

**MODULE 5**  
**RESIDENTIAL FACILITIES FOR GROUPS**  
**HOMES FOR INDIVIDUAL RESIDENT CARE**  
**A LOOK AT ALZHEIMER'S**

**REVIEW MODULE 4**



**RESIDENTIAL FACILITIES FOR GROUPS**

**Defined**

**NRS 449.017 “Residential facility for groups” defined.**

1. Except as otherwise provided in subsection 2, “residential facility for groups” means an establishment that furnishes food, shelter, assistance and limited supervision to a person with mental retardation or with a disability or a person who is aged or infirm. The term includes, without limitation, an assisted living facility.

2. The term does not include:

(a) An establishment, which provides care only during the day;

(b) A natural person who provides care for no more than two persons in his own home;

(c) A natural person who provides care for one or more persons related to him within the third degree of consanguinity or affinity;

(d) A halfway house for recovering alcohol and drug abusers; or

(e) A facility funded by a division or program of the Department of Health and Human Services.

(Added to NRS by 1973, 1278; A 1979, 212; 1983, 1657; 1985, 930, 1736; 1991, 1974; 1993, 1213; [1999, 114, 125](#); [2001, 57, 546, 2519, 2522](#))

Residential facilities for groups may specialize in care for different groups: elderly and disabled, mentally ill, Alzheimer’s and related dementia, hospice care, mentally retarded adults, and persons with chronic illnesses. In order to specialize in care for different groups, a facility must obtain an endorsement on its license authorizing it to operate as a residential facility that provides care to a specific population, e.g., persons with Alzheimer’s disease.

*A residential facility for elderly or disabled persons* means a residential facility that provides care to persons requiring assistance and protective supervision due to infirmity or disability. *A residential facility that cares for persons with Alzheimer’s disease* means a residential facility that provides care and protective supervision for persons with Alzheimer’s disease or a related disease, including, without limitation, senile dementia, organic brain syndrome, or other cognitive impairment.

**Citation** Residential Facilities for Groups, Nevada Revised Statutes 449.017 et seq.; Nevada administrative code 449.156-2766

**General Approach and Recent Developments**

Effective January 2004 Nevada amended their Home and Community Based Services (HCBS) waiver for the Elderly in Group Care Homes to include an assisted living service. Legislation has passed that requires licensed facilities to obtain an endorsement on its license authorizing it to operate as a residential facility which provides “assisted living services.” Facilities may not market themselves as providing assisted living services

unless they obtain an endorsement from the State. Facilities will provide to any potential resident a full written disclosure describing what personalized care services will be available and the amount charged for those services. Physical plant standards will require independent units to contain toilet facilities and a sleeping area or bedroom. In facilities with 11 or more residents, units will be able to be shared by consent only. New care principles are described including the promotion of resident quality of life, individualized needs, and personal choice; creative and innovative service provision; resident autonomy; fostering a community atmosphere; and facility operations that minimize the need for residents to move out of the facility as resident needs change over time.

### **Unit Requirements**

Single occupant rooms must have 80 square feet of floor space and multiple resident rooms must have 60 square feet of floor space per resident. No more than three residents may share a room. One toilet and lavatory is required for every four residents. A tub or shower is required for every six residents. However, new legislation provides that units may be shared “with another occupant only upon consent of both occupants and all units must include toilet facilities. Doors of bedrooms may be equipped with locks for use by residents if the doors may be unlocked from the corridor and keys are readily available. Provisions must be made for privacy in all bathrooms and for all toilets located in bedrooms for use by more than one resident.

Facilities serving people with Alzheimer’s disease must be have sprinklers and have 24-hour awake staff. Exit doors must have alarms or time-delay locks. Local audible alarming units must be installed. Facilities serving people with Alzheimer’s disease must have a secure yard, completely fenced and gated with locking devices.

### **Admission/Retention Policy**

Residents are considered Care Category 1 (ambulatory) and Care Category 2 (non-ambulatory).

*Ambulatory residents* are physically and mentally capable of moving from an unsafe area to an area of safety within four minutes unassisted.

*Non-ambulatory residents* require the assistance of at least one other person to move to a safe area within four minutes. Facilities licensed prior to January 1, 1997, are not required to meet requirements for installing automatic sprinkler systems unless they seek to serve Category 2 residents. Sprinklers must be installed prior to a change of ownership, an increase in licensed beds, or admission of non-ambulatory residents. Requirements for hard-wired smoke detectors with battery back up are also waived for small homes unless the above changes are proposed.

People who are bedfast, require 24-hour skilled nursing or medical supervision, and/or require restraints or confinement in locked quarters may not be admitted. The rules do not allow facilities to admit or retain residents with a lengthy list of health conditions with some exceptions. Residents with (or needing) catheters, colostomies or ileostomies, contractures, pressure ulcers, diabetes, unmanageable incontinence, enemas/suppositories, oxygen, injections, protective supervision, or wound care may not be admitted or retained unless the resident is physically and mentally capable of performing the required care or if the care is provided or supervised by an appropriately skilled medical professional. Residents needing gastronomy care, naso-gastric tubes, or have staph or other serious infections or tracheotomies cannot be admitted or retained unless a written request is submitted by the Administrator documenting the resident’s condition and how care can be provided and the request is approved by the licensing agency. A resident who is suffering from an illness or injury from which the resident is

expected to recover within 14 days after the onset of the illness or the time of the injury may be cared for in the facility. A resident may reject medical care. This rejection must be recorded and signed by the resident.

A resident may be **discharged** from a residential facility without his approval if he fails to pay his bill within 5 days after it is due; he fails to comply with the rules or policies of the facility; or the Administrator of the facility or the BLC determines that the facility is unable to provide the necessary care for the resident.

