



Bureau of Assisted Living

“STATE OF ASSISTED LIVING – CY 2014”
March 31, 2015



Alfred C. Johnson, Director



Agenda

1. Organizational Chart/ Regional office locations
2. Trends and Statistics
 - ✓ AL Capacity
 - ✓ Affiliation/Ownership Trends
 - ✓ AL Complaints
 - ✓ AL Self-Reports
 - ✓ AL Post-Survey Results
 - ✓ AL Survey
 - ✓ Abbreviated Surveys
 - ✓ AL Enforcement
3. WCCEAL
4. Bureau of Assisted Living Strategies
5. Regulatory Stories
6. Wrap up

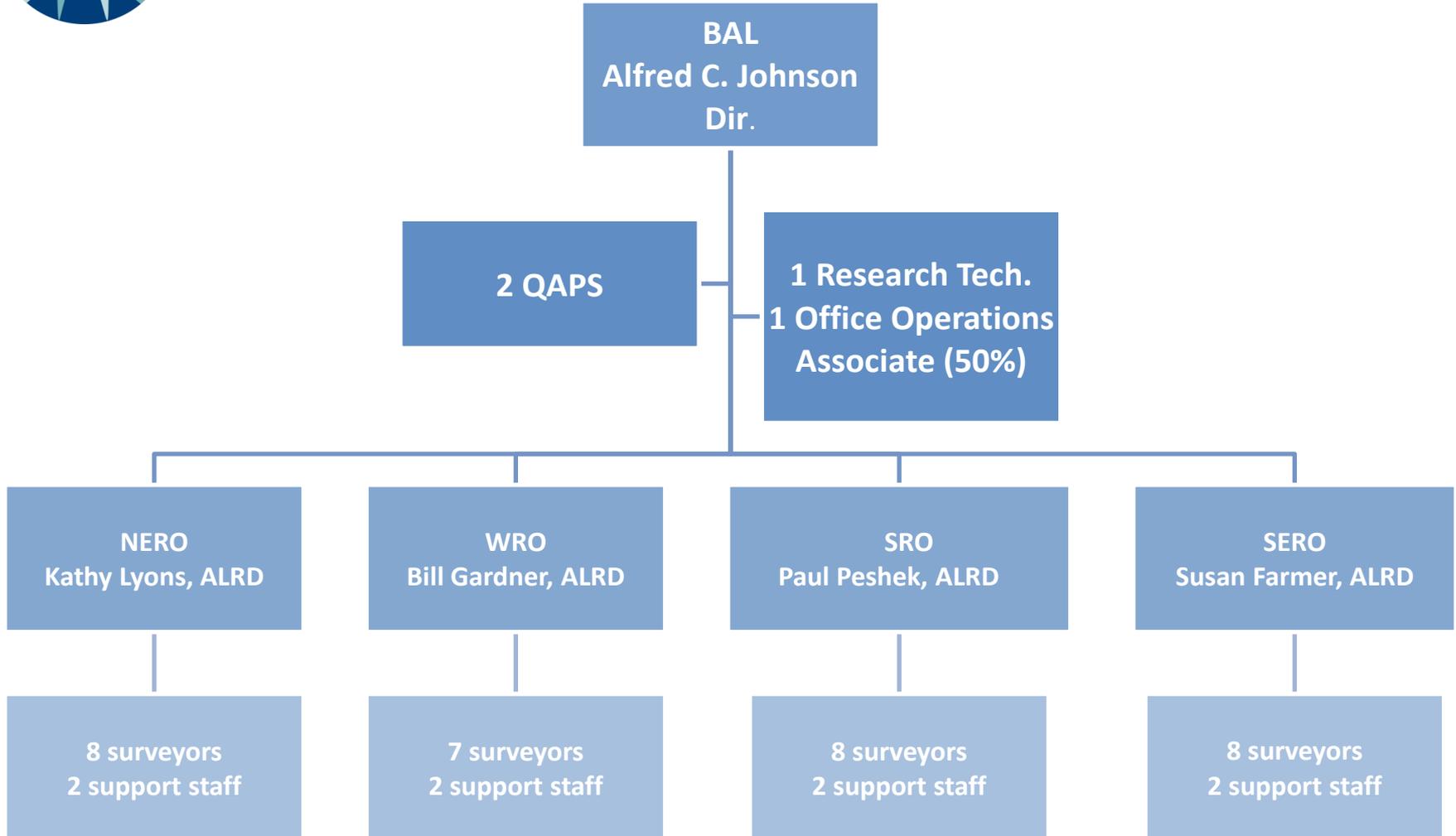


Bureau of Assisted Living Regulatory Goal

Using existing statutes, rules, and agency resources--and through collaboration with stakeholders--promote the development of effective systems (e.g., procedures, trained workforce, effective care plans, etc.) in regulated communities.



BAL Org. Chart





BAL Western Regional Office





BAL Southern Regional Office





BAL South Eastern Regional





BAL North Eastern Regional Office



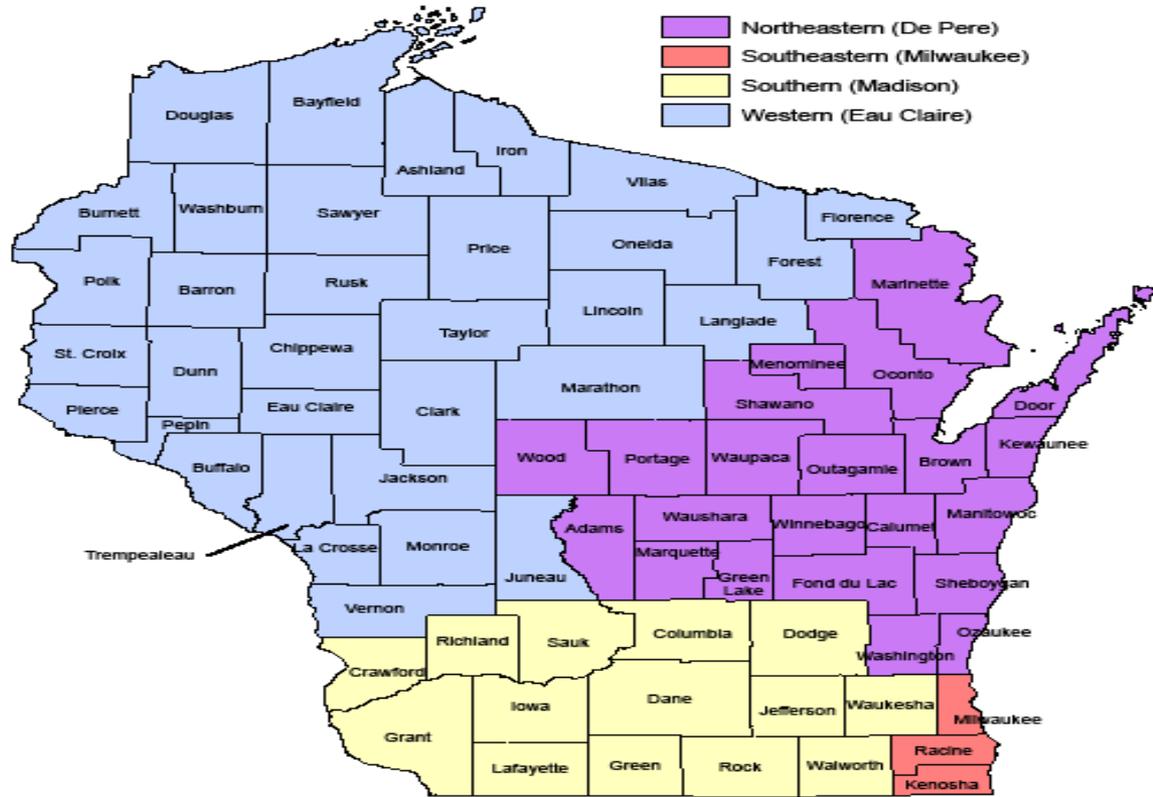


BAL Central Office





Bureau of Assisted Living Regional Assignments April 2009



Wisconsin Department of Health Services
Division of Quality Assurance



Bureau of Assisted Living Regional Assignments

SERO

- Kenosha, Milwaukee, Racine

NERO

- Adams, Brown, Calumet, Door, Fond du Lac, Green Lake, Kewaunee, Manitowoc, Marinette, Marquette, Menominee, Oconto, Outagamie, Ozaukee, Portage, Shawano, Sheboygan, Washington, Waushara, Waupaca, Winnebago, Wood

SRO

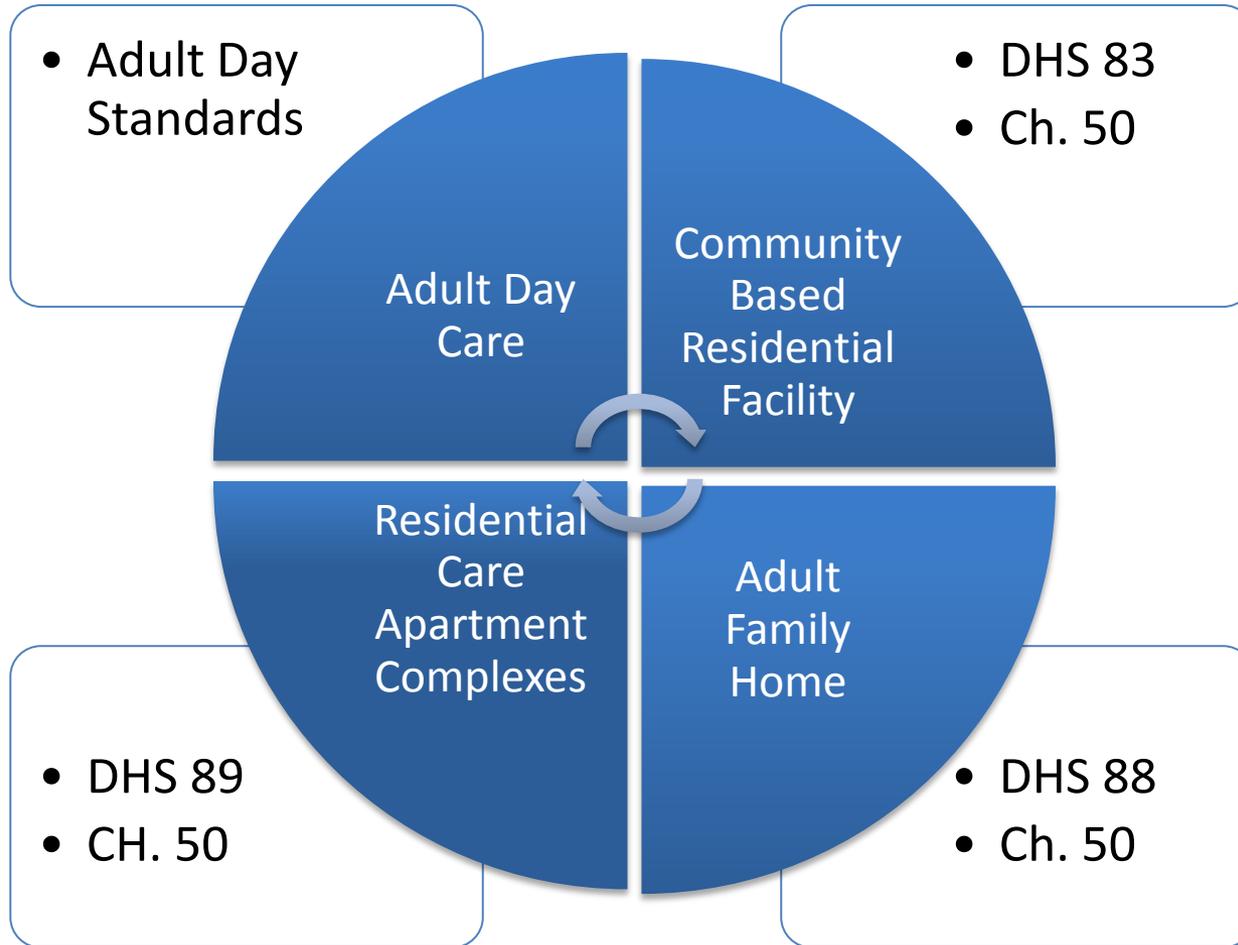
- Columbia, Crawford, Dane, Dodge, Grant, Green, Iowa, Jefferson, Lafayette, Richland, Rock, Sauk, Walworth, Waukesha

WRO

- Ashland, Barron, Bayfield, Buffalo, Burnett, Chippewa, Clark, Douglas, Dunn, Eau Claire, Florence, Forest, Iron, Jackson, Juneau, Langlade, La Crosse, Lincoln, Marathon, Monroe, Oneida, Pepin, Pierce, Polk, Price, Rusk, Sawyer, St. Croix, Taylor, Trempealeau, Vernon, Vilas, Washburn



Wisconsin Assisted Living Communities



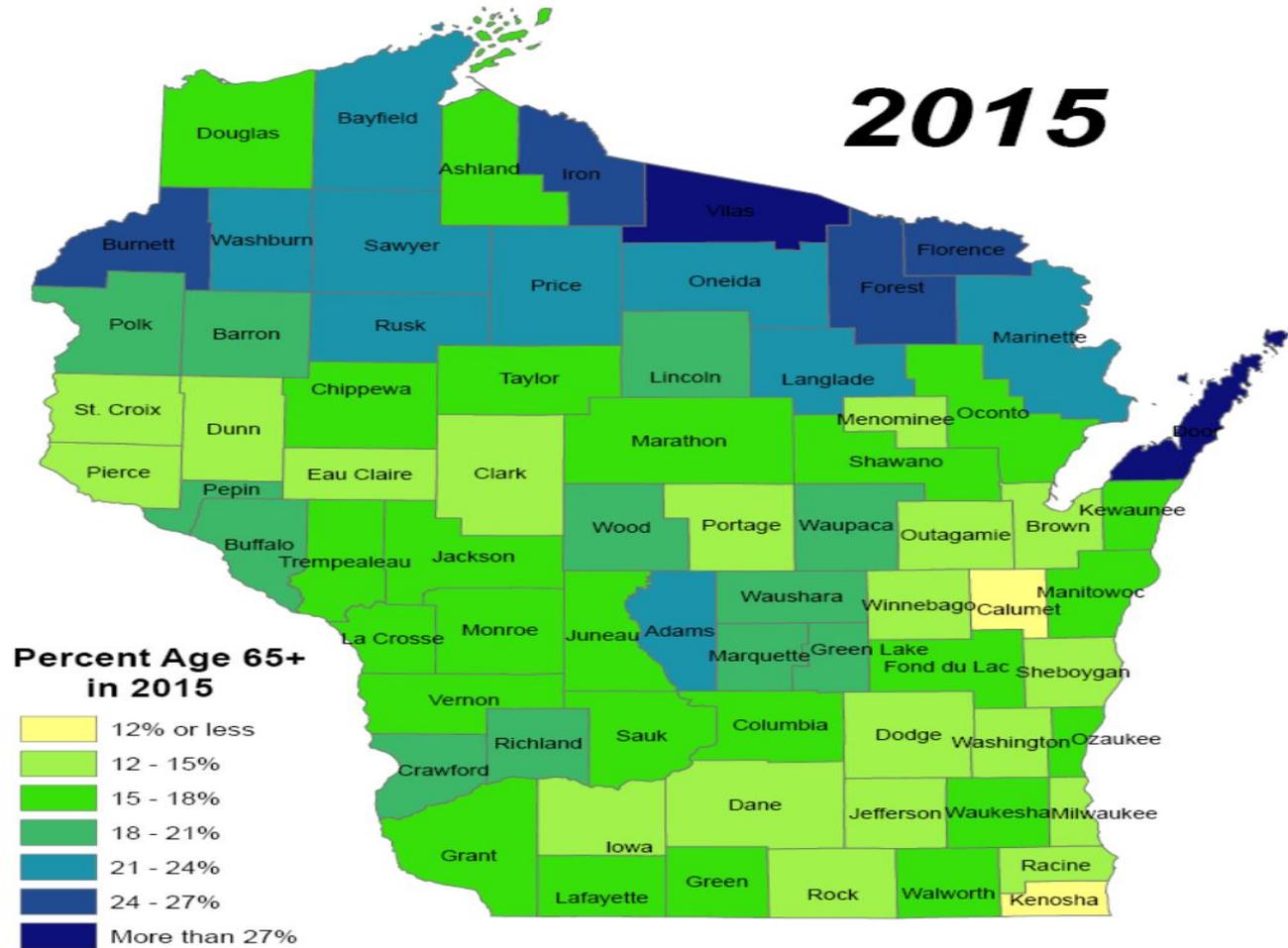


Trends & Statistics



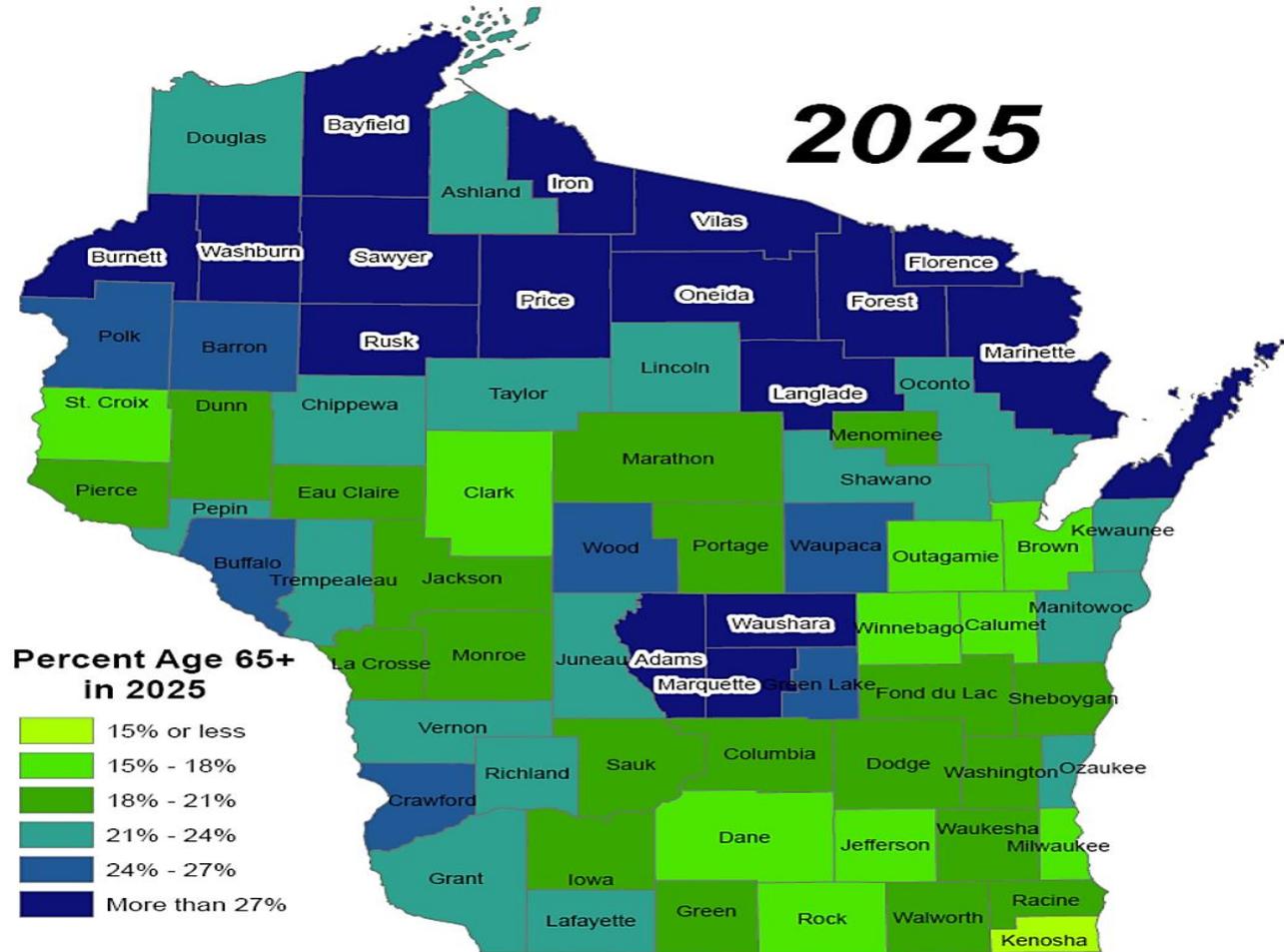


Wisconsin Population Changes





Wisconsin Population Changes





Assisted Living Trends

Provider Growth:

Largest growth in AFH

Complaints:

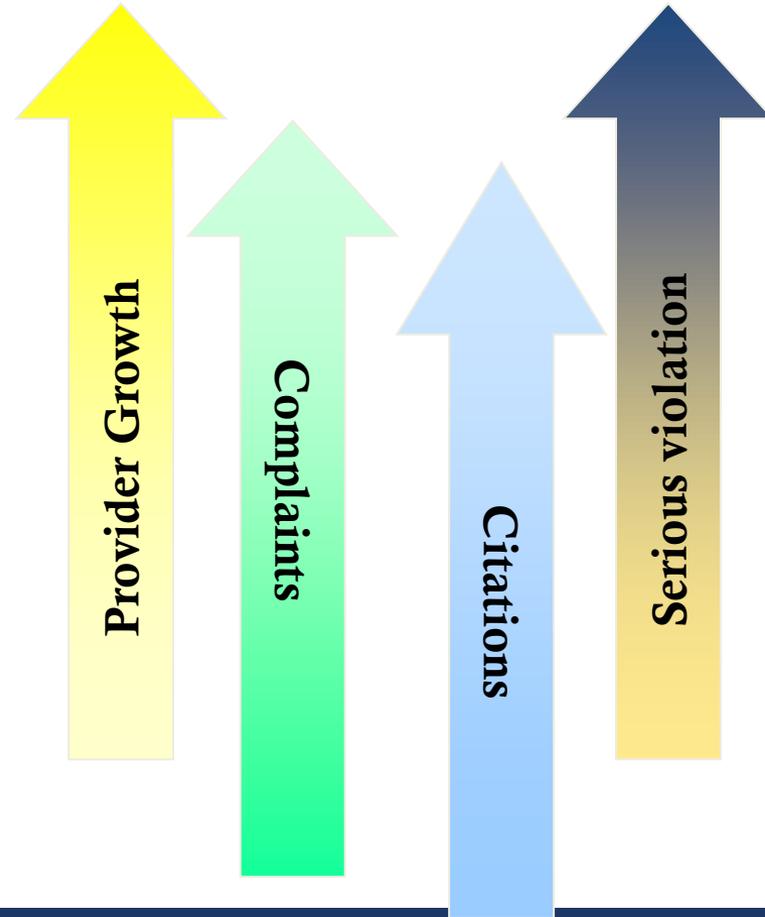
Complaints have increased

Citations:

Citations have increased

Severity:

