



for your INFORMATION

Friends Of Residents In Long Term Care Newsletter

Winter 2005

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Issue One

in this
ISSUE

2005 Short and Long Term Advocacy Goals
Page 1

First Fall Fun Fling Fundraiser a Success
Page 3

Words from the Board Chair
Page 4

Medicaid Alert
Page 4

Better Jobs/ Better Care
Page 5

October & December 2004 Penalty Review Committee Actions
Pages 5-10

Contributions Oct. 2004 - Jan. 2005
Page 11

2005 Short and Long Term Advocacy Goals

In the January meeting of the Board of Directors the following short and long term advocacy goals were adopted for Friends of Residents in Long Term Care:

I. CONSUMER CHOICE/NO INSTITUTIONAL BIAS

• Consumer choice

- o Remove limits for the Community Alternative Programs (CAP) and in-home assistance; consumers should not be forced into an institution because CAP slots are not available.
- o Maximize non-institutional options.

• Funding Streams

- o Expand Home and Community Care Block Grant (HCCBG) to encompass individuals who are close to Medicaid eligible, but not currently eligible.
- o Expand Community Alternative Programs for Disabled Adults (CAP/DA).
- o Expand in-home care/Special Assistance (SA).
- o Expand Medicaid outside of a waiver program to include adult day health as a regularly covered service without having to be eligible for CAP/DA.
- o Expand eligibility for Medicaid-funded personal care to individuals in adult day care.

• Institute pre-admission screening.

- o Mandate pre-admission screening for both full pay and Medicaid before a resident enters a long term care facility.
- o Require financial screenings to be conducted initially by a qualified independent reviewer. If it is determined that maintaining an individual in his/her home exceeds the cost of institutional care, then screening would be terminated.

• Develop an adequate core set of services for the elderly in each county.

- o Implement a core services plan developed by the Division of Aging and Adult Services in the Department of Health and Human Services.
- o Ensure adequate funding to implement the core services plan.

• Make complete information available on line about facilities, facilities' ownership, performance audits, and violations/penalties within 30 days after staff in the Department of Health and Human Services becomes aware of such information.

II. ENFORCEMENT/MONITORING

- Keep monitoring of adult care homes at the local level.
- Develop minimum staffing and training and maximum workload standards for adult homes specialists.
- Develop and implement a system for rated licenses for nursing homes and adult care homes.
- Develop and implement performance-based reimbursement reform for adult care homes.

The mission of Friends of Residents in Long Term Care is to promote the highest quality of life for those who cannot live independently, and for those who care for them.

- **Enforce laws related to accountability/transparency in the use of Medicaid funds.**
 - o Ensure the institution of biannual audits of adult care homes conducted by the State Auditor and include the financial implications of related enterprises operated by the same corporation that operates the facility.
 - o Ensure the development of objective cost models for adult care homes that determine actual cost of care and the development of reimbursement models based on the cost models.
- **Require each county's office of emergency services to develop an emergency/disaster plan for special medical needs populations residing in the county, whether located in long term care facilities or at home.**
- **Fund and use the current temporary management law.**
- **Require the Division of Facility Services to deny a license to homes that are part of chains with persistent problems of noncompliance and inadequate care.**

III. STAFFING

- **Require adequate staff training based on individual resident needs.**
- **Provide adequate pay and health insurance for direct care staff to increase retention and improve quality of care.**
- **Improve staff-to-resident ratio.**
 - o Base staff-to-resident ratio on resident assessment.
 - o Increase minimum staffing requirements to provide sufficient staff to meet the needs of residents.
- **Mandate drug testing for all long term care employees in an effort to reduce medication errors and drug diversions.**
- **Improve staff working conditions to include limiting the number of consecutive hours worked by registered and licensed nurses, medication technicians, and certified nursing aides/assistants.**