### **Services**

Services provided include personal care; at least ten hours of activities a week; three meals a day; protective supervision; laundry; and assistance with access to dental, optical, social, and related services as needed by residents. Assistance with medical needs described in the Admission/Retention Policy section may be provided through a contract with a community agency or directly by staff hired by the facility. A physician completes assessments.

### **Dietary**

Three meals a day and snacks that meet the recommended dietary allowance of the Food and Nutrition Board must be provided. Meals must be nutritious, served in an appropriate manner, suitable for the residents and prepared with regard for individual preferences and religious requirements. At least three meals a day must be served at regular intervals. The times at which meals will be served must be posted. Not more than 14 hours may elapse between the meal in the evening and breakfast the next day. Snacks must be made available in between meals for the residents who are not prohibited by their physicians from eating between meals. A resident must be served meals in his bedroom for not more than 14 consecutive days if he is temporarily unable to eat in the dining room because of an injury or illness. The facility may serve meals to other residents in their rooms upon request. Special diets may be provided if ordered by a physician or dietician. Facilities with more than ten residents must consult at least quarterly with a registered dietician concerning development and review of weekly menus, training for kitchen employees, compliance with nutritional program of the facility, and other observations regarding preparation and serving of meals.

### **Agreements**

Agreements include basic rate and the services included, schedule of payment, charges for optional services, and the refund policy.

### **Provisions for Serving People with Dementia**

Facilities serving people with Alzheimer's disease must obtain an endorsement on its license to do so. Administrators must have three years' experience caring for residents with Alzheimer's disease or a combination of education and training. The facility's policies and procedures must include a description of the basic services, activities, the manner in which behavioral problems will be addressed, medication management, steps to encourage family involvement, criteria for admission and discharge, and steps that have been developed to prevent and respond to wandering. Facilities must offer activities related to gross motor skills, social activities, sensory enhancement activities, and outdoor activities. At least one awake staff must be on duty at all times. Within three months of employment, staff must complete eight hours of training in providing care to residents with Alzheimer's disease and providing support to family members. Exits must have warning devices. The grounds must be secure.

## **Medication Administration**

*NAC 449.2746*

Facility staff may administer medication and assist with self-administration of medications when the resident's condition is stable and following a predictable course, the amount of medication is at a maintenance level and does not require daily assessment, and a written plan of care has been prepared by a physician or registered nurse. The staff assisting with self-administration must complete a training program in medications. The training consists of a three-hour course called "Management of Medication" and is approved by the BLC. Upon completion of the course, the individual must pass an exam in order to receive a certificate of successful completion. The course must be repeated every three years.

## **Medication Administration: Maintenance and contents of logs and records. ([NRS 449.037](#))**

*NAC 449.2744*

1. The Administrator of a residential facility that provides assistance to residents in the administration of medications shall maintain:

(a) A log for each medication received by the facility for use by a resident of the facility. The log must include:

- (1) The type and quantity of medication received by the facility;
- (2) The date of its delivery;
- (3) The name of the person who accepted the delivery;
- (4) The name of the resident for whom the medication is prescribed; and
- (5) The date on which any unused medication is removed from the facility or destroyed.

(b) A record of the medication administered to each resident. The record must include:

- (1) The type of medication administered;
- (2) The date and time that the medication was administered;
- (3) The date and time that a resident refuses, or otherwise misses, an administration of medication; and
- (4) Instructions for administering the medication to the resident that reflect each current order or prescription of the resident's physician.

2. The Administrator of the facility shall keep a log of caregivers assigned to administer medications that indicates the shifts during which each caregiver was responsible for assisting in the administration of medication to a resident. This requirement may be met by including on a resident's medication sheet an indication of who assisted the resident in the administration of the medication, if the caregiver can be identified from this indication.

(Added to NAC by Bd. of Health by R003-97, eff. 10-30-97; A by R052-99, 9-27-99; R073-03, 1-22-2004)

## **Licensing Endorsements**

A licensed Residential Facility for Groups may obtain numerous endorsements for: Care of the Elderly and Disabled (NAC 449.2758), Care for Mental Illness (NAC 449.2764), Care for Chronic Illness (NAC 449.2766), Provision of Assisted Living Services (NAC 449.2751), and Care for AI Disease (NAC 449.173). With each of these endorsements come some additional regulatory requirements.

The regulations for Residential Facilities for Groups have allowances for nursing level services under the heading, "Restrictions on Admitting or Retaining Residents With Certain Medical needs or Conditions". This section starts with NAC 449.271 and

continues through NAC 449.2738. This section takes into consideration many medical needs and provides for exceptions. However, facilities must also comply with a set of strict prohibitions, indicated in NAC 449.2702(4). The only exception to these prohibitions is for a resident receiving hospice services wherein the retention of the resident has received approval from BLC.

### **Public Financing**

Amendments effective January 2004 to the Home and Community Based Services (HCBS) DAS manages several Medicaid Waiver programs including, Waiver for the Elderly in Adult Residential Care (WEARC), Assisted Living Waiver, Community Home-Based Initiatives Program (CHIP), and the Community Service Options Program for the Elderly (COPE).

The DAS role is responsibility for the proper and efficient operation of these Medicaid Waivers. Duties include eligibility determination, evaluation of level of care, assessment of service needs, utilization review, and quality management.

Medicaid Waiver Eligibility includes the financial eligibility guidelines established by the Department of Welfare and Social Services (DWSS) for institutional care.

Applicants / recipients must also meet and maintain the following criteria; be 65 years or older, demonstrate a level of care for admission into a nursing home, be determined as at-risk for nursing home placement within 30 days if waiver services were not provided, and demonstrate a continued need for waiver services.