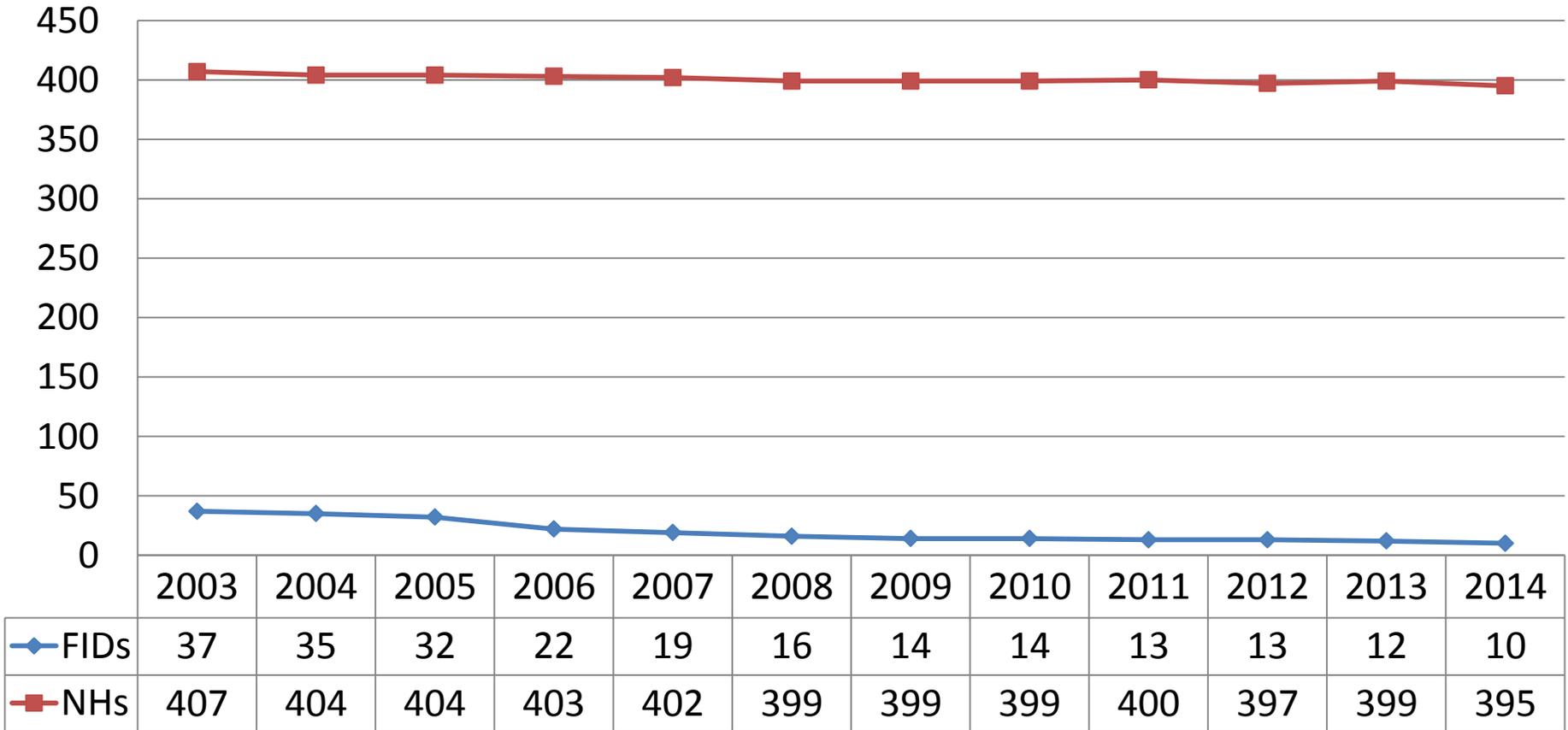
Serious Violations have increased





Nursing Home & FID

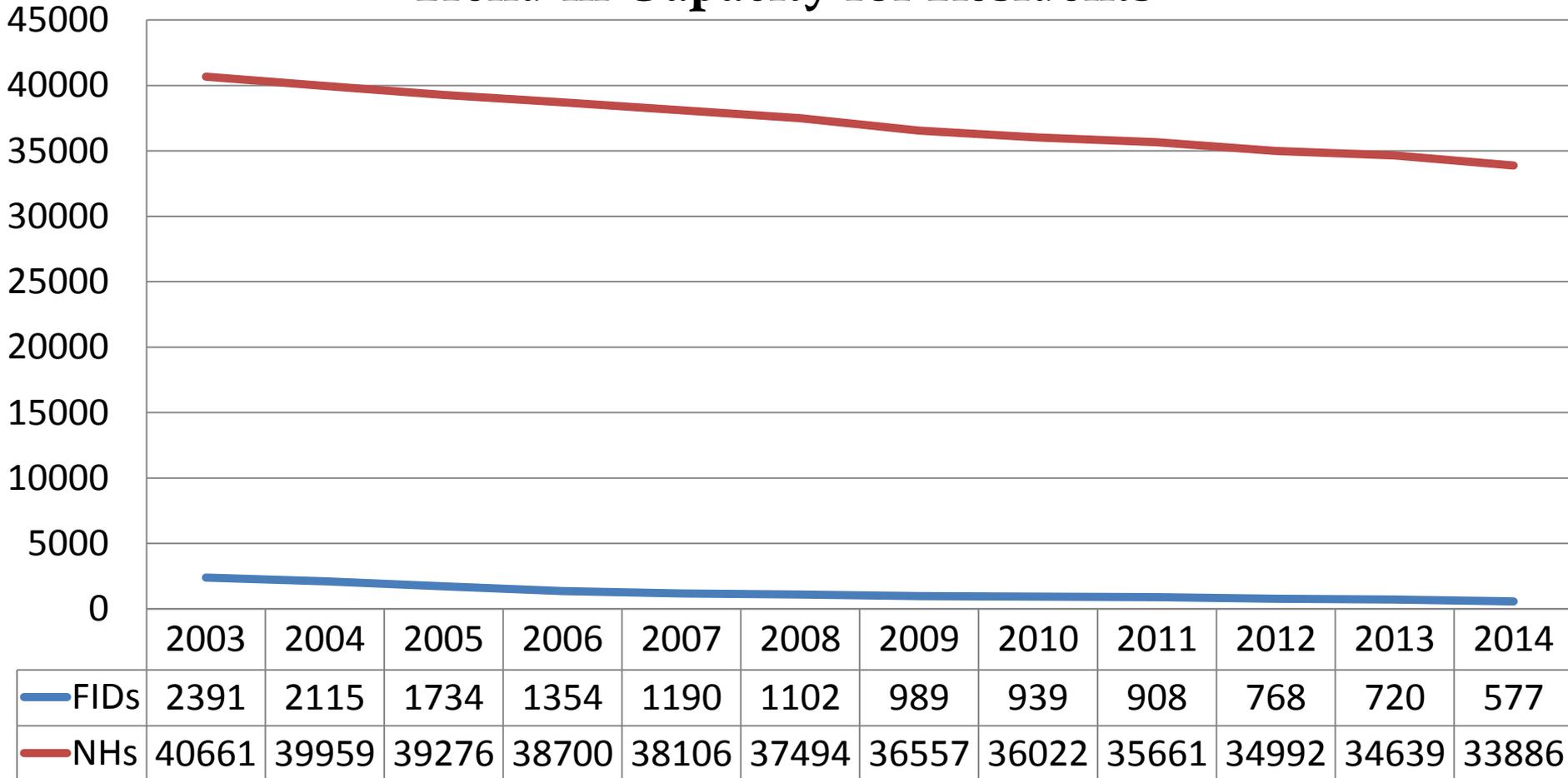
Trend in Number of Facilities





Nursing Home & FID

Trend in Capacity for Residents





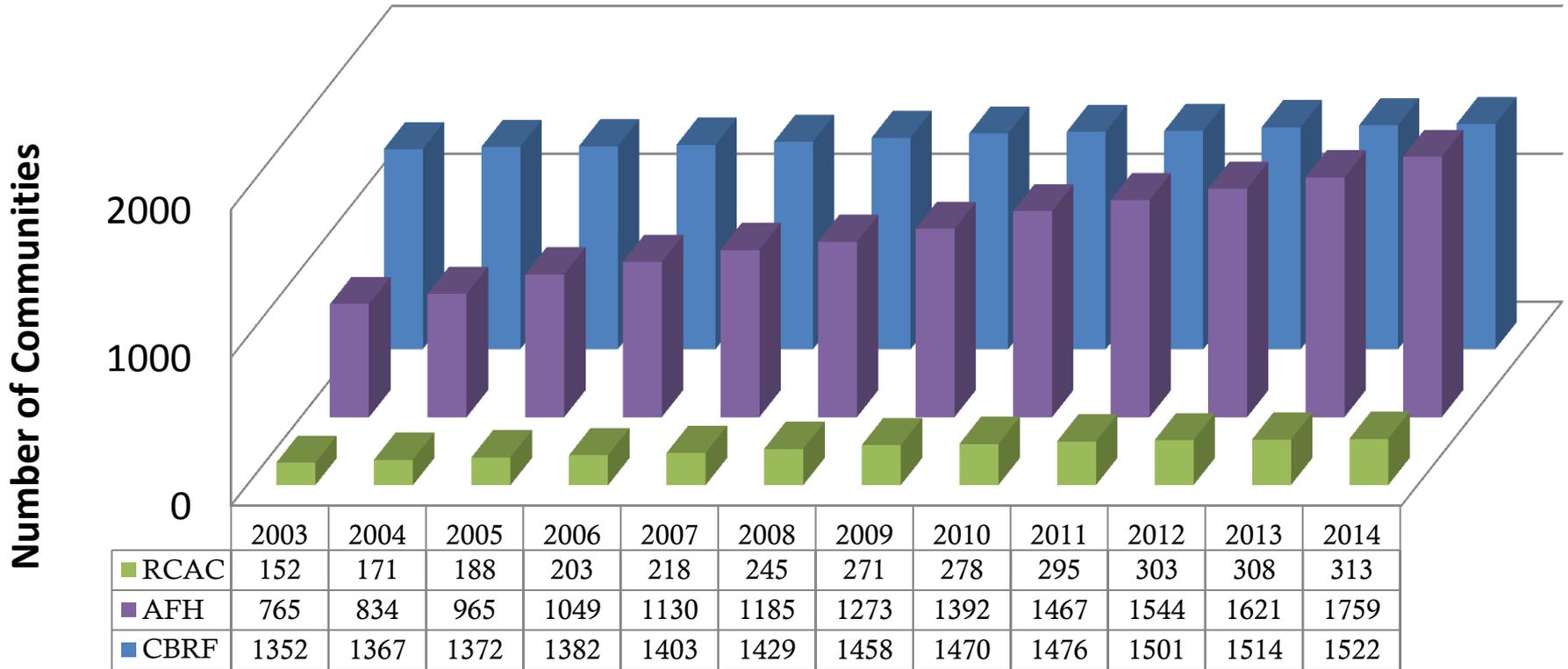
Wisconsin Assisted Living 36th Consecutive Year of Growth!!





Assisted Living Communities

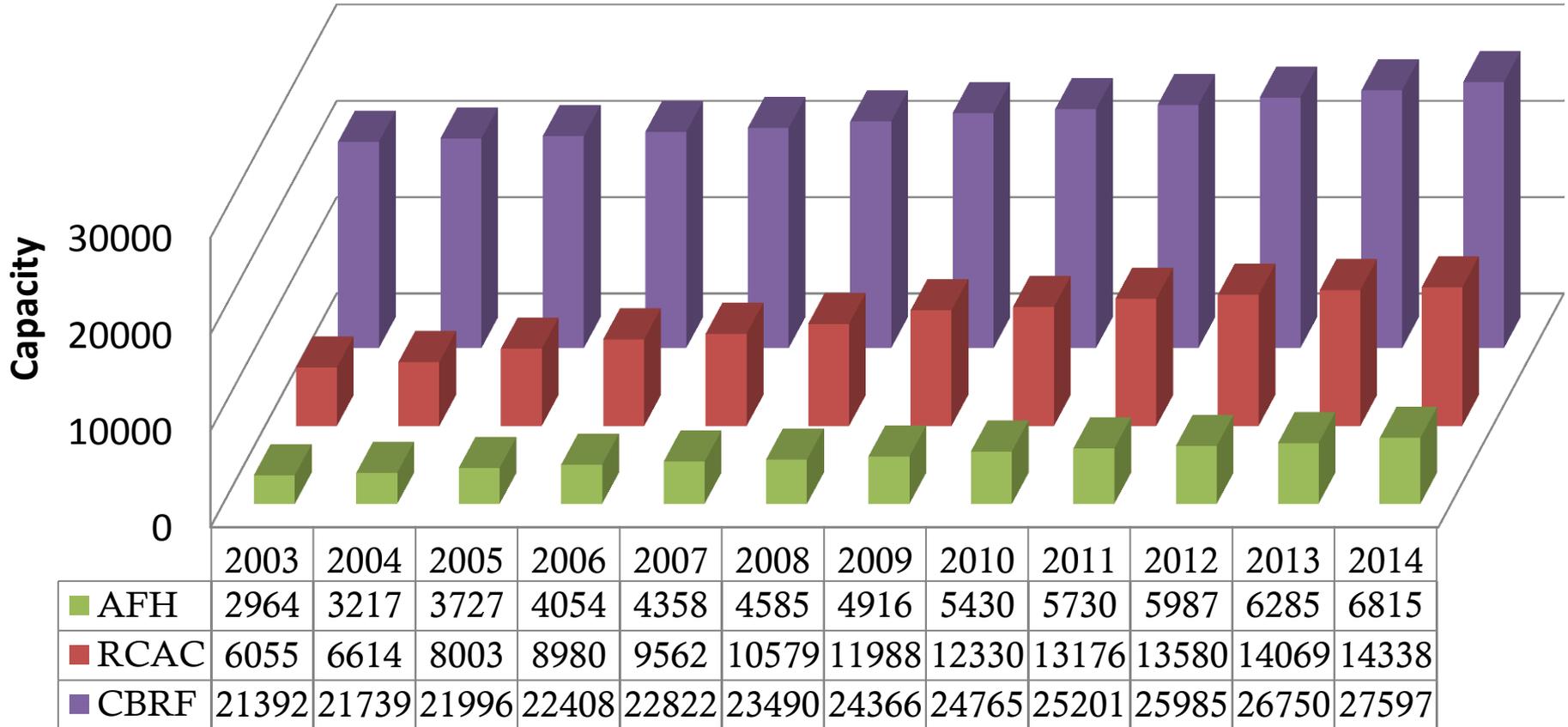
Trend in Number of Communities





Assisted Living Capacity

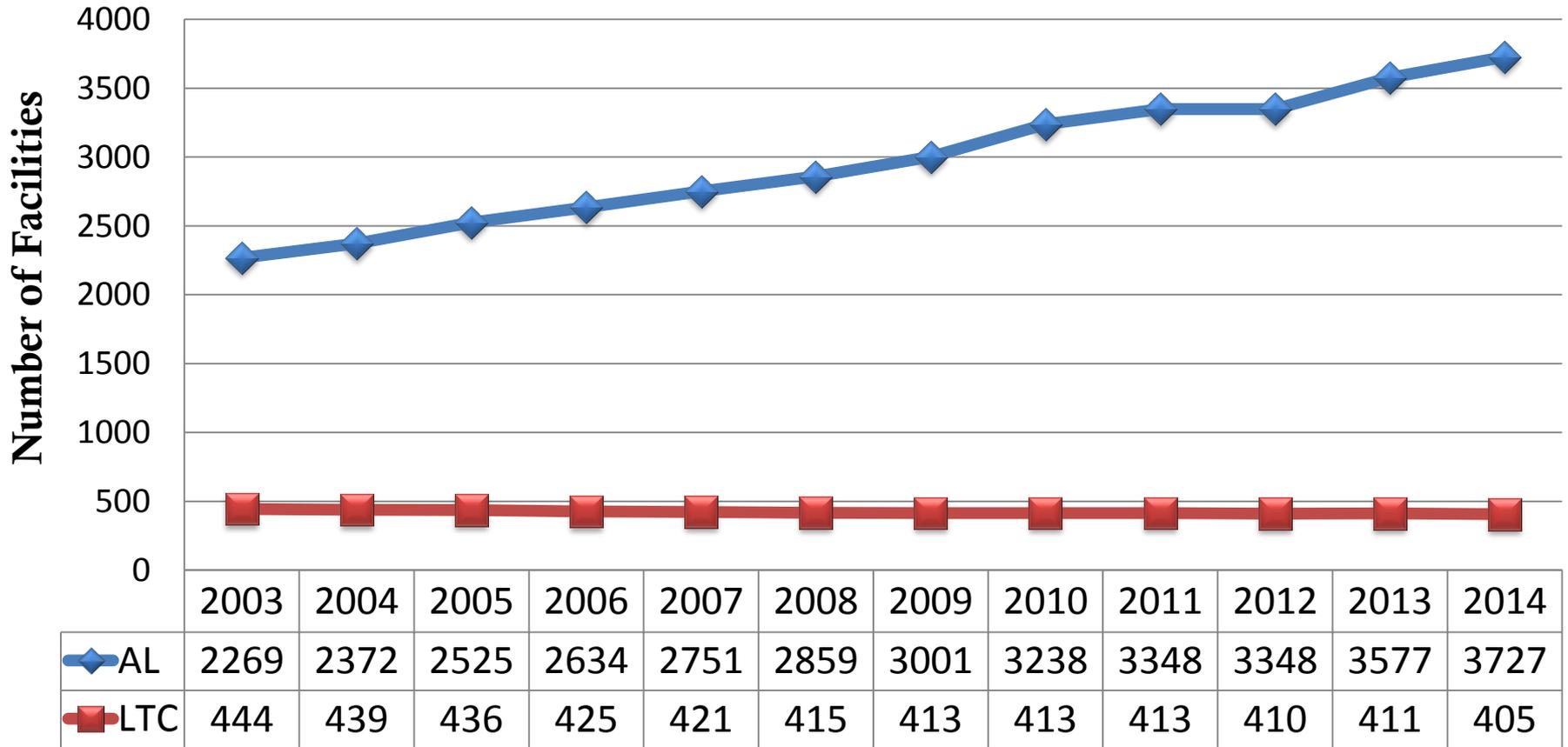
Trend in Assisted Living Capacity





AL vs. LTC Facilities

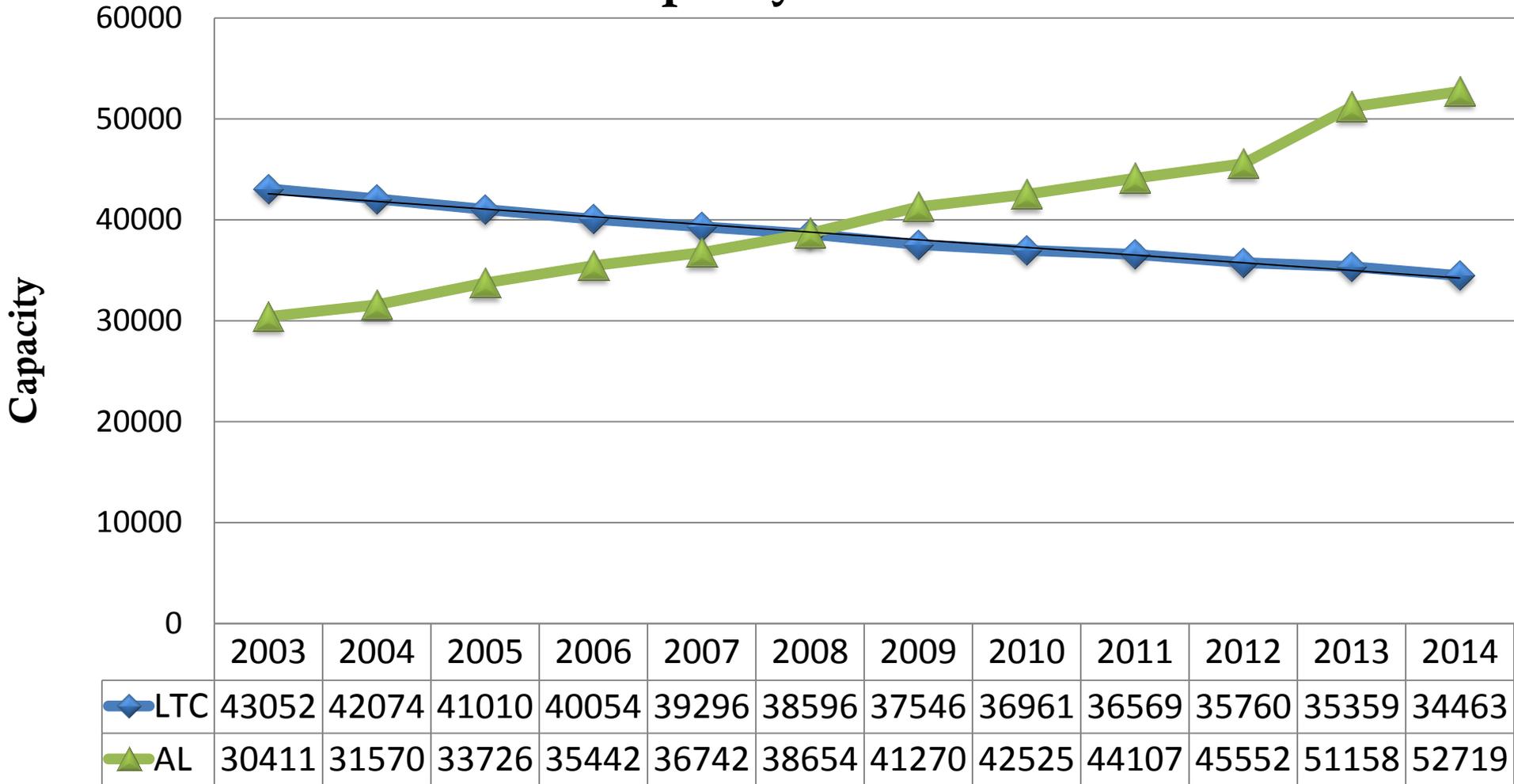
Trend in Number of Facilities





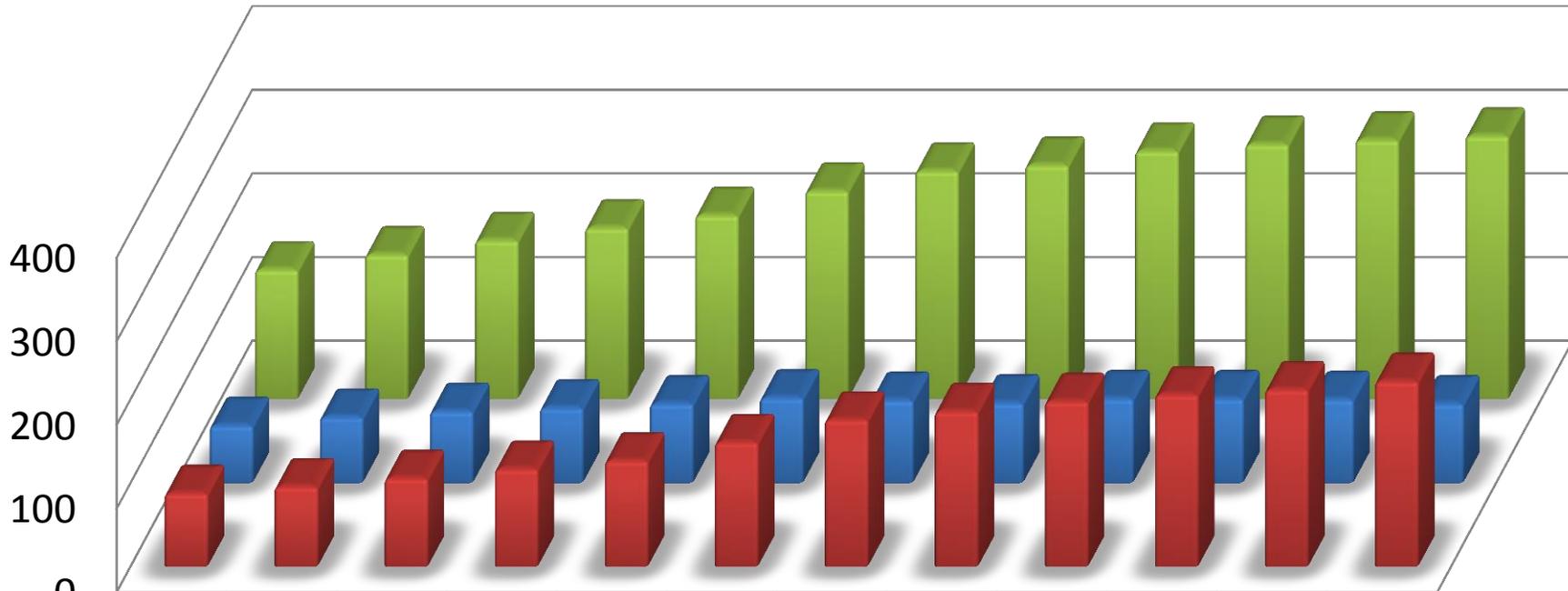
AL vs. LTC Capacity

Trend in Capacity for Residents





Residential Care Apartment Complex

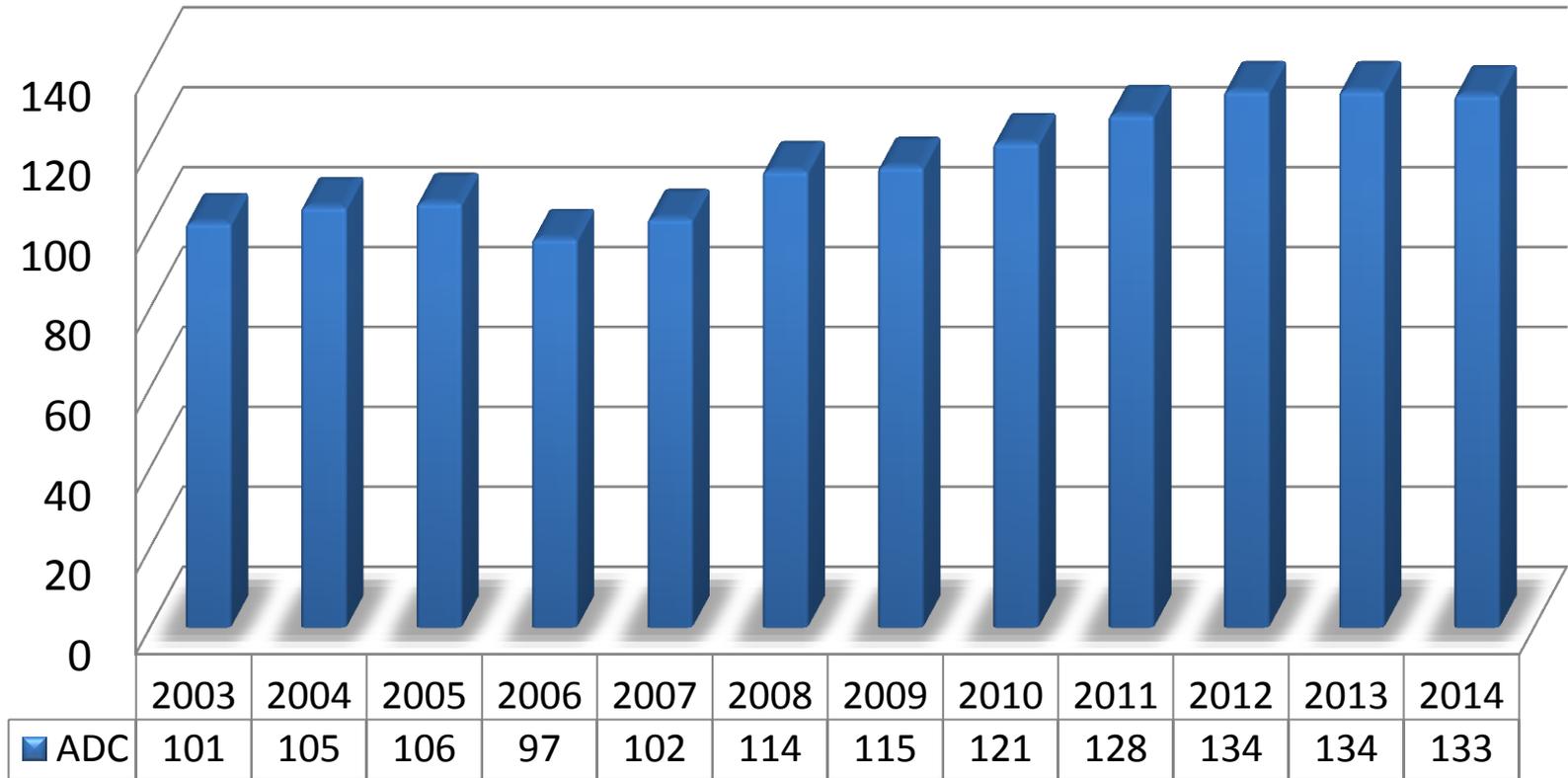


	2003	2004	2005	2006	2007	2008	2009	2010	2011	2012	2013	2014
Certified	86	94	104	115	125	147	174	184	196	204	210	220
Registered	67	77	84	88	93	100	97	94	99	99	98	93
Total	153	171	188	203	218	247	271	278	295	303	308	313



