



OREGON
LONG-TERM CARE
OMBUDSMAN



Memory Care in Oregon

An Initiative Conducted by the Oregon Long-Term Care Ombudsman's Office

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An Introductory Message from the Oregon Long-Term Care Ombudsman, Fred Steele – MPH, JD

Oregon's Long-Term Care Ombudsman program, built on a foundation of an energetic group of volunteers, works to ensure and enhance the rights, dignity, and quality of life of residents in Oregon's long-term care facilities. In most instances, ombudsman work starts from the request and with direction from the resident. Our focus is to represent the resident's voice so that their rights and dignity are protected.



We entered 2016 with a recognition that our efforts for residents in memory care settings needed further examination. In these settings, the resident often has difficulty conveying their needs and concerns because of the inherent nature as to why they reside in specialized memory care settings. Historically our volunteers and our Office have received far fewer requests from residents or even their family members – and we wanted to assess how we could better advocate for these valued individuals.

Our Memory Care Initiative arose from this recognition and need for improved advocacy. By studying our approach to the otherwise perceived issue areas – engaged caregiving staff, meal times, and meaningful activities – we designed an initiative that would allow us to gain additional insights into the aggregated issues for residents in specialized memory care.

What we learned is that:

- Staffing issues are quite prevalent:
 - In 32% of our study visits, our volunteers observed staffing levels simply not at the level even the facility expected as needed for a shift.
 - In only 63% of observations did facility staff engage with residents in a personal manner.
- Meal time in memory care needs systemic improvement to address regularly hectic practices that are arguably impacting the dignity of residents during this time of day:
 - In 55% of observations, residents did not receive the assistance our volunteers believed the residents should have been receiving during meal time.
 - Only half of facilities posted readable menus for residents

- Wait times are frequently and excessively long for residents to receive meals once brought to the dining area
- Staff shortages often lead to the chaotic meal time environments
- Meaningful activities, though required and believe to be foundational to individuals with memory care needs, similarly appear to be haphazardly approached systemically in Oregon, thus challenging the dignity and quality of life expected for residents with memory care needs:
 - In 44% of our visits, scheduled activities to engage residents did not occur.
 - In our visits where scheduled activities occurred, only about half meaningfully engaged residents.
 - The “Activities Director” position, where filled, often provided meaningful activities; where not filled, residents were neglected in this area.

In addition to our internal efforts to improve our own advocacy for memory care residents, systemic approaches must be taken to address these issue areas. It is the opinion of the Oregon Long-Term Care Ombudsman that:

- Staffing shortages must be greatly reduced. Acuity-based staffing at the correct levels for all residents’ needs must become a reality. Facilities must become more dedicated to appropriate staffing, but there is a probable need for systemic conversations to address workforce and career development of the type of appropriately trained caregiver needed for specialized memory care settings.
- Culture around meal times must be respected and improved significantly. Meal times must not be seen as mere requirements to provide daily nutrition to residents – they must be approached (as some facilities do) as an important element of the quality of life a resident experiences while living their last years in specialized memory care.
- The Activities Director position needs to be valued and, while not currently required by Oregon Administrative Rule, become a necessary aspect of all memory care settings.

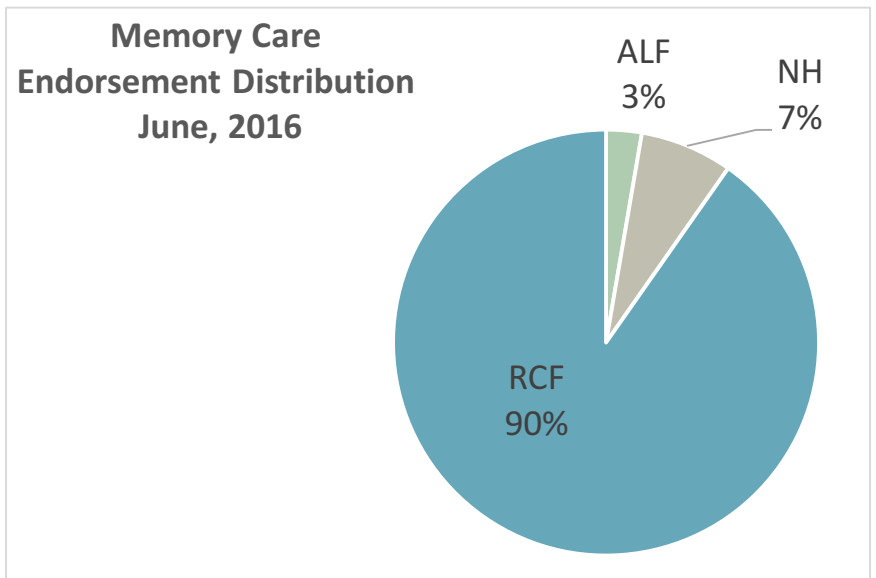
For a sense of what is really occurring for residents of memory care in Oregon, please read through this report and the numerous quotes provided from our volunteers reflecting on the direct observations of what they see in care facilities throughout Oregon. There are many positives, but also extraordinary insights into the additional efforts that we as a state must continue to embark upon to ensure the dignity and quality of life for Oregonians with diminished capacities and diminished abilities to care for their own daily needs.

I also want to specifically thank the volunteers who agreed to receive additional training, complete additional documentation and engage in additional visits to the memory care settings to which they are assigned. The program already asks a lot of our volunteers in their day-to-day and week-to-week advocacy to their fellow community members residing in care facilities. We asked even more and had well over 30 volunteers who volunteered for additional duty – all in the name of ensuring the rights, dignity, and quality of life of their fellow community members.

None of this work would be possible without our dedicated, hard-working volunteers!

What Memory Care Looks like in Oregon

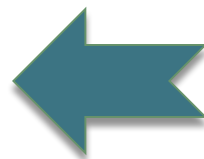
In Oregon, a Nursing Facility (NF), Assisted Living Facility (ALF), or a Residential Care Facility (RCF) may choose to obtain an additional Memory Care Endorsement for any or all of their licensed beds. As the chart to the right shows, the vast majority of Memory Care endorsements are granted to Residential Care Facilities. Note that while many Adult Foster homes in Oregon serve individuals with memory related needs, they are not covered by



Memory Care Endorsements.

Consumer Tip:

A facility may not advertise that they are a Memory Care Community (MCC) unless they have a Memory Care Endorsement issued by the Department of Human Services. ***Potential consumers should specifically ask potential facilities if they have a DHS issued Memory Care Endorsement.*** Any facility advertising in violation of this requirement is subject to civil penalties and a cease and desist order.

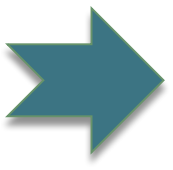


In choosing to be endorsed, facilities must not only meet all the requirements for their primary licensure, but also meet the requirements outlined in Oregon Administrative Rule [**411-057-0100 to 411-057-0190**](#).

While the requirements for endorsement are numerous, the primary distinctions between these beds and those not endorsed as memory care can generally be thought of as the following:

- Staff are expected to have training specific to memory related diagnosis, needs of individuals with memory related diagnosis, and the provision of care to these individuals. For additional information about staff training in Memory Care Settings, see page 8.
- Outdoor space must be present for residents to access, but unable to be exited by the residents.

