



AANHR

Arkansas Advocates for Nursing Home Residents

PROTECTING NURSING
HOME RESIDENTS
**February
2012**

Conway (501) 450-9619 · Fairfield Bay (501) 884-6728
Conway (501) 450-7405

AANHR's Mission Statement:
"To protect and improve the quality of care and life for residents in Arkansas nursing homes."

**Next Meeting
Feb 13**

MEETING

PLACE:

**First Assembly of God
Church**

**4501 Burrow Road
North Little Rock**

**Directions to church
on back of Newsletter.**

10:00 a.m.

**Meeting for
members, family and
friends of residents
(Closed to persons
representing the
nursing home
industry).**

11:00 a.m.

**Public Meeting
(see article at right)**



**Happy
Valentine's Day**

**UAMS' Donald W. Reynolds Institute on Aging
Offers A Wealth of Assistance for Arkansas' Elderly Citizens**

Learn about this public health center at Feb. 13 AANHR Meeting

Now is the time . . . to expertly care for those who cared for us.

Established in 2000, the UAMS Donald W. Reynolds Institute on Aging is a noted authority on geriatric care. The Donald W. Reynolds Department of Geriatrics, housed in the same facility, is one of only a few free-standing departments in the nation. Arkansas, with one of the highest percentages of residents over 65, faces the challenge of offering its citizens long, healthy and independent lives.

The Institute is dedicated to helping older adults maintain functional independence by offering specialized geriatric care, research breakthroughs and educational programs.

The Arkansas Aging Initiative, a statewide program of the Institute, includes eight satellite centers strategically positioned throughout Arkansas. No other state can claim a similar network of health care and education services for seniors. Through partnerships with local hospitals and organizations treating older adults, almost every senior in Arkansas can reach quality health care in as few as 60 miles.

Thirty years ago, geriatrics was a new word in most people's vocabularies. Often spoken in a hushed voice, it referred to sick senior citizens residing in nursing homes with limited futures.

UAMS has trained more than 60 geriatricians through its postdoctoral program. Today, Arkansas has more geriatricians per capita than any state in the nation.

The Institute recognizes that by 2021 there will be as many octogenarians as infants, and that the focus of health care must shift from merely keeping people alive longer to making those later years healthier and more productive. In other words, the focus is not adding years to life but adding life to years. It's up to us to ensure access to high-quality, compassionate care for our aging loved ones. UAMS is seizing the opportunity to advance research and find more answers to the mysteries of aging. Frailty prevention is a key focus, and the Institute has already accomplished much in the study of muscle mass improvement and regeneration in seniors.

Please join us at 11:00 a.m. February 13 to learn about the *Reynolds Institute on Aging* an invaluable resource for Arkansas' elderly citizens.



From the President's Desk Martha Deaver

Important NEWS RELEASE!

Almost 30 Violations Not “Minor,” Says Patients’ Rights Advocate Group
Fayetteville Veterans Home Should Be Model of Nursing Home Care According to
Arkansas Advocates for Nursing Home Residents

FAYETTEVILLE, AR (Dec. 13, 2011) - A Dec. 11, 2011 article in the *Northwest Arkansas Times* reporting on the state of violations at the Department of Veterans’ Affairs Fayetteville Veterans Home has a patients-rights advocate group enraged.

Martha Deaver, President of Arkansas Advocates for Nursing Home Residents, a nonprofit organization focused on patients’ rights and reform in nursing homes in the state, said the 22 violations reported in March as well as the five violations noted in June of this year is more than two times the average of nursing homes in the state.

“This is completely unacceptable, and I find it appalling that the administrator of the facility trivialized the violations,” Deaver said. “Another nursing home administrator in the area said the report was ‘bad, but not awful.’ The residents in this facility are men and women who put their very lives on the line for every one of us in this country, and the best we can offer them now is ‘bad, but not awful’? The administrators should be ashamed. As the only veterans’ nursing home owned by the State of Arkansas, it should be setting the standard for care.”

In addition to the violations outlined in the reports, Deaver says she has uncovered other abuses at the Fayetteville Veterans’ Home, including failure to properly treat wounds, dispense medications according to federal law and perform background checks on 10 employees. The violation reports also observed the facility’s nurses were not following Arkansas State Board of Nursing standards or guidelines.

