

**REPORT TO THE ASSISTED LIVING FACILITY (ALF)
QUALITY MEASURES WORK GROUP
Survey of States' ALF Quality Metric System Programs**

EXHIBITS

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Exhibit 1
Washington AFL State Interview Guide

Transforming
Lives



Survey Purpose:

Washington State's legislature enacted Engrossed House Bill (EHB) 2750, which directs the Department of Social and Health Services (DSHS) to establish a work group to make recommendations to the Legislature by September 1, 2020, regarding a "... quality metrics system" for assisted living facilities."

EHB 2750 directs the work group to survey other states with quality metric methodologies for Assisted Living Facilities to assess: 1) How well each state is achieving quality care outcomes; 2) Whether the data that must be reported reflect and promote quality of care; and, 3) Whether reporting the data is unnecessarily burdensome upon assisted living facilities.

The purpose of this survey is to collect information from states about their Assisted Living Facility program and quality metrics system. This information will be used to prepare a report for the EHB 2750 work group on these states.

Survey Definitions:

The following definitions are used in this survey:

1. Assisted Living Facility:

An Assisted Living Facility is a home or other institution for the purpose of providing housing, basic services, and responsibility for the safety and well-being of the residents, and may also provide domiciliary care. In Washington State, Assisted Living Facilities serve seven or more residents. Facilities that serve less than seven residents are licensed as Adult Family Homes.

Assisted Living Facilities are entities licensed by the state. They are not a nursing facility or an independent senior housing, independent living units in continuing care retirement communities, or other similar living situations including those subsidized by the Department of Housing and Urban Development. Assisted Living Facilities are analogous to Assisted Living Communities, Homes, Centers, and Residences. They are also known as Residential Facilities for Groups and Homes for the Aged in some states.

Assisted Living Facilities provide basic services, including housekeeping services, meals, nutritious snacks, laundry, activities, and transportation. They also may directly or indirectly provide domiciliary care, including: assistance with activities of daily living (ADL); arrangements for health support; intermittent nursing services; and medication management.

2. Assisted Living Facility Quality Metric System:

A system that systematically and routinely collects data used to compute outcome measures that are publicly reported. Outcome measures refers to observed resident or Assisted Living Facility experiences or changes over time.

The data used for the measures may come from a survey of Assisted Living Facility residents or licensed Assisted Living Facilities, state Assisted Living Facility licensing or contracts, or existing Assisted Living Facility payment or other administrative data.

Examples of Assisted Living Facility measures include: staffing levels; occupancy rates; survey deficiencies; resident satisfaction; abuse/neglect complaint rates; grievance resolution rates; fall rates; re-hospitalizations; depression screening; use of anti-psychotics; immunizations; and medication errors.

The quality metrics system is often intended to fulfill one or more of the following purposes:

- To help a person, family member, advocate and/or member of the public select an Assisted Living Facility;
- Used by the state to determine if the Assisted Living Facility meets licensing requirements;
- Used by the state to measure Assisted Living Facility contract compliance;
- Used by the state to determine rates for Medicaid residents;
- Used by the state to improve the quality of the Assisted Living Facility and Assisted Living Facility program;
- Used by Assisted Living Facility management or its Association to improve resident satisfaction or service outcomes; or,
- Used by Assisted Living Facilities for marketing.

Survey Design:

The survey is in three parts.

- Part 1 asks for information on the State's Assisted Living Facilities, including demographic, licensing and contract information.
- Part 2 asks questions on whether the State has an Assisted Living Facility "quality metrics system" (see above for a definition of a quality metrics system and its purpose). If the State has a quality metrics system, the survey is seeking information on its measures, who calculates the measures and how they are used to achieve the quality metrics system's purpose.
- Part 3 asks for information on the State's Assisted Living Facility association(s) and long-term care ombuds program.

The survey instrument is SurveyMonkey.

The survey interview will be with Washington State staff and members of the EHB 2750 Assisted Living Facility Workgroup.

If possible, **we ask that State officials complete the first part of the survey prior to the conference call** .

Instructions:

1. Please complete Part 1 of the survey in SurveyMonkey. A copy and Word version of the survey is provided to aid in collecting information so that it is available during completion of the survey. More than one staff may be needed to provide the information requested in the survey. It is recommended that Part 1 be completed in the Word version of the survey. It can then be entered into SurveyMonkey at one time.

Please use this link to access the SurveyMonkey document. Note: SurveyMonkey will allow you to enter partial information and return to the survey at a later time. However, you must keep the survey document open, or you will lose the information you have recorded. If you click the "Exit this survey" button, it will exit the survey, but no information will be retained. Once the survey is submitted you will no longer be able to add information or make changes to your responses. Please contact our principal investigator, Roger Gantz, to make corrections after the survey has been submitted: Roger.Gantz@dshs.wa.gov

2. If you have the information needed to complete Part 2 and 3 of the survey in SurveyMonkey, please enter your responses and submit these responses with Part 1.
3. States indicating that performance measures are being developed or implemented will be invited to participate in a telephone interview. We will contact the staff person listed in the survey. You are welcome to include others in the telephone interview.

Survey Results:

Submission of information for this survey implies the state's consent to share this information with other states, our legislature, and the public.

We will send an electronic copy of the completed survey and a summary report of the states submitting survey responses.

We will also send an electronic copy of the final report detailing the activities and recommendations of the Assisted Living Facility Quality Measures Work Group due to the Washington Legislature on September 1, 2020.

PART 1: TO BE COMPLETED BY STATE STAFF

Interviewee Information:

Name of State:

State Agency:

Interviewee's Name:

Interviewee's Job Title:

Interviewee's Telephone Number:

Interviewee's E-Mail Address:

Does your State have licensed Assisted Living Facilities?

- Yes
- No
- Don't Know

As used in this survey, Assisted Living Facilities are:

An Assisted Living Facility is a home or other institution for the purpose of providing housing, basic services, and responsibility for the safety and well-being of the residents, and may also provide domiciliary care.

Assisted Living Facilities are entities licensed by the state. They are not a nursing facility or an independent senior housing, independent living units in continuing care retirement communities, or other similar living situations including those subsidized by the Department of Housing and Urban Development.

Assisted Living Facilities provide basic services, including housekeeping services, meals, nutritious snacks, laundry, activities, and transportation. They also may directly or indirectly provide domiciliary care, including: assistance with activities of daily living (ADL); arrangements for health support; intermittent nursing services; and medication management.

About Assisted Living Facilities:

How many licensed Assisted Living Facilities does your state currently have (a/o December 2018)?

How many licensed Assisted Living Facility apartments/beds does your state currently have (a/o December 2018)?

What type of license must an Assisted Living Facility have?

Who licenses Assisted Living Facilities?

What is the link to the Internet site of the licensure survey instrument (or send a copy)?

Are any of the following services provided by Assisted Living Facilities?

	Yes	No
Private apartment-like unit	<input type="radio"/>	<input type="radio"/>
Access to an on-site washing machine and dryer	<input type="radio"/>	<input type="radio"/>
Meals, beverages and snacks	<input type="radio"/>	<input type="radio"/>
Transportation	<input type="radio"/>	<input type="radio"/>
Personal care (ADL) services	<input type="radio"/>	<input type="radio"/>
Supportive services to promote independence and self-sufficiency	<input type="radio"/>	<input type="radio"/>
Medication assistance	<input type="radio"/>	<input type="radio"/>
Intermittent nursing services	<input type="radio"/>	<input type="radio"/>
Dementia care	<input type="radio"/>	<input type="radio"/>
Mental health and/or substance use disorder services	<input type="radio"/>	<input type="radio"/>
Specialized services for persons with intellectual disabilities	<input type="radio"/>	<input type="radio"/>

Other types of Assisted Living Facility services provided:

Yes

No

Other:

(please specify)

Are there restrictions on the number of beds/apartments that an Assisted Living Facility may have?

- Yes
- No
- Don't Know

If YES, describe restrictions:

Are there restrictions on the number of residents in an apartment that an Assisted Living Facility may have?

- Yes
- No
- Don't Know

If YES, describe restrictions (such as: square footage, number of beds, and number of occupants):

Are there restrictions on who can reside in an Assisted Living Facility?

- Yes
- No
- Don't Know

If YES, describe restrictions:

Are the Assisted Living Facility licensing requirements codified in law or rules?

- Yes
- No
- Don't Know

If YES, what are the statutory and rule citations?

Does your State have Assisted Living Facility service contracts for Medicaid ALF residents?

- Yes
- No
- Don't Know

If YES, what type of Medicaid contracts (Name & Type of Contract/Funding Source)?

Does your State have an Assisted Living Facility directory that persons can use to locate an ALF?

- Yes
- No
- Don't Know

How is the directory made available to the public?

If there is a public website link, what is the link?

Are these types of information in the Assisted Living Facility directory?

	Yes	No
Assisted Living Facility's name and address	<input type="radio"/>	<input type="radio"/>
Assisted Living Facility ownership	<input type="radio"/>	<input type="radio"/>
Number of apartments/beds	<input type="radio"/>	<input type="radio"/>
Pictures of the Assisted Living Facility	<input type="radio"/>	<input type="radio"/>
Meal menus	<input type="radio"/>	<input type="radio"/>
List of Assisted Living Facility's state contracts	<input type="radio"/>	<input type="radio"/>
List of services that Assisted Living Facility can provide	<input type="radio"/>	<input type="radio"/>
State license status, including licensing deficiencies	<input type="radio"/>	<input type="radio"/>
State contract status	<input type="radio"/>	<input type="radio"/>
Rating system	<input type="radio"/>	<input type="radio"/>
Quality metrics measures	<input type="radio"/>	<input type="radio"/>

Other types of information in the Assisted Living Facility directory:

Yes

No

Other:

(please specify)

Are Assisted Living Facilities required to submit to the state licensing agency a completed "Disclosure of Services" form or other similar document describing the services they provide to residents?

- Yes
- No
- Don't know

If YES, would you e-mail (gantzrp@dshs.wa.gov) a copy of the disclosure form?

- Yes
- No
- Don't know

If Assisted Living Facilities are required to submit service information, is the information also available to the public?

- Yes
- No
- Don't know

PART 2: TO BE COMPLETED BY WASHINGTON STATE STAFF

Does your State have an Assisted Living Facility “quality metrics system”?

- Yes – It is in the design stage.
- Yes – It is in the implementation stage
- Yes – It is operational
- No
- Don't Know

Quality Metrics System: For this survey, “quality metrics systems” refers to a system that systematically and routinely collects data used to compute outcome measures that are publicly reported. Outcome measures refers to observed resident or Assisted Living Facility facility experiences or changes over time.

The data used for the measures may come from the survey of Assisted Living Facility residents or licensed Assisted Living Facilities, existing Assisted Living Facility payment or other administrative data, state Assisted Living Facility licensing or contracts.

Examples of Assisted Living Facility measures include: staffing levels; occupancy rates; survey deficiencies; resident satisfaction; abuse/neglect complaint rates; grievance resolution rates; fall rates; re-hospitalizations; depression screening; use of anti-psychotics; immunizations; and medication errors.

The quality metrics system is often intended to fulfill one or more of the following purposes:

- To help a person, family member, advocate and/or member of the public select an Assisted Living Facility;
- Used by the state to determine if the Assisted Living Facility meets licensing requirements;
- Used by the state to measure Assisted Living Facility contract compliance;
- Used by the state to determine rates for Medicaid residents;
- Used by the state to improve the quality of the Assisted Living Facility and Assisted Living Facility program;
- Used by Assisted Living Facility management or its Association to improve resident satisfaction or service outcomes; or,
- Used by Assisted Living Facilities for marketing.

If YES, how many Assisted Living Facilities are participating in the quality metrics system?

What percentage of all licensed Assisted Living Facilities are participating in the quality metrics system?

Which of these are purposes of the Assisted Living Facility's quality metrics system?

	Yes	No
Help consumers, family member or advocates select an Assisted Living Facility	<input type="radio"/>	<input type="radio"/>
Used by state to determine if the Assisted Living Facility meets licensing requirements	<input type="radio"/>	<input type="radio"/>
Used by state to determine if the Assisted Living Facility meets contract requirements	<input type="radio"/>	<input type="radio"/>
Used by state to determine rates for Medicaid residents	<input type="radio"/>	<input type="radio"/>
Used by state to improve quality of Assisted Living Facilities	<input type="radio"/>	<input type="radio"/>
Used by Assisted Living Facility management and/or Association to improve resident satisfaction or service outcomes.	<input type="radio"/>	<input type="radio"/>
Used by Assisted Living Facilities for marketing	<input type="radio"/>	<input type="radio"/>

Other purposes of the Assisted Living Facility quality metrics system:

	Yes	No
Other: (please specify) <input type="text"/>	<input type="radio"/>	<input type="radio"/>
Other: (please specify) <input type="text"/>	<input type="radio"/>	<input type="radio"/>
Other: (please specify) <input type="text"/>	<input type="radio"/>	<input type="radio"/>
Other: (please specify) <input type="text"/>	<input type="radio"/>	<input type="radio"/>
Other: (please specify) <input type="text"/>	<input type="radio"/>	<input type="radio"/>
Other: (please specify) <input type="text"/>	<input type="radio"/>	<input type="radio"/>

What quality metric measures does your State collect on Assisted Living Facilities?

Can you provide us a copy of your State quality measures and their technical specifications?

- Yes
- No
- Don't Know

Who collects the data and computes the quality metrics measures you identified:

Help consumers, family member or advocates select an Assisted Living Facility

Used by state to determine if the Assisted Living Facility meets licensing requirements

Used by state to determine if the Assisted Living Facility meets contract requirements

Used by state to determine rates for Medicaid residents

Used by state to improve quality of Assisted Living Facilities

Used by Assisted Living Facility management and/or Association to improve resident satisfaction or service outcomes.

Used by Assisted Living Facilities for marketing

Who collects the data and computes the "other" quality metric's measures you identified?

Other:

Other:

Other:

Other:

Other:

Other:

Assisted Living Facility State Survey Instrument

For each objective/purpose identified, how are the measures used to achieve the purpose?

Help consumers, family member or advocates select an Assisted Living Facility

Used by state to determine if the Assisted Living Facility meets licensing requirements

Used by state to determine if the Assisted Living Facility meets contract requirements

Used by state to determine rates for Medicaid residents

Used by state to improve quality of Assisted Living Facilities

Used by Assisted Living Facility management and/or Association to improve resident satisfaction or service outcomes.

Used by Assisted Living Facilities for marketing

For each "other" objective/purpose identified, how are the measures used to achieve the purpose?

Other:

Other:

Other:

Other:

Other:

Other:

For each objective/purpose identified, how are the measures publicly presented (e.g., website, published document)?

Help consumers, family member or advocates select an Assisted Living Facility

Used by state to determine if the Assisted Living Facility meets licensing requirements

Used by state to determine if the Assisted Living Facility meets contract requirements

Used by state to determine rates for Medicaid residents

Used by state to improve quality of Assisted Living Facilities

Used by Assisted Living Facility management and/or Association to improve resident satisfaction or service outcomes.

Used by Assisted Living Facilities for marketing

For each "other" objective/purpose identified, how are the measures publicly presented (e.g., website, published document)?

Other:

Other:

Other:

Other:

Other:

Other:

If the measures are used in a quality improvement initiative, who is responsible for administering the initiative?

Given the acuity range and care support needs among Assisted Living Facility residents, are the Assisted Living Facility measurements risk adjusted to account for these differences?

- Yes
- No
- Don't Know

If YES, please describe the risk adjustment mechanism you use, and could we have a copy of its technical specifications?

Are the quality metrics system's measures audited for accuracy and integrity?

- Yes
- No
- Don't Know

If YES, please describe who is responsible for conducting the measurement audit?

If the measures are audited, who pays for the audit?

- State licensing agency
- State Medicaid agency
- Assisted Living Facility
- Assisted Living Facility association

Other (please specify)

Does collecting and reporting data for the measures create a burden on the Assisted Living Facilities?

- Yes
- No
- Don't Know

If YES, what does the State do to reduce the burden on the Assisted Living Facilities?

Has your legislature mandated that your agency collect data on quality measures?

- Yes
- No
- Don't Know

If YES, please provide an Internet link to the enabling legislation:

Has your State received any funding for your initiative?

- Yes
- No
- Don't Know

If YES, what is the funding source?

Has your State made any efforts to include consumers and family members in the discussion about quality metrics for Assisted Living Facilities?

- Yes
- No
- Don't Know

If YES, what approaches have been used to include consumers and family members in improving the quality of care in Assisted Living Facilities?

PART 3: TO BE COMPLETED BY WASHINGTON STATE STAFF

Does your State have an association and/or organization that represents Assisted Living Facility providers?

- Yes
- No
- Don't Know

What are the names and addresses of the associations and/or organization(s)?

1.

2.

3.

Are any of the associations collecting data for their own performance measures?

