OHCQ
Office of Health Care Quality

DEPARTMENT OF HEALTH & MENTAL HYGIENE

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MARYLAND'S ASSISTED LIVING PROGRAM 2005 EVALUATION

FINAL REPORT AND RECOMMENDATIONS

Report to the Senate Finance and the
House Health and Government Operations Committees

JANUARY 2006

Acknowledgements

The Evaluation of Maryland's Assisted Living Program would not have been possible without the hard work and commitment from all of the participants in the Assisted Living Forum and numerous other meetings. Besides the work commitment, participants bore the expense of travel to many meetings. Some participants took on added responsibility by serving on various committees and workgroups.

The participants of the Assisted Living Forum appreciated the many speakers who presented research and information on assisted living including Dr. Adam Rosenblatt, from Johns Hopkins School of Medicine; Barbara Newman, RN, from the Maryland Board of Nursing; Dr. John Balch, from the Maryland Board of Pharmacy; Marcia S. Dashevsky, from the Centers for Medicare and Medicaid Services; Lissa Abrams, from the Mental Hygiene Administration; Lisa Meyers, RN, from the Maryland Institute for Emergency Medical Services Systems; Anne Marie Spellbring, RN, PhD, University of Maryland; and William Vaughan, Chief Nurse of the Office of Health Care Quality.

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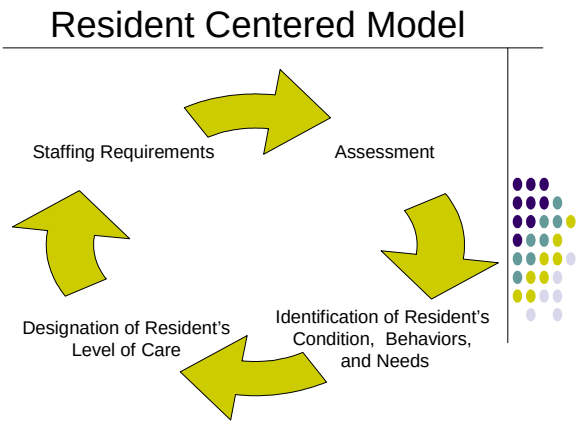
Foreword

I am pleased to present you with the final report on Maryland's Assisted Living Program. My visions for the Office of Health Care Quality include enhancing efficiency and standardization in our own internal protocols and procedures, and developing regulations that are responsive to specific public health concerns. Maryland's Assisted Living Program offers great opportunity in these areas.

Since I was appointed Acting Director last August, I have reviewed five years of sanctions, talked to my staff, stakeholders, advocates, and members of the community, and visited some very good and some not-so-good providers. It became clear that the size of the facility should not be the sole determining factor in how Maryland regulates Assisted Living. Indeed, over the past five years, most of the troubling and sometimes life threatening deficiencies have occurred in smaller Assisted Living sites.



Maryland needs a *resident centered model* for regulating Assisted Living that focuses on the needs of residents for on-site nursing and awake overnight staff. Assisted Living can be a wonderful alternative. There are many caring providers who every day offer quality services and would do so even without regulation. But, there are an increasing number who view Assisted Living, and specifically the availability of government funding for Assisted Living, as a *get rich quick* venture. To ensure Maryland consumers a meaningful choice of Assisted Living providers with confidence that the facility selected will be safe and appropriate, we must use the information and experience gathered over the years to redefine Maryland's regulation of Assisted Living. I believe that the recommendations contained in this report take a significant step toward accomplishing that goal.

I thank you for your continued support of the Office of Health Care Quality.

Very truly yours,

Wendy Kronmiller
Acting Director

Executive Summary

Background. In 1996, the Assisted Living Program was established in Maryland consolidating 12 to 15 programs administered by three executive departments (the Department of Aging, the Department of Human Resources, and the Department of Health and Mental Hygiene), which each had separate rules or standards and each of the departments had a different regulatory approach. The major areas of focus when the regulations were originally developed included: the philosophy of aging in place, the need for flexibility versus strict regulation, cost, and establishing a single standard for all programs. Over six years regulating assisted living programs, we have learned that the "one size fits all" approach is not realistic and does not work.

The Department acknowledges that how to define and regulate assisted living are difficult issues. As a result, the Department initiated a multi-year, comprehensive evaluation of assisted living. Over the last two years, the Office of Health Care Quality (OHCQ) has held over 20 Forums with assisted living providers and stakeholders to discuss assisted living and to identify quality standards that should be strengthened to better protect the health and safety of residents in assisted living facilities.

In 2005, the Department submitted legislation to redefine assisted living, establish three categories of providers, require those programs with special care units to disclose specified information and increase penalties. This legislation was unsuccessful.

Efforts already initiated to improve the quality of care in assisted living include the following changes:

- Mandating that all delegating nurses working in assisted living complete a 16 hour training course.

- Mandating an 80 hour assisted living manager training course for managers employed in programs with more than five beds and 20 hours of continuing education every two years.

- Requiring the certification of medication technicians, mandating a 20-hour training course, and providing the Board of Nursing with disciplinary authority over medication technicians.

- Strengthening the "nursing overview" requirement by requiring registered nurses rather than a licensed nurse to perform the resident assessments.

- Requiring annual training for all assisted living employees in specified areas rather than only initial training for employees.

- Requiring all employees to have more advanced training in cognitive impairment and mental health issues, five hours of training for direct care workers and two hours for all other workers.

Recommendations include:

- Revising regulations to ensure that care provided meets the needs of residents by requiring mandatory overnight awake staff or the equivalent electronic monitoring system and enhanced on-site nursing presence for certain providers, based upon resident need.

- Revising regulations to establish provisions for false advertising, minimum licensing standards, and enhanced notification requirements.

- Revising regulations to enhance standards for Special Care Units or Programs.

- Strengthening criminal penalties for those who purposefully avoid or violate licensure or regulatory requirements.

- Recruiting an OHCQ assisted living manager position to ensure that the state's survey and licensure resources are being used as efficiently as possible.

- Evaluating workload and priorities to ensure that OHCQ staff are deployed most efficiently.

- Establishing a Health Care Quality Account for Assisted Living that uses funds obtained through civil money penalties for violations of standards for purpose of improving the quality of care in assisted living programs.

Introduction

How should Maryland define assisted living? How should assisted living be regulated? These are difficult issues and there are many different opinions on what an assisted living program should look like and the level of regulation government should impose. The State's assisted living program has grown rapidly since its implementation in 1996 and the Office of Health Care Quality (OHCQ) has identified an emerging pattern of serious quality of care issues in assisted living facilities. As a result, the Department of Health and Mental Hygiene (DHMH) and members of the Legislature have expressed concerns about the direction the State should take in regulating assisted living facilities.

In the Summer of 2003, the DHMH initiated a multi-year, comprehensive evaluation process for Maryland's Assisted Living Program. The OHCQ convened an assembly of providers, stakeholders, advocates, health professional regulatory boards, State and local governments, family members, and other interested parties. The result was the Assisted Living Forum ("ALF") where matters or questions relating to assisted living were discussed. The goal of the ALF is to identify quality standards that should be strengthened in order to better protect the health and safety of assisted living facility residents.

The Department published interim reports in 2003 and 2004 that each contained a series of recommendations to improve the quality of care in the State's Assisted Living Program. This is the final report which sets forth recommendations on the following quality standards:

- On-site nursing presence
- Requirements for special care units
- Penalties
- Denial of License
- Minimum licensing requirements
- Bond requirements
- Liability insurance
- Notification requirements
- Emergency generators
- Awake overnight staff
- Mandatory participation and drop in-services in adult medical day care programs
- Transfers between licensed assisted living programs
- Uniformed service disclosure forms
- Automated external defibrillators (AEDs)

These recommendations form the basis of the Department's new regulatory framework for Maryland's Assisted Living Program that is centered on the needs of the resident.

Background

In the early and mid 1990s, there was growing concern in Maryland and across the country about the development of community residential programs for the frail and elderly. At that time, Maryland was aware of some 12 to 15 programs administered by three executive

departments (Department of Aging (DoA), Department of Human Resources (DHR) and the DHMH). Each of the programs had a separate set of rules or standards and each department had a different regulatory approach to monitoring and ensuring safety and quality. Anecdotal evidence suggested serious safety and quality issues particularly in the areas of medication management and resident rights. Because the programs' were fragmented among the three agencies, there was no clear knowledge of what was actually happening in these homes.

In 1996, the Maryland General Assembly passed a bill establishing a consolidated statewide Assisted Living Program that created a single point of entry for all assisted living providers, a standardized database, and placed oversight responsibility within the DHMH.[1] The new definition established assisted living in Maryland as a "residential or facility-based program that provides housing and supportive services, supervision, personalized assistance, health-related services, or a combination thereof that meets the needs of individuals who are unable to perform or who need assistance in performing the activities of daily living or instrumental activities of daily living in a way that promotes optimum dignity and independence for individuals".[2] This definition captured a large variety of programs and included large (sometimes caring for over 150 individuals) and small (caring for fewer than four individuals) providers, not-for-profit and for-profit (those that only take SSI or SSDI payments or are private pay and charge several thousand dollars a month), and that offered very diverse services (some provide only minimal supervision and other provide services similar to nursing homes).

Development of the regulations to implement the new law was lengthy and controversial. The final regulations were, at best, a compromise because of the varied interests and often opposing viewpoints. Major areas of focus during the development process included:

- ***Aging in place.*** There was a strong movement to allow an individual to remain in the same environment regardless of his or her conditions. Some interests, however, believed that an individual should be moved into a nursing home or other appropriate setting as he or she aged and became frailer and medically compromised The final regulations allow for an assisted living program to request a resident-specific level of care waiver provided they can demonstrate the capability to provide adequate care to the resident and that the needs of the other residents would not be jeopardized. The regulations stipulate seven exemptions wherein an assisted living program may not admit an individual.[3]

- ***Need for flexibility versus strict regulation.*** There was tremendous fear that the State assisted living regulations would be fashioned after the federal nursing home requirements. The workgroup recommended and the Department accepted recommendations to minimize prescriptive standards and to allow flexibility as long as the needs of the residents were adequately met. For example, there are no requirements for certain types (nurses, activity directors, etc.) or numbers of required staff.

