Lifespark™

Age Magnificently

Memory Care Guide

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Enriching Connections: Critical Elements

Enriching Connections is the initiative that displays our company's dedication to providing person-centered care for our residents with dementia. This multidimensional framework involves our mission, and core values as well as evidence-based structural elements, operational practices and personalized approaches.

Lifespark's Foundation within the Structural Elements:

1. **Relationships & Community:** Each and every individual is made to feel as if they belong; we stress "community" versus just a place to live or work.
2. **Governance:** Commitment and active involvement from company leaders have been the driving force for establishing and sustaining the operational culture of person-centered care.
3. **Leadership:** We provide specialized training for our leaders which ensures they are knowledgeable within dementia care and are able to support key practice and promote staff empowerment
4. **Care Partners/Workforce:** Not only are all staff who work in our Memory Care Units certified in dementia care, they are also asked to complete additional research based training. This special attention assures that our care staff has the proper knowledge to be successful in upholding our high standards in providing person-centered care.
5. **Services:** Various evidence based tools and techniques have been introduced and sustained that promote care based upon personal preferences, dignity and independence. Also, families are now more involved than ever in creating care plans for their loved ones.
6. **Meaningful Life & Engagement:** Our Inspire Wellness Program is the root system that ensues quality of life for our residents and staff
7. **Environment:** Architectural, supplies and equipment improvements have been made and will continue to be made so each and every community maintains a dementia-friendly environment
8. **Accountability:** When striving for such high standards within our care, it is important to evaluate all aspects of the initiative. We continuously monitor operations, processes and even culture via staff/family/resident surveys as well as internal and external data collection.

Leadership Engagement

- » QAPI
- » Customer Service Rounds
- » Dining Experience
- » Dementia Training Plan
- » Dementia Experience
- » Care Conferences

Resident Engagement

- » Memory Care Wellness Calendar
- » Ability Level Engagement
- » Vocational Sets/Stations
- » Customer Service Rounds
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- » Non-Pharm Interventions
- » Oshibori Program
- » Dining Experience
- » Care Conferences

Employee Engagement

- » Dementia Training Plan
- » Dementia Experience
- » Customer Service Rounds
- » NAR & HHA Care Plans
- » Brief/Handoff Sheet
- » 24 Hour Report
- » Dining Experience
- » Memory Care Wellness Calendar
- » Ability Level Engagement

Family & Stakeholder Engagement

- » Care Conferences
- » Family Council
- » Newsletters
- » Education/Support
- » Memory Boxes
- » Volunteers
- » Ability Level Engagement
- » Memory Care Wellness Calendar
- » Care Conferences

Minnesota Clinical Assessment Guide

Pre–Admission RN	Day of Move IN RN	Due By 14 Days RN	Due Every 30 Days LPN/RN	Due Every 90 Days RN	Change In Condition/ Hospitalization RN	Discharge or Deceased
Level of Care Tool	Review/Revise Services *if needed*	Nursing Assessment	Safety Check: Bed Rail *if applicable*	Nursing Assessment	Nursing Assessment	MN Discharged or Deceased Resident Roster
BIMs	Alteration in Skin Inegrity *(if applies - to be completed weekly until resolved)*	Level of Care-Reviewed	Monthly Weight/Vitals	Level of Care	Level of Care Tool	Discharge Summary
Medication/ Treatment	Smoking Safety Screen *if applicable*	Finalize Service Agreement		Care Conference	Care Conference - sign new service agreement	
Create Resident Chart	Signed Service Agreement	MN Roster State		Smoking Safety *if applicable*	MN Current Resident Roster: state evaluation	
Consent Forms TCP, Primary Care Enrollment **Lifespark COMPLETE as appropriate**	Consent Forms TCP, Primary Care Enrollment **Lifespark COMPLETE as appropriate** *(If not obtained pre-admit)*			Physician Orders: send for signature	Smoking Safety *if applicable*	
Signed Provider Orders	Emergency Info Form					
Services in Eldermark	Insurance Info					

Other: Alteration in Skin Integrity: Complete weekly only if applicable until resolved

Paperwork, Preparing Services & Chart

Pre–Admission RN	Day of Admission	Due By 14 Days RN	Due Every 30 Days	Due Every 90 Days LPN/RN	Change In Condition/ Hospitalization RN	Discharge or Deceased
	POA Paperwork					
	POLST/ Honoring Choices					
	Services in Eldermark					
	Admission Note in Eldermark					
	Apply pendant or wanderguard as applicable					

Service Plan

To ensure that there is clear documentation of requested services, frequency of cares being provided, the type of staff providing each service, the frequency of supervision, and fees for services prior to providing cares.