Yes

No

Don't Know

If YES, how long have they been collecting data?

Is this information available to the public?

Yes

No

Don't Know

If YES, who should we contact to obtain information on the data?

What is the name and address of your State's ombuds organization?

Name

Address

City/Town

State/Province

ZIP/Postal Code

Does that organization collect data for their own performance measures?

- Yes
- No
- Don't Know

If YES, how long have they been collecting data?

Is this information available to the public?

- Yes
- No
- Don't Know

If YES, who should we contact to obtain information on the data?

Thanks for taking our survey. We appreciate your feedback.

FOLLOWING TO BE COMPLETED BY WASHINGTON STATE INTERVIEW STAFF

Interviewer's Name:

Interviewer's Organization:

Interviewer's Telephone Number:

Interviewer's E-Mail Address:

Press "Done" below to complete the survey. Make sure you are completely finished with the survey before you press "Done."

ADDITIONAL QUESTIONS

1. Date the quality metric system was officially implemented?
2. Who (e.g., state agency, ALF association, legislature) initiated the implemented of the quality metrics system?
3. Does a higher quality metrics rating alter an individual AFLs survey cycle?
4. Does the quality metrics system have an advisory group? If so, who is on the group?
5. Has the state agency seen improvement in the ALF quality metric measures or licensure compliance? If so, could you provide data/information to support?
6. Does the state agency publish a report on the project and its outcomes? If so, could we have a copy of the report?

Exhibit 2
WI-NJ-OR Quality Metric Measures

WI-NJ-OR Quality Metric Measures

Domain	Measures	Type of Measure	Wisconsin WCCEAL Program	New Jersey HCANJF AS Program	Oregon RCQM Program
AFL Profile	How many residents were living in this ALF on the last day of the reporting period?	Structural	Yes		
AFL Profile	How many residents were covered by public funding on the last day of the reporting period?	Structural	Yes		
AFL Profile	What resident population represents the highest percentage of current residents?	Structural	Yes (Drop Down 11 checkbox options)		
AFL Profile	How many residents fit that category on the last day of the reporting period	Structural	Yes		
AFL Profile	What resident population represents the second highest percentage (if applicable) of current residents?	Structural	Yes (Drop Down 12 checkbox options)		
AFL Profile	How many residents fit that category on the last day of the reporting period?	Structural	Yes		
AFL Profile	Is this a standalone ALF or owned by an organization with multiple facilities/ALCs.	Structural	Yes		
Staffing	Counting only those with direct resident interactions, how many direct caregiver/support staff full time equivalents (FTEs) were employed by this ALC on the last day of the reporting period.	Structural	Yes		
Staffing	Counting only those with direct resident interactions, what percentage of your direct caregiver/support staff has worked at the ALF more than a year on the last day of the reporting period.	Structural	Yes		Yes
Staffing	Does the ALF have a Registered Nurse (RN) on staff.	Structural	Yes		
Staffing	If no, does the AFL have access to an RN.	Structural	Yes (Five options)		
Staffing	Does the ALF have a formal on-going training program for all employees.	Structural		Yes (Compliance Visit)	
Staffing	What percentage of staff have completed all training modules during the report period.	Structural			Yes
Quality Improvement	Which of the following does the ALF use to measure quality?	Structural	Yes (Drop Down 8 checkbox options)		
Quality Improvement	Which of the following does the ALF use to address systematic continuous quality improvement?	Structural	Yes (Drop Down 8 checkbox options)		
Quality Improvement	Which of the following does the ALF use to keep each resident and/or the resident's representatives informed.	Structural	Yes (Drop Down 10 checkbox options)		
Quality Improvement	Which of the following does the AFL use to obtain input from each resident and/or the resident's representative about the resident's care, services, and satisfaction.	Structural	Yes (Drop Down 8 checkbox options)		

WI-NJ-OR Quality Metric Measures

Domain	Measures	Type of Measure	Wisconsin WCCAL Program	New Jersey HCANJF AS Program	Oregon RCQM Program
Quality Improvement	Which of the following does the AFL use to involve residents and/or residents' representatives in decision making about the ALC as a whole and the services it provides	Structural	Yes (Drop Down 10 checkbox options)		
Quality Improvement	Does the ALF act upon feedback provided at Resident Council. Is the Resident Council include of residents with dementia	Structural		Yes (Compliance Visit)	
Quality Improvement	Does the AFL use advanced care planning with residents to determine individual preferences for end-of-life care.	Structural		Yes (Compliance Visit)	
Fall Prevention	What falls prevention protocols or programs is the ALF using.	Structural	Yes (Drop Down 28 checkbox options)		
Fall Prevention	When does the AFL conduct a falls risk screening/assessment?	Structural	Yes (Drop Down 8 checkbox options)		
Fall Prevention	What components are included in the ALF's falls risk screening/assessment.	Structural	Yes (Drop Down 27 checkbox options)		
Fall Prevention	After a falls risk is identified, does the AFL routinely check.	Structural	Yes (Drop Down 11 checkbox options)		
Fall Prevention	After a fall occurs, does the AFL routinely check.	Structural	Yes (Drop Down 14 checkbox options)		
Fall Prevention	Does the AFL track all known falls in this ALF.	Structural	Yes		
Fall Prevention	Would the ALF share how many falls occurred during the reporting period?	Structural	Yes		
Fall Prevention	How many falls occurred at the AFL during the report period	Outcome	Yes		Yes (falls resulting in physical injury)
Fall Prevention	How many falls have occurred that required medical care outside the ALF or from outside the ALF during the reporting period.	Outcome	Yes		
Infections	Does the ALF track how many staff receive the annual flu vaccine in this ALF.	Structural	Yes		
Infections	What percentage of ALF staff received the annual flu vaccine.	Outcome	Yes		
Infections	Which of the following does this ALC use for infection control and prevention.	Structural	Yes (Drop Down 10 checkbox options)		
Infections	How many cases of norovirus have occurred during the reporting period?	Outcome	Yes		
Infections	How many cases of influenza have occurred during the reporting period.	Outcome	Yes		
Hospitalization	Would the AFL tell how many total hospitalizations occurred during the reporting period?	Structural	Yes		

WI-NJ-OR Quality Metric Measures

Domain	Measures	Type of Measure	Wisconsin WCEAL Program	New Jersey HCANJF AS Program	Oregon RCQM Program
Hospitalization	How many residents were admitted to the hospital during the report period.	Outcome		Yes	
Hospitalization	How many hospital readmissions within 30-days have occurred during the reporting period.	Outcome/Performance	Yes	Yes (Benchmark - Decrease re-hospitalization rate to 20% or lower)	
Residents Behavior	To what extent does this ALC experience challenging or disruptive resident behaviors?	Outcome	Yes (Drop Down 3 checkbox options)		
Residents Behavior	Does the AFL use a specific plan to address/reduce challenging or disruptive behaviors (e.g. Behavioral Support Plan (BSP), Resident Behavior Records (RBR), Individual Service Plan (ISP) specific to behaviors).	Structural	Yes		
Residents Behavior	What interventions is the AFL using to address challenging or disruptive resident behavior prior to, during or after a behavior incidence.	Structural	Yes (Drop Down 17 checkbox options)		
Residents Behavior	Does the AFL track/monitor the number of residents who have a specific plan to address challenging or disruptive behaviors?	Structural	Yes		
Residents Behavior	Would the AFL share the number of residents who have a specific plan to address challenging or disruptive behaviors during the reporting period.	Structural	Yes		
Residents Behavior	How many residents have a specific plan to address challenging or disruptive behaviors during the reporting period.	Outcome	Yes		
Residents Behavior	Has the AFL seen an overall reduction in incidence of challenging or disruptive resident behaviors as a result of the initiation of the resident's plan?	Outcome	Yes		
Medication Errors	Does the staff at the AFL administer or dispense medications to residents living in the ALF.	Structural	Yes		
Medication Errors	Does the ALF track/monitor staff medication errors.	Structural	Yes		
Medication Errors	Would the ALF share information about the number of staff medication errors.	Structural	Yes		
Medication Errors	How many total medication errors occurred in the ALC during this reporting period.	Outcome	Yes		
Medication Errors	How many total medication errors were associated with administering a medication to the wrong person.	Outcome	Yes		
Medication Errors	How many total medication errors were associated with administering the wrong medication.	Outcome	Yes		
Medication Errors	How many total medication errors were associated with administering the wrong medication dose.	Outcome	Yes		
Medication Errors	How many total medication errors were associated with administering the medication at the wrong time/omission.	Outcome	Yes		
Medication Errors	How many total medication errors were associated with administering the medication via the wrong route.	Outcome	Yes		

WI-NJ-OR Quality Metric Measures

Domain	Measures	Type of Measure	Wisconsin WCCEAL Program	New Jersey HCANJF AS Program	Oregon RCQM Program
Medication Errors	How many total medication errors were associated with not properly documenting that the medication was administered to the resident.	Outcome	Yes		
Medication Errors	How many residents have off-label antipsychotic drug use.	Outcome/Performance		Yes (Benchmark - Decrease anti-psychiatric drug use to 15% or lower)	Yes
Resident Weight Changes	Does the ALF monitor/track changes in residents weight.	Structural	Optional (Pilot Question)		
Resident Weight Changes	Would the ALF share how many residents experienced an unplanned weight loss or gain of 5% or greater in any 30-day period of the past quarter.	Structural	Optional (Pilot Question)		
Resident Weight Changes	How many residents experienced an unplanned weight loss or gain of 5% or greater in any 30-day period of the past quarter.	Outcome	Optional (Pilot Question)		
Resident Weight Changes	Would the AFL monitor/track changes in resident weight in the future.	Structural	Optional (Pilot Question)		
Resident Staff Experience - Survey	Staff member are courteous.	Outcome (Resident Satisfaction Survey)	Yes (5 Point Likert Scale)		
Resident Staff Experience - Survey	Staff members are available to talk with me.	Outcome (Resident Satisfaction Survey)	Yes (5 Point Likert Scale)		
Resident Staff Experience - Survey	Staff members know what I like and dislike.	Outcome (Resident Satisfaction Survey)	Yes (5 Point Likert Scale)		
Resident Staff Experience - Survey	I can get help when I need it.	Outcome (Resident Satisfaction Survey)	Yes (5 Point Likert Scale)		
Resident Staff Experience - Survey	Staff recognize and respond in a timely manner to changes in my needs.	Outcome (Resident Satisfaction Survey)		Yes (5 Point Likert Scale)	
Resident Staff Experience - Survey	Overall, how would you rate the staff.	Outcome (Resident Satisfaction Survey)		Yes - CoreQ (5 Point Likert Scale)	Yes - CoreQ (5 Point Likert Scale)
Resident Staff Experience - Survey	Management is timely in their response to my and my family's suggestions and concerns.	Outcome (Resident Satisfaction Survey)		Yes (5 Point Likert Scale)	
Resident Rights Experience - Survey	I was informed of my rights.	Outcome (Resident Satisfaction Survey)	Yes (5 Point Likert Scale)		
Resident Rights Experience - Survey	The people who work here protect my rights.	Outcome (Resident Satisfaction Survey)	Yes (5 Point Likert Scale)		
Resident Rights Experience - Survey	My privacy is respected.	Outcome (Resident Satisfaction Survey)	Yes (5 Point Likert Scale)		
Resident Rights Experience - Survey	I am informed of rate and policy changes that might affect me.	Outcome (Resident Satisfaction Survey)	Yes (5 Point Likert Scale)		
Resident Rights Experience - Survey	I am treated with dignity and respect.	Outcome (Resident Satisfaction Survey)	Yes (5 Point Likert Scale)	Yes (5 Point Likert Scale)	

WI-NJ-OR Quality Metric Measures

Domain	Measures	Type of Measure	Wisconsin WCCEAL Program	New Jersey HCANJF AS Program	Oregon RCQM Program
Resident Environment Experience - Survey	The residence is homelike and well-maintained.	Outcome (Resident Satisfaction Survey)	Yes (5 Point Likert Scale)		
Resident Environment Experience - Survey	I feel safe here.	Outcome (Resident Satisfaction Survey)	Yes (5 Point Likert Scale)	Yes (5 Point Likert Scale)	
Resident Environment Experience - Survey	My personal belongings are safe here.	Outcome (Resident Satisfaction Survey)	Yes (5 Point Likert Scale)		
Resident Activity Experience - Survey	Activity programs are offered daily that interest me.	Outcome (Resident Satisfaction Survey)	Yes (5 Point Likert Scale)		
Resident Activity Experience - Survey	There are opportunities for me to fulfill my spiritual needs.	Outcome (Resident Satisfaction Survey)	Yes (5 Point Likert Scale)		
Resident Activity Experience - Survey	I have the opportunity to socialize with others.	Outcome (Resident Satisfaction Survey)	Yes (5 Point Likert Scale)		
Resident Activity Experience - Survey	Overall, I am satisfied with the way my choices and preferences are met	Outcome (Resident Satisfaction Survey)		Yes (5 Point Likert Scale)	
Resident Meals Experience - Survey	I get enough to eat.	Outcome (Resident Satisfaction Survey)	Yes (5 Point Likert Scale)		
Resident Meals Experience - Survey	The menus offer a variety of food selections.	Outcome (Resident Satisfaction Survey)	Yes (5 Point Likert Scale)		
Resident Meals Experience - Survey	I can participate in meal planning if I want.	Outcome (Resident Satisfaction Survey)	Yes (5 Point Likert Scale)		
Resident Meals Experience - Survey	My special diet needs are met.	Outcome (Resident Satisfaction Survey)	Yes (5 Point Likert Scale)		
Resident Meals Experience - Survey	The food is to my liking.	Outcome (Resident Satisfaction Survey)	Yes (5 Point Likert Scale)		
Resident Meals Experience - Survey	The temperature of the food is to my liking.	Outcome (Resident Satisfaction Survey)	Yes (5 Point Likert Scale)		
Resident Meals Experience - Survey	Overall, how would you rate the food.	Outcome (Resident Satisfaction Survey)		Yes - CoreQ (5 Point Likert Scale)	Yes - CoreQ (5 Point Likert Scale)
Resident Care Experience - Survey	My family/representative is kept informed about me as I choose	Outcome (Resident Satisfaction Survey)	Yes (5 Point Likert Scale)		
Resident Care Experience - Survey	My choice of health care providers are respected.	Outcome (Resident Satisfaction Survey)	Yes (5 Point Likert Scale)		
Resident Care Experience - Survey	I get the care and services I need.	Outcome (Resident Satisfaction Survey)	Yes (5 Point Likert Scale)		
Resident Care Experience - Survey	I receive medications on time in a manner acceptable to me.	Outcome (Resident Satisfaction Survey)	Yes (5 Point Likert Scale)		

WI-NJ-OR Quality Metric Measures

Domain	Measures	Type of Measure	Wisconsin WCEAL Program	New Jersey HCANJF AS Program	Oregon RCQM Program
Resident Care Experience - Survey	How would you rate the care you receive.	Outcome (Resident Satisfaction Survey)		Yes - CoreQ (5 Point Likert Scale)	Yes - CoreQ (5 Point Likert Scale)
Resident Overall Experience - Survey	My lifestyle choices are respected.	Outcome (Resident Satisfaction Survey)	Yes (5 Point Likert Scale)		
Resident Overall Experience - Survey	I am satisfied with my overall experience here.	Outcome (Resident Satisfaction Survey)	Yes (5 Point Likert Scale)		
Resident Overall Experience - Survey	I would recommend this residence and its services to a friend or loved one.	Outcome (Resident Satisfaction Survey)	Yes (5 Point Likert Scale)	Yes - CoreQ (5 Point Likert Scale)	Yes - CoreQ (5 Point Likert Scale)

Exhibit 3
Wisconsin
WCCEAL Quality Improvement
Measures & Data Entry Form

Quality Improvement Variables Data Entry Form (Version 13)

ALC PROFILE

Occupancy

How many residents were living in this ALC on the *last day of the reporting period*? P542

Public Pay

How many residents were covered by public funding on the *last day of the reporting period*? P198

Primary Population

What resident population represents the highest percentage of current residents? P119

See Options in Appendix ▾

How many residents fit that category on the *last day of the reporting period*? P820

Secondary Population

What resident population represents the second highest percentage (if applicable) of current residents? P266

See Options in Appendix ▾

How many residents fit that category on the *last day of the reporting period*? P995

Affiliation

Is this a standalone ALC or owned by an organization with multiple facilities/ALCs? P883

Standalone Organization

STAFFING

Direct Caregiver/Support Staff

Counting only those with direct resident interactions, how many direct caregiver/support staff full time equivalents (FTEs) were employed by this ALC on the *last day of the reporting period*? S501

Retention: Direct Caregiver/Support Staff

Counting only those with direct resident interactions, what percentage of your direct caregiver/support staff has worked at the ALC more than a year on the *last day of the reporting period*? S890

