Office of Ombudsman for Long-Term Care

Uniform Disclosure of Amenities and Services

An Analysis of Information Disclosed Regarding Facilities, Staffing, and Care Practices in Minnesota Assisted Living Facilities

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Introduction

On August 1, 2021, the Assisted Living Licensure law went into effect in Minnesota. More than two thousand facilities obtained the new assisted living license. Many previously operated under the Housing with Services registration, with a licensed home care agency delivering care under a service agreement separate from a housing lease with a landlord. The new law and associated rules created standards, regulatory oversight, and provisions to assure the health, safety, well-being and appropriate treatment of residents of licensed assisted living facilities. The law created two categories of license holders – Assisted Living and Assisted Living with Dementia Care. The law also established requirements to ensure respect for individual autonomy and choice for residents of these facilities and overall enhanced resident rights.

One component of the regulation was the development of a tool that has come to be known as the Uniform Disclosure of Assisted Living Services and Amenities (UDALSA). The precursor of this document from the Housing with Services registration was called the Uniform Checklist Disclosure of Services. The new UDALSA was created by the Minnesota Department of Health and other partners. All licensed Assisted Living and Assisted Living with Dementia Care facilities must complete the document and make it available to residents who are considering moving there. The forms can be accessed by the public on the Minnesotahelp.info website.

The OOLTC explored the information on these forms in our UDALSA Project. The project was designed to identify trends across the assisted living industry. More specifically, some areas of focus included:

- What do staffing patterns tell us?
- How many, and what limitations exist, for facilities who accept public funding (Waivers or Housing Support)?
- How many facilities provide assistance to residents who require the use of bariatric equipment?
- What are the limits to available services for residents who have symptoms of dementia or mental illness?

Data on these and other subjects were collected and analyzed. There are other variables that impact quality of life such as access to air conditioning and dietary accommodations. We decided to keep our scope narrow and focused on financial supports, staffing levels, and capacity for care. While informative trends emerged, the research process itself highlighted additional insights about the accessibility of the information. Key details and recommendations for the UDALSA form will be documented in this report and several are highlighted below:

- This current system for finding and accessing UDALSAs is confusing and difficult to navigate.
- Less than half (47%) of all Licensed facilities reported a Registered Nurse (RN) on-site full-time.

- Facilities with a capacity of 5 or fewer residents reported the lowest rate of hiring licensed staff. 65% did not report having an Activities Director. Only 24% reported having an RN on-site full time.
- Providers self-reported 94% waiver acceptance for services but that does not indicate if all of the rooms accept waivers and does not match the experiences residents share with the Office of Ombudsman for Long Term Care (OOLTC).

The stated purpose of the UDALSA is to provide prospective residents and their families with information to help them determine if a facility can meet their needs, compare care options, and make informed decisions about their care and where they live. In order for consumers to be able to use them as designed, the UDALSAs must be accurate and clear. About one third of UDALSAs were missing some of the information being looked at, and 40 UDALSAs had major missing components such as blank pages or incomplete data. Additionally, navigating minnesotahelp.info is challenging, making it difficult to easily find this information.

Methodology

The data used in this research was collected between February and July of 2024 from UDALSAs completed by providers across Minnesota. UDALSAs from licensed Assisted Living facilities and licensed Assisted Living Facility with Dementia Care facilities as well as facilities with provisional licenses were reviewed. The UDALSAs were obtained from the minnesotahelp.info website where they are presented as PDF documents. Each facility required an individual search using two different search fields to find the facility. The UDALSA could be found only when looking at the Assisted Living or Assisted Living with Dementia Care service page for that facility. A facility might offer other services, but the UDALSA would not be found on those other pages. Typically, the other services were the first or only result after using the search function, however a link to the correct page could be found after clicking the resulting facility listed. The relevant data from each facility's UDALSA PDF was entered by hand into an Excel spreadsheet, prepared by the OOLTC, to be analyzed.

Information was collected from 2,203 UDALSAs of the 2,217 licensed facilities in the system. When some facilities could not be found using the search function of the website, we obtained the completed form from the Minnesota Department of Health (MDH); this accounted for 377 of the UDALSAs that we reviewed. Only 8 facilities are not represented in this report because we could not obtain their UDALSAs. Some of the facilities on our list closed prior to the attempt to obtain their UDALSA, so the forms were unavailable. All the data in the UDALSAs is self-reported by facility staff. No other data sources were used in this analysis.

The UDALSA is an 18-page document that captures twelve different topics from payments and staffing to cares, security and amenities. Only a few variables were chosen to analyze from the UDALSA form. The focus was on variables that would have the biggest impact on the resident experience. Staffing

levels have one of the largest impacts on resident experience, both unlicensed staff ratios as well as access to licensed staff were studied in this report. Unlicensed staff includes certified nursing assistants, nurse aids, etc. and they provide most of the care for residents. Licensed staff includes Registered Nurses and Activities Directors. Registered Nurses (RNs) provide assessments and guidance to the unlicensed staff on how to provide care. Activities Directors ensure there are enriching activities to keep residents active.

The availability of transfer with assist of two staff, or two-staff transfers, was another way to look at basic staffing levels. Transfers with assist of two staff is what it sounds like - when two staff are required to help someone safely move from sitting to standing or standing to sitting on a toilet for example. We looked at housing support and waiver acceptance for services because those impact residents' abilities to pay for and secure housing and services. To analyze the care available to a wide spectrum of residents, language accessibility and access to bariatric equipment for transferring were also looked at. Facilities which indicated they could handle challenging behaviors were also reviewed, providing further insight into what facilities may be best prepared to support residents throughout the course of dementia and its progression, as well as other cognitive, degenerative or mental health related conditions that might involve the need for behavioral management.

For this analysis facilities were sorted into four different size categories based on capacity: large (21 or more residents), medium (11-20 residents), small (6-10 residents), and super small (1-5 residents). The small and super small categories were separated to allow examination of any potential difference in the residential home style facilities versus more traditional apartment style settings. While this isn't exact, this was viewed as the best approximate cut-off to get this information.

Facilities were listed as for-profit facility if their license type fell in the following categories: corporations, for-profit corporations, for-profit LLC, LLC, sole proprietorship, and partnerships. Nonprofits included those who listed as: nonprofit corporations, and nonprofit LLC. The final category is called public entity which includes facilities listed as church-related, city, county, health district or authority, and tribal facilities.

In the tables below, column labels in bold are questions directly asked in the UDALSA. Any label not in bold, mostly all restrictions, was information gathered from the comments of that question. For example, "Managing Challenging Behaviors" is in bold because it was a check box on the UDALSA, "Limit type of behavior they manage" was gathered from the comments box.