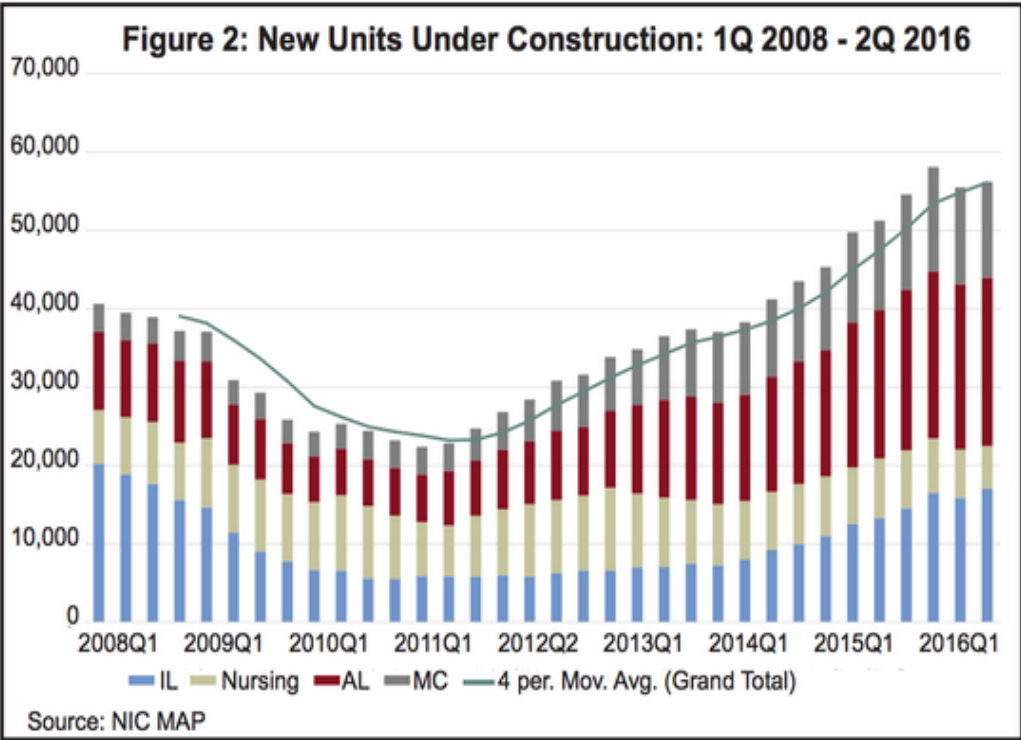
- The doors to exterior exits of memory care units are locked with provision in place in the event of emergencies.



Consumer Tip: Only individuals with a diagnosis of dementia AND in need of supports related to that diagnosis to ensure their physical safety or function may reside in memory care. Families are often encouraged by facility staff or administration to move their loved one into Memory Care to receive higher levels of staffing or dementia related supports. ***However, those without exit seeking or wandering behaviors may not yet be appropriate for placement in these secured settings.***

As of November, 2017 there were 7155 endorsed Memory Care Beds in Oregon. The number of endorsed beds in any given facility ranges substantially from as few as 5 to as many as 114.

Memory Care is a growing business not only in Oregon but throughout the country. The graph here, from the National Investment Center, shows new construction over the past 8 years, with the grey portion of the bar representing Memory Care. Over this same period of time, Memory Care Units in Oregon increased **58%**, from 105 to 182. When the LTCO began the Initiative in June 2016, there were 185 Memory Care Units in Oregon, by February 2017 this number had risen to 192, and at the time of this writing in November, 2017 there are 203 endorsed Memory Care Units.

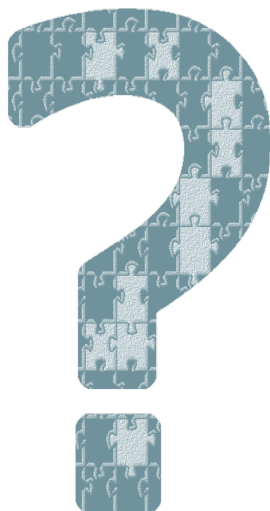


In the state of Oregon, Memory Care Units are present in all but seven counties (Tillamook, Lake, Harney, Morrow, Wheeler, Sherman, and Crook).

<u>County</u>	<u>Facility #</u>	<u>County</u>	<u>Facility #</u>
BAKER	1	KLAMATH	2
BENTON	3	LANE	20
CLACKAMAS	23	LINCOLN	1
CLATSOP	2	LINN	6
COLUMBIA	1	MALHEUR	1
COOS	3	MARION	18
CURRY	3	MULTNOMAH	23
DESCHUTES	8	POLK	5
DOUGLAS	4	UMATILLA	3
GILLIAM	1	UNION	1
GRANT	1	WALLOWA	1
HOOD RIVER	2	WASCO	3
JACKSON	10	WASHINGTON	27
JEFFERSON	1	YAMHILL	12
JOSEPHINE	6		

The LTCO’s Approach to the Memory Care Initiative

In early 2016, the LTCO began discussing the possibility of launching the Memory Care Initiative (MCI). This conversation was driven by a number of factors.



- 1) In reviewing internal data, it became evident that there was an opportunity to provide more comprehensive advocacy to Memory Care residents. The data reflected that the average length of a visit in a Memory Care Unit was shorter, and there were fewer reports generated from these visits, when compared to other facility types.
- 2) Requests for information from various legislative, media, and partner agencies highlighted how little data the LTCO had regarding these settings. While information based on specific cases was available, it was evident that the full picture of the Memory Care environment was not truly known.

The LTCO's Approach to the Memory Care Initiative - Continued

Once the need to identify opportunities for improved Ombudsman advocacy for residents who are not fully able to communicate their wishes or concerns was evident, the LTCO focused initial efforts on training specialized volunteers, providing them with objectives and tools for a series of topic specific facility visits, and attempted to compile information and data from other partner and stakeholder sources to form a full picture of Memory Care facilities in Oregon.

Each of these efforts will be described in further detail throughout this report with each section containing:

- Relevant **Oregon Administrative Rules**. All Oregon Administrative Rules may be found at the Oregon Secretary of State website. Links are included throughout this report. In the case of Long-Term Care settings, Oregon Administrative Rules are enforced by the Safety, Oversight and Quality unit of the Department of Human Services.
- National best practices identified in the ['Dementia Care Practice Recommendations for Assisted Living Residences and Nursing Homes'](#) report published by the Alzheimer's Association Campaign for Quality Residential Care. The report was developed in collaboration with over 25 leading health and senior care organizations and addresses the fundamental aspects of what constitutes quality dementia care. Amongst those who have endorsed these practice recommendations are the American Health Care Association, the Service Employees International Union, AARP and the National Center for Assisted Living.
- The first hand observations of **LTCO staff and volunteers**. Each year over 180 LTCO volunteers serve as the eyes and ears in Oregon's long-term care settings. Visiting their facilities an average of once a week, they are able to identify and address issues before they become more serious matters needing to be referred to Adult Protective Services, Licensing, or other oversight and compliance entities. Between July, 2016 and June, 2017, volunteers donated 29,438 hours of their time advocating for the rights of facility residents.

Memory Care Units Visited During the Initiative

Of the 185 endorsed Memory Care Units operating in June 2016, 49 were included in the Initiative. Many of these 49 facilities already had Certified Ombudsmen (CO) assigned to their facility. If the existing CO opted to participate in the Initiative, they maintained this assignment. Facilities that had not had a CO assigned prior to the Initiative were chosen primarily for geographic location and an effort to achieve a representative sample of the industry in terms of size and facility type.

In no case was a facility chosen for inclusion in the Initiative based on licensing survey performance, complaints received by the LTCO, or APS involvement.

A list of the facilities included in the Initiative, their location, capacity and license type is included in Appendix A.

Training of Memory Care Specialists

Before visits to Memory Care Units could begin, Certified Ombudsmen who would be conducting the visits received additional training covering the following topics:

- ❖ An overview of Memory Care Endorsed facilities
- ❖ Best practices in Memory Care
- ❖ The role of the Memory Care Administrator
- ❖ Observation techniques
- ❖ Staffing requirements per Oregon Administrative Rule and best practices, including staff training requirements
- ❖ Recognizing chemical restraints
- ❖ Food and meal-time requirements per Oregon Administrative Rules and best practices
- ❖ Activity requirements per Oregon Administrative Rules and best practices.
- ❖ Working with families, establishing family councils
- ❖ Certified Ombudsmen who completed the Initiative training were designated Memory Care Specialists (MCS).

Over 30 Memory Care Specialists agreed to visit their assigned facility at least weekly, during differing periods of time including weekends and evenings, to complete a report after each visit, and to participate in the same training program that the staff in their memory care would attend.

Staff Training



Those working in Memory Care facilities are entrusted with the care of some of the most vulnerable residents of Oregon. These same residents have considerable care needs in order to maintain their health, dignity, and basic needs. The provision of such care needs to be conducted in a manner consistent with the unique aspects of dementia and memory loss. Thus, proper and thorough training of staff is in many ways the foundation of quality care.

