STATE OF NORTH CAROLINA
Office of the State Auditor

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April 9, 2008

Mr. Dempsey Benton, Secretary
North Carolina Department of Health and Human Services
101 Blair Drive
Adams Building
Raleigh, North Carolina 27603-2040

Dear Secretary Benton:

We received a complaint through the *State Auditor's Hotline* concerning the procedures performed by the North Carolina Department of Health and Human Services' Adult Care Licensure Section (ACLS) regarding its oversight of two adult care homes, one licensed and the other, unlicensed. Pursuant to North Carolina General Statute §147-64.6(c)(16), our investigation of this matter resulted in the following findings and recommendations.

An adult care home's ownership includes the same individual who was in ownership when the home received numerous citations and had their admissions suspended.

After receiving a suspension of admissions and numerous citations, an adult care home received new ownership although it continues to include one of the same individuals in the new ownership structure as in its former one. The ownership group of this home has changed twice between May 1, 2006 and July 1, 2007. The North Carolina Department of Health and Human Services has granted a license to each group to operate the home**.** During this time period, the individual's ownership of the home ranged from 12.5 percent to 50 percent.

North Carolina General Statute §131D-2(b) states the Department of Health and Human Services has the authority to license the majority[1] of adult care homes for persons who are aged or mentally or physically disabled. A significant component of the licensing process is the approval of the home's principal owners. North Carolina Administrative Code (NCAC), Title 10A, Subchapter 13F, states in part that "…*No new license shall be issued for any adult care home to an applicant for licensure who is the owner, principal, or affiliate of an adult care home that has had its admissions suspended until six months after the suspension is lifted."* As shown in the table on page 3, there was a suspension of admissions in June 2007 that was

[1] Does not include (1) Facilities licensed under North Carolina General Statute 122C or 131E; (2) Persons subject to rules of the Division of Vocational Rehabilitation Services; (3) Facilities that care for no more than four persons, all of whom are under the supervision of the United States Veterans Administration;(4) Facilities that make no charges for housing, amenities, or personal care service, either directly or indirectly; and (5) Institutions that are maintained or operated by a unit of government and exempt from licensure by the Department on September 30, 1995.

followed by the approval of another ownership group in July 2007. The new group included one of the individuals from the previous group. Therefore, the agency's regulations were violated by allowing this person to continue in an ownership capacity.

Based on the continuing citations assessed against this same adult care home, the risk is high that improper operations will persist as long as a similar management structure continues. These citations could lead to resident injuries or death as was the case in May 2007. According to ACLS documentation from their investigation, the facility's noncompliance with North Carolina Administrative Code (NCAC), Title 10A, Subchapter 13F.1501 regarding the use of a restraint, resulted in the death of one resident. This documentation also states that the restraint was used "*without a complete assessment and care planning process which would have assured the use of a restraint that would provide safety and prevent a decline in the resident's physical function.*"

ACLS management stated that granting the July 2007 license with this individual as part of the ownership group was an oversight and changes in the approval process would be made.

Recommendation

ACLS should change its procedures for approving applications to include a more intense review of the individual ownership components in the licensing process of adult care homes.

Licensed Adult Care Home
Partial History of Ownership Changes and Violations or Citations

Date	Regulation Criteria	Violation/Citation
01/18/08	10A NCAC13F.0311(a)	Call bell system not operating properly
01/18/08	10A NCAC 13F.0901(a)	Failure to attend to residents personal needs
11/20/07	10A NCAC 13F.1004(a)(1)	Medications not administered in accordance with physician's orders
11/20/07	10A NCAC 13F.0901(a)(b)(c)	Personal care and supervision
07/09/07	10A NCAC 13F.0904	Facility did not have adequate supply of and residents were not served required food
07/09/07	NCGS§131D-21(2)(4)	Failed to ensure residents were free of physical and mental abuse, neglect and exploitation
07/09/07	10A NCAC 13F.0306	Facility not clean in dining area
07/09/07	10A NCAC 13F.0305	Failed to secure chemicals and hazardous materials
07/09/07	10A NCAC 13F.0702	Failed to give an adequate reason and placement of discharge
07/01//07	**New ownership with the exception of the same person as 5/16/06**	
June 2007	**Communication sent to suspend admissions**	
5/24/07	10ANCAC 13F.0311(a)	Call bell system not operating properly
5/24/07	10ANCAC 3F.0407(a)(5)	Personnel registry includes prior findings for staff person
5/24/07	10ANCAC 13F.0901(a)	Failed to provide personal care needs for residents such as toileting and personal hygiene
5/24/07	10A NCAC 13F .1501(a)	Residents placed in a restraint without a complete assessment and care planning process
5/24/07	10ANCAC 13F.0909	Transporting soiled residents for medical treatment and not giving residents prior notice for medical appointments
2/09/07	10A NCAC 13F.1211	Failed to develop and implement a policy and procedure regarding high and low blood sugar
2/09/07	10A NCAC 13F.1002(a)	Failed to ensure contact with the resident's physician for verification of medications
11/14/06	10A NCAC .0904 (a)(2)	Food not properly stored
11/14/06	10A NCAC 13F .1004	Failed to assure all medications were administered as ordered
11/14/06	10ANCAC 13F.0403(a)	Documentation for qualifications of medication staff
8/23/06	10ANCAC 13F.0406	Test for tuberculosis
8/23/06	NCGS§ 131D-21(2)	Inappropriate care provided
05/16/06	**New ownership with the exception of one person**	
03/22/06	10A NCAC 13F.1212(e)(1)	Facility failed to notify resident's responsible person or contact person of illness requiring medical treatment or evaluation.
03/08/06	10A NCAC 13F .1004	Medications not administered in accordance with physician's orders
01/01/06	**Ownership of 4 people**	

