

DIVISION OF PUBLIC AND BEHAVIORAL HEALTH
Interagency Workgroup to Address Alzheimer's and Dementia Care Regulations
AGENDA

Date: August 1, 2019

Time: 2:00 PM

Meeting locations Videoconference to:

Division of Public and Behavioral Health
Bureau of Health Care Quality & Compliance
4220 S. Maryland Park Way, Building D, Suite 810
Las Vegas, Nevada 89119

Division of Public and Behavioral Health
Bureau of Health Care Quality and Compliance
727 Fairview Drive, Suite E
Carson City, Nevada 89701

Please use landline to call in:

TELECONFERENCE CALL IN NUMBER: 1-888-398-2342 Access Code 1530727

NOTE: SOME AGENDA ITEMS MAY BE TAKEN OUT OF ORDER, COMBINED FOR CONSIDERATION, AND/OR REMOVED FROM THE AGENDA AT THE CHAIRPERSON'S DISCRETION

1. Introductions.
2. Continued discussion and recommendations for improving Nevada Administrative Code 449.173, 449.2754-.2756, and 449.2768 addressing residential facilities which provide care to persons with Alzheimer's disease and other forms of dementia. *Kyle Devine, Clinical Program Manager II.*

PUBLIC COMMENT
FOR POSSIBLE ACTION

3. Discussion and recommendations for improving Nevada Administrative Code 449.1565, .1595, .1599, and .172-.2746, addressing residential facilities for groups with respect to caring for persons with Alzheimer's disease or other forms of dementia. *Kyle Devine, Clinical Program Manager II.*

PUBLIC COMMENT
FOR POSSIBLE ACTION

4. Adjournment.

AGENDA FAXED OR EMAILED FOR POSTING AT THE FOLLOWING LOCATIONS:

Nevada State Library, 100 Stewart Street, Carson City, NV

Washoe County Health District, 1001 East 9th and Wells, Reno, NV

Division of Public and Behavioral Health, 4220 S. Maryland Parkway, Suite 810, Bldg., D, Las Vegas, NV

Grant Sawyer State Office Building, 555 East Washington Street, Las Vegas, NV

Bureau of Early Intervention Services, 2667 Enterprise Road, Reno, NV

Division of Public and Behavioral Health, 4150 Technology Way, Carson City, NV

Emergency Medical Services, 1020 Ruby Vista Drive, Suite 310, Elko, NV

Division of Public and Behavioral Health, 727 Fairview Drive, Carson City, NV

On the Internet at the Division of Public and Behavioral Health website:

[http://dpbh.nv.gov/Reg/HealthFacilities/dta/Boards/Health_Facilities - Boards/](http://dpbh.nv.gov/Reg/HealthFacilities/dta/Boards/Health_Facilities_-_Boards/)

<https://notice.nv.gov/>

In the event of videoconference technical difficulties, the meeting may be conducted by teleconference from the same locations. We are pleased to make reasonable accommodations for members of the public who are disabled and wish to attend the meeting. If special arrangements are necessary, please notify Nenita Wasserman, Division of Public and Behavioral Health, in writing please send to, 727 Fairview Drive, Carson City, Nevada 89701 or by calling (775) 684-1033 before the meeting date. Anyone who wants to be on the advisory council mailing list can sign up on the listserv at the following website. <http://dpbh.nv.gov/Reg/HealthFacilities/dta/Lists/Listservs/>

If you need supporting documents for this meeting, please notify Nenita Wasserman, Division of Public and Behavioral Health, Health Care Quality and Compliance, at 775-684-1033 or by email at nwasserman@health.nv.gov. Supporting material will be available for the public at the following locations at: 727 Fairview Drive, Suite E, Carson City, Nevada, or 4220 So. Maryland Parkway, Suite 810, Bldg. D, Las Vegas. WO139352 B.H. 1-888-398-2342 ,WO# 162898 Approved by Legal Counsel.

Alzheimer's and Dementia Regulation Assessment - as of 07/29/2019

Purpose: The purpose of this worksheet is to identify areas of change to Nevada's Administrative Code (449) as it relates to caring for persons with Alzheimer's and other forms of Dementia.

Instructions: Please use the template below to make recommendations and comments on Nevada's current regulations regarding the care of persons with Alzheimer's and other forms of dementia. The first section of the template below is specific to Alzheimer's and Dementia Endorsements. The second section consists of general regulations for Residential Facilities for Groups. As there are so many regulations, some which may not be applicable to this project have been excluded. If there are other regulations not included in the template which you feel are applicable, please state those at the end of this document. In the template, please fill in the changes and any rationale for those changes in the second column which correspond to the listed regulation, Changes Needed/Comments/Notes. If applicable, please list any referring documents which may support the recommended change. These may be based on studies, other state's regulations, and National or International recommendations.

Guidelines:

- Regulations should set the **minimum** standard to protect the health and safety of Nevada's population;
- Nevada's population effected by Alzheimer's and other forms of dementia is growing and may exceed current resources for care;
- Changing environments for persons with Alzheimer's or other forms of dementia can have negative effects on their disease progression;
- Alzheimer's and other forms of Dementia are progressive diseases and have a spectrum of behavioral symptoms with or without a diagnosis;
- Regulations are more easily followed and enforced when the criteria are explicit and clear;
- Regulatory standards should be consistent with current science.