What the Oregon Administrative Rules Say About Staff Training

411-057-0140: Responsibilities of Administration

(3) The administrator of the memory care community must complete and document that at least 10 hours of their required annual continuing educational requirements, as required by the licensing rules of the facility, relate to the care of individuals with dementia.

411-057-0150: Staffing and Staff Training

(1) STAFFING AND STAFF TRAINING. The facility must provide residents with dementia-trained staff who have been instructed in the person directed care approach. All direct care and other community staff assigned to the memory care community must be specially trained to work with residents with Alzheimer's disease and other dementias.

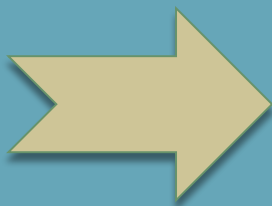
(a) Only staff trained as specified in sections (2) and (3) of this rule shall be assigned to the memory care community.

(2) A memory care community must ensure that staff who provide support to residents with dementia have a basic understanding and fundamental knowledge of the residents' emotional and unique health care needs. Direct care and other staff must be trained on the topics outlined in Table 1. ([To See this Table, follow this link](#)) These requirements are in addition to the facility licensing requirements for training.

(3) Persons providing or overseeing the training of staff must have experience and knowledge in the care of individuals with dementia.

What the Alzheimer's Association Campaign for Quality Residential Care says about Staff Training

- 1) Direct care staff need education, support and supervision that empowers them to tailor their care to the needs of residents.
- 2) Staff who understand the prognosis and symptoms of dementia and how this differs from normal aging and reversible forms of dementia are better prepared to care for people with dementia.
- 3) Effective initial and ongoing staff training addresses:
 - a) Dementia, including the progression of the disease, memory loss, and psychiatric and behavioral symptoms
 - b) Strategies for providing person-centered care
 - c) Communication issues
 - d) A variety of techniques for understanding and approaching behavioral symptoms, including alternatives to restraints
 - e) An understanding of family dynamics
 - f) Information on how to address specific aspects of care (e.g., pain, food and fluid, social engagement)



Consumer Tip: When considering a facility for yourself, a friend, or family member, make sure you receive the **Uniform Disclosure Statement**. The Oregon Administrative Rules require each facility to provide this to everyone requesting information about the facility. Section VI of this document describes the orientation training for new staff, including methods of training and how many hours of training new staff receive before working unsupervised. It also speaks to the ongoing training staff receive.

What the Memory Care Specialists Observed in the area of Staff Training

The initiative approached the question of staff training from several perspectives.

- 1) Facility staff were asked a series of questions about their training experiences by the Memory Care Specialists (MCS).
 - a. Staff reported having been trained anywhere from a ½ day to 1 full day.
 - b. Training was either web based or a combination of web based and staff led.
 - c. While one staff member reported shadowing an experienced staff member for only 1 shift, it was more common for shadowing to have occurred from 2 – 5 days.
 - d. Almost all staff described their initial training as “an okay introduction” but added that they had learned a great deal more from their actual work experience since then.

- 2) Memory Care Specialists attended the same training that facility staff attend. Their observations include the following:

“I attended a four-hour training for the newly hired caregivers detailing the Expressions activities designed for dementia and Alzheimer’s residents. Their program team includes David Troxel, who is the author of ‘A Dignified Life, the Best Friends Approach to Alzheimer’s Care’. This book provides the framework for their activities program.”

“I was there for the training on Universal Precautions. Not very well presented, no engagement, but better than nothing.”

- 3) Memory Care Specialists gathered training materials. The LTCO would especially like to thank Baycrest Memory care and Chehelam Health and Rehab for providing not only access to their training, but extensive written copies of their curriculum and training materials. Many other facilities provided information, both written and verbal, regarding their training processes.

Many of the facilities visited use training curriculum developed by outside vendors such as the Care and Compliance Group and the Institute for Professional Care Education, who have both written and online resources.

“They have an extensive training packet, about 200 pages, and they gave me an orientation and training checklist for new staff. They also have a monthly training calendar posted for the year.”



Staff Interactions with Residents

The residents of Memory Care are often rendered unable to communicate their needs, their wants, their personal history, and to express their feelings. It is often easy, therefore, for those caring for them to focus primarily on the many, many pressing tasks at hand and the essential care of the resident. But the need for meaningful human interaction between caregiver and staff cannot be underestimated and is essential for quality of life.

What the Oregon Administrative Rules Say About Staff Interactions with Residents

Other than standard regulations regarding the prohibition of abuse, the **Oregon Administrative Rules** do not dictate how staff interact with residents. However, the training requirement for staff does include instruction about communication techniques that facilitate better resident-staff relations. The rule also requires one to one activities that encourage positive relationships between residents and staff.

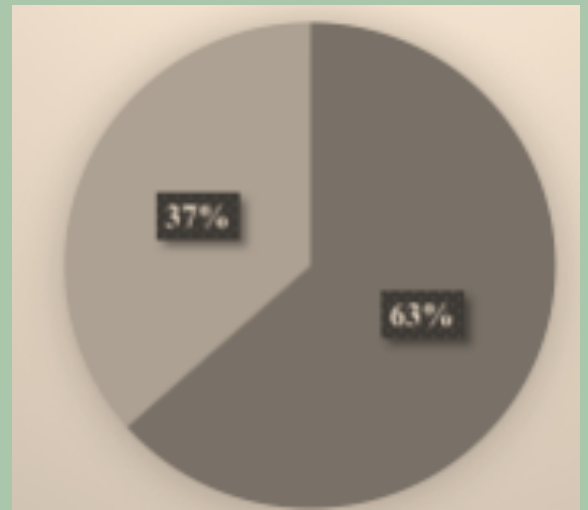
What the Alzheimer's Association Campaign for Quality Residential Care says about Staff Interactions with Residents

- 1) Every event, encounter or exchange between residents and staff is a potential activity. Design interactions to do with — not to or for — the resident.
- 2) Social engagement of residents is not the sole responsibility of the activities staff. Every staff member has the responsibility and the opportunity to interact with each resident in a manner that meets the resident's needs and desires.
- 3) A plan for social engagement and meaningful activity is a critical part of the care plan.
- 4) Staff can achieve both brief and extended interactions with residents throughout the day. Brief but meaningful encounters may greatly enhance a resident's life.
- 5) Lack of verbal communication skills does not prevent residents with dementia from being socially engaged. On the contrary, staff may play an even more important role by initiating an engagement.

What the Memory Care Specialists Observed in the area of Staff Interactions

Memory Care Specialists were asked to observe staff interactions with residents throughout the first two months of their visits. Specifically they were asked to determine if the interactions were strictly task related or if they were personal, engaging, or social in nature.

In 63% of the cases, MCS were able to find some level of personalized interaction, even if a task or care giving was also occurring. **Common observations in which both tasks and personal communication were observed:**



“Toileting, getting ready for dinner, chasing alarms, helping a resident understand the mail she received, laundry.”

“Getting residents up, toileted, dressed, showered and to table. Spoke to one resident re. movie she was watching. Otherwise interactions were task focused.”

MCS also observed some very positive and encouraging interactions, some reminding us that interactions do not have to be verbal in nature:

“Verbal exchanges, staff spoke to residents with humor about resident’s preferences and knowing them well, having worked at facility for years.”

“Brushing residents hair solely for calming reaction.”

“Appointed tasks but also hugging, hand holding, walking, talking with residents, especially one who was very teary.”

Of concern were observed interactions described as follows:

“Staff taking care of residents needs only.”

“The only interaction on a personal level was with a new resident and his family. Otherwise, bringing residents to dining, setting tables, serving food, working in med room”

“Toileting, then they were all in an All Staff Meeting and I could find no staff to assist the residents.”



Staffing Patterns and Staffing Sufficiency

The question of what constitutes sufficient staffing for any licensed care setting is a topic of much debate. As previously noted, only Nursing Facilities have mandatory minimum staff to resident ratios in addition to requirements that there be sufficient staffing to meet resident needs. All other settings, including Memory Care, rely solely on acuity

measures to determine how many staff are necessary on a given shift. And yet, there is no standard acuity tool and how acuity is measured varies from provider to provider.

