

Adult Care Home Facility Summaries

Introduction

In order to investigate the condition of Adult Care Homes in North Carolina, Disability Rights NC partnered with the University of North Carolina School of Law to organize a pro bono project sending eight students across the state to monitor and survey fifteen Adult Care Homes. The project occurred over a two week period (May 17 – May 28, 2010), during which students and Disability Rights NC staff observed the condition of each facility and interviewed Adult Care Home residents, staff and administrators. Disability Rights NC chose five of the fifteen Adult Care Homes because of recent resident-on-resident deaths. The remaining ten facilities were chosen because Disability Rights NC believed these facilities had a large population of residents with mental illness. The investigation revealed the large size and institutional quality of the Adult Care Homes visited, as well as a dearth of community interaction for residents. Some facilities were not at full-capacity due to staffing shortages, sections of the facility being under construction, or the facility limiting its admissions only to residents without histories of substance abuse or violent tendencies. The majority of facilities visited were located in small, rural towns. In many cases, the lack of public transportation or other nearby activities contributed to the facilities' geographic and psychosocial isolation. A summary of the project findings follows.

1. Britthaven of Kannapolis

- Britthaven, located in Kannapolis, NC, is an Adult Care Home licensed for 106 residents. On the day of the student visit, it had approximately 83 residents, 90 percent of whom, or approximately 75 residents, had a mental illness. Resident ages varied widely from late twenties to late seventies.
- While at the facility, we noted overmedicated residents, long hallways, bad lighting, crowded rooms (three residents per room), offensive odors, reports of violent altercations among the residents, minimal and dilapidated furniture and a lack of anything to make it feel like home.
- Residents' community interactions were limited to the occasional group outing to the Dollar General discount store and to walking to a nearby gas station for soda, candy and cigarettes. The primary activities of the residents were watching television, pacing up and down the hallways, sleeping, and smoking.

Facility

Kannapolis is a rural suburb of Charlotte with a population of approximately 37,000. The facility was not easily identifiable from the road because it did not have a sign of any sort. Immediately upon entering Britthaven, the students noticed a strong, offensive odor that permeated throughout the facility. The students also smelled smoke in some of the rooms but did not observe anyone smoking inside. There were also flies throughout the facility, landing on patients during student interviews. Many residents complained about how loud it was at the facility. Others complained of a lack of privacy. The air conditioning made the facility extremely cold and several residents

complained that staff ignored requests to remedy the problem. Residents lying in bed had multiple blankets piled up on top of them. Many rooms lacked accessible bathrooms and there were complaints that the bathtubs were too small for bathing even though many residents find taking a shower very difficult.

Staff

The Britthaven staff appeared wary of the students' presence and made it quite clear upon their arrival that they were not welcome there, despite having scheduled the visit in advance. Several residents reported that they were not supposed to be talking to the students or that they were scared to talk to them. Students observed that staff members seemed generally inattentive and uncaring. Residents also complained that staff members are verbally abusive and unkind. One resident reported that she sometimes waits almost an hour to have her diaper changed after asking for assistance. Another resident had not been given feminine products and was consequently bleeding on her clothes and linens. Another resident reported that staff members yelled at her if she was unable to fall asleep when she was supposed to or if she had an accident in her bed.

Residents

Nearly every resident interviewed expressed unhappiness with life at Britthaven. A large number of residents displayed symptoms of overmedication including tardive dyskinesia, dilated pupils, tremors, anxiety, restlessness and confusion. There were complaints of a mean, disrespectful staff, substance abuse occurring in the facility and the presence of street drugs such as crack and alcohol as well as abuse of prescription medications. Many complained that they had no money to buy anything. Several residents said they were not diagnosed with a mental illness before they moved to Britthaven but as a result of their stay, they had developed anxiety and were now receiving medication for it. Many reported violent incidents between residents which seem to have unnerved many.

When students arrived, the facility cook was performing karaoke and one resident said this happened once a month. Residents did not appear engaged in the karaoke performance, and there were no signs of other organized activities during the visit. The residents' primary activities observed by the students were watching television, pacing up and down the hallways and lying in bed and smoking. Nearly every mobile resident spends a large portion of their day outside smoking. Residents are told when to go to bed at night, when to get up in the morning, when to shower and when to eat. Most residents seemed unhappy with this regimented schedule. At least one resident said he had previously been receiving therapy and no longer received it, despite his belief that he did need it. One resident complained that Britthaven gets a new psychiatrist every year and he does not feel like his medications, diagnoses, and treatments are the same from year to year. None of the residents reported receiving active treatment for their mental illness.

There are residents currently living at Britthaven that have successfully lived in the community in the past, express an interest in returning to a community placement, and could be successfully served in an integrated and inclusive community setting.

2. Canterbury Hills

- Canterbury Hills, located in Candler, NC, is an Adult Care Home licensed for 99 residents. On the day of the student visit, it had approximately 94 residents, all of whom had mental illness. Resident ages varied widely from late twenties to late seventies.
- A guard shack at the entrance, residents waiting in long lines for medication and food, the constant shouting by staff and residents, overmedicated residents, and the “longest hallway in Western NC” made the facility feel like an institution.
- Residents’ community interaction was severely limited. The facility is isolated from the nearest town. Mountain Transportation, the local paratransit service, refuses to pick up or drop off Canterbury Hills residents and the facility only provides transportation for medical appointments. There have been objections voiced by neighbors of the facility because residents of the facility have caused trouble by stealing from nearby homes.

Facility

Candler is a small, rural unincorporated community near Asheville in Buncombe County. No residents are admitted who are not receiving SSI or other disability payments. On the day of the visit, there were 15 people on the waiting list for admission to the facility. The number of available beds had been reduced because the facility had turned off two bathtubs. The facility had an overall institutional feel. A guard shack greets every visitor entering and leaving Canterbury Hills. Most residents lived in rooms along a very long, shabby, and old institutional-style hallway. The operating manager, in fact, referred to the hallway as the “longest in Western NC,” which made it feel very much like a hospital. Residents lined up all day long in the hallway in order to receive medications and meals, as well as to purchase cigarettes, candy bars, and soft drinks from the “Country Store” at one end of the long hallway. Aside from the long lines, the facility had a chaotic atmosphere. There was a lot of noise in the facility, with residents constantly shouting, bartering, or running and walking up and down the hall. At different places in the facility, students noticed the smell of vomit and urine. There was no air conditioning and there were large, loud fans in the hallway in an attempt to increase ventilation.

