





# Caregivers **FOCUS ON** Sharpening **SKILLS**

**In response to rising acuity levels in many states, assisted living administrators are hiring more clinical staff and training frontline caregivers to detect residents' changing health status.**

Kathleen Lourde

**A**lthough regulations in some states are impeding the trend, in many states acuity levels are noticeably rising in assisted living. While this is a good thing for residents who want to stay in the least restrictive setting, sometimes even well-prepared facilities with well-trained staff can find themselves tasked with caring for a resident whose needs may be greater than the capabilities of the facility.

Michelle Donahue is a registered nurse (RN) and campus manager of Citadel Assisted Living Center in Mesa, Ariz. There is “absolutely” a trend in assisted living toward higher-acuity residents, says Donahue, a licensed nursing facility administrator and certified assisted living manager who is also on the board of the National Center for Assisted Living (NCAL) and president of the Arizona Health Care Association.



“I am seeing increasingly acute residents. At my facility we are now providing diabetic care, addressing more chronic diseases, and managing a much higher level of acuity,” says Donahue. The reason, in part, for the rising acuity is seniors’ desire to stay in assisted living facilities because of their homelike and person-centered environments, Donahue says. And she believes the trend will likely continue to grow in momentum due to public demand.

“What I’m mostly concerned about with increasing acuity within assisted living is people not being prepared for it,” she says. In response to the trend, Donahue took steps at her 118-unit Arizona facility to prepare for it.

#### **Preparing For Higher Acuity**

“I increased the expertise level by hiring more licensed nurses,” Donahue says. Arizona doesn’t require frontline caregivers in assisted living facilities to be certified, but “we

hold our caregivers almost to a CNA [certified nurse assistant] standard,” she says. “We do a lot of training here.”

Citadel revamped its assessment form to address higher-acuity needs. “We completely redid our medication technician program so we could meet

almost to the point that if you can’t maintain higher-acuity residents you’re probably going to find yourself struggling in the marketplace,” says Flores.

Even facilities that admit “alert” residents find the residents fall in love with assisted living and don’t want to leave.



**‘Another indication of the rising acuity levels in assisted living in many states is the proliferation of regulations in recent years that attempt to create standards for care, training, and staffing.’**

the needs of higher-acuity residents and retrained our staff to start looking out” for any small indication that a resident’s health status may be changing.

They further changed their medication administration and assistance program, going with a single pharmacy provider because residents were getting their medications from a wide variety of pharmacies, resulting in “unchecked polypharmacy.”

Donahue’s response is similar to other assisted living providers that are responding to the higher levels of acuity by hiring more clinical staff, implementing more training, and computerizing systems to prevent errors or detect resident health changes.

Sandi Flores, RN, clinical director of an Arizona facility owned by Solana Beach, Calif.-based Senior Resource Group, which has facilities in Arizona, California, Florida, and Oregon, and executive director of the American Assisted Living Nurses Association (AALNA), also sees the trend. “It’s

“I think this whole aging in place and rising acuity is not really being driven by operators, but by what the consumer wants,” she says.

#### **Rising Acuity Documented**

The resident population of assisted living is looking more and more like that of nursing facilities. “Residents in both assisted living and skilled nursing use an average of between eight and 10 medications,” says Karl Polzer, NCAL senior policy director. “And more than 90 percent of assisted living residents need help with medications.”

Assisted living residents now need help with 2.8 activities of daily living (ADLs), according to the newly created “Scope and Standards of Assisted Living Nursing Practice for Registered Nurses,” published by AALNA, Napa, Calif. Both need similar assistance, although in assisted living the resident might need help with two or three ADLs while in skilled nursing it might be three or four, says Polzer.

“Seventeen percent of residents are in good physical health but suffer significant cognitive impairment, 9 percent are functionally impaired due to chronic illness, 14 percent are dually impaired, and 45 percent have no impairment,” the AALNA report says. “Between 66 percent and 81 percent of assisted living residents suffer from dementia, depression, or another psychiatric illness or receive psychotropic medications.”

Another indication of the rising acuity levels in assisted living in many states is the proliferation of regulations in recent years that attempt to create standards for care, training, and staffing and identify who may and who may not be admitted or retained in assisted living.

#### **State Regs Follow Resident Conditions**

“Some data sources show an acuity rise in the last five years, and some don’t show that,” says Polzer. “What you see in the regulations [is] the states still responding to higher-acuity levels quite vigorously, especially with dementia. In general, what I see happening in the marketplace is providers creating housing with services that people need and want, and then regulation follows. It takes public policy a few years to respond, typically.”