What the Oregon Administrative Rules Say About Staffing Patterns and Staffing Sufficiency

Oregon Administrative Rules do not provide specific staffing ratios for Endorsed Memory Care settings. In fact, no ratios exist for any type of licensed care in Oregon other than Nursing Facilities. However, the rules do state that staffing must be sufficient to meet the scheduled and unscheduled needs of each resident. Staffing levels during nighttime hours shall be based on the sleep patterns and needs of residents. **(411-057-0150, 1 (b))**

What the Alzheimer's Association Campaign for Quality Residential Care says about Staffing Patterns and Sufficiency

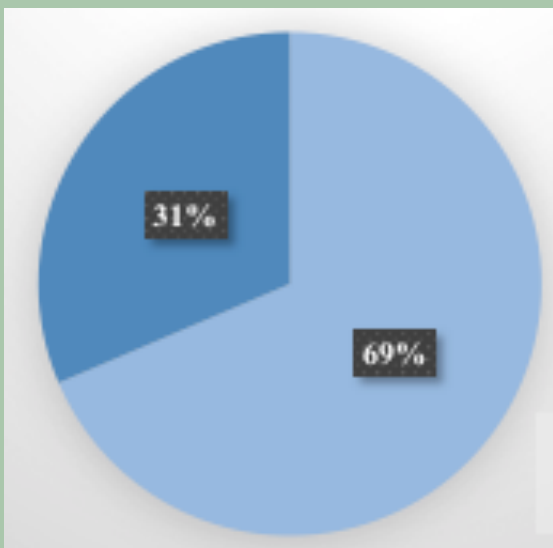
Per the Alzheimer's Association, staffing patterns should ensure that residents with dementia have sufficient assistance to complete their health and personal care routines and to participate in the daily life of the residence.

Consistent staff assignments help to promote the quality of the relationships between staff and residents.

What the Memory Care Specialists Observed in the area of Staffing Patterns and Sufficiency

For the first two months of the MCI, volunteers and staff were asked to check the posted staffing plan as well as the actual staffing of the unit to determine consistency.

In 79% of the visits conducted, it was possible to locate a posted staffing plan. Of the 79% posted, the actual staff on hand was consistent with the posting 69% of the time.



MCS were asked to report as to whether they felt the number of staff they observed was sufficient to meet the scheduled and unscheduled needs of the residents, as required by rule. Most expressed the difficulty of making such a determination as staffing could appear adequate during the first ten minutes of their visit and markedly inadequate the next moment, when resident's immediate needs exceeded the available staff. This is undoubtedly the challenge faced by the providers as well. However, the consistency of observations such as those below are cause for concern and fall into three distinct categories.

Short staffing:

"One thing I noted on the staffing list was that two of the caregivers were scheduled for double shifts. This is due to their staffing shortage I was told"

"I over heard two of the people on shift commenting that they were without a med aide that morning. The administrator wasn't there as he had worked again in the evening to cover the shift. He subs as a caregiver and a med aide."

"I am again voicing my concern over the number of double shifts the caregivers are working, especially when they are doing so more than one day in a row."

"Staff 50% short as is often typical on weekends. Some call in; some simply don't show up."

Inadequate staffing:

“Noted difficulty of one person transfer. Med aide called for help but transfer still seemed dangerous. I was asked to help and explained that I could not.”

“The number of staff has always been an issue. Three people seem quite inadequate to take care of the needs of the residents and also give them individual attention.”

“There were inadequate staff to address the needs of residents. A resident who had been covered in feces two hours prior had been cleaned up, but her room was still covered in feces.”

Staff present but not meeting resident needs:

“Observed a high functioning resident standing near office, wanting to make a phone call. No one asked her if she needed someone, although they congregate in that area.”

“There were six care-givers and one med tech. Most were interacting with other staff. One was hectic going from thing to thing. Resident had a fall while I was there.”

“I received another complaint from a caregiver about another caregiver not doing her job properly. I again referred her to admin and possibly union representative.”

“There appear to be plenty of staff but their actions are not resident focused. I observed them sitting at tables and chit chatting with one another.”

The observations regarding staffing adequacy was not all bad. In fact, some of the observations were quite positive:

“I have observed what feels like very caring relationships between staff and residents. The staffing poster calls the staff “Elder Companions”; but what I see is truly “caregiving.”

“I have seen a lot of real caregiving from the staff to the residents. I have been to the facility various times of the day and evening, weekdays and weekends, and there are usually at least 2 caregivers at any one time, with the Med Aide going from house to house as needed. The house with residents with the highest needs usually had 3 or 4 caregivers while residents are awake.”

“The staff appear caring and cheerful. The administrative staff is responsive to issues and complaints and strive to make the lives of the residents as full and comfortable as possible.”

Meal Times



The ability to enjoy a good meal is one of the basic pleasures that almost everyone enjoys. However, in a Memory Care setting this is complicated by the need to provide food to a congregate setting, accommodate special diets, assist individuals who have lost the ability to feed themselves, and accomplish all of this with available staffing. Given both the pleasurable and essential components of nutrition, it's not surprising that this was one of the focus areas of the Memory Care Initiative.

What the Oregon Administrative Rules Say About Nutritional Services and Supports in Memory Care

411-057-0160: Resident Services in a Memory Care Community

(2) At time of move-in, the community must make reasonable attempts to identify the customary routines of each resident and the resident's preferences in how services may be delivered. Minimum services to be provided include:

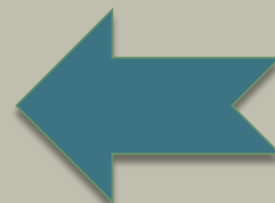
(a) Assistance with activities of daily living that addresses the needs of each resident with dementia due to cognitive or physical limitations.

(c) A daily meal program for nutrition and hydration must be provided and available throughout each residents waking hours. The individualized nutritional plan for each resident must be documented in the resident's service or care plan. In addition, the memory care community must:

(A) Provide visual contrast between plates, eating utensils, and the table to maximize the independence of each resident; and

(B) Provide adaptive eating utensils for those residents who have been evaluated as needing them to maintain their eating skills.

Consumer Tip: Most facilities will allow prospective residents and their families to eat a meal at the facility prior to moving in. There may be a small fee, but not always.



What the Alzheimer's Association Campaign for Quality Residential Care says about Meal Time and Nutritional Services In Memory Care

- 1) Residents should have a pleasant, familiar dining environment free of distractions to maximize their ability to eat and drink.
- 2) Various activities can engage residents in the mealtime experience and stimulate appetite.
 - a) Create opportunities for residents to help plan the menu and set the table.
 - b) Stimulate olfactory senses by baking bread or a pie prior to the meal.
- 3) During the meal, residents often require assistance to maximize their own ability to eat and drink.
 - a) If assessment shows that a resident can eat independently, but does so slowly, the resident can eat at his or her own pace, perhaps with verbal reminders to eat and drink.
 - b) Mealtimes can be extended for slower-eating residents.
 - c) Adaptive utensils and lipped plates or finger foods may help individuals maintain their ability to eat.
 - d) For those residents who manage better if they face fewer choices, serving one food item at a time is preferable.
 - e) If residents need hand feeding, guide the resident's hand using the "hand-over-hand" technique.
 - f) It is ideal for staff to sit, make eye contact and speak with residents when assisting with meals.
- 4) Residents need opportunities to drink fluids throughout the day. Incorporate fluids into activities and have popsicles, sherbet, fruit slushes, gelatin desserts or other forms of fluid always available to residents.

DID YOU KNOW??

If you couldn't see your mashed potatoes, you probably wouldn't eat them. "**The Red Plate Study**" found that Alzheimer's patients eating from red plates consumed 25 percent more food than those eating from white



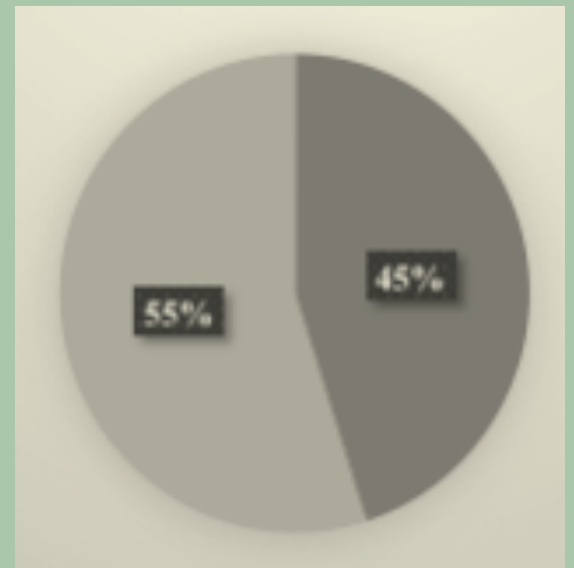
What the Memory Care Specialists Observed in the area of Meal Time in Memory Care

During the second two-month period of the Initiative, MCS were asked to focus their observations on meal times.

