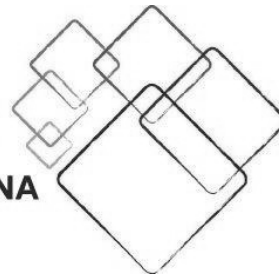


# DISABILITY RIGHTS NORTH CAROLINA

Champions for Equality and Justice



## Memorandum

**To:** Disability Rights NC Team Leaders  
**From:** Abuse Neglect/investigations Team  
**Date:** July 22, 2010  
**Re:** Dangerous Conditions in North Carolina's Adult Care Homes

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### SUMMARY OF FINDINGS

Between October 2008 and July 2009, four residents of North Carolina's Adult Care Homes died as a result of resident-on-resident assaults. Disability Rights North Carolina has learned that all of the residents involved had mental health diagnoses. Disability Rights North Carolina considers all of the people involved in these tragic assaults to be victims of North Carolina's failed policy decision to rely on Adult Care Homes<sup>1</sup> for the primary form of publicly-funded housing for people with mental health disabilities.

An account of each death is included in this memo. All the residents lived in large Adult Care Homes licensed to care for between 56 and 80 people. In each case, one of the residents involved—sometimes the victim and sometimes the aggressor—had a history of exhibiting

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<sup>1</sup> Adult Care Homes are licensed "assisted living facilities" that provide, at a minimum, one meal a day and housekeeping services and provide personal care services to two or more residents. Homes where care is provided to two to six unrelated residents are called Family Care Homes. According to information provided to the NC Institute of Medicine Task Force on co-locations of Different Populations in Adult Care Homes, as of December, 2009, North Carolina had 631 Family Care Homes with 3,533 beds, and 627 Adult Care Homes with 36,564 beds. See Interim Report to the N.C. General Assembly, March 2010, page 69.

difficult behaviors. In at least three cases, the Plan of Care and/or FL2 noted behaviors such as “can be physically abusive and injurious to self and others,” “physical abuse, disruptive behavior and history of being injurious to others,” and “loud and sometimes confrontational.” Community mental health services were involved in three of the situations.

Disability Rights North Carolina also reviewed NC Department of Health Service Regulation (NC DHSR)<sup>2</sup> surveys at Adult Care Homes with dangerous situations that resulted, in serious violence and injuries. This memo provides the accounts of seven surveys from 2008 forward. In several cases the number of people with mental illness living in the congregate setting was startling: 29 out of 50 residents at one facility, and all 32 residents of another. The involuntary commitment process was frequently invoked by the Adult Care Home in an attempt to remove or discharge a resident or as the root of problems when a resident. After admission to the facility after a hospital discharge, and the facility could not provide supervision that met the needs of the resident. In several cases the dangerous conditions continued or were exacerbated because there were no alternative placements that would accept the resident.

North Carolinians with mental health disabilities in need of housing do not live in Adult Care Homes because it is considered “best practice.” It is not. Nor did our State make an affirmative policy decision to use our public funds to support large congregate living settings for people with mental health disabilities. It did not. This situation exists because the State failed to have a plan to care for and treat the large number of people de-institutionalized pursuant to the 1999 U.S. Supreme Court ruling in *Olmstead v. L.C.*,<sup>3</sup> and has allowed the Adult Care Homes to “fill the gap.” Historically, Adult Care Homes cared exclusively for the elderly in North Carolina. After *Olmstead*, they began accepting people who were being discharged from psychiatric facilities.

The Adult Care Home crisis continues today because the State has failed to adequately address both the need for treatment leading to recovery and the need for safe permanent housing in the community for people with disabilities. The failure of the current system of housing-support for people with mental health disabilities is well documented and has been acknowledged in official state reports for years. The North Carolina General Assembly ordered studies of the problem in 2004 and again in 2007. Many other studies and reports have been commissioned and produced. Currently, a third study ordered by the Legislature is ongoing at the North Carolina Institute of Medicine. So far the reports to the North Carolina Legislature have included band-aid type suggestions such as better screening of residents and better staff

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<sup>2</sup> NC DHSR is a division of the NC Division of Health and Human Services that oversees medical, mental health and group homes.

<sup>3</sup> 527 U.S. 581 (1999).

training—solutions which will not be sufficient to result in a safe and healthy future for citizens with mental health disabilities in North Carolina, nor achieve the state’s obligation under the Americans with Disabilities Act (ADA) to treat people in the most integrated setting appropriate to their needs.

The four resident-on-resident deaths described in this memo demonstrate it is critical that the state adopt a new approach to housing for people with mental health disabilities. In each of the cases investigated by Disability Rights North Carolina, the “band-aid solutions” identified in the reports to the Legislature (resident screening and staff training) would not have prevented the deadly assaults. In these cases, the problems were known by the facility before the assaults, the resident’s behaviors were identified and North Carolina’s mental health system was altered. The recommendations made to the Legislature fail to confront the root of the crisis: the large scale, publicly-supported transfer of people from hospitals to Adult Care Homes instead of to the community with services and supports.

North Carolina is at a crossroads in terms of the appropriate use of public funds to support the housing needs of people with disabilities. Four people died while North Carolina spent time and resources on studies with recommendations, many of which have not been implemented. It is time to provide people with the best chance of recovery and a decent quality of life. North Carolina can largely achieve this goal without new expenditures by redirecting state and county money from Adult Care Homes to housing in the community with supports and services. Disability Rights North Carolina urges North Carolina to stop endangering our citizens by maintaining the status quo, and to start moving people with disabilities out of Adult Care Homes and into housing with greater community integration and better opportunity for recovery.

In addition to the deaths, Disability Rights North Carolina found other dangerous conditions and incidents at Adult Care Homes. These problems, including resident-on-resident assaults that resulted in non-life threatening injuries, raise substantial concern regarding the safety of residents in Adult Care Home settings.