 %

RN Access

Does this ALC have a Registered Nurse (RN) on staff? S613

Yes No

If no, does this ALC have access to an RN? S412

No

Organization shared employee

Outside contractor/temp

Other

Quality Measurement

Which of the following does this ALC use to measure quality? (check all that apply) Q211

0 checked ^

See Options in Appendix

Quality Improvement Activities

Which of the following does this ALC use to address systematic continuous quality improvement? (check all that apply) Q737

0 checked ^

See Options in Appendix

Informing Residents

Which of the following does this ALC use to keep each resident and/or the resident's representatives informed? (check all that apply) Q312

0 checked ^

See Options in Appendix

Resident Input about Personal Care

Which of the following does this ALC use to obtain input from each resident and/or the resident's representative about the resident's care, services, and satisfaction? (check all that apply) Q978

0 checked ^

See Options in Appendix

Resident Involvement in ALC Decision-Making

Which of the following does this ALC use to involve residents and/or residents' representatives in decision making about the ALC as a whole and the services it provides. (check all that apply) Q560

0 checked ^

See Options in Appendix

FALLS PREVENTION

Falls Prevention Programs

What falls prevention protocols or programs are you using in this ALC? (check all that apply) F193

0 checked ^

See Options in Appendix

Falls Risk Screening/Assessment

When does this ALC conduct a falls risk screening/assessment? (check all that apply) F931

0 checked ^

See Options in Appendix

What components are included in your falls risk screening/assessment? (check all that apply) F103

0 checked ^

See Options in Appendix

Falls Intervention

After a falls risk is identified, do you routinely (check all that apply) F748

0 checked ^

See Options in Appendix

After a fall occurs, do you routinely (check all that apply) F378

0 checked ^

See Options in Appendix

Falls Outcomes

Do you track all known falls in this ALC? F251

Yes No

If yes, would you be willing to share how many falls occurred **during the reporting period**? F652

Yes No

How many? F153

How many falls have occurred that required medical care outside the ALC or from outside the ALC **during this reporting period**? F359

INFECTIONS

Staff Immunization

Do you track how many staff receive the annual flu vaccine in this ALC? I471

Yes No

If yes, what percentage of your staff received the annual flu vaccine? I430

 %

Infection Control and Prevention Activities

Which of the following does this ALC use for infection control and prevention? (check all that apply) I769

0 checked ^

See Options in Appendix

Infection Outcomes

How many cases of norovirus have occurred **during this reporting period**? I340

How many cases of influenza have occurred **during this reporting period**? I500

HOSPITALIZATIONS

Hospitalization Outcomes

Would you be willing to tell us how many total hospitalizations occurred **during this reporting period**? H647

Yes No

How many? H665

How many hospital readmissions within 30 days have occurred **during this reporting period**? H591

CHALLENGING OR DISRUPTIVE RESIDENT BEHAVIORS

Extent of Challenging or Disruptive Resident Behaviors

To what extent does this ALC experience challenging or disruptive resident behaviors? B805

See Options in Appendix ▾

Plans to Address Challenging or Disruptive Resident Behaviors

Does this ALC use a specific plan to address/reduce challenging or disruptive behaviors? (e.g. Behavioral Support Plan (BSP), Resident Behavior Records (RBR), Individual Service Plan (ISP) specific to behaviors) B187

Yes No

Interventions to Address Challenging or Disruptive Resident Behaviors

What interventions is this ALC using to address challenging or disruptive resident behavior prior to, during or after a behavior incidence? (check all that apply) B299

0 checked ▲

See Options in Appendix

Residents with Specific Plans for Challenging or Disruptive Behaviors

Does this ALC track/monitor the number of residents who have a specific plan to address challenging or disruptive behaviors? B568

Yes No

If yes, would you be willing to share the number of residents who have a specific plan to address challenging or disruptive behaviors **during this reporting period**? B800

Yes No

How many? B152

Challenging or Disruptive Resident Behaviors Outcomes

Have you seen an overall reduction in incidence of challenging or disruptive resident behaviors as a result of the initiation of the resident's plan? B957

Yes No N/A

MEDICATION ERRORS

Medication Administering/Dispensing

Does the staff at your ALC administer or dispense medications to residents living in the ALC? M373

Yes No

Medication Error Outcomes

Does this ALC track/monitor **staff medication errors**? M397

Yes No

If yes, would you be willing to share information about the number of staff medication errors? M149

Yes No

How many total medication errors occurred in the ALC **during this reporting period**? M235

How many of the total medication errors were associated with:

Administering a medication to the **wrong person**? M867

Administering the **wrong medication**? M493

Administering the **wrong medication dose**? M991

Administering the medication at the **wrong time/omission**? M451

Administering the medication via the **wrong route**? M274

Not properly documenting that the medication was administered to the resident? M996

PILOT QUESTIONS (OPTIONAL)

Resident Weight Changes

Do you monitor/track changes in resident weight? *PQ182*

Yes No

If yes, would you be willing to share how many residents experienced an unplanned weight loss or gain of 5% or greater in **any 30-day period of the past quarter**? *PQ177*

Yes No

How many? *PQ930*

If no, will you monitor/track changes in resident weight in the future? *PQ900*

Yes No

COMMENTS

Additional Information

Anything else you want to tell us? *C834*



APPENDIX A DROP-DOWN AND CHECKBOX OPTIONS

Primary Population

(Question P119)

- Advanced Age
- Developmentally Disabled
- Alcohol/Drug Dependent
- Physically Disabled
- Terminally Ill
- Irreversible Dementia/Alzheimer's
- Correctional Clients
- Emotionally Disturbed/Mental Illness
- Veterans Administration
- Traumatic Brain Injury
- Pregnant Women/Counselling

Secondary Population

(Question P266)

- Not Applicable
- Advanced Age
- Developmentally Disabled
- Alcohol/Drug Dependent
- Physically Disabled
- Terminally Ill
- Irreversible Dementia/Alzheimer's
- Correctional Clients
- Emotionally Disturbed/Mental Illness
- Veterans Administration
- Traumatic Brain Injury
- Pregnant Women/Counselling

Quality Measurement

(Question Q211)

- WCCAL quality improvement variables
- WCCAL resident satisfaction survey
- Quality indicators from other sources
- Other resident survey
- Family survey
- Staff survey
- None
- Other

Quality Improvement Activities

(Question Q737)

- Daily quality checks
- Weekly QI meetings
- Monthly QI meetings
- Quarterly QI meetings
- Twice annually QI meetings
- Training Programs
- None
- Other

Informing Residents

(Question Q312)

- ALC house meetings
- ALC newsletter or email
- ALC website
- Notification board in common area of building
- Notification board in resident's room
- Resident mailbox
- Personal email to resident and/or resident's representative
- Timely telephone call to resident's representative
- None
- Other

Resident Input about Personal Care

(Question Q978)

- WCCAL resident satisfaction survey
- Other anonymous survey
- Other non-anonymous survey
- Anonymous complaint/comments form or process
- Non-anonymous complaint/comments form or process
- Regular care conferences other than at admission
- None
- Other

Resident Involvement in ALC Decision-Making

(Question Q560)

- Monthly resident council meetings
- Quarterly resident council meetings
- Residents' representatives are included in resident council meetings
- Residents' representatives have their own council meetings
- House meetings including residents and staff
- Residents' representatives are included in house meetings
- Process for residents and/or residents' representatives to participate in meal planning
- Process for residents and/or residents' representatives to participate in activities planning
- None
- Other

Falls Prevention Programs Plus

(Question F193)

- Do not have a falls prevention program
- Non-applicable due to nature of community population
- In-house/internal falls prevention program
- Corporate falls prevention program
- A Matter of Balance
- AHRQ The Falls Management Program: A Quality Improvement Initiative for Nursing Facilities
- Arthritis Foundation Tai Chi Program
- CDC STEADI (Stopping Elderly Accidents, Deaths & Injuries)
- CMS QAPI tools and resources-Root Cause
- FallScope
- FallsTalk
- Gentiva Home Health Safe Strides Program
- Gunderson-Lutheran Everyday Exercises
- Heritage Falls Management Program
- LeadingAge Wisconsin - CBRF Module 6: Falls Risk
- LeadingAge Wisconsin - CBRF Quality Initiative D: Falls/Falls Management/Injury Prevention
- LeadingAge Wisconsin - RCAC Falls Risk Review
- LeadingAge Wisconsin - RCAC Quality Initiative 6: Falls
- Otago Exercise Programme
- Promise to Protect
- Stay Active and Independent for Life (SAIL)
- Stepping On (WIHA)
- StrongWomen/StrongBones
- Sure Step
- Tai Chi: Moving for Better Balance
- VA National Center for Patient Safety - Falls Toolkit
- WALA - Walking Tall in Assisted Living
- Other

Falls Risk Screening/Assessment

(Question F931)

- Admission
- After a fall
- Change of health status
- Quarterly
- Every 6 months/semi-annually
- Yearly
- Never
- Other

Falls Risk Screening/Assessment Components

(Question F103)

- ADLs/IADLs
- Behavioral issues
- Cardiovascular status/Postural Hypotension
- Cognitive Impairment
- Depression
- Dizziness/Vertigo
- Environmental assessment including hazards
- Falls history
- Fear of falling
- Foot problems and Footwear
- Gait and/or balance issues
- Hearing Assessment/Screening
- Impulsivity
- Incontinence/Urgency
- Medical Conditions
- Medication Changes/Side Effects
- Medication review
- Mobility Assessment (e.g., TUG test)
- Muscle strength of Lower Extremities
- Neurological Function
- Pain Assessment
- Physical Therapy/Occupational Therapy involvement
- Resident Assistive devices or equipment use
- Resident Psychological Change/Stability, including due to change in condition
- Substance abuse screening
- Vision Problems/Eye Exam
- Other

Falls Intervention Components - Risk Identified

(Question F748)

- Perform a follow-up falls risk assessment
- Provide tailored education about falls risk to the resident and/or their family
- Encourage resident to engage in an exercise program that includes balance, gait and strength training
- Encourage resident to engage in appropriate physical therapy
- Conduct a full medication review
- Address vision problems and/or eye exam
- Assess and treat postural hypotension as needed
- Provide Vitamin D supplementation as needed
- Modify environmental factors
- Address issues associated with footwear or foot related health problems
- Appropriate use of assistive devices

Falls Intervention Components - Fall Occurs

(Question F378)

- Perform a follow-up falls risk assessment
- Provide tailored education about falls risk to the resident and/or their family
- Encourage resident to engage in an exercise program that includes balance, gait and strength training
- Encourage resident to engage in appropriate physical therapy
- Conduct a full medication review
- Address vision problems and/or eye exam
- Assess and treat postural hypotension as needed
- Provide Vitamin D supplementation as needed
- Modify environmental factors
- Address issues associated with footwear or foot related health problems
- Appropriate use of assistive devices
- Conduct a root cause analysis
- Notify resident's family
- Notify resident's primary care provider

Infection Control and Prevention Activities

(Question I769)

- Written infection control protocol plans
- Collection of data on infections
- Monitoring and analysis of data on infections
- Regular meetings to review data on infections
- Unplanned meetings to address infection outbreaks
- Ongoing staff in-services on infection control and prevention
- Staff specialized in infection control and prevention (e.g., Infection Control Nurse)
- Resident education on infection prevention
- None
- Other

Extent of Challenging or Disruptive Resident Behaviors

(Question B805)

- Most of the time
- Some of the time
- Almost none of the time

Challenging or Disruptive Resident Behaviors Interventions

(Question B299)

- Change environment to reduce stimulation
- Consult with the resident's care team (e.g., physicians, psychiatrist, case manager, etc.)
- Development of a care plan, ISP, or BDSP
- Identify resident triggers or foreshadow/anticipate needs
- Inform and engage the family
- Interdisciplinary Team (IDT) meeting
- Keep resident engaged with activities that they enjoy doing
- Medication management
- Monitor resident for pain
- One on One interaction with resident
- Refer the resident to geropsychiatric care if needed
- Refer the resident to palliative care if needed
- Review and address unmet resident needs
- Staff training and education
- Utilize non-pharmacological interventions such as aromatherapy, Music & Memory
- None
- Other

Exhibit 4
New Jersey
HCANJ Quality Measurement Guidelines - 2019

HCANJ Quality Measurement Guidelines – 2019 (6 Total)

1. **Quality Measure:** Does the community have a formal on-going training program for all employees?

Guideline: Training modules should be established to educate all staff on areas not currently required in the assisted living regulations; in other words, above and beyond what is specified by regulation.

3. **Quality Measure:** Does the community act upon feedback provided at Resident Council? Is Resident Council inclusive of residents with dementia?

Guideline: An ongoing action plan on the progress made on feedback given at Resident Council meetings is documented and provided at the beginning of the Compliance Visit. **Any resident identifiers MUST be redacted.** Resident Council includes residents with a dementia diagnosis.

4. **Quality Measure:** Does the community use advanced care planning with residents to determine individual preferences for end-of-life care?

Guideline: In addition to Advance Directives, Practitioner Orders for Life-Sustaining Treatment (POLST) is made available to all residents who wish to complete one with their medical practitioner, and a policy developed and implemented for its use.

5. **Quality Measure:** Does the community track the number of residents admitted to the hospital as well as the number readmitted to the hospital within 30 days of hospital discharge?

Guideline: The community not only tracks those numbers but is actively engaged in working to decrease re-hospitalization rates to 20% or lower. Data is submitted by the 15th of each month.

6. **Quality Measure:** Does the community track off-label use of antipsychotic drugs?

Guideline: The community not only tracks the usage but is actively engaged in working to reduce off-label antipsychotic drug use to 15% or lower. Data is submitted by the 15th of each month.

Exhibit 5
Oregon
Requirements for Collecting Metris
(Draft: October 2019)



Quality Measurement Council

Requirements for Collecting Metrics For the Residential Care and Assisted Living Quality Measurement Program October 2019

Oregon's Residential Care Facilities and Assisted Living Facilities must start tracking metrics by the year 2020 to allow comparison of facilities across the state. This new program measuring facility performance is required by Oregon House Bill 3359, passed during the 2017 legislative session.

Measuring performance will provide useful information to facilities and also allow residents, potential residents, and family members to compare regions of the state and individual facilities.

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- **Legislative Background and Creation of Quality Measurement Program.....2**
- **Metric #1 – Retention of Direct Care Staff.....4**
- **Metric #2 – Compliance with Staff Training Requirements.....5**
- **Metric #3 – Number of Resident Falls.....7**
- **Metric #4 – Use of Antipsychotic Medications for Nonstandard Uses.....9**
- **Metric #5 – Results of Annual Satisfaction Survey.....12**

Legislative Background and Creation of the Residential Care Quality Measurement Program

Background:

The Oregon Legislative Assembly passed House Bill 3359 in 2017, amending state regulation of Residential Care Facilities (RCFs) and Assisted Living Facilities (ALFs), along with Nursing Facilities and Adult Foster Homes. This new law mandates the development of the Residential Care Quality Measurement Program and requires that each residential care facility and assisted living facility annually submit quality metrics data.

Creation of the Quality Measurement Council:

The purpose of the Residential Care Quality Measurement Program is to develop a uniform quality metrics reporting system to measure and compare performance of residential care and assisted living facilities (facilities) across the state. The system will be established by a Quality Measurement Council, in consultation with the Department. The council was appointed by the Governor, to represent specific stakeholder groups. Initial membership of the council:

Required representatives:	Appointed members:
Oregon Patient Safety Commission	Sydney E. Edlund , MS, Director of Research and Analytics, Oregon Patient Safety Commission
Residential care facilities representative	Mauro L. Hernandez , PhD, Pricipal, ita partners
Alzheimer’s advocacy organization	Sara E. Kofman , Public Policy Director, Oregon Alzheimer’s Association
Practitioner with geriatric experience	Dr. Maureen Nash , MD, MS, FAPA, FACP, Medical Director, Providence Elderplace Oregon
Academic representative with expertise	Paula Carder , PhD, Portland State University
Academic representative with expertise	Carolyn A. Mendez-Luck , PhD, MPH, Oregon State University
Long Term Care Ombudsman	Fred Steele , MPH, JD, State Long-Term Care Ombudsman
Department representative	Ann McQueen , PhD, MS, Research and Policy Integration Manager, APD, Oregon Department of Human Services

Purpose of the Quality Measurement Council:

ORS 443.447 established the Quality Measurement Council to manage the Residential Care Measurement Program. This Governor-appointed council is tasked with developing metrics to measure the quality of care provided by facilities. The council is also responsible for ensuring the measurement program won’t be burdensome to facilities.

Responsibility of RCFs and ALFs to report metrics annually:

All residential care and assisted living facilities (including those with memory care endorsements) will soon be required to track and report annually on the following quality metrics:

1. Retention of direct care staff
2. Compliance with staff training requirements,
3. Incidence of falls with injury,
4. Use of antipsychotic medications for nonstandard purposes, and
5. Results of annual resident satisfaction survey conducted by a third party.