Adult Day Care Centers

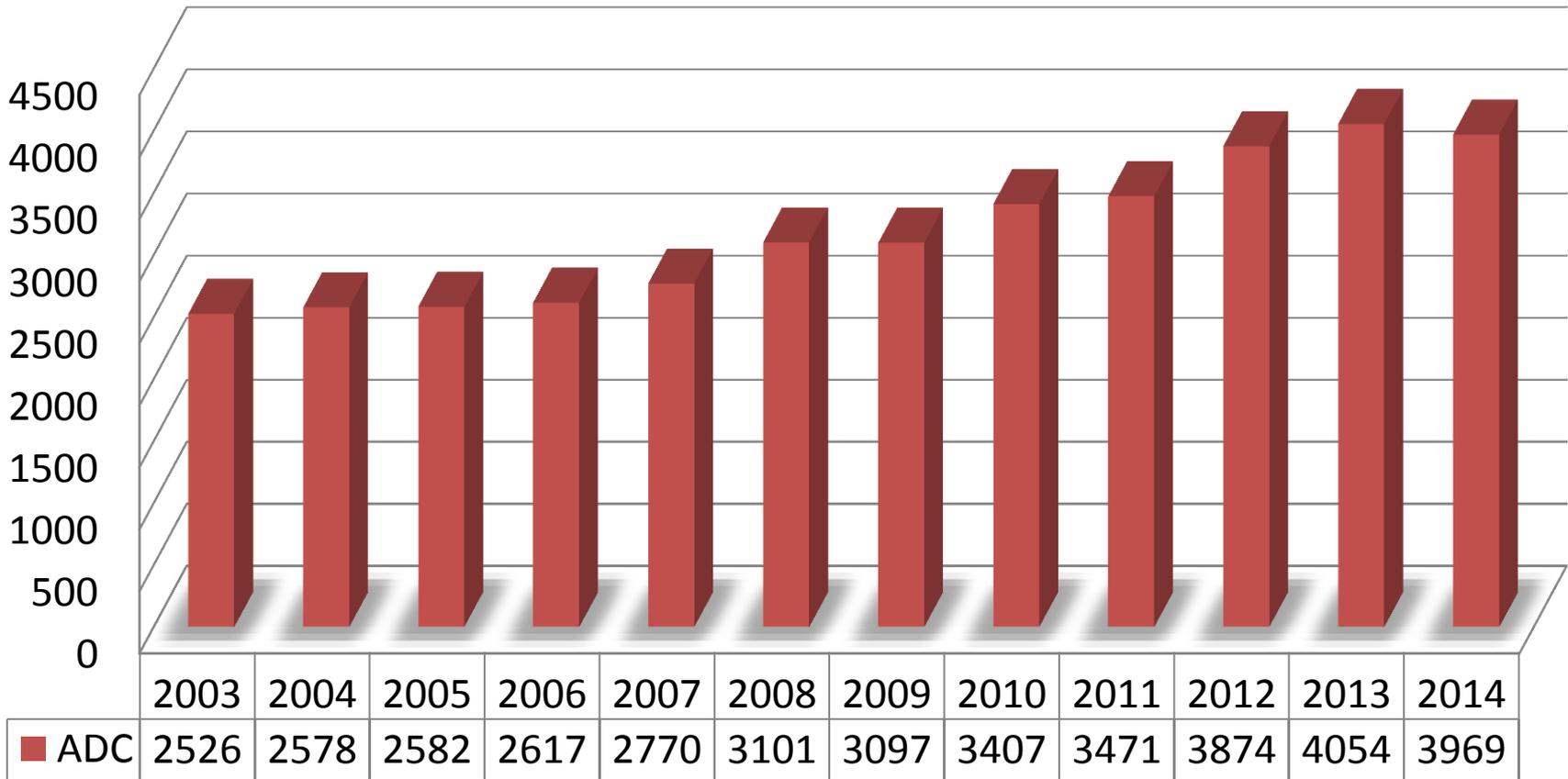
Trend in Number of Centers





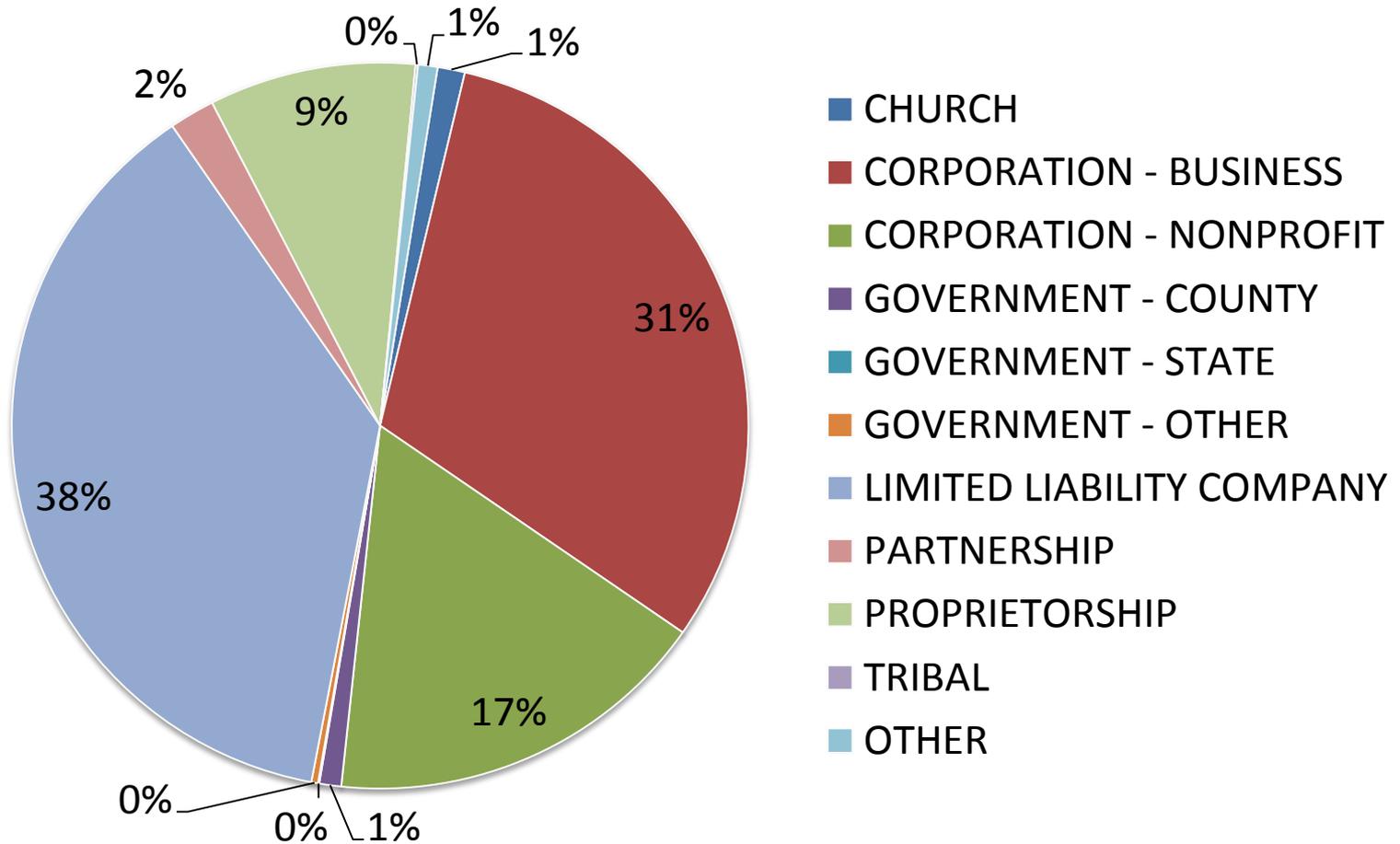
Adult Day Care Centers

Trend in the Capacity for Participants



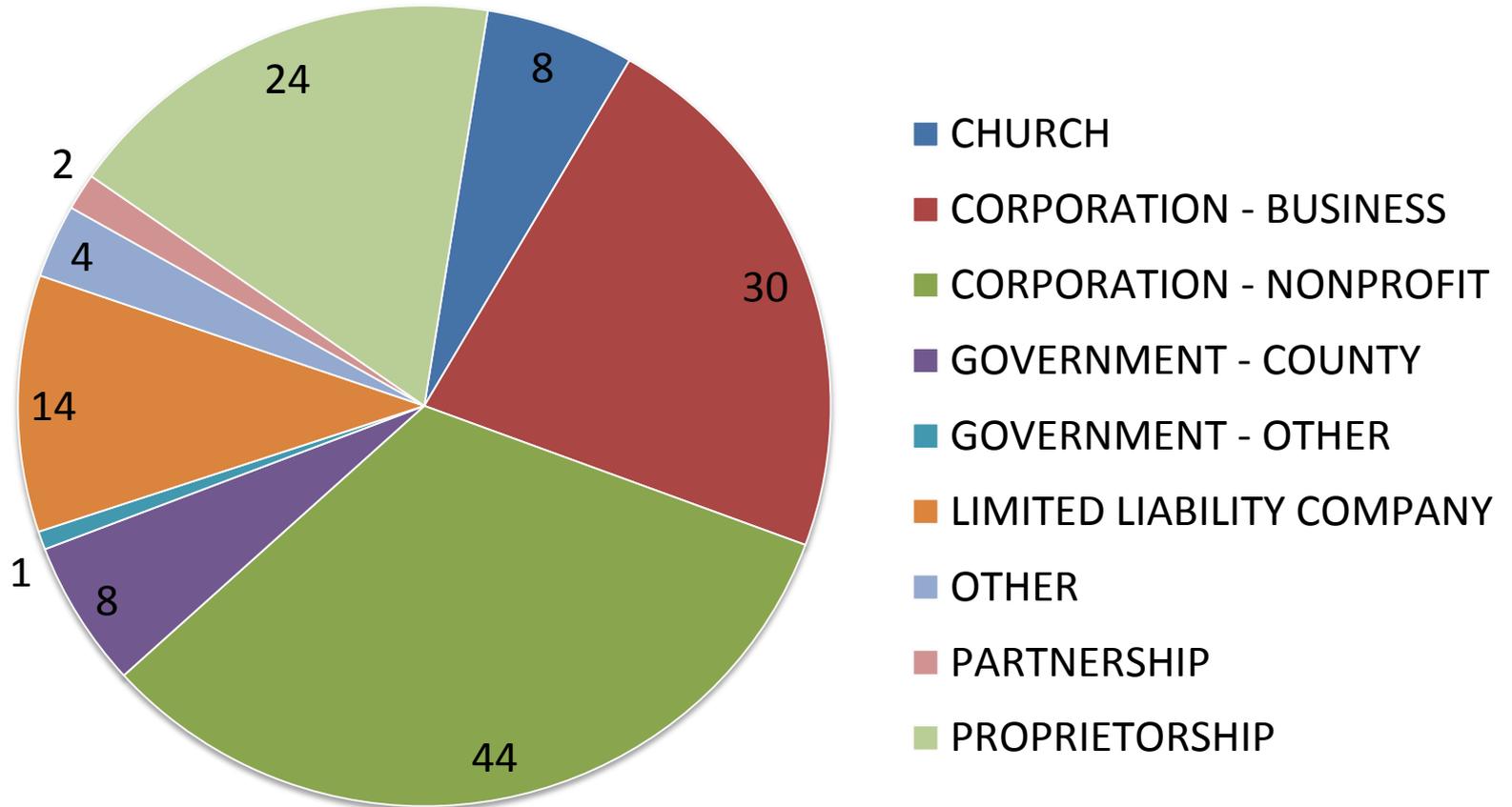


Ownership by Count ALL CY 2014



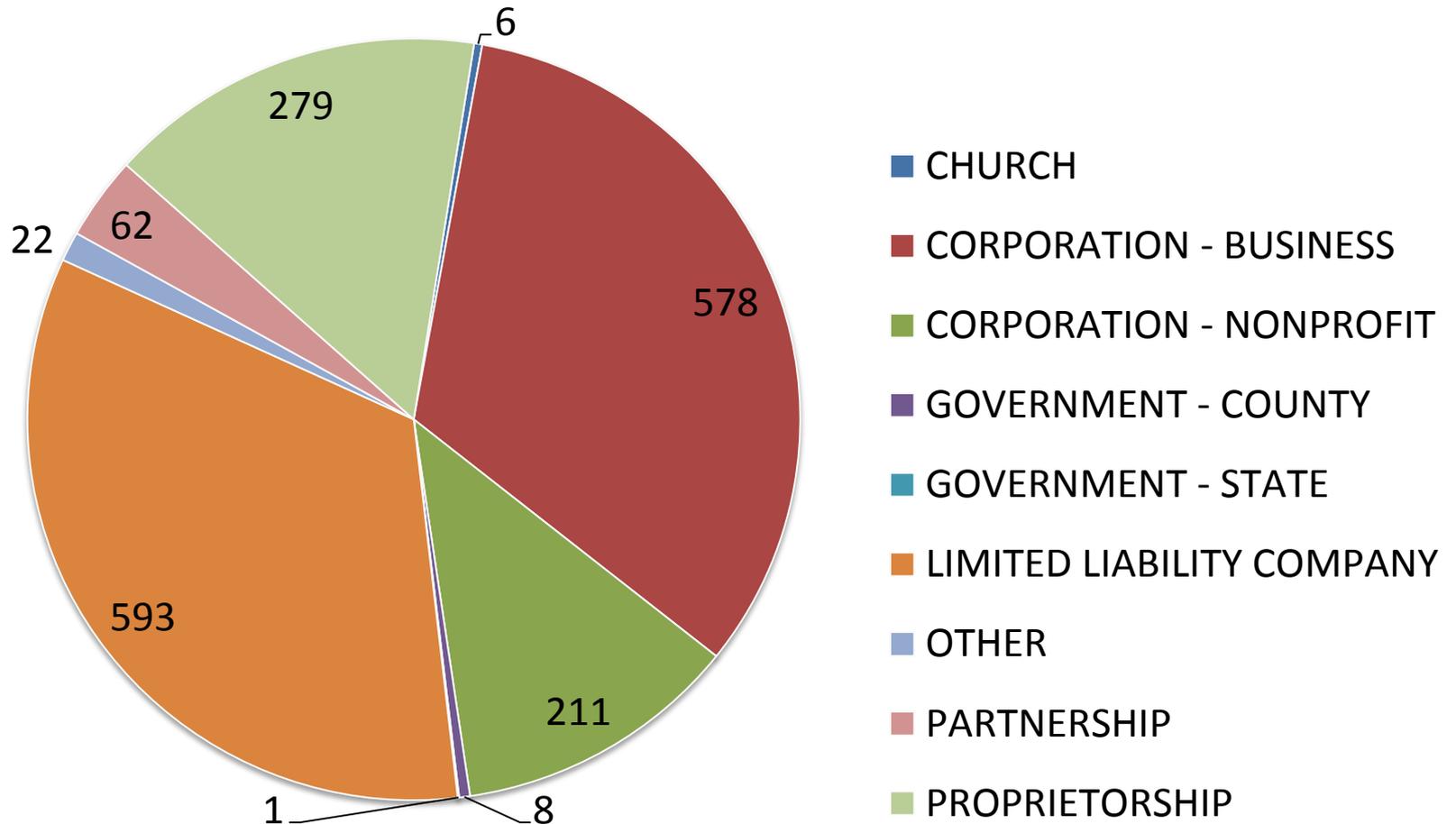


Ownership-ADC CY 2014



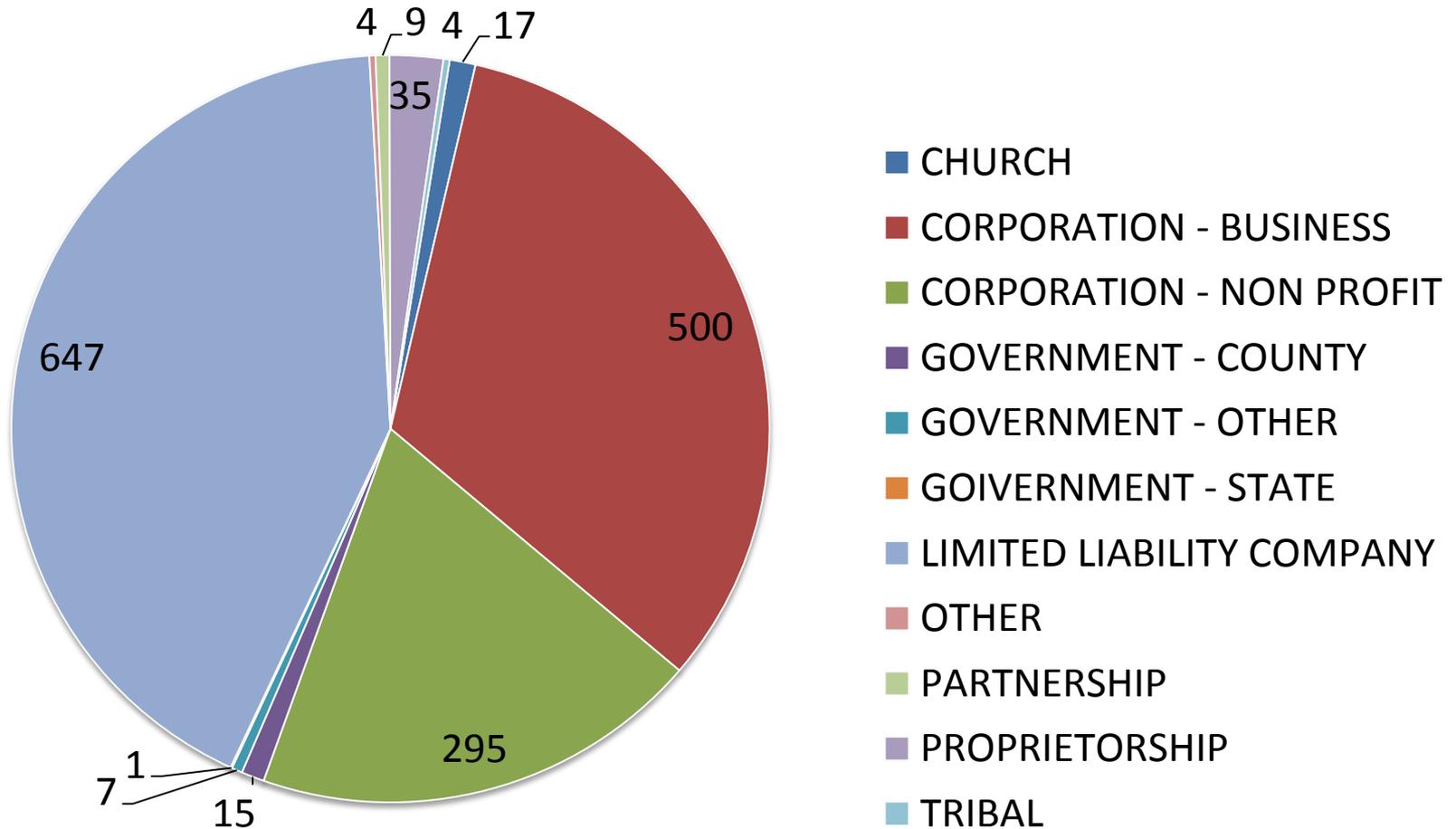


Ownership-AFH CY 2014



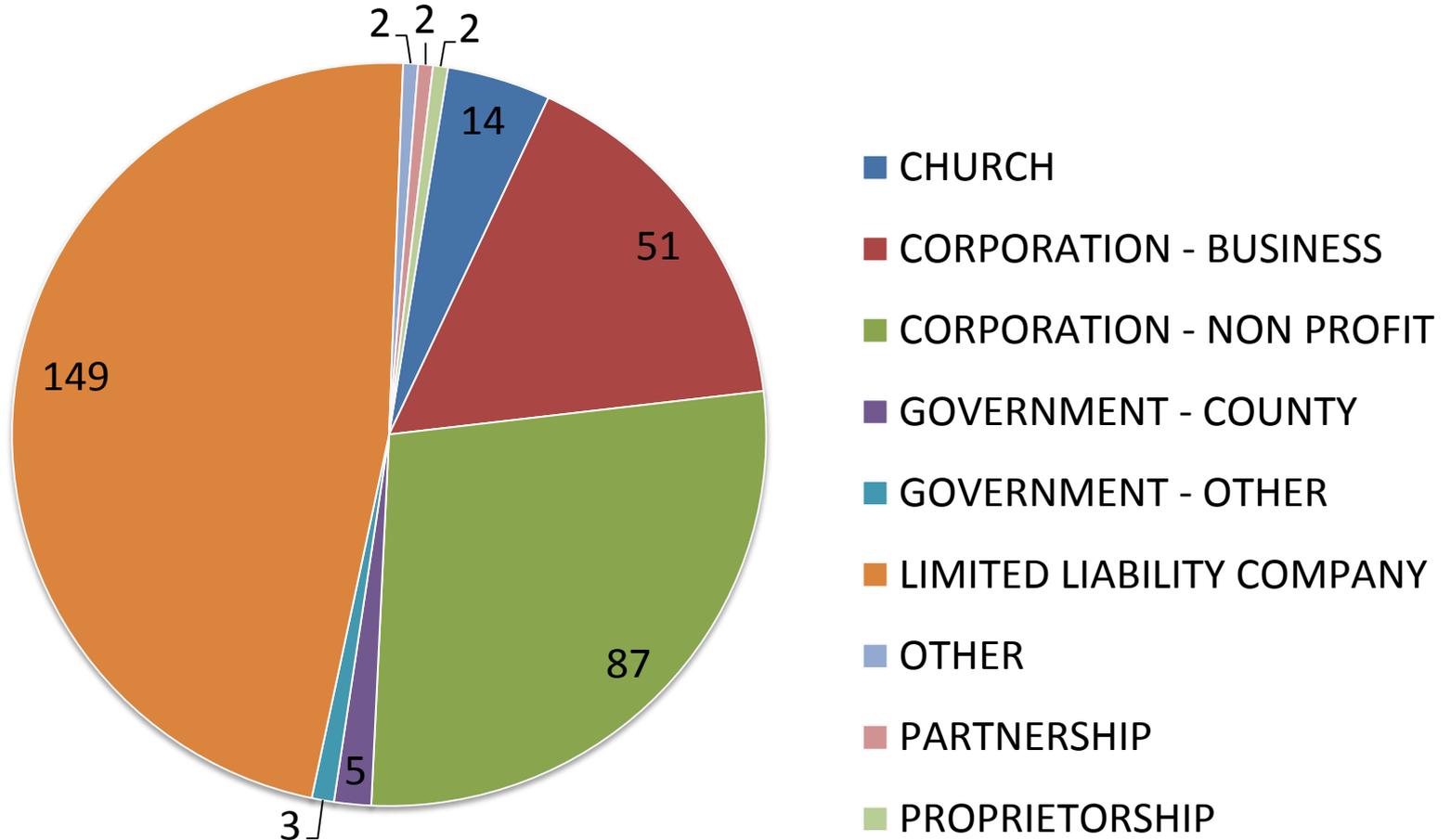


Ownership-CBRF CY 2014





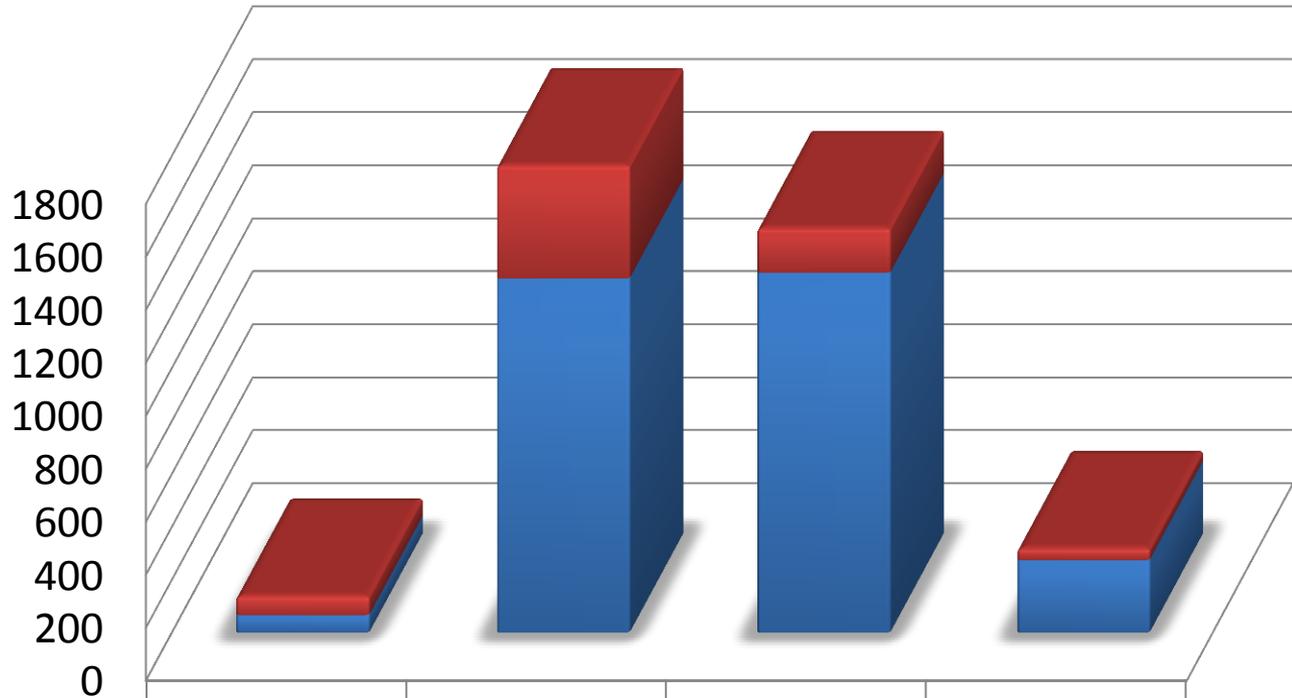
Ownership-RCAC CY 2014





Assisted Living Communities by Affiliation CY 2014

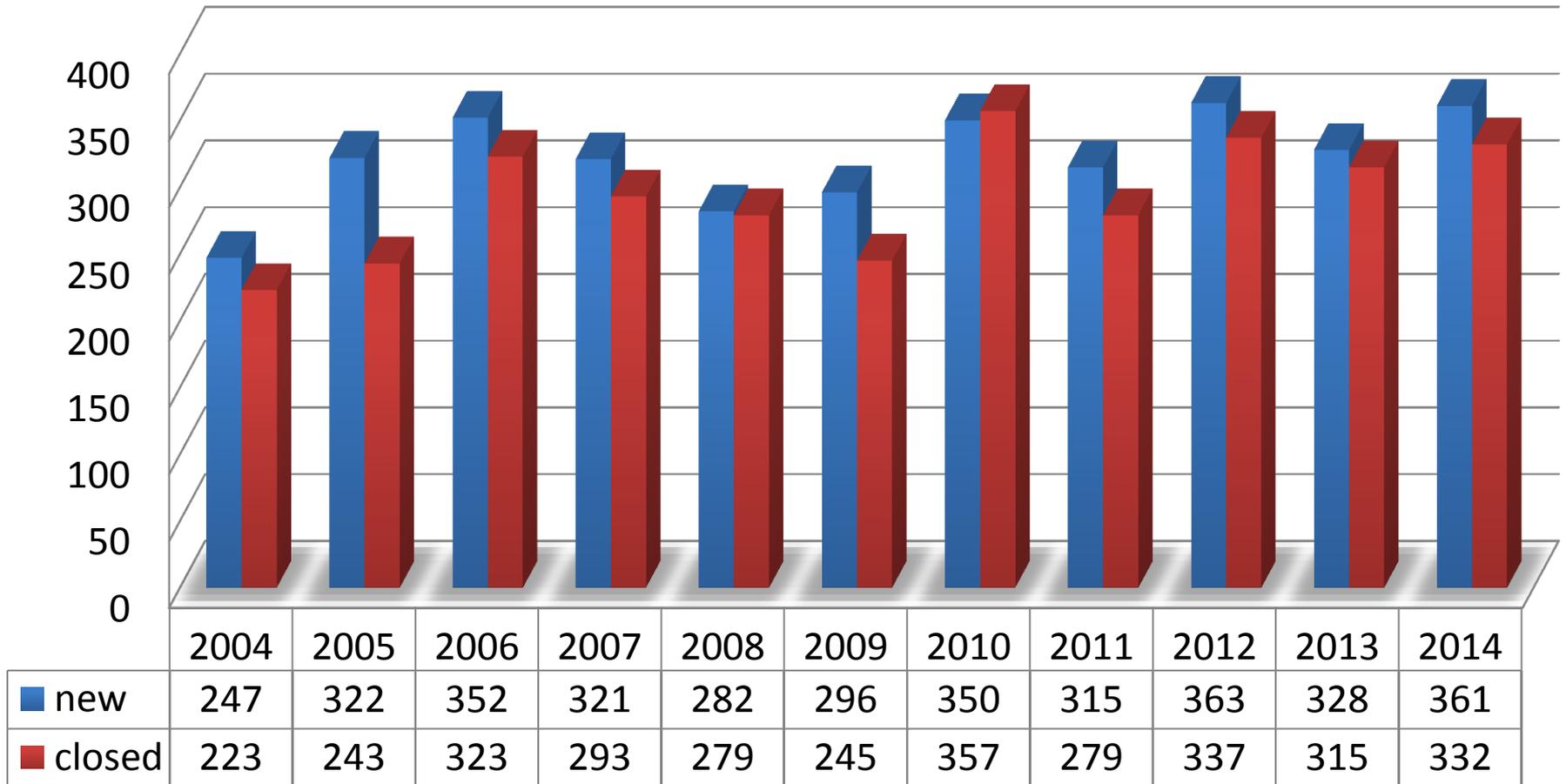
Number of Communities



	ADC	AFH	CBRF	RCAC
■ Independent	67	422	163	39
■ Affiliated	66	1337	1359	274

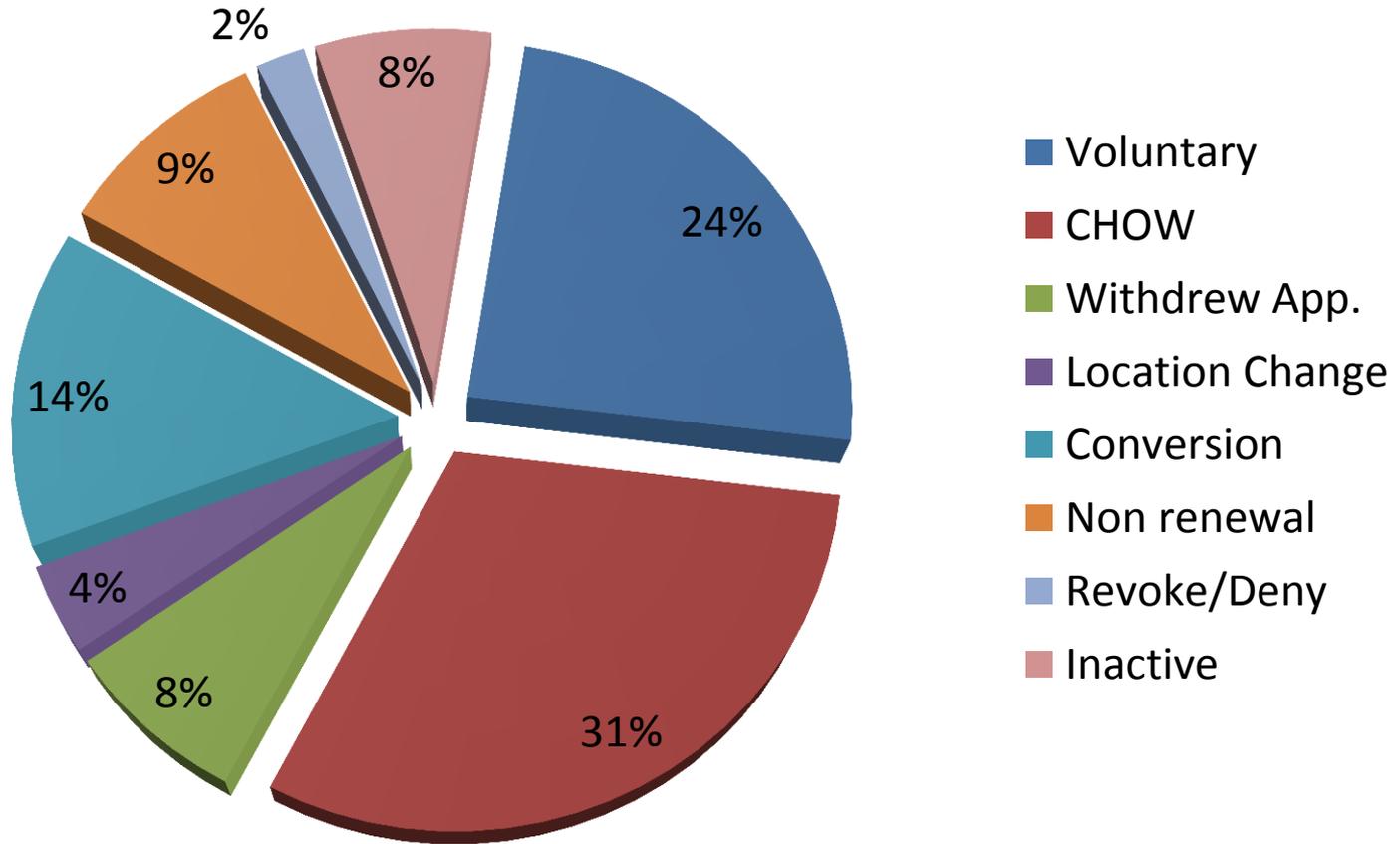


New AL vs. Closed AL





Why Facilities Closed CY 2014

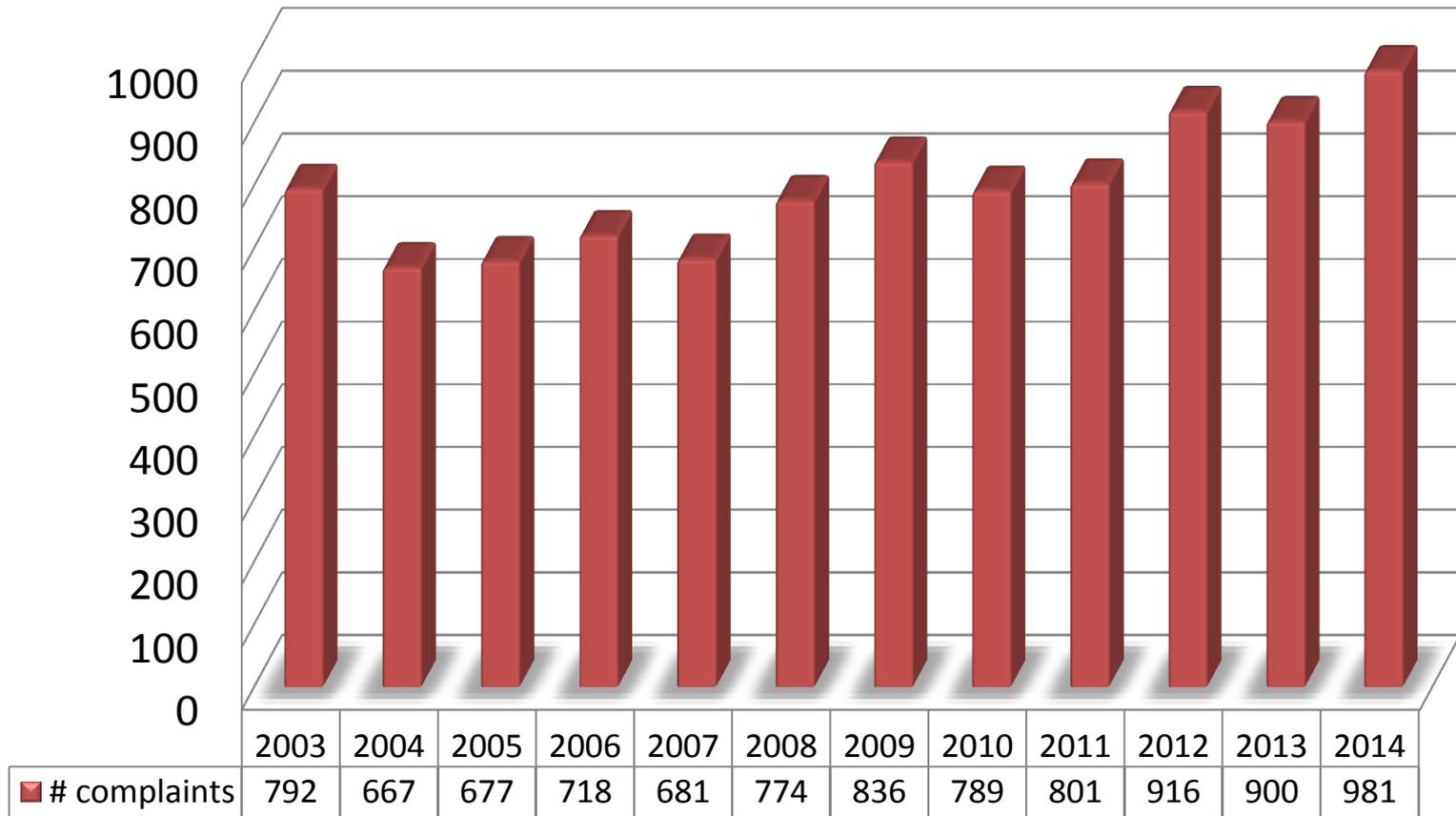




Assisted Living Complaints CY 2014



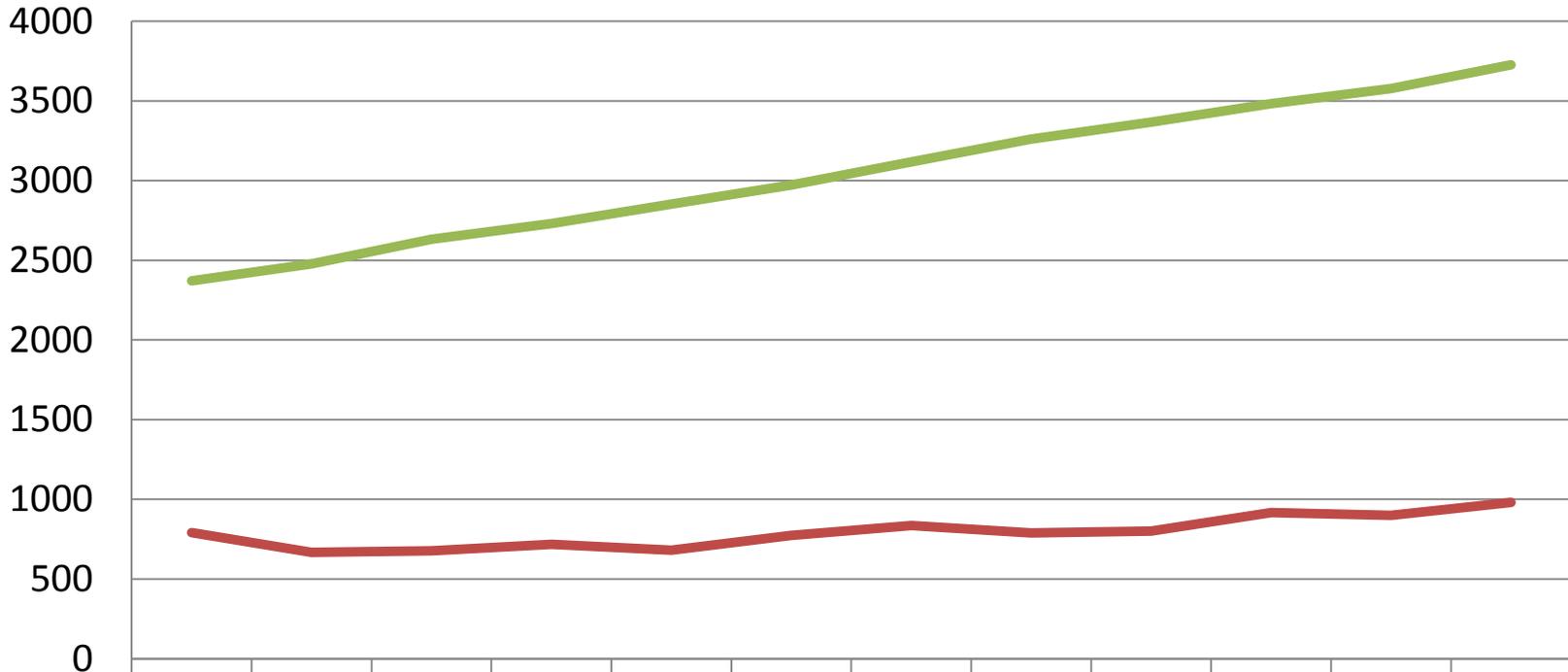
ASSISTED LIVING COMPLAINTS RECEIVED





Complaints vs. Growth

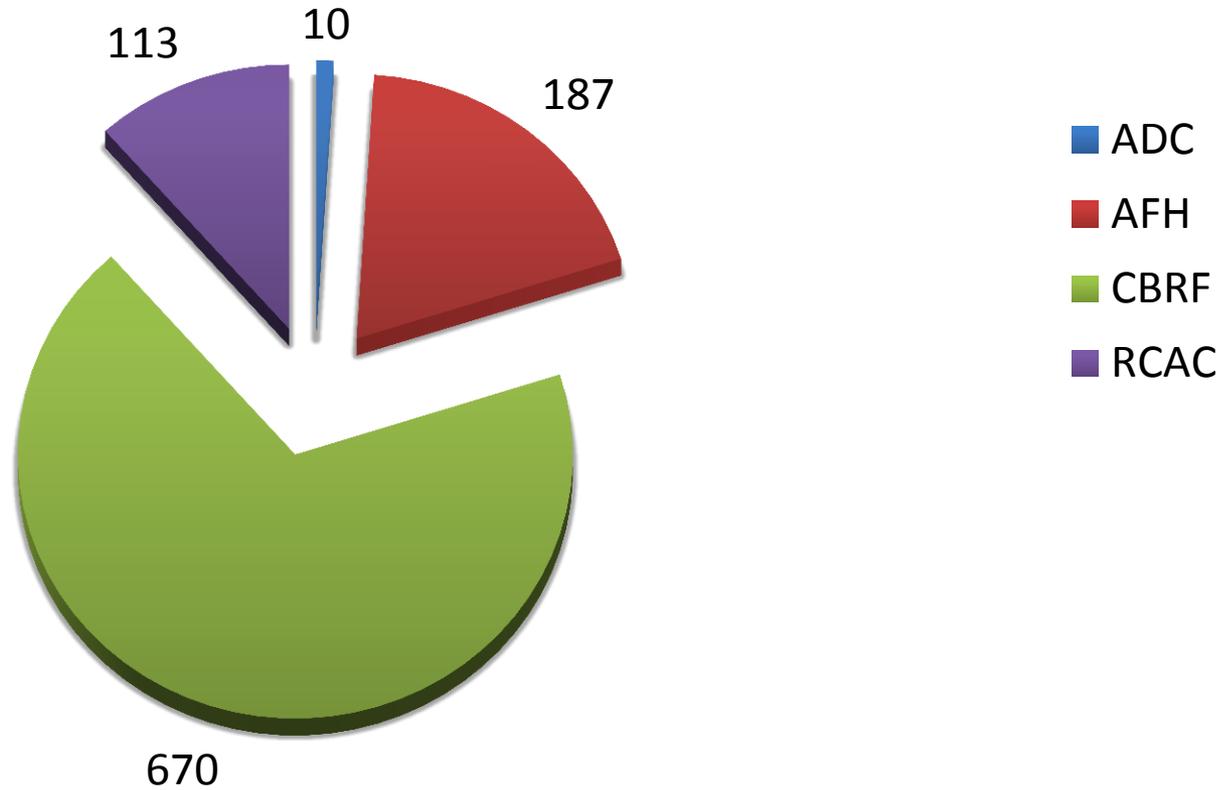
2003- 2014



# complaints	792	667	677	718	681	774	836	789	801	916	900	981
# AL Facilities	2370	2477	2631	2731	2853	2973	3117	3261	3366	3482	3577	3727

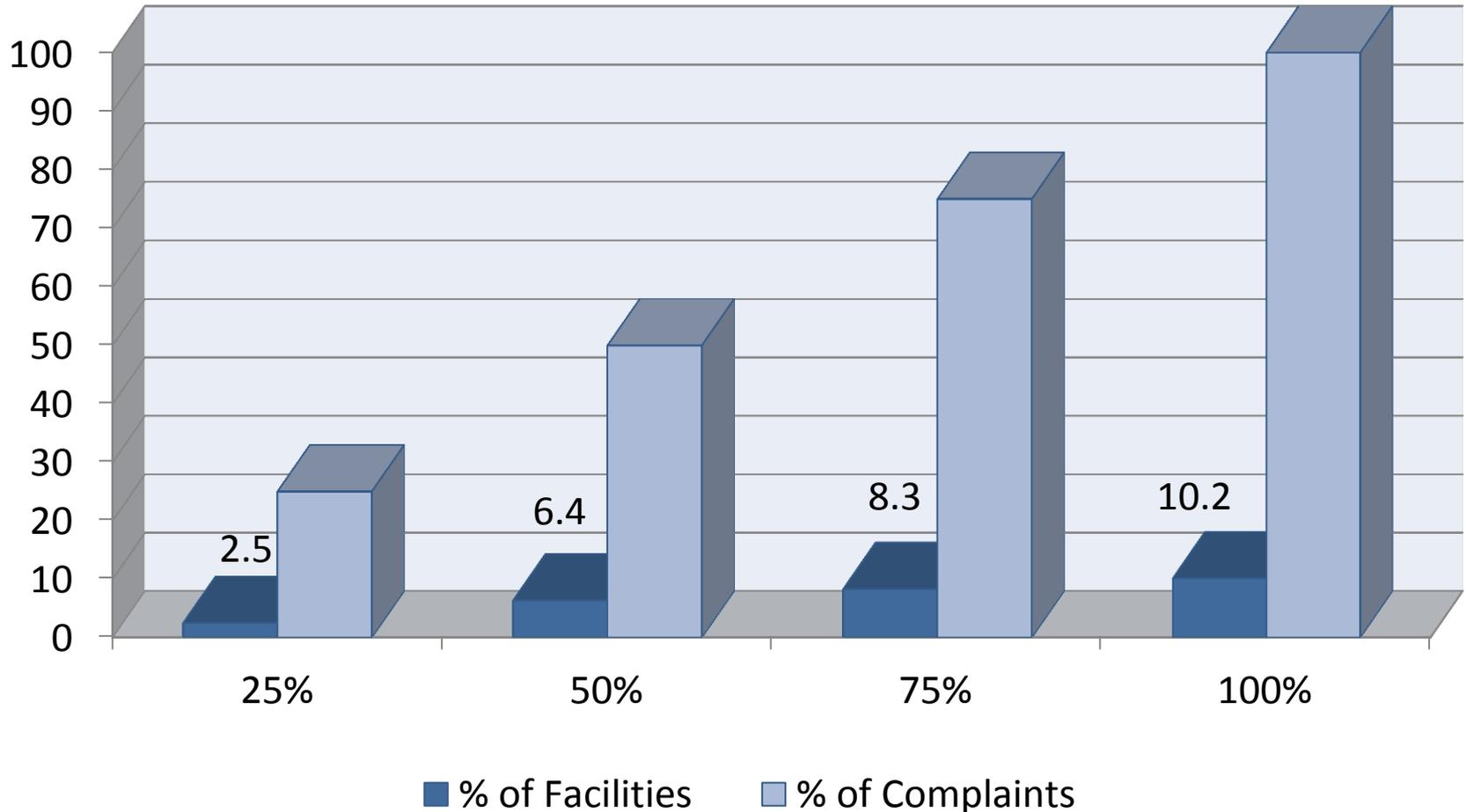