### **I. Dangerous Conditions in North Carolina’s Adult Care Homes.**

In 1999, the U.S. Supreme Court ruled in *Olmstead v. L.C.* that it is illegal for states to segregate individuals with disabilities in institutions in order to receive long-term services. At that time there were few places in North Carolina for low-income people with psychiatric disabilities to live. Using public funds to pay for part or all of the cost of a bed, Adult Care Homes, which historically cared for the elderly, became an alternative to homelessness for thousands of North

Carolinkians discharged from our hospitals and institutions. This movement of people with mental health disabilities from state institutions into private Adult Care Homes was **not** the product of careful planning. The 2005 *Study of Issues Related to Persons with Mental Illness in Long-Term Care Facilities*, General Assembly of N.C. Session 2004 House Bill 1414 section 10.2(a) and (b) ("2005 Report") well describes what happened:

*"When the locus of care for persons with mental illness first shifted from the large state hospitals to the community decades ago, there were few residential options available to persons with mental illness, and many adult care homes stepped forward to fill that gap, providing shelter for those who had none..."*

*North Carolina's current mental health reform effort is designed to improve the state's capacity to meet the needs of persons with mental illness according to evidence based practices, but many with mental illness continue to live in long term care settings because there are not yet more appropriate alternatives available to them in their communities..."*

*[L]ong term care facilities have been an unavoidable choice for many individuals with mental illness, **despite the fact that these facilities are not designed to provide psychiatric treatment or the rehabilitative services to allow persons with mental illnesses, particularly younger adults, to achieve a greater measure of independence.**"*

(2005 Report, page 4, emphasis added.)

Today, North Carolina Adult Care Homes continue to be the major component of the residential placement array for citizens with mental health disabilities. In 2004, five years after the U.S. Supreme Court decided *Olmstead*, North Carolina Department of Health and Human Services (NC DHHS) found that more than 40 percent of the Adult Care Home population carried an active diagnosis of mental illness.<sup>4</sup> A yet to be released *Study of North Carolina's Adult Care Homes, Family Care Homes, Group Homes and Permanent Supportive Housing for People with Disabilities in North Carolina* ordered by N.C. DHHS and prepared by Technical Assistance Collaborative, Incorporated (TAC) concluded in 2008 that more than 5,000 adults with mental health disabilities were living in North Carolina's Adult Care Homes. Data reported in the March 1, 2008, "*Study of Rules and Regulations Regarding Housing Individuals with Mental Illness in the Same Facility Vicinity as Individuals without Mental Illness*" General Assembly of N.C.

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<sup>4</sup> "Adult Care Home Mental Health Needs Assessment Report of Findings," *First Health*, July 15, 2004, referenced in "*Final Report and Recommendations of the Study of Issues Related to Persons with Mental Illness in Long Term Facilities*," December 1, 2005, page 3.

Session 2007, Session Law 2007-156, Senate Bill 164 (“2008 Report”) revealed 6,234 individuals with a primary diagnosis of mental illness resided in Adult Care Homes, including Family Care Homes, and 2010 data presented to the N.C. Institute of Medicine Task Force revealed 6,432 persons with mental illness were residents of North Carolina Adult and Family Care Homes.

### **Thousands Live in Dangerous Conditions**

Despite the important role Adult Care Homes play in the North Carolina mental health system, Adult Care Homes are not regulated as mental health facilities. They are “assisted living residences” licensed by NC DHHS under rules adopted by the State Medical Care Commission. Staffing requirements and qualifications are not designed for the care of residents with mental health needs. For example, during first and second shifts an Adult Care Home with 41 to 50 residents is only required to have three staff present at the Home (1:16.6 ratio). At night only two staff need be present (1:25 ratio). 10A N.C.A.C. 13F.0604, Personal Care and Other Staffing. By contrast, mental health group homes are limited to a total of six residents, a ratio of 1:6. Additionally, staff at a mental health group home are supervised by a Mental Health/Developmental Disability/Substance Abuse Services qualified professional. 10A N.C.A.C. 27G.0104, .0204, .5603.

For some time there have been serious concerns raised about residents with mental illness who reside in Adult Care Homes. State policy makers have repeatedly been informed of the inadequacy of North Carolina’s response to the *Olmstead* mandate and to the de-institution of North Carolinians with mental health disabilities. Consider the statements in the following study reports commissioned by our Legislature in 2004 (“2005 Report”) and again in 2007 (“2008 Report”):

#### **Findings from the 2005 Report**

- *“The issue of serving the mental health needs of long term care residents is not new and pre-dates the current re-design of the publicly funded MH/DD/SAS system. **In fact, state agencies and long-term health care providers have been engaged in a discussion of how best to provide this care for a decade or more.** [Page 3, emphasis added.]*
- *“While many persons with a diagnosis of mental illness reside in long term care settings without difficulties, others, because of the nature of their illness, inadequate treatment, or lack of expertise among facility staff, can exhibit behaviors that can impact other residents and/or pose a potential safety risk to staff and residents. [Page 5.]*

- *“...[I]ndustry representatives report that these facilities are increasingly struggling with safety issues related to a growing number of residents with challenging behaviors that have an impact on the safety of residents in the facilities. [Page 5.]*
- *“In adult care homes some older adult residents . . .cite concerns about the safety and the vulnerability of other older adults due to reports of behavior problems such as verbal/physical/sexual abuse by some younger residents. [Page 6.]”*

#### Findings from the 2008 Report

- *“Over the past several years, [NC DHHS] has worked to improve the care to individuals who have mental illness and are residing in adult care homes, while acknowledging that other housing and treatment options need to be available to serve this population.” [Page 2.]*
- *“The Department recognizes that there are serious concerns about residents with mental illness who are currently in assisted living facilities and who exhibit behaviors related to their illness.” [Page 19.]*
- *“The Division of MH/DD/SAS continues to explore the types of housing and residential services that can appropriately meet the varied needs of adults with mental illness [that] are not currently being met in long term care settings in North Carolina.” [Page 19.]*

Disability Rights North Carolina’s report of four resident-on-resident deaths over a ten-month period (October 2008 through July 2009) illustrates that North Carolina can no longer wait to launch a new direction for housing people with disabilities. The eight people involved in these assaults are all victims of North Carolina’s decisions, time and again, to provide only band-aid solutions for this dangerous situation.