In 2006, one-third of the states made changes to their assisted living regulations and seven of those states made major regulatory changes, according to NCAL’s “Assisted Living State Regulatory Review 2007.”

“Many states made regulatory changes in response to increasing levels of resident acuity and need for health services, continuing a trend in recent years,” the report says.

At least two states—Missouri and New Hampshire—created new licensure categories “in part to accommodate higher resident acuity levels,” according to the NCAL report. “Several states added requirements relating to fire safety, incident report-



## Alzheimer's: A Growing, High-Acuity Niche

**A**lzheimer's care, which can be very high acuity, is a growing niche within the assisted living market.

"The biggest growth in assisted living is in the cognitively impaired population," says Karl Polzer, senior policy director of the National Center for Assisted Living (NCAL). "Thirty or so percent [of assisted living residents] are cognitively impaired; some studies put that figure at 50 percent."

"In facilities that are [not specialized Alzheimer's care facilities] they might not notice an increase in acuity levels, but then you have facilities that specialize in Alzheimer's."

State regulations show a trend toward creating enhanced standards for the care of residents with Alzheimer's and other dementias, according to NCAL's "Assisted Living State Regulatory Review 2007."



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"Many states added staff training requirements, staffing requirements, and other standards to ensure appropriate care for people with Alzheimer's," the report says. Massachusetts created a new Special Care Residence certification category that includes care for people with dementia. Florida began requiring facilities to monitor and manage residents that wander.

### ADLs In Freestanding Assisted Living Versus Freestanding Dementia Care

ADL	Freestanding AL	Freestanding DC
Need bathing assistance	60%	90%
Need dressing assistance	41%	83%
Need toileting assistance	30%	78%
Need transferring assistance	25%	65%
Need eating assistance	19%	60%

Source: "2006 Overview of Assisted Living," compiled by leading organizations in the assisted living industry.

ing, emergency preparedness, disease control, and other resident safety issues," the report says.

"I see more and more states creating standards for higher acuity so consumer protection is in place," says Polzer.

States often won't allow continuous nursing care, but might allow intermittent nursing care. They might specify certain conditions that an assisted living resident cannot have and remain in the facility.

"When you look back 20 years, especially in the Oregon of the world where assisted living is highly evolved, you see a rise in acuity levels, but that's not true in a lot of the South and in a lot of [other] states," Polzer says.

However, regulatory requirements vary from state to state. "In some states, the level of acuity allowed in assisted living is limited by regulation," says Polzer.

In New Jersey, for example, regulations are allowing an increase in acuity

levels. Kathy Fiery, director of the Division of Assisted Living/Alternative Care of the Health Care Association of New Jersey in Hamilton, N.J., does see a trend toward higher acuity in New Jersey's assisted living facilities.

"As the field has continued to grow and residents have stayed in their assisted living facilities, their acuities have increased as they've stayed on," says Fiery. "New Jersey doesn't require people to move prematurely."

#### Not A Trend Everywhere

Vicki Cox, RN, is administrator of the Heritage at Dover, in Dover, Del. Cox is also an NCAL board member. She doesn't think there's necessarily a trend toward higher-acuity residents, although "I think we are having residents coming in that have higher-acuity needs," she says, "but you have to look at the whole house." Whether aging in place is occurring depends on the facility, she notes.

"Quite honestly, when a resident

wants to age in place, you have to look at the health and overall acuity of the individual," says Cox.

"While it would be nice to stay in one facility for the rest of your life, it doesn't always work; your needs may extend beyond the capabilities of assisted living facilities. We have to look to skilled nursing facilities to support those needs."

There's another reason having high-acuity residents in assisted living doesn't seem like a good idea to Cox. "My feeling is that most residents come into assisted living because they don't want to go to a nursing home, so if assisted living takes on the appearance of a nursing facility then we're not providing the environment we promised in the first place. That's why we have the continuum of care; they're staffed differently and provide different levels of care.

"If a resident comes in that has a very high-acuity level, you have to look at how the resident is going to affect

the entire house,” she adds. “Not to mention affordability. A lot of residents are on a fixed income, and if acuity is driving too high, you’re going to be looking at pricing that’s outside of what they’re typically going to be able to afford.”

Deb Choma, the administrator of Shard Villa in Salisbury, Vt., is an AALNA and NCAL board member. She is also the assisted living representative to the Vermont Health Care Association. Choma doesn’t quite yet see a trend toward higher acuity within her own facility, in part because she tends to steer clear of higher-acuity residents because it puts more of a burden on staff and “takes away” from other residents.

