



Nursing Home Community Advisory Committee Handbook

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SECTION I

**The Nursing Home
Community Advisory
Committee**

Nursing Home Community Advisory Committee

A. Purpose

Nursing home residents in the United States are a particularly vulnerable population and are often too frail, sick, isolated, or reluctant to assert their own rights. As a result, in 1977 Congress took action to establish the Nursing Home Residents' Bill of Rights and required the establishment of a Long Term Care Ombudsman Program in each state, that same year.

The NC General Assembly enacted a comprehensive Bill of Rights which also established a Nursing Home Community Advisory Committee in every county that has a nursing home. The committee's primary function is to maintain the spirit of the North Carolina Nursing Home Residents' Bill of Rights. The purpose of this law is to involve the local community, through this volunteer citizens group, in an effort to improve the quality of care for nursing home residents. A major responsibility of advisory committees is to monitor nursing home care and resolve grievances of nursing home residents and their families involving quality of care issues. An equally important role of these committees is to serve as the catalyst for increased community interaction with nursing homes and to promote better community education and awareness of issues affecting the residents. This includes working cooperatively with facility administrators and staff, as well as those local agencies and organizations that have an impact on nursing homes and their residents. A similar committee, the Adult Care Home Community Advisory Committee, serves the residents of adult care homes.

The work conducted by the community advisory committees enables them to obtain firsthand knowledge of conditions in nursing homes. This focus allows the committees to work toward improving the quality of care for nursing home residents. Although, the committees maintain a community focus, the committees' experiences and efforts are tied to the broader statewide network of the Long Term Care Ombudsman Program.

In addition to over 1,100 nursing and adult care home community advisory committee members statewide, there are regional long term care ombudsmen housed within the area agencies on aging

who serve all 100 counties in North Carolina. The State Long Term Care Ombudsman's Office is housed within the Division of Aging and Adult Services. The Office includes the State Long Term Care Ombudsman who is responsible for administration and supervision of the Program statewide. This network of advocates at the state, regional and community level work to improve the quality of care and the quality of life for residents in long term care facilities.

B. Statutory Requirements – G.S. 131E-128

1. Committee Appointments

a. Role of county commissioners

Boards of county commissioners have been given the responsibility for appointing Nursing Home Community Advisory Committee members. This is an important role since the effectiveness of a committee depends largely on its members.

The legislation that mandates these committees stipulates certain criteria which must be adhered to in the appointment of committee members:

- (1) Each county that has a nursing home must establish a community advisory committee. The number of nursing homes in the county determines the number of persons on a committee. In a county with three nursing homes or less, the committee shall have five (5) members. In a county with four (4) or more nursing homes, the committee shall have one additional member for each nursing home in excess of three, and may have up to five additional members appointed at the discretion of the county commissioners.
- (2) In a county with four (4) or more nursing homes, the committee shall establish a subcommittee of no more than five (5) and no less than (3) members. Each member must serve on at least one subcommittee.
- (3) The county commissioners must choose not less than one third, but as close to one-third as possible, of the committee members from among persons nominated by a majority of the chief nursing home administrators in the county (a chief nursing home administrator is the administrator having the recognized responsibility for the operation of a home). If nursing home

administrators fail to make a nomination within 45 days after written notification has been sent to them by the county commissioners requesting a nomination, such appointments may be made by the county commissioners without nominations.

(* **Note:** *Councils on aging and other agencies, groups, and organizations that have an impact on the elderly should be contacted for suggestions concerning the remaining committee member nominations.*)

- (4) The following persons are excluded by legislation from serving on the committee:
- (a) Persons or immediate family members of persons with a financial interest in a home served by a committee.
 - (b) An employee or governing board member or immediate family member of an employee or governing board member of a home served by a committee. (A person paid by a home as a consultant is considered an employee).
 - (c) The immediate family member of a resident in a home served by a committee.

(* **Note:** *An "immediate family member" is defined as mother, father, sister, brother, spouse, child, grandmother, grandfather, and in-laws of the above. Whenever an immediate family member of an appointee enters a facility served by the committee, that appointee automatically becomes ineligible to serve on the committee.*)

- (5) Any county commissioner who is appointed to the committee shall be deemed to be serving on the committee in an ex-officio capacity.
- (6) Each committee member must be a resident of the county which the committee serves.
- (7) Each committee member shall serve an initial term of one year (the term begins with date of appointment). Any person re-appointed to a second or subsequent term in the same county shall serve a three-year term. In regard to re-appointments for second or subsequent terms, persons who were originally nominees of nursing home chief administrators, or who were appointed by the county commissioners when the nursing home administrators failed to make nomination, may not be reappointed

without the consent of a majority of the nursing home chief administrators within the county. If the nursing home chief administrators fail to approve or reject the re-appointments within 45 days of being requested by the County Commissioners, the Commissioners may re-appoint the members if they so choose.

- (8) Vacancies on the committee shall be filled by appointment of a person for a one-year term. Any person replacing a member nominated by the chief nursing home administrators or a person appointed when the chief administrators failed to make a nomination shall be selected from among persons nominated by the administrators.
- (9) If the county commissioners fail to appoint members to a committee, or fail to fill a vacancy, the appointment may be made or vacancy filled by the Secretary or the Secretary's designee no sooner than 45 days after the commissioners have been notified of the appointment or vacancy if nomination or approval of the nursing home administrators and the governing bodies of the hospitals licensed under Article 5 of G.S. Chapter 131E, which operate nursing homes is not required. If nominations or approval of the nursing home administrators and the governing bodies of the hospitals licensed under Article 5 of G.S. Chapter 131E, which operate nursing homes is required, the appointment may be made or vacancy filled by the Secretary or the Secretary's designee no sooner than 45 days after the commissioners have received the nomination or approval, or no sooner than 45 days after the 45-day period for action by the nursing home administrators and the governing bodies of the hospitals licensed under Article 5 of G.S. Chapter 131E, which operate nursing homes.

b. Additional Guidelines

- (1) Special care should be taken to see that persons with the interest, the time, and knowledge of nursing home matters are selected to serve on the committee. To the extent possible, committees should be composed of persons that represent a wide range of backgrounds, including those with interest in the concerns of older adults, demonstrated involvement in the community, and a willingness to serve.
- (2) The committee shall elect from its members a chairman and other officers, as needed, to serve a one-year term. The committee should adopt by-laws to facilitate functions of the committee.

- (3) Members of the committee shall serve without compensation, but may be reimbursed for the actual expenses incurred by them in the performance of their duties from local funds. The level of reimbursement and the funding must be set by the County Commissioners.
- (4) A list of the committee members, including addresses and indication of members who are nominees of the chief nursing home administrators, along with dates of expiration of the members' terms, shall be filed by regional ombudsmen with the State's Division of Aging and Adult Services.
- (5) Each committee member must receive training as specified by the State's Division of Aging and Adult Services prior to exercising any duties and responsibilities. This training will be provided by regional long term care ombudsmen with assistance from other appropriate and available resources such as local departments of social services, health departments, mental health, and nursing home staff.

2. Role of Committee Members

a. Duties

- (1) Each committee shall apprise itself of the general conditions under which the residents are living in the homes, and shall work for the best interests of the residents. This may include assisting persons who have grievances with the home and facilitating the resolution of grievances at the local level.
- (2) At a minimum, each committee shall quarterly visit the nursing home(s) it serves. For each official quarterly visit, a majority of the committee members shall be present. This visit should normally be made between the hours of 10 am and 8 pm. In addition, each committee may visit the nursing home(s) it serves whenever it deems it necessary to carry out its duties. In counties with four or more nursing homes, the subcommittee assigned to a home shall perform the duties of the committee under this subdivision, and a majority of the sub-committee members must be present for any visit.
- (3) Each individual member of a committee shall have the right between 10 am and 8 pm to enter into the facility the committee serves, in order to carry out the members' responsibilities. In a county where subcommittees have been established, this right of access shall be limited

to particular homes served by the subcommittee to which the member has been appointed.

- (4) The committee or subcommittee may communicate through its chairman with the NC Department of Health and Human Services or any other agency in relation to the interest of any resident. The names of all complaining persons and residents shall remain confidential unless written permission is given for disclosure.
- (5) Each home shall cooperate with the committee as it carries out its duties.
- (6) Before entering into any nursing home, the committee, subcommittee, or member shall identify him/herself to the person present at the facility who is in charge of the facility at that time.

b. Confidentiality

Sec. 712 (5) (C) iii) of the Older Americans Act requires that the State must establish procedures to protect the confidentiality of residents' records and the identity of the complainant and/or resident. Ombudsman files are kept confidential with disclosure only at the discretion of the State Ombudsman or the person designated by the State Ombudsman to disclose files and records. The ombudsman's "discretion" does not include the right to disclose the name of a complainant or resident without the written permission by the complainant or resident or his legal representative, the complainant or the resident's oral consent which is documented contemporaneously in accord with state policy or as required by court order. North Carolina law also stipulates that the committees observe the same confidentiality requirements.

c. Open Meetings Law

The NC Open Meetings Law applies to NHCAC meetings; therefore, anyone from the general public may attend. If the committee needs to discuss an individual resident and/or complaint during a meeting where others are present, the committee must go into executive session (committee members and ombudsman only), in order to comply with the confidentiality requirement.

d. Access to Information

- (1) **Records:** Under special circumstances involving specific complaint investigations, committees may need to view a resident's personal and/or medical records. In order to view such records, several conditions must be met. The committee is permitted access to the records if: (a) they have the permission

of the resident or the legal representative of the resident; or (b) if the resident is unable to consent to the review and has no legal representative; or (c) access to the records is necessary to investigate a complaint, and a legal guardian of the resident refuses to give the permission, and the committee has reasonable cause to believe that the guardian is not acting in the best interests of the resident; and the committee receives the approval of the State Ombudsman.

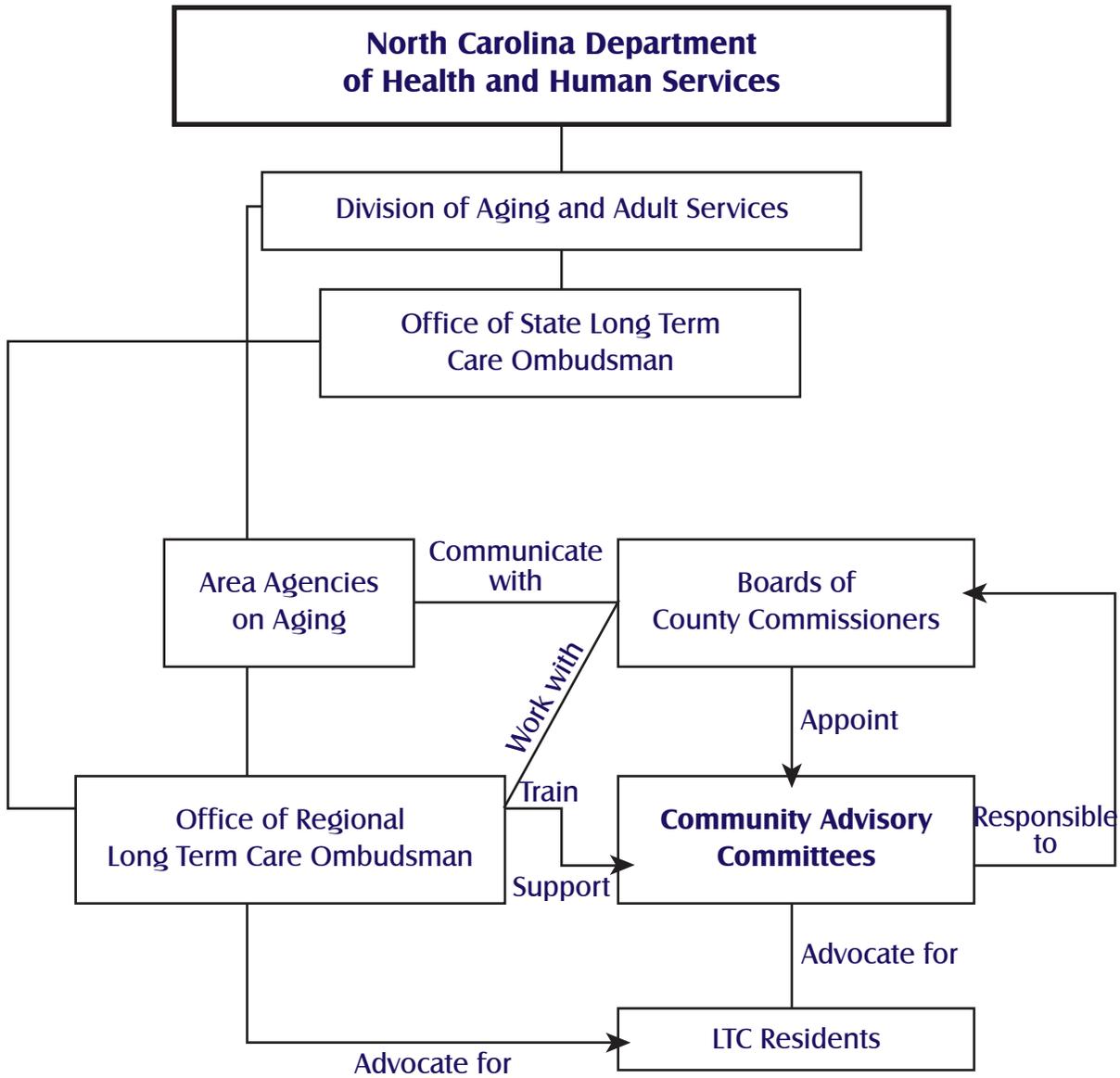
- (2) **Facilities:** The Nursing Home Community Advisory Committees have access to facilities on a 24-hour basis. Any member may enter a facility he/she serves between the hours of 10 am and 8 pm. A quorum of the committee or designated subcommittee may enter at any time necessary to carry out its duties.

e. Committee Support Network

In addition to the support of the regional ombudsman, one or more agencies may be identified in each county to provide local back up. In those counties with an organized aging program or council on aging, it is hoped this agency will assume this responsibility. In cases where there is no council on aging or it is not feasible for the council to assume this role, the ombudsman will coordinate with other agencies such as the local department of social services, or the mental health program, to provide support. The support provided by local back-up agencies will vary from county to county; however, it is hoped that each agency will serve as a point of contact for requests of information and for complaints regarding nursing home matters. Since community advisory committee members receive no compensation for their services, it may not always be practical to have their private telephone numbers made available to the general public. Agencies, such as councils on aging, that have established public telephone numbers could provide this service by utilizing their existing staff to handle information and referral functions. Complaints or other appropriate matters would be referred by the agency to the advisory committee through its chairperson. Other ways in which the local agency(ies) can be supportive are:

- To assist the advisory committee in publicizing the needs of the institutionalized elderly and the role of the nursing home in the health care delivery system.
- To keep abreast of issues affecting long term care in order to provide current and relevant information to committees.
- To assist the advisory committee in coordinating with local agencies and organizations when needed to carry out their job functions.
- To assist the advisory committee in promoting increased community involvement with nursing homes in the area.

Community Advisory Committee Organizational Diagram



SECTION II

**The Patients'
Bill of Rights**

General Statutes of North Carolina

Chapter 131E. Health Care Facilities and Services

Article 6

Health Care Facility Licensure Act

Part B. Nursing Home Patients' Bill of Rights

G.S. 131E-115. Legislative intent.

It is the intent of the General Assembly to promote the interest and well-being of the patients in nursing homes and adult care homes licensed pursuant to G.S. 131E-102, and patients in a nursing home operated by a hospital which is licensed under Article 5 of Chapter 131E of the General statutes. It is the intent of the General Assembly that every patient's civil and religious liberties, including the right to independent personal decisions and knowledge of available choices, shall not be infringed and that the facility shall encourage and assist the patient in the fullest possible exercise of these rights. (1977, c. 897, s. 1; 1983, c. 143, s.2; c.775, s. 1; 1995, c. 509, s. 72; c. 535, s. 25.)

G.S. 131E-116. Definitions.

As used in this Part, unless otherwise specified:

- (1) "Administrator" means an administrator of a facility.
- (1a) "Commission" means the North Carolina Medical Commission.
- (2) "Facility" means a nursing home and a home for the aged or disabled licensed pursuant to G.S. 131E-102, and also means a nursing home operated by a hospital which is licensed under Article 5 of G.S. Chapter 131E.
- (3) "Patient" means a person who has been admitted to a facility.
- (4) "Representative payee" means a person certified by the federal government to receive and disburse benefits for a recipient of governmental assistance. (1977, c. 897, s. 1.; 1983, c. 143, s. 1.; c. 775, s. 1; 1993, c. 499, s. 1.)

G.S. 131E-117. Declaration of patients' rights.

All facilities shall treat their patients in accordance with the provisions of this Part. Every patient shall have the following rights:

- (1) To be treated with consideration, respect, and full recognition of personal dignity and individuality;
- (2) To receive care, treatment and services which are adequate, appropriate, and in compliance with relevant federal and State statutes and rules;
- (3) To receive at the time of admission and during the stay, a written statement of the services provided by the facility, including those required to be offered on an as-needed basis, and of related charges. Charges for services not covered under Medicare or Medicaid shall be specified. Upon receiving this statement, the patient shall sign a written receipt which must be on file in the facility and available for inspection.
- (4) To have on file in the patient's record a written or verbal order of the attending physician containing any information as the attending physician deems appropriate or necessary, together with the proposed schedule of medical treatment. The patient shall give prior informed consent to participation in experimental research. Written evidence of compliance with this subdivision, including signed acknowledgments by the patient, shall be retained by the facility in the patient's file;
- (5) To receive respect and privacy in the patient's medical care program. Case discussion consultation, examination, and treatment shall remain confidential and shall be conducted discreetly. Personal and medical records shall be confidential and the written consent of the patient shall be obtained for their release to any individual, other than family members, except as needed in case of the patient's transfer to another health care institution or as required by law or third party payment contract;
- (6) To be free from mental and physical abuse and, except in emergencies, to be free from chemical and physical restraints unless authorized for a specified period of time by a physician according to clear and indicated medical need;
- (7) To receive from the administrator or staff of the facility a reasonable response to all requests;
- (8) To associate and communicate privately and without restriction with persons and groups of the patient's choice on the patient's initiative or that of the persons or groups at any reasonable hour; to send and receive mail promptly and

- unopened, unless the patient is unable to open and read personal mail; to have access at any reasonable hour to a telephone where the patient may speak privately; and to have access to writing instruments, stationery, and postage;
- (9) To manage the patient's financial affairs unless authority has been delegated to another pursuant to a power of attorney, or written agreement, or some other person or agency has been appointed for this purpose pursuant to law. Nothing shall prevent the patient and facility from entering a written agreement for the facility to manage the patient's financial affairs. In the event that the facility manages the patient's financial affairs, it shall have an accounting available for inspection and shall furnish the patient with a quarterly statement of the patient's account. The patient shall have reasonable access to this account at reasonable hours; the patient or facility may terminate the agreement for the facility to manage the patient's financial affairs at any time upon five days' notice;
 - (10) To enjoy privacy in visits by the patient's spouse, and, if both are inpatients of the facility, they shall be afforded the opportunity where feasible to share a room;
 - (11) To enjoy privacy in the patient's room;
 - (12) To present grievances and recommend changes in policies and services, personally or through other persons or with others, on the patient's personal behalf or that of others to the facility's staff, the community advisory committee, the administrator, the Department, or other persons or groups without fear of reprisal, restraint, interference, coercion, or discrimination;
 - (13) To not be required to perform services for the facility without personal consent and the written approval of the attending physician;
 - (14) To retain, to secure storage for, and to use personal clothing and possessions, where reasonable;
 - (15) To not be transferred or discharged from a facility except for medical reason, the patient's own or other patients' welfare, nonpayment for the stay, or when the transfer or discharge is mandated under Title XVIII (Medicare) or Title XIX (Medicaid) of the Social Security Act. The patient shall be given at least five days advance notice to ensure orderly transfer or discharge, unless the attending physician orders immediate

transfer, and these actions, and the reasons for them shall be documented in the patient's medical record.

- (16) To be notified within 10 days after the facility has been issued a provisional license because of violation of licensure regulations or received notice of revocation of license by the North Carolina Department of Human Resources and the basis on which the provisional license or notice of revocation of license was issued. The patient's responsible family member or guardian shall also be notified. (1977, c. 897, s. 1; 1983, c. 775, s. 1; 1989, c. 75; 1997-443, s.11A.118(a).)

G.S. 131E-118. Transfer of management responsibilities.

The patient's representative who has been given the power in writing by the patient to manage the patient's financial affairs or the patient's legal guardian as appointed by a court or the patient's attorney-in-fact as specified in the power of attorney agreement may sign any documents required by the provisions of this Part, may perform any other act, and may receive or furnish any information required by this Part. (1977, c. 897, s. 1; 1983, c. 775, s. 1.)

G.S. 131E-119. No waiver of rights.

No facility may require a patient to waive the rights specified in this Part. (1977, c. 897, s. 1; 1983, c. 775, s. 1.)

G.S. 131E-120. Notice to patient.

- (a) A copy of G.S. 131E-115 through G.S. 131E-127 shall be posted conspicuously in a public place in all facilities. Copies of G.S. 131E-115 through G.S. 131E-127 shall be furnished to the patient upon admittance to the facility, to all patients currently residing in the facility, to the sponsoring agency, to a representative payee of the patient, or to any person designated in G.S. 131E-118, and to the patient's next of kin, if requested. Receipts for the statement signed by these persons shall be retained in the facility's files.
- (b) The address and telephone number of the section in the Department responsible for the enforcement of the provisions of this Part shall be posted and distributed with copies of the Part. The address and telephone number of the county social services department shall also be posted and distributed. (1977, c. 897, s.1; 1983, c. 775, s.1.)

G.S. 131E-121. Responsibility of administrator.

Responsibility for implementing the provisions of this Part shall rest on the administrator of the facility. (1977, c. 897, s. 1. 1983, c. 775, s. 1)

G.S. 131E-122. Staff training.

Each facility shall provide appropriate staff training to implement each patient's rights included in this Part. (1977, c. 897, s. 1; 1983, c. 775, s. 1.)

G.S. 131E-123. Civil action.

Every patient shall have the right to institute a civil action for injunctive relief to enforce the provisions of this Part. The Department, a general guardian, or any person appointed as guardian ad litem pursuant to law, may institute an action pursuant to this section on behalf of the patient or patients. Any agency or person named above may enforce the rights of the patient specified in this Part which the patient is unable to personally enforce. (1977, c. 897, s.1; 1983, c. 775, s. 1.)

G.S. 131E-124. Enforcement and investigation; confidentiality.

- (a) The Department shall be responsible for the enforcement of the provisions of this Part. The Department shall investigate complaints made to it and reply within a reasonable time, not to exceed 60 days, upon receipt of a complaint.
- (b) The Department is authorized to inspect patients' medical records maintained at the facility when necessary to investigate any alleged violation of this Part.
- (c) The Department shall maintain the confidentiality of all persons who register complaints with the Department and of all medical records inspected by the Department. (1977, c. 897, s. 1; 1983, c. 775, s. 1.)

G.S. 131E-125. Revocation of a license.

- (a) The Department shall have the authority to revoke a license issued pursuant to G.S. 131E-102 in any case where it finds there has been a substantial failure to comply with the provisions of this Part or any failure that endangers the health, safety or welfare of patients. A revocation shall be effected by mailing to the licensee by registered mail, or by personal service of, a notice setting forth the particular reasons for such action. Such revocation shall become effective 20 days after the mailing or service of the notice,

unless the applicant or licensee, within such 20 day period, files a petition for a contested case, in which case the notice shall be deemed to be suspended. At any time at or prior to the hearing, the Department may rescind the notice of revocation upon being satisfied that the reasons for the revocation have been or will be removed.

- (b) In the case of a nursing home operated by a hospital which is licensed under Article 5 of G.S. Chapter 131E, when the Department of Human Resources finds that there has been a substantial failure to comply with the provisions of this Part, it may issue an order preventing the continued operation of the home. Such order shall be effected by mailing to the hospital by registered or certified mail, or by personal service of, a notice setting forth the particular reasons for such action. Such order shall become effective 20 days after the mailing of the notice, unless the hospital, within such 20-day period, files a petition for a contested case, in which case the order shall be deemed to be suspended. At any time at or prior to the hearing, the Department of Human Resources may rescind the order upon being satisfied that the reasons for the order have been or will be removed. (1977, c.897, s. 1; 1983, c. 143, s. 3; c. 775, s. 1;1987, c. 827, s. 251.)

G.S. 131E-126. Repealed by Session Laws 1987 c. 600, s. 1.

G.S. 131E-127. No interference with practice of medicine or physician-patient relationship.

Nothing in this Part shall be construed to interfere with the practice of medicine or the physician-patient relationship. (1977, c. 897, s.1; 1983, c. 775, s.1)

G.S. 131E-128. Nursing home advisory committees.

- (a) It is the purpose of the General Assembly that community advisory committees work to maintain the intent of this Part within the nursing homes in this State, including nursing homes operated by hospitals licensed under Article 5 of G.S. Chapter 131E. It is the further purpose of the General Assembly that the committees promote community involvement and cooperation with nursing homes and an integration of these homes into a system of care for the elderly.

- (b) (1) A community advisory committee shall be established in each county which has a nursing home, including a nursing home operated by a hospital licensed under Article 5 of G.S. Chapter 131E, shall serve all the homes in the county, and shall work with each home in the best interest of the persons residing in each home. In a county which has one, two, or three nursing homes, the committee shall have five members. In a county with four or more nursing homes, the committee shall have one additional member for each nursing home in excess of three.
 - (2) In each county with four or more nursing homes, the committee shall establish a subcommittee of no more than five members and no fewer than three members from the committee for each nursing home in the county. Each member must serve on at least one subcommittee.
 - (3) Each committee shall be appointed by the board of county commissioners. Of the members, a minority (not less than one-third, but as close to one-third as possible) must be chosen from among persons nominated by a majority of the chief administrators of nursing homes in the county and of the governing bodies of the hospitals licensed under Article 5 of G.S. Chapter 131E, which operate nursing homes. If the nursing home administrators and the governing bodies of the hospitals licensed under Article 5 of G.S. Chapter 131E, which operate nursing homes fail to make a nomination within 45 days after written notification has been sent to them by the board of county commissioners requesting a nomination, these appointments may be made by the board of county commissioners without nominations.
- (c) Each committee member shall serve an initial term of one year. Any person reappointed to a second or subsequent term in the same county shall serve a three-year term. Persons who were originally nominees of nursing home chief administrators and the governing bodies of the hospitals licensed under Article 5 of G.S. Chapter 131E, which operate nursing homes, or who were appointed by the board of county commissioners when the nursing home administrators and the governing bodies of the hospitals licensed under Article 5 of G.S. Chapter 131E, which operate

nursing homes, failed to make nominations, may not be reappointed without the consent of a majority of the nursing home chief administrators and the governing bodies of the hospitals licensed under Article 5 of G.S. Chapter 131E, which operate nursing homes within the county. If the nursing home chief administrators and the governing bodies of the hospitals licensed under Article 5 of G.S. 131E, which operate nursing homes fail to approve or reject the reappointment within 45 days of being requested by the board of county commissioners, the commissioners may reappoint the member if they so choose.

- (d) Any vacancy shall be filled by appointment of a person for a one-year term. Any person replacing a member nominated by the chief administrators and the governing bodies of the hospitals licensed under Article 5 of G.S. Chapter 131E, which operate nursing homes or a person appointed when the chief administrators and the governing bodies of the hospitals licensed under Article 5 of G.S. 131E, which operate nursing homes, failed to make a nomination shall be selected from among persons nominated by the administrators and the governing bodies of the hospitals licensed under Article 5 of G.S. Chapter 131E, which operate nursing homes, as provided in subsection (b). If the county commissioners fail to appoint members to a committee or fail to fill a vacancy, the appointment may be made or vacancy filled by the Secretary or the Secretary's designee no sooner than 45 days after the commissioners have been notified of the appointment or vacancy if nomination or approval of the nursing home administrators and the governing bodies of the hospitals licensed under Article 5 of G.S. Chapter 131E, which operate nursing homes is not required. If nominations or approval of the nursing home administrators and the governing bodies of the hospitals licensed under Article 5 of G.S. Chapter 131E, which operate nursing homes is required, the appointment may be made or vacancy filled by the Secretary or the Secretary's designee no sooner than 45 days after the commissioners have received the nomination or approval, or no sooner than 45 days after the 45-day period for action by the nursing home administrators and the governing bodies of the hospitals licensed under Article 5 of G.S. Chapter 131E, which operate nursing homes.

- (e) The committee shall elect from its members a chair, to serve a one-year term.
- (f) Each member must be a resident of the county which the committee serves. No person or immediate family member of a person with a financial interest in a home served by a committee, or employee or governing board member or immediate family member of a patient in a home served by a committee may be a member of a committee. Membership on a committee shall not be considered an office as defined in G.S. 128-1 or G.S. 128-1.1. Any county commissioner who is appointed to the committee shall be deemed to be serving on the committee in an ex officio capacity. Members of the committee shall serve without compensation, but may be reimbursed for the amount of actual expenses incurred by them in the performance of their duties. The names of the committee members and the date of expiration of their terms shall be filed with the Division of Aging, which shall supply a copy to the Division of Health Service Regulation.
- (g) The Division of Aging, Department of Health and Human Services, shall develop training materials which shall be distributed to each committee member and nursing home. Each committee member must receive training as specified by the Division of Aging prior to exercising any power under subsection (h) of this section. The Division of Aging, Department of Health and Human Services, shall provide the committees with information, guidelines, training, and consultation to direct them in the performance of their duties.
- (h)
 - (1) Each committee shall apprise itself of the general conditions under which the persons are residing in the homes, and shall work for the best interests of the persons in the homes. This may include assisting persons who have grievances with the home and facilitating the resolution of grievances at the local level.
 - (2) Each committee shall quarterly visit the nursing home it serves. For each official quarterly visit, a majority of the committee members shall be present. In addition, each committee may visit the nursing home it serves whenever it deems it necessary to carry out its duties. In counties with four or more nursing homes, the subcommittee assigned to a home shall perform the

duties of the committee under this subdivision, and a majority of the subcommittee members must be present for any visit.

- (3) Each member of a committee shall have the right between 10:00 A.M.- 8:00 P.M. to enter into the facility the committee serves in order to carry out the members' responsibilities. In a county where subcommittees have been established, this right of access shall be limited to homes served by the subcommittees to which the member has been appointed.
- (4) The committee or subcommittee may communicate through its chair with the Department or any other agency in relation to the interest of any patient. The identity of any complainant or resident involved in a complaint shall not be disclosed except as permitted under the Older Americans Act of 1965, as amended, 42 U.S. C. 3001 et seq.
- (5) Each home shall cooperate with the committee as it carries out its duties.
- (6) Before entering into any nursing home, the committee, subcommittee, or member shall identify itself to the person present at the facility who is in charge of the facility at that time.
 - (i) Any written communication made by a member of a nursing home advisory committee within the course and scope of the member's duties, as specified in G.S. 131E-128, shall be privileged to the extent provided in this subsection. The privilege shall be a defense in a cause of action for libel if the member was acting in good faith and the statements or communications do not amount to intentional wrongdoing. To the extent that any nursing home advisory committee or any member thereof is covered by liability insurance, that committee or member shall be deemed to have waived the qualified immunity herein to the extent of indemnification by insurance. (1977, c. 897, s. 2; 1977, 2nd sess., c. 1192, s. 1; 1983, c. 143, ss. 4-9; c. 775, s. 1; 1987, c. 682, s.1; 1995, c. 254, s. 7; 1997-176, s. 1; 1997-443, s. 11A.118(a).)

G.S. 131E-129. Penalties.