The 2005 Report contained five recommendations including: implement a screening system prior to admission; implement an automated assessment and care planning system; and conduct a study to inform the development of a residential continuum designed to meet the needs of persons with mental illness. Only the recommendation for a study of housing needs materialized, and NC DHHS contracted with TAC to provide recommendations and a plan for implementation of changes to North Carolina’s residential service array. For reasons unknown

to Disability Rights North Carolina, TAC's Draft 3 Report, dated January 11, 2009, has not been released by NC DHHS.<sup>5</sup>

The 2008 Report to the Legislature again recommended a screening and assessment system as well as staff training. The focus of the 2010 N.C. Institute of Medicine Task Force includes: how to appropriately identify/screen people for behavioral health disorders; and training of adult care home staff.<sup>6</sup> For Disability Rights North Carolina, one more recommendation for a screening tool or for more staff training is not an adequate response to the situation. Rather than applying another band-aid, North Carolina must immediately adopt a new approach to disability housing policy.

### **Implementing Best Practices for Recovery**

An equally important reason for a new approach is the dignity and recovery needs of people with disabilities. It is well-acknowledged by state officials that the current housing of people with mental health disabilities in Adult Care Homes is not best practice and is not aimed toward recovery for the persons with mental health disabilities. Again, consider the statements of North Carolina state agencies:

- *"Adequate and appropriate living arrangements have always been part of successful clinical treatment, habilitation and rehabilitation plans for persons with disabilities."*<sup>7</sup>
- *"...[M]any with mental illness continue to live in long term care settings because there are not yet more appropriate alternatives available to them in their communities."*<sup>8</sup>
- *"Permanent supportive housing is the recognized best practice in meeting the housing needs of the majority of persons with disabilities."*<sup>9</sup>

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<sup>5</sup> DRNC learned of the TAC report and requested and obtained a copy through N.C.'s Public Records Law. In April 2010, a DHHS official confirmed the TAC report has not been "finalized or released."

<sup>6</sup> See IOM Task Force "Interim Report to the North Carolina General Assembly, March 2010."

<sup>7</sup> *Welcome Home! A Report on Housing North Carolinians with Disabilities, Task force on Housing, NC Commission for MH/DD/SAS. Presented August 2004.*

<sup>8</sup> *2005 Report, page 4.*

<sup>9</sup> *Final Plan for Efficient and Effective use of State Resources in the Financing and Development of Independent and Supportive-living Apartments for Persons with Disabilities, prepared by NC DHHS and The North Carolina Housing Finance Agency, March 1, 2009, page 3.*

Nationwide, “permanent supportive housing” is recognized as the best practice housing policy for people with disabilities. Permanent supportive housing allows persons with disabilities to live in safe and affordable community housing that is linked to individualized supports and services. While the type and intensity of services will differ according to the needs of the individual, the need for decent affordable housing units in the community is common across all disability populations.<sup>10</sup> Moreover, the Americans with Disabilities Act and the *Olmstead* decision require that services and supports be provided in the most integrated, appropriate community setting. Supportive housing in the community is essential to improving personal outcomes, improving the quality of life for people with disabilities in North Carolina, and meeting the state’s legal responsibility under the ADA to treat people in the most integrated setting appropriate to their needs.

### **The Role of the “State/County Special Assistance for Adults” Fund**

In North Carolina the large scale placement of low income people with mental health disabilities in Adult Care Homes is facilitated by a state and county funding program commonly called “Special Assistance.” Special Assistance provides a cash supplement that enables low-income individuals to reside in Adult Care Homes. The program was established 60 years ago as the “State Boarding Home Fund for the Aged and Infirm.” *Preface, Special Assistance for Adults, NC DHHS Manual*. The fund, now named “State/County Special Assistance for Adults,” **supplements** the resources the resident has; this is often the federal Supplemental Security Income (SSI) benefit received by people with disabilities and the elderly. Thus it is State and County funds through Supplemental Assistance that actually pay for housing of many people in Adult Care Homes, including people with mental health disabilities.

The Special Assistance payment is funded by 50 percent county dollars and 50 percent state dollars. Effective October 1, 2009, the basic rate the North Carolina General Assembly set for residents to pay the facility each month is \$1,182. The amount contributed to the Adult Care Home by Special Assistance is the difference between the resident’s monthly income and \$1,182, plus \$46.00 for the resident as personal allowance for clothes, co-pay requirements, and other incidental expenses. The standard federal SSI payment in 2010 is \$674.00 a month. If the resident had no other income, the Adult Care Home would be paid \$674.00 by the resident and \$554.00 (\$508.00 toward the basic rate and \$46.00 for personal allowance for the

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<sup>10</sup> See “Interim Plan for Efficient and Effective use of State Resources in the Financing and Development of Independent and Supportive-living Apartments for Person with Disabilities,” for endorsement of this model as best practice for North Carolina, submitted to the Joint Legislative oversight Committee on MH/DD/SAS, March 1, 2008.

resident) by the State/County Special Assistance funds. After deducting SSI or other income, the Special Assistance supplements, up to the \$1,182 monthly cost of care. The Special Assistance budget for 2007-2008 exceeded \$148 million for more than 30,000 recipients.

### **The Technical Assistance Collaborative (TAC) Study**

The 2005 Report to the North Carolina General Assembly recommended a study be funded to inform the development of a residential continuum designed to meet the needs of person with mental illness, and the 2008 Report confirmed that NC DHHS contracted with TAC to conduct the study and offer recommendations. Founded in 1992, TAC is a non-profit organization that offers interdisciplinary teams of national experts to identify and offer solutions in areas of health, housing and social services. From 2006 to 2009, TAC worked with NC DMH/DD/SAS to conduct a wide range of consulting and technical assistance services for the Division and its stakeholders, including the study of housing needs of people with disabilities.

In response to the 2005 Study recommendation, TAC was tasked to study the number of people needing service and treatment now residing in Adult Care Homes, and identify housing and service models that are evidence-based to help address the needs in North Carolina. TAC performed that study and delivered a draft "*Study of Adult Care Homes, Family Care Homes, Group Homes and Permanent Supportive Housing for People with Disabilities in North Carolina*" in January, 2009. TAC focused on individuals with disabilities who need a place to live and need services and supports to make community living successful. These individuals frequently end up receiving Special Assistance to reside in Adult Care Homes because there are no other options available.

