Creating a Family Council:

A Group for Success

A North Carolina Guide for

Families and Friends

Creating a

Family Council

In a Long Term Care Facility

2013

Provided by Friends of Residents in Long Term Care

Statement of Purpose

Residents of nursing homes and adult care homes should receive the best possible quality of care. To achieve this goal, it is important that families and friends of loved ones in long-term care facilities assume an active role in facility life.

One of the most effective ways to participate in the services provided to your loved ones is through the creation of and participation in a family council. The contributors and supporters of this manual hope to provide the tools needed to engage in the development of effective family councils. On a larger scale, this creation of a family council is a key example of getting involved on a local level with basic human rights, speaking up for those who may not have a voice or who may need your voice to add to theirs.

The goal of this manual is to improve the quality of life for residents in nursing homes and adult care homes through the positive contributions and oversight that family councils can provide to North Carolina facilities.

Acknowledgements

Creating a Family Council: A Group Bound for Success was the brain child of Carol Teal, former Executive Director of Friends of Residents in Long Term Care, who chose to make 2003 the *"Year of the Family Council."* In honor of this designation she envisioned creating a state specific manual to guide and direct families in assuring their loved ones receive quality care as they reside in long term care facilities. This manual is a culmination of many months of hard work and dedication by committed advocates for family empowerment. We appreciate the time and expertise of all the individuals who contributed to this manual.

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The committee would also like to acknowledge and thank the following states for the creation and publication of their manuals: *Family Councils in Action*- Created by the Minnesota Alliance for Health Care Consumers, and *Nursing Home Family Council Manual*-Created by the Texas Advocates for Nursing Home Residents. These two manuals served as excellent guidebooks for the workgroup as we developed and customized the content of our own manual, *Creating a Family Council: A Group Bound for Success.*

The 2013 edition of the manual was revised and edited by Gail Holden, *Executive Director of Friends of Residents in Long Term Care.*

Friends of Residents in Long Term Care

This guide is being produced at no cost for the groups potentially benefiting from its contents. We wish to acknowledge the support of Brookcare of North Carolina, Inc. for underwriting the costs of printing the manual. We do encourage you and members of your family council to become members of Friends of Residents in Long Term Care. Friends is a North Carolina 501(c)(3) membership organization of individuals and associations committed to improving the quality of life for over 80,000 North Carolina citizens in long term care. Our work covers many aspects of long term care in various settings: nursing homes, assisted living facilities, adult care homes, family care homes, multi-unit housing with services, continuing care retirement communities and home and community services. Access membership information at www.forltc.org or by calling 919-782-1530.

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CHAPTER ONE: WHY FORM A FAMILY COUNCIL?

What is a family council?

A family council is an organized group of friends and family members of residents committed to improving the quality of life for those living in the facility. In all aspects of nursing home and adult care home life, from the physical environment to daily care provision, a family council can influence facility decisions to ensure that residents are properly cared for and supported.

Individual family councils may have different ideas about what they hope to achieve as a group. One group might be more concerned with improving or creating family and resident activities. Another might function as a support group for family members, using meeting times to discuss solutions to resident and family concerns. It is important that each family council work towards developing and establishing its own unique goals. Chapter 5 addresses the process of establishing your group's particular goals and objectives. Many family councils participate in a range of activities that support a set of proactive ideals. You might consider these ideals as a central framework of an effective family council.

Key Activist Ideals Important for Family Councils

Advocacy	The family council should serve as advocates of resident rights, needs and concerns.

Education	The family council should work to educate its members and other consumers about the rights and privileges of facility residents.
Empowerment	The family council should empower individuals within the facility to make the best possible choices in order to create the most positive home environment possible.
Improvement	The family council should be committed to the improvement of all aspects of the facility experience.
Involvement	The family council should engage in a process of active involvement with families, residents, staff, social services, and the administration to ensure that effective communication is taking place at all times.

Regardless of the goals set by individual groups, family councils play an important role in the protection of resident rights and improving the care offered to residents in long term care facilities.

How do family councils help?

While an important role of a family council is to ensure that quality care is provided to residents, the development of such a group has several other advantages.

1. All individuals residing in nursing homes and adult care homes deserve to be treated with dignity and respect. While this is the intent of most facilities, sometimes residents are unable to serve as effective advocates of their own needs. When this is the case, it becomes the responsibility of other concerned parties to best express the needs of that individual. The active involvement of

family members and friends can help establish what is best for residents living in a facility who are unable to advocate for themselves.

2. While family councils are extremely supportive of long term care residents who have exceptional needs, family councils are also important contributors to the lives of higher functioning residents as well. In this case, such residents may be more active participants in expressing their concerns to their loved ones and allowing the family council to help address them. And all residents are able to benefit from systemic changes or through the addition of activities and other facility programs organized through the efforts of the family council.
3. Creating a family council not only signifies family members' commitments to their loved ones, but also creates a mechanism of support for families and friends of those residing in the home. Group members are able to discuss and listen to concerns and then work as a group to address problems. They are also able to share similar experiences caring for loved ones in nursing homes and adult care homes. Working as a group, family members and friends are able to participate in facility life in ways they may not have been able to as individuals.
4. The facility itself also benefits from the existence of a family council. Often, this group helps to organize activities that

provide a positive experience for staff, residents and family members alike. Family councils may also benefit the facility by voicing discussions and concerns, developing possible solutions and then presenting them to the home's administration in a productive way. Often family, staff and administrators have similar goals and family councils can help aid in the discussion and decision-making process.

Ultimately, everyone benefits when the care provided in the facility is improved. Residents experience better health outcomes and improved quality of life. Facility staff and administrators benefit when the positive features of the facility are publicized and their good reputation spreads in the community.

The right to organize a family council

The many benefits of family councils in nursing home facilities have been widely recognized. Both federal and state governments recognize the importance of family councils and have, therefore, provided them certain legal rights. A federal law was established to guarantee the right of family councils to exist in nursing homes across the United States.

Federal Regulations **42 CFR § 483.15 (c)**
(1) A resident has the right to organize and participate in resident groups in the facility. **(2) A resident's family has the right to meet in the facility with the**

families of other residents in the facility.
(3) The facility must provide a resident or family group, if one exists, with a private space to meet.
(4) Staff or visitors may attend meetings only at the group's invitation.
(5) The facility must provide a designated staff person responsible for providing assistance and responding to written requests that result from group meetings. That person also may attend, but only when invited.
(6) When a resident or family group exists, the facility must listen to the views and act upon the grievances and recommendations of residents and families concerning proposed policy and operational decisions affecting resident care and life in the facility.
(7) The facility must assist residents in attending the meetings.
(8) Responsible parties may examine the resident's nurses' and physicians' notes on that person so as to better monitor the care of that person.

Understanding the law regarding family councils is an important part of the formation process, and it helps to ensure that these groups are given the rights and respect that the law guarantees.

Taking the next step

The process of organizing a family council might seem overwhelming. It is important to remember, however, that family councils

exist in many other facilities and that you, along with the help of fellow family members, can create an effective group in your facility as well.

The next chapter will outline the process of creating and establishing a family council in your facility. These suggestions have come from several expert sources and from family members, just like you, who have already been through the process of organizing a family council and who have shared their experiences.

CHAPTER TWO: GETTING STARTED

Perhaps the best way to approach the task of forming a family council is to break it down into several manageable steps.

Step 1: Connect

The first and probably most important step toward creating an effective family council is to begin interacting with the families and friends of other residents within your facility. You can engage in this process in several ways.

- First, if activities or groups of families already exist at your facility, it might be possible to meet others during such events. At such functions you might connect with others informally, such as by starting a one-to-one conversation.
- Or, you might decide to connect with potential members in a more formal manner, such as working within an existing group to give a presentation regarding the benefits of creating a family council.

Step 2: Contacts in the Community

There are resources within your community to help you during the early stages of forming a family council.

1. One of the very best resources is the Regional Long-term Care Ombudsman. The ombudsman is an official advocate for nursing homes residents who will provide you with information, training, guidance and support. For information on how to contact your ombudsman, visit the NC Division of Aging and Adult Services website at http://www.ncdhhs.gov/aging/ombud/ombstaff.htm .
2. If your facility has a social worker, then contacting this person might be helpful as well. However, it is important to remember that family members are guaranteed the right to organize and meet without the assistance of the nursing home staff. If you choose to bring in staff to help out with some beginning basics, it is important that you and other families have control over your family council.
3. Existing family councils in your area might also be valuable resources during the start of a new family council. Your regional ombudsman may have an established list. Consider contacting these family councils and talking with their chairperson or other members for their advice.

Step 3: Establish a Place and Time

Once a few families have organized and agreed to begin the process of initiating a new family council, it is important to establish a place for it within a facility.

The first and most important individual to contact to discuss the new family council is facility Administrator. It is important to be well prepared when meeting with the administrator, so the family council will appear to be well organized.

There are several recommendations about how to have an effective first meeting with a facility's administrator.

1) Set an official meeting time with the administrator. Often administrators are exceptionally busy people, so you should be as respectful of their time as possible. It is typically not a good idea to bring up the subject of a new family council in a casual setting. Instead, be sure to schedule a large enough block of time that you and the administrator will be able to talk in a private and professional setting.
2) Consider how many members want to attend the meeting. It is probably best not to have so many attend that it appears overwhelming to the administrator. Perhaps two family members or a smaller steering committee could attend the initial meeting. You might also consider inviting the Ombudsman to attend for support

and information. Advise the administrator when you set up the meeting that other people will be attending as well.

3) Think through and anticipate, as a group, any concerns that the administrator may raise in discussion and plan possible responses. For example, if the administrator states that a facility staff member should be present at family council meetings, you might be prepared to respond that families often need to be able to discuss their concerns in a private setting and that federal law gives them the right to meet privately. (See Appendix C.)
4) Develop a list of the many advantages of a family council to the families, residents and facility alike. Emphasize the benefits to the facility. (See Chapter 1.)

Here is a suggested outline for the initial meeting:

1) Greet the administrator and introduce yourself.
2) Discuss your intentions to form a family council and the many benefits of doing so.
3) Discuss any information that the administrator may need regarding the formation of the group. Be sure to emphasize that a group of this type is very important and that any other type of group, such as a resident council, cannot perform the same functions as a family council. Also stress that this group will be led and run by the families.

4) Discuss the type of support that the family council would need from the facility. Some expectations might include:

   a. A commitment from the administrator to appoint a staff liaison to hear the initial concerns of the group and to act as a liaison between the family council and the facility;
   b. A commitment from the administrator that family council concerns will be attended to and heard in a timely and effective manner;
   c. A commitment to provide a private meeting space within the facility;
   d. A regularly reserved time to use the meeting space, to be decided by the council, and a reservation method for securing the meeting space;
   e. A bulletin board or other reserved space to regularly communicate with family council members;
   f. A commitment from the facility to assist the new family council with outreach projects. For example, the group might want to send out information to families regarding meetings or to include information on the group in admissions packets. According to law, the facility has to send out the notices of the meetings to the responsible parties.

Step 4: Address Challenging Factors

It is important to remember that even the most organized and effective attempts to start a family council may encounter some challenges along the way. As a new family council, it is important not to become discouraged, but to meet these challenges in a positive way.

One of the most important goals for beginning family council groups may be to attract a large group of other interested families. A family council does not have to be large for it to be successful. Some of the most effective family councils have humble beginnings. Even a small one can successfully represent a much larger facility, if the group establishes ways of keeping less active family members involved.

Methods that may help communications include:

- Posting attractive flyers around the facility notifying everyone of upcoming meeting.
- Posting minutes and other family council announcements within the facility to keep people informed of ongoing council activities.

The second most commonly cited challenge for new family councils is to communicate effectively with facility administrators and staff. Often the process of establishing good rapport with administrators takes time, understanding and patience. A pleasant approach and an understanding manner will go a long way.

Although a facility's administrator should be receptive to the formation of a family council in his or her facility, sometimes this is not the case. In the event that your administrator is reluctant about the idea of a family council, there are several things to keep in mind.

1) It is possible for your family council to be successful even if the facility's administrator is not 100 percent supportive. If this is the case, then you can work with the appointed facility liaison or a staff social worker to be a liaison between the group and the facility.

2) Relations between your family council group and the facility will improve if the group remains respectful and open to the administrator's opinions and needs as well. Ask the administrator to help you better understand his or her concerns and position. In some cases, you may be able to alleviate some of the administrator's concerns by clarifying the role that your group intends to play within the facility. Stress that the ultimate goal of a family council is to improve the facility life for everyone involved and that this can be done through open communication within the facility.

3) If, despite persistent efforts on your part, the administrator is uncooperative, remember that such actions are illegal. The law guarantees many of the rights

of family councils including the right to form such a group, the right to meet within a facility and the right to have the council's concerns heard and responded to in a timely manner. (See Appendix C.) Therefore, if your family council is being denied these rights then you can contact your regional long-term care ombudsman's office for assistance. To contact your ombudsman, visit the NC Division of Aging and Adult Services website at http://www.ncdhhs.gov/aging/ombud/ombstaff.htm .

CHAPTER THREE: THE FIRST MEETING

The first meeting for a family council is very important. This meeting will help recruit more family members and act as an introduction to the importance of having a family council. It is important to approach the first meeting in a well-organized and positive manner.