Staff

One resident accused a staff member of stealing his medications and selling them. The staff member was not disciplined even after the accusations were substantiated. Staff shortages were a major problem. The facility had difficulty taking residents to their doctors’ appointments because there were not enough staff members to accompany residents to their appointments. The local paratransit service, Mountain Transportation refused to transport residents of the facility, so transportation was a chronic problem for residents trying to get out into the community. Although there were a few residential homes within walking distance of the facility, any true community interaction required transportation.

Residents

There were few activities available for patients’ recreation and rehabilitation. Students observed karaoke during their visit, but did not observe any other activities. Some residents reported living in fear of other violent residents. Theft among residents was also a problem. Residents complained about an underground bartering system at Canterbury Hills through which drugs,

cigarettes and other luxury items were traded. There were problems with drugs coming in from outside the facility, and abuse of prescribed medication became so frequent that a pill-crush policy was implemented for all crushable medications. A large number of residents displayed symptoms of overmedication including tardive dyskinesia, dilated pupils, tremors, anxiety, restlessness and confusion.

A number of the residents appear capable of living in a less restrictive/more integrated setting. One resident, G, reported that he had been in and out of hospitals for his mental health diagnosis (schizophrenia) at least 40 times. Prior to living at Canterbury Hills, G was living independently in his own home until it burned down. After losing his home, he spent a year in a state psychiatric hospital and was discharged to Canterbury Hills, where he has remained for two years. Another resident, R, had been given extensive responsibilities within the facility and acted as his own guardian. R and his girlfriend, Q, also a resident, expressed a desire to leave the facility and go to college. R and Q, who appeared to be in their late thirties, both have schizophrenia.

D, a resident in his late twenties, had already obtained a two-year degree and was interested in furthering his education. Another resident, P, reported that she felt that she did not belong at Canterbury Hills and had tried in vain to find a more independent living arrangement. P stated that she has been told she cannot participate in group outings because she “has too much sense.” It seems that P would be a good candidate for independent living.

There are residents currently living at Canterbury Hills that have previously lived in the community with success. Many residents expressed an interest in returning to a community placement, and could be successfully served in an integrated and inclusive community setting.

3. Cedarbrook

- Cedarbrook, located in Nebo, NC, is an Adult Care Home licensed for 80 residents. On the day of the student visit, it had approximately 67 residents, all of whom had mental illness. Resident ages varied widely from late twenties to late seventies.
- With residents queuing in long lines for medication and food, bad lighting, shabby interior, the long, hospital-like hallway, and residents constantly pacing up and down the hallway, the facility felt like an institution, not a home.
- Residents’ community interaction was severely limited. The facility is very isolated and there is little to no opportunity for residents to leave Cedarbrook. Their only interaction with non-disabled individuals was with the facility staff and on-site Community Support Team.

Facility

Nebo is a small, rural unincorporated community in McDowell County in the North Carolina mountains with a population of approximately 3,700. The facility was not easily identifiable from the road because it did not have a sign of any sort. Some parts of the facility, the smoking porch in particular, looked new, but most of the facility was quite dilapidated. There was no air conditioning, which makes the facility very uncomfortable during the summer. Most residents

lived along a long hallway, similar to the one seen at Canterbury Hills. The long, shabby hallway created an institutional feel. The facility does offer therapy and substance abuse counseling on-site. There is a garden, a snack bar, a pool table, and a racing video game for residents' use. However, most residents were smoking and walking up and down the hallway during the student visit. Only residents with individual Community Support Team members were allowed to go on facility outings. The residents must stand in line to receive medications and meals. There was a long line for food and medication observed throughout the student visit.

Staff

Students observed twelve to fourteen staff and Community Support Team members at the facility. There were more staff members present at Cedarbrook than at other facilities, and the staff seemed to care more about the residents than at other facilities. Residents were often accompanied by staff members, although the staff members did little to engage residents. Residents and staff members alike spent most of their time walking up and down the hallway or smoking.

Residents

Nearly every resident at Cedarbrook was unhappy with their life at the facility. Every resident had a diagnosis of mental illness and many were at the facility because of a court order. There was a general atmosphere of chaos, instability, and fear. Most residents had cycled in and out of state hospitals, jails, and other facilities, finding themselves at Cedarbrook as a last resort. One resident, N, had been expelled from another facility for smuggling liquor into the facility. B, a resident with bipolar disorder, had been expelled from his previous facility after he stabbed another resident with a box cutter. There were many incidents of violence and fighting among residents reported by the residents interviewed. One resident, W, had thrown another resident out of a window. W said that he had not been punished, because "nobody liked" the victim of his attack. W acknowledged that he had a mental illness diagnosis but did not want to discuss the diagnosis with students.

Residents complained about the lack of freedom and about not being given the opportunity to interact with anyone in the community. During the student visit, residents were primarily observed smoking, pacing up and down the hallway, standing in line, or lying in bed. A large number of residents displayed symptoms of overmedication including tardive dyskinesia, dilated pupils, tremors, anxiety, restlessness, and confusion. Only the few residents receiving Community Support Team services were allowed to leave the facility and go on outings.

Residents with a history of substance abuse expressed fear of relapse if they returned to the community. Other residents were unsure of their ability to manage their medications. These hesitations were usually based on the belief that they would have no community supports if they left the facility. Once told that they could receive supportive services in the community, some residents expressed a desire for a community placement. Some residents had held jobs in the community previously, and appeared to be able to function in a more integrated community placement with supportive services. Residents expressing some preference for Cedarbrook did so only because they found it preferable to jail.

There are residents currently living at Cedarbrook that have previously lived in the community with success. Many residents expressed an interest in returning to a community placement, and could be successfully served in an integrated and inclusive community setting.