TAC found that "North Carolina *already* spends substantial public resources for the current set of facility based housing services, and that *opportunities exist to redirect a portion of those resources into best practice models of housing and services without the necessity of new appropriations.*" (TAC Draft Report at p. 5 (emphasis added)). TAC concluded that the amount of funds North Carolina spends per person for facility-based care would be sufficient in many cases to cover the housing subsidy and housing-related service costs for individuals to live in permanent supported housing in the community. In fact, because the State does not spend sufficient funds on housing subsidies and housing-related service costs, TAC determined that the State's policies were in violation of *Olmstead*. TAC acknowledged that there are coordination, statutory and budgetary hurdles to be overcome in North Carolina, but concluded "it is not necessarily a lack of overall financial resources that prevents people with disabilities from having the option of living in integrated community settings." (TAC Draft Report, p. 36.)

## **Conclusion**

Housing of people with mental health disabilities in Adult Care Homes not only creates dangers for all the residents, it also denies people the best chance for recovery and for a decent quality of life. The official studies and reports cited by Disability Rights North Carolina demonstrate that North Carolina understands it is funding dangerous and clinically unsupportable congregate housing for people with disabilities. Every report since 2004 has acknowledged the mis-placement of large numbers of people with mental health disabilities in Adult Care Homes—a situation that violates the integration mandates of the Americans with Disabilities Act and the U.S. Supreme Court’s *Olmstead* decision. NC DHHS recognizes that for many the best practice outcomes will flow from independent housing opportunities with full community integration. A new housing policy will both promote recovery and bring North Carolina in compliance with its obligation to provide services “in the most integrated setting appropriate for the needs of the individual.”<sup>11</sup>

Adult Care Homes are neither designed nor equipped to meet the service needs of people with mental illness. Moreover, the State’s resources should follow and support the best recovery and integration practices available, rather than support dangerous congregate living settings in Adult Care Homes. North Carolina is at a crossroads in terms of the treatment and care of people with disabilities who are dependent on public sector support for their basic housing and service needs. It is time that North Carolina embrace the ruling in *Olmstead* that integration is fundamental to the purposes of the ADA. It is time for North Carolina to provide community-based services rather than institutional placements for individuals with disabilities. North Carolina must reshape the housing possibilities for people with disabilities now and commence to move people with mental illness out of Adult Care Homes and into greater community integration and recovery.

The state’s failure in this regard has resulted in preventable deaths and injuries to citizens in these homes. While official state reports since 2004 have called for developing a full continuum of housing for people with disabilities in the community, thousands of people with mental health disabilities remain in Adult Care Homes and remain without a community alternative available. Band-aid efforts such as resident screening and staff training are not a solution. Disability Rights North Carolina urges North Carolina policymakers, including the ongoing NC Institute of Medicine Task Force, to embrace new concepts for housing people with disabilities rather than focus on improved screening and more staff training.

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<sup>11</sup> *Olmstead*, 527 U.S. at 592.

The 2004 Report *Welcome Home!* recommended using the North Carolina Special Assistance program for individuals with disabilities to reside in homes rather than licensed residential settings. In 2009, TAC made a similar recommendation to use funds to support individuals in supported housing in the community. In their 2009 *Final Plan For Efficient and Effective Use of State Resources In the Financing and Development of Independent and Supportive-living Apartments for Persons with Disabilities*, NC DHHS and the NC Housing Finance Agency urged the creation of supported housing through a tenant-based rental assistance program (TBRA). Disability Rights North Carolina recommends that North Carolina adopt these time-tested recommendations and establish concrete targets and timetables for moving a set number of Adult Care Home residents into more integrated settings with services and supports. It is now 11 years since the *Olmstead* decision, yet people with disabilities are still segregated in large facilities. North Carolina must initiate a new approach to the deinstitutionalization of people with mental health disabilities. It is time, before there are more deaths, to move people with disabilities out of Adult Care Homes and into safe community housing.

## RECOMMENDATIONS

### **Supported Permanent Housing**

*Supported permanent housing is the best practice for meeting the housing and recovery needs of persons with mental health disabilities.*

Permanent supportive housing allows persons with disabilities access to decent, safe, and affordable housing that is integrated into the community. Such housing also provides individually tailored and flexible supportive services in the community setting. Nationwide and in North Carolina<sup>12</sup> supported housing is considered the “best practice” for housing people with disabilities because it is successful, cost-effective<sup>13</sup> and promotes integration, consumer choice and dignity. Since 2002, NC DHHS has partnered with the NC Housing Finance Agency to develop integrated permanent supporting housing

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<sup>12</sup> Final Plan for Efficient and Effective Use of State Resources In the Financing and Development of Independent and Supportive-living Apartments for persons with Disabilities, NC DHHS and the North Carolina Housing Finance Agency, submitted to the Joint Legislative Oversight Committee on Mental Health, Developmental Disabilities and Substance Abuse Services March 1, 2009, page 3 (After surveying practices nationwide and conducting additional research N.C. DHHS concluded in this Report that permanent supportive housing is the best practice in meeting the housing and recovery needs of people with mental health disabilities.).

<sup>13</sup> The Cost-Effectiveness of Supportive Housing: A Service Cost Analysis of Lennox Chase Residents. UNC-CH School of Social Work, Jordan Institute for Families, 12/2007.  
<http://www.ncdhhs.gov/homeless/pdfs/lennoxchase.pdf>

*July 26, 2010*

across North Carolina. Their collaboration has produced approximately 250 integrated supported housing units each year since 2002, and is considered a model for supported housing development that is now being replicated in other states.

In 2009, NC DHHS recommended the Legislature continue to fund the expansion of supported housing units, in part by authorizing a Tenant-Based Rental Assistance Program (TBRA). TBRA would operate similar to the Special Assistance fund, currently used primarily to place people in Adult Care Homes.

Unfortunately, the TBRA program was not implemented by the legislature. Supportive housing was further hampered in 2010 because 187 planned LIHTC units designated for the program had not yet been completed. The budget for subsidized units was accordingly reduced by \$561,000, although this change is non-recurring.