[1] Chapter 147 of the Acts of the General Assembly of 1996 (Senate Bill 545 – "Assisted Living Programs").
[2] Maryland Health-General 19-1801.
[3] COMAR 10.07.14.10J(1) – (7).

- ***Cost.*** Because there was little public assistance available to assisted living programs, the law required that the Department keep the cost of assisted living to a minimum. This resulted in less regulation with the hope that quality services would be provided.

- ***Single standard of care.*** When the regulations were developed, it was well known that some providers would have difficult complying with even the most minimal regulations. Nevertheless, the workgroup recommended that there be one set of quality standards for all providers regardless of size, charges, number of residents, or level of care. This has resulted in administrative, paperwork and clinical requirements being essentially the same in homes regardless of the level of care the residents required.

When the regulations were implemented, it was understood that they would need to be evaluated within a few years. Therefore in 2003, pursuant to the introduction of several pieces of assisted living legislation, the Department initiated a multi-year evaluation.

Current Status of Assisted Living Study and Reform

In the 2005 General Assembly Session, House Bill 1326 was introduced with the purpose of changing the definition of assisted living, establishing three categories of providers, requiring programs with special care units to disclose specified information, and increasing penalties. Although the bill was unsuccessful, it identified many issues requiring further discussion and clarification. Those issues included:

- Housing needs of individuals with mental illness. A mental health advocacy group raised concerns about the need for a new type of housing and regulatory oversight for individuals with mental illness. It was suggested that the current Assisted Living regulations impose unnecessary requirements for providers serving individuals with mental illness who may only need assistance with medication and/or instrumental activities of daily living.[4] In response, the Mental Hygiene Administration established a workgroup to look at the broad range of housing issues for individuals with mental illness. This workgroup will issue a report in the Winter of 2005 to the Secretary of DHMH with its findings and recommendations.

- Residents in assisted living are medically compromised and more frail than originally anticipated. The DHMH has confirmed, from a review of national and Maryland-specific studies, that individuals in assisted living programs are more frail than was anticipated when the program was implemented in 1996. According to studies detailed more specifically herein, up to two-thirds of residents in assisted living programs have moderate to severe dementia and less than half receive adequate treatment for this condition. Most residents have multiple medical diagnoses, some debilitating, and take, on average, 9 to 14 medications per day.

[4] COMAR 10.07.14.02(B)28 defines "instrumental activities of daily living" as meaning home management skills, such as shopping for food and personal items, preparing meals, or handling money.

- The "one-size fits all" regulatory framework does not work. When the assisted living regulations were initially developed, one set of quality standards for all providers regardless of the number or level of care required by residents was adopted. Therefore, the administrative, paperwork, and clinical requirements are essentially the same for all programs regardless of the level of care required by the resident. A new regulatory structure that balances safety and quality with an appropriate level of oversight and that maintains protections for all residents is needed.

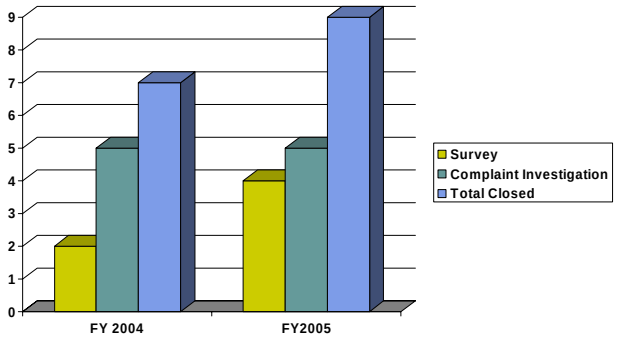
- The Department has broad authority to change regulations. The Office of the Attorney General has determined that the Assisted Living Program subtitle (HG 19-1801 et seq.) provides the Department with broad authority to improve the regulatory framework for assisted living. Although the Department cannot change the definition of assisted living without legislation, it can continue to strengthen regulatory standards to improve the quality of care in assisted living facilities. Therefore, regulations will be promulgated according to the State process and thus be subject to public comment.

- Maryland was a leader in the development of assisted living and now we are behind. In 1996, we were ahead of curve with strong assisted living requirements. Many states have revised their regulations to strengthen quality standards and enhance consumer protections. For example, many states have implemented a multi-tiered framework for regulating assisting living. This type of approach appears to provide appropriate safeguards as well as addressing the uniqueness of certain residential settings.

- Numerous sanctions have been issued. Despite having weak standards, there has not been a lack of enforcement when poor quality of care is found. Examples of the problems that the Department have found include:

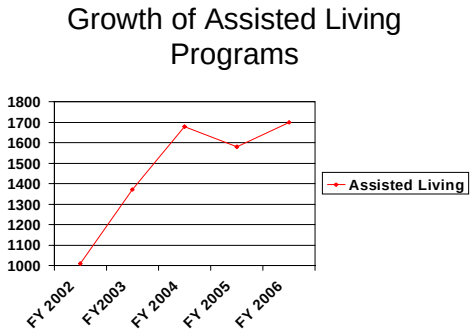
  - Surveyors found a resident with 13 decubitus ulcers.
  - An elderly resident was found frozen to death after wandering outside. The staff was asleep and the door alarm did not work.
  - Residents admitted to the hospital with stage three and four decubitus ulcers. There was no indication of any nursing or physician involvement.
  - Resident was left unsupervised on a porch during a summer heat wave. The individual's core body temperature was 107 degrees.
  - Residents were locked in a boiler room because of behavioral problems.
  - Blood pressure medicines were not given for four months.
  - Residents being moved daily between different licensed or unlicensed assisted living programs from their adult medical day care program.

Table One. Assisted Living Facilities Closed – FY 2004 and FY 2005.



- A resident was picked up from the hospital by an unlicensed assisted living provider and not given any medications for ten days until he was found to be unresponsive; he died a few days later.
- An assisted living provider misrepresented herself to families and health care providers as a medical doctor and a currently licensed nurse, without holding either license.
- No evaluation of a resident who had fallen and hit her head six times within a seven weeks.
- An assisted living manager did not provide the hospital with a resident's durable power of attorney for health care and the resident, with end-of-life dementia, was given a feeding tube against her wishes. When asked why, the assisted living manager responded that the advance directive did not coincide with the assisted living manager's personal beliefs.
- An assisted living manager refused to acknowledge two resident's power of attorney, wrote checks out to herself using the resident's checkbook and forged a resident's name on the back of a dividend check.
- Resident with a stage four pressure ulcer on each hip. The resident was transferred to the hospital where she died two days later.

- <u>Coordination of local resources, lack of appropriate survey staff, and budgetary concerns identified.</u> While the current licensing system is insufficient to meet the challenge of ensuring safety in assisted living programs, coordination of local resources, lack of appropriate survey staff, and budgetary concerns have been identified. First, when the law was passed in 1996, it required the Department via the OHCQ to work together with DHR, DoA and local governments to coordinate and delegate inspection authority to other agencies. As cited in the 2003 Evaluation Report, there are more 40 agencies across the State conducting surveys in assisted living programs. It is possible that four different agencies in one county will conduct an assisted living survey. However, recent budget difficulties across the State have resulted in many local agencies relinquishing their delegation authority back to the State. In jurisdictions where the Department was expected to provide technical assistance and oversight, it is now expected to conduct the majority of surveys; yet the OHCQ faces its own significant staffing shortages. The Department identified in a recent Joint Chairmen's Report that the OHCQ is experiencing a surveyor shortage of approximately 55 full-time equivalent positions. As a result, only approximately 31-percent of required surveys of assisted living programs are conducted each year.[5] Compounding this situation is the fact the number of assisted living programs continues to grow. Therefore, because there are no routine inspections, there is little continuity or even assurance that a provider who barely met standards last year meets minimal requirements this year.



[5] For Fiscal Year 2005, there were 1580 licensed assisted living facilities and 495 surveys were conducted.

- Get rich quick scams. In August of 2005, state officials attended a Maryland licensure seminar with 500 other individuals who were told that government funding of health care was the next way to "get rich quick". There was no discussion of quality or standards – just get a license and bill for services rather they were rendered or not. Similar seminars are now being held regularly in Maryland.

- Size should not be the exclusive factor in how to regulate assisted living. The OHCQ has reviewed five years of sanctions. Troubling and gruesome deficiencies were as likely to occur in smaller providers as larger ones. A regulatory model needs to be developed that focuses on *resident needs* for on-site nursing and awake overnight staff. The Department is open to the use technology for monitoring systems in lieu of awake overnight staff when it is appropriate and safe.

Figure 1. Actual Flyer form a Seminar held in December 2005

- Consumers need to be provided the necessary information to make appropriate choices. Consumer choice needs to play a greater role in assisted living. Individuals and families need to be given the necessary information to make educated and informed choices. Uniform disclosure statements, which are used in other states, provide consumers with a better mechanism to evaluate and choose assisted living providers.

- Role of the assisted living manager needs to be clarified. The assisted living manager and the delegating nurse must develop a collaborative relationship. The Department has found that in some ALPs there exists tension between the roles of the assisted living manager and the delegating nurse. To the extent possible, the responsibilities of the delegating nurse and the assisted living manager – and how they interrelate - need to be better captured in the regulations.

Studies, National Reports, and Presentations to the ALF

Over the course of the Department's comprehensive evaluation, the ALF has reviewed numerous studies, national reports and received many presentations on how quality of care can be improved in assisted living. Maryland is not unique in its findings. The US Special Committee on Aging and the National Academy for State Health Policy have also identified similar concerns. Some of these materials included:

Johns Hopkins University of Geriatric and Neuropsychiatry Study on Dementia Care in Maryland's Assisted Living Programs. Johns Hopkins conducted a study on the prevalence, recognition and treatment of dementia in Maryland's assisted living programs. The study was prompted because of the lack of knowledge concerning individuals who live in assisted

living and their clinical characteristics. It is widely known that dementia is very common in the elderly, progressive in nature and frequently undiagnosed. While it was believed that many individuals in assisted living have dementia, Alzheimer 's disease or other psychological needs that go undiagnosed and untreated, there was no data to support that conclusion. Therefore, Johns Hopkins decided to conduct the first comprehensive study to look at this issue using direct examination of randomly sampled individuals.