4. Crescent Green

- Crescent Green, located in Carrboro, NC, is an Adult Care Home licensed for 120 residents. On the day of the student visit, it had approximately 72 residents, the majority of whom were elderly. Resident ages varied widely from forty-two to 100.
- Having a garden, chickens and a newer facility made Crescent Green appear less institutional than many Adult Care Homes visited by the students. However, the cinderblock walls, institutional-style furnishings, the general resident monotony, lack of vigor, and physical austerity were reminiscent of an institution.
- Residents living at Crescent Green had more opportunity for community interaction than most Adult Care Home residents due to the availability of public transportation.

Facility

Carrboro is a small town near Chapel Hill in Orange County with a population of approximately 18,000. Crescent Green was a newer facility and had an atmosphere more like a nursing home, but retained some qualities of an institution with its institutional-style furniture and cinderblock walls. The doors of the unisex bathroom off the central hallway had been removed, permitting residents no privacy. There was a large garden, which residents could tend, and several chickens fenced in near the garden. The facility provided a phone room that residents could use at any time. There were accessibility problems in the facility: residents in wheelchairs had difficulty navigating many of the doorways. The area near the smoking patio was muddy and as a result, residents and staff often tracked dirt inside. There was only one poster informing residents of their rights, and it was located at the far end of one hallway. Residents complained about the quality of the food at the facility and said that the staff would not accommodate the needs of those with dietary restrictions. Residents also complained that they were not receiving their full amount of SSI payments. Some said they received no money at all after the facility took their share of the SSI money.

Staff

As with most Adult Care Homes, the staff were generally apathetic. One staff member had been accused of stealing money from the residents. One resident, L, also accused the staff of opening or withholding her mail.

Residents

Residents at Crescent Green were a mixture of elderly adults and younger individuals (those under 50) with mental illness. The age disparity was more noticeable at Crescent Green than at other facilities. Younger individuals complained about feeling alone and isolated in the facility because they could find no companionship there. Younger individuals seemed generally less satisfied with the facility than the elderly residents. Elderly residents appeared to be the majority and they were more likely to report that they were happy living at Crescent Green. During the

student visit, residents were primarily observed smoking, pacing up and down the hallway, standing in line, or lying in bed.

One resident, L, had lived at Crescent Green since she had fallen a year and a half ago. She did not want to discuss her mental illness diagnosis but did mention her psychiatrist during the conversation. She expressed a strong desire to return to apartment living in Carrboro and appeared capable of taking care of herself. Residents F and B had previously received physical therapy, but told students they were no longer able to afford it because of Medicaid cuts. F and B wanted to continue physical therapy because they noticed that their physical condition was deteriorating. F was also suffering from depression. A few residents had an active interest in performing music and poetry. One resident, E, had previously held a job as a courier for UNC and had lived in his own apartment. He became very agitated when asked about his mental illness diagnosis, but did tell students that he had been in Butner (possibly referencing the state psychiatric facility, Central Regional Hospital, located in that town) before moving to Crescent Green. Because of E's young age and previous success in the community, E could likely be better served in an integrated community placement. Another resident, C, had been diagnosed with schizophrenia while she was attending Eastern Carolina University and had since cycled in and out of state psychiatric hospitals, homeless shelters, and other facilities. It appears that C, a previously successful college student, would be a good candidate for placement in the community.

Another resident, S, was clearly overmedicated to the point that her speech was affected. S was clearly intelligent and stated that she did not like living there. S disagreed with the doctor prescribing her medication. She was barely able to speak, drooled, and could not keep her mouth closed. Her eyes were bulging and she was wearing a housecoat when interviewed in a common area. Staff members walking by warned the interviewer to be careful because S was violent.

There are residents currently living at Crescent Green that have previously lived in the community with success. Many residents expressed an interest in returning to a community placement, and could be successfully served in an integrated and inclusive community setting.

5. GlenCare of Mount Olive

- GlenCare, located in Mount Olive, NC, is an Adult Care Home licensed for 121 residents. On the day of the student visit, it had approximately 50 residents, 50% of whom had mental illness. Resident ages varied widely from early thirties to late nineties.
- The lack of air conditioning, gaping holes where window units had been removed, dim lighting, sparse furnishings, and the residents' fear of the staff and administrator gave GlenCare a very institutional and frightening feel.
- Residents' interaction with the community was limited to facility visitors, medical appointments, and walking to a nearby convenience store. Although the facility had a van, residents reported it often needed repairs and had broken down in the past, making outings few and far between.

Facility:

Mount Olive is a small, rural town in eastern North Carolina with a population of approximately 5,000. The facility did not have air conditioning and was very hot and muggy. The administrator blamed the temperature on residents, claiming they turned on the heat. One wing of the facility was empty and the window-mounted air conditioners that had been in the wing had been removed, leaving gapping holes open to the outdoors. Residents complained that bugs and animals entered through the holes. The hallways were dimly lit and the common areas were cramped and cluttered. The game room had broken wood with nails in it on the floor. The common areas were sparsely furnished, and the only furniture present was old and uncomfortable. The bedrooms were fairly large, and residents were able to decorate their rooms as they please. The halls and bathrooms looked and smelled dirty, and a number of bathrooms were out of order or locked and unavailable for use. Some individual rooms had private bathrooms. Others had only toilets and mirrors. The dining area was reminiscent of a cafeteria because the residents lined up and staff placed food on plastic dishes.

Staff:

Residents accused staff members of abuse and neglect. Neither the staff nor the administrator were observed interacting with the residents. The residents seemed intimidated by the staff. The administrator followed the visiting students around, restricting private interaction with the residents.

Residents:

Residents at GlenCare are between the ages of thirty-three and ninety-nine. One-half of the residents have a diagnosis of mental illness and the remainder have a primary diagnosis of Alzheimer's Disease. Many of the residents had difficulty with mobility, and of these many were left lying in bed, undressed or with open gowns. Residents were free to come and go at any hour as long as they signed in and out. The unlocked doors allowed residents to spend time in the front and back yards. Many of the activities were religious or physical. Many residents had limited mobility, making it difficult for these residents to participate in the few physical activities provided by the facility. During the student visit, residents were primarily observed smoking, pacing up and down the hallway, standing in line, or lying in bed.