Step 1: The Basics

When planning for the first family council meeting, be sure to address the basics, including:

1) LOCATION – Where will the meeting be held? The location should be convenient and comfortable for the number of people you anticipate attending. While the facility is responsible for providing a meeting place, it is not necessary that you hold the first meeting within the facility. If you feel the facility is not the best choice, then feel free to choose another location.

2) WHEN – What day and time will the meeting be held? Choose a time that is convenient for most working families. Often family members are not only responsible for their loved ones who live in a facility, but they are also caring for children and spouses, and working full-time. It might be difficult to find a time that will work for everyone,

so the best you can do is try to accommodate the majority. Make a strong commitment to keep those families unable to attend well informed about the meeting's events. Mail copies of the meeting's minutes to those who were unable to attend.

3) HOW – When publicizing the family council's first meeting, it is important to inform as many families as possible. Check to see if the facility will mail flyers on your behalf or include an announcement in the facility bulletin or newsletter. Also, posting flyers or publicizing by word-of-mouth are also effective reminders. Seek out family members each time you visit the facility and call any family members that you or others know. You can also ask any helpful staff, especially the facility social worker, to spread the word. You might also try placing flyers on visitors' cars - with permission from the facility - or placing an ad in a local newspaper.

4) WHAT – When you begin the planning process for the first family council meeting, consider what type of format you are planning to use. For example:

- Do you want this to be an informal gathering?
- Who do you want to lead the meeting?
- Will there be one leader or several?

- Will someone provide refreshments?
- Will you provide any handouts?
- How will you publicize the meeting? Providing a brief statement of purpose in your publicity is a good idea. You might want to say something like, "Come meet fellow residents' families and join in the discussion about improving our loved ones quality of life," or "Come support the first family council meeting: a group engaging in change and improvement." Whatever you decide to say, it should clarify the purpose of the family council meeting.

Step 2: The Meeting

Deciding the manner in which you will approach each family council meeting is important. For the first meeting, you might want to consider hosting a more casual event. For future meetings, however, you might want to develop a more formal meeting format. For either approach, having an outlined agenda for each meeting will be helpful. The most effective agendas tend to prioritize important sections of the meeting, and include who is responsible for the meeting's events. (See Appendix A.)

While it is important for you and your fellow family council members to remain active in meetings, it is also possible to invite long-term care experts, other interested parties, and facility staff to family council meetings. For example, solicit the assistance of the regional ombudsman or facility social worker for your first family council meeting. Expert individuals may be better prepared to answer any questions of the group and to give a detailed background and history about family councils. If you decide to invite outside experts, it is still important that you and the other family members determine what you want to discuss at this first meeting.

Residents at the facility may be invited to attend the meeting, but keep in mind that the purpose of the group is to offer support and information to family members. Residents have their right to organize, attend and speak at their own residents council, which is a separate entity from the family council.

How is a Family Council different from a Residents Council?

The two groups share some similar traits and characteristics. However, they differ in their goals and the manner in which they achieve them.

Family councils focus on supporting the needs of family members and friends as caregivers vs. the daily direct concerns of residents. There will be times when the topics raised for discussion at a family council meeting would be very alarming or upsetting to residents. For example, a family member may be having a very difficult time acknowledging their loved one's impending death and may seek support and encouragement from the family council's members. The family council may need to discuss their strategy of how to address the administration regarding allegations of abuse that are occurring in the facility. As one can see in both of these examples, the subject matter could be very unsettling or simply inappropriate for a resident to be exposed to prematurely.

The focus of the family council is somewhat more global in purpose than the residents council. They are concerned about improving the quality of life of residents, making sure families have a voice in the decision-making process and encouraging the facility to continue striving for excellence. They can play a crucial role in ensuring that staff and administration are shown appreciation for their efforts to work collaboratively with them and advocate as a group when situations that need improvement are not adequately addressed.

The two councils run parallel but each has its own goals and objectives. There can be some overlap between the councils, but it should be done with a clear understanding where one group begins and the other ends. It would be acceptable for the two councils to invite the president/chairperson to meetings that had specific topics that would require input from the designated representative. The invitee could sit in on a meeting either in part or whole, based on the subject or topic for discussion at that particular meeting.

For more information on the purpose of the residents council, see Appendix C or contact your regional ombudsman. The complete list of ombudsmen is located at

http://www.ncdhhs.gov/aging/ombud/ombstaff.htm

Suggestions for activities or topics that you might want to include at your first family council event include:

1) Welcome and Introductions: It is important to greet every person who comes to the meeting. Nametags should be distributed and worn. It is also important to write down everyone's name and contact information. This can be done in several ways. Some groups decide to have a greeter stationed at the door, or some have a sign-in sheet to get each person's information as they enter the session. Others may choose to have an introduction session once the meeting has begun and pass around a sign-in sheet at that time.

2) The Importance of Family Councils: This brief explanation might be done by a well-informed family member, or you can invite the regional ombudsman or experienced members of other local family councils to speak. This may be the most important part of the first meeting since some families may know very little about what a family council is, how it works and what its benefits are. By highlighting the strengths of family councils with anecdotes from other groups or suggesting possible group activities, families will get a chance to envision the many advantages and possibilities linked to forming such a group.

3) Group structure: It is also important to approach the subject of how the families want the council to be structured. As a group they may only want to agree upon some basic features initially. Ask for volunteers to develop the structure of this new family council, and report back at the next meeting.

a. Meeting Time: One of the most important issues to discuss deals with meeting times. As a group they might want to determine which days of the week and which times work best for the majority of family members. It is also important to determine how frequently the group would like to and would be able to meet. A word of caution about making this decision: often families feel overwhelmed by a frequently occurring commitment and therefore vote to meet quarterly or even less frequently. Although some family councils with quarterly meeting schedules may be highly successful, such infrequent meetings could slow the groups' good intentions. Instead, it's best that a commitment is made to meet monthly, at least initially. If the families seem hesitant to adopt this structure, you can remind them that not everyone has to be present at each meeting. And if a quarterly meeting schedule is adopted, then the group might want to work

on developing an effective method of communicating with absentee members, such as by e-mail or distributing minutes of the meetings.

b. Group Leadership: Since the first meeting is only an introductory session, it may be difficult for families to choose leadership at that time. Still, you can begin discussing how the group will be led initially, if only for a few meetings. If there are a few families responsible for bringing the family council together, then perhaps those family members could function as interim leaders or as an Executive Committee until elections are held. In some situations, families have asked the regional ombudsman or the facility's social worker to lead the meeting. While these individuals may be knowledgeable and helpful, it is important to remember that no amount of professional experience should take the place of the families' ownership over their council group. So, even if you do decide to invite a professional to speak at meetings, it is still important to have defined leaders who are representative of the families.

4) Plan for the next meeting: Once the group has decided on a basic format for the next meeting, set a date and time for the next meeting and to appoint someone responsible for

ensuring that this will take place. You may even want to establish a list of items to be discussed at the next session. No matter what type of format your first family council meeting takes, and even if the meeting ends without any final decisions about future meeting formats, this step will get people invested in the success of the group and to spark interest in having the next meeting.

5) Evaluate the first meeting: The Executive Committee should have a brief discussion following the first meeting to discuss what went well and what could be improved upon. Holding this brief session will help to clarify the meeting's highlights and solidify what can be learned from the first session.

CHAPTER FOUR: ENSURING CONTINUITY

While holding a first family council meeting is a true accomplishment, there are several features of family councils that help to ensure their future success.

Leadership

Your family council may decide to adopt any of a variety of leadership structures. Some groups elect a single leader to serve for a designated term; other groups appoint rotating leaders, and still others elect co-leaders. Your family council may also elect or appoint other leadership positions such as vice-president and secretary. A coalition that serves as a Board of Directors is also an option. Your group can work over time to develop a leadership structure that works best for you.

One main thing to remember is that collective action is one of the major features of a family council. In such a style, the more individuals that are involved in decisions and remain active, the stronger the council will become. Selecting a leadership format that is inclusive of all of the members and desires is important to the overall group's success.

Facilitation

The overall success of a family council often relies upon the productivity of monthly meetings. The development of good group

facilitation skills by leaders can be very important to the success of meetings.

Facilitation is the process of guiding a group through discussion. Essentially facilitation involves leading a group in such a way that you assist and guide people in the process of change to produce goals and solutions. There are several components of effective facilitation included below.

- Help the group stay on task
- Ensure the participation of all group members
- Clarify thoughts and provide feedback
- Shield individuals from personal attacks by reinterpreting negative thoughts in a more positive fashion
- Help to negotiate within the group to reach solutions
- Listen actively
- Summarize the group's viewpoint
- Ask, "Tell us more about that" or "Anyone else have something to add?"
- Be supportive of everyone's ideas
- Be non-judgmental.

Goals and Actions

Part of the process of holding effective meetings involves establishing attainable long- and short-term goals. The long-term goals

developed by the group should be broad enough to be accomplished over time.

For example, one family council had the goal of "improving the quality of care provided to residents." Under this long-term goal, several short-term goals were developed, such as "foster increased staff appreciation activities" and "provide feedback to improve facility mealtimes."

Activities should be linked to each short-term goal. Once the group decides upon some basic short-term goals, it can brainstorm ways to achieve them, then establish activities that will help meet them. For example, if the group is trying to foster staff appreciation, the family council might host a staff appreciation lunch or give a Staff Of The Month award. If the group desires to offer feedback to the facility about mealtimes, then the family council might decide to meet with the staff nutritionist or distribute surveys to residents to determine food likes and dislikes.

Whatever goals and action steps the group agrees upon, documenting these goals and encouraging volunteers to oversee the completion of each action step is as important as the goal itself. A few initial successes can go a long way toward building confidence and support for the group.

Get Educated

Another feature for maintaining a successful family council is for families and friends to be well-educated about topics pertaining to the best possible resident care, nursing home structure and residents' rights. The family council may sponsor separate educational events open to all family members outside of the monthly meetings, or they may invite speakers to give brief presentations at meetings. While regional ombudsmen and social workers are always good resources, you can also get creative when searching for guest speakers. Recruit professors from local colleges or health care workers who specialize in issues of aging and long-term care. Educational topics to consider are:

- Medicare and Medicaid Regulations
- Residents' Rights
- Nutrition and Hydration
- Healthy Aging
- Rehabilitation Services
- Bereavement Counseling
- Pharmacists
- Psychiatrists
- Organ and Tissue Donation
- Feeding Tube Issues

- DNR (Do Not Resuscitate) Instructions
- Recognizing Signs of Abuse and Neglect
- Caring for Yourself as a Caregiver.

Group members may have ideas for additional topics. Regardless of the topics chosen, remember that the more families and friends know about the care that is provided to their loved ones, the more essential the group will become.

Be Empowered

The commitment of family councils to improve the quality of life of facility residents is a notable and achievable goal. It is also an example of exercising your rights of free speech and assembly. Families who have delegated the caregiving of their loved ones to others have not given up the rights to the quality of their loved ones' lives.

Get involved - get going - and use the resources we've listed in the appendices to make a difference! Your loved ones *and* your community will benefit.

Never doubt that a small, group of thoughtful, committed citizens can change the world. Indeed, it is the only thing that ever has.
- Margaret Mead

Appendix A

Tools for Effective Meetings

Do You Really Have a Family Council ?

Family Night ?

In most homes, Family Night is an event planned and led by staff for the families of residents. Usually Family Night is held quarterly or semi-annually. In some homes, it is completely social in nature; in others a program of education or information is included.

Family Support Group ?

A family support group is often organized to allow families to share and resolve the emotional conflicts and negative feelings they have associated with placing a loved one in a nursing home. The support group can be led by a staff member, typically a social worker who is trained to conduct such group. It can be lead by a therapist from the community or by a family member who has training or experience in this area or has the desire to help others who have similar concerns and issues.

Family Council ?

A family council is a self-led, self-determined consumer group of families, friends and other concerned individuals of residents who live in long term care settings. Family councils meet on a regular basis and engage in a variety of activities.

Family councils may have activities similar to those mentioned above. For example, a council might sponsor a family support group or provide activities and events for residents. However, a council is not limited to these activities and is not led or directed by staff. Family councils give members opportunities to express concerns and to work for meaningful changes in the home.

Because a family council is a self-determining group of individuals and not limited to one type of activity, its focus can change as it needs and interests of its members change.

Each of these groups is important to a nursing home. Each has important functions. However, they are not interchangeable. Family night is not a family council. A support group is not a family council. The first step in making your council active and effective is to understand the special and unique role you can play. Your input can have a direct impact on enhancing and expanding the quality of life for all residents by ensuring they have quality care.