Phase One of the study was a cross-sectional study of 198 participants from 22 randomly selected small and large assisted living programs.[6] This type of sampling ensures the study was conducted in a statistically sound manner. A team of experienced professionals, including a geriatric neuropsychiatrist, nurses, a psychometrician and research assistants, evaluated individuals participating in the study. Comprehensive histories were obtained from the resident, family members, and staff. The evaluation team reviewed the resident's chart for diagnoses, medications, treatments, and laboratory studies. Residents' vital signs were taken and were given a mental status exam and neurological exam. All of the data gathered was then reviewed by the consensus panel to determine diagnosis, whether dementia was fully evaluated or whether dementia or psychiatric disorder was fully treated.

The study found that the overall profile of a typical assisted living resident was on average 85.6 years old; 75-percent are over the age of 80; gender – 78-percent are female and 22-percent are male; mean length of residence in an assisted living program – 25 months; ethnicity – 83-percent Caucasian, 16-percent African American, and 2-percent other ethnicity; and the primary reason for moving into assisted living – 62-percent decline in independent function, 24-percent medical conditions, 7-percent behavioral problem, and 4-percent loss of caregiver.

With regard to the prevalence of dementia and psychiatric disorders, the study found that 67.7-percent of the individuals had been diagnosed with dementia, an active psychiatric diagnosis, such as mood, psychological disorders or delirium, and 26.3-percent neuro-psychiatric symptoms, such as behavioral problems. However, only about 52-percent of those individuals diagnosed with dementia received full treatment, 33-percent received partial treatment and 15-percent received no treatment. Dr. Rosenblatt indicated that the panel was extremely generous in what it considered partial treatment.

The study also looked into the effect of the individual's diagnoses on the amount of caregiver time required. Those individuals with no diagnosis received approximately 50 minutes per day caregiver time, whereas those individuals who had a dementia and/or psychiatric diagnoses received much more caregiver time per day (ranging between 200 to 250 minutes per day).[7]

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[6] The majority of the assisted living programs randomly selected for the study were licensed to serve level of care 3 residents and had been in operation for approximately 10.9 years (mean). Some of the programs (6) had locked or dementia special care units. The day staff per resident ranged from 1:20 to 2:3. The median monthly facility cost was $2,900.

[7] Phase Two of the study is a five-year longitudinal study. Researchers will return to the same facilities, follow the original cohort and identify another 200-member cohort to follow. The aim of the study is to describe longitudinal course, detection, treatment, effects on quality of life and effects on the time of death or discharge. The preliminary findings indicate that 14 individuals from the original cohort had no dementia; 27 had dementia

Other national studies confirm that 40, 50, to 60-percent of individuals in assisted living have some level of dementia.[8]

University of Maryland Study to Evaluate Nursing Delegation Review at 45 Days. At the request of the Legislature, a study was conducted by the Maryland Board of Nursing through a contract with the University of Maryland School of Nursing to evaluate the 45-day interval for delegating registered nurses (DRN) to perform on-site review of medication administration by unlicensed personnel in assisted living facilities. The study was prompted by legislation introduced in 2000 that proposed to extend the on-site review timeframe from 45 to 90-days.

The University of Maryland offered participation in the study to any licensed assisted living program that utilized unlicensed medication assistants to administer medications with a supervising delegating registered nurse. Only 35-percent of the facilities contacted agreed to participate in the study. Of the 44 facilities that agreed to participate in the study, the mean size of the facility was six to seven residents. The findings indicated that there was ongoing verbal interaction between the DRN and the medication assistant during visit intervals and that a significant portion of the DRN's on-site visit was spent on instruction and reinstruction.

Although the study deemed the 45-day review adequate, there was a 50-percent medication error rate noted by the observers. Errors ranged from minor mistakes to major risks of harm, including failure to document that medications were given, failure to note expiration of medications and failure to read the label three times to ensure accuracy. It is important to note that the 67-percent facility refusal rate may have significantly skewed the data. If there was a 50-percent medication error rate in the assisted living programs that agreed to participate in the study, it is reasonable to expect that the rate would be significantly higher in those that refused to participate.

American Society of Consultant Pharmacists Study Concerning the Role of the Pharmacist Recommendations in Reducing Potentially Inappropriate Medications in the Assisted Living Setting (Fleetwood Project). It is known from national studies that most residents in assisted living will have multiple diagnoses, some debilitating, and will take on average 9 to 14 medications per day benefit from drug regimen reviews (DRR). The Fleetwood Project demonstrates the health and cost benefits of utilizing DRR. Pharmacists can play a role in the assisted living setting. They can identify drug interactions, inappropriate medications, address medication-related questions, etc. DRR can greatly benefit providers through

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at both intervals; and 3 converted to a diagnosis of dementia. The findings indicate treatment matters: morbidity increases when treatment is not received. Phase Three will look toward implementation of interventional measures, such as behavior management, exercise/restorative nursing, dementia medication optimization, incontinence training, wandering management and the outcome of such interventions.

[8] Hawes, Catherine. "Assisted Living: Policy Implications of Data" Presentation to the Association of Health Facility Survey Agencies, October 2005. Studies that indicate moderate to severe cognitive impairment: Nebraska 58%, Maine – 44%, North Carolina - 64%, and Maryland 65%. Under-recognition and under-treatment cognitive impairment results of three studies – Less than 50% had no diagnosis, less than 75% were not treated for dementia, and 22% self-administered medications.

potential cost savings on their pharmaceuticals expenses, as well as providing an effective means of preventing or correcting drug-related problems.

Update from the Maryland Board of Nursing: Changes for the Requirements for Certified Medication Technicians and Delegating Nurse/Case Manager. The Maryland Board of Nursing has strengthened training requirements for delegating nurses and medication assistants, now known as certified medication technicians.

Certified Medication Technicians

In 2004 the Maryland General Assembly passed Senate Bill 405, strengthening the requirements for medication assistants in assisted living, school health, adult day care, juvenile service, Developmental Disabilities Administration alternative living units and group homes, etc.

- The New Board approved Medication Technician Training Program. The new Medication Technician Training program has three parts – classroom, simulations and clinical observations. *Part one* contains classroom content (e.g., how to transfer a medication order onto a medication administration record) and content which is unique to each practice setting (e.g., disease processes, medications, and high risk drugs). The theory classroom time is increased from 16 to 20 clock hours. New classroom requirements include that all mini-tests/feedback exercises be completed in the class by each individual student, not as part of a group activity or take home examination. Classroom limits were also established that include no more than six classroom clock hours at one time and one instructor per 15 students. *Part two* of the course deals with simulations wherein the student must demonstrate in the simulated skills laboratory a medication pass. *Part three*, which is a new component, requires a clinical observation of the student administering medication to a client in the assisted living program, not to be included in the 20 classroom clock hours. The instructor of the course may observe only one student pass medication at one time in this component. In addition, *prerequisites* have been established for the course that require a student to be at least 18 years of age, pass a basic reading comprehension and basic math test, and be an employee of an assisted living program. Clinical updates are required every two years in order for certification to be renewed.

- Individuals who are seeking certification as a Medication Technician. – An individual who wants to become a certified medication technician must be at least 18 years old and successfully complete a Board approved Medication Technician Training Program. The individual must submit to the Board an application that is signed by a registered nurse approved to teach the Medication Technician Training Program along with a 2x2 passport size photo. The individual will receive initial certification in the practice setting in which they receive training. For example: if the individual is trained in assisted living, their certificate would appear as "Medication Technician-Assisted Living". Only the initial certification will identify the practice setting. Should the medication technician change practice settings, it is the responsibility of the employer to ensure that a registered nurse approved to teach the Medication Technician Training Program specific to that practice

setting, provides the employee with the course content specific to that new practice setting.

- Individuals who are renewing the Technician Certificate. – Certification of a medication technician will need to be renewed every two-years.[9] The medication technician must successfully complete a Board approved clinical update specific to their practice setting within 90 days prior to expiration of their certificate. As already required, the registered nurse approved to teach the Medication Technician Training Program will submit the medication technician's clinical update verification electronically. The Board will electronically match the clinical update verification with the medication technician's renewal form and a new certificate will be mailed.

If an assisted living program has a medication assistant that has completed the appropriate training and whose name does not appear on the Board's registry, the program should contact the Board of Nursing immediately. The provider should be prepared to provide the Board the following information: (1) the individual's name, (2) their social security number, (3) the date of their initial training, (4) the date of their last clinical update, (5) the name of the registered nurse who provided their training, and (6) the date the information was submitted to the Board of Nursing.

Delegating Nurse/Case Manager

The Board of Nursing became aware that delegating nurses needed additional training to improve their skill set in both the theory and clinical aspects concerning the delegation of nursing acts to unlicensed individuals. The Board, therefore, developed a 16-hour course that all delegating nurses must complete. The course reviews topics such has how to effectively delegate nursing acts to unlicensed personnel, what degree of supervision is required, the principles of case management, ethical and legal concerns, contractual obligations, etc. The course will provide a foundation from which delegating nurses will be able to effectively advocate for residents' needs as well as learn how to access community resources. Delegating nurses will also learn how to improve the 45-day assessment process. The Central Maryland Red Cross, the Health Facilities Association of Maryland, the Beacon Institute of LifeSpan and nine community colleges statewide are approved by the Board to provide the delegating nurse/case manager training.[10]

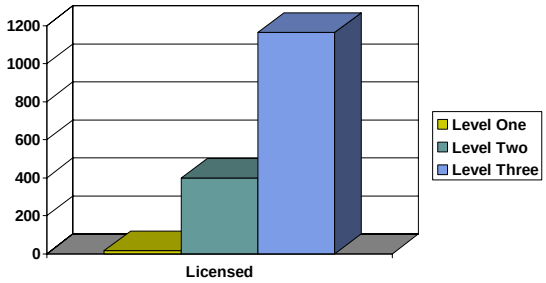
[9] An individual registered on the Board's web page as a medication assistant on or before October 1, 2004, will be certified as a medication technician. The Board began the certification process for medication assistants in early 2005 and estimates that it will take approximately two-years to certify all individuals.