IV. MIXED POPULATIONS

- **Meet adequately the needs of medically diverse populations in appropriate settings and appropriate groupings through appropriate reimbursement structures, resulting in adequate assessment, diversion, and specialized services for such populations.**
- **Address the need for mental health facilities for those who cannot live at home.**
 - o When a person's mental health needs override physical care needs, the person should be served in settings licensed by G.S. 122-C, administered through the State Mental Health Commission.
 - o When a person's physical care needs override mental health needs, an adult care home or nursing home should serve that person.
 - o To meet the needs of aggressive persons or sexual offenders, a Pre-Admission Screening and Resident Review (PASARR)-type evaluation should be conducted to determine how best to meet that person's needs.
- **Define clearly the meaning and operation of special care units.**
 - o Where locked units or groupings of patients with Alzheimer's or related dementias exist, require that the locked units be deemed special care units so that all such units will be required to have enhanced staffing, training, and activities to meet the needs of the residents.
 - o Use Medicaid and Special Assistance funding to improve the reimbursement structure for those units that meet the higher standards, thus enhancing the safety and health of residents, increasing staffing, and improving availability.

FORLTC will use these public policy goals to drive our legislative priorities and to focus our advocacy efforts. If you are interested in working on these goals or participating on our public policy committee, contact the FORLTC office.

For Your Information

The newsletter of Friends of Residents in Long Term Care

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For Your Information is published four times yearly and is a benefit of annual membership in Friends of Residents in Long Term Care.

Hold the Date!

Long Term Care Policy Conference and Advocacy Day
April 18 and 19, 2005
Brownstone Holiday Inn, Raleigh N.C.

Learn about emerging issues in North Carolina; develop your advocacy skills; network with others; meet your legislator; make an impact. This conference will be open to anyone interested in long term care. Registration material will be mailed out in late February/early March. For more information check the Friends of Residents website or call 919-782-1530.

First Fall Fun Fling Fundraiser a Success

Advocating for the frail elderly living in long-term care requires time, commitment and...money. Memberships and donations to Friends of Residents in Long Term Care are not enough to keep the organization and its goals moving forward, so in Spring 2004 a group of Friends members met and created a new fundraiser called "Fall Fun Fling for Friends, " or in shorthand, "F5." This event raised over \$15,000 while raising awareness of FORLTC's education and advocacy programs and services.

Comprising the committee were Charlene Reidel-Leo, Sharon Wilder, Helen Savage, Beverley Wheeler, Jeanne Lawson, and June Brotherton. Meeting during evenings to allow participation from members scattered across the state, this group brought the event together in just six months. Tickets were sold by FORLTC members and board members, by other advocates for the elderly, and through a series of non-profit opportunities at local malls and stores.

Held Friday, November 5 at the NC University Club, the Fall Fun Fling brought advocates for the frail elderly together with donors of goods and services for an evening of fun and prizes. Bill Gaines, news anchor for NCN-TV 17, the local NBC affiliate, was master of ceremonies for the event, adding humor and providing information about FORLTC advocacy activities as he announced all drawing and silent auction winners.

Key to F5 was a drawing for three great prizes – a \$1000 shopping spree at Lowe's Home Improvement won by Cheryl Young, a \$500 shopping spree at Nordstrom's won by Marge Link, and a pig pickin' for 50 people, valued at \$600 won by Mike Calhoun. To be eligible for the drawing, elderly advocates purchased drawing tickets for \$20 each.

A second component of the F5 event was a silent auction. Merchants, FORLTC board members, and members across the state donated almost 60 prizes. The night of the event, over 200 people sampled heavy hors d'oeuvres and listened to instrumental bluegrass music while vying for the right to purchase the items by viewing them, reading the descriptions and bidding against each other. Needless to say, some healthy rivalries occurred during bidding, leading to increased proceeds for FORLTC's education and advocacy activities.

Examples of prizes donated included a gift certificate for a set of mattresses; signed NC State and Duke basketballs and posters; a weight bench; jewelry; a complete set of antique sterling silver; a piece of Phil Morgan crystalline pottery; tickets to "Handel's Messiah" at Duke and to a production of "Victoria" at NCSU's Center Stage; a get-away weekend at the Capital Sheraton, complete with Caffè Luna gift certificate and event tickets at Meymandi Center; gift certificates for home-baked desserts and gingerbread houses; original artwork; a fresh-cut NC Fraser fir Christmas tree and wreath; a donation of attorney services for a package of services including a will, living will and power of attorney; a SPA Health Club membership; handmade quilts and other crafts; and an array of other gifts (**see website for a complete list of donors and silent auction items**).