Results

Several different aspects of UDALSAs were analyzed. Most aspects focused on staffing levels and the services those staff offered. Waiver (or public funding of services) acceptance and limitation of those

supports which directly impact who and where consumers can live, was also studied. These gave the best insight into the experiences of the residents living in these settings.

Understanding the differences in assisted living facility types is critical in this analysis. The data collected reflect the number of facilities with licenses during the data collection phase from February to July 2024. There are 1,075 super small settings making up 49% of all licensed facilities. Super small facilities also make up 1,066 of the 1,876 for-profit facilities. Because they make up 57% of the full data set, they can strongly affect the results. The vast majority of all facilities are for-profit, with 1,876 representing 85% of all facilities with available UDALSAs. There were only 18 public entity run facilities, making this the smallest ownership type. In terms of license type, Assisted Living (AL) Facilities represent the most common license type with 1,371, and provisional Assisted Living with Dementia Care (ALDC) Facilities represents the smallest category with 18.

Table 1: Facility Type Overview

Total Facilities			
2,203			
By Size			
Large	Medium	Small	Super Small
741	140	246	1,075
By License Type			
Assisted Living	Provisional Assisted Living	Assisted Living with Dementia Care	Provisional AL with Dementia Care
1,371	234	579	18
By Profit Status			
For Profit	Non Profit	Public Entity	
1,876	308	18	

Chart 1

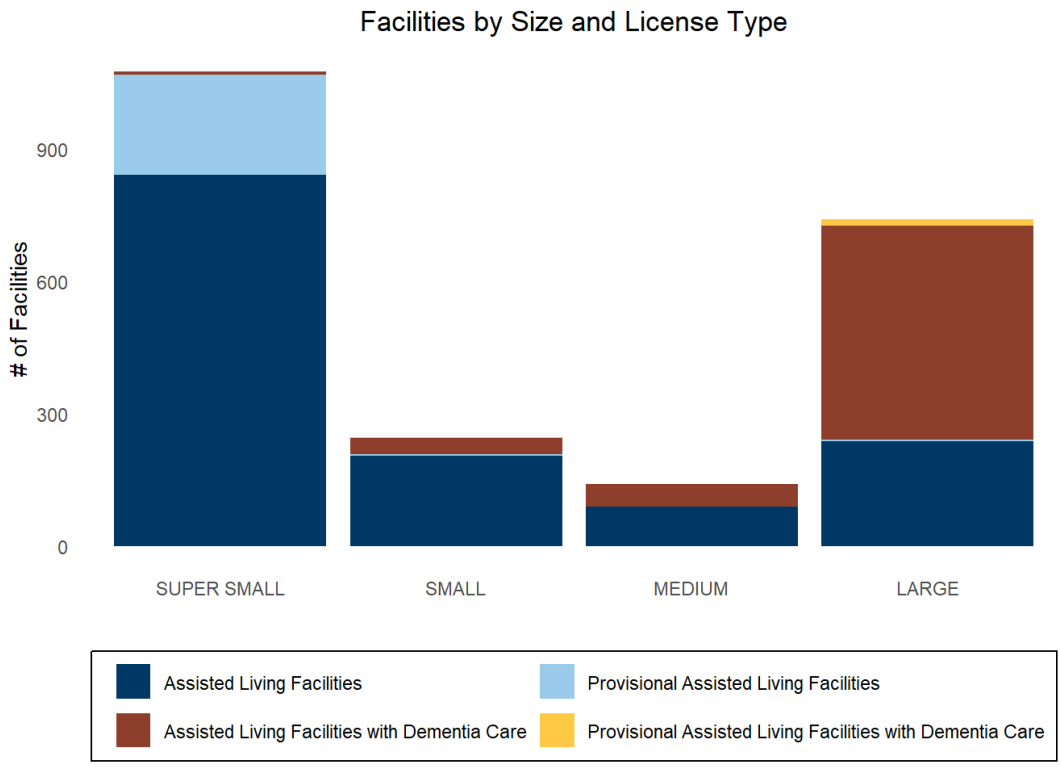
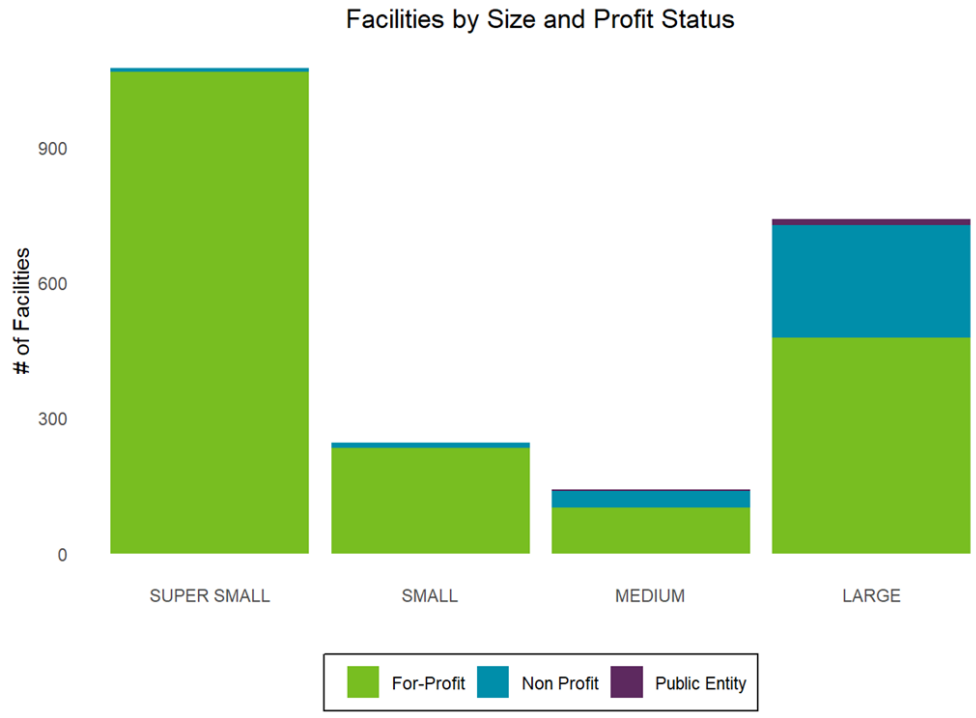


Chart 2



Licensed Staff

OOLTC recognizes the importance of licensed staff in assisted living facilities. Registered Nurses (RN) provide a significant amount of high quality of care to residents and also guide unlicensed staff in care provision. RNs assess residents once every 90 days or when needs change. RNs modify care plans based on those assessments which may impact cost. Activities Directors provide essential support for residents by creating opportunities for social engagement, pursuing interests, and managing the symptoms that can result from loneliness, isolation, boredom, and inactivity. Licensed professionals are essential to assisted living facilities providing excellent care to residents.