WEARC: This program was formerly known as the Group Care Waiver and is open to anyone needing assistance and resident within the community. This program provides for case management and attendant care to recipients who need 24-hour supervised care in a licensed residential facility for groups. Reimbursement rates are based on the resident's assessed level of service required.

Assisted Living Waiver: This waiver became effective as of July 1, 2006 and is only available in the Las Vegas area. Applicants must also qualify for housing assistance in accordance with the Housing Division and Federal Guidelines. This program provides case management and augmented personal care assistance to residents residing in licensed assisted living facilities that receive low-income tax credits through the Housing Division. Reimbursement rates are based on the recipient's assessed level of service.

CHIP: This waiver helps frail seniors to maintain independence in their own homes as an alternative to nursing home placement. Services offered include, case management, homemaking, social model adult day care, adult companion services, personal emergency response systems, chore services, respite, and nutrition therapy.

COPE: This is a state funded program and was established by the Commission on Aging (COA) for those not financially eligible for Medicaid benefits. There is limited funding and limited slots available statewide. Some clients may have a cost share depending on their income. Services for this program include, case management, homemaking, social model adult day care, adult companion services, personal emergency response systems, chore service, and respite.

### **Staffing**

#### *NAC 449.199*

Residential Facilities for Groups must maintain staffing patterns that are sufficient to meet the care needs of residents and to enable residents to achieve and maintain their functioning, self-care, and independence. Facilities with more than 20 residents must have at least one awake staff member and an additional person available within 10 minutes. Staff of all facilities must receive annually eight hours of training that is directed

toward meeting the needs of group-care residents. Facilities licensed for 20 to 49 residents must have one staff member designated to organize, conduct, and evaluate activities. Facilities with 50 or more beds must have a full-time person for activities. Volunteers may be used to supplement the services and programs of a residential facility, but may not be used to replace members of the staff of the facility.

### **Training**

*Administrators* must have the necessary skills to meet, or to direct staff to meet the needs of residents, unless such skills are met by appropriately skilled medical professionals who are employed by, or contract with the facility. Administrators must receive annually eight hours of training that is directed toward meeting the needs of group-care residents.

All *staff* must possess the necessary skills to meet the needs of the residents in the residential facility with the exception of those needs/skills that are to be met in a contract with other service providers. Within 60 days after being employed by a residential facility for elderly or disabled persons, a caregiver must receive not less than 4 hours of training related to the care of those residents. Staff must receive annually eight hours of training that is directed toward meeting the needs of group-care residents.

*NAC 449.231*

Within 30 days after an Administrator or caregiver of a residential facility is employed at the facility, the Administrator or caregiver must be trained in first aid and cardiopulmonary resuscitation. The advanced certificate in first aid and adult cardiopulmonary resuscitation issued by the American Red Cross or an equivalent certification will be accepted as proof of that training.

### **Background Check**

Under *NRS 449*, you must conduct a fingerprint-based criminal history background check on each employee and each independent contractor if you are the Administrator of, or you are licensed to operate, any of the following:

- Agency to provide personal care services in the home
- Agency to provide nursing in the home
- Facility for intermediate care
- Facility for skilled nursing
- Residential facility for groups

These background checks must be conducted through the Central Repository for Nevada Records of Criminal History, an agency of the Nevada Department of Public Safety, Records and Technology Division. Even if you use another agency to conduct a preliminary criminal history check, you must conduct a background check by submitting fingerprints to the Central Repository, as required by the statute and summarized here. If your business is not one of the five types of entities listed above then you may choose to voluntarily submit fingerprints under [NRS 179A.210](#) to obtain criminal history information with each employee's consent, but you are not authorized to have the Department of Public Safety evaluate an individual's criminal history under NRS 449. NRS 449.179 applies to every employee or independent contractor, including the Administrator and the person licensed to operate the agency or facility, regardless of whether the individual provides direct patient care. You must conduct the background check *in addition to* any other fingerprint-based criminal history background check that the individual may have already undergone, such as to obtain a professional license, including a nursing license or a long term care Administrator license. The statute does not apply to a volunteer. The

statute does not apply to an individual that is not hired by you or your licensed entity but rather is hired directly by a resident at your licensed entity.

## **Overview of the Process under NRS 449**

### ***Instructions to Facilities***

If you learn from a background check or receive evidence *from any other source* that an employee or independent contractor has been convicted of a crime listed in NRS 449.188, then you must terminate that individual's employment after allowing him time to correct the information, as described in NRS 449.185 and summarized below.

Under NRS 449.179, when you accept an individual for employment, you must complete the following steps within ten days of hiring that individual as an employee or an independent contractor:

- Obtain a written statement from the individual stating whether the individual has been convicted of any crime listed in NRS 449.188,
- Obtain oral and written confirmation of the information in that statement,
- Obtain the individual's fingerprints and written authority from the individual the you may submit those fingerprints to the Central Repository for Nevada Records of Criminal History, and
- Submit those fingerprints to the Central Repository of Nevada Records of Criminal History.

You must ensure that the criminal history of each employee or independent contractor who works for you is investigated at least once every five years by submitting fingerprints to the Central Repository.

You may avoid the initial criminal history background check when you hire the individual if the individual can provide you with proof that an investigation of his criminal history was conducted by the Central Repository within the immediately preceding six months and the investigation did not indicate that the individual had been convicted of any crime listed under NRS 449.188. That proof would consist of a copy of the *Applicant Fingerprint Response* that the Department of Public Safety Criminal History Records Repository provided to another employer indicating that the individual's status was *449.188 NEGATIVE*. If you forego the initial criminal history background check on this basis, then you must keep a copy of the *Applicant Fingerprint Response* on which you relied in your files.