The first issue on which they were asked to report was the presence of a posted menu and its ability to actually be read by residents in terms of both font and location. Menus were found to be posted in 70% of the visits. However, of those menus posted, only 51% were in a font residents could easily read and 56% were posted in a location in which residents could read them.

MCS were then asked to observe meals times and assess whether residents were receiving the assistance they needed to receive proper nutrition. MCS felt that in 45% of the cases, they were. They were also asked to determine if individual food needs (finger foods, pureed foods, etc.) were being provided for. In 67% of the cases they believed that they were.

In general, the observations of meal time in Memory Care painted a somewhat hectic and unsettling picture much of the time, in some cases due to what seemed to be inadequate staffing and/or inadequate staff training, in others due to environmental factors, and in many cases due to the many varied needs of the residents being served. Consistent concerns arose regarding the length of time residents have to wait between being brought to the dining room and receiving their meal. 45 minutes waits were frequently observed. The following observations are representative of this part of the initiative:



“This property has two wings and two dining rooms. Tables are served one at a time, which resulted in a 40 minutes time lag between the first table being served and the last. Staff are focused on getting food out, but no one seemed to be monitoring the environment of the dining room.”

“Staff not noticing that resident is not able to use either a fork or spoon. Resident resorted to eating even her jello with her fingers.”

“Resident bangs loudly on table upsetting other residents. One resident is blocked in by other chairs so she can’t get up and leave. Plates are put in front of residents without any communication from staff. Residents are brought in 20-30 minutes prior to actually getting any food. Thickened liquids are so thick the residents can’t get the beverage out of their glass.”

“The dining room is too small for residents and people assisting residents. Five are fed in another area of the house. There aren’t enough staff to ensure eyes on throughout the meal. A resident didn’t have any silverware at his place setting. He called out loudly that he needed a spoon but wasn’t acknowledged.”

“Complete chaos. Once resident was spitting up onto the floor. Thickened liquids were too thick to drink. Resident was given pureed food, but not given a spoon, so they tried to eat it with their fingers. One resident’s clothes were covered in food that had been there since snack time. Staff were just plopping the food in front of resident without saying anything.”

“There were 2 caregivers and one med aide during meal time, but med aide took their lunch break. Then one caregiver took a resident to the bathroom. The second caregiver had to take another resident to her room to care for her dentures since she appeared in pain. The caregiver asked the RN to assist, but the administrator called the RN away.”

“12 residents were present with 2 care givers. A resident asked twice for water with no response from either care giver. Several residents fell asleep during the meal.”

“There is minimal staff to resident interaction during meal time, mostly just telling resident to “sit down” or “you can’t have milk.” Once all the residents are served, some staff leave to take their own lunch break.”

As with all other aspects of the Initiative, there were some extremely positive meal time observations. A number of the facilities involved seem to have accurately identified the staffing needs of the residents and a number of cooks/chefs clearly take pride in their work. Many facilities utilize contrasting plates, placemats, and food. Their success is evident by the following observations:

“Food service and presentation seemed good. Residents with pureed food also appeared well presented and residents receive assistance. One resident is vegetarian and received a very appealing vegetarian meal. Chicken fingers and steak fries allowed for finger food.”

“Plates are green and provide great contrast. There is one vegetarian and she gets a plate of a variety of vegetables with dressing. She really likes what she gets. There is one person that gets fed and there is a staff with her at mealtime to feed her.”

“The food today was lovely on the plates. I wanted to take a picture but wasn’t sure if that was okay. I wanted to show an example of what a nice meal would look like on the plates.”

Activities

It's no accident that the Oregon Administrative Rules, the Alzheimer's Association Campaign for Quality Residential Care, and our volunteers have more to say about activities than nearly any other aspect of Memory Care. Although activities are not traditionally thought of as essential aspects of health and safety, the presence or lack of ongoing meaningful activities in which residents are actively engaged will ultimately impact nearly all other aspects of care, not to mention quality of life.

DID YOU KNOW??

The benefit of activities in Memory Care setting go well beyond filling time. Many believe they can [reduce the use of anti-psychotic medications](#) and overall [improved health outcomes](#). Click on the hyperlinks to read recent articles

What the Oregon Administrative Rules Say About Activities in Memory Care

411-057-0160: Resident Services in a Memory Care Community

(2) At time of move-in, the community must make reasonable attempts to identify the customary routines of each resident and the resident's preferences in how services may be delivered. Minimum services to be provided include:

(d) Meaningful activities that promote or help sustain the physical and emotional well-being of residents. The activities must be person directed and available during residents' waking hours.

(A) Each resident must be evaluated for activities according to the licensing rules of the facility. In addition, the evaluation must address the following:

- (i) Past and current interests;
- (ii) Current abilities and skills;
- (iii) Emotional and social needs and patterns;
- (iv) Physical abilities and limitations;
- (v) Adaptations necessary for the resident to participate; and
- (vi) Identification of activities for behavioral interventions.

(B) An individualized activity plan must be developed for each resident based on their activity evaluation. The plan must reflect the resident's activity preferences and needs.

411-057-0160: Resident Services in a Memory Care Community – Continued

(C) A selection of daily structured and non-structured activities must be provided and included on the resident's activity service or care plan as appropriate. Daily activity options based on resident evaluation may include but are not limited to:

- (i) Occupation or chore related tasks;
- (ii) Scheduled and planned events (e.g. entertainment, outings);
- (iii) Spontaneous activities for enjoyment or those that may help diffuse a behavior;
- (iv) One to one activities that encourage positive relationships between residents and staff (e.g. life story, reminiscing, music);
- (v) Spiritual, creative, and intellectual activities;
- (vi) Sensory stimulation activities;
- (vii) Physical activities that enhance or maintain a resident's ability to ambulate or move; and
- (viii) Outdoor activities

What the Alzheimer's Association Campaign for Quality Residential Care says about Activities in Memory Care

- 1) Meaningful activities are the foundation of dementia care because they help residents maintain their functional abilities and can enhance quality of life.
- 2) Every event, encounter or exchange between residents and staff is a potential activity.
- 3) Access to personal space and opportunities for free time to relax are essential elements for enhancing quality of life.
- 4) Elements in the structure or layout of assisted living residences or nursing homes can create opportunities for meaningful activity.
 - a) Develop walking paths that encourage exploration and strolling when the home's facility layout permits.
 - b) Develop interest points such as a fish tank or a colorful tapestry that encourage visual or tactile stimulation.
 - c) Activity materials can be available at all times for use by non-activity staff and visitors.
- 5) Resident functioning can improve when the environment minimizes distractions that can frighten or confuse residents.
 - a) Hold an activity in a quiet room free of distractions or noise.
 - b) Ensure appropriate lighting, temperature and comfort for residents
- 6) Frequent, meaningful activities are preferable to a few, isolated programs.

What the Alzheimer's Association Campaign for Quality Residential Care says about Activities in Memory Care - Continued

- 7) Activities should proactively engage residents.
 - a) Having residents watch staff make decorations for a party is not as meaningful as asking residents to help make the decorations.
 - b) The outcome of an activity or social interaction is not as important as the process of engaging the residents.
 - c) Word games may be highly successful for residents at one cognitive level and highly frustrating for residents at another.
- 8) Group sizes and lengths of time for the activity need to be tailored to the functional level of residents.
 - a) Ideal group sizes range from four to 10, depending on the activity and abilities of the residents.
 - b) Thirty minutes or less of one specific activity or task is appropriate for most individuals with dementia before transitioning to another task.
 - c) When an activity includes multiple participants, consider the group dynamic and the overall mood of the group, and be flexible in adapting the focus and purpose of the activity.