For this report, the percent of Registered Nurse (RN), Licensed Practical Nurse (LPN), and Advanced Practice Registered Nurse (APRN) who were reported as being on-site "full-time" were analyzed. APRN can address acute medical needs on site and prescribe medication and new care orders. RNs provide nursing assessments of residents, supervise and train aides and LPNs on care skills. LPNs can do medication management and wound care. There is no statutory requirement to have RNs on site however they must be available by phone 24/7. There is also no requirement to hire LPNs or APRNs. Due to the lack of requirements few facilities hire these staff, see tables A 2 & 3 in the appendix for more information. The percent of facilities that had an Activities Director on-site "part-time" or "full-time" were analyzed. If neither option was chosen, it was assumed that they did not have an Activities Director. Facilities are not required to hire an Activities Director but assisted living facilities are required to offer daily social and recreational services. When facilities don't hire Activities Directors these responsibilities often fall to very busy unlicensed direct care staff.

When looking at all UDALSAs only 47% of facilities self-reported having an RN on-site full-time. Only 31% reported having an Activities Director on-site full-time, and 46% did not indicate having an Activities Director. Size of the facility was the largest determining factor in access to licensed staff. Large facilities had the highest self-reported percentages of licensed staff on-site full-time. 86% of large facilities self-reported having an RN on-site full-time, whereas only 24% of the super small facilities self-reported having an RN on-site full-time. 70% of large facilities also self-reported having an Activities Director on-site full-time compared to medium facilities who had the second highest self-reported percentage at 19% of facilities with a full-time on-site Activities Director. Super small facilities had the lowest percentage of reported full-time on-site licensed professionals: 65% of facilities did not report having an Activities Director. Licensed Dementia Care facilities had a higher rate of on-site full-time Activities Directors with around 75% of facilities verses 16% of non-Dementia Care facilities hiring these roles. Residents receiving dementia care might have a harder time engaging in activities so having an assigned person help with engagement can be critical for quality of life.

Table 2: RN on-site full-time

	RN on-site full-time
Whole data pool	47%
Large Facilities	86%
Medium Facilities	37%
Small Facilities	39%
Super Small Facilities	24%

Table 3: Licensed Activities Directors in Facilities

	Activities Director on-site full-time	Activities Director on-site part-time	No Activities Director
Whole data pool	31%	27%	46%
Large Facilities	70%	17%	17%
Medium Facilities	19%	39%	44%
Small Facilities	15%	40%	54%
Super Small Facilities	9%	29%	65%
Assisted Living	16%	33%	54%
Assisted Living with Dementia Care	74%	15%	17%
Provisional Assisted Living License	7%	21%	74%
Provisional Assisted Living with Dementia Care License	78%	22%	6%

Unlicensed Direct Care Staff

Unlicensed direct care staff are responsible for the bulk of the care that residents receive. When residents need assistance, unlicensed care staff respond first. Helping with dressing, grooming, showering, escorting residents to meals, and responding to call lights are just a few examples of daily responsibilities. In some facilities, these staff members are also responsible for cooking, cleaning, and laundry as well as social and recreational activities in addition to the direct, hands-on care they provide.

To analyze unlicensed staffing levels, a ratio was created from the self-reported number of unlicensed direct care staff typically scheduled per shift and the licensed capacity of the facility. This ratio is not exact as many assisted living facilities had a reduced census when initially completing the form during the height of the Covid-19 pandemic. While many facilities have seen their census increase, the full extent of these changes are not reported in the UDALSA. Additionally, because the staffing levels are self-reported, it might not reflect current hiring or staff retention patterns or be up-to-date. A number of facilities that reported a range of staff scheduled and for those the middle value was chosen (5-7 staff became 6), this was a

best faith effort to set this information up in a way that can be analyzed across the data set. When facilities reported a ratio instead of the number of staff, that ratio was used rather than the calculated ratio of residents per staff member. In tables 6-8, each value represents the number of residents cared for by one staff person.

Each facility is unique in the population it serves. Super small facilities may appear to have a better staffing ratio because of their limited capacity. Facilities with dementia care might have lower staffing ratios because the populations they serve have more care needs. These factors can make broad comparisons difficult. Only looking at one category such as size, license type, or profit goal was misleading. Disaggregating the data gave a more accurate picture of the differences in staffing levels. When taking a disaggregated view, it can be seen that many of the for-profit staffing ratios are lower (better) than comparable nonprofit or public entity facilities, but this is not true for all types of facilities.

Overall day shifts had better (smaller) calculated ratios than evening and night shifts. This data tracks with complaints reported to OOLTC by residents and family members. When looking at large for-profit facilities as a whole, the calculated daytime staffing ratio was 17.3 residents per 1 unlicensed direct care staff. This calculated ratio grows to 18.6 residents per staff in the evening, and again to 29.9 residents per staff at night. Large for-profit Assisted Living with Dementia Care facilities had a lower calculated staffing ratio with 15.8 to 1 during the day, 16.4 to 1 in the evening, and 28.2 to 1 at night. This data is representative of unlicensed professionals only. Licensed staff are not included in these tables.

Table 6: Unlicensed Direct Care Staffing Ratios in all Facilities

ALL	Day shift	Evening Shift	Night Shift
For Profit Large	17.3	18.6	29.9
Non Profit Large	22.0	24.2	39.3
Public Entity Large	21.7	23.2	30.4
For Profit Medium	7.8	8.3	12.4
Non Profit Medium	11.0	11.5	14.8
Public Entity Medium	12.2	14.0	16.0
For Profit Small	4.8	5.0	6.6
Non Profit Small	5.5	5.9	7.3
Public Entity Small	5.0	5.0	10.0
For Profit Super Small	3.6	3.8	4.3
Non Profit Super Small	2.2	2.2	3.3
Public Entity Super Small	-	-	-

Table 7: Unlicensed Direct Care Staffing Ratios in Assisted Living Facilities

AL	Day shift	Evening Shift	Night Shift
For Profit Large	20.7	24.0	34.1
Non Profit Large	29.9	34.0	50.4
Public Entity Large	23.8	25.1	30.9
For Profit Medium	8.4	9.1	12.8
Non Profit Medium	13.0	13.7	15.6
Public Entity Medium	15.3	18.0	18.0
For Profit Small	4.9	5.1	6.5
Non Profit Small	5.2	5.8	8.1
Public Entity Small	5.0	5.0	10.0
For Profit Super Small	3.5	3.7	4.2
Non Profit Super Small	2.3	2.3	3.3
Public Entity Super Small	-	-	-

Table 8: Unlicensed Direct Care Staffing Ratios in Assisted Living with Dementia Care Facilities