Note some of the material referenced in this document were works created by the Advocacy Center for Long Term Care, 2626 E. 82nd St., Suite 220, Bloomington, MN 55425, (952) 854-7304, E-mail: www. ac4ltc2cce@aol.com

SAMPLE AGENDA FOR FAMILY COUNCIL MEETINGS

WELCOME

INTRODUCTIONS OF INDIVIDUALS PRESENT

READING AND APPROVAL OF THE MINUTES FROM PREVIOUS MEETING

- ***OPTIONAL- FACILITY UPDATE FROM ADMINISTRATOR OR DESIGNATED STAFF MEMBER***

BUSINESS PORTION OF MEETING
- COMMITTEE REPORTS
- OLD BUSINESS
- NEW BUSINESS

INTRODUCTION OF GUEST SPEAKER OR TOPIC TO BE ADDRESSED BY THE COUNCIL

PRESENTATION OR DISCUSSION

QUESTION AND ANSWER PERIOD

FINAL COMMENTS OR DISCUSSION REGARDING THE CURRENT MEETING

ANNOUNCEMENT OF NEXT MEETING TIME, DATE, LOCATION

ADJOURNMENT

SOCIAL HOUR

Promoting Participation in Family Councils

One challenge faced by many family councils in nursing homes is recruiting and maintaining members. Frequent changes in residents and, therefore, family members, can cause levels of participation to fluctuate and have an impact on the stability and continuity of a family council. Below are suggestions for family councils on how to contact families of new residents and create strategies for ongoing recruitment.

Points to Remember about Promoting Family Council Participation

- Do not get discouraged. Even a small group can be effective. Many family councils have active participation by only about 10% of the families of the residents in the facility.

- Efforts to notify families and friends concerning family council meetings, events, and accomplishments must be ongoing due to frequent changes in residents/families.

Supporting New Families

- Participate in new family orientations at the facility to provide information about family council activities.

- Visit a new resident and their family members shortly after their arrival to share information about the council.

- Sponsor social events to meet new families and residents.

Personal Contacts

- Personal contact (i.e. personal invitations, introductions, etc.) is essential for promoting participation in family councils. Each participant should make a point of inviting other family members to participate between meetings.

- Consider having family members volunteer to be "greeters" in the lobby of the nursing home to introduce themselves and to tell families about the benefits of a family council.

Building a Network

- Provide a sign-in sheet at meetings for names, phone numbers, and addresses of families who attend in order to make future contacts and share reminders of meetings.

- Appoint or elect family members to act as floor/unit representatives to recruit new members and advertise meetings.

- Include in the admissions packets a permission slip to allow the release of the new families' phone numbers to the council.

- Provide ongoing support to one another during and between council meetings.

Develop Written Materials

- Produce brochures, fliers, and newsletters so that families have visual reminders.

- Ask the nursing home to put information about the family council in their newsletter to families.

- Place a bulletin board in the lobby to share the mission statement and successes of the family council, information about meetings and other items of interest to family members.

NCCNHR NATIONAL CITIZENS' COALITION FOR NURSING HOME REFORM
… protecting the rights, safety, and dignity of America's long-term care residents

William F. Benson, President
Alice H. Hedt, Executive Director

Tips for Making Family Council Meetings Meaningful

One of the challenges in starting a family council is promoting participation in the council. One important way to do this is to conduct efficient and meaningful meetings for those who participate. Some tips for having successful family council meetings are below:

Use Structure

Agenda. Use an agenda -- even if it contains just a few simple items. You may even want to assign suggested time limits to agenda items to keep the meeting moving and give participants an idea of what to expect from the beginning.

Meeting Length. If at all possible, try to limit the length of meetings to between 1 hour and 1.5 hours. Because family members' time is limited, people may hesitate to come to meetings if they are too lengthy.

Regular meeting time. Try setting a regular meeting time (Ex. the 3rd Thursday of each month) so that family members can plan to attend family council meetings ahead of time even if they do not receive announcements or see fliers.

Meeting Procedures. Try using parliamentary procedure, Roberts Rules of Order, or some other agreed-upon structure to keep meetings moving in an orderly and efficient manner.

Make Time for Shared Input

Input/Setting Group Goals. In order for family members to be committed to and active in the family council, they must feel that they have input into group decisions and priorities and that council activities will have an impact on the care their loved one receives. The council should schedule time for family members to have discussion and brainstorming without facility staff present. This private discussion will allow family members to voice any concerns freely and allow the council to decide on group issues and goals. When facility staff are present for these discussions, the discussion can become a "complaint session" rather than an honest, proactive discussion of concerns and actions the family council can take to bring about improvements.

Structure for Input. In order to make this input constructive for the activities of the family council, it is important to facilitate this process with some kind of structure.

Some suggestions for ways to keep the discussion moving are:

- use a flip chart to compile a list of shared concerns/interests during brainstorming sessions,

- for large groups, appoint a time keeper who will remind the group to move on if discussion gets stuck on a particular agenda item,

- hand out index cards and ask people to list top three areas of concern or interest and then compile a group list,

- introduce discussion by asking each person to limit their comments to a certain number of minutes,
    - ▪ you can use an egg timer with a bell to help remind the group when it is the next person's turn to speak,

    - ▪ ask each person in the group to verbally list their top three areas of interest or concern.

Focus on Action and Efficiency

Next Steps. Before the end of each meeting, always plot out next steps, review action items and delegate tasks to be accomplished before the next meeting.

Business vs. Pleasure. Try rotating responsibility among members for bringing refreshments. This will enable family members to get to know each other, socialize and support each other informally after the meeting.

Formulate Solutions/Recommendations. Brainstorm with the council for ideas for solutions to concerns raised. Formulate a specific request for how a concern should be addressed.

SAMPLE AGENDA FOR INITIAL FAMILY COUNCIL MEETING

- WELCOME & PURPOSE OF MEETING
- INTRODUCTION OF STEERING COMMITTEE MEMBERS
- INTRODUCTION OF ADMINISTRATOR AND/OR STAFF LIAISON
    - FACILITY REMARKS AND STATEMENT OF COMMITMENT
- GENERAL OVERVIEW OF FAMILY COUNCILS
    - WHAT IS A FAMILY COUNCIL ?
    - BENEFITS OF HAVING AND MAINTAINING AN EFFECTIVE COUNCIL
    - THE RIGHT TO ORGANIZE
    - STRUCTURE
        - OFFICERS
        - BY-LAWS
        - PARLIMENTARY PROCEDURES
    - EXAMPLES OF ISSUES THAT FAMILY COUNCILS HAVE SUCCESSFULLY ADDRESSED
- QUESTION AND ANSWER PERIOD
- DISCUSSION/VOTE WHETHER TO FORM A PERMANENT COUNCIL
- DECISION REGARDING TYPE OF LEADERSHIP FORMAT DESIRED
- NOMINATION OR SELECTION OF INDIVIDUALS TO SERVE IN LEADERSHIP ROLES
- DISCUSS THE USE OF BY-LAWS AND PARLIMENTARY PROCEDURES
- DETERMINE WHEN ELECTION OF OFFICERS WILL TAKE PLACE
- DECIDE WHAT COMMITTEES THE GROUP THINKS WOULD BE MOST BENEFICIAL
- ASK FOR VOLUNTEERS TO SERVE AS COMMITTEE CHAIRPERSONS/LEADERS
- DISCUSS THE FORMAT OR ACTIVITY THAT WILL TAKE PLACE AT THE NEXT MEETING
- SET TIME, DATE AND LOCATION OF NEXT MEETING

SAMPLE FORMAT FOR FAMILY COUNCIL BYLAWS

Article I- ***Name of Group***

The name of the organization is the _____Family Council

(Name of Facility)

Article II- ***Purpose***

The purpose of the organization is to …

Article III- ***Officers***

The _____Family Council officers may consist of : *President, Vice-President, Secretary, and Treasurer, et al.*

Officers shall be elected to serve a _____year term to be decided by the membership. Nominations for officers shall be taken from the floor or submitted in writing. The entire slate of candidates will then be presented to the body for voting purposes.

A. The election shall take place in the form of either secret ballot or by a majority voice vote stating Yea or Nay on the nominees.

B. When a Vacancy (ies) occurs it will be filled as soon as possible, preferably at the next scheduled meeting by a majority vote of the group's members or within two months whichever timeframe is sooner.

Article IV- ***Membership***

A. Membership will consist of families, former families and friends of residents in the facility.

B. Nursing home staff or employees may not be members of the organization. *(If an employee has a family member who is a resident of the facility then another family member may join the council to represent that family's interest).*

C. The council shall establish membership dues, if so desired.

Article V - *Committees and Duties*

Standing Committees: ***Welcome, Program, Resident Life Enhancement, Advocacy, and Grievance***

A. Welcome – shall consist of at least two or three members. Duties of the committee are to welcome and inform new families of the existence of the council and its activities.

B. Program – Chairperson and designated members will be responsible for choosing the content and focus of programs that will take place during meetings.

C. Resident Life Enhancement – Chairperson and/or designated members will conduct activities to contribute to the quality of life and well being of residents. These activities shall be carried out in a variety of ways including seasonal parties/events, birthday celebrations, excursions in the community for socialization and recreation, facilitating worship services if desired, etc.

D. Advocacy- Chairperson will designate a select number of members address issues regarding Residents Rights, living conditions and other topics of relevance that arise.

E. Grievance- shall consist of two or three family members chosen by the council. The selected committee members will take notes regarding the issues brought before the council that need to be addressed by the administration. This group will then meet with the appropriate department heads and administrator to discuss the matters presented. The staff must review the grievances from the council and resolve the concerns and issues or reach a mutually agreeable solution for all interested parties. The administrator and staff must make a written report regarding how the grievances will be addressed. This plan of action will be presented at the next meeting and the content of the document will be recorded in the minutes.

Article VI- *Amendments to Bylaws*

A Bylaw committee must be elected or appointed by the President and/or a Chairperson to recommend changes to the bylaws. The committee shall recommend any proposed changes to the council body. The bylaw changes must be discussed at a regular meeting and the amendments must be voted on and approved by at least a 2/3 majority of the council.

STRATEGIES FOR DEALING WITH COMMON PROBLEMS IN FAMILY COUNCIL MEETINGS

Problem # 1

Case Example: Somebody criticizes the Family Council and the Family Council Leadership by saying, " Meetings are a waste of time. Nothing ever gets accomplished."

Strategies:

- Don't get defensive
- Acknowledge that person's opinion and agree to disagree
- Invite the person to be more active—give them a concrete task that fits their areas of concern. "You seem like someone who has many good ideas about how to improve nursing care and a lot of energy. We need people like you to make the Council stronger. Why don't you join our Nursing Committee?"
- Don't get drawn into the debate. Move on and offer to speak after the meeting.

Problem # 2

Case example: Person arrives at a meeting to get their individual issues resolved and takes up a lot of time with a long story.

Strategies:

- Refer the individual to the appropriate nursing home staff member
- Refer the individual to the Regional Ombudsman
- Interrupt politely. Kindly, but firmly explain that the meeting needs to stay on the agenda and that either the chairperson or a member of the executive committee would be available after the meeting to speak them and help them problem solve.
- If the individual's issue is one of common concern to other family council members put in on the agenda for the next meeting or has a committee look into the matter.

Problem#3

Case Example: Person is completely discouraged and hopeless about

making improvements. He/She makes comments during the meeting that are very negative and discouraging to other members.

Strategies:
Validate the feeling. "I know sometimes we all feel very discouraged. It's difficult to see your loved one suffer and to feel like there's nothing you can do to help."

- ❖ Offer Family Council work as an effective way of making change together with others who understand their feelings of discouragement. Many times people have not gotten anywhere with individual advocacy but may have never tried to advocate collectively via a family council.
- ❖ Talk about success as a result of being well organized and having committed members who are willing to do work. "I can see that you are very discouraged, but I can assure you that if we get organized and everyone commit to working together we'; be able to make improvements at this nursing home."
- ❖ Talk to the individual after the meeting. Invite them to take a more positive role. Honestly express your concerns about how their comments impact group morale.

Problem # 4

Case example: A family member who doesn't recognize the benefit of being part of a team and is only interested in individual advocacy- a person who doesn't have the time or desire to get to know other families, residents or staff.

Strategies:
- ❖ Distinguish between problems that can and should be resolved by individuals and problems that require the collective advocacy of a family council.
- ❖ Distinguish between changes for individual residents and systemic changes. "An individual can improve care for one resident; it takes a family council to improve care for all residents."
- ❖ Highlight the power of working as a group. "Many voices untied are stronger than one voice speaking alone."

Problem #5

Case example: Person is off topic and is not following the group

discussion or agenda

Strategies:

- ❖ Gently say "What you're saying is important but I'm not sure how it relates to the topic of discussion which is…" Could you please make the connection clear for everyone?"
- ❖ Redirect the speaker to a more appropriate section of the agenda. "It seems like your concern or comment is more applicable to point # 3 on our agenda, could you hold your thought or comment until we reach that portion of the meeting?"

Problem #6

Case example: Person interrupts others and speaks out of turn, basically tries to monopolize the meeting.

Strategies:

- ❖ Ground rules for participation should be established in the by-laws (ex. "members shall raise their hand and be recognized by the chair") Refer to these mutually agreed upon ground rules when members fail to exercise parliamentary procedures.
- ❖ Don't allow people to interrupt one another, Step in quickly and respectfully and be sure to model this behavior as chair when facilitating meetings.

Problem # 7

Case example: People are having side conversations.

Strategies:

- ❖ Say to all attendees, "Let's stay focused and avoid side conversation so that we can get through the agenda in a timely manner."
- ❖ Address the people directly and politely, "Please stay with us and don't have side conversation. It makes it difficult for everyone to focus on the subject at hand."
- ❖ Say "Do you want to share your thoughts with everyone; you may be discussing a concern that's on the minds of other members? If not, perhaps you can continue the conversation outside or after the meeting?