- (a) **Violations classified.** The Department shall impose an administrative penalty in accordance with provisions of this Part on any facility which is found to be in violation of the

requirements of G.S. 131E-117 or applicable State and federal laws and regulations. Citations issued for violations shall be classified according to the nature of the violations as follows:

- (1) **“Type A Violation”** means a violation by a facility’s licensee of the regulations, standards, and requirements set forth in G.S. 131E-117, or applicable State or federal laws and regulations governing the licensure or certification of a facility which results in death or serious physical harm, or results in substantial risk that death or serious physical harm will occur. Type A Violations shall be abated or eliminated immediately. The Department shall require an immediate plan of correction for each Type A Violation. The person making the findings shall do the following:
 - a. Orally and immediately inform the administrator of the facility of the specific findings and what must be done to correct them and set a date by which the violation must be corrected;
 - b. Within 10 working days of the investigation, confirm in writing to the administrator the information provided orally under sub-subdivision a. of this subdivision; and
 - c. Provide a copy of the written confirmation required under sub-subdivision b. of this subdivision to the Department. The Department shall impose a civil penalty in an amount not less than five hundred dollars (\$500.00) or more than ten thousand dollars (\$10,000) for each Type A Violation.
- (2) **“Type B Violation”** means a violation by a facility’s licensee of the regulations, standards and requirements set forth in G.S. 131E-117 or applicable State or federal laws and regulations governing the licensure or certification of a facility which presents a direct relationship to the health, safety, or welfare of any resident, but which does not result in substantial risk that death or serious physical harm will occur. The Department shall require a plan of correction for each Type B Violation and may require the facility to establish a specific plan of correction within a specific time period to address the violation.

- (b) Penalties for failure to correct violations within time specified.
- (1) Where a facility's licensee has failed to correct a Type A Violation, the Department shall assess the facility's licensee a civil penalty in the amount of up to five hundred dollars (\$500.00) for each day that the deficiency continues beyond the time specified in the plan of correction approved by the Department or its authorized representative. The Department or its authorized representative shall ensure that the violation has been corrected.
 - (2) Where a facility's licensee has failed to correct a Type B Violation within the time specified for correction by the department or its authorized representative, the Department shall assess the facility's licensee a civil penalty in the amount of up to two hundred dollars (\$200.00) for each day that the deficiency continues beyond the time specified in the plan of corrections approved by the Department or its authorized representative without just reason for such failure. The Department or its authorized representative shall ensure that the violation has been corrected.
 - (3) The Department shall impose a civil penalty on a facility's licensee which is treble the amount assessed under subdivision (1) of subsection (a) when a facility under the management, ownership, or control of that same licensee has received a citation and paid a penalty for violating the same specific provision of a statute or regulation for which the facility's licensee has received a citation during the previous 12 months. The counting of the 12 month period shall be tolled during any time when the facility is being operated by a court-appointed temporary manager pursuant to Article 13 of this Chapter.
- (c) Factors to be considered in determining amount of initial penalty. In determining the amount of the initial penalty to be imposed under this section, the Department shall consider the following factors:
- (1) The gravity of the violation, including the fact that death or serious physical harm to a resident has resulted; the severity of the actual or potential harm, and the extent

- to which the provisions of the applicable statutes or regulations were violated.
- (1a) The gravity of the violation, including the probability that death or serious physical harm to a resident will result; the severity of the potential harm, and the extent to which the provisions of the applicable statutes or regulations were violated.
 - (1b) The gravity of the violation, including the probability that death or serious physical harm to a resident may result; the severity of the potential harm, and the extent to which the provisions of the applicable statutes or regulations were violated;
 - (2) The reasonable diligence exercised by the licensee to comply with G.S.131E-256 and G. S. 131E-265 and other applicable State and federal laws and regulations;
 - (2a) Efforts by the licensee to correct violations;
 - (3) The number and type of previous violations committed by the licensee within the last 36 months;
 - (4) The amount of assessment necessary to insure immediate and continued compliance; and
 - (5) The number of patients put at risk by the violation.
 - (c1) The facts found to support the factors in subsection (c) of this section shall be the basis in determining the amount of the penalty. The Secretary shall document the findings in written record and shall make the written record available to all affected parties including:
 - (1) The penalty review committee;
 - (2) The local department of social services who is responsible for oversight of the facility involved;
 - (3) The licensee involved;
 - (4) The residents affected; and
 - (5) The family members or guardians of the residents affected.
 - (c2) Local county departments of social services and Division of Health Service Regulation personnel shall submit proposed penalty recommendations to the Department within 45 days of the citation of a violation

- (d) The Department shall impose a civil penalty on any facility's licensee which refuses to allow an authorized representative of the Department to inspect the premises and records of the facility.
- (e) Any facility's licensee wishing to contest a penalty shall be entitled to an administrative hearing as provided in the Administrative Procedure Act, Chapter 150B of the General Statutes. At least the following specific issues shall be addressed at the administrative hearing:
 - (1) The reasonableness of the amount of any civil penalty assessed, and
 - (2) The degree to which each factor has been evaluated pursuant to sub-section (c) of this section to be considered in determining the amount of an initial penalty. If a civil penalty is found to be unreasonable or if the evaluation of each Factor is found to be incomplete, the hearing officer may recommend that the penalty be adjusted accordingly.
- (f) The Secretary may bring a civil action in the superior court of the county wherein the violation occurred to recover the amount of the administrative penalty whenever a facility's licensee:
 - (1) Which has not requested an administrative hearing fails to pay the penalty within 60 days after being notified of the penalty; or
 - (2) Which has requested an administrative hearing fails to pay the penalty within 60 days after receipt of a written copy of the decision as provided in G.S. 150B-36.
- (g) The penalty review committee established pursuant to G.S. 131D-34(h) shall review administrative penalties assessed pursuant to this section.
- (g1) In lieu of assessing an administrative penalty, the Secretary may order a facility to provide staff training if:
 - (1) The cost of training does not exceed one thousand dollars (\$1000);
 - (2) The penalty would be for the facility's only violation within a 12 month period preceding the current violation and while the facility is under the same management; and

- (3) The training is:
 - a. Specific to the violation;
 - b. Approved by the Department of Health and Human Services; and
 - c. Taught by someone approved by the Department and other than a provider.
- (h) The Department shall not assess an administrative penalty against a facility under this section if a civil monetary penalty has been assessed for the same violation under federal enforcement laws and regulations. (1987, c. 600, s. 2; 1989, c. 556, s.2; 1993, c.390, s. 2; 1995, c. 396, s. 11995(Reg. Sess., 1996), c. 602, s. 2; 1997- 431, s. 2; 1997-443, s. 11A.122.)

G.S. 131E-130. First available bed priority for certain nursing home patients.

- (a) If a patient is temporarily absent, for no more than 15 days, from a nursing home to obtain medical treatment at a hospital other than State mental hospital, the nursing home;
 - (i) shall provide the patient with the first bed available at or after the time the nursing home receives written notification of the specific date of discharge from the hospital; and
 - (ii) shall grant the patient priority of admission over applicants for admission to the nursing home. The duration of the temporary absence shall be calculated from the day of the patient's admission to a hospital until the date the nursing home receives written notice of the specific date of discharge. This subsection shall not apply in instances in which the patient's treatment can no longer be provided by the nursing home upon re-admission.
- (b) If the Department finds that a nursing home has violated the provisions of subsection (a) of this section, the Department may assess a civil penalty of fifty dollars (\$50.00) a day, up to a maximum of one thousand five hundred dollars (\$1,500), against the nursing home, for each violation.

- (c) The provisions of Chapter 150B of the General Statutes that govern contested cases apply to appeals from Department action pursuant to this section. (1987 (Reg. sess,1988) c. 1080, s. 1.)

NOTE The Division of Aging is now known as the Division of Aging and Adult Services; The Division of Health Service Regulation was formerly known as the Division of Facility Services; and the Department of Health and Human Services was formerly known as the Department of Human Resources.

Interpretation of Patient's Bill of Rights

131E-117. Declaration of patient's rights.

All facilities shall treat their patients in accordance with the provision of this Part. Every patient shall have the following rights:

Interpretation

There is little doubt that each facility and its staff subscribe fully to the purpose expressed by the General Assembly and the sixteen rights outlined below. However, to more readily assure compliance, each facility must develop written policies to reflect how residents are to be treated and procedures for implementing and assuring such treatment.

Right 1 – To be treated with consideration, respect, and full recognition of personal dignity and individuality.

Interpretation

1. It should be recognized that in an institutional setting each and every resident cannot have complete freedom to do as he wishes as he might in his own home. In general, the meaning of this particular Right would be for one to ask oneself, "How would I like to be treated in a similar situation"?
2. The staff of the facility should speak courteously to the residents at all times. Speaking with, caring for and talking with and about residents afford staff the opportunity to constantly affirm the individuality and dignity of the resident. Calling residents by name, and addressing residents informally; avoiding the use of endearments like "Sweetie" and "Honey"; avoiding talking "about" rather than "to" a resident in his presence; knocking before entering a bathroom or the resident's own room, in the case circumstances require it; and similar courtesies will all contribute to the resident's self-respect and should be no less than what we would allow other people whom we deal with in life.
3. Daily activities such as eating, bathing and other activities should allow maximum flexibility for residents to exercise choice about what they will do and when they will do it. Allowing the expression of individual residents' preferences such as clothing, religious activities, friendship with staff and other residents, activity programs and

entertainment will be a demonstration that the facility respects the resident's right to be an individual. When possible, resident's likes and dislikes will be honored.

4. The staff of the facility should ensure the privacy of the resident and that such privacy is maintained at all times, A closed door or drawn curtains will shield the residents from passersby during examination, treatment, or during personal hygiene. In cases where resident's safety is a consideration, assistance by other staff may require that they be present at such times.
5. Except for compelling medical reasons, residents are expected to be able to sleep until at least 6:00 a.m. daily unless it is their wish to arise earlier in accordance with previous life-time habits. Bathing is expected to be conducted during normal waking hours of the day. Bathing will be conducted at night only when dictated by special needs of the resident. The resident has a right to expect a full bath (including a bed bath) no less than twice a week.

Right 2 – To receive care, treatment and services which are adequate, and in compliance with relevant federal and State statutes and rules.

Interpretation:

1. Essentially the facility must have the capability to provide the type of care which the resident needs according to what is prescribed by the attending physician.
2. The resident has the right to know that when a facility admits him, it is properly licensed, staffed and equipped to provide the care for which the resident was admitted and, in fact, does deliver such care. For example, failure to meet this patient Right would be the admission of a resident requiring physical therapy services when the facility does not have the capability to deliver such services.
3. The staff of the facility are properly licensed, registered or otherwise qualified in accordance with state law to perform the care and treatment to the residents in the facility.
4. The facility itself complies with state and local laws governing sanitation, fire safety, and other relevant codes and regulations.
5. Failure to provide adequate and appropriate care as measured against contemporary standards of practice is a violation of this law. It is expected that a prudent administrator will, through

effective management, monitor staff performance to reasonably assure that no resident's health, safety or welfare is endangered.

Right 3 – To receive at the time of admission and during the stay, a written statement of the services provided by the facility, including those required to be offered on an as-needed basis, and of related charges. Charges for services not covered under Medicare or Medicaid shall be specified. Upon receiving this statement, the patient shall sign a written receipt which must be on file in the facility and available for inspection.

Interpretation

1. This particular Right requires little interpretation. It is important to note however, that it does require a written receipt, signed by the resident acknowledging delivery of the required statement. The statement must be in writing and may be signed for by anyone qualified under G.S. 131E-118. The signed receipt may either be maintained in the medical record of the resident or in the business office file. In either case, the signed receipt must be filed individually and not in a single file for all patients. When the provisions of G.S. 131E-118 are invoked, a copy of the signatory's authorization should be kept on file with the receipt. Should circumstances exist which prevent the facility from obtaining an authorized signature, a brief explanation should be entered into the file. When doubt exists as to the mental competence of the resident and G.S. 131E-118 signature authorization does not exist, it is recommended that a family member co-sign the receipt with the resident.
2. The statement should identify nursing care, professional services and supplies as well as recreation, personal care services and items (laundries, haircuts, cosmetics, and beautician services) which are provided.
3. Charges for services not included in the facility's basic per diem rate must be identified.
4. Items covered under Medicaid must be clearly indicated as well as all items that will be charged directly to the resident.
5. The statement should be explained to the resident, guardian, or representative and any question answered fully.

6. Residents must be informed in advance of any changes in the cost or the availability of services.

Right 4 – To have on file in the patient’s record a written or verbal order of the attending physician containing any information as the attending physician deems appropriate or necessary, together with the proposed schedule of medical treatment. The patient shall give prior informed consent to participation in experimental research. Written evidence of compliance with this subdivision, including signed acknowledgments by the patient, shall be retained by the facility in the patient’s file.

Interpretation

1. The Federal Residents’ Rights are most stringent in that they require the resident to be fully informed of his medical condition whereas the state statute requires such information to be on file only. In addition, the federal regulations specifically recognize the right of the resident to participate in resident care planning and to refuse treatment.
2. Paragraph 1 above applies only to facilities participating in the Medicare and/or Medicaid program.
3. As indicated by the Right, the meaning of this requirement is a function of the medical staff and particularly the attending physician for each resident. The administrator is responsible for ensuring the medical staff is aware of this law. Medical staff rules, policies or by-laws should be reviewed.
4. The medical director or advisory physician should be responsible for working with the attending physician(s) in the implementation of this patient Right. If the attending physician decides that informing the resident is medically contraindicated, he should document such opinion in the resident’s chart.
5. Obviously, no facility should undertake experimental research with any resident without receiving his prior consent. Experimental research is taken to mean that there is to be independent research on a resident or residents to the extent there is actual manipulation of the resident. In the event there are studies which do not disclose the names of residents or involve manipulation of residents, these would not be considered as experimental research. Informed consent and resident

acknowledgment must be signed by the resident or in accordance with G.S. 131E-118.

Right 5 – To receive respect and privacy in the patient’s medical care program. Case discussion, consultation, and treatment shall remain confidential and shall be conducted discreetly. Personal and medical records shall be confidential and the written consent of the patient shall be obtained for their release to any individual, other than family members, except as needed in case of the patient’s transfer to another health care institution or as required by law or third party payment contract.

Interpretation

1. Medicare/Medicaid Nursing Facility Residents’ Rights as well as the standard for skilled nursing facilities (405:1132) requires confidentiality of medical records and medical care. Generally, most facilities require a written consent for release of confidential information such as would be contained in the medical record.
2. Each facility should allow access to medical records on a “need to know” basis. The “need to know” is defined as being involved in the direct care of the resident such as provided by staff and the consultants.
3. The same policy should prevail in the matter of personal records (financial and social).
4. To protect the facility, it is recommended that it obtain written consent for the release of confidential information to any person whether related or not.
5. Should a resident be denied access to his own medical record, the reason for such denial must be documented in the resident’s chart.

Right 6 – To be free from mental and physical abuse and except in emergencies, to be free from chemical and physical restraints unless authorized for a specified period of time by a physician according to clear and indicated medical need.

Interpretation

1. The federal certification requirements are practically identical to the State requirement in that neither forbids the use of chemical or physical restraints; rather, they allow the use, where appropriate, and forbid their use where inappropriate. Mental abuse includes such acts as humiliation, harassment, and threats of punishment or deprivation. A physical restraint is anything which prevents a resident from doing something he might voluntarily do or which limits his access to his own body parts. Physical restraint includes all devices such as restraining straps, mittens, etc., as well as denial of access to a wheelchair or other device which renders the patient immobile. Physical restraints do not include supportive devices used to achieve proper body position or balance. A chemical restraint is defined as the inappropriate prescribing, administering, or monitoring of pharmacological agents.
2. Chemical and physical restraints are not to be used:
 - a. to control or limit resident mobility for the convenience of staff;
 - b. as punishment;
 - c. for indefinite periods of time;
 - d. as a substitute for adequate resident supervision;
 - e. as a substitute for programs dealing with specific behaviors.
3. Restraints may be used when necessary to protect the resident from injury to himself and others, and such uses should be the exception and not regarded as the routine method of dealing with an ongoing problem.
4. Blanket standing orders for "restraints PRN" (to restrain as needed) are not permitted. PRN (as needed) orders should be specific and individualized according to resident need such as "may restrain PRN with mitten on right hand to prevent eye scratching (which would result in damage)".
5. A physician may write an order for restraints to be used in an emergency situation. However, such order must specify when and under what circumstances the restraints can be used and must clearly justify the reason(s) for the use of the restraints. When an "emergency" problem is reported, documentation should show the facility's efforts to deal with that problem in a less restrictive and more appropriate manner.
6. Any order for the use of a restraint(s) must be for a specified maximum period of time. Renewal of orders for emergency

restraints must be in conjunction with a treatment procedure designed to modify the behavioral problems for which the resident is restrained or, as a last resort, after failure of attempted therapy.

7. Should a resident emergency occur for which there is no alternative to physical restraint, and the attending physician's orders reflect that the emergency had not been anticipated, minimum effective restraint measures may be applied in accordance with nursing judgment when it is not possible to contact the resident's physician to report the significant change in the resident's condition and obtain instructions from the physician. Should the emergency occur at night, it is reasonable to assume that a physician can be contacted and telephone orders obtained prior to 10:00 the following morning.

Right 7 – To receive from the administrator of the facility a reasonable response to all requests.

Interpretation

1. One question that would arise regarding this particular Right would be, "What is considered reasonable"? One definition of "reasonable" is fair or moderate and this definition would seem to be appropriate. Furthermore, each and every resident cannot and should not expect that his every request will be granted as it is obvious that this would be impractical or could be detrimental to the resident's health or safety.
2. There should be clear indications that the facility does not arbitrarily dismiss or ignore resident requests which are not excessive and which would improve the quality of the resident's life.
3. The facility should document the denial of a request if a particular resident becomes upset because of a denial.
4. The facility must in all cases of denial explain to the resident why the particular request cannot be granted, whether it is recorded or not.

Right 8 – To associate and communicate privately and without restriction with persons and groups of the patient's choice on the patient's initiative or that of the persons or groups at any reasonable hour; to send and receive

mail promptly and unopened, unless the patient is unable to open and read personal mail; to have access at any reasonable hour to a telephone where the patient may speak privately; and to have access to writing instruments, stationery and postage.

Interpretation

1. In exercising this right the word "reasonable" is used and has been defined as being fair or moderate. Also, the words without restriction appear to indicate that the resident can do whatever he/she wishes to do. Of course, in this case, it should be emphasized that this would imply without restriction only if it did not interfere with the rights of other residents or the welfare of the particular resident.
2. The facility should make provisions where a resident may meet privately with a relative or friend. Obviously, if the resident has a private room this would suffice. In the case of semi-private rooms, provisions should be made to ensure that the resident could associate or communicate privately with anyone whom he/she desires.
3. The facility does have the right to restrict the visiting hours as long as such visiting hours permit the residents to have visitors each day of the week. The actual hours allowed for visiting can be established by the facility and may be tailored to the facility's work activities.
4. In the case of unusual circumstances, the facility must allow a visitor to see a resident at the resident's own request. This, of course, would be at the discretion of the facility but it would be unreasonable to prohibit visitation at other hours when such visitation would not interfere with the health and welfare of the resident or other residents.
5. For purposes of this patient Right, reasonable hours are considered to be the normal waking hours of the day. However, here again, the facility should use discretion should an emergency situation arise where the resident has a visitor, for example, coming from out of town or there is a need for the visitor to relay important information to the resident or vice versa.
6. The facility has the right to restrict a particular visitor or restrict the number of visitors a resident may have at any given time. The facility may refuse entry to a particular visitor when (a) the resident

does not wish to see the visitor; (b) the visitor would be disruptive of the facility's proper function.

7. When a decision to prohibit a visitor is made, the administrator or other staff member should document such action in the resident's file.
8. It is believed that a telephone in the hall, lobby, activity room, or other area would afford all the privacy a resident needs in the majority of situations. However, in the cases where privacy is absolutely necessary, a resident should be allowed to use a telephone in a private office, such as the administrator's, director of nursing, etc.
9. Staff should assist residents who require help in reading or sending mail when the residents so request.
10. Mail containing checks or negotiable instruments may not be opened or withheld by the facility without written authorization from the resident or his legally designated representative.
(See G.S. 131E-118)

Right 9 - To manage the patient's financial affairs unless authority has been delegated to another pursuant to a power of attorney, or written agreement, or some other person or agency has been appointed for this purpose pursuant to law. Nothing shall prevent the patient and facility from entering a written agreement for the facility to manage the patient's financial affairs. In the event that the facility manages the patient's financial affairs, it shall have an accounting available for inspection and shall furnish the patient with a quarterly statement of the patient's account. The patient shall have reasonable access to this account at reasonable hours; the patient or facility may terminate the agreement for the facility to manage the patient's financial affairs at any time upon five days notice.

Interpretation

1. Management of one's own financial affairs means that an individual is in sole control of all his financial wealth and liabilities. He receives checks and currency by mail without restrictive control by the facility. Obviously, such election by the resident is fraught with risks such as theft or loss of money and checks. In many

instances, facilities provide the special financial services of taking custody of check bearing mail addressed to residents, a position of fiduciary trust. In many instances, and quite prudently, custody and control of the instruments never pass to the resident. In such instances of involvement, facility management of the resident's financial affairs is deemed to exist.

2. The extent of any involvement in any resident's financial affairs must be established in writing and authorized by the resident or pursuant to the provisions of G.S. 131E-118. This includes the authorization to manage or control a resident's check bearing mail.
3. Authorization for automatic billing or deduction posted against a resident's assets must be established in writing.
4. Each resident's account shall be maintained in accordance with accepted accounting principles clearly showing all debits, credits, and balance on hand. This applies equally to large management accounts for private residents as well as small petty cash or personal needs funds.
5. Each resident must be granted reasonable access to his account at reasonable hours. The interpretation of "reasonable access" would mean during the hours that the business office is open and the facility should have in place a provision for the disbursement of funds in an emergency situation. Withdrawals must be paid on demand to the person authorized to make such withdrawals and in accordance with the financial agreement existing between the resident (and his representative) and the facility. The facility may not delay payment to an authorized recipient without reasonable and just cause (i.e.; the rationale for a large withdrawal may appear to be imprudent and payment may be delayed pending contact with an appropriate significant other).
6. Each resident or his legally designated representative shall receive a statement of the resident's account at least quarterly. The facility may choose to issue statements more frequently than the minimum period specified in the law. The statement must be sufficiently complete as to reflect all receipts, disbursements and on-hand balances (cash savings accounts and other negotiable instruments). The statement must be prepared in such a fashion that a reasonable person would be able to recognize all checks signed and turned over to the facility, the amount of public assistance liability, the cost of other goods and services received, the amount of cash withdrawals and current extent of their wealth.

Right 10 – To enjoy privacy in visits by the patient’s spouse, and, if both are inpatients of the facility, they shall be afforded the opportunity where feasible to share a room.

Interpretation

1. The basic intent of this Right is to assure that there is a method of arranging for privacy as may be necessary for visits between spouses. In the case of semi-private rooms or wards, other special arrangements may have to be made.
2. There should be provisions to assure conjugal visits and that complete privacy can be maintained at all times.
3. A husband and wife should be allowed to share a room unless in the judgment of the attending physician or physicians such sharing of the room would be adverse to the health of one or both residents.

Right 11 – To enjoy privacy in the patient’s room.

Interpretation

1. In semi-private rooms and wards it is not possible for a resident to have the privilege of complete privacy in conversations or from outside noise. This Right overlaps with certain other of the 15 patient rights outlined in the law and thus should be considered in the same light as are the others.
2. The resident should not have to expect to have his room used for ingress or egress to other resident rooms or areas.
3. The resident should expect the greatest degree of privacy that is possible under institutional circumstances and as his conditions allow. A partially closed door or drawn curtain allows privacy from the staff and visitors as they pass in the hallways.
4. Provisions should be made to allow residents to be alone at times when they wish to do so and when it does not interfere with other residents or proper medical care.
5. Privacy should be allowed for each resident’s personal belongings as might be contained in their personal closets, dressers or bedside tables. This does not mean that they must be locked but it does mean that the staff has no right to search through a resident’s personal items without reasonable justifiable cause. Where it is necessary for cleaning purposes, such cleaning should be done under controlled conditions preferably with the resident present.

Right 12 – To present grievances and recommend changes in policies and services, personally or through other persons or in combination with others, on the patient’s behalf or that of others to the facility’s staff, the community advisory committee, the administrator, the Department, or other persons or groups without fear of reprisal, restraint, interference, coercion, or discrimination.

Interpretation

1. The facility should have a procedure to assure that each resident has a means of making recommendations for changes which he/she feels are necessary or beneficial. It should be understood that the residents do not have the right to order a change in policies or procedures.
2. The facility should have a hearing procedure for resident grievances and take appropriate action as the case might dictate.
3. The facility should have a policy and procedure to assure that each and every resident has the privilege of contacting any agency, group or other persons without restraint or interference from the facility. If a resident is to be transferred and such resident had previously registered a complaint with the Division of Health Service Regulation, or other regulatory agency, then the facility should document in their file as to the reason(s) for such transfer and ensure that any move that takes place should not appear retaliatory in nature.

Right 13 – To not be required to perform services for the facility without personal consent and the written approval of the attending physician.

Interpretation

1. This requires very little comment as it is generally the practice to require written consent and approval of the attending physician if a resident wishes to perform services for the facility. It is obvious that under the present Fair Labor Standards Act no facility can require a resident to perform services for the facility.
2. In no case is a resident to perform services for the facility or be allowed to perform such services without specific written consent of his physician.

3. If the plan of care for a resident recommends work activities for therapeutic reasons, and the resident consents, the plan for these activities must be reviewed by a resident planning committee and implemented as part of the plan. Such work assignments must also comply with the requirements of the Fair Labor Standards Act regarding "resident workers".

Right 14 – To retain, to secure storage for, and to use personal clothing and possessions, where reasonable.

Interpretation

1. Prior to admission, the facility should clearly specify in writing any limitations on the amount and type of personal property or clothing which will be allowed; resident and facility responsibilities for maintenance of personal items such as pictures, certain small decorative items, and possibly a personal chair as long as such chair is small enough not to interfere with the other resident(s) in the room or interfere with proper care or cleaning of the room.
2. The word "reasonable" appears in the resident rights. It is felt that as long as the facility exercises judgment, they can make the determination of what is or is not reasonable in the area of personal clothing and possessions. The resident should be allowed to have his own personal clothing within the storage limits of the facility. It is only reasonable that the resident would have adequate clothing to be properly dressed at all times, even when other clothing is being cleaned or laundered.
3. Other personal furnishings or items should be allowed when they do not interfere with proper resident care and do not allow for excessive clutter, which could be unsanitary or a fire hazard.
4. It would not be reasonable to allow a resident to bring his own double bed for a semi-private room, for example, or a large color television or any other large furnishings that the facility does not have space to accommodate.

Right 15 – To not be transferred or discharged from a facility except for medical reasons, the patient's own or other patient's welfare, nonpayment for the stay, or when the transfer or discharge is mandated under Title XVIII (Medicare) or Title XIX (Medicaid) of the Social Security Act. The patient shall be given at least five days'

advance notice to ensure orderly transfer or discharge, unless the attending physician orders immediate transfer, and these actions, and the reasons for them, shall be documented in the patient's medical record. (1977, c. 897, s.1; 1983, c. 775, s.1.)

Interpretation

1. As a positive approach the following is a list of the reasons why a resident can be transferred or discharged:
 - (1) at his own request;
 - (2) for medical reasons;
 - (3) the resident's own welfare;
 - (4) other residents' welfare;
 - (5) nonpayment; and
 - (6) mandated under Title XVIII and XIX.
2. The term transfer applies to movement of a resident from one location to another within a facility as well as movement to another facility. Although the law indicates that a five days' notice is required, a resident may be transferred within three days if this is a determination by the attending physician and utilization review committee.

In any case where a resident is transferred or discharged, it should be specifically indicated as to the reason(s) for the transfer or discharge so as to assure that the reason(s) for such action was not predicated upon the resident or resident's family complaining about the type of care and services provided by the facility.

If a nursing home plans to discharge a resident from the facility and it is Medicare/Medicaid certified, then the federal regulations pertaining to the Transfer/discharge of residents (OBRA) must be followed.

Right 16 – To be notified within 10 days after the facility has been issued a provisional license because of violation of licensure regulations or received notice of revocation of license by the North Carolina Department of Human Resources and the basis on which the provisional license or notice of revocation of license was issued. The patient’s responsible family member or guardian shall also be notified.

Interpretation

Self-Explanatory

SECTION III

Visiting the Facility

Visiting the Facility

Visiting facilities is an important part of the committee's responsibilities; therefore, it is important to do it well. Committee members have a commitment to the residents to see that the facilities in your area maintain "the intent of" the Residents' Bill of Rights and provide quality care.

If you are to be effective in visiting and complaint resolution, your regular presence in facilities will make you familiar with the staff and residents and will help you build trust.

The purpose of your visit is to establish relationships with residents and staff; to gain some understanding of the procedures and conditions of a particular home and its residents; and to make note of and help resolve violations of residents' rights.

A. Types of Visits

There are four types of visits which committee members can make in nursing homes:

1. **Official Quarterly Visits:** Members have a statutory responsibility to conduct an official visit quarterly and to fill out a report form for each of the facilities that it serves. A majority of the committee or subcommittee must be present for this visit and it should normally be conducted between the hours of 10:00 a.m. and 8:00 p.m. More details about this type of visit are discussed in this section.
2. **Investigative Visits:** Investigation of complaints must be conducted by at least two committee or subcommittee members at the direction of the Committee Chairperson. These visits may be made at any time necessary to carry out the committee's duties.
3. **Friendly Visits:** An individual member may visit residents in the facility anytime between the hours of 10:00 a.m. and 8:00 p.m.
4. **Activity Visit:** Committee members may enter facilities to participate in and/or sponsor activities of a social, educational, religious, political, cultural, etc. nature for the residents. Hours for conducting activities should be coordinated with appropriate nursing home staff.

When an individual member of a committee or the committee makes a visit to a nursing home they must identify themselves to the person in charge of the facility at the time of the visit.

B. How to Conduct an Official Quarterly Visit

1. How to Start

Make sure you have the majority of the committee or quorum of your subcommittee. Do not visit on your own when conducting a quarterly official visit. Visit between the hours of 10:00 am -8:00 pm. Introduce yourself to the administrator or person on duty. If the person is new explain your role. Name tags or identification cards may be used to identify members.

Before going to the home for the first time, it is advised that the committee chairman call and establish communication with the administrator on this initial visit; the committee should talk with the nursing home administration about the community advisory committee program and how it can positively impact on the nursing home and its residents. Emphasis should be placed on the fact that the committee wants to work cooperatively with the home and its staff. It is not advised that subsequent visits be announced in advance or scheduled in such a way that they become predictable.

Ex. The third Tuesday of the third month from 1pm-2pm.

2. What To Look for (General Atmosphere)

Use your senses: What do you smell when you first enter the facility? What's the atmosphere like? Is it relaxed or tense? Are staff smiling or are they overworked and bad tempered? Observe the interaction between the staff and the residents. Is there laughter? Good humor? Is it too hot or too cold? Is it clean or dirty?

3. How to Look

Do not use a notebook or checklist but write up comments on the official report form after the visit. Each member should visit either one on one or in pairs with residents. If concerned about something you observe, have someone else take a look at the situation and see if they have the same reaction or not. Be a keen observer. However, remember you are not "inspectors," especially when issues are not related to the Bill of Rights.