ALDC	Day shift	Evening Shift	Night Shift
For Profit Large	15.8	16.4	28.2
Non Profit Large	16.3	17.2	31.7
Public Entity Large	16.4	18.2	29.5
For Profit Medium	6.7	7.0	11.5
Non Profit Medium	6.9	7.0	13.4
Public Entity Medium	6.0	6.0	12.0
For Profit Small	4.8	4.8	7.1
Non Profit Small	6.0	6.0	6.3
Public Entity Small	-	-	-
For Profit Super Small	3.4	3.7	4.4
Non Profit Super Small	-	-	-
Public Entity Super Small	-	-	-

Waiver Acceptance

Waiver services are services paid through Medical Assistance that provide a variety of long-term care services for residents based on financial and medical eligibility determinations. There are different categories of waivers including: Elderly Waiver (EW), Community Access for Disability Inclusion (CADI), or Brain Injury (BI). EW is available for those 65 and older. These waivers are funded through federal and state tax dollars and only cover services, not the cost of rent. Under current Minnesota law there is no requirement that assisted living facilities accept waivers to pay for services. While there are other Medical Assistance waivers, they do not cover assisted living services and are not included in the UDALSA.

OOLTC casework indicates residents experience many challenges with finding a facility that will accept waivers to pay for assisted living services. The UDALSA data supports this notion when you look at the

average number of units that are waiver supported is only 14% for the overall data pool, representing about 9 units per facility. However, many facilities simply reported that they accepted waivers without going into meaningful detail on restrictions. For example, 94% of facilities self-reported accepting waivers with only 12% specifying any restriction. Large facilities had the lowest reported acceptance rate, 88%, with the highest rate of additional restrictions, 33%. In large facilities with restrictions about 81% restricted the number of units available to those with waivers. On average, only 14% of the units were available for waiver support in those facilities that accepted waivers with restrictions. Super small facilities had the highest reported acceptance rate for waivers, 98%, with the lowest rate of additional restrictions, 1%. Licensed Assisted Living with Dementia Care (ALDC) facilities had a lower reported acceptance rate than facilities who did not provide dementia care with an 86% acceptance rate at ALDCs, 38% of which had additional restrictions. When restrictions were reported, they were found in the comments section of the UDALSA. The most common restriction was a limit on number of units available, 76% of facilities with restrictions had a limited number of units. Facilities self-reported an average of nine units were available to those using waiver support.

Despite the high acceptance rate of waivers, very few UDALSAs stated which waivers they accepted. Only 235 or 11% affirmatively said they accept EW, and those numbers drop for CADI and BI to 127 and 73 respectively. It was surprising to note the self-reported 94% acceptance of the waivered services because resident frequently report to OOLTC they have difficulty using waivers to pay for care. Examples of other related issues reported to OOLTC include waivers only covering the cost of services and not all the additional fees charged by assisted living facilities. A higher reported percentage of waiver acceptance does not translate to all consumers being able to use the waivers when they need to. It is possible consumers who have to use a waiver for service will also need assistance paying for rent; however, only about 56% of facilities accept housing support which reduces the overall ability for residents to live in the facility of their choosing.

Table 9: Waiver Services Acceptance

	Waiver services accepted	Accept EW	Accept CADI	Accept BI	Additional waiver restrictions	Ave length (years) of private pay	Limited # of units	Ave % of units for waiver support	Ave # units for waiver support
Whole data pool	94%	235	127	73	12%	1.9	76%	14%	9
Large Facilities	88%	170	35	6	33%	2.0	81%	14%	9
Medium Facilities	95%	17	8	6	12%	1.6	56%	21%	4
Small Facilities	93%	15	22	14	5%	2.3	45%	-	-
Super Small Facilities	98%	33	60	44	1%	0.1	36%	40%	2
Assisted Living	97%	86	81	62	4%	1.6	77%	23%	12
Assisted Living with Dementia Care	86%	138	36	4	38%	2.0	76%	12%	8
Provisional Assisted Living License	99%	9	8	4	3%	-	43%	-	-
Provisional Assisted Living with Dementia Care License	56%	2	0	0	50%	2.0	80%	-	-

Housing Support

Housing Support (HS), formerly Group Residential Housing or GRH, is a program funded by state tax dollars that pays for rent and raw food costs for income-eligible residents in eligible facilities. Most folks who received Housing Support do pay for services with a waiver.

Overall, 56% of assisted living facilities self-report accepting HS. Medium facilities have the highest percentage of reported housing support acceptance with 86%, super small facilities have the lowest reported HS acceptance at 35% of facilities. Facilities run by public entities had the highest percentage of reported housing support with 83%, for-profit facilities self-reported the lowest HS acceptance with 52% of facilities. About 9% of facilities who report accepting HS stated some sort of reported limitation to that acceptance. Large facilities had the highest percentage of facilities that have reported limitations on acceptance of HS with nearly 18% of facilities accepting HS stating a limitation. The next highest percent of restrictions was medium facilities with about 3% of accepting facilities having a limitation.

The two most common types of restrictions reported were the length of private pay required before accepting housing support, and a limited number of units being available to be funded by housing support. Those who have a private pay requirement, require an average of 1.6 years of private pay before being able to use housing support. Nearly half of the facilities with restrictions limit the number of units available or the type of unit available for Housing Support. Of the large facilities with restrictions, 57% of them have a restricted quantity of units available to those using housing support. Large facilities were the only ones who stated the number of units available to housing support users and roughly 16% of those housing units accept housing support.

Table 10: Housing Support Acceptance

	Housing support accepted	Housing support with restrictions	private pay length (years) before housing support	Limited units or types of units available	# facilities with limited units for housing support	Ave % units for housing support	Ave # of units for housing support
Whole data pool	56%	9%	1.6	47%	61	16%	10
Large Facilities	78%	18%	1.7	57%	60	16%	10
Medium Facilities	86%	3%	2.0	17%	1	-	-
Small Facilities	68%	1%	-	0%	0	-	-
Super Small Facilities	35%	2%	0.1	0%	0	-	-
For-Profit	52%	6%	1.5	35%	26	16%	8
Non-Profit	79%	22%	2.3	64%	34	17%	12
Public Entity	83%	13%	1.5	50%	1	10%	8

Dementia Care and Challenging Behavior

Only facilities who offer dementia care were required to answer if they are prepared to manage "challenging behaviors," a term that is not defined in the UDALSA. The OOLTC does not agree with the use of this phrase because the symptoms it encompasses are not exclusive to those with dementia diagnoses. These symptoms can manifest as combativeness, refusal of care, anxiety, agitation, and wandering, among others. Some of the facilities who don't offer dementia care also answered this question saying they do have this capability. Managing challenging behaviors is defined differently by each facility but it is a critical component of care.