Alzheimer's/Dementia Endorsement

Nevada Administrative Code (NAC)	Changes Needed/Comments/Notes	Reference	Summary Notes
NAC 449.173 “Residential facility which provides care to persons with Alzheimer’s disease” defined. (NRS 449.0302)			NRS 449.0302 requires separate regulations for residential facilities for groups which provide care for persons with Alzheimers.
“Residential facility which provides care to persons with Alzheimer’s disease” means a residential facility that provides care and protective supervision for persons with Alzheimer’s disease or a related disease,	Would suggest removing the word “facility”, as this sounds institutional and the shift is to become more person centered. Replace with “residential care home” for those homes that have XX # of beds or less. Understanding this affects more sections of NRS.	HCBS new rule	Must use same language as NRS

<p>including, without limitation, senile dementia, organic brain syndrome or other cognitive impairment. (Added to NAC by Bd. of Health by R003-97, eff. 10-30-97; A by R073-03, 1-22-2004)</p>	<p>Instead of referring to Alzheimer’s disease, refer to dementia including Alzheimer’s disease and progressive cognitive decline.</p> <p><i>Dementia and Alzheimer’s disease, including without limitation, senile dementia, organic brain syndrome or other progressive cognitive impairments.</i></p> <ol style="list-style-type: none"> 1) This definition does not make sense as a differentiator between “Alzheimer’s” and “non-Alzheimer’s” residential care, because the predominant resident population in ALL assisted living/residential care communities is living with dementia. While it may not always appear true for a variety of reasons, such as the fact that only 50% of people living with dementia have a diagnosis, studies demonstrate that approximately 70% of residents in AL/RC have some form of cognitive impairment (Zimmerman et al., 2014). Therefore, the ideal scenario is not one in which we distinguish between Alzheimer’s and non-Alzheimer’s communities, but rather implementing a strategy to assure that ALL residential care communities have the necessary staffing and staff training to support residents living with dementia. Also, the number of people living with dementia is expected to increase dramatically in the next six years alone, quickly reaching a point where designating “special living environments” is simply not practical even in the short term. Good care should be present in all communities. 2) “Senile dementia” and “organic brain syndrome” are out-of-date and obsolete terms, which are not commonly used in current practice. The current preferred general term for “dementia” as included in the latest DSM is “neurocognitive disorders” – that is the umbrella term. Alzheimer’s and other specific causes (i.e., disease) of dementia are also relevant, or you could use 	<p>Zimmerman, Sloane & Reed (2014)</p> <p>Power (2017)</p>	<p>Makes sense as Alzheimer’s’ is a form of Dementia.</p> <p>Dementia and Alzheimer’s should be defined in the regulation.</p> <p>Definitions from New York to work with:</p> <p>Dementia</p> <p>Dementia is not a specific disease, but rather a general term for a gradual and progressive decline in mental and physical functions. Dementia can affect various areas of brain function, such as memory, language, problem solving and attention.</p> <p>Alzheimer's disease is the most common type of dementia.</p> <p>Alzheimer's Disease</p> <p>Alzheimer's disease is a progressive, neurodegenerative disorder that causes disorientation and behavioral changes, and obstructs memory, thinking, and judgment. Symptoms usually develop slowly and worsen over time. Alzheimer's disease is not a normal part of aging.</p>
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	<p>simply “dementia” or “cognitive disability” as better general terms if preferred.</p> <p>3) Dementia is not a specific disease; rather it is a syndrome—a collection of signs and symptoms involving cognitive function that can follow many different patterns and have many different causes. Most specialists agree that there are well over 100 different diseases or injuries that can result in a dementia syndrome. Within these multiple causes, there are many levels of ability, individuals with many different amounts of reserve, various talents and shortcomings, different cultures, relationships, coping styles...but these regulations are intended to prescribe only one kind of living environment and approach to care/activity programming. This issue, which affects many communities nationwide, constitutes what may be “the greatest misconception in aged care” (Power, 2017b): the idea that such a diverse population is alike enough to justify such sweeping generalizations about how ‘they’ should live. It is all too common to hear people recite the old saw that “if you’ve met one person with dementia, you’ve only met one person with dementia”—and then quickly reduce that person to a stereotype in talking about “dementia care.” Nevada should avoid this mistake.</p>	Indiana Administrative Rules	
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"Residential care facility" defined "Residential care facility" means a health care facility that provides residential nursing care. "Residential nursing care" defined "Residential nursing care" may include, but is not limited to, the following:

- (1) Identifying human responses to actual or potential health conditions.
- (2) Deriving a nursing diagnosis.
- (3) Executing a minor regimen based on a nursing diagnosis or executing minor regimens as prescribed by a physician, physician assistant, chiropractor, dentist, optometrist, podiatrist, or nurse practitioner.
- (4) Administering, supervising, delegating, and evaluating nursing activities as described in this section.

Nursing care would need a different licensing. Group homes do not provide medical care.