Each RCF and ALF shall submit the required quality metrics data to the Department using a web-based Quality Metrics Portal (Portal). The Department, with the Council's input, is currently creating this user-friendly web-based system for facilities to submit data. This system will be beta tested by a small group of facilities in late 2019, to "work out the bugs" before all facilities are required to begin collecting data. Following these tests, the Department and partners will conduct a series of webinars to train all facilities on how to track data and submit the required data electronically using the Portal.

The first reporting cycle will begin with facilities tracking 2020 data and reporting that data via the Portal by January 31, 2021. By each January 31st after this, metrics data will be required for the previous year's data.

The following chart indicates the frequency and duration of time that each quality metric is to be tracked:

<i>Metric #</i>	<i>Metric Name</i>	<i>Data Collection Frequency</i>	<i>Duration of Time</i>
1	Retention of Direct Care Staff	Once, after 12/31 of each year (for previous year)	Full calendar year
2	Compliance with Staff Training Requirements	Once, after 12/31 of each year (for previous year); monthly tracking tool is available/recommended.	Full calendar year
3	Number of Resident Falls with Injury	Once per month for each month of the year; four data elements to report per month	Full calendar year
4	Antipsychotic Meds Prescribed for Non-standard Use	Report daily for all 31 days of October of each year.	31 days (October)
5	Results of Annual Satisfaction Survey/Resident Experience	Once, before 12/31 of each year (for previous year)	Once a year, at about the same time each year

Annual Report

The Department will compile the information received from all residential care facilities and assisted living facilities and publish an annual report describing statewide patterns and trends. This report will be available online to be used by facilities and the general public to evaluate and compare facilities. Quality metrics data will also be posted as part of each facility's record on the Long-term Care Settings Search Tool website: <https://ltclicensing.oregon.gov/>

Quality Metric #1: Retention of Direct Care Staff

Background and Reason for Tracking:

Research indicates retention of trained staff results in better care to residents, while high rates of staff turnover are associated with poorer quality of care. Experienced staff are more effective at providing quality care, given their familiarity with residents. As staff become more knowledgeable about resident preferences, health status and behaviors, these staff are better able to anticipate and meet residents' needs, and build trusting relationships with residents. Experienced staff also know and understand the practices, policies and routines of the facility.

What Facilities Need to Do:

1. Determine:
 - Total number of direct care staff who have worked in the facility for one calendar year (full 12 months) or longer.
 - Total number of current direct care staff on payroll at the end of calendar year.
2. The two numbers above are used to determine how many staff have maintained employment with the facility for the duration of the year ("retention").

$$\text{Retention}^1 = \frac{\text{Total number of direct care staff employed by facility for calendar year or longer}}{\text{Total number of direct care staff employed at end of calendar year}}$$

Data Facilities Need to Track for this Metric:

- Hire date for each direct care staff – this will allow facilities to determine which direct care staff have been employed for at least a year as of 12/31 of the past year.
- Total number of direct care staff (regardless of hire date) on payroll on December 31st, at end of calendar year

Timeline for Tracking and Reporting:

- **Tracking:** Facilities will need to begin tracking the data for this measure on 1/1 of each year and track through 12/31 of that year.
- **Reporting:** The *total number of direct care staff employed for at least the calendar year* (full 12 month period between 1/1/ and 12/31) AND the *total number of direct care staff employed on December 31st* must be entered into the Portal by January 31st of the following year.

¹ Reference source: Formula for calculating staff retention is from American Health Care Association (AHCA) 2012 Staffing Report

Quality Metric #2: Compliance with Staff Training Requirements

Background and Reason for Tracking:

For the health and safety of residents, it is essential to have trained staff caring for residents in facilities. Staff who are adequately trained provide residents better care and service and also experience greater job satisfaction. This metric covers all staff hired by the facility, whether direct care staff, non-direct care staff, or universal workers.

What Facilities Need to Do:

- Facilities need to track training data for all staff for the entire calendar year.
- For this metric, facilities must first record the following:
 - Name of each staff person, and whether person provides direct care² or non-direct care.
 - Universal workers³ are also included, and the training that relates to the individual worker’s duties should be tracked.
 - Number of total staff (direct care and non-direct care) working in the facility.
 - The date each staff person was hired.
 - For direct care staff, the date each person began to provide direct care.

- Facilities should then track:

- The date each direct care staff person completed the following training courses:

• Resident rights	• Activities of Daily Living (ADLs)
• Abuse reporting	• Change of condition
• Infection control	• Required assessment
• Fire safety and emergency procedures	• Food safety
• Pre-service dementia training	• Medication and treatment administration
• Pre-service orientation to residents	• 6 hours annual dementia inservice training
• Service plans	• 6 hours annual inservice on “other” topics

- The date each non-direct care staff person completed the following training courses:

• Resident rights	• Fire safety and emergency procedures
• Abuse reporting	• Food handling and safety
• Infection control	

- The date each staff person left facility employment (termination date), if applicable.

² Reference: Oregon’s definition of “Direct Care Staff” as defined in OAR 411-054-0005

³ “Universal Workers,” as defined in OAR 411-054-0005(84), can be assigned tasks such as housekeeping or food service, in addition to providing direct resident services.

DHS will provide a sample Training Tracking tool facilities may choose to use. This tool will be optional and available for facilities to assist in tracking staff training required for this metric. There will be no technical assistance available to facilities wishing to use this form, and the Department takes no responsibility for inaccuracies in data related to the use of this form.

Data Facilities Need to Track for this Metric:

- Date each employee completes each required training component.
- Total number of staff who have completed all required training modules.
- Total number of staff in facility at the end of the reporting period.

Timeline for Tracking and Reporting:

- **Tracking:** Beginning on 1/1 of each year, and ending after 12/31 of each year, track the date each employee completes each required training component.
- **Reporting:** The tracking percentage must be entered into the Portal by January 31st of the following year. Facilities may choose to track this data using their own tracking tool before entering the data into the Portal, or may use the model Training Tracker.

Final Metric:

The Portal will divide the number of staff who completed all training modules by the total number of staff = **percentage of staff who have completed all trainings.**

Sections of OAR 411-054-0070 outlining trainings that must be completed by direct care staff:

<i>Training requirement</i>	<i>Section of OAR 411-054-</i>
Resident rights	(3)(a)(A)
Abuse reporting	(3)(a)(B)
Infection control	(3)(a)(C)
Fire safety and emergency procedures	(3)(a)(D)
Pre-Service Dementia training	(4)
Pre-Service Orientation to individual residents	(4)(g)
Service plans	(5)(b)(A)
Activities of Daily Living (ADLs)	(5)(b)(B)
Changes associated with aging	(5)(b)(C)
Change of condition	(5)(b)(D)
Required assessment	(5)(b)(E)
Food safety	(5)(b)(F)
Medication and treatment administration	(5)(b)(G)
6 hours annual dementia inservice training	(6)(b)
6 hours annual inservice training on "other" topics	(6)(a)

Sections of OAR 411-054-0070 that must be completed by non-direct care staff:

<i>Training requirement</i>	<i>Section of OAR 411-054-</i>
Resident rights	(3)(a)(A)
Abuse reporting	(3)(a)(B)
Infection control	(3)(a)(C)
Fire safety and emergency procedures	(3)(a)(D)
Food handling	(3)(b)

Quality Metric #3: Number of Resident Falls

Background and Reason for Tracking:

Falls are a primary cause of resident injury and can lead to premature death.

A “fall with injury” is defined as: an unintended descent to the floor or other object (e.g., sink, table, surrounding furniture) that requires care outside of the facility (hospital, urgent care or other medical facility). It is important to note that not all falls are preventable, and not all falls are serious enough to cause injury.

Facilities with more residents at risk for falls will likely have consistently higher numbers for this metric, whereas facilities with lower numbers of residents at risk for falls would have lower numbers for this metric. This is to be expected.

For all facilities, it is crucial for staff to learn as much as possible about why falls are occurring and to determine what may be done to lessen the number and severity of falls as much as possible.

What Facilities Need to Do:

1. Count every “fall with injury.”

For the purposes of this metric, an “injury” is defined as any of the following:

- **Bruise, abrasion or wound requiring simple intervention such as dressing, ice, limb elevation, topical medications, oral pain medications, etc.**
 - These injuries may be treated within the facility or may involve a resident leaving the facility for care.
- **Dislocation, fracture, intracranial injury, laceration requiring sutures/stitches, skin tear/avulsion or significant bruising.**
 - These injuries generally require outside intervention and may require splints, sutures, surgery, casting or further examination (e.g., for possible neurological injury).
 - These injuries frequently involve the resident leaving the facility for assessment and/or treatment and/or they may require home health care.

- #### **2. For each month, track (4) data points (or a total of 48 data points per year).**
- Facilities may enter data into the Portal following each month or all at once for the entire year.

Data Facilities Need to Track for this Metric:

For each month, facilities must provide the following four (4) data points:

1. **Total number of residents living in the facility on the last day of the month.** Enter this number into the correct row and column on the Portal page for this metric.
2. **Total number of falls with injury that involved residents living in the facility on the last day of the past month.** Enter this number into the correct row and column on the Portal page for this metric.
3. **Number of residents living in the facility on the last day of the past month who fell with injury during the month.** Enter this number into the correct row and column on the Portal page for this metric.
4. **Number of residents living in the facility on the last day of the past month who fell more than once with injury during the month.** Enter this number into the correct row and column on the Portal page for this metric.

Timeline for Tracking and Reporting:

- **Tracking:** Track the four items listed above for all 12 months of the year.
- **Reporting:** Facilities may enter data into the Portal following each month or all at once for the entire year.

Final metric:

The Portal will calculate the annual average for each of the four fields. Partial data will not be used. If a facility fails to report any falls data on any month, averages will not be calculated, and the facility will be listed as not reporting data for this measure. All 48 fields in the Portal must have data entered into them for a facility to receive credit for completing this measure.

Yearly averages will be reported for each facility for all four data points for entire year:

	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Average Reported to Public
Total # of residents on last day of month	40	42	44	41	43	43	40	38	39	42	44	42	41.5
Total number of falls with injury during the past month	3	4	5	4	4	5	4	5	5	4	6	6	4.6
Number of residents who fell with injury during past month	2	2	3	2	2	2	1	3	3	3	3	3	2.4
Number of residents who fell more than once with injury during past month	0	0	1	0	0	0	0	2	2	2	2	2	0.9

Quality Metric #4: Use of Antipsychotic Medications for Nonstandard Uses

Background and Reason for Tracking:

Antipsychotic medications were designed to treat symptoms of psychosis due to a variety of causes. Antipsychotics have helped numerous people live more productive lives by treating these psychotic symptoms.

Antipsychotics can be a standard treatment when a resident with dementia has psychosis, physical aggression, or a psychiatric illness. Neuropsychiatric symptoms (also known as behavioral psychological symptoms of dementia) are common and can be distressing; however they are usually not dangerous and are best addressed through person-centered planning and care routines. Thorough assessment, knowledge about each individual's history and current preferences, and adequate staffing and staff training related to behaviors are all crucial elements in providing person-centered care. Medications including antidepressants, antianxiety, and antipsychotics can also be part of a person-centered plan.

There is concern antipsychotic medications are being overused in facilities to calm undesirable behavioral and psychological symptoms of residents with dementia. Thus, the goal is for facilities to ensure antipsychotics are only prescribed following a person-centered assessment and careful consideration of the specific needs of each individual resident, as well as ensuring these medications are used in conjunction with ongoing non-pharmacological approaches (such as meaningful activities).

The purpose of this metric is to encourage the appropriate use of antipsychotics, not to discourage all use of antipsychotic medications. It is recognized there are evidence-based reasons for prescribing antipsychotic medications for residents. Data is needed to determine the prevalence of nonstandard antipsychotic medication use and to encourage facilities to examine their use of these medications.

The first step is to measure the number of residents receiving nonstandard antipsychotic medications. This includes tracking both nonstandard⁴ "scheduled"⁵ and nonstandard "PRN"⁶ antipsychotic medications. Facilities will be provided a list of specific antipsychotic medications⁷ that must be tracked for this purpose.

⁴ A **non-standard use** is an antipsychotic prescribed for a use other than the uses approved by the FDA

⁵ A **scheduled medication** is prescribed by a qualified practitioner to be used immediately, for a specific time period

⁶ A **PRN medication** means medications and treatments prescribed by qualified practitioner to be administered as needed. (PRN stands for "pro re nata" which loosely translates to "as needed")

⁷ The **Food and Drug Administration (FDA) list** is provided at end of this section. The list may change from year to year.

What Facilities Need to Do:

- Facilities must track the use of **non-standard, scheduled antipsychotic** medication, as indicated on the MAR⁸ for the entire month of October (October 1 – 31) of each year.⁹ This includes both regularly scheduled and PRN (as needed) antipsychotic medications.

Data Facilities Need to Track for this Metric:

- Use the 31-day time period from October 1-31 each year as the measurement period.
 1. At this end of this 31-day time period, count the total number of residents in the facility.
 2. Review each MAR and determine which residents were prescribed an antipsychotic on the Food and Drug Administration (FDA) list (2020 FDA list appears on the next page).
 3. Exclude any residents who have a diagnosis listed on the following **Exclusions List**:
 - Schizophrenia,
 - Schizoaffective Disorder,
 - Huntington’s Disease,
 - Tourette’s Syndrome,
 - Bipolar Disorder,
 - Depression or
 - Autistic Disorder.
 4. Of the residents remaining after excluding those on the “Exclusions List,” determine how many of these:
 - a. Were prescribed a **non-standard, scheduled antipsychotic** medication, as indicated on the MAR during the 31-day time period and
 - b. Were prescribed a **PRN antipsychotic medication**, as indicated on the MAR at the end of the 31-day time period.

Timeline for Tracking and Reporting:

- Tracking: Facilities will need to begin tracking the data for this measure on 10/1 of each year and track through 10/31 of that year.
- Reporting: Data for this measure may be entered into the Portal any time after 10/31 of each year but before 1/31 of the following year. In other words, data collected 10/1/2020 – 10/31/2020 will need to be entered into the Portal between 11/1/2021 – 1/31/2021.

⁸ MAR stands for “Medication Administration Record.”

⁹ Used by AHCA/NCAL Quality Initiative

Final Metric:

The Portal will use the information provided to calculate:

1. Percentage of residents with **scheduled non-standard use of an antipsychotic drug:**

$$\frac{\% \text{ of residents with non-standard use of an antipsychotic drug} \times \# \text{ of residents with scheduled non-standard antipsychotic drug use indicated on the MAR}^{10} \text{ on 10/31}}{\text{Total \# of residents in the facility as of 10/31}}$$

2. Percentage of residents with **PRN non-standard use of an antipsychotic drug:**

$$\frac{\% \text{ of residents with PRN use of an antipsychotic drug} \times \# \text{ of residents with PRN use of nonstandard antipsychotic drug as indicated on the MAR on 10/31}}{\text{Total \# of residents in the facility on 10/31}}$$

Antipsychotic Medications List for 2020, as approved by the Food and Drug Administration:

First-Generation Antipsychotics

Generic Name	Brand or Trade Name
Chlorpromazine	Thorazine
Droperidol	Inapsine
Fluphenazine	Prolixin
Haloperidol	Haldol
Loxapine	Loxitane
Perphenazine	Trilafon
Pimozide	Orap
Prochlorperazine	Compazine
Thiothixene	Navane
Thioridazine	Mellarill
Trifluoperazine	Stelazine

Second-Generation Antipsychotics

Generic Name	Brand or Trade Name
Aripiprazole	Abilify
Asenapine	Saphris
Clozapine	Clozaril
Iloperidone	Fanapt
Olanzapine	Zyprexa
Paliperidone	Invega
Quetiapine	Seroquel
Risperidone	Risperdal
Ziprasidone	Geodon
Lurasidone	Latuda

Exhibit 6
Wisconsin
2018 WCCEAL Resident Satisfaction Survey

00001 (CBRF) - Sample Community 01
Wisconsin Coalition for Collaborative Excellence in Assisted Living
2018 WCCEAL Satisfaction Survey

Your satisfaction with your living experience at Sample Community 01 is important to us.

Please share your opinion with us by filling out the attached survey.

1. For each item, please mark the box that best indicates your opinion.
 2. Please detach the completed survey.
 3. Place it in the attached preposted envelope (no stamps needed).
 4. If you wish to remain anonymous, please seal the envelope. If remaining anonymous is not important to you, you do not need to seal the envelope.
 5. Please place your sealed envelope in the outgoing mail bin at the front desk.
- Surveys will not be valid after April 30, 2018.

