports Planners may assist residents leaving nursing homes or that reside in assisted living facilities. The local ombudsmen do not provide these services. If there is ever a conflict between the supports planner and the local representative of the office that cannot be worked out, Ombudsman would work with the host agency and local ombudsman For all situations, the Ombudsmen, local ombudsmen, and the host agency would work to resolve any issue that would arise. If the supports planners report to a supervisor within the local department of aging this supervisor may report directly to the AAA director or to another supervisor within the host agency.

Other: For all conflicts see the remedy below	Both State and Local	In the SLTCOP policy and procedures there is a process for organizational conflict of interest review, removal and remedy. This includes an organizational conflict of interest form that was completed for FY16 that has a specific remedy for any identified potential conflicts. This form will be reviewed annually and as needed. . Many of the local ombudsman offices have their own phone number with calls coming directly to them, their own password - protected computer, and some ombudsman offices has own fax machines so hat faxes come directly to the ombudsmen and no one else. Promotional materials are clearly labeled Long-term Care Ombudsman Program with no other program name, and on the website the Ombudsman Program as a separate program describing the role of the ombudsman and services available (this is the common practice in most of the local ombudsman programs) and contact information. Records are locked and only the ombudsmen staff has access to the records and files. The ombudsman software is a web-based program, password protected, and only ombudsman staff that document in the software have access. The access to the ombudsman software is approved by the State Ombudsman and local Ombudsman Manager when appropriate. In Maryland, only ombudsman staff has access to the ombudsman software. The State Ombudsman Program has policy and procedures that went into effect in 2017 that clearly delineates the role of representatives of the office, and the conflict of interest policy. In the State Ombudsman Office, staff have their own phone number, private voice mail, their own password protected computers, locked files (that only ombudsman staff have access to), and their own offices separate from other staff.
Responsible for eligibility determinations for the Medicaid/public benefits	Local	This is the assisted living and group home subsidy. See the remedy for sets LTC reimbursement rates. Residents can apply for this program and receive assisted living services at a fixed rate based on income. More information can be provided about this program if needed.

Sets reimbursement rates for LTC facilities	Local	This is related to a program called the assisted living and group home subsidy. More information can be provided upon request about this program. None of the ombudsman work in this program. The remedy is the same for guardianship and the other potential conflicts. if there is an issue that arises, the Ombudsman would be notified and would work with the local ombudsman staff and the host agency to remedy the situation.
Provides guardianship, fiduciary, or surrogate decision-making services	Both State and Local	All counties have guardianship programs for older adults. The local representatives of the office do not provide these services. In several counties, the guardianship case manager and the ombudsmen both report directly to the AAA director. If there is an issue that arises another manager and the Ombudsman would work with the host agency and local ombudsman and guardianship case manager to resolve the issue. In at least one county, the guardianship program is in a different division in the local Dept. of Aging. Consequently, the ombudsman and guardianship case manager report to different staff members. In several counties, the guardianship manager and the ombudsmen have different supervisors. For all situations, the Ombudsmen, local ombudsmen, and the host agency would work to resolve any issue that would arise. For the state conflict: Provides long- term care coordination or case management for residents of long-term care facilities, makes decisions related to admission or discharge for long-term care and provides guardianship because the MDoA Secretary can be appointed as a guardian for an individual. At this time, no one receives guardianship services from MDoA. The local offices do have guardianship clients. If an issue arises and cannot be resolved related to an individual that has a MDoA guardian, the remedy for this potential conflict is that the guardianship case manager reports to a different supervisor than the Ombudsman. If legal counsel is needed, the Ombudsman and the guardianship case manager would have different staff from the Maryland Attorney General Office appointed.

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Staff and Volunteers

Office of State Ombudsman Staff

Total staff	3	
Total full-time equivalent (FTE)	3	
Total state volunteer representatives	1	
Total hours donated by state volunteers representatives	20	Hours
Total other volunteers (not representatives)	0	

Local Ombudsman Entity Staff

Total staff	41	
Total full-time equivalent (FTE)	35	
Total local volunteer representatives	48	
Total hours donated by local volunteer representatives	4,336	Hours
Total local volunteers (not representatives)	19	

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Funds Expended

Funds Expended from OAA Sources

Federal - OAA Title VII, Chapter 2, Ombudsman	$330,799
Federal - OAA Title VII, Chapter 3	$75,800
OAA Title III - State level	$125,000
OAA Title III - AAA level	$325,994
Other Federal Sources	
There are no other Federal sources	
Total other Federal funds expended	
Other State Sources	
There are no other State sources	
Total other State funds expended	$1,153,493
Other Local Sources	
There are no other Local sources	
Total other Local funds expended	$1,137,249

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Facility - Number and Capacity

Licensed Nursing Facilities

Total number	227
Total resident capacity	27956

Residential Care Communities

Total number	1756
Total resident capacity	25784

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Facility - Residential Care Community Information

RCC type	RCC type definition	Minimum RCC capacity	Maximum RCC capacity
assisted living	assisted living	2	

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Program Activities

Certifications and Training

Certification training hours	40	Hours
Training hours required to maintain certification	20	Hours
Number of new individuals completing certification training	11	

Ombudsman Program Activities

Information and assistance to individuals	9232
Community education	73

Ombudsman Program Activities - Facilities

Activity	Nursing Facility	Residential Care Community
Training sessions for facility staff	13	0
Information and assistance to staff	3181	3653
Number of facilities that received one or more visits	186	521
Number of visits for all facilities	827	843
Number of facilities that received routine access	1	0
Total participation in facility survey	156	19
Resident council participation	99	29
Family council participation	34	16

State and Local Level Coordination Activities

Area agency on aging programs, Aging and disability resource centers, Adult protective services programs, Protection and advocacy systems, Facility and long-term care provider licensure and certification programs, The State Medicaid fraud control unit, Victim assistance programs, State and local law enforcement agencies, Courts of competent jurisdiction, The State legal assistance developer and legal assistance programs, Centers for Independent Living

Other Coordination Activities

Maryland also works with disease specific organizations like the Alzheimer's Association and other stakeholders.,
Work with Provider Groups and Professional Organizations such as Leading Age and the Maryland Chapter of the National Association of Social Workers.,
Work with other state agencies such as the Behavioral Health Administration, Department of Disabilities, and Department of Health

Describe any state or local level coordination and leadership activities with the entities listed, as applicable.

Case work, committee work, work on laws, policies and initiatives, presentations and training, individual advocacy, Stakeholder's Groups, Councils, and Commissions, and other types of coordinated systemic advocacy