4. Specific Areas of Concern Related To Bill of Rights

- a. Does the staff talk courteously to the residents?
- b. Do the residents exercise choice about the clothing they wear, freedom to worship, their personal preferences, etc.?
- c. Is the resident's privacy respected during examination or during personal hygiene activities? Do you see staff close the door or draw the curtains to protect the resident from unnecessary exposure?
- d. Check that the license is posted in a prominent place, also look for the Residents' Bill of Rights, fire and health certificates and other codes and regulations.
- e. Ask the administrator if there are any special charges for physicians and related services – wheelchairs, walkers, crutches, haircuts, and personal laundry.
- f. Ask if all residents receive an itemized written statement of charges for services provided by the facility. Items covered under Medicare/Medicaid must be clearly indicated. Request to review a copy of this statement.
- g. Residents may refuse to be used as a subject for experimental research. Residents should be fully informed of their medical condition unless the attending physician deems it medically inadvisable. This should be documented in the resident's medical records.
- h. All medical records are confidential. If investigating a complaint, you must have the written consent of the resident or his/her legal representative to look at these documents.
- i. Chemical and physical restraints can only be used when necessary to protect a resident from injury to themselves and others. Restraints can be used only for a specified time as prescribed by the physician. Physical restraints are blankets, straps, mittens, denial of wheelchair, and anything that limits residents from doing something for themselves that they might do voluntarily.
- j. Remember that residents must be free of mental abuse, e.g., humiliation, harassment, threats of punishment, deprivation. Pay attention to staff attitudes toward residents and how residents respond to the staff.

- k. Does the resident speak freely with the administrator? Does the administrator know residents by name? Is there a mechanism where a resident's problem or complaint can be heard free from threat of retaliation. Residents should feel free to present grievances to the staff, Community Advisory Committee, the Department of Health and Human Services and the county department of social services.
- l. Is there a residents' council? Do residents understand their rights? Is there a family night? Resident newsletter? Are there active social groups?
- m. Can the residents make phone calls in private? Receive visitors in private? Do residents receive mail unopened? Are visitors freely admitted? If a visitor is prohibited the reason must be documented in the resident's file.
- n. The residents can have their mail read to them by the staff; however, it should be opened in front of the resident rather than in the office and taken to them already opened by the staff.
- o. Is there access to writing instruments, stationery, postage, etc? (Residents are expected to pay for these items). Does the staff assist in writing and sending mail when necessary?
- p. Residents should manage their own financial affairs unless the authority has been delegated to someone else. The resident has the right to examine the account at any time.
- q. Is there a private room for visits with the resident's spouse? Are spouses living in the same facility allowed to share a room when feasible?
- r. Do the residents have reasonable privacy in their own rooms? Where rooms are shared this is more difficult, but it can be achieved with closed curtains.
- s. Residents should not be required to work for the facility without their consent. The physician must give written consent.
- t. Residents should have space for personal clothing and possessions where reasonable.
- u. Are their mementos and personal property in the room? Are residents being transferred within or out of the facility?

Transfers are only acceptable for the following:

1. *Medical reasons,*
 2. *Resident's own or another resident's welfare, or*
 3. *Non-payment for the stay or where transfer is mandated under Title XVIII Medicare or Title XIX Medicaid of the Social Security Act.*
- w. Make sure that the posted activity of the day is actually happening. Can residents read the Activity Chart? Is the print large enough? Are the activities varied?
- x. The meal served should be the same as what is listed on the posted menu. If it is not then ask the dietitian why this has happened as she should mark and sign the change. Is the food presented in an attractive manner, is it served at the appropriate temperature? Are special diets available? Are meals served at normal times? Is there plenty of time for each meal? Is help given with eating if needed? Do residents have to wait a long time to be fed due to a shortage of staff?
- y. Committee members are reminded that any physical assessment of a resident is to be conducted by authorized facility staff and/or appropriate regulatory agency staff only.

Common Problems to Note

- Apparent absence of staff on the hall and tardiness in answering call bells, staff moving from floor to floor as you visit. Talk to staff as you visit. Are they happy, or overworked? As you get to know them, discuss problems that they may have.
- Laundry – smelling, left in corridors (uncovered and for long periods), out when food trolleys arrive.
- Are residents dressed in day clothes? Do they have shoes or slippers on their feet?
- No smoking - staff smoking on duty?
- Are residents encouraged and assisted in getting out of bed and walking as appropriate on a regular basis?
- Are residents in wheelchairs because they need to be or for the convenience of the staff?
- Is there a physical therapist available?
- Is equipment in good repair?

- Are there chemicals left open and unattended?
- Are there odors present when you arrive and also when you leave?
- Are residents encouraged to participate in the activities offered?
- Are wet floor signs in use when floors are being cleaned?

Conclusion

Absorb the atmosphere as you visit; talk to the residents; empathize with them, but don't take too long. After a few visits, staff and residents will get to know you and why you're there.

Meet with the other members of the committee to discuss the visit and fill out the quarterly visit report form.

Have an exit interview with the administrator or person in charge to let them know your findings – positive and/or negative. If you find something negative in the home discuss it with the administrator and arrange a time to come back and check on the agreed upon change. (See the "Complaint Management" section of this handbook for more detailed information about handling complaints.) By the same token, if you see or hear something positive that staff did for a resident or you notice an improvement in the facility, be sure to mention it to the administrator as well.

If the administrator is not on duty, perhaps one member of the committee can call him/her the next day to discuss the visit; otherwise he/she might not know you visited. Most administrators like to know things firsthand, if possible.

Remember you have a right to be there, but do not abuse it. Be courteous at all times.

C. Establishing Rapport With Residents

The daily lives of residents can be very different from our own. As a result, it is sometimes difficult for us to begin a conversation with them or know what to do in an unfamiliar situation. Many people are uncomfortable with what they see in a nursing home. The concentration of older people who have suffered some degree

of physical or mental disability may be disturbing to you. Here are suggestions to help you feel more at ease and to make your visits more successful.

1. Understanding Residents

When you visit with residents, there are a few things to consider. First, try to look beyond physical appearances. Think of each of these residents as interesting individuals who have experienced much in life. Each person has a unique personality which is not dependent upon physical appearance. You may be bothered by those who appear to be confused or disoriented. These people often can be reached simply by gently holding their hands and looking into their eyes. Second, independence is very important for their self-esteem, and residents should be encouraged to care for themselves to the extent possible. You should be aware of this goal. If he or she should ask for help, say "I'll be glad to help."

But at the same time encourage independence by having the resident participate. Also, does the resident want a visitor? If they seem withdrawn and unreceptive, make your visit brief. A valuable relationship can be developed from short visits over a period of time.

The key to developing a good relationship is to encourage the resident to share his or her feelings. Listening can be difficult, but remember that it shows you care. It is also very important that you talk about what is happening in the community. This keeps the resident in touch with the world outside the facility.

2. The Visit

When people visit you in your own home, they come to the door and knock or ring the doorbell. A resident's room in a nursing home is home. Knock before entering and ask permission to enter. If the resident is unable to respond, then announce yourself before walking in. Proceed cautiously; do not interrupt the resident's private space abruptly or loudly.

Greeting usually involves some sort of physical contact. Shake hands or touch them on the hand, arm, or shoulder in a warm manner. Nursing home residents are often removed from family and friends who provide this sense of touch.

Think a moment about what the quality of your life would be if no one ever touched you except to bathe or toilet you. Touching tells us that we are accepted, human, and desirable. Once in the room, make some form of contact unless it is absolutely inappropriate.

3. How to Talk with Residents

- a. Addressing the resident by name is one of the best ways to begin to establish rapport. Find out their names before calling on them. To communicate respect, it is suggested that you use the resident's surname, "Mrs. Smith", unless he/she asks to be called by another name. Of course, you can always ask the residents how they prefer to be addressed.
- b. Communicate respect by requesting permission to engage in conversation. Make it clear who you are and why you are there. "I am Mary Smith, a volunteer appointed by our county's commissioners to help you and the home in making sure you receive the best possible care." Establish physical and verbal warmth. Let them know you are attentive and interested in them through your body language. Make eye contact, sit facing the resident directly, if possible, and touch when appropriate. Ask about their contacts outside the home-family, friends, visitors, letters, and phone calls. Explore their personal history and try to discover their interests. Be honest about your own reactions and feelings. Share with them just as you are asking them to share with you. Remember that some residents may have hearing difficulties; others may have communication problems that require patience.
- c. Encourage reminiscing by asking questions about the resident's life and achievements. (Examples: What is the high point of your life? Who is the most important person in your life? What was your favorite food as a child?) sometimes when the memory is failing, it's easier to remember distant events. The older person frequently wants to discuss important roles they have played and significant happenings in their lives.
- d. Empathize with their feelings of loneliness or distress. Do not try to deny these feelings. Often a sympathetic ear is all that is needed. Try positive reinforcement such as, "It is difficult to adjust to new places." (Recognition and self-expression help residents accept change.)
- e. Discuss the history of their stay in the facility, and when you have developed an adequate level of rapport, talk with them

about their feelings about being in the home. You might not reach this level on the first visit, but it's something to work towards. If residents express any displeasure or dissatisfaction regarding any circumstances of their lives in the home, try to uncover their whole story. Listen carefully so that you can take note of the important information that you may need to refer to at a later point in time. Pursue comments residents make don't let offhand remarks slide.

- f. Do not give advice unless asked. Instead, ask their advice or opinion. This helps them to feel useful.
- g. Devise a system for remembering names and something about the person. Perhaps keeping a little notebook in which you jot down a few notes when the visit is over would be a good idea. When you return for your next visit you can then review the names and notes to refresh your memory. The fact that you have remembered something about them will enhance their self-esteem.
- h. Be careful not to make commitments to residents that you cannot keep.

4. How to Handle Residents with Complaints

- a. **Listen.** Listen very carefully to the complaint or complaints.
- b. **Evaluate.** If everything is wrong, the resident may still be adjusting to the home. He or she may feel alienated and uncomfortable in new surroundings. However, the resident may be having difficulty "zeroing in" on his/her particular concern. The committee member should encourage residents to be as specific as possible with what is troubling them. If there are specific complaints, listen carefully and try to discern the truth. You may want to talk to the appropriate staff who may not be aware of the resident's concerns. Often, misunderstandings can be cleared up easily. If the complaint cannot be cleared up easily, refer it to the committee chairman.

Note: **Be sure to get the resident's permission before you talk to anyone about the complaint. Respect their confidentiality.** Use of a resident's or complainant's name requires permission of the resident or their legal representative.

- c. **Explain.** When you have reached a conclusion or a solution for the complaint, be sure the resident understands the

explanation. You may have to explain the results more than once.

- d. **Limit.** Finally, for the chronic complainer who is never satisfied, set a limit to the complaint time. We all need to express our feelings and emotions. Then turn to something positive. *(See Complaint Management Section of this Handbook for more details).*

5. Points about Communicating with a Person with Mental Retardation

(You will, of course, need to adapt these suggestions to each individual, since in this case, as in all things, each person is different and will respond differently).

- a. Be sure the person is aware that you are speaking to him/her. This is especially important because, either in an institution or at home, the individual may often have been a bystander to conversations where his/her presence was ignored. Saying their name before you speak is one way to get their attention. If they don't look at you when you speak, encourage them to do so.
- b. Try to use words that are easily understood. Keep the conversations going with short and concise sentences. You want to be consistent in the message you're trying to send by using the same words each time you mean the same thing. Do not go into detailed explanations and try to limit what you say to one idea at a time. Wait for a response (whether in words or action) and then present the next idea or information.
- c. If possible, help the person to see what you are talking about as well as hear you. For example, you can often pantomime what you want (*in fact, you may already do this without even thinking about it*). Or you may be able to demonstrate what you mean at the same time that you explain it.
- d. Allow a slightly longer reaction time than you would with other people. You will soon learn how much time is needed for each person.
- e. If someone's speech is hard to understand, don't be afraid to ask them to slow down or repeat. Do this courteously as though asking a favor, because you really do want to understand. It's more polite to say "I don't understand you" rather than, "You don't talk well." Another way to help is to repeat what you think you hear and ask the person if you are

right. Or, ask if he can show you what is on his mind. You will often find that another **resident** can interpret for you. If, in spite of everything, you still don't understand, or the person seems angry or ready to give up, reassure him again that you wish you knew what he was saying, and let the matter drop. Don't despair; you will soon find it much easier to know what is being said even through the most difficult speech impairments.

Conclusion

Visiting should be pleasant for you and the resident. Plan ahead, be polite. Remember to touch if and when appropriate and above all, keep a good sense of humor.

SECTION IV

The Aging Process

The Aging Process

A. Demographics of Aging

Recognizing and adjusting to the demographics of the population one is serving, allow service providers to better accommodate the needs of those they are trying to help. This is particularly true in the aging arena. The number of elderly continues to grow and will continue to do so at a rate never seen before. The U.S. older population, persons 65 years or older—numbered 37.3 million in 2006. They represented 12.4% of the population, which means roughly one in every eight Americans is an older adult. By 2030, there will be about 71.5 million older persons, more than twice their number in 2000 and they will represent about one in every six Americans.

North Carolina ranks tenth among states in the number of persons 65+ and tenth in the size of the entire population. The fast pace of growth in the state is evident in a U.S. Census Bureau document stating North Carolina was ranked fourth nationally in the increased number of Individuals 65+ (47,198 in NC) between April 2000 and July 2003. Only three other states (California, Texas and Florida) reported a greater increase among their older populations. Even so, when combined with the equally strong growth in other age groups, North Carolina continues to maintain an overall healthy demographic balance among the generations as it is thirty-seventh among states in the proportion of the population over 65.

- Estimated NC population age 65+ in 2007 = 1,087,442 (12% of total population)
- Estimated NC population age 85+ in 2007 = 134,815 (1.5% of total population)

Older women represent 58.7 percent of the 65+ age group and 70.9 percent of the 85+ age group. The higher rate of poverty among older women remains a primary issue today and on into the future. Data shows that being unmarried, widowed, divorced, separated or never married increases a woman's vulnerability to poverty. Levels of poverty often have a direct correlation with individuals needing long term care. Therefore, since women tend to out live men and their financial resources are not as vast; their presence in facilities is greater.

B. Biological Aspects of Aging

The knowledge that physical changes are an inevitable part of the aging process will help an older person to deal with them, and will assist the community advisory committee member to better understand the needs of the nursing home resident.

The human body is made up of cells that in turn form the tissues, organs, and bones. These cells are constantly being created, developing and dying, and new cells are generated to replace them. In an aged person, the cell regeneration rate appears to decrease and a slowing down of biological functions and reduction in reserve follows. The person will usually show some of the following signs of aging:

1. Skin and Appearance

The skin loses some of its elasticity, and becomes dry and wrinkled because the sweat and sebaceous glands function less effectively. As the circulation of the blood to the skin slows, cold is felt more readily. With aging, the skin becomes thinner and may be more susceptible to being broken or cut. When broken, the skin may be more prone to infection.

Changes in the face appear as well. The loss of teeth causes a shortening of the lower part of the face, while the nose lengthens. Hollows may develop beneath the eyes. The hair whitens and thins. In our youth-oriented society, the beginning of any of these changes can seem a terrible threat.

2. Bones

As a person becomes older, the bone mass decreases by as much as 10 percent after the age of 35. For example, the spinal discs in the backbone compress, causing a bowed back. In addition, the bones lose elasticity and become more brittle, making breaks more likely. Osteoporosis is a significant concern to older people. The older a person is, the more at risk they are. In particular, older women have very high rates of osteoporosis. Estrogen has a protective effect on bones, yet they no longer produce it in levels effective to protect them from brittle bones. Osteoporosis accentuates the decrease in bone mass, resulting in additional breaks and fractures. There may also be slight changes in the bone angles, causing new stresses and a higher probability of breaks. These changes make an older person more vulnerable, and perhaps more cautious in moving around and traveling.

3. Senses and Reactions

The senses – hearing, sight, taste, smell, and touch – become less sharp with age because of the decreased number of cells in these systems. In addition, there is a general slowing down of responses to stimuli. Rapid, voluntary movements are not performed as quickly. The muscles are slower and less precise and balance is not as acute.

Any of these changes may produce a chain of crises in an older person. For instance, as taste and smell diminish, food becomes less appetizing. Their senses are no longer as sharp, leaving older adults less aware of what their bodies are telling them. Messages of hunger or thirst can go unrecognized in an older person. If a person eats too little or improperly, mental confusion may result and missed meals will only increase. A downward cycle of malnutrition, inactivity, and disorientation could follow. An aging individual may experience a loss of coordination, causing him/her to fall more often. This may lead to withdrawal from community activities, which in turn could mean loneliness, depression, lost appetite and a reduction in vitality.

All of these changes are hard to endure. Nonetheless, in many cases the changes need not impair behavior. An older person does not have as much physiological reserve as a younger person, but fortunately, most stimuli are far above the ordinary thresholds of perception, and people do not often operate at the limit of their capacities. An active life-style is still possible, particularly if an older person adjusts creatively to the changes and losses that have occurred.

C. Psychological Aspects of Aging

1. Memory and Learning

Memory and learning involve our ability to register, retain and recall experiences. Under most circumstances, age-related changes in the primary ability to learn appear to be small. However, there may be problems in sensory perception, control of attention, motivation or poor general health. In addition, with the general slowing down of responses that come with aging there may be a reduction in handling complex activities and unfamiliar tasks. But, usually learning ability does not decline, especially in those who continue to exercise it. It should also be noted that long-term

memory in older people generally remains pretty sharp even as their short-term memory skills are decreasing.

2. Mental Illness

One of the most myth-shrouded areas of aging is that of mental illness. For many years, senile brain deterioration has been thought of almost as a normal result of the passage of time. It is true that brain disease in later life occurs more frequently than do the mental illnesses of early life. Even so, only a minute percentage of the total population can expect to be institutionalized for mental illness in later-life.

Further, it has been found that mental illness in older persons can occur as a side effect of physical illness. Medications, and poor nutrition and dehydration can result in behaviors that are misconstrued as mental illness. Infectious diseases and malnutrition can cause mental symptoms that remain long after the original condition is controlled.

As clearly noted, mental illness is not a requisite to aging. Yet, there is one area of mental health to which the elderly are often vulnerable. This area is depression. The increased changes to their life that include physical, emotional and social, combined with often acute periods of isolation, leave a considerable number of our elderly in a state of depression. Detection may be difficult, but if treated, over 80% show improvement.

3. Attitudes Toward Death and Dying

Are elderly persons inordinately anxious about death? According to stereotypes, yes. But the fact is that younger persons are more likely to be concerned about death. Older persons are seemingly more concerned with finances.

One study comparing interviews with persons who died within the year and interviews with those who survived the year revealed that the individuals closest to the time of their death showed a much greater interest in their immediate environment. This suggests

that isolation is a great disservice to the dying. Denying the dying person access to others and to a normal, stimulating environment reduces the likelihood that he/she will be able to resolve his or her own departure with dignity. Isolation of the dying may be a reflection on the attitudes of younger professionals who are contemplating their own morality. None the less, isolation is a problem and must be addressed.

4. Some Characteristics of Older Persons

Society often tends to lump older persons together in a discriminatory way – “He’s getting old and senile,” “You can’t teach an old dog new tricks,” or “Old people live in the past.” This is ageism. It is important to recognize there is great variability in character, ability, interests and personality among older individuals. Nonetheless, gerontologist Dr. Robert Butler lists ten late-life characteristics, which tend to appear frequently among older persons:

- Change in the sense of time. Since the future is short, some retreat to the past. Others emphasize the importance of the here and now, of living in the moment.
- Sense of the life cycle. Older persons can experience in a personal sense the entire life cycle.
- Tendency toward life review. The realization of approaching death stimulates older persons to relive and review their past experiences. Through this process, they may resolve troubling conflicts and fears. Attentive listeners may help older persons to recount their lives.
- Reparation and resolution. Older persons may feel guilt for and try to atone for past actions.
- Attachment to the familiar. Familiar objects facilitate the life review and provide a sense of security.
- Conservation and continuity. The old have the opportunity to pass on knowledge to younger generations.
- Desire to leave a legacy. Older persons are concerned about leaving something behind when they die, be it grandchildren, possessions, a work of art or social importance.
- Transmission of power. One of the psychological issues of old age is when to surrender one’s power and authority to others.

- Sense of fulfillment in life. Some older persons experience a sense of satisfaction and pride upon looking back over their lives.
- Capacity for growth. The capacity for creativity and wonder need not decline with old age.

D. Age Related Sensory Changes

1. Vision

- a. Behaviors which may indicate visual problems:
 - Coordination difficulties
 - Positioning of objects
 - Squinting of eyes
 - Color selections
 - Uncontrolled eye movements
 - Depth perception
 - Inability to cope
- b. Helping older persons with visual problems:
 - Positioning of objects in visual field
 - Labeling objects – use large lettering
 - Simplify the visual field – remove objects that are cluttering the area
 - Consistently position objects – do not move or rearrange objects
 - Give pre-warning – announce to person what you are going to do
 - Helping to use other senses as compensation

2. Hearing

- a. Behaviors which may indicate hearing loss:
 - Increased volume of speaking
 - Positioning of the head
 - Asking for things to be repeated
 - Blank looks and disorientation
 - Isolation

- Attention span
 - Not reacting
 - Emotional upset
- b. Communicating with individuals with hearing problems:
- If person has a hearing aid, make sure it is used, or find out why not
 - Face the person – allow him/her to read lips
 - Make sure he/she is aware that you are addressing him/her – touch person to ensure having attention. Speak slowly and distinctly
 - Use short sentences
 - Give short explanations – ***Ex. I like to shop at Food Town, grocery store.***
 - Do not repeat the same phrase over and over – use different expressions until one point gets across – ***Ex. I have a cold. I'm sick. I don't feel well, etc. (Make sure that the person doesn't have dementia, because this could be very confusing to them).***
 - Do not shout – lower pitches are heard more clearly
 - Use gestures and/or objects which illustrate verbal messages (***Point to an object while retrieving it***)
 - Attempt to speak in the ear in which the person retains the best hearing
 - Avoid standing in front of window or other light sources the glare from behind makes it difficult to read lips

3. Touch

- a. Behaviors which may indicate tactile loss:
- Avoidance of touching
 - Extremes in recognizing pain
 - Oral exploration
 - Not responding
 - Grasping

b. Assisting persons with tactile loss:

- Use touch therapy - communicating through touch
- Talk – tell person what you are doing, helps him/her to use multiple senses
- Gripping – make sure person has adequate hold on the object
- Pressure – increase pressure when touching someone

4. Taste

a. Behaviors that may indicate taste changes:

- Loss of or increased appetite
- Complaints about food
- Questions about food person is eating
- Tongue coating
- Excessive seasoning

b. Making food more appealing:

- Food presentation
- Separating food
- Texture of food
- Mouth and dental care
- Taste parties

5. Smell

a. Behaviors which may indicate olfactory changes:

- Not reacting
- Congestion
- Person says he/she can't smell objects
- Increased body odor
- Can no longer taste food

b. Tips for compensating for loss of smell:

- Allow person the opportunity to smell food before it is placed in his/her mouth

- Explain what food has been prepared – and allow the person to think about and possibly remember the smell
- Label items that look alike so person can use other senses to compensate

6. Mobility and Balance

- a. Behaviors which may indicate mobility limitations:
 - Poor posture
 - Dizziness
 - Gait
- b. Helping person to maintain or strengthen the
 - Capability of movement
 - Support person on the side that needs support
 - Assist person in standing
 - Teach person to grasp you for support, rather than you holding them
 - Carefully check to insure that any hazards, such as trash cans or foot stools, are removed from the path of the older person
 - Be patient, some older people do not move as rapidly as some younger people

E. Arthritis

The most frequently occurring chronic condition in the elderly is arthritis. It is reported that one out of every two elders suffers from this condition. There are more than 100 different types of Arthritis, but they all share common symptoms of pain and limited movement. With the pain frequently comes stiffness in and around joints. The most common form of arthritis is known as Osteoarthritis. This form involves the breakdown of cartilage and bone. Rheumatoid arthritis is a disease that causes inflammation of the joint lining.

Most forms of arthritis last a long time and have no cure. There can be reductions in pain and increased mobility in many cases via medications and exercises. Treatment is based on whether the person is diagnosed with osteoarthritis or rheumatoid arthritis.

F. Alzheimer's Disease

Alzheimer's disease, named for the German neurologist who first described it in a 51-year old patient in 1906, is a widespread but little-known brain disorder. Alzheimer's is a progressive, degenerative disease that attacks the brain, resulting in impaired memory, thinking and behavior. Ultimately, Alzheimer's will result in death.

Many victims cannot be left alone. Their wanderings and forgetfulness – often unknown to outsiders – make extraordinary demands on their families and other caregivers.

Alzheimer's most often strikes the old, but it may also affect persons as young as 40 years old. An estimated one-half of all cases of pre-senile and senile dementia – "senility" – stem from Alzheimer's.

Diagnosis, though increasingly sophisticated, still depends on painstaking elimination of other possibilities. Currently, no effective treatment for Alzheimer's exists.

The cause is unknown. Specialists now believe heredity, once the number one suspect, accounts only for a small percentage of suspected Alzheimer's cases. Alzheimer's does not usually affect more than one member of any family. Researchers have turned their attention to viruses, environmental toxins and changes in brain chemistry.

One theory: Nerve endings in the outer layer of the brain degenerate and disrupt the passage of signals between cells. When the brains of Alzheimer's victims are examined at autopsy, two types of microscopic abnormalities – called plaques and tangles – characteristically appear. From onset of symptoms, Alzheimer's can last anywhere from three to 20 years or more.

SECTION V

**The Role of Government
in Assuring Quality Control
in Nursing Homes**

The Role of Government in Assuring Quality Control in Nursing Homes

A. Introduction

The purpose of this introduction is to identify and describe the roles and responsibilities of the respective groups who have a role in the licensure, regulation and monitoring of nursing homes in North Carolina. It outlines procedures by which the various agencies, organizations and individuals conduct their separate and joint functions. The Division of Health Service Regulation has responsibility for licensure and certification of nursing homes. The Division of Medical Assistance, the State Ombudsman, the regional ombudsmen and the Nursing Home Community Advisory Committees (NHCAC's) also have roles and responsibilities related to the oversight of nursing homes. Further, boards of county commissioners, nursing home administrators, and NHCAC's also have important roles in the implementation of the Patients' Bill of Rights. In addition, the County Departments of Social Services have statutory responsibility for the investigation of adult protective service (*i.e. abuse, neglect, misappropriation*) cases in nursing homes.

B. State Licensing

All states have laws requiring providers of nursing home services to be licensed in order to operate. North Carolina's licensing regulations are established by the N.C. Medical Care Commission and are enforced by the Department of Health and Human Services.

Direct responsibility for ensuring compliance with State regulations and standards rests with the Department of Health and Human Services' Division of Health Service Regulation. Within the Medical Facilities branch, the Licensure and Certification Section conducts initial licensure surveys as well as, surveys facilities not certified to receive Medicare or Medicaid funding. The Licensure and Certification Section also conducts complaint and follow up surveys in problem facilities.

Registered nurses, pharmacists, dietitians, and social workers conduct the inspections of nursing homes along with engineers or others familiar with the physical layout and operation of nursing homes. As a part of the survey, the inspection teams make certain that the nursing home is in compliance with the State's Patients' Bill

of Rights in addition to the federal Medicare/Medicaid Residents' Bill of Rights.

C. Federal Certification

In order for a nursing home to participate in either the Medicaid or Medicare programs it must be "federally certified" in addition to the licensure requirements previously mentioned. Certification surveys are conducted annually (*must occur nine to fifteen months from previous inspection*) by federally trained survey teams located within the Licensure and Certification Section of the Division of Health Service Regulation. This activity is a separate function from the inspection required to receive a license. There are designated field staff that conduct routine monitoring of nursing homes for compliance with federal certification requirements. Registered nurses, pharmacists, dietitians, and social workers conduct the inspections of nursing homes along with engineers or others familiar with the physical plant of the nursing home. The survey teams, as a part of their monitoring, make certain that the nursing home is ensuring that residents' rights are being respected. A facility must be certified to receive reimbursement from the Medicaid or Medicare programs. A nursing facility must maintain compliance with the federal standards in order to be reimbursed for residents covered by Medicaid and/or Medicare.

Nursing homes are not required to participate in either Medicaid or Medicare, but if they participate in Medicaid they must participate in Medicare. If you are not sure whether the nursing homes in your area participate, you should ask the administrator of the home or the Division of Health Service Regulation (DHSR). (*Note: The fact that a facility is certified for Medicare does not necessarily mean that Medicare will pay for nursing home care for persons otherwise eligible for Medicare services. Complicated medical criteria determine this on an individual basis*).

All information concerning the certification inspection is maintained in the Licensure and Certification Section within the Division of Health Service Regulation, and is forwarded to the U.S. Department of Health and Human Services. When deficiencies are found, there are a wide variety of enforcement mechanisms available. [See Enforcement Section Below].

Financial matters concerning the Medicaid program are handled by the County Department of Social Services or the State Division of Medical Assistance.

D. Enforcement

When a nursing home is found to be out of compliance with any regulation or standard (including Residents' Rights violations) the facility is "cited for a violation." The facility must then submit a response often called a ***Plan of Correction*** to the state agency for approval. A subsequent re-survey of the facility is conducted to make certain the corrective action was implemented.

When a facility feels that a specific deficiency or finding in a survey is factually inaccurate, the facility has an opportunity to dispute the alleged discrepancy through the Informal Dispute Resolution Process (IDR). This process allows the provider to submit evidence to a three member panel regarding the refuted deficiency(ies) and explain why they feel the citation is inaccurate. During this meeting, affected residents, family members, and the ombudsman also have an opportunity to present new information pertinent to the alleged violation(s). After hearing the evidence, the panel then decides to either uphold the deficiency(ies) or delete them from the survey.

The enforcement tools available to remedy noncompliance with state and federal law vary. The list of remedies that the state can impose under state licensing law for substantial noncompliance with applicable laws and rules include:

- (1) reducing a facility from a full to provisional license;
- (2) suspending new admissions;
- (3) appointing a temporary manager to operate a facility;
- (4) revoking the license of a facility;
- (5) summarily suspending a license and relocating the residents without prior due process in the event that there are imminent lifethreatening conditions in a facility;
- (6) imposing civil monetary penalties whose amount depends on the seriousness and risk of harm to residents.

Federal enforcement mechanisms include:

- (1) directed plans of correction, including directed in-service training;
- (2) state on-site monitoring;
- (3) denial of payment for new individuals;
- (4) denial of payment for all individuals;

- (5) temporary management;
- (6) termination from the Medicare/ Medicaid programs;
- (7) civil monetary penalties ranging from \$50 to \$10,000.

It is important for members of the NHCAC to be at least generally familiar with the various requirements for the licensure and certification of nursing homes. Members must be especially familiar with the Residents' Bill of Rights section and any questions should be directed to the regional ombudsman, the State Ombudsman, the Division of Health Service Regulation, or the administrator of the nursing home.

E. Government Complaint Investigation

The Complaint Investigation Branch (CIB), within the Division of Health Service Regulation, *Medical Facilities Licensure and Certification Section* also receives and investigates individual complaints about resident care in skilled nursing facilities and combination facilities within the purview of North Carolina General Statutes, Chapter 131E, Article 6 which includes the Nursing Home Licensure Act and the Nursing Home Patients' Bill of Rights.

The CIB staff investigates complaints about nursing homes and responds to complainants within a reasonable time, not to exceed 60 days. Reports of alleged *abuse, neglect or exploitation* regarding *specifically named people* in a nursing home, combination home, or adult care home should be made to the department of social services adult protective services (APS) worker in the county in which the home is located. The APS worker will investigate the case and take immediate action to protect a resident if necessary and will also notify the Division of Health Service Regulation. These cases would come under the Adult Protective Services Law. (See *Appendix A for a copy of this law*). If non-compliance with the Nursing Home Licensure Act or Rules and Regulations for the Licensing of Nursing Homes is substantiated in a complaint investigation, a written citation is given to the facility. A written response stating how and by what date the deficiency will be corrected is required of the facility. Division of Health Service Regulation (DHSR) staff makes an unannounced follow-up visit to ensure that deficiencies cited are corrected. Complaint investigation reports are also a matter of public record after confidential information has been deleted. A committee desiring a report from DHSR on its findings in a complaint investigation should request it at the time the referral is made.