A self-reported 83% of Assisted Living with Dementia Care (ALDC) licensed and Provisional Assisted Living with Dementia Care (PALDC) licensed facilities report they are prepared to manage individuals with challenging behaviors. The percent of facilities who said yes to this category did not have much variation in size with the exception of only 38% of super small ALDCs saying they could manage challenging behaviors. This low percentage is because there are only 8 super small licensed dementia care facilities. The OOLTC strongly believes facilities must be able to care for all aspects of Dementia Care if they obtain this license and the ability to manage "challenging behaviors" is not exclusive to those with dementia diagnoses.

Nearly a third of ALDCs who answered that they are prepared to manage challenging behaviors listed some sort of restriction. Around 19% of ALDCs who have a restriction state that managing challenging behaviors will come at an additional cost. This increases to 67% of PALDCs self-reported managing challenging behaviors came with an additional cost. Of the ALDCs with restrictions, 72% stated they limit the type of challenging behavior they are prepared to manage. Many of the facilities did not state the exact type of limitations they might have; many provide a vague statement of "on a case-by-case basis." These limitations can make it difficult for consumers to know if a facility can meet their needs presently or in the future, especially with progressive illnesses such as dementia.

Table 11: Able to Manage Challenging Behaviors in Assisted Livings Facilities with Dementia Care (ALDC) and Provisional Assisted Living Facilities with Dementia Care (PALDC)

	Manage challenging behavior	With additional restrictions	Increase in cost	Limit type of behavior they manage
ALDC	83%	32%	19%	72%
PALDC	83%	20%	67%	33%
For-Profit ALDC	88%	33%	20%	74%
Non-Profit ALDC	68%	28%	13%	70%
Public Entity ALDC	100%	60%	0%	33%
Large ALDC	83%	34%	21%	71%
Medium ALDC	88%	40%	0%	83%
Small ALDC	83%	0%	-	-
Super Small ALDC	38%	0%	-	-

Transfers

Transfer with Assist of Two Staff

In the UDALSA this service is called transfer with assist of two staff however in this report it will be referred to as "two-staff transfers." Transfers are when staff assist a person to move from one place to another, for example from a bed to wheelchair, or a wheelchair to a toilet, or a chair to standing. Nearly 64% of all facilities reportedly offer two-staff transfers to residents. Medium sized facilities had the lowest percentage of facilities who offer this service with 53%, whereas super small facilities have the highest percent of facilities offering this service with 67%. Although super small facilities have the highest percentage of facilities who reportedly offer this level of service, the majority of them report only having one staff member on site at any given time, so this will likely result in residents needing to wait for another staff member to arrive. This calls into question the regular accessibility of two staff transfers at these settings. And this limits residents' freedoms in being able to dictate their own schedule as well as their safety.

Large and medium sized facilities reported some type of restriction with 31% and 22% respectively. In large facilities who offer two staff transfers, 34% only offer the service to those in memory care. Additionally, 20% of large facilities who offer two-person transfer only offer it on a limited time basis. Nearly 12% of large facilities with restrictions offer two staff transfers have an additional cost associated with the service. In medium facilities with restrictions, 29% provide this service during limited hours.

Table 12: Two-Staff Transfers

	Two-staff transfers	Additional restrictions	Additional cost	Staffing level dependent	Offered for a limited time	Limit hours available	Memory care only
Whole data pool	64%	14%	14%	20%	18%	7%	24%
Large Facilities	61%	31%	12%	14%	20%	3%	34%
Medium Facilities	53%	22%	0%	18%	24%	29%	0%
Small Facilities	61%	1%	0%	100%	33%	33%	0%
Super Small Facilities	67%	5%	31%	39%	6%	11%	0%

Bariatric Transfers

Bariatric transfers are transfers that often require specialized equipment or additional staff to support higher weight residents, this could include ceiling lifts or larger capacity machines. Only 21% of facilities self-report offering transfers with bariatric equipment. Of those facilities that do report offering this care, 7% have additional restrictions. The most common restriction is the resident must provide the equipment; 40% of all facilities with restrictions stated the resident must provide the equipment. Of facilities with restrictions on this service 11% provided transfer with bariatric equipment at an

additional cost. Large facilities are the lowest percentage of facilities who report offering this service with only 13% providing bariatric transfers. Only 14% of Assisted Living with Dementia Care facilities report providing bariatric transfers whereas 24% of all Assisted Living facilities offer the service. Small facilities had the highest percent of facilities who offer bariatric transfers with 40% of facilities self-reporting this service.

Table 13: Transfers with Bariatric Equipment

	Transfers with bariatric equipment	Additional restrictions	Resident provides equipment	Additional cost
Whole data pool	21%	8%	40%	11%
Large Facilities	13%	24%	41%	3%
Medium Facilities	14%	15%	25%	0%
Small Facilities	40%	1%	100%	0%
Super Small Facilities	23%	4%	36%	36%
Assisted Living	24%	4%	32%	21%
Assisted Living with Dementia Care	14%	22%	43%	5%
Provisional Assisted Living License	16%	8%	67%	0%
Provisional Assisted Living with Dementia Care License	41%	29%	50%	0%

Languages

Language accessibility drastically limits options for non-English speakers seeking care. 39 different languages were listed by facilities as primary languages spoken by staff. Somali was the second most spoken language (10%) behind English. Only 238 facilities offered languages besides English, just under 11% of all facilities. Consumers who need dementia care have severely limited options with 15 Assisted Living with Dementia Care Facilities statewide self-reported having staff speaking languages other than English. 199 facilities of the 238 who have staff that speak languages other than English were super small facilities. As discussed earlier in this report, the super small facilities are the least likely to have an RN on-site full-time or a full-time Activities Director.

One of the limitations in this data is that it isn't clear how often multi-lingual staff are scheduled and if these facilities try to hire new staff with those language capabilities when staff move to other opportunities. Having access to staff with whom you can communicate in your preferred language improves care and comfort.

Table 3: Facilities with Staff that Speak Languages Other Than English

	Facilities with mulitple languages spoken by staff
Whole data pool	238
Large Facilities	15
Medium Facilities	7
Small Facilities	17
Super Small Facilities	199
For-Profit	234
Non-Profit	4
Public Entity	0
Assisted Living	189
Assisted Living with Dementia Care	15
Provisional Assisted Living License	34
Provisional Assisted Living with Dementia Care License	0

Limitations

Over the course of the research, several limitations with the UDALSA itself and the information that can be obtained from it were discovered. The information used for this report is based on self-reported data, those who fill out the form may be answering the question from a “best possible” perspective. Some of these UDALSAs weren’t filled out completely. About one third of UDALSAs had information missing in sections being looked at, 40 UDALSAs had major missing information or incomplete pages, and eight UDALSAs could not be obtained.