"We plan for this event to be an annual one," said Bill Lamb, chair of the FORLTC board. "We hope this event will expand and grow, both in donations of goods and services for the silent auction, as well as in participation by our friends, members, and the public. It is an opportunity to enjoy fun and fellowship while raising money for a cause that is so critical – advocacy for and protection of the rights of frail elders and the disabled living in long-term care facilities."

Words from the Board Chair

By Bill Lamb

Friends of Residents in Long Term Care has completed a very busy year in 2004 in which we achieved a number of legislative goals highlighted by passage of a requirement for a national criminal background check for employees in long-term care facilities. We also completed the writing of a family council manual, coordinated pest management training in cooperation with NCSU, and produced a successful fall celebration event. My thanks go out to all the staff and volunteers who made these achievements possible.

This year, our plate is just as full. We plan to advocate for a comprehensive legislative agenda; produce and distribute the family council manual with support from a trained speakers bureau; cosponsor a long term care policy conference and advocacy event; host other events in the spring and fall to recognize and celebrate best practices in long-term care; continue the pest management training state-wide; develop and provide an orientation to long-term care to aid individuals and families in making informed decisions; continue to produce our newsletter; and respond to the many calls made by the public to our offices. What makes this year different, however, is that we will be managing these activities primarily from our base of volunteers. We begin this year without paid staff. Our Executive Director, June Brotherton, accepted a position with Plants Delight Nursery in November and our Office Manager, Jeanne Lawton, resigned because of family commitments. The Board has decided to recruit a person to help us with development and we have just hired Kirsten Hicks to assist us in fund raising. She will be working half-time in that capacity. We have also renewed our contract with Pat Yancey to act as our lobbyist for our legislative agenda.

For the time being the office is being managed by volunteers. Marlene Chasson has given generously of her time in December and January to assist in our mailings and responding to telephone inquiries. I hope to continue to have regular office coverage, but our situation does entail that messages may not be responded to immediately. If you leave a message, be patient. We are regularly checking; and we are trying to respond as quickly as we can. Do not think that Friends is without resources. We have received two generous grants from the Department of Health and Human Services. One through the Better Jobs/Better Care Partnership will support getting the message out about that initiative and the second through an appropriation from the General Assembly will support our education and outreach initiatives—integrated pest management and the long-term care orientation program. The Board will be looking to recruit staff to help address these functions. I want to express my thanks to all the folks who are helping out as we make this transition in staffing and I want to thank all of our members and supporters for your assistance as we work to promote the highest quality of life for those who cannot live independently and for those who care for them. I am confident that the changes you will see in Friends of Residents in this coming year will strengthen our capacity to address our mission.

Medicaid Alert!

On Monday, February 7, President Bush sent Congress his 2006 budget. In it he proposed approximately \$60 billion in Medicaid cuts to help meet the Administration's target of reducing the federal budget deficit in half by 2009. A substantial proportion of these cuts will directly affect nursing home care. Medicaid is the primary payer for 71 percent of North Carolina's certified nursing facility residents. Any cut in Medicaid funding will have a profound effect on the economic viability of North Carolina's health care system. Contact our Senators and Representatives and let them know your concerns. For additional information on the budget and Medicaid threats, see the following websites:

National Citizens' Coalition for Nursing Home Reform: <http://www.nccnhr.org/>

Families USA: <http://www.familiesusa.org/>

The Center for Community Change: <http://www.communitychange.org/>

The Center on Budget and Policy Priorities: <http://www.cbpp.org/>

North Carolina Senators are considered key persons to contact:

Senator Elizabeth Dole, 202-224-3154

Senator Richard Burr, 202-224-1100

In each office, a real person will answer the phone!