The Alzheimer's Association of Oregon offers Facilitator Training for their Memories in the Making Program and frequently trains activities staff in Memory Care settings to facilitate the program in their place of employment. For information about upcoming Facilitator Training Sessions, visit their website at

<https://www.alz.org/oregon/>

Memories in the Making[®] is a unique fine-arts program for people with Alzheimer's disease and other dementias. The program's creative process provides a safe and validating environment for artistic expression, resulting in a creative and nonverbal way to communicate and capture precious moments through art. **Memories in the Making**[®] is much more than a traditional arts and crafts class or hobby activity; it has been proven to be beneficial and therapeutic, and it can stimulate the brains of persons with dementia. In this group, the creative process and the stories that evolve through it are as important and meaningful as the artwork itself.

What the Memory Care Specialists Observed in the area of Activities in Memory Care

The final two months of the Memory Care Initiative focused on activities. Was an activity schedule posted? Was it followed? And most importantly, did the activities seem to meaningfully engage the residents?

Activity schedules were found to be posted during 84% of the visits during this phase of the initiative. In 56% of these cases, the activity was actually occurring.

Whether or not residents appeared engaged in these activities was roughly a 50/50 split. Music and animals consistently appeared favorites of the residents.

What was evident during this phase of the initiative was the value of a designated Activity Director specifically trained in dementia care. In these cases activities were truly tailored to resident's prior interests and current abilities and a higher level of resident engagement was noted. When trained Activity Directors are present, this is what is observed:

"Today I observed the morning activities which include sing-alongs, review of a daily newsletter, light exercise and watching a series of video sermons followed with Q & A sessions. The residents were most engaged during the Q & A sessions, with the activity director calling on residents by name."

"They had music in the dining room. About 20 residents were there. The piano player encourages them to participate and so does the activities director. They clap, sing and remember the words to all the old songs. They smile and enjoy it more than anything!"

"The Activity Assistant led the residents in a discussion about flowers, using their computer program to provide pictures and leading question. The Activity Assistant actively personalized the discussion and engaged residents. Approximately 12 residents involved."

"12 residents participated in the Resident Council. The new Activity Director facilitated the meeting in such a way that there was much more participation and involvement from the residents than previously observed."

"Activities Director has taken the lead in producing a brief profile of resident with name and significant interest outside each resident's door."

“Things are improving! Today the residents were making centerpieces for the tables. They were gluing and pasting and seemed to be enjoying themselves. You could smell the cookies baking that they had previously assisted with.”

“13 residents were engaged and enjoying Slap Happy Drums, singing along, tapping feet, clapping hands and using instruments. What a pleasure to see these residents with a genuine smile on their faces!”

“There is a new Activities Assistant and she is taking an activity training course. There will be an activity schedule soon! There has been such a lack of stimulation at this facility...the new activity person is like a breath of fresh air.”

Unfortunately, the Activity Director position in Memory Care settings appear to be prone to high levels of turnover, vacancy, and being pulled to cover direct care tasks. When that is the case, MCS observations look more like this:

“Very little going on in the way of activities. A few mags, cards and puzzles on the dining room table. Main activity is “Singing in the Rain” on tv. Most residents asleep in front of the television.

“Resident reports ‘There’s nothing to do.’ I confirmed that there are few free choice activities. The activities room was closed and, while not locked, had items stacked everywhere that made access with residents wheelchair difficult, if not impossible.”

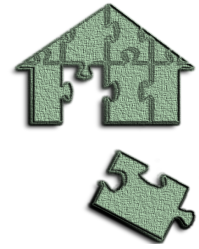
“When I asked about off site activity, the facility staff replied that there are none.”

“This is my third visit to XX in as many weeks. Each time, the Disney movie Tangled has been playing in the TV room.”

“There were some activities in the common area, but not the one that was scheduled. Activities were not tailored to address the needs of residents with varying levels of ability. Access to unstructured activities was limited. There were no off site activities.”

“One thing that bothers me very much is that residents have no way to interact with the community away from the facility. The disclosure statement says otherwise. They do not have an activities bus and only last week received a van large enough to take a resident to an appointment”

What the LTCO Learned About Physical Environments



What the Oregon Administrative Rules Say About the Physical Environment in Memory Care (portions that apply to MCI only)

411-057-0170

Physical Design, Environment, and Safety

(5) SECURE OUTDOOR RECREATION AREA. The memory care community must comply with facility licensing requirements for outdoor recreation areas as well as the following standards.

(b) Fences surrounding the perimeter of the outdoor recreation area must be no less than six feet in height, constructed to reduce the risk of resident elopement, and maintained in functional condition;

(d) Outdoor furniture must be sufficient weight, stability, design, and be maintained to prevent resident injury or aid in elopement; and

(6) COMMON AREAS. Common areas must include the following requirements:

(a) Freedom of movement for the residents to common areas and to the resident's personal spaces;

(b) A multipurpose room for dining, group and individual activities, and family visits that complies with the facility licensing requirements for common space;

(c) Comfortable seating;

(d) Safe corridors and passageways through the common areas that are free of objects that may cause falls; and

(8) RESIDENT ROOMS.

(a) Residents may not be locked out of or inside of their rooms at any time.

(b) Residents must be encouraged to decorate and furnish their rooms with personal items and furnishings based on the resident's needs, preferences, and appropriateness.

(c) The memory care community must individually identify residents' rooms to assist residents in recognizing their room.

What the Alzheimer's Association Campaign for Quality Residential Care says about the Physical Environment of Memory Care

- 1) The physical environment can encourage and support independence while promoting safety.
- 2) A positive environment has recognizable dining, activity and toileting areas as well as cues to help residents find their way around the residence.
- 3) The optimal environment feels comfortable and familiar, as a home would, rather than a hospital.
 - a. A home environment provides opportunities for residents to have privacy, sufficient lighting, pleasant music and multiple opportunities to eat and drink, and also minimizes negative stimuli such as loud overhead paging and glare.
 - b. A home environment might entail a private room and bathroom and the opportunity for residents to have personal furnishing, pictures and other items in their living area.
- 4) Providing easy, safe and secure access to the outdoors while maintaining control over unauthorized exiting enhances the environment.
 - a. Residents who have elopement behaviors need opportunities for safe wandering.

What the Memory Care Specialists Observed regarding the Physical Environment Memory Care

Memory Care Specialists were asked to observe the condition of the physical environment upon initial visitation or as problems arose. In general, observations were neutral to positive in nature. When issues were identified, they were most commonly regarding unpleasant odors in the environment. Only one facility involved in the Initiative had ongoing significant physical environmental concerns. Observations made by MCS include:

“There are several sets of patios/courtyard, one of which is accessible to residents. The ones on the other side which are quite nice and fenced, are not available to residents. Don't know who sits there, guess the staff who have the codes to get through the doors since the door codes are not given to anyone, including me or family members.”

“Volunteers have planted an outside flower and vegetable garden. Residents are able to pick flowers for their rooms and vegies to take back to the kitchen. Noticed staff helping a blind resident touch and smell a tomato even through she could not see it.”

“The staff is aware of residents urinating in the hallway, but has not addressed it. This leads to terrible smells and an unsafe condition.”

