10th Annual Forum On Post-Acute, Long-Term Care & Assisted Living

Program Handouts

Thursday, June 4, 2026

Itasca Country Club
400 E Orchard St
Itasca, IL 60143

ACHC

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10th Annual Forum On Post -Acute, LTC & ALF

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The Program

7:30 AM — **REGISTRATION OPENS**

7:30 AM – 8:25 AM — **BREAKFAST**

08:30 AM – 9:30 AM — ***Cutting Through the Hype: Real Uses of Artificial Intelligence in Long-Term Care***

Thomas Annarella, BS, LNHA
Valley Hi Nursing & Rehabilitation, Administrator

9:30 AM – 10:30 AM — ***Panel Discussion-Turning Points Ahead: Critical Changes for Senior & Long-Term Care in 2026***

Thomas Annarella, BS, LNHA
Valley Hi Nursing & Rehabilitation, Administrator

Lorena Amarillo BA, CDP, DCS
Montclair Senior Living, Executive Director

Pamela Bryan Kramer, BA, LPhT (Moderator)
Forum Extended Care Services, Executive Vice President

10:30 AM - 11:00 AM — **BREAK / VENDOR EXHIBITS**

11:00 AM – 12:00 PM — ***Partnering With Hospice in LTC: Roles, Regulations & Best Practices***

Carol Sotir, MSN, FNP-BC
Executive Director, Family Centered Hospice

Lorena Amarillo BA, CDP, DCS
Montclair Senior Living, Executive Director

12:00 PM – 12:55 PM — **LUNCH PRODUCT THEATER**

1:00 PM – 2:00 PM — ***The Behavior Toolkit: Hacks, Fixes & Game-Changers, Part 2***

Benjamin Surmi, MSG
Arvo, Social Gerontologist

2:00 PM – 3:00 PM — ***Risk, Responsibility & Readiness in Long-Term Care***

Meredith Duncan, BS, JD
Polsinelli, Shareholder Attorney

3:00 PM – 3:30 PM — **BREAK / VENDOR EXHIBITS**

3:30 PM – 4:30 PM — ***Engage, Empower, Partner: Upskilling our Core Careforce***

Benjamin Surmi, MSG
Arvo, Social Gerontologist

4:30 PM — **CLOSING REMARKS, DISTRIBUTION OF C.E. LINK, RAFFLE DRAWING & ADJOURNMENT**

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Welcome to the 10th Annual Forum on Post-Acute, LTC & ALF. Enjoy a day of learning with quality programming, dynamic speakers, and a forum to exchange ideas, share information, and earn 6 free continuing education credits.

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Administrators: This program has been approved for six hours of continuing education credit by the National Continuing Education Review Services (NCERS) of the National Association of Long-Term Care Administrator Boards (NAB) – Approval # 20260611-6-A113593-IN.

Get your link/QR code for CE before you leave: A QR code will be provided to attendees at the close of the event; use it to submit your CE request. Your license number and a valid email address are required.

Upon successful form submission, an email containing your PDF certificate will be sent within 24 hours to address provided. Note: if unable to locate in your inbox, please check any spam/junk folders.

Cutting Through the Hype: Real Uses of Artificial Intelligence in LTC

Thomas Annarella, BS, LNHA
Valley Hi Nursing & Rehabilitation
Administrator
Jordan Healthcare Group

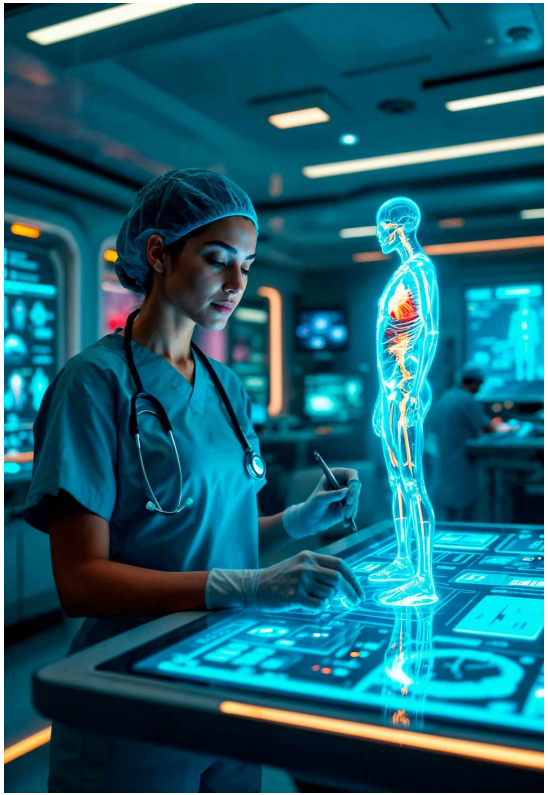
Thomas Annarella is the Administrator of Valley Hi Nursing and Rehab in Woodstock, IL, the McHenry County owned nursing home. Valley Hi is a 2016 Bronze National Quality Award winner and a 2023 Silver National Quality Award winner through the American Health Care Association. Thomas earned his Bachelor's degree in Health Care Administration from Southern Illinois University in 2000 and has been a licensed nursing home administrator since 2002.

He also works with Jordan Healthcare Group, a consulting firm offering a wide range of support services to long term care communities. Thomas has been active with the Illinois Health Care Association for more than 20 years, currently serves as Chair of the IHCA Board of Directors and the Chair and is the founder of the Illinois Leaders Program.

Thomas was recognized in 2015 by *Provider Magazine* as one of the year's Top 20 To Watch and graduated from the American Health Care Association's Future Leaders Program.

Agenda

- Setting the Stage – What is AI
- Real-World Applications in LTC
- Benefits vs Reality Check
- Compliance, Ethics, and Risks
- Practical Implementation / Operationalization
- Q & A



Setting the Stage – What is AI?

- What AI **is not**
  - SkyNet / Terminator
  - Going to replace doctors, nurses, and or caregivers

- What AI **is**
  - Useful tool, helps with workplace efficiency when properly used
  - AI has been around for a long time, but it is just rapidly gaining speed

AI is not going to take your job – but the person who knows how to leverage it *will*!

Setting the Stage – What is AI?

Common staff concerns:

- AI is here to monitor me
- AI will take my job
- AI can't understand residents
- AI will make care less personal

Common leadership assumptions:

- AI will quickly reduce labor costs
- AI will allow for staff reduction
- Staff will naturally adopt it
- If we buy and/or use the tool, outcomes will improve

Both sides of the argument usually need education around what AI can and cannot realistically do.

Setting the Stage – What is AI?

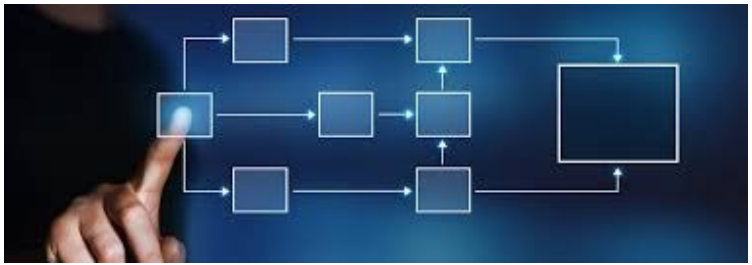
- Why is AI gaining traction in LTC?
  - Business office efficiency
  - Knowledge at your fingertips
  - Data analytics
  - Proactive healthcare

Question we should be asking our teams:

Where can AI reduce burden so staff can spend more time on care?

Real-World Applications in LTC

- Workflow Improvements – Where AI can make an immediate impact
  - Speech-to-documentation tools / talk-to-text
  - Call light trend analysis
  - Staffing forecasting and scheduling
  - Fall prediction alerts
  - Wound monitoring support
  - Medication review assistance
  - Earlier interventions
  - Fewer preventable hospitalizations / predictive hospital readmission modeling
  - Assisting in care plan development



Real-World Applications in LTC

- Clinical Support / Predictive Analytics
- Leveraging the EMR data already being collected
- Assisting in care plan development
- Robotics

Real-World Applications in LTC

Impact on LTC admissions needs to be noted

- AI is allowing people to stay at home longer
  - Smart home monitoring (movement, sleep, routines)
  - Voice assistants for communication, reminders, and easy answers
    - Conversational AI companions
  - Wearables collect data in real-time and send to 24-hour monitoring
  - Immediate fall detection and notification
  - Wander monitoring / tracking
  - Faster emergency care
  - Increased peace of mind for families

Benefits vs. Reality Check

- Do the benefits outweigh the downside?

AI comes with some risk

- ✓ AI entering the courtroom
- ✓ Datamining made easy (again, think legal)
- ✓ Privacy concerns / HIPAA
- ✓ Bias in algorithms
- ✓ Patient comfort with the use of technology (uncanny valley)

Benefits vs. Reality Check

- AI being used to audit you – without you even knowing it
  - Offsite data-mining
  - 2026 CMS announced it was using AI to crackdown on fraud – has saved $2 **billion** since March 2025
  - PBJ audits
  - Antipsychotic use with Schizophrenia diagnosis

Benefits vs. Reality Check

AI entering the legal arena

- 3 recent staffing verdicts – (McKnight's LTC News 3-2026)
  - $12.2 million – Chicago negligence case – family alleged understaffing and poor oversight caused a woman's wounds
  - $15.8 million – California negligence case – family alleged staff failed to turn a resident at risk for wounds
  - $110 million – California ALF wrongful death case – attorneys targeted the private equity firm

Data-mining using AI is making it easier for plaintiffs to find cases and making it more difficult to fight

Can we use AI to flip the script? – time will tell

Compliance, Ethics, and Risks

Beware

- AI is ***not*** HIPAA compliant
- Different open AI platforms have different bias
- AI results need to be checked for accuracy
- AI should not be looked at as a replacement for human contact and interaction

Practical Implementation / Operationalization

How the different generations view AI

Generation	Views on the Use of AI
Silent Generation / Traditionalist	Afraid of the technology they do not understand
Baby Boomer	More cautious and skeptical – less likely to use it Common concern – misinformation, privacy, loss of human interaction, trustworthiness of data
Gen X	Pragmatic, interested in productivity benefits but cautious about the risk Common concern – job displacement, reliability of data, data security
Millennials	Optimistic and willing to experiment Common concern – impact on careers, ethics, bias, and long-term societal effects
Gen Z	Comfortable with AI integration into daily life, education, and creativity Common concern – authenticity, academic integrity, deepfakes, future employment

Practical Implementation / Operationalization

- Adoption Strategies
  - Across all generations, acceptance of AI in LTC increases when:
    - AI supports rather than replaces caregivers
    - Residents retain their autonomy, choice, control, and rights
    - Privacy protections are clear
    - Benefits are clearly highlighted
    - Human oversight and control are maintained
  - Beware of implementation pitfalls when:
    - AI reduces face-to-face contact
    - AI makes decisions without explanation
    - AI collects extensive personal data

Practical Implementation / Operationalization

- Adoption Strategies
  - Outputs are only as good as the input data
    - Remember sequencing and data inclusion matter
  - AI outputs need human review, validation, and oversight
  - AI provides rapid data processing – clinicians bring clinical judgement and context
  - Human connection is central to healthcare and AI simply cannot replace that

AI Final Thoughts

- Things AI cannot do
  - Show compassion and empathy
  - Understand environmental context
  - Pick up a patient's on-verbal care cues
    - Subtle behavior change
    - Facial expressions
    - Family concerns / dynamics
    - Tone of voice
  - Replace the frontline caregiver

Thank You

Bottom line – AI is a tool that should be leveraged. It is not coming for your jobs, but embracing the opportunity, with the right set of guardrails, can make your organizations more efficient and proactive in the delivery of high-quality healthcare.

Thomas Annarella
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Panel Discussion—Turning Points Ahead: Critical Changes for Senior & Long-Term Care in 2026

Thomas Annarella, BS, LNHA
Administrator
Valley Hi Nursing & Rehabilitation

Lorena Amarillo, BA, CDP, DCS
Executive Director
Montclair Senior Living

Moderator: **Pamela Bryan Kramer BA, LPhT**
Executive Vice President, Forum Extended Care Services

Forum 50 YEARS+ EXTENDED CARE SERVICES

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Thomas was recognized in 2015 by *Provider Magazine* as one of the year's Top 20 To Watch and graduated from the American Health Care Association's Future Leaders Program.

Lorena Amarillo, the Executive Director at The Montclair Senior Living and Memory Care, leads a team of dedicated professionals in providing high-quality care and services to seniors. A Certified Dementia Practitioner and Dementia Connection Specialist, she is also a Certified Trainer with the American Red Cross. With these skills and experience, she has developed expertise in management, dementia care, and teaching, which enable her to ensure the safety and well-being of both residents and staff. Her goal is to create a supportive and inclusive environment where seniors can thrive and live their best lives.

Lorena holds a Bachelor of Arts from Knox College.

Learning objectives

- Identify at least three major regulatory or policy changes impacting AL and SNFs in 2026.
- Evaluate strategies to address workforce shortages and retention challenges.
- Apply at least two actionable approaches to improve compliance and care quality in their organization.

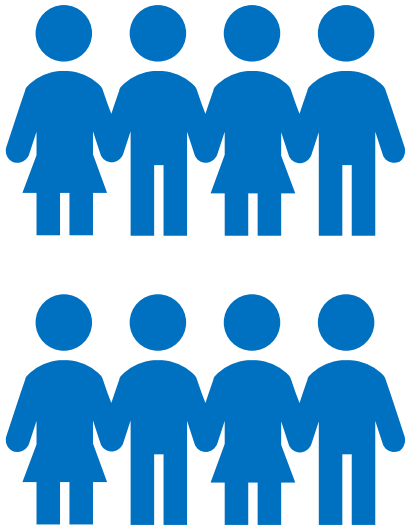
Initial thoughts

- What is the single biggest challenge your organization is facing in 2026?
- What trend or issue keeps administrators & clinical leaders awake at night right now?
- What is one positive change or opportunity you see emerging in senior care and disability services?

Regulatory & policy changes

- Which new regulatory requirements, compliance gaps identified by surveyors, or policy changes are creating the greatest operational or financial pressure for providers?
- How are changes in reimbursement, Medicaid, or managed care affecting service delivery?
- Tom just discussed AI in our last presentation — what role is technology playing in helping your organization?

Workforce shortages & retention strategies

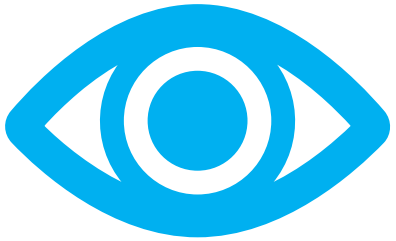


- What workforce retention initiatives are you seeing that actually make a measurable difference?
- How are you addressing staff burnout and morale?
- How can management improve communication and engagement with frontline staff?

Improving compliance & care quality

- ✓ How can facilities build a culture of accountability without creating fear among staff?
- ✓ What is one low-cost or high-impact strategy that organizations—or staff—can implement to improve compliance or care quality within the next 30 days?
- ✓ Can you share an example of a successful process improvement initiative you've seen or implemented?

Final insights



- What is one action every organization or staff member should prioritize in the next six months?
- What is one mistake we should avoid in 2026?
- If you could give attendees one practical takeaway to implement immediately, what would it be?

Any additional questions?

Thank you!

Partnering With Hospice in LTC: Roles, Regulations & Best Practices

Carol Sotir, MSN, FNP-BC
Family Centered Hospice
Chief Clinical Officer

Lorena Amarillo, BA, CDP, DCS
Montclair Senior Living
Executive Director

Carol Sotir is the Chief Clinical Officer at Family Centered Hospice, where she has the privilege of leading an interdisciplinary team dedicated to supporting patients and families during life's final chapter. Her work is grounded in a deep commitment to dignity, comfort, and quality of life. Partnering closely with nurses, physicians, social workers, chaplains, aides, and volunteers, she works to ensure care is compassionate, coordinated, and aligned with each patient's goals and values. She feels that it's an honor to support the patients and care teams who walk beside patients and families during some of life's most meaningful moments.