<p>NAC 449.2754 Residential facility which provides care to persons with Alzheimer’s disease: Application for endorsement; general requirements. (NRS 449.0302)</p>			
<p>1. A residential facility which offers or provides care for a resident with Alzheimer’s disease or related dementia must obtain an endorsement on its license authorizing it to operate as a residential facility which provides care to persons with Alzheimer’s disease. The Division may deny an application for an</p>	<p>What is the Criteria, education, on how to get an endorsement? Facility design and layout; color scheme; “Alzheimer’s friendly environment” staff training, etc... Is the criteria mentioned in NAC 449.2768 applicable regarding the 12 month recertification? The underlying premise for this designation is flawed. There is no legitimate justification for a special or separate endorsement for supporting people living with dementia. As noted above,</p>		<p>Training criteria should be adopted</p> <p>NRS would need to be changed to do this. The concept is correct but how do we bridge the two?</p> <p>Suggested to make the endorsement voluntary and not required.</p>

<p>endorsement or suspend or revoke an existing endorsement based upon the grounds set forth in NAC 449.191 or 449.1915.</p>	<p>dementia is present, in significant proportion, in all AL/RC communities. As such, “good residential care” is the same as “good dementia care”. A community that provides care for any elders should be offering high-quality, person-centered care with well-trained staff capable of doing so, including being capable of supporting a person living with dementia.</p>		
<p>2. If a residential facility is authorized to operate as a residential facility which provides care to persons with Alzheimer’s disease and as another type of facility, the entire facility must comply with the requirements of this section or the residents who suffer from Alzheimer’s disease or other related dementia must be located in a separate portion of the facility that complies with the provisions of this section.</p>	<p>Again, all residential care communities should be held to the same standard. Further, a diagnosis of dementia absolutely should not be used as a justification for “locked” or “segregated” living. A recent review in the Gerontologist, quoted below, demonstrates that such segregation or locked approaches to dementia care do not improve outcomes (Calkins, 2018): “A recent Cochrane review (Lai, Yeung, Mok, & Chi, 2009) suggests there is a lack of evidence for better clinical outcomes, and other studies demonstrate an increased risk of elder-to-elder aggression or mistreatment (Lachs et al., 2016) and potentially higher antipsychotic use in segregated units (Cadigan, Grabowski, Givens, & Mitchell, 2012; Powers, 2017b)...Van Haitsma, Lawton, and Kleban (2000), in a well-designed and controlled study, found there were poorer outcomes for individuals who lived on the segregated living area than for a matched sample of residents who lived in integrated living areas.” (p. 117) Thus, this type of restriction on autonomy may very well be the cause of much of what is interpreted as so-called</p>	<p>Calkins (2018) Namazri & Johnson (1992)</p>	<p>Not necessary. Delete</p>

	<p>“problem behaviors”. The disease/diagnosis of dementia is not the issue in this case, the confinement is causing distress and a palpable (and understandable) desire for freedom. The role of autonomy in quality of life and the constraints created by segregated living environments has long been recognized, as shown in a 1992 study published in the American Journal of Alzheimer’s Disease (Namazari & Johnson, 1992).</p>		
<p>3. A residential facility which provides care to persons with Alzheimer’s disease may admit or retain a resident who requires confinement in locked quarters.</p>	<p>Delete this regulation. Residents should not be confined, rather there should be audible devices (required elsewhere in the regulations) and sufficient staffing (required elsewhere in the regulations) to ensure redirection of exit seeking residents.</p> <p>“Alzheimer’s disease dementia and other related dementia may retain a resident who requires confinement to locked quarters for the purposes of safety and to reduce risk of elopement.”</p> <p>Confinement in “locked quarters” is a violation of human rights. There is only one group of people – outside of convicted prisoners – who can still be compelled to live apart from others, and that is people living with a diagnosis of dementia. Such restrictions infringe on the rights of people living with dementia to have a choice of housing – a right declared by the United Nations</p> <p>Convention on the Rights of Persons with Disabilities (which has been deemed to be</p>		<p>Delete</p>

applicable to people living with dementia). The choice of housing is also guaranteed by the United States Supreme Court in their 1999 Olmstead vs. L.C. decision, which reinforced the right of people with “mental impairment” to live in an integrated setting for as long as they may safely do so with the necessary supports. Supporting the integration mandate in the Americans with Disabilities Act (ADA; 1990), the Olmstead decision asserts that the medically unjustifiable institutionalization of persons with disabilities constitutes a violation of the ADA. States must provide services to people living with disabilities in the community, as opposed to in an institution, and failure to do so constitutes discrimination. In short, people living with dementia are protected under the ADA and Olmstead decision to live in the least restrictive setting possible. It is important to note that “the terms of the ADA are not limited by age or by type of disability: the law protects persons of any age who meet its functional disability test and who are considered ‘qualified’ (Rosenbaum, 2001, p. 1). While dementia is not specifically listed as an impairment in the ADA, as a condition that affects one or more major life activities, it would presumably fall within the general category of “mental impairment.” Essentially, the court held that you cannot use mental impairment and its associated disabilities as an excuse to deprive someone of their choice regarding where they live, which is clearly the case when restricting people living with dementia to certain designated facilities. Furthermore, the reality is that locked doors are a primary cause of distress among institutionalized

people living with dementia, as illustrated in the following quotes from Namazi (1992): “the locked doors precipitated 52 instances of agitated behavior. Under the unlocked door condition, there was a dramatic decline in agitated behaviors...” “Among those who were most eager to exit the unit, the experience usually ended when the resident was assured that the door was open and he or she could depart. Several residents held the door ajar with one hand, stepped outside, looked around, and then came back inside. This activity was repeated by residents several times during the morning trials. Once a resident's sense of curiosity was satisfied, i.e., the resident recognized that he or she was not confined within the unit and was free to go in or out, he or she often chose to remain indoors. The element of choice also appeared to decrease negative exit door behaviors.” In summary, people try to escape places where they feel locked in, and locked doors do more harm than good. The researchers’ conclude: “The decrease in agitated behaviors suggests that the issue of autonomy for the cognitively impaired is crucial and warrants changes in institutional policy if patient needs are to be addressed”.