You must submit the fingerprints of each employee and independent contractor to the Central Repository, which is in the Department of Public Safety (DPS) Records and Technology Division. You must establish an account with DPS to submit fingerprints for any purpose. DPS uses this information to determine what kind of background check to conduct and where to send the results. This account establishes your authority to receive criminal history information, and provides information that you will need for your fingerprint records. Each employee fingerprint record must have in the "Reason Fingerprinted" field "NRS 449.176" (not NRS 449.179) and in the "MNU Miscellaneous Number" field your DPS account number. You must pay for the background check, but you may recover up to half of the cost from the individual. See [NRS 449.179\(5\)](#) for details and limitations.

If you use printed fingerprint cards, then you must submit to DPS two cards for each employee: one for the state check and one for the FBI check. You must keep a copy of each card in your files. A photocopy of each card is sufficient. If you use a fingerprint agency that can submit fingerprint records electronically, then you need to keep in your files only one copy of the fingerprints submitted along with the receipt indicating that the

prints were submitted electronically. We strongly encourage you to submit fingerprints electronically because:

There is a lower probability that the fingerprints will be rejected for poor quality. You are likely to receive a faster response on the background check.

As of October 1, 2007, the cost of the FBI check is lower for fingerprints submitted electronically.

Either way, DPS keeps one copy of the fingerprints to conduct the check of state criminal history records and forwards a copy to the FBI to check for criminal convictions in other states.

After DPS completes its background check, it sends to you an "Applicant Fingerprint Response" indicating the status of the individual. You must keep a copy of the Applicant Fingerprint Response from DPS in your files, along with the criminal history statement signed by the individual and a copy of the individual's fingerprints. Based on the status indicated in the **Applicant Fingerprint Response**, the table on the next page illustrates the specific action you must take.

Status	Action you must take
449.188 POSITIVE	You may <b>not</b> employ the individual, and you <b>must</b> terminate the individual's employment immediately*. The individual has a Nevada State or FBI criminal history record that lists at least one disqualifying conviction listed in NRS 449.188.
449.188 FBI POSITIVE or 449.188 POS FBI	You may <b>not</b> employ the individual, and you <b>must</b> terminate the individual's employment immediately*. The individual has an FBI criminal history record that lists at least one disqualifying conviction listed in NRS 449.188.
449.188 STATE POSITIVE	You may <b>not</b> employ the individual, and you <b>must</b> terminate the individual's employment immediately*. The individual has a Nevada State criminal history record that lists at least one disqualifying conviction listed in NRS 449.188.
449.188 NEGATIVE	You may employ the individual. The individual has no convictions in Nevada State or FBI criminal history records, which would disqualify the individual under NRS 449.188.
STATE NEGATIVE	The individual's Nevada State criminal history has no disqualifying convictions listed in NRS 449.188. The background check is not complete until you have an answer regarding the individual's FBI status, but you may continue to employ the individual until you receive that FBI response.
FBI NEGATIVE	The individual's FBI criminal history has no disqualifying convictions listed in NRS 449.188. The background check is not complete until you have an answer regarding the individual's state of Nevada status, but you may continue to employ the individual until you receive that state response.
449.188 UNDECIDED	The individual has been arrested for an offense, which would disqualify the individual under NRS 449.188 if the individual is convicted when the case is adjudicated. You may employ the individual, if you choose to do so, but we strongly encourage you to determine the status of the pending case. DPS will <b>not</b> notify you of the disposition of the case when it is finally adjudicated; but you are required to terminate the individual if you learn from <b>any</b> source that the individual is convicted of a disqualifying offense.
STATE REJECT 1	The individual's fingerprints were not readable, and you must take and submit a new set of fingerprints for the background check if you still employ the individual. If you re-submit the fingerprints within 90 days, then you will not be charged by DPS for this second submission. You can improve the quality of fingerprints by using an agency with live scan fingerprint equipment, which uses laser-scanning technology instead of ink to raise fingerprints. The live scan fingerprint sites on the BLC website includes agencies that are equipped with live scan equipment for fingerprinting.
STATE REJECT 2	If the individual's fingerprints are rejected a second time, and you have tried live scan equipment to raise suitable prints, then you may ask DPS to conduct a name check only by providing DPS with appropriate identifying information about the individual. Be sure to keep copies of the reject print notices in your files, along with the results of the name check.

\* If the individual believes that the information provided by the Central Repository is incorrect and immediately notifies you, then NRS 449.185 requires that you give the individual a reasonable amount of time of not less than 30 days to correct that information with the Central Repository before you terminate the individual on the basis of being disqualified under NRS 449.188. See instructions below for how an individual may challenge a disqualification with the Central Repository.

## **Monitoring**

The Bureau of Licensure and Certification licenses residential facilities for groups. The Bureau conducts unannounced, annual, on-site inspections and investigates complaints. The annual inspection follows standard protocols for a focused survey that looks at primary health and safety regulations such as care needs, staff training, background checks, and medication needs.

A full survey is conducted as needed, based on observation and the results of the focused review. Inspectors review resident records and interview a sample of residents that includes residents recently admitted from a hospital or community setting, those who have special care needs, and those who receive home health or hospice care. All residents in facilities of ten or less are interviewed; in larger facilities, surveyors interview a sample of residents based facility size. Inspectors ask residents how long they have lived at the facility, what their interests are, what kind of care they are receiving, and questions about medications and food service.

Consultation is not provided, but inspectors explain the regulations and comment on how other facilities respond to problems as they are identified. Inspectors may be registered nurses, social workers, or generalists with a health or aging background. Nursing home inspectors do not typically inspect residential facilities for groups, but some are cross-trained to help if there is a backlog.