NCGS: North Carolina General Statute
NCAC: North Carolina Administrative Code

Source: Department of Health and Human Services- Adult Care Licensure Section
Wake County Human Services

A violation of ACLS policy extended the time residents lived in an unsafe facility

ACLS did not adhere to its policy of responding promptly to violations found in a county investigation of an unlicensed adult care home. On April 25, 2007 county adult home specialists conducted an investigation of this adult care home. Findings from this investigation included the following conditions:

> *Resident 1 was elderly, sitting in a chair, and made no contact or acknowledged the Adult Home Specialist when approached.*
> *Resident 2 was lying in a hospital bed with both side rails up; made eye contact and was non-verbal when approached*

The county's investigative report revealed testimony from a caregiver hired in September, 2006 to provide personal care services (bathing, feeding, dressing, and toileting assistance) for one of the two residents. The caregiver stated the other resident is bed bound and receives all services through Hospice. It is a violation of North Carolina General Statute §131D-2 to provide these services for two or more residents without a license.

The ACLS received the county's investigative report on April 30, 2007. The ACLS procedures require it to verbally respond to the county followed by a written notice to both county officials and the home's operator within five (5) working days. The ACLS did not respond with its own investigation until August 10, 2007**,** or more than three (3) months after receiving the county's report. The ACLS investigation revealed, similar to the county's report, that residents were receiving personal care services and medication in an unlicensed facility. In addition**,** the report showed that no verification was performed of the personal care administrator's professional credentials, and that the number of residents being cared for had increased to three (3). On August 13, 2007, the homeowner received a notice to cease providing adult care home services from ACLS.

By not responding to the county's investigative report in a timely manner, the ACLS did not address the situation in which elderly residents remained in an environment that jeopardized their health and safety. The ACLS indicated the delay in responding to the county's report was caused by a filing error.

Recommendation

ACLS should restructure its process of receiving, reviewing, and responding to county investigations to ensure prompt action is taken and compliance with policies is adhered to in performing its oversight responsibilities.

Residents and their responsible persons were not contacted after Cease and Desist Letter[2] issued

ACLS did not notify a homeowner of the obligation to inform residents and responsible persons of the need to remove residents from the home as part of an order to cease services. On August 13, 2007, ACLS notified an adult care home to cease providing adult care home services, such as feeding and administering medication, without a license. Regarding this notification, ACLS procedures state the following:

> *If any residents of the home are determined to be needing and receiving care and services that would make the home subject to licensure as an adult care home according to GS §131D-2, the written notice will require removal of those residents deemed in need of such care and services (except those covered under the exemptions outlined in statute). The notice will state that the operator of the home must inform the affected residents and their responsible persons that the residents must be removed from the unlicensed home as soon as other placement arrangements can be made and that the county Division of Social Services will assist in the appropriate relocation of residents as necessary.*

As stated, it is the responsibility of ACLS to inform the homeowner to notify residents and their responsible persons of the home's conditions when a written notice is issued. The notice to this adult care home did not include this information and there is no indication the homeowner made contact with any of the residents' responsible persons. Further, ACLS did not speak to residents or responsible persons about the home's inappropriate operations. Therefore, the families or responsible persons were not contacted regarding this notice to cease providing adult care home services at this home.

Notification of responsible persons is an important step in the process of removing residents expeditiously from an environment where there is a risk of endangering their health and safety.