Better Jobs/Better Care

North Carolina is one of five state-based coalitions to receive a Better Jobs/Better Care demonstration grant funded by the Robert Wood Johnson Foundation and Atlantic Philanthropies. A "Partner Team," including Friends of Residents in Long Term Care, has been funded under this grant to develop standards for a special licensure designation to be piloted in 60 sites in 2005. Sites will be divided equally among home care agencies, adult care homes and nursing homes. The purpose of the pilots is to promote practices which positively affect the recruitment, retention and job satisfaction of direct care workers. The intent of the special licensure designation is to provide a basis for labor enhancement funding or a reimbursement incentive which North Carolina might adopt in the future. John Young, a FORLTC board member has been representing FORLTC in the Partner Team deliberations. For additional information about the Better Jobs/Better Care initiative go to <http://www.dhhs.state.nc.us/ltc/bjobcare.htm>. This program will also be highlighted in events sponsored by FORLTC in 2005 and featured in future newsletters.

OCTOBER 2004 PENALTY REVIEW COMMITTEE ACTIONS

<u>Facility/County</u>	<u>DFS Proposed</u>	<u>PRC Approved</u>	<u>Explanation</u>
A Place to Call Home #2 Alamance County	Type B \$3,725	Type B \$3,725	The facility has continually failed to assure that residents received adequate and appropriate care and services. The facility failed to comply with requirements for maintaining furniture in residents' bedrooms and for assuring competent and qualified staff in the facility. These violations directly affected the health safety or welfare of the residents. The facility had obtained no evidence that their staff met requirements for TB testing or qualifications for Health Care Registry. Criminal Records checks or personal care aide training. The facility's continued failure to provide bedroom furniture storage was considered a violation impacting resident welfare.
Carrboro Senior Living Orange County	Type A \$2,000	Type A \$2,000	Based on the findings of a complaint investigation the facility failed to make necessary arrangements for appropriate health care as needed. Resident #1 had physician orders for Home Health Care Agency involvement for daily dressing changes and daily subcutaneous injections of lovenox (anticoagulant) which the facility failed to assure was administered. Resident #2 was hospitalized for dehydration, and order to have HCTZ (diuretic/blood pressure medication) to be discontinued but the facility continued to administer. Resident #2 did not have dietary supplements as ordered. Resident #3 on orders for Depakote and valporic acid levels, did not have these levels taken.
Cherry's Family Care Home #2 Bertie County	Type A \$1,000	Type A \$1,000	Based on the findings of a complaint investigation conducted by Bertie DSS the facility failed to assure all residents received adequate and appropriate care and services. The facility failed to notify the resident's responsible person, the appropriate law enforcement agency and the county department of social services when a resident's whereabouts were unknown. With the resident's diagnoses of Alcohol Abuse, Bi-polar Disorder, Seizure Disorder and Asthma, there was reason to be concerned for the resident's safety. During the time Resident # 1 was missing from the facility this resident was seen in two different hospitals for seizure disorder. The resident's Dilantin levels were documented below therapeutic levels on 4/01/04 and 4/02/04.
Concord Retirement Center Cabarrus County	Type B \$1,800	Type B \$1,800	The facility failed to correct a type "B" violation by the specified correction date. The specified date of correction was 4-15-04 survey. The violation was in the area of Health Care. This represents 18 days past the directed correction date.