F. Admissions Procedures

All nursing home patients/residents must first be referred by a physician licensed to practice medicine in North Carolina before they are admitted to a nursing home. Once the referral is made, the resident who expects Medicaid coverage must be approved for financial eligibility by the local department of social services. The resident must also have prior approval from the Division of Medical Assistance to determine whether the resident is medically qualified for Medicaid; then the appropriate level of care must be authorized. No resident may be admitted to a nursing home without prior approval if the care is being paid for by the Medicaid program, unless payment is handled privately during the interim. For *Medicare* recipients, the facility will notify the resident as to whether Medicare will pay for that level of care.

Once the admission is made, specific periodic reviews by the Medicaid and Medicare program are required to make sure the proper level of care is maintained. Nurses and physicians regularly monitor the level of care. Discharge from the facility can result when levels of care are changed, and when the resident depends on Medicare and/or Medicaid to pay for their care. When the resident has been classified at a lower level of care, he/she may remain in the higher level of care pending appeal. The resident who loses that appeal must move to the lower level of care unless he/she chooses to pay the higher rate "out of pocket."

Each facility participating in the Medicaid program must also conduct an in-house review to monitor, on a more frequent basis, the appropriate level of care. These reviews are conducted to utilize Medicare and Medicaid resources in the most efficient manner.

Residents or their families who are dissatisfied with the determinations made on the level of care can appeal the decisions through the Division of Medical Assistance for Medicaid. Residents or their families who are dissatisfied with Medicare coverage determination can appeal the decisions through the Social Security Administration.

Resources:

Division of Health Service Regulation Licensure Section

Mail Correspondence: 2711 Mail Service Center, Raleigh, NC 27699-2701

Physical Location: Lineberger Bldg, Dorthea Dix Campus, 1205 Umstead Drive

Important Phone Numbers:

(919) 855-4520 Nursing Home Licensure Section

(919) 855-3873 Certificate of Need Section

(919) 855-4500 Complaint Investigation Branch

(919) 855-3765 Adult Care Licensure and Certification Section

1(800) 624-3004 DHSR Complaint Hotline

Each state has a Peer Review Organization (PRO) that represents the interests of Medicare recipients. They typically contract with Medicare to ensure that beneficiaries receive quality medical care from doctors, hospitals, skilled nursing facilities, outpatient centers, and home health agencies. This information can be found on the Medicare website at: www.cms.hhs.gov using the search term "Quality Improvement Organization."

The Social Security Administration (SSA) provides information about eligibility for Social Security, SSI, and Medicare benefits. It also provides customers with the location of the nearest SSA office and can provide a copy of the *Medicare Handbook*. 1-800-772-1213.

Additional Resources:

North Carolina Health Care Facilities Association

5109 Burr Oak Circle

Raleigh, N.C. 27612

(919) 782-3827

(For profit nursing homes)

North Carolina Association of Non-Profit Homes for the Aging

3700 National Drive, Suite 218

Raleigh, NC 27612

(919) 571-8333

G. Long Term Care Ombudsman Program

The Nursing Home Residents' Bill of Rights in addition to providing for enforcement of these rights by the North Carolina Division of Health Service Regulation, establishes the foundation of the advocacy role for NHCAC's. As a part of the North Carolina Long Term Care Ombudsman Program, the committees provide the primary point of contact for residents of nursing homes to ensure the implementation of the Bill of Rights. The following description outlines the functions and roles of the North Carolina Long Term Care Ombudsman Program.

1. State Long Term Care Ombudsman

North Carolina Division of Aging and Adult Services

On the state level, the ombudsman program is administered by a State Long Term Care Ombudsman in the Division of Aging and Adult Services who has responsibility for the following:

- a. Certifying persons to serve as regional ombudsmen in each of the multi-county planning and service areas in the state. The Division is also responsible for providing these regional ombudsmen with information, guidelines, training and consultation.
- b. Appointing persons to serve on the Nursing Home Community Advisory Committees when full committee membership is not set by local boards of county commissioners.
- c. Providing information, guidelines, training and consultation to the Nursing Home Community Advisory Committees, in conjunction with the regional ombudsmen, to direct them in the performance of their duties.
- d. Investigating and resolving complaints made by or for older persons in long term care facilities that may affect their health, safety, welfare or rights. This responsibility is primarily delegated to the regional ombudsmen and the Nursing Home Community Advisory Committee
- e. Monitoring the development and implementation of federal, state, and local laws, regulations and policies pertaining to long term care including nursing homes.
- f. Providing information to public agencies about concerns of older persons in long term care facilities.
- g. Conducting other activities consistent with the requirements of the Older Americans Act of 1965, as Amended, such as the establishment of procedures to ensure appropriate access

to long term care facilities, residents and records and to ensure that confidentiality and disclosure requirements are met. Also, the state agency is responsible for establishing a statewide uniform reporting system to collect and analyze information on complaints and conditions in long term care facilities for the purpose of identifying and resolving significant problems.

2. Regional Long Term Care Ombudsman

In each of the area agencies on aging in our state, a Regional Long Term Care Ombudsman Program is the connecting link between the State Long Term Care Ombudsman and the Community Advisory Committees. The regional ombudsmen are responsible for the following:

- a. Assisting in the organization of Nursing Home Community Advisory Committees (NHCAC's) as nursing homes are established in a county for the first time.
- b. Providing training, technical assistance and administrative support to the NHCAC's.
- c. Consulting with the NHCAC's to support members in performing their proper roles and activities.
- d. Investigating and helping to resolve complaints made on behalf of nursing home residents: 1) When the regional ombudsman receives the complaint directly, 2) The NHCAC refers the complaint to the regional ombudsman and 3) At the direction of the State Ombudsman when this intervention is deemed appropriate.
- e. Providing non-confidential information to community agencies and organizations, citizens groups, nursing providers and the general public about issues pertaining to residents of nursing homes.
- f. Maintaining records (e.g., committee minutes, NHCAC quarterly visit reports) and preparing reports, including a compilation and analysis of complaint information, for use by the State Ombudsman and the Nursing Home Community Advisory Committees.
- g. Maintaining a list of committee members and the dates of expiration of their terms, and filing this information with the State Ombudsman and the county Departments of Social Services. Filing new appointments and the designated terms

of office with these agencies/persons within 30 days after their appointment.

- h. Disseminating information received from the Division of Aging and Adult Services to committee members.

3. Nursing Home Community Advisory Committee

The Nursing Home Community Advisory Committee is responsible for the following:

- a. Apprising itself of the general conditions of nursing homes in their community and conducting at least one visit each quarter to all nursing homes.
- b. Promoting community involvement with nursing homes and their residents to enhance the quality of life for the residents.
- c. Promoting education and awareness of the operation of nursing homes and the needs of elderly and persons with disabilities residing in these homes, to include reporting at least annually its appraisal of nursing home care to the local board of county commissioners, regional ombudsman, and the Division of Aging and Adult Services, State Long Term Care Ombudsman Program.
- d. Submitting quarterly reports and complaint investigation reports to the regional ombudsman.
- e. Communicating with the nursing home administrators for the purpose of maintaining the intent of the Nursing Home Residents' Bill of Rights.
- f. Assisting persons who have grievances with nursing homes and facilitating the resolution of grievances at the local level.
- g. Notifying the County Department of Social Services of all reports of abuse, neglect, or exploitation of residents.
- h. Advocating on behalf of residents in the county who currently reside in nursing homes as well as those in need of nursing home care.

H. Functions of Agencies Involved in Monitoring Nursing Home Care

Department of Health and Human Services		
Division of Health Service Regulation	Division of Medical Assistance	Division of Aging and Adult Services
Licensure & Medicare/Medicaid Certification	Medicaid Program	Long Term Care Ombudsman Program Adult Protective Services Program
Enforcement of regulations and Bill of Rights	Prior Approval and Level of Care Assessment	Nursing Home Community Advisory Committees Maintain Spirit of Residents' Bill of Rights

Department of Environment, Health and Natural Resources		
Division of Health Services		
Sanitation	Local Departments of Health Services	Grades Nursing Homes on Sanitation



NC Division of Health Service Regulation Health Care Personnel Registry General Information

The Health Care Personnel Registry Section operates under state and federal laws for unlicensed health care workers and their employers. Our scope includes review and approval of Nurse Aide I education programs and of Nurse Aide I and Medication Aide testing programs. We maintain competency based registries for Nurse Aide I and Medication Aides.

We investigate abuse, neglect, and other allegations against unlicensed health care workers and list allegations and substantiated findings on the Health Care Personnel Registry. Information from the registries is used by health care providers in their hiring process (see Verification Requirements).

Contact Information

Center for Aide Regulation and Education (CARE)

Mailing Address: 2709 Mail Service Center, Raleigh, NC 27699-2709

Registry Staff

Office Hours: 9-3, Monday-Friday

Telephone: 919-855-3969

24-Hour Listing Verification: 919-715-0562

Educator Support Staff

Office Hours: 8-5, Monday-Friday

Telephone: 919-855-3970; Fax: 919-733-9764

Health Care Personnel Registry Investigations

Mailing Address: 2719 Mail Service Center, Raleigh, NC 27619-2709

Office Hours: 8-5, Monday-Friday

Phone: 919-855-3968

Fax: 919-733-3207

Verification Requirements

Nurse Aide Registry

Federal regulations for long-term care facilities [skilled nursing and nursing facilities] require that before allowing an individual to serve as a nurse aide, a facility must receive registry verification that the individual has met competency evaluation requirements. Nursing home employers must also verify listing on the Health Care Personnel

Registry prior to employing a nurse aide or other unlicensed assistant personnel who provide hands-on care. Nurse aides who have substantiated findings of resident abuse, resident neglect, or misappropriation of resident property in a nursing home listed against them on the North Carolina Nurse Aide Registry (or on any State's Nurse Aide Registry) are prohibited from working in a nursing facility [42 U.S.C. Section 1395i-3(g)(1)(C); 42 U.S.C. Section 1396r(g)(1)(C); 42 CFR 483.13 (c)(1)(ii)(B)]. (see Health Care Personnel Registry).

Medication Aide Registry

Effective July 1, 2006, state regulations for long-term care facilities [skilled nursing and nursing facilities] require that the facility must verify an individual is listed on the NC Medication Aide Registry before allowing an individual to work as a medication aide. An employer must keep a record of accessing the registry and must note each incidence of access in their business files. Nursing home employers must also verify listing on the Health Care Personnel Registry and Nurse Aide I Registry prior to employing a medication aide. A substantiated finding on the Health Care Personnel Registry disqualifies the medication aide from employment in a skilled nursing facility per NC G.S. 131E-270(C) (PDF) (see Health Care Personnel Registry).

Health Care Personnel Registry

The Health Care Personnel Registry is a state-mandated registry (NC G.S. 131E-256 (PDF); 10A NCAC 130 (PDF)), that contains the names of health care personnel who have pending investigations of allegations or substantiated findings by the department of resident abuse, resident neglect, misappropriation of resident or facility property, fraud against a resident or facility, or diversion of drugs belonging to a resident or facility. The Health Care Personnel Registry includes all of the findings contained in the Nurse Aide I Registry (resident abuse, resident neglect, or misappropriation of the property of a resident in a nursing facility by a nurse aide) under NC G.S. 131E-255. Before hiring health care personnel into a health care facility or service, health care facility employers as defined in NC G.S. 131E-256(b) must access the Health Care Personnel Registry and note each incident of access in their business files.

Note: Listing verification requirements and employment prohibitions unique to other health care employers may also apply. Health care employers needing guidance on verification requirements and prohibitions specific to them can contact their respective survey or licensure section within the Division of Health Service Regulation or other appropriate regulatory agency.

How to Verify

Verification of individuals listed on the North Carolina Nurse Aide I Registry, North Carolina Medication Aide Registry, or the North Carolina Health Care Personnel Registry may be obtained from www.ncnar.org or by calling the registry's 24-hour automated telephone voice response system at 919-715-0562. Both verification systems provide date-specific confirmation numbers to validate each inquiry.

Comparison of State and Federal Penalty Process for Nursing Homes and Adult Care Home		
Questions	State Process	Federal Process
Which process applies to adult care homes and which one applies to nursing homes?	The state process applies to both adult care homes (ACH) and nursing homes (NH) that have adult care home beds but don't accept Medicare or Medicaid funding	The federal process only applies to nursing homes that receive Medicare and Medicaid funds.
What is the statutory authority?	North Carolina General Statute 131D-34 (N.C.G.S.) applies to ACH and N.C.G.S. 131E-129 applies to nursing homes.	The Social Security Act and Code of Federal Regulations (CFR Part 401 et al.) See Penalty Grid.

Comparison of State and Federal Penalty Process for Nursing Homes and Adult Care Home		
Questions	State Process	Federal Process
Who monitors the facilities for compliance?	<p>Free Standing ACH's are monitored by county departments of social services who do routine and complaint investigation on a regular basis. The staff of the Division of Health Service Regulation also conducts annual surveys of these facilities. They also assist counties with some complaint investigations.</p> <p>Nursing homes that are not certified to receive <i>Medicare</i> or <i>Medicaid funds</i> are surveyed by staff in the Licensure and Certification Section of DHSR every 3 years and as needed for complaint investigations</p>	<p>Staff in the NH Licensure and Certification Section of DHSR does all the routine monitoring of compliance with federal requirements. They also monitor for compliance during the complaint investigations.</p>
Who imposes penalties?	<p>ACH – The Chief of Adult Care Licensure in DHSR, following recommendations from the Penalty Review Committee. The members of the PRC are appointed by the Secretary of Health and Human Services.</p>	<p>NH – Category (1) violations are remedied by sanctions imposed by DHSR. Violations at the higher levels of harm are recommended by DHSR and imposed by the Centers for Medicare and Medicaid Services (CMS).</p>

Comparison of State and Federal Penalty Process for Nursing Homes and Adult Care Home		
Questions	State Process	Federal Process
Cont.	For an ACH violation in a combination NH, (<i>a facility that has both ACH and NH beds</i>) the Chief of Nursing Home Licensure and Certification issues the penalty(ies) .	
What are the criteria for monetary penalties?	<p>Type A violations are those infractions that create substantial risk that death or serious physical harm will occur or where death or serious harm has occurred.</p> <p>Type B violations are the type of infractions that present a direct relationship to the health, safety or welfare of residents, but not substantial risk of death or serious physical harm.</p>	The federal determination of civil monetary penalties depends on the scope and severity of the violations. There are monetary fines when no actual harm occurred, but there was a high likelihood of serious harm, death or impairment. Violations that constitute immediate jeopardy can trigger fines ranging from \$3,050 -10,000 per/ day or per instance fines ranging from \$1,000 -\$10,000. Civil money penalties are also recommended for noncompliance found at a revisit and substandard quality of care.

Comparison of State and Federal Penalty Process for Nursing Homes and Adult Care Home		
Questions	State Process	Federal Process
What enforcement tools are available besides monetary fines?	<p>In both types of facilities any of the following can be used:</p> <ol style="list-style-type: none"> 1) A Provisional License-Reduction from a full to a provisional license can occur when the provider fails to substantially comply with applicable laws and rules. 2) Suspension of New Admissions – The facility is prohibited in accepting new residents when a provider fails to substantially comply with applicable law and rules. This is always done in conjunction with a provisional license. 	<p>In addition to monetary fines, federal remedies may include the following:</p> <ul style="list-style-type: none"> Directed Plan of Correction (POC) In-service training State on-site monitoring Denial of payment for all current residents Temporary Management Termination from the Medicare program

Comparison of State and Federal Penalty Process for Nursing Homes and Adult Care Home		
Questions	State Process	Federal Process
Cont.	<p>3) Temporary Management – The General Assembly passed a law in 1993 which enables DHSR in lieu of using revocation or summary suspension action to ask the courts to appoint a temporary manager to operate a facility where the condition exist that create a substantial risk of death or serous physical harm to residents. Unfortunately, the instances in which the Division needed to use this option it was not available because the Division could not wait 20 days for the Court to act. In addition to this barrier, there haven't been any funds allocated to pay for temporary managers.</p>	

Comparison of State and Federal Penalty Process for Nursing Homes and Adult Care Home		
Questions	State Process	Federal Process
<p>Cont.</p>	<p>4) Revocation – This action can occur when a provider fails to substantially comply with applicable laws and rules.</p> <p>5) Summary Suspension of License – This most drastic of options which can mean literally closing the facility and moving residents without prior due process in the event that there are imminent life-threatening conditions in a facility.</p>	

SECTION VI

Complaint Management

Complaint Management

This section discusses a variety of issues related to the management of complaints made by or on behalf of residents in long term care facilities. It provides a practical approach to handling complaints, in five parts:

- A. Complaint Receipt
- B. Complaint Investigation
- C. Complaint Resolution
- D. Complaint Follow-up
- E. Documentation of the Complaint Resolution Process

A. Complaint Receipt

This part stresses the various sources and types of complaints and the general approach that should be taken by the CAC.

1. Sources of Complaint

The CAC will receive complaints via telephone, mail, or personal contact from a variety of sources, including:

- Residents in long term care facilities;
- Resident's family;
- Resident councils;
- Regional Ombudsmen;
- Friendly visitor groups;
- Facility staff;
- Facility administrator (against a family member or guardian);
- Social work and human service agencies;
- Legislators and political leaders.

The most common sources of complaints are relatives or residents. However, they may hesitate to complain for fear of retaliation against their loved ones. Families may also fear that once the facility staff has labeled them as "complainers" or "guilty children" their credibility will decrease.

Staff members are a frequent source of complaints. Staff complaints may be based on a variety of motives. On the one hand, many staff are concerned about residents and want to

provide the best care possible. On the other hand, some staff members become disgruntled with their employer due to low pay, poor working conditions or other disputes with management.

Another important source of complaints comes from observations made by CAC members during official quarterly visits or friendly visits to the facility. These complaints might pertain to the general conditions of the facility or a violation of a specific resident's right. Some of these complaints may be such that they can easily be verified and resolved "on the spot." (*Examples: checking with staff to see if meals have been served, drugs administered and clothes washed, etc., are concerns that can easily be checked and answered*). Other complaints might be sensitive and/or complex enough to necessitate consultation with the committee chairperson.

When a complaint is received from any of these sources, it should be brought to the attention of the committee chairperson. The committee should then analyze the complaint and create a plan of action for investigation.

2. Complaint Resolution Procedures

Complaints received by the State Long Term Care Ombudsman are referred to the appropriate regional ombudsman if the complaint is deemed appropriate for resolution by the Long Term Care Ombudsman Program. The State Ombudsman will provide technical assistance throughout the complaint resolution process if needed.

The following procedures will be followed by regional ombudsmen and community advisory committees in the complaint resolution process:

- a. Complaints Received by Community Advisory Committee Members
 - (1) When a complaint is received by a community advisory committee member, it will be referred to the chairperson of the committee for investigation. The chairperson may consult with the regional ombudsman to obtain technical assistance regarding the complaint. If the chairperson does not reveal the complainant's identity he/she maintains jurisdiction over the complaint and is expected to follow required protocol for investigations. The chairperson is

responsible for completion of the Case Record, maintaining confidentiality of the resident unless appropriate consent is obtained to disclose his/her identity. The Case Record will be completed and forwarded to the regional ombudsman, who provides coverage for that facility.

- (2) The regional ombudsman is responsible for training community advisory committees in complaint resolution procedures, including timely response to complaints, use of appropriate consent forms, confidentiality requirements, procedures for reporting suspected cases of abuse, neglect and/or exploitation as well as possible licensure violations. S/he is also responsible for supplying copies of reporting and consent forms to the committee.
 - (3) If the community advisory committee chairperson discloses the identity of the resident to the regional ombudsman, the regional ombudsman then assumes jurisdiction and oversight over the complaint. S/he may utilize the community advisory committee for grievance resolution if consent of the resident or resident's legal representative is obtained. However, s/he is responsible for ensuring appropriate procedures are followed, the appropriate consent forms are signed and that the Case Record is completed and kept in the regional ombudsman's confidential locked files.
 - (4) The regional ombudsman is responsible for referring complaints which cannot be resolved through mediation, conciliation and persuasion with the facility administration to the appropriate licensure agency.
- b. Complaints Received Directly by a Regional Ombudsman
- (1) When a regional ombudsman receives a complaint directly, s/he retains jurisdiction and oversight over the complaint throughout the complaint resolution process. S/he is responsible for ensuring proper procedures are followed and appropriate consent forms are obtained.
 - (2) The regional ombudsman will visit the resident in the facility within 1-4 working days from the date the complaint is received. The regional ombudsman is responsible for obtaining information on the facility's visitor registration policy prior to visiting the facility and shall comply in full with that policy. The regional ombudsman will proceed to the resident's room after

registration with the facility if required. The regional ombudsman shall identify himself to the resident. The resident has the right to refuse to communicate with the ombudsman. The resident also has the right to participate in planning any course of action to be taken on his behalf by the regional ombudsman. In addition, s/he has the right to approve or disapprove any proposed action to be taken on his behalf by the ombudsman.

If the resident refuses to communicate with the ombudsman, the complaint will be referred to a regulatory agency for investigation if appropriate and no further action will be taken by the regional ombudsman on this resident's behalf. If the complaint is filed by the resident's guardian or other responsible party, s/he will be informed of the resident's decision and alternative methods and options for complaint resolution will be discussed.

If the resident requests the services offered by the regional ombudsman, the regional ombudsman will inform the resident that either written consent, oral consent or a court order must be obtained in order to disclose the identity of the resident or complainant. Furthermore, in order for the ombudsman or a representative of the ombudsman's office to have access to the medical and social records of a resident, one of the following three conditions have to be met: (1) the representative has the permission of the resident or the legal representative of the resident; or (2) the resident is unable to consent to the review and has no legal representative; or (3) access to the records as necessary to investigate a complaint if – (a) a legal guardian of the resident refuses to give permission; (b) a representative of the Office has reasonable cause to believe that the guardian is not acting in the best interests of the resident; and (c) the representative obtains the approval of the State Ombudsman.

If the resident gives permission for the regional ombudsman to disclose his/her identity, the *Resident Authorization Form (DHRDAAS- 9112)* shall be completed and signed by the resident. The *Consent to Review Medical/Social Records Form (DHR-DAAS- 9113)* must be completed in order to review the above mentioned documents. If oral consent is obtained the *Resident Oral Consent Form (DHR-DAAS-9114)* must be completed. If another individual is the complainant then use

the *Complainant Authorization Form (DHR-DAAS-9115)*. If the resident is incapable of giving permission to pursue the complaint then the written consent of their legal representative must be obtained on form (*DHR-DAAS-9116*).

If the resident does not give permission for the regional ombudsman to disclose his identity, but requests the regional ombudsman to advocate on his behalf, the regional ombudsman will attempt to resolve the complaint and not disclose the identity of the resident. If the resident gives permission to review his medical/social records, but does not give permission for his name to be disclosed, the *Resident Authorization Form (DHR-DOA-9113)* must be signed reflecting this decision, as well as the *Consent to Review Medical/Social Records Form (DHR-DOA-9118)*.

If the facility's policy requires disclosure of the name of the resident in order to access medical/social records and the resident requests that his/her name not be disclosed, the regional ombudsman will inform the resident of the facility's policy and discuss alternative methods for facilitating resolution of the complaint by referral of the complaint to the appropriate regulatory agency for investigation or the regional ombudsman can attempt to resolve the complaint without viewing the resident's records. If the regional ombudsman utilizes any community advisory committee members for grievance resolution, permission must be obtained from the resident to utilize them for this purpose. The community advisory committee members may resolve the complaint, but the regional ombudsman must maintain jurisdiction and oversight over the complaint since s/he received it directly. The regional ombudsman is responsible for completing the Case Record and attaching the appropriate consent form(s).

(3) The regional ombudsman shall meet with the facility administrator or designated person in charge in an exit conference before any action is taken to allow the facility the opportunity to respond, provide additional information or take appropriate action to resolve the complaint. The regional ombudsman will utilize techniques of mediation, conciliation and persuasion in attempting to resolve the complaint with the administrator of the facility. If these efforts are unsuccessful and the regional ombudsman determines that the complaint has not been resolved, it will be

referred by the end of the next working day of the regional ombudsman to the appropriate licensure agency pursuant to G.S.131E-100 through 110 and G.S.131D-2. If the regional ombudsman determines that the complaint is not substantiated, s/he will explain why it was not substantiated and indicate that no further action will be taken by the regional ombudsman.

- (4) Complaint information will be recorded on the *Case Record (DHR-DAAS-004)*. The appropriate consent form(s) must be attached to the Case Record. This information is confidential and shall be kept in the regional ombudsman's locked files. When the regional ombudsman refers a complaint to a regulatory agency, s/he will request a written follow-up report on the findings of the investigation and/or whether it was substantiated.

Upon completion of the complaint resolution process, the regional ombudsman will provide follow-up information on the findings to the appropriate individual(s), (i.e. resident, resident's guardian and/or legal representative).

c. Regional Ombudsman Receives Complaint Directly/Resident or Legal Representative Does Not Give Consent for Involvement of Community Advisory Committees in Complaint Resolution Process

- (1) When a regional ombudsman receives a complaint directly, s/he will visit the resident in the facility within 1-4 working days from date the complaint is received. The regional ombudsman is responsible for obtaining information on the facility's visitor registration policy and shall comply in full with this policy. The regional ombudsman will proceed to the resident's room after registration with the facility if required. The regional ombudsman shall identify himself to the resident. If the resident or resident's legal representative requests the services of the regional ombudsman, but does not give permission for other individuals to be involved in the complaint resolution process, the regional ombudsman cannot involve the community advisory committees in the complaint resolution process. The regional ombudsman is responsible for obtaining appropriate consent of the resident or resident's legal representative on the appropriate consent form(s) (see Forms) to review the

resident's medical/social records and the appropriate consent to disclose the identity of the resident.

- (2) The resident or resident's legal representative has the right to participate in planning any course of action to be taken by the regional ombudsman on the resident's behalf. In addition, s/he has the right to approve or disapprove any proposed action to be taken on his/her behalf.
- (3) The regional ombudsman will gather as much relevant information as possible in an effort to resolve the complaint locally.
- (4) The regional ombudsman shall meet with the facility administrator or person in charge in an exit conference before any action is taken to allow the facility the opportunity to respond, provide additional information or take appropriate action to resolve the concern. The regional ombudsman will utilize techniques of mediation, conciliation and persuasion in attempting to resolve the complaint with the administrator or the facility. If these efforts are unsuccessful and the regional ombudsman determines that the complaint has not been resolved, it will be referred by the end of the next working day of the regional ombudsman to the appropriate licensure agency pursuant to G.S. 131E-100 through 110 and G.S. 131D-2.

If the regional ombudsman determines that the complaint is not substantiated, s/he will explain to the complainant and the resident or resident's legal representative why it was not substantiated and indicate that no further action will be taken by the regional ombudsman.

- (5) Complaint information will be recorded on the *Case Record (DHR-DAAS-004)*. The appropriate consent form(s) must be attached to the Case Record. This information is confidential and must be kept in the regional ombudsman's locked files.

When the regional ombudsman refers a complaint to a regulatory agency, s/he will request a written follow-up report on the findings of the investigation and/or whether it was substantiated.

Upon completion of the complaint resolution process, the regional ombudsman will provide follow-up information on the findings to the appropriate individual(s).

d. General Concerns Regarding Problems Observed While in a Facility

- (1) While visiting a facility, if a regional ombudsman\ community advisory committee member observes any problems, s/he can address these concerns with the facility administration even if a formal complaint has not been filed.
- (2) If the regional ombudsman/community advisory committee member is unable to resolve the issue with the facility administrator and it involves possible licensure violations, it will be referred to the appropriate licensure agency.
- (3) The regional ombudsman/community advisory committee member is responsible for completion of the Case Record and maintaining confidentiality of the resident(s).

e. Anonymous Complaints Received by a Regional Ombudsman/ Community Advisory Committee Member

- (1) When the regional ombudsman/CAC receives an anonymous complaint s/he will attempt to resolve the complaint as a concern or issue with the facility administration utilizing techniques of mediation, conciliation and persuasion.
- (2) If the regional ombudsman/CAC is unable to resolve the issues or concerns, s/he will refer it to the appropriate licensure agency for investigation.
- (3) The regional ombudsman/CAC is responsible for completion of the Case Record and maintaining confidentiality of the resident(s).
- (4) If the regional ombudsman/CAC receives an anonymous complaint about a specific complaint resolution, procedures discussed under Section VI shall be followed.

3. Confidentiality

Frequently, the complainant will request that his/her name and/or name of a resident be kept confidential during the resolution

process. Many people will only make a complaint if they are assured of this confidentiality.

You should explain the requirement for confidentiality required by law (G.S. 131D-31 and G.S. 13E-128) and Division of Aging and Adult Services Policies and Procedures to the complainant before initiating the complaint resolution process. If individuals insist that their names be kept confidential, they should be told that even though you will do everything possible to protect their identity, there is the possibility that the facility may be able to determine who made a complaint. You should also explain that certain types of complaints are virtually impossible to investigate without revealing the identity of the resident. You should discuss with the complainant the risks involved in being identified. A guarantee that retaliation will not occur should never be offered to obtain the complainant's permission to use his/her name. In cases where complainants agree to have their names revealed, the CAC should have the appropriate consent form(s) signed authorizing the disclosure of names.

4. Anonymous Complaints

Anonymous complaints pose similar problems to maintaining complainant or resident confidentiality. There are two types of anonymous complaints.

One involves a complaint so general you may be unable to document the complaint.

Visiting the facility to observe the general conditions as well as discussions with residents will better enable the committee and/or the regional ombudsman to determine the quality of care being provided.

Licensure records and any complaint investigation records available should be reviewed also. (*Check with the regional ombudsman on how to obtain*).

If no investigation is made, then the complaint should be noted on the complaint form. In the event the facility is investigated in the future, the allegations of the anonymous complaint can be included in the inquiry.

The second type of anonymous complaint is specific and surrounded by supporting data. For example: In a phone conversation an unidentified resident made the charge that a home had no air-conditioning and the food was inadequate; the food service was not the same as described in the menu plan. The caller provided the name and address of the home and hung up.

Because there is specific information about the general conditions in this complaint, an investigation can be made.

B. Complaint Investigations

Investigation is at the heart of any complaint resolution process. The investigation determines whether the complaint is valid and gathers information necessary to resolve it. This section will cover classifying and analyzing the complaint, organizing a strategy for investigation techniques, and assessing the facts uncovered in the investigation.

1. Clarify and Analyze the Complaint

a. Get a clear statement of the complaint.

After a complaint has been received, the complaint will need to be clarified in order to determine how to pursue complaint resolution effectively. The following objectives should be met during this phase: Contact the person who made the complaint. Try to get as many facts as possible. Most people who make a complaint about conditions in long-term care facilities need help focusing on the actual problem. Often people will call or write about a complaint, which involves several problems. These need to be stated separately and ranked in order of importance. Also, problems often are stated in sweeping terms (“the food there is terrible”) and you will need to work with the complainant to pinpoint what it is about the food that makes it unacceptable. Be sure that you have clearly defined the complaint and that it is mutually understood by you and the complainant. Be aware of how the complainant’s physical, mental and emotional condition can affect or relate to the complaint. Some of the more seriously ill residents may be taking medication that could affect their thinking processes. Also, there may be complainants with severe memory lapses, fears of retribution from staff or a very weak understanding of their own

problems. It is frequently necessary to assist the complainant in stating and clarifying the complaint. However, try to remain unbiased. Be an objective listener. Do not assume that the complaint isn't valid or the resident is too ill to know what he is talking about without a thorough investigation into all the facts of the complaint.

b. Categorize the Complaint

The CAC should now determine what type of complaint this is. Does this complaint involve the rights of a specific resident, or is it a complaint about the general conditions of the home? Who is the complainant and has the complainant requested his/her name be kept confidential? Is the complaint anonymous? Is the complaint vague or specific? Answering these questions will help you determine how to proceed with your investigation. The CAC is responsible for determining which of the complaints it receives it can properly investigate. If the community advisory committee elects not to pursue complaint resolution, the complaint should be referred to the regional ombudsman, the Division of Health Services Regulation or the county department of social services. G.S. 108A-105 mandates that complaints received that appear to involve an immediate threat to the health, welfare, or safety of any resident(s) must be referred immediately to the county department of social services director (or his/her designee). It is the responsibility of the county department of social services to designate one person to whom the CAC should refer complaints.

c. Identify the Significant Persons/Resources

You should ask yourselves: Who is responsible and who has the power to do something about it? It is important to gather names, phone numbers and addresses of all people who might have some role in the situation including physicians, pharmacists, social workers, etc. A complaint about resident care could include: the complainant, the resident, the facility staff and the facility administrator.

d. Identify Relevant Agencies

Complaints may involve public or private agencies. Complaints about resident care, for example, may involve a hospital or other health care facility. A problem concerning Medicaid, Supplemental Security Income or State-County Special

Assistance for Adults most likely would involve the county department of social services. You will need to identify any other agencies that may play a role in the problem and become familiar with their areas of responsibilities. The regional ombudsman can provide technical assistance in identifying appropriate agencies.

e. Identify Steps Already Taken by the Complainant

If the complainant has taken some action, you will need to know this. For example, has the complainant talked with anyone at the facility, such as the administrator or supervisor in charge? Have there been any meetings with staff? Has there been any correspondence regarding the case to local or state agencies responsible for monitoring the home or to others? If the complainant has not attempted to deal with the complaint yet, the CAC is then in a position to suggest possible steps that the complainant can take. Advice of this nature helps the complainant to learn self-advocacy.

f. Identify Information Gaps that Might Require Research

Determine what regulations or records need to be reviewed. Determine who needs to be interviewed to obtain more information. Decide what should be observed when you visit the facility.