“The administrator of the Fayetteville Veterans Home called the following violations ‘minor,’ Deaver said. “She also acknowledged that *‘to someone reading this report out of the blue, these things sound shocking, yes. But there are many variables to each of these things, and the answer is monitoring and observation.’* I have worked with nursing home residents and facilities for decades and read reports just like these so I have the context in which these violations were reported, and I have never read anything as horrific as this one.”

A list of the violations is outlined on the next page. For more information about Arkansas Advocates for Nursing Home Resident’s response to this story, please contact Martha Deaver at 501-450-9619/501-269-4626 or e-mail MarthaDeaver@aanhr.org or visit www.aanhr.org.

Complimentary Lunch

The Wilkes McHugh Law Firm has graciously offered those who attend AANHR monthly meetings a complimentary catered lunch at noon following the meetings. Please feel free to stay for this time of fellowship after our meetings. AANHR thanks Wilkes McHugh for their many years of support to our organization.

Department of Veterans' Affairs Fayetteville Veterans Home Cited for:

- failure to do wound care,
- failure to ensure pain management for wound treatments,
- failure to ensure wounds were assessed properly,
- failure to dispense medications according to federal law - 26.3 percent medication error rate when federal law requires a below five percent error rate,
- failure to keep residents free of significant medication errors,
- failure to insure diabetic residents received the proper dose of insulin,
- failure to treat bedsores,
- failure to supply enough food for the veteran,
- failure to do background checks on 10 employees,
- failure to follow doctor's orders in dealing with catheters,
- failure to clean catheter residents properly,
- failure to follow doctor's orders in dealing with oxygen,
- failure to insure residents with oxygen in use had current physician order for oxygen therapy,
- failure to ensure a licensed nurse monitored administration of updraft treatments,
- failure to ensure residents were given oxygen therapy according to doctor's orders,
- failure to ensure doctor's orders and care plans were accurate and complete,
- failure to give diabetics a diabetic diet,
- failure to give doctor ordered pain medication to an amputee before doing wound care,
- failure to have a system in place for dispensing medications for all residents,
- failure to treat the veterans with dignity and respect,
- failure to investigate allegations of abuse,
- failure to protect confidential medical records,
- failure to follow doctor's orders when dispensing medications,
- failure to follow doctor's orders in dealing with catheters,
- failure to contact doctor when bedsores deteriorated,
- failure to ensure medications were labeled and stored in accordance with state law,
- failure to meet pharmaceutical standards and guidelines, and
- failure to follow Arkansas State Board of Nursing standards and practices.

In all, 15 pages of poor infection control also were noted in the reports. The list above is a synopsis of the deficiencies cited in the surveys.

*Actual Surveys available at aanhr.org or contact AANHR Pres. Martha Deaver for instructions on receiving printed copies of surveys.

A Personal Response to the “Fayetteville Veterans Home Situation”

By Jeanie Wilson, S.C. 1-11-12

I am writing in response to the article “Veterans’ homes in state see violations,” which was published in the *Arkansas Gazette* on December 20, 2011. I believe it is necessary to counter the misinformation given by people quoted in the article.

My brother, Billy Don “Bill” Ramey was briefly a resident at the Fayetteville V.A. home, from mid-April to July 3, 2009. Bill was a very good big brother -- funny and bright, friendly and kind. He didn’t talk about his good deeds; most people never knew about them...he just went around quietly helping, oftentimes, people that others overlooked. He was extremely proud of his service in the U.S. Navy. Veterans were an important part of his social life and he often spoke fondly of his service on board the aircraft carrier U.S.S. Independence, where he honorably served most of his enlistment.

Few of us get to choose the way we leave this life. In only his 66th year of life, Bill became gravely ill. Cancer overtook his body leaving his bones so brittle that he could barely stand, his lungs so scarred and his mind so poisoned from medication that he could no longer remember his loved ones or even speak audibly. Even in these most dire circumstances, one nurse at the V.A. Home told me that she really liked Bill because, when he could speak, he tried to make everyone smile. That was so like my big brother.

