Dementia Special Care Amendment
(Advertising Care Home)

It is the intent of facility to advertise, promote, and hold itself out as providing dementia special care, programming and special environment for persons with dementia or related disorder. Facility has read and understands Title 22 Sections 87208, 87705, 87706, and 87707, and Health and Safety Code Sections 1569.626, 1569.627, 1569.698 and 1569.699.

In addition, the Facility will inform the resident and the resident's responsible person, if any, or the conservator, that the facility features, as specified in Section 87706(a)(2), are described in the facility's plan of operation, and that the plan of operation is available for review upon request. The facility's admission agreement also contains the resident notification that facility's plan of operation describing its dementia special care is available upon request.

All dementia residents are in nonambulatory rooms, as approved by the local fire marshal. This includes residents who may be diagnosed with mild cognitive impairment (MCI), as MCI may eventuate into mild dementia. Facility believes it is best to keep any resident with any form of cognitive impairment in a nonambulatory room.

The following amendments are made to the Plan of Operation as required by Title 22, Division 6, Chapter 8 Sections 87208, 87705, 87706, and 87707.

Philosophy of Care
The Facility will accept individuals with mild cognitive impairment to mild through moderate Alzheimer's disease and related forms of dementia. (Severe dementia residents will be evaluated on a case-by-case basis.) Facility philosophy is to provide care and services to seniors in a home-like environment that nurtures the spirit, protects privacy, fosters individuality, personalizes services, enables freedom of choice, encourages independence, preserves dignity, and involves family and friends.

Additionally, the Facility provides a safe and secure environment in which a resident can wander freely in a safe setting. Facility looks to escort residents as often as possible when wandering to ensure safety. Facility will intervene with residents' choices and independence only when residents demonstrate the inability to make safe choices and to provide their own personal activities of daily living.

Preadmission Assessment
Prior to admission, the prospective resident is assessed using the State of California's Pre-placement Appraisal form (LIC603), which evaluates service needs, functional limitations, social factors, medical history, and mental status to determine the resident's suitability for the facility. The facility will also utilize the new physician's report (LIC602A). In addition, the facility utilizes the Mini-Mental State Exam (MMSE) for resident assessment purposes. This assessment tool is an abbreviated form of the Folstein Test, the most commonly used assessment among physicians and other health

care professionals in assessing level of dementia. As indicated in Title 22 87706(a)(2)(D), the resident, the resident's family or designated representative, and the Facility Licensee/Administrator will be encouraged to participate in this assessment.

Admission

The dementia special care will be provided in the entire facility. Additional services beyond basic services include visual and verbal cueing for orientation purposes; gross and fine motor skill activities; frequent offerings of liquids and food; safe indoor and outdoor wandering space; a secure, safe, familiar and consistent environment; redirection; validation; quarterly assessment of dementia care needs; a "homeostatic" environment; and, based upon resident abilities, as much freedom of choice in dressing, arising from sleep, walking, and related tasks. This is an ongoing part of the resident's stay at the Facility.

It is not the intent of the Facility to admit residents determined by a physician to have an ongoing behavior caused by a mental disorder that would upset the general resident group [as indicated in Title 22 Section 87455(c)(3)].

The facility permits the resident, family and/or responsible party to review its plan of operation upon request. This provision is also contained in the Facility's admission agreement.

Assessment

The initial assessment process utilizes the Reappraisal form LIC603A, done at least annually. In addition, the Mini-Mental State Exam (MMSE) is also utilized as an assessment tool. The resident is always involved in every assessment, and family is asked to be present when an assessment is performed. Additionally, Administrator/Licensee is involved in the assessment. Others, as indicated by family, may also be present. Every assessment is updated, in writing, as frequently as necessary to note significant changes such as changes in the resident's physical, medical, mental, and social condition. The family and physician are notified of any such changes to the resident's condition as soon as resident is calmed and composed. Facility will attempt to notify within two to four hours of the occurrence.

Facility conducts its assessments at least quarterly, and updates residents' needs and services plan as best fits the residents' dementia needs. Additionally, Facility documents in writing all findings of resident reappraisals. As required by the State of California and at a minimum, an annual physician's assessment will be secured. Finally, Facility will create a needs and services plan within two weeks of admission, as allowed by Health and Safety Code 1569.80 and Title 22 section 87467, with input from the family and post-admission assessment. These plans are updated to correspond to changing conditions of the resident.