2. Organizing a Strategy for Investigation

A plan of action for investigating complaints should be developed. This involves determining who will be involved in the complaint resolution process. This activity should be coordinated by the committee chairperson and the chairperson should be kept informed at all times of the results of the investigation as it is carried out.

3. Investigation Techniques

a. Observation in the Facility

Investigating observation is more than casually looking at something. It is a method of obtaining information that uses the senses to receive information which is not available through other techniques and which supplements other techniques of collecting information. It is a planned, disciplined approach to using the five senses.

Many complaints can only be understood and verified by sharing in the experience of the complainant. Complaints that have to do with items such as staffing, sanitary conditions and food often can only be fully checked out through observation. You should approach a situation requiring investigative observation with an open mind and understanding of what is observed. Having an open mind means that the observation will be interpreted without emotional bias.

Having an understanding of what is observed means the ability to recognize the implications of what is observed and concentrating on the relevant data. During an investigative observation it is crucial for you to be as impartial as possible. If the observer only looks for evidence that fits a preconceived notion or theory, other evidence may be missed or much of the evidence may be misinterpreted. Also, keep in mind that simply by being there you may have an effect on what's going on. Plan your visit for a time when you may have less of an effect and try to maintain the objective observer role. Any attempts to cover up or evade issues should be noted.

Finally, be aware of your personal reactions to your observations, and control them, *i.e., you don't show approval or censure of any particular occurrence*. Hold an exit conference with administrator(s) or his/her representative(s) specifying allegations and findings (if conclusive), and indicating if the investigation is concluded or will continue.

b. Interview

Interviewing is a primary component of complaint investigation. In order to discover the facts of a case (the who, what, when, where, why, and how), you might interview a resident, an administrator, the facility staff, or an employee of another agency or institution. One of the elements which you must remember is that the interview itself is a social situation, and the relationship between you and the interviewee will affect what is said. Although you will want to direct the interview in order to achieve its goals, most of the time will be spent listening. You should be alert to more than spoken word. Facial expressions, voice inflection, eye contact, gestures and general behavior should be noted. More may be learned from an interviewee's body language than from his/her comments. In many cases, more can be learned from what is not said than from what is said.

During all interviews observe the following guidelines:

- ❑ maintain objectivity;
- ❑ try to establish rapport before addressing the problem;
- ❑ explain the purpose of the interview and the function of the CAC;
- ❑ encourage responses about the problem area using open-ended questions, such as, "Can you tell me more about the food here?"
- ❑ attempt to obtain specific details and facts through the use of closed-ended questions such as, "Are you getting enough to eat?"
- ❑ use language that is easy to understand and explain any technical terms;
- ❑ guide the interview toward the desired goals, yet be flexible enough to adjust the goals according to any new information received;
- ❑ listen carefully in order to be able to distinguish between fact and fiction;
- ❑ let the interviewee know when the interview is about to end and summarize what has been accomplished; and
- ❑ explain how the information will be used and other steps anticipated in conducting the investigation. Also explain what, if any, future involvement the person being interviewed can expect.

At the beginning of a resident interview, inform the resident of the confidentiality requirements regarding written consent for disclosure of names of the complainant(s). In addition, it's extremely important to avoid making promises to the resident regarding resolution of the problem. At the conclusion of the interview secure the resident's consent to the planned course of action before proceeding.

The notes taken during the interview should be written up as quickly as possible.

Note: *The administrator or, in his/her absence, the supervisor in-charge should be interviewed first in every complaint investigation. This is sometimes called the entry conference. He/she may not be aware of every problem*

in the home and may not be able to provide information. However, he/she should be included in each investigation for the following reasons:

- to seek the administrator's assistance in identifying individuals who can contribute information regarding this case;
- he/she is ultimately responsible; and
- to develop and maintain a relationship with the administrator which may be useful in future work.

c. Examine Records and Official Documents

Some of the records and documents that might provide information to verify or discredit a complaint are:

- The resident's health records with written consent.
- Copies of bills, letters, written agreements, house rules, etc. (e.g. an admission contract, grievance procedures).
- Inspection reports, license applications, and complaint investigation reports (maintained by the Division of Health Services Regulation and the county department of social services).

Although health records are useful, there are two problems which may arise regarding them. First, health records are confidential. The resident, or the legal guardian if one has been appointed, must sign a written statement authorizing release of the records.

Second, health records are often not totally complete and/or accurate. Records are sometimes filled out hurriedly. If the records are available to review there may be portions which you do not understand. You must determine if an interpretation of medical information is needed. Committee members may decide that the complaint should be referred to the regional ombudsman or the appropriate licensure agency for action if there are no appropriately licensed professionals on the committee, (*i.e. nurses, dietitians, etc.*) to interpret medical information.

4. Assess All Information Collected to Verify or Discredit the Complaint

A complaint is verified if it is shown that the alleged problem does exist or did occur. Verifying a complaint does not involve repeating the investigatory process. It is the final step in the investigating process. Verification provides an opportunity for you to review what has been done on the complaint and to determine whether you have sufficient reason to proceed with complaint resolution. Throughout the complaint investigation the CAC should meet to analyze the case in order to try to answer the following questions:

- Is there a problem?
- Why did the problem occur ?
- What evidence is available to show what happened ?
- What justification or explanation does the facility give for the situation ?
- Who, if anyone, is at fault in causing the problem ?

Answering these questions will help you to verify or discredit the complaint, and provide the information you need to select a resolution strategy.

After the CAC has investigated the complaint and attempted to substantiate it, there may appear to be no basis for the complaint. At this point, you should explain the situation to the complainant and encourage the complainant to contact you if there are any further developments. The fact that you investigated the case may help the complainant to get some resolution of the problem. You should also explain that not substantiating the complaint does not mean that you question the honesty or sincerity of the complainant. Finally, you should discuss any alternative steps that might be available.

For example, there may be another agency better suited to deal with the complainant's concern. In some cases there may be a reason for suggesting that the resident consider moving to another home or a different type of facility.

C. Complaint Resolution

1. Factors to Recognize and Respect in Pursuit of Resolution

The CAC cannot expect to resolve every complaint. Some complaints are unreasonable. You must have a realistic understanding of what changes the committee can or cannot effect. Don't be surprised if you discover there is nothing you can do about a complaint even when the data indicates it is both verified and valid. You may refer the problem to other sources/agencies for assistance in negotiating/solving.

The second factor you should keep in mind is that a resolution is not always clear cut and decisive. Many complaints are so complex that pieces of the total complaint pass through periods of relative states of resolution. Each one of the items of a complaint can be resolved for a time, but can be frustrating due to their reoccurrence.

2. Complaint Negotiation

Negotiation is bargaining with another party in an effort to arrive at an agreement. However, while negotiation is often thought of as a tense encounter between two hostile parties, it is in many cases a peacemaking activity. However, in any negotiation, no matter how amiable, both sides are attempting to realize or achieve their particular and usually opposite agenda.

You will usually not be negotiating from a position of power; that is, you do not possess something that the opposing party (usually the administrator) wants or desires. However, with the knowledge of the law and regulations, adequate preparation, and understanding of the facts of the situation, you will be able to convince the opposing party of the soundness and correctness of your position.

a. Preparing for the Negotiation

Adequate preparation for negotiation can never be minimized. Before the negotiation session, an agenda should be prepared so that the discussion does not get sidetracked. Remember that you will not be able to develop your case during the negotiation but must have it fully outlined and prepared in advance of the actual session. Keep the materials which you take to the negotiation session as brief as possible so that you

do not become tangled up in trying to find materials which you have brought along.

It is critical that you know whom you are representing, what changes the client wants, and in what areas you will consider a compromise. Negotiations should not be entered into without knowing what can and cannot be done by all parties to achieve the desired results. This means that you will have to prepare both sides of the argument; knowing your weak points and theirs will enable you to maneuver creatively around them. Be prepared to concede points that will not affect the ultimate outcome of the negotiation and have clearly in mind the range of settlement positions which would be acceptable. This kind of preparation will give you the confidence resulting in control of the agenda and the flow of the discussion itself.

b. Negotiation Strategies

(1) Be Reasonable

Being reasonable never requires you to give up more than you want to. It is simply a matter of showing the other side that you are willing to listen and respond to their issues and that you expect them to do the same.

A reasonable attitude helps to diffuse an atmosphere of tension that might have built up as the problem neared the negotiation state. It also can be a disarming strategy when the other side expects you to come in shouting threats.

Another facet of being reasonable is avoiding highly rhetorical arguments of polarized positions. Rather than accusing a facility operator of being “cruel” or “heartless,” explain the position of the resident in a cool but articulate manner. Let the facts speak for themselves.

A third part of being reasonable is to show a certain amount of empathy with the other side. While you obviously want to represent the resident, it is first necessary to fully understand the other side’s position. This will reveal possible areas of compromise and at the same time prepare you to better oppose those positions with which you disagree. An empathetic attitude also encourages one’s opponent to divulge information more freely. (See *Appendix F for “Key Points in Persuading”*).

(2) Rebuttal

If you've adequately prepared your opponent's position you can be ready to challenge any statements he makes. But, first keep in mind how important it is not only to allow the opponent sufficient time to make his point but, also listen carefully to all that he says. It is helpful to restate the opponent's expressed position to confirm for yourself and the opponent your understanding of it. Many times your questioning of his position will show him the feebleness of his stand and assist in furthering your goal.

Another approach is to bring out points in opposition to an opponent's statement as follows:

- The facts as they know them are incorrect. (*You should have supporting documentation of what the facts really are*).
- The facts as they are applied are incorrect.
- The proposed action is opposed to general policy considerations.
- The proposed action is contrary to the best interest of the client.
- The opponent is mistaken in their interpretation of rules, regulations or the law.
- Your client is either an exception to or not included in the policy, regulation, or law being applied. (*You should be able to explain why this is the case and be prepared to offer proof or additional information*).

Your statements will be convincing if you have a thorough knowledge of the issues. Be careful not to antagonize the opposing party(ies) by appearing overly forceful in your presentation.

D. Complaint Resolution Follow-Up

The CAC should have a program to follow-up on complaint resolution. The purposes of the follow-up are to:

1. Verify that the resolution of the complaint has in fact occurred;

2. Assure the complainant that everything possible has been done;
3. Monitor the continued performance of the agreed upon action;
4. Detect deficiencies in long term care standards.

Follow up on complaints should take place within in a designated timeframe such as 30-90 days after resolution. At this point, the CAC should determine if anything has gone wrong and take further action if necessary. Remember that no action should be taken without the permission of the complainant and/or the resident involved.

E. Documentation of the Complaint Resolution Process

Enough cannot be said about the importance of accurately documenting the events that occur in every step of the complaint process.

Documentation can prevent or reduce mistakes or misunderstandings and can be used to support claims filed in a court of law. Also, if you should have to refer the complaint to another agency for resolution, supportive evidence is crucial and should be reported in a logical and sequential order.

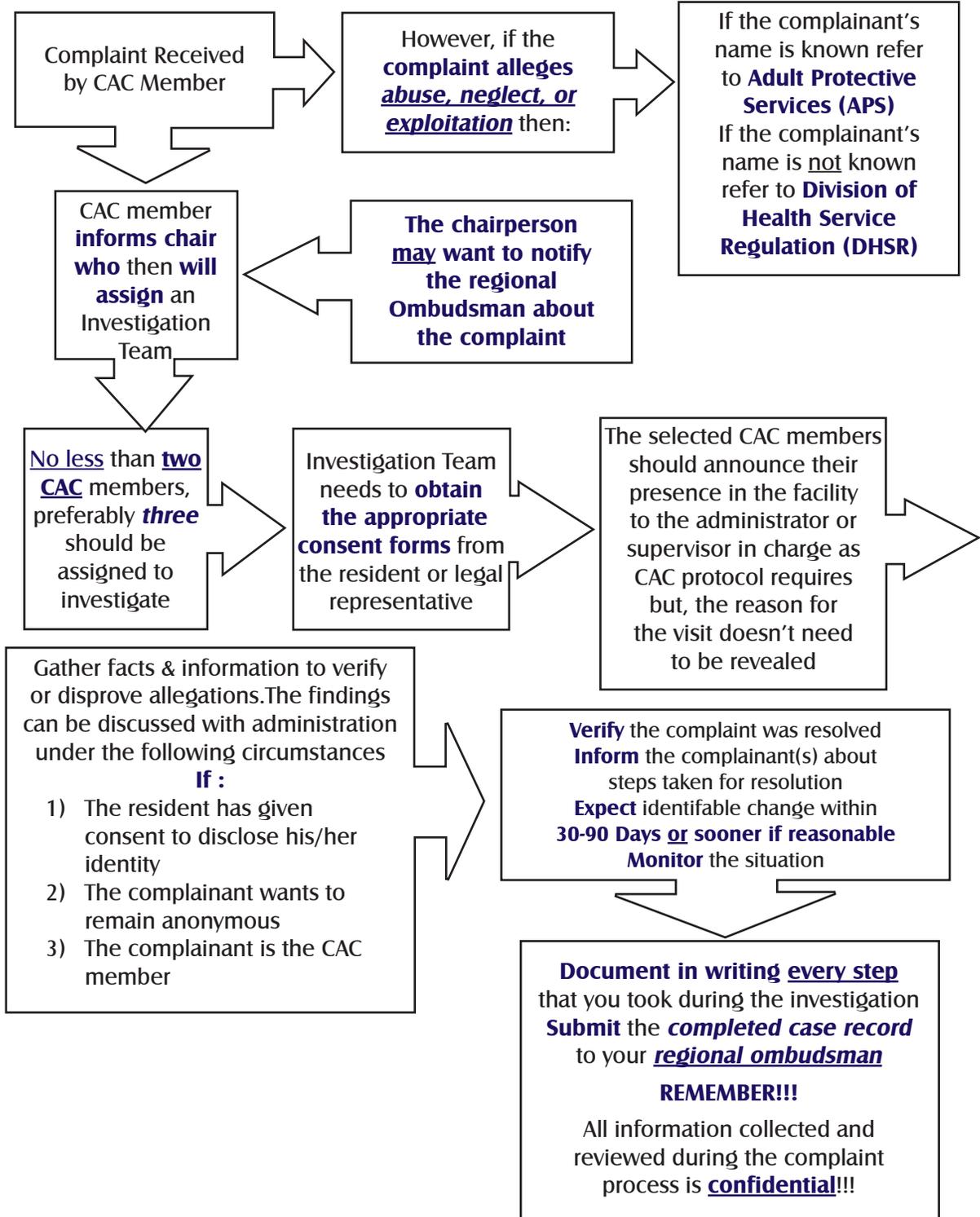
All documentation should be dated and should ideally include:

1. The complaint statement
2. The investigation report, including:
 - the investigation plan
 - interview summaries
 - documents reviewed (or summaries of the significant data in those documents as it refers to the complaint)
 - results of observation of facility settings
 - witnesses' statements
 - committee members involved
3. Conclusions drawn from a review of data collected

4. Results of the negotiation
 - who agreed to do what and when
 - suggestions for follow-up plan to determine if the complaint has been, in fact, resolved
5. Follow-up report to record effectiveness of complaint resolution strategy. All data collected and recorded during the complaint resolution process is to be kept confidential. Do not talk to residents, facility staff, or anyone else about what other residents, staff, or other participants have told you, unless you're specifically directed by the committee chairman to do so. You should keep silent about all the specifics related to any case in which you are involved. This means that you are expected not to tell ANYONE (friends, relatives, general public, etc.) even the name of the facility or type of complaint you are investigating.

The CAC member(s) must report all licensure violations that it substantiates to the appropriate regulatory agency. Complaints involving adult care homes are referred to the county department of social services. Substantiated complaints regarding care in nursing homes are referred to the *Complaint Investigation Unit* at the *Division of Health Services Regulation*. You can call the toll free number (1-800-624-3004) and ask for the *Nursing Home Licensure Section*. You can also contact them directly at (919) 855-4520. The complaint report should include the nature of the violation of the Residents' Bill of Rights (including the name of the resident(s) involved in the complaint if they have given written permission for the disclosure of this information), the name of the facility, the complainant's name and phone number if they have given written permission for the disclosure of this information, an indication whether the complainant desires a follow-up report, and any additional facts that may be of assistance resolving the complaint.

CAC Complaint Investigation Flow Chart



RESIDENT AUTHORIZATION FORM

Your signature on this Resident Authorization Form gives written consent for the Regional Ombudsman and/or Community Advisory Committee to pursue complaint resolution on your behalf. The signed form is kept in the Regional Ombudsman's file.

A. Permission to Pursue Complaint

_____ (Name) _____ (Title)

has my permission to discuss the complaint(s) I have regarding my care with the administration and staff of _____ (Facility)

as well as with other individuals deemed necessary to resolve the complaint(s).

_____ **yes** _____ **no**

I also give permission for my name to be disclosed in the complaint resolution process.

_____ **yes** _____ **no**

_____ **Signature of Resident** _____ **Date**

RESIDENT AUTHORIZATION FORM**B. Permission to Review Medical/Social/Financial Records**

_____ (Name) _____ (Title)
has my permission _____ to view my
(Resident's Name)
medical/social/financial records in order to pursue complaint resolution on my
behalf at _____.
(Facility)

Resident Signature Date

Witness Signature Date

RESIDENT ORAL CONSENT FORM

TO WHOM IT MAY CONCERN:

I have obtained the oral consent of:

_____ at _____
Resident **Facility**

to disclose his/her identity for the purpose of complaint investigation.

Such consent was obtained by me on _____

Date

Regional Ombudsman

or

Community Advisory Committee Member

Date

(NOTE: If the complainant and resident are not the same individual, the consent of each is required).

COMPLAINANT AUTHORIZATION FORM

A. Written Consent

_____ has
my Name Title

permission to discuss with individuals deemed appropriate the complaint I
have filed as well as my name.

_____ yes _____ no

Complainant Signature

Date

OR

B. Oral Consent

TO WHOM IT MAY CONCERN:

I have obtained the oral consent of:

Complainant

to disclose his/her identity for the purpose of complaint investigation.

Such consent was obtained by me on _____
Date

Regional Ombudsman
or

Community Advisory Committee Member

Date

(NOTE: If the complainant and resident are not the same individual, the consent of
each is required).

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LEGAL AUTHORIZATION

To Whom it May Concern:

_____ has
my

(Name)

permission to talk with the administration and staff of _____

_____,
(Facility)

as well as any other individual(s) deemed necessary regarding the care

of _____ and to facilitate resolution of
the

(Resident)

the complaint(s) filed.

_____ has my permission to
view

(Name)

the medical/social records of _____

.

(Resident)

My relationship to _____ is _____

.

(Resident)

(Relationship)

I am legally authorized to give such permission. _____ yes _____ no

Legal Representative Signature

Date

(Form appropriate for Guardians, Health Care Powers of Attorney & Durable
Powers of Attorney ONLY)

DHHS-DAAS-9116

3/06

SECTION VII

Reporting System

Complaint Reporting System

A. Introduction

This section describes the quarterly reports that the CAC members and chairpersons are required to submit to the regional ombudsman.

These reports have been designed to comply with the requirements of the U.S. Administration on Aging and the North Carolina Division of Aging and Adult Services.

Receiving this information from the CAC at the local level on individual cases is essential for identifying patterns of complaints made on behalf of residents as well as general information on the ombudsman program and its complaint resolution function. More specifically, it will help the Division of Aging and Adult Services to:

- Identify gaps in the existing standards and regulations so that appropriate action can be taken to facilitate change;
- Identify and analyze nursing home issues to be used for the development of proposed legislation;
- Determine if the ombudsman program is being implemented as planned;
- Measure quality of care in particular facilities.

B. Required Reports

1. **Confidential Case Record Reports** should be filled out by the CAC whenever a complaint is received. A "complaint" is defined as any issue/concern involving a resident in a nursing or adult care home, which the CAC is asked to investigate and resolve. It is more than a friendly visit or an information and referral call.

The Confidential Case Record Report requires documentation of information that starts from the time the complaint is received and continues through to the followup after the case has been closed.

2. **CAC Quarterly/Annual Visit Worksheets** are to be filled out by one of the CAC members participating in the official

quarterly visit to a nursing home. One form should be completed for each home visited.

3. **Committee Member Activities Record.** Each CAC member is encouraged to submit this information to the regional ombudsman at the end of each quarter. This running log of activities will provide the ombudsman with information he/she needs in order to fill out his/her quarterly report to the Division of Aging and Adult Services as well as provide information regarding contributions by volunteers throughout the State.
4. **Consent Forms.** Permission shall be obtained to disclose the name(s) of any complainant and/or resident involved in a complaint prior to initiation of the complaint resolution process. The appropriate consent forms are listed below:
 - a) *Resident Authorization Form (DHR-DAAS-9112)*
 - b) *Resident Authorization Form (DHR-DAAS-9113)*
 - c) *Resident Oral Consent Form (DHR- DAAS-9114)*
 - d) *Complainant Authorization Form (DHR-DAAS-9115)*
 - e) *Legal Authorization Form (DHR-DAAS-9116)*

The appropriate form(s) shall be completed and attached to the Case Record upon completion of the complaint resolution process. The Case Record is forwarded to the regional ombudsman for review and is placed in the regional ombudsman's confidential files.

Office of the State Long-Term Care Ombudsman ODIS – North Carolina Complaint Categories and Codes

Complaint categories provide only the identification of the problem area, not a statement of the problem or complaint. The following major headings are for complaints involving actions by staff or management of the facility, or problems that staff or management of the facility have the responsibility to resolve:

- Abuse, gross neglect, exploitation
- Access to information
- Admission, transfer, discharge
- Autonomy, choice, rights, privacy
- Financial/property
- Rehab/maintenance of function
- Restraints: chemical and physical
- Activities and social services
- Dietary
- Environment
- Policies, procedures, attitudes

The remaining categories are for complaints against individuals or agencies other than a long-term care facility. The following headings are in this group:

- Certification, Licensing and Monitoring Agency
- Medicaid Agencies (DMA/DSS)
- Other Systems

Complaints Against the Provider Abuse, Gross Neglect, Exploitation

This category is used to code serious complaints of willful mistreatment of residents by facility staff, management, other residents or unknown or outside individuals who have gained access to the resident through negligence or lax security on the part of the facility or for neglect which is so severe that it constitutes abuse.

According to the Older Americans Act, Section 102[13], the term abuse means the willful (A) infliction of injury, unreasonable confinement, intimidation, or cruel punishment with resulting physical harm, pain or mental anguish; or (B) deprivation by a person, including a caregiver, of goods or services that are necessary to avoid physical harm, mental anguish or mental illness. The term (financial) exploitation means the illegal or improper act or process of an individual, including a caregiver, using the resources of an older individual for monetary or personal benefit, profit or gain (Older Americans Act, Section 102[24]).

Use resident-to-resident physical or sexual abuse only for willful abuse of one resident by another resident, not for unintentional harm or altercations between residents who require staff supervision, which should be coded as #903 resident conflict including roommates. For example, a confused resident who strikes out is coded as #903 resident conflict including roommates and an alert resident who strikes out should be coded as #106 willful resident-to-resident abuse.

101 Abuse, physical (including corporal punishment): Includes hitting, slapping, pinching, kicking, etc. It also includes controlling behavior through corporal punishment.

102 Abuse, sexual: Includes, but is not limited to, sexual harassment, sexual coercion, or sexual assault.

103 Abuse, verbal/psychological (including punishment, seclusion):

Verbal abuse: Refers to any use of oral written or gestured language that includes disparaging and derogatory terms to clients or their families, or within their hearing distance, to describe clients, regardless of their age, ability to comprehend, or disability. (Use #403 dignity, respect – staff attitudes for less severe forms of staff rudeness or insensitivity; use #1305 if staff is unavailable, unresponsive to clients.)

Psychological or mental abuse: Includes, but is not limited to, humiliation, harassment, threats of punishment or deprivation.

Involuntary seclusion means the separation of a client from other clients or from his/her room against the client's will or the will of the client's legal representative. Emergency or short-term monitored separation is not considered involuntary seclusion if used for a limited period of time as a therapeutic intervention to reduce agitation.

- 104 Financial exploitation** (Use codes in complaint category “Financial/Property” for less severe financial complaints). The illegal or improper act or process of an individual, including a caregiver, using the resources of an older individual for monetary or personal benefit, profit or gain.
- 105 Gross neglect** (Use other complaint types for non-willful forms of neglect): Willful deprivation by a person, including a caregiver, of goods or services that are necessary to avoid physical harm, mental anguish or mental illness. (Use only for the most extreme forms of willful neglect. Use the appropriate codes in other categories for less severe forms or manifestations of client neglect.)
- 106 Resident-to-resident physical or sexual abuse:** Use only for complaints of abuse by a client against one or more other clients that meets the definition of abuse provided above. (For unintentional harm or altercations between residents who require staff supervision use #903 Resident conflict, including roommates.) Use #903 if a confused client strikes out; for an alert client, who strikes out, use #106.

Access to Information by Resident or Resident’s Representative

Use the most appropriate code for complaints involving access to information or assistance made by or on behalf of the resident or the resident’s representative. Use code #202 Access to ombudsman if the ombudsman is denied access in response to a complaint. Complaint types #207 information communicated in understandable language, #406 language barrier in daily routine, #1301 communication/language barrier all involve communication/language barriers under different circumstances. Ex. use #207 information communicated in understandable language if information regarding rights, medical condition, benefits, services, etc. is not communicated in an understandable language.

- 201 Access to own records:** Use if resident or resident’s representative is denied or delayed access to client’s record.
- 202 Access by or to ombudsman/visitors:** Use if access to the facility or certain parts of the facility is denied to the ombudsman. Use also if ombudsmen or visitors are denied access to a resident.
- 203 Access to facility survey/staffing reports/license:** Use if the licensing and certification agency’s survey is not posted in a

prominent place or not provided when requested. Use also when the facility's license is not posted or available. Use if the facility's daily staffing report is not posted.

- 204 Information regarding advance directive:** Use related to advance health care directive, living will, do not resuscitate (DNR) order, and similar problems.
- 205 Information regarding medical condition, treatment and any changes:** Use if information is denied, delayed.
- 206 Information regarding the rights, benefits, services, the resident's right to complain:** Use related to residents' rights (including the right to complain), Medicaid information/process, social services, staff not wearing name badges, and similar problems.
- 207 Information Communicated In Understandable Language:** Use if information isn't provided in language which the resident or the resident's representative can understand or the staff speaks in a confusing manner.

Admission, Transfer, Discharge, Eviction

Use the appropriate code for complaints involving admission, whether into, within or outside of the facility. If a resident requests assistance in transferring to another facility and there is no stated problem (**complaint**), report as an AGI Activity by selecting the topic "LTC service selection assistance" in AGI. If the resident requests assistance in moving out of the facility but there are no feasible alternative options, use code #1614 Request for less restrictive environment since the problem is a lack of care alternatives within the long-term care system.

- 301 Admission, contract and/or procedure:** Use if there is no contract; the contract contains illegal wording requiring waiver of rights or guarantee of payment; the admission procedure is not followed; the admission procedure does not contain required elements and similar problems.
- 302 Appeal process – absent, not followed:** Use if the resident or representative is not given the required numbers of days to appeal a discharge; the facility failed to follow the appeal ruling; no appeal process is in place; and similar problems.
- 303 Bedhold – written notice/refusal to readmit:** Use if the bed is not held the required number of days; the resident/representative was not advised of bed hold policies; incorrect

bed hold procedures were followed; the bed was held but the resident was not readmitted and similar problems.

- 304 Discharge/eviction – planning, notice, procedure, implementation, including abandonment subtypes:**
(If there is a hearing, must select one of the two “hearing” subtypes)
- Discharge Notice/Procedure**
 - Discharge Planning**
 - Hearing, Client Prevailed**
 - Hearing, Provider Prevailed**
 - Resolved Without Hearing**
- 304** Use if there is no discharge notice; the required notice is not given to the resident/representative; the required notice not given in required time frame, required notice lacks documentation, is incomplete, incorrect; discharge is for inappropriate reasons; discharge planned or implemented to inappropriate environment; level of care is changed against resident’s will; and similar problems.
- 305 Discrimination in admission due to condition, disability:** Use if the facility refuses to admit a resident due to a medical condition or a disability.
- 306 Discrimination in admission due to Medicaid status:** Use if the resident is not admitted due to Medicaid status or pending Medicaid status.
- 307 Room assignment/room change/intrafacility transfer:** Use if the resident wants a room change or the resident objects to the planned room change; there is no notice or inadequate notice of change; there are excessive room changes; or similar problems.
- 308 Improper admission:** Use if the resident requires a greater level of care than can be provided by the facility; if a resident with MI diagnosis is in an improper environment.
- 309 Transfer due to Medicaid status:** Use if the resident is discharged or transferred due to their status of Medicaid.
- 310 DRGs:** Use if the resident has been prematurely discharged to a facility.

Autonomy, Choice, Preference, Exercise of Rights, Privacy

Use the appropriate code for any complaint involving the resident's right, as stated in the category. If it is a related problem, but not one specific to this heading, use a category under another heading. For example, if the resident is permitted to choose a personal physician but that physician is unavailable use code #1609 physician not available. Use code #404 exercise preference/choice and/or civil/religious rights, individual's right to smoke. Use code #1101 air/environment: temperature and quality (heating, cooling, ventilation, water), and noise.

401 Choose personal physician/pharmacy/hospice, other health care provider:

Subtypes: Physician

Pharmacy

Hospice

Use when the resident is denied the right to choose his/her own physician/pharmacy/hospice.

- 402 Confinement of facility against will (illegally):** Use when the resident is denied the right to leave the facility or go outside of the facility. Use code #1614 need less restrictive environment for resident requests for assistance in moving out of the facility when feasible alternative options are not available.
- 403 Dignity, respect -staff attitudes:** Use when the resident is treated with rudeness, indifference or insensitivity, including failure to knock before entering the room, facility posts signs relating to the resident's care and similar problems.
- 404 Exercise preference/choice and/or civil/religious rights, individual's right to:** Use when the resident is denied choice and exercise of rights; for example: voting, speaking freely; access to a smoking area, preference in sleeping and rising times, community activities, the outdoors, television program of choice and similar problems. Use code # 408 privacy: phone, visitors, couples, mail for rights involving privacy.
- 405 Exercise right to refuse care and treatment:** Use if the resident is denied the right to refuse care and treatment; including the resident's right to refuse eating, bathing or taking medication.
- 406 Language barrier in daily routine:** Use if the caregiver does not speak the resident's language or if the resident cannot communicate.

407 Participate in care planning by resident and/or designated surrogate: Use if the resident or the resident's sponsor (legal representative) is denied access to or not informed of a care plan/care plan meeting.