Most residents feared the administrator and staff, refusing to talk to students when either was present. When students were able to speak to residents in private, most expressed fear of the administrator and staff. C, the President of the Resident Council, told students that most residents would not participate in the council for fear of retaliation from the administrator and staff. One student was speaking with B, and when the administrator arrived, she quickly disengaged from the conversation, wanting to move on so she was not seen speaking with him.

R, a resident in her 70's, said that staff-turnover, neglect, and general living conditions were the main problems at the facility. R told students she had been retaliated against after she had complained about GlenCare. The administrator had threatened to evict her, had gone through her things, and ordered her to get rid of some of her personal belongings. R was forced to share a room with a roommate, even though her roommate's boyfriend often stayed in their room, making her very uncomfortable. R told students that another resident had become ill, wandering the halls for weeks, screaming and crying for her mother, before staff took her to a doctor. She

was diagnosed with a severe Urinary Tract Infection, an uncomfortable and painful condition that could have easily been treated with antibiotics and alleviated her discomfort much earlier. R said that staff were unhappy to work there, work multiple jobs, and often do not stick around for long. She said staff have thrown medicine bottles at residents when they are upset and threatened to evict residents in retaliation for reporting abuse. R's bed dry-rotted and fell apart beneath her, leaving her mattress lying on the floor. R is unhappy with her life in the Adult Care Home and said she would prefer placement in the community.

B, a 30-year-old GlenCare resident, said that she used to be employed as a registered nurse. B has a driver's license, can cook and clean, expressed a desire to live independently, and appeared capable of doing so. She had been in two bad car accidents and uses a wheelchair as a result. Those interviewing B believed that she may have a mental illness or a traumatic brain injury. However, B could likely be served in a community placement.

There are residents currently living at GlenCare that have previously lived in the community with success. Many residents expressed an interest in returning to a community placement, and could be successfully served in an integrated and inclusive community setting.

6. Greystone Manor

- Greystone Manor, located in Red Springs, NC, is an Adult Care Home licensed for 81 residents. On the day of the student visit, it had approximately 70 residents, nearly all of whom had mental illness. The administrator told students that most residents were between forty and fifty years old.
- Clean hallways and rooms, a well-furnished dining room, more personalized and less institution-like rooms, and a mini-library made this facility feel less like an institution than most facilities visited. However, coded and locked doors, constant announcements over the loudspeakers, and a lack of organized activities reminded students and residents of the facility's institutional feel.
- Residents' interactions with the nearby community were limited to facility visitors and medical appointments. Residents reported that there had been an outing to a bowling alley in the past and a trip to Wal-mart, but during these outings, residents only interacted with members of their group.

Facility:

Red Springs is a small town in Robeson and Hoke counties in eastern NC with a population of approximately 4,000. The town of Red Springs is approximately three square miles. The facility was well-maintained and clean overall. Some hallways had a slight odor and felt warm and humid. Individual rooms were spacious and had their own air conditioning units. The atmosphere was less institutional than other facilities. Some furnishings were uncomfortable. Handrails along the hallways helped residents navigate the halls. During the student visit, many announcements were made over the facility's loudspeaker system. Most residents were free to sign themselves out, but doors were coded and locked and some residents were not given the

code. In the past, some residents had gotten stuck in between the coded double doors. A review of the regulatory records for Greystone Manor showed that facility had been cited a number of times since 2006, including failing to provide supervision to a unsafe smoker; failing to provide supervision or initiating discharge of a resident with history of aggression who subsequently sexually assaulted another resident; failing to initiate CPR on a resident found unresponsive; failing to thicken liquids as ordered for two residents; and failing to correctly apply restraints to a resident.

Staff:

The staff was observed to have little interaction with the residents. Many staff appeared idle even though students noticed a number of residents clearly needing assistance getting around or help with daily tasks such as changing their linens. Several residents complained about poor treatment by staff.

Residents:

Although Greystone Manor had less of an institutional feel in some ways than other facilities, residents were still generally unhappy with life at the facility. Residents primarily complained about boredom and the lack of activities or community involvement. During the student visit, residents were primarily observed smoking, pacing up and down the hallway, standing in line, or lying in bed. Several residents were “parked” in wheelchairs in the lobby and remained there throughout the visit. The students did not observe any posted activities and the activity room was locked and not staffed. Some residents complained of violence and theft among residents. One resident, D, told students that two residents had committed suicide by walking in front of oncoming traffic on a nearby highway, although this claim was impossible to verify.

D had previously lived in two other Adult Care Homes and had been living in his own apartment until a bicycle accident two years ago. After the accident, D had been placed in Greystone Manor. D did not know what medications he took and told students he did not know the name of his “psychiatric illness,” although he seemed to think he had one. D expressed a desire to live in his own apartment again. Another resident, J, had been hospitalized after a suicide attempt and was later discharged to Greystone Manor. J stated that she can cook and do laundry and believes she can live more independently with some community support.

There are residents currently living at Greystone Manor that have previously lived in the community with success. Many residents expressed an interest in returning to a community placement, and could be successfully served in an integrated and inclusive community setting.

7. Lake Pointe

- Lake Pointe, located in Lake Waccamaw, NC, is an Adult Care Home licensed for 80 residents. On the day of the student visit, it had approximately 60 residents, nearly all of whom had mental illness. Residents varied in age from late twenties to early seventies.

- Clean hallways and rooms, a well-furnished dining room, more personalized and less institution-like rooms, and tasteful decorations made this facility feel less like an institution than most facilities visited.
- Residents' interaction with non-disabled individuals or the community was limited to facility visitors and medical appointments. Residents reported that there were occasional trips to Wal-mart and Dollar General, but during these times residents only interacted with members of their own group.

Facility:

Lake Waccamaw is a small, rural town in Columbus County in eastern NC with a population of approximately 1,500. The town of Lake Waccamaw is approximately three and a half square miles. The building and grounds are clean, well-maintained, and clearly designed for the comfort and accessibility of residents. Highlights include small tables in the dining area that create a less institution-like atmosphere, a wall-mounted hand railing throughout the hallways, and tasteful decoration throughout. The atmosphere is generally warm and welcoming. Announcements for meals and activities tended to disrupt the overall tranquility of the facility.