Complaints Received CY 2014



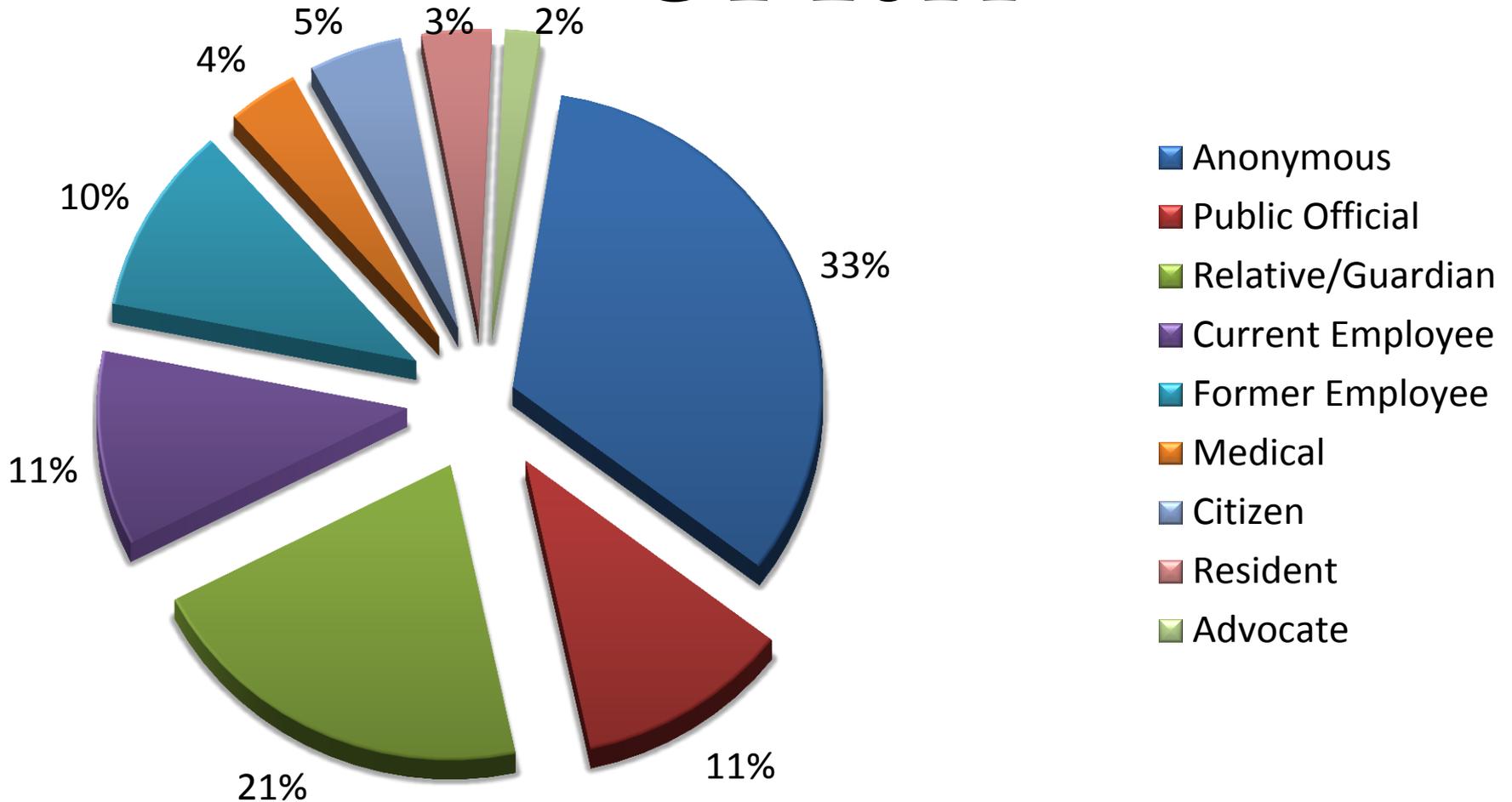


Percent of Facilities Making up a Percent of Complaints





Source of Complaint CY 2014





Ranking – Subject Areas of Complaint Investigations

	2008	2009	2010	2011	2012	2013	2014
Administration	2	1	1	2	2	2	1
Medications	1	3	3	3	3	3	4
Resident Rights	3	2	2	1	1	1	2
Program Services	4	4	4	5	5	4	3
Nutrition & Food	6	6	8	4	4	7	8
Staff Adequacy	5	8	6	7	7	8	6
Supervision	8	5	5	8	8	6	5
Staff Training	9	7	7	6	6	5	7



Ranking – Subject Areas of Complaint Investigations

	2008	2009	2010	2011	2012	2013	2014
Abuse	7	9	11	12	12	12	11
Homelike environment	10	10	10	10	10	9	14
Physical Plant & Hazards	13	11	12	11	11	11	12
Res. Behavior/ Facility practice	11	13	13	13	13	10	13
Quality of Life	12	12	9	9	9	13	9
Admission/ Discharge	14	14	14	14	14	14	10
License capacity or class	15	15	15	15	15	15	15
Restraints	16	16	16	16	16	16	16



Source of Complaint vs. Substantiation CY 2014

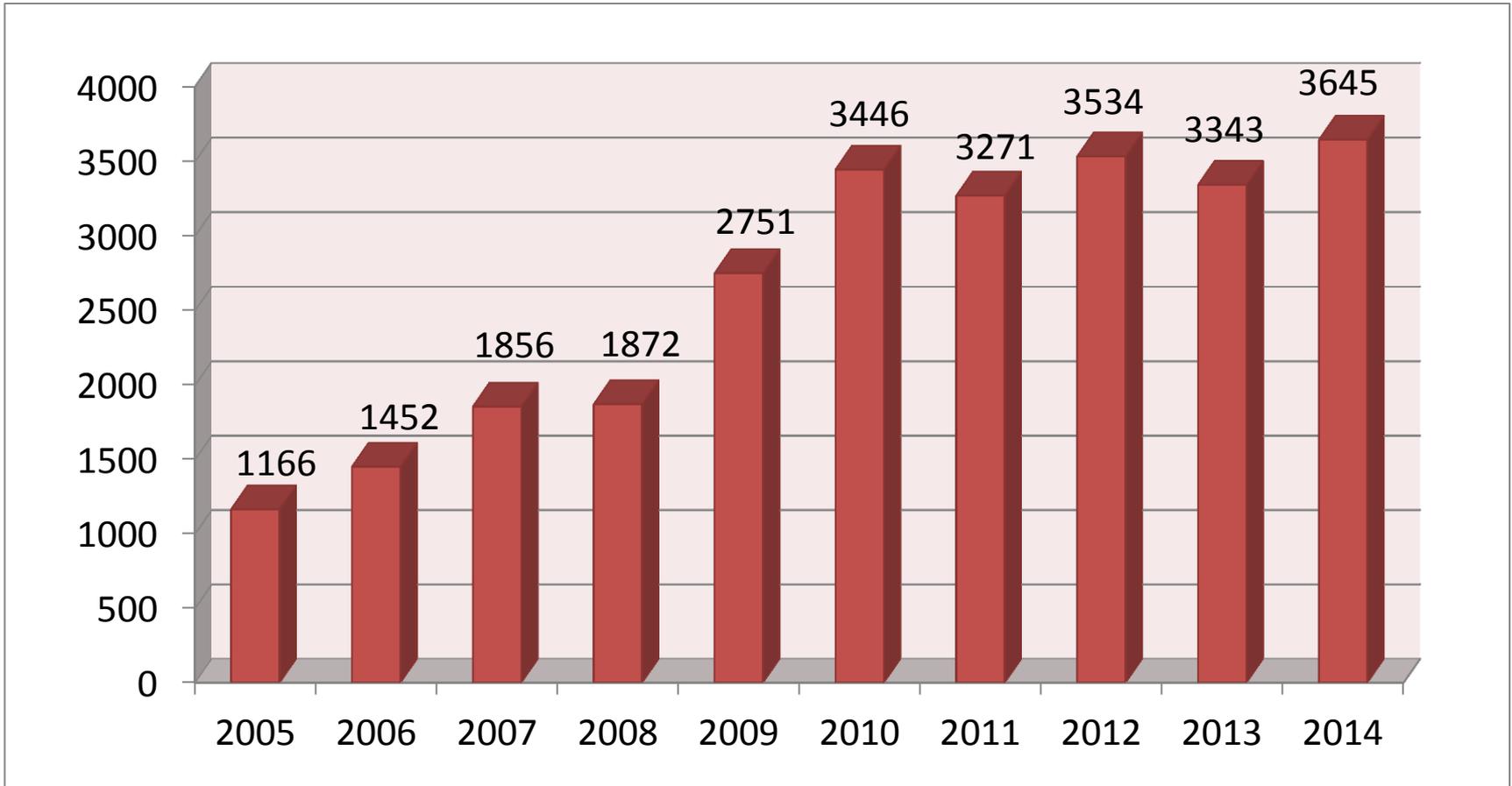
<u>Source</u>	<u>% rec. & Inv.</u>	<u>% substantiated</u>
Anonymous	33	25
Public Official	11	49
Relative/Guardian	21	40
Current Employee	11	31
Former Employee	10	26
Advocate	02	68
Citizen	05	29
Medical	04	41
Resident	<u>04</u>	<u>23</u>
	100%	43%