[10] A list of approved programs is available on the Board's web site at http://www.mbon.org/main.php?v=norm&p=0&c=practice/rncmdn_training_sites.html. A list of delegating nurses who have taken the training is also available on the Board's website at http://www.mbon.org/main.php?v=norm&p=0&c=practice/rncmdn2005/del_nurses2005.html and is sorted by county.

Statistics: What Does Maryland's Assisted Living Program Look Like?

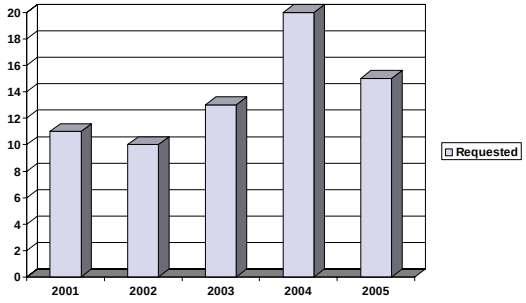
In Maryland, as of October 2005, there were 1578 licensed assisted living programs and 526 unlicensed sites identified as assisted living programs. The average program is licensed to serve 14 individuals with the median being around five individuals. The vast majority (74-percent) are licensed to provide the highest level of care; while only about one-percent elects to be licensed to provide the lowest level of care.

Table Two. Assisted Living Level of Care Designations & Licensure



The Johns Hopkins study, which was referenced before, tells us that an average assisted living resident is 85 years of age, female, and that about two-thirds of the residents in any assisted living facility have some form of dementia or cognitive impairment.

Table Three. Level of Care Three Plus Waivers - Trends



As previously noted, assisted living programs routinely elect to become licensed for the highest level of care. Typically, there is little correlation between the level of care required by the resident and the level for which the program chooses to become licensed.

Impact of Resident-Specific Waivers. In 1999, the Maryland General Assembly passed a bill requiring the Department to report on an annual basis, for the period of five years, the impact of level of care waivers granted to assisted living programs.[11] This legislation was passed out of concerns expressed by members of the General Assembly that the "aging in place" process would lead to overly frail and medically complex persons being cared for in assisted living programs.

The assisted living regulations provide that a licensee that chooses to continue to care for a resident whose level of care exceed the level of care for which the program has the authority to provide may request a resident-specific waiver in order to continue to provide services to the resident.[12]

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[11] Chapter 195 of the Acts of the General Assembly of 1999 (Senate Bill 721 – "Department of Health and Mental Hygiene – Assisted Living Programs – Report on Level of Care 3 Plus Waivers").

[12] COMAR 10.07.14.10 – Resident-Specific Level of Care Waiver. COMAR 10.07.14.10(J) – An assisted living program may not provide services to individuals who at the time of initial admission, as established by the initial assessment, would require: (1) More than intermittent nursing care; (2) Treatment of stage three or stage four skin ulcers; (3) Ventilator services; (4) Skilled monitoring, testing, and aggressive adjustment of

While the purpose of the resident-specific waiver is to determine if there is a negative impact on resident safety due to the "aging in place" philosophy, we cannot draw any conclusions from the number of wavier requests or the evaluation of such requests. We believe that many providers, for various reasons, may not be able to effectively identify when level of care waivers should be requested. Therefore, our ability to develop a resident centered regulatory model for assisted living that links the care needs of residents to the services that they receive becomes even more important.

2005 Evaluation Process

The Department reconvened the ALF during the 2005 Interim to refine its previous recommendations and discuss new areas that were identified during the 2005 General Assembly Session, such as uniform disclosure statements, AEDs, and bond and liability requirements.

Over 80 participants attended each ALF meeting, with many more individuals subscribing to the e-distribution list. All meetings were open to the public and publicized on the Forum's web site and in the Legislative Hearing Schedule.[13] There were a total of ten meetings held – five ALF meetings and five steering/planning committee meetings. Each of the meetings ran two to three hours.[14]

Meeting notes, materials and handouts were distributed electronically, handed out at meetings, posted to the ALF web site, and mailed, if requested, to stakeholders who did not have access to the Internet. Periodic updates were provided to the Secretary of DHMH and legislative committees. The inclusiveness of the process, like the 2003 and 2004 Evaluation, resulted in many diverse and creative ideas being brought forward for consideration and discussion. At the conclusion of the ALF's deliberations, the Department continued to accept comments and have discussions with any party who requested.

While on many issues there was no consensus of opinion, the Department made every effort to balance the varying opinions. Thus, the following recommendations while based on the work of the ALF, individual discussions with advocacy and provider organizations, and discussions with the Attorney General's Office, the Medical Assistance Program, the Board of Nursing, the Board of Pharmacy, sister agencies and others, are the Department's recommendations to strengthen oversight and improve the quality of care in Maryland's Assisted Living Program.

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medications and treatment where there is the presence of, or risk for, a fluctuating acute condition; (5) Monitoring of a chronic medical conditions that is not controllable through readily available medications and treatments; (6) Treatment for an active reportable communicable disease; or (7) Treatment for a disease or condition which requires more than contact isolation.

[13] ALF web site: http://dhmh.md.gov/ohcq/alforum/home.htm

[14] See Appendix A.

DHMH Recommendations

Definition of Assisted Living – A New Approach

In the 2003 and 2004 Reports, the Department recommended redefining assisted living to include three different classifications of programs to recognize the varied dynamics of different sized programs and residential settings. The recommendation proposed three categories of housing programs to include: assisted living programs – 10 or more beds; residential care homes – five to nine beds; and, adult care homes – less than four individuals served in a private residence where the owner is also the primary care giver.

Each year, the ALF has spent considerable time discussing the proposal for re-defining assisted living. Advocates, such as the Alzheimer's Association and Legal Aid, were concerned that any lessening of requirements in the small homes (those that serve one to four) would result in decreased quality of care. During the hearings on House Bill 1326, a mental health advocacy organization expressed concern over the removal of instrumental activities of daily living from programs defined as assisted living.[15] There was also significant discussion that any lessening of the regulations for smaller programs could be a regression of policy.

A review of all State definitions indicates that Maryland's definition of assisted living is among the most broad and inclusive. For example, New Jersey with almost twice the population of Maryland has only one-tenth the number of assisted living programs.[16] This is not because Maryland has a higher number of elderly who require assisted living services; it is because Maryland includes a variety of programs that are not regulated as assisted living in New Jersey and in many other states. Currently, there are more than 2,000 providers who fit in Maryland's assisted living definition.

In retrospect, establishing one set of regulations did not work. However, developing regulations based solely on size solves only part of the problem. Staff at the OHCQ reviewed five years of assisted living sanctions. It became apparent that needs of residents were not being adequately met both in smaller and larger settings. Providers were failing to link the level of care of residents to preparing an appropriate care plan for the resident. This resulted in numerous deficiencies where individuals, who would otherwise be cared for in nursing home, were injured or died as the result of inappropriate care and supervision. Therefore, the effort to enhance regulation must consider the resident's needs and level of care.

The Department has, therefore, refined its recommendation to stratify the assisted living program according to the level of care as well as to establish specific quality standards that address the unique dynamics that occur when a program aggregates a larger number of residents. Special care will be taken to create a new regulatory structure that balances safety

[15] The Mental Hygiene Administration established a Housing Workgroup to evaluate the needs of individuals with mental illness. The Workgroup has made recommendations for a type of housing program that would meet the needs of individuals who require assistance with the instrumental activities of daily living.
[16] Mollica, R. State of Assisted Living, National Academy for State Health Policy. November 2002.

and quality with appropriate level of oversight that would at least maintain minimal protections for all residents.

The recommended categories of Assisted Living programs are as follows:

1. Assisted Care Facility: This is the highest level of care category of assisted living program. Programs that choose residents who have significant care needs would be required to become licensed in this category. The standards and regulations would be strengthened to ensure the needs of these residents, who would otherwise be served in a nursing home, are adequately met. Surveys would be conducted annually and enforcement activities would remain the same. New regulations would require mandated hours of on-site nursing and awake overnight staff or an equivalent electronic monitoring system approved by the Department for residents who require it. Regardless of the size of the facility the managers of all assisted care facilities should be required to complete a Department approved 80-hour assisted living manager training course.

2. Residential Care Home: This is the middle level of care category of assisted living programs. The standards and regulations would be strengthened to ensure the needs of these residents are adequately met. Surveys would be conducted annually and enforcement activities would remain the same. New regulations would require awake overnight staff or a Department approved electronic monitoring system and on-site nursing sufficient to meet the needs of residents. Regardless of the size of the program, managers of all residential care facilities should be required to complete a Department approved 80-hour assisted living manager training course.

3. Adult Care Home: This is lowest care level category of assisted living programs. Programs that choose to serve level of care one residents would be required to become licensed in this category. The standards and regulations would be developed to ensure the needs of these residents are adequately met. Programs that serve five or more residents should be required to complete a Department approved 80-hour assisted living manager training course.

Implementation – This recommendation requires statutory change to implement.

Assisted Living Manager Training Requirements

In 2004 and 2005, the Maryland General Assembly passed bills requiring managers of specified assisted living programs to complete, by January 1, 2006, an 80-hour training course that includes an examination and 20-hours of continuing education every two years. Grandfathering is provided for those managers who have been employed as managers for one-year prior to the implementation date.[17]

[17] Chapter 310 of the Acts of the General Assembly of 2004 (House Bill 1190 – "Assisted Living Programs – Assisted Living Managers – Training Requirements") and Chapter 292 of the Acts of the General Assembly of 2005 (Senate Bill 265 – "Assisted Living Programs – Criteria for Requiring Manager Training.

The Department, in consultation with Mid-Atlantic LifeSpan, the Alzheimer's Association, the Mental Health Association of Maryland, the Small Assisted Living Alliance, the Maryland Association of Small Assisted Living Providers, the Beacon Institute and the Health Facilities Association of Maryland, developed core content areas for the assisted living manager training. The core content areas were also reviewed and discussed with the ALF. The core content areas cover the philosophy of assisted living, aging process and its impact, assessment and level of care wavier, service planning, clinical management, admission and discharge criteria, nutrition and food safety, dementia, mental health and behavior management, end-of-life care, management and operation, emergency planning, quality assurance, and the survey process.[18]

The Department promulgated regulations, which became effective October 2005. We are actively recruiting education programs, associations and various training/vocational schools to offer the manager training course. However, we have been told that schools require a full-blown curriculum to be prepared. We have begun working with stakeholders to develop the curriculum.