Croatian Village Craven County	Type A \$2,000	Type A \$2,000	The facility failed to assist residents when necessary with personal needs that residents may be incapable of or unable to attend for themselves. The county was notified that by a neighbor that a resident was found in the street with her walker. Even though there was no injury the resident was put at risk of danger because she wandered a quarter mile down a secondary road. Residents #1, #2, #3 are documented as being disoriented or wanderers. Only resident #2 had wandering identified in the care plan but included no intervention. Although the exit doors had alarms, the front door alarm was deactivated with no plan of monitoring for the disoriented or wandering residents at that door.
McLean Family Care Home Cumberland County	Type A \$2,000	Type A \$2000	The violation involved the licensee's failure to provide facility staff to perform personal care and supervision to residents during his absence. Based on the observations of DSS during an on-site visit, there were two residents in the facility but no facility staff. Resident #1, diagnosed with shizoffective disorder was being visited by a Community Based Services Worker, not employed by the facility. Resident #2, diagnosed as being constantly disoriented, was also in the facility without facility staff. The DSS determined that the violation placed the residents at substantial risk for serious harm or death.
New Hope Living Center at RTP	Type A \$2,000	Type A \$2,000	The facility failed to assure that there was an adequate supply of food to serve the planned menu, including therapeutic diets. The facility had failed to assure that medication was administered by qualified medication aides at all times. The facility failed to assure that, in the absence of the administrator, there was a qualified administer-in-charge or supervisor-in-charge in the facility or immediately available to be responsible for the total operation of the facility. DSS documented that there was only a personal care aide on duty on 5/06/04 and that medication had not been administered for 8PM on 5/05/04 or 8AM on 5/06/04. Noon medications were administered approximately two hours late on 5/06/04. MAR's indicated that administrations were either not given or not documented during 5/01/04 - 5/06/04. Food supplies were inadequate to serve the planned menus and to meet needs of the therapeutic diet orders. DSS determined that these violations placed residents at substantial risk for serious physical harm or death.
Stone Meadows Family Care Home	Type A \$3,000	Type A \$3,000	The facility failed to assure adequate staff coverage in the absence of the administrator and failed to ensure adequate access to health care. Based on staff interviews residents were left unattended on occasion. Resident #2, after complaining for over 6 weeks of symptoms of increased fluid in legs was, chest pain and shortness of breath, was transported from church via ambulance to the hospital. The resident was diagnosed with multiple arterial blockages. Resident #5 was taken to the emergency room with rectal bleeding on 2/29/04. The resident had missed medical appointments in January and February including a hospital discharge notice instructing a three day follow up with a specialist and two appointments with the eye doctor after recent cataract surgery. The resident had also experienced falls with no medical follow up. Resident #5 was not transported to a medical specialist on at least 5 occasions to discuss treatment of a growing aneurysm. These violations directly contributed to substantial risks for serious harm or death.

A Place to Call Home #2 Alamance County	Type B \$3,725	Type B \$3,725	The facility has continually failed to assure that residents received adequate and appropriate care and services. The facility failed to comply with requirements for maintaining furniture in residents' bedrooms and for assuring competent and qualified staff in the facility. These violations directly affected the health safety or welfare of the residents. The facility had obtained no evidence that their staff met requirements for TB testing or qualifications for Health Care Registry. Criminal Records checks or personal care aide training. The facility's continued failure to provide bedroom furniture storage was considered a violation impacting resident welfare.
Carrboro Senior Living Orange County	Type A \$2,000	Type A \$2,000	Based on the findings of a complaint investigation the facility failed to make necessary arrangements for appropriate health care as needed. Resident #1 had physician orders for Home Health Care Agency involvement for daily dressing changes and daily subcutaneous injections of lovenox (anticoagulant) which the facility failed to assure was administered. Resident #2 was hospitalized for dehydration, and order to have HCTZ (diuretic/blood pressure medication) to be discontinued but the facility continued to administer. Resident #2 did not have dietary supplements as ordered. Resident #3 on orders for Depakote and valporic acid levels, did not have these levels taken.
Cherry's Family Care Home #2 Bertie County	Type A \$1,000	Type A \$1,000	Based on the findings of a complaint investigation conducted by Bertie DSS the facility failed to assure all residents received adequate and appropriate care and services. The facility failed to notify the resident's responsible person, the appropriate law enforcement agency and the county department of social services when a resident's whereabouts were unknown. With the resident's diagnoses of Alcohol Abuse, Bi-polar Disorder, Seizure Disorder and Asthma, there was reason to be concerned for the resident's safety. During the time Resident # 1 was missing from the facility this resident was seen in two different hospitals for seizure disorder. The resident's Dilantin levels were documented below therapeutic levels on 4/01/04 and 4/02/04.
Concord Retirement Center Cabarrus County	Type B \$1,800	Type B \$1,800	The facility failed to correct a type "B" violation by the specified correction date. The specified date of correction was 4-15-04 survey. The violation was in the area of Health Care. This represents 18 days past the directed correction date.
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McLean Family Care Home Cumberland County	Type A \$2,000	Type A \$2,000	The violation involved the licensee's failure to provide facility staff to perform personal care and supervision to residents during his absence. Based on the observations of DSS during an on-site visit, there were two residents in the facility but no facility staff. Resident #1, diagnosed with shizoffective disorder was being visited by a Community Based Services Worker, not employed by the facility. Resident #2, diagnosed as being constantly disoriented, was also in the facility without facility staff. The DSS determined that the violation placed the residents at substantial risk for serious harm or death.