### Preparing For Higher-Acuity Care

The most important things a residence needs to remember if it sees its acuity level rising, or if it plans to begin taking on higher-acuity residents, is to prepare well, establish a top-notch clinical system, train staff to meet new needs, step up the visibility of nurses, and perhaps add staff, say those in the field. The most difficult component of being prepared to care for high-acuity residents is finding the personnel, says Fiery.

The biggest obstacle to caring for residents whose acuity is rising “is the nursing shortage,” she says. “And as they might want to add on an additional nurse, the biggest obstacle is trying to find nurses that are available and want to work in this environment. It’s a struggle to find the right fit,” says Fiery. Assisted living facilities are trying to come up with creative ways to hire nurses. “They might try to find people to job share, for example, or see whether they can do some tuition reimbursement for nurses—CNAs to LPNs [licensed practical nurses], LPNs to RNs.”

### Introducing Clinical Systems

“Companies that have the higher-acuity residents must have the clinical sys-



### ADLs In Assisted Living

Assisted living residents need assistance with a mean of two ADLs, and in any given 90-day period, 18 percent will decline in their ability to assist themselves in some area of ADLs.

<b>Need bathing assistance</b>	<b>68%</b>
<b>Need dressing assistance</b>	<b>47%</b>
<b>Need toileting assistance</b>	<b>34%</b>
<b>Need transferring assistance</b>	<b>25%</b>
<b>Need eating assistance</b>	<b>22%</b>

### Assistance With Walking In Assisted Living

While 22.6 percent of residents walk unaided, 51.8 percent require the use of a walking device (a cane, crutch, or walker), and 24.8 percent use a wheelchair some or all of the time.

<b>Walk unaided</b>	<b>22.6%</b>
<b>Use walking device</b>	<b>51.8%</b>
<b>Use wheelchair</b>	<b>24.8%</b>

*Source: “2006 Overview of Assisted Living,” compiled by leading organizations in the assisted living industry.*

tems in place,” says Flores. “I mean ways that you systematically catch change in status, not just once in a quarter doing a change analysis.”

Frontline caregivers must be trained to catch even subtle changes in residents, she says. “If not, you’re going to wind up in trouble.”

Facilities that don’t do this “set themselves up for the Stage IV decubitus ulcer, or put the person in a very precarious situation simply because

their health status change wasn’t caught soon enough,” says Flores. “But there are some people in this industry who are doing it very well.”

The key is a highly capable clinical director who is able to set up systems, says Flores. “Some companies will end up with a thousand different forms and think they’ve got a real clinical system.” Not so, Flores says. “Strong clinical leadership is No. 1.”

What makes a good clinical director? “Someone who has a strong understanding, obviously, of geriatric care, but also a strong understanding of assisted living, and that includes an understanding of regulations, because when your residents are higher acuity you’re walking a fence. So, understand regulations, risk, and geriatric care. And if you miss one of those three pieces, you’re in big trouble,” says Flores.

Loretta Kaes is vice president of health services for Chelsea Senior Living, based in Summit, N.J., which has eight assisted living facilities, seven in New Jersey.

“The main thing,” says Kaes, when caring for higher-acuity residents, is making sure they receive “the medical observation, the skilled time that it takes [to] oversee the health care needs of the resident and arrange a clinical path for residents with such high-acuity conditions as dementia, congestive heart failure, or irretractable pain that needs constant reevaluation and assessment.”

To track acuity and the care being given, Chelsea Senior Living instituted a computerized system that was customized with New Jersey’s assisted living regulations. “With this, we’re able to catch the time and task that the resident requires,” says Kaes.

The computerized system not only prompts assessments required by state regulation—upon admission, every six months, and upon significant change, such as the loss of ability to do two or more ADLs—but it “helps us track things not so readily seen by the nurse,



because nurse assistants do the care,” says Kaes.

For example, if a nurse assistant needs to spend a little more time with a certain resident to assist in bathing, the administrator or director of nursing will be informed and can assess the resident for a possible change in health status.

### Team Must Be On Alert

Beyond the computer system, Chelsea’s care team monitors residents for a variety of indicators that show health status may be changing.