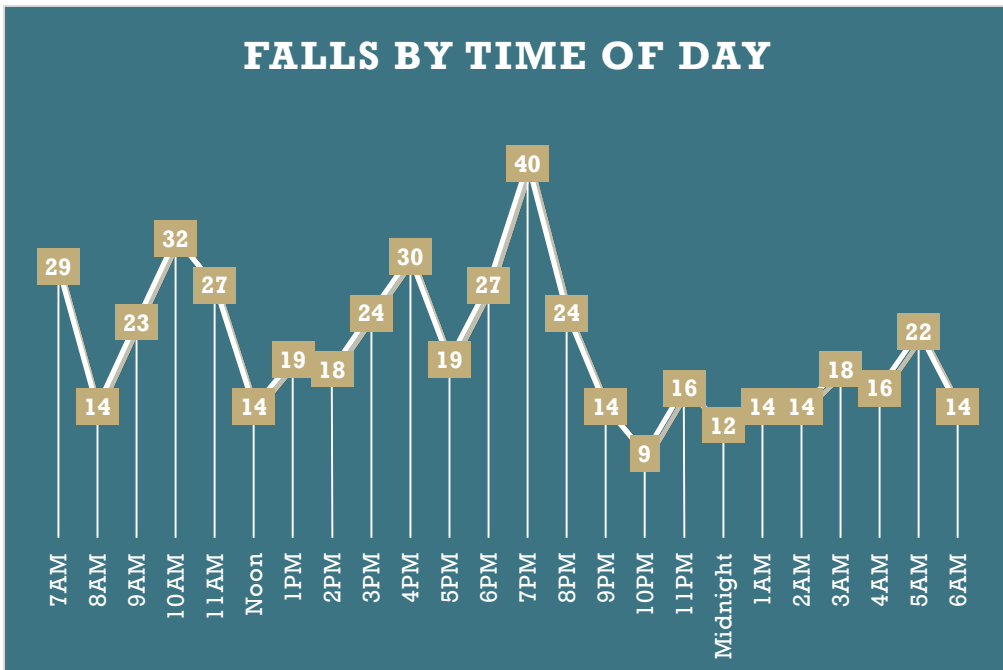
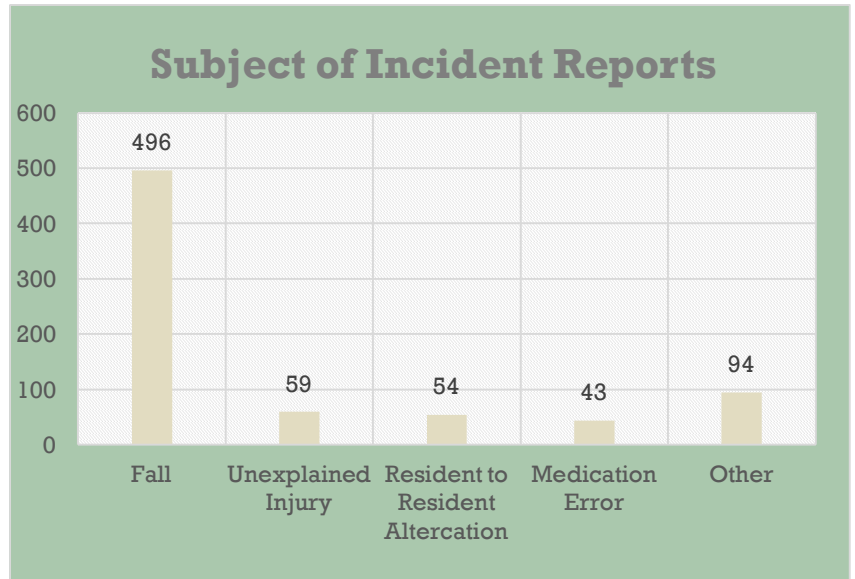
“This facility has an outdoor space that is used in the summer months for walks and planting things. The rooms are personalized.”

“In my opinion, the paradigm of individual cottages does not seem to be optimum for the residents. It is a failed model in that the residents lose the care and watchful eye on all staff except the one or two assigned to their cottage. In inclement weather residents are understandably reluctant to brave the wind, rain or cold to attend an activity in another building. The cottage setting also limits a resident’s ability to walk making one feel confined and sometimes agitated.”

What the LTCO Learned About Incident Reports

In an effort to better understand the challenges faced by both providers and residents of Memory Care, the LTCO requested incident reports for the duration of the Initiative. Reports could be provided as written, in redacted form, or in aggregate form. Of the 49 facilities visited during the Memory Care Initiative, the vast majority opted to not provide the LTCO with incident reports in any form, having been advised by their trade association, corporate offices, or the Safety, Oversight and Quality (formerly the Office of Licensing and Regulatory Oversight) that they were not statutorily required to do so.

However, 8 facilities fully participated in this aspect of the initiative and provided incident reports for LTCO review. (Six others began providing Incident Reports but ceased this practice early in the initiative after receiving the above noted advice.) In the end, over 745 reports were received and tabulated.



A broad overview of the incident reports received indicates that resident **falls** are overwhelmingly the subject of those reports. In addition, falls seem to spike slightly following dinnertime /prior to bedtime with a smaller but similar spike around breakfast/waking time.

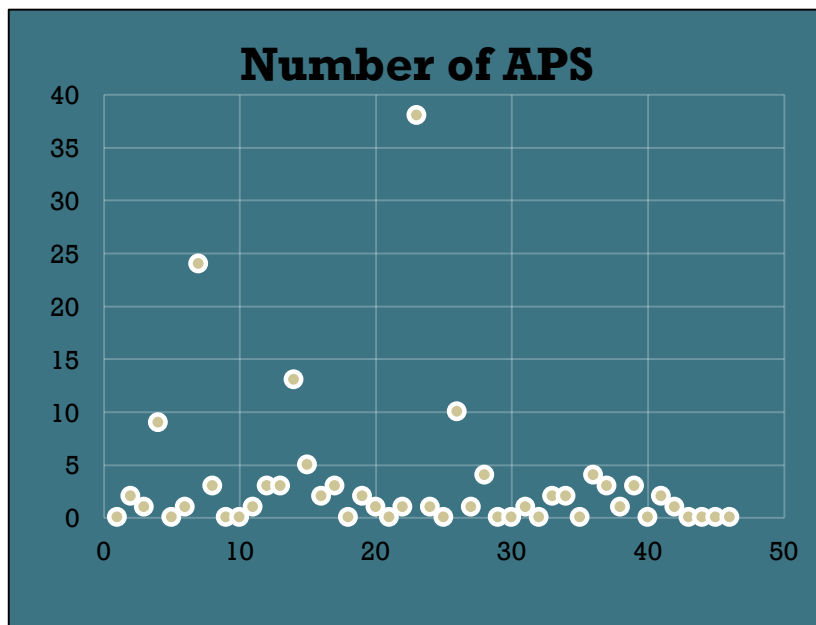
Adult Protective Services in Endorsed Memory Care



Allegations of abuse in licensed care settings are investigated by local DHS employees and/or AAA employees. Redacted copies of abuse investigation reports are available to the public at local offices and at the Central State office. Substantiated allegations of abuse are available on line (see consumer tip) although the reports themselves are not viewable.

As part of the initiative, the OLTCO reviewed Substantiated abuse investigations during both

2015 and 2016 occurring in the facilities that were part of the MCI. The total number of Substantiated Abuse allegations during that time was 147, with the range in numbers being 0 per facility to 38. However, as the chart shows, the higher number of Substantiated Abuse allegations were among the outliers; it was far more common for a facility to have had five or



allegation type. These were:

- Failure to provide safe environment resulting in failure to receive needed services.*
- Failure to provide a safe environment resulting in impact to other residents and escalation.*
- Failure to address resident behavior resulting in impact to other residents and escalation.*

Consumer Tip: Individuals considering a Memory Care setting for their friend or family member should research the abuse history of the facility. All substantiated allegations of abuse in licensed facilities in Oregon are available to the public at <https://apps.state.or.us/cf2/sp>

fewer in the two-year period and as many as 16 had zero.