But on June 9, 2009, evening staffers at the V.A. Home brutalized my brother in unspeakable ways. Later, they requested “permission” from my sister, his P.O.A., to use restraints on him. Although that request was denied, by the time a family member could get there, the bruises on his frail body clearly showed where the restraints had been used anyway.

His case was briefly referred to in this article about the controversy, which quoted an administrator at the home as saying that “he was cared for appropriately for his condition.” Another article said that my accusations had been thoroughly investigated and found to be without merit; this is also false. Following my complaint to the AR Office of Long Term Care (OLTC), the V.A. Home was investigated and reprimanded in 2009.

Then, just days before his death, staff members at the V.A. Home brutalized Bill again. This time they completely removed all shreds of modesty and personal dignity, stripping him naked and tying him into a cage-like chair commonly called a “merry walker.” They left this terrified, gravely ill, weak and helpless human being alone in a room with the door closed -- without access to ANY food, toileting, clothing, ANY medication or ANY type of relief from what must have been hours of stark terror. (Because different staff members told different stories, we could only estimate the duration of his torture, which was 5-10 hours.)

Some politicians have said that these places should be gutted. I must disagree. I have been to the V.A. Home in Fayetteville, AR. It is a great facility and much needed by our veterans. It has the potential to be a shining example of our nation’s honor for, as well as the safety net and safe haven we have promised to our veterans. Instead, it has become a place that should embarrass and disgust every honorable American. But the problem is NOT the facility, which is clean and relatively new and well-equipped.

The problem at the Fayetteville V.A. Home is the administration of the facility. I met the administrator, when I checked Bill into the Home. At that time, she seemed to me to be somewhat hostile and cold. In the newspaper article, a representative for the Home, Mr. David Fletcher, was quoted as saying he thought she was “good people.” I found this to be an extremely bizarre remark, considering that he had recently been informed that she had “mislead” her superiors, apparently including Mr. Fletcher, and violated both state regulations and patients’ rights. One is forced to wonder about an administrator who thinks that untruthfulness, repeatedly violating regulations, and abusing patients is no problem -- something that all “good people” do.

(continued on page 5)

“Speak up for those who cannot speak for themselves, for the rights of all who are destitute. Speak up and judge fairly; defend the rights of the poor and needy.” Proverbs 31:8 NIV

(continued from pg. 4)

Bill left this life near midnight on July 3, 2009 -- his independence day. He had made a commitment to protect, with his life if necessary, the freedoms that we so glibly take for granted. But when it came time for us to honor our commitment to Bill -- and who knows how many others - that commitment was not upheld. Not only have this administrator and the staff dishonored our veterans, they have shamed our nation by violating the promise we made to them. Apparently that is acceptable to Mr. Fletcher, but a great many Americans do not agree with him.

A nursing home administrator is the commander of the ship! It is his/her responsibility to oversee every aspect of every policy and federal guideline the state and federal government has established for taking care of nursing home residents. He/she can not be licensed as an administrator without this knowledge.

I am very familiar with the senior-health-care "industry," having worked for several years for one of the largest providers in the United States. It is an industry that is marked by low wages and poorly trained staff and administrators and, consequently, it is riddled with uneducated, uncaring, sometimes abusive workers. But we now have one of the highest unemployment rates ever in this country. Perhaps with a larger pool of more qualified people available, many of the problems in this vital industry could be improved, but only if there are administrators who are more committed to providing quality services than to garnering profit or covering up abuses. It is essential that there is adequate oversight by the government agencies we have empowered to ensure our seniors are not abused.

Our veterans need facilities like those at the V.A Home in Fayetteville, and that is not going to lessen any time soon. As the large numbers of veterans from wars in Iraq and Afghanistan - especially those seriously injured -- begin to age, they will require more care. Our military families have already made tremendous sacrifices, and it is essential that when the time comes, they have facilities like the V.A. Home to turn to. No family should have to endure the pain of knowing their loved one has been abused by those entrusted with their care.

We have made a promise to our veterans and it is our duty to honor that promise, just as they have already honored their promise to protect us with their very lives. Our seniors deserve it, our veterans deserve it and our country can and should do better. Please hold these uncaring administrators accountable for the lies, deceptions and abuses promulgated on their watch. This time it happened to my family, the next time it could happen to yours.