Assisted Living Self-Reports CY 2014



Self-Reports Received





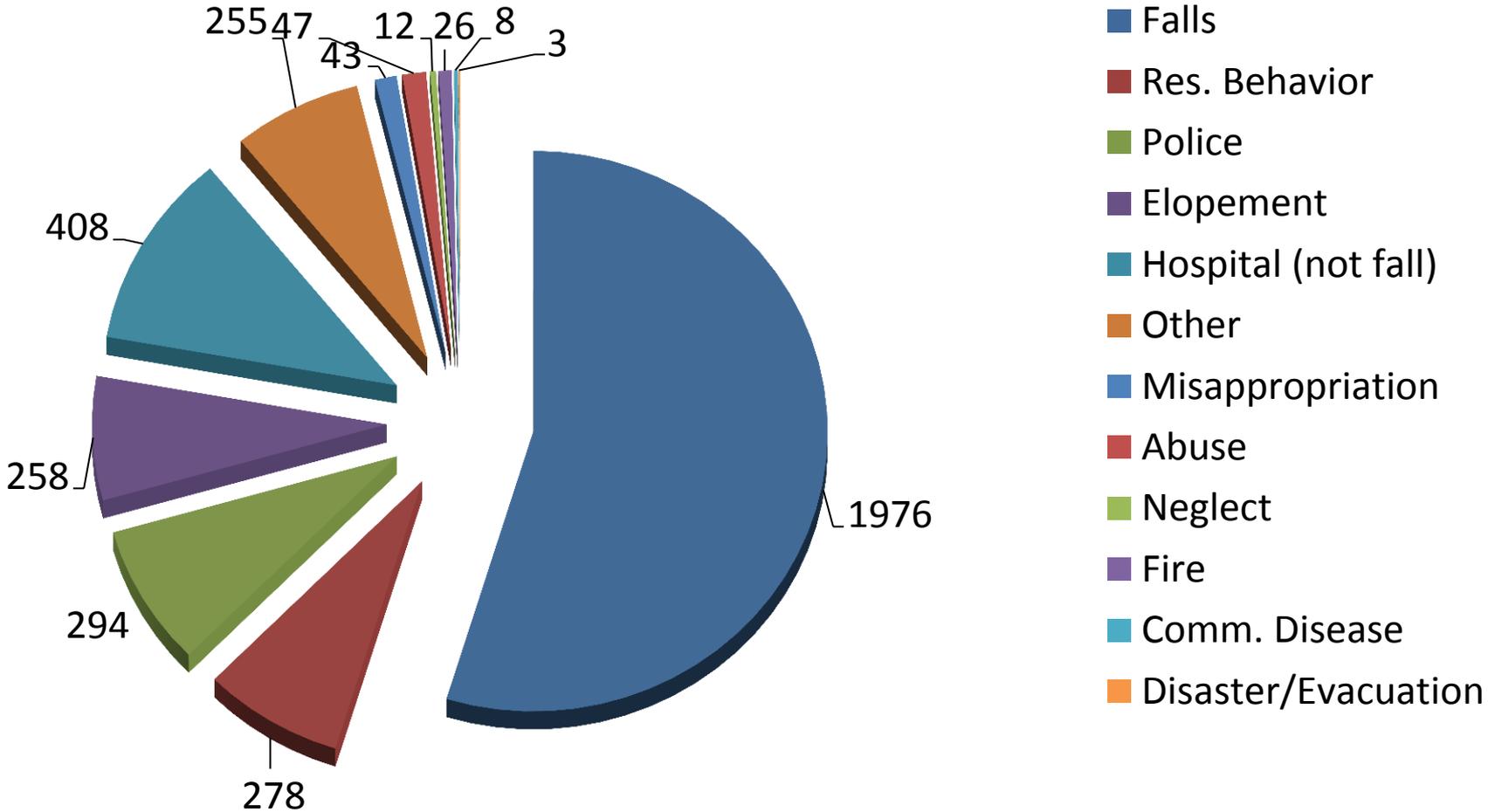
Self-Reports Received CY 2014 (3,645)

- Open Investigation
- Review next visit
- File



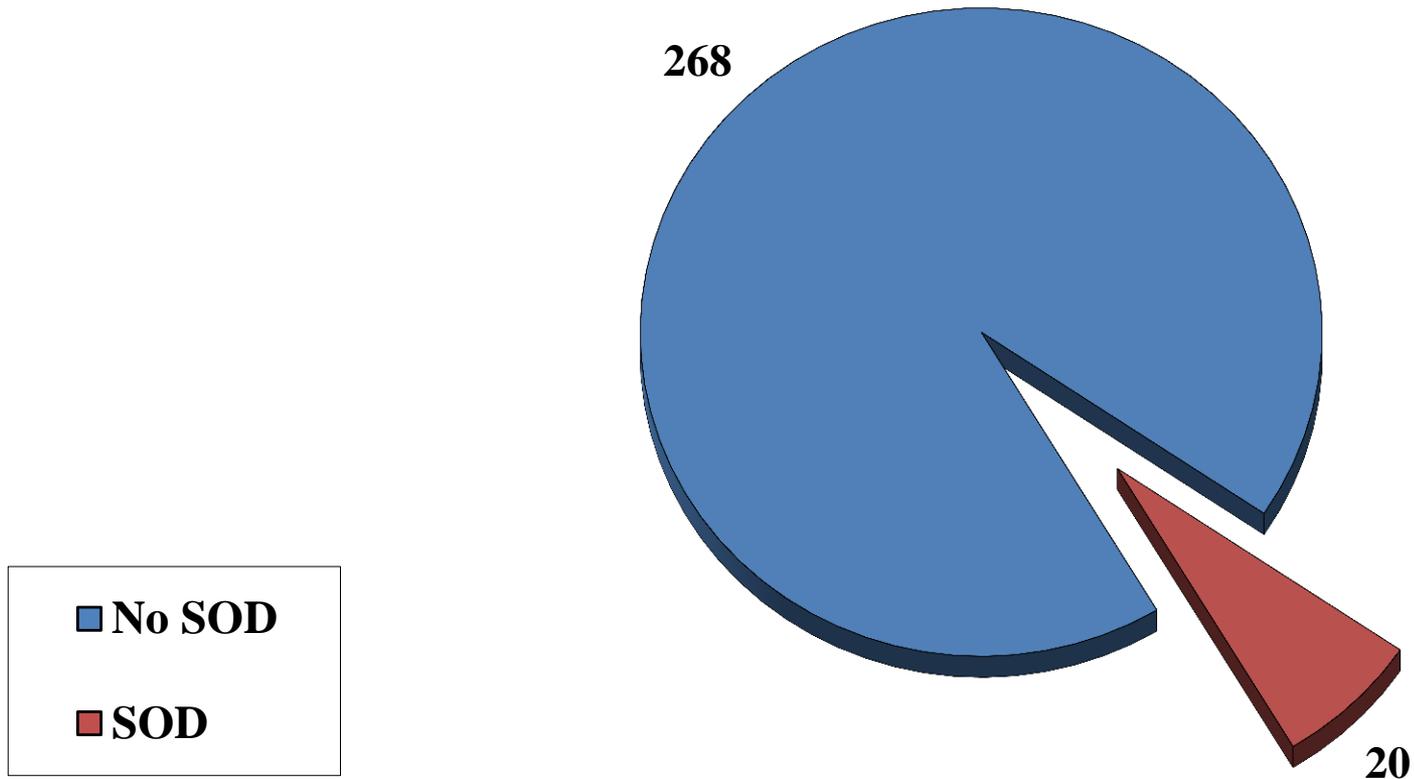


Number of Self-Reports by Subject Area CY 2014





Self-Reports Investigated - CY 2014 (288)





Assisted Living Post-Survey Results CY 2014



Post-Survey Questionnaire



- 2014 - 54 respondents
- Satisfaction with survey tasks
94.41 %
- On Site - 4.62
 - Knowledgeable - 4.75
 - Professional - 4.71
 - Respectful - 4.73
- SOD – 4.22

1 = strongly disagree,
5 = strongly agree





Assisted Living Standard/Abbreviated Survey Process



BAL Survey Processes

- Unannounced
- Standard surveys (2 year cycle)
- Abbreviated surveys
 - No substantiated complaints
 - No enforcement x 3 years
 - Licensed at least 3 years
- Complaint investigations
- Verification Visits
- Initial Licensing/Certification
- Self-Report investigations



Standard Survey

- An outcome-based survey that focuses on the quality of life and care provided by assisted living communities
- Interviews, observations, record review
- Obtain input from consumers, family members, advocates, and staff to evaluate compliance, systems, and outcomes



Key Code (Core Areas)

- Consumer Rights
- Provision of Services / Quality of Care
- Nutrition and Food Service
- Physical Environment & Safety
- Staff Training
- Medication Management



Survey Results

- No deficiencies
- Notice of Finding
- Statement of deficiency
- Statement of deficiency with enforcement



Provider's Plan of Correction

- What corrective action and system changes will be made to ensure violations are corrected and regulatory compliance is maintained?
- Who is responsible for monitoring for continued regulatory compliance?
- Department Orders, if applicable. Submit documentation, if requested.
- Date of completion for each corrective action (Violation, Order).



Stakeholder Collaboration

- Sharing Statements of Deficiency (SOD)
- Posting SODs, enforcement notices, profiles
- Referrals (OCQ, DSPS, OIG, Human Service Agencies, Case Managers, Departments of Justice, Fraud)



Assisted Living Regulatory Activity CY 2014

- Standard Surveys 533
- Initial Surveys 371
- Abbreviated 287
- Other (Enf. VV & Complaint) 1321



Abbreviated Surveys CY 2014

- No Deficiency Survey - 66%
- Statement of Deficiency - 33%

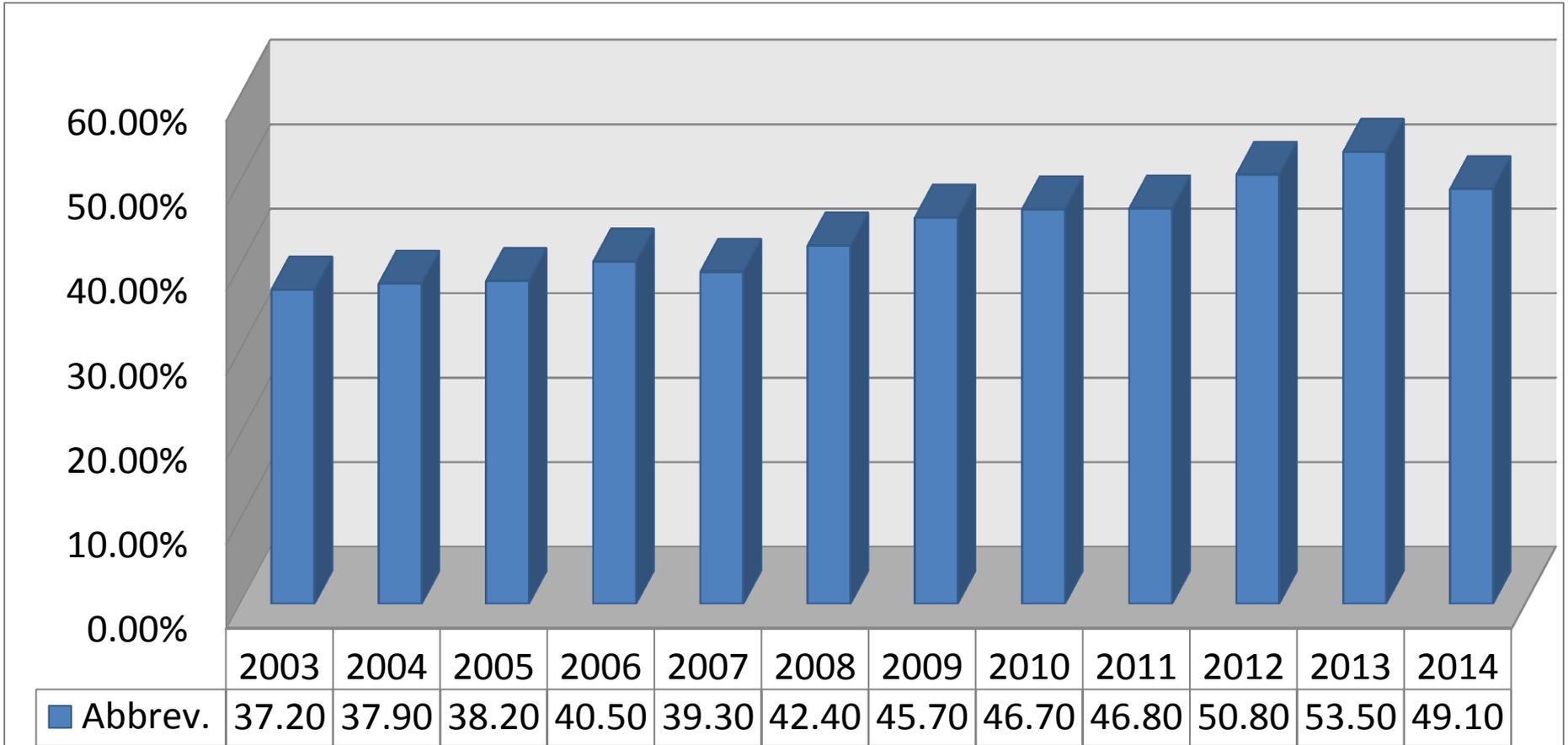


Facilities Qualifying for Abbreviated Surveys – CY 2014

• Adult Day Care	61.2%
• Adult Family Homes	48.8%
• Community Based Residential Facility	45.8%
• Residential Care Apartment Complex	<u>52.8%</u>
• Statewide	49.1%

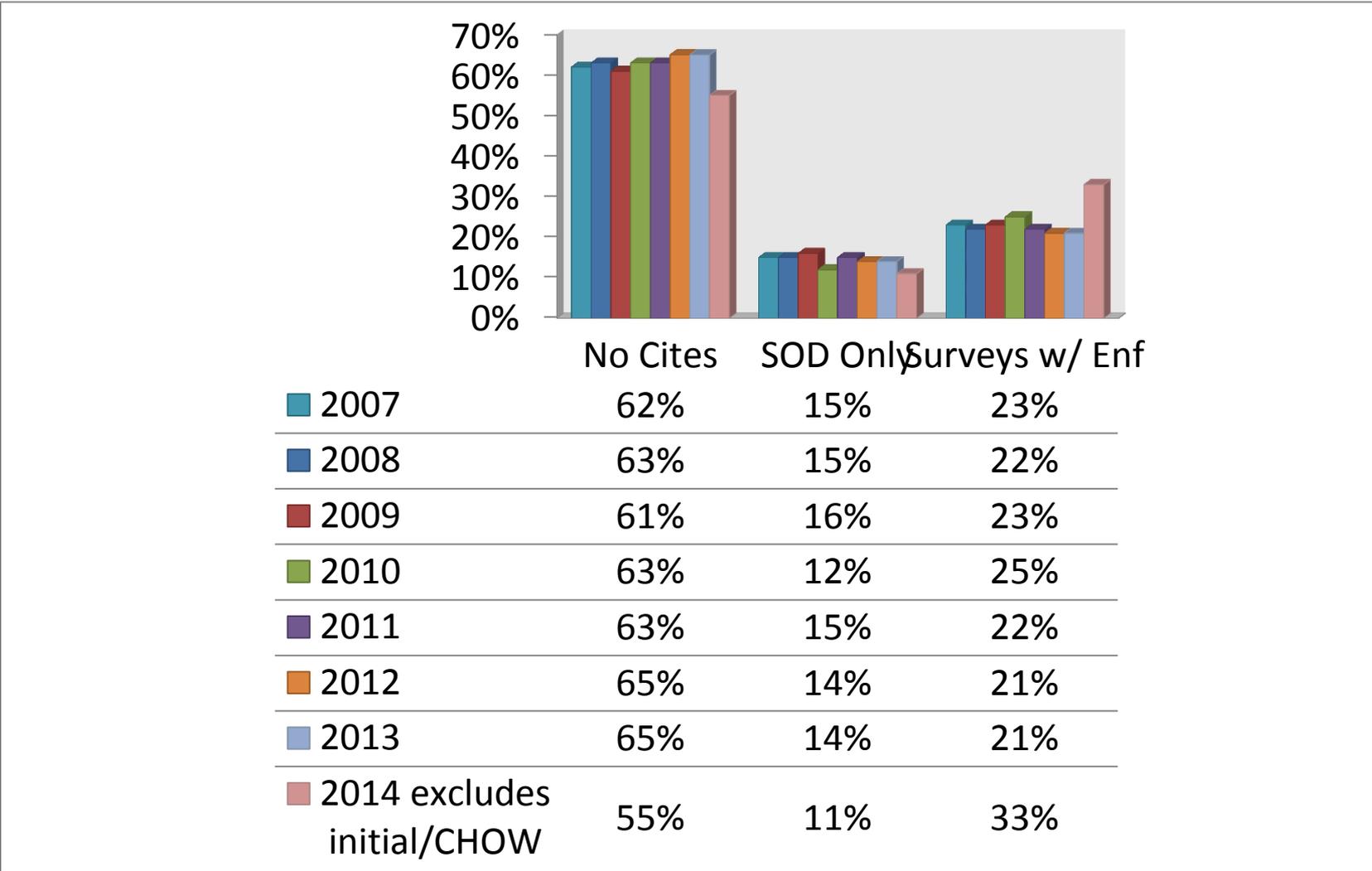


Facilities Qualifying for an Abbreviated Survey



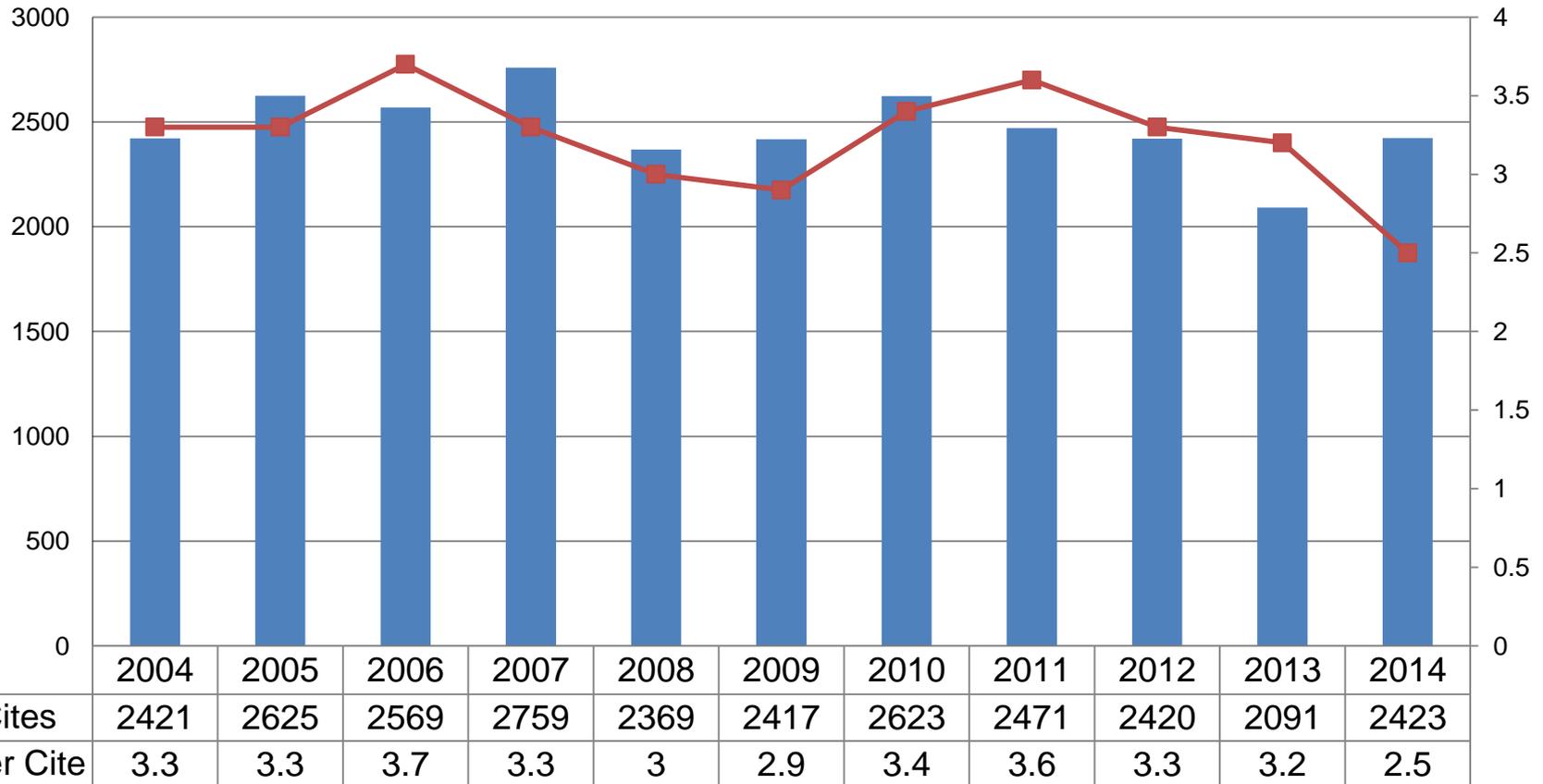


Survey Results – Statewide



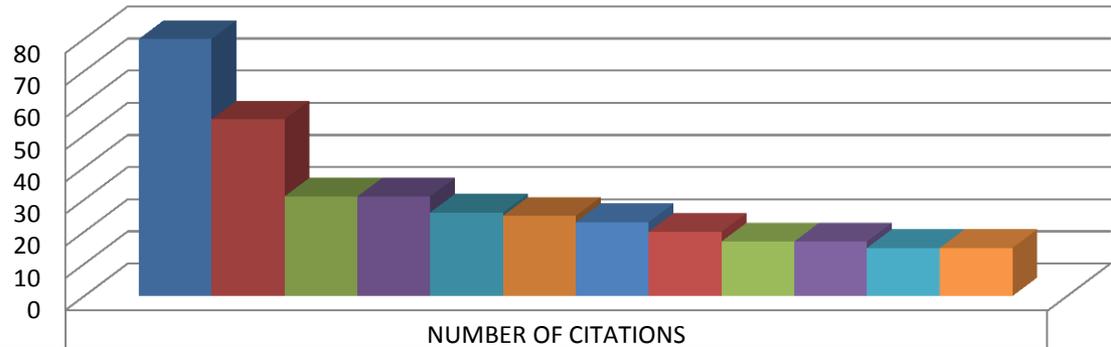


Assisted Living Citations Issued





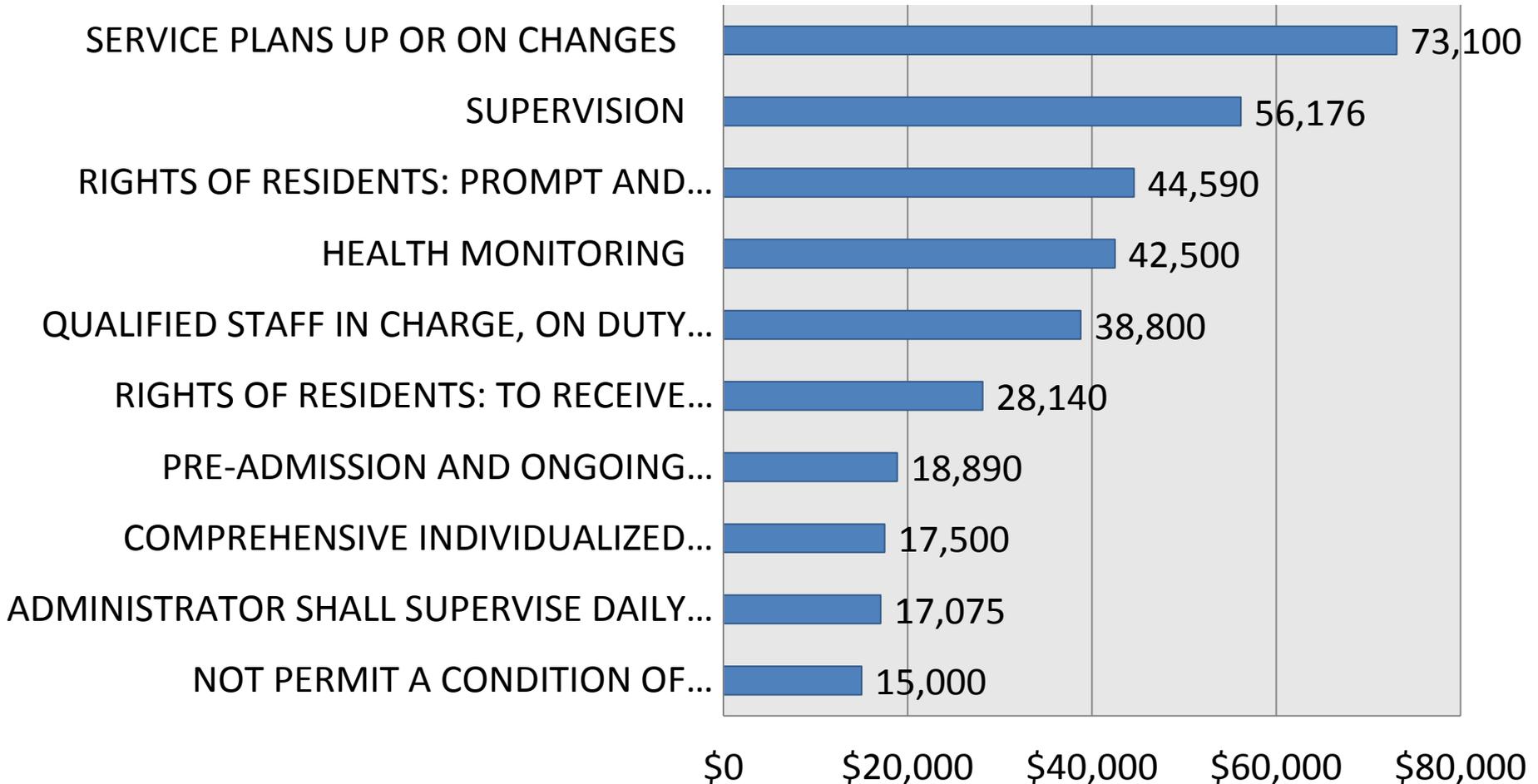
CBRF Top Ten Citations CY 14



	NUMBER OF CITATIONS
■ ENTITY SANCTION (4 YEAR CBC)	80
■ SERVICE PLANS UP ANNUALLY OR ON CHANGES	55
■ FIRE DRILLS	31
■ OTHER EVACUATION DRILLS	31
■ 5-YEAR DELAY FOR SPRINKLER SYSTEM: CLASS C	26
■ COMPREHENSIVE INDIVIDUALIZED SERVICE PLAN	25
■ LICENSEE COMPLIES WITH LAWS	23
■ SUPERVISION	20
■ RIGHTS OF RESIDENTS: TO RECEIVE MEDICATION	17
■ PRE-ADMISSION AND ONGOING ASSESSMENTS	17
■ RIGHTS OF RESIDENTS: PROMPT AND ADEQUATE TREATMENT	15
■ ADMINISTRATOR SHALL SUPERVISE DAILY OPERATION	15