## **Licensing Fees**

Initial fees will apply to licenses and are subject to change with each legislative session. There is also a per bed fee, as well as renewal fees. Facilities that wish to increase their bed capacity must pay a fee for each additional bed. For beds that serve the low-income, the fees will vary from those beds that are not low-income.

## **Resident Rights**

**NAC 449.268 Rights of residents; procedure for filing grievance, complaint or report of incident; investigation and response. ([NRS 449.037](#))**

1. The Administrator of a residential facility shall ensure that:
  - (a) The residents are not abused, neglected or exploited by a member of the staff the facility, another resident of the facility or any person who is visiting the facility;
  - (b) A resident is not prohibited from speaking to any person who advocates for the rights of the residents of the facility;
  - (c) The residents are treated with respect and dignity;
  - (d) The facility is a safe and comfortable environment;
  - (e) Residents are not prohibited from interacting socially;
  - (f) Residents are allowed to make their own decisions whenever possible;
  - (g) Residents are aware that they may file a complaint or grievance with the Administrator and that a resident who files such a complaint receives a response in a timely manner;
  - (h) A resident is informed as soon as practicable that he is being moved to a new room or that he is receiving a new roommate; and
  - (i) Residents are afforded the opportunity to initiate an advance directive or power of attorney for health care and that the employees of the facility comply with the wishes contained in such a document.
2. The Administrator of a residential facility shall provide a procedure to respond immediately to grievances, incidents and complaints. The procedure must include a method for ensuring that the Administrator or a person designated by the Administrator is notified of the grievance, incident or complaint. The Administrator or

a person designated by the Administrator shall personally investigate the matter. A resident who files a grievance or complaint or reports an incident pursuant to this subsection must be notified of the action taken in response to the grievance, complaint or report or be given a reason why no action needs to be taken.

3. The employees of the facility shall comply with the procedures adopted pursuant to subsection 2.

## **HOMES FOR INDIVIDUAL RESIDENTIAL CARE (HIRC)**

### **Defined**

**NRS 449.0105 “Home for individual residential care” defined.** “Home for individual residential care” means a home in which a natural person furnishes food, shelter, assistance and limited supervision, for compensation, to not more than two persons with mental retardation or with disabilities or **who are aged or infirm**, unless the persons receiving those services are related within the third degree of consanguinity or affinity to the person providing those services. The term **does not include**:

1. A halfway house for recovering alcohol and drug abusers; or
2. A home in which supported living arrangement services are provided by a provider of supported living arrangement services during any period in which the provider of supported living arrangement services is engaged in providing supported living arrangement services.

**NOTE:** Webster’s defines consanguinity as *1: the quality or state of being consanguineous 2: a close relation or connection. Consanguineous means of the same blood or origin; specifically: descended from the same ancestor. For example, if the HIRC Home has a census of two, the Administrator or owner may choose to have their elderly parent or other relative, such as an aunt or uncle admitted to the home. This would be acceptable according to the statutes. (Notes and emphasis added)*

**NAC 449.15511 Definitions. (NRS 449.249)** As used in [NAC 449.15511](#) to [449.15529](#), inclusive, unless the context otherwise requires, the words and terms defined in [NAC 449.15513](#) to [449.15519](#), inclusive, have the meanings ascribed to them in those sections.

### **NRS 449.249 License required for operation of home; application for license; minimal standards for licensing.**

1. A person, state or local government or agency thereof shall not operate a home for individual residential care without first obtaining a license for the home from the Health Division. An application for the license must be made in the manner provided in [NRS 449.040](#).

2. The State Board of Health shall adopt minimal standards for licensing that provide for care and sanitation to prevent the abuse, neglect or exploitation of residents of homes for individual residential care.

**NAC 449.15513 “Caregiver” defined. (NRS 449.249)** “Caregiver” means a person who provides care, assistance and protective supervision to a resident of a home.

(Added to NAC by Bd. of Health by R131-99, eff. 11-29-99)

**NAC 449.15515 “Director” defined. (NRS 449.249)** “Director” means a person:

1. Whose name appears on a license issued by the Bureau as the director of record for a home; and
2. Who is legally responsible for the care of the residents and the daily operation of the home.

(Added to NAC by Bd. of Health by R131-99, eff. 11-29-99)

**NAC 449.15517 “Home” defined. ([NRS 449.249](#))** “Home” means a home for individual residential care.

**NAC 449.15519 “Protective supervision” defined. ([NRS 449.249](#))** “Protective supervision” means supervision that protects the residents of a home from potential danger to their physical and mental well being.

**NAC 449.15521 Director: Qualifications. ([NRS 449.249](#))** The director of a home must:

1. Be at least 21 years of age and have a high school diploma or its equivalent. A person who proposes to act as the director of a home must provide the Bureau with evidence that he satisfies the requirements of this subsection.
2. Possess the appropriate knowledge, skills and abilities to meet the needs of the residents of the home.

**NAC 449.15523 Director: Duties. ([NRS 449.249](#))** The director of a home shall:

1. Post the license to operate the home in a conspicuous place within the home.
2. Ensure that the needs of each resident of the home are assessed upon admission of the resident to the home, and that the assessment is updated as the needs of the resident change. Such an assessment must include:
  - (a) Documentation of the abilities of the resident to function independently; and
  - (b) A complete list of the matters for which the resident requires assistance.
3. Ensure that the residents of the home:
  - (a) Are treated with dignity and respect and are not abused, neglected or exploited; and
  - (b) Receive:
    - (1) The personal care they require;
    - (2) A balanced daily diet that meets their nutritional needs;
    - (3) Protective supervision and adequate services to maintain and enhance their physical, mental and emotional well-being; and
    - (4) The names of, and the telephone numbers for the registration of complaints with, the Bureau and the Aging Services Division of the Department of Health and Human Services.
4. Ensure that a caregiver, who is capable of meeting the needs of the residents and has been trained in first aid and cardiopulmonary resuscitation, is on the premises of the home at all times when a resident is present.
5. Ensure that appropriate sanitary procedures are carried out for the handling, cleaning and storage of linens and personal laundry in the home.