Carol is a Nurse Practitioner and holds both a Master and Bachelor of Science in Nursing from Chamberlain University.

Lorena Amarillo, the Executive Director at The Montclair Senior Living and Memory Care, leads a team of dedicated professionals in providing high-quality care and services to seniors. A Certified Dementia Practitioner and Dementia Connection Specialist, she is also a Certified Trainer with the American Red Cross. With these skills and experience, she has developed expertise in management, dementia care, and teaching, which enable her to ensure the safety and well-being of both residents and staff. Her goal is to create a supportive and inclusive environment where seniors can thrive and live their best lives.

Lorena holds a Bachelor of Arts from Knox College.

Learning objectives

- Describe the role of hospice in long-term care settings, including services provided and eligibility criteria for residents.
- Differentiate the responsibilities of hospice staff and facility staff in coordinating care, communication, and symptom management.
- Identify best practices for successful hospice collaboration in nursing homes and assisted living communities to support resident comfort and family satisfaction..

Family Home Health Network

PROVIDING COMPASSIONATE CARE FOR PATIENTS NEARING END-OF-LIFE

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HOSPICE CARE OVERVIEW

Why hospice when they are in a long-term care facility ?

Hospice in Long-Term Care Settings

- Comfort and Quality of Life
  - Hospice care focuses on comfort, dignity, and quality of life for residents with serious, life-limiting illnesses in LTC settings.
- Holistic Symptom and Emotional Support
  - Hospice addresses physical symptoms and emotional, social, and spiritual needs of residents and their families holistically.
- Partnership with Facility Staff
  - Hospice complements existing care through collaboration with LTC staff, ensuring specialized end-of-life support.
- Family Education and Support
  - Hospice supports families with education, counseling, and reassurance during the difficult end-of-life journey.

What Is Hospice Care?

Focus on Quality of Life

Hospice care prioritizes comfort, dignity, and respect for personal choices over curative treatments.

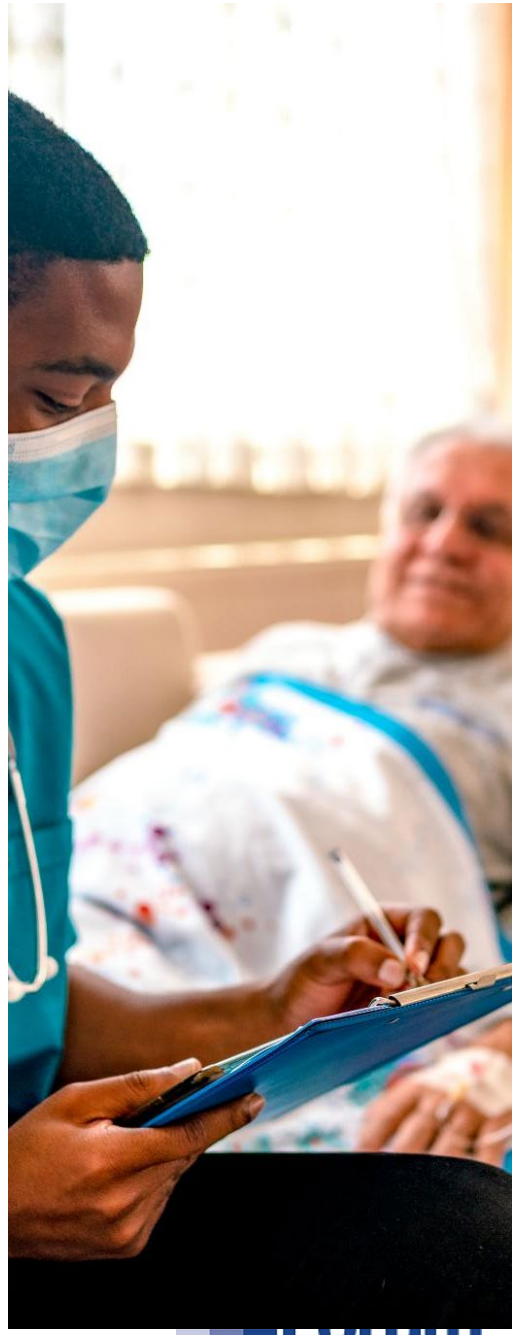
Interdisciplinary Care Team

Hospice care is delivered by a team including physicians, nurses, social workers, chaplains, nurse's aides and volunteers.

- **Various Care Settings**
- Hospice care can be provided at an individual's home, in a hospitals setting as GIP , or long-term care facilities ensuring continuity of care.

- **Education and Communication**

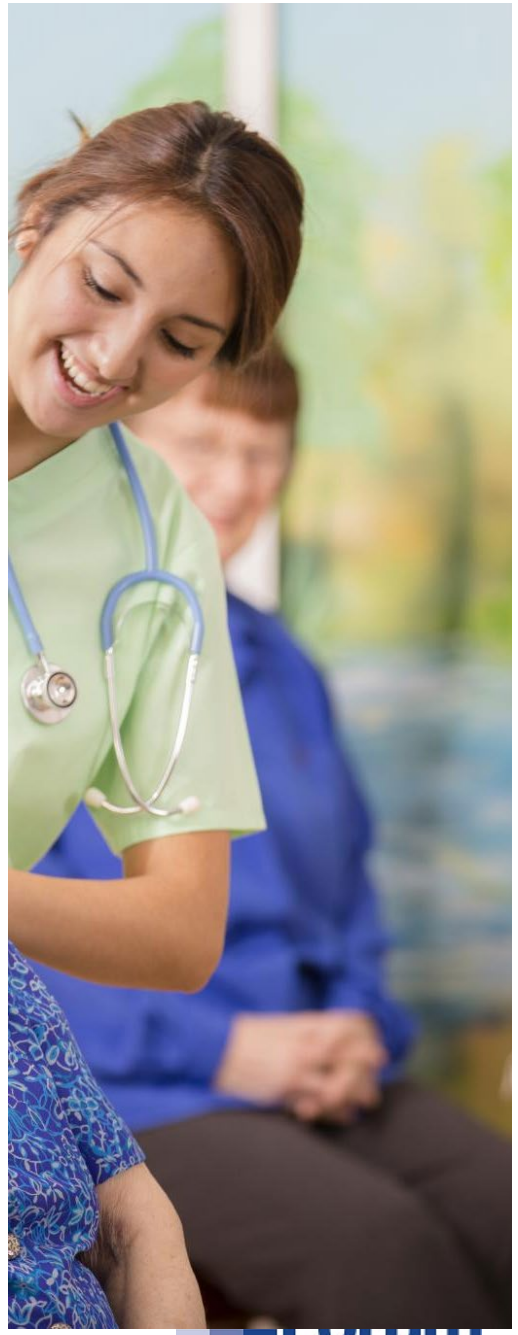
Education helps families understand hospice care, supporting informed decisions aligned with patients' wishes.



Hospice Roles and Services in Long-Term Care

Role of Hospice in Long-Term Care

- **Specialized End-of-Life Expertise**
  - Hospice professionals offer expert management of complex symptoms like pain, anxiety, and breathlessness in long-term care settings.
- **Collaborative Care Approach**
  - Hospice teams collaborate with nurses and caregivers for assessments, care planning, and aligning care with resident preferences.
- **Family Support and Counseling**
  - Hospice supports families with counseling, explanation of condition changes, and coping with anticipatory grief.
- **Improved Care Outcomes**
  - Partnerships with hospice have 3 major impacts on patient care
    - enhance quality outcomes with better symptom control, fewer unmanaged crises and increased resident comfort.
    - prevent unnecessary hospital transfers early intervention and proactive are planning which results in lower rehospitalization's, reduces fragmented care and improves continuity of care for the patient.
    - increase staff confidence by reconfiguring care from reactive and uncertain to proactive supported and skill driven.



Hospice Team Members

- **Medical Oversight**
  - Physicians and nurse practitioners oversee medical care and symptom management in hospice settings.
- **Nursing and Personal Care**
  - Registered nurses manage assessments and medications; hospice aides assist with personal care needs.
- **Emotional and Social Support**
  - Social workers address emotional and practical concerns, aiding families and residents with resources.
- **Spiritual and Volunteer Support**
  - Chaplains offer spiritual care, while volunteers provide companionship and respite to families.
- **Complementary/Integrative Therapies**
  - Pet therapy and music therapy to focus on comfort emotional well-being and holistic support

Services Provided by Hospice

- **Pain and Symptom Management**
  - Hospice clinicians assess and treat pain, breathing issues, nausea, anxiety, and other distressing symptoms that can occur at end of life.
- **Medical Equipment and Medication**
  - Hospice supplies medications that are related to the terminal diagnosis and medical equipment like hospital beds, oxygen, and mobility aids for patient comfort.
- **Emotional and Spiritual Support**
  - Emotional and spiritual care helps residents and families cope with illness progression and end-of-life concerns.
- **Care Coordination and Bereavement**
  - Hospice coordinates care among staff and families and provides 24-hour urgent support and bereavement assistance for 1 year post passing of their loved one.

Benefits and Collaboration

WORKING TO PROVIDE COMFORT
AND COMPASSION AT END OF LIFE

Benefits of Hospice in Long-Term Care

- **Improved Resident Comfort**
  - Hospice enhances comfort, symptom control, and quality of life for residents with advanced illness.
- **Family Support and Education**
  - Families receive emotional support, education, and reassurance, reducing anxiety and improving care satisfaction.
- **Staff Collaboration and Confidence**
  - Hospice provides expert consultation and shared responsibility, reducing staff stress and improving care consistency.
- **Organizational Benefits**
  - Hospice partnerships improve quality metrics, regulatory compliance, and facility reputation for compassionate care.

Collaboration With Facility Staff

Clear Communication
Effective communication ensures all caregivers understand resident care plans, goals, and current conditions.

Shared Care Responsibilities
Hospice staff provide specialized expertise while facility staff offer continuous bedside support daily.

Regular Interdisciplinary Meetings
Meetings and care conferences align interventions and address changes in resident needs effectively.

Education and Training
Hospice provides staff training on pain management, decline signs, and family communication for better care.

Eligibility

Eligibility Criteria for Hospice

- Medical Certification Requirement
  - A physician must certify the patient has a terminal illness with a life expectancy of six months or less if the disease progresses along the normal trajectory based on clinical guidelines.
- Common Eligible Diagnoses
  - Common hospice diagnoses include advanced dementia, cancer, heart failure, COPD, Parkinson's Disease, liver disease, CVA or other chronic degenerative neurological diseases
- Patient Choice and Election
  - The patient or legal representative must elect hospice care, shifting focus from curative treatment to comfort and quality of life.
- Care Focus and Flexibility
  - Hospice care prioritizes comfort and symptom relief and can be discontinued or re-elected if health circumstances change.

Conclusion

- **Holistic Comfort and Dignity**
  - Hospice care prioritizes comfort, dignity, and holistic support for residents with life-limiting illnesses in long-term care settings.
- **Interdisciplinary Teamwork**
  - Hospice utilizes a collaborative interdisciplinary approach addressing physical, emotional, spiritual, and family needs effectively.
- **Targeted Eligibility and Outcomes**
  - Eligibility criteria ensure hospice services target residents who benefit most, improving outcomes and reducing hospitalizations.
- **Compassionate End-of-Life Support**
  - Hospice care promotes peace, comfort, and honors individual values supporting quality of life at end-of-life stages.

Best Practices for Hospice Collaboration with Long-Term Care Facilities

Enhancing teamwork to improve patient-centered care quality

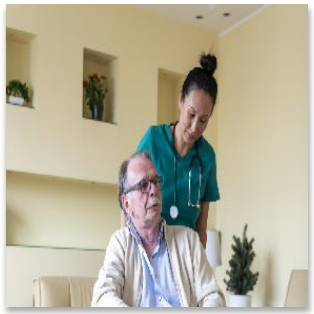
Hospice & Long-Term Care Collaboration Overview

Integrated Care Approach

Hospice and long-term care teams align goals and expertise to deliver comfort-focused, person-centered care.

Shared Responsibility Model

Teams function as extensions of each other, building trust and working toward shared outcomes of dignity and quality of life.



Improved Outcomes and Support

Collaboration leads to fewer crises, smoother transitions, better staff confidence, and reassurance for families.

Why Collaboration Matters

Proactive Comfort-Centered Care

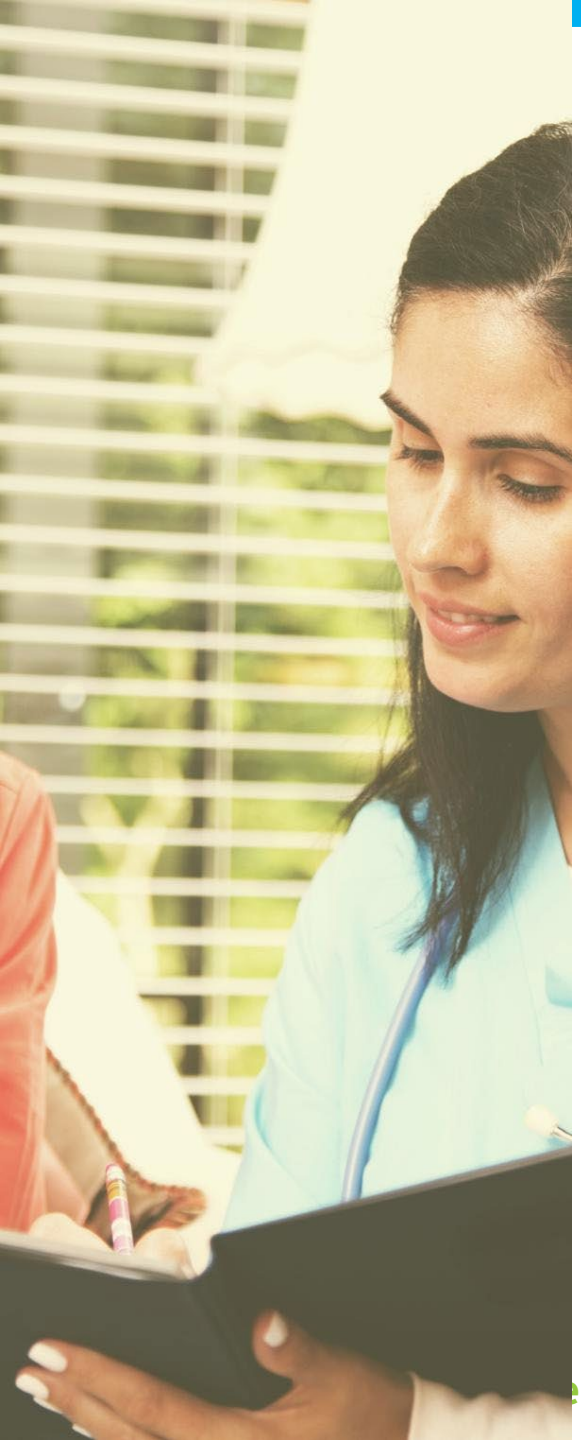
Collaboration shifts care to be proactive and comfort-centered, anticipating needs before crises occur.

Improved Resident Quality of Life

Hospice expertise in symptom management improves resident comfort and reduces distressing episodes in LTC.

Support for Staff and Families

Collaboration offers staff guidance and families consistent communication, education, and emotional support.



Establishing Clear Roles and Responsibilities

Define Hospice vs LTC Roles

Hospice manages symptom control and support, while LTC staff provide daily nursing and resident monitoring.

Communication and Protocols

Clear communication pathways and written protocols ensure coordinated care and timely issue escalation.

Mutual Respect and Teamwork

Role clarity fosters respect, empowering staff and strengthening collaborative teamwork for seamless care.