Pre-admission assessment describes a process for determining whether a prospective resident has a cognitive impairment. Knowing whether a resident will benefit from dementia care services, including a locked unit, is one way of assuring that individuals are not deprived of their freedom of movement by being placed in a setting that

State
Approaches
to Dementia
Care gnw1

	<p>potentially... provides services unneeded by the individual. Fourteen states require RC/AL settings to do a pre-admission assessment of prospective dementia care unit residents (Table 2). South Dakota requires a physician’s order for “confinement” of each resident, including medical symptoms that “warrant seclusion.” Similarly, Colorado requires an assessment by a qualified professional who can evaluate the need for a “secured environment.” Wyoming does not allow facilities to admit or retain in a secure dementia unit an individual who scores more than 20 or less than 10 on the Mini-Mental State Examination. Alabama requires a clinical history, mental status examination, geriatric depression screen, physical functioning screen, and a behavior screen before admission.</p> <p>Providing easy, safe and secure access to the outdoors while maintaining control over unauthorized exiting enhances the environment. Note : Residents who have elopement behaviors need opportunities for safe wandering. Pre-admission assessment describes a process for determining whether a prospective resident has a cognitive impairment. Knowing whether a resident will benefit from dementia care services, including a locked unit, is one way of assuring that individuals are not deprived of their freedom of movement by being placed in a setting that is potentially more expensive than general RC/AL care and that provides services unneeded by the</p>	<p>Brochure_DC PRphases1n2</p> <p>State Approaches to Dementia Care gnw1</p>	
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	<p>individual. Fourteen states require RC/AL settings to do a pre-admission assessment of prospective dementia care unit residents (Table 2). South Dakota requires a physician’s order for “confinement” of each resident, including medical symptoms that “warrant seclusion.” Similarly, Colorado requires an assessment by a qualified professional who can evaluate the need for a “secured environment.” Wyoming does not allow facilities to admit or retain in a secure dementia unit an individual who scores more than 20 or less than 10 on the Mini-Mental State Examination. Alabama requires a clinical history, mental status examination, geriatric depression screen, physical functioning screen, and a behavior screen before admission.</p>		
<p>4. A residential facility which provides care to persons with Alzheimer’s disease must be administered by a person who:</p> <ul style="list-style-type: none"> (a) Has not less than 3 years of experience in caring for residents with Alzheimer’s disease or related dementia in a licensed facility; or (b) Has a combination of education and training that the Bureau determines 	<p>The training should be clearly outlined- the home’s administrators shouldn’t have to guess what trainings are acceptable.</p> <p>Add certification requirement at the individual level?</p> <p>Again, this should not be specific to Alzheimer’s. All RC/AL should have administrators with appropriate experience and training, including dementia experience and education.</p>	<p>Indiana Administrative Rules</p>	<p>May need some criteria, but we do not want any existing administrators out of a job.</p>

<p>is equivalent to the experience required pursuant to paragraph (a).</p>	<p>The administrator shall have an earned degree from an educational institution in a health care, mental health, or social service profession or be a licensed health facility administrator. The administrator shall have a minimum of one (1) year work experience with dementia or Alzheimer's residents, or both, within the past five (5) years. Persons serving as administrator for an existing Alzheimer's and dementia residential facility at the time of adoption of this rule are exempt from the degree and experience requirements. The administrator shall have a minimum of twelve (12) hours of dementia-specific training within three (3) months of initial employment as the director of the Alzheimer's and dementia special care unit and six (6) hours annually thereafter to: (1) meet the needs or preferences, or both, of cognitively impaired residents; and (2) gain understanding of the current standards of care for residents with dementia. (x) The administrator shall do the following: (1) Oversee the operation of the facility. (2) Ensure that: (A) personnel assigned to the unit receive required in-service training; and (B) care provided to Alzheimer's and dementia care unit residents is consistent with: (i) in-service training; (ii) current Alzheimer's and dementia care practices; and (iii) regulatory standards</p>		
<p>5. The administrator of such a facility shall prescribe and maintain on the premises of the facility a written statement which includes:</p>	<p>No changes but guideline would be helpful</p> <p>5.c.1. Revise to read: "The basic services provided for the needs of all residents, including residents living with dementia." (Notes: person-centered</p>	<p>Tilly and Reed, 2006 Dupuis et al., 2012</p>	<p>Communication of unmet needs. Good point</p>