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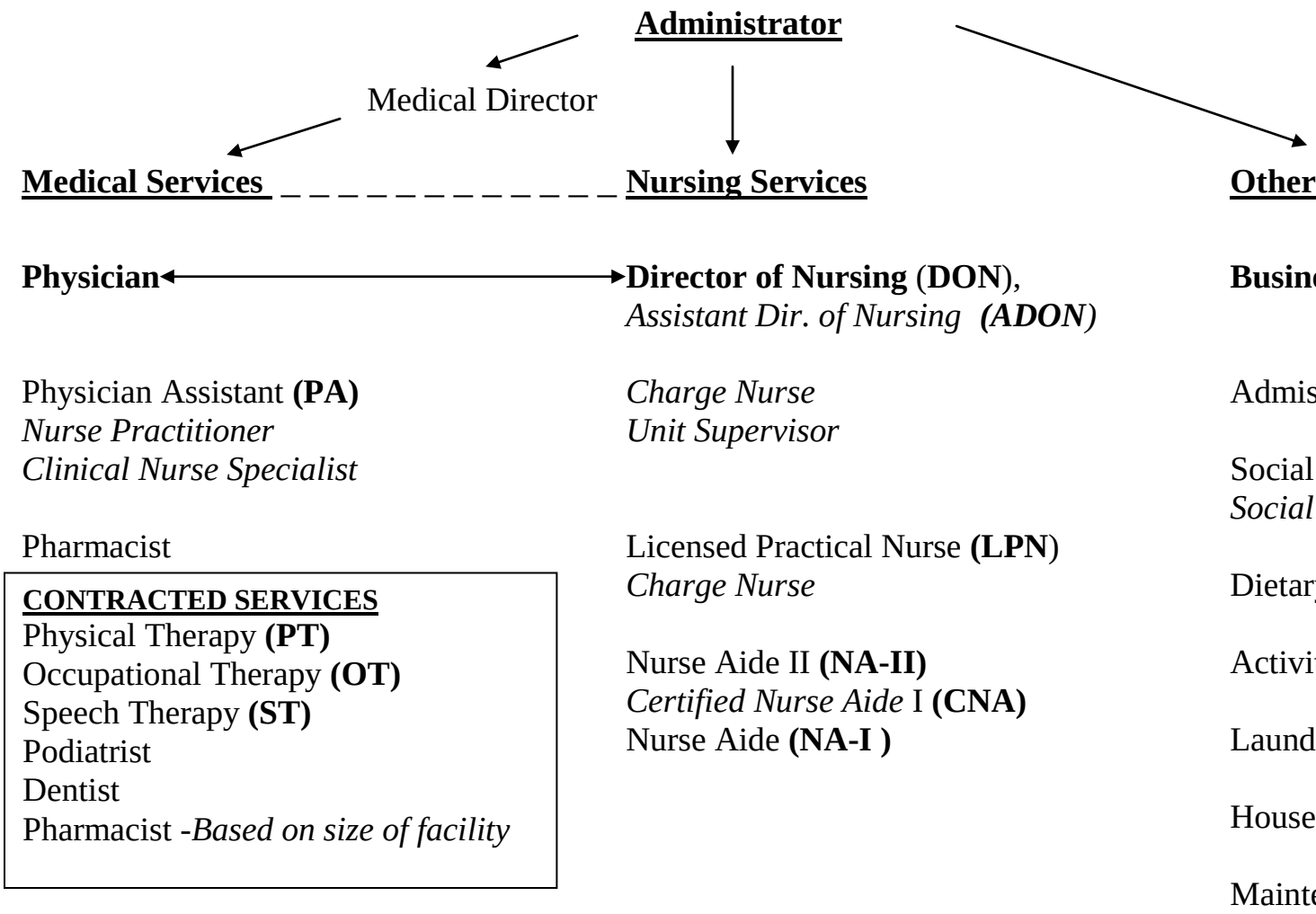
APPENDIX B

FACILITY

ORGANIZATIONAL

STRUCTURE

NURSING HOME ORGANIZATIONAL CHART



- Terms in ***Italics*** represent other ***names/titles*** you may hear ***staff referred*** to in the ***NH setting.***
- Items in **Bold Print** represent commonly used **abbreviations.**
- Broken lines represent very close working relationships

NURSING HOME STAFF

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

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

Administrator: a person licensed by the state to administer a nursing home. This individual is ultimately responsible for all nursing home activities. He/she may or may not have special training in psychosocial and medical aspects of aging. Continuing professional education is usually required by the state where they are licensed. In some cases an administrator is also the owner of the facility or a relative of the owner.

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

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

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

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

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

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

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

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

Nurse Aide: an employee of a nursing home usually responsible for personal care of the residents (*assisting with bathing, feeding, eating, walking, turning in bed, etc*.). An aide cannot work at the home for more than four months without being trained and completing a competency evaluation. Aides may not perform tasks for which they are not competent. The state maintains a register of all aides who have completed the training evaluation program. They work under the supervision of a professional nurse. Although aides provide 80-90 % of nursing home care, generally little training or experience is required. They are sometimes called "Nursing Assistants", "Certified Nursing Assistants," or simply "Aides."

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

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

Dietary Supervisor: a person trained in planning menus, regular and special diets. This staff member also establishes dietary procedures. If a dietary supervisor is not licensed, this person may receive consultation from a licensed dietitian.

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

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

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

Speech Therapist: A person trained to conduct therapy to maintain, restore or improve speech, swallowing, and hearing as it relates to processing language and the spoken word.

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

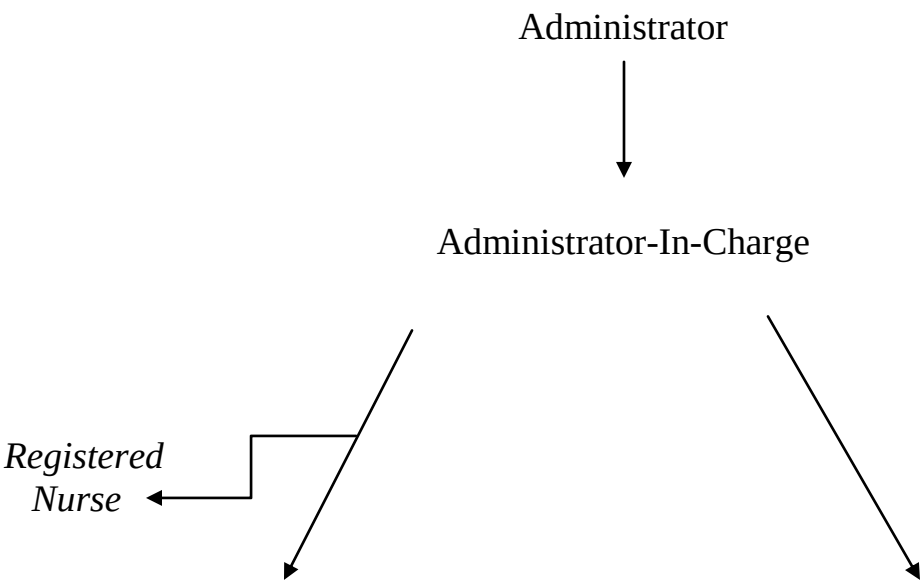
Maintenance
Staff members are responsible for the upkeep & appearance of the interior and exterior of the building. They're also expected to make sure equipment in the building is functioning properly. In addition to these duties they also keep equipment that residents have to use such as wheelchairs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

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

COMMONLY USED ABBREVIATIONS

MD =	**MEDICAL DOCTOR *or* MEDICAL DIRECTOR**
ADM =	**ADMINISTRATOR**
PA =	**PHYSICIAN ASSISTANT**
DON =	**DIRECTOR OF NURSING**
ADON =	**ASST. DIR. OF NURSING**
RN =	**REGISTERED NURSE**
LPN =	**LICENSED PRACTICAL NURSE**
NA =	**NURSE AIDE *or* NURSING ASSISTANT**
CNA =	**CERTIFIED NURSING ASSISTANT**
OT =	**OCCUPATIONAL THERAPIST**
PT =	**PHYSICAL THERAPY**
ST =	**SPEECH THERAPY**

ADULT CARE HOME ORGANIZATIONAL STRUCTURE



<u>Personal Care Services</u>

Personal Care Aide Supervisor

Personal Care Aide

Medication Aide

<u>Other</u>

Activities Director

Food Service Supervisor

Housekeeping

Maintenance

ADULT CARE HOME STAFF

State regulations establish minimum standards of care for adult care homes, including what services they must provide to residents, and what personnel they must have to provide these services. The following is a list of personnel that adult care homes are likely to have on staff or working as consultants to provide services to residents.

Administrator: a person certified by the state to administer the adult care home. This person is ultimately responsible for all adult care home activities. He/she must earn annual continuing education credits related to the management of an adult care home or care of aged and disabled persons.

Administrator-In-Charge: a person responsible to the administrator for carrying out the program in an adult care home in the absence of the administrator. This person must be 21 years old, be a high school graduate or have a G.E.D., have six months experience related to management or supervision in long term care or health care settings and earn annual continuing education credits related to the management of an adult care home or care of aged and disabled persons.

Registered Nurse: validates the competency of non-licensed personnel who perform licensed health professional support tasks such as bowel/bladder training programs, collecting and testing of finger stick blood samples, care of pressure ulcers, range of motion exercises and medication administration through injection.

Medication Aide: a person responsible for administering medications and treatments to residents according to orders by a licensed prescribing practitioner. He/she must complete a clinical skills evaluation competency and pass a written medication exam. In addition, this person must earn annual continuing education credits related to medication administration.

Personal Care Aide: a person responsible for providing personal care services to residents. He/she must complete an 80 hour competency evaluation program and receive on-the job training necessary for the performance of individual job assignments.

Personal Care Aide Supervisor: A person on duty in the facility to oversee or direct the performance of personal care aides. He/she must complete an 80 hour competency evaluation program and receive on-the-job

training necessary for the performance of individual job assignments.

Activities Director: a person who plans and implements the facility's activities program. He/she must be a high school graduate or have a G.E.D. and have completed the basic activity course for assisted living activity directors offered by community colleges.

Food Service Supervisor: a person responsible for the preparation and delivery of meals. He/she must be experienced in food service and be willing to accept consultation from a registered dietitian.

Housekeeping: a person responsible for maintaining the facility in an uncluttered and organized manner, free of obstructions and hazards.

Maintenance: a person responsible for maintaining the building and equipment in a safe and operating condition.

ORGANIZATIONAL CHART FOR _____

TITLE OF STAFF MEMBERS	1ST SHIFT	2ND SHIFT	3RD SHIFT
ADMINISTRATOR			
MEDICAL DIRECTOR			
MEDICAL SERVICES DEPARTMENT			
PHYSICIAN			
PHYSICIAN ASSISTANT (PA)			
NURSE PRACTIONER			
CLINICAL NURSE SPECIALIST			
PHARMACIST			
CONTRACTED DEPARTMENTS			
PHARMACY COMPANY			
OCCUPATIONAL THERAPIST (OT)			
OT ASSISTANT			
SPEECH THERAPIST (ST)			
PODIATRIST			
DENTIST			

TITLE OF STAFF MEMBERS	1ST SHIFT	2ND SHIFT	3RD SHIFT
NURSING SERVICES DEPARTMENT			
DIRECTOR OF NURSING (DON)			
ASSISTANT DIR OF NURSING (ADON)			
CHARGE NURSE			
UNIT SUPERVISOR			
LICENSED PRACTICAL NURSE (LPN)			
NURSE AIDE (NA or CNA)			
NURSE AIDE (NA or CNA)			
OTHER SERVICE DEPARTMENTS			
BUSINESS DIRECTOR			
ADMISSIONS DIRECTOR			
SOCIAL WORKER/SOC. SERV. DIR			
DIETARY SUPERVISOR			

TITLE OF STAFF MEMBERS	1ST SHIFT	2ND SHIFT	3RD SHIFT
ACTIVITIES COORDINATOR			
HOUSEKEEPING/ LAUNDRY			
MAINTENANCE			

Information presented here developed by Kathryn Lanier, Ombudsman Program Specialist for the NC Division of Aging and may be reproduced.

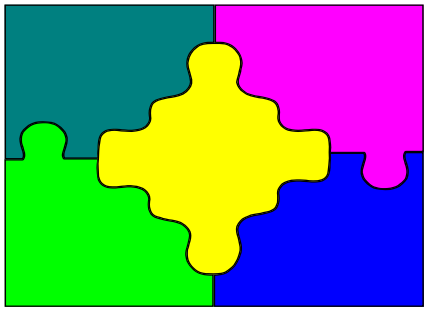
APPENDIX C

COMMUNICATION

AND

RELATIONSHIP BUILDING

YOU DON'T HAVE TO BE PUZZLED !
MAKE SURE THEY GET THE CARE THEY DESERVE



Communication and **Documentation** are the key components in receiving good care. The best methods to have your loved one's needs met are to make sure you are doing the following:

1) **Addressing them to the correct person(s) within the organization and**

2) **Put your concerns in writing and share them with the administration in addition to keeping a copy for your personal records.**

The **(6) Dimensions** printed below will help you present your concerns clearly and concisely to the various individuals who can and are responsible for ensuring quality services are provided to the residents in their care.