Communication Best Practices

Timely Team Communication

Effective communication involves regular, scheduled discussions ensuring all care team members stay informed about residents.

Real-Time Response

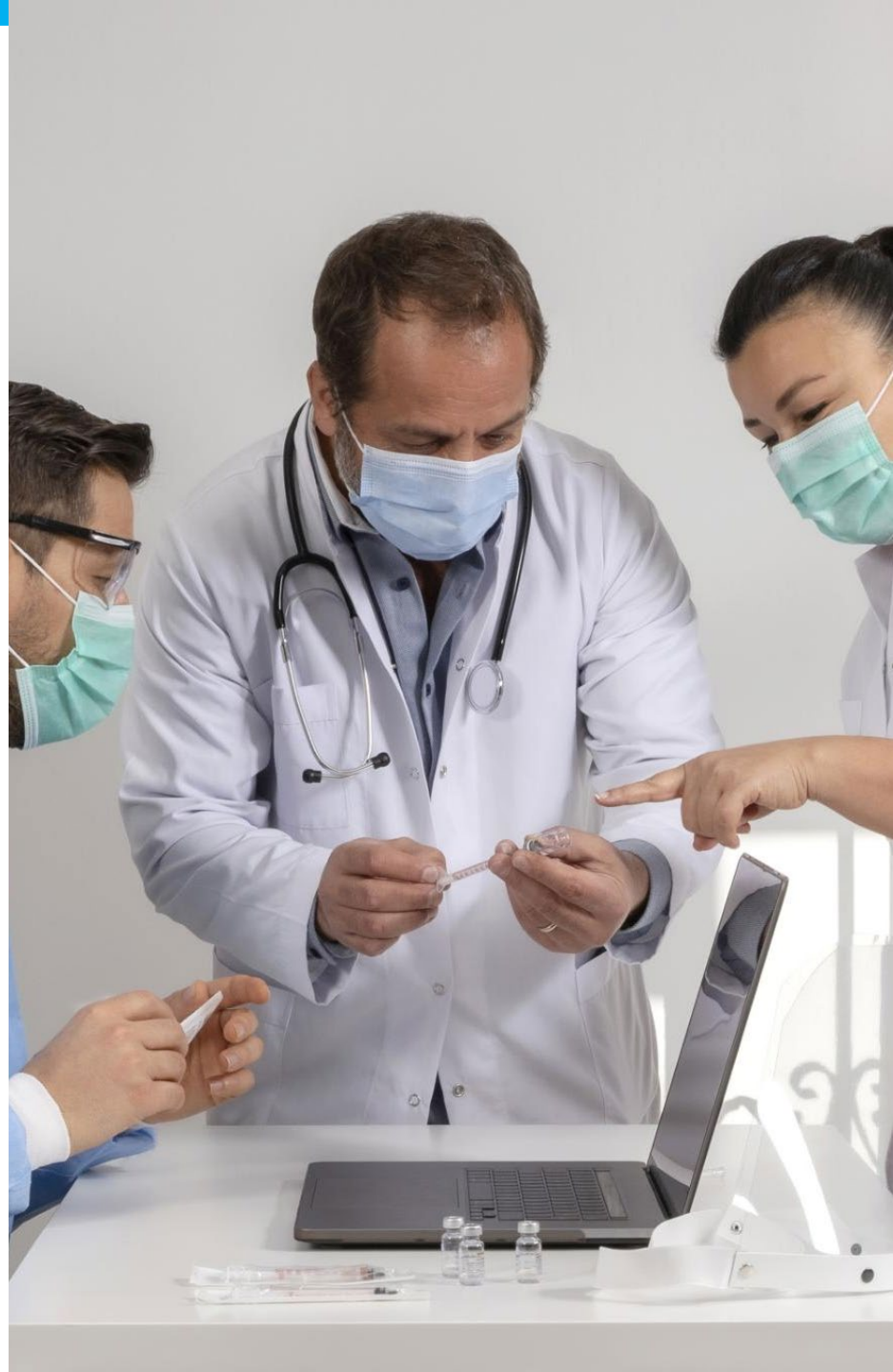
Prompt communication during changes in resident condition ensures quick hospice guidance and coordinated follow-up.

Aligned Documentation

Clear, accessible care plans and symptom management records reduce errors and support care continuity across shifts.

Consistent Family Messaging

Unified communication with families fosters trust, reduces anxiety, and ensures informed care decisions.



Interdisciplinary Team Integration

Expanding the Care Team

Hospice collaboration enriches care by adding nurses, physicians, social workers, chaplains, aides, and volunteers to the LTC team.

Holistic Care Planning

Including hospice members in care meetings ensures plans address physical, emotional, social, and spiritual needs holistically.

Comprehensive Assessments

Close collaboration helps detect subtle health changes and psychosocial stressors early for better resident outcomes.

Strengthening Care Quality

Integrating hospice philosophy improves overall care quality and creates a cohesive experience for residents and families.

Proactive Care Planning

Anticipating Patient Needs

Hospice teams anticipate symptom progression and end-of-life needs to align care with resident goals.

Symptom Management Planning

Anticipatory symptom management includes medication plans and comfort measures before symptoms worsen.

Advance Care Planning

Discussions document resident wishes on hospitalization, resuscitation, and life-prolonging treatments.

Benefits of Proactive Care

Reduces crisis decisions, smooths care, empowers staff, reassures families, and ensures compassionate care.

Staff Education and Training

Importance of Ongoing Training
Continuous education ensures staff are skilled in end-of-life care, symptom recognition, and pain management.

Building Staff Confidence
Training increases staff confidence and competence in managing complex resident needs and symptom control.

Enhancing Quality and Safety
Well-trained staff reduce errors and improve consistency, delivering safer, comfort-focused care.

Supporting Staff Engagement
Education fosters staff engagement, reduces burnout, and promotes a culture of excellence in care.

Family Engagement and Support

Importance of Family Engagement

Family engagement is vital in hospice care within LTC, helping families feel supported during emotional distress.

Clear and Consistent Communication

Hospice and LTC staff coordinate to provide honest, clear information about disease progression and symptom management.

Emotional and Spiritual Support

Social workers and chaplains provide emotional and spiritual care, addressing grief and existential concerns.

Benefits of Strong Family Engagement

Engagement improves satisfaction, reduces complaints, and assures families of compassionate, dignified care.

Measuring Performance Metrics

Key Performance Metrics

Hospitalization rates, symptom management, family satisfaction, and staff retention measure partnership effectiveness.

Impact of Hospice Collaboration

Collaboration reduces avoidable hospital transfers and improves symptom control, benefiting patients and stakeholders.

Staff Well-Being and Retention

Enhanced collaboration lowers staff burnout, boosts confidence, and strengthens retention in care teams.

Continuous Improvement Focus

Regular performance reviews promote quality and focus on outcomes important to residents and families.

Thoughts From the Facility Side…

Improved resident satisfaction through personalized, comfort-centered care

- Families receive education, emotional support, and guidance during difficult decisions.
- Communities benefit from reduced hospitalizations and stronger care outcomes.
- Collaboration enhances reputation and supports resident retention within the community.

Unique Considerations & Benefits for Assisted Living

Residents View Communities as Home, Preferring to Age in Place

- Hospice allows residents to remain in a familiar environment with trusted caregivers.
- Reduces disruptive hospital transfers and promotes comfort-focused care.
- Supports resident choice, dignity, and quality of life.

Unique Hospice Considerations for ALF

- Assisted Living staff balance independence with increasing care needs.
- Hospice provides clinical expertise for symptom management and end-of-life support.
- Partnership strengthens communication between families, providers, and community staff.
- Additional education helps staff recognize changes in condition earlier.

QUESTIONS & DISCUSSION

Key Takeaways and Summary

Foundations of Effective Collaboration

Clear roles, strong communication, and interdisciplinary integration build a foundation for quality hospice and LTC collaboration.

Outcomes and Experience Benefits

Collaboration enhances clinical outcomes and improves resident and family care experiences through consistent communication and support.

Operational Advantages

Collaboration boosts staff confidence, reduces burnout, and helps meet regulatory requirements in long-term care settings.

Hospice Integration Importance

Hospice collaboration is essential for high-quality long-term care, ensuring dignity and support at end of life.

QUESTIONS & DISCUSSION

The Behavior Toolkit: Hacks, Fixes, and Game-Changers, Part 2

Benjamin Surmi, MSG
Arvo, Social Gerontologist

Forum 50 YEARS
EXTENDED CARE SERVICES

The focus of **Benjamin Surmi**'s work as a social gerontologist is to empower people to thrive, no matter the disability or cognitive disorder they may have. He is passionate about designing powerful user experiences for elders and the people who serve them. Benjamin joined Koelsch Senior Communities in 2016 as the Director of Programs and Training before moving into the Director of Education and Culture in 2018, where he shaped innovative engagement experiences for seniors, as well as specialized programming for people living with dementia. Benjamin has also guided person-centered training for over 2,000 employees in 8 states, led the Koelsch Innovation Lab, and coached 70+ wellness directors and 32+ Executive Directors who support over 1,500 seniors. His passion is imagining the impossible and building alliances that make it possible. Benjamin holds a Bachelor's degree in Communication and Sociology from Biola University and a Master's degree in Gerontology from California State University.

Learning objectives

- Differentiate between teaching a specific, nameable tool and teaching general principles — and understand why that difference matters for frontline learning.
- Recognize a wide range of concrete behavior tools across sensory, relational, environmental, and communication categories — and which ones fit your setting.
- Choose three tools to bring back and teach your team, and sketch a simple plan for introducing them.

De-escalation and Distraction

Beauty Bomb

What it is:

A sensory surprise that interrupts distress.

How to use it:

- Keep a few tools on hand: bubble wand or machine, snow globe, mini prism, or light-reflecting object.
- Enter quietly and activate the object without comment—let it capture attention first.
- Follow with a gentle statement: “This always reminds me of being at the fair.” Or offer a sincere compliment: “You have excellent eyebrows.”

Why it works:

Unexpected beauty triggers attention and orientation systems in the brain. The visual or emotional novelty disrupts fixated patterns and invites curiosity or recognition—often connected to familiar or treasured past experiences.

Power Up the Hands

What it is:

A redirection method using hand-focused activity.

How to use it:

- Offer simple tactile tasks like yarn to untangle, buttons to sort, towels to fold, a face outline to trace, or zipper bags to open and close.
- Say: “You’re good at this. I need your help with this one.”
- Keep their hands busy while continuing care (e.g., hygiene, changing clothes) with minimal verbal commentary.

Why it works:

Hands-on engagement activates the brain’s motor and sequencing networks. Giving the hands something to do creates direction and purpose, which reduces overwhelm and channels physical energy productively.

Bring in the Animals

What it is:

A redirection method that uses animal presence.

How to use it:

- Choose the type that works best for the person: live therapy dog, robotic pet (e.g., Joy for All), or realistic stuffed animal.
- Place the animal on their lap or beside them. Gently stroke or pet it yourself and invite them to join in.
- Say: “She’s been waiting for you all morning. Would you mind saying hello?”

Why it works:

Animal presence meets a person where they are without language or social pressure. It supports nervous system regulation and offers a familiar way to reconnect with roles like nurturer, friend, or observer.

Tell a Story

What it is:

Using familiar narrative to change emotional state.

How to use it:

- Sit beside them and begin with a line like: “Do you remember the first time it snowed in October?” or “This reminds me of the time...”
- Tell a simple, warm story from their own life (if known) or a fictional but familiar one (e.g., Little House on the Prairie, The Wizard of Oz).
- Let the story drift naturally into a familiar action like sipping coffee, folding socks, or looking through pictures.

Why it works:

Storytelling invites the brain into a recognizable pattern with a beginning, middle, and end. It gives structure to the moment and can stabilize emotional intensity through familiarity and rhythm.

The Escape Valve

What it is:

A dignified way to let the resident exit confrontation.

How to use it:

- Recognize when a resident is locked in refusal or agitation. Do not push the task.
- Offer a neutral exit: “Could you walk with me to check something?” or “Let’s go see what’s happening in the hallway.”
- Once you’re in a new location or task, reset the interaction without mentioning the refusal.

Why it works:

Many people resist because they feel backed into a corner. This tool preserves their sense of control by letting them leave on their own terms. The movement also shifts their sensory environment, breaking the escalation loop.

The Silent Companion

What it is:

A nonverbal co-regulation strategy.

How to use it:

- Sit quietly nearby with a simple object: a folded towel, magazine, lotion bottle, or photo book.
- Avoid direct eye contact. Just share the space.
- After 1–3 minutes, gently shift posture or offer a quiet cue if appropriate. Or remain still and calm.

Why it works:

Nervous systems can synchronize without speech. When words feel overwhelming, presence and posture offer a steadier signal. This works particularly well when the person is overstimulated or burned out by repeated instruction.

Upside-Down Mirror

What it is:

A playful exaggeration of the resident's behavior.

How to use it:

- If a resident insists on going to the airport, start packing with them. If they're yelling at a wall, ask it what it wants for dinner.
- Match their energy level slightly, then exaggerate gently and pause.
- Smile or freeze in mock seriousness—invite them to laugh or shift tone with you.

Why it works:

Humor and mutual play create micro-moments of partnership. This tool turns the caregiver into a co-conspirator rather than a controller. It works especially well when the behavior itself feels absurd or stuck in a loop.

The Puzzle Lock

What it is:

A fidget or tactile object with a purposeful “lock” story.

How to use it:

- Hand them a tactile object like a TV remote, coin purse, combination lock, or puzzle cube.
- Say: “This only opens when we’re steady enough—can you figure it out?”
- Let them focus on the object while you proceed with your task nearby.

Why it works:

Tactile puzzles activate the brain’s executive and motor planning functions. When paired with a task-related cue (“This only works when…”), it builds narrative and emotional redirection into something they control.

Meaning and Memory

Fractal Familiarity

What it is:

A method of reinforcing safety through repeated sensory cues.

How to use it:

- Identify 1–2 consistent sensory elements for daily care routines: a song, a scent, a color.
- Use them only during specific transitions or care tasks. For example:
  - Lavender scent during dressing.
  - “Moon River” played softly every time you enter their room.
  - Matching aprons for morning staff.
- Add a comforting ritual, such as a favorite snack offered only on shower days.

Why it works:

Predictable sensory inputs create familiarity and stability. This engages procedural memory—more durable than short-term memory—and builds subconscious safety through repetition.

Open the Heart's Treasure Chest

What it is:

Using personally meaningful objects to spark emotion or engagement.

How to use it:

- Choose an object with deep emotional resonance: a wedding photo, church bulletin, quilt, or childhood toy.
- Sit beside the resident and offer it slowly. Say: "This made me think of you."
- Allow space for reaction—don't rush or narrate too much.

Why it works:

Objects tied to long-term memory can anchor a person's sense of identity, especially when language or awareness is fragmented. This approach reconnects them to their own life story.

Reconnect Through Tech

What it is:

Playing recorded voices or videos from familiar people.

How to use it:

- Ask families to record short video or audio messages with comforting phrases, songs, or stories.
- Play the recording before entering or during transitions: “Hi Dad, I’m just checking in. You’re doing great.”
- Use a tablet, speaker, or even an old phone to play the message.

Why it works:

Voice recognition is preserved even in advanced NCD. Hearing a loved one before seeing a caregiver builds safety and pre-loads emotional familiarity.

Phone Power

What it is:

Connect residents with one another over the phone.

How to use it:

- Pair residents over the phone, even if their converation is nonsensical.

Why it works:

The phone gives people a sense of power, control, agency, and the dignity of being an adult. It creates structure and reduces distress through a familiar ritual.

Decade Translator

What it is:

Speaking in the language of their remembered era.

How to use it:

- Learn their formative decade—what slang, songs, and media shaped their worldview.
- Use era-specific phrases: “Let’s get dolled up,” or “Time to hit the diner.”
- Sing or hum a tune from their youth during care.