Definition

A "Service Plan" means the written plan between a resident or resident's designated representative and the assisted living facility about the services that will be provided to the resident. The facility shall only accept a resident if it has staff, sufficient in qualifications, competency, and numbers, to adequately provide the services agreed to in the Service Plan with each resident and are within the scope of the Assisted Living license.

General Procedures

All services provided to residents will be delivered after an assessment by an RN is completed, an up-to date Addendum to the Contract- Service Plan is signed by an RN and the resident or the resident's designated representative.

- The assisted living provider shall finalize a written service plan within 14 days after the initiation of services to a resident.
- The service plan and any revision must include a signature or other authentication by the assisted living provider and by the resident or the resident's representative documenting agreement on the services to be provided.
- The service plan must be revised, if needed, based on the results of required resident monitoring and/or reassessments.
- The assisted living provider must implement and provide all services required by the current service plan.
- The service plan and any revised service plans must be entered into the resident's record, including notice of a change in a resident's fees.
- Staff providing services must be informed of the current written service plan.

Required Elements

A description of the services to be provided, the fees for services (including any change to the provider's fee for services), and the frequency of each service, according to the resident's current review or assessment and resident preferences.

The identification of the type of staff (RN/LPN, Therapist, Unlicensed Personnel, HHA, etc.) that will provide the services.

The schedule and methods of monitoring reviews or assessments of the resident.

The frequency of sessions of supervision of staff and type of personnel who will supervise staff.

A contingency plan that includes:

- the action to be taken by the provider and by the resident or resident's representative if the scheduled service cannot be provided.
- information and method for a resident or resident's representative to contact the home care provider.
- names and contact information of persons the resident wishes to have notified in an emergency or if there is a significant adverse change in the resident's condition, including identification of and information as to who has to sign for the client in an emergency; and
- the circumstances in which emergency medical services are not to be summoned consistent with chapters 145B and 145C, and declarations made by the client under those chapters.

Information regarding how to contact the Minnesota Office of the Ombudsman for Long-Term Care.

Date/Signature of resident or resident's representative. The signature may be obtained by mail or fax if an agreement was reached in person or by telephone.

Service Plan

Monitoring

A Registered Nurse will review and monitor all health related services provided to the resident within 14 days of admission and at least every 90 days. The Registered Nurse will complete an initial individualized assessment within 14 days after initiation of services and if there is a change in residents condition. The Registered Nurse will complete the initial medication management assessment prior to providing managing services and at least every 12 months. Assessments will be conducted in their place on residence face to face. All delegated services are supervised by the Registered Nurse within 14 days of initiation of services, and at least every 90 days by the Registered Nurse. Supervision of unlicensed personnel will be conducted by the Registered Nurse in person within 30 days of hire and as needed based on performance.

Modification of Service Plan

To ensure compliance with the Assisted Living regulations, any changes to the service plan or agreement must be in writing and must be signed by the resident or the resident's responsible person and the RN.

See Above Requirements

Date/Signature of client or the resident's representative each time a modification is made. The signature may be obtained by mail or fax if an agreement was reached in person or by telephone.

Additional Services Referral

If the facility believes a resident is in need of or could benefit from other medical or health related services, including that of a physician, osteopath, dentist, podiatrist, chiropractor, other health professional, or social service, provider will:

1. Inform the client or the resident's responsible party of the possible need;
2. Assist, as needed, to initiate services and or make resources available to the resident or their responsible party
3. Provide a list of providers, as available

Medications & Treatments

To ensure medications and treatments systems are in accordance to the Assisted Living regulations.