## FOUR DEATHS IN TEN MONTHS

### Death of LM, CASE #1.

#### **Adult Care Home licensed to care for 80 residents located in the sandhills of North Carolina.**

On December 27, 2008, during the start of second shift checks, LM was found in his room face down and unresponsive. His roommate, MG, was naked and in a sitting position on top of LM. MG said he was tired of being accused of stealing. Paramedics were called. LM was pronounced dead at the scene. MG was charged with second degree murder. In 2010 he was convicted of voluntary manslaughter. He received a suspended sentence and was placed on 60 months of supervised probation.

LM, 69-years-old, had been a resident of the 80 bed Adult Care Home for just over a year at the time of his death. LM had a diagnosis of paranoid schizophrenia. According to the NC DHSR investigation complaint survey, LM was known to accuse other residents and staff of stealing his belongings, and was described by the facility manager as loud and sometimes confrontational. The local mental health team was involved in LM's care and had provided training to facility staff in ways to redirect and de-escalate LM. Records show that LM was receiving his medication as prescribed.

MG, 60-years-old at the time, had lived at the facility since 2000. He was diagnosed with schizophrenia and dementia. Records show he received his medication as prescribed. MG was described by the facility manger as quiet and non-confrontational. Because of MG's calm demeanor he was eventually paired as LM's roommate. One resident stated that he saw MG walk away from LM when LM began to argue.

The NC DHSR investigation found that the facility failed to meet minimum staffing requirements. The facility scheduled three direct care staff for 1<sup>st</sup> and 2<sup>nd</sup> shift for the more than 60 residents when the Rule required a minimum of four direct care staff per shift for that size population. According to the complaint investigation report, "it could not determine that residents failed to receive adequate staff supervision."

## Death of JL, CASE #2.

### **Adult Care Home licensed to care for 65 residents located in the middle of the state.**

JL was 27-years-old and had diagnoses of schizoaffective disorder, bipolar disorder, intermittent explosive disorder and Asperger's disorder. On May 21, 2009, JL became agitated. He left the facility and was brought back by staff sometime before 1:00 pm. JL and staff were on the porch of the facility when another resident, DE, who was 55-years-old and diagnosed with schizophrenia, came across the porch and started swinging his metal cane at JL. DE was angry because someone told him that JL had cursed and kicked his dog. JL dodged some swings but was then hit several times in the head, shoulder, and arm by the cane. DE continued to hit JL with the cane until staff separated the residents. Later, staff offered JL a bag of ice when he complained of head pain and staff observed a knot on the back of his head.

According to the facility report of death sent to NC DHSR, after the attack JL continued to be "verbal and agitated." A facility administrator traveled to the Magistrate's office and petitioned for the involuntary commitment of JL. He was picked up by law enforcement and transported to a local hospital for evaluation for the commitment. During his evaluation for involuntary commitment, JL began vomiting. A test showed a large hematoma in the right brain. JL was airlifted to NC Baptist Hospital where he died on May 25, 2009. The cause of death was blunt trauma to the head.

According to newspaper reports, facility management told the family and law enforcement that JL hurt his head as he was backing away from DE, stumbled on some bicycles, fell, and hit his head on the corner of an air conditioning unit and then on the cement porch. Surveillance footage of the attack shows DE swinging at JL with his metal cane, missing, and then hitting JL in the side of the head with his cane in a baseball-type swing. The bicycles are seen still upright when JL fell.

DE has a criminal history for assaults and was arrested later the same day as the attack on JL for threatening to hit an employee with his cane. Later DE was additionally charged with the second degree murder of JL. In 2010 he was convicted of voluntary manslaughter and sentenced to 129 – 164 months in the N.C. Department of Correction.

A complaint investigation survey was conducted by Surry County Department of Social Services and NC DHSR. No violation of rules was substantiated.

### **Death of RS, CASE #3.**

#### **Adult Care Home licensed to care for 56 residents located in the foothills of North Carolina.**

RS was 70-years-old when he was assaulted and killed on July 8, 2009 by 43-year-old DS, another resident of this facility. On July 8, 2009, staff heard a disturbance outside on the smoking patio. According to newspaper reports DS repeatedly hit RS in the head with a stick and then ran off. Facility staff observed part of the assault and saw blood splattered on the patio and on DS.

RS was reported to be a quiet person and was receiving treatment for several heart-related illnesses. DS was diagnosed with paranoid schizophrenia with chronic alcohol and cannabis abuse in remission. In July 2009, DS was receiving mental health services and medication for his mental illness. DS's care plan revealed his behaviors included a history of physical abuse, disruptive behavior and a history of being injurious to others.

According to NC DHSR records, DS had a history of violent outbursts and fellow residents at the facility were afraid of him. It is reported that DS was verbally abusive towards the facility staff, using offensive slang and cursing. DS is charged with second degree murder and has been jailed since the attack. Charges remain pending.

According to the NC DHSR report, 29 of the 50 residents residing in the facility had diagnoses which included mental illness. The Adult Care Home had received 29 police calls from January 2008 to July 8, 2009. According to the reports, these calls included three assaults and four attempted suicides. According to the facility staff, outbursts, violence and threats of violence were not uncommon at the facility.

NC DHSR found seven deficiencies as a result of the investigation and issued Type A Violations with a Directed Plan of Correction, including: identify all residents who have behavioral symptoms that require supervision and develop individual care plans to assure the supervision is provided; provide supervision of residents in accordance with residents' assessed needs and current symptoms; develop and implement procedures to ensure accurate assessment of new and current residents specific to identification of at-risk behaviors; and provide training to staff by a mental health specialist.

## **The Death of WD, Case #4.**

### **Adult Care Home licensed to care for 80 residents in western North Carolina.**

On October 26, 2009, WD, a 67-year-old resident, was killed by another resident of the facility who severely beat him with his hands and feet. The other resident was KH, who is 43-years-old. It is reported that the fight was over \$4.25. Both residents are reported to have mental health disabilities. WD received multiple injuries and was taken by EMS to a hospital where he died three days later on Oct. 29, 2009. The final autopsy diagnosis notes multiple blunt injuries of the face, head and neck, described in a newspaper report as a “cranial bleed.” According to information gathered by Disability Rights North Carolina, facility staff were in a nearby room when the beating occurred.