Why it works:

Long-term language memory lasts longer than present-day comprehension. Switching into a known speech pattern reduces processing strain and builds rapport faster.

Memory Scene Rebuild

What it is:

Recreating an emotionally significant environment or scenario.

How to use it:

- Choose a scene they loved: grandma's kitchen, Sunday church, farm chores, the beach.
- Rebuild sensory elements: cinnamon scent, apron, gospel music, seashell.
- Narrate gently: "Feels like Sunday morning again."

Why it works:

Multisensory cues can transport the brain to stored emotional landscapes. This lowers threat perception and gives the resident a familiar mental script to follow.

The Handed-Down Promise

What it is:

Giving symbolic authority to care actions through a trusted figure.

How to use it:

- Hold or wear something that could plausibly come from their loved one (e.g., scarf, note, keychain).
- Say: “Your daughter asked me to bring this. She said it means she trusts me to help today.”
- Let the object serve as both reassurance and a bridge to your role.

Why it works:

When trust is broken with caregivers, using a proxy authority figure (especially one rooted in memory) bypasses resistance. The object becomes a vehicle for transferred permission.

Partnership and Positioning

Give a Grip

What it is:

Offering an object to hold in order to redirect grabbing, hitting, or resistance.

How to use it:

- Hand the resident a towel, sock, stuffed animal, or piece of clothing.
- Say: “Hold this for me while we get started.” Or “You’ve got this one—I’ll take care of the other side.”
- Position the object between their hands and their body or your body.

Why it works:

Many residents resist care by grabbing or swatting. Giving them something to grip provides a substitute outlet for that impulse, while also restoring a sense of control.

Eye Contact + Motor Guidance

What it is:

Pairing gentle, focused eye contact and non-invasive touch with movement-based prompting.

How to use it:

- Begin by establishing calm eye contact for about 3 seconds.
- Touch the shoulder, forearm, or elbow gently while giving a short, clear cue.
- Offer a guiding touch or steadying grip to initiate motion: e.g., taking a step, raising an arm, or shifting weight.

Why it works:

Eye contact builds presence and attention. Paired with rhythmic, familiar movement, it activates motor memory and allows the person to respond physically even if verbal processing is impaired.

The Three-Way Hug

What it is:

Using a shared object to create mutual participation in a care task.

How to use it:

- Offer a towel, blanket, or piece of clothing.
- Say: “Let’s hold this together—makes it easier that way.”
- Guide their hand to one end while you hold the other, and begin the task (e.g., drying, dressing, repositioning).

Why it works:

Instead of reaching into their space, you're now engaged in a mutual task. This removes the feeling of being "done to" and replaces it with shared effort.

The Steadying Wrap

What it is:

A physical bridge between you and the resident using fabric.

How to use it:

- Drape a shawl, bath sheet, or large towel over both of your shoulders.
- Say: “I’ll keep hold here—you’ve got your side. We’ll stay steady this way.”
- Proceed with the care task while maintaining that shared contact point.

Why it works:

Fabric offers both comfort and modesty. It can reduce tension, limit flailing, and transform care into a cooperative act.

Anchored Touch Through a Familiar Object

What it is:

Using a known or preferred object as a buffer during care.

How to use it:

- Hand the resident a pillow, doll, or object of personal importance.
- Say: “Let’s steady ourselves here. Hold onto this, and I’ll take care of the rest.”
- Guide their body as they hold the object.

Why it works:

When direct touch is distressing, a familiar or soft object can act as a safe barrier. It also helps the resident stay grounded and less likely to resist.

Prove You Care

What it is:

Gradually building trust through layered presence.

How to use it:

- Visit briefly, multiple times, without initiating care.
- Begin by passing through or sitting nearby without asking anything.
- Over time, add giving them something to hold, add soft greetings, then eye contact, light conversation, and finally physical assistance.
- Let them see you return even when no care is needed.

Why it works:

Trust cannot be rushed. This method respects boundaries and shows you care more about the person than the task. It works especially well when trust has been broken.

The Overcoat Transfer

What it is:

Encourage the resident to wear a protective garment before care begins.

How to use it:

- Offer a familiar coat, robe, or shirt.
- Say: “Let’s put this on first—it’s your helper today.”
- Proceed with care actions using or through the garment when possible.

Why it works:

Wearing something restores modesty, dignity, and control. It also changes the dynamic: they are dressing for something rather than being undressed.

The Spiral Step-In

What it is:

Approaching the resident slowly and indirectly.

How to use it:

- Enter the room in a wide arc or curved path.
- Avoid standing directly in front of them—move diagonally or at an angle.
- Let them spot you first if possible, and wait for a visual cue before moving closer.

Why it works:

Direct approaches can feel like threats. Angled movement is less intrusive, giving the brain time to assess safety and reducing the likelihood of a defensive reaction.

Protective Mimicry

What it is:

Subtly mirroring posture, gestures, or vocal tone.

How to use it:

- If they're seated and tense, mirror their posture.
- If they speak slowly or with hesitation, do the same.
- If they raise their hand or shift weight, echo the motion gently.

Why it works:

Mirroring helps build subconscious rapport. It communicates, "I see you," without words, and reduces the feeling of being controlled or misread.


Remove and Reduce

Remove Team Members

What it is:

Reducing the number of people in the room to reduce threat.

How to use it:

- Step back and observe: Are too many people involved?
- If safe, ask others to leave temporarily: “I’ve got this one—can you give us a moment?”
- Reintroduce others only if the resident stabilizes.

Why it works:

Multiple staff can feel like a threat or punishment. Reducing to one calm, confident presence often lowers defensiveness and shame.

Clear the Room

What it is:

Removing bystanders to lower social pressure.

How to use it:

- If a resident is escalating, gently move other residents, family, or visitors elsewhere.
- Say: “Let’s give her a little privacy right now.”

Why it works:

Being watched increases distress, embarrassment, or defiance. Privacy lowers emotional temperature and lets the caregiver focus without an audience.

Remove Expectations

What it is:

Adjusting care goals to what's necessary and possible.

How to use it:

- Ask: "Does this task have to happen right now?" or "What matters most today?"
- Rethink non-essential care like full showers, multiple showers per week, clothing changes, or time-based routines.

Why it works:

Unnecessary expectations increase conflict. Reducing the ask can preserve the relationship while still maintaining dignity and safety.

Remove Reasons to Say No

What it is:

Proactively eliminating common sources of conflict.

How to use it:

- If someone repeatedly grabs a fragile item, replace it with a safe version.
- If they resist an activity, move it or reframe it before asking.
- Rearrange the environment so fewer limits are needed.

Why it works:

Saying "no" over and over teaches a person to resist. Redesigning the situation means you don't have to challenge them to keep them safe.

Remove Reasoning

What it is:

Letting go of logic-based explanations during distress.

How to use it:

- Stop trying to convince, explain, or correct.
- Instead, redirect through movement: offer a hand, begin walking, hand them a towel or item.
- Narrate the physical present: “Here we go. This way now.”

Why it works:

When the brain is flooded or confused, it can't process explanations. Gentle physical guidance and emotionally warm tone are far more effective.

Remove Yes/No Questions

What it is:

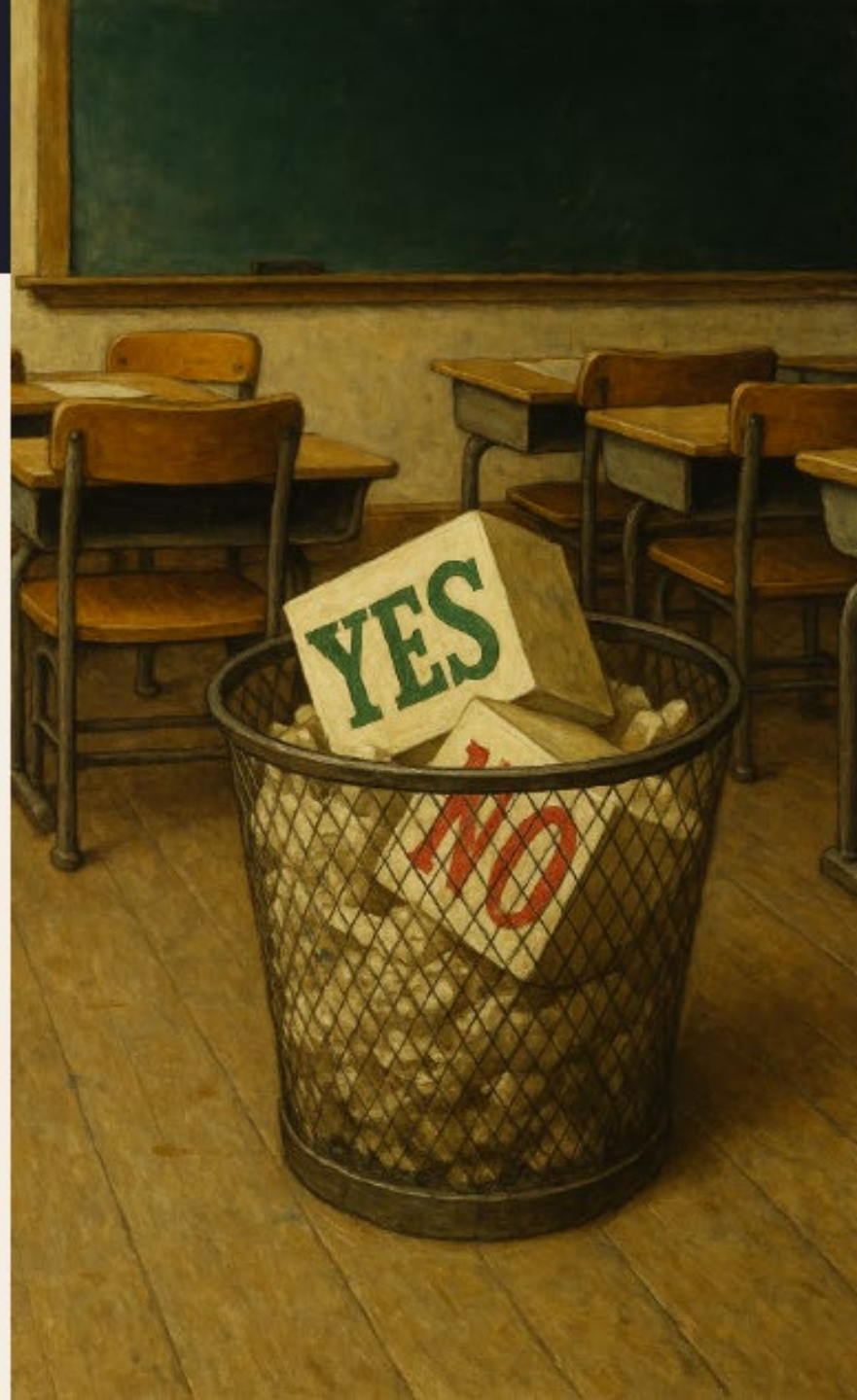
Switching from choice-based to confident narration.

How to use it:

- Replace “Do you want to get dressed?” with “Let’s get this cozy shirt on next.”
- Say “Here comes your warm towel” instead of “Can I clean you?”
- Narrate actions as you do them.

Why it works:

Yes/no questions invite refusal. During care, confidence signals safety. The resident is more likely to follow a steady lead than negotiate a decision.



Clear + Covered Meals

What it is:

Making food feel visibly safe by using see-through or sealed packaging.

How to use it:

- Use cling wrap, clear lids, or sealed containers to serve food to residents with delusions about poisoning.
- Say: “Here it is—just like it left the kitchen.”
- Offer pre-packaged items like yogurt, apple sauce, or crackers with intact labels.

Why it works:

Transparency builds trust. Seeing an unopened or untouched item reassures residents who fear contamination, sabotage, or poisoning.


Reset and Repair
Norman Rockwell

Scheduled Reset Nap

What it is:

A proactive rest period to reduce evening distress.

How to use it:

- Observe if a resident becomes exit-seeking or agitated consistently in the afternoon or evening.
- Schedule a short nap (15–30 minutes) 1–2 hours before that time.
- Create a restful atmosphere: dim light, cozy blanket, quiet sound.

Why it works:

Sleep refreshes cognitive and emotional capacity. A well-timed nap can prevent escalation by restoring attention and reducing overstimulation before sundowning begins.

One-Minute Switch

What it is:

A respectful tag-out to interrupt conflict and reset the interaction.

How to use it:

- When escalation is rising, say: “Hey James, could you take over for a minute?”
- Let a new caregiver enter while you calmly step away.
- Option: Everyone leaves for 60 seconds, then returns as if starting fresh.

Why it works:

It avoids forced resolution and resets the emotional tone. It gives both caregiver and resident a clean slate, without blame or explanation.

Reset Through Rest

What it is:

Using rest, even brief, to interrupt an escalating state.

How to use it:

- Say: “Let’s take a break. You don’t have to do anything right now.”
- Guide the person to a recliner, bed, or soft chair—even if it’s mid-morning or late afternoon.
- Dim the lights, reduce sound, and offer comfort items like a blanket.

Why it works:

Intense behaviors often stem from overstimulation or fatigue. A short nap or quiet moment can lower cortisol and give the brain time to reorganize.

Give a Gift

What it is:

Using a kind gesture to repair trust after conflict or refusal.

How to use it:

- Offer something small and specific: a cup of juice, hand lotion, a postcard, or a compliment.
- Say: “I found this and thought of you.” Or “You don’t have to do anything —I just wanted to give this to you.”
- Avoid using it as a bribe; let the gift stand on its own.

Why it works:

When trust is damaged, a surprise act of generosity can signal reconciliation without needing a conversation. It also models respect and resets the emotional tone.

The Light Reset

What it is:

Using visual change to mark the end of one moment and the start of another.

How to use it:

- Flip the overhead light off and back on gently, or close and reopen the curtain.
- Narrate softly: “Let’s restart the scene.”
- Begin care or redirection as if nothing happened before.

Why it works:

Sudden yet gentle sensory shifts can trigger a mental reset—especially in those who thrive on visual cues. It signals a new beginning without requiring words.

Ritual Closure

What it is:

A symbolic action that helps both resident and caregiver move past a hard episode.

How to use it:

- Choose a brief shared gesture: tearing up a paper, folding a napkin, placing a sticker on a chart.
- Say: “We made it through. Let’s finish it off together.”
- Keep it light, short, and familiar.

Why it works:

Just as rituals mark endings in daily life, they also help mark emotional closure. It tells the brain: "That’s over. We’re moving on."

The Shared Secret

What it is:

Creating a private code or signal that connects you and the resident.

How to use it:

- Develop a short, playful gesture or phrase ahead of time: touching your nose, saying “peanut butter,” or doing a two-finger tap.
- Use it in moments of tension to signal continuity: “Remember our code?”

Why it works:

A shared secret is a relationship shortcut. It builds trust, lowers defensiveness, and makes the resident feel seen.


Roleplay and Misdirection
TONIGHTS
Norman

Southern Sweetheart Switch

What it is:

Stepping into the voice and role of a loved one, especially a spouse.

How to use it:

- If the resident frequently asks for or misses their spouse, gently begin a phone call or in-person interaction in that person's voice or tone.
- Use affectionate language that fits the relationship: "I love you, Honey." or "I've been waiting for you all day."
- Keep the tone warm, familiar, and non-theatrical—this is not a performance, it's emotional mirroring.

Why it works:

Love and rhythm live deep in procedural memory. Familiar vocal cadence and phrases offer comfort and orientation, especially for those longing for a partner who is absent or deceased.

Enter the Scene

What it is:

Using theater-like cues to reframe the care interaction as a shared performance.

How to use it:

- Dim the lights before entering, then slowly raise them or open the curtains like a stage reveal.
- Step into the room and say: “The stage is ready whenever you are.”
- Wear soft or costume-like clothing, such as a shawl, bow tie, or cap, and use calm, deliberate movements.