This satisfaction survey is part of a state wide initiative called the Wisconsin Coalition for Collaborative Excellence in Assisted Living (WCCEAL). The goal of WCCEAL is to continuously improve the quality of service provided by participating assisted living provider organizations. WCCEAL is an unprecedented collaboration between:

- Wisconsin Department of Health Services
- University of Wisconsin-Madison
- Center for Health Systems Research and Analysis (CHSRA)
- Board on Aging and Long Term Care
- Disability Service Provider Network (DSPN)
- LeadingAge Wisconsin
- Wisconsin Assisted Living Association (WALA)
- Wisconsin Center for Assisted Living (WHCA/WiCAL)

For more information, please visit <https://wceal.chsra.wisc.edu>

Thank you for your participation.

Thank you for taking a few minutes to let us know how you feel about living here.

**2018 WCCEAL Satisfaction Survey
00001 (CBRF) - Sample Community 01**

Survey filled out by <input type="checkbox"/> Resident (tenant) alone <input type="checkbox"/> Resident assisted by helper <input type="checkbox"/> Helper on resident's behalf	Helper is <input type="checkbox"/> Family member <input type="checkbox"/> Guardian/POA <input type="checkbox"/> Friend <input type="checkbox"/> Staff/volunteer	Resident (tenant) has lived here <input type="checkbox"/> 0-6 months <input type="checkbox"/> 7-12 months <input type="checkbox"/> 1-2 years <input type="checkbox"/> Over 2 yrs	5	4	3	2	1	
			Strongly Agree	Agree	Neutral	Disagree	Strongly Disagree	Not Applicable
			<input type="checkbox"/>					
			<input type="checkbox"/>					

A. STAFF

1. The staff members are courteous	<input type="checkbox"/>					
2. The staff members are available to talk with me	<input type="checkbox"/>					
3. The staff members know what I like and dislike	<input type="checkbox"/>					
4. I can get help when I need it	<input type="checkbox"/>					

B. RIGHTS

1. I was informed of my rights	<input type="checkbox"/>					
2. The people who work here protect my rights	<input type="checkbox"/>					
3. My privacy is respected	<input type="checkbox"/>					
4. I am informed of rate and policy changes that might affect me	<input type="checkbox"/>					
5. I am treated with dignity and respect	<input type="checkbox"/>					

C. ENVIRONMENT

1. The residence is homelike and well-maintained	<input type="checkbox"/>					
2. I feel safe here	<input type="checkbox"/>					
3. My personal belongings are safe here	<input type="checkbox"/>					

D. ACTIVITIES

1. Activity programs are offered daily that interest me	<input type="checkbox"/>					
2. There are opportunities for me to fulfill my spiritual needs	<input type="checkbox"/>					
3. I have the opportunity to socialize with others	<input type="checkbox"/>					

E. MEALS AND DINING

1. I get enough to eat	<input type="checkbox"/>					
2. The menus offer a variety of food selections	<input type="checkbox"/>					
3. I can participate in meal planning if I want	<input type="checkbox"/>					
4. My special diet needs are met	<input type="checkbox"/>					
5. The food is to my liking	<input type="checkbox"/>					
6. The temperature of the food is to my liking	<input type="checkbox"/>					

F. HEALTH MANAGEMENT/CARE

1. My family/representative is kept informed about me as I choose	<input type="checkbox"/>					
2. My choices of health care providers are respected	<input type="checkbox"/>					
3. I get the care and services I need	<input type="checkbox"/>					
4. I receive medications on time in a manner acceptable to me	<input type="checkbox"/>					

G. OVERALL

1. My lifestyle choices are respected	<input type="checkbox"/>					
2. I am satisfied with my overall experience here	<input type="checkbox"/>					
3. I would recommend this residence and its services to a friend or loved one	<input type="checkbox"/>					

H. COMMENTS. How can we improve your living experience?

Exhibit 7
New Jersey
HCANJ Quality Measurement Guidelines
Resident Satisfaction Survey

HCANJ Quality Measurement Guidelines – 2019 (6 Total)

2. **Quality Measure:** Does the community measure resident and family satisfaction?

Guideline: At a minimum, each resident (or their designated responsible party) and their family, as appropriate, should be provided with a formal, written inquiry on their level of agreement with the following statements (using five-point scale):

1. Overall, I am satisfied with this community.
2. I would recommend this community to others.
3. Overall, staff shows genuine respect and treats me (for family: my loved one) with dignity.
4. Overall, I am satisfied with the way my (my loved one's) choices and preferences are met.
5. Management is timely in their responses to me (my loved one's) and my family's suggestions and concerns.
6. Staff recognizes and responds in a timely manner to changes in my (my loved one's) needs.
7. Overall, I (my loved one) feel(s) safe in this community.

A comment section should be included for additional feedback on each of the areas, above.

OR

Coincide with the CoreQ Measures of LTC Trend Tracker – Likert scale: Poor, Average, Good, Very Good, Excellent

1. In recommending this facility to your friends and family, how would you rate it overall?
2. How would you rate the staff?
3. How would you rate the care you receive?
4. Overall, how would you rate the food?

Blank surveys are made available for review at the time of the Compliance Visit. The required questions are highlighted. Feedback is collected, and an action plan developed and administered, for areas that meet with low levels of satisfaction. Written feedback is provided to all residents and families on the action plan. At the very minimum, there must be at least one area identified for improvement.

Exhibit 8
Oregon
Requirements for Collecting Metris
Resident Satisfaction Survey
(Draft: October 2019)



Quality Measurement Council

Requirements for Collecting Metrics For the Residential Care and Assisted Living Quality Measurement Program October 2019

Oregon's Residential Care Facilities and Assisted Living Facilities must start tracking metrics by the year 2020 to allow comparison of facilities across the state. This new program measuring facility performance is required by Oregon House Bill 3359, passed during the 2017 legislative session.

Measuring performance will provide useful information to facilities and also allow residents, potential residents, and family members to compare regions of the state and individual facilities.

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- **Metric #1 – Retention of Direct Care Staff.....4**
- **Metric #2 – Compliance with Staff Training Requirements.....5**
- **Metric #3 – Number of Resident Falls.....7**
- **Metric #4 – Use of Antipsychotic Medications for Nonstandard Uses.....9**
- **Metric #5 – Results of Annual Satisfaction Survey.....12**

Quality Metric #5: Results of Resident Annual Satisfaction Survey

Background and Reason for Tracking:

Research suggests that high customer satisfaction is directly linked to the quality of care and resident experiences. Conducting a resident survey is an effective way of determining how satisfied residents are with facility care and services.

The Quality Measurement Council chose to adopt the CoreQ questions for assisted living (AL) to measure satisfaction for this metric; the CoreQ questions have been independently verified as reliable.

To ensure this measurement is unbiased and accurately reflects the responses of resident satisfaction consistent with standard practice and legislative requirements, surveys using CoreQ questions are required to be **conducted by a contracted third party**.

Each facility must contract with a CoreQ vendor to complete an annual survey. To learn more about the CoreQ process and see the list of third-party consultants with CoreQ capacity, go to: www.CoreQ.org.

Three Items to Note:

- Surveys may be administered in different ways (i.e., by mail, by phone, etc.).
- The method of administration, as well as the ability to respond to questions, may cause some residents to be unable to participate.
- In order to protect confidentiality of residents and to maintain a fair measurement process, facilities with fewer than 10 responses will not have results shown individually on the final report. (Their results will, however, be used to calculate statewide and regional averages.)

What Facilities Need to Do:

- Hire a third-party vendor to conduct an annual CoreQ survey.
- Once the third-party vendor has completed the survey, the facility should enter that data into the Portal.

Data that Needs to be Tracked:

- Surveys should be conducted annually by an independent third-party vendor who is CoreQ approved; preferably surveys should take place at approximately the same time each year.
- The following scale will be used for the annual satisfaction survey¹¹:
 Poor (1), Average (2), Good (3), Very Good (4), and Excellent (5)
- During the survey, the following questions will be asked in exactly the same way they are asked below (CoreQ approved vendors are trained to do this). Vendors will supply facilities with final data, and facilities will enter data for each question into the Portal:
 1. In recommending this facility to friends and family, how would you rate it overall?
 2. Overall, how would you rate the staff?
 3. How would you rate the care you receive?
 4. Overall, how would you rate the food?

Timeline for Tracking and Reporting:

- **Tracking:** Each facility must hire an independent, third-party vendor that is CoreQ approved to conduct an annual satisfaction survey that addresses the questions listed above. For a list of third-party consultants with CoreQ capacity/approval, see: <http://www.coreq.org/> and click on “Customer Satisfaction Vendors” at the top of the page.)
- **Reporting:** This survey information must be entered into the Portal by January 31st of the year after the survey. Facilities are required to enter:
 - The surveyors’ results to each of the four questions.
 - Name of the third-party vendor who conducted the survey.

¹¹ Rating scale and questions come from CoreQ survey instrument.
DRAFT Quality Metrics for RCFs/ALFs October 2019

Exhibit 9A
Ohio
Department of Aging
2017 Resident Satisfaction Survey



INTERVIEW DETAILS

Today's Date: _____

Resident ID: _____

Length of Stay: Long-term
 Short-term

Facility ID: _____

Admission Date: _____

Resident Gender: Male
 Female

Interviewer ID: _____

Mark only if interview was interrupted and re-started

Start Time 1: _____ : _____ am / pm
 Hr Min

Start Time 2: _____ : _____ am / pm
 Hr Min

End Time 1: _____ : _____ am / pm
 Hr Min

End Time 2: _____ : _____ am / pm
 Hr Min

INTERVIEW STATUS

Complete

Incomplete → Reason why interview is incomplete (if applicable)

Resident fatigue

Necessary clinical care

Assistance with interview
(if applicable)

Unable to respond to questions

Resident illness

Family member

Refusal to continue

Other

Volunteer

Guardian

Other

MOVING IN

FIRST, I'D LIKE YOU TO THINK BACK TO WHEN YOU FIRST MOVED HERE.

Generally,
yes

Generally,
no

DK/NA/NR

1. Do you remember what it was like when you first moved in here?

(If no, skip to Spending Time, question 4.)

2. Were you given enough help to learn how things work here? (Probe: When meals are served, where to sit in the dining room, how to find out about activities)

3. Did you feel warmly welcomed as a new resident?

SPENDING TIME

NEXT, I'D LIKE YOU TO THINK ABOUT HOW YOU SPEND YOUR TIME.

- | | Generally,
yes | Generally,
no | DK/NA/NR |
|--|-----------------------|-----------------------|-----------------------|
| 4. Do you usually enjoy how you spend your time? | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| 5. Do you have something to look forward to most days? | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| 6. Do the people who work here keep you connected to the community?
(Probe: Knowing about things that are going on here and outside the facility) | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| 7. Are you given plenty of opportunities to do things that are meaningful to you?
(Probe: Things that are important to you, things that matter) | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| 8. Does this facility provide plenty of opportunities to go on outings and special events? | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| 9. Do you like the activities that are provided here? (Probe: Games like bingo, entertainers, movies, parties) | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| 10. Do you spend too much time waiting for things? (Probe: Activities to begin, meals to be served) | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| 11. Does this facility [or facility name] provide enjoyable things to do on the weekends? (Probe: Games and bingo, entertainers, movies, parties) | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |

CARE AND SERVICES

NOW, I'D LIKE YOU TO THINK ABOUT THE HELP YOU GET HERE.

- | | Generally,
yes | Generally,
no | DK/NA/NR |
|--|-----------------------|-----------------------|-----------------------|
| 12. Are your preferences about daily routines carried out? (Probe: Meals are served at the time you want, you get help with a bath when you want it) | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| 13. Does this living arrangement help you to be as independent as you want to be? | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| 14. Have you gotten or are you getting special therapies, like physical therapy, occupational therapy or speech therapy, while living at this care facility? | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |

(If no, skip to Caregivers, question 18.)

- | | | | |
|--|-----------------------|-----------------------|-----------------------|
| 15. Did the therapists help you set goals? | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| 16. Did the therapy help you meet your goals? | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| 17. Did (Do) you know who to speak to about your therapy progress? | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |

CAREGIVERS

NEXT, I'D LIKE YOU TO THINK ABOUT THE PEOPLE WHO TAKE CARE OF YOU.

- | | Generally,
yes | Generally,
no | DK/NA/NR |
|---|-----------------------|-----------------------|-----------------------|
| 18. Are the people who work here knowledgeable about your medical conditions and treatments? | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| 19. Do the people who work here do things the way you want them done?
<i>(Probe: Clean your room properly, turn on music that you like, prepare your coffee the way you like it)</i> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| 20. Do the people who work here check on you often enough to see if you need anything? | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| 21. Do the people who work here encourage you to be as independent as you are able to be? | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| 22. Are you given opportunities to actively engage in maintaining your health and wellness? | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| 23. Do you feel confident the people who work here would come quickly anytime you needed help? | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| 24. Do the people who work here ever get angry at you? | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| 25. Do the people who care for you explain your care and services to you?
<i>(Probe: Explain what is going to happen next, describe what they are doing)</i> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| 26. Do the same people take care of you most of the time? | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |

MEALS AND DINING

NOW, I WANT YOU TO THINK ABOUT THE FOOD AND MEALTIME.

- | | Generally,
yes | Generally,
no | DK/NA/NR |
|---|-----------------------|-----------------------|-----------------------|
| 27. Do you get your favorite foods here? | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| 28. Does the menu change often enough? | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| 29. Do you have input into the food that is served? | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| 30. Do you like the food here? | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| 31. Do you look forward to mealtimes? | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |

ENVIRONMENT

NEXT, I'D LIKE YOU TO THINK ABOUT YOUR ROOM OR APARTMENT AND THE BUILDING.

	Generally, yes	Generally, no	DK/NA/NR
32. Is it very clean here?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
33. Is it easy for you to get around in your room or apartment?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
34. Can you enjoy the outdoors when you want to?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
35. Do you feel you have enough privacy? (<i>Probe: To have a conversation, meet with visitors, do things by yourself</i>)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
36. Can you find a place to be alone when you want to be alone?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
37. Are your personal items safe here? (<i>Probe personal items: Your clothing, other things that belong to you; Probe safe: Things don't get lost or stolen, things don't get damaged</i>)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
38. Do you feel safe here?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

FACILITY CULTURE

FOR THESE LAST QUESTIONS, I'D LIKE YOU TO THINK ABOUT THINGS OVERALL.

	Generally, yes	Generally, no	DK/NA/NR
39. Are you encouraged to speak up about things you don't like here? (<i>Probe: Your bathing schedule, the food, your room</i>)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
40. Are your concerns taken care of in a timely way? (<i>Probe: The food, your room</i>)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
41. Are you involved in decisions about your care?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
42. Do the people who work here seem happy to work here? (<i>Probe: Aides, nurses, dining room servers</i>)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
43. Do the people who work here go above and beyond to give you a good life? (<i>Probe: Go the extra mile, do extra things</i>)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
44. Do you feel included in life here? (<i>Probe: Know about things that are happening, feel part of a community</i>)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
45. Are you friends with anyone who lives here? (<i>Probe: Is there anyone you enjoy spending time with</i>)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
46. Would you highly recommend this residential care facility to a family member or friend?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

THOSE ARE ALL THE QUESTIONS I HAVE FOR YOU. THANK YOU VERY MUCH FOR ANSWERING ALL MY QUESTIONS.

[GO TO THE FIRST PAGE AND RECORD INTERVIEW STATUS AND INTERVIEW END TIME.]

Exhibit 9B
Ohio
Department of Aging
2018 Family Satisfaction Survey

Ohio | Department of Aging

John Kasich, Governor
Beverley L. Laubert, Interim Director

Dear Family Member or Friend of an Ohio Long-Term Care Facility Resident:

You have the right to expect excellence from the providers who give long-term care and support to your loved ones. At the Ohio Department of Aging, we work every day to help our elders and their families seek and receive the highest quality care and live the highest quality of life possible at every nursing home and assisted living facility in the state.

We are working with the Scripps Gerontology Center at Miami University to survey family members, friends or guardians of Ohioans who live in long-term care facilities, including nursing homes, residential care facilities and hospital sub-acute units. We want to know what you think about your relative's or friend's home. The results of this Family Satisfaction Survey will be posted on the Ohio Long-Term Care Consumer Guide Web site (www.ltc.ohio.gov) early in 2019. The Consumer Guide helps people select a long-term care provider by offering comparative information. The survey results also help long-term care providers improve their services.

I hope you will add your voice to this important conversation about quality care. The information that you provide in this survey is anonymous; nothing on the survey identifies you, and providers will not see your responses to the multiple-choice questions. Your participation is voluntary, but critical. More than 32,000 family members and friends participated in the 2016 survey.

You may submit your survey responses online using the instructions on the front cover of this packet or complete the printed survey form and return it anonymously to the researchers at Scripps using the enclosed postage-paid envelope. If your family member has received care in several places, please respond thinking about the home identified on the form. Even if their stay was a short one or they have already returned home, your input about their brief experience is still very important.

Please submit or mail your survey responses within two weeks of receiving this packet.