Volunteer Ombudsman Needed

Do you have one hour per week to visit with residents (those who have few/if any visitors) in a nursing home? We have a place for you. After one day of training and a short orientation period one can become a Certified Volunteer Ombudsman and can choose to be assigned to a specific nursing home where just two hours service per week is expected.

Regardless of whether or not you end up becoming a volunteer ombudsman, your knowledge will increase greatly by attending an ombudsman training session. Volunteer Ombudsman training takes only one day and can make an incredible difference in the life of a nursing home resident. A volunteer ombudsman is authorized to help residents with any concerns. Protecting the resident's rights is a priority. The volunteer ombudsman is authorized to take complaints and report things they see that are questionable to their regional ombudsman, who can take steps to remedy the situation. A volunteer ombudsman can make a big difference brightening the life of a nursing home resident. If interested, please contact Martha Deaver at 501-450-7405; she will put you in touch with your regional ombudsman.



Cecilia Vinson, MSN, RN Speaks on Informal Dispute Resolution (IDR)

Every nine to fifteen months state and federal survey teams visit each nursing home in Arkansas. They follow strict guidelines as they observe every aspect of care being given to the residents of the facility.




AANHR members were given information to help them understand the Informal Dispute Resolution (IDR) - a tool given to long term care providers to provide them an opportunity to show evidence that deficiencies should NOT have been cited.

Cecilia Vinson, MSN, RN, Nurse Manager and Certified Long Term Care Surveyor with the Office of Long Term Care (OLTC) spoke at the Jan.9th meeting to explain the process that was established by Act 1108 of 2003 and amended by Act 1144 of 2011. The Independent Decision Maker (IDM) agency within the Department of Health and a 2011 amendment added that if the cited deficiency was pharmacy related, the Independent Decision Maker process shall include a Pharmacist. The amendment also provides that both parties can have an exchange of questions and answers.

If a facility desires to challenge a cited deficiency, it must make an IDR request in writing within ten calendar days of receiving the Statement of Deficiencies. The facility must state which deficiency is being disputed and add documentary evidence. The facility cannot dispute assessments of actual harm or immediate jeopardy or any remedies imposed. The facility cannot challenge the surveyor personally nor any alleged inconsistency of the team as related to other facilities.

The hearing is limited to two hours. Each party may reserve ten minutes for rebuttal and shall address their argument to the IDM. Neither party may interrupt. The IDM will make the determination recommendation and will notify OLTC and the facility. The OLTC reviews the Statement of Deficiencies and the facility evidence defending the deficiencies. OLTC agrees or disagrees with IDM recommendations and can issue a revised Statement of Deficiencies. OLTC sends a final letter with their decision to the facility. For Nursing Homes participating in Medicare, CMS will review all IDRs and has the final decision on enforcement of penalties.

Steps to take if you find care lacking.....

1. Talk to the CNAs on duty for your hall. —————→ 
2. Talk to the nurse for your hall. —————→ 
3. Talk to the Director of Nursing or the Administrator. —————→ 
4. Call the Office of Long Term Care or the Regional Ombudsman. —→ **OMBUDSMAN**

★ The Office of Long Term Care phone number is 1-800-582-4887.

★ Regional Ombudsman contact information complete with a photo of the ombudsman should be posted in a prominent place in your facility. You may also have a certified volunteer ombudsman (CVO) for your facility who might offer advice.

AANHR Special Thanks

We extend our heartfelt thanks to the following people and groups who make our outreach possible:

Bob Edwards of Wilkes and McHugh for its financial assistance in the printing and mailing of AANHR's newsletter and other publications as well as financing the attendance of two board members to the annual NCCNHR conference.

Paschall Strategic Communications for their continued assistance with public relations needs.

First Assembly of God Church in North Little Rock for providing AANHR a meeting room.

David Couch of The Law Offices of David A. Couch, PLLC, PA, for employing Brent Birch of One6 Media, LLC, to create and maintain AANHR's website.

Gary Miller of ProSmart Printing for assistance in newsletter and brochure publication.