408 Privacy – telephone, visitors, couples, mail:

Subtypes: Couples

Mail

Phone

Visitors

Use if the resident is denied access to a telephone, visitors or mail; phone calls are monitored; mail is opened by someone other than the resident or the resident's legal representative; or couples are denied privacy.

409 Privacy in treatment, confidentiality: Use if the resident is denied privacy in treatment; confidential information has been disclosed.

410 Response to complaints: Use if complaints are ignored or trivialized by facility staff: administrator, social worker, nurses, and other staff.

411 Reprisal, retaliation: Use if the resident has experienced reprisal/retaliation (threat of discharge, lack of care, requests ignored, call lights unanswered, rough handling, etc.) as a result of a complaint.

Financial, Property (except for Financial Exploitation)

Use the appropriate code for complaints involving non-criminal mismanagement or carelessness with residents' funds and property or billing problems. Use #104 financial exploitation for complaints involving willful financial exploitation, including, but not limited to, possible criminal activity.

501 Billing/charges – notice, approval, questionable, accounting wrong or denied (includes overcharge of private pay residents): Use if the complainant alleges the resident does not owe the amount billed; the resident never received the bill for the amount owed; the bill is in error, supplies were not provided as part of the daily rate and similar problems.

502 Personal funds – mismanagement, access/information denied, deposits and other money not returned (report criminal-level misuse of personal funds in #104):

Subtypes: Access

Mismanagement Not Returned

Use for any problems with personal funds. For example, staff deny a resident use of their personal needs allowance; staff use a resident's trust fund without consent, and similar problems.

503 Personal property: lost, stolen, used by others, destroyed/damaged, withheld: Use for property (including prostheses, dentures, hearing aides, glasses, radios, watches, missing stolen at the facility. Use #1106 for loss of laundry.

Resident Care

Use the appropriate code for complaints involving negligence, lack of attention and poor quality in the care of residents. If the care situation is so poor that the resident is in a condition of overall neglect which is threatening to health and/or life, use #105 gross neglect.

601 Accidental or injury of unknown origin, falls, improper handling

Subtypes: Accidents

Falls

Improper Handling

Injury Of Unknown Origin

Use for unexplained bruises, scratches, cuts, skin tears; falls from bed wheelchair, or when standing; when resident is handled improperly or dropped during transfer or other assistance; and similar problems.

602 Failure to respond to requests for assistance: Use when call lights or requests for assistance are not answered, or not answered in a timely manner. Includes requests for going/returning to resident's room, transfers to chair/bed, etc.

603 Careplan/resident assessment -inadequate, failure to follow plan or physician orders (put lack of resident/surrogate involvement under #407). Also use this when there is no care plan with subtype "lacking,"

Subtypes: Inadequate**Lacking (there is no care plan)
Not Followed**

Use for complaints related to the care plan: plan is incomplete or not reflective of the resident's condition; staff has disregarded or is not informed of the plan; staff fails to respond, or responds slowly to physician orders and similar problems.

- 604 Contracture:** Use for complaints related to the resident's hands, arms, feet or legs being drawn up and contorted.
- 605 Medications: Administration, organization:** Use for complaints of medications not given on time or not at all, medication administration not documented or incorrectly documented, medications not secured, incorrect medication or dosage; negligence, lack of attention or poor quality in care related to medication that is: run out; expired; not filled in a timely manner; incorrectly labeled and similar problems.
- 606 Personal hygiene (includes nail care and oral hygiene) and adequacy of dressing and grooming:** Use for resident: not bathed in a timely manner, not clean, not bathed at all, allowed to remain in soiled clothing, incontinence brief, bed, chair; hands and face not washed after meals; teeth/dentures not cleaned and similar problems.
- 607 Physician services including podiatrist:** Use if the facility failed to obtain physician services upon a change in the resident's condition, or if medical attention, including podiatrist service is not obtained in a timely manner or not obtained at all.
- 608 Pressure sores:** Use for pressure sore(s) that may have occurred at the facility or elsewhere. Use when the facility failed to treat, document or monitor pressure sores.
- 609 Symptoms unattended including pain, pain not managed, no notice to others of changes in condition:** Use if the facility fails to accommodate, notify, or provide services related to a change in the resident's condition.

Subtype: Pain

- 610 Toileting, incontinent care:** Use when the resident is not toileted in a timely manner, as needed or requested, or as directed by the care plan. If the facility is using incontinence

briefs or catheters rather than toileting the client, use #702 bowel and bladder training for inadequate or non-existent bowel and bladder plans or training.

**Subtype: Toileting Incontinent
Care**

- 611 **Tubes – Neglect of catheter, gastric, ng tubes (use #405 exercise right to refuse care and treatment for complaints of inappropriate or forced use):** Use if tube is not cleaned, changed, or monitored appropriately.
- 612 **Wandering, failure to accommodate/monitor exitseeking behavior:** Use if the resident is wandering, failure to redirect wanderers.
- 613 **Kept up too long**
- 614 **Administration by unqualified staff:** Use for the complaints regarding the administrator not having a valid license; nursing is delegating tasks to untrained staff.

Rehabilitation and/or Maintenance of Function

Use the appropriate code for complaints involving failure to provide needed rehabilitation or services necessary to maintain the expected level of function.

- 701 **Assistive devices or equipment:** Use if the facility lacks, fails to maintain or has problems with: Hoyer lifts, handrails/grab bars, toilet seats elevators, ambulation aids, wheelchairs (no brakes or foot rests, etc.), hearing or visual aids, and any other assistive devices or equipment.
- 702 **Bowel and bladder training:** Use if the facility fails to provide training, has no schedule or schedule not maintained.
- 703 **Dental services:** Use if dental services are not provided or arranged for the resident.
- 704 **Mental health/psychosocial services:** Use if these services are not provided or arranged for the resident.
- 705 **Range of motion/ambulation, exercise:** Use if the services are not provided to the resident; the resident is not assisted or encouraged in ambulation as appropriate; no appropriate exercise available; the exercise the resident wants is unavailable.
- 706 **Therapies, physical, occupational, speech:** Use for failure to provide or arrange for therapies.

- 707 Vision and hearing:** Use for the facility's failure to provide or arrange for vision and hearing services or for problems with services.
- 708 Not turned:** Use if the client is not turned per medical order or treatment standard or when turning is undocumented.

Restraints: Chemical & Physical

Use the appropriate code for any complaint involving the use of physical or chemical restraints.

- 801 Physical restraint: Assessment, use, monitoring:** Use for any physical restraint complaint: lap buddy, bed rail(s), bindings(s), placement of furniture, resident not released from the restraints for a specified time; no order in the medical record; and similar problems including locked units (enter "locked" in complaint type note field).
- 802 Psychoactive drug: Assessment, use, evaluation:** Use for any chemical restraint including excessive or unnecessary medications.

Activities and Social Services

Use the appropriate code for any complaints involving social services for and/or social interaction of residents. Transportation is included in #902 because community interaction is sometimes (not always) dependent upon transportation. Use #902 for any complaint involving the client's need for transportation, for whatever reason.

- 901 Activities: Choice and appropriateness:** Use for a lack of activities appropriate for each resident; facility failure to consider the resident's ability to perform certain activities and preferences; limited variety of activities; no activities; posted activities not conducted.
- 902 Community interaction, transportation:** Use for any complaint involving the resident's need for transportation, for whatever the reason and/or when the facility does not assist the residents in participating in community services or activities or curtails community interactions.
- 903 Resident conflict, including roommates:** Use for any complaint involving conflict between residents, including

roommate conflict and inappropriate behaviors that impact another resident's quality of life.

- 904 Social services -availability/appropriateness:** Use if the social services department fails to provide social services or encourage social interaction; fails to provide services if the resident isolates himself or refuses to participate in activities and similar problems. Use #704 for mental health, psychosocial counseling and services.

Dietary

Use the appropriate code for complaints involving food and fluid intake. For willful cases of food deprivation, use code #101 or code #105.

- 1001 Assistance in eating or assistive devices:** Use if the facility failed to provide assistance in eating or if the facility has not provided tools to assist the resident in self-feeding, meal set-up, i.e., opening milk cartons, tray not within reach.
- 1002 Fluid availability/hydration:** Use if the resident is not reminded to drink; if water is not provided at the bedside, is not fresh or is not in reach; if fluids are not readily available or if the resident is dehydrated.
- 1003 Food service – Quantity, quality, variation, choice, condiments, utensils, menu:** Use if posted menus are not served; alternate selections are not offered; servings are too small; there is no variety; quality of the food is poor; or if food has little nutritional value, nutrients are out of date, condiments or utensils are not provided, presentation, timely delivery and/or removal of trays.
- 1004 Snacks, time span between meals, late/missed meals:**
Subtypes: Snacks Time Span Between Meals
Use if snacks are not readily available or offered between meals; if there is an excessive time span between dinner and breakfast.
- 1005 Temperature:** Use if the food or beverages are not served at the appropriate temperature.
- 1006 Therapeutic diet:** Use for complaint that resident's therapeutic diet is not served as ordered; resident's dietary needs are not accommodated.

- 1007 Weight loss due to inadequate nutrition:** For willful cases of food deprivation, use codes #101 or code #105.

Environment/Safety

Use the appropriate code for complaints involving the physical environment of the care setting and clients' space.

- 1101 Air/environment: temperature, quality (heating, cooling, Ventilation, water), noise:** Use for complaints about the building room or water temperature being too hot or too cold; ventilation is inadequate; indoor cigarette smoke; noise in the facility, and similar problems including inadequate space.
- 1102 Cleanliness, pests, general housekeeping:**
Subtypes: Cleanliness Pests
Use for lack of cleanliness or pests (insects, vermin, alive or dead) in the resident's room or other facility areas. Also use this for ant, snake, rat or mosquito bites. For general housekeeping complaints, use the subtype "cleanliness."
- 1103 Equipment/buildings: disrepair/hazard/poor lighting/fire safety/not secure:** Use for elevators that are malfunctioning or not maintained; paint/wallpaper peeling; lights burned out or insufficient lighting; exterior not maintained, littered or inaccessible entrances, exits or hallways; inadequate/nonfunctioning or expired fire extinguishers; malfunctioning automatic doors; fire alarms, smoke detectors and other emergency equipment not present, malfunctioning or inadequate and any other building maintenance problems. Also use this code if the premises is not secured; is lacking or has broken window bars; unauthorized person gained entrance to the facility; unauthorized weapon in the facility and similar problems.
- 1104 Furnishings, storage for residents:** Use for any furnishing in disrepair; lack of furnishings; inadequate storage space for resident belongings, including valuables.
- 1105 Infection control:** Use for insufficient measures to prevent infection; spread of infection; resident is put at risk of infection, if the infection is unreported or not treated appropriately and similar problems.

1106 Laundry: lost,condition:**Subtypes: Condition
Lost Items**

Use if the resident has no clean clothes available or clothing is lost or damaged.

1107 Odors: Use for urine, feces, and any other offending odor or any odor that is a detriment to the health of the resident.

1108 Space for activities or dining: Use for inadequate space for scheduled activity or resident's attendance/participation in activity; dining area does not promote resident interaction; inadequate space for wheelchair or other assistive devices while dining; activity, dining areas converted to other uses.

1109 Supplies and linens: Use for no clean linens available or in poor condition; shortage of supplies, for example, soap, gloves, toilet paper, incontinence pads and nursing supplies.

1110 Americans with Disabilities Act (ADA) accessibility: Use for complaints regarding facility's compliance with the ADA; for example, no handicapped access.

Policies, Procedures, Attitudes, Resources

Use the appropriate code for complaints of commission or omission by facility managers, operators or owners in areas other than staffing or specific problems included in previous sections.

1201 Abuse investigation/reporting, including failure to report: Use for failure of the facility to report or investigate suspected resident abuse, neglect or exploitation to the specified authority, no matter where alleged abuse occurred.

1202 Administrator(s) unresponsive or unavailable: Use for failure of the administrator or administrative staff to respond to or communicate with others.

1203 Grievance procedure: Use if there is no grievance procedure for handling complaints or if the procedure is not made known to the residents or with which the facility failed to comply.

1204 Inappropriate or illegal policies, practices, record keeping: Use if records are incomplete, missing or falsified, including staff references not checked, or when required background screening has not been performed. Use also for complaints about health care fraud, waste, and abuse.

- 1205 Insufficient funds to operate:** Use if there is substantiated complaint of shortage of staff, lack of food, utilities are cut off etc., that could indicate bankruptcy or insufficient funds. Also use if a complainant alleges the facility has insufficient funds to operate.
- 1206 Operator inadequately trained:** Use for complaints that the owner or administrator has no documentation of an administrator's license, training or updates and other certifications required by the state.
- 1207 Offering inappropriate levels of care (nh, ach, or fch):** Use if the facility admits or retains residents whose medical and or care needs are greater than the facility can meet or arrange to have met and similar problems.
- 1208 Resident or family council/committee interfered with, not supported:**
- Subtypes: Resident Council
Family Council**
- Use if the facility interferes with or fails to support resident or family councils, attempts to organize councils and related problems.

Staffing

Use the appropriate code for complaints regarding staff unavailability, training, turnover and supervision.

- 1301 Communication, language barrier:** Use for staff language or other communication barriers. Use code #406 if the complaint involves the resident's inability to communicate.
- 1302 Shortage of staff:** Use for insufficient staff to meet the needs of the resident(s); staffing is below the minimum standard.
- 1303 Staff training:** Use when staff has not received training sufficient to meet the needs for the resident(s); including, but not limited to, basic care and technical training including the use of a Hoyer lift, CPR, first aid, mental health and dementia training.
- 1304 Staff turnover, over-use of staffing pools:** Use when there is no continuity of care for the residents; new staff is on board and or pool/agency staff is regularly used.

- 1305 Staff unresponsive, unavailable:** Use if the staff is unresponsive or unavailable. Use #403 if staff is available but rude or otherwise disrespectful to the resident. Use #103 if rudeness or disrespect is so severe that it qualifies as abuse.
- 1306 Supervision:** Use when the staff duties are not overseen or not reviewed by a supervisor. Use when there is no ALF staff monitoring residents.
- 1307 Dining/eating assistants:** Use for complaints about inappropriate use of and training of dining assistants. Use #1001 assistance eating or assistive devices for failure to provide assistance in eating or facility has not provided tools to assist resident in self-feeding, meal set-up, i.e., opening milk cartons, tray not within reach.

Certification and Licensing Agency

Use the appropriate code for complaints involving decisions, policies, actions or inactions by the North Carolina State Department of Health and Human Services which licenses and certifies nursing homes and adult care homes for participation in Medicaid and Medicare.

- 1401 Access to information (including survey):** Use if the certification/licensing agency does not provide the facility information to the ltc ombudsmen, public.
- 1402 Complaint, response to:** Use when agency fails to respond adequately to any complaint or referral, from the resident, ombudsmen, or the public.
- 1403 Decertification/closure:** Use for individual complaints about decertification or closure and if agency fails to decertify/close a facility when within residents' best interests or decertifies/closes with disregard to residents' rights.
- 1404 Sanction, including intermediate:** Use if licensing or certification agency refuses to sanction provider appropriately.
- 1405 Survey process:** Use if agency fails to survey the facility as required by law.
- 1406 Survey process – Ombudsman participation:** Use if the ombudsman program is not notified and/or included in the survey process.
- 1407 Transfer or eviction hearing:** Use for complaints of decisions, policies, actions or inaction by licensing or certification agency regarding resident discharge hearings.

State Medicaid Agency

Use the appropriate code for complaints about Medicaid coverage, benefits and services.

- 1501 Access to information, application:** Use if information is denied or delayed to the resident or legal representative; caseworker is unavailable or unresponsive to requests for information or application status.
- 1502 Denial of eligibility:** Use when the resident is denied Medicaid or Medicaid-covered services.
- 1503 Non-covered services:** Use for complaints about services not covered by Medicaid.
- 1504 Personal needs allowance:** Use for complaints about the insufficiency of the personal needs allowance.
- 1505 Services:** Use for complaints about the quality or quantity of services covered by Medicaid or difficulty in obtaining services. Use #1503 for noncovered services.

System/Others

Use the appropriate code for complaints against or involving individuals who are not managers/staff of facilities or of the state's licensing and certification or Medicaid agency. (*Except for #1603, as specified)

- 1601 Abuse/neglect/abandonment by family member/friend/guardian or, while on visit out of facility, any other person:** Use for abuse/abandonment by individuals other than facility staff, when the facility could not reasonably have been expected to observe the acts. Use #101 or other #100 codes when the facility should have overseen and acted.
- 1602 Bed shortage – Placement/admission:** Use when the resident is unable to find facility to admit or for a bed shortage.
- 1603 Facilities operating without a license:** Use for complaints about facilities providing services to residents which should only be offered in a regulated environment.
- 1604 Family conflict; interference:** Use when a family conflict interferes with resident's care. Use only if the conflict or problem affects the resident's care or well being.
- 1605 Financial exploitation or neglect by family or others not affiliated with the facility:** Use for complaints of financial

exploitation or financial neglect of a client by individuals whose actions the provider could not reasonably be expected to oversee or be responsible.

1606 Legal – guardianship, conservatorship, power of attorney, wills:

**Subtypes: Probate Authority
(Guardianship, Conservatorship, And Wills)
Power Of Attorney**

Use if the complaint involves any of the above legal issues.

1607 Medicare: Use if the resident has a complaint related to Medicare coverage. For example, complaint related to physician not accepting Medicare.

1608 Mental health, developmental disabilities including PASRR: Use for complaints with access to services for persons with mental illness or developmental disabilities or for complaints involving implementation of the Pre-Admission Screening and Resident Review (PASRR) requirements of the Nursing Home Reform Act related to individuals with mental illness or mental retardation or a developmental disability living/making application to live in a Medicaid-certified nursing home.

1609 Problems with resident’s physician: Use if the resident’s physician fails to provide information, services, or is not available. Use #607 physician service if the facility fails to arrange for physician service or #609 symptoms unattended, no notice of change if the facility fails to attend to medical symptoms or notify the family of a change in the client’s condition.

1610 Protective service agency: Use for complaints involving the agency in the state charged with investigating reports of adult abuse or exploitation and providing protective services for victims of abuse or exploitation. Always use when the provider type is adult protective services.

1611 SSA, SSI, VA, other benefits/agencies:

**Subtypes: SSA and SSI VA
Other**

Use for complaints for these non-Medicaid and non-Medicare benefits and the agencies that administer them.

1614 Request for less restrictive environment

Subtypes: Lack Of Resources

Use for a complaint against any other agency or individual, but not facility staff or licensing/certification agency staff. Use for resident requests for assistance in moving out of facility and/or ombudsman initiative to help resident find a less restrictive environment. Includes work to implement the Supreme Court's Olmstead decision.

Case Record Details



Office of the State LTC Ombudsman Program

Case Identification Details

Case Number: **ODISNC generates case number**

Lead Handled By:

Intake By:

Assigned To:

Clients/Residents					
Name	Address	Tel.(Home)	Age	Alert	Legal Rep.

Client Demographics:

Total:

Low Income:

Male:

Other1:

Minority:

Female:

Other2:

Low Income Minority:

Age 60+:

Miscellaneous:

Rural:

Age 75+:

Disabled:

Provider (Long Term Care Facility) Details	
Provider Name:	
Provider Address:	
Provider County:	
Provider Phone:	
Provider Type:	

Complaints								
Date Received	Date Started	Date Closed	Source of Complaint	Complaint Type	Verified	Status	Prob. Harm	Resolution Strategy

Complainant - 1 of 1

Complainant:	
Name:	
Source:	
Relationship:	
Address:	
Home Phone:	
Work Phone:	
Mobile Phone:	
Fax:	
Problem as presented by Complainant & Goal:	
Prior Action taken by Complainant / Client:	
Complainant / Client Advised of LTCOP Proc. & options for handling Complaint:	
Written consent to reveal Complainant's Identity:	
Verbal consent to reveal Complainant's Identity:	

Client/ Resident Detail - 1 of 1

Client/Resident:	
Name:	
Address:	
County:	
Home Phone:	
Mobile Phone:	
Tel. (Other):	
Age:	
Gender:	
Client/Resident Details :	
Funding Source:	
Able to Communicate:	
Admission Date:	
Attending Physician:	
Legal Representative Details :	
Legal Representative:	

Address:	
Telephone (Home):	
Telephone (Work):	
Cell Phone:	
Fax:	
Guardian of Person:	
Guardian of Estate:	
DPOA Healthcare:	
DPOA Financial:	
POA:	
<u>Client/Resident Consent :</u>	
Consent to Review Records:	
Verbal Consent to Investigate:	
Verbal Consent to Reveal Identity:	
Willing to Speak to Surveyors:	
Written Authorization Mailed:	
Date Authorization Mailed:	
Date Authorization Received:	
State Ombudsman Consent:	
<u>Legal Representative Consent :</u>	
Consent to Review Records:	
Verbal Consent to Investigate:	
Verbal Consent to Reveal Identity:	
<u>Sponsor/Representative Consent :</u>	
Verbal Consent to Investigate:	
Verbal Consent to Reveal Identity:	

Complaint -

<u>Complaint Details :</u>	
Date Received:	
Date Started:	
Source of Complaint:	
Problem as Presented by Client & Goal:	
Complaint Type:	
Complaint Sub Type:	

Complaint Type Note:	
Verified:	
Status:	
Status Sub Type:	
Conflict of Interest:	
Resolution Strategy:	
Closing Details:	
Date Closed:	
Reason for Closing:	
Deviations in Complaint Handling Practice/Policy:	
Client advised of further LTCO involvement:	
Client advised of outcome:	
Complainant advised of outcome:	
Volunteer advised of outcome:	
Administrative or Legal Assistance Remedies:	

Complaint - 2 of 3

Complaint Details:	
Date Received:	
Date Started:	
Source of Complaint:	
Problem as Presented by Client & Goal:	
Complaint Type:	
Complaint Sub Type:	
Complaint Type Note:	
Verified:	
Status:	
Status Sub Type:	
Probable Harm:	
Conflict of Interest:	
Declining Investigation:	
Resolution Strategy:	
Closing Details:	
Date Closed:	
Ombudsman Name:	
Reason for Closing:	

Deviations in Complaint Handling Practice/Policy:	
Client advised of further LTCO involvement:	
Client advised of outcome:	
Complainant advised of outcome:	
Volunteer advised of outcome:	
Administrative or Legal Assistance Remedies:	

Complaint - 3 of 3

Complaint Details :	
Date Received:	
Date Started:	
Source of Complaint:	
Problem as Presented by Client & Goal:	
Complaint Type:	
Complaint Sub Type:	
Complaint Type Note:	
Verified:	
Status:	
Status Sub Type:	
Probable Harm:	
Conflict of Interest:	
Declining Investigation:	
Resolution Strategy:	
Closing Details:	
Date Closed:	
Ombudsman Name:	
Reason for Closing:	
Deviations in Complaint Handling Practice/Policy:	
Client advised of further LTCO involvement:	
Client advised of outcome:	
Complainant advised of outcome:	
Volunteer advised of outcome:	

Administrative or Legal Assistance Remedies:	
--	--

Action Plan	
Plan of Action (Identify parties and relevant Agencies):	ENTRY DT. ACTION STEP TARGET DT. FINISH DT. -----
Other Agencies Involved:	.
Referrals:	
Referral Control #	
Referral Target 1:	
Referral Target 2:	
Referral Target 3:	

Running Case Notes:

Other Contacts						
Name	Address	Tel.(Home)	Tel.(Work)	Tel. (Cell)	Fax	Email

Volunteer/CAC Details	
Volunteer Coverage:	
If Yes, Name:	
Telephone:	
Email:	
Notification Date:	
Volunteer Activity:	

Complaint Activity Details					
Complaint Type	Date	Travel Time	Investigative Time	Document Time	Ombudsman
	Total:				

Information in this case record has been reviewed and is an accurate report of activity in this case.

Ombudsman name _____

Date of signature _____

DAAS-004 ODISNC Case Record

Complaint Codes	Abuse, Gross Neglect, Exploitation	Complaint Codes	Resident Care
101	Abuse, physical	601	Accidents, improper handling
102	Abuse, sexual	602	Call lights, requests for assistance
103	Abuse, verbal/psychological	603	Care plan inadequate, lack, not followed
104	Financial exploitation	604	Contracture
105	Gross neglect	605	Medications-administration, organization
106	Resident-to-resident phys/sexual abuse	606	Personal hygiene (incl oral)
		607	Physician services
		608	Pressure sores
		609	Symptoms unattended, no notice of change
		610	Toileting
		611	Tubes - neglect
		612	Wandering-failure to accommodate/monitor
		613	Kept up too long
		614	Administered by unqualified staff
			Rehabilitation and/or Maintenance of Function
		701	Assistive devices or equipment
		702	Bowel and bladder training
		703	Dental Services
		704	Mental health, psychosocial services
		705	Range of motion/ambulation/exercise
		706	Therapies - outside
		707	Vision and hearing
		708	Not turned
			Restraints: Chemical & Physical
		801	Physical Restr-assess, use, monitoring
		802	Psychoactive Drugs-assess, use, monitor
			Activities and Social Services
		901	Activities-choice and appropriateness
		902	Community interaction, transportation
		903	Roommate conflict
		904	Social Svcs-availability, appropriateness
			Dietary
		1001	Assistance eating or assistive devices
		1002	Fluid availability, hydration
		1003	Food Service-Quantity, Quality, Variation, Choice
		1004	Snacks, time span between meals, late/missed meals
		1005	Temperature
		1006	Therapeutic diet
		1007	Weight loss due to inadequate nutrition
			Abuse, Gross Neglect, Exploitation
			Access to Information by Resident or Resident's Rep.
			Access to own records
			Access by or to ombudsman/visitors
			Access to facility survey/ staffing reports/ license
			Info re: advance directive
			Info re: med condition/treatment, change
			Info re: rights/benefits/services
			Info comm. in understandable language
			Admission, Transfer, Discharge, Eviction
			Admission Contract and/or procedure
			Appeal process - absent, not followed
			Bed hold-written notice, refuse to readmit
			Disch/Evict: planning/notice/procedure
			Discrim.in admIss.due to condition/disability
			Discrim.in admIss.due to Medicaid status
			Room assignment/room change
			Improper Environment
			Transfer due to Medicaid Status
			DRGS
			Autonomy, Choice, Preference, Exercise of Rights
			Choose personal physician/pharmacy
			Confined against will (illegal)
			Dignity, respect - staff attitudes
			Exercise choice/civil or consumer rights
			Exercise right to refuse care/treatment
			Language barrier in daily routine
			Participate in care planning
			Privacy-phone, visitors, couples, mail
			Privacy in treatment, confidentiality
			Response to complaints
			Reprisal, retaliation
			Financial, Property (Except Financial Exploitation)
			Billing/charges-notice, approval, questionable
			Pers. funds-mismanaged/access/not returned
			Pers. Property -lost/stolen/used/destroyed/damaged

Complaint Codes	Environment/Safety	Complaint Codes	Certification and Licensing Agency
1101	Air temp/quality (heat,cool,vent,smoking)	1401	Access to info (including survey)
1102	Cleanliness, pests	1402	Complaint - response to
1103	Equipment-disrepair, hazard, poor light	1403	Decertification/closure
1104	Furnishings, storage for residents	1404	Intermediate sanction
1105	Infection control	1405	Survey process
1106	Laundry - lost, condition	1406	Survey process-Ombudsman participation
1107	Odors	1407	Transfer or eviction hearing
1108	Space for activities, dining		
1109	Supplies and linens		
1110	Americans with Disabilities Act (ADA) Accessibility		
	Policies, Procedures, Attitudes, Resources		State Medicaid Agency
1201	Abuse investigation/reporting	1501	Access to information, application
1202	Administrators unresponsive, unavailable	1502	Denial
1203	Grievance procedure	1503	Non-covered services
1204	Inadequate record keeping	1504	Personal needs allowance
1205	Insufficient funds to operate	1505	Services
			System/Others
1206	Operator inadequately trained	1601	Abuse/neglect/abandonment by family member/friend/guardian
1207	Offering inappropriate level of care (B Res/Fam council/Com Interfered/Not Supported	1602	Bed shortage - placement
1208		1603	Board and care licensing, regulation
		1604	Family conflict
		1605	Financial exploitation by family/other
		1606	Legal - Guardian, conservator, POA, wills
		1607	Medicare
		1608	PASRR
1301	Communication, language barrier	1609	Physician not available
1302	Shortage of staff	1610	Protective service agency
1303	Staff training, lack of screening	1611	SSA, SSI, VA, Other benefits/agencies
1304	Staff turnover, Over-use of staffing pools	1614	Need less restrictive environment
1305	Staff unresponsive, unavailable		
1306	Supervision		
1307	Dining Assistants		

Appendix J
Example Report

Community Advisory Committee Quarterly/Annual Visitation Report

County	Facility Type - <input type="checkbox"/> Family Care Home <input type="checkbox"/> Adult Care Home <input type="checkbox"/> Nursing Home <input type="checkbox"/> Combination Home	Facility Name
Visit Date / /	Time Spent in Facility hr min	Arrival Time : <input type="checkbox"/> am <input type="checkbox"/> pm
Name of Person Exit Interview was held with _____ <input type="checkbox"/> Other Staff Rep _____ (Name & Title)		Interview was held <input type="checkbox"/> In-Person <input type="checkbox"/> Phone <input type="checkbox"/> Admn. <input type="checkbox"/> SIC (Supervisor in Charge)
Committee Members Present:		Report Completed by:
Number of Residents who received personal visits from committee members:		
Resident Rights Information is clearly visible. <input type="checkbox"/> Yes <input type="checkbox"/> No		Ombudsman contact information is correct and clearly posted. <input type="checkbox"/> Yes <input type="checkbox"/> No
The most recent survey was readily accessible. <input type="checkbox"/> Yes <input type="checkbox"/> No (Required for Nursing Homes Only)		Staffing information is posted. <input type="checkbox"/> Yes <input type="checkbox"/> No
Resident Profile		Comments & Other Observations
1. Do the residents appear neat, clean and odor free? <input type="checkbox"/> Yes <input type="checkbox"/> No 2. Did residents say they receive assistance with personal care activities, <i>Ex. brushing their teeth, combing their hair, inserting dentures or cleaning their eyeglasses?</i> <input type="checkbox"/> Yes <input type="checkbox"/> No 3. Did you see or hear residents being encouraged to participate in their care by staff members? <input type="checkbox"/> Yes <input type="checkbox"/> No 4. Were residents interacting w/ staff, other residents & visitors? <input type="checkbox"/> Yes <input type="checkbox"/> No 5. Did staff respond to or interact with residents who had difficulty communicating or making their needs known verbally? <input type="checkbox"/> Yes <input type="checkbox"/> No 6. Did you observe restraints in use? <input type="checkbox"/> Yes <input type="checkbox"/> No 7. If so, did you ask staff about the facility's restraint policies? <input type="checkbox"/> Yes <input type="checkbox"/> No		
Resident Living Accommodations		Comments & Other Observations
8. Did residents describe their living environment as homelike? <input type="checkbox"/> Yes <input type="checkbox"/> No 9. Did you notice unpleasant odors in commonly used areas? <input type="checkbox"/> Yes <input type="checkbox"/> No 10. Did you see items that could cause harm or be hazardous? <input type="checkbox"/> Yes <input type="checkbox"/> No 11. Did residents feel their living areas were too noisy? <input type="checkbox"/> Yes <input type="checkbox"/> No 12. Does the facility accommodate smokers? <input type="checkbox"/> Yes <input type="checkbox"/> No 12a. Where? <input type="checkbox"/> Outside only <input type="checkbox"/> Inside only <input type="checkbox"/> Both Inside & Outside. 13. Were residents able to reach their call bells with ease? <input type="checkbox"/> Yes <input type="checkbox"/> No 14. Did staff answer call bells in a timely & courteous manner? <input type="checkbox"/> Yes <input type="checkbox"/> No 14a. If no, did you share this with the administrative staff? <input type="checkbox"/> Yes <input type="checkbox"/> No		
Resident Services		Comments & Other Observations
15. Were residents asked their preferences or opinions about the activities planned for them at the facility? <input type="checkbox"/> Yes <input type="checkbox"/> No 16. Do residents have the opportunity to purchase personal items of their choice using their monthly needs funds? <input type="checkbox"/> Yes <input type="checkbox"/> No 16a. Can residents access their monthly needs funds at their convenience? <input type="checkbox"/> Yes <input type="checkbox"/> No 17. Are residents asked their preferences about meal & snack choices? <input type="checkbox"/> Yes <input type="checkbox"/> No 17a. Are they given a choice about where they prefer to dine? <input type="checkbox"/> Yes <input type="checkbox"/> No 18. Do residents have privacy in making and receiving phone calls? <input type="checkbox"/> Yes <input type="checkbox"/> No 19. Is there evidence of community involvement from other civic, volunteer or religious groups? <input type="checkbox"/> Yes <input type="checkbox"/> No 20. Does the facility have a Resident's Council? <input type="checkbox"/> Yes <input type="checkbox"/> No Family Council? <input type="checkbox"/> Yes <input type="checkbox"/> No		
Areas of Concern		Exit Summary
Are there resident issues or topics that need follow-up or review at a later time or during the next visit?		Discuss items from "Areas of Concern" Section as well as any changes observed during the visit.