Call the Family Satisfaction Survey toll-free helpline at **1-844-864-0049** between 9 a.m. and 4 p.m. or e-mail familysurvey@miamioh.edu if you have any questions about the survey.

If you have concerns about the care your loved one is receiving, please contact the Office of the State Long-term Care Ombudsman at **1-800-282-1206** for assistance. Comments written on the survey form itself may not otherwise be seen by an ombudsman who can help.

Thank you for your participation.

Sincerely,



Beverley L. Laubert
Interim Director

246 N. High St. / 1st Fl.
Columbus, OH 43215-2406 U.S.A.
www.aging.ohio.gov

Main: (614) 466-5500
Fax: (614) 466-5741
TTY: Dial 711

Facility ID:

2018 Ohio Residential Care Facility Family Satisfaction Survey

Thank you for taking the time to complete the Ohio Residential Care Facility (RCF) Family Satisfaction Survey. It is for family members and other people involved in the lives of Ohio's RCF or assisted living residents. Please answer as many questions as you can, even if you were only involved with a resident for a short stay. If a question does not apply to your resident, or you do not know about the service or care, please check the "Don't know/Not applicable" box. You may skip any question you don't want to answer. Do NOT remove this page from your survey. We won't know which facility you are responding about.

You may complete your survey via the Internet if you would prefer.

Type the URL <http://miamioh.edu/scrippsaging/2018-RCF-family-survey> into the address line of your Internet browser. You will be asked to enter a facility identification number and serial number to login to the survey. Type the facility identifier (the code above beginning with OH) exactly as it appears in the upper right corner of this page. Enter the serial number from the lower right corner when you login to the survey. Do NOT complete and return this paper survey if you complete the survey online.

If you have questions or concerns after reading the letter from ODA on the next page, please call the **toll-free survey helpline at 1-844-864-0049** 9:00-4:00, M-F or send e-mail to **familysurvey@miamioh.edu**. You may leave a message and a phone number any time and your call will be returned the next business day.

PLEASE DO NOT FOLD YOUR SURVEY.

Ohio Department of Aging Residential Care Facility Family Satisfaction Survey 2018

Marking Instructions - Use a dark-colored ink (ball-point, gel, roller-ball, felt-tip will all work well).

Please do not use pencil.

If you make a mistake, cross out the incorrect answer and check the correct one.

Correct:

If you make a mistake:

***** Please do not fold your survey *****

Moving In

	<i>Definitely No</i>	<i>Probably No</i>	<i>Probably Yes</i>	<i>Definitely Yes</i>	<i>Don't know /Not Applicable</i>
1. When the resident moved in, were you given thorough information to help you know what to expect?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2. Was the resident given a thorough orientation to residential care?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3. Did you feel warmly welcomed as a new family member?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Spending Time

	<i>Definitely No</i>	<i>Probably No</i>	<i>Probably Yes</i>	<i>Definitely Yes</i>	<i>Don't know /Not Applicable</i>
4. Does the resident have something enjoyable to look forward to most days?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5. Do the staff do a good job keeping the resident connected to the community?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6. Does the resident have plenty of opportunities to do things that are meaningful to them?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7. Does the residential care facility have enough opportunities for your resident to go on special outings and events?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
8. Does the resident like the provided activities?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
9. Does the residential care facility provide things the resident enjoys doing on the weekend?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
10. Do you have plenty of opportunities to be involved in the residential care facility?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Care and Services

	<i>Definitely No</i>	<i>Probably No</i>	<i>Probably Yes</i>	<i>Definitely Yes</i>	<i>Don't know /Not Applicable</i>
11. Does this living arrangement help the resident maintain their independence?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
12. Do you have enough opportunities for input into decisions about your resident's care?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
13. Do you get enough information to make decisions with or about your resident?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Caregivers

	<i>Definitely No</i>	<i>Probably No</i>	<i>Probably Yes</i>	<i>Definitely Yes</i>	<i>Don't know /Not Applicable</i>
14. Do you feel confident the staff is knowledgeable about the resident's medical condition(s) and treatment(s)?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
15. Do the staff know what the resident likes and doesn't like?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
16. Do the staff regularly check to see if the resident needs anything?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
17. Have you gotten to know the staff who care for your resident?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
18. Do the staff encourage your resident to be as independent as they are able to be?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
19. Do you feel confident staff would come quickly anytime your resident needed help?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Meals and Dining

	<i>Definitely No</i>	<i>Probably No</i>	<i>Probably Yes</i>	<i>Definitely Yes</i>	<i>Don't know /Not Applicable</i>
20. Is there a lot of variety in the meals?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
21. Are you included in mealtimes if you want to be?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
22. Is the food good?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Environment

	<i>Definitely No</i>	<i>Probably No</i>	<i>Probably Yes</i>	<i>Definitely Yes</i>	<i>Don't know /Not Applicable</i>
23. Is the residential care facility thoroughly clean?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
24. Can the resident get outside often enough?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
25. Are the resident's belongings safe?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Facility Culture

	<i>Definitely No</i>	<i>Probably No</i>	<i>Probably Yes</i>	<i>Definitely Yes</i>	<i>Don't know /Not Applicable</i>
26. Are you encouraged to speak up when you have a problem?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
27. Are your concerns addressed in a timely way?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
28. Are you kept well informed about how things are going with your resident?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
29. Do the staff seem happy to work at the residential care facility?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
30. Do the staff go above and beyond to give your resident a good life?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
31. Do you feel confident that staff would help your resident beyond their personal care needs if you could not (e.g. things like paperwork, purchasing clothing)?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
32. Do you have peace of mind about the care your resident is getting when you aren't at the residential care facility?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
33. Would you highly recommend this residential care facility to a family member or friend?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Background Information

1. How old is the resident (years)?

Example: 101

1	<input type="checkbox"/>	0	<input type="checkbox"/>
2	<input type="checkbox"/>	1	<input checked="" type="checkbox"/>
3	<input type="checkbox"/>	2	<input type="checkbox"/>
4	<input type="checkbox"/>	3	<input type="checkbox"/>
5	<input type="checkbox"/>	4	<input type="checkbox"/>
6	<input type="checkbox"/>	5	<input type="checkbox"/>
7	<input type="checkbox"/>	6	<input type="checkbox"/>
8	<input type="checkbox"/>	7	<input type="checkbox"/>
9	<input type="checkbox"/>	8	<input type="checkbox"/>
10	<input checked="" type="checkbox"/>	9	<input type="checkbox"/>

1

2

3

4

5

6

7

8

9

10

0

1

2

3

4

5

6

7

8

9

2. How old are you (years)?

Example: 85

	<input type="checkbox"/>	0	<input type="checkbox"/>
1	<input type="checkbox"/>	1	<input type="checkbox"/>
2	<input type="checkbox"/>	2	<input type="checkbox"/>
3	<input type="checkbox"/>	3	<input type="checkbox"/>
4	<input type="checkbox"/>	4	<input type="checkbox"/>
5	<input type="checkbox"/>	5	<input checked="" type="checkbox"/>
6	<input type="checkbox"/>	6	<input type="checkbox"/>
7	<input type="checkbox"/>	7	<input type="checkbox"/>
8	<input checked="" type="checkbox"/>	8	<input type="checkbox"/>
9	<input type="checkbox"/>	9	<input type="checkbox"/>

1

2

3

4

5

6

7

8

9

0

1

2

3

4

5

6

7

8

9

3. What is your race/ethnicity?

Asian/Pacific Islander	<input type="checkbox"/>	Hispanic	<input type="checkbox"/>
African American/Black	<input type="checkbox"/>	Native American/Indian	<input type="checkbox"/>
Caucasian/White	<input type="checkbox"/>	Other	<input type="checkbox"/>

6. What is your educational level?

Less than high school	<input type="checkbox"/>	Completed college	<input type="checkbox"/>
High school completed	<input type="checkbox"/>	Master's or higher	<input type="checkbox"/>

4. Mark the gender for the resident

Male

Female

7. Do you expect the resident's total stay in this residential care facility to be: (Please try to answer to the best of your ability. Select the category closest to your expectations.)

5. Mark the gender for you

Male

Female

Less than 1 month.....

From 1 to 3 months.....

Greater than 3 months.....

8. On average, how often do you visit the resident?

Daily	<input type="checkbox"/>	Two or three times a month	<input type="checkbox"/>
Several times a week	<input type="checkbox"/>	Once a month	<input type="checkbox"/>
Once a week	<input type="checkbox"/>	Few times a year	<input type="checkbox"/>

9. When you visit the resident, what do you help the resident with?

Help with:

	Never	Sometimes	Always
I. Eating	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
II. Dressing	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
III. Toileting	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
IV. Grooming (combing hair, cutting nails)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
V. Going to activities	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

10. What is your relationship to the resident? You are their _____.

Spouse.....	<input type="checkbox"/>	Brother/sister	<input type="checkbox"/>
Child.....	<input type="checkbox"/>	Friend.....	<input type="checkbox"/>
Grandchild	<input type="checkbox"/>	Parent	<input type="checkbox"/>
Niece/Nephew.....	<input type="checkbox"/>	Professional /Volunteer Guardian.	<input type="checkbox"/>
Son/Daughter in law.	<input type="checkbox"/>	Other.....	<input type="checkbox"/>

11. Do you talk to the following staff?

	Never	Sometimes	Always
I. Nurse Aides	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
II. Nurses	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
III. Social Workers	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
IV. Physician	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
V. Administrator(s)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
VI. Other	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

12. How much help does the resident need with the activities below? Please check the appropriate box.

12a. Eating

Needs no assistance or supervision from another person.....

Needs some assistance or supervision from another person.....

Needs a great deal of assistance or supervision from another person

Resident is totally dependent.....

12c. Dressing

Needs no assistance or supervision from another person.....

Needs some assistance or supervision from another person.....

Needs a great deal of assistance or supervision from another person

Resident is totally dependent.....

12b. Going to bathroom

Needs no assistance or supervision from another person.....

Needs some assistance or supervision from another person.....

Needs a great deal of assistance or supervision from another person

Resident is totally dependent.....

12d. Transferring (moving from or to a bed or chair)

Needs no assistance or supervision from another person.....

Needs some assistance or supervision from another person.....

Needs a great deal of assistance or supervision from another person

Resident is totally dependent.....

■

■

Thank you for your time! Your participation will help others know more about Ohio residential care facilities. Please review your survey, making sure no pages were skipped and only one answer was chosen for questions 1-33. Place your completed survey in the business reply envelope and drop into the mail.

***** Please do not fold your survey *****

Return to: Scripps Gerontology Center
Miami University
Oxford, OH 45056

Your comments below will be shared anonymously with the residential care facility and the Ohio Long-Term Care Ombudsman 's office:

Exhibit 10
North Carolina
AFL Star Rating Calculations & Worksheet

North Carolina ALF Star Rating Score ¹

What is the Star Rating based on?

Star Ratings are based on the results of:

1. DHSR annual inspections
2. DHSR follow-up inspections
3. DHSR Construction inspections (Type A and Type B violations cited)
4. Recommendations of Type A and uncorrected Type B violations from the County Department of Social Services (DSS), which have been reviewed and concurred by DHSR.

Learn more about the [Survey Inspection Process](#) and Type A and Type B violations.

Beginning January 1, 2009, upon annual inspection by DHSR each facility begins with a base score of 100 points. Based on the facility's compliance or non-compliance with rule areas during inspections, the facility earns merit or demerit points which are added or subtracted from the 100 base points respectively. After each annual inspection, a rating certificate (showing a numeric score and number of stars earned) and the worksheet used to calculate the rating score will be sent to the facility within 45 days of the survey report (called a "Statement of Deficiencies") being mailed. A new certificate and worksheet will be generated after each annual inspection, after subsequent inspections, and each time the rating score changes for administrative licensure actions. Facilities are required to post the most recent certificate and worksheet in the facility in a location visible to the public.

Demerit Points

Demerit points are points that are subtracted from the base score for citations and violations cited. Citations and Type B violations cited by DHSR under the fundamental rule areas will count against a facility's rating score. If a citation or Type B violation is not from a fundamental rule area, it will not count against the facility's rating. Type A and Uncorrected Type B violations from any rule area cited by DHSR or DSS will count against the rating score.

Demerit point values are as follows:

- Citations: -2.0 points each
- Type A violations (in any rule area): -10.0 points each
- Type B violations: -3.5 points each
- Uncorrected Type B violation (in any rule area): -3.5 points each

Administrative licensure action issued by DHSR will also result in demerit points being deducted from the rating score:

- If a Suspension of Admissions is issued by DHSR: -10 points
- If a Notice of Revocation of License is issued by DHSR: -31 points
-

*Note: This does not include a Suspension of Admissions that is issued for the facility's failure to submit a Cost Report.

¹ SOURCE: North Carolina Department of Health and Human Services' Division of Health Services Regulation Adult Care Licensure Section "Star Rating Program" website. <https://info.ncdhhs.gov/dhsr/acls/star/calculate.html>

Merit Points

Merit points are points that are added to a facility's score for correction of citations and violations upon follow-up inspection.

- Corrected citation: +1.25 points each
- Corrected Type A violation (in any rule area): +2.5 points each
- Corrected Type B violation: +1.25 points each
- Uncorrected Type B violation corrected (in any rule area): +1.25 points each

Administrative licensure actions rescinded by DHSR will also result in merit points being added to the rating score:

- If DHSR issues a Removal of Suspension of Admissions: +5.0 points

Also, if a facility corrects the citation for which a Type A violation was identified, they will receive the 2.5 merit points upon correction, and will receive an additional 2.5 merit points following the next annual inspection if no further Type A violations are identified.

Additional Merit Point Opportunities

There are four opportunities for a facility to earn extra merit points at each annual inspection. It is important to note that these extra merit point opportunities are just that, extra. The extra merit points are given to recognize when a facility has taken additional measures to go above and beyond what is minimally required by state rules to ensure the health, safety, welfare, and quality of life of their residents. Facilities do not lose points by not putting these measures in place. The four extra merit point opportunities are:

1. Emergency Power Back-Up

Facilities who have made arrangements for emergency power back-up (i.e. have a generator on-site or have a current contract with an emergency power back-up provider) will receive extra merit points at their annual inspection.

Facilities will receive the extra merit points for emergency power back-up based on whether it is "new" or "existing." Merit points will be issued as follows:

- If the facility's generator was installed (or contract is dated) before July 3, 2008, it will be considered "existing" and the facility will receive +1.0 merit points.
- If the facility's generator was installed (or contract is dated) after July 3, 2008, it will be considered "new" and the facility will receive +2.0 merit points.

2. Automatic Sprinkler System

Facilities who have installed an automatic sprinkler system in the facility will receive extra merit points at their annual inspection.

Facilities will receive the extra merit points for an automatic sprinkler system based on whether the system is "new" or "existing." Merit points will be issued as follows:

- If the facility's automatic sprinkler system was installed before July 3, 2008, it will be considered "existing" and the facility will receive +2.0 merit points.
- If the facility's automatic sprinkler system was installed after July 3, 2008, it will be considered "new" and the facility will receive +3.0 merit points.

3. NC NOVA Designation

Better Jobs Mean Better Care

The North Carolina New Organizational Vision Award, or NC NOVA, is a voluntary special license awarded to adult care homes, home care agencies and nursing facilities that meet rigorous workplace standards for their direct care workers.

Successful applicants receive a special state license over and above their operating license, designating them as NC NOVA providers committed to the idea that better jobs mean better care. NC NOVA recognizes long-term care employers that take extra steps to support their workers on the job. NC NOVA licensure tells families this provider has met higher workforce standards designed to keep a well-trained, effective, and satisfied team of quality caregivers. Any licensed provider in good standing may apply for NC NOVA licensure. NC NOVA licensure is issued for two years.

Upon each annual inspection, facilities will receive +2.5 additional merit points for having a current NC NOVA special licensure designation.

For more information and a list of current NC NOVA designees, visit the website at www.ncnova.org 

4. Participation in a Quality Improvement Program Approved by DHHS

Facilities who participate in a Quality Improvement (QI) program that has been approved by DHHS will be issued +2.5 extra merit points.

QI Program approval will be performed on-site by the DHSR survey team during a facility's annual inspection.

There are some facilities that participate in QI programs offered through various departments of DHHS, such as the Division of Aging. QI programs offered through DHHS are approved for Star Rating merit points. In order for facilities in these programs to receive the extra points they must be enrolled in the program and participating at the time of their annual inspection.