Why it works:

This shifts the resident into a narrative space where they are not being interrupted or managed, but stepping into a role. It creates a sense of control, story, and predictability that’s easier to accept than direct reality.

The Curiosity Drop

What it is:

Leaving a prop or note to awaken interest and break a negative pattern.

How to use it:

- Quietly place an item just within sight: a small package, note, or vintage object.
- Say: “Special delivery. I’ll check back soon.”
- Return later as a “different person” with a follow-up line: “Looks like the sender left a message for you.”

Why it works:

Curiosity activates problem-solving centers in the brain and deactivates threat circuits. The resident becomes the investigator, not the target.

Friendly Hallucination Join-In

What it is:

Joining the resident's perception without challenging it.

How to use it:

- If they see bugs, pretend to wipe them away calmly: "Got it. You're good now."
- If they see children or animals, acknowledge them: "Oh, she's so cute!" or "Looks like he's resting."
- Avoid arguing or correcting—stay matter-of-fact and relaxed.

Why it works:

Validating the perception prevents conflict. It respects their current reality, allowing redirection or continuation without confrontation.

Reverse Intercom

What it is:

Playing a pre-recorded message before entering a room or making a request.

How to use it:

- Record a trusted voice—family member, pastor, or favorite character—saying something like: “Good morning! You’re safe. Help is just outside.”
- Play it on a wireless speaker outside the door or from a hidden device in the room.
- Enter only after the message finishes.

Why it works:

Sound is less threatening than physical presence. Familiar voices create emotional continuity and reduce the stress of sudden interaction.

Mission Interrupt

What it is:

Creating a fictional mission to redirect behavior into purposeful action.

How to use it:

- If the resident is exit-seeking or resisting care, offer a job: “We’ve been chosen to test this blanket and report back.”
- Use props to reinforce the story: clipboard, stopwatch, sampling cup.
- Stay in character until the task is complete.

Why it works:

Purpose reframes resistance. When the resident is “needed,” they shift from defiance to contribution. This is especially powerful for former professionals or helpers.

The Role Rehearsal

What it is:

Turning a care task into a practice session for a pretend performance.

How to use it:

- Frame the moment as preparation: “Places please! Time for the warm-up routine.”
- Use familiar movements from theater, sports, or dance: “And… stretch!”
- Narrate each action as a rehearsal cue.

Why it works:

Rehearsal feels low-stakes, playful, and self-directed. It also invites familiar body memories through embedded sequences.

Surveillance Reframe

What it is:

Inviting the resident to take on the role of a helper or observer.

How to use it:

- Say: “We need your eyes on this hallway. You’re the best one for the job.”
- Set up a stool, clipboard, and maybe a small radio or notebook.
- Check in periodically: “Anything to report?”

Why it works:

Surveillance reframes stillness and relocation as contribution. It also honors past identity roles—like guard, teacher, or parent—without requiring accuracy.

Echo Persona

What it is:

Adopting a new character to step out of a tense dynamic.

How to use it:

- If they mistake you for someone they fear or dislike, say: “I’m just the neighbor today, here to visit.”
- Use an unfamiliar hat, accent, or mannerism to create separation.
- Offer a neutral task or comment: “Mind if I rest here a minute?”

Why it works:

Arguing identity creates more confusion. Adopting a new role gives the resident room to reset the interaction on different terms.

Shadow Partnering

What it is:

Referring to an outside imaginary authority to shift compliance.

How to use it:

- Mention a loved one or trusted figure: “Your daughter asked me to bring this.”
- Refer to a supervisor: “The nurse said we needed to test this.”
- Use the name of someone they respect—even if fictional.

Why it works:

The request doesn’t come from you. This preserves autonomy and allows the resident to cooperate without giving in to pressure.

Fake News Broadcast

What it is:

Playing or reading a fictional update that resolves their fear.

How to use it:

- If they're stuck in a delusion (e.g., a missing child), play a short clip: "Local boy found safe. No danger expected."
- Create a typed "newspaper" with reassuring headlines.
- Present it as something you just received.

Why it works:

Instead of challenging the belief, this completes the narrative in a satisfying way. It brings resolution without confrontation.

The Delivery Drop

What it is:

Pretending to be a courier or messenger instead of a caregiver.

How to use it:

- Approach the resident with a tote bag or box and say: “Delivery for you—signature not required.”
- Drop the item nearby (scarf, note, snack) and exit.
- Return later to help them unpack or read the "instructions."

Why it works:

Care is no longer being imposed—it’s something that arrived. This gives the resident space to choose how and when to respond.

Sensory and Regulation

Water That Looks New

What it is:

Making water more appealing and believable with subtle visual cues.

How to use it:

- Add a tiny drop of food coloring (blue, pink, or lemon-yellow) to the water.
- Serve in a clear cup with a straw or garnish (citrus slice or umbrella).
- Narrate confidently: “Here’s your fancy water for today.”

Why it works:

Some residents resist drinking due to apathy, paranoia, or lack of sensory interest. A colored or decorated drink provides novelty, increasing both safety and hydration.

Cold Snap Shift

What it is:

A sensory interruption using cold.

How to use it:

- Offer a chilled washcloth, cold lemon water, or even an ice cube.
- Say: “Let’s cool off together—feel this.”
- Let them hold or sip it while you continue care or guide a change in location.

Why it works:

Cold sensory input creates a sharp but non-threatening shift in body awareness. It gives the brain something new to focus on and can interrupt overwhelm through direct physiological input.

Scent Start

What it is:

Using smell to gently signal safety and transition.

How to use it:

- Use a diffuser, scented card, or sachet with familiar smells like lavender, coffee, or lemon balm.
- Associate each scent with a phrase: “Today smells like home.”
- Pair the scent with a consistent time or task (e.g., dressing, mealtime).

Why it works:

Smell bypasses cognitive filters and accesses emotional memory quickly. It helps the resident feel grounded even if they don’t know why.

Rhythmic Sync

What it is:

Using rhythm to regulate body and brain.

How to use it:

- Walk beside the resident while matching their pace and footfalls.
- Gently tap a surface, hum a slow song, or use a metronome app.
- Repeat simple movements together: rocking, brushing, swaying.

Why it works:

Repetitive rhythm supports regulation and connection. It lowers heart rate and provides nonverbal reassurance.

Weighted Comfort

What it is:

Offering deep pressure through blankets, shawls, or lap pads.

How to use it:

- Drape a weighted item across their lap, shoulders, or back.
- Introduce it like a gift or custom: “Here’s your blanket—like always.”
- Use it during transitions, rest times, or stressful care.

Why it works:

Deep pressure triggers parasympathetic nervous system responses. It reduces the brain’s sense of physical vulnerability and promotes stillness.

The Metronome Trick

What it is:

Using steady sound to calm the environment.

How to use it:

- Set a metronome app or ticking clock to 60–72 bpm.
- Place it nearby during high-stress tasks like bathing or dressing.
- Let the sound play quietly in the background.

Why it works:

Auditory rhythm helps synchronize internal states. It draws attention without demanding it, offering a low-effort focus anchor.

Environmental Decoy

What it is:

Giving the resident something visual to focus on that isn't you.

How to use it:

- Place a mirror to reflect flowers or natural light, not people.
- Add a sign or picture with a message: “You’re not alone. We’re close by.”
- Let them wake or orient to the image before engaging.

Why it works:

Early moments (waking, post-escalation) are especially sensitive. Giving the brain something peaceful and nonverbal to latch onto first can change the tone of the whole interaction.

Scene Setter

What it is:

Use visual or environmental elements like posters, wall hangings, murals, or screens to redirect perception and interrupt distress.

How to use it:

- Observe environmental triggers that fuel distress (e.g., sun glare interpreted as fire).
- Replace or overlay with calming, familiar, or neutral visuals: landscape posters, curtains, artwork.

Why it works:

Visual anchors reframe misinterpretations, offering residents a safer mental script to follow.

Example:

A man would yell fire every afternoon as the sun would shine into his room. The team put up a huge waterfall poster. The yelling ended.

Anchored Object Rituals

What it is:

Assigning specific sensory objects to consistent routines.

How to use it:

- Always offer the same fuzzy socks for bedtime, the same scarf for walks, or the same playlist for meals.
- Offer the same blanket, apron, or photo album whenever a routine starts fresh.
- Let the object or sound be the first signal that the routine is beginning.
- Say: “You know what this means—must be time.”

Why it works:

Repetition builds safety. Anchoring a sensory cue to a specific activity activates procedural memory and prepares the body to cooperate.

Shower DJ

What it is:

Before the resident ever arrives in the shower room, have their favorite songs or music playing on a boombox.

How to use it:

- Start familiar, calming music in the care area before entering with the resident.
- Choose music tied to positive memories, or consistent genre cues (jazz, big band).
- Let the music create rhythm, familiarity, and positive anticipation.

Why it works:

Sensory priming prepares the nervous system, associates the task with pleasure, and reduces resistance by shifting focus.

Gentle Vestibular Reset

What it is:

Resetting orientation through subtle movement.

How to use it:

- Offer a rocker, glider, or soft swivel chair.
- If standing, gently sway side to side with them or lead a stretch.
- Match your voice and motion to the rhythm: slow, even, grounded.

Why it works:

The vestibular system helps regulate balance, mood, and spatial awareness. Gentle movement recalibrates this system and resets agitation from disorientation.

Questions?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Risk, Readiness and Responsibility in Long-Term Care

Meredith Duncan, BS, JD
Polsinelli
Shareholder Attorney

Meredith Duncan is a litigator at heart, advocating for clients before government regulators, administrative law judges, and courtrooms alike. She focuses mainly on the compliance and operational issues facing health care providers, including long-term care providers, senior housing entities, and hospitals, handling all aspects of provider practice.

Meredith appears regularly before regulatory agencies, including the Centers for Medicare and Medicaid Services, the Office of the Inspector General, the Department of Healthcare and Family Services, the Illinois Department of Public Health, and the Illinois Department of Professional and Financial Regulation. Meredith also has significant experience with Medicare, Medicaid, and Managed Care Organizations, assisting clients with payer relationships and responses to reimbursement disputes, audits, and appeals.

Meredith is a Shareholder Attorney with Polsinelli and holds a BS in Business Administration from the University of Missouri-Columbia and earned her JD from Chicago-Kent College of Law at the Illinois Institute of Technology.

Learning objectives

- Describe how liability arises for long term care providers.
- Identify strategies and best practices to develop and maintain documentation to defend against liability concerns.
- Review examples of areas of high liability and how your documentation can mitigate or prevent liability.

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What a law firm *should* be.™

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Agenda

- Where does liability come from?
- The most common liability risks that communities face.
- What you can do now.

Liability

Duty **(du·ty)** noun

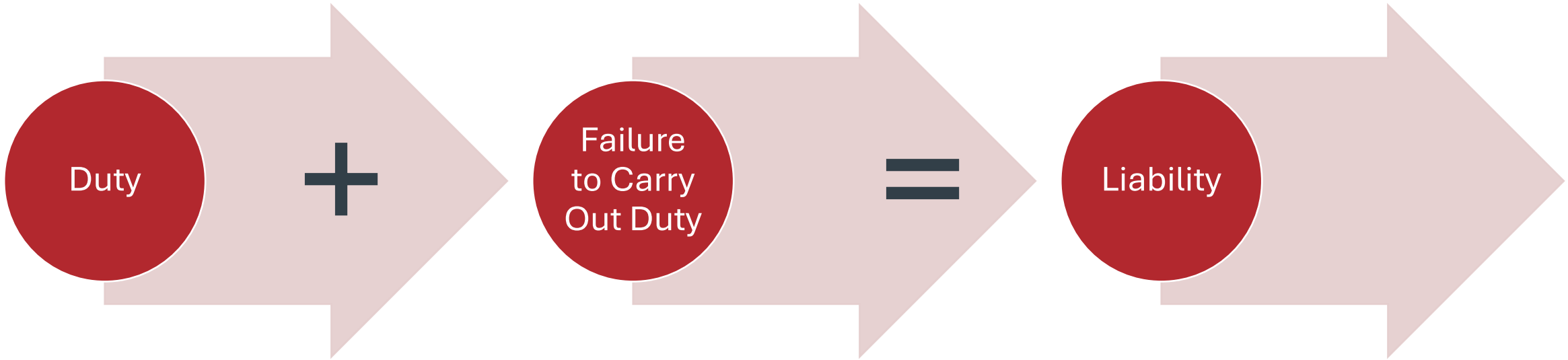
1. a moral or legal obligation; a responsibility
2. a task or action that someone is required to perform

A duty can be created by

- statute
- promise or representation
- industry standard

And a duty can be difficult to get rid of……

Liability Equation



Meet the Reasonable Person

The “**reasonable person**” is a *hypothetical individual* who approaches *any situation* with the *appropriate amount of caution* and then *sensibly takes action*.

It is a standard created to provide courts and juries with an *objective test* that can be used in *deciding whether a person's actions constitute negligence*.

The Reasonable _____?

- Reasonable ***person***
- Reasonable ***administrator***
- Reasonable ***nurse***
- Reasonable ***care aide***
- Reasonable ***doctor***
- Reasonable ***facility***

What is Reasonable?

- To comply with your policies.
- To meet the regulatory requirements.
- To meet the industry standard (i.e., what others do).
- And, to do these things consistently

Liability-O-Meter

Keep in Mind

Hindsight is always 20/20.

If you didn’t document, it wasn’t done.

Can’t count on immunity from state or federal authorities.

Every Dog Gets One Bite

- Once you know that your dog bites, you need to take action.
  - What if you ***know*** that a resident is exhibiting a behavior?
  - What happens if you have ***heard*** that a caregiver has done something wrong?
  - What if you ***suspect*** that staff are using social media to post about the facility and residents?

Standard is what you "knew or <u>should have</u> known"

Causes of Liability

- Human error
- Failure to follow a care plan/physician orders
- Failure to assess and/or document same
- Failure to document care
- Failure to follow policies / making exceptions
- Failure to address warning signs
- Failing to listen to that “little voice”
- Failure to fire poor staff
- Hiring the wrong staff
- Admitting the wrong resident

Causes of Liability

PEOPLE

PEOPLE

PEOPLE

Where Claims Come From

Where do claims come from?

- The family
- The resident
- Your staff

The basis for these claims come from:

- Your staff
- The care they deliver
- Your policies
- Your response to events/information

Effective Risk Management Can…

Identify and address risks proactively

Prevent the bad act from happening.

Minimize the community's liability when the bad thing happens

Implement lessons learned for further improvement

Look for the warning signs

- Multiple prior placements
- Difficult family
- Arguments within the family
- Complaints about the prior placement, doctor, hospital care
- Something just doesn’t seem right
- Story just doesn’t add up

Smart Hiring/Firing

Pay attention to warning signs

Attitude means more than skills

Do not ignore warning signs

Do not ignore your gut

Establish bright lines that can’t be crossed

Mandatory Training Lessons

- No exceptions to bright line rules
- If you aren’t sure, ask
- If you see anything that makes you uneasy, tell someone
- Failure to report is as bad as or even worse than the mistake/issue itself
- If you need help or support, ask
- Communication is key

Bright Lines with Staff

Abuse	Transferring resident correctly	Getting angry with residents
Handling residents roughly	Failure to follow service plans	Failure to communicate (Doctors, other staff, reporting)

Most Common Problems with Documentation

- Non-existent
- The reality / documentation gap
  - Speculation
  - Best case scenario driven
  - “No one will read this, right?”
  - No one does read it.

Plaintiffs' Attorneys are Looking for ONE Thing

What did your community

do or fail to do

that

caused

the harm?

Policies

- Required by law.
- Provide guidance to staff.
  - Create consistency in practice.
  - Communicates expectations.
  - Remove the chance for error.
  - Promotes compliance.
- Rules of the road.
- Sets the standard of care you will live up to.