Monitoring weight is an extremely important indicator of health status, says Kaes. “We monitor weight in our dementia units weekly,” she says. Weight loss is “a great indicator that something isn’t right even if the resident can’t tell you.” Monitoring weight gain is equally important. For people with congestive heart failure, for exam-

ple, weight gain could mean they’re holding fluid and may need an adjustment of their medications, or sometimes hospital intervention may be required to drain the fluid. “That level of medication is too high for a non-medical facility to take the responsibility for,” she says.

“Another place we catch [change in health status] is when the resident comes back from the hospital. We do a reassessment that will pick up” indicators that a required deeper analysis must be made if too many changes in the resident have taken place.

Another area that nurses must monitor is when psychological problems are involved. “Residents who are being seen by either psychological groups or geriatric psychiatrists need to be monitored closely for efficacy of medications—to make sure the depression isn’t worsening, that blood levels [of medications] are reached.”

Dementia is another area where the nurse is critical to the maintenance of residents so that no untoward illness occurs because they haven’t been properly observed, says Kaes. “Anyone with a diagnosis of dementia has a 50 percent chance of falling, which can lead to serious consequences and even death, so they need careful observation and monitoring.”

Nurses are also alert to seasonal illnesses that can lead to a change in residents’ health status.

“Seasonally, you have the viruses, such as pneumonia. This population is very prone to these diseases, and we have to be very vigilant that it doesn’t spread through our home.” But recognizing that a resident is ill, and possibly contagious, isn’t always easy. “In the elderly, pneumonia isn’t so symptomatic. They can be really sick and not show the degree of their illness. Usually, they don’t spike a tempera-

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ture; they may not even have a cough.” This, she says, is an example of when it’s important that the nurse and direct care staff are so familiar with the resident and his or her health status that picking up on the fact that something is wrong is second nature.

Ultimately, caring for higher-acuity residents means marshalling all a facility’s resources. “You utilize all the assessment skills and clinical skills that you have in order to plan for the best possible outcome,” says Kaes.

### **Staff-To-Resident Ratios**

Flores says that following strong clinical leadership, “No. 2 is a commitment for adequate staffing.” However, when it comes to staffing, “there is not a magic number. Where you may have a community staffed 1:6 and it is understaffed, you may have a community staffed 1:15 and it is overstaffed.

“It depends on the clinical status of the residents you’re caring for. Being locked into a magic number is a very dangerous thing to do.”

Faun Spencer, RN, is administrator of Steven’s Residence, a seven-bed facility in Minnetonka, Minn., that specializes in dementia care. Spencer is also an NCAL board member.

The acuity level in the Steven’s Residence is very high; many residents stay until the ends of their lives. The home is somewhat typical of private care homes in Minnesota. “There’s a small majority of us who do the higher needs,” Spencer says.

One of the benefits of small residences is the high staff-to-resident ratio.

“With two staff on during the night and only seven residents, staff are constantly watching them and seeing if they need to get up,” for example, says Spencer. “There can be four or five staff people here during the day so the safety quotient is very high. Staff are awake 24 hours a day.”

With higher staffing “comes a higher rate” of fees to the residents, “and families are willing to pay it,” says Flores. “Rare is the family that says, ‘I don’t like this because of the money.’ They’re willing to spend whatever it takes to keep them in assisted living.”

In an era of nurse shortages, finding the right nurses is a major challenge. The biggest obstacle facilities face in caring for higher-acuity residents is “trying to find the right people. Sometimes it’s not in the numbers. [Facilities are] trying to find competent nurses who can do a tremendous job,” says Fiery.

### **Training Staff**

The effect of rising acuity on the workforce is that “it can lead to higher staff turnover if you’re not training staff to deal with the issues,” says Flores. “If you have caregivers



who are not CNAs and don't know how to transfer dependent people, you need to give them those skills."

Although Choma's residence isn't seeing a rise in acuity yet, she knows it's rising in many assisted living facilities. "Residents are a little sicker; there are more requirements on health maintenance and medication management."

As a result, Choma does a lot of training with her staff. "It's almost like we're preparing them," she says. "It's all

**'Training opportunities should also include the formal variety, allowing upward mobility on the floor.'**

about education in my book anyway. That's the No. 1 priority." She also brings in ancillary services to "try to increase the function of the resident, keep them going as long as they can" rather than just maintaining their condition.

Spencer conducts a lot of training with staff on lifting people differently, as so many of her residents are nonambulatory. "We always use two people to move a resident who can't walk," says Spencer.