### **Resident’s Rights**

Since there are no Resident’s Rights specifically mentioned in the statutes, we can see that NAC 449.15523.3 (a)-(b) - (4) (above) lists duties of the owner that reflect how the resident shall be treated.

**NAC 449.15525 Requirements for safety and sanitation of facility. ([NRS 449.249](#))**

1. The interior and exterior of a home must be clean and free of hazards and offensive odors.
2. A home must contain:

- (a) Appropriate and well-maintained furnishings;
  - (b) At least one functional, portable fire extinguisher;
  - (c) A first-aid kit;
  - (d) Equipment that is sufficiently clean and adequate for the preparation, service and storage of food; and
  - (e) Adequate areas and equipment to carry out appropriate sanitary procedures for the handling, cleaning and storage of linens and personal laundry.
3. The temperature of a home must be maintained at levels that are comfortable and safe. Portable heaters are prohibited in a home.

**NAC 449.15527 Agreement between operator of home and resident concerning rates; maintenance of records of residents.** ([NRS 449.249](#)) The operator of a home shall:

1. Enter into a written agreement with each resident of the home that sets forth the basic rate for the services of the home and the charges for any optional services.
2. Maintain a separate, organized file for each resident of the home and retain the file for 5 years after the resident permanently leaves the home. Each file must include:
  - (a) The full name, address, date of birth and social security number of the resident;
  - (b) The address and telephone number of the resident's physician and a person who is responsible for the resident;
  - (c) A copy of the results of a general physical examination of the resident conducted by his physician; and
  - (d) A current copy of the assessment of the needs of the resident conducted pursuant to [NAC 449.15523](#).

**NAC 449.15529 On-site survey of home by Bureau.** ([NRS 449.249](#)) The Bureau (BLC) shall conduct:

1. An initial on-site survey of a home:
    - (a) After the Bureau (BLC) receives a completed application for a license to operate the home and the fee required pursuant to [NAC 449.016](#); and
    - (b) Before the issuance of a license to operate the home.
  2. Additional on-site surveys of a home not less than once every 3 years after conducting the survey of the home pursuant to subsection 1.
- (Added to NAC by Bd. of Health by R131-99, eff. 11-29-99)

### **Resident Care Standards**

A summary of the care standards for residents of Homes for Individual Residential Care:

- Assess the resident's abilities
- Treat residents with dignity and respect
- Keep residents free from abuse, neglect and exploitation.
- Balanced diet
- Protective supervision
- Caregivers are trained in first aid and CPR, and on the premises of the home at all times when a resident is present.

## A LOOK AT ALZHEIMER'S

### Introduction

Alzheimer's disease is a brain disorder named for German physician Alois Alzheimer, who first described it in 1906. Scientists have learned a great deal about Alzheimer's disease in the century since Dr. Alzheimer first drew attention to it. Today we know that Alzheimer's:

- **Is a progressive and fatal brain disease.** More than 5 million Americans now have Alzheimer's disease. Alzheimer's destroys brain cells, causing problems with memory, thinking and behavior severe enough to affect work, lifelong hobbies or social life. Alzheimer's gets worse over time, and it is fatal. Today it is the seventh-leading cause of death in the United States
- **Is the most common form of dementia**, a general term for the loss of memory and other intellectual abilities serious enough to interfere with daily life. Vascular dementia, another common type of dementia, is caused by reduced blood flow to parts of the brain. In mixed dementia, Alzheimer's and vascular dementia occur together.
- **Has no current cure.** But treatments for symptoms, combined with the right services and support, can make life better for the millions of Americans living with Alzheimer's. We've learned most of what we know about Alzheimer's in the last 15 years. There is an accelerating worldwide effort under way to find better ways to treat the disease, delay its onset, or prevent it from developing. Learn more about recent progress in Alzheimer science and research funded by the Alzheimer's Association in the Research section.

### **Alzheimer's And The Brain**

Just like the rest of our bodies, our brains change as we age. Most of us notice some slowed thinking and occasional problems remembering certain things. However, serious memory loss, confusion and other major changes in the way our minds work are not a normal part of aging. They may be a sign that brain cells are failing.

The brain has 100 billion nerve cells (neurons). Each nerve cell communicates with many others to form networks.

Nerve cell networks have special jobs. Some are involved in thinking, learning and remembering. Others help us see, hear and smell. Still others tell our muscles when to move.

To do their work, brain cells operate like tiny factories. They take in supplies, generate energy, construct equipment and get rid of waste. Cells also process and store information. Keeping everything running requires coordination as well as large amounts of fuel and oxygen.

In Alzheimer's disease, parts of the cell's factory stop running well. Scientists are not sure exactly where the trouble starts. But just like a real factory, backups and breakdowns in one system cause problems in other areas. As damage spreads, cells lose their ability to do their jobs well. Eventually, they die.

## **The Role Of Plaques And Tangles**

Two abnormal structures called plaques and tangles are prime suspects in damaging and killing nerve cells. Plaques and tangles were among the abnormalities that Dr. Alois Alzheimer saw in the brain of Auguste D., although he called them different names.