<p>(a) The facility’s policies and procedures for providing care to its residents;</p> <p>(b) Evidence that the facility has established interaction groups within the facility which consist of not more than six residents for each caregiver during those hours when the residents are awake;</p> <p>(c) A description of:</p> <p>(1) The basic services provided for the needs of residents who suffer from dementia;</p> <p>(2) The activities developed for the residents by the members of the staff of the facility;</p> <p>(3) The manner in which the behavioral problems will be managed;</p> <p>(4) The manner in which the medication for residents will be managed;</p> <p>(5) The activities that will be developed by the members of the staff of the facility to encourage the involvement of family members in the lives of the residents; and</p> <p>(6) The steps the members of the staff of the facility will take to:</p>	<p>care is appropriate for all residents regardless of cognitive ability; Also, the word “suffering” is inherently stigmatizing to all people living with dementia, in or outside of a residential care community; Finally, people living with dementia say that most of the “suffering” from dementia does not come from the disease itself, but from the social response toward people living with dementia.)</p> <p>5.c.3. We need to shift away from blaming behaviors on dementia to understanding these so-called “behaviors” as communication of unmet needs (i.e. ineffective/poor care practices) and take a proactive approach to supporting well-being (vs. reactive interventions). Most distress (i.e. so-called problem behaviors) among persons living with dementia represents an expression of unmet need. Instead of treating ill-being through reactive pharmacological and/or non-pharmacological interventions, our primary goal should always be proactively supporting well-being. An approach that recognizes the importance of well-being can be used to decode and respond to expressions of stress and distress, thus reducing excess disability and unnecessary drug use. à This is a critical element to include in administrator / staff training. They should understand “behavior” as a communication of distress due to unmet need, not as a result of the disease. Please see Tilly & Reed (2006) for the Alzheimer’s Association’s National Practice Recommendations for Assisted Living</p>		<p>Activities should be a part of personal care plans. Should be a negotiated care plan.</p>
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<p>(I) Prevent residents from wandering from the facility; and</p> <p>(II) Respond when a resident wanders from the facility; and</p> <p>(d) The criteria for admission to and discharge and transfer from the facility</p>	<p>Residences and Nursing Homes, which discusses behavior as a form of communication.</p> <p>5.c.4. Add to this statement “...as well as the efforts being made to decrease / eliminate the use of anti-psychotics and other chemical restraints among residents living with dementia.”</p> <p>5.c.6.I. Replace with steps staff will take to: “negotiate and safely support resident autonomy and freedom, including the right to move, walk, access the outdoors and leave the community.” (Notes: “Wandering” is also highly stigmatizing language that implies aimlessness simply because staff may not be aware of the resident’s intended purpose. This is also another critical training element for administrators and staff – how do they learn to safely support residents in negotiating risk in order to avoid restricting their freedom.)</p> <p>5.c.6.I. Revise to read “how to respond when a resident leaves the community without appropriate support or escort, as determined by a negotiated resident care plan”.</p>		
<p>6. The written statement required pursuant to subsection 5 must be available for review by members of the staff of the facility, visitors to the facility and the Bureau.</p>	<p>Also include access for resident review.</p>		<p>Change to include resident review.</p>
<p>7. The administrator shall ensure that the facility complies with the provisions of the statement required pursuant to subsection 5</p>	<p>Delete this regulation. Whether it’s the administrator or other facility staff, the facility as an entity must comply. (this regulation is redundant)</p>		<p>Delete</p>