Star Rating Scores

Star Rating Scores					
This facility is rated:		Star Rating Score Key			
		Four Stars	= 100 points or greater		
		Three Stars	= 90.9 - 99.9 points		
		Two Stars	= 80.0 - 89.9 points		
		One Star	= 70.00 - 79.9 points		
		Zero Stars	= 69.9 and lower		
Total Merit Points	Total Demerit Points	Base Points	Facility Rating Score		
			Base Points - Total Demerits + Total Merits = Rating Score		
0	0	100	100		

Annual Inspection Report - Star Calculation Worksheet

Merit Points Earned	Demerit Points Issued	Statute or Rule Category	Measurement Evaluated
		13F/G.0300 - Physical Plant Requirements	For each citation of noncompliance with the rules related to physical plant, the facility will receive a demerit of 2 points. (citation(s): _ x 2.0 = _)
		13F/G.0700 - Admission & Discharge Requirements	For each citation of noncompliance with the rules related to admission and discharge, the facility will receive a demerit of 2 points. (citation(s): _ x 2.0 = _)
		13F/G.0800 - Resident Assessment & Care Plan	For each citation of noncompliance with the rules related to resident assessment & care plan, the facility will receive a demerit of 2 points. (citation(s): _ x 2.0 = _)
		13F/G.0900 - Resident Care & Services	For each citation of noncompliance with the rules related to resident care & services, the facility will receive a demerit of 2 points. (citation(s): _ x 2.0 = _)
		13F/G.1000 - Medication Management	For each citation of noncompliance with the rules related to medication management, the facility will receive a demerit of 2 points. (citation(s): _ x 2.0 = _)
		13F.1300 - Special Care Units for Alzheimer's & Related Disorders (ACH Only)	For each citation of noncompliance with the rules related to special care units for Alzheimer's & related disorders, the facility will receive a demerit of 2 points. (citation(s): _ x 2.0 = _)
		13F.1400 - Special Care Units for Mental Health Disorders (ACH Only)	For each citation of noncompliance with the rules related to special care units for mental health disorders, the facility will receive a demerit of 2 points. (citation(s): _ x 2.0 = _)
		13F/G.1500 - Use of Physical Restraints & Alternatives	For each citation of noncompliance with the rules related to physical restraints and alternatives, the facility will receive a demerit of 2 points. (citation(s): _ x 2.0 = _)
		G.S.131D-21 - Residents' Rights	For each citation of noncompliance with the statutes related to residents' rights, the facility will receive a demerit of 2 points. (citation(s): _ x 2.0 = _)
		13F/G.0215 - Type A Violation	For each citation of noncompliance, which results in a Type A violation, the facility will receive a demerit of 10 points. (citation(s): _ x 10.0 = _)
		13F/G.0215 - Type B Violation	For each citation of noncompliance, which results in a Type B violation, the facility will receive a demerit of 3.5 points. (citation(s): _ x 3.5 = _)
		13F/G.0215 - Type B Violation Uncorrected	For each Type B violation that is uncorrected, the facility will receive a demerit of 3.5 points. (Type B violations uncorrected: _ x 3.5 = _)
		13F/G.0214 Suspension of Admissions	If the facility's admissions are suspended, the facility will receive a demerit of 10 points.
		13F/G.0212 Notice of Revocation of License Issued	If a notice of revocation of license is issued, the facility will receive a demerit of 31 points.
		13F/G.1603 - Citation of noncompliance corrected or Type B Violation correction	For each citation of non-compliance of Type B Violation correction with rules related to 10A NCAC 13F .1603, which is corrected, the facility will receive a merit of 1.25 points. (citation(s): _ x 1.25 = _)
		13F/G.0215 - Type A Violation corrected	For each citation, which is corrected, which previously resulted in a Type A violation, the facility will receive a merit of 2.5 points. (citation(s): _ x 2.5 = _)
		13F/G.0215 - Uncorrected Type B Violation corrected	For each uncorrected Type B violation that is corrected, the facility will receive a merit of 1.25 points. (Type B violations corrected: _ x 1.25 = _)
		Removal of Suspension of Admissions	If the facility has a Suspension of Admissions removed, the facility will receive a merit of 5 points.
		G.S.131D-10(d)(2) - Participation in a Quality Improvement Program	If the facility participates in a quality improvement program approved by DHHS, it will receive a merit of 2.5 points.
		G.S.131E - NC NOVA designation awarded	If the facility has been awarded NC NOVA designation, it will receive a merit of 2.5 points.
		Emergency power back-up	The facility will receive 2 merit point for new (On or after 07/03/2008) emergency power arrangements and 1 point for existing power arrangements.
		Automatic sprinklers	The facility will receive 3 merit points for newly (On or after 07/03/2008) installed sprinklers and 2 points for existing sprinklers.

Exhibit 11
Wisconsin
Online License ALF Example

Bureau of Assisted Living
Online License and Certification Continuations
via e-Licensure

STATE OF WISCONSIN
Division of Quality Assurance
Bureau of Assisted Living



P-01731 (02/2017)

Example: Page 1 of the Biennial/Annual Report (Note, your copy will be unique to y

ADULT FAMILY HOME BIENNIAL REPORT

The Department of Health Services' data system reflects the following information related to the licensed Adult Family Home. Please contact the regional office with any questions.

Type	AMBULATORY STATUS	Facility ID	County
AFH	AFH	0009180	RACINE

Facility: SHARPIES HOUSE
RICK COLORS
5 SHARPIE LANE
RACINE, WI 53402
(414) 444-5678

Licensee: ORIGINAL LIVING
CAROL PERMANENT
2 COLOR WAY
S MILWAUKEE, WI 53217
(414) 423-8394

Administrator: RICK COLORS

FEIN#: 098765432

Mailing: DENNIS SILVER
COMMUNITY CONNECTION LLC
3 GOLD COLOR WAY
MILWAUKEE WI 53218

Resident Capacity: 4

Gender: Both

Email: cindy.oconnell@dhs.wisconsin.gov

Profit/Non-Profit: Non-Profit

Ownership: LIMITED LIABILITY COMPANY

Client Group Served:
DEVELOPMENTALLY DISABLED
PUBLIC FUNDING

Other Licenses/Certifications:

Does the Adult Family Home have a contract with any agency to serve individuals eligible for public funding?

YES NO If yes, what agency? ContinU.S.

Minimum Monthly Rate: \$5400.0

Maximum Monthly Rate: \$6100.0

Monthly Operating Expenses:

Salary Expenses \$1600.0

Example: Page 2 of the Biennial/Annual Report

Lease or Mortgages Expenses	<u>\$2100.0</u>
All Other Expenses	<u>\$3200.0</u>
Total Monthly Expenses	<u>\$6900.0</u>

Other Source of income.

- | | |
|--|--|
| <input type="checkbox"/> Savings | <input type="checkbox"/> Contract agreement with non-profit agency |
| <input type="checkbox"/> Purchase Contract | <input type="checkbox"/> Loan |
| <input checked="" type="checkbox"/> Outside Employment | <input type="checkbox"/> Other |
| <input type="checkbox"/> Line of Credit | |

Names of all persons, age 10 or older, who live in the facility and are not client residents.

Full Name	Relationship	Date of Birth
<u>JONES MICHAEL ALAN</u>	<u>SON</u>	<u>2000-05-01</u>
<u>Jones Mary Ann</u>	<u>Daughter</u>	<u>2000-05-01</u>

Days and hours when residents are not in the facility.

HOURS: 8:30 AM To 3:30 PM DAYS: Monday-Friday

<u>O'Connell Cindy</u>	<u>12/05/2016</u>
ID of person submitting this report.	Date submitted

Exhibit 12
New Jersey
Health Care Association of New Jersey
Assisted Living Community Disclosure Statement



Health Care Association of New Jersey
ASSISTED LIVING COMMUNITY DISCLOSURE STATEMENT

INTRODUCTION

The New Jersey Department of Health does **NOT** require assisted living residences and comprehensive personal care homes to provide this disclosure statement to all prospective residents. This residence chooses to provide you with this form to assist prospective residents and their families to better understand the services provided in this community.

The purpose of this disclosure statement is to give you and your family information you can use to compare services offered by different communities in New Jersey. Even if another community does not provide this form, you can and should ask the community to give you information to help you better understand their services.

This disclosure statement should **not** take the place of visiting a community, talking with residents, or meeting individually with community staff. You should use the information included in this disclosure statement to help you compare different options and select the community that best suits your needs. As a prospective resident, it is your responsibility to ask questions of the community and carefully read the residency agreement/admissions contract before making a final decision, as these agreements/contracts will contain more specific information regarding fees and discharge criteria.

Please note: This disclosure provides information only. The written residency agreement/admission contract governs your relationship with the community, not this disclosure statement. This disclosure statement describes policies and services that are in effect on the day you receive this statement and may change.

COMMUNITY INFORMATION

1. Community Name	
2. Address	
3. Number of Licensed Beds	4. Telephone Number
5. This Community is Owned By	
6. Contact Address for this Community's Owner(s)	
Contact Telephone Number	
7. Name and Signature of Prospective Applicant for Whom this Form is Completed	
8. Name of Administrator	
9. Name and Title of Individual Completing this Form, if not Administrator	
10. Signature of Individual Completing this Form	11. Date Form Completed

**ASSISTED LIVING COMMUNITY DISCLOSURE STATEMENT
(Continued)**

SECTION 1 – ADMISSION PROCESS

The following are included in this community's admission process, either prior to and/or at the time of admission:

- Application
- Community tour
- Family interview
- Medical records assessment
- Nursing assessment
- Credit check
- Background investigation
- Residency agreement/Admission agreement
- Doctor's orders;
- History and physical; and
- Nursing assessment, which includes documentation of the resident's ability to self-administer medication.
- Other _____

This community offers a trial period for new residents:

- Yes
- No

If Yes, the length of this trial period is: _____

This community has a formal procedure for responding to resident suggestions and grievances which involves:

SECTION 2 – FINANCIAL POLICIES

Financial policies are governed by the residency agreement/admission contract. You should review all charges – for room and board, service level, a la carte services, and miscellaneous charges -- carefully, and make sure you understand the pricing policy of the communities you are considering.

An assisted living community should provide applicants with a rate and/or fee schedule, which may be attached to this form or may be separately provided with admission information and the admission agreement/contract.

Other fees required at time residency contract/admission agreement is signed.

Required Fees

Description of Fee ⁽¹⁾	Required? (Yes/No)	Amount	Refundable? (Yes/No)	Creditable? (Yes/No)	Refundable/ Creditable When
Application Fee					
Security Deposit			Yes ⁽²⁾		
Deposit, Due When Application is Submitted					
Prepayment Amount					
Community Fee					

⁽¹⁾ **Medicaid recipients are not subject to these fees.**

⁽²⁾ **Pursuant to State law, security deposits are refundable providing at least 30-days notice is given to the community of the resident moving out.**

**ASSISTED LIVING COMMUNITY DISCLOSURE STATEMENT
(Continued)**

SECTION 3 – STAFF COVERAGE

The number of staff members varies by community based on the number of units/apartments and the health care needs of the residents who live there. The number of staff alone does not determine that a community is "well-staffed." It is important that while comparing communities, you ask about staffing levels and the manner in which the community delivers certain services, such as medications and other treatments.

Every New Jersey's assisted living community must meet the following staffing requirements:

- Staff in sufficient number and with sufficient ability and training to provide the basic resident care, assistance, and supervision required, based on an assessment of the severity of residents' needs.
- At least one registered professional nurse available at all times.
- At least one awake personal care assistant and one additional employee to be present at all times in the community.

Please speak directly with a community representative to discuss any questions you may have regarding this community's staffing.

SECTION 4 – DISCHARGE PROCESS

Voluntary Move-out:

Residents who choose to move from the community must provide notice to the community in accordance with the residency agreement/admission contract. You should review the residency agreement/admission contract for more specific information.

Involuntary Discharge:

Involuntary discharge is governed by NJ law and your residency agreement/admission contract. Please note, a community may involuntarily discharge a resident for non-payment and/or for reasons stated in the residency agreement/admission contract.

The following staff member at this community would make the discharge decision:

- Administrator
- Other: _____

With the resident's consent, if the resident's family is available, they will have input into the discharge decision:

- Yes
- No

Note: The resident retains the right to appeal a discharge decision to the community's administrator. The community must provide the resident and the resident's family assistance in discharge planning.

**ASSISTED LIVING COMMUNITY DISCLOSURE STATEMENT
(Continued)**

SECTION 5 – MEDICAID DISCLOSURE STATEMENT

Pursuant to N.J.S.A. 26:2H-12.16, communities licensed on or after September 1, 2001 are required within three years from their date of initial licensure to reserve 10 percent of their beds in operation for residents who are eligible for Medicaid. This can be accomplished by retaining private-pay residents who spend down and become Medicaid eligible or by directly admitting Medicaid beneficiaries.

Does this community participate in the Medicaid program?

- No - This community is not required by law to accept Medicaid.
- Yes - This community is required by law to accept Medicaid. The number of available Medicaid beds fluctuates based on the number of residents living in the community at any given time.
- Yes - Though not required by law to participate, this community accepts Medicaid and makes beds available on a case-by-case basis.

Communities that participate in Medicaid must complete the following information:

- Does this community accept room and board supplementation for a Medicaid resident's room and board?
 - Yes
 - No
- This community may require you to move to another room when you become Medicaid eligible.
 - Yes – If Yes, it is suggested that you discuss this with the community.
 - No
- Does this community have a policy that will require you to pay privately before you become eligible for Medicaid?
 - Yes – Number of months of private funds required: _____
– If Yes, it is suggested that you discuss this with the community.
 - No
- Does this community maintain an internal waiting list for Medicaid beds?
 - Yes – If Yes, see community's Medicaid Disclosure Handout.
 - No
- If this community has a dementia unit or specialized program for residents with memory impairment, are Medicaid residents accepted into this unit?
 - Yes
 - No
 - This community does not have a dementia unit.

Please note: *The community requests regular updates concerning residents' financial circumstances prior to the date they become financially eligible for Medicaid. The community is available to assist you with understanding the Medicaid eligibility process.*

**ASSISTED LIVING COMMUNITY DISCLOSURE STATEMENT
(Continued)**

ASSISTED LIVING SERVICES CHECKLIST

Prospective residents and their families may find it helpful to use this checklist to inquire about programs and services offered.

This community has a...	Yes/No	The council meets every...
Resident's Council		
Family Council		

Service	Included in Base Rate	Available for Additional Fee and/or May Effect Level of Care	Not Offered	Provided by Staff	Provided by Contracted Service
Health Related Services					
Alzheimer's/Dementia program					
Assistance in transferring to/from wheelchair					
Bathing (_____ days per week)					
Behavior management for verbal/physical aggression					
Bladder and/or bowel incontinence care					
Bladder and/or bowel incontinence products					
Diabetic care					
Feeding residents					
Special diets					
Tube feeding					
Health care supplies					
Home health services					
Hospice services					
Injections					
Intravenous (IV) therapy					
Medication Management					
Oxygen therapy					
Personal care supplies					
Private duty aides					
Rehabilitative services <input type="checkbox"/> Space leased on site to a rehabilitative services company to provide rehabilitative services					
<i>Note: As rehabilitative services are available under several Medicare options, you should inquire about your eligibility for rehabilitative services as a Medicare benefit.</i>					
Use of wheelchair/walker					

**ASSISTED LIVING COMMUNITY DISCLOSURE STATEMENT
(Continued)**

Service	Included in Base Rate	Available for Additional Fee and/or May Effect Level of Care	Not Offered	Provided by Staff	Provided by Contracted Service
Wound care					
Amenities					
Linen change (_____ days per week)					
Barber/beauty shop					
Transportation					
Personal laundry (_____ days per week)					
Housekeeping (_____ days per week)					
Recreation					
Activities program (_____ days per week)					
Other: _____					
Other: _____					
Other: _____					

Communities are required to provide a means to communicate with residents. This community provides the following services either directly and/or through outside services:

- Staff who can sign for the deaf
- Services for persons who are blind
- Interpretation services
- Other: _____

The following staff members routinely administer medications at this community:

- Registered nurse
- Licensed practical nurse
- Certified medication aide

The following safety features are provided in this community:

Description	Included in Basic Rate	Offered at Additional Cost
Emergency call system		
Wander management system		
Other monitoring, specifically: _____		
Other: _____		

Exhibit 13
Oregon
DHS Uniform Disclosure Statement
Assisted Living/Residential Care Facility

Uniform Disclosure Statement Assisted Living/Residential Care Facility

The purpose of this Uniform Disclosure Statement is to provide you with information to assist you in comparing Assisted Living and Residential Care facilities and services. Oregon Department of Human Services requires all Assisted Living and Residential Care facilities to provide you with this Disclosure Statement upon request. Facilities are also required to have other materials available to provide more detailed information than outlined in this document.

The Disclosure Statement is not intended to take the place of visiting the facility, talking with residents, or meeting one-on-one with facility staff. Please carefully review each facility's residency agreement/contract before making a decision.