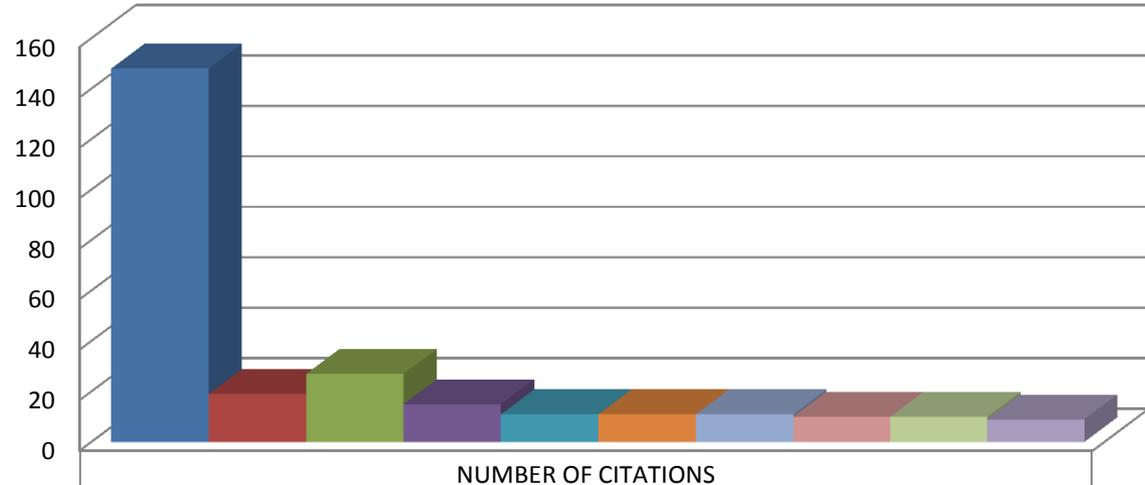


Top Ten Cites with Forfeiture CBRF 2014





AFH Top Ten Citations CY 14

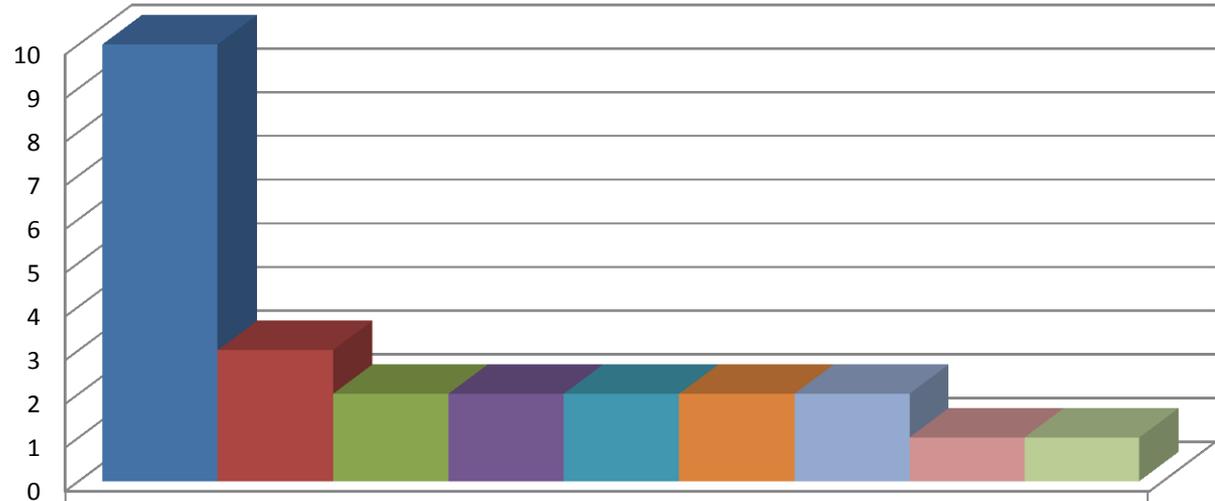


NUMBER OF CITATIONS

■ ENTITY SANCTION (4 YEAR CBC)	148
■ EXITING FROM THE FIRST FLOOR	19
■ REVIEW OF ISP	27
■ SMOKE DETECTORS-TESTING AND MAINTENANCE	15
■ TRAINING-15 HOURS WITHIN 6 MONTHS	11
■ MEDICATION- WRITTEN ORDER	11
■ MEDICATION- WRITTEN ORDER	11
■ INDIVIDUAL SERVICE PLAN & ASSESSMENT	10
■ SERVICE AGREEMENT EXCEPT RESPITE	10
■ SAFE PHYSICAL ENVIRONMENT	9



RCAC Top Ten Citations CY 14

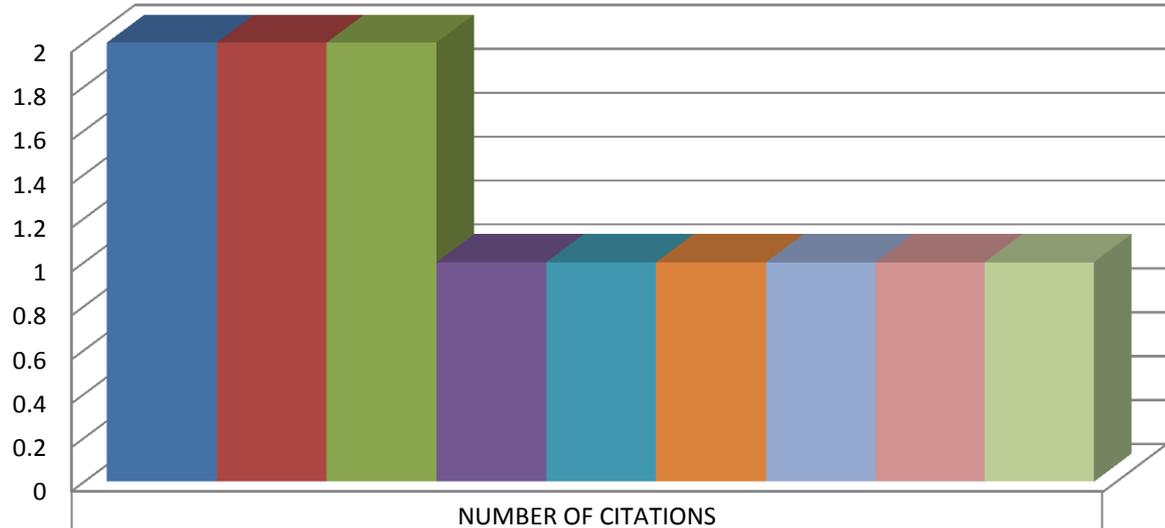


NUMBER OF CITATIONS

■ 12.05(1)a ENTITY SANCTION (4 YEAR CBC)	10
■ 89.34(16) TENANT RIGHTS	3
■ 89.23(1) SERVICES	2
■ 89.35(3) GRIEVANCES	2
■ 89.29.23(2)(a)2.c SERVICES	2
■ 13.05(2) CLIENT PROTECTION	2
■ 89.26(4) ANNUAL REVIEW	2
■ 89.23(2)(b)1 SERVICES	1
■ 89.29(1)b ADMISSION/RENTENTION	1



ADC Top Ten Citations CY 14



	NUMBER OF CITATIONS
■ ENTITY SANCTION (4 YEAR CBC)	2
■ PLAN-QUARTERLY DOCUMENTING	2
■ TRAINING-CONTINUING EDUCATION	2
■ PLAN-REVIEWED & UPDATED EVERY 6 MONTHS	1
■ PLAN-FOSTER INTERACTION	1
■ HEALTH STATEMENT	1
■ PLAN-COMPREHENSIVE WRITTEN ASSESSMENT	1
■ PLAN-IDENTIFIED NEEDS WITH 30 DAYS	1
■ PERSONNEL-HEALTH EXAMINATION	1



Assisted Living Enforcement CY 2014



Bureau of Assisted Living

- Surveyors
 - Registered nurses
 - Health/human service professionals
- Regional Office Directors
- Program Support
- Quality Assurance Staff
 - Enforcement Specialist (centralized)
 - Lead Internal QA program.



Bureau of Assisted Living Structure

- Enforcement Specialist Qualifications
 - Experienced investigator
 - Clinical expertise (health or human service)
 - Regulatory experience
 - Program evaluation
- Lead Role / Quality Assurance
- Appeals / Hearings



BAL Enforcement Philosophy

1. Use sanctions that can improve systemic concerns so communities can correct and sustain compliance
2. Progressive sanctions
3. Aggressive action against the communities with persistent or serious noncompliance
4. Root Cause Analysis
5. Collaborate with other agencies, including Advocates, OCQ, DSPS, OIG, Counties, MCOs and Department of Justice and Attorney General



BAL Enforcement “Rule of Thumb”

Apply constructive enforcement strategies that require providers to address the "root causes" of violations and use a "progressive" enforcement approach by reserving higher forfeitures and stronger sanctions for serious and repeat compliance problems.





PROMISING PRACTICES IN STATE SURVEY AGENCIES

Achieving Better Outcomes Using Survey & Certification Enforcement Strategies
Wisconsin

Summary

In 2003, the Bureau of Assisted Living, Division of Quality Assurance (DQA) at the Wisconsin Department of Health and Family Services implemented a process for utilizing directed plans of correction as an enforcement strategy to address serious and repeat violations in assisted living and community-based facilities. This practice was initiated in response to concerns that financial penalties alone were not effective for all facilities in prompting and sustaining compliance. The directed plans of correction expand upon and clarify existing state codes and licensing requirements by prescribing concrete steps for facilities to achieve compliance and improve services. While this practice does not fall under the CMS federal survey and certification regulations, it does provide for improved state enforcement effectiveness and efficiencies in an area where many states find compliance issues are rapidly increasing.

Introduction

This report describes the structure and functioning of Wisconsin's directed plan of correction practice, its impact, and lessons learned that might benefit other agencies considering similar enforcement approaches. The information presented is based on interviews with agency management staff and review of documentation supporting the program.

Background

In addressing more and increasingly serious violations in Wisconsin's assisted living and community-based facilities, the DQA found that financial penalties alone were not an effective enforcement strategy for achieving compliance. Poor compliance in these facilities often was found to result from inadequate infrastructure and/or operational systems (e.g., lack of policies/procedures, poorly trained workforce, insufficient staffing), many of which would be only perpetuated by strictly monetary and/or punitive penalties. A key goal of the Wisconsin directed plan of correction program therefore was to move away from strictly punitive enforcement methods to a more constructive approach that encourages facilities to develop and implement durable, effective systems (e.g., policies,

procedures, training, care planning) for improving and sustaining compliance. Although the DQA had the authority to direct plans of correction prior to 2003 and did so on occasion primarily for straightforward environmental and structural issues – this enforcement method was adapted, expanded, and formalized by issuing an ordinance to assist multi-resident facilities in 2003.

Intervention

Directed plans of correction expand upon and clarify existing state codes and licensing requirements by prescribing concrete steps toward achieving compliance and improving services. Under the directed plan of correction approach, all completed statements of deficiency (SOD) undergo a supervisory review to determine whether a sanction or other enforcement action may be warranted. Based on this supervisory review, citations that warrant further enforcement review are forwarded to the DQA's Enforcement Specialist, who determines whether a directed plan of correction might help the facility achieve compliance. In preparing the directed plan of correction, the Enforcement Specialist evaluates the SOD, following up with surveyors and regional supervisors as needed, to

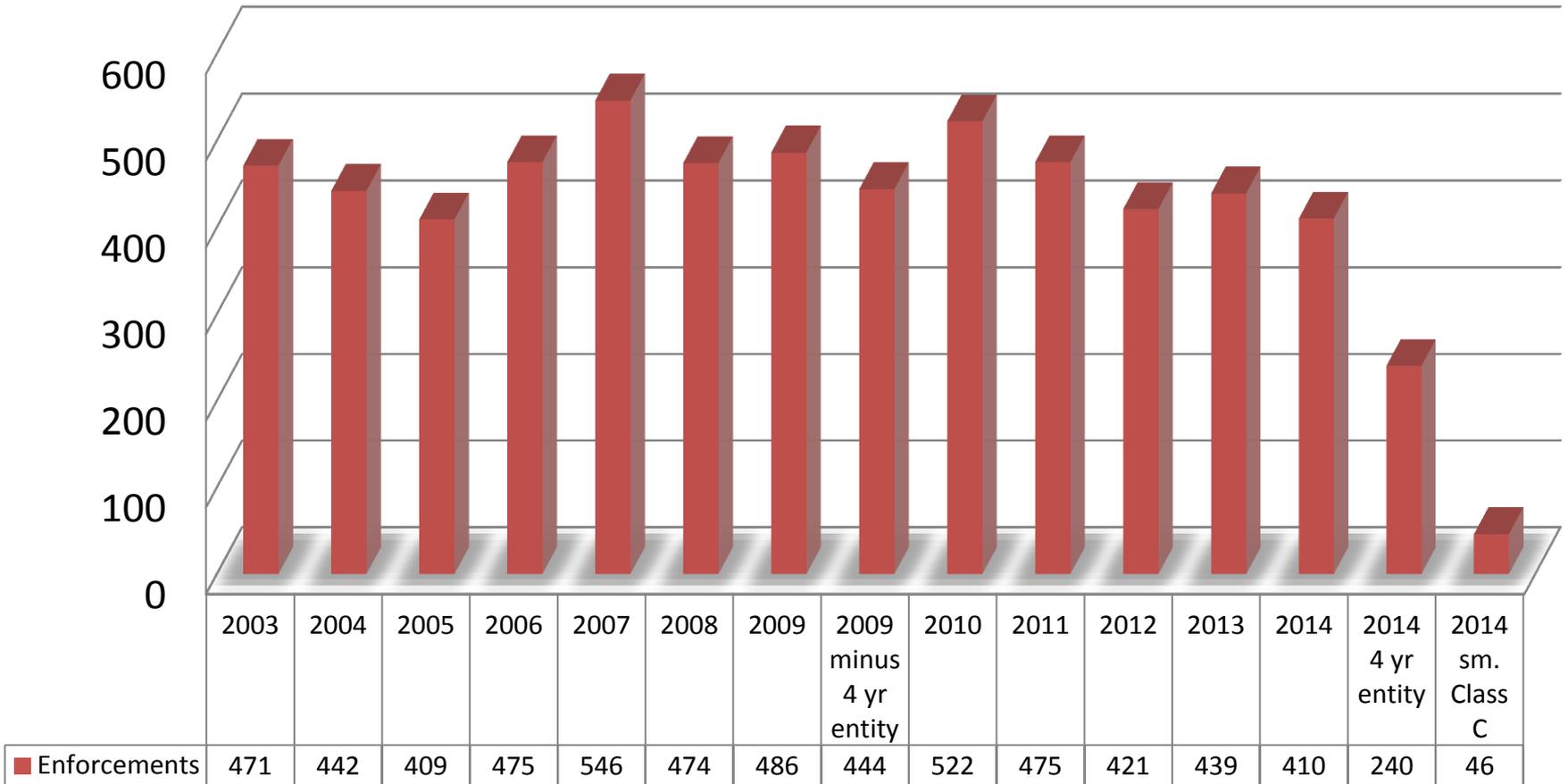
12/18/07

Centers for Medicare & Medicaid Services - Promising Practices Project

<https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/SurveyCertPromPractProj/downloads/CreativeEnforcementIssueBrief.pdf>

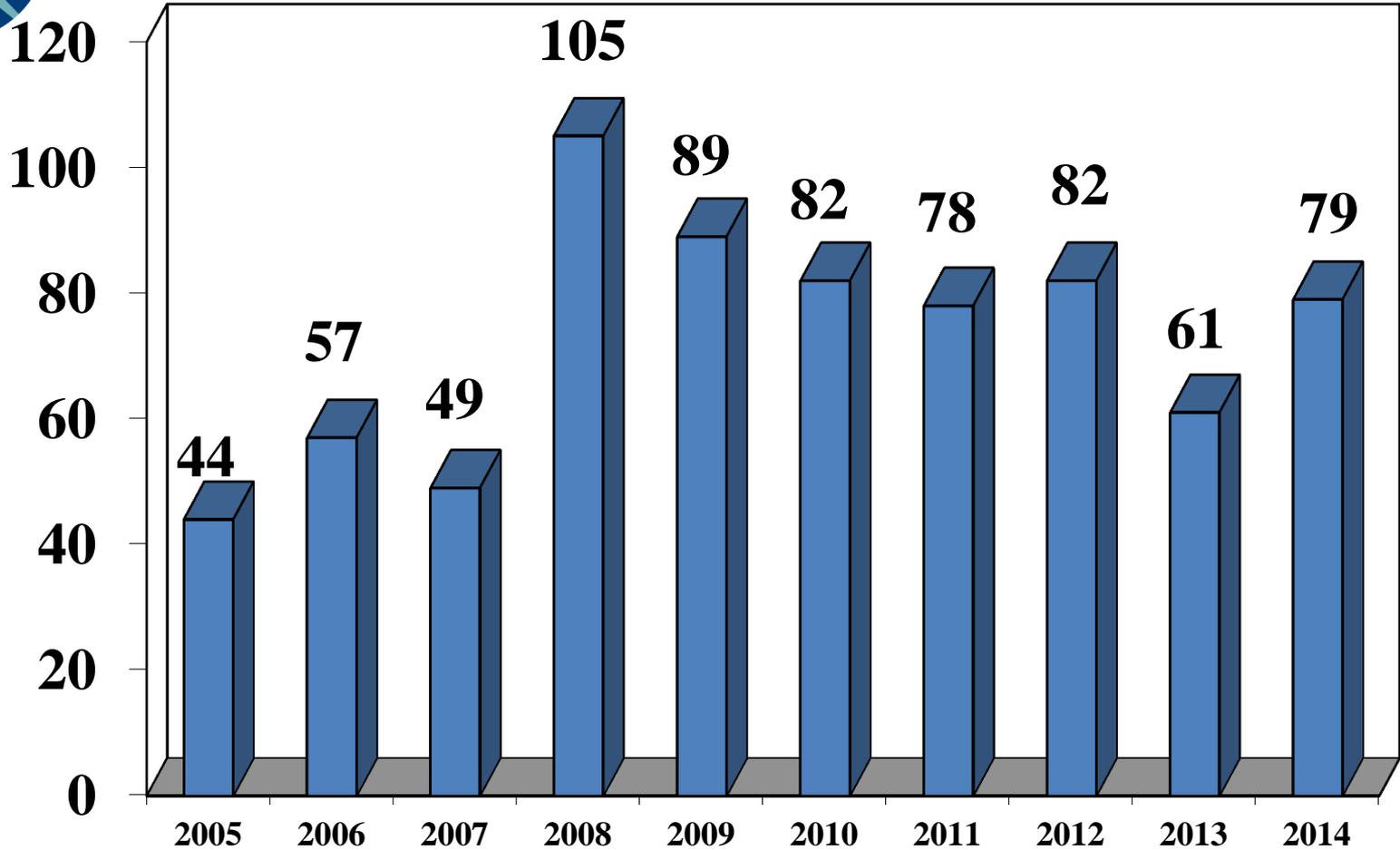


AL Surveys with Enforcement



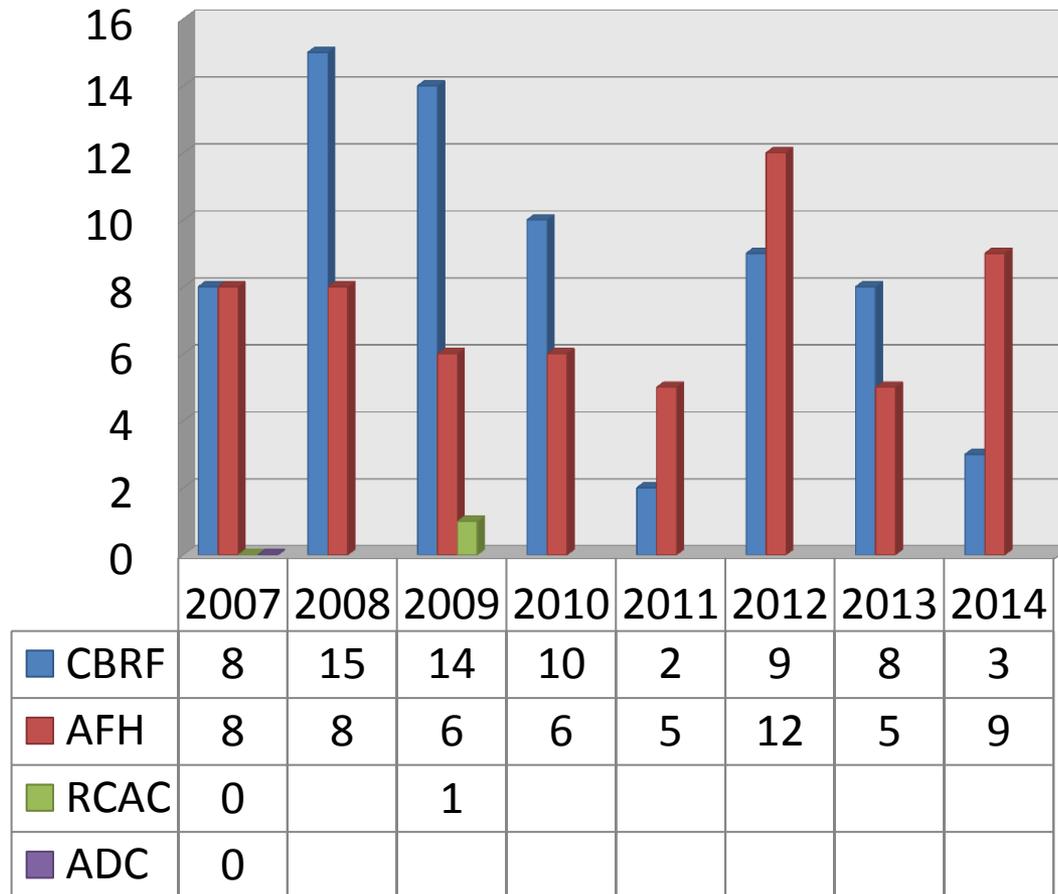


Assisted Living No New Admission Orders



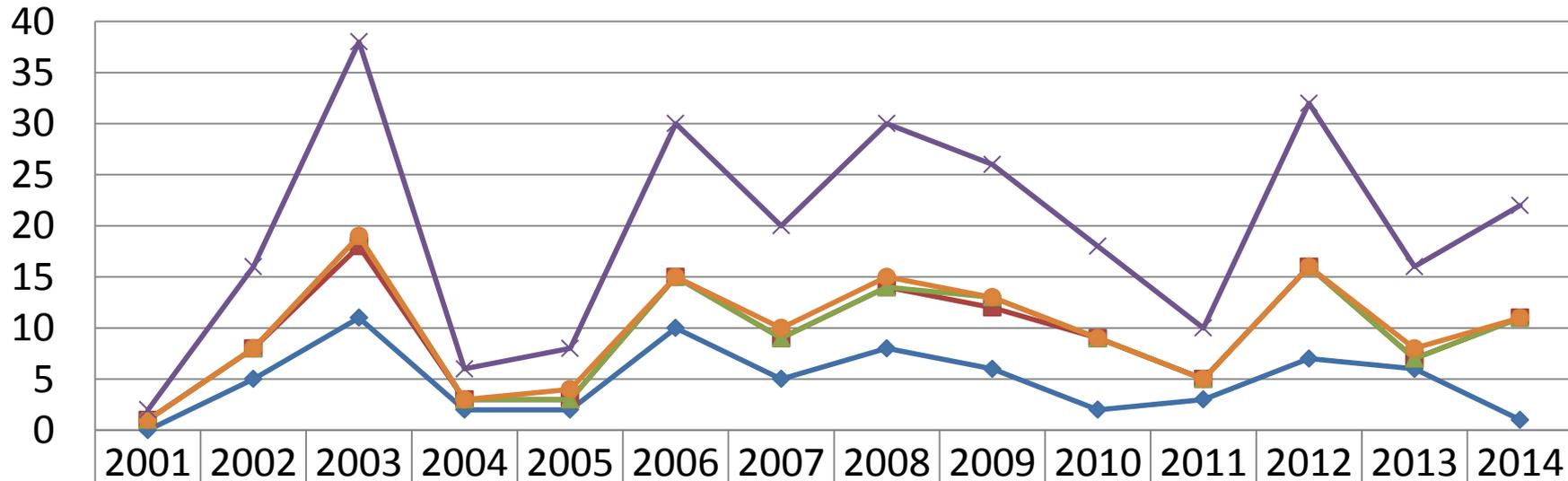


Impending Revocations





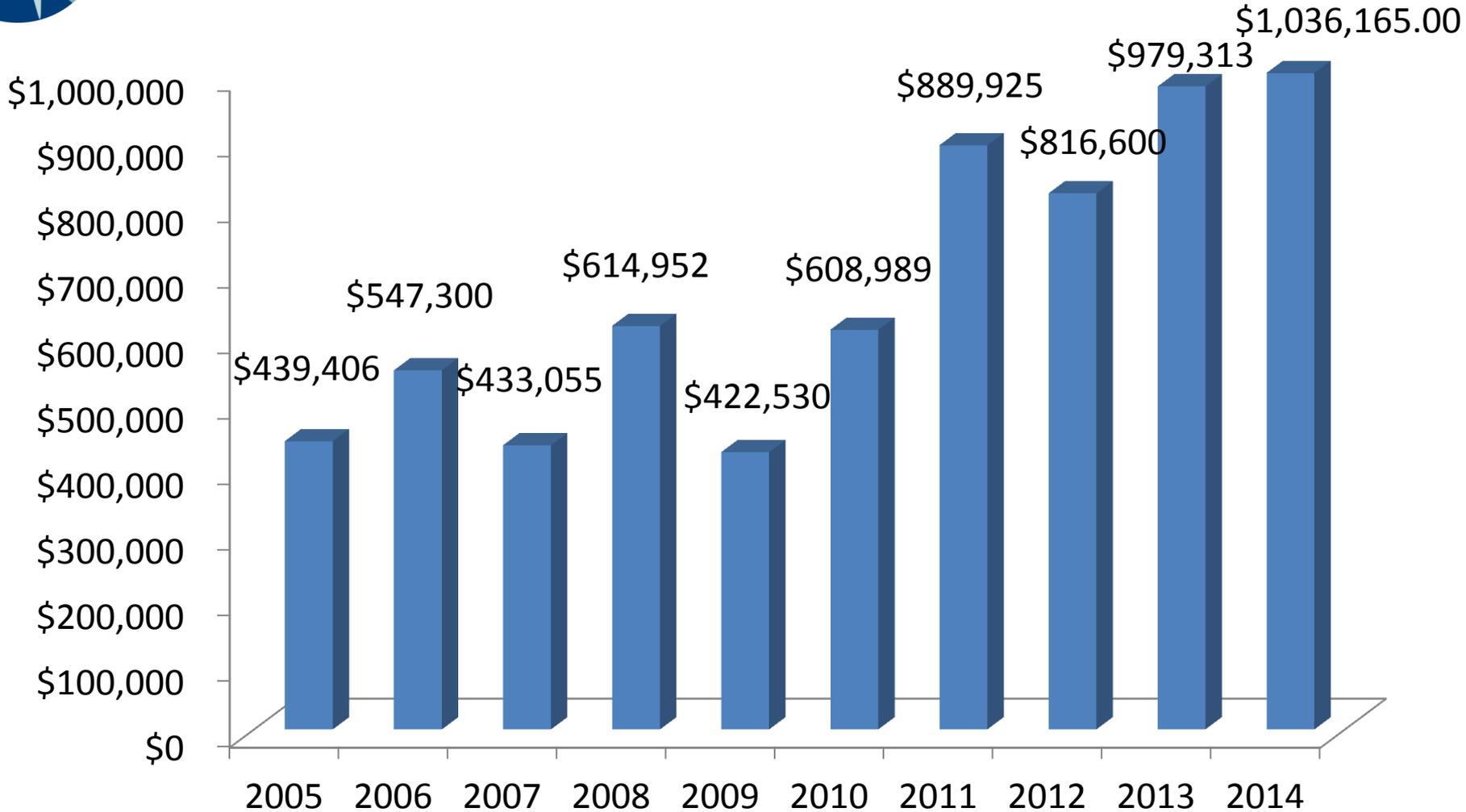
Revocations by Community Type – Historical



	2001	2002	2003	2004	2005	2006	2007	2008	2009	2010	2011	2012	2013	2014
✕ Total	1	8	19	3	4	15	10	15	13	9	5	16	8	11
● ADC					1		1	1					1	
▲ RCAC			1						1					
■ AFH	1	3	7	1	1	5	4	6	6	7	2	9	1	10
◆ CBRF		5	11	2	2	10	5	8	6	2	3	7	6	1