Activities

The Facility is fully aware of the need for activities for dementia residents. Facility is also aware that residents' functional decline limit certain activities. The following is a sample

of activities for the mild to moderate dementia resident. In formulating this activity schedule, the Facility used criteria from the book written by the Geriatric Education Center of Michigan, “Understanding Difficult Behaviors,” for guidance. One the strongest points contained in the book is necessary resident “inactivity” to avoid having to process activity completion all day. Facility is also aware that “reality orientation,” as taught by the National Alzheimer’s Association, is not an appropriate approach to care as it can cause agitation, wandering, fear, and cognitive overload leading to aggression. Reality orientation is used only to current time, day, and date (not year). Other reality indicators are discouraged to avoid possible aberrant behaviors and use of medication.

Facility recognizes that for a dementia resident everything is an activity—bathing, eating, dressing and grooming, doctor visits, etc. “Down time” or “inactivity” should precede these and other activities. In formulating these activities the Facility also recognizes the rights of residents to maintain individualized eating and sleeping patterns [Title 22 Section 87468(a)(3) states “to be free from interfering with daily living functions such as eating or sleeping patterns.”]

7:00 a.m.	Residents to be awakened, dressed and groomed
8:00 a.m.	Approximately 15 minutes of non-activity
8:15 a.m.	Breakfast
9:00 a.m.	Rest time (non-sleeping)
10:00 a.m.	Exercise based upon level—dancing, walking, lifting food cans, etc. for Large motor skills functioning, if possible outdoors
11:00 a.m.	Rest time outdoors if possible (research indicates that outdoor exposure Between 11 am and noon can diminish wandering and interrupted sleep). Include “sensory stimulation” as therapy and preparation for lunch. This can include the smell of popcorn, bread baking, cookies baking, vanilla, cinnamon, etc. Additionally, scrapbooks, “texture books,” and ball catching will be utilized.
12:00 p.m.	Clean up before lunch with rest time
12:30 p.m.	Lunch, if possible, outdoors
1:30 p.m.	Rest time, outdoors if possible
2:00 p.m.	Games, puzzles, crafts (using non-toxic materials), crossword puzzles, etc. for perceptual stimulation, if possible outdoors
3:00 p.m.	Rest time with playing of old music
4:00 p.m.	Old movies on TV, reminiscence activities, scrapbook remembrances, music, etc.
5:30 p.m.	Clean up for dinner
6:00 p.m.	Dinner
7:00 p.m.	Rest time
8:00 p.m.	Preparations for bed

Outings will be scheduled based upon resident levels of dementia. This might include walking in the mall (early when less crowded), lunch before or after peak restaurant hours, church on a voluntary basis (and consent of family if resident is too cognitively impaired to consent), drives, walks, etc. These activities will be conducted when

residents are rested and early in the day. Other activities will be incorporated based upon resident capabilities and the need or lack of need for rest times between activities. The Facility's activities also provide for visual cues and gentle reminders, plus non-confrontational guidance from the staff in assisting with a resident's ADLs. Facility activities are resident-specific and dementia-specific, and do not push residents beyond current levels or capabilities. Facility will not do for a resident what the resident is capable of doing for him or herself. Facility shows its residents respect and cultivates their self-esteem.

Facility's assessment at admission will gain information regarding the resident's likes and dislikes. This information will be expanded to include beliefs and culture, values, and life experiences. Activities can be one-on-one or group, and will encompass the above gained information. One-on-one activities are frequently conducted by Facility staff with new admissions, and with residents who may be experiencing behavioral problems and in need of more attention.

Staff Qualifications

Staff is always in ample supply to provide a high level of supervision for residents with dementia while meeting the needs of all facility residents. Staffing ratio for current census is at least 2 persons during peak times. Awake night staff is not mandated as indicated in Title 22 Section 87415, unless a resident with dementia requires night supervision. Staff will have been trained in dementia care prior to being employed. Previous dementia care experience will be a specific hiring criterion.

Staff Training

All newly hired staff is provided 40 hours of general training, as outlined in Health and Safety Code 1569.625 that requires 12 hours of dementia-specific training in the first four weeks of employment. Annually, the staff will receive eight hours of dementia training.