- **Plaques** build up between nerve cells. They contain deposits of a protein fragment called beta-amyloid (BAY-tuh AM-uh-loyd). Tangles are twisted fibers of another protein called tau (rhymes with “wow”).
- **Tangles** form inside dying cells. Though most people develop some plaques and tangles as they age, those with Alzheimer’s tend to develop far more. The plaques and tangles tend to form in a predictable pattern, beginning in areas important in learning and memory and then spreading to other regions.

Scientists are not absolutely sure what role plaques and tangles play in Alzheimer’s disease. Most experts believe they somehow block communication among nerve cells and disrupt activities that cells need to survive.

## **Early Stage And Early Onset**

Early-stage is the early part of Alzheimer’s disease when problems with memory, thinking and concentration may begin to appear in a doctor’s interview or medical tests. Individuals in the early-stage typically need minimal assistance with simple daily routines. At the time of a diagnosis, an individual is not necessarily in the early stage of the disease; he or she may have progressed beyond the early stage.

The term early-onset refers to Alzheimer’s that occurs in a person under age 65. Early-onset individuals may be employed or have children still living at home. Issues facing families include ensuring financial security, obtaining benefits and helping children cope with the disease. People who have early-onset dementia may be in any stage of dementia – early, middle or late. Experts estimate that some 500,000 people in their 30s, 40s and 50s have Alzheimer’s disease or a related dementia.

## **History**

At a scientific meeting in November 1906, German physician Alois Alzheimer presented the case of “Frau Auguste D.,” a 51-year-old woman brought to see him in 1901 by her family. Auguste had developed problems with memory, unfounded suspicions that her husband was unfaithful, and difficulty speaking and understanding what was said to her. Her symptoms rapidly grew worse, and within a few years she was bedridden. She died in the spring of 1906, of overwhelming infections from bedsores and pneumonia. Dr. Alzheimer had never before seen anyone like Auguste D., and he gained the family’s permission to perform an autopsy. In Auguste’s brain, he saw dramatic shrinkage, especially of the cortex, the outer layer involved in memory, thinking, judgment and speech. Under the microscope, he also saw widespread fatty deposits in small blood vessels, dead and dying brain cells, and abnormal deposits in and around cells.

The condition entered the medical literature in 1907, when Alzheimer published his observations about Auguste D. In 1910, Emil Kraepelin, a psychiatrist noted for his work in naming and classifying brain disorders, proposed that the disease be named after Alzheimer.



Auguste D.



Dr. Alois Alzheimer

## Symptoms Checklist

The Alzheimer's Association has developed a checklist of common symptoms to help you recognize the difference between normal age-related memory changes and possible warning signs of Alzheimer's disease.

There's no clear-cut line between normal changes and warning signs. It's always a good idea to check with a doctor if a person's level of function seems to be changing. The Alzheimer's Association believes that it is critical for people diagnosed with dementia and their families to receive information, care, and support as early as possible.

### **10 Warning Signs Of Alzheimer's:**

**1. Memory loss.** Forgetting recently learned information is one of the most common early signs of dementia. A person begins to forget more often and is unable to recall the information later.

*What's normal?* Forgetting names or appointments occasionally.

**2. Difficulty performing familiar tasks.** People with dementia often find it hard to plan or complete everyday tasks. Individuals may lose track of the steps involved in preparing a meal, placing a telephone call or playing a game.

*What's normal?* Occasionally forgetting why you came into a room or what you planned to say.

**3. Problems with language.** People with Alzheimer's disease often forget simple words or substitute unusual words, making their speech or writing hard to understand. They may be unable to find the toothbrush, for example, and instead ask for "that thing for my mouth."

*What's normal?* Sometimes having trouble finding the right word.

**4. Disorientation to time and place.** People with Alzheimer's disease can become lost in their own neighborhood, forget where they are and how they got there, and not know how to get back home.

*What's normal?* Forgetting the day of the week or where you were going.

**5. Poor or decreased judgment.** Those with Alzheimer's may dress inappropriately, wearing several layers on a warm day or little clothing in the cold. They may show poor judgment, like giving away large sums of money to telemarketers.

*What's normal?* Making a questionable or debatable decision from time to time.

**6. Problems with abstract thinking.** Someone with Alzheimer's disease may have unusual difficulty performing complex mental tasks, like forgetting what numbers are for and how they should be used.

**What's normal?** Finding it challenging to balance a checkbook.

**7. Misplacing things.** A person with Alzheimer's disease may put things in unusual places: an iron in the freezer or a wristwatch in the sugar bowl.

**What's normal?** Misplacing keys or a wallet temporarily.

**8. Changes in mood or behavior.** Someone with Alzheimer's disease may show rapid mood swings – from calm to tears to anger – for no apparent reason.

**What's normal?** Occasionally feeling sad or moody.

**9. Changes in personality.** The personalities of people with dementia can change dramatically. They may become extremely confused, suspicious, fearful or dependent on a family member.

**What's normal?** People's personalities do change somewhat with age.

**10. Loss of initiative.** A person with Alzheimer's disease may become very passive, sitting in front of the TV for hours, sleeping more than usual or not wanting to do usual activities.

**What's normal?** Sometimes feeling weary of work or social obligations.

### **The difference between Alzheimer's and normal age-related memory changes**

<b>Someone with Alzheimer's disease symptoms</b>	<b>Someone with normal age-related memory changes</b>
Forgets entire experiences	Forgets part of an experience
Rarely remembers later	Often remembers later
Is gradually unable to follow written/spoken directions	Is usually able to follow written/spoken directions
Is gradually unable to use notes as reminders	Is usually able to use notes as reminders
Is gradually unable to care for self	Is usually able to care for self

### **Communicating With People With Dementia**

We tend to think of communication as talking, but in fact it consists of much more than that. As much as 90 per cent of our communication takes place through nonverbal communication such as gestures, facial expressions and touch.