New Hope Living Center at RTP	Type A \$2,000	Type A \$2,000	The facility failed to assure that there was an adequate supply of food to serve the planned menu, including therapeutic diets. The facility had failed to assure that medication was administered by qualified medication aides at all times. The facility failed to assure that, in the absence of the administrator, there was a qualified administrator-in-charge or supervisor-in-charge in the facility or immediately available to be responsible for the total operation of the facility. DSS documented that there was only a personal care aide on duty on 5/06/04 and that medication had not been administered for 8PM on 5/05/04 or 8AM on 5/06/04. Noon medications were administered approximately two hours late on 5/06/04. MAR's indicated that administrations were either not given or not documented during 5/01/04 - 5/06/04. Food supplies were inadequate to serve the planned menus and to meet needs of the therapeutic diet orders. DSS determined that these violations placed residents at substantial risk for serious physical harm or death.
Stone Meadows Family Care Home	Type A \$3,000	Type A \$3,000	The facility failed to assure adequate staff coverage in the absence of the administrator and failed to ensure adequate access to health care. Based on staff interviews residents were left unattended on occasion. Resident #2,, after complaining for over 6 weeks of symptoms of increased fluid in legs was, chest pain and shortness of breath, was transported from church via ambulance to the hospital. The resident was diagnosed with multiple arterial blockages. Resident #5 was taken to the emergency room with rectal bleeding on 2/29/04. The resident had missed medical appointments in January and February including a hospital discharge notice instructing a three day follow up with a specialist and two appointments with the eye doctor after recent cataract surgery. The resident had also experienced falls with no medical follow up. Resident #5 was not transported to a medical specialist on at least 5 occasions to discuss treatment of a growing aneurysm. These violations directly contributed to substantial risks for serious harm or death.

DECEMBER 2004 PENALTY REVIEW COMMITTEE ACTIONS

<u>Facility/County</u>	<u>DFS Proposed</u>	<u>PRC Approved</u>	<u>Explanation</u>
Autumn Green Adult Care Home	Type B \$1,850	Type B \$1,850	According to information from the Health Care Personnel Registry, Patricia Tiller, live-in-administrator and care-giver was listed with one substantiated finding of Neglect of a Resident, entered on 4/04/03. Another finding was substantiated for misappropriation of a resident's property on or about May 22, 2003. Wake DSS determined that the violation directly affected the health, safety and welfare of the residents and issued a Type B Directed Plan of Correction directing the administrator to employ staff other than Ms. Tiller for responsibilities for carrying out the work of the family care home. The facility failed to implement any corrective measures. Instead, prior to the issuance of any negative sanctions from either DSS or DFS, Ms. Tiller filed petition for a contested case hearing and filed complaint for a restraining order against both agencies. At this time, the petitions have not been heard or dismissed. As of the last documented monitoring visit conducted on 8/24/04 by Wake DSS, Ms. Tiller continued to staff the facility.