<p>8. The members of the staff of the facility shall develop a program of activities that promotes the mental and physical enhancement of the residents. The following activities must be conducted at least weekly:</p> <ul style="list-style-type: none"> (a) Activities to enhance the gross motor skills of the residents; (b) Social activities; (c) Activities to enhance the sensory abilities of the residents; and (d) Outdoor activities. <p>(Added to NAC by Bd. of Health by R003-97, eff. 10-30-97; A by R073-03, 1-22-2004; R119-10, 1-13-2011)</p>	<p>Modify this regulation. Requiring weekly activities is not nearly enough. Residents should have the opportunity to participate in each of the activities listed on a daily basis.</p> <p>This should not be about therapy for “mental or physical enhancement” or “to enhance the sensory abilities of the residents” unless that is a resident’s expressed desire, but rather about offering a range of planned and unplanned (structured and informal) recreational and leisure opportunities that are meaningful to each resident’s interests, preferences and goals for everyday life. Again, this is an element to include in both negotiated care plans and staff / administrator training. Sensory activities should be integrated as a natural part of normalized opportunities for recreation and leisure, and not implemented as some type of artificial “sensory stimulation” program. Same with gross motor skills – normalization is key. Please see Tilly & Reed (2006) for the Alzheimer’s Association’s National Practice Recommendations for Assisted Living Residences and Nursing Homes, which take into account the needs of residents living with dementia as the gold standard for practice in supporting meaningful engagement. Also see, Dupuis et al. (2012), a study in which researchers worked in partnership with people living with dementia to understand and describe their preferred recreation and leisure experiences. In summary, people living with dementia said they could live well with dementia and experience a high quality of life as long as they are afforded with opportunities for: being me, being with, seeking</p>	<p>Tilly and Reed, 2006 Dupuis et al., 2012</p>	<p>???</p>
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	<p>freedom, finding balance, making a difference, growing and developing, and having fun. These needs are not unique to residents living with dementia, but are, in fact, universal in nature. A high quality recreation program should be reflective of these fundamental human needs for engagement. To put a point on it, leisure is a human right, and this right should be guaranteed.</p> <p>Activities should be Person Centered – dependent upon cognitive ability and interest of the resident, increased frequency. Depending on the resident, how are these activities are received. The point is to engage the resident, provide a stimulating environment, and reduce isolation at the facility.</p> <p>No changes except “ as tolerated by individual residents”</p> <p>Therapeutic Activities. Therapeutic activities shall be provided to the residents of the A/D Unit seven (7) days per week. The therapeutic activities shall be scheduled by a Certified Therapeutic Recreation Specialist, a Qualified Therapeutic Recreation Specialist, or an Activity Consultant Certified, which must provide a minimum of eight (8) hours monthly in-house consultation to an activities designee.</p> <ol style="list-style-type: none">1. Activities shall be delivered at various hours.2. Opportunities shall be provided for daily involvement with nature, and sunshine (i.e., as in outdoor activities) as weather permits.	<p>Mississippi 118</p>	
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	<p>3. Residents will not be observed with negative outcome for long periods without meaningful activities.</p> <p>4. Activities will: a. tap into better long-term memory than short; b. provide multiple short activities to work within short attention spans; c. provide experience with animals, nature, and children; and d. provide opportunities for physical, social, and emotional outlets.</p> <p>5. Productive activities that create a feeling of usefulness shall be provided.</p> <p>6. Leisure activities shall be provided.</p> <p>7. Self-care activities shall be provided.</p> <p>8. Planned and spontaneous activities shall be provided in the following areas: a. structured large and small groups; b. spontaneous intervention; c. domestic tasks/chores; d. life skills; e. work;</p> <p>f. relationships/social; g. leisure; h. seasonal; i. holidays, j. personal care; k. meal time; and l. intellectual, spiritual, creative, and physically active pursuits.</p> <p>9. Activities will be based on cultural and lifestyle differences.</p> <p>10. Activities shall be appropriate and meaningful for each resident, and shall respect a person's age, beliefs, culture, values, and life experience. SOURCE: Miss. Code Ann. §43-11-13 Subchapter 5</p>		
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<p>NAC 449.2756 Residential facility which provides care to persons with Alzheimer’s disease: Standards for safety; personnel required; training for employees. (NRS 449.0302)</p>	<p>Administrators / staff should be encouraged to include a negotiation of risk for all safety-related items / issues in the resident care plan process and should do so in a manner that recognizes the relevance and possibilities of “upside risk” in addition to potential “downside risk” as articulated in the concept of “surplus safety” (Thomas & Ronch). This will help ensure an appropriate balance of physical safety with personal autonomy to preserve resident rights.</p>		
<p>1. The administrator of a residential facility which provides care to persons with Alzheimer’s disease shall ensure that:</p> <p>(a) Swimming pools and other bodies of water are fenced or protected by other acceptable means.</p> <p>(b) Operational alarms, buzzers, horns or other audible devices which are activated when a door is opened are installed on all doors that may be used to exit the facility.</p> <p>(c) At least one member of the staff is awake and on duty at the facility at all times.</p> <p>(d) Each employee of the facility who has direct contact with and provides care to residents with any form of dementia, including, without</p>	<p>No change is necessary. However, (1)(a) should be enforced in all facilities, not just Alzheimer’s endorsed facilities.</p> <p>Any restriction such as locking up sharps should be noted in the individuals care plan. This is part of the HCBS new regulation.</p> <p>No changes. That staff member should have some certification for care of such demented individuals</p> <p>1.b. Alarms have been shown to be problematic as they create disruptive and chaotic noises that can be confusing and upsetting to residents, thus diminishing quality of life and triggering episodes of distress. The alarms can actually be terrifying for people living with dementia. Also, there is research showing that alarms are often ignored by staff due to “alarm fatigue” in which the sound of an alarm becomes so commonplace that it is no longer worth noting. Other than emergency exits, no audible alarms should be in place on doors, and there are more appropriate / ideal technology solutions that can produce a better outcome</p>		