There were also some difficulties retrieving the information. While working on this project several concerns were uncovered related to the ability to easily access information on the minnesotahelp.info website. After receiving helpful tips on how to use the website most of the UDALSAs were able to be gathered; however, it was still necessary to ask colleagues at Minnesota Department of Health for help finding 162 UDALSAs. Additionally, 43 UDALSAs wouldn’t load and 172 had broken links, again colleagues at MDH helped to fix these problems. The solutions that were available to OOLTC are not available to the average consumer.

One of the other challenges noted is there are no set definitions for any of the categories. When looking at staffing, unlicensed staff is separated into day, evening, and night shifts on the form; however, some facilities schedule 12-hour shifts and left one of those categories blank. The form allows for selecting RN full-time and part-time, however, the hours per week qualifying as full or part-time are left to the discretion of the facility and may vary. One of the sections not reviewed in this project, Amenities, offers examples of how seemingly clear options still have room for confusion. For example, semi-private units will have different interpretations depending on who is reading it: is there a shared

bedroom, a shared bathroom, or a shared living space? Does internet access mean Wi-Fi is provided throughout the facility, or is there just the capability to set up your own Wi-Fi in the individual rooms? Does internet access mean there is a share computer available to Residents in a public space?

The UDALSA is mostly set up as a form with “yes/no” questions and a space for limitations and comments. There were many different ways facilities filled out these comment sections that made it difficult to understand the answer. Often facilities in the comments put in “see exhibit” or “see contract for details.” These extra exhibits and contract details were not attached to the UDALSA posted online making it difficult for consumers to understand what limitations there might be. One of the UDALSAs seemed to have notes meant for decisions to be made by another staff at the facility. They wrote in the two staff transfer section “We do have this but I don't know if this is something we are trying to get away from.” Some UDALSAs listed the schedule for unlicensed staff instead of the number that worked each shift, and others in that section wrote "it varies”, or left the section blank entirely. These answers don’t give the appropriate information and make it difficult for consumers to make informed choices.

Impact

The UDALSA plays an important role in providing information to consumers so they can make informed decisions for themselves or their loved ones. The self-reported data was difficult to find and sometimes had missing information making it an unreliable tool. Despite the limitations of this project there were many important findings that came from looking at the UDALSAs.

Staffing Levels

Large facilities had the highest self-reported percent of RNs and Activities Directors on-site full time. These two positions are critical for resident quality of life. Having access to an RN on-site can lead to faster decision making if problems arise. However, this form does not indicate if full-time is 24/7 or 40 hours a week, the form has the full-time designation in quotation marks suggesting they do mean 40 hours per week. The form fields currently offered do not give consumers a clear understanding of how much time RNs spend on direct care versus guiding or managing staff, which can be an area of interest for many, depending on their needs. Activities Directors, who are not required staff, are critical for quality of life because they ensure there are enriching activities to engage residents. It is concerning that 54% of small facilities and 65% of super small facilities self-reported not having an activities director. Many of these residents cannot leave the facilities on their own and must find ways to entertain themselves. Isolation and loneliness are known to harm mental and physical health. When facilities do not have Activities Directors, the requirement of facilities to provide daily recreational activity then falls to already busy unlicensed direct care staff who might not have time to do more than turn on the tv or set out coloring pages.

The majority of the needs residents have are handled by unlicensed staff. Having clarity and consistency in how this section is answered is critical for consumer understanding. Unlicensed staff at some facilities are responsible for cares as well as laundry, cooking, and many other activities; at others unlicensed staff might only be focused on cares. Additionally, weekends might have different staffing levels than weekdays. This can make it difficult to know how quickly staff might be to respond to resident needs. Some UDALSAs stated a range of staff but that does not indicate how often the facility is at either end of that range. Some locations didn't answer the question all together by leaving it blank, stating it depends on the needs of residents, or stating the hours it considers each shift. Consistent staffing is critical for consistent care, resident wellbeing, and peace of mind. Showing the unlicensed staff as a ratio better lets consumers compare facilities.

Waiver Acceptance and Housing Support

Waiver acceptance can be critical in keeping residents in the care facilities of their choosing. Through OOLTC case work and interviews with residents, they face much higher difficulty accessing the waivers than the 94% acceptance rate would suggest. For larger facilities only one third of them reported restrictions on waivers, 81% of those restrictions limited the number of units available for waiver usage. It is believed the 33% that self-reported restrictions is under reported. Restricted units can be smaller, shared, or otherwise less desirable rooms. The UDALSAs showed an average wait time of nearly two years paying private pay before waivers are accepted. Restricting specific units to be available for waivered services can lead to resident anxiety that there won't be units available when they need to use waivers to pay for services. It also might lead to additional downsizing or other stress from unanticipated required moves. Many times this happens after residents have spent their life's savings receiving care from that facility. Housing Support is another important government program to help residents stay in the care facility of their choosing. Super small facilities have the lowest acceptance rate of HS with only 35%, this is 30 percentage points lower than the next lowest facility type. This may be because counties want to discourage single family homes for this purpose. Super small facilities have the most self-reported language accessibility. If there is an effort to discourage residential house style assisted living facilities they might be disproportionately limiting options for non-English speakers.

Challenging Behaviors

Managing "challenging behaviors" can be a critical element of providing care. As discussed earlier in this report, the OOLTC does not feel that section titled "managing challenging behaviors" should be limited to only Dementia Care Licensed facilities nor does the verbiage best define the actions providers undergo to provide care in their facilities. Challenging behaviors is ill defined and can include many symptoms expressed by those with mental illness in addition to those with cognitive loss, dementia or other related diagnoses. Dementia is a progressive illness whose symptoms and

expressions cannot be clearly predicted. Nearly 20% of facilities licensed to handle Dementia Care self-report they cannot handle “challenging behaviors” indicating they are not prepared to care for a patient throughout the course of the progressive disease. Forcing patients to have to relocate because a facility cannot handle a symptom of a disease for which they are licensed to provide care can lead to trauma for the resident. Additionally, this might move the resident further from their families cutting ties to their support networks leaving them more vulnerable. Often the UDALSA is used by facilities to show when a resident’s care needs exceed what a facility can provide and by allowing this ill-defined term on the UDALSA, it opens up the possibility for facilities to push out a resident for being a bit “too difficult”.

Transfers

Two-staff transfer is a support that is more staffing intensive, and it was encouraging to see nearly two-thirds of licensed facilities offer this support. One surprising finding is 67% of super small facilities offer this service despite the majority of those only having one unlicensed staff scheduled at any given time. It is concerning that by offering and accepting residents who need this service without changing facility staffing levels it will impede resident rights and safety. Additionally, some UDALSAs (mostly super small facilities) marked "all mobility services" as available. This seems unlikely and may suggest those who filled them out did not do so accurately.