The 12-hours of training will include the criteria outlined in Health and Safety Code 1569.625 will include the use and misuse of antipsychotics, the interaction of drugs commonly used by the elderly, the adverse effects of psychotropic drugs for use in controlling the behavior of persons with dementia, the special needs of persons with Alzheimer's disease and dementia, including non-pharmacologic, person-centered approaches to dementia care.

Additional training may include knowledge about hydration; skin care; communication; therapeutic activities; sundowning as required by Health and Safety Code 1569.7; behavioral challenges; the environment; assisting with activities of daily living; recognizing symptoms that may create or aggravate dementia behaviors, including, but not limited to, dehydration, urinary tract infections, and problems with swallowing; wandering, aggression, and inappropriate sexual behavior; positive therapeutic interventions and activities such as exercise, sensory stimulation, activities of daily living; social, recreational and rehabilitative activities; communication skills

(resident/staff relations); promoting resident dignity, independence, individuality, privacy and choice; and end of life issues, including hospice.

Facility staff training incorporates the use of gentle redirection when a resident with dementia attempts to leave the facility.

Sundowning

The number of hours required for sundowning training is not specified. The research on sundowning indicates that residents are less prone to sundown (defined by Health and Safety Code 1569.2(m) as “a condition in which persons with cognitive impairment experience recurring confusion, disorientation, and increasing levels of agitation that coincide with the onset of late afternoon and early evening.”

The law, Health and Safety Code 1569.7, states, “Residential care facilities for the elderly that serve residents with Alzheimer's disease and other forms of dementia should include information on sundowning as part of the training for direct care staff, and should include in the plan of operation a brief narrative description explaining activities available for residents to decrease the effects of sundowning, including, but not limited to, increasing outdoor activities in appropriate weather conditions.”

Research and education presented by vendors has placed emphasis on dementia activities held outdoors, especially between 11:00 am to 3:00 pm. Facility’s activity program has listed activities to be held, if possible, outdoors such as exercise, sensory stimulation, scrapbooks, “texture books,” and ball catching, plus lunch, rest time, games, puzzles, crafts, and the playing of old music. Staff will be trained to encourage clients to be outdoors as much as possible.

In compliance with California Health and Safety Code 1569.317 (AB620) regarding missing residents facility will develop and comply with an absentee notification plan as part of the facility’s written record of the care the resident will receive in the facility, as described in Health and Safety Code 1569.80. The plan, developed by the administrator or designee, and involving the resident’s authorized representative, will outline the circumstances in which the administrator or designee will notify local law enforcement when a resident is discovered to be missing from the facility.

Physical Environment

Facility uses the safest mechanisms possible to ensure a resident’s safety such as a staff alert device on all doors when exiting presents a hazard to the resident. This staff alert device informs staff when residents enter or exit Facility. Facility’s safety features include prevention of unsupervised wandering, minimizing aggressive behaviors by avoiding confrontation, and Facility insures no toxic materials are available for possible ingestion, but storing items inaccessible to residents as outlined in Title 22 section 87308.

The Facility has attempted to create a “familiar and consistent environment” by attending to the details of its overall decor: handrails where needed; exit alert features;

fire department approved locks on doors and gates; higher illumination in darker areas; inviting colors, carpeting, and wallpapers; avoidance of highly patterned visual contrasts in furniture, staff dress, wallpaper, tablecloths, etc.; visual cuing to the bathroom; reduction of outside and inside noises; frequent offerings of nourishment and fluids; and Facility has attempted to keep its outdoor space as inviting and safe as possible by insuring no resident access to storage areas, hazardous plants (i.e. roses, cactus); and the facility has created a place for residents to safely wander.

Physical Plant Safety

Facility's physical plant safety includes the inaccessibility of ranges, heaters, wood stoves, inserts, and other heating devices; fenced swimming pools or other bodies of water; knives, matches, firearms, tools and other items that could constitute a danger to the residents are locked away. In addition, over-the-counter medications, nutritional supplements or vitamins, alcohol, cigarettes, and toxic substances such as certain plants, gardening supplies, cleaning supplies and disinfectants are made inaccessible.

If the residents' physicians have documented that a resident may be at risk if allowed access to personal grooming and hygiene items, then said items will be secured to prevent any possible risk of ingestion or improper use.

Facility outdoors space is completely fenced. Any fencing has self-closing latches and gates, and gates are secured using fire marshal approved locks. All gate and latch mechanisms are approved by the fire department. It is not the intent of the Facility to use egress alert wristbands or delayed egress doors. Facility does employ egress alert devices on facility exits.