Biggest Problems with Policies

- Too elaborate
- Too strict
- Too many
- Too secret
- Contrary to practice

Policy Do's

- ✓ Clear.
- ✓ One policy per issue.
- ✓ To the point – what is the takeaway?
- ✓ Easy to carry out.
- ✓ Known and remembered. If staff can't tell you the policy when you ask they probably aren't carrying it out.
- ✓ Shared with residents and families as appropriate.

Common Liability Risks

- Abuse
- Falls
- Elopement
- Wounds

Top Four Errors with Abuse

1. Staff fail to identify an incident or allegation of abuse.
2. Staff fail to report an allegation of abuse.
3. Once a report has been made, staff are not suspended pending investigation.
4. Failure to conduct a thorough investigation & dig deeper.

Three Golden Rules

1

Treat every allegation as if it were true and as if it were abuse.

2

Treat every allegation as if it were true and as if it were abuse.

3

Treat every allegation as if it were true and as if it were abuse.

Policy and Training Foundation

You **must report** anything that you see or hear about that makes you feel **uneasy or just doesn't seem right.**

You will **never be disciplined for reporting** something like this . . . . . but ***you will be disciplined if you fail to do so.***

Resident Abuse by Staff

- Make sure that your Staff:
  - are trained comprehensively and often on the ***unique care needs*** of residents
  - understand how to ***step away from frustrating situations***
  - ***report anything they see or hear*** that makes them uneasy
  - know that ***management cares***, but also know that ***management is watching***

Falls

Deviations from the care plan / inappropriate transfer are impossible to defend

- After a fall
  - Documented Investigation / Root Cause Analysis
  - New interventions to prevent similar fall (or document that all interventions are in place and there are no additional interventions that could be applied without restraining the resident)
  - Anticipate future falls and address in the care plan
  - Consider clinical issues and follow-up
  - Update the care plan to show that this process was completed after a fall
  - Train the staff on any care plan updates
  - Wash, rinse & repeat for each different fall

Lost Residents/ Elopement

How do you monitor residents in the building?

If a resident is lost have a checklist:

- Head count.
- Search team.
- Notification.
- Alarm check.
- Investigation of cause.

How often do you check your door alarms?

Can door alarms be disabled?

Drills – do staff know what to do?

Medication Errors

- Residents are unable to self-identify
- Residents need medication assistance/administration
- Residents may be unable to communicate adverse effect

Wounds

- Train staff to **identify** and **document** skin changes
- **Root cause analysis** for each new skin change
- Get a **physician/clinician note** at the outset to discuss the “why”
- **Document** treatment interventions & pressure relief
- **Follow-up** on nutrition, medication and other clinical components
- Periodic notes and input from clinicians discussing the “**why**”

Key is to have contemporaneous documentation explaining unavoidable skin breakdown.

Assisted Living Level of Care Concerns

295.2000(a) No individual shall be accepted for residency or remain in residence

- ***if the establishment cannot provide or secure appropriate services,***
- *if the* ***individual requires a level of service or type of service for which the establishment is not licensed*** *or which the establishment does not provide, or*
- *if the establishment* ***does not have the staff*** *appropriate in numbers and with appropriate skill to provide such services.*

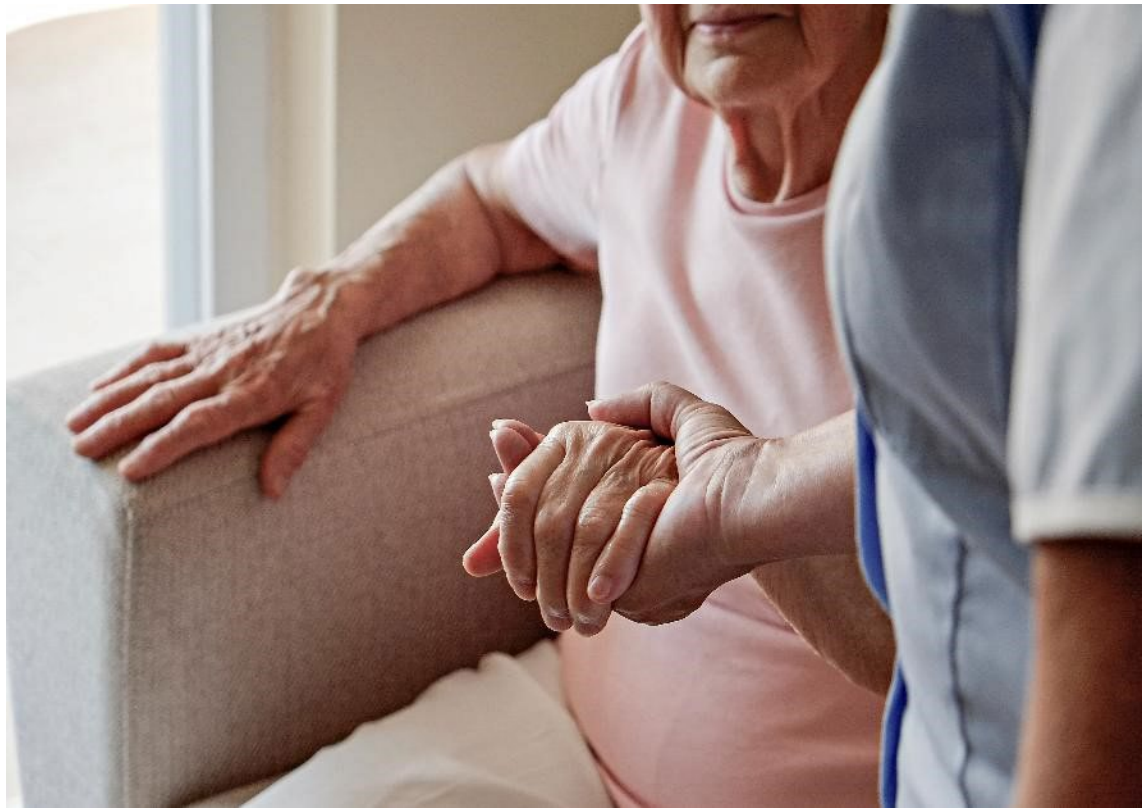
How do we demonstrate residents are still appropriate?

Assessments!

What You Can Do Now

What You Can Do Now… To Get Ready

- Perform a self-assessment
- Identify areas of risk
- Identify residents/occurrences you know are going to be scrutinized
- Review your survey performance
- Assess your in-service and training topics
- Look critically at your QA
- Consider pre-emptive audits
- Mock survey
- Practice interviews with staff



What You Can Do Now... To Respond

- Gather all documentation
- Preserve documents and materials involved
- Make a timeline
- Review your policies
- Start re-training
- If necessary, notify your insurance carrier and get your legal counsel involved.

Questions?

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Engage, Empower, Partner: Upskilling our Core Careforce

Benjamin Surmi, MSG
Arvo, Social Gerontologist

Forum 50 YEARS+
EXTENDED CARE SERVICES

The focus of **Benjamin Surmi**'s work as a social gerontologist is to empower people to thrive, no matter the disability or cognitive disorder they may have. He is passionate about designing powerful user experiences for elders and the people who serve them. Benjamin joined Koelsch Senior Communities in 2016 as the Director of Programs and Training before moving into the Director of Education and Culture in 2018, where he shaped innovative engagement experiences for seniors, as well as specialized programming for people living with dementia. Benjamin has also guided person-centered training for over 2,000 employees in 8 states, led the Koelsch Innovation Lab, and coached 70+ wellness directors and 32+ Executive Directors who support over 1,500 seniors. His passion is imagining the impossible and building alliances that make it possible. Benjamin holds a Bachelor's degree in Communication and Sociology from Biola University and a Master's degree in Gerontology from California State University.

Learning objectives

- Evaluate training tools and strategies used by peers through live polling—identifying what's already in use and what's actually working.
- Identify where different training methods—including video, mobile, conversational tech, and in-person approaches—fit best in real-world community settings.
- Select two to three specific, ready-to-use tools or strategies matched to your community's real needs and priorities.

The Training Toolbox: What Works Now

AhaSlides

Magic wand: ONE thing you wish all your staff did. Go.

0

When staff hear "mandatory training," they look like...

Honestly — how much does training actually change anything?

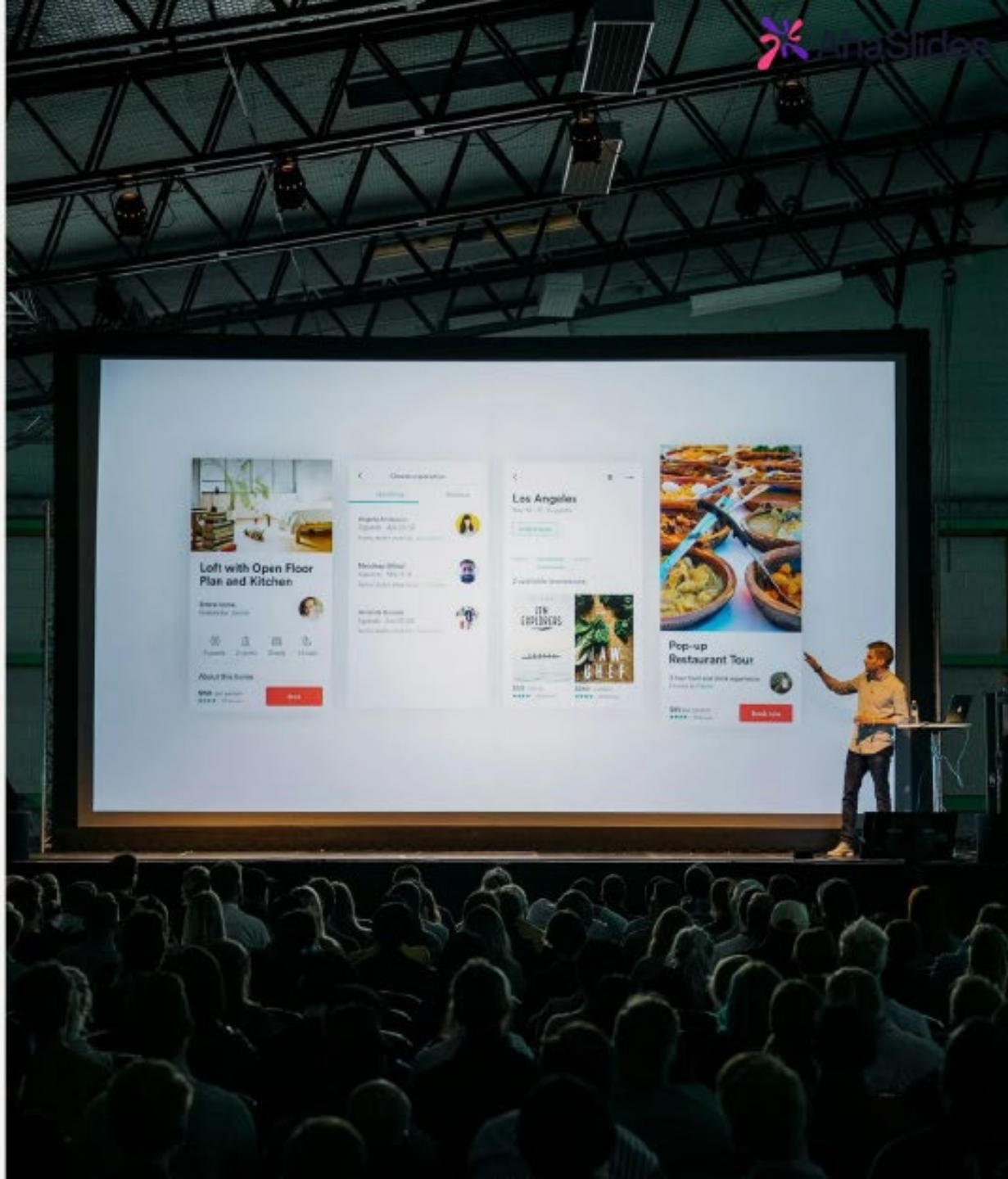
AhaSlides

Your role with training?

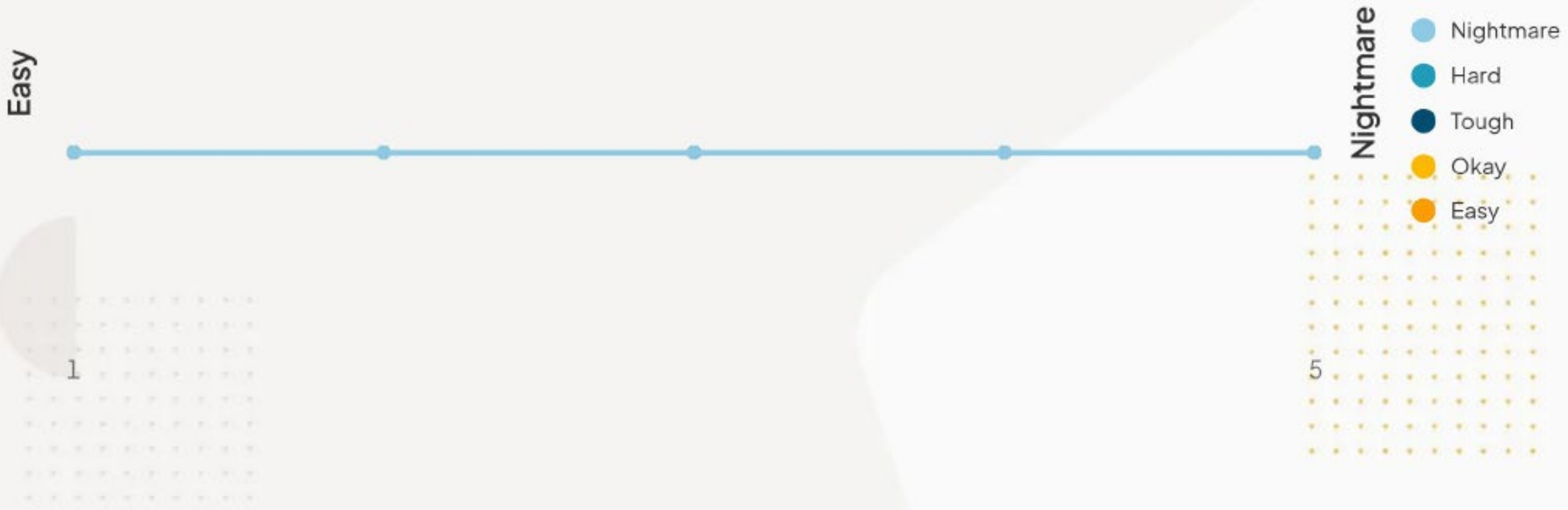
AhaSlides

Let's see the room

Your answers shape what gets built



How hard is it to get staff to FINISH required training?



AhaSlides

What ACTUALLY works to get training done? Share your trick — upvote what you've seen work.

1 Submission — There are no submissions yet.

2 Voting (0)

3 Result

AhaSlides

0

Rank by what your STAFF actually engage with.

Short video

In-person hands-on

Click-through modules

Live discussion

Written handouts

AhaSlides

0

Now rank by what's EASIEST for YOU to deliver.

Short video

In-person hands-on

Click-through modules

Live discussion

Written handouts

AhaSlides

0

Perfect world — online vs. in-person split?

AhaSlides

When staff do online training, what's it on?

AhaSlides

Do staff use their OWN phones for work training?