Effective bariatric care, including skillful transfers into and out of bed, chairs, or commodes or toilets, is important to support the physical and socio-emotional health needs of residents who need this level of care. As of this review of UDALSAs, only 89 facilities that are licensed to provide assisted living with dementia care indicated offering bariatric services without elaborating on exactly what this means in each facility. Based on OOLTC’s casework, these facilities are too few to care for all residents who need bariatric care. Additionally, accessibility within the facility is an unanswered question. For example, is a given facility accessible as a whole, including entryways, doors, and hallways, etc.? Bathrooms are often not constructed to be accessible to residents needing bariatric care, so have doorways and walls been remodeled to create the needed space? Do staff have necessary training to ensure cares are administered appropriately, respectfully, and in a manner that considers the whole person?

Language

Language accessibility is critical for non-English speakers to feel comfortable and receive the care they need. Only 238 facilities had staff that spoke languages besides English with 199 of those with resident capacity of 5 or fewer. As discussed earlier in this report, these facilities have a lower percentage of licensed staff full time and are the least likely to have an activities director. This can contribute to a lower standard of care for these residents. Furthermore, these super small facilities had the lowest acceptance of housing support making it even more difficult to access care in a language you can communicate in if you are low income. Another limitation of this section is the lack of clarity about a

commitment to provide consistent staffing of individuals who can speak that language or if this was just what the staff spoke at the time the form was completed.

Recommendations

After looking at limitations and impacts documented in the UDALSAs, the OOLTC has several recommendations for the UDALSA form to make it more useful as well as recommendations about gaps in care that this analysis has identified and highlighted. First, the information regarding waiver access needs to be clearer. Requiring providers to specify which waivers they accept could potentially alleviate confusion and avoid inaccurate assumptions. In OOLTC case work, many limitations are seen on waiver acceptance, particularly limited unit availability, and most facilities do not disclose this in their UDALSA. Additionally, OOLTC sees many limitations in case work on waiver acceptance, particularly limited unit availability; most facilities did not state this or any limitation.

OOLTC has several recommendations regarding staffing as well. With the UDALSA's intended purpose being consumer-related, it is important that the form be as clear as possible. Some of the words in the document are ambiguous and some fields can elicit answers that are inconsistent across providers, especially with unlicensed staffing levels. For this report it was difficult to compare staffing levels from the raw numbers in the forms therefore these were turned into an imperfect staffing ratio in order to understand unlicensed staffing levels. OOLTC believes that requiring a staffing level to be presented as a ratio would be helpful for consumers when making their own decisions about where they want to move. Unlicensed care staff numbers are listed, but it is not clear whether those staff are also doing other tasks such as activities, cooking, cleaning or laundry. Requiring all assisted living facilities to indicate whether they employ an Activities Director will help residents assess their future quality of life. There are many super small facilities who are owned by the same entity, these could share resources and increase the number of facilities with at least part time Activities Directors. The OOLTC hears from residents that Activities Directors are critical to providing a good quality of life and residents should have access to activities regularly.

Through this research it became clear there need to be more options for those receiving bariatric care as well as those who speak languages other than English. For both groups there are limited options particularly if needing dementia care.

The UDALSA form can also be improved by having more person-centered language. "Challenging behaviors" should be reworded because of this. Challenging behaviors placement in a section where only those with Dementia Care Licenses need to answer, wrongfully suggests that challenging behaviors are exclusive to those individuals. All assisted livings should be asked to report on the UDALSA about the ability to serve clients with challenging behaviors. Many of the limitations that facilities wrote in the comments were vague, not making it clear to perspective or current residents when the facility has the capabilities to care for them.

The UDALSA has achieved some transparency to help consumers understand what different assisted living facilities offer, supporting their choice and understanding of available services. However, this research found ways in which the form itself and the system through which it is made available to the public could be improved. This form is difficult to locate and not particularly helpful for an individual looking to find a facility that meets their needs. The OOLTC supports creating a database where facilities could easily update information that changes. This database could be used to help create searchable information so potential residents could find a facility that is close to their family, provides memory care, and has staff that speaks Spanish, for example. This is not possible with the current system. Having a database can also compel those who fill out the form to answer all the questions decreasing the one third of UDALSAs that have missing information.

The UDALSA is a helpful tool and we hope its accessibility and clarity can be improved so it can be even more widely used. The goal of this project was to assess whether the implementation of the law change is having its intended result. Overall, it has been a success in that most of the UDALSAs were able to be obtained and they were able to provide useful information from the contents; however, more can be done to make comparing facilities easier through the information provided in the UDALSAs.

Appendix

Table A 1RN on-site full-time

	NUMBER OF FACILITIES	RN on-site full-time
Whole data pool	**2203**	47%
Large Facilities	741	86%
Medium Facilities	141	37%
Small Facilities	246	39%
Super Small Facilities	1075	24%
For-Profit	1877	41%
Non-Profit	308	82%
Public Entity	18	83%
Assisted Living	1372	37%
Assisted Living with Dementia Care	579	84%
Provisional Assisted Living License	234	14%
Provisional Assisted Living with Dementia Care License	18	89%

Table A 2 LPN on-site full-time

	NUMBER OF FACILITIES	LPN on-site full-time
Whole data pool	**2203**	24%
Large Facilities	741	46%
Medium Facilities	141	21%
Small Facilities	246	17%
Super Small Facilities	1075	12%
For-Profit	1877	22%
Non-Profit	308	41%
Public Entity	18	44%
Assisted Living	1372	17%
Assisted Living with Dementia Care	579	49%
Provisional Assisted Living License	234	9%
Provisional Assisted Living with Dementia Care License	18	17%

Table A 3 APRN on-site full time

	NUMBER OF FACILITIES	APRN on-site full-time
Whole data pool	**2203**	1%
Large Facilities	741	1%
Medium Facilities	141	0%
Small Facilities	246	0%
Super Small Facilities	1075	1%
For-Profit	1877	1%
Non-Profit	308	1%
Public Entity	18	0%
Assisted Living	1372	1%
Assisted Living with Dementia Care	579	1%
Provisional Assisted Living License	234	0%
Provisional Assisted Living with Dementia Care License	18	0%

Table A 4 Availability of Activities Director

	NUMBER OF FACILITIES	Activities Director on-site full-time	Activities Director on-site part-time	No Activities Director
Whole data pool	**2203**	31%	27%	46%
Large Facilities	741	70%	17%	17%
Medium Facilities	141	19%	39%	44%
Small Facilities	246	15%	40%	54%
Super Small Facilities	1075	9%	29%	65%
For-Profit	1877	26%	28%	50%
Non-Profit	308	58%	20%	24%
Public Entity	18	33%	11%	56%
Assisted Living	1372	16%	33%	54%
Assisted Living with Dementia Care	579	74%	15%	17%
Provisional Assisted Living License	234	7%	21%	74%
Provisional Assisted Living with Dementia Care License	18	78%	22%	6%