<p>limitation, dementia caused by Alzheimer’s disease, successfully completes the training and continuing education required pursuant to NAC 449.2768.</p> <p>(e) Knives, matches, firearms, tools and other items that could constitute a danger to the residents of the facility are inaccessible to the residents.</p> <p>(f) The facility has an area outside the facility or a yard adjacent to the facility that:</p> <ul style="list-style-type: none"> (1) May be used by the residents for outdoor activities; (2) Has at least 40 square feet of space for each resident in the facility; (3) Is fenced; and (4) Is maintained in a manner that does not jeopardize the safety of the residents. <p>↪ All gates leading from the secured, fenced area or yard to an unsecured open area or yard must be locked and keys for gates must be readily available to the members of the staff of the facility at all times.</p> <p>(g) All toxic substances are not accessible to the residents of the facility.</p>	<p>without the disruption to residents (e.g., door-open messages sent to i-phones or other devices).</p> <p>1.c. A blanket statement like this could be woefully inadequate and would be better framed as a ratio. For larger communities, a single person awake may be insufficient for meeting resident care needs and addressing emergencies.</p> <p>1.d. This should be reframed as a requirement to provide training on dementia care for all staff in all RC/AL, not just among those “having direct contact”, because all staff are supporting people living with dementia, whether it is explicitly in their job description or not, and whether they know it or not. Dementia is simply so present in RC/AL that staff interacting with residents living with dementia is unavoidable. Also, good dementia care is the same as good elder care – so, again the distinction is a false dichotomy.</p> <p>The most common feature—concerned requirements for egress features designed to restrict residents from leaving the building unescorted. Delayed egress doors have locking systems that prevent a door from opening in nonemergency situations. States may specify whether to permit these devices and the conditions for use. New Mexico describes a “secured environment” as any locked area in which doors and fences restrict access through the use of double alarm systems, gates connected to the fire alarm, and tab alarms for residents at risk for elopement. California requires settings that use</p>	<p>State Approaches to Dementia Care gnw1</p>	
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<p>2. The training required pursuant to NAC 449.2768 may be used to satisfy the requirement of paragraph (f) of subsection 1 of NAC 449.196 for the year in which the training is received.</p> <p>(Added to NAC by Bd. of Health by R003-97, eff. 10-30-97; A by R052-99, 9-27-99; R073-03, 1-22-2004; R071-04, 8-4-2004)</p>	<p>delayed egress and locked doors/perimeters to receive fire department clearances and licensing agency approval, and that residents or their responsible persons consent to the use of delayed egress devices or locked facility doors.</p> <p>The Emergency Disaster Plan, as required in Section 87212, addresses the safety of residents with dementia</p>	<p>California dementia-care-regs</p>	
<p>NAC 449.2768 Residential facility which provides care to persons with dementia: Training for employees. (NRS 449.0302, 449.094)</p>	<p>As noted above: This section should be reframed as a requirement to provide training on dementia care for all staff in all RC/AL, not just among those “having direct contact”, because all staff are supporting people living with dementia, whether it is explicitly in their job description or not, and whether they know it or not. Dementia is simply so present in RC/AL that staff interacting with residents living with dementia is unavoidable. Also, good dementia care is the same as good elder care – so, again the distinction is a false dichotomy. This section largely focuses on the number of hours of training, but does not include any consideration of appropriate content and/or training delivery modalities. It is important to provide direction on the parameters of trainings that are acceptable. TFAD has a current effort to identify and assess national / Nevada training programs to make recommendations for “suggested” trainings that have been determined to meet basic dementia training principles and approaches.</p>		

	<p>Further, the following content areas (with current non-stigmatizing dementia language revisions made) are articulated in related NRS, which is worth consideration in the context of NAC training requirements:</p> <ul style="list-style-type: none"> • understanding dementia, with a special focus on Alzheimer’s disease, including the symptoms, prognosis and treatment; • communicating with a person living with dementia; • providing personal care to a person living with dementia; • supporting opportunities for recreational and social activities for a person living with dementia; • preventing, interpreting and responding to personal expressions, actions and reactions (so-called “difficult behaviors”) of a person living with dementia; and advising family members of a person with dementia concerning interaction with the person with dementia. 		
<p>1. Except as otherwise provided in subsection 2, the administrator of a residential facility which provides care to persons with any form of dementia shall ensure that:</p> <p>(a) Each employee of the facility who has direct contact with and provides care to residents with any form of dementia, including, without</p>	<p>No change is necessary, unless there’s a desire to increase the educational requirements.</p> <p>1.a.2. Can we increase the number of hours of training required? 8 is very inadequate given the prevalence of dementia. Other states have significantly higher requirements and are more directive in terms of the quality of training (e.g., see Washington State’s Administrative Code).</p> <p>1.b. It is important to bring in considerations of the quality of training being provided rather than just tracking the number of hours. Can we ask</p>		