Recommendation

Management should revise the ACLS policies and procedures to add the responsibility of notifying residents and responsible persons when a notice to cease operations is issued**.** Management should also adhere to the established policies and procedures and include all of the required information in any written communication to the adult care homeowner.

[2] An official notice from ACLS requiring the homeowner to stop providing adult care home services until such time that a valid North Carolina license can be obtained.

The necessary steps to halt improper operations of an adult care home were not taken

The inability to communicate with the appropriate legal personnel allowed an adult care home to continue operations months after a notification to cease operations was issued. On April 25, 2007**,** an investigation by the county documented operational concerns at an unlicensed adult care home. On August 13, 2007 this adult care home operator was notified by ACLS to cease providing adult care home services, such as feeding and administering medication to residents, without a license. Since the receiver of this notice has the right to appeal, these improper operations did not stop immediately.

After issuing the notice, the ACLS's procedures require the ACLS to contact the county District Attorney's (DA's) Office. However, rather than contacting the DA's office directly, ACLS solicits the assistance of the Attorney General's (AG's) Office to contact the DA's office. The AG's Office then consults with the county District Attorney's (DA's) office to stop operations in the adult care home cited.

During September and October 2007, ACLS made contact with the AG's Office. An Assistant AG assigned to ACLS stated he made multiple telephone calls and placed messages on an Assistant DA's voicemail in October and November of 2007. The Assistant AG also states telephone calls were returned, but due to their conflicting schedules, contact between the two attorneys was unsuccessful. Because the communication was not made, the unlicensed adult care home was allowed to continue its operations months after the improper operations had been initially identified.

Recommendation

Clear and concise procedures should be written outlining the appropriate actions taken after a cease and desist letter is issued. The ACLS and AG's Office, along with input from the county DA's office, should decide on the most effective steps to physically and expeditiously halt improper operations at an adult care home. Based on our discussions with the AG's Office and the DA's Office, the possibility of having the AG's Office file documents directly with Superior Court should be included in the discussions on procedural changes.

Please provide your written response to these findings and recommendations, including corrective actions taken or planned, by April 23, 2008. In accordance with General Statute §147-64.6(c)(12), the Governor, the Attorney General, and other appropriate officials, will receive a copy of this management letter. If you have any questions or wish to discuss this matter further, please contact us. We appreciate the cooperation received from the employees of the North Carolina Department of Health and Human Services Adult Care Licensure Section during our review.

Sincerely,

Leslie W. Merritt, Jr.

Leslie W. Merritt, Jr., CPA, CFP
State Auditor

Management letters and responses receive the same distribution as audit reports.

North Carolina Department of Health and Human Services
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Michael F. Easley, Governor

Dempsey Benton, Secretary

April 21, 2008

The Honorable Leslie W. Merritt, Jr. CPA, CFP
State Auditor
20601 Mail Service Center
Raleigh, NC 27699-0601

RE: Management Report on the Adult Care Licensure Section
Sunshine Care Unlicensed Residence/Parkway Retirement Home, Inc.

Dear Mr. Merritt:

This is a response to the State Auditor's investigative report regarding a Hotline complaint concerning the procedures performed by the DHHS Division of Health Services Regulation - Adult Care Licensure Section (ACLS). The report specifically addressed policies and processes and their application to the licensing of an adult care provider.

Complaint: An adult care home's ownership included the same individual who was in ownership when the home received numerous citations and had their admissions suspended.

Department Response:

Issuance of licenses for adult care homes statutorily requires compliance history reviews for any individual that owns 5% or more of the potential licensing entity. The ACLS had initiated a process including verification with the Secretary of State, review of the Department of Health and Human Services' provider penalty tracking database, and ACLS' long term care safety initiative (LTi) database for licensing and penalty historical data. Licensing reviews occur annually for the 1,300 facilities and their owners; and for each of the over 100 annual change of ownerships as well as for all pending new facilities applications. Thus, there is a significant amount of work required as a routine process prior to the issuance of any license.

Management reviewed the processes utilized to ensure that the owners met the legal requirements for licensing of facilities. Two issues were noted which have been addressed. One component of the compliance review, verifying the adult care home owner's past compliance history, has been changed. The Section's LTi database has had coding changes implemented last month to identify variations on the owner's name. This change has resulted in selecting all facilities licensed under the owner's name.