Staff:

The Lake Pointe staff members were friendly, easily identifiable, and knew all the residents by name. They brought medication to members on a cart, rather than making the residents line up for medication. The facility has apparently improved significantly under new leadership.

Residents:

The facility schedules daily activities, but residents were not engaged in any activities during the student visit. Scheduled activities included church and prayer services, separate women's and men's events, outings to stores, and outings to lakes and parks. Several residents said they really enjoyed the outings, but others said they did not think there was enough to do. Some activities were available at all times, such as a crafts room. However, the crafts room seemed to be poorly supplied and under-utilized.

Many residents felt out of place at the facility, stating that they could not find people with whom they could relate. They were eager to be active in the community and live elsewhere. Many residents expressed a desire to live more independently. One resident, B, appeared very capable of living on her own and expressed a strong desire to do so. B is a hoarder and has a diagnosis of Obsessive-Compulsive Disorder in addition to a minor physical disability. Prior to coming to Lake Pointe she lived independently and still has independent-living skills, as well as a car and driver's license. She was forced to come to Lake Pointe because her home was declared unsanitary by Social Services due to her hoarding. B could live successfully in the community with supportive services.

There are residents currently living at Lake Pointe that have previously lived in the community with success. Many residents expressed an interest in returning to a community placement, and could be successfully served in an integrated and inclusive community setting.

8. Pinebrook Residential Center

- Pinebrook Residential Center, located in Yadkinville, NC, is an Adult Care Home licensed for 112 residents. On the day of the student visit, it had approximately 89 residents, all of whom had a mental illness. Residents varied in age from late twenties to early seventies.
- Run-down, dirty buildings, sparsely furnished rooms, offensive odors, bad lighting, flies, and crowded rooms made this facility extremely institutional.
- Residents' community interactions were very limited. Residents are able to walk to the Dollar General and to a nearby convenience store, but have no meaningful interaction with non-disabled individuals.

Facility:

Yadkinville is a small, rural town in Yadkin County in western NC with a population of approximately 2,818. Yadkinville is the county seat and largest city in Yadkin County. The Facility consists of two unattached buildings, one of which is male-only housing and the other is co-ed. The buildings were run-down, dirty, and had very poor lighting. Furnishings were sparse and dilapidated. The hallways smelled like urine and the outside area had an even stronger offensive odor. Even though the facility was not operating at capacity, there were as many as three residents in a single room. Several rooms were "under construction." The rooms in use were sparsely furnished, containing only a bed and dresser. Despite "bug zappers" throughout the facility, the students noticed a number of flies. These qualities along with the poor condition of the common rooms, contributed to an overall institutional feel.

Staff:

There were more staff members at Pinebrook than at many facilities and they were also more engaged with residents than those at other facilities. There were some complaints that staff members were idle and lazy, but the students did not observe that firsthand during their limited visit.

Residents:

The residents have a fairly regimented daily schedule that includes set meal times and lining up three times each day for medication. Most residents seem satisfied with the staff members and food, although some complained of excessive rules. Many of the residents had been at Pinebrook for many years, some for over a decade. Several residents had been homeless before coming to Pinebrook. Residents can choose to participate in several different activities including a work program and math classes. At least one major activity is scheduled each day. The work program consists of household chores such as sweeping and mopping, and residents who participate receive credit for the snack shop. Organized community outings such as bowling are also scheduled from time to time. Karaoke was the activity for the day the students visited. Residents can also choose to walk to local stores on their own (a convenience store and a discount store are both within walking distance). Starting in July 2010, the facility plans to provide substantive therapy, including Peer Support, substance abuse counseling, and group/individual therapy. The provider for these services is partially owned by the owner of the facility.

There are residents currently living at Pinebrook that have previously lived in the community with success. Many residents expressed an interest in returning to a community placement, and could be successfully served in an integrated and inclusive community setting.

9. Pinewood Manor

- Pinewood Manor, located in Ahoskie, NC, is an Adult Care Home licensed for 121 residents. On the day of the student visit, it had approximately 60 residents, 90% whom had a mental illness. Residents varied in age from late thirties to early sixties.
- Comfortable furnishings, cleanliness, the presence of an aviary and garden, and a variety of daily activities made this facility feel less institutional compared to other facilities visited.
- Residents were much more involved in the community than residents at most Adult Care Homes. By allowing residents to spend time at Rachel's House in Windsor, a psychosocial rehabilitation day treatment program, and taking residents on frequent community outings, residents seemed generally happier than those interviewed at other facilities.

Facility:

Ahoskie is a small, rural town in Hertford County in eastern NC with a population of approximately 4,500. The facility is divided into three wings: two open-door wings for men and women primarily diagnosed with schizophrenia, and one locked "special care" unit for individuals with Alzheimer's Disease or dementia. The men's and women's wings were generally comfortable in temperature, furnishings, and cleanliness. In comparison, the dining room was cafeteria-like and had uncomfortable furniture. The furniture in other areas was more comfortable. The open-door wings were generally clean and did not smell bad. Residents had been allowed to creatively paint some of the walls and there were resident-created decorations throughout the open-door wings. The "special care" unit was not nearly as nice as the open-door wings. It had an offensive odor and was unbearably hot. Most of the residents were lying in bed with their doors open. There were bug zappers throughout the facility and flies were everywhere. There were telephones available for residents, but no private telephone area in the special care unit.

Staff:

The staff and administrator were friendly, eager to help, and easy to talk to. They interacted with residents and knew the residents by name. Staff members knew the residents' stories as well as personal preferences about activities, food, etc. Some staff members work exclusively in one wing while others move around.