- Non-verbal communication is particularly important for a person with dementia who is losing their language skills.
- When a person with dementia behaves in ways that cause problems for their caregiver, they may be trying to communicate something.

Difficulties with communication can be distressing and frustrating for the person with dementia and for you as a caregiver. But there are lots of ways to help make sure that you understand each other.

### **Tips**

Listen carefully to what they have to say.  
Make sure you have their full attention before you speak.  
Pay attention to body language.  
Speak clearly.  
Think about how things appear in the person with dementia's reality.  
Consider whether any other factors are affecting their communication.  
Show them respect.  
Don't argue with them.

### **Listening Skills**

- Try to listen carefully to what the person is saying and give them plenty of encouragement.
- If they have difficulty finding the right word or finishing a sentence, ask them to explain in a different way. Listen for clues.
- If their speech is hard to understand, give them time to speak, don't finish sentences, and listen carefully.
- If the other person is feeling sad, let them express their feelings without trying to 'jolly them along'. Sometimes the best thing to do is to just listen, and show them that you care.

### **Getting Their Attention**

- Try to catch and hold the attention of the person before you start to communicate.
- Make sure they can see you clearly.
- Make eye contact. This will help them focus on you.
- Try to minimize competing noises, such as the radio, TV, or other people's conversation.

### **Using Body Language**

- A person with dementia will read your body language. Agitated movements or a tense facial expression may upset them and can make communication more difficult.
- Be calm and still while you communicate. This shows the person that you are giving them your full attention, and that you have time for them.
- Try to find ways to relax so that your body language communicates confidence and reassurance.
- If words fail the person, pick up cues from their body language. The expression on their face and the way they hold themselves and move about can give you clear signals about how they are feeling.

### **Speaking Clearly**

- Ask questions one at a time and phrase them in a way that allows for a yes or no answer. As the dementia progresses, the person will become less able to start a conversation, so you may have to start taking the initiative.
- Speak clearly and calmly. Avoid speaking sharply or raising your voice as this may distress the person, even if they can't follow the sense of your words.

- Use simple, short sentences.
- Processing information will take the person longer than it used to – so allow them enough time. If you try to hurry them, they may feel pressured.
- Avoid asking direct questions. People with dementia can become frustrated if they can't find the answer, and they may respond with irritation or even aggression. If you have to, ask a question that allows for a 'yes' or 'no' answer.
- Try not to ask the person to make complicated decisions. Too many choices can be confusing and frustrating.
- If the person doesn't understand what you are saying, try getting the message across in a different way rather than simply repeating the same thing.
- Humor can help to bring you closer together and is a great pressure valve. Try to laugh together about misunderstandings and mistakes – it can help.

### **Whose Reality?**

- Fact and fantasy can become confused as dementia progresses. If the person says something you know isn't true, try to find ways around the situation rather than responding with a flat contradiction.
- If they say, 'We must leave now – mother is waiting for me', you might reply, 'Your mother used to wait for you, didn't she?'
- Always avoid making the person with dementia feel foolish in front of other people.

### **Other Causes**

As well as dementia, communication can be affected by:

- Pain, discomfort, illness or the side effects of medication.
- Problems with sight, hearing or ill-fitting dentures. Make sure the person's glasses are the correct prescription, that their hearing aids are working properly, and that their dentures fit well and are comfortable.

### **Show Respect**

- Make sure no one speaks down to the person with dementia or treats them like a child, even if they don't seem to understand what people say. No one likes being patronized.
- Try to include the person in conversations with others. You may find this easier if you adapt the way you say things slightly. Being included in social groups can help a person with dementia to preserve their fragile sense of their own identity. It also helps to protect them from the overwhelming feelings of exclusion and isolation.
- If you are getting little response from the person, it can be very tempting to speak about them as if they weren't there. But disregarding them in this way can make them feel very cut off, frustrated and sad.

### **Communicating With Someone With Dementia – Tips**

- Listen carefully to what they have to say.
- Make sure you have their full attention before you speak.
- Pay attention to body language.
- Speak clearly.
- Think about how things appear in the person with dementia's reality.
- Consider whether any other factors are affecting their communication.

- Show them respect

### **Tips From A Person With Dementia**

Christine Boden was diagnosed with Alzheimer's disease at age 46. She now lives with a re-diagnosis of front temporal dementia, made when she was 49. She has shared a number of her insights about ways family and caregivers can help a person with dementia. Christine is also the author of "*Who Will I Be When I Die?*", which was the first book written by an Australian with dementia.

### ***Here are some of Christine's suggestions for communicating with a person with dementia:***

- *Give us time to speak. Wait for us to search around that untidy heap on the floor of the brain for the word we want to use. Try not to finish our sentences. Just listen, and don't let us feel embarrassed if we lose the thread of what we say.*
- *Don't rush us into something because we can't think or speak fast enough to let you know whether we agree. Try to give us time to respond and to let you know whether we really want to do it.*
- *When you want to talk to us, think of some way to do this without questions, which can alarm us or make us feel uncomfortable. If we have forgotten something special that happened recently, don't assume it wasn't special for us too. Just give us a gentle prompt – we may just be momentarily blank.*
- *Don't try too hard to help us remember something that just happened. If it never registered, we are never going to be able to recall it.*
- *Avoid background noise if you can. If the TV is on, mute it first.*
- *If children are underfoot, remember we will get tired very easily and find it very hard to concentrate on talking and listening as well. Maybe one child at a time and without background noise would be best.*



“What makes old age hard to bear is not the failing of one's faculties, mental and physical, but the burden of one's memories”

**William Somerset Maugham**