KH was arrested on October 29, 2009 and charged with the murder of WD. As of the date of this report KH was still in the jail and the murder charge was still pending.

The facility filed a “Report of Death to DHHS” listing the cause of death as “unknown.” On the death reporting form, the facility described the events surrounding the death including that WD “was involved in a[n] altercation with another male resident;” that WD received “multiple injuries requiring immediate medical attention;” and that he was “transported to a hospital by EMS.” According to staff at the NC DHSR, because the facility wrote that the cause of death was “unknown” in the box on the form titled “Cause of death,” NC DHSR did not forward the report to Disability Rights North Carolina as required by law.<sup>14</sup> Disability Rights North Carolina did not learn of WD’s death until April 2010.

According to the November 2, 2009 complaint investigation report: “NC DHSR staff assisted the local department of social services with their complaint investigation<sup>15</sup> related to a resident death. Based on the record review, staff, resident and resident family interviews there were no findings to substantiate the complaint.”

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<sup>14</sup> N.C.G.S. 131D-34.1 requires facilities to report to NC DHSR when a resident’s death results from violence, accident, suicide or homicide, and further requires NC DHSR to notify the state Protection and Advocacy system, Disability Rights North Carolina, of the report of death.

<sup>15</sup> The NC DHSR Complaint Intake Unit receives complaints regarding the care and services provided to patients/residents/consumers by the health care facilities/agencies/homes they license. Each complaint is prioritized for investigation according the seriousness of the situation. Complaints about Adult Care Homes are forwarded to the local Department of Social Services for investigation. On a case-by-case basis staff from NC DHSR may also be involved in the complaint investigation regarding an Adult Care Home.

## **II. Accounts of Non-Lethal Assault and Fear in North Carolina Adult Care Homes**

Disability Rights North Carolina also found incidents of resident-on-resident assaults that did not result in death but raise substantial concern regarding the safety of residents in Adult Care Home placements. The circumstances in the seven Adult Care Homes described below are documented in state investigations obtained by Disability Rights North Carolina. Disability Rights North Carolina's goal is not to single out particular homes or operators, but rather to demonstrate the depth of the problems created by housing many people with mental illness in Adult Care Homes. Therefore we have only generally identified the location and size of each facility.

**In a 40-bed Adult Care Home in a large North Carolina city**, a NC DHR 2008 survey found three (3) residents who repeatedly physically assaulted other residents and staff. There had been 58 calls to 911 from the facility over an eight-month period: 21 for disturbances, eight for fights or assaults and four were alcohol or drug related.

Resident #2<sup>16</sup> was diagnosed with schizophrenia-paranoid type and was receiving ongoing mental health services. In five months, Resident #2:

- physically assaulted another resident who required emergency room treatment (4/17/08);
- physically assaulted another resident who "tried to stab him" (4/18/08);
- was arrested, charged with assault on a handicapped person and readmitted to the facility the next day (5/6/08 and 5/7/08);
- assaulted a resident (6/29/08);
- was involved in a loud argument with another resident (9/4/08); and
- attempted to injure another resident (9/11/08).

Other residents reported they were afraid of Resident #2. The administrator reported the resident's behavior in the resident's records, thus making his transfer more difficult because

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<sup>16</sup> The residents are referred to in this report in the same way NC DHR referred to them in its surveys.

few facilities would be willing to admit a resident with known violent propensities which made alternative placement difficult.

Resident #5, diagnosed with schizophrenia and mild retardation, shouted obscenities, threw a binder, and pushed a door into a staff member.

Resident #10 was diagnosed with paranoid schizophrenia and borderline intellectual functioning. He was referred to mental health for verbal abuse, hollering, yelling, screaming and angry outbursts. The resident physically fought with his roommate over a cigar and burned the facility walls in an attempt to “get rid of Jesus who is a faggot.” Later he fought with two residents. Resident #10’s Community Support case manager revealed she saw him weekly, that he periodically had delusions about religious figures, and will find a lighter and try to burn the walls, getting “Jesus out.” She stated she felt the lax supervision at the Adult Care Home was not in the resident’s best interest. The case manager was working on alternative placement but was having little success.

NC DHSR issued a Type A violation<sup>17</sup> and ordered, in a Directed Plan of Correction,<sup>18</sup> that the facility immediately review the FL-2s of all residents and evaluate their service and care needs to determine if each resident’s behavior can be addressed with the level of supervision in the facility.

**In a 48-bed Adult Care Home in central North Carolina** NC DHSR found in a 2008 survey that *all 32 residents of the facility had a diagnosis that included mental illness*. NC DHSR found the facility failed to discharge three residents whose behaviors placed themselves and/or others at risk for serious physical harm and/or death.

Resident #9 told staff she was seeing things, she was talking to herself and slapping at staff and residents. The resident was not added to a list of “aggressive” residents who should be checked every 15 minutes until days later—only after she cut another resident on the arm. Later, Resident #9 further decompensated (“very paranoid, trying to harm others, thinks people

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<sup>17</sup> A Type A violation means a violation of the regulations, standards and requirements governing Adult Care Homes that results in a death or serious physical harm or results in a substantial risk that death or serious physical harm will occur. N.C.G.S. 122C-24.1.

<sup>18</sup> When a Type A violation is identified the regulator must immediately inform the administrator of the facility what must be done to correct the violation, thus the plan of correction is directed by the regulator.

after her"). The resident was sent to the local hospital for evaluation for involuntary commitment. She was not committed and was returned to the facility.

Resident #2 was documented to have aggressive behaviors, elopements and psychotic breaks. Resident #2 tried to hit staff with a stick and said he wanted to kill himself. The resident was taken to the hospital for evaluation for involuntary commitment and returned the same evening. The next day Resident #2 was throwing books into the hallway. He took his roommate's clothes and shoes out of the closet and threw them on the floor. Then the resident began throwing chairs. Resident #2's physician was not notified *until one month later* when a change in medication orders was made. Over the course of two months Resident #2 was involuntarily committed twice and returned to the facility. Resident #2's guardian planned to pursue alternative placement.