Implementation - The Department is actively recruiting education programs, associations and schools to offer the manager training course. However, unless a school will offer the training and develop a curriculum, the Department must coordinate stakeholders to do so.

Assessment Tool

In the 2003 Evaluation Report, it was noted that the Assessment Tool and the Scoring Guide needed to be revised to enhance its effectiveness. It was noted that providers identified problems that indicated that the scoring ranges may be too broad. This was attributed to the wide range which allows for heavy care residents to be scored as level two and the vast majority of level two residents scoring at around 35 points or above. The scoring range did not adequately capture:

- Behaviors that would require greater need for attention by the assisted living manager and/or staff to manage (e.g., combativeness, biting, kicking, starting fires, disrobing, etc.); or,
- Increased physical dependencies that when linked with a behavior presents care/staffing issues (e.g., any of the above with medical complexity such as bed sores, renal dialysis, seizures, oxygen, post surgical wounds).

The Assessment Tool and the Scoring Guide have been revised and tested. The new Resident Assessment Tool was implemented on September 1, 2005, and the following implementation schedule is being utilized: (1) All residents admitted on or after September 1, 2005, must be assessed using the revised Resident Assessment Tool and supporting documentation; and (2) All residents admitted before September 1, 2005, must have an assessment completed using the revised Resident Assessment Tool before March 1, 2006.

[18] See Appendix B for Assisted Living Manager Core Content.

Awake Overnight Staff

The National Assisted Living Workgroup recommended in 2003 that ALPs should be required to have awake overnight staff. Of the workgroup's membership, 22 organizations supported the recommendation for awake overnight staff and 10 others wanted it stronger with specified numbers of awake overnight staff.[19] Only the Assisted Living Federation of America opposed the recommendation. According to the National Center for Assisted Living, there are 12 states that specifically require awake overnight staff.[20]

In 2003, the Department recommended requiring awake overnight staff for those programs that served 17 or more individuals and in 2004, it refined its recommendation to include those programs licensed to serve five or more individuals and included a provision for a Department-approved electronic monitoring system. In 2005, the Department has moved beyond size requirements and linked the requirement to care needs.

The Department strongly supports the requirement for awake overnight staff in ALPs when residents have overnight care needs, such as dementia, wandering behaviors or are unable to toilet independently. We know from the Johns Hopkins study that two-thirds of individuals in ALPs have some form of dementia or cogitative impairment. Other national studies have been conducted with similar results. One of the characteristics of individuals with dementia is that they tend to be awake during night and wander.

The existing level of care instrument, the Resident Assessment Tool, will be used to determine when these types of needs are present. The Department will consult with a gerontologist to develop a methodology to measure when a resident scores in certain specified areas on the level of care instrument, such as medical and psychiatric history, risk factors, sensory impairments, cognitive and behavioral status, mobility, ability to transfer, continence, wandering, sleep disturbance, resistive or uncooperative behaviors, etc. will require the program to have awake overnight staff.

Implementation – This recommendation requires the Department to promulgate regulations. The Department will circulate draft regulations in the late Spring.

On-site Nursing

The National Assisted Living Workgroup did not reach consensus for an on-site nursing requirement, and this was also difficult discussion for Maryland's ALF. In the 2003 and 2004, the Department recommended on-site nursing requirements on a sliding scale for

[19] The Assisted Living Workgroup. "A Report to the U.S. Senate Special Committee on Aging: Assuring Quality for Assisted Living: Guidelines for Federal and State Policy, State Regulation, and Operations". April 2003.

[20] National Center for Assisted Living. "Assisted Living State Regulatory Review 2004". March 2004. The state's that require awake overnight staff include: Delaware, Illinois, Indiana, Kentucky, Montana (for category B and C facilities), Nevada (for facilities with more than 20 residents), New Jersey, Rhode Island, South Carolina, South Dakota, Wisconsin (in facilities with one or more residents requiring continuous care), and Wyoming.

specified programs based on the number of residents served. In 2005, the Department again moved beyond just the size of the program and linked on-site nursing to the level of care of the resident.

The Department strongly supports on-site licensed nursing requirements for programs that aggregate more than 17 residents and when the residents' needs require an enhanced nursing presence. The Department will consult with a gerontologist to develop a methodology based on the existing level of care instrument that identifies when a resident requires on-site nursing presence. The methodology will point to certain specified areas in the level of care instrument, such as those identified for awake overnight staff as well as the nutritional needs of the resident, wounds, and whether they have high risk medication management needs.

Table Four. On-Site Nursing Requirements

Program Size	Hours of Nursing Required per Week
1 to 16	Sufficient to meet the needs of residents.
17 to 25	Sufficient to meet the needs of residents, but at a minimum 20-hours and available as needed.
26 to 34	Sufficient to meet the needs of residents, but at a minimum 30-hours and available as needed.
35 to 49	Sufficient to meet the needs of residents, but at a minimum 40-hours and available as needed.
50 or More	Sufficient to meet the needs of residents, but at a minimum 56-hours (eight hours a day, seven days a week) and available as needed.

The on-site licensed nurse would work in partnership with the delegating nurse (or could in fact be the delegating nurse) and program staff to ensure adequate assessment of residents, identification of change in resident condition, completion of adequate service plans, planning of medical services, and oversight of nursing activities in general. Depending upon the needs of the residents and consistent with the Board of Nursing's standards, the on-site nursing requirements could even be met with the use of licensed practical nurse.

Implementation – This recommendation requires the Department to promulgate regulations. The Department The Department will circulate draft regulations in the late Spring.

Quality Assurance

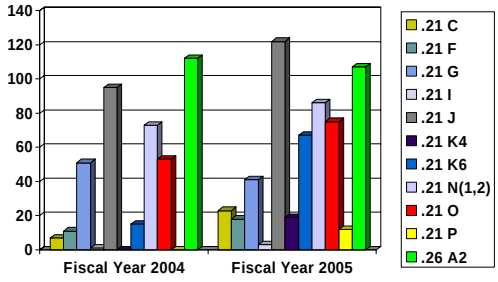
The role of the assisted living manager and the delegating nurse/case manager should be clarified in the regulations because there appears to be some confusion in the community about their respective responsibilities. This is an opportunity to help ensure the care needs of the resident are being met, a corner stone of a resident centered model. The assisted living manager, the delegating nurse/case manager, and the pharmacist should meet periodically to review the change of status of the program's residents, outcomes of pharmacy reviews and care planning requirements. These meetings should be documented in some manner by the assisted living manager.

Implementation – This recommendation requires the Department to promulgate regulations. The Department will circulate draft regulations in the late Spring.

Medication Management

It is known from national studies that most residents in assisted living have multiple diagnoses, some debilitating, and will take, on average, 9 to 14 medications per day. The Fleetwood Project demonstrates the health and cost benefits of utilizing drug regimen reviews (DRR) and the Delegating Nurse Study points to the numerous medication administration errors in assisted living programs. In addition, data surveys conducted indicates that for the period of Fiscal Year 2004 and 2005, the number of deficiencies related to medication administration have increased 37-percent.

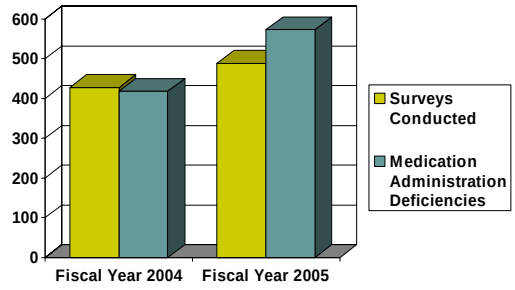
Table Four. Medication Administration Deficiencies by Citation



Refers to COMAR 10.07.14.21 and 10.07.14.26

Pharmacists can play an integral role in the assisted living setting. They can identify drug interactions, inappropriate medications, address medication-related questions, etc. DRR can greatly benefit providers through potential cost savings on their pharmaceuticals expenses, as well as providing an effective means of preventing or correcting drug-related problems.

Table Five. Medication Administration Deficiency Comparison by Fiscal Year.



The Department strongly supports quarterly reviews by a licensed pharmacist, mandated compliance packaging, and an annual medication review by a physician or nurse practitioner.

Implementation - This recommendation requires the Department to promulgate regulations for pharmacy review. The Department will circulate draft regulations in the late Spring.

Disclosure Requirements for Special Care Units or Programs (SCU)

Over the past eight years, the Department has noted that many assisted living programs advertise SCUs specializing in Alzheimer's care, or rehabilitation care. In 2002, the General Assembly passed Senate Bill 746 that required assisted living programs to disclose the nature of special care units to the Department and to potential residents.

Typically, assisted living programs charge additional fees to residents who receive services in a SCU. Most residents with cognitive disorders, such as Alzheimer's disease, decline in a progressive manner resulting in an ongoing loss of functional ability. Therefore, the services to those individuals in SCU should be different in nature to those offered in the rest of the assisted living program.

Current law provides that an assisted living program operating a SCU must disclose how the care of unit is specifically designed for individuals with Alzheimer's disease or a related disorder. It also requires that a SCU provide at the time of licensure or licensure renewal to the Department a written description that includes:

- Statement of mission and philosophy;
- Staff training and job titles;
- Admission procedures and screening criteria;
- Staffing patterns;
- Description of physical environment, including any special features;
- Description of activities;
- Charges to residents; and,
- Discharge procedures.

The Department strongly supports requiring an assisted living program that operates a SCU to at the time of licensure provide the Department with the written description of the program and at the time of licensure renewal a written description of any changes that have been made to the SCU and how those changes differ from the description of the unit on file with the Department. The Department should also have the authority to restrict or close the operation of a SCU if the Department determines that the health and safety of the residents are risk. Programs should also be required to disclose to residents and their family members how the SCU services are different from those provided in the rest of the assisted living program.

Implementation – This recommendation requires the Department to promulgate regulations for the stronger standards for special care units. The Department will circulate draft regulations in the late Spring.