Assessment

Individual Medication & Treatment Management Plan

Develop and maintain a current individualized Medication and Treatment Management Plan based on resident assessment. The assessment will be conducted in person by a registered nurse face to face with the resident prior to receiving services, annually and with a change in condition.

1. The Medication and Treatment Management Plan will describe the medication or treatment service provided.
2. A description of storage of medications
3. Documentation of resident specific instructions for medications or treatments
4. Identify the person responsible for ordering supplies and assuring medications are refilled timely
5. The plan will identify which medications or treatments are delegated to unlicensed personnel
6. The plan will identify the procedure for notifying the registered nurse or other licensed staff when a problem arises
7. The plan will identify resident specific instructions for documenting medication or treatment administration verification.
8. The plan will identify which medications or treatments are delegated to unlicensed personnel
9. The Medication and Treatment Management Plan will identify measures for preventing a diversion of medications by tenants or others who have access to the medication.
10. The licensed nurse will ensure that the prescriber reviews/ renews a medication or treatment order at least every 12 months, or more frequently as needed.
11. A complete medication / treatment list will be sent for review and signature to the primary prescriber every 9 0 days
12. An evaluation of all psychoactive medications will be conducted every 90 days for residents receiving antipsychotic, antidepressant, anxiolytic and hypnotic medications.

    The evaluation will include:

    - the diagnosis or indication for administering the medication,
    - the goal of the medication,
    - evaluation of behavioral symptoms, nonpharmacological interventions that are individualized approaches to care provided as part of a supportive physical and psychosocial environment, directed toward understanding, preventing, relieving, and/or accommodating a resident's distress or loss of abilities, as well as maintaining or improving a resident's mental, physical or psychosocial wellbeing.
    - an evaluation of the drug's effectiveness and including any potential adverse (unintended) reaction to the medication.

Medication Management

Preparation:

1. Only licensed nursing or other unlicensed trained staff may padrepare, administer, or document medication administration.
2. Disposable containers/medication soufle cups will be maintained for the administration of medications. Disposable containers are never reused.
3. Prior to administration, the medication and dosage schedule on eMAR is compared with the medication label. If the label and the MAR are different or there is any other reason to question the dosage or directions, the physician's orders are checked for correct dosage schedule.
4. If breaking tablets is necessary to administer the proper dose, the provider pharmacy is requested to package half tablets.
5. If it is safe to do so, medication tablets may be crushed or capsules emptied out with a provider order.
    - » Crushed medications are to be administered individually unless a provider order states otherwise for a resident who is unable to consume numerous individual crushed doses.
    - » Each medication preparation area includes a device that is specifically used for crushing medications.
    - » If the crushing device allows for contact with the medication, it is to be properly cleaned between uses.
    - » The need for crushing medications is indicated on the resident's orders and the MAR so that all staff administering medications are aware of this need and the consulting pharmacy can advise on safety issues and alternatives.

Administration:

1. Medications are administered only by licensed nursing or other personnel trained in medication administration including competency testing and the resident's individualized medication management plan.
2. Medications are administered in accordance with written orders of the attending physician or physician extender.
3. Medications are administered at the time they are prepared.
4. The person who prepares the dose for administration is the person who administers the dose.
5. Residents are identified before medication is administered.
6. Hands are washed before and after administration of topical, ophthalmic, otic, parenteral, enteral, rectal, and vaginal medications.
7. At least 4 (four) ounces of liquid are given with oral medications unless fluid restrictions apply.
8. Medications are administered within one hour before or one hour after scheduled time.
9. Residents are allowed to self-administer medications when specifically authorized by the attending physician as long as it is safe to do so.
10. Medications supplied for one resident are never administered to another resident.
11. All medications are kept secure between medication administration passes.
12. For resident's not in their rooms or otherwise unavailable to receive medication on the pass, staff are to document reason for held medication(s).
13. For resident's who refuse medications, the licensed or ULP returns and reattempts to administer the medication after a short period of time or has an alternate provider make the attempt to administer the medication. Refusals are documented in the record.
14. The resident is always observed after administration to ensure that the dose was completely ingested. If only a partial dose is ingested, this is noted on the eMAR.