Resident #8 had a history of chronic paranoid schizophrenia. On June 17, 2008, he was admitted to the hospital for stabilization after acute exacerbation of his paranoid schizophrenia, including self injury. Resident #8 was discharged back to the facility seven days later. At the facility he refused some medication and eloped, returning seven days later. At that time, Resident #8 kicked and beat on the door asking for money. The facility called Crisis Services, which told the facility to call the police. Resident #8 then eloped and, upon return the next day, exhibited inappropriate sexual behavior toward another resident. The next day Resident #8 was involuntarily committed. The local Mental Health Agency filed for guardianship as the family had not responded to paperwork sent earlier. The case manager was to seek an alternative placement.

NC DHSR found the facility failed to provide supervision to meet the needs of the residents, in some cases exacerbating their mental illness leading to injury to self and threatened injury to others. A Type A Violation was issued with a Directed Plan of Correction to immediately review the FL2s of residents and evaluate their service; care and supervision needs; and to provide services if the facility could meet the residents' needs. If the facility cannot meet the needs of the resident, NC DHSR directed the facility to provide required discharge notification and establish a Quality Assurance System to assure compliance with the Plan of Correction.

**NC DHSR surveyed a Family Care Home (six beds or fewer) in a large North Carolina city in 2008 and issued a Type A penalty for violation of the Personal Care and Supervision rule. This family care home is no longer in operation under the 2008 name.**

Based on review of records and local law enforcement reports, NC DHSR concluded that five out of six client records surveyed demonstrated a need for increased supervision. During a ten month period in 2008, police were called to this small facility 59 times. The nature of the 59 calls to law enforcement included assault (resident attacked staff, sitting on her chest and punching and hitting her in the face and chest, "going after her like some kind of animal"), disturbance, larceny, drugs, disturbance with weapon, threats (one resident would hit another and demand money and cigarettes) and involuntary commitment.

Resident #1's diagnoses include bipolar disorder and substance abuse. Resident #2 was diagnosed with schizoaffective disorder and mild mental retardation. At the time of the survey, Resident #3, diagnosed with schizoaffective disorder and substance abuse/dependence, was recently hospitalized due to altered mental status from ingesting Zyprexa (antipsychotic) tablets. During the survey Resident #3 refused to eat the soup for lunch fearing the soup had "orange cyanide" in it. Resident #4 was diagnosed with paranoid schizophrenia and health problems. A care plan described Resident #4 as "verbally abusive, physically abusive, resists care, and injurious to self and property." Resident #6 was diagnosed with schizoaffective disorder, substance abuse and borderline personality disorder.

NC DHSR issued a Directed Plan of Correction requiring the facility to: assess all current residents; develop a plan of care for supervision of any resident whose diagnoses and current symptoms place the resident at risk for aggression; have a plan in place to provide additional supervision to an aggressive/threatening resident to protect others from harm; provide training to the staff on care of persons with mental illness or dementia; and to assure adequate staffing to meet the residents' needs.

**In an 81-bed Adult Care Home in southeastern North Carolina** NC DHSR found the following conditions during a 2010 survey:

Resident #1 was diagnosed with schizophrenia, paranoid type, intermittently disoriented, history as a wanderer and verbally abusive. On Dec. 18, 2009, Resident #1 died when he walked into the street and was run over. Resident #1 recently spent four months in a psychiatric hospital, returning to the facility 16 days before his death. At the hospital, Resident #1 received a diagnosis of schizoaffective disorder, lack of support and chronic severe psychiatric illness. The facility did not request or receive the discharge summary. The facility only had an FL-2 and a medication administration record. No one from the facility interviewed

Resident #1 or reviewed his treatment at the hospital before accepting him back. According to NC DHSR interviews with facility staff, Resident #1 returned to the facility unchanged. Before hospitalization, Resident #1 eloped when angry, hit other residents and staff, and had a history of refusing medication.

After Resident #1 died, the physician employed by the facility stated Resident #1 was not appropriate for the facility due to his severe mental diagnosis. NC DHSR learned during the investigation that the facility did not contact the physician until after Resident #1 returned from his hospitalization when, according to the doctor, he was then left to “manage his symptoms.” The facility’s protocol was to call the physician upon change in condition or behavior but the physician stated he was not called by the facility even after Resident #1 refused medication.

Resident #2, admitted December 2, 2009, had a history of paranoid schizophrenia and developmental disability, and was confused at times requiring re-orientation. Resident #2 was receiving medication for mental illness/behaviors but was not receiving mental health or developmental disability services. Resident #2 did not have a crisis plan. On December 21, 2009, a physician progress note reported Resident #2 was “severely mentally unstable.” Two days later Resident #2 tied a scarf around her neck and pulled twice resulting in bruises on her neck. An ambulance was called and the physician was informed but the resident refused to go to the hospital. The doctor ordered 15-minute checks and an increase in medication, but was unsure the facility was an appropriate setting for the resident.

NC DHSR issued a Type A Violation based on the facility’s failure to “provide supervision of residents in accordance with each resident’s assessed needs, care plan and current symptoms.” The Directed Plan of Correction required the facility to assess new and current residents and implement interventions to address their needs.

**A 2008 NC DHSR survey of a Family Care Home (six beds or fewer) in north-central part North Carolina** found three residents with the following mental health diagnoses: schizophrenia; schizoaffective disorder/bipolar type; mental retardation, depression, schizoaffective disorder and altered mental status. On August 6, 2008, staff left the residents of this family care home alone to run errands. When staff left the facility, Resident #2 accused Resident #1 of taking his money. Resident #1 denied he took Resident #2’s money. Resident #2 became agitated and made threatening comments. Then Resident #2 assaulted Resident #1 outside on the sidewalk and driveway. Resident #1 suffered a black and purple eye and scratches on his face. Due to

his report of pain, Resident #1's jaw was x-rayed. The administrator was aware of Resident #2's behavior problem and of an earlier assault conviction but had no plan in place to address his behavior.