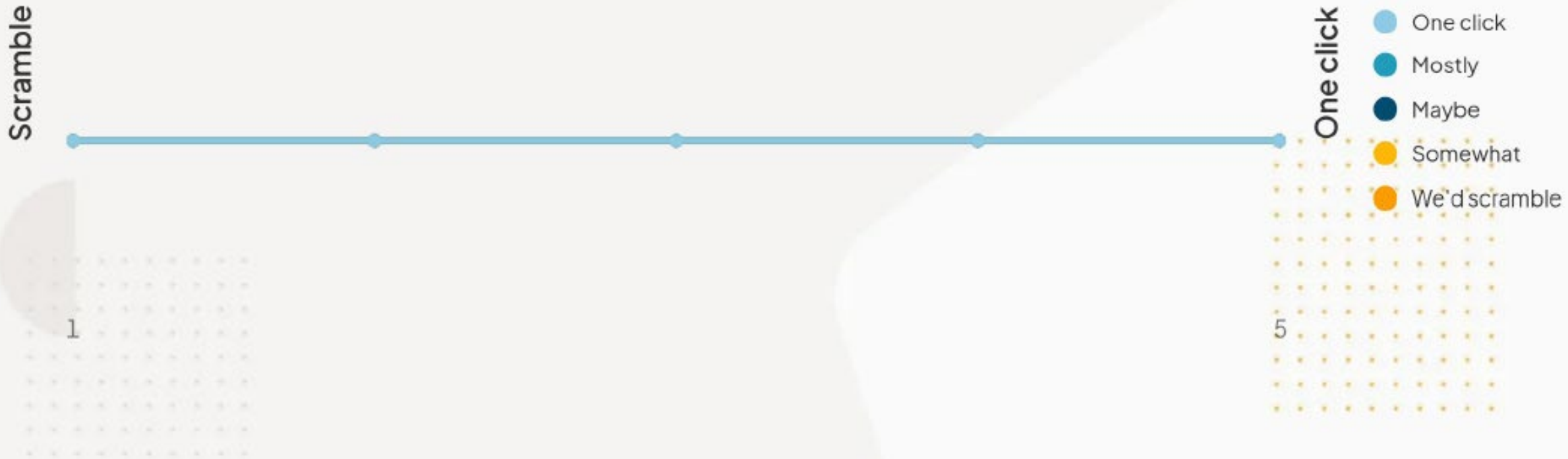
AhaSlides

When does required training actually get done? (pick all)

AhaSlides

AhaSlides

Could you PROVE every required training was done if a surveyor walked in tomorrow?



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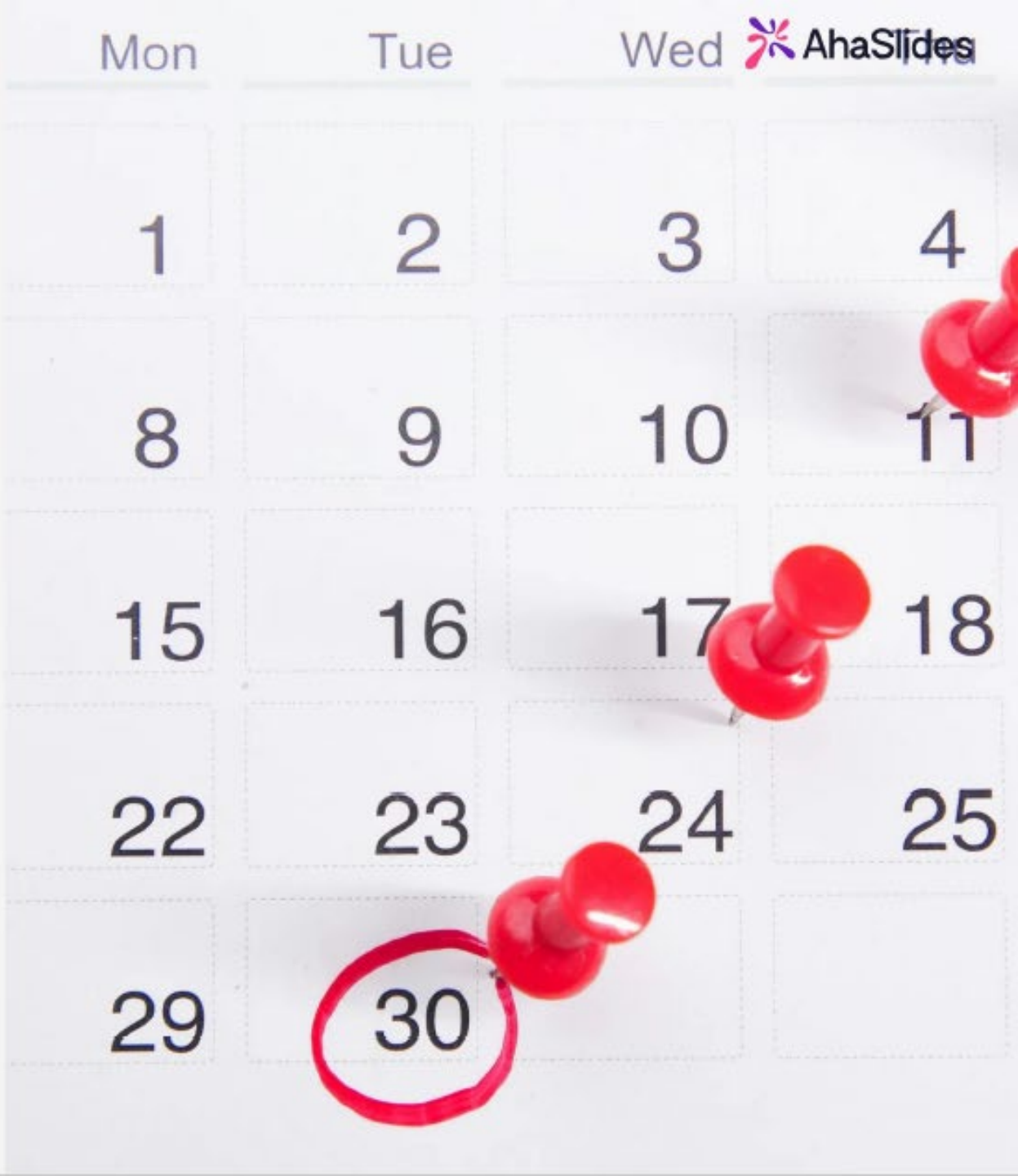
17 agencies. 50 trainings.

Overwhelmed people change less



AhaSlides

If you could build only TWO skills in every employee — what would they be?

0

Respect · Creative Problem-Solving

Respect is how we act.

Creative problem-solving is the bedrock of care.

Train for both.

Policies won't keep you safe

People will

Onboarding · Annual · As-needed

All three count as training

Most training is snake oil

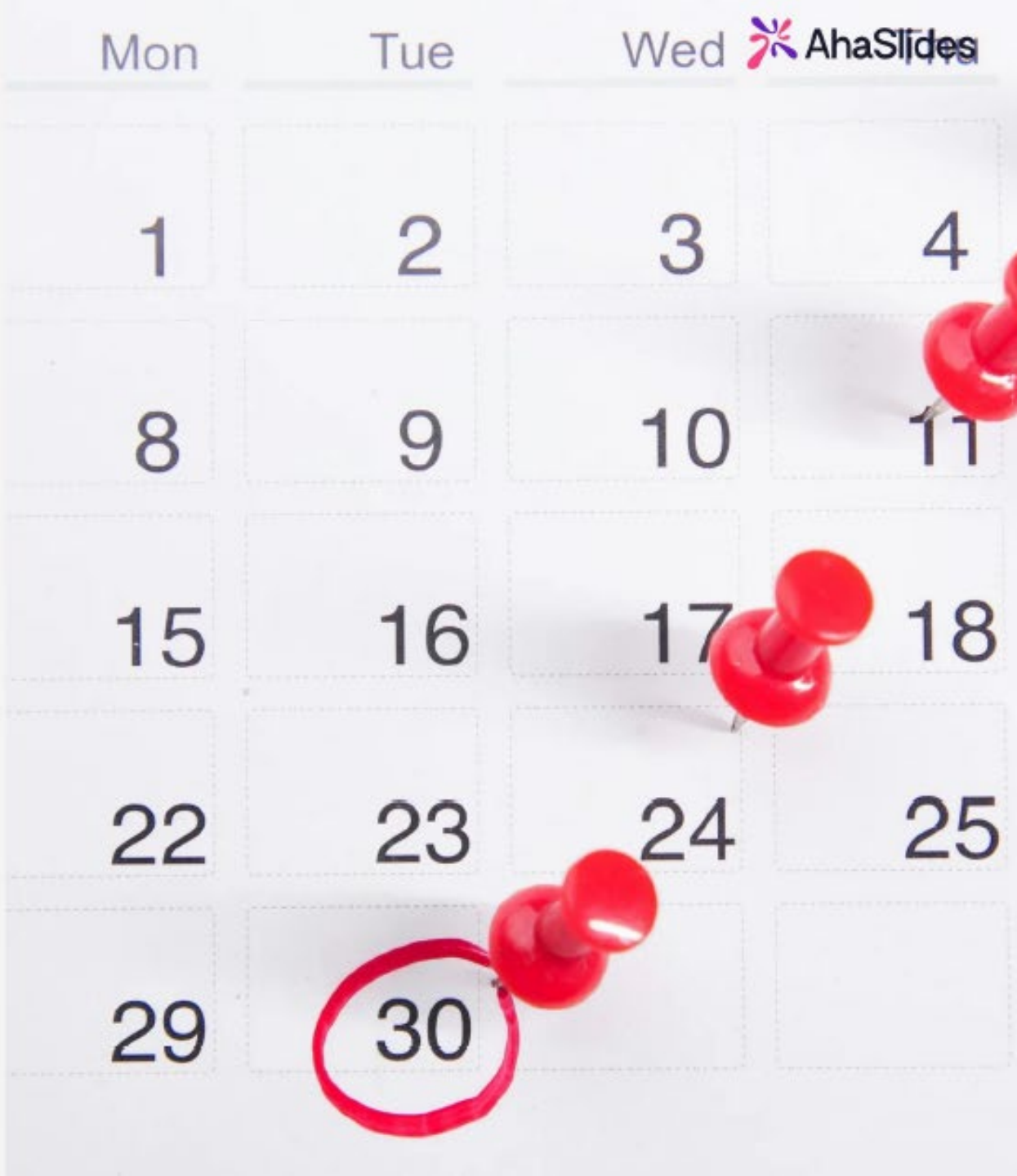
Here's what I'll actually stand behind

Honor the expert in the room

Ask them to help build the checklist first

Reps, not events

Brief, spaced repetition beats one big class



Build a culture, not a program

Let learning ride on what already happens

Start tomorrow

No sign-off needed

TWI Job Breakdown Sheet

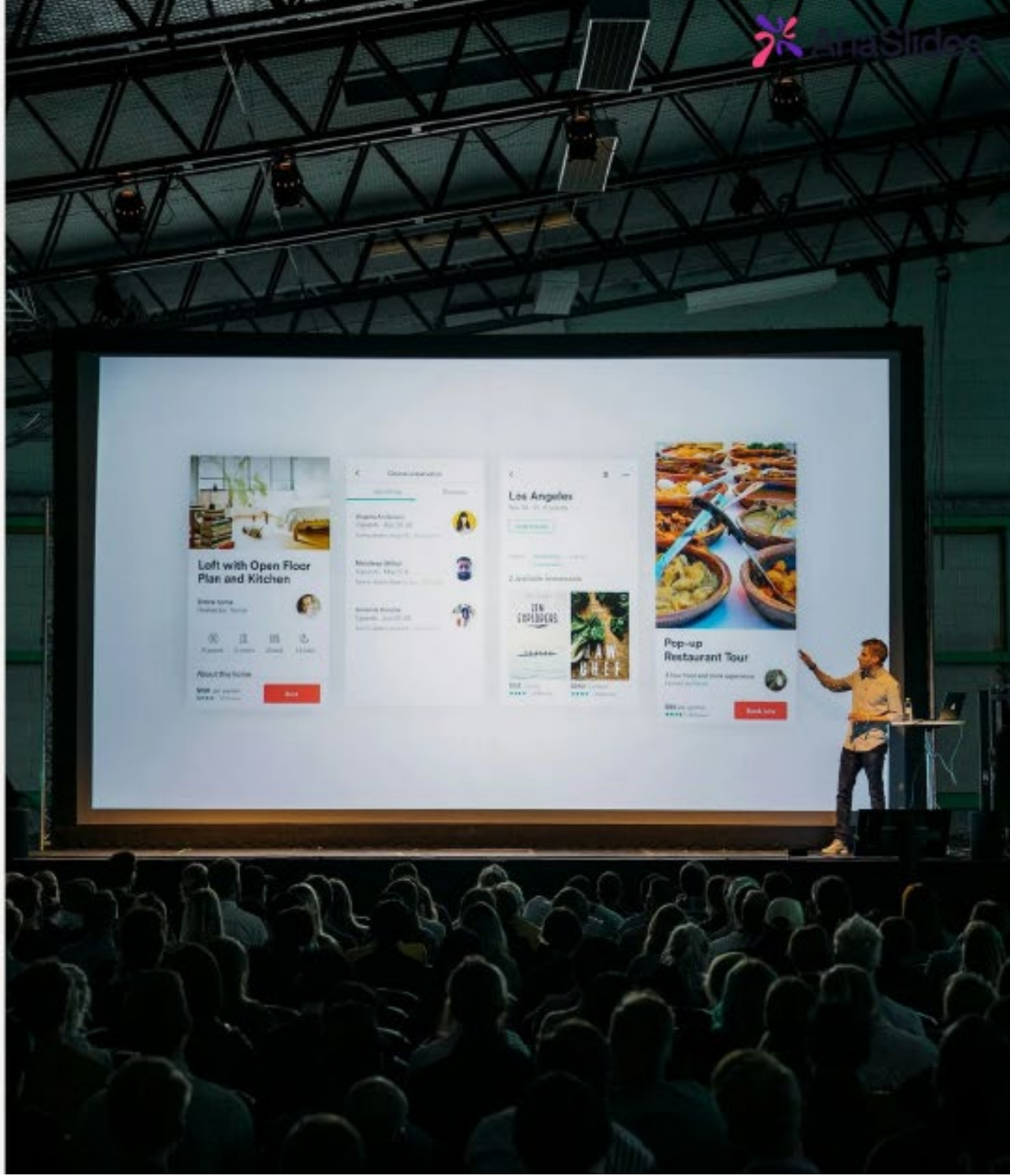
3 columns: important step, key point, reason why.

Use it for high-failure, high-injury jobs.

AI can help draft the first version.

After Action Review

What happened? Why? What do we change?