Champions Assisted Living New Hanover County	Type A \$3,000	Type A \$3,000	The facility failed to provide adequate supervision to prevent elopement of two of seven residents with a diagnosis of Dementia/Cognitive Decline and failed to implement the facility's elopement policy and procedures when Resident #1 and Resident #3 identified as wanderers, left the facility. One resident, with a history of elopement and living in the special care unit, was permitted to walk around the facility outside the special care unit unsupervised. The other resident was seen going outside of the facility unsupervised, but no action was taken. The facility is located where traffic is heavy and dangerous. These violations created substantial risk for serious harm or death.
Dayspring Assisted Living of Burgaw Proposal # 1 Pender County	Type B \$6,350	Type B \$6,350	The facility failed to assure that staff who administered medications successfully completed clinical skills' validation prior to administration of medications. The facility failed to ensure contact with the resident's physician or prescribing practitioner for verification or clarification of orders for medications or treatments and failed to assure that staff administered medications as ordered. The facility failed to assure that hot water temperatures at fixtures used by residents were maintained abetween 100 degrees F and 116 degrees F.
Dayspring Assisted Living of Burgaw Proposal # 2 Pender County	Type A \$1,000	Type A \$1,000	The facility failed to assure the provision of transportation to appropriate health facilities or make arrangements for appropriate health care to enable the resident to be in the best possible health condition. Based on the investigation six of six residents had missed seven scheduled physician appointments from 5/11/04 to 5/20/04. Of these, resident #19's diagnoses include history of brain injury, hypertension, obesity, hyperlipidemia, urinary incontinence, and constipation. The resident was seen by the primary physician on 5/17/04 for left leg swelling and pain and was referred to have a Venous Duplex Ultrasound test on 5/20/04 to confirm or rule out a deep vein thrombus. The facility had no staff to provide the necessary transportation and rescheduled for 6/07/04 without notifying the primary physician. This created potential for significant risk of death or serious harm for Resident #19.
G. Anthony Rucker Rest Home	Type A \$2,000	Type A \$2,000	The facility failed to ensure that, prior to administering medications or treatments, there was verification or clarification of physician orders. The facility also failed to document medications as administered on the medication administration record. Resident #3 was diagnosed with vascular dementia, acute delirium, major depression and psychotic features according to a current FI-2 dated 12/15/03, On 5/15/04, facility staff administered narcotic skin patches to Resident #3 on five body areas without appropriate physician orders and without documentation that these narcotic patches were administered. Resident #3 had been assessed by the facility with decubitus ulcers to those areas and according to staff interview, the administrator had purchased Curad Telfa pads to treat the areas prior to obtaining a physician appointment. Instead Duragesic 25mcg foil packets were administered. Upon admission to the hospital, the resident was noted by emergency room staff to be "virtually unresponsive" and in an altered mental state. Resident #3 was admitted to the hospital and monitored for four days, then discharged to a skilled nursing home

<p>The Oasis of Four Oaks Johnson County</p>	<p>Type A \$4,000</p>	<p>Type A \$4,000</p>	<p>Resident #74, #82, #9, #83,#36 #46, #61 and #85 did not receive coordination of care between the facility,,, the contracted mental health services, and the medical physicians. The facility had 69 of 102 residents with mental illness diagnoses, including schizophrenia, bipolar disorder, psychosis disorders, mild and severe retardation, and alcohol /drug abuse. The sampled eight of the eleven residents were diagnosed with mental illness or substance abuse. These residents exhibited significant behaviors that included confrontation, threatening outbursts, hallucinations, substance abuse, drug overdose, or suicide attempts during the time period investigated. There were no staff interventions for these behaviors or coordination with health providers. These violations placed these residents at increased risk for serious physical harm or death. Residents #36 and #46 had made suicide attempts. Based on staff interviews, the administrator had physically and mentally abused residents over a period of time, with increased frequency since January 2004.</p>
<p>Soul Family Care Home Buncombe County</p>	<p>Type A \$1,000</p>	<p>Type A \$1,000</p>	<p>According to an investigation by the Buncombe County DSS, the facility failed to assure that staff was in the facility at all times to provide all required duties. In addition, the facility failed to administer medications within one hour before or after the prescribed or scheduled time and to assure that each resident is served at least three nutritionally adequate meals per day at regular hours. This placed residents at risk by not receiving their scheduled evening meal and PRN medications.</p>
<p>The Meadows of Garner</p>	<p>Type A \$2,000</p>	<p>Type A \$5,000</p>	<p>According to Wake DSS during April and May, 2004 the facility failed to provide adequate supervision when Resident A was discovered to be missing from the facility between 4/19/04 and 4/20/04. Based on staff interviews conducted by the administrator and the police, staff determined that Resident A was last seen at approximately 10:45 pm on 4/19/04 but was not considered missing until approximately 8:00 am on 4/20/04. At that point a search was conducted and the police contacted. Resident A's diagnoses included schizophrenia, mental retardation, coronary artery disease, history of congestive heart failure, history of ventricular arthritis, pacemaker with chronic pain at site, and GERD. Additionally, Resident A had been adjudicated incompetent and had a general guardian appointed. The facility's failure to conduct routine supervision based on residents' needs, placed Resident A at increased substantial risk for death or serious physical harm.</p>
<p>Zollieville Rest Home #2 Franklin County</p>	<p>Type A \$2,000</p>	<p>Type A \$2,000</p>	<p>Assessments were not completed for all residents following a significant change in the residents condition. For restrained residents, requirements were not followed regarding appropriate restraint checks and releases. Resident # 13 was not positioned correctly, or checked and released according to requirements. Upon further direct observation of Resident #13, this resident had experienced skin breakdown. Three pressure ulcers had developed on the resident's buttocks ranging from Stage 1 to II-III. The resident was diabetic, non ambulatory, incontinent of bowel and bladder, restrained in a geri-chair on a daily basis and had a recent history of pressure ulcers. Residents #8,#10,#13, #15,and #23 were restrained daily. Facility records for all five of these residents contained incomplete documentation of staff providing required monitoring and positioning. Resident #13 had experienced a significant change that went unevaluated. These violations created substantial risk of serious harm or death.</p>