NC DHSR issued a Type A Violation for failing to supervise the residents in accordance with their needs, care plan and current symptoms. A Directed Plan of Correction instructed the facility to not leave residents unattended or unsupervised; to utilize Mental Health to develop plans for residents with behavior problems; and to discharge residents that have behaviors that cannot be addressed with the level of supervision in the facility.

**A 2008 NC DHSR survey of a 60-bed Adult Care Home in the foothills of North Carolina** found Resident #1 was diagnosed with alcohol-induced persisting dementia with functional limitations including "injurious to others." Resident #1's Assessment and Care Plan revealed she was verbally abusive, physically abusive, resists care, has disruptive behavior, is intrusive and is injurious to others. Resident #1's plan did not include anything to address these behaviors.

On August 24, 2008, Resident #1 pushed down Resident #9 who sustained a hip fracture; hit Resident #9 causing black eyes on two separate occasions; and hit three other residents, each more than once.

The County Adult Care Specialist issued a Type A Violation finding the facility failed to provide adequate supervision of a resident who displayed behaviors placing themselves and/or others at risk for serious physical harm and/or death. The directed Plan of Correction required the facility to immediately provide supervision of residents to ensure the health, safety and welfare of all residents are not endangered; to assess residents to identify at-risk behaviors; to develop interventions (care plans) for residents at-risk; and to ensure all staff are aware of the individualized care plans.

**A 2008 NC DHSR survey of an 80-bed Adult Care Home in southeastern North Carolina** found the following situations at the facility during a five month period:

- Failure to notify doctors of changes in patient behavior
- Residents cycling in and out of psychiatric hospitals
- Residents physically and sexually attacking other residents
- Aides locking themselves in the medication room in order to protect themselves from residents

- Residents carrying weapons to protect themselves from other residents; and
- Deaths

Resident #71, admitted to the facility in March 2008, was described on the FL-2 as constantly disoriented and “injurious to others.” Resident #71 began making sexual comments to two aides. The behavior caused the aides to lock themselves in the medication room. Resident #71 then redirected the sexual comments to two other aides who were unable to redirect him and also locked themselves in the medication room and called 911. Four of the direct care staff required by the Rules to be present to supervise residents were hiding in the medical room for their own safety. When law enforcement arrived, Resident #71 failed to comply with the police officer’s orders that he return to his room, and instead reached out at the police officer, who then tased Resident #71. Additional officers took Resident #71 to the local emergency room. He was discharged back to the facility the next day. No changes were made to Resident #71’s plan of care. Seven days later Resident #71 began making sexual comments to staff again. PRN medications were administered. Nine days later Resident #71 attacked a female resident at the picnic tables outside the facility. He pushed her to the ground, pinning her hands above her head and began feeling her genitals. A janitor ran out of the facility and found resident #71 getting off the female resident. She reported she had been attacked. Police arrived and arrested resident #71 for second degree sex offense.

In February, 2008, behavioral changes were noted in Resident #39. He hit two residents and fought another resident in self defense. His community mental health worker was contacted and she spoke with him. He later hit another resident causing the resident to bleed from the mouth. Four days later he hit another resident. Survey staff conducted confidential interviews with residents which revealed two of them carried weapons as protection from Resident #39.

Resident #38 exhibited the following behaviors in a two-month period: February 23, 2008 – wandered into town; March 13, 2008 - found sitting outside naked, became aggressive toward staff; March 18, 2008 - walked around naked half the night and flooded the men’s bathroom; March 25, 2008 - attempted to destroy mini blinds in the common room; March 26, 2008 - naked in the men’s dayroom; March 27, 2008 - walking through the facility with no pants on; March 28, 2008 - found unresponsive, transported to hospital and returned same morning; March 29, 2008 - put powders all over himself and his room; March 31, 2008 - stopped up the sink in the front lobby and flooded the floor and also had no pants on; April 2, 2008 - hit in the

face by Resident #39 resulting in black eye and bloody swollen lip; April 4, 2008 – wandered; April 5, 2008 - broke out lights with a pool stick; April 5, 2008 - hit in the mouth by Resident #39; April 6, 2008 - wandered, found injured by another resident; April 8, 2008 - flooded the big bathroom; April 9, 2008 - flooded the men's hall bathroom; and April 22, 2008 - observed wandering.

Resident #40 was admitted to the facility September 28, 2007. Diagnoses on the FL-2 included altered mental status secondary to heavy sedation. Resident #40's record revealed: September 29, 2007 - involved in a fight with another resident while they were both trying to get out the facility's back door; October 20, 2007 - became agitated in the dining room and threw his plate on the floor and cursing; November 16, 2007 - threatened another resident; November 25, 2007 - tried to reach between a med tech's legs; December 30, 2007 - slapped another resident; January 30, 2008 – eloped; February 27, 2008 - made a female resident feel uncomfortable with offensive moves; March 12, 2008 - tossed Kool-Aid on another resident and grabbed, choked and punched a resident in the back.

Resident #37 was diagnosed with schizoaffective disorder – depressed. On January 28, 2008, he complained of being depressed and having “dead thoughts;” on January 30, 2008, he complained of suicidal thought; on March 19, 2008, he was depressed and wanted to get himself committed. He threatened to harm himself and was taken to the hospital and returned with orders to follow up with a psychiatrist and continue home medications. On March 25, 2008, another mental health referral was made. He refused medication 20 times between April 1, 2008, and April 21, 2008. On April 21, 2008, he told staff he was depressed and a mental health referral was made. On April 22, 2008, he told staff he was extremely depressed and was considering harming himself. He turned over razors to staff. On April 22, 2008, he was taken to hospital emergency department at request of the NC DHSR surveyor and kept there.

NC DHSR issued a Type A Violation concluding the facility failed to assure supervision was provided in accordance with assessments, care plans, and current symptoms for four residents who were documented to be physically and/or verbally aggressive and failed to assure referral and follow up for psychiatric medication refusals. A Directed Plan of Correction required the facility to assess all residents; develop plans of care for supervision; provide staff training on care for person with mental illness or dementia; and assure adequate staffing pattern to meet residents' needs.