- **Who do I speak to about my concern ?**
- **What is it about the care that troubles me ?**
- **Where does this problem occur ?**
- **When did you notice that something wasn't right ?**
- **Why is this occurring ?**
- **How often does this problem arise ?**

Assessment and Care Planning

Each and every person in a nursing home has a right to good care under the 1987 Federal Nursing Home Reform Law. The law, which is part of the Social Security Act, says that a nursing home must help each resident "attain or maintain" his or her highest level of well being - physically, mentally, and emotionally. To give good care, staff must ***assess*** and ***plan care*** to support each resident's life-long patterns, current interests, strengths, and needs. Care planning conferences are a valuable forum for residents and families to voice concerns, ask questions, give suggestions, learn nursing home strategies, and give staff information (such as resident background and daily routine). This requirement in the law is vital to making sure residents get good care.

Resident Assessment

Assessments gather information about the health and physical condition of a resident and how well a resident can take care of themselves. This includes assessing when help may be needed in activities of daily living (ADL's) or "functional abilities" such as walking, eating, dressing, bathing, seeing, hearing, communicating, understanding, and remembering. Assessments also should examine residents' habits, activities, and relationships in order to help him or her live more comfortably and feel at home in the facility.

The assessment helps staff to be aware of strengths of the resident and also determine the reason for difficulties a resident is having. An example of where a good assessment helps: A resident begins to have poor balance. This could be the result of medications, sitting too much, weak muscles, poorly fitting shoes, or a urinary or ear infection. Staff must find out the cause of a problem in order to give good treatment. Figuring out the cause is much easier with a good assessment.

Assessments must be done within 14 days of the resident's admission to a nursing home (or 7 days for Medicare residents) and at least once a year after that. Reviews are held every three months and when a resident's condition changes.

Plan of Care

After the assessment is completed, the information is analyzed and a care plan is developed to address all the needs and concerns of the resident. The initial care plan must be completed within seven days after the assessment. The care plan is a strategy for how the staff will help a resident every day. This care plan says what each staff person will do and when it will happen (for example, a nursing assistant will help Mrs. Jones walk to each meal to build her strength). Care plans must be reviewed regularly to make sure they work and must be revised as needed. For care plans to work, residents must feel they meet their needs and must be comfortable with them.

Care Planning Conference

The care plan is developed by an interdisciplinary team -- nurse, nurse aide, activities and dietary staff, and social worker, **with critical input from the resident and/or family members.** All participants discuss the resident's care at a Care Plan Conference to make certain that all medical and non-medical issues, including meals, activities, therapies, personal schedule, medical and nursing care, and emotional needs are agreed upon and addressed. Resident and family member concerns should be listened to by staff and addressed in the care plan. A good Care Plan Conference takes time. It should not be rushed, and could take at least one hour. Every 90 days after development of the initial plan, or whenever there is a big change in a resident's physical or mental health, a Care Plan Conference is held to determine how things are going and if changes need to be made.

Good Care Plans Should

- Be specific to that resident;
- Be followed as an important guideline for providing good care for the resident;
- Be written so that everyone can understand it and know what to do;
- Reflect the resident's concerns and support his or her well-being;
- Use a team approach involving a wide variety of staff and outside referrals as needed;
- Assign tasks to specific staff members;
- Be re-evaluated and revised routinely.

Steps for Residents and Family Participation in Care Planning

Residents and family members have the right to be involved in the care plan conference in order to make choices about care, services, daily schedule, and life in the nursing home. Even if a resident has dementia, involve them in care planning as much as possible. Be aware that they may understand and communicate at some level and help the staff to find ways to communicate and work with them. They can express when they hurt or suffer if they are actively listened to. Participating in care plan conferences is a way to be heard, raise questions, and come to a clear agreement with the facility about how the resident will be cared for.

Before the meeting:

- Ask staff to hold the meeting at a convenient time for you and/or your family member;
- Ask for a copy of the current care plan (if one already exists) so that you can examine each aspect thoughtfully;
- Know about or ask the doctor or staff about your or your loved one's condition, care, and treatment;
- Plan your list of questions, needs, problems, and goals, and;
- Think of examples and reasons to support changes you recommend in the care plan.

During the meeting:

- Make sure the resident is involved and listened to carefully.
- Discuss options for treatment and for meeting your needs and preferences;
- Ask questions if you need terms or procedures explained to you;
- Be sure you understand and agree with the care plan and feel it meets your needs;
- Ask for a copy of the care plan;
- Find out who to talk to if changes in the care plan are needed, and;
- Find out who to talk to if there are problems with the care being provided.

After the meeting:

- Monitor whether the care plan is being followed;
- Inform the resident's doctor about the care plan if s/he was not directly involved;
- Talk with nurse aides, staff or the doctor about the care plan, and;

- Request another meeting if the plan is not being followed.

See NCNHR's "Resolving Problems in Nursing Homes" for additional information.

Care Resolution Tools

Take a deep breath, "walk it off", count to 10…

These are tools we use in our daily lives before addressing emotional everyday challenges. These same tools are extremely important as you become a problem solver for your loved one who is living in a long-term care facility. Your heightened emotions are real and understandable when facility services fail to meet the needs of your loved one. But leave those emotions at the door to be a successful problem solver.

- **Be knowledgeable of the residents' rights and facility policies.**
  In your quest to resolve care issues and improve quality of life for your loved one, it is helpful to familiarize yourself with the Residents' Bill of Rights and the facility's policies and structure.

  The Residents' Bill of Rights provides the standards for good care and quality of life. The rights will assist you to understand fair expectations and what are reasonable requests to resolve issues such as personal privacy and choice, healthcare decision making, and due process related to transfer and discharge regulations.

  Understanding how the system works within the facility will direct you to the appropriate process to address your concern or complaint. With whom will you speak to about your concern? Would you complain to the certified nursing assistant that your loved one is not receiving meals according to the restricted diet that the physician has ordered? How do you file a formal grievance? Who will receive and respond to your grievance?

  The nursing home structure should allow regular meetings of an independent family council.

- **Be a strong advocate by acting thoughtfully to ensure best results**.
  Respect the fact that there are many people involved in providing care for your loved one and many other residents. Prioritize the issues so that you are able to emphasize the more significant problems. A lost article of clothing is minor when medication is not being administered correctly.

- **Consider and include your loved one's opinions in handling the situation.**
  Who has the problem--you or your loved one? Your loved one lives in the facility 24 hours a day. Often they may need to air their feelings and a listening ear may be all that is needed. Encourage participation in the resident council that meets regularly in nursing homes. Resident councils provide opportunities for residents to make recommendations for change. Respect your loved one's wishes but make them aware the problem can be solved.

- **Be prepared to state the problem clearly.**

Just complaining that the food is terrible and the care is awful is not specific enough to determine where the problem lies. Providing facts such as the soup is cold and the chicken is too tough to chew should give staff direction to correct the problem. It may be helpful to keep a memory calendar or journal to record the day and time an incident occurs, who was involved, and the outcome for your loved one.

Filing a formal grievance provides facility administration a working document and an excellent organizational tool. Presenting your complaint in writing establishes a formal process that can be helpful if the problem continues. The facility may have a formatted grievance form or you may prepare your own in the form of a letter. Be prepared to state the facts about who, what, when, where and why. Decide and express what you want the outcome to be. Request a reasonable time frame for facility staff to respond and for change to occur in accordance with the severity of the issue. Keep a copy of the grievance form for future reference.

- **Determine if a meeting is needed.**
  Sometimes it is difficult to communicate a concern on the hallway when direct are busily attending to the needs of many residents. Should you have the need to address failed services that you have been unable to resolve, schedule a meeting with the administrator and request additional facility staff to attend if the individuals are in a position to help solve the problem.

  Attending the regularly scheduled quarterly care plan meetings is important for continued dialogue. If your loved one has experienced a healthcare status change (a major decline or improvement), a care plan meeting should occur in addition to the quarterly care plan. When healthcare needs change and or residents choose to make lifestyle changes, a care plan revision is required.

- **Take a deep breath, "walk it off", count to 10… then communicate your concerns.**
  Anger creates ill will in direct contrast to cooperation. Anger from both parties then becomes the problem and your loved one's care and quality of life can be ignored. Gather your facts, prioritize the issues, state the problem clearly (verbally or in written form) and speak confidently on your loved one's behalf. And remember, putting concerns in writing often allows time for emotions to calm. If you need advice or assistance, contact a long-term care resource professional.

- **Seek help from a long-term care resource professional.**
  Often families need advice and direct support to resolve issues. The Ombudsman Program offers state and local consumer advocacy at no charge. The ombudsman is responsible for providing information, investigation and complaint resolution. You may contact the regional ombudsman by calling the regional Council of Governments' office in your area or obtain their contact information from the North Carolina Division of Aging, Office of the State Ombudsman at 919 733-8395. You can also obtain this information from the Division of Aging and Adult Services website at www.ncdhhs.gov/aging or by calling the North Carolina Care-Line at 1 800 662-7030 or 1 877 452-2514 (TTY Dedicated).

Private eldercare consultants assist families with personal decisions regarding long-term care planning, in-home care resources, choosing a facility to meet your loved one's needs, and care coordination. Some consultants also advise and assist families to resolve complaints. You may obtain contact information through the state or local ombudsman offices, Council on Aging county offices and private advertisements in senior publications.

If you feel you have exhausted your facility resources in an effort to resolve your loved one's concerns, you may also contact the regulatory agency responsible for investigating compliance of the laws. The North Carolina Division of Facility Services, Complaints Division can be reached at 919 733-8499 or 1 800 624-3004.

Remember to Avoid the Following:

- **Upsetting your loved one with your frustration.**
  Just getting older comes with psychological and, of course, healthcare changes. Knowing that you are upset can add to their worries.

- **Storing up problems causing an avalanche of emotions.**
  Allowing problems to accumulate can interfere with objectivity. Communicate the facts as you know them.

- **Putting staff on the defensive.**
  Confronting staff with a problem while angry may cause them to react defensively. Staff may become afraid to provide care due to fear of making mistakes. Questions and comments made in anger create a negative atmosphere of mistrust. Staff may begin to second guess themselves resulting in making more errors in judgment.

- **Blaming.**

Should a staff member make a mistake, obtain the facts and report them to the appropriate supervisor or administrator. If you feel your loved one is in an unsafe environment due to the actions of a staff member, request that the staff member be removed from your loved one's care.

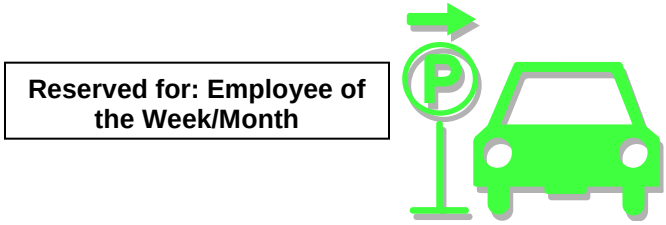
See NCNHR's "Resolving Problems in Nursing Homes" for additional information.

Ideas for Fostering Good Relationships with Long Term Care Facility Staff by showing Appreciation for what they do

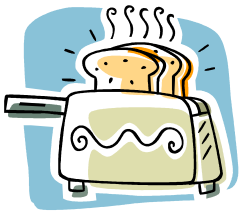
1) Administrator and Staff Appreciation Activities

2) Shadow an Employee-(*A Day in the Life of a LTC Staff Member*)

3) Special Privileges for Staff Members



4) Meals on the Go- The committee can hire a caterer or personally deliver Breakfast, Lunch or Dinner to all the shifts of employees.



5) Gift Certificates for Staff Members

6) Outstanding Service Award- *"The Sky's the Limit Award"*

Service Award

This certificate is presented to

_____

In recognition of the dedication, concern and hard work exhibited in
enhancing the quality of life for the residents of

_____

_____
Presented on

_____
Family Council President/Chairperson

APPENDIX D

ADMINISTRATIVE CODES

AND

STATUTES

Federal and State Laws Regulating Nursing Homes

Nursing homes who receive federal funds are required to comply with federal laws that specify that residents receive a high quality of care. In response to reports of widespread neglect and abuse in nursing homes in the 1980s, the Congress, in 1987, enacted legislation to reform nursing home regulations and require nursing homes participating in the Medicare and Medicaid programs to comply with certain requirements for quality of care. The legislation, included in the Omnibus Budget Reconciliation Act of 1987 (OBRA 1987), also known as the Nursing Home Reform Act, specifies that a nursing home **"must provide services and activities to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident in accordance with a written plan of care..."**

Care Requirements

To participate in the Medicare and Medicaid programs, nursing homes must be in compliance with the federal requirements for long term care as prescribed in the U.S. Code of Federal Regulations (42 CFR Part 483). Under the regulations, the nursing home must:

Have sufficient nursing staff to provide nursing and related services to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care (42 CFR § 483.30).

The facility must conduct initially and periodically a comprehensive, accurate, standardized, reproducible assessment of each resident's functional capacity. (42 CFR § 483.20).

Develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The care plan must be developed within 7 days after completion of the comprehensive assessment and describe the services that are to be furnished. Also, the care plan must be periodically reviewed and revised by a team of qualified persons after each assessment (42 CFR § 483.20).

Provide appropriate treatment and services to incontinent residents to restore as much normal bladder functioning as possible and prevent urinary tract infections and to restore as much normal bladder function as possible (42 CFR § 483.25).

Ensure that the resident receives adequate supervision and assistive devices to prevent accidents (42 CFR § 483.25).