This Document is a PUBLIC RECORD. Do not identify any Resident(s) by name or inference on this form.
 Top Copy is for the Regional Ombudsman's Record. Bottom Copy is for the CAC's Records.

**ANNUAL REPORT
FOR
ADULT CARE AND NURSING HOME COMMUNITY ADVISORY COMMITTEES**

COUNTY _____ REPORTING YEAR _____

COMMITTEE _____ CHAIRPERSON _____

1. Were all the homes in the county served by the committee? _____
If not, why? _____

2. Describe educational efforts by the committee. _____

3. Describe community involvement by the committee. _____

4. Describe problems encountered by the committee. _____

5. Was the committee involved in grievance resolution during the year? _____

6. Summarize the strengths and weaknesses of the facilities in the county.

7. Other comments:

THE REGIONAL OMBUDSMAN WILL DISTRIBUTE THIS REPORT TO THE COUNTY COMMISSIONERS, THE COUNTY DEPARTMENT OF SOCIAL SERVICES, AND THE DIVISION OF AGING AND ADULT SERVICES.

Prepared by: _____

Date prepared: _____

SECTION VIII

**Enhancing Community
Involvement in Nursing
Home Life**

Enhancing Community Involvement in Nursing Home Life

In order to achieve quality nursing home care for all nursing home residents, a total community approach must be used. Although nursing home owners/administrators have specific and major responsibilities to ensure the highest level of care and daily living for residents, the community can provide even more. Involvement of the community in the nursing home can enhance the care received and contribute to a greater quality of life for the residents of the facility.

The practice of caring for the aged in group settings has developed and grown in such a way that generally excludes the community at large. The lack of involvement in the past could be partially due to the fact that often citizens and community groups have not been made aware of issues needs, and have lacked leadership and vehicles for constructive action.

However, the Nursing Home Community Advisory Committees are excellent vehicles and now have the opportunity and responsibility to:

- educate the community about needs,
- motivate citizens to care and act, and
- give guidance and opportunities for involvement.

Here are some examples of specific ways the NHCAC's can fulfill these responsibilities:

Ways to Mobilize Volunteer Visitors for Facilities

Person to Person. It is often said that there is no better recruiter than a well satisfied volunteer. The enthusiasm of a NHCAC member about the program can be transmitted to others and can be the most effective form of recruitment.

Media. Potential volunteers can be reached through skillful use of the media. Public service announcements on radio and television are one beneficial vehicle; human interest or feature stories placed in newspapers, highlighted on radio or television are other ways to educate the public about how important and crucial the role of CACs are in the community.

Presentations. Contact women’s groups, schools, church groups, youth groups and civic organizations and tell them you are available to present a program on how visitors of any age can alleviate the loneliness and isolation of nursing home residents. For this program a film, such as “Because Somebody Cares,” could be used. Prepare a handout including such information as how to visit and build rapport with the elderly; description of levels of care; names of facilities along with the number of beds that have been designated either adult care home or nursing home in the facility; names of residents whom volunteers can personally deliver cards to on their individual birthdays.

When bringing the community into the nursing home, plan well, down to the smallest detail. **Communicate** with facility personnel because you will need their cooperation (including the administrator). Also, be sure to **track** development of the event, **communicating** all the way. You will avoid unwelcome “surprises” by coordinating your efforts with the nursing home administrator and staff, thereby not disappointing the volunteers and residents or jeopardizing your credibility.

APPENDICES

Appendix A:
Adult Protective
Services

Protection of Abused, Neglected or Exploited Disabled Adult Act G.S. 108A-100 et. seq.

The mistreatment of disabled adults is a serious problem. North Carolina is one of many states which recognized this and passed legislation to protect adults who are vulnerable and unable to protect themselves from abuse, neglect, or exploitation. This law affects adults, regardless of their living situation, who are incapacitated due to mental or physical disabilities. It requires anyone suspecting that a disabled adult is in need of protection to notify the local department of social services. This department, in turn, is responsible for evaluating and providing or arranging for services to persons in need of protection.

Who must report?

The law requires that anyone who suspects that a disabled adult needs protective services must report the case to the county director of social services. This is referred to as a *mandatory reporting law*. A person who reports does not have to have actual knowledge or proof that abuse, neglect or exploitation is occurring in order to trigger the law's requirement that anyone who has "reasonable cause to believe that a disabled adult is in need of protection services shall report such information."

Who is a disabled adult?

The legal definition of a 'disabled adult' covered by the reporting law is broad. It covers much more than a physically incapacitated person. It includes anyone who is 18 or older and is physically or mentally incapacitated by mental retardation, cerebral palsy, epilepsy, autism, organic brain damage caused by advanced age, or any other physical degeneration connected with these disabilities. This term also includes any adult who is physically or mentally incapacitated by conditions incurred at any age as a result of accident, organic brain damage, mental or physical illness, or continued consumption or absorption of "substances". The definition also covers lawfully emancipated minors who are incapacitated as defined above.

When is a disabled adult in need of protective service?

The law states: “A disabled adult shall be in need of protective services if that person, due to his physical or mental incapacity, is unable to perform or obtain for himself essential services and if that person is without able, responsible, and willing persons to perform or obtain for his essential services.” Lacking essential services is only part of it: inability to obtain or without someone who can and will get the essential services is really the point.

The definition of ‘essential services’ is broad; it means “those social, medical, psychiatric, or legal services necessary to safeguard the disabled adult’s rights and resources and to maintain the physical or mental well-being of the individual. These services shall include, but not be limited to, the provision of medical care for physical and mental health needs, assistance in personal hygiene, food, clothing, adequately heated and ventilated shelter, protection from health and safety hazards, protection from physical mistreatment, and protection from exploitation.”

Adult Protective services are thus required to protect a disabled adult “from abuse, neglect, or exploitation.” These terms are defined as following:

Abuse means the intentional infliction of pain, injury, or mental anguish; unreasonable confinement; or willful deprivation by a caretaker of services necessary to keep a person mentally or physically well.

Neglect is the inadequate care of a disabled adult who therefore does not receive the services that are necessary to maintain his mental and physical health. The law states: “The word “neglect” refers to a disabled adult who is either living alone and not able to provide for himself the services which are necessary to maintain his mental or physical health or is not receiving such services from his caretaker.”

Exploitation means the illegal or improper use of a disabled adult or his resources for another’s profit or advantage.

The term “protective services” is more broadly defined than “essential services.” Protective services include evaluating the need for service and mobilizing essential services on behalf of the disabled adult. Protective services also include evaluating the need for emergency protection and arranging for essential services to be delivered.

Making A Report

Reports of a suspected need for protection should be made to the director of social services in the county where the disabled person resides or is found. The report need not be made personally to the director. Most social services departments have a specified unit or staff in the department that is responsible for receiving these reports. Reports may be oral or written and may be made by telephone. Anonymous reports are also accepted. The county DSS would prefer, however, to know who is making the report and how to contact him/her in case additional information is needed.

The reporting law specifies what must be included in a report of suspected abuse, neglect, or exploitation: the name and address of the disabled adult, his age, the nature and extent of his injury or condition that results from abuse or neglect, the name and address of his caretaker, and other pertinent information. If the reporter does not know everything that the law requires about the disabled adult, he should simply give whatever information he has.

Protection of Reporters

Anyone reporting suspected abuse, neglect, or exploitation of a disabled adult has immunity from any civil or criminal liability that may arise after such a report is made unless he acted with malice or in bad faith.

The NC Administrative Code governing the provision of adult protective services specifies that the reporter's name be kept confidential unless court action necessitates that the reporter's identity be revealed. This information may also be revealed if it is requested by any of the three following agencies, the *Division of Health Service Regulation*, the *District Attorney's Office* or any branch of law enforcement conducting an investigation or prosecuting a case of abuse, neglect or exploitation.

Responsibilities of the County Department

After receiving a report alleging the abuse, neglect or exploitation of a disabled adult the county director is required to do a screening on the report. If the report is screened in the county director is required by law to make a prompt and thorough evaluation to determine whether the person needs protective services. The evaluation must include a visit to the person about whom the report was made and consultation

with others to learn the facts of the reported case. After the evaluation, adult protective services is required to notify the person who made the report whether a need for protective services was found. Statutory rules require that the evaluation process begin within 72 hours after the report is received. Evaluations of reports involving life-threatening emergencies are responded to immediately.

Authority of the County Director

The county department of social services director or his staff has the authority to review and copy any and all records, or parts of records, kept by a facility or agency when this is necessary to conduct a thorough evaluation report. This includes records maintained by facilities licensed by the Department of Health and Human Services. The department of social services also has the authority to interview the disabled adult without any one else present.

Right of the Disabled Adult to Consent

If the county social services department determines that a disabled adult needs protective services, the director is required by law to provide or arrange for such protective services if the disabled adult consents (G.S. 108A-104). The disabled adult has a right to determine whether he wants the protective services. If the disabled adult consents to protective services but his caretaker (such as the adult with whom he lives) refuses to allow them to be provided, the law authorizes the director of social services to petition the District Court for an order enjoining interference by the caretaker. The autonomy of an adult is thus respected.

When the Disabled Adult lacks Capacity to Consent

If the social services department finds that a disabled adult is in need of protective services but lacks the capacity to consent to protective services, the reporting law authorizes the county agency to petition the District Court for an order authorizing these services. G.S. 108A-105 determines that the disabled adult lacks capacity to consent to protective services when he "lacks sufficient understanding or capacity to make or communicate responsible decisions concerning his person, including but not limited to, provisions for health or mental health care, food, clothing, or shelter because of physical or mental incapacity." The petition must allege specific facts sufficient

to show that the disabled adult is in need of protective services and lacks capacity to consent to protective services.

If the judge finds by clear, cogent, and convincing evidence that a person needs protective services and lacks the capacity to consent, he may order that protective services be provided. The order designates the person or agency which is to perform or obtain essential services for the disabled adult or consent to protective services on his behalf.

Within 60 days after ordering protective services for a disabled adult who has been found to lack the capacity to consent, the court must review the case to determine whether a petition should be filed with the Clerk of Superior Court to appoint a guardian for the disabled adult under Article 1 of Chapter 35A of the North Carolina General Statutes. Under certain conditions, the court may extend the original 60-day period for an additional 60 days, and again make a determination of whether a petition for guardianship should be filed. Adult Protective services are not provided for more than a total of 120 days under court order.

Emergency Services by Court Order

In certain specified situations, the county director can petition the district court to authorize emergency services to be provided to a disabled adult. To do this, a finding must be made that there is a reasonable cause to believe that (1) the adult lacks the capacity to consent and needs protective services; (2) an emergency exists; and (3) no one else authorized by the law or court order to give consent is available or willing to arrange for the emergency services. A hearing is held on the petition and 24-hour notice must be given to the disabled adult and other specified parties.

The law authorizes the court to issue an emergency order without a hearing only if the court finds, among other things, that the disabled person may suffer irreparable injury or death if the order is delayed for a hearing. Such an order is referred to as an ex parte emergency court order.

APPENDICES

**Appendix B:
North Carolina General
Statute 131 E-128**

North Carolina General Statute

§ 131E-128. Nursing home advisory committees.

- (a) It is the purpose of the General Assembly that community advisory committees work to maintain the intent of this Part within the nursing homes in this State, including nursing homes operated by hospitals licensed under Article 5 of G.S. Chapter 131E. It is the further purpose of the General Assembly that the committees promote community involvement and cooperation with nursing homes and an integration of these homes into a system of care for the elderly.
- (b) (1) A community advisory committee shall be established in each county which has a nursing home, including a nursing home operated by a hospital licensed under Article 5 of G.S. Chapter 131E, shall serve all the homes in the county, and shall work with each home in the best interest of the persons residing in each home. In a county which has one, two, or three nursing homes, the committee shall have five members. In a county with four or more nursing homes, the committee shall have one additional member for each nursing home in excess of three, and may have up to five additional members per committee at the discretion of the county commissioners.
- (2) In each county with four or more nursing homes, the committee shall establish a subcommittee of no more than five members and no fewer than three members from the committee for each nursing home in the county. Each member must serve on at least one subcommittee.
- (3) Each committee shall be appointed by the board of county commissioners. Of the members, a minority (not less than one-third, but as close to one-third as possible) must be chosen from among persons nominated by a majority of the chief administrators of nursing homes in the county and of the governing bodies of the hospitals licensed under Article 5 of G.S. Chapter 131E, which operate nursing homes. If the nursing home administrators and the governing bodies of the hospitals licensed under Article 5 of G.S. Chapter 131E, which operate nursing homes fail to make a nomination within 45 days after written notification has been sent to them by the board of county commissioners requesting a nomination, these

appointments may be made by the board of county commissioners without nominations.

- (c) Each committee member shall serve an initial term of one year. Any person reappointed to a second or subsequent term in the same county shall serve a three-year term. Persons who were originally nominees of nursing home chief administrators and the governing bodies of the hospitals licensed under Article 5 of G.S. Chapter 131E, which operate nursing homes, or who were appointed by the board of county commissioners when the nursing home administrators and the governing bodies of the hospitals licensed under Article 5 of G.S. Chapter 131E, which operate nursing homes failed to make nominations, may not be reappointed without the consent of a majority of the nursing home chief administrators and the governing bodies of the hospitals licensed under Article 5 of G.S. Chapter 131E, which operate nursing homes within the county. If the nursing home chief administrators and the governing bodies of the hospitals licensed under Article 5 of G.S. Chapter 131E, which operate nursing homes fail to approve or reject the reappointment within 45 days of being requested by the board of county commissioners, the commissioners may reappoint the member if they so choose.
- (d) Any vacancy shall be filled by appointment of a person for a one-year term. Any person replacing a member nominated by the chief administrators and the governing bodies of the hospitals licensed under Article 5 of G.S. Chapter 131E, which operate nursing homes or a person appointed when the chief administrators and the governing bodies of the hospitals licensed under Article 5 of G.S. Chapter 131E, which operate nursing homes failed to make a nomination shall be selected from among persons nominated by the administrators and the governing bodies of the hospitals licensed under Article 5 of G.S. Chapter 131E, which operate nursing homes, as provided in subsection (b). If the county commissioners fail to appoint members to a committee, or fail to fill a vacancy, the appointment may be made or vacancy filled by the Secretary or the Secretary's designee no sooner than 45 days after the commissioners have been notified of the appointment or vacancy if nomination or approval of the nursing home administrators and the governing bodies of the hospitals licensed under Article 5 of G.S. Chapter 131E, which operate nursing homes is not required. If nominations or approval of the nursing home administrators and the governing bodies of the hospitals licensed under Article 5 of G.S. Chapter 131E, which

operate nursing homes is required, the appointment may be made or vacancy filled by the Secretary or the Secretary's designee no sooner than 45 days after the commissioners have received the nomination or approval, or no sooner than 45 days after the 45-day period for action by the nursing home administrators and the governing bodies of the hospitals licensed under Article 5 of G.S. Chapter 131E, which operate nursing homes.

- (e) The committee shall elect from its members a chair, to serve a one-year term.
- (f) Each member must be a resident of the county which the committee serves. No person or immediate family member of a person with a financial interest in a home served by a committee, or employee or governing board member or immediate family member of an employee or governing board member of a home served by a committee, or immediate family member of a patient in a home served by a committee may be a member of a committee. Membership on a committee shall not be considered an office as defined in G.S. 128-1 or G.S. 128-1.1. Any county commissioner who is appointed to the committee shall be deemed to be serving on the committee in an ex officio capacity. Members of the committee shall serve without compensation, but may be reimbursed for the amount of actual expenses incurred by them in the performance of their duties. The names of the committee members and the date of expiration of their terms shall be filed with the Division of Aging, which shall supply a copy to the Division of Health Service Regulation.
- (g) The Division of Aging, Department of Health and Human Services, shall develop training materials which shall be distributed to each committee member and nursing home. Each committee member must receive training as specified by the Division of Aging prior to exercising any power under subsection (h) of this section. The Division of Aging, Department of Health and Human Services, shall provide the committees with information, guidelines, training, and consultation to direct them in the performance of their duties.
- (h) (1) Each committee shall apprise itself of the general conditions under which the persons are residing in the homes, and shall work for the best interests of the persons in the homes. This may include assisting persons who have grievances with the

home and facilitating the resolution of grievances at the local level.

- (2) Each committee shall quarterly visit the nursing home it serves. For each official quarterly visit, a majority of the committee members shall be present. In addition, each committee may visit the nursing home it serves whenever it deems it necessary to carry out its duties. In counties with four or more nursing homes, the subcommittee assigned to a home shall perform the duties of the committee under this subdivision, and a majority of the subcommittee members must be present for any visit.
 - (3) Each member of a committee shall have the right between 10:00 A.M. and 8:00 P.M. to enter into the facility the committee serves in order to carry out the members' responsibilities. In a county where subcommittees have been established, this right of access shall be limited to homes served by those subcommittees to which the member has been appointed.
 - (4) The committee or subcommittee may communicate through its chair with the Department or any other agency in relation to the interest of any patient. The identity of any complainant or resident involved in a complaint shall not be disclosed except as permitted under the Older Americans Act of 1965, as amended, 42 U.S.C. § 3001 et seq.
 - (5) Each home shall cooperate with the committee as it carries out its duties.
 - (6) Before entering into any nursing home, the committee, subcommittee, or member shall identify itself to the person present at the facility who is in charge of the facility at that time.
- (i) Any written communication made by a member of a nursing home advisory committee within the course and scope of the member's duties, as specified in G.S. 131E-128, shall be privileged to the extent provided in this subsection. This privilege shall be a defense in a cause of action for libel if the member was acting in good faith and the statements or communications do not amount to intentional wrongdoing.

To the extent that any nursing home advisory committee or any member thereof is covered by liability insurance, that committee or member shall be deemed to have waived the qualified immunity herein to the extent of indemnification by insurance. (1977, c. 897, s. 2; 1977, 2nd Sess., c. 1192, s. 1; 1983, c. 143, ss. 4-9; c. 775, ss. 1, 6; 1987, c. 682, s. 1; 1995, c. 254, s. 7; 1997-176, s. 1; 1997-443, s. 11A.118(a); 2007-182, s. 1.)

NOTE The *Division of Aging* is now known as the **Division of Aging and Adult Services**; The *Division of Facility Services* is now known as the **Division of Health Service Regulation**; and The *Department of Human Resources* is now known as the **Department of Health and Human Services**

APPENDICES

**Appendix C:
Nursing Homes
Operated by Hospitals**

Nursing Homes Operated by a Hospital

Nursing homes operated by a hospital in North Carolina are not licensed as nursing homes per se, but are licensed as a part of a hospital; pursuant to G.S. 131E-75 and follow the North Carolina General Statutes. Thus, they are not subject to the rules and regulations which apply to licensed nursing homes. They are subject, however, to the rules and regulations which apply to licensed hospitals, which stipulates to a large extent many of the same requirements required of independent nursing homes, particularly regarding the physical plant.

Nevertheless, most hospital-based nursing homes participate in the Medicare and Medicaid programs and are thus responsible for meeting the Conditions of Participation for those programs. The Conditions of Participation apply equally to hospital-based and independent nursing homes, and they are enforced by the Division of Health Service Regulation. Hospital-based nursing homes are also subject to the Nursing Home Residents' Bill of Rights, Nursing Home Community Advisory Committees, and complaint investigations by the DHSR. In addition, most hospitals are accredited by the Joint Commission on the Accreditation of Healthcare Organizations (J.C.A.H.O.) and are thus subject to the specific J.C.A.H.O. standards for long-term care when operating nursing homes.

One of the main differences for hospital-based nursing homes is that they are not required to be operated by a licensed nursing home administrator. This is because North Carolina law, as in most states, does not require that hospital administrators be licensed. Since hospital-based nursing homes are operated under the hospital's license and under the auspices of the hospital administrator, there is no provision for requiring a licensed nursing home administrator.

When resolving resident complaints or performing other resident advocacy functions, the community advisory committee should find out who is in charge of the nursing home section of the hospital. Although the hospital administrator is ultimately responsible, some hospital administrators may delegate supervisory functions for the nursing home to an assistant administrator, the nursing director, or some other person, depending on the size of the institution and whether the nursing home is in the same building or on the same campus. If in doubt as to whom you should deal with on a routine basis, check with the hospital administrator.

APPENDICES

**Appendix D:
Nursing Home
Staff Description**

NURSING HOME STAFF

Federal and state regulations establish minimum standards of care for nursing homes, including what services they must provide to residents, and what personnel they must have to provide these services. Some staff exceed federal minimum standards and have specific staffing ratios or require additional services.

The following is a list of personnel that nursing homes are likely to have on staff or working as consultants to provide services to residents:

Administrator: A person licensed by the state to administer a nursing home. This individual is ultimately responsible for all nursing home activities. He/she may or may not have special training in psychosocial and medical aspects of aging. Continuing professional education is usually required by

the state where they are licensed. In some cases an administrator is also the owner of the facility or a relative of the owner.

Medical Director: A physician who is supposed to formulate and direct policy for medical care in the nursing home. Medical directors are required only in skilled nursing facilities. Few facilities have full-time medical directors. Facilities may receive waivers to bypass this requirement.

Attending Physician: A person responsible for the medical care of residents. A physician must visit residents: in skilled nursing facilities once a month for the first 3 months, then every 60 days, in nursing facilities. An exception is if a change in the resident's status occurs, the physician then would be expected to visit more frequently.

Physician Assistant:

An individual who has advance training in direct health care service provision. The PA serves or acts under the licensure and supervision of a Board Certified Physician. Some of the services they provide include taking medical histories, performing physical exams, ordering and interpreting lab tests in addition to consulting with patients without a physician being present.

An important health related function they perform is the writing of prescriptions. This authority is a key distinguishing factor between them and Registered Nurses. However, for complex cases they are expected to consult with a physician. This particular health team member can alternate with the attending physician to perform the federally mandated NH Assessments Nursing Home residents.

NURSING HOME STAFF

Physician Extenders: Nurse Practitioners and Clinical Nurse Specialists are additional members of the health care team. They serve in a role similar to that of PA's. These professionals assist physicians with regular health assessments in addition to performing highly skilled nursing services, such as wound care.

Director of Nursing: A Registered Nurse (RN) who oversees the nursing department, including: nursing supervisors, licensed practical nurses and nurse aides. The Director of Nursing writes job descriptions, hires and fires nursing staff, and writes and executes policies and procedures for nursing practice. The DON consults with residents, families, physicians, and committees. The DON is responsible for quality and safety in patient care.

Charge Nurse: RN or LPN in charge of care in a given unit of the nursing home or in charge of nursing care in the absence of the director of nursing.

Licensed Practical Nurse (LPN): One who has completed one year in a school of nursing or vocational training school. LPN's are in charge of nursing in the absence of a registered nurse. LPN's often give medications and perform treatments. They are licensed by the state in which they work.

Nurse Aide: An employee of a nursing home usually responsible for personal care of the residents (*assisting with bathing, feeding, eating, walking, turning in bed, etc.*). An aide cannot work at the home for more than four months without being trained and completing a competency evaluation. Aides may not perform tasks for

which they are not competent. The state maintains a register of all aides who have completed the training evaluation program. They work under the supervision of a professional nurse. Although aides provide 80-90% of nursing home care, generally little training or experience is required. They are sometimes called "Nursing Assistants", "Certified Nursing Assistants," or simply "Aides."

Pharmacist: Nursing homes will either have a pharmacy on the premises and a pharmacist on staff, or will contract with a community pharmacy and a pharmacist to provide services. The pharmacist is responsible for supervising the pharmacy program in the facility and for reviewing each resident's drug treatments at least monthly.

NURSING HOME STAFF

Social Service

Director: A person who identifies medically related social and emotional needs of the residents and provides services necessary to meet them. If the social service director is not licensed or trained, this person may receive consultation from a licensed person, such as a social worker. Most often a facility employs a social service director on a consultant basis. Full-time social services directors are required in nursing homes of more than 120 beds. Other facilities are required to provide a social service director's services. Sometimes an activity director "doubles" as a social service director.

Dietary Supervisor: A person trained in planning menus, regular and special diets. This staff member also establishes dietary procedures. If a dietary supervisor is

not licensed, this person may receive consultation from a licensed dietitian.

Activities

Coordinator: A person trained in social, recreational, or therapeutic programming that provides an ongoing program of meaningful activities to promote self-care and physical, social and mental well-being of residents. The coordinator need not be fulltime. If he/she does not have professional qualifications, the facility may arrange for consultation by a professionally qualified specialist.

Occupational

Therapist: A person trained to conduct therapy to maintain, restore, or teach skills to improve manual dexterity and eye-hand coordination. Most often a therapist serves in a part-time or consultant capacity to the facility.

Physical Therapist: A person trained to retain or restore functioning in the major muscles of the arms, legs, hands, feet, back, and neck through movement exercises or treatments. Most often a therapist serves in part-time or consultant capacity to the facility.

Speech Therapist:

A person trained to conduct therapy to maintain, restore or improve speech, swallowing, and hearing as it relates to processing language and the spoken word. Most often a therapist serves in part-time or consultant capacity to the facility.

Medical Records

Supervisor: An employee of the facility with the responsibility for supervising medical record services. If this employee is not a qualified medical record librarian, the person may function with consultation from someone so qualified.

NURSING HOME STAFF

Maintenance

Staff members are responsible for the upkeep & appearance of the interior and exterior of the building. They're also expected to make sure equipment in the building is functioning properly. In addition to these duties they also keep equipment that residents have to use such as wheelchairs and walkers in working order. Maintenance will have a direct supervisor who trains and oversees the work of several other staff members.

Housekeeping:

The Housekeeping department is responsible for providing laundry services, cleaning rooms, hallways and common areas. This department may be divided into smaller subsections, such as laundry. Some Nursing Homes do laundry on-site while others send items offsite for cleaning.

COMMONLY USED ABBREVIATIONS

MD =	MEDICAL DOCTOR <i>or</i> MEDICAL DIRECTOR
ADMN =	ADMINISTRATOR
PA =	PHYSICIAN ASSISTANT
DON =	DIRECTOR OF NURSING
ADON =	ASSISTANT DIRECTOR OF NURSING
RN =	REGISTERED NURSE
LPN =	LICENSED PRACTICAL NURSE
NA =	NURSE AIDE <i>or</i> NURSING ASSISTANT
CNA =	CERTIFIED NURSING ASSISTANT
OT =	OCCUPATIONAL THERAPIST
PT =	PHYSICAL THERAPIST
ST =	SPEECH THERAPIST
POA =	POWER OF ATTORNEY
HCPOA =	HEALTH CARE POWER OF ATTORNEY
RP =	REPRESENTATIVE PAYEE <i>or</i> RESPONSIBLE PARTY

APPENDICES

**Appendix E:
Glossary of Aging
and Long Term Care
Terms**

Glossary of Aging and Long Term Care Related Terms

Activities of Daily Living – Basic self-care activities, including eating, bathing, dressing, transferring from bed to chair, bowel and bladder control, and independent ambulation, which are widely used as a basis for assessing individual functional status.

Administration on Aging (AOA) – The primary agency in the federal government having responsibility to administer the provisions of the Older Americans Act. It advocates at the federal level for the needs, concerns and interests of older citizens throughout the nation.

Administrator – The person who is responsible for the total operation of a nursing home and is responsible for the facility meeting standards and maintaining rules as established by the state.

Adult Care Home – A facility licensed in North Carolina that provides custodial care for (7) or more people who do not need nursing care but are no longer able to remain in their own homes because they need assistance in meeting their day-to-day needs.

Adult Care Home Community Advisory Committee – Members are residents of the county who are appointed to work to maintain the spirit of the Residents' Bill of Rights as well as promote community education and awareness of the operation of adult care homes in that county and the needs of the persons residing in these homes.

Adult Care Home Licensure Section – The unit within the Division of Health Service Regulation which issues adult care home licenses and enforces overall compliance with the licensure standards.

Adult Home Specialist – The person(s) in the county department of social services given primary responsibility for responding to complaints, issues regarding licensure and assessing the need for adult care homes in the county.

Adult Protective Services – Services provided to protect disabled adults 18 years of age and older from abuse, neglect and exploitation. All 100 county departments of social services within the state have a legal mandate to receive and evaluate all reports alleging an adult with disabilities has been abused, neglected or exploited, and provide

and/or arrange for services to prevent further abuse, neglect or exploitation.

Alzheimer’s Disease – A progressive, degenerative disease that attacks the brain and results in impaired memory, thinking and behavior.

Ambulatory with Assistance – Able to walk with the aid of assistive devices such as a cane, walker, etc.

Analgesics – A class of drugs used to reduce pain. (*Aspirin, Tylenol, Darvon* are common examples).

Anti-Inflammatory Drugs – Drugs used to reduce inflammation in the body; Ex. Pain experienced from arthritis. (*Aspirin* and *Butazolidin* are examples).

Anti-Hypertensives – Drugs that lower the blood pressure. (*Serpasil* is an example).

Area Agency on Aging (AAA’s) – A regional planning body of governments which plans, coordinates and advocates for development of a comprehensive service delivery system to meet the needs of older people in a specific geographic area. They together with the federal level Administration on Aging, State Offices on Aging, and local service provider agencies comprise the “aging network”.

Arteriosclerosis or Atherosclerosis – Fatty deposits inside artery walls causing a decrease in size and flexibility of the artery. The following terms are used in conjunction with the basic condition:

Heart Attack – Common term used to describe sudden internal damage to the heart often as a result of disease.

Stroke – Sudden lack of blood to some parts of the brain causing the affected area to no longer function properly.

Arthritis – An inflammation of a joint or joints.

Authorized Representative – Is the person that the Social Security beneficiary or Supplemental Security Income beneficiary requests to be given the right to represent him or her in any business with the Social Security Administration. The right to have an authorized representative exists for all claimants of Social Security and SSI benefits and is

obtained by securing and completing the "Appointment of Representative" form SAA-1696 which defines the limit for fees to be charged by an authorized representative, the penalties for charging an unauthorized fee, and conflict of interest.

Case Management – An inter-agency, standardized process focusing on the coordination of a number of services needed by vulnerable citizens. It includes an objective assessment of client needs; the development of individualized care plan based on assessment that is goal oriented and time limited; arrangement of services; and reassessment, including monitoring and follow-up.

Community Advisory Committee – Appointed citizens who work to maintain the spirit of the Residents' Bill of Rights as well as promote community education and awareness of the operation of long term care facilities in a county and the needs of the persons residing in these facilities.

Catheter – A tube inserted to pass through the urethra into the bladder to drain urine. Other names used are Foley, Foley catheter, and indwelling catheter.