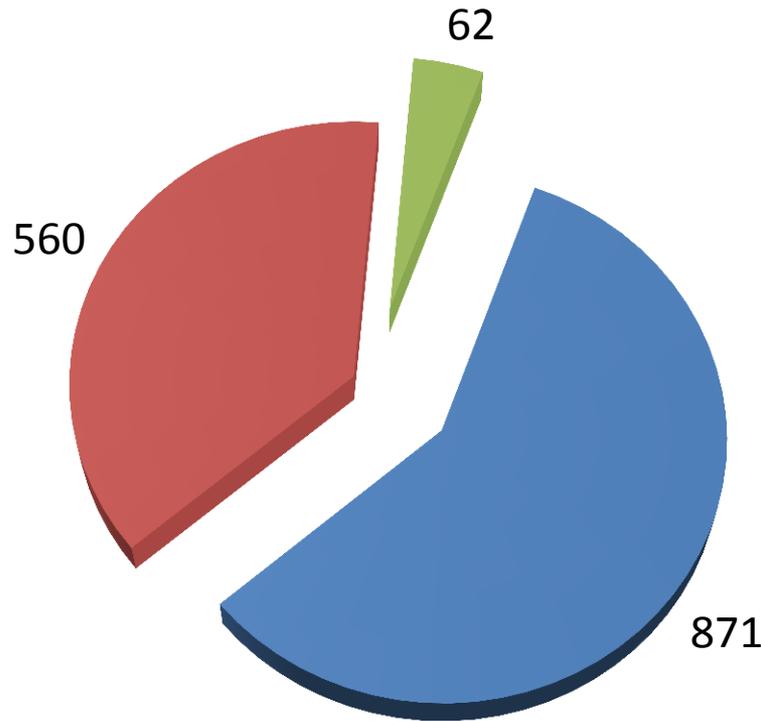


Forfeiture Assessments





Sanctions Imposed (1,493) CY 2014



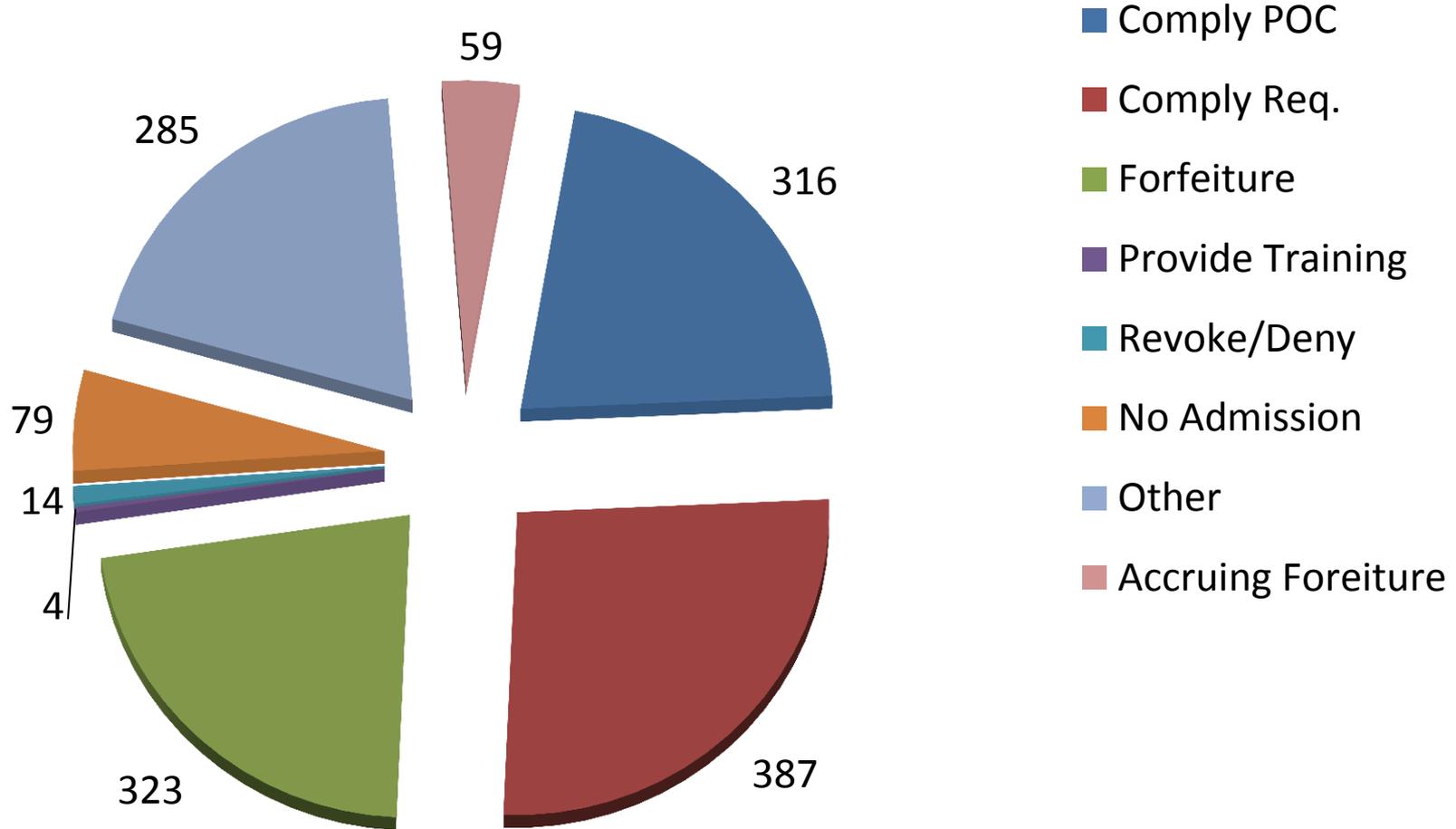
 CBRF

 AFH

 RCAC

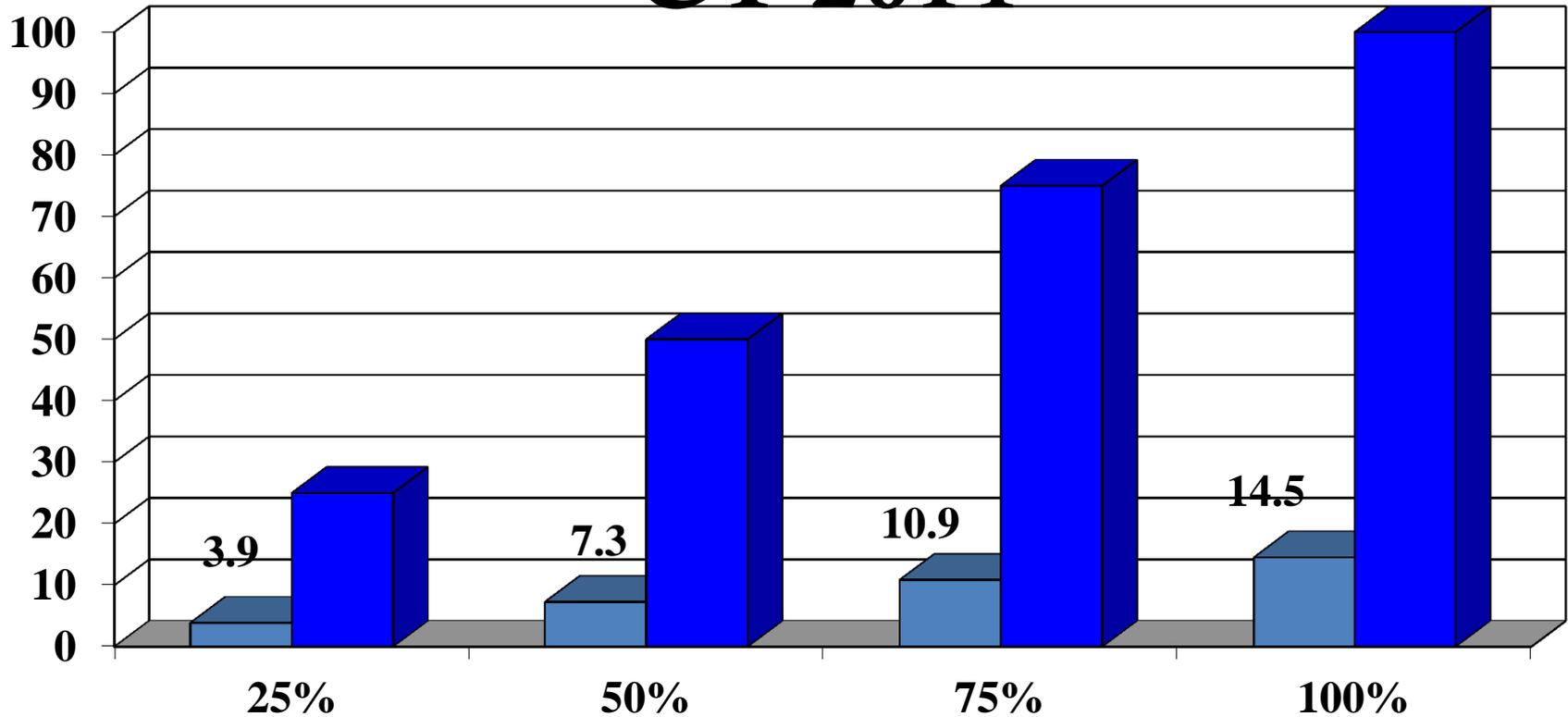


Type of Sanctions per survey CY 2014





Percent of Facilities Making Up a Percentage of Enforcements CY 2014

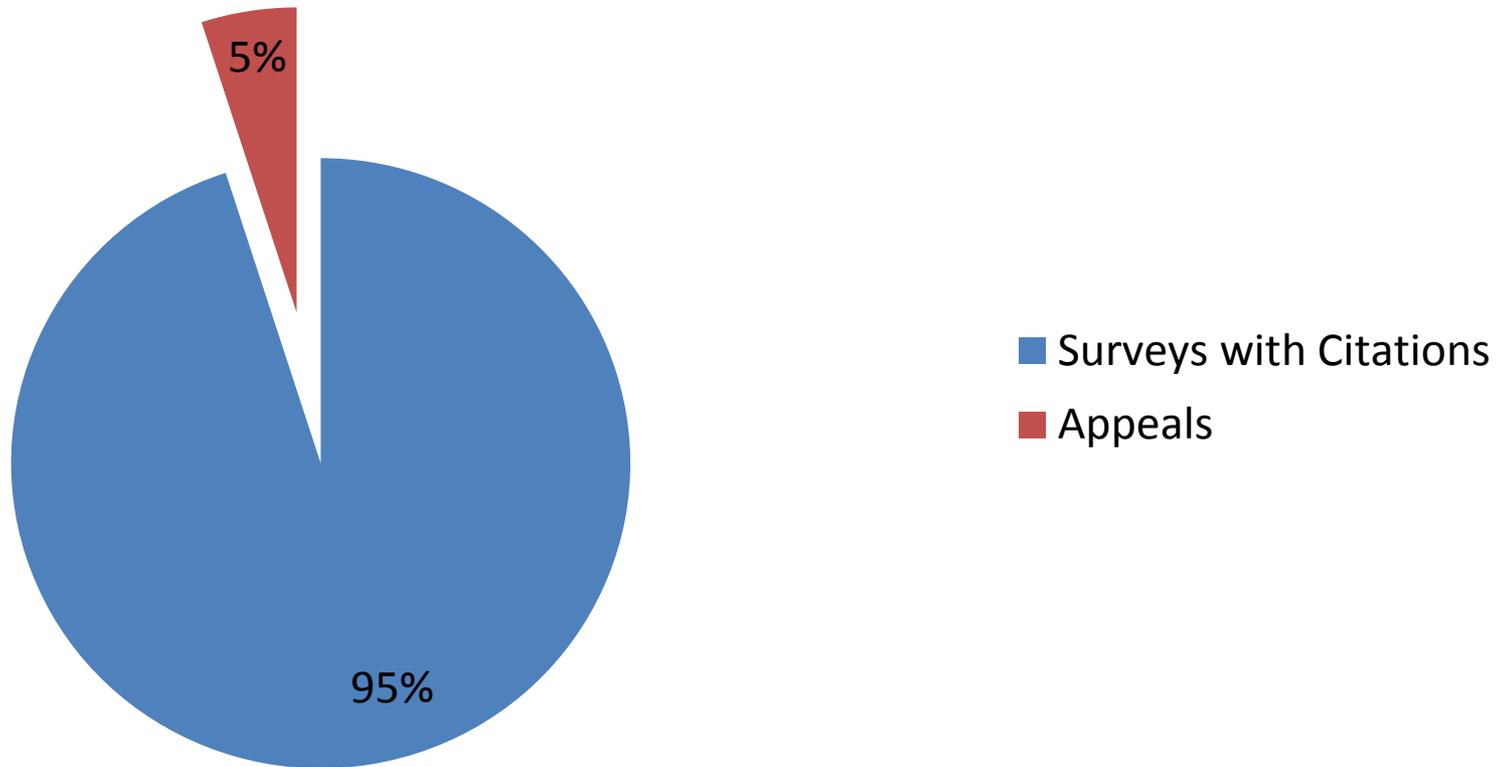


■ % of Facilities

■ % of Enforcement



Assisted Living Surveys with Citations/ Appeals

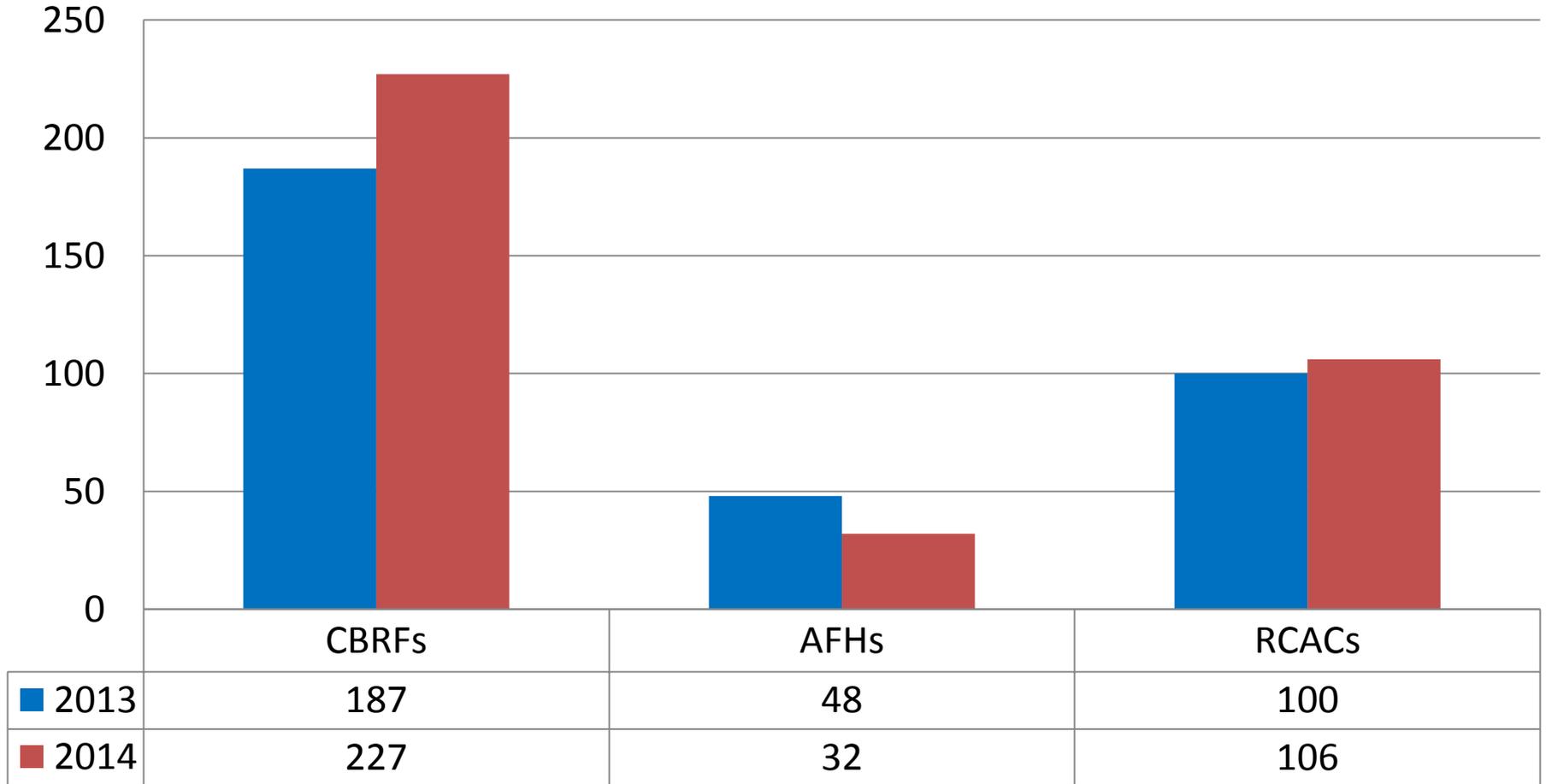




Assisted Living WCCEAL Regulatory Data CY 2014

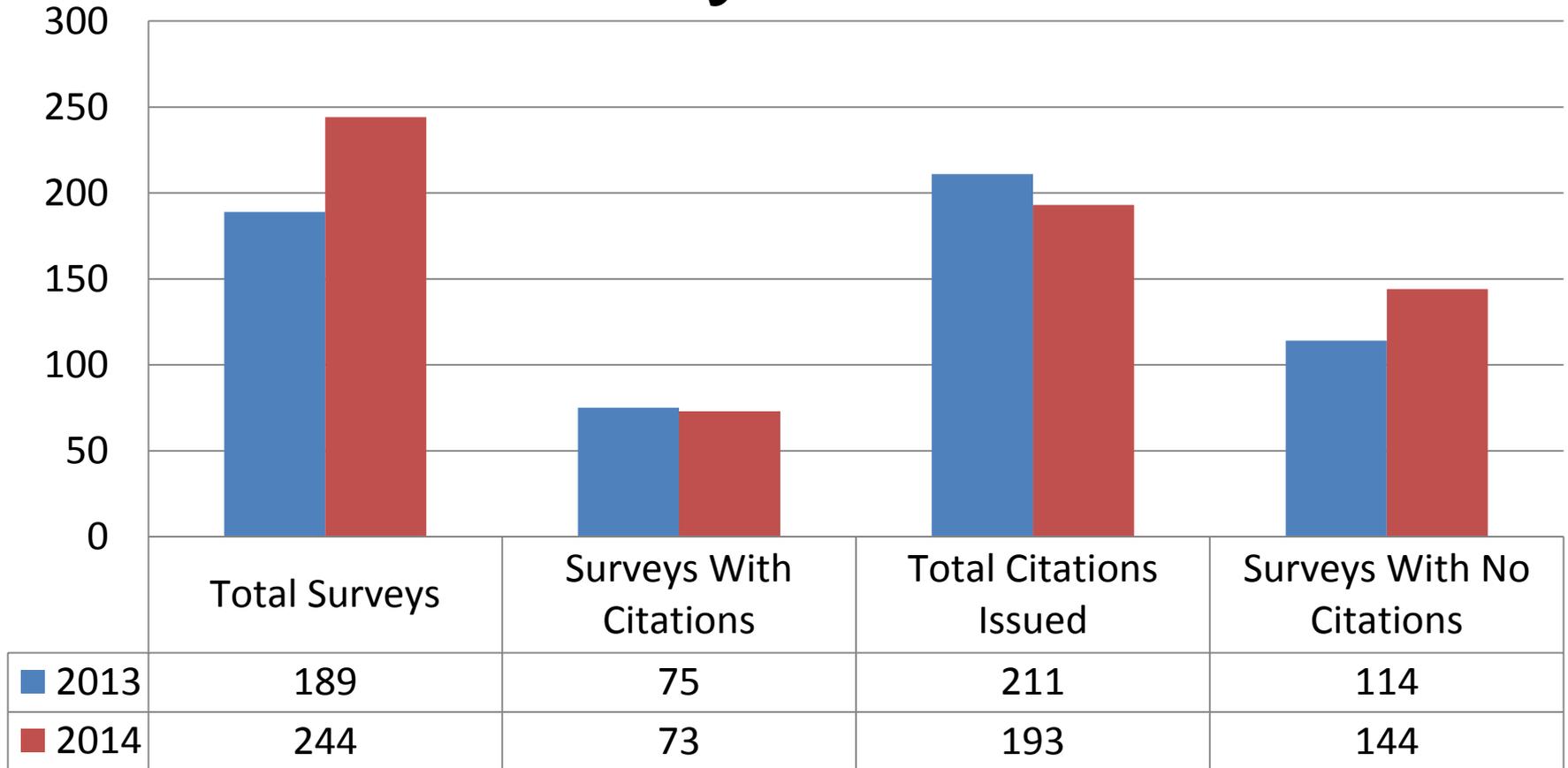


WCCEAL Regulated Communities



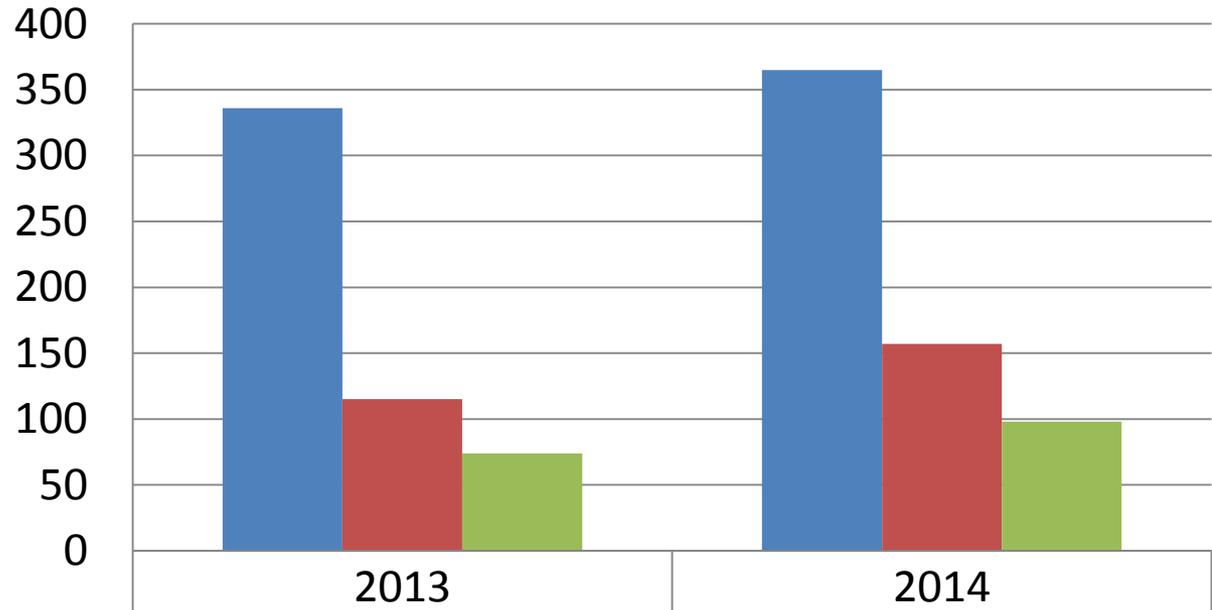


WCCEAL Communities Surveys Conducted





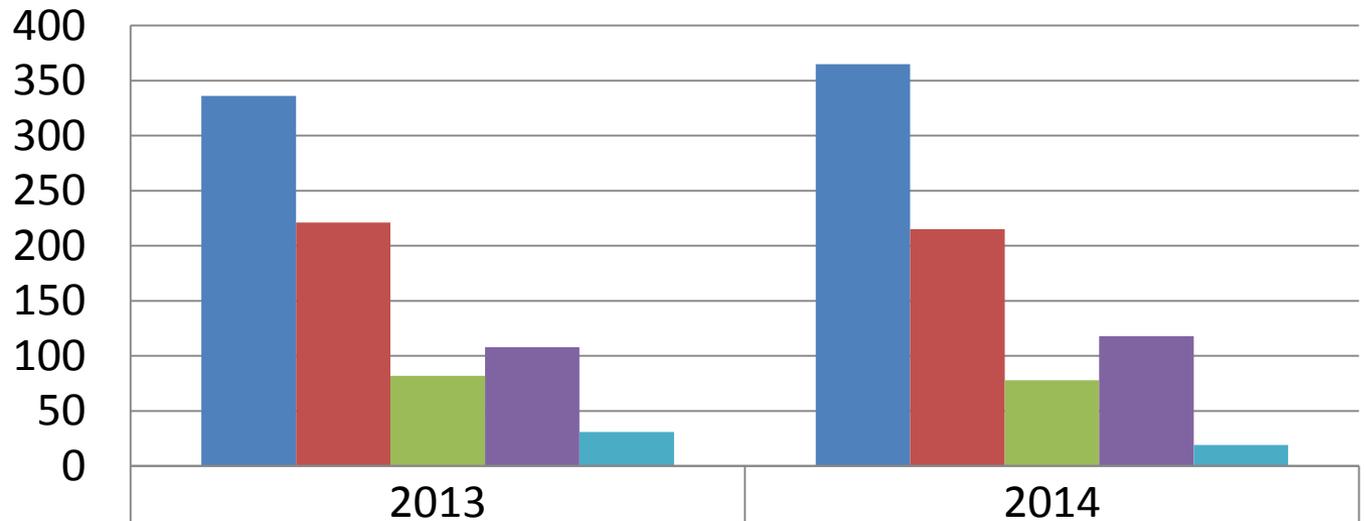
WCCEAL Members Complaints



■ Total Facilities	336	365
■ Total Complaints	115	157
■ Facilities With Complaints	74	98



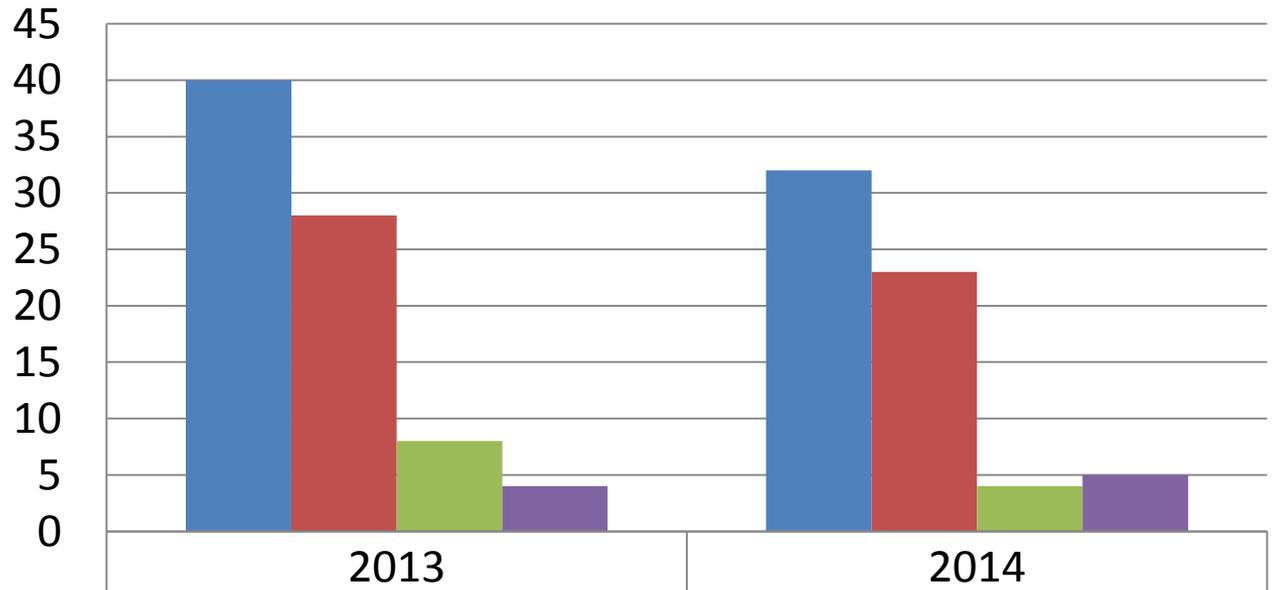
WCCEAL Regulated Communities Qualifying for Abbreviated Surveys