M. Darren O'Quinn, Attorney, Little Rock, for his continued assistance to and support of AANHR.

AANHR Officers and Board Members

President - Martha Deaver, Conway (501-450-9619)

Vice President - Gary Melton, Searcy (501-230-2846)

Secretary - Betty Buckta, Judsonia (501-593-8860)

Treasurer - Frances Walker, Benton (501-316-0260)

Program Chairman - Gary Melton, Searcy

Members of the Board: Nancy Allison, Conway (501-327-3152) ; Martha Blount, Searcy (501-278-9168); Linda Brimer, Searcy (501-268-4699); James Brooks, North Little Rock (501-454-6279); Julie Edwards, Alexander ; Pat McGuire, Alexander (501-847-1016); Nancy Patterson, Searcy (501-305-4034); and Ann Pinney, Benton (501-249-1084).

Honorary Board Member: Faye Sandstrum, Searcy.

Newsletter Editors: Martha & Ernie Blount, Searcy

Helpful/Important Numbers

The Office of Long Term Care (OLTC)

has a toll-free number for information, assistance and complaints for residents and family members:

1 - 800 - LTC - 4887 between 8 a.m. and 4:30 p.m. on weekdays.

You may also write to: Office of Long Term Care (OLTC) P.O. Box 8059, Slot 400 Little Rock, AR
72203-8059

OLTC website:

<http://humanservices.arkansas.gov/dms/Pages/oltcHome.aspx>

You should also report complaints to the Arkansas Attorney General

Toll Free: 1 - 866 - 810 - 0016

Little Rock Local: 682 - 7760

For additional assistance or a listening ear, call AANHR at

(501) 450 - 9619 in Conway;

(501) 884 - 6728 in Fairfield Bay;

Visit our website at www.aanhr.org or e-mail us at Info@aanhr.org

Your local Ombudsman's number should be posted in a prominent place in the nursing home, preferably near the front entrance. You may also call your local Area Agency on Aging to secure the name and phone number of the Ombudsman.

The UALR Senior Justice Center can be reached at: **501 - 683 - 7153.**

www.ualr.edu/seniorjustice



Arkansas Advocates for Nursing Home Residents

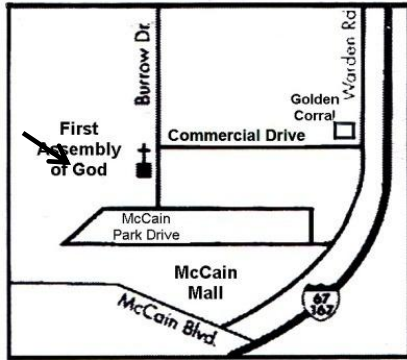
AANHR

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www.aanhr.org

NON-PROFIT ORGANIZATION
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Strength in Numbers-AANHR Needs You!

AANHR is a nonprofit organization run by non-paid volunteers dedicated to protecting and improving the quality of care and life for Arkansas residents in long term care facilities.

Please lend your support by joining AANHR. Your membership dues help to pay for our activities that support our mission statement. Memberships are available on a calendar year basis. Join now and you will be a member through **December 31, 2012.**

Today's Date _____

Name _____

Mailing address _____

City/State/Zip _____

Phone _____

Email _____

- () I wish to receive the AANHR newsletter.
- () \$15 per individual membership enclosed.
- () \$20 per family or corporate membership.
- () \$4 per student or CNA membership.
- () Waive dues because of financial hardship.

Please make checks payable to: AANHR and mail to 2336 Riverview Circle, Benton AR 72019

Driving directions to First Assembly of God Church, 4501 Burrow Road, North Little Rock

Coming from the North:

When driving South on Highway 67/167, take exit #1A onto Warden Road. As soon as you safely can, move into the right-hand lane, as you will be turning right at the Golden Corral Restaurant onto Commercial Drive.

Coming from East, West or South:

If you are on either I-30 or I-40, take Highway 67/167 North. Take exit #2 onto Landers Road. Stay in the left-hand lane, as you will be turning left and going under Highway 67/167 and enter Warden Road going southbound. As soon as you safely can, move into the right-hand lane, as you will be turning right at the Golden Corral Restaurant onto Commercial Drive.

Commercial Drive terminates at the church. Proceed straight across Burrow Road into the church's parking lot and turn right at the far side of the building into the narrow alley-like drive.

The entry door is located about half-way down this side of the church and the meeting room (#113) is immediately inside the entrance door.