It was also noted that the form specifically utilized for documenting the compliance history review for the change of ownership did not clearly identify the list of current owners (those that have 5% or more interest in the licensee entity) from the potential owners (those having 5% or more ownership in the entity attempting to now license the facility). Review of the compliance history form documenting the specific case involving owners of Parkway Retirement Home, Inc., listed the named owner in the complaint as "OK" but the form noted a suspension of admission against the current licensee. As a result, it was licensed to an individual who had a percentage of interest in both the potential licensee and the licensed entity which had administrative actions pending against it.

After the problem was identified, the manager reviewed the process with the assigned processing staff and explained how to properly complete the compliance review task. The form was revised to provide a discrete location to list all potential owners and a separate location to list current owners.

Complaint: A violation of ACLS policy extended the time residents lived in an unsafe facility.

Department Response:

The Section management reviewed its processes and policy regarding complaints of unlicensed operators. This review included the implementation of the March 2007 policy in investigating and responding to unlicensed operators providing personal care and supervision to individuals residing in these homes. The issues identified in the report noted lack of the Section's response to the Wake County Human Services report. This was a result of the correspondence being misplaced in the manager's office and Section staff was not assigned for follow-up.

The Section is establishing a tracking system initiated upon receipt of complaint of an unlicensed operator. It requires documentation of key events. The Section had begun development of a data system to track receipt of all county Department of Social Services (DSS) correspondence. Since all 100 counties DSS' offices are required by G.S.131D-2 to submit onsite monitoring reports, complaint investigation reports and corrective action reports within 21 days of a visit (over 5,000 reports annually), the Section hoped to document initial receipt of each document. A request for support from a Microsoft Access software specialist has been made and the Section awaits assignment of this individual.

Complaint: Residents and their responsible persons were not contacted after Cease and Desist Letter issued.

Department Response:

The ACLS staff investigated the unlicensed operations but did not notify the operator to contact residents and family members for alternate placement of their loved ones in our correspondence, nor did the county staff do so. The investigations determined that the placed individuals did not need Adult Protective Care protection based on the initial investigation by Wake County Human

Services and that licensed home care and hospice staff were engaged in the care of residents. Residents were not removed from the premises as the operator indicated intentions to submit a licensure application.

In the case reviewed, once the operator was aware of the need to be licensed as an adult care home (or registered as a multi-unit assisted housing with services), she made application for registration as a multi-unit assisted housing with services. The residents were not removed and the agency continued a prolonged consultation to assist the operator to meet registration requirements. During this process, ACLS staff did contact the resident's physician and some family members.

The policy addressing unlicensed operators has been revised. If the operator fails to notify family members within the five day period, ACLS staff will contact family members if unable to confirm facility's efforts that notification has occurred and arrangements are being made for appropriate placement.

Complaint: The necessary steps to halt improper operations of an adult care home were not taken.

Department Response:

The agency did work with counsel from the Attorney General's office to refer the case to the Wake County District Attorney's office for consideration of prosecution. Though the Assistant Attorney General attempted contacts and left voice messages requesting prosecution with the Wake County District Attorney's Office district court supervisor, ultimately no direct interaction occurred and no action was taken by the Wake County District attorney's office.

In review of the findings by the ACLS, the policy for addressing an allegation of unlicensed operator has been revised. The significant changes are that the Section assumes primary responsibility for investigation; an operator who is found in violation is required to notify family members to remove loved ones from the facility within five days;; written notification is submitted to the county District Attorney's office; and notification is also sent to the Assistant Attorney General asking the office to prepare to file an injunction in Superior Court requiring the operator to cease operation when the operator fails to notify families or ceases operation.

This revised policy has been reviewed by Division management, submitted for posting on our website and ACLS staff as well as county DSS offices contacted regarding the revised policy.

CONCLUSION

The Adult Care Licensure Section's mandate is to assure the health and safety of citizens being served in adult care residences. The Section's primary responsibility is the licensing and inspection of 1,300 licensed adult care homes. It also certifies over 300 administrators annually, and bi-annually processes 1,200 certificate renewals. ACLS also administers over 4,000 written test examination of medication aides and administrators each year, approves over 500

continuing education credits for entities to provide training to staff of adult care homes, and has oversight responsibility of the 100 county DSS adult home specialists' activities. Recently a new provider rating system has been mandated to be implemented in January 2009. The ACLS continues to prioritize its efforts to maximize the efficiency of its 67 staff members, to improve its performance in its inspection role, and streamline the licensure and administrative processes. The changes in the systems are being implemented and will be evaluated to determine further refinement.

We hope this information provides sufficient response to the report. If there are questions or additional information is needed, please do not hesitate to contact Barbara Ryan at 855-3784.

Sincerely,

Dempsey Benton

Cc: Dan Stewart
Bob Fitzgerald
Barbara Ryan