Ensure that a resident maintains acceptable parameters of nutritional status, such as

body weight and protein levels (42 CFR § 483.25).

Provide each resident with sufficient fluid intake to maintain proper hydration and health (42 CFR § 483.25).

Ensure that residents are free of any significant medication errors (42 CFR § 483.25).

Care for its residents in a manner and in an environment that promotes maintenance or enhancement of each resident's quality of life (42 CFR § 483.15).

Promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality (42 CFR § 483.15).

Ensure that the resident has the right to choose activities, schedules, and health care consistent with his or her interests, assessments and plan of care (42 CFR § 483.15).

Ensure that the medical care of each resident is supervised by a physician and must provide or arrange for the provision of physician services 24 hours a day, in case of an emergency (42 CFR § 483.40).

Provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident (42 CFR § 483.60).

Be administered in a manner that enables it to use its resources effectively and efficiently to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident (42 CFR § 483.75).

Maintain clinical records on each resident in accordance with accepted professional standards and practices that are complete, accurately documented, readily accessible, and systematically organized (42 CFR § 483.75).

In addition to federal laws regulating the quality of care in nursing homes, states have enacted laws as well. The state laws must be at least as stringent at the federal laws. Some states have adopted laws that are tougher than the federal laws.

In short, a nursing home must conduct an initial comprehensive assessment of each resident and periodic reassessment quarterly or as needed if there is a significant change in the condition of the resident. From the assessment, a

plan of care must be developed that specifies the necessary care that must be provided. The facility must have sufficient nursing personnel to provide all the necessary care to each resident in accordance with the assessment and plan of care. The nursing home is required to document the assessments, plans of care, and the care provided, in the resident's clinical record. With both federal and state laws regulating nursing homes, almost every aspect of a nursing home's operation and resident care are covered under the regulations. Thus, when a nursing home willfully does not provide required care that results in the deterioration and/or death of the resident, the nursing home may have violated federal and state laws. If the resident's care was being reimbursed by Medicare or Medicaid, then the nursing home may have submitted false claims to the government.

State Laws Regulating Adult Care Homes

Adult Care Homes must comply with state requirements regarding the maintenance and operation of the facility and must provide services and activities that assist residents in maintaining the highest level of physical and emotional health.

Care Requirements

As outlined in NC administrative code 10A NCAC 13F and 13G adult care homes must:

Comply with prescribed staffing ratios for management and personal care staff. In addition, adult care homes must employ sufficient additional personnel to perform housekeeping and food service duties. (13F .0604)

Conduct an assessment of each resident using the Resident Register within 72 hours of admission. An additional assessment of the resident is to be conducted within 30 days of admission and annually thereafter to determine the resident's level of functioning including cognitive status and ability to perform activities of daily living. (13F .0801)

Establish a care plan in conjunction with the resident assessment within 30 days of the date of admission. The care plan is a written individualized program of personal care for each resident and should be updated as needed but at least on an annual basis. (13F .0802)

Provide personal care and supervision to residents according to residents' care plans, assessed needs and current symptoms. (13F .0901)

Assure referral and follow up to meet the routine and acute health care needs of residents. (13F .0902)

Serve residents three well balanced meals a day in addition to snacks between each meal. The facility must maintain an accurate and current listing of residents with physician-ordered therapeutic diets for guidance of food service staff. (13F .0904)

Develop a program of activities designed to promote the residents' active involvement with each other, their families, and the community. (13F .0905)

Assure that the rights guaranteed to each resident under General Statute 131D-21 are maintained and are exercised without hindrance. (13F .0909)

Assure that the preparation and administration of medications and treatments to residents are in accordance with orders by a licensed prescribing practitioner. (13F .1004)

Permit residents who are competent and physically able to self-administer medications as long as the self-administration is ordered by a licensed physician and specific orders for administration are printed on medication labels. (1005)

Assure a readily retrievable record of controlled substances by documenting the receipt, administration and disposition of controlled substances. (13F. 1008)

Obtain the services of a licensed pharmacist or prescribing practitioner for pharmaceutical care at least quarterly. (13F .1009)

NURSING HOME ADMISSION, TRANSFER AND DISCHARGE RIGHTS

Electronic Code of Federal Regulations

Current as of July 31, 2013

TITLE 42--Public Health

CHAPTER IV--CENTERS FOR MEDICARE & MEDICAID SERVICES, DEPARTMENT OF HEALTH AND HUMAN SERVICES

SUBCHAPTER G--STANDARDS AND CERTIFICATION

PART 483--REQUIREMENTS FOR STATES AND LONG TERM CARE FACILITIES

Subpart B – Requirements in Long Term Care Facilities

§ 483.12 Admission, transfer and discharge rights.

(a) Transfer and discharge—

(1) *Definition:* Transfer and discharge includes movement of a resident to a bed outside of the certified facility whether that bed is in the same physical plant or not. Transfer and discharge does not refer to movement of a resident to a bed within the same certified facility.

(2) *Transfer and discharge requirements.* The facility must permit each resident to remain in the facility, and not transfer or discharge the resident from the facility unless—

(i) The transfer or discharge is necessary for the resident's welfare and the resident's needs cannot be met in the facility;

(ii) The transfer or discharge is appropriate because the resident's health has improved sufficiently so the resident no longer needs the services provided by the facility;

(iii) The safety of individuals in the facility is endangered;

(iv) The health of individuals in the facility would otherwise be endangered;

(v) The resident has failed, after reasonable and appropriate notice, to pay for (or to have paid under Medicare or Medicaid) a stay at the facility. For a resident who becomes eligible for Medicaid after admission to a facility, the

facility may charge a resident only allowable charges under Medicaid; or

(vi) The facility ceases to operate.

(3) *Documentation.* When the facility transfers or discharges a resident under any of the circumstances specified in paragraphs (a)(2)(i) through (v) of this section, the resident's clinical record must be documented. The documentation must be made by—

(i) The resident's physician when transfer or discharge is necessary under paragraph (a)(2)(i) or paragraph (a)(2)(ii) of this section; and

(ii) A physician when transfer or discharge is necessary under paragraph (a)(2)(iv) of this section.

(4) *Notice before transfer.* Before a facility transfers or discharges a resident, the facility must—

(i) Notify the resident and, if known, a family member or legal representative of the resident of the transfer or discharge and the reasons for the move in writing and in a language and manner they understand.

(ii) Record the reasons in the resident's clinical record; and

(iii) Include in the notice the items described in paragraph (a)(6) of this section.

(5) *Timing of the notice.* (i) Except as specified in paragraphs (a)(5)(ii) and (a)(8) of this section, the notice of transfer or discharge required under paragraph (a)(4) of this section must be made by the facility at least 30 days before the resident is transferred or discharged.

(ii) Notice may be made as soon as practicable before transfer or discharge when—

(A) the safety of individuals in the facility would be endangered under paragraph (a)(2)(iii) of this section;

(B) The health of individuals in the facility would be endangered, under paragraph (a)(2)(iv) of this section;

(C) The resident's health improves sufficiently to allow a more immediate transfer or discharge, under paragraph (a)(2)(ii) of this section;

(D) An immediate transfer or discharge is required by the resident's urgent medical needs, under paragraph (a)(2)(i) of this section; or

(E) A resident has not resided in the facility for 30 days.

(6) *Contents of the notice.* The written notice specified in paragraph (a)(4)

of this section must include the following:

(i) The reason for transfer or discharge;

(ii) The effective date of transfer or discharge;

(iii) The location to which the resident is transferred or discharged;

(iv) A statement that the resident has the right to appeal the action to the State;

(v) The name, address and telephone number of the State long term care ombudsman;

(vi) For nursing facility residents with developmental disabilities, the mailing address and telephone number of the agency responsible for the protection and advocacy of developmentally disabled individuals established under Part C of the Developmental Disabilities Assistance and Bill of Rights Act; and

(vii) For nursing facility residents who are mentally ill, the mailing address and telephone number of the agency responsible for the protection and advocacy of mentally ill individuals established under the Protection and Advocacy for Mentally Ill Individuals Act.

(7) *Orientation for transfer or discharge.* A facility must provide sufficient preparation and orientation to residents to ensure safe and orderly transfer or discharge from the facility.

(8) *Notice in advance of facility closure.* In the case of facility closure, the individual who is the administrator of the facility must provide written notification prior to the impending closure to the State Survey Agency, the State LTC ombudsman, residents of the facility, and the legal representatives of the residents or other responsible parties, as well as the plan for the transfer and adequate relocation of the residents, as required at § 483.75(r).

(9) *Room changes in a composite distinct part.* Room changes in a facility that is a composite distinct part (as defined in § 483.5(c)) must be limited to moves within the particular building in which the resident resides, unless the resident voluntarily agrees to move to another of the composite distinct part's locations.

(b) *Notice of bed-hold policy and readmission* —(1) *Notice before transfer.* Before a nursing facility transfers a resident to a hospital or allows a resident to go on therapeutic leave, the nursing facility must provide written information to the resident and a family member or legal representative that specifies—

(i) The duration of the bed-hold policy under the State plan, if any,

during which the resident is permitted to return and resume residence in the nursing facility; and

(ii) The nursing facility's policies regarding bed-hold periods, which must be consistent with paragraph (b)(3) of this section, permitting a resident to return.

(2) *Bed-hold notice upon transfer.* At the time of transfer of a resident for hospitalization or therapeutic leave, a nursing facility must provide to the resident and a family member or legal representative written notice which specifies the duration of the bed-hold policy described in paragraph (b)(1) of this section.

(3) *Permitting resident to return to facility.* A nursing facility must establish and follow a written policy under which a resident, whose hospitalization or therapeutic leave exceeds the bed-hold period under the State plan, is readmitted to the facility immediately upon the first availability of a bed in a semi-private room if the resident—

(i) Requires the services provided by the facility; and

(ii) Is eligible for Medicaid nursing facility services.

(4) *Readmission to a composite distinct part.* When the nursing facility to which a resident is readmitted is a composite distinct part (as defined in § 483.5(c) of this subpart), the resident must be permitted to return to an available bed in the particular location of the composite distinct part in which he or she resided previously. If a bed is not available in that location at the time of readmission, the resident must be given the option to return to that location upon the first availability of a bed there.

(c) *Equal access to quality care.* (1) A facility must establish and maintain identical policies and practices regarding transfer, discharge, and the provision of services under the State plan for all individuals regardless of source of payment;

(2) The facility may charge any amount for services furnished to non-Medicaid residents consistent with the notice requirement in § 483.10(b)(5)(i) and (b)(6) describing the charges; and

(3) The State is not required to offer additional services on behalf of a resident other than services provided in the State plan.

(d) *Admissions policy.* (1) The facility must—

(i) Not require residents or potential residents to waive their rights to Medicare or Medicaid; and

(ii) Not require oral or written assurance that residents or potential

residents are not eligible for, or will not apply for, Medicare or Medicaid benefits.

(2) The facility must not require a third party guarantee of payment to the facility as a condition of admission or expedited admission, or continued stay in the facility. However, the facility may require an individual who has legal access to a resident's income or resources available to pay for facility care to sign a contract, without incurring personal financial liability, to provide facility payment from the resident's income or resources.

(3) In the case of a person eligible for Medicaid, a nursing facility must not charge, solicit, accept, or receive, in addition to any amount otherwise required to be paid under the State plan, any gift, money, donation, or other consideration as a precondition of admission, expedited admission or continued stay in the facility. However,—

(i) A nursing facility may charge a resident who is eligible for Medicaid for items and services the resident has requested and received, and that are not specified in the State plan as included in the term “nursing facility services” so long as the facility gives proper notice of the availability and cost of these services to residents and does not condition the resident's admission or continued stay on the request for and receipt of such additional services; and

(ii) A nursing facility may solicit, accept, or receive a charitable, religious, or philanthropic contribution from an organization or from a person unrelated to a Medicaid eligible resident or potential resident, but only to the extent that the contribution is not a condition of admission, expedited admission, or continued stay in the facility for a Medicaid eligible resident.

(4) States or political subdivisions may apply stricter admissions standards under State or local laws than are specified in this section, to prohibit discrimination against individuals entitled to Medicaid.

[56 FR 48869, Sept. 26, 1991, as amended at 57 FR 43924, Sept. 23, 1992; 68 FR 46072, Aug. 4, 2003; 76 FR 9511, Feb. 18, 2011; 78 FR 16805, Mar. 19, 2013]

ADULT CARE HOME ADMISSION AND DISCHARGE RULES

10A NCAC 13F .0701 ADMISSION OF RESIDENTS

(a) Any adult (18 years of age or over) who, because of a temporary or chronic physical condition or mental disability, needs a substitute home may be admitted to an adult care home when, in the opinion of the resident, physician, family or social worker, and the administrator the services and accommodations of the home will meet his particular needs.

(b) People shall not be admitted:

(1) for treatment of mental illness, or alcohol or drug abuse;

(2) for maternity care;

(3) for professional nursing care under continuous medical supervision;

(4) for lodging, when the personal assistance and supervision offered for the aged and disabled are not needed; or

(5) who pose a direct threat to the health or safety of others.

History Note: *Authority G.S. 131D-2; 143B-165; S.L. 2002-0160;*
Eff. January 1, 1977;
Readopted Eff. October 31, 1977;
Temporary Amendment Eff. July 1, 2003;
Amended Eff. June 1, 2004.