Medication Management

Documentation:

1. The individual who administers the medication dose records the administration on the resident's eMAR directly after the medication is given. At the end of each medication pass, the person administering the medications reviews the MAR to ensure necessary doses were administered and documented. In no case should the individual who administers the medication report off-duty without first recording the administration of any medications.
2. When PRN medications are administered, the following documentation is provided:
    - » Date and time of administration, dose, and route of administration
    - » Complaints or symptoms for which the medication was given.
    - » Results achieved from giving the dose and the time results were noted.
3. The RN is responsible for assuring:
    - » current, authorized prescriber orders for medications or treatments administered by the staff are kept on file in the resident's records,
    - » changes in orders are addressed in the resident's service plan
    - » changes are communicated to the staff.

Minnesota Assisted Living (144G)

COMPANY STANDARDS NO MATTER WITH OR WITHOUT MEMORY CARE

Job Type	New Hire Requirement	Lifespark Action Plan (Auto Enrollment via Relias)	Annual Training Requirement	Lifespark Action Plan (Auto Enrollment via Relias)
» Maintenance » Housekeeping » Food Service » Other that does not provide direct care or supervise those who provide direct care	4 Hours of Training w/in 160 work hours after 1st day of hire	4 Hours of Training via BASIC CARES plus Exam	2 Hours of Training for each twelve months of employment after initial training	3 Hours of Training via Relias Annual Education Schedule
» DHS » RN » Memory Care Coordinator » All Community Life Staff » Mentors » Other Supervisors of direct care staff	8 Hours of Training w/in 120 work hours after 1st day of hire	4 Hours of Training via BASIC CARES plus Exam 6 Hours of Training via ADVANCED CARES plus Exam	2 Hours of Training for each twelve months of employment after initial training	3 Hours of Training via Relias Annual Education Schedule
» AL Director (ED)	8 Hours of Training w/in 120 work hours after 1st day of hire 2 years of work experience *(Alzheimer's disease or related, health care, gerontology, or related field)*	4 Hours of Training via BASIC CARES plus Exam 6 Hours of Training via ADVANCED CARES plus Exam *(Need both course and exam uploaded)*	10 hours of Training for each twelve months of employment after initial training *(just dementia related, not necessarily accredited)*	4 Hours of Training via Enriching Connections Courses 6 Hours of Training via ADVANCED CARES plus Exam
» LPN » HHA » Other direct care staff	8 Hours of Training w/in 80 work hours after 1st day of hire *(Cannot work w/ Dementia Residents until complete)*	4 Hours of Training via BASIC CARES plus Exam 4 Hours of Training via Enriching Connections Courses	2 Hours of Training for each twelve months of employment after initial training	3 Hours of Training via Relias Annual Education Schedule

MN *** Orientation Training Information must include: (144G.63 Subd 5., 144G.64 (b) & 144G.83 (a)(b))

- An explanation of Alzheimer's disease and related disorders
- Assistance with activities of daily living
- Problem solving with challenging behaviors
- Communication skills
- Person-centered care approach, planning and service delivery

MN ***Past 18 months qualify from previous employer

Responding to a Missing Resident — Elopement

To ensure all necessary steps are taken in the event that a resident/tenant may have wandered or is missing.

Immediate Action

Any person who discovers that a resident/tenant is missing should immediately notify the employee in charge. The employee in charge (Executive Director, Director of Nursing, Director of Health Services, designated Manager, Charge Nurse, or Lead HHA) must immediately initiate the missing resident/tenant procedures (below).

Procedure

Initial response to report of missing resident/tenant:

1. Check:

» the missing person's residence, including closets and under a bed.

» with other team members via walkie/talkie or walking halls.

» locations within the building where the resident/tenant is frequently found such as Activity Room, Dining Room/ Bistro, Family Room, etc.

» the resident/tenant sign out/in book.

» with the family to see if the resident/tenant/tenant has been taken out of the building.

If the resident/tenant is not located, expand the search:

1. Inside search:

» Contact all staff on shift about the missing resident/ tenant. Executive Director or designated manager will determine a staff central meeting point in the building and provide details on conducting the search.