Standardized or Uniform Service Disclosure Forms

During the 2005 General Assembly Session House Bill 1424 was introduced which would have required the Department to develop a standardized assisted living program disclosure statement modeled after Appendix III of the Federal Government Accounting Office Report GAO-04-684 entitled, *Assisted Living, Examples of State Efforts to Improve Consumer Protections*. The report highlighted a Texas policy that requires all assisted living facilities to fill out a disclosure statement, the purpose of which is to help consumers' to better compare facility policies and services in uniform categories.

The purpose of the disclosure statement is to provide consumers with information about the actual services an assisted living program provides and to aid the consumer in choosing the most appropriate program to meet their needs. The bill would have been applicable to assisted living program licensed to serve five or more individuals. Those programs would have been required to file a disclosure statement with the OHCQ as part of the licensure

application process. A program would have been required to submit an amended disclosure statement within 30 days of any change in services provided by the program.

The Department believes that increasing access to information about assisted living facilities would be extremely beneficial to consumers regardless of the size of the program. Developing a standardized format for specific data relating to the services provided by an assisted living facility will better assist consumers in assessing facilities and determining whether or not the facility can either meet their needs or the needs of their loved ones.

The Department supports expanding the accessibility of disclosure statements to include family members or a responsible party of a consumer; requiring an assisted living program at the time of licensure, licensure renewal or within 30 days of a change to notify the Department of any changes or services provided; and requiring the assisted living provider to provide a copy of the service disclosure statement to any person that requests a copy. The OHCQ is developing a draft uniform service disclosure form that will be shared with industry representatives and advocates for their review and comment in Spring of 2006.

Implementation - This recommendation requires the Department to develop a uniform service disclosure form and to promulgate regulations. The Department will draft a uniform service disclosure form and circulate it, along with draft regulations, in the late Spring.

Emergency Generators

House Bill 20 during the 2005 General Assembly Session would have required the assisted living programs licensed to serve 50 or more individuals to have an emergency power generator on premises that meets specified criteria, provides lighting and supports certain systems. In Maryland, nursing homes with 50 or more beds are required to have an emergency power generator as well as a disaster plan; and those with 49 or fewer beds have the option to install an emergency generator or to provide a written evacuation/relocation plan for patients that is approved by the Department.[21] Nursing homes are also required to have signed agreements between the nursing facility and the facility that agrees to accept the patients.[22]

During Hurricane Isabelle some local jurisdictions had to provide emergency power to some assisted living programs. Of the 1,580 licensed assisted living facilities in Maryland, if the cut-off is 50 beds, 98 facilities would be subject to this requirement. The Department conducted an informal survey of those programs during the Legislative Session and found that 21 of the 98 programs did not have any type of emergency generator.

The Department recommends that generators be required for ALPs licensed to serve 50 or more individuals and that an exception for this requirement be given to those programs that can safely transfer residents via an enclosed corridor to another facility with an emergency generator or power. In addition, ALPs that can demonstrate financial hardship that would

[21] COMAR 10.07.02.26(F).
[22] COMAR 10.07.02.23(A).

adversely affect the program's viability can apply for a waiver for this requirement on a year-to-year basis.

Implementation –This recommendation requires the Department to promulgate regulations. The Department will circulate draft regulations in the late Spring.

Automated External Defibrillators (AEDs)

House Bill 21 from the 2005 General Assembly Session, would have required nursing homes and assisted living facilities, with the exception of those facilities (1) is licensed for nine or fewer beds; (2) participates in the Certified Adult Residential Environment Program administered by the Department of Human Resources (DHR); or (3) has a defibrillator on-site, to have and maintain an automated external defibrillator (AED) and have a trained operator on-site 24-hours each day. It would have also allowed an assisted living program and a nursing facility to participate in the Maryland Institute of Emergency Medical Services Systems' AED program. House Bill 21 would, therefore, have applied to 353 of the 1,580 licensed assisted living facilities in Maryland.

In its fiscal analysis, the Department of Legislative Services notes that the average cost range for an AED is somewhere between $800 for a refurbished unit to more than $4,000 for a new unit. In addition, employee training would be required. While the effectiveness of an AED program in a facility is based upon immediate access to a unit and intervention in the event of an arrest by a trained operator, assisted living facilities may need to purchase more than one unit. These costs may be a financial burden for some medium sized facilities. It is also uncertain how a facility's use of an AED may interact with a resident's advanced directive or its potential impact on end-of-life care.

The Department does not recommend mandating the use of AEDs for assisted living programs. It should be noted that the Maryland Institute of Emergency Medical Services Systems' study indicates that relatively few cardiac events occur in assisted living facilities.[23] Assisted living facilities should be permitted, and encouraged, to participate in the Institute's AED program. Facilities should disclose to residents in the ALPs admission agreement if they participate in the program and provide residents with the program's policy on the use AEDs.

Implementation – This recommendation would require legislation to allow assisted living programs to participate in Maryland Institute of Emergency Medical Services Systems' AED program as well as the Department to promulgate regulations.

Discharge Planning

In 2005, the Maryland General Assembly passed a bill that adopted the Joint Commission on Accreditation of Health Care Organization's requirements regarding patient discharge or

[23]Maryland Cardiac Arrest Surveillance System - Maryland Out-of-Hospital Cardiac Arrests – 2001 to 2003. A report by the Maryland Institute of Emergency Medical Services System.

transfer from the hospital. In Maryland all hospitals must be JCAHO accredited.[24] The hospital's process for transfer or discharge must be based on the patient's assessed needs. Specifically, a hospital must assess a patient's needs, plan for discharge or transfer; facilitate the discharge or transfer process; give the patient written discharge instruction; and help to ensure continuity of care, treatment and services. The bill also provided that if a hospital fails to meet these requirements it is subject to a civil money penalty up to $10,000 for each failure to comply. The Department has drafted regulations to implement the provisions of this bill and they were published in the December 2005 Maryland Register.

Many hospitals use "placement agencies" to assist them in identifying alternatives for individuals who can not return to their home or are homeless. These agencies are not regulated. Many market or solicit services for assisted living providers that may not be licensed. Hospitals, while having the duty to provide for appropriate discharge planning, are often told by these agencies that the facilities they represent are licensed and may even provide informational brochures indicating such. The Department recommends that additional evaluation be given to the use of these agencies and their impact on the discharge planning process.

Implementation – This recommendation requires the formation of a workgroup, with representation from the hospital and assisted living industry, as well the OHCQ and the Boards of Nursing and Social Work, to evaluate the use of placement agencies and their impact on the discharge planning process.

Patient's Plan of Care

In 2004, the Maryland General Assembly passed a bill requiring the Office of the Attorney General to develop a "patient's plan of care" form that reflects an individual's preferences for treatment and care, including the use of life-sustaining procedures and transfer to a hospital from a non-hospital setting.[25] While the bill pertained to comprehensive care or extended care facilities, assisted living residents would benefit from the use of this form. The OHCQ is aware of situations where emergency medical personnel have had to take the resident's entire medical record on transfer to the hospital. This scenario presents numerous problems for emergency medical personnel, the hospital and the assisted living facility. Emergency personnel are required to skim through the record to determine what medications the resident is taking, if there is an advanced directive or specific treatment preferences, medication allergies, etc. Because the entire file has then been transferred with the resident and the assisted living facility has no records. The hospital has a file which contains information that may not be germane to care and may be confidential. Therefore, the Department strongly supports requiring assisted living facilities to use the "patient's plan of care" form.

Implementation – This recommendation would require legislation.

[24] Chapter 296 of the Acts of the General Assembly of 2005 (Senate Bill 303 – "Sara Hohne Patient Protection Act").
[25] Chapter 506 of the Acts of the General Assembly of 2004 (House Bill 566 – "Patient's Plan of Care" Form – Communication of Patient Preferences").

Transfer Between Assisted Living Providers

The Department has become aware that some providers have been "shuffling" residents between programs for various administrative reasons. Concerns of relocation trauma and quality of care necessitates additional parameters be put into place for the transfer of residents. The Department, therefore, proposes strengthening COMAR 10.07.14.24 (A), which provides that an assisted living program may not relocate a resident except in accordance with the terms and conditions of the resident agreement. An assisted living program should be required to notify a resident and the resident's representative at least ten days before any relocation. Except for in the event of an emergency, an assisted living program should be required to obtain the consent of the resident or the resident's representative. The program should also document in the resident's record how the requirements of the regulation have been met. In addition, the Department proposes adding a new item to COMAR 10.07.14.26 (Resident's Rights) to specify that a resident of an assisted living program, or their representative, has the right to consent to the transfer.

Implementation – This recommendation requires the Department to promulgate regulations. The Department will circulate draft regulations in the late Spring.

Liability Insurance

Also contemplated in House Bill 1425 from the 2005 General Assembly Session was whether or not the State should require all assisted living programs to have liability insurance. Liability insurance is not required for the licensure of other health care facilities in Maryland. Providers indicated that they had trouble finding companies that would provide liability insurance coverage and as a result they have become "self" insured. The Small Assisted Living Alliance of Maryland has indicated that it is working with its members to determine the availability of liability insurance.

The Department does not recommend that liability insurance be required for licensure of assisted living programs.

Bond Requirements

During the 2005 General Assembly Session House Bill 1425 was introduced which would have required evaluation of the effectiveness of care provided by Adult Family Homes (assisted living programs licensed to serve four or fewer individuals) in Maryland, specifically addressing issues, such as requirements for liability insurance, notification, surety bonds, etc. COMAR 10.07.14.28(E)(3) already requires that an assisted living program that manages residents' personal funds, regardless of the amount managed, shall maintain a bond, a letter of credit or net assets one-and-one-half times the average monthly balance of all of the funds held or managed by the program. The bond, letter of credit or list of assets shall be kept at the ALP for inspection by the Department or its designee. This is similar to requirements for other licensed health care facilities.

The Department does not recommend additional bonds be required for the licensure of assisted living programs.

Notification

Also contemplated in House Bill 1425 from the 2005 General Assembly Session was whether or not ALPs should be required to register with their local health departments, law enforcement agencies, and local fire departments. Currently COMAR 10.07.14.06(A)(4)(h) requires that a minimum a prospective ALP shall provide notification to the local health department and local area on aging of its request for licensure. The Department proposes that a new section should be added to require ALPs to notify the local fire department once they become licensed.