Fiery believes that the areas of increased training need to mirror the specific needs of a facility's population and anticipate shifts in those needs. So if a certain condition, such as Alzheimer's or Parkinson's, becomes more prevalent, the amount of training in that condition should increase. "The training should be more tailored to the needs of the people in their building, and that can shift over time," says Fiery. Training should extend to all staff, including housekeeping, dietary, and maintenance, she says.

"The rest of the staff need to be aware of what higher acuities mean so they can report back. Maintenance people, dining people—if they know what to look for they might notice more quickly that a resident isn't eating, or maintenance and housekeepers might find things that need to be fixed," says Fiery.

Training opportunities should also include the formal variety, allowing upward mobility on the floor. "At my facility alone, we've graduated 12 to 14 nurses from laypeople," says Choma.

### **Sharpening Nurses' Skills**

Along with adding more nurses to the staff, some facilities are working to sharpen their nurses' skills in geriatric care as provided in the assisted living setting.

To safeguard the health of residents as acuity levels rise,

nurses are doing a lot of assessments, wellness checks—blood pressure, weight, checking on medications—and ensuring residents get yearly physicals, says Fiery.

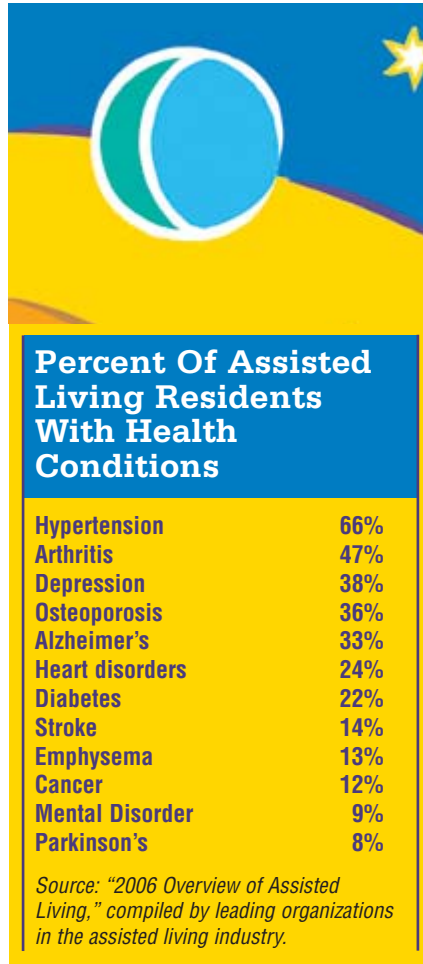
An increasing number of assisted living nurses are joining AALNA, which provides education and networking opportunities for assisted living RNs and LPNs. The Health Care Association of New Jersey recently helped establish a new AALNA chapter in the state that has attracted nearly 75 members.

Many nurses have achieved certification as a gerontological nurse through the American Nurse Credentialing Center (ANCC), which until recently was the only credentialing opportunity open to RNs specific to geriatric care. Diane Thompkins, assistant director for certification for ANCC, says the credentialing benefits any nurse who works with the elderly. Further, “It’s external evidence that they’ve met a level of knowledge base for that group,” she says.

But now AALNA is offering a certification in geriatric nursing that is specifically for nurses in assisted living—and the certification is open to LPNs, another first for the assisted living nursing field. AALNA published its “Scope and Standards of Assisted Living Nursing Practice” for RNs and LPNs in early 2007 to gain recognition for this relatively new field of nursing. AALNA also developed companion self-study modules to help the RNs and LPNs prepare for the certification exam.

Flores says the exam goes far beyond testing “to see if you know what the general philosophy of assisted living is, but to see if you really know geriatric nursing.”

The exams are based on AALNA’s “Scope and Standards of Assisted Living Nursing Practice,” a document that includes the scopes, standards, and competencies developed for the assisted living nursing profession. Always with the assisted living setting in



mind—whether the facility serves primarily high- or lower-acuity residents, is large or small, independent or part of a chain—the scopes, standards; and competencies detail assisted living nurses’ ethical obligations and duties, practice, and conduct; and the profession’s commitment to health care, nursing, and society.

The exams cover the context of care of the older adult (demographics, theories of aging, culture, communication, advance care planning); health issues of the older adult (geriatric syndromes, pain management, decision-making capacity); the long term care continuum (settings of care, regulations, data collection, and reimbursement); professionalism (leadership types, skills, and issues in management); research utilization; and ethical issues. The competencies expected and monitored

arise from standards of practice based on a theoretical and evidence basis of practice, according to AALNA.

Assisted living nurses are geriatric nurses practicing in a unique, relatively new domain of long term care, according to an AALNA report.