Certificate of Need (CON) – A certificate issued by a government body to a health care provider who is proposing to construct, modify, or expand facilities, or to offer new or different types of health services. CON is needed to prevent duplication of services and creation of unnecessary beds. The certificate signifies that the change has been approved. In NC the Division of Health Services Regulation in the Department of Health and Human Services handles CON.

Combination Facility – A facility licensed under G.S. 131E-102 providing both nursing care and adult home care.

Continent – Able to control the passage of urine and feces. The opposite is incontinent or unable to control the passage of urine and feces.

Continuum of Care – A comprehensive system of long-term care services and support systems in the community, as well as in institutions. Continuum includes: (1) community services such as senior centers; (2) in-home care such as home-delivered meals, homemaker services, home health services, shopping assistance, personal care, chore services, and friendly visiting; (3) community-based services such as adult day care; (4) non-institutional housing

arrangements such as congregate housing, shared housing, and board and care homes and (5) nursing homes.

Contractures – Stiffening of muscles and joints.

Copayment – A type of cost sharing whereby insured or covered persons pay a specified flat amount per unit of service or unit of time, and the insurer or public agency pays the rest of the cost.

Council on Aging – (**Department on Aging** or **Office on Aging**) – A private nonprofit organization or public agency that serves as a county focal point on aging and which traditionally provides supportive services to older adults.

Decubitus Ulcer – A sore or ulcer caused by the lack of blood circulating to some area of the body. This condition usually results from sitting or lying in one position too long. Other names are bedsore, pressure sore, and decubitus sore.

Deductible – The amounts payable by the enrollee for covered services before Medicare or private health insurance makes reimbursements. The Medicare hospital insurance's deductible applies to each new benefit period, is determined each year by using a formula specified by law, and approximates the current cost of a one-day inpatient hospital stay.

Department of Social Services – An agency of county government through which many programs and services for older adults are administered.

Dehydration – Lack of adequate fluid in the body; a crucial factor in the health of older people.

Diabetes – A condition caused by a failure of the pancreas to secrete enough insulin. An older person may have poor circulation, poor eyesight, or other debilitating complications from the disease.

Discharge Planning – A centralized, coordinated plan developed by a hospital or nursing home to ensure that each patient has a structured program designed to enhance or maintain their physical and psychological health once they leave the facility.

Disorientation – Loss of one’s bearing’s loss of sense of familiarity with one’s surroundings; loss of one’s bearings with respect to time, place and person. The opposite of this is oriented.

Division of Health Service Regulation (DHSR) - The state agency which oversees medical, mental health and group care homes, emergency medical services, and local jails. Their authority also extends to long term care settings such as adult care homes and nursing homes. This Division has the responsibility of ensuring that people receiving care in these facilities are safe and receive appropriate care through the monitoring and enforcement of state and federal requirements. This Division performs many key functions, including developing licensure rules and regulations for consideration by the Medical Care Commission, issuing, denying, or revoking licenses for the facilities under their direction.

Family Care Home – A residential home that is licensed in North Carolina to provide care for 2 to 6 people. The building itself is a normal house and is usually in a regular neighborhood with other homes and families next door. The care provided includes: room and board, personal assistance, supervision, and meaningful activities provided in a family-like setting.

FL-2 – The form used by a physician to indicate the appropriate level of care for an individual who is in need of long term care placement.

Functionally Disabled – A person with a physical or mental impairment that limits the individual’s capacity for independent living.

Grab Bar – Bars or railings placed around tubs, showers, and toilets to be used to steady oneself.

Geriatrician – A physician who specializes in the diagnosis and treatment of diseases of aging and the aged.

Guardianship – The legal power and duty given by the court to a person (guardian) for the purpose of serving as the legal surrogate decision maker for another person (ward) who has been determined incapable of making decisions about his or her personal and financial affairs. The legal powers and duties given to a guardian depend on the type of guardianship ordered by the court. The court may order that the guardian’s power and duties be limited resulting in a limited guardianship.

Guardian of the Estate – Responsible for collecting, preserving and administering the ward’s real and personal property.

Guardian of the Person – Responsible for making decisions, such as where the ward will live, and gives consent for medical care, counsel and professional treatment for the ward.

General Guardian – Performs the duties of both the Guardian of the Estate and Guardian of the Person.

Hospice Care – Care that addresses the physical, spiritual, emotional, psychological, social, financial, and legal needs of the dying patient and his family. Hospice care is provided by an inter-disciplinary team of professionals and volunteers in a variety of settings, both inpatient and at home, and includes bereavement care for the family.

Medicaid – A medical assistance program for low-income people administered by the state through the Division of Medical Assistance in the North Carolina Department of Health and Human Services. To be eligible a person must meet income and asset limits, be aged, blind, disabled, or a member of a family with dependent children, or a pregnant woman. Some people are covered by both Medicare and Medicaid. Medicaid pays the Medicare deductible and coinsurance and the Part B premium for persons eligible for both Medicare and Medicaid. The program is based on regulations from both federal and state.

Medical Care Commission – A state body which promulgates rules which govern the operation of all adult care homes, except those exempt in subsection (c) of G.S. 131D-2.

Medically Needy – A category of persons who may receive medical assistance under some states’ Medical Assistance Program. Medically needy coverage is the same as categorical coverage except that it often does not pay for emergency hospitals, intermediate care facilities, clinic services, and psychologists.

Medicare – A federal health insurance program for people 65 or older and other individuals with disabilities. It is run by the U.S. Department of Health and Human Services. Social Security Administration offices across the country take applications for Medicare and provide general information about the program. Medicare is composed of many segments, but the areas or parts that most people are familiar with or use are Parts, A, B, C and D. Hospital Insurance,

known as (Part A) helps pay for inpatient hospital care, inpatient care to a skilled nursing facility, home health care and hospice care. Medical Insurance (Part B) helps pay for doctors' services, outpatient hospital services, durable medical equipment, and a number of other medical services and supplies that are not covered by the Hospital Insurance part of Medicare. (Part C) Medicare Advantage Plans are health plan options that are part of the Medicare program. If you join one of these plans, you generally get all your Medicare-covered health care through that plan. This coverage can include prescription drug coverage. Medicare Advantage Plans include: Medicare Health Maintenance Organizations (HMOs); Preferred Provider Organizations (PPO); Private Fee-for-Service Plans; and Medicare Special Needs Plans. Part C is unique because it's provided through private insurance companies approved by Medicare. Prescription Drug Coverage (Part D) helps beneficiaries pay for their medications through a number of provider related programs.

Nursing Home – A health care facility licensed by the state to provide longterm medical services according to the directives of a patient's physician and standards of quality set by the state and the facility. Nursing homes in North Carolina are staffed by professional personnel under the direction of a licensed nursing home administrator; they deliver a variety of medical and social services to their patients.

Nursing Home Community Advisory Committee – Members are residents of the county who are appointed to work to maintain the spirit of the Residents' Bill of Rights as well as promote community education and awareness of the operation of nursing homes in that county and the needs of the persons residing in these homes.

Ombudsman – A representative of a public agency or a nonprofit organization who investigates and resolves complaints made by or on the behalf of individuals who are residents of long-term care facilities. In North Carolina the State Long-Term Care Ombudsman is located within the Division of Aging and Adult Services an agency within the state's Department of Health and Human Services. The daily duties and responsibilities of the Ombudsman Program are carried out by regional ombudsmen. Regional ombudsmen cover every county in the state and their offices are located within Area Agencies on Aging, which are a part of regional councils of government.

Personal Care – Care that involves help with eating, dressing, walking, and other personal needs but very little or no nursing supervision. The terms “custodial care”, “domiciliary care”, “adult care” and “residential care” are often used interchangeably with “personal care”, although strictly defined “personal care” may imply a somewhat higher level of service.

Personal Needs Fund – A sum of money which residents who are Medicaid eligible, living in long-term care facilities are allowed to retain from their income to purchase personal items and/or services.

Power of Attorney – The simplest and least expensive legal device for authorizing one person to manage the affairs of another. In essence, it is a written agreement, usually with a close relative, an attorney, or financial advisor, authorizing that person to sign documents and conduct transactions on the individual’s behalf. The individual may delegate as much or as little power as desired and end the arrangement at any time.

Health Care Power of Attorney – A person designated to make healthcare decisions for another person when the designator is not capable of making those decisions.

Representative Payee – An individual who is chosen by the Social Security Administration and agrees to receive a social security or SSI recipient’s check and to handle the funds in the best interest of the recipient.

Residents’ Council – An organization of nursing home residents. Its goal usually is to improve the quality of life, care and communication within an institution by providing some measure of control or self-determination by the residents.

Restraint – A device used to prevent a resident from falling out of a chair; e.g. a belt around the waist tied to a wheelchair or a jacket with straps tied to a wheelchair. A jacket restraint could be used to prevent a resident from crawling over the side rails of a bed. Wrist restraints are used under unusual circumstances. Restraints should be used as protection for the resident and when other means are not reasonable.

Sedatives – Drugs which provide calm and quiet to those in a state of nervous excitement (Noctec, Nembutal, Seconal, Chloral Hydrate, and Phenobarbital are commonly used examples).

Self Care – Bathing, dressing, toileting, and feeding oneself.

Social Security Administration (SSA) – The federal government agency which administers programs throughout the United States. These programs include: SSI, old age and survivors' benefits, and disability.

Spend Down – Also known as a deductible. Under the Medicaid program spend-down refers to a method by which an individual establishes Medicaid eligibility by reducing gross income through incurring medical expenses until their net income (after medical expenses) meets Medicaid financial requirements.

State-County Special Assistance for Adults – The Special Assistance Program provides financial assistance to help pay for room and board for older adults or adults with disabilities who are living in licensed adult care homes, licensed adult care home beds in combination nursing home/adult care home facilities, group homes and some residential hospice facilities. Eligible recipients automatically receive Medicaid to assist in paying for medical services and personal care. There is a special higher rate for persons living in licensed special dementia care units. The Special Assistance In-Home program, available in most counties, provides financial assistance to help Medicaid eligible individuals remain at home if they need the type of care provided in adult care homes. These programs are administered by local departments of social services.

Supervisor-in-Charge – A person whose qualifications have been cleared by the county Department of Social Services and approved by the N.C. Division of Health Service Regulation to live in the home full-time or have charge of the management of it when the administrator does not live in or remain in the home full-time. There should be a supervisor assigned on each of the three shifts if they do not live-in.

State Unit on Aging – An agency of state government designated by the governor and the legislature as the focal point for all matters related to the needs of older persons within the state. Currently, there are 57 State Units on Aging located in the 50 states, the District of Columbia, and the U.S. territories. In North Carolina, the Division of Aging and Adult Services (DAAS) in the Department of Health and Human Services (DHHS) is the state office on aging.

Supplemental Security Income (SSI) – A federal program that pays monthly checks to people in need who are 65 years or older and to people in need at any age who are blind and disabled. The purpose of the program is to provide sufficient resources so that anyone who is 65, or blind, or disabled can have a basic monthly income. Eligibility is based on income and assets. SSI is administered nationally and locally by the Social Security Administration.

APPENDICES

**Appendix F:
Difficult Behaviors**

Understanding and Responding to Difficult Behaviors

Changes in behavior are often associated with dementing illnesses such as Alzheimer's disease. Increased restlessness, agitation, wandering, abrupt changes in mood, inappropriate responses to social situations, repeating the same question over and over, wanting to go home--these are behaviors which caregivers may be called upon to manage.

Each victim of a dementing illness is unique. The presence of behaviors such as these, and the intensity of the behaviors, will vary greatly from patient to patient. It is important to realize that the behavior is a manifestation of the illness, and is therefore something beyond the patient's control.

There are many reasons why a difficult behavior may occur. The most common causes relate to the following:

- The person's physical and emotional health
- The environment and what's taking place around them
- The task that is being requested of them
- Communication can be very frustrating for both the resident and the caregiver when they don't want the other is trying to express.

Since we cannot expect the person with Alzheimer's disease to change his behavior, we must find ways to accommodate and work with behaviors that are difficult for us.

Caregivers are encouraged to problem solve in the following ways:

- When does the problem occur? Were there precipitating factors?
- What was happening right before the behavior occurred?
- Was the behavior brought about by one of the reasons listed above?
- What emotions did the patient exhibit before the behavior? During the behavior? Can you respond to the emotion rather than the behavior?

- Develop a list of responses to the behavior. Ask other caregivers to review the list.

Be flexible!! What works for one occasion may not work for another. What works for one caregiver may not work for another. Don't be upset if your strategy is not successful, or has limited success.

For additional information on Alzheimer's and other types of dementia visit the following websites: NC Alzheimer's Associations – www.alz.org/northcarolina (Western Chapter); www.alznc.org (Eastern Chapter); www.alz.org (National Organization).

Special Management Issues

(Excerpts from *Caring for the Memory Impaired: Strategies and Techniques That Work*, by Janet C. Sawyer, Edna Ballard and Pamela Autrey. NC Department of Human Resources, Division of Aging, Revised, 1990.)

Orientation to time/place/person

- **Problem:** The patient is confused or mistaken about the time of day or year (i.e. thinking their mother is still alive, or that it's time for lunch when she just ate lunch); about where she is (she thinks she's in the house she grew up in, or she can't find her way around the nursing home and keeps "losing" the dining room, the bedroom, or the bathroom); about who's who (she may call her daughter her mother, or think that you are her child, or not recognize her husband of 50 years).
- **Causes:** Patient has limited recollection—or no recollection at all—of people or places or events due to memory loss. This may be compounded by prior vision or hearing losses and by misinterpreting sensory information.

What you can do:

- Calmly identify time, place, or person to the patient. If the patient insists that her perception is correct and yours is wrong, don't argue! For example, if the patient insists that she needs to go home to take care of her children (she is disoriented to time and place), you might say, "I understand how much you love your children. Do you remember how you used to

cook mashed potatoes for them every night?”—effectively distracting her while validating her roles as a mother and caretaker.

- ❑ Visual cues—name tags, door markers, “landmarks” such as pieces of furniture or changes in the decor—can help orient some patients if they are pointed out and consistently used.
- ❑ If your patient has trouble remembering the nature of relationships, you can support him by saying, “Your grandson, John, is coming to see you,” or “Your neighbor, Fran, is here to take you out to lunch.” Whenever possible, assist him in recognizing the person who is significant to him.
- ❑ The same goes for orientation to time and place. Your “introduction” helps the patient know where he is and what he’s supposed to do. (“Let’s go to the kitchen. It’s almost time for lunch.” “Your friend, Mark, is here to take you to the barber shop. You have an appointment at 2:30 this afternoon.”)

Combativeness and Catastrophic Reactions

“When you’re upset, they’re upset. I’ve learned I have to keep calm when my husband gets angry about something that I can’t do anything about.”

Problem: Patient overreacts, sometimes over minor things, and quickly becomes unmanageable or combative.

Causes: Catastrophic reactions may be caused by something external in the environment—the sound of the television, over stimulation at mealtime, being touched from behind when it isn’t expected—or by the patient’s own frustration with his limited abilities (for instance, not being able to button a shirt, not recognizing a face that seems familiar, not knowing where he is or what he’s supposed to do there). The patient may misunderstand stimuli or may misinterpret what is going on around him. He may strike out in his fear or confusion.

What you can do:

- ❑ Look for the cause of the patient’s immediate acute confusion.
- ❑ Do not argue with the patient--turn him in another direction, walk him into another part of the room, give him something to hold.

- ❑ Reassure the patient that you know he's upset and that you'll take care of the problem.
- ❑ Stay calm yourself!!
- ❑ Remove objects which may be dangerous to the patient during catastrophic reactions.
- ❑ The best approach for managing catastrophic reactions is to diffuse them before they happen! Look for excessive agitation, tenseness, or unusual facial expressions or gestures. These often give you nonverbal clues about what is bothering the patient.
- ❑ If you feel that either the patient or you are in danger, get help immediately.

Suspiciousness/Paranoia

Problem: Patient mistrusts you or others. Patient may believe that something is true which she is actually imagining.

Causes: Because the patient mistrusts her own memory and knows that she may be making mistakes, she may be fearful of trusting others to take care of her affairs the way she would like. She may become fixated on ideas that have no basis in reality: the nurses are trying to poison her; her son is stealing all her money; the man in the television is talking to her; the man who says he's her husband is not really her husband although he looks like him. Her poor memory and her inability to make sense of the environment, of events, or of situations exacerbate the problem.

What you can do:

- ❑ Respect the patient's view of reality without "buying into it." ("I know you think that there's something wrong with your applesauce.")
- ❑ Acknowledge her feelings of fearfulness, mistrust, etc., and offer to help her with the immediate problem. ("I certainly wouldn't want anything to happen to you. I will look into this matter myself.")
- ❑ Don't react defensively to her accusations. ("How could you possibly think that I would want to poison you?") Don't take things personally!

- ❑ Remain calm. Reassure the patient of your concern and desire to help.
- ❑ Try distraction – take the patient to another location, give her something to hold or look at, or spend a few moments talking about something else.
- ❑ Even if the patient cannot be distracted from her incorrect beliefs, she will subconsciously respond to your concern and your interest in her.

“I used to have my feelings hurt all the time by things mom would say to me. Now I know she doesn’t really mean it—it’s just the Alzheimer’s talking.”

Hallucinations

Problem: Patient sees or hears things that are not there.

Causes: Vision or hearing problems, misinterpretation of the environment, physical problems (such as pain, fever), dehydration, nutritional, or psychosis related problems.

What you can do:

- ❑ Don’t argue or try to reason with the patient. (Remember, the experience is real to them).
- ❑ Reassure, if upset; distract if you can. “I will stay with you,” or “Let’s walk down to the living room,” for instance.
- ❑ Reduce clutter so patient can see better and have less stimuli present
- ❑ Make sure patient can see and hear adequately (be aware of glare, reflections, noise, etc.).
- ❑ Respond to the patient’s feeling about the hallucination – “That must be frightening for you.” This reassures the patient that you understand her fear and that you care about her feelings.
- ❑ Monitor medications which might contribute to the patient’s tendency to hallucinate. Inform the physician about tendency to hallucinate.

Delusions

Problems: Patient has a fixed belief about something with no basis in truth: i.e., believing that someone is trying to harm him, steal from him, spy on him.

Causes: May be caused by any number of factors. The patient may be confused about the intent of others, may misunderstand actions, may be compensating for forgetfulness by misinterpreting the reality of the situation, may be having adverse reaction to medication.

What you can do:

- ❑ Don't argue with the patient.
- ❑ Try to reassure the patient if he is agitated or anxious.
- ❑ Inform the physician of the delusion.
- ❑ If the delusion is harmful or interferes with good care (i.e., the patient refuses to eat and thinks the food is poisoned, and distractions or reassurances don't work), report this to the physician. Medications may be indicated to reduce the delusional behavior.
- ❑ Sometimes the delusion is harmless (for instance, the patient seems to enjoy an imaginary friend or pet). In this case, support the patient in his feelings without "buying into" the delusion.

"One of the hardest things for me was having my mom tell everyone that I was taking her money. She couldn't pay her own bills, and she was always accusing me of stealing from her. I knew I had to take care of her finances, but I couldn't convince her that I was acting in her best interest. She worried about money for a long time. Even though I never convinced her, I had to accept the fact that I was doing the best I could for her, and go on from there."

Anxiety/Agitation

Problem: Patient becomes extremely upset or concerned about her safety or well-being and may react in a number of ways, including withdrawing, striking out, pacing, exhibiting uncooperative behavior, crying, using excessive or abusive language.

Causes: Fear of not being able to perform a task or activity; too much stimulation; fatigue; confusion; embarrassment over losses.

What you can do:

- Stay calm even in the face of extreme agitation.
- Reduce activity or demand on the patient.
- Remember that clutter, noise, too many people can all be upsetting or threatening to the AD patient.
- Remove patient from the environment and take her to a quiet place.
- Leave the patient alone and come back later.
- Provide structure, routine, and safe environment.
- The patient will function best in a predictable routine. Avoid changes in her environment or in her schedule unless planned out in advance.

“With kids and the schedules, we were always coming and going. I learned that we needed to keep a predictable routine that Mom could get used to. It was hard for us to do this, but it really helped Mom, so I guess it helped us out, too!”

Sleep

Problem: Patient has trouble falling or staying asleep; gets up frequently through the night (often wanders, gets lost, and rummages about).

Causes: Older adults have less efficient sleep, resulting in less “deep sleep” and in more frequent periods of arousal. Patient may need to go to the bathroom; may be confused about the time to get up; may be fearful and need comforting or reassuring. Many Alzheimer’s patients experience extended periods of sleeplessness and restlessness, going for days or weeks with very little sleep.

What you can do:

- Provide sufficient exercise, activity and fresh air during the day.
- Take the patient to the bathroom before he retires.
- Provide a bedside commode if incontinence is a problem and the patient has difficulty finding his way to and from the bathroom.
- Tell the patient, “Go back to bed. It’s time to sleep.”
- Let the patient pace a while if he is very restless.
- Provide a favorite “security blanket”.
- Give the patient a snack. Hunger may be keeping him awake.
- Give the patient warm milk or decaffeinated tea or coffee.
- Monitor medicines which may cause the patient to sleep too much during the daytime. Ask the physician if the schedule can be changed to ensure longer sleep at night.
- Secure the house against nighttime wandering; install a baby monitor to alert yourself to the patient’s rising at night.
- Experiment with lighting--determine if increased or decreased lighting helps orient the person at night.

“Sleep, that knits up the ravell’d sleeve of care...” – Shakespeare

Inappropriate Social Behavior

Problem: Patient screams, curses, makes rude remarks, strikes out, exhibits poor manners.

Causes: Poor judgment or loss of memory regarding appropriate social behavior or consequences of actions; loss of ability to control his initial impulses.

What you can do:

- Respond in a calm, reassuring manner.
- Look for precipitating events in the environment. (For instance, too much noise, too many people, too much stress on patient, patient is in pain or discomfort.)
- Acknowledge appropriate behavior. (“I like it when you use a calm voice to talk to me.”)
- Do not take behavior or remarks personally. Patient may be reacting to his own frustration or to stressors in the environment rather than to you individually.
- Acknowledge your feelings about the behavior. (For example, “I am sure that you did not mean to hurt me just then. But I do not like it when you hit me.”)
- Try to satisfy the needs expressed through the behavior—is the patient really asking for security, structure, love or reassurance?

“Remember that your friends are there for you. You can unload a lot of resentment by just talking. I couldn’t believe it the first time Jim yelled at me. He never raised his voice before he got sick. We both cried afterwards, but I knew that he was changing and that I had to start looking to my friends for the support and love that he had once provided.”

Sundowning

Problem: Patient becomes confused, restless, agitated in late afternoon or evening.

Causes: Patient becomes tired, and coping ability is sapped; patient may have difficulty in adjusting to a change in routine (such as increase or decrease in activity level of people around him, children coming home from school, shift change in a nursing home). Patient may misinterpret environment changes such as noises, shadows, activity. Researchers suggest that there may be other causes of sundowning which we don't fully understand at this time.

What you can do

- Turn on the lights prior to twilight.
- Reduce noise, glare, excessive activity that may distract patient.
- Highly structuring activity and exercise periods for the Alzheimer's patient preceding the time he "sundowns" may be helpful in preventing excessive agitation during the late afternoon.
- Provide a safe place to pace or rummage, and be sure that the patient has sufficient rest periods during the day.
- Provide security with favorite items--pictures of family or their home, a doll, a stuffed animal, a pet, etc.
- Reassure the patient.
- Try giving a snack or something to drink.
- Sometimes patients respond well to music.

"Late afternoon was the worst time for us..."

Mealtime Problems

“Dad kept losing weight, even when he ate everything in sight. We checked with the doctor and gave him supplements, but nothing seemed to help. For some reason the body didn’t metabolize nutrients well. The dietitian told us that some Alzheimer patients go through that stage and then they usually stabilize.”

Problem: Patient can no longer handle utensils; has increased or decreased appetite; eats inappropriate things.

Causes: Patient may have forgotten how to use utensils or how to actually begin the process. You may need to demonstrate or begin the motion for her. Patient can’t make the connection between eating and the sensation of being hungry, and has lost good judgment concerning what is appropriate to eat and when to eat. Too many food choices may confuse the patient and she may become “stuck”, in which case she may play with her food or wander away from the table. Patient may have difficulty chewing or swallowing.

What you can do.

- Provide quiet, uncluttered places to eat.
- Limit food choices and amount of stimulation on the table and in the room.
- Demonstrate or give directions on getting started. Remain friendly, calm and unhurried.
- Present foods according to the patient’s ability—finger foods when he is no longer able to handle utensils, pureed foods when there are chewing or swallowing difficulties.
- Do not assume that an AD patient is not hungry if he does not eat his meal. He may not be able to associate being hungry with the food that is in front of him.
- Make use of assistive devices such as suction plates, large-handled utensils.
- If the patient consistently refuses to eat, check for poorly fitting dentures or sore gums.
- Allow enough time for the patient to complete a meal. Remember, the patient’s slow reaction time may require a long time to finish the meal.

- ❑ Don't force an agitated patient to eat. Be sure patient sits up for 20 minutes after eating to avoid choking. Also, be sure that the patient is not holding food in his mouth.

Difficulty with Bathing

"Mom would always say she'd just taken a bath, and that she'd take another one tomorrow. She smelled awful, and she never changed her clothes. She used to be so neat and tidy..."

Problem: Patient refuses to bathe, and becomes angry, agitated or violent in refusing to take a bath.

Causes: Patient may feel overwhelmed by the bathing process. The different steps necessary to take a bath may be confusing. The patient may be unable to follow directions, or to understand what to do even when being assisted in such a personal and intimate task. A lack of privacy may heighten these feelings. The patient may not understand why bathing is necessary, and may have a diminished sense of personal hygiene. Patient may fear the water, or other noises or sensations associated with bathing. Depression associated with dementia may cause the patient to have difficulty in participating in any activity.

What you can do:

- ❑ Follow the same routine each time you give the patient a bath.
- ❑ Learn the patient's bath routine. Does he prefer a bath or a shower? When does he like to take his bath?
- ❑ In preparation for the bath, gather everything you will need ahead of time. This may reduce the anxiety level for your patient.
- ❑ Do not ask the patient, "Would you like to take a bath?" The answer invariably is "No!" Instead, say something like, "It's time for your bath. Take my arm and we'll walk down the hall to the bathroom."
- ❑ If the patient is agitated, approach calmly. Return later if you are not successful initially.
- ❑ Respect the patient's need for privacy and draw the curtain

or close the door if he can be left without direct supervision.

- Respect the reason for resistance. For example, the patient may be angry or frustrated over not being able to do the job himself.
- Model how to do the task. Simplify your instructions and support the patient in doing as much as he can for himself.
- Monitor water level and temperature carefully. The patient may have lost the ability to react to dangerously hot water.
- The patient does not need a complete bath everyday. A sponge bath may be sufficient. It is important, however, to wash and dry thoroughly the genital area to prevent rashes or skin breakdown, especially if the patient is incontinent.
- If the patient also resists washing hair, the bathing process may be easier if the two are separated.

“We finally solved the problem of Mom’s not changing clothes by buying two of everything. That way she could wear one while we washed the other. She did best in sweat suits and in dresses that could slip on. Button and close-fitting dresses were more of a problem for her.”

Toileting and Incontinence

Problem: Patient has difficulty finding or using the bathroom; patient is incontinent of bowel or bladder.

Causes: In earlier stages, patient may forget where the bathroom is, may forget how to manage undressing, or may have difficulty unfastening clothing in time to avoid having an accident. In later stages, patient may be unaware of the urge to void and how to respond appropriately.

What you can do:

- Train yourself to respond to the patient’s particular bowel and bladder needs.
- Regular trips to the toilet, with as much assistance with clothing as necessary, will help the patient to avoid the

discomfort and distress of incontinence.

- ❑ Try clear, concise signs or pictures, such as (“BATHROOM”) which can be read or seen easily from a wheelchair or with poor eyesight.
- ❑ Watch for increased agitation, fidgeting, or calling out which might indicate a need to use the bathroom.
- ❑ If the patient retains some independence in toileting, make certain that the fastenings on his clothes are easy to manipulate and that he heads for the bathroom in plenty of time to avoid an accident.
- ❑ In the later stages, when a patient may not understand what he is to do in the bathroom, it is important to monitor him regularly to make sure he is clean and dry.

Resources to Help Families with Problems Caused by Incontinence

Caregiver Support at www.caregiver.com

National Kidney Foundation at www.kidney.org

National Association for Continence at www.nafc.org

Wandering

Wandering behavior is one of the most risky, frightening behaviors with which caregivers must deal. Not every person wanders, but the potential for getting lost and wandering away poses serious risks to the patient. For that reason, every caregiver should take some preliminary precautions:

- ❑ Have a current photograph of the patient.
- ❑ Have information about the patient, which describes hair color, identifying marks, medical condition, color of eyes, complexion, blood type, jewelry which is customarily worn, use of glasses and/or hearing aids.
- ❑ Collect the patient’s scent and store it. (*While wearing rubber gloves take a cotton ball and stroke the patient’s skin to collect his scent. Store the cotton in a tightly closed plastic bag.*)
- ❑ Inform neighbors, local police, firemen and others of the patient’s condition. Keep a list of their telephone numbers

handy. Consider using a medic-alert type bracelet or locket that includes the patient's name, telephone number, memory problem and medical condition. Consider also marking dentures, eyeglasses, keys and shoes with identifying information.

To Safety Proof a Home:

- ❑ Place locks out of the line of sight or out of reach. Since dementia victims have difficulty accomplishing tasks that require several steps, use several locks of different types—hook & eye, bolt, doorknob lock. Consider a child proof door knob, or a buzzer system that rings when the door is opened.
- ❑ Put hedges or fences around your patio or yard.
- ❑ Put locks on gates.
- ❑ Place a pressure-sensitive mat at the door or person's bedside. Use "Baby monitors" (such as Fischer-Price) to monitor activity in another room.
- ❑ Camouflage some doors with a screen or curtain, or put a two-foot square of a dark color in front of the door knob.
- ❑ Use a safety gate across doors or at the top or bottom of stairs.

Printed materials that offer suggestions and additional insight into the disease are available from the Alzheimer's Association either on-line or hard copy. www.alz.org/national/documents/brochure_behaviors.pdf

APPENDICES

**Appendix G:
Communication
Techniques**

Communication Strategies that are Helpful When Working with the Confused Elderly

General Attitude and Approach

Calm

Flexible

Non-resistive

Guiding (not controlling)

Verbal Approaches

1. Use concrete, exact, positive phrases; repeat the same phrase.
2. Trigger automatic responses.
3. Break tasks down into single instructions like “walk forward”, “stop”, “turn around” and “sit down”.
4. Make a suggestion if the person is unable to make a choice.
5. Use a calm, soft, slow voice pattern.
6. Ask one question at a time and WAIT for a response.
7. Do not argue or try to reason.
8. Use distraction.

9. Keep your promises, so promise only what you will be able to do.
10. Include the person in your conversation.
11. Identify the person's vocabulary and use it—if he uses the word "potty" for bathroom, then staff should use that word.
12. Treat the resident as an elder or peer, not as a child.
13. Acknowledge the person's feelings and help her "name it" if she has difficulty—for example: "You look sad. Do you miss your daughter after she leaves?"
14. Give directions within attention span.

Nonverbal Approaches

1. Practice "looking friendly"—Your attitude/mood is contagious, felt by all, even if you share it verbally only with other staff.
2. Make your verbal and nonverbal messages the same.
3. Stand in front of the person, make sure they can see you and make eye contact with them.
4. Assume an equal or lower position, which means getting on their eye level or taking a seated position near them. This especially helpful if the resident feels powerless.
5. Move slowly.
6. Approach from the front, not the side or behind.
7. Avoid overwhelming the resident physically or verbally (*approaching an anxious resident with three or more people may lead to a catastrophic reaction*).
8. Use lots of touch, if the resident enjoys it. and allow time for the resident to touch you.
9. Identify symbolic behaviors and their meaning- the cup the resident wishes to hang onto often after meals may be symbolic for having coffee with friends and relatives and be a source of security and comfort.



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