Implementation –This recommendation requires the Department to promulgate regulations. The Department will circulate draft regulations in the late Spring.

False Advertising

The Department has become aware that there are some assisted living programs who falsely advertise services that they can provide, for example, an Alzheimer's Unit or other special services. Consumers rely upon those representations when making decisions and it may be costly and difficult to transfer a resident once they are admitted to an assisted living facility. The Department recommends that providers who willfully and purposely false advertise should be subject to an administrative penalty up to $10,000.

Implementation – While this standard can be established via regulation we believe that it may be made easier by having legislation that specifically address false advertising. Absent such legislation, the Department will promulgate regulations and circulate draft regulations in the late Spring.

Operating without a License

In Fiscal Year 2004, the Department imposed 20 sanctions and in Fiscal Year 2005, 27 sanctions on assisted living providers. These are generally the most egregious cases when residents have been abused or neglected. Even so, it has been difficult to get attorneys to prosecute providers that operate without a license and we have been told that the reason is that the crime is a misdemeanor and not a felony.

Currently, an individual who operates an unlicensed assisted living program is subject to a misdemeanor criminal penalty, five years in prison, and up to a $10,000 fine. Fines may not be an effective deterrent when providers are incorporated or are judgment proof.

Providers have stressed that any increase in penalty should be applicable only to those programs where a deliberate or purposeful intent to violate has occurred rather than those providers who have attempted to apply for licensure but who have not yet received a license. The Department agrees and recommends that an individual who operates an assisted living

program without a license with the intent to be unlicensed should be subject to a felony criminal penalty, five years in prison, and up to a $10,000 fine.

Implementation - This recommendation requires a statutory change to implement.

Falsification or Alteration of Licenses

The Department has experienced situations a provider has either falsified or altered their assisted living license. In these instances, the Department has referred the cases for criminal prosecution. Because of the reasons referenced above, it has been difficult to prosecute these providers.

As previously referenced, the Office of the Attorney General has determined that the Assisted Living subtitle provides the Department with broad authority to improve the regulatory framework for assisted living. The Department recommends that the regulations should be changed to provide that if an individual either falsifies or alters a license they will be subject for referral for criminal prosecution and the imposition of civil fines.

Implementation – This recommendation requires the Department to promulgate regulations. The Department will circulate draft regulations in the late Spring.

Mandatory Participation of Residents in Adult Medical Day Care (AMDC)

The Department has become aware that there are some assisted living providers that require all of their residents to AMDC programs every day without exception. COMAR 10.07.14.14 requires that an assisted living program have a staffing plan that includes on-site staff in number and qualifications to meet the 24-hour scheduled and unscheduled needs of the resident. Participation in AMDC programs, while encouraged, should be voluntary, not mandatory and AMDC availability and policies should be disclosed in the admission agreement.

Implementation - This recommendation requires the Department to promulgate regulations. The Department will circulate draft regulations in the late Spring.

Assisted Living Programs Offering Drop-In or Day Services

The Department has become aware that there are some assisted living providers advertising "drop-in" adult medical day care services. That is, people who are not program residents receiving day care services, but who leave at the end of the day. COMAR 10.07.14.09(D) requires that an assisted living program may provide short-term residential care defined as either continuous or intermittent stay in an assisted living program of not more than 30 days a year from the date of initial admission. Therefore, assisted living programs may provide respite residential or short-term residential care with appropriate agreements and consents within the program's licensed capacity. The Department recommends that the regulations be strengthened to include a statement that assisted living programs may not provide day, partial day or hourly services without appropriate AMDC licensure.

Implementation - This recommendation requires the Department to promulgate regulations. The Department will circulate draft regulations in the late Spring.

Change of Initial Application Process

During the 2004 General Assembly Session, legislative leaders requested that the Office of Health Care Quality (OHCQ) develop a work plan for Fiscal Year 2005 and 2006 because of their concern about the loss of survey staff.[26] In order to better allocate scarce resources, assisted living programs seeking initial licensure will be required to provide prerequisite licensure documents, such as policies and procedures, educational training, fire inspection, zoning (if applicable), and criminal background checks of managers and assistant managers, before an application will be sent to the provider and an on-site pre-licensure inspection scheduled.

Implementation - The Department has already changed its initial licensure process and has implemented this recommendation.

Efficiency in the Oversight and Monitoring of Assisted Living Programs

The current licensing system is insufficient to meet the challenge of ensuring safety in assisted living programs. When the Assisted Living statute was passed in 1996, it required the Department to work with DHR, DoA, and local governments and to delegate inspection authority to other agencies. There are more than 40 agencies including county Health Departments and Area Offices on Aging across the State are involved in conducting surveys in assisted living. This has created uneven fee structures, confusion, and unevenness in the application of the assisted living regulations and statute.

It was originally envisioned that the Department provide technical assistance and oversight of the State's Assisted Living Program; it is now expected to conduct the majority of surveys. Budget challenges have resulted in many agencies relinquishing all or part of their delegation authority back to the State. While some efforts to increase staffing to accommodate workload have been made, the OHCQ remains severely understaffed.

A more streamlined approach to oversight and monitoring needs to be developed that recognizes and utilizes existing resources and agreements. The Department recommends that all existing delegation agreements and memorandums of understanding be inventoried, reviewed and updated to most effectively utilize local, other agency and perhaps volunteer resources.[27] The Department recognizes that local agencies are under considerable pressure

[26] Since Fiscal Year 2002, the OHCQ has lost approximately 44 full-time equivalent (FTE) positions. The staffing analysis in the January 2005 Report to the Senate Budget & Taxation and the House Appropriations Committees indicates that the OHCQ is experiencing a surveyor shortage of 55 FTE positions.

[27] Montgomery County has an existing program through its Ombudsman Program that utilizes trained volunteers to review care in assisted living facilities. Montgomery County's model could be replicated in other jurisdictions.

to place individuals and acknowledges that this tension may affect enforcement. Therefore, enforcement would remain centralized within the State agency.

The OHCQ has also requested approval to hire a Program Manager for the Assisted Living program. The manager will be responsible for directing surveyor resources in the most efficient and effective manner, managing the day-to-day operations of the program, and ensuring that the interpretation of compliance standards are consistent amongst all surveyors.

Implementation – This recommendation requires the OHCQ to hire a manager for the Assisted Living program. The OHCQ has requested approval to hire a manager for the program. The recommendation would require the program manager to review the agreements with the jurisdictions who participate in the Assisted Living Program to assess efficiency and consistency.

Project Home

The Department recognizes the unique nature of the DHR's Project Home Program, which distinguishes it from other assisted living providers. Some levels of care provided by the Project Home program may not be a good fit for assisted living level of regulation. Project Home is a program administered by the DHR that provides housing and related services for adults, who because of disability, require a supportive housing arrangement to reside in the community. While the program has evolved over its 25 years of operation, it has remained consistent in its core value of providing a family-oriented, home-like residential setting for adults. The Project Home statute requires that DHR may only provide this housing and care in program that is also licensed as an assisted living facility. [28]

There exists an opportunity for the Department to delegate various aspects of its responsibilities under the subtitle to monitor and inspect assisted living programs and facilities to the DHR, in accordance with an interagency agreement, for oversight and monitoring of the Project Home Program.[29] The DHR-Project Home and DHMH-OHCQ, therefore, met in September to begin discussions on how a Memorandum of Understanding (MOU) can be utilized to accomplish this goal.

Table Six. Statistics on the Project Home Program

- There are 263 Project Home programs licensed under the Assisted Living statute.
- Average program provides services to 3 individuals
- Number of Providers by Level of Care:
  - Level 1 – 1
  - Level 2 – 216
  - Level 3 – 46

A MOU would set out the parameters of a delegation agreement and delineate the roles and responsibilities of the respective agencies. To support the agreement that DHR provides sufficient self regulation the MOU include a description of the program; a cross-walk of the DHR regulations to assisted living regulations noting what elements are duplicative; a statement regarding the level of care and program size limitations; a

[28] Article 88A – Department of Human Resources, Section 140.
[29] Health-General Article §19-1804(3).

description of the clients served by the program; description of the accreditation process that Project Home is currently undergoing; and the safeguards that Project Home has in place for its providers. While legislation is required to remove DHR-Project Home from the definition of assisted living, a MOU is an immediate remedy to the situation.

DHR-Project Home representatives have expressed concerns regarding nursing standard compliance (delegating nurse and medication technician), but these are not requirements that the OHCQ has the authority to address or to waive. These issues should be directed to the Maryland Board of Nursing.

Minimum Licensing Standards and Denial of License

The Department through its survey experience has noted that minimum licensing standards need to be strengthened to ensure that assisted living program operators have appropriate experience to operate a program. Therefore, the Department recommends that COMAR 10.07.14.06(B) be strengthened to require an applicant to submit: (a) information concerning the applicant's past or current operation of health or residential facilities or similar health care program; (b) information demonstrating financial and administrative ability to operate an ALP in compliance with this chapter; (c) policies and procedures to be implemented; (d) identification of relief personnel; and (e) any other information relevant to the provider's ability to care for assisted living residents.

Implementation – While the Department plans to strengthen COMAR 10.07.14.06(B), we believe that strengthening the regulations may be made easier by having legislation that specifically addresses minimum licensing standards as well as our ability to deny a license. Absent the introduction of legislation, the Department will circulate draft regulations in the late Spring.

Prioritization of Survey Activity

State law requires at least one unannounced, on-site survey per year in each of Maryland's licensed assisted living programs.[30] The OHCQ was only able to accomplish 428 surveys or 27-percent in Fiscal Year 2004 and 495 surveys or 31-percent in Fiscal Year 2005.[31] While the percentage of assisted living facilities has increased over the two fiscal years and although there are other reasons for the inability to accomplish this requirement, lack of resources is a primary concern.

[30] Health-General Article, Title 19, Subtitle 18, Annotated Code of Maryland.
[31] Survey activity data: Fiscal Year 2004 – 428 surveys of 1575 licensed facilities; and Fiscal Year 2005 – 495 surveys of 1580 licensed facilities.