10A NCAC 13F .0702 DISCHARGE OF RESIDENTS

(a) The discharge of a resident initiated by the facility shall be according to conditions and procedures specified in Paragraphs (a) through (g) of this Rule. The discharge of a resident initiated by the facility involves the termination of residency by the facility resulting in the resident's move to another location and the facility not holding the bed for the resident based on the facility's bed hold policy.

(b) The discharge of a resident shall be based on one of the following reasons:

(1) the discharge is necessary for the resident's welfare and the resident's needs cannot be met in the facility as documented by the resident's physician, physician assistant or nurse practitioner;

(2) the resident's health has improved sufficiently so the resident no longer needs the services provided by the facility as documented by the resident's physician, physician assistant or nurse practitioner;

(3) the safety of other individuals in the facility is endangered;

(4) the health of other individuals in the facility is endangered as documented by a physician, physician assistant or nurse practitioner;

(5) failure to pay the costs of services and accommodations by

the payment due date according to the resident contract after receiving written notice of warning of discharge for failure to pay; or

(6) the discharge is mandated under G.S. 131D-2(a1).

(c) The notices of discharge and appeal rights as required in Paragraph (e) of this Rule shall be made by the facility at least 30 days before the resident is discharged except that notices may be made as soon as practicable when:

(1) the resident's health or safety is endangered and the resident's urgent medical needs cannot be met in the facility under Subparagraph (b)(1) of this Rule; or

(2) reasons under Subparagraphs (b)(2), (b)(3), and (b)(4) of this Rule exist.

(d) The reason for discharge shall be documented in the resident's record. Documentation shall include one or more of the following as applicable to the reasons under Paragraph (b) of this Rule:

(1) documentation by physician, physician assistant or nurse practitioner as required in Paragraph (b) of this Rule;

(2) the condition or circumstance that endangers the health or safety of the resident being discharged or endangers the health or safety of individuals in the facility, and the facility's action taken to address the problem prior to pursuing discharge of the resident;

(3) written notices of warning of discharge for failure to pay the costs of services and accommodations; or

(4) the specific health need or condition of the resident that the facility determined could not be met in the facility pursuant to G.S. 131D-2(a1)(4) and as disclosed in the resident contract signed upon the resident's admission to the facility.

(e) The facility shall assure the following requirements for written notice are met before discharging a resident:

(1) The Adult Care Home Notice of Discharge with the Adult Care Home Hearing Request Form shall be hand delivered, with receipt requested, to the resident on the same day the Adult Care Home Notice of Discharge is dated. These forms may be obtained at no cost from the Division of Medical Assistance, 2505 Mail Service Center, Raleigh, NC 27699-2505.

(2) A copy of the Adult Care Home Notice of Discharge with a copy of the Adult Care Home Hearing Request Form shall be hand delivered, with receipt requested, or sent by certified mail to the resident's responsible person or legal representative on the same day the Adult Care Home Notice of Discharge is dated.

(3) Failure to use and simultaneously provide the specific forms according to Subparagraphs (e)(1) and (e)(2) of this Rule shall invalidate the discharge. Failure to use the latest version of these forms shall not invalidate the discharge unless the facility has been previously notified of a change in the forms and been

provided a copy of the latest forms by the Department of Health and Human Services.

(4) A copy of the completed Adult Care Home Notice of Discharge, the Adult Care Home Hearing Request Form as completed by the facility prior to giving to the resident and a copy of the receipt of hand delivery or the notification of certified mail delivery shall be maintained in the resident's record.

(f) The facility shall provide sufficient preparation and orientation to residents to ensure a safe and orderly discharge from the facility as evidenced by:

(1) notifying staff in the county department of social services responsible for placement services;

(2) explaining to the resident and responsible person or legal representative why the discharge is necessary;

(3) informing the resident and responsible person or legal representative about an appropriate discharge destination; and

(4) offering the following material to the caregiver with whom the resident is to be placed and providing this material as requested prior to or upon discharge of the resident:

(A) a copy of the resident's most current FL-2;

(B) a copy of the resident's most current assessment and care plan;

(C) a copy of the resident's current physician orders;

(D) a list of the resident's current medications;

(E) the resident's current medications;

(F) a record of the resident's vaccinations and TB screening;

(5) providing written notice of the name, address and telephone number of the following, if not provided on the discharge notice required in Paragraph (e) of this Rule:

(A) the regional long term care ombudsman; and

(B) the protection and advocacy agency established under federal law for persons with disabilities.

(g) If an appeal hearing is requested:

(1) the facility shall provide to the resident or legal representative or the resident and the responsible person, and the Hearing Unit copies of all documents and records that the facility intends to use at the hearing at least five working days prior to the scheduled hearing; and

(2) the facility shall not discharge the resident before the final decision resulting from the appeal has been rendered, except in those cases of discharge specified in Paragraph (c) of this Rule.

(h) If a discharge is initiated by the resident or responsible person, the administrator may require up to a 14-day written notice from the resident or responsible person which means the resident or responsible person may be charged for the days of the required notice if notice is not given or if notice is

given and the resident leaves before the end of the required notice period.. Exceptions to the required notice are cases in which a delay in discharge or transfer would jeopardize the health or safety of the resident or others in the facility. The facility's requirement for a notice from the resident or responsible person shall be established in the resident contract or the house rules provided to the resident or responsible person upon admission.

(i) The discharge requirements in this Rule do not apply when a resident is transferred to an acute inpatient facility for mental or physical health evaluation or treatment and the adult care facility's bed hold policy applies based on the expected return of the resident. If the facility decides to discharge a resident who has been transferred to an acute inpatient facility and there has been no physician-documented level of care change for the resident, the discharge requirements in this Rule apply.

History Note: Authority G.S. 131D-2; 131D-4.5; 131D-21; 143B-165; S.L. 2002-0160;
Eff. January 1, 1977;
Readopted Eff. October 31, 1977;
Temporary Amendment Eff. July 1, 2003;
Amended Eff. July 1, 2004.

NORTH CAROLINA ADULT CARE HOME RESIDENTS BILL OF RIGHTS

(Condensed Version)

EVERY RESIDENT SHALL HAVE THE FOLLOWING RIGHTS:
1) To be treated with respect, consideration, dignity, and full recognition of his or her individuality and right to privacy.
(2) To receive care and services which are adequate, appropriate, and in compliance with relevant federal and State laws and rules and regulations.
(3) To receive upon admission and during his or her stay a written statement of the services provided by the facility and the charges for these services.
(4) To be free of mental and physical abuse, neglect, and exploitation.
(5) Except in emergencies, to be free from chemical and physical restraint unless authorized for a specified period of time by a physician according to clear and indicated medical need.
(6) To have his/her personal and medical records kept confidential and not disclosed without the written consent of the individual or guardian, which consent shall specify to whom disclosure may be made, except as required by applicable state or federal statue, regulations, or third party contracts. In the case of an emergency, disclosure can be made to agencies, institutions or individuals who are providing the emergency medical services.
(7) To receive a reasonable response to his or her requests from the facility administrator and staff.
(8) To associate and communicate privately and without restriction with people and groups of his or her own choice on his or her own or their initiative at any reasonable hour.
(9) To have access at any reasonable hour to a telephone where he or she may speak privately.
(10) To send and receive mail promptly and unopened, unless the resident requests that someone open and read mail, and to have access at his or her expense to writing instruments, stationary, and postage.
(11) To be encouraged to exercise his or her rights as a resident and citizen, and to be permitted to make complaints and suggestions without fear of coercion or retaliation.
(12) To have and use his or her own possessions where reasonable and have an accessible, lockable space provided for security of personal valuables. This space shall be accessible only to the residents, administrator and supervisor-in-charge.
(13) To manage his or her personal needs funds unless such authority has been delegated to another. If authority to manage personal needs funds has been delegated to the facility, the resident has the right to examine the account at any time.
(14) To be notified when the facility is issued a provisional license or notice of revocation of license by the Carolina Department of Human Resources and the basis on which the provisional license or notice of revocation of license was issued. The resident's responsible family member or guardian shall also be notified.
(15) To have freedom to participate by choice in accessible community activities and in social, political, medical, and religious resources and to have freedom to refuse

such participation.
(16) To receive upon admission to the facility a copy of this section.
(17) To not be transferred or discharged from a facility except for medical reasons, the resident's own or other residents' welfare, nonpayment for the stay, or when the transfer is mandated under State or federal law. The resident shall be given at least 30 days advance notice to ensure orderly transfer or discharge, except in the case of jeopardy to the health or safety of the resident or others in the home. The resident has the right to appeal a facility's attempt to transfer or discharge the resident. The resident shall be allowed to remain in the facility until resolution of the appeal.

NORTH CAROLINA NURSING HOME RESIDENTS BILL OF RIGHTS

(Condensed Version)

EVERY RESIDENT SHALL HAVE THE FOLLOWING RIGHTS:
(1). To be treated with consideration, respect, and full recognition of personal dignity and individuality.
(2). To receive care, treatment, and services that are adequate and appropriate, and in compliance with relevant federal and State statutes and rules.
(3). To receive at the time of admission and during stay, a written statement of services provided by the facility, including those required to be offered on an as needed basis, and of related charges. Charges for services not covered under Medicare and Medicaid shall be specified. The patient will sign a written receipt upon receiving the above information.
(4). To have on file physician’s orders with proposed schedule of medical treatment. Written, signed evidence of prior informed consent to participation in experimental research shall be in patient’s file.
(5). To receive respect and privacy in his medical care program. All personal and medical records are confidential.
(6). To be free of mental and physical abuse. Except in emergencies, to be free of chemical and physical restraint unless authorized for a specified period of time by a physician according to clear and indicated medical need.
(7). To receive from the administration or staff of the facility a reasonable response to all requests.
(8). To associate and communicate privately and without restriction with persons and groups of the patients choice at any reasonable hour. To send and receive mail promptly and unopened. To have access to a telephone where the patient may speak privately. To have access to writing instruments, stationary and postage.
(9). To manage his/her own financial affairs unless other legal arrangements have been implemented. The facility may also assist the patient, but is required to follow stringent guidelines.
(10). To have privacy in visits by the patient’s spouse, and if both are patients in the same facility, they shall be given the opportunity, where feasible, to share a room.
(11). To enjoy privacy in his/her room.

(12). To present grievances and recommend changes in policies and services personally, through other persons or in combination with others, without fear of reprisal, restraint, interference, coercion, or discrimination.
(13). To not be required to perform services for the facility without personal consent and the written approval of the attending physician.
(14). To retain, to secure storage for, and to use his personal clothing and possessions, where reasonable.
(15). To not be transferred or discharged from a facility except for medical, financial, or their own or other patient's welfare, nonpayment for the stay or when mandated by Medicare or Medicaid. Any such transfer shall require at least five days' notice, unless the attending physician orders immediate transfer, which shall be documented in the patient's medical record.
(16). To be notified within ten days after the facility's license is revoked or made provisional. The responsible party or guardian must be notified as well.

APPENDIX E

RESOURCES

AGING AND LTC ADVOCACY RELATED WEBSITES

http://www.forltc.org
(Friends of Residents in Long Term Care)

http://www.medicare.gov
(Medicare's Nursing Home Compare Website for information on specific facilities)

http://www.aoa.gov/
(United State Administration on Aging)

http://www.law.wfu.edu/
(Wake Forest University-School of Law) Elder Law Clinic

http://www.aarp.org/
(American Association of Retired Persons)

http://www.ces.ncsu.edu/
(North Carolina Cooperative Extension)
Enter the following search terms: ***Long* Term *Care*; *Estate Planning* or *Elder Law***

http://www.canhr.org
(California Advocates for Nursing Home Reform)

http://www.txanhr.org
(Texas Advocates for Nursing Home Residents)

http://www.cbcmi.org/
(Citizens for Better Care)

http://ncdhhs.gov/dhsr
(Division of Health Services Regulation) NC Regulatory Authority for Nursing Homes

North Carolina Division of Aging and Adult Services
2101 Mail Service Center
Raleigh, NC 27699-2001
(919) 733-8395 Phone
(919) 715-0868 Fax#
www.ncdhhs.gov/aging

Long Term Care Ombudsman Program

North Carolina's Long Term Care Ombudsman Program consists of state and regional ombudsmen who help residents of long term care facilities to exercise their rights. In addition to being an advocate for residents, they educate the public and facility staff about rights and help resolve grievances between residents/families and facilities. The regional ombudsmen, who are located within Area Agencies on Aging, also help support the efforts of Adult Care Home and Nursing Home Community Advisory Committees (N.C.G.S. 131E-128 and 131D-3). These local committees, which are composed of volunteers appointed by county commissioners, routinely visit facilities, serve as advocates for residents, help ensure that the intent of the resident's bill of rights is maintained, and work to increase community involvement in long term care facilities. There are over 1,300 such volunteers statewide, with committees in each county. The State Ombudsman is Sharon Wilder. The services provided by the Ombudsman Program include:

1. Answering questions and giving guidance about the long term care system. An ombudsman will:
    - explain long term care options
    - give pointers on how to select a long term care facility provide information on specific facilities (such as the latest and past certification reports and complaint information)
    - explain residents' rights and other federal and state laws and regulations affecting long term care facilities and residents
    - give guidance on the Medicaid and Medicare programs--specifically qualification criteria, application procedures and what services these programs cover

- give guidance on such matters such as powers of attorney, living wills and guardianship.