The nature of the substantiated abuse is also important to examine. Facility abuse allegations are written in a very case specific manner. Therefore, it is difficult to compile them in a manner that spots trends. However, of those that were part of our review, there were three allegations that had at least twice the number of cases than any other

Licensing and Survey

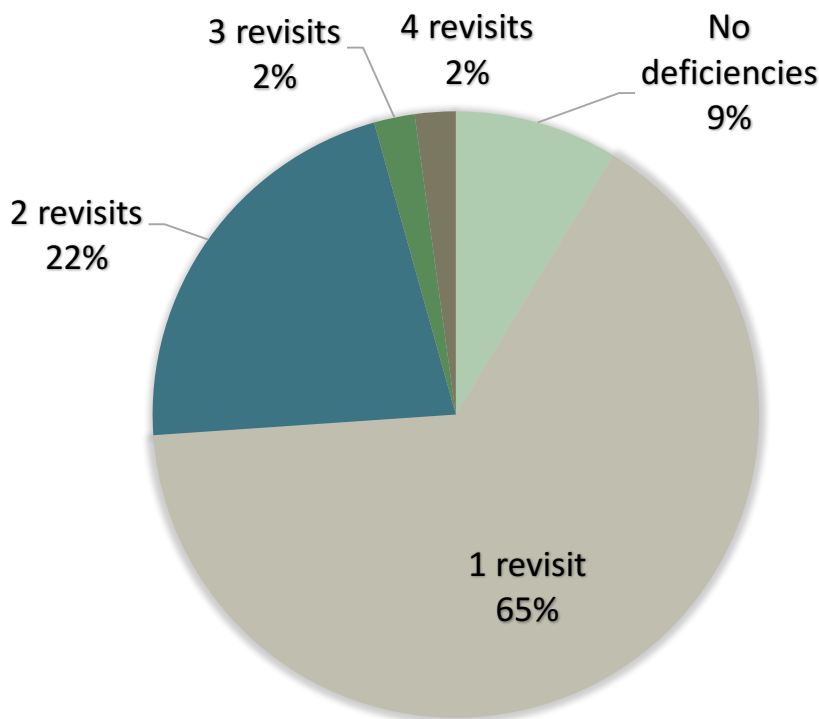
Another source of information available to consumers and their families regarding Memory Care Facilities is licensing and survey information. Routine licensing and surveys are conducted by the DHS unit called the Safety and Oversight unit. They also conduct investigations into licensing related complaints. For more information about all of their activities, visit the [Facilities Licensing website](#).



Facilities are required to be licensed every two years and if a facility is not found to be in substantial compliance with the Oregon Administrative Rules, revisits will occur until the facility has come into compliance

For the purposes of the Initiative the most recent

Consumer Tip: Much as potential consumers should research abuse history, they should also ask to see the most recent licensing survey. Facilities are required to provide this information, as well as any associated plans of correction, upon request. Survey information may also be obtained by calling the Office of the Long-Term Care Ombudsman who maintains survey, follow up visits, sanctions and civil penalties for consumer education purposes.



surveys were reviewed for the facilities included.

Four of the facilities in the Initiative passed their initial survey with no need for any revisits. The vast majority required one revisit, but two facilities required 3 – 4 revisits before being reissued a license.

Of the surveys reviewed, there were 123 citations issued in 12 categories.

What's Next?

This report contains a lot of information and the first hand observations of many dedicated volunteers. Moving forward, the Office of the Long-Term Care Ombudsman will use this information towards the goal of improving the lives of individuals residing in Memory Care in the following ways.

An increased focus on memory care related consumer education:

- ❖ Consumers contacting the LTCO or present at LTCO outreach events will be encouraged to read the MCI report, which will be posted on the LTCO website, and will also be provided with a one page summary of consumer tips.
- ❖ One page consumer tip sheets will be provided to partner agencies who also provide consumer education and will include, but not be limited to, tips from the report as well as the following:
 - Don't consider memory care unless the prospective resident not only has a dementia diagnosis but is also in need of supports related to that diagnosis to ensure their physical safety or function. Specifically, the prospective resident should have the need for a locked setting to prevent wandering or other unsafe behaviors.
 - Make sure that facility staff are aware of you or your loved ones prior lifestyle choices, food preferences, routines, and favored activities upon moving in and ask that these be documented and incorporated into the care plan.
 - Insist on being part of your ongoing care planning process and inviting the participants you wish to have with you at the table.
 - Ask if there is a dedicated Activities Coordinator, what their training and educational requirements are, and whether they have received training as an Alzheimer's Association Memories in the Making facilitator.
 - Participate in the resident council meetings or, as a family member, consider forming or attending a family council.

DID YOU KNOW??

During both the Memory Care Initiative and in the course of routine LTCO activity, volunteers have routinely identified individuals who do not meet the criteria for memory care placement and have advocated on their behalf for placement in a less restrictive setting.

Improved training of Certified Ombudsmen Volunteers serving in Memory Care Settings. All Certified Ombudsmen assigned to memory care settings will be:

- ❖ Asked to review the training program provided to Memory Care Specialists as part of this Initiative.
- ❖ Trained on the criteria for placement in a memory care setting, know how to identify individuals who may not be appropriate for that setting, and receive support in advocating for those residents.
- ❖ Provided with information regarding family councils and how to assist families of memory care residents in forming one.
- ❖ Provided with the national best practices identified in the [‘Dementia Care Practice Recommendations for Assisted Living Residences and Nursing Homes’](#) report published by the Alzheimer’s Association Campaign for Quality Residential Care.

Ongoing work with legislative partners and stakeholders to address issues faced by Memory Care consumers. Work will be specifically focused on:

- ❖ Developing professionalized caregivers through workforce and career development opportunities to achieve the level of training needed in staff providing services in these settings.
- ❖ Staffing requirements that not only meet the expected and unexpected needs of residents but that also provide for
 - Meaningful activities,
 - A mealtime experience conducive not only to adequate nutrition but positive social interactions and reasonable wait times for meals, and
 - Personalized non-task related interactions between staff and residents.
- ❖ A greater focus on the importance of relevant, resident specific and meaningful activities through:
 - The enforcement of all aspects of Oregon Administrative Rule 411-057-0160, and specifically the requirement for an individualized activity plan for each resident based on their activity evaluation, and
 - Establishing the Activities Director role as a necessary component of all memory care settings.

Appendix A

<u>Typ</u> <u>e</u>	<u>Name</u>	<u>City</u>	<u>Beds</u>
RCF	Atrium at Flagstone, The	The Dalles	33
RCF	Autumn House of Grants Pass	Grants Pass	15
RCF	Avamere at Hillsboro	Hillsboro	24
RCF	Bartlett House of Medford Memory Care Community	Medford	15
RCF	Baycrest Memory Care	Coos Bay	55
RCF	Bonaventure of Albany Memory Care	Albany	23
RCF	Brookdale Beaverton	Beaverton	60
RCF	Brookdale Geary Street Memory Care	Albany	44
RCF	Brookdale Grants Pass Pointe	Grants Pass	64
RCF	Brookdale McMinnville City Center Memory Care	McMinnville	15
RCF	Brookdale McMinnville Westside	McMinnville	37
RCF	Chateau Gardens Memory Care Community	Springfield	28
NF	Chehalem Health & Rehab Center	Newberg	20
RCF	Churchill Estates Residential Care	Eugene	44
RCF	Clarendon Court Alzheimer's Residence	Portland	15
RCF	Clatsop Memory Care Community	Warrenton	32
RCF	Courtyard at Mt.Tabor Garden House	Portland	20
RCF	ElderHealth & Living	Springfield	95
RCF	Emerson House	Portland	55
RCF	Farmington Square - Eugene	Eugene	24
RCF	Farmington Square - Medford	Medford	81
RCF	Fern Gardens Memory Care	Medford	84
RCF	Fircrest Memory Care	McMinnville	52
RCF	Footsteps at Mill Creek	The Dalles	25
RCF	Gateway Gardens	Eugene	75
RCF	Heritage House of Woodburn	Woodburn	15
ALF	Laurel Parc at Bethany	Portland	23
RCF	Pacific Gardens Alzheimer's Special Care Center	Portland	60
RCF	Pacific View Memory Care Community	Bandon	30
RCF	Pacific View Memory Care Community	Bandon	30
RCF	Pacifica Senior Living Portland	Portland	84
RCF	Powell Valley Memory Care Community	Gresham	42
RCF	Quail Park Memory Care Residences	Eugene	79

	Regent at Sheldon Park, a Blue Harbor Senior Living		
RCF	Community	Eugene	32
RCF	Revere Court of Portland	Portland	40
RCF	River Grove Memory Care	Eugene	60
RCF	Russellville Park West Memory Care	Portland	20
RCF	Skylark Memory Care	Ashland	32
RCF	Southtowne Living Center	Eugene	65
RCF	St. Andrews Care Center	Portland	75
ALF	St. Anthony Village	Portland	24
RCF	Sweetbriar Villa	Springfield	9
RCF	Timberwood Court Specialty Care Community	Albany	48
RCF	Touch of Grace, A	Medford	13
RCF	Washington Gardens Memory Care	Tigard	48
RCF	Waterford Grand Memory Care	Eugene	64