Residents:

Residents at Pinewood appeared largely satisfied with their living situation. Many cleaned their own rooms and bathrooms and did their own laundry. Activities were posted on a calendar and included bingo, card games, arts and crafts, movies and popcorn, pool, shopping, a therapy dog, croquet, and birthday parties. Permanent fixtures like an aquarium and aviary bring nature indoors, and the facility planned to get a dog or cat for therapeutic purposes. Residents could come and go as they pleased and many took part in community activities such as the Rachel

House where they are able to spend three to four hours per day and remain involved in the community. Staff members take residents shopping, to walking trails, and other outings. A spiritual leader comes weekly to play music, pray, and sing with residents. Residents can also help with gardening around the facility. Residents in the special care unit have a much more limited activity calendar and much less access to activity rooms and outings.

Residents at Pinewood were much happier than those at most facilities. Having daily activities and being allowed to interact with non-disabled community members gave them a sense of purpose and enriched their lives. Even with the activities and amenities at Pinewood, several residents, such as M and C, still desired a more independent living arrangement. M has schizoaffective disorder and C has either a mental illness or a traumatic brain injury. These residents were not unhappy at Pinewood and appreciated the facility, but still wished to live on their own.

There are residents currently living at Pinewood that have previously lived in the community with success. Many residents expressed an interest in returning to a community placement, and could be successfully served in an integrated and inclusive community setting.

10. Reynolds House

- Reynolds House, located in Winston-Salem, NC, is an Adult Care Home licensed for 112 residents. On the day of the student visit, it had approximately 67 residents, 90% whom had a mental illness. Residents varied in age from late thirties to early seventies.
- Overmedicated residents, loud door buzzers, offensive odors, poor lighting, flies, peeling paint, institutional-style furniture, and a general atmosphere of malaise made this facility extremely unwelcoming and institutional.
- Residents living at Reynolds House have little to no interaction with non-disabled individuals outside of the facility. While many residents are able to check themselves in and out freely, their community interactions are meaningless with no one to facilitate the interaction.

Facility:

Winston-Salem is a medium-sized city located in Forsythe County, approximately twenty miles west of Greensboro, with a population of approximately 197,000. The building and property were in generally poor condition. The doors were equipped with loud, obnoxious buzzers. The hallways were also very loud and difficult to navigate due to poor lighting, very slick floors, and repairmen doing various projects. Residents complained about termites and a roof that leaked. Frequent and unnecessary announcements over loudspeakers contributed to the noise levels throughout the large facility. The furnishings were sparse, old and dilapidated, and there was peeling paint on the walls. The downstairs hallway had flies everywhere. The upstairs area had a very strong and offensive odor. One upstairs shower was shared by 15 residents. Rooms had institutional-style furnishings and hard, uncomfortable mattresses. A courtyard was barren and covered in cigarette butts and ashes. The general feel of the building was very institutional.

Staff:

Staff members were helpful, but tended to follow the students around, making private conversations with residents difficult. Staff members seemed nervous about the students' response to the condition of the facility. While students were present, the staff was attentive to sanitation concerns such as spills, but did not interact with residents very much. Several residents said that the staff did a good job.

Residents:

Reynolds House currently only admits residents over forty years old. However many younger residents admitted before this policy was adopted still reside there. Approximately forty percent of the residents act as their own guardian. These individuals could come and go by checking themselves out of the facility with two week's notice. Many residents were unhappy with their lives at Reynolds House, complaining about bad food, rundown facilities, and drug and alcohol abuse in the facility. Several residents also complained about not having enough money and some were seen panhandling near the facility.

Most of the residents were not engaged in any activity during the visit, although the loudspeaker did announce that popcorn, drinks, and bingo would be provided. During the student visit, residents were primarily observed smoking, pacing up and down the hallways, standing in line, or lying in bed. A large number of residents displayed symptoms of overmedication including tardive dyskinesia, dilated pupils, tremors, anxiety, restlessness, and confusion. Several residents complained of being bored, feeling overly restricted in their activity, or feeling fearful of other residents. One resident said he was beaten up by another resident. Students observed residents fighting upon their arrival at Reynolds House. One resident said that people in the facility live a "gang lifestyle."

S, a resident with bipolar disorder and depression, expressed a strong desire to leave Reynolds House. She has been threatened by other residents and fears for her safety. S would like to live independently, and stated that she can do her own chores and take care of herself. S stated that she has been so desperate to get away from Reynolds House that she voluntarily checked herself into a psychiatric hospital. S would like to go community college and get an education so that she can support herself. Another resident, N, also felt capable of returning to work and independent living. She has schizophrenia and had lived at Reynolds House for two years. She communicated clearly, dressed herself, and did her own shopping. N said she previously worked as a janitor and said she missed having a job. She has a guardian as well as friends and other contacts she has maintained in the community.

There are residents currently living at Reynolds House that have previously lived in the community with success. Many residents expressed an interest in returning to a community placement, and could be successfully served in an integrated and inclusive community setting.

11. Rosewood Assisted Living

- Rosewood Assisted Living, located in Gastonia, NC, is an Adult Care Home licensed for 48 residents. On the day of the student visit, it had approximately 19 residents, 17 of whom had a mental illness. Residents varied in age from early forties to early seventies.
- Isolation from the community, the barbed wire fence, and the dilapidated facilities made Rosewood very institutional.
- Residents living at Rosewood have little to no interaction with non-disabled individuals outside of the facility. Transportation from the facility is limited to medical appointments. Residents have little community involvement.

Facility

Gastonia is a rural suburb of Charlotte with a population of approximately 70,000. Although Rosewood is located close to the city center, it is surrounded by a barbed wire fence and is set back from the road by a long driveway. It was very intimidating from the outside and looked more like a prison than a home for individuals with mental illness. The building itself is old and in need of repair, but it did appear clean and well-kept. There were no offensive odors and residents generally seemed well cared for. Residents with mobility problems had difficulty accessing the smoking patio because the door to the patio was difficult to open. The facility is operating below capacity, partly because it no longer accepts young residents. Although the facility did have a residents' rights poster, there was no number posted for residents to call in case of a complaint or rights violation. North Carolina regulators have cited Rosewood often since 2008, finding at least five violations with substantial fines.

Staff

The staff members were kind and demonstrated genuine concern for the residents. Residents did not complain about the staff.