■ Total Number of Facilities	336	365
■ Qualifying Facilities	221	215
■ RCAC	82	78
■ CBRF	108	118
■ AFH	31	19



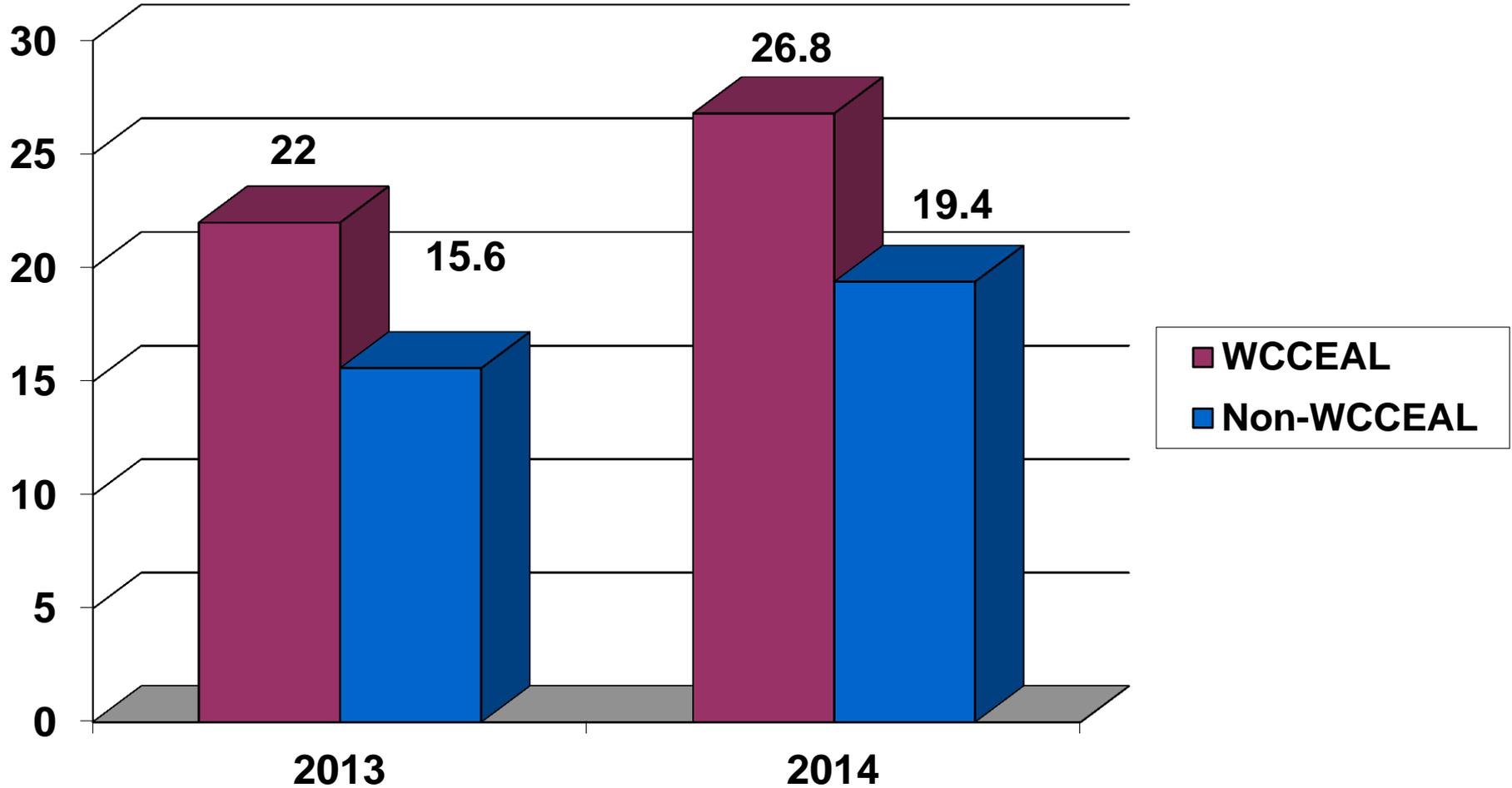
WCCEAL Regulated Communities Abbreviated Survey Results



■ Total Abbreviated Surveys	40	32
■ Surveys with no citations	28	23
■ Surveys with citations only	8	4
■ Enforcement Action	4	5

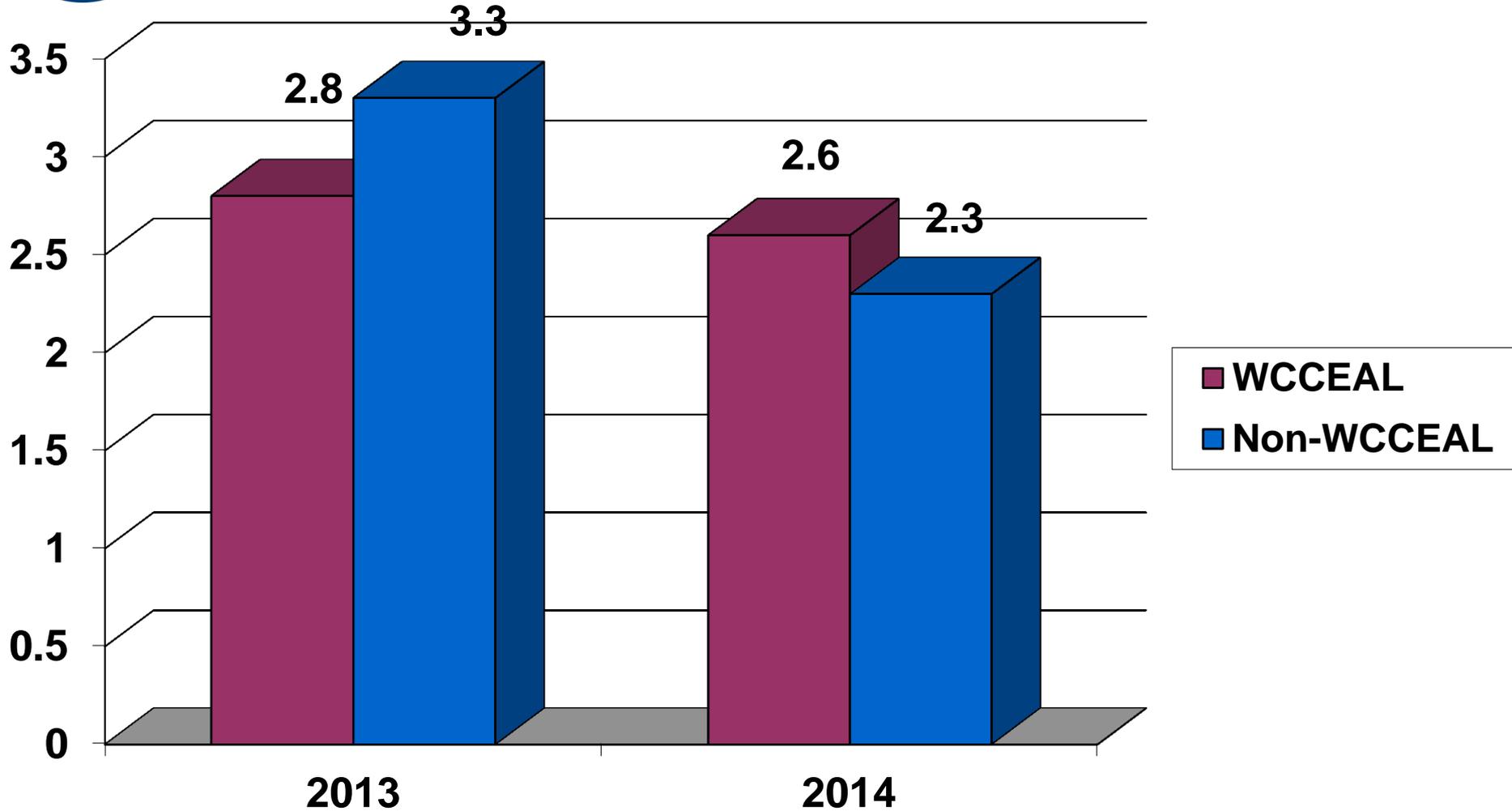


Percent of Facilities Making up a Percent of Complaints





Average Citation Per Survey





Bureau of Assisted Living Strategies



2014 BAL Initiatives (Past)

- RESOLVE Forums
- LEAN Application Project
- Assisted Living Summit
- Transitions in Care (Assisted Living Transitions Coalition)
- Intellectual Disability training



2014 BAL Initiatives (Past)

- Individual Service Plan/ Assessment training
- Continued Implementation of WCCEAL
- Resident Centered Care Workshops
- Bureau of Assisted Living Publications
 - [Strategies to Enhance Resident Care.](#)



Provider Search Application

Division of Quality Assurance Provider Search

Enter at least county, or ZIP code to perform a search:

- To search by provider name, enter at least the first 4 letters of name **and** a county (you may also select a city) and/or ZIP code.
- To search by provider location, select county (you may also select a city) and/or ZIP code.
- To search by proximity, enter ZIP code and then select a distance.

Search Criteria

Provider Name

County (Select [County Map](#) to view a Wisconsin county map)

City Please select county to get list of cities. (Select [City/County List](#) to view list of city names and counties)

State WI

ZIP Code Distance

Number of Records to Display 50

Sort Order Provider Type

Include Closed Facilities



Resident Centered Care: Back to the Basics



WI State Bureau of Assisted Living and Wipfli LLP

WIPFLI^{LLP}
CPAs and Consultants



ISP Train the Trainer

ISP Train-the-Trainer

Individual Service Plan (ISP): Only as Good as its Assessment

This two day train-the-trainer course is offered in collaboration with DHS, Bureau of Assisted Living to develop high quality, functional Individual Service Plans utilizing practical learning strategies and innovative approaches.

Participants will be able to:

- Train staff and other adult learners to create assessments and individual service plans utilizing practical strategies
- Identify multiple factors that influence a proper assessment
- Describe the documentation necessary for a compliant ISP
- Identify specific questions to ask while gathering assessment and ISP information
- Apply practical strategies and innovative approaches to complete a compliant resident assessment/ISP

UW-Green Bay Trainer: Kathy Kilka



Kathy has over thirty years of training experience in the development and operations of community-based services for individuals with intellectual/developmental disabilities, brain injuries, mental illness, advanced age, and physical disabilities.



SAVE THE DATES

April 16-17, 2015 - Milwaukee

June 25-26, 2015 - Wausau

Sept. 10-11, 2015 - Green Bay

• 8:00am - 4:00pm

• Fee: \$499

• 2 day training includes registration, training materials, resource manuals, lunch and snack

Audience: Administrators, caregivers, trainers, and health care facility consultants from assisted living facilities, licensed and certified adult family homes, adult day cares, community based residential facilities, residential care apartment complexes, Medicaid personal care agencies and supportive home care agencies.

For more information or to register online visit:

www.uwgb.edu/outreach/profed



UNIVERSITY of WISCONSIN
GREEN BAY
360° OF LEARNING

Offered in collaboration with the University of Wisconsin-Green Bay, Wisconsin Department of Health Services, Bureau of Assisted Living, Division of Quality Assurance and the Wisconsin Caregiver Academy

Wisconsin Department
of Health Services





Strategies to Enhance Resident Care

Strategies to Enhance Resident Care

In recent years the Bureau of Assisted Living developed recommended practices and strategies to help providers avoid being issued any of the "Top 10" citations most frequently issued to adult family homes, community-based residential facilities, and residential care apartment complexes.

In continued efforts towards promoting regulatory compliance in Wisconsin Assisted Living Facilities; the Bureau of Assisted Living has developed strategies designed to help providers avoid the types of serious violations that generally result in enforcement action. Serious violations are deficiencies that have or may adversely affect the health, safety, or welfare of residents.

During the calendar year 2013, 21% of surveys resulted in deficiencies with enforcement; and 9.3% of regulated entities were responsible for 100% of the sanctions issued.

Violations subject to enforcement include those that:

- **create a condition or occurrence that presents a substantial probability that death or serious mental or physical harm to a resident will result (or did occur); or**
- **create a condition or occurrence that presents a direct threat to the health, safety or welfare of a resident.**
- **indicate a breakdown in facility systems that could contribute to serious harm or adverse consequences for residents, or creates a direct threat to the health, safety or welfare of a resident or residents.**

Failure to provide services that contribute to actual or potential negative resident outcome (harm) often stems from a lack of assessment and planning. Ensuring comprehensive pre-admission and ongoing assessments and developing individualized service plans can be an effective means for avoiding serious negative outcomes for residents of assisted living facilities.

The chart below shows citations frequently issued in 2013.

CBRF Top-Ten Citations		AFH Top-Ten Citations		RCAC Top-Ten Citations	
83.35(3)(d)	Service plans updated annually or on changes	88.10(3)(l)	Safe Physical Environment	13.05(3)(a)	Entity Allegation Reporting
83.14(2)(a)	Licensee Ensures Facility Complies with Laws	88.05(3)(a)	Home Environment	89.23(4)(d)1	Services-Staff Training in safety procedures
83.32(3)(h)	Rights of	88.05(4)(d)2.b	Fire Evacuation	89.26(4)	Annual Review

Risk Agreement-requirement	head laceration resident died due to	determine if of the "who,	ed on the information to be implemented if	information plemented if
Risk Agreement - Updating			er are reviewed All individual resident's care team ctive, the behavior nd/or DHS Oversight plan would include:	viewed dual care team e behavior IS Oversight ld include:
Admission & retention of Tenants	ing in injury. A blems, muscle w blood tal/situational cured rugs); and poor eyesight o go to the	too loose ng up the pants	scheduled activities in	d activities in
Services-Nursing Services			behaviors. as time of day, eds, interaction with	s. of day, action with
Services-Appropriate to needs, abilities and Preferences	ision to the increase the risk	s and erventions to	pecific approaches to supervision of e for the care needs	pproaches to sion of e care needs
Services-Provider Qualifications	conditions a; lower body rior issues; of falls.	the falls and s residents ffing patterns,	s prescribed as part of s current f a resident's behavior	bed as part of ent's behavior
Services- Nurse Qualifications	on or adaptive approaches that	ds for each	ted according to e part of the resident's	rding to the resident's
	ropriate al at risk for falls.		ministering the ative effects of the (j).	ng the cts of the
	roper installation, a and mental d becoming due to covers were Valet.	o respond if a check to be what needs to be	as required by	red by
	ith 12 falls, s or incorporate	s, supervision,	idents are in place to are unsafe, he procedures should orkers and guardians,	re in place to fe, edures should nd guardians,



Transitions in Care Coalition

Transitional Care Acute Care and Assisted Living Coalition

Maria Brenny-Fitzpatrick MSN, FNP-C, GNP-BC

Program Director Transitions of Care
University of Wisconsin Hospitals and Clinics





Intellectual Disability Train the Trainer

This one-day train-the-trainer workshop is designed for staff, trainers, and healthcare facility consultants from assisted living facilities, licensed and certified adult family homes, adult day care, community based residential facilities, residential care apartment complexes, Medicaid personal care agencies and supportive home care agencies.

Port Washington
Friday, October 10, 2014
9:00 am to 4:00 pm
 Registration 8:30 am to 9:00 am
Lake View Conference Center
 350 East Severn Hill Road,
 Port Washington, WI

Wausau
Friday, May 1, 2015
9:00 am to 4:00 pm
 Registration 8:30 am to 9:00 am
Field Inn and Suites
 7100 Stone Ridge Drive,
 Wausau, WI

Train-the-Trainer Workshop
Fee: \$299
 Includes registration, continental breakfast, lunch, manuals, DVD and CE certificate.

Continuing Education:
 This workshop is approved by the Wisconsin Department of Health Services Bureau of Assisted Living (BAL) for 6 hours of continuing education.

Contact Information:
 (920) 465-2642
 Margie Reichwald
 mreichw@uwgb.edu
 Joy Busch
 jbusch@uwgb.edu

Register Online:
www.uwgb.edu/outreach/wicare

INTELLECTUAL DISABILITY
 Understanding Changes as We Age

Offered in collaboration with the University of Wisconsin-Green Bay, Wisconsin Department of Health Services Bureau of Assisted Living (BAL) and Wisconsin Caregiver Academy.

As people with an intellectual disability live longer, administrators and staff in assisted living environments will be encountering new caregiving challenges. In these environments, questions arise about needed resources and the role of caregiving personnel in helping support individuals as they age. Research indicates individuals with disabilities suffer more undiagnosed and untreated health conditions than the rest of the population. While there are many reasons for this, personnel in group homes, assisted living facilities and adult family homes are in an ideal position to recognize and assess the symptoms of illness and to be effective advocates for the individuals they care for.

Learning objectives:
 This workshop seeks to assist and develop participants in the following areas:

- Understand physical and cognitive changes that are considered normal aging.
- Recognize when a change may not be related to normal aging and needs professional attention from a health care provider.
- Distinguish dementia from a spectrum of behavioral cues and identify ways to support persons with dementia in daily living.
- Effectively document health information for health care providers to improve diagnosis accuracy and/or treatment.
- Know how to support residents through illness and hospitalizations and advocate for the care they need.
- Identify resources to help individuals to receive the health care they need to age in place.

PRESENTERS

Barbara Bowers, PhD, RN, is a professor at the University of Wisconsin-Madison, School of Nursing. She is an educator, researcher and policy consultant on the care of older adults, particularly in long-term care settings. The past ten years her work has focused primarily on aging individuals with intellectual disabilities and support staff. Dr. Bowers co-authored the Australian and United States versions of *Support for Older People with Intellectual Disability: A Manual for Promoting Health*. She has published over a hundred articles related to aging.

Kim Nokes, MS, is a long-term care researcher at the University of Wisconsin-Madison School of Nursing. Ms. Nokes has helped design educational offerings related to the care of older adults including workshops, manuals and online courses for direct caregivers, organizational leaders and the long-term care workforce. Most recently Kim co-authored the Australian and United States versions of *Support for Older People with Intellectual Disability: A Manual for Promoting Health*, with a particular goal of creating practical tools for caregivers.

Find more programs designed to meet your continuing education requirements on our website:
www.uwgb.edu/outreach/wicare



WI Coalition for Collaborative Excellence in Assisted Living

- Provider Association Sponsored
- Department Approved
- Comprehensive QA & QI



Internal Quality Assurance

- Essential to maintain quality!
- Structure, process and outcome measures used to evaluate quality





What does DHS expect if there are issues identified with individual AL communities ...

- The AL community will develop mechanisms to improve quality;
- CHSRA will assist the associations to identify issues from the reports and propose strategies to improve;
- The AL community's associations will provide assistance and support to improve; and
- The AL community's association will hold the community responsible for implementing their QI/QA program.



2015 BAL Initiatives (Future)

- Completion of LEAN Application Project
- E-Licensure/E-payment
- RESOLVE Forums
- Individual Service Plan Train-the-Trainer
- Explore Licensing Application Workshops
- Reducing Falls project



2015 BAL Initiatives (Future)

- Assisted Living Self-reports Project
- Increase electronic delivery of Statement of Deficiencies
- Assisted Living Forum
- Increase awareness of evidence-based practices
- Evaluate the Assisted Living Survey Process
- Develop a pilot of the INTERACT tools
- HCBS Implementation



INTERACT



Interventions to Reduce Acute Care Transfers

[Home](#) ♦ [About INTERACT](#) ♦ [INTERACT Tools](#) ♦ [Educational Resources](#) ♦ [Links to Other Resources](#) ♦ [Project Team](#) ♦ [Contact Us](#)

Assisted Living Tools **New!**

Overview of the INTERACT Quality Improvement Program for Assisted Living

-  [INTERACT Assisted Living Version 1.0 Tools Table](#)
-  [Using the INTERACT Assisted Living Version 1.0 Tools In Every Day Care - Overview Figure](#)
-  [Assisted Living V 1.0 Tool Implementation Guide 2014](#)

Quality Improvement Tools for Assisted Living



BAL Initiatives: Individual AL Community

- Conduct thorough onsite surveys and provide results in a timely manner.
- Provide technical assistance as needed.
- Encourage development of internal QI program.
- Share evidence-based practices.
- Promote individual meetings with AL Community to engage in dialogue about compliance issues and AL communities plans to achieve substantial compliance.



BAL Initiatives: Consumer Access to Regulatory Information

- Develop BAL manual that includes all relevant regulatory information in provider-specific documents
- Ensure all relevant information is included on the provider search application





BAL Initiatives: Assisted Living Stakeholders

- Engage assisted living stakeholders to support quality improvement activities in AL communities.
- Identify, plan and implement in-person or web based trainings to address compliance issues.
- Encourage the recognition and implementation of evidence-based practices.





Evidence-Based Practices

- Encourage utilization of current evidence-based practices.
- Develop facility policy and procedures, based off of current evidence-based practices.
- Staff training on policies and procedures.



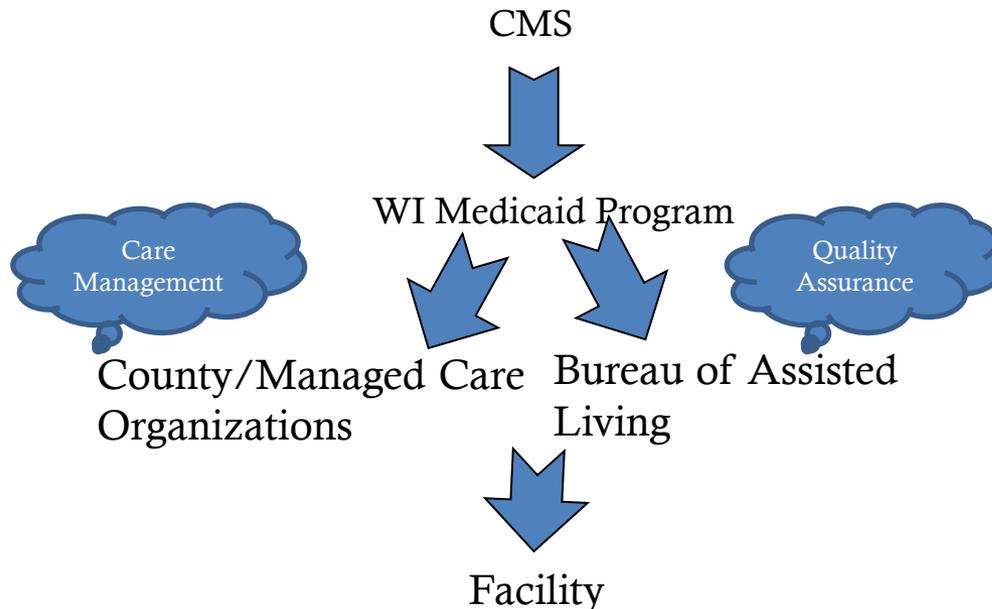
Bridging the two models of care





Home Community Based Services Waiver

- **Public funding agencies should use the work of the regulatory agency as part of their quality assurance program**



Shared Goal:
Improve Personal
Health and the Health
Care Delivery system



Regulatory Stories





Regulatory Stories

A licensee failed to provide proper care and treatment for a resident with intellectual disabilities. The licensee would not allow the resident to dress him/herself as “it was quicker to just do it.” The surveyor observed the licensee “abruptly” thrust a tooth brush into the resident’s mouth without forewarning or explanation. The resident’s head “jerked back” and the resident repeatedly verbalized wanting the licensee to “stop.” The licensee responded by asking if the resident wanted his/her teeth “pulled out instead.” The licensee acknowledged pressing a “cold gallon of milk” on the resident’s stomach, putting “ice” down the resident’s shirt, and pulling the back of the resident’s shirt over the top of his/her head to purportedly “redirect” behaviors and “improve mood.” The licensee also stated that the residents “are really just kids in adult bodies and they need to be treated like children.”



Regulatory Stories

A facility did not provide needed care and services for a resident with complex medical needs including multiple pressure sores and weight loss. Pressure relieving devices were not provided as prescribed by the physician. Weight loss was not monitored because the facility “did not have the proper scale to weigh a resident who was unable to stand and bear weight.” The facility continued to send the resident to a day program despite his/her markedly frail condition. Hospital records indicated the resident was “severely malnourished” with 14 pressure sores, including one wound that was described as a “Stage 4 pressure ulcer with bone exposed, with no viable tissue noted...and odor... In the patient’s current state, there is little hope that s/he will heal any wounds.” The resident was discharged with hospice services.



Regulatory Stories

A facility maintenance worker was observed “hugging and kissing a resident.” During a second incident, witnesses reported the worker was in the bathroom with the resident and the door was closed. A caregiver knocked on the door and waited for “a minute to a minute and a half.” When the door opened, the worker came out quickly and went down the hall. Upon entering the bathroom, the caregiver observed the resident with “pants unbuttoned, pants and undergarment rolled together and a portion of the resident’s upper buttocks showing.” The employee was permitted to continue working, without monitoring, for 26 more days.



Regulatory Stories

A resident had a witnessed fall resulting in bruising and worsening pain. The facility did not seek prompt medical care until 2 days later when a family member insisted on medical care. The resident was admitted to the hospital with 4 fractured ribs and returned to the facility with Hospice care. The resident died the same month.



Regulatory Stories

Over a 6-month period, the facility failed to protect residents from abuse. A resident with known behavioral problems, including aggressive outbursts, yelled at, bullied, threatened, kicked, threw objects at, and hit other residents.



Regulatory Stories

Inexperienced caregivers had been assigned to transfer a resident with MS (Multiple Sclerosis) from the bed to a wheelchair with a Hoyer lift. The resident was not properly positioned and the resident's leg became entangled between the bed and wheelchair. Once in the wheelchair, the caregiver pulled on the Hoyer sling for repositioning and a "loud pop" was heard. The resident had sudden, severe leg pain and was admitted to the hospital with a fractured femur.



Regulatory Stories

A resident, hospitalized 7 times in a 2-month period, did not receive adequate treatment for multiple falls with injuries, including head lacerations requiring staples, a neck fracture, and significant urinary tract infections requiring hospitalizations due to sepsis (a severe infection that has spread via the blood stream). Caregivers did not consistently apply a neck brace or adjust the brace to prevent open areas from developing, did not ensure that chair/bed alarms were applied and functioning, and did not provide needed incontinence care to prevent skin breakdown and urinary tract infections



Regulatory Stories

Caregivers neglected to intervene promptly when a resident with dementia fell. Instead, caregivers informed oncoming staff during a verbal shift report that the resident had fallen and was lying on a bedside mat. The resident was found non-responsive, with a cut to the head. When rescue personnel arrived, it appeared that the resident had been left on the floor mat, “unchanged” and “smelling of urine” for an unknown length of time. The resident sustained a laceration on the right forearm that extended about $\frac{1}{2}$ of the forearm and a skin abrasion above the left eye.



Regulatory Stories

Over a 3-month period, staff did not administer pain patches, anxiety medications, and other prescribed medications for a resident with diagnoses of chronic pain and anxiety

Bureau of Assisted Living Vision

Promotes public health and safety

Fosters quality of life

Promotes provider responsibility

Promotes regulatory agency responsibility

Fosters collaboration

Supports consumer awareness, responsibility
and satisfaction

Promotes consumer independence and choice

Protects vulnerable adults



Wisconsin Bureau of Assisted Living

**DQA - Working to Protect - Promote - Provide Quality in Wisconsin's
Health Care Facilities**

**Alfred C. Johnson, Director
Bureau of Assisted Living
Phone: 608-266-8598
Email: alfred.johnson@wi.gov**