Table A 5 Staffing ratio in Provisional Assisted Living facilities

Provisional AL	Day shift	Evening Shift	Night Shift
For Profit Large	18.7	29.2	37.3
Non Profit Large	-	-	-
Public Entity Large	-	-	-
For Profit Medium	-	-	-
Non Profit Medium	-	-	-
Public Entity Medium	-	-	-
For Profit Small	3.8	5.0	5.8
Non Profit Small	-	-	-
Public Entity Small	-	-	-
For Profit Super Small	4.0	4.1	4.6
Non Profit Super Small	1.3	2.0	4.0
Public Entity Super Small	-	-	-

Table A 6 Staffing ratio in Provisional Assisted Living with Dementia Care facilities

Provisional ALDC	Day shift	Evening Shift	Night Shift
For Profit Large	22.2	22.2	31.9
Non Profit Large	16.5	17.3	24.8
Public Entity Large	-	-	-
For Profit Medium	10.0	10.0	20.0
Non Profit Medium	-	-	-
Public Entity Medium	-	-	-
For Profit Small	5.0	-	10.0
Non Profit Small	-	-	-
Public Entity Small	-	-	-
For Profit Super Small	-	-	-
Non Profit Super Small	-	-	-
Public Entity Super Small	-	-	-

Table A 7 Waiver Services Acceptance and Restrictions

	NUMBER OF FACILITIES	Waiver services accepted	Accept EW	Accept CADI	Accept BI	Additional waiver restrictions	average length (years) of private pay	Limited # of units	Average % of units for waiver support	Ave # units for waiver support
Whole data pool	**2203**	94%	235	127	73	12%	1.9	76%	14%	9
Large Facilities	741	88%	170	35	6	33%	2.0	81%	14%	9
Medium Facilities	141	95%	17	8	6	12%	1.6	56%	21%	4
Small Facilities	246	93%	15	22	14	5%	2.3	45%	-	-
Super Small Facilities	1075	98%	33	60	44	1%	0.1	36%	40%	2
For-Profit	1877	95%	152	111	68	9%	1.9	65%	12%	6
Non-Profit	308	86%	81	14	2	36%	2.0	94%	16%	11
Public Entity	18	89%	2	0	0	25%	-	75%	20%	9
Assisted Living	1372	97%	86	81	62	4%	1.6	77%	23%	12
Assisted Living with Dementia Care	579	86%	138	36	4	38%	2.0	76%	12%	8
Provisional Assisted Living License	234	99%	9	8	4	3%	-	43%	-	-
Provisional Assisted Living with Dementia Care License	18	56%	2	0	0	50%	2.0	80%	-	-

Table A 8 Housing Support Acceptance and Restrictions

	NUMBER OF FACILITIES	**Housing support accepted**	Housing support with restrictions	private pay length (years) before housing support	Limited units or types of units available	# facilities with limited units for housing support	Ave % units for housing support	Ave # of units for housing support
Whole data pool	**2203**	56%	9%	1.6	47%	61	16%	10
Large Facilities	741	78%	18%	1.7	57%	60	16%	10
Medium Facilities	141	86%	3%	2.0	17%	1	-	-
Small Facilities	246	68%	1%	-	0%	0	-	-
Super Small Facilities	1075	35%	2%	0.1	0%	0	-	-
For-Profit	1877	52%	6%	1.5	35%	26	16%	8
Non-Profit	308	79%	22%	2.3	64%	34	17%	12
Public Entity	18	83%	13%	1.5	50%	1	10%	8
Assisted Living	1372	51%	2%	1.0	22%	6	8%	11
Assisted Living with Dementia Care	579	76%	22%	1.7	56%	54	17%	10
Provisional Assisted Living License	234	35%	5%	-	20%	1	4%	2
Provisional Assisted Living with Dementia Care License	18	44%	14%	-	0%	0	-	-

Table A 9 Availability of Two-Staff Transfers and Restrictions

	NUMBER OF FACILITIES	**Two-staff transfers**	Additional restrictions	Additional cost	Staffing level dependent	Offered for a limited time	Limit hours available	Memory care only
Whole data pool	**2203**	64%	14%	14%	20%	18%	7%	24%
Large Facilities	741	61%	31%	12%	14%	20%	3%	34%
Medium Facilities	141	53%	22%	0%	18%	24%	29%	0%
Small Facilities	246	61%	1%	0%	100%	33%	33%	0%
Super Small Facilities	1075	67%	5%	31%	39%	6%	11%	0%
For-Profit	1877	70%	12%	16%	21%	14%	7%	25%
Non-Profit	308	30%	37%	6%	17%	34%	6%	19%
Public Entity	18	11%	100%	50%	0%	0%	0%	50%
Assisted Living	1372	57%	6%	12%	33%	16%	24%	0%
Assisted Living with Dementia Care	579	76%	30%	12%	13%	20%	1%	35%
Provisional Assisted Living License	234	73%	6%	42%	50%	8%	8%	0%
Provisional Assisted Living with Dementia Care License	18	72%	31%	25%	0%	0%	0%	50%

Table A 10 Availability of Transfers with Bariatric Equipment and Restrictions

	NUMBER OF FACILITIES	Transfers with bariatric equipment	Additional restrictions	350 lb limit	450 lb limit	Resident provides equipment	Additional cost
Whole data pool	**2203**	21%	8%	16%	2%	40%	11%
Large Facilities	741	13%	24%	24%	0%	41%	3%
Medium Facilities	141	14%	15%	0%	25%	25%	0%
Small Facilities	246	40%	1%	0%	0%	100%	0%
Super Small Facilities	1075	23%	4%	0%	0%	36%	36%
For-Profit	1877	24%	7%	12%	2%	44%	10%
Non-Profit	308	3%	25%	67%	0%	0%	0%
Public Entity	18	6%	100%	0%	0%	0%	100%
Assisted Living	1372	24%	4%	0%	5%	32%	21%
Assisted Living with Dementia Care	579	14%	22%	29%	0%	43%	5%
Provisional Assisted Living License	234	16%	8%	0%	0%	67%	0%
Provisional Assisted Living with Dementia Care License	18	41%	29%	50%	0%	50%	0%

Table A 11 Facilities with Multiple Languages Spoken by Staff

	NUMBER OF FACILITIES	Facilities with multiple languages spoken by staff
Whole data pool	**2203**	238
Large Facilities	741	15
Medium Facilities	141	7
Small Facilities	246	17
Super Small Facilities	1075	199
For-Profit	1877	234
Non-Profit	308	4
Public Entity	18	0
Assisted Living	1372	189
Assisted Living with Dementia Care	579	15
Provisional Assisted Living License	234	34
Provisional Assisted Living with Dementia Care License	18	0

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