Residents

Because Rosewood had experienced problems with violent residents in the past, the facility limits the types of residents that it admits. No current residents had a history of substance abuse or criminal behavior. Residents at Rosewood were generally satisfied with their living arrangements and many did not express a desire to live independently. The facility director noted that most residents were at the facility because of an inability to manage their medications. She believed that many could live on their own if they had assistance with their medication. Other than smoking and watching television, there did not appear to be many activities available for residents. The facility director said that some activities, like bingo, took place regularly. Several residents did say that transportation into town and activities had been recently cut. Previously the center had provided buses to take residents into the community for activities, but currently the facility only provided transportation for medical appointments.

One resident, G, was involved in local church group, which would come pick her up and take her to church once a week. One student spoke at length to a member of G's church who was visiting G during the student visit. The church member stated that G could live alone as long as she received daily assistance with medications. G already received a great deal of support from her church. G only leaves the facility when someone from her church picks her up for church

services. Residents echoed the facility director's opinion that their major barrier to living alone would be medication management. With help taking medications, some of the residents felt that they would be able to live on their own.

12. Shadybrook

- Shadybrook, located in Black Mountain, NC, is an Adult Care Home licensed for 49 residents. On the day of the student visit, it had approximately 22 residents, all of whom had mental illness. Residents varied in age from early forties to early seventies.
- The smaller size, caring staff, and residential setting made Shadybrook appear less like an institution than most Adult Care Homes.
- Residents living at Shadybrook had more opportunity for community interaction than most Adult Care Home residents due to the availability of public transportation.

Facility

Black Mountain is small, rural town near Asheville in Buncombe County with a population of approximately 7,500. Shadybrook is a small, sparsely populated facility, located in the middle of a residential community. Public transportation is accessible from the facility which gives residents more freedom than most Adult Care Home residents. The small size of the facility allowed it to blend in with the residential neighborhood surrounding it, and rocking chairs out front gave the facility a welcoming feeling. However, students noticed black mold at the front entrance of the facility and were told the entrance floods every time it rains. The facility was well-worn but otherwise appeared clean. Shadybrook has been cited for three violations since 2008 for failing to provide prescribed antibiotics to a resident with respiratory congestion; failing to monitor a resident's blood sugar levels or provide the ordered amount of insulin; and failing to ensure that residents did not smoke in their rooms, which led to a fire in the room of a resident who was using oxygen and smoking.

Staff

Staff members appeared to be very active in the residents' lives. In the past, they said they had used their own money to pay for a resident's activities if the resident could not afford to pay. The administrator was particularly involved with the residents and had a good rapport with them. Although the facility currently has a good administrator and staff, the facility has had trouble with both in the past. The previous administrator had stolen residents' income rather than pay for residents' medical bills or the facility's bills and as a result, the facility was struggling to survive. The new administrator fired most of the staff members under the previous administrator because they either refused to take or failed a drug test.

Residents

Residents generally preferred Shadybrook to other Adult Care Homes in which they had lived. One resident, L, said that many residents had chosen to return to Shadybrook after being in other facilities. L complained that he had not been given the hearing aids he needed. L said that even though Shadybrook was nice, he felt disrespected and marginalized by the mental health system in North Carolina.

Another resident, S, appeared younger than the other residents and expressed a desire to live independently. S had taken the initiative to contact the housing authority, and was told he could not live independently because he needed help managing his medication. S did not discuss his mental illness diagnosis. S's needs could likely be served in the community if provided with appropriate support.

One resident had difficulty forming words and communicating verbally. He became frustrated when a student could not understand him and pulled out several internet printouts that explained his condition -- aphasia resulting from a stroke. Apart from his communication disability, the resident appeared able to care for himself.

There are residents currently living at Shadybrook that have previously lived in the community with success. Many residents expressed an interest in returning to a community placement, and could be successfully served in an integrated and inclusive community setting.

13. The Arc Community

- The Arc Community, located in Jacksonville, NC, is an Adult Care Home licensed for 32 residents. On the day of the student visit, it was at full capacity. All of the residents had a primary diagnosis of Alzheimer's Disease or dementia and a secondary diagnosis of mental illness. There is currently a waiting list for placement at The Arc Community. Most residents were in their seventies, although there were a few residents in their forties and fifties.
- The smaller size, devoted staff and warm atmosphere made The Arc Community appear less institutional than most Adult Care Homes.
- Despite being dually diagnosed with Alzheimer's or dementia and mental illness, residents at the Arc Community had more opportunity for community interaction than residents with less debilitating diagnoses at most Adult Care Homes. Residents often enjoyed a nearby park, went shopping, and often had visitors from the community.

Facility:

Jacksonville is a rural town in eastern NC approximately an hour north of Wilmington. It has a large military presence and a population of approximately 81,000. The building was pleasant, well-maintained, and very clean. There were no bad smells, but the air freshener/cleaner scent was quite strong in areas. The outdoor patio area was nicely furnished and well-maintained as a very nice space for residents. Residents' rooms were spacious and kept at a very comfortable temperature. Staff members would play the piano located in the main living area for the residents' enjoyment. The facility doors were coded and locked and an alarm sounds if anyone attempts to open the doors without the code. The door to the patio area remained open, but a tall fence surrounds the outdoor area to keep residents from wandering off.

Staff:

The staff members had a very positive, warm relationship with the residents. Most knew all residents by name and seemed well-attuned to their individual needs. Students observed staff

members hugging residents and generally treating them with love and respect. On all community outings the facility maintains a 1 to 3 staff to resident ratio.

Residents:

The majority of residents at The Arc Community appeared happy and seemed to enjoy interaction with each other and the staff. Many residents congregated in the common areas, rather than isolating themselves as was common in other facilities. An activities board detailed the months' activities including, daily inspirational, sing-a-long, exercise, bingo, trivia, wine and cheese, card games, resident pick, etc. Classic movies played on nice television sets in several lounge areas. The residents were very involved with the "staff and resident led" activities and snacks. The facility is located across the street from a public park and staff members often take residents to the park for a walk or a cookout. Staff members also take residents shopping and to medical appointments. Residents receive many visits from members of the local community. Rather than having residents line up for medication, staff members deliver their medication. Because of the special characteristics of the residents at The Arc Community, it is not likely that any of the residents are candidates for independent living. The Arc Community appeared to be a facility that was less like an institution with residents treated respectfully and kept engaged in life by a dedicated staff.