2. Educating community groups and long term care providers on various topics such as residents' rights, restraint use, care planning, activities and new laws.

3. Investigating and assessing matters to help families, residents and families resolve concerns and problems. Common areas of complaints include:

    - medical and personal services being provided to residents such as problems with medication, nutrition and hygiene
    - financial concerns such as handling of residents' funds, Medicare, Medicaid, and Social Security
    - rights of residents, such as the right to be treated with courtesy and to have individual requests and preferences respected
    - nursing home administrative decisions, such as admission to or discharge from a facility.

4. Working with appropriate regulatory agencies and referring individuals to such agencies when resolutions to the issues of concern are not possible through the Ombudsman Program alone.

5. Raising long term care issues of concern to policymakers.

Webster's Dictionary defines the Swedish word *Ombudsman* as a "public official appointed to investigate citizens complaints against local or national government agencies that may be infringing on the rights of the individual."

NATIONAL RESOURCES

Centers for Medicare & Medicaid Services
7500 Security Boulevard, Baltimore MD 21244-1850
1-877-267-2323
1-866-226-1819- TTY
http://www.medicare.gov **-** ***Nursing Home Compare website***

Administration on Aging *(AoA)*
Washington, DC 20201
Phone: 202 619-0724
Fax: (202) 357-3555
Office of the Assistant Secretary for Aging: (202) 401-4634
Public Inquiries: (202) 619-0724
Eldercare Locator -(A toll free number created to help find services for older adults in their local community).
(800) 677-1116
http://eldercare.gov/Eldercare.NET/Public/Index.aspx

Region IV: AL, FL, GA, KY, MS, NC, SC, TN
Costas Miskis
Regional Administrator
Atlanta Federal Center
61 Forsyth Street, SW - Suite 5M69
Atlanta, GA 30303-8909
Phone: 404-562-7600
Fax: 404-562-7598
http://www.aoa.gov/about/Organization/regional.aspx

North Carolina Area Agencies on Aging

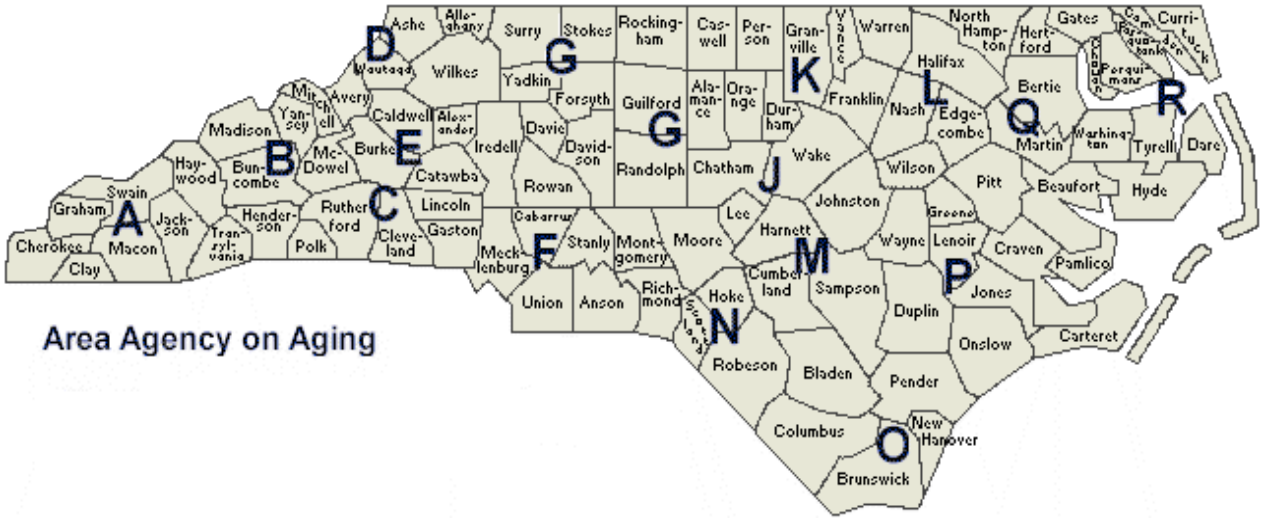
Region	Agency Name	Counties	Address	Phone	Fax	Website
A	**Southwestern Commission Area Agency on Aging**	Cherokee, Clay, Graham, Haywood, Jackson, Macon, Swain (EBCI)	125 Bonnie Ln Sylva NC 28779	(828) 586-1962	828) 586-1968	www.regiona.org
B	**Land-of-Sky Regional Council**	Buncombe, Henderson, Madison, Transylvania	339 New Leicester Highway Suite 140 Asheville, NC 28806	(828) 251-6622	(828) 251-6353	www.landofsky.org
C	**Isothermal Planning & Development Commission**	Cleveland, McDowell, Polk, Rutherford	P.O. Box 841 Rutherfordton, NC 28139	(828) 287-2281	(828) 287-2735	www.regionc.org
D	**High Country Council of Governments**	Alleghany, Ashe, Avery, Mitchell, Watauga, Wilkes, Yancey	468 New Market Boulevard Boone, NC 28607	(828) 265-5434	(828) 265-5439	www.regiond.org
E	**Western Piedmont Council of Governments**	Alexander, Burke, Caldwell, Catawba	P.O. Box 9026 Hickory, NC 28603	(828) 322-9191	(828) 322-5991	www.wpcog.org
F	**Centralina Council of Governments**	Anson, Cabarrus, Gaston, Iredell, Lincoln, Mecklenburg, Rowan, Stanly,	525 North Tryon Street 12th Floor Charlotte, NC 28202	(704) 372-2416	(704) 347-4710	www.centralinaaging.org

		Union				
G	**Piedmont Triad Regional Council**	Alamance, Caswell, Davidson, Davie, Forsyth,Guilford, Montgomery, Randolph, Rockingham, Stokes, Surry, Yadkin	**Greensboro Office** 2216 W. Meadowview Road, Suite 201 Greensboro, North Carolina 27407 **Winston-Salem Office** 400 W Fourth Street, Suite 400 Winston Salem, NC 27101	(336) 294-4950 (336) 761-2111	(336) 632-0457 (336) 761-2112	www.ptrc.org
J	**Triangle J Council of Governments**	Chatham, Durham, Johnston, Lee, Moore, Orange, Wake	P.O. Box 12276 Research Triangle Park, NC 27709	(919) 558-2711	(919) 549-9390	www.tjaaa.org
K	**Kerr Tar Regional COG**	Franklin, Granville, Person, Vance, Warren	1724 Graham Avenue P.O. Box 709 Henderson, NC 27536	(252) 436-2040	(252) 436-2055	www.kerrtarcog.org/aging
L	**Upper Coastal Plain Council of Governments**	Edgecombe, Halifax, Nash, Northampton, Wilson	121 W. Nash Street PO Box 9 Wilson, NC 27894	(252) 234-5952	252) 234-5971	www.ucpcog.org

M	**Mid-Carolina Council of Governments**	Cumberland, Harnett, Sampson	P.O. Drawer 1510 Fayetteville, NC 28302	(910) 323-4191	(910) 323-9330	www.mccog.org
N	**Lumber River Council of Governments**	Bladen, Hoke, Richmond, Robeson, Scotland	30 CJ Walker Road COMtech Park Pembroke, NC 28372	(910) 618-5533	(910) 521-7556	www.lumberrivercog.org
O	**Cape Fear Council of Governments**	Brunswick, Columbus, New Hanover, Pender	1480 Harbour Drive Wilmington, NC 28401	(910) 395-4553	(910) 395-2684	www.capefearcog.org
P	**Eastern Carolina Council of Governments**	Carteret, Craven,Duplin, Greene, Jones, Lenoir, Onslow, Pamlico, Wayne	233 Middle Street P.O. Box 1717 New Bern, NC 28563	(252) 638-3185 1-800-824-4648	(252) 638-3187	www.eccog.org
Q	**Mid-East Commission**	Beaufort, Bertie, Hertford, Martin, Pitt	1385 John Small Avenue Washington, NC 27889	(252) 946-8043	(252) 948-1852	www.mecaaa.org
R	**Albemarle Commission**	Camden, Chowan, Currituck, Dare, Gates, Hyde, Pasquotank, Perquimans, Tyrrell, Washington	512 South Church PO Box 646 Hertford, NC 27944	(252) 426-5753	(252) 426-8482	www.albemarlecommission.org

North Carolina Division of Aging and Adult Services

Area Agencies on Aging (AAA)



Region A, *Southwestern Planning Commission*
Region B, *Land-Of Sky Regional Council*
Region C, *Isothermal Commission*
Region D, *High Country Council of Governments*
Region E, *Western Piedmont Council of Governments*
Region F, *Centralina Council of Governments*
Region G, *Piedmont Triad Council of Governments*
Region J, *Triangle J Council of Governments*
Region K, *Region K Council of Governments*
Region L, *Upper Coastal Plains COG*
Region M, *Mid-Carolina Council of Governments*
Region N, *Lumber River Council of Governments*
Region O, *Cape Fear Council of Governments*
Region P, *Eastern Carolina Council*
Region Q, *Mid East Commission*
Region R, *Albermarle Commission*

SERVICES FOR OLDER ADULTS
IN NORTH CAROLINA

North Carolina Long Term Care Ombudsman Program: The State Long Term Ombudsman serves as the chief advocate for residents of long term care facilities. The office receives and responds to complaints filed by or on behalf of residents whose human rights have been violated.

(919) 855-3400

North Carolina Division of Health Services Regulation: The Regulatory Agency within the Department of Health and Human Services responsible for receiving and investigating reports of failure to comply with state and federal laws governing nursing & adult care homes.

(919) 855-3750

North Carolina Division of Aging and Adult Services: Provides information and referral pertaining to programs and services designed for North Carolina's senior citizens and disabled adults age 18+.

(919) 855-3400

North Carolina Division of Medical Assistance: Manages Medicaid and NC Health Choice for Children for the state of North Carolina. Medicaid is a health insurance program for certain low-income and needy people paid with federal, state, and county dollars. It covers more than 1 million people in our state, including children, the aged, blind, and/or disabled, and people who are eligible to receive federally assisted income maintenance payments.

(919) 855-4000

DHHS Customer Service Center : Provides information and referral pertaining to human service programs in North Carolina. It has a bilingual specialist for Spanish- speaking callers and TTY for hearing impaired callers.

1-800-662-7030 or 1-877-452-2514 (TTY)

REFERENCE NUMBERS AND AGENCIES FOR OLDER ADULTS SERVICES IN NORTH CAROLINA

Alcohol/Drug Council of North Carolina: Resource and referral helpline for alcohol and drug abuse concerns.

1-800-688-4232

Alzheimer's NC: Provides information on Alzheimer's disease and related disorders.

919-832-3732 or 1-800-228-8738

The Alzheimer's Association: Alzheimer's care, support and research

1-800-272-3900

American Diabetes Association of North Carolina

704-373-9111 or 919-743-5400

American Heart Association of North Carolina

1-800-284-6601

American Lung Association of North Carolina

1-800-586-4872 or 919-424-6069

Arthritis Foundation - North Carolina Chapter: Provides information pertaining to arthritis.

1-800-365-3811

REFERENCE NUMBERS AND AGENCIES FOR OLDER ADULTS SERVICES IN NORTH CAROLINA

NC Disability Hotline: Provides information and referral pertaining to Social Security and Supplemental Security Income (SSI) Disability Programs.

1-800-636-6810

Duke Alzheimer's Family Support Program: Serves as central Alzheimer's resource and clearinghouse for North Carolina.

1-800-672-4213

Easter Seals UCP North Carolina & Virginia: Serves as a resource for persons with disabling conditions, including stroke.

1-800-662-7119

Friends of Residents in Long Term Care (FORLTC): The primary mission of this non-profit advocacy organization is to promote the highest possible quality of life for adults who cannot live independently and for those who care for them.

919-782-1530

Disability Rights NC: Protects the rights of children and adults living with disabilities in North Carolina.

1-877-235-4210

Home Health Complaint Hotline

1-800-624-3004 (within NC) or (919) 855-4500

REFERENCE NUMBERS AND AGENCIES FOR OLDER ADULTS SERVICES IN NORTH CAROLINA

Carolinas Center For Hospice and End of Life Care: Provides information on hospice services and benefits and provides referral information for any hospice program in the country.

1-800-662-8859

Consumer Service : NC Department of Insurance: Receives questions pertaining to insurance coverage and problems (except Medicare). Also see Seniors' Health Insurance Information Program.

1-800-546-5664

North Carolina Lawyer Referral Service

1-800-662-7407

Medical Review of North Carolina: Provides information about home health care agencies.

919-380-9860

Medicare Durable Medical Equipment Regional Carrier (Palmetto Government Benefits Administrators)**:** Provides information and handles inquiries about Medicare coverage for durable medical equipment and supplies.

1-866-238-9652

North Carolina Medical Board: The North Carolina Medical Board exists to protect the public interest through the enforcement of the North Carolina Medical Practice Act. It licenses and oversees the practice of physicians, physician assistants, nurse practitioners, and clinical pharmacist practitioners

(919) 326-1100, or 1-800-253-9653