» Begin a search throughout the entire building/campus; all departments should be checked (Community Life, Dining Services, Environmental Services, etc.).

2. Outside search:

» If the resident/tenant is not located inside the building(s), begin an exterior search of the building(s). Two or more staff members will walk around the building(s) in opposite directions and meet in the designated location, so the entire exterior is covered uniformly and to ensure the resident/tenant is not walking in circles around the building.

» Utilize a satellite map of the building/campus to assist with the search. www.google.com/maps

If the resident/tenant is still not located:

1. Notify local law enforcement agency by calling 911. Ask for assistance in locating a wanderer and give them a description of the resident/tenant.

» When the authorities arrive, give them a picture of the resident/tenant, if available.

» Provide them with a satellite map of the building/campus.

» The authorities will assume command and direction of the search from this point forward. The briefing of authorities shall consist of identification and other pertinent information about the resident/tenant that could assist in locating the individual.

2. Notify the family and/or responsible party of the resident/tenant. Explain what is being done to locate the resident/tenant and encourage them to assist, if able.

3. Notify executive management.

Prevention and Elopement Drills

Facilities will perform Elopement Drills on a quarterly basis, completing the Elopement Drill Evaluation form after each drill. Any immediately needed change in process and/or training will be completed, if necessary.

» Leadership will review Elopement Drill results as part of Quality Assurance Process Improvement (QAPI) and take appropriate action to improve any area of drill practice, if necessary.

» The Assisted Living Director and clinical nurse supervisor will review all tenants elopement plans quarterly

Over-Head Public Address System

To ensure that the ambience of the Assisted Living and Memory Care community is therapeutic in nature and does not have unnecessary noise that could agitate or frighten residents and distract from a homelike environment. In order to maintain a homelike environment unnecessary noise will be kept at a minimum. Overhead and/or phone paging will be restricted to emergencies, evacuation drills, and in some cases entertainment purposes.

It is the practice of our community to only utilize public address systems in the event of emergency, an emergency drill, or for the purpose of facilitating entertainment. Our system may at times play music throughout our common areas, but this does not include memory care. Our staff do communicate with each other, but not via a public address system.

Procedures

- Use overhead paging for emergencies only
- Do not page staff over the telephone intercom system
- Use earpieces with walkies or keep walkies turned down to the minimum level possible that still allows you to hear your page
- When talking with other staff keep your voice down; don't call across the room to another staff member unless it is an emergency call for help.
- When talking with residents only raise your voice if the resident is hard of hearing and it is not practical to move the resident to a quiet area to talk with them.
- When closing doors, do so quietly.
- When music is playing or a movie is being shown make sure the noise level is sufficient for residents to hear, but not so loud as to be an irritant.
- Do not use your cell phone for personal calls when in the community.
- When talking on the telephone speak only as loudly as necessary for the person you are speaking with to hear you.

Safe-Keeping of Possessions

To ensure that all residents have a lockable storage area for safekeeping of personal items and to inform residents and their representatives of the reality that due to the disease process of dementia, the safety of items brought into the building cannot be guaranteed.

The disease process of dementia increases the likelihood that a resident's personal belongings may be misplaced or discarded, clothing may be worn by another resident and/or damage to items may occur. Individuals with dementia may tend to hide things, throw items away, misplace items and forget the proper use and care of personal appliances such as dentures, hearing aids and glasses. Our community cannot be responsible for items in the possession of residents; however, we will take every precaution to ensure the safety of a resident's belongings.

We ask that residents and/or their representatives refrain from bringing items of great value into the community and encourage them to obtain personal property or renters' insurance to provide replacement coverage for necessary personal items. This policy does not waive a resident's right to seek remedy in the event community staff is found to be negligent in the safekeeping of a resident's possessions.

Our community will provide a lockable storage space (e.g., drawer, cabinet, or closet) for the safekeeping of a resident's small valuable items. A key will be kept by the Executive Director or designee, and one will be given to the resident/family/or guardian if the resident/family/or guardian wishes to utilize the lockable storage space.