14. Walden House

- Walden House, located in Hickory, NC, is an Adult Care Home licensed for 56 residents. On the day of the student visit, it had approximately 45 residents, approximately one-half of whom had a mental illness. Resident ages varied widely from forties to late seventies.
- Although a newer facility, Walden's architecture and coded and locked doors created an institutional feel.
- Residents living at Walden House had limited interaction with non-disabled individuals in the community. Shopping trips to Wal-Mart and occasional bowling excursions did not produce meaningful community interaction.

Facility

Hickory is located in Catawba County in western NC with a population of approximately 50,000. The building appeared fairly new and was reminiscent of a hospital. The facility interior was pleasant and clean. Facility doors were locked and coded, but many residents knew the door codes and were able to move in and out freely. Posters about residents' rights were prominently posted throughout the facility. Residents had few complaints about the condition of the facility. Walden House had been cited with one violation since 2007 for failing to supervise two residents who were confused and disoriented who left the building and crossed a nearby highway.

Staff

The staff members at Walden seemed generally apathetic. Staff members ignored a woman beating on the pantry door, even though she was extremely loud. One resident, B, told students that staff hours had been cut because the facility was below capacity which also limited the number of activities and outings available to residents. B also complained that the facility

psychiatrist was in such high demand when he came to the facility that she was not able to see him when she needed to.

Residents

The facility appeared to offer a lot of activities, such as games, daily devotions, and shopping trips to Wal-Mart. Residents earn “points” by doing chores and then use those points to bid on items like soda or candy. Residents seemed to enjoy these “auctions.” The facility has its own bus that takes residents to and from activities in the community, although residents complained that transportation had been cut recently because the facility was not at full capacity. At mealtimes, residents can choose between menu options. The residents’ main complaint was that the facility no longer allowed pets. Residents expressed the desire for “pet days” during which therapeutic animals could visit them.

B, a resident suffering with depression, also expressed a desire to live on her own, telling a student she could live in a more independent setting with some community supports. B had been told by staff at Walden House that she would lose her Medicaid if she attempted to leave the facility. Another resident, M, told students she was able to drive and enjoyed playing the piano. She has spent time at Broughton Hospital and Banner Elk Hospital as a result of bipolar disorder. M’s needs could very likely be met in a more integrated community setting.

One young resident, T, had previously lived in a supported-housing style arrangement, and wished to return to a placement of that kind. T told students that he had a mental illness but did not want to discuss his diagnosis. Another resident, S, expressed a desire to live more independently and appeared highly functional. He told students he had previously lived in apartments and could do his own laundry and take care of himself if he had some community support. He mainly received assistance with medication management for bipolar disorder, a need that can be served in a community placement.

There are residents currently living at Walden House that have previously lived in the community with success. Many residents expressed an interest in returning to a community placement, and could be successfully served in an integrated and inclusive community setting.

15. Windsor House

- Windsor House, located in Windsor, NC, is an Adult Care Home licensed for 60 residents. On the day of the student visit, it had approximately 35 residents, the majority of whom have a primary diagnosis of Alzheimer’s or dementia. Residents were mainly over seventy.
- The newer facility, smaller size, attentive staff, and friendly atmosphere made Windsor House appear less institutional than most Adult Care Homes.
- Community interaction for residents living at Windsor House was limited to outings and visits with family and friends.

Facility:

Windsor is a small, rural town in Bertie County in eastern NC with a population of approximately 2,300. The town of Windsor is approximately two and a half square miles. The building is new and generally clean and comfortable inside. Classical music played over the sound system and decorations, including candles in the hallways, made it feel less like an institution. Hallways were quiet and there was a generally restful feeling throughout the facility. The facility doors were locked and coded. The building appeared well-maintained, although the landscaping was somewhat overgrown.

Staff:

The Windsor House staff members were open and helpful during the tour. They answered questions and led students around, but also allowed the students and residents to speak in private. The activities director knew every resident by name, where they were from, and their story. Staff members were dispensing medicine in residents' rooms rather than making them line up. The residents spoke highly of the staff.

Residents:

Every resident at Windsor had a diagnosis of Alzheimer's, dementia, or acquired brain injury (e.g., a stroke), and the majority were elderly. Many of the residents were non-verbal or unresponsive to students. Several residents were parked in wheelchairs in the hallway and appeared unable to move on their own. Residents had little community involvement. They were only able to leave the facility when family and friends visit. Activities for each day were posted and included visiting musicians, sing-along and karaoke, arts and crafts rooms, dolls and cribs, hair salon, and television. There were rocking chairs in a garden area outside that served as a popular area for mobile residents to smoke.

One resident, L, was an obvious misfit in Windsor House. L is in his late sixties and has been living at Windsor House for a year after moving there for treatment of his depression. L reported that he felt much better now that his medication had been adjusted. L feels unhappy and out of place at Windsor because other residents cannot communicate at his level due to their dementia. He wants very badly to live in the community and seems physically capable of doing so. He does his own dressing, grooming, and chores every day and believes he could also cook for himself. Before the visiting student left, L asked them to please help him because he feels like he is in jail.

There are residents currently living at Windsor House that have previously lived in the community with success. Many residents expressed an interest in returning to a community placement, and could be successfully served in an integrated and inclusive community setting.

Conclusion

The investigation Disability Rights NC conducted at fifteen large Adult Care Homes during two-weeks from May 17 to May 28, 2010, revealed a distressing picture of the fractured system of care through which adults with mental illness are falling. The interviews and on-site visits confirmed our fears that the State is warehousing scores of individuals with mental illness in unsuitable and dangerous institution-like facilities, where they lack appropriate care and treatment. Located in remote settings with inadequate staffing, few activities or diversions, and no opportunities for community integration, these institutions are wholly inadequate and illegal. If the principles embodied in the Americans with Disabilities Act and articulated in *Olmstead* are to have any meaning for the unfortunate individuals forced to live in these facilities, the State of North Carolina must make a concerted effort to create more humane options for the residential care of those with mental illness.