Changes in Condition

The decline of a person with dementia is not predictable. It can be subtle or dramatic depending on the severity of the dementia condition. Any time a change in condition is noted by physician or our trained staff, corresponding changes are made in the care and supervision provided to that resident. Any newly manifested behaviors will be addressed with new training for staff specific to that resident's behavior.

Additionally, an update is made to the resident's appraisal/needs and services plan. This always involves the family as noted in Title 22 section 87467. If the resident's needs cannot be met, Facility will have a follow-up physician's medical assessment performed. If physician indicates the resident's needs are beyond Facility's services, the resident will be relocated with the assistance of family.

Success Indicators

Because Facility evaluates its residents at a minimum quarterly, Facility believes it can quickly make adjustments to meet residents' needs. Any programs or activities, which may be above or below resident levels, would signal a modification in Facility activities.

Facility will utilize the input from staff, administrator and others to insure proper staffing levels, the degree to which residents can participate in their individualized service plans,

activity participation, physician's input regarding dementia needs, and any and all incident reports will be examined often.

Advertising

Facility will maintain copies of all of its advertising and marketing materials that indicated the Facility provided dementia special care. These materials will be kept for at least 3 years. Should facility discontinue its dementia programming all residents and resident families will be notified at least 30 days prior to such discontinuation. Any such notice will be kept in the residents' files.

Staff Training and Consultants

Dementia experts, using the criteria from Title 22 section 87707 will at least once per year professionally train Facility staff. The Facility follows up that training with hands-on, resident-specific training at the Facility. In the minimum, dementia staff training will consist of eight (8) hours per year, plus newly hired employees will receive six (6) hours of dementia-specific training in the first four (4) weeks of employment. In addition to dementia care, our staff will be trained in identifying and reporting resident abuse and neglect, and the behavioral effects of medications on residents with dementia.

Facility "basic training" includes 10 hours of initial training in the first 4 weeks of employment on the subject areas outlined in Title 22 section 87411(c) and Health and Safety Code 1569.625 and 1569.626, and training specific to the job assigned as outlined in 87411(d). All training will include the ability to properly communicate with residents and the signs and symptoms of dementia and its progression. Evidence of completion of all above training will be kept in staff records.

Emergency Disaster Plan

The requirement regarding fire and earthquake drills applies only if facility is using delayed egress devices or is locking exterior doors or fence gates. However, Facility's emergency disaster plan for residents with dementia does include fire and earthquake drills conducted at least once every three months on every shift. All direct care staff will participate in these drills. Additional staff will be called in when needed to assist with any actual emergency. Facility realizes that a dementia resident requires structure and routine, thus residents will not be actually awakened on the night shift, nor will residents be taken to evacuation sites during these drills. Facility fully recognizes that a dementia resident will not remember the drill to be compliant should an actually emergency occur. Our staff will be trained on each shift to know the emergency procedures.

Minimizing the Need for Psychoactive Medications

Although no longer contained in the new dementia regulations of Title 22, Chapter 8, Division 6, Facility favors minimizing the use of psychoactive medications. Facility will keep current on alternative approaches, and any over-the-counter or nonprescription medications will only be used with physician order and permission. A non-medication approach is highly encouraged by the National Alzheimer's Association. One example of a non-medication approach is to utilize the natural sleep aid melatonin, with physician order, to help residents sleep. Melatonin is a non-narcotic, naturally occurring hormone

in the body. Possible use of melatonin might assist with sleep inducement thus eliminating the need for sleep medication. This approach does show that Facility sees alternatives to psychoactive medications. Because psychoactive medications have numerous side effects Facility will work with physicians to titrate (slowly diminish) residents off medication if so indicated. Any psychoactive medication will be used sparingly with staff having knowledge of possible side and behavioral effects.

Additional Family Involvement

As indicated by Title 22 section 87467 and Health and Safety Code 1569.80, the Facility's relationship with family will include the encouragement to attend dementia support groups to help the family better realize good techniques on visiting. Facility believes that family can upset a resident by testing memory, yelling at the resident, correcting stories, etc.

It is the intent of the Facility to accept and retain residents with dementia who cannot respond to emergency signals and instructions. The Facility hereby submits this addendum to its Plan of Operation, and would benefit from additional materials or information deemed necessary by Community Care Licensing and its representatives.