“While not needing the complex 24/7 oversight of skilled nursing/nursing homes, the assisted living resident is probably in a more vulnerable position precisely because of their independent autonomy vs. safety/oversight needs,” according to the report, which was written by Ethel Mitty, RN, adjunct clinical professor at New York University’s College of Nursing.

Assisted living nurses are even more autonomous in terms of decision making, managing care, and managing clinical systems than acute care nurses or even nursing facility nurses, according to the report.

Many RNs in assisted living are in management positions, such as administrators, wellness coordinators, or consultants that oversee residents’ well-being. “Now many of us that are nurse managers are going for the certification through AALNA,” says Choma. “We’re considered a specialty nurse within our discipline.”

### Assisted Living Nurse As Administrator

More and more nurses are being promoted to the administrator level, perhaps because of the increasing health care needs of assisted living facility residents. Being both a nurse and an administrator can be helpful in some ways.

“I know you get the whole picture,” says Spencer of Steven’s Residence. “Being here so often, we can really prevent a lot of problems with residents.” Because there are so few residents, “we get to know them individually, what their body status is.” Being both a nurse and an administrator also helps in “having very open discussions with family members about what’s going on, how long they’re likely to be

here,” and what their other options are or will be. “Also, these homes don’t make a lot of money so it helps if you’re the nurse and the owner, so you’re not pressured to come up with that \$50,000 to \$70,000 a year.”

Others think it can actually be a drawback.

ing facility can safely provide. “What do you mean they have to leave now?” they seem to say.

Sometimes the situations that arise can be very challenging, requiring clinical expertise and leadership. “In my facility we have the ability to take [very high-acuity] residents and do so when

we can’t meet all their needs, we want to make sure they’re in the appropriate setting,” says Cox.

“The facility needs to be very clear on the level of care they’re going to provide, making sure they disclose that and not only talk about the move-in process,” she says. Staff need to talk about the continuum of care and how the facility is going to support residents when they need to move on to the next level, says Cox.

“A building that does really well has been in constant communication with the family about the resident and what would trigger a move to a nursing home,” says Fiery. “Whoever has the better relationship with the family, nurse or administrator, should be on the phone to the family. We can handle things when they’re not sprung on us,” says Fiery.

And, most importantly, assisted living facilities have to know their own limits and not cross them.

“If we have rogue providers out there who are overestimating their ability to provide assisted living, they’re crossing the bounds,” Donahue says.

“At some point it crosses the line into health care or illness care, and providers have to be careful that they don’t make those mistakes.

“In my opinion, assisted living is our profession’s chance to do long term care right, in a nice, homelike setting where we’re providing assistance with ADLs,” she says. “We must police ourselves as a profession and set attainable standards for the delivery of quality care.” ■

*Kathleen Lourde is a freelance writer based in Dakoma, Okla.*

#### For More Information

■ For more information on nurse credentialing, visit the American Assisted Living Nurses Association Web site at [www.alnursing.org/](http://www.alnursing.org/) or call (707) 252-3411, ext. 10.



**‘A building that does really well has been in constant communication with the family about the resident and what would trigger a move to a nursing home.’**

“There’s so much to running an assisted living facility,” says Fiery. “Some people would argue that a finance person would be best; others would say a social worker. I think what you need at the helm is someone who’s attuned to all those different realms. What can be a danger is that some facilities might see an RN lead in two functions, and that can make it difficult” to be objective while wearing one hat or the other, says Fiery. “The problem is saying ‘I can kill two birds with one stone,’” she notes, acknowledging that the situation could be very different in a small facility.

#### When It’s Time To Move On

Sometimes good things must end. Even assisted living facilities that take higher-acuity residents have a point at which they can no longer meet the needs of some residents.

It can be difficult for families to accept that their loved one finally needs more care than the assisted liv-

ing situation is appropriate and we can meet the care needs,” says Donahue.

“There are situations where families desire assisted living when their loved one really needs a higher level of care in a skilled nursing facility.” Donahue works with families to get them to understand that the resident’s care needs have changed. “Residents need to be in an appropriate environment,” she says.

It’s essential to discuss discharge criteria when the resident moves in, so “they don’t move in thinking they can stay here forever,” says Cox.

“We explain things that might happen in their health care and that we’ll work with them to improve that,” she says.

“And we always work with the resident and family to find another environment that’s acceptable to them. I think that’s been the key to our success: that we talk about discharge at move-in and that the resident and families are involved in that. If we feel like