**Contributions from
Oct. 2004 – Jan. 2005**

Thank you to these contributors
for helping continue our
mission!

SUPER FRIENDS

(\$1,000 for three years)

Anonymous

Blanchard, Jenkins,
Miller, Lewis & Steller

Steve Guggenheim

BENEFACTOR

(\$1,000 - \$2999)

Blue Cross Blue Shield

PATRON

(\$500 - 999)

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(\$100 - 249)

Linda Allison

Lanier and Fred Blum

Val and Jerry Cooper

Anne Dahl

Laura Drey

Yvonne Eaves

Laurence Graham

Thomas Henson

Bertha Holt

Alfred Keyes

Troy Lenderking

Rebecca Leonard

Evelyn Reiman

Leigh Phillips

Christina Shafale

Dierdre Shore

Cheryl Theriault/Aging Family
Services

Suzanna Winters

IN HONOR OF

Marlene and Al Chasson

By Robert and Sally Buckner
Ann Dahle

Doris and Tom Henderson

By Martha Henderson

Ann Tunstall

By Laura Drey

Nellie T. Tolbert

By Carolyn Jordon

Mr. and Mrs. Gregg Penland

By Annie Louise Wilkerson, MD

IN MEMORY OF

Rose Scannage

By Gwen Jackson

Maria Wynne

By Jim and Susan Annas
Diane Atkinson
Marlene Chasson
Steve B. Davis and family
Charlie and Marjorie Turner

**NEW & RENEWING
MEMBERS**

Frank Abrams

Susan Annas

Joseph Anderson

P. Bryan Averette

Vickie Barfield

Mary Bethel

James & Carolyn Bland

Laurel Boyles

Mac Brownlee

Jeanne Browder

Sally Buckner

Dawn Byrd

Jack Clifford

Marion Crenshaw

Dana Courtney

Barbara DeBerry

Representative Beverly Earle

Yvonne D. Eaves

Marjorie Eckels

Michiele Elliott

Jennifer M. Ellis

Stacy Flannery

Luella Graves

Spike Graham

Aurora Gregory

Mr. and Mrs. Richard Hatch

Martha Henderson

Jennifer Hoffman

Lucile Isenhour

Jacqueline Jackson

Carolyn Jordan

Martha LeFebvre

Rebecca Leonard

Paul Luebke & Carol Gallione

Alice Mahy

Dr. A. Helen Martikainen

Jane Maynard

Jean Newman

Deborah E. Davis-Noell

Janet O'Keefe

Tha Jane Park

Joan M. Pellettier

John Piaski

Hoyt Ponder

Sarah Ratchford

Evelyn Reiman

Denise Rogers

Judy Rosser

Anne Schmitt

Donald Shaffer

Deirdre M. Shore

Pam Silberman

Emmett Y Stafford

Charles Stone

Phillip Sloane

Mary Fran and Darrell Spencer

Lloyd Steen

Christine O'Conner Trottier

Elizabeth Turk

Arnold Valdmets

Kaye White

Sharon Wilder

Susanna Winters

Linda Zittel