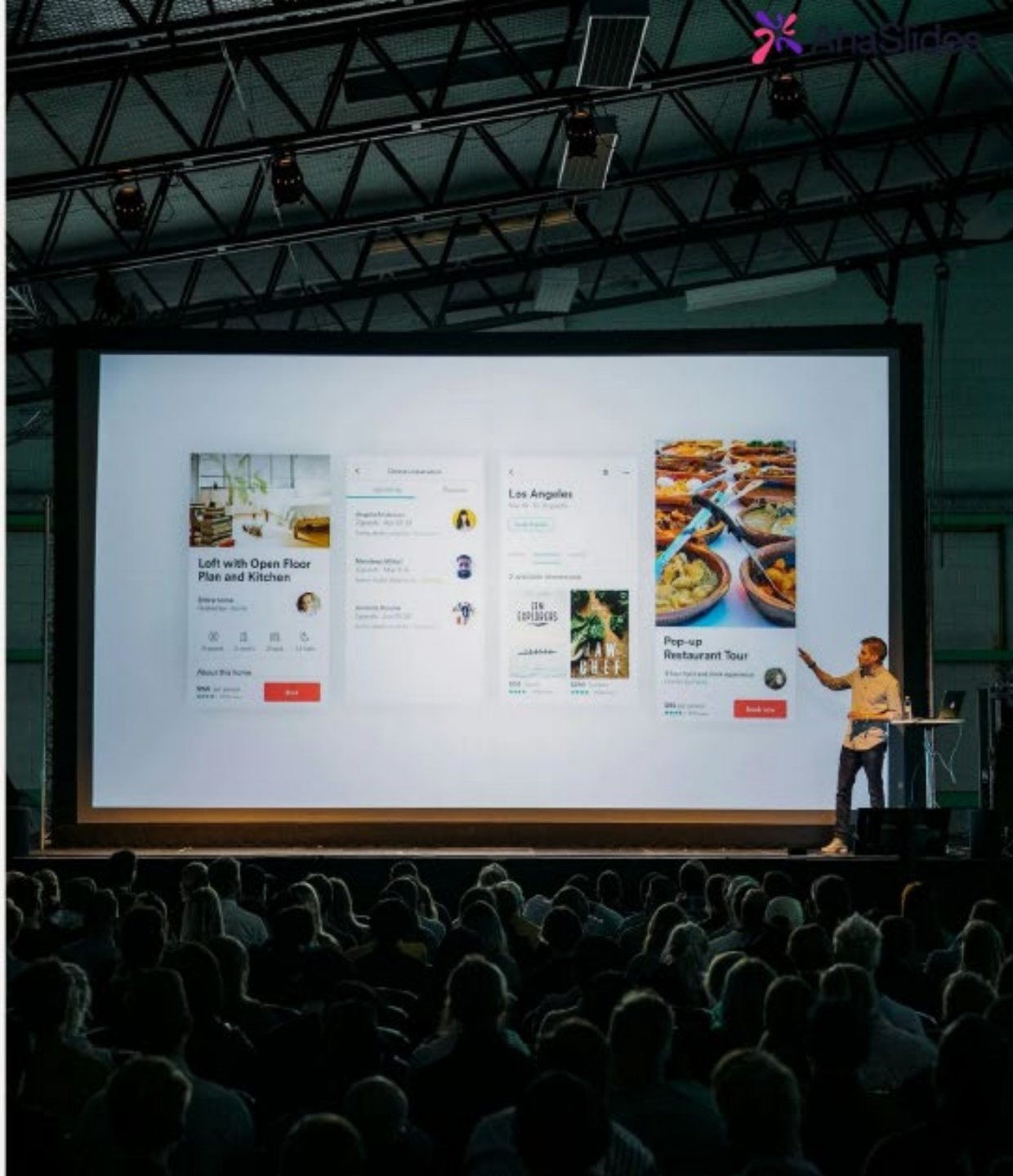


What's the dumbest thing you had to work

Fix one thing within a week

Peer teaches peer — one thing

Tonight, teach one coworker one skill

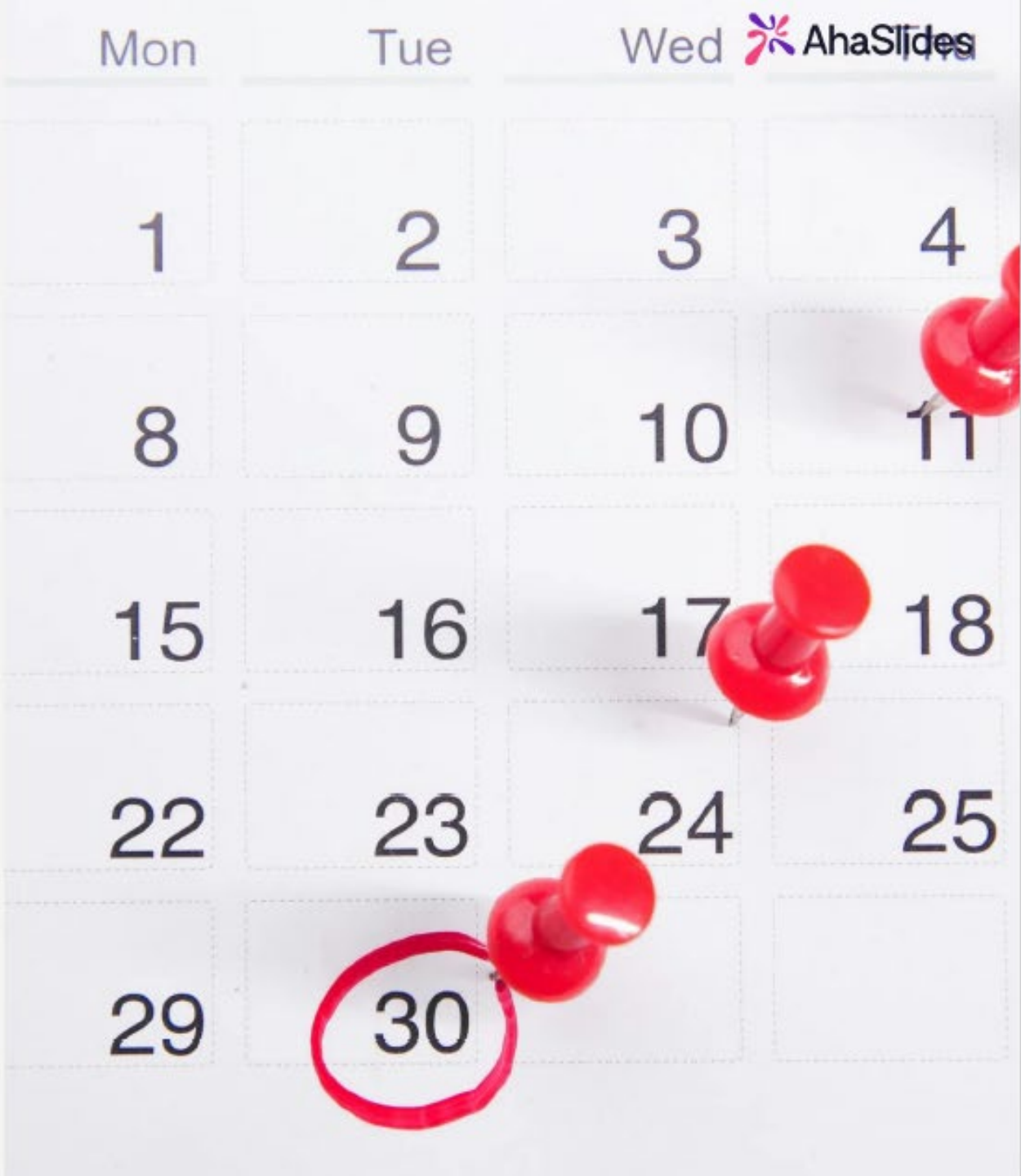


Genchi Genbutsu

Go and see the actual work

Practice to a checklist

Training in the flow of work



Pre-job brief

Point and call before high-risk work

Behavioral nudges

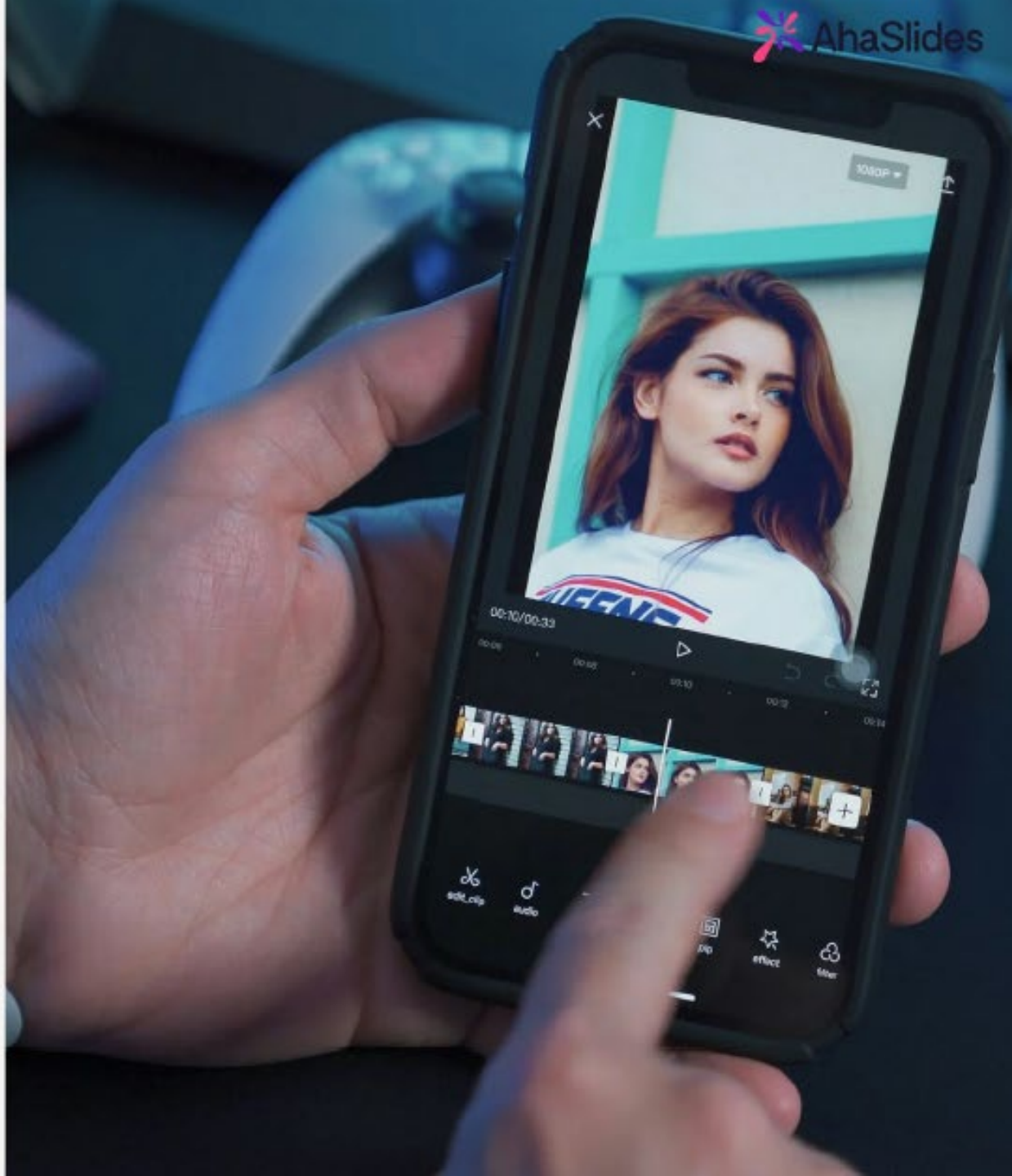
Placement · Defaults · Stickers · Anchor habits

Short-form video

Meet them where they already learn

Have staff make 30-second videos

One tip, one minute, real expertise



Games — while they work

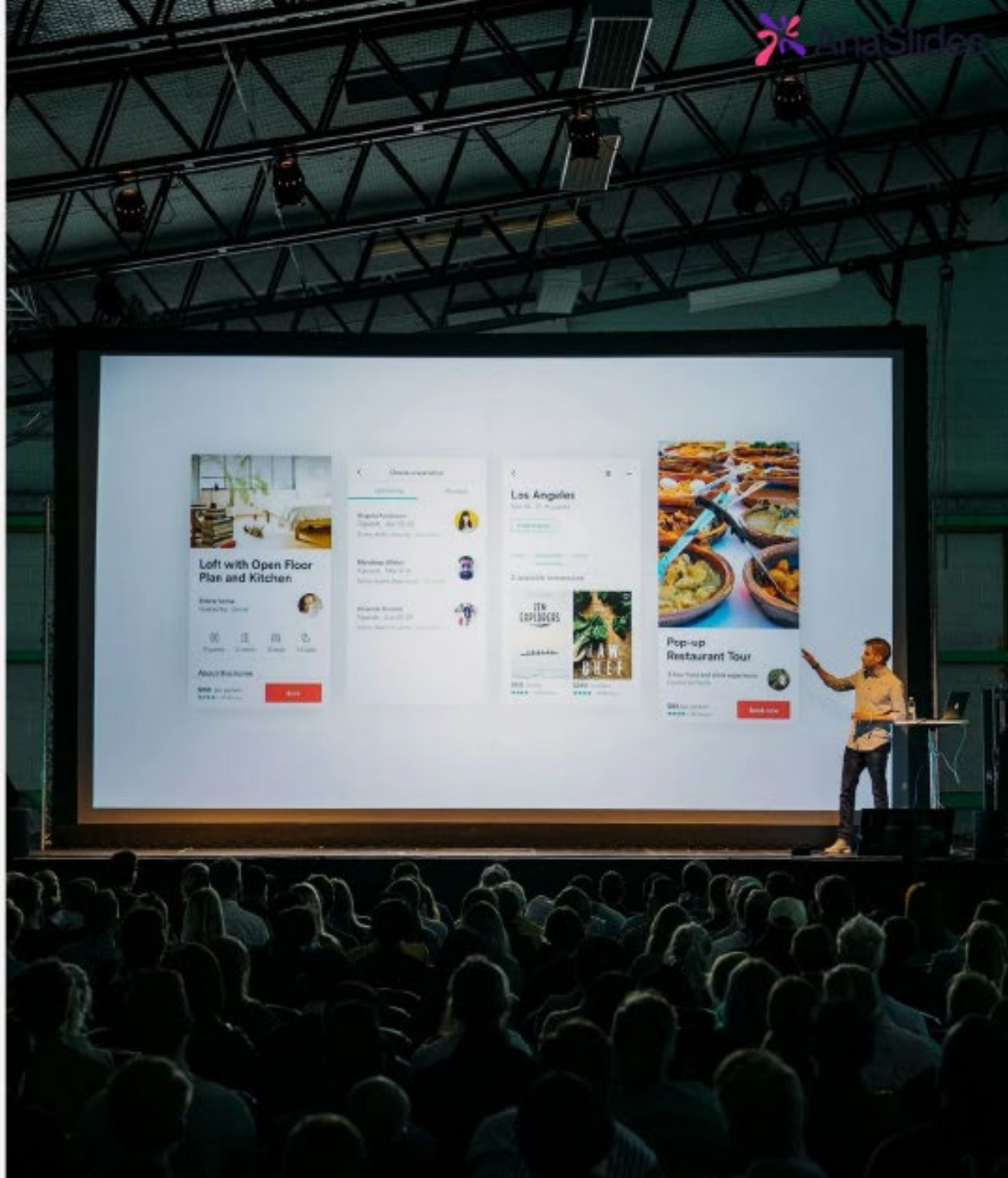
Cards, scavenger hunts, ordering games

JeopardyLabs

Cheap gamification, today

Google Portraits

Talk to Kim Scott about one hard conversation



Google Learn About / Illuminate

Self-driving learning

NotebookLM

Turn your policies into a podcast

Yoodli

AI role-play with feedback

Maya (Sesame) — LIVE DEMO

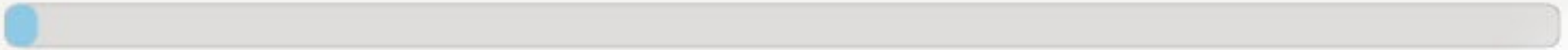
Switch to the Maya app here.

I'll role-play a resident refusing a shower.

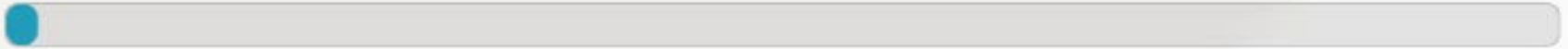
Watch the feedback live.

Pick your TOP 3 — what will you actually try first?

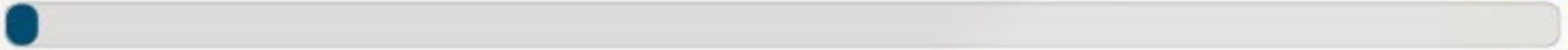
TWI Job Breakdown Sheet



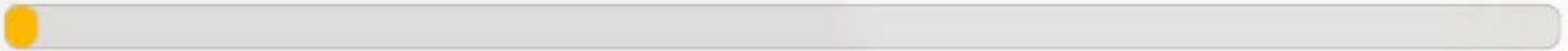
After Action Review



Peer teaches peer



Practice to a checklist



Short-form video

AhaSlides

One thing you'll do differently Monday?

AhaSlides

0

What did I NOT cover that you could teach this room?

AhaSlides

0

RESPECT · CREATIVE PROBLEM-SOLVING

Bookend the session

Go build something your team will love