<p>limitation, dementia caused by Alzheimer’s disease, successfully completes:</p> <p>(1) Within the first 40 hours that such an employee works at the facility after he or she is initially employed at the facility, at least 2 hours of training in providing care, including emergency care, to a resident with any form of dementia, including, without limitation, Alzheimer’s disease, and providing support for the members of the resident’s family.</p> <p>(2) In addition to the training requirements set forth in subparagraph (1), within 3 months after such an employee is initially employed at the facility, at least 8 hours of training in providing care to a resident with any form of dementia, including, without limitation, Alzheimer’s disease.</p> <p>(3) If such an employee is licensed or certified by an occupational licensing board, at least 3 hours of continuing education in providing care to a resident with dementia, which must be completed on or before the anniversary</p>	<p>providers to also report on the training completed? Is it a named/branded program? Is it a video/online/in-person/in-service, etc? The quality makes a huge difference in building the capacity of staff to best support people living with dementia. It may be worth considering a competency-based requirement like Washington State.</p> <p>(2) In addition to required training requirements in subsection (1) and (2) staff who have direct contact with residents will three (3) hours annually to meet the needs or preferences, or both, of cognitively impaired residents effectively and to gain understanding of the current standards of care for residents with dementia.</p> <p>(3) Inservice records shall be maintained and shall indicate the following:</p> <p>(A) The time, date, and location.</p> <p>(B) The name of the instructor.</p> <p>(C) The title of the instructor.</p> <p>(D) The names of the participants.</p> <p>(E) The program content of inservice.</p> <p>....(d) An Alzheimer’s disease and related dementias curriculum must include at a minimum the following topics: understanding dementia, effectively communicating with individuals with dementia, assisting individuals with dementia in performing activities of daily living, problem solving with individuals with dementia who exhibit challenging behavior, fundamentals of dementia</p>	<p>Indiana Administrative Rules</p> <p>Illinois General Assembly</p>	
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<p>date of the first date the employee was initially employed at the facility. The requirements set forth in this subparagraph are in addition to those set forth in subparagraphs (1) and (2), may be used to satisfy any continuing education requirements of an occupational licensing board, and do not constitute additional hours or units of continuing education required by the occupational licensing board.</p> <p>(4) If such an employee is a caregiver, other than a caregiver described in subparagraph (3), at least 3 hours of training in providing care to a resident with dementia, which must be completed on or before the anniversary date of the first date the employee was initially employed at the facility. The requirements set forth in this subparagraph are in addition to those set forth in subparagraphs (1) and (2).</p> <p>(b) The facility maintains proof of completion of the hours of training and continuing education required pursuant to this section in the personnel file of each</p>	<p>care, safe environments, and managing the activities of individuals with dementia.</p> <p>Training requirements for staff who do not provide direct care, including maintenance, housekeeping and food service staff initially and annually on topics related to dementia care</p> <p>A defining characteristic of the Washington model is the extent to which it fleshes out the general requirement for dementia training. As an example, long-term care worker specialty training must include the following competencies and learning objectives: introduction to the dementias; dementia, depression, and delirium; dementia caregiving principles; communicating with people who have dementia; sexuality and dementia; rethinking ‘problem’ behaviors; hallucinations and delusions; helping with activities of daily living (ADLs); and working with family and friends. Managerial staff, in addition to training in these competencies, must demonstrate competencies in medication and dementia including: extrapyramidal side effects; medications to treat dementia and their side effects; and treating dementia with antipsychotic drugs. The requirements within each competency are spelled out in further detail. For example, the competency on communicating with people who have dementia, and communicating in a respectful and appropriate manner with residents with dementia requires that the person who has been trained be</p>	<p>Minnesota Statutes 2018 144D/065</p> <p>Article on Dementia Training Standards</p>	
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<p>employee of the facility who is required to complete the training or continuing education.</p>	<p>able to: (a) Describe common dementia-caused cognitive losses and how those losses can affect communication; (b) Identify appropriate and inappropriate nonverbal communication skills and discuss how each impacts a resident's behavior; (c) Describe how to effectively initiate and conduct a conversation with a resident who has dementia; and; (d) Identify communication strategies to work with residents who have dementia. See Wash. Admin. Code § 388-112-0132 (2013).</p>		
<p>2. A person employed by a facility which provides care to persons with any form of dementia, including, without limitation, dementia caused by Alzheimer's disease, is not required to complete the hours of training or continuing education required pursuant to this section if he or she has completed that training within the previous 12 months. (Added to NAC by Bd. of Health by R071-04, eff. 8-4-2004)</p>	<p>Modify this regulation as follows: A person employed by a facility which provides care to persons with any form of dementia, including, without limitation, dementia caused by Alzheimer's disease, is not required to complete the hours of training or continuing education required pursuant to this section if he or she has completed that training elsewhere within the previous 12 months and provides the facility with evidence of the same.</p> <p>What training and where to receive? What is the criteria for training? There is a time frame but not content. List content to be included in the training.</p>		

Missing items in current regulations:

1) The allowance for a written exception in the California, Provider Information Notice (PIN) is a concept Nevada already has available at NAC 449.2736, but when it comes to NAC 449.2732, it indicates when a resident requires protective supervision and other factors, the facility must meet Alzheimer's standards. So, written exception requests are not a foreign concept to Nevada, but this is not the safest way to deal with dementia issues.

2) It's interesting that the recent code being adopted by Illinois indicates, "'Alzheimer's disease and related dementias services" means services offered to individuals diagnosed with Alzheimer's disease or a dementia-related disease for the purpose of managing the individual's disease.'" This is interesting, because this is the standard HCQC's DAG supports, but there's also an acknowledged fallacy with this standard, because not all residents who require additional safety features have yet been diagnosed and yet others who have been diagnosed, only suffer very mild symptoms and could live safely in an environment that doesn't offer the additional safety features of an Alzheimer's endorsed facility.

3) Indiana's regulations regarding Alzheimer's are so rudimentary, that they don't appear to be useful.

4) The new law in Massachusetts is interesting in that it requires more of physicians to provide explanations to family member of someone diagnosed with Alzheimer's.

Section 12G1/2. A physician registered under this chapter, upon express or implied

consent of a patient diagnosed with Alzheimer's disease, pursuant to and consistent with any

federal or state law or regulation, shall report the Alzheimer's diagnosis to a family member or

legal personal representative of the patient, and provide to said family member or legal personal

representative information about care planning services, including assistance understanding the

diagnosis as well as the medical and non-medical options for ongoing treatment, services, and

supports, and information about how to obtain such treatments, services and supports.

5) Mississippi's rules are very similar to Nevada and appear to be well developed even regarding, "Security controls on all entrances and exits".

6) The Maine studies and state plan appear to be a thorough look at how a state might want to provide services to that part of it's population suffering from Alzheimer's.

7) Minnesota's law regarding dementia training makes sense.

8) Nebraska's state plan, much like Maine's appears comprehensive and other states could learn from how they are handling the disease.

9) It appears North Carolina is very rudimentary in their requirements for dementia care, only requiring training.

For as long as I can remember, residential care, regulation, funding, etc. has varied widely across the nation. We can certainly learn from what others are doing, but because there's no national standard for this level of care, each state has the responsibility to set it's own standards and make them work within the existing laws of the state, while protecting rights and safety of persons receiving care in licensed facilities.