There are a total of 30 staff in the Assisted Living Unit. There are 17 professional staff persons who are assigned to do survey work only. The unit also includes an appropriate infrastructure necessary to support the surveyors' activities and to issue over 1,500 licenses annually. This 13 member support system includes: three team leaders or coordinators who schedule surveys, assign and triage complaints and manage information required for State purposes, five clerical or secretarial support staff; one nurse who manages the help desk to provide technical assistance to assisted living providers; two professional staff (a nurse and an administrative officer) who work with citizens to take and triage 325 complaints and referrals, and two coordinators of special programs that provide various administrative services.

Table Seven. Assisted Living Surveyor Shortage[32]	
Current Number of Surveyors	17.00
Number of Surveyors Required	39.95
Surveyor Shortage	-22.95

Because there are few routine inspections, there is little continuity or even assurance that a provider who barely met standards last years meets minimal requirements this year. The Department recommends that surveys be prioritized for assisted living programs based upon, but not limited to, the following criteria:

- Level of care designation;
- Compliance history;
- Past survey findings;
- Ability of the provider to meet standards;
- Change of management or ownership;
- Change of license; Number of beds;
- Length between surveys;
- Severity and scope of compliant; and,
- Participation in the Medicaid Home and Community Based Services Waiver for Older Adults.

The OHCQ can implement this recommendation through the development of an internal policy to re-direct its limited resources. For example, two coordinators previously doing office work have been conducting surveys part-time. It is important to note that absent statutory change, on-site unannounced annual inspections will still be required. Given the current level of resources, however, OHCQ will be unable to meet this mandate.

Implementation - This recommendation requires the OHCQ to develop an internal policy to direct its survey resources. The internal policy should be completed by late Spring.

Creation of a Health Care Quality Account for Assisted Living

Maryland's Health Care Quality Account for nursing homes was established in 2000 by the General Assembly and mirrors the account established by federal regulation to be used to improve the quality of care in nursing homes.[33] The account is funded through civil money

[32] Office of Health Care Quality, *Work Plan for Fiscal Years 2005 and 2006*. Report to the Senate Budget and Taxation and House Appropriations Committees, as Required by the April 2004 Joint Chairmen's Report – Operating Budget. January 2005.
[33] Chapter 488 of the Acts of the General Assembly of 2000 (House Bill 634 – "Nursing Homes – Sanctions and Penalties").

penalties assessed to nursing homes for violations of standards. Penalties are assessed to nursing homes when a deficiency exists or there is an ongoing pattern of deficiencies. The account is non-lapsing, special funds to be used for training, grant awards, demonstration projects or other purposes designed to improve the care in Maryland's nursing homes.

Applications for grants from the Health Care Quality Account are accepted from September to April, selected in May, and are awarded on a fiscal year basis. Grant amounts vary and depend upon the number of successful applications received and the availability of funds. Applications are evaluated on specified criteria.[34] This process results in a diverse pool of applicants. For Fiscal Year 2006, the OHCQ awarded four grants for a broad range of timely issues facing the long-term care industry from accessing end-of-life care needs to enhancing the efficacy and communication of family advocates.

The Department recommends establishing a Health Care Quality Account for assisted living. The funds obtained through civil money penalties for violations of standards could be accessed by providers, trade associations, consumer groups, or other interested parties for purpose of improving the quality of care in assisted living programs.

Implementation - This recommendation requires statutory change to implement.

Conclusion

While problems have emerged as the State attempts to regulate assisted living, there is no question that since the implementation of the assisted living statute, the quality of care in assisted living has improved. The Department believes that a resident centered regulatory model is the next step to link the needs of residents to appropriate standards. This will permit the Department to manage its resources to better ensure the needs of residents of assisted living facilities are being met.

This Spring, the Department will begin to draft regulations to implement many of the recommendations contained in this report. This is an exciting time for Maryland's Assisted Living Program. This new regulatory approach will place order in a system that is cumbersome to manage. Because of the level of interest in Assisted Living, we know that any attempt at change will yield numerous comments, complaints, and suggested alternatives. We have developed the recommendations in this report after hearing many stakeholders active in the ALF. These recommendations are our best effort to take the next step with Maryland's Assisted Living Program and to ensure that assisted living is not just an option, but a dependably safe option for vulnerable citizens and that citizens are given meaningful information to make an educated selection when choosing an assisted living facility.

[34] Applications are evaluated on the following criteria: (1) Background information concerning the person(s) or organization requesting the grant; (2) Description and scope of the project and explanation of how the grant would improve the quality of care for nursing home residents; (3) Description of measures that will be used to quantitatively analyze the impact of the project; (4) Timeline and dates by which each phase of the project will be completed and the projected completion date for the entire project; (5) Project cost, including specific breakdown of expenses; and, (6) Quarterly reporting to the OHCQ on the status of the project and date by which the final report will be submitted.

Appendix A: Meeting Dates

2005 Meeting Dates

Assisted Living Forum Meeting Dates

- July 13, 2005
- August 24, 2005
- September 21, 2005
- October 18, 2005
- November 14, 2005

Steering/Planning Committee

- June 20, 2005
- August 4, 2005
- September 8, 2005
- November 7, 2005

2004 Meeting Dates

Assisted Living Forum Meeting Dates

- May 12, 2004
- June 9, 2004
- July 7, 2004
- September 8, 2004
- September 22, 2004

Steering/Planning Committee

- June 22, 2004
- July 6, 2004
- July 19, 2004

2003 Meeting Dates

- May 27, 2003
- June 9, 2003
- June 24, 2003
- July 9, 2003
- July 22, 2003
- August 12, 2003
- August 27, 2003
- September 11, 2003
- September 17, 2003

Appendix B: Assisted Living Manager Core Content

ASSISTED LIVING MANAGER TRAINING COURSE CORE TOPICS

Core Topic Area	Content Hours

PHILOSOPHY OF ASSISTED LIVING — **2**

- Philosophy and Background of Assisted Living and Aging in Place
- Objectives and Principles of Assisted Living Resident Programs
- Comparison of Assisted Living to Other Residential Programs
- Basic Concepts – Choice, Independence, Privacy, Individuality, Dignity
- Normalization of the Environment

AGING PROCESS AND ITS IMPACT — **4**

- Physical
- Psychosocial
- Basic Needs of the Elderly and Disabled
- Activities of Daily Living

ASSESSMENT AND LEVEL OF CARE WAIVER — **6**

- Purpose and Process
- Guidelines for Conducting Assessments
- Level of Care Assessments
- Collaboration with Case Manager Delegating Nurse

SERVICE PLANNING — **6**

- Required Services
- Enhanced Scope of Services
- Development of Individualized Service Plans
- Scheduling of Appropriate Activities
- Structure of Activities
- Care Notes
- Collaboration with Case Manager Delegating Nurse

CLINICAL MANAGEMENT — **20**

- Role of the Delegating Nurse
- Appropriate Nurse Delegation
- Concept of Self-Administration
- Concept of Medication Management
- Assistance with Self-Administration of Medications
- Administration of Medications
- Coordination of Services and Care Providers
- Collaboration with Case Manager Delegating Nurse
- Medication Error Prevention
- Patient Safety
- Medication Monitoring
- Pharmacy Consultation
- Medication Storage
- Infection Control
- Universal Precautions
- Appropriate Staffing Patterns
- Pressure Sores
- Effective Pain Management
- Basic First Aid
- CPR
- Substance Abuse

ADMISSION AND DISCHARGE CRITERIA — **4**

- Overview of Criteria for Admission and Discharge
- Resident Contracts
- Resident Rights
- Financial Management of Resident's Funds
- Working with Residents' Families

NUTRITION AND FOOD SAFETY — **8**

- Menu and Meal Planning
- Basic Nutritional Needs
- Safe Food Handling
- Preventing Foodborne Illnesses
- Therapeutic Diets
- Dehydration

DEMENTIA, MENTAL HEALTH AND BEHAVIOR MANAGEMENT — **12**

Overview

- Description of normal aging and conditions causing cognitive impairment
- Description of normal aging and conditions causing mental illness
- Risk factors for cognitive impairment
- Risk factors for mental illness
- Health conditions that affect cognitive impairment
- Health conditions that affect mental illness
- Early identification and intervention for cognitive impairment
- Early identification and intervention for mental illness
- Procedures for reporting cognitive, behavioral and mood changes

Effective Communication
- Effect of cognitive impairment on expressive and receptive communication
- Effect of mental illness on expressive and receptive communication
- Effective communication techniques: verbal, non-verbal, tone and volume of voice, word choice
- Environmental stimuli and influences on communication: i.e. setting, noise, visual cues

Behavioral Intervention
- Identifying and interpreting behavioral symptoms
- Problem solving for appropriate intervention
- Risk factors and safety precautions to protect other residents and the individual
- De-escalation techniques
- Collaboration with case manager delegating nurse

Making Activities Meaningful
- Understanding the therapeutic role of activities
- Creating opportunities for activities – productive, leisure, self-care
- Structuring the day

Staff and Family Interaction
- Building a partnership for goal-directed care
- Understanding families needs
- Effective communication between family and staff

Managing Staff Stress
- Understanding the impact of stress on job performance, staff relations and overall facility milieu
- Identification of stress triggers
- Self-care skills
- De-Escalation techniques
- Devising support systems and action plans

END OF LIFE CARE **4**
- Advanced Directives
- Hospice Care
- Power of Attorney
- Appointment of a Health Care Agent
- Living Will
- Pain management
- Providing comfort and dignity
- Supporting the family

MANAGEMENT AND OPERATION **4**
- Role of the Assisted Living Manager
- Overview of Accounting – Accounts Payable, Receivable
- The Revenue Cycle and Budgeting
- The Basics of Financial Statements
- Hiring and Training of Staff
- Developing Personnel Policies and Procedures
- Census Development
- Marketing

EMERGENCY PLANNING **4**
- Fire, Disaster and Emergency Preparedness
- OSHA Requirements
- Maintaining Building, Grounds and Equipment
- Elopements
- Transfers to Hospital
- Evacuations
- Power Outages
- Severe Weather
- Fire
- Emergency Response Systems
- Security Systems

QUALITY ASSURANCE **4**
- Incident Report
- Quality Improvement Processes

SURVEY PROCESS **2**
- State Statute and Regulations
- What to Expect
- Documentation

TOTAL HOURS **80**