The Assisted Living and Residential Care facility licensing rules, Oregon Administrative Rule 411-054-0000, are available on the DHS website www.oregon.gov/DHS/spd/index.shtml

Facility Type:

Assisted Living Facility Residential Care Facility Alzheimer's Endorsed

Facility Name: _____

Address: _____

Telephone Number: _____ Number of Apts/Units: _____

Administrator: _____ Hire Date: _____

Facility Owner: _____ Address: _____

City/State/Zip: _____ Telephone: _____

Facility Operator: _____ Address: _____

City/State/Zip: _____ Telephone: _____

Does this facility accept Medicaid as payment source for new residents? Yes No

Does this facility permit residents who exhaust their private funds to remain in the facility with Medicaid as a source of payment? Yes No

Does this facility require the disclosure of personal financial information? Yes No

Does this facility allow smoking? No Yes If yes, in what location?

designated indoor area designated outdoor area, covered

designated outdoor area, uncovered

Does this facility allow pets? Yes No Specify limitations: _____

I. REQUIRED SERVICES

These services must be provided by the facility, and may be included as part of the base rate, or may be available at extra cost.

I = Included in the base rate

\$ = Available at extra cost

A. Dietary/Food Service

The facility must provide three nutritious meals daily with snacks available seven days a week, including fresh fruit and fresh vegetables. Modified special diets are provided. A modified special diet means a diet ordered by a physician or other licensed health professional that may be required to treat a medical condition (e.g. heart disease, diabetes). Modified diets include but are not limited to: small frequent meals, no added salt, reduced or no added sugar and simple textural modifications.

I = Included in the base rate

\$ = Available at extra cost

I \$

- Meals (3 per day)
 Snacks/beverages between meals
 Modified diets provided: _____

- Vegetarian diets Yes No
 Other: _____

Diets that facility is not able to provide: _____

B. Activities of Daily Living

I = Included in the base rate

\$ = Available at extra cost

I \$

- Assistance with mobility, including transfers from bed to wheelchair, etc., that require the assistance of one staff person
 Assistance with bathing and washing hair. How many times a week? _____

- Assistance with personal hygiene (*i.e., shaving and caring for the mouth*)
 Assistance with dressing and undressing
 Assistance with grooming (*i.e., nail care and brushing/combing hair*)

- Assistance with eating (*i.e., supervision of eating, cuing, or use of special utensils*)
- Assistance with toileting and bowel and bladder management
- Assistance for cognitively impaired residents (*e.g. intermittent cuing, redirecting*)
- Intermittent intervention, supervision and staff support for residents who exhibit behavioral symptoms
- Other: _____

C. Medications and Treatments

The facility is required to administer prescription medications unless a resident chooses to self-administer and the resident is evaluated for the ability to safely self-administer and receives a written order of approval from a physician or other legally recognized practitioner.

I = Included in the base rate
\$ = Available at extra cost

- I \$**
- Assistance with medications
 - Assistance with medications/treatments requiring Registered Nurse training and supervision (*e.g. blood sugar testing, insulin*)

D. Health Services

I = Included in the base rate
\$ = Available at extra cost

- I \$**
- Provide oversight and monitoring of health status
 - Coordinate the provision of health services with outside service providers such as hospice, home health, therapy, physicians, pharmacists
 - Provide or arrange intermittent or temporary nursing services for residents

E. Activities

The facility is required to provide a daily program of social and recreational activities that are based upon individual and group interests, physical, mental, and psychosocial needs, and creates opportunities for active participation in the community at large.

I = Included in the base rate
\$ = Available at extra cost

- I \$**
- Structured activities

How many hours of structured activities are scheduled per day? _____

What types of programs are scheduled? Music Arts Crafts Exercise
 Cooking Other: _____

F. Transportation

The facility is required to provide or arrange transportation for medical and social purposes.

I = Included in the base rate

\$ = Available at extra cost

I \$

- Facility provides transportation for medical appointments
- Facility provides transportation for social purposes
- Facility arranges transportation (*e.g. cab, senior transports, volunteers, etc.*) for medical appointments
- Facility arranges transportation for social purposes

Other: _____

G. Housekeeping/Laundry

I = Included in the base rate

\$ = Available at extra cost

I \$

- | | | | |
|---|---------------------------|------------|-------|
| <input type="checkbox"/> <input type="checkbox"/> | Personal laundry | How often? | _____ |
| <input type="checkbox"/> <input type="checkbox"/> | Launder sheets and towels | How often? | _____ |
| <input type="checkbox"/> <input type="checkbox"/> | Make bed | How often? | _____ |
| <input type="checkbox"/> <input type="checkbox"/> | Change sheets | How often? | _____ |
| <input type="checkbox"/> <input type="checkbox"/> | Clean floors/vacuum | How often? | _____ |
| <input type="checkbox"/> <input type="checkbox"/> | Dust | How often? | _____ |
| <input type="checkbox"/> <input type="checkbox"/> | Clean bathroom | How often? | _____ |
| <input type="checkbox"/> <input type="checkbox"/> | Shampoo carpets | How often? | _____ |
| <input type="checkbox"/> <input type="checkbox"/> | Wash windows/coverings | How often? | _____ |
| <input type="checkbox"/> <input type="checkbox"/> | Other: | | _____ |

II. OTHER SERVICES AND AMENITIES

The facility may provide the following services and amenities. Facilities are required to provide toilet paper to residents who are Medicaid eligible.

I = Included in the base rate

\$ = Available at extra cost

A = Arranged with an outside provider

N = Not available

- | I | \$ | A | N | |
|--------------------------|--------------------------|--------------------------|--------------------------|--|
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Barber/beauty services |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Sheets/towels |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Health care supplies |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Personal toiletries (<i>e.g. soap, shampoo, detergent, etc.</i>) |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Apartment/Unit furniture |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Personal telephone |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Cable TV |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Internet Access |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Meals delivered to resident's room |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Transfer from bed to wheelchair, etc., that requires the assistance of two staff persons |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Other: _____ |

III. DEPOSITS/FEEES

Deposits and/or fees are charged in addition to rent.

- | | | | | |
|--------------------------|--|-----------------|-------------|--|
| <input type="checkbox"/> | Application | How much? _____ | Refundable? | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| | If refundable, under what circumstances? _____ | | | |
| <input type="checkbox"/> | Security/Damage | How much? _____ | Refundable? | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| | If refundable, under what circumstances? _____ | | | |
| <input type="checkbox"/> | Cleaning | How much? _____ | Refundable? | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| | If refundable, under what circumstances? _____ | | | |
| <input type="checkbox"/> | Pet | How much? _____ | Refundable? | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| | If refundable, under what circumstances? _____ | | | |
| <input type="checkbox"/> | Keys | How much? _____ | Refundable? | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| | If refundable, under what circumstances? _____ | | | |
| <input type="checkbox"/> | Other: (<i>describe</i>) _____ | How much? _____ | Refundable? | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| | If refundable, under what circumstances? _____ | | | |

IV. MEDICATION ADMINISTRATION

The facility must have safe medication and treatment administration systems in place. The administrator is responsible for ensuring adequate professional oversight of the medication and treatment administration system.

A. Who on the staff routinely administers medications? _____

B. Do the staff who administer medication have other duties? Yes No

C. Describe the orientation/training staff receive before administering medications.

D. Who supervises staff that administer medications? _____

E. Residents may use a pharmacy of their choice. If the resident requires medication administration, the facility's policy for ordering and packaging medications is:

1. Is there additional charge for not using the facility pharmacy? Yes No

2. If so, what is the cost? _____

V. STAFFING

A. Registered Nurse

Assisted Living and Residential Care facilities are required to have a Registered Nurse on staff or on contract. A nurse in these facilities typically does not provide hands-on personal nursing care. The nurse is usually available to provide consultation with the facility staff regarding resident health concerns.

Number of hours per week a nurse is on-site in the facility: _____

B. Direct Care and Other Staff

Facilities must have qualified, awake caregivers, sufficient in number, to meet the 24-hour scheduled and unscheduled needs of each resident. Caregivers provide services for residents that include assistance with activities of daily living, medication administration, resident-focused activities, supervision and support. Individuals whose duties are exclusively housekeeping, building maintenance, clerical/administrative or food preparation, as well as the administrator and licensed nurse, are not considered caregivers. The facility must post a current, accurate facility staffing plan in a conspicuous location for review by residents and visitors.

Note: Assisted Living and Residential Care facilities in Oregon are not required to employ Certified Nursing Assistants (CNA) or Certified Medication Aides (CMA) as resident care staff.

Typical staffing patterns for full-time personnel. **Note to facility:** each staff may only be shown under one title per shift (i.e., if employee provides resident care and medications assistance, show either as Universal Worker or Medication Aide.)

Shift Hours:	Number of Staff per shift				
	Direct Care Staff	Medication Aide	*Universal Worker	Activity Worker	Other Worker

* A universal worker is a person who provides care and services to residents in addition to having other tasks, such as housekeeping, laundry or food services.

VI. STAFF TRAINING

Facilities must have a training program that has a method to determine caregiver performance capability through a demonstration and evaluation process.

A. Describe the facility’s training program for a new caregiving staff:

B. Approximately how many hours of training do new caregiving staff receive prior to providing care that is not directly supervised? _____

C. How often is continuing education provided to caregiving staff? _____

VII. DISCHARGE TRANSFER

Licensed community-based care facilities may only ask a resident to move for reasons specified in applicable Oregon Administrative Rule. Oregon rules do not require that a resident be moved out of a facility due to increased medical services; however, if a facility is unable to meet a resident’s needs based on criteria disclosed in the facility’s information packet and according to the administrative rules, a resident may be given a written notice to move from the facility.

A person has the right to object to a move-out notice and can request a hearing with the Department of Human Services. If you need someone to advocate on your behalf, you may contact the Office of the Long-Term Care Ombudsman at 1-800-522-2602. Information about these rights and who to contact will be included on the move-out notification.

Date this Disclosure Statement was completed/revised: _____

Exhibit 14
Ohio
Ohio Long-Term Care Consumer Guide
Residential Care Facility

Ohio Long-Term Care Consumer Guide Residential Care Facility Entry Page

This form has been provided to you as part of the application process to become an ODA—approved provider of Assisted Living Services. Ohio Department of Aging staff will enter the information provided on this form on the Ohio Long-Term Care Consumer Guide website to be shared with interested consumers as well as be available to the general public.

The first two pages are required for all facilities applying to become an ODA-approved provider of Assisted Living Services. The additional information requested may be completed at the facility's discretion and is intended to help the consumer make an informed choice regarding the selection of a facility

The facility may be contacted by Ohio Department of Aging staff to participate in future projects associated with the Long-Term Care Consumer Guide.

Name of the person completing this form: _____

Telephone number of person completing this form: () - , Ext:

Facility Name: _____ (the name by which the facility is commonly known in your community)

Facility Address:

Address 1: _____

City: _____

Zip Code: _____

Facility Phone Number: () - , Ext:

Facility Fax Number: () -

Facility Contact's E-mail Address, if available: _____

Facility Web site address, if available. URL: _____

The Consumer Guide will link to your site for consumers to learn more about your facility.

Ohio License ID Number: _____

Optional Information for Assisted Living Waiver Provider Applicants

Staffing Information:

Please enter the total number of nurses, direct care staff (such as aides who assist residents with personal care), and other staff (such as social workers, activity or spiritual staff) that your facility typically has on duty during each shift:

WEEKDAYS

Nurses			Direct Care Staff			Other Staff		
Day	Evening	Night	Day	Evening	Night	Day	Evening	Night

WEEKENDS

Nurses			Direct Care Staff			Other Staff		
Day	Evening	Night	Day	Evening	Night	Day	Evening	Night

Other Staffing Comments (You may want to include comments about contract staff your facility uses, such as nurses on-call from an attached nursing facility or therapists used on an as-needed basis, etc.):

Special Care Services:

Residential Care Facilities provide a wide range of services. Although there are no special standards or requirements in place, some facilities specialize in certain services.

Check the box to indicate your facility provides specialized care in the services listed below. If needed, Circle Yes or No to indicate if the service is provided in a specific unit of the facility.

Provide a description of or more information about the special service, if desired. Note: The text field will accept no more than 1000 characters. Your description should be factual and simple. For example: "We provide Alzheimer Care services in a secure unit that features an enclosed courtyard. Staff receive additional training regarding best practices in dementia care."

[] Alzheimer/Dementia Care

Is the service provided within a specific unit of the facility: **Yes / No**

Description of Service (You may wish to indicate that secured areas or devices are available if needed):

[] Hospice Care

Is the service provided within a specific unit of the facility: **Yes / No**

Description of Service:

Special Diets

Description of Service:

Rehabilitative Therapy (e.g. Physical, Occupational, Speech)

Is the service provided within a specific unit of the facility: **Yes / No**

Description of Service:

Short-Term Stays for Respite Care

Is the service provided within a specific unit of the facility: **Yes / No**

Description of Service:

Advanced Skin Care

Is the service provided within a specific unit of the facility: **Yes / No**

Description of Service:

Medication Administration

Description of Service:

Assistance with Self-Administration of Medication

Description of Service:

24-Hour Licensed Nursing

Is the service provided within a specific unit of the facility: **Yes / No**

Description of Service:

Transfer Assistance

Description of Service:

Transportation

Description of Service:

Formalized Wellness Programs

Is the service provided within a specific unit of the facility: **Yes / No**

Description of Service:

Total Incontinence Care

Is the service provided within a specific unit of the facility: **Yes / No**

Description of Service:

Services to Non-Residents provided in affiliation with the facility:

Check the services your facility offers to members of the community.

- Adult Day Care Hospice Care Transportation
- Home Health Care Short-Term Stays for Respite
- Outpatient Therapies (Occupational, Physical, Speech)
- Independent Living Care Skilled Nursing Facility (on the premises)

Other Community Services (see below)

List other services to non-residents provided by your facility or in affiliation with your facility, which are not in the above groups. Provide a description of each service, up to 1000 characters. Use additional pages if needed.

Service: _____

Description: _____

Methods of Payment:

Check all methods of payment your facility accepts.

Self Pay Residential State Supplement

(Please note: The Medicaid Waiver for Services program, when implemented in July 2006, will be listed as another payment option on the Consumer Guide.)

Facility Policies:

Check the boxes below regarding policies if appropriate for your facility.

Pets Allowed Smoking Allowed Alcohol Allowed

Honor Do Not Resuscitate Have a Family Council in existence

Write other policies of your facility you wish to highlight in this area. You may write up to 1000 characters total. Other Policies: (Examples: Visiting hours, discharge policies, etc.)

Senior Staff Positions:

These pages allow you the opportunity to present the senior staff of your facility. Use them to let consumers know of the expertise and qualifications the staff member brings to the facility. In addition to the areas for education and certifications, there is an area where you may include additional information, perhaps philosophy of care, what they like best about their job, the rewards of working with older adults, etc.

1. Administrator

Name: _____

Title, if other than "Administrator": _____

of years employed as a long-term care administrator: _____

of years employed at this facility as the administrator: _____

Education and degrees:

Special certifications or awards:

Additional Descriptive Information (up to 1000 characters).

1. Nursing Director/Health Care Coordinator/Medical Director/Etc.

Name: _____

Title: _____

#of years employed in long-term care in the above position: _____.

of years employed at your facility in the above position: _____.

Education and degrees:

Special certifications or awards:

Additional Descriptive Information (up to 1000 characters).

Other Senior Staff (This is optional. You may highlight any staff member positions, i.e. Volunteer Coordinator, Dietician, Social services, etc.)

Staff Title: _____

Name: _____

Descriptive Information: _____

Religious Affiliation:

Check the boxes regarding any religious affiliations of your facility.

- Catholic Lutheran Jewish Presbyterian
- Brethren Mennonites Protestant United Church of Christ
- Episcopalians Methodist Other religion _____

Fraternal Affiliations: List any fraternal or other organizational affiliations of the facility. If your facility is privately accredited, you may wish to provide the name of the accrediting body and its website or other contact information.

Facility Picture: If you send a picture of your facility, it will be posted at your facility page.

For more information:

Erin Pettegrew
Consumer Guide Team Leader
Ohio Department of Aging
50 West Broad Street, 9th fl.
Columbus, OH 43215

See the next page for record keeping tips and update planning.

Keep this page and a copy of the entire document for future reference.

Information completed by: _____

Document mailed to ODA on: _____

Next update to be completed and mailed to ODA on: _____

PLAN FOR DATA UPDATES

<u>Area of Information</u>	<u>Date / Frequency</u>
Facility Picture	_____
License and Certification numbers:	_____
Facility comments:	_____
Facility Address	_____
Primary Contact for updates:	_____
Family Survey Coordinator	_____
Resident Satisfaction Coordinator	_____
Phone, fax, e-mail	_____
Owner / Operator data	_____
Beds and Staff	_____
Special Care Services	_____
Community Services:	_____
Methods of Payment:	_____
Policies:	_____
Senior Staff information:	_____
Religious and Fraternal Affiliations:	_____

For more information or assistance:
Long-Term Care Consumer Guide Team Leader
Ohio Department of Aging
50 W. Broad St., 9th floor
Columbus, OH 43215.
(614)466-5500