At the time of move in the resident/family/guardian will be informed of the option for lockable storage and any applicable charge for replacing lost keys.

Procedures

- Give copy of policy to the resident/family or guardian at the time of move in.
- Review policy with resident/family/guardian.
- Obtain signed acknowledgement of receipt of policy.
- Have resident/family/guardian sign key log acknowledging receipt of key

Transportation (Non-Emergent)

For resident's enjoyment and convenience, the community offers transportation on shopping and activity outings. Our community does not offer transportation for an individual resident's personal needs, however, can often assist in making transportation arrangements for other purposes such as outside medical appointments.

Procedures

- When outside appointments are necessary, our first contact for arranging transportation will always be a family member. In the event a family member or friend is not available, it is important to note that our community does not provide transportation.
- We will assist with arranging outside transportation, most likely at a cost to the resident. We encourage all residents of our community to utilize the services of our in-house medical providers, where provided.
- Transportation for community outings is offered to residents via community or Lifespark GO© (where available) bus/van on the days/hours set forth by the facility's management.
- In the event of mechanical failure or accident that results in community's bus being inoperable during scheduled hours, the community will not be able to transport residents on the bus. Under these circumstances the community staff attempt to arrange other transportation for the scheduled outing.

Care Conferences

To provide services to prepare and educate residents living with dementia and their legal and designated representatives about transitions in care and ensuring complete, timely communication between, across, and within settings.

Schedule

An initial Care Conference will occur within the first 30 days of admission:

- Review services and Service Agreement
- Lifespark COMPLETE™-LCM notes
- Medications/ Treatments
- Code Status
- Mental Status/ Mood/Behavior
- Skin
- Nutrition/Weight gain/loss
- Falls/Adverse Events
- Psychoactive Medications

A Care Conference shall occur with a transition to:

- Memory Care
- Hospice
- Change in Condition
- Lifespark COMPLETE™ LS Primary Care Referral

Ultimately, the care conference shall occur on a quarterly basis following admission or as needed per any resident and or family request

Pre-Conference Preparation

Care Conference Letter will be sent to resident representative within two (2) weeks in advance of conference.

Direct Staff Input Form - set out for nursing staff to comment about the resident, changes noticed, any items the resident may need that family can bring in or any pertinent information they feel the family would like to know.

A copy of the care conference schedule will be provided to IDT members.

Attendance

All IDT members noted below are invited to attend care conferences. If unable to attend, the information noted below should be provided to the team member leading the conference.

Care Conferences

To provide services to prepare and educate residents living with dementia and their legal and designated representatives about transitions in care and ensuring complete, timely communication between, across, and within settings.

Departmental Review

Nursing:

- Medical status
- Advanced Care Plan
- Recent falls
- Pain levels
- Medications
- Psychoactive medications
- Behaviors
- Continent status
- Physical devices used
- Review of service plan
- Requirements of assistance needed to complete daily cares

Dining Services:

- Satisfaction with their diet
- Food preferences
- Weight loss
- Ideas on increasing weight

Community Life:

- Participation in activities
- Vision
- Hearing
- Communication
- Socialization

Documentation

- Any interdisciplinary team member can be responsible for documenting the care conference.
  - Documentation will include attendee names, areas discussed, any concerns presented, and any action items for follow up.
- Care Conference Summary completed in electronic record
- Feedback Forms for specific concerns are completed and routed timely
- Offer resident representative a copy of Care Plan/ Service Plan
- If resident or family is not present at care conference, a member of the IDT will follow up with resident representative and provide an overall written summary.

Etiquette

- Supporting all administrative decisions or facility policies that the family has issues with or disagrees with.
- Supporting the team members with decisions they make or politely disagreeing with them in a constructed discussion in front of the family, if necessary.
- Respecting the team members by allowing them their time to report without interruption.
- Refrain from writing progress notes or lengthy word-for-word notes during conference time. SHORT notes can be taken to document the contents of the discussion, but all attention and eye contact should be given to families as much as possible.
- Talk to the resident if they are present, not about them.
- Keep resident records nearby instead of the conference table, to reduce clutter.
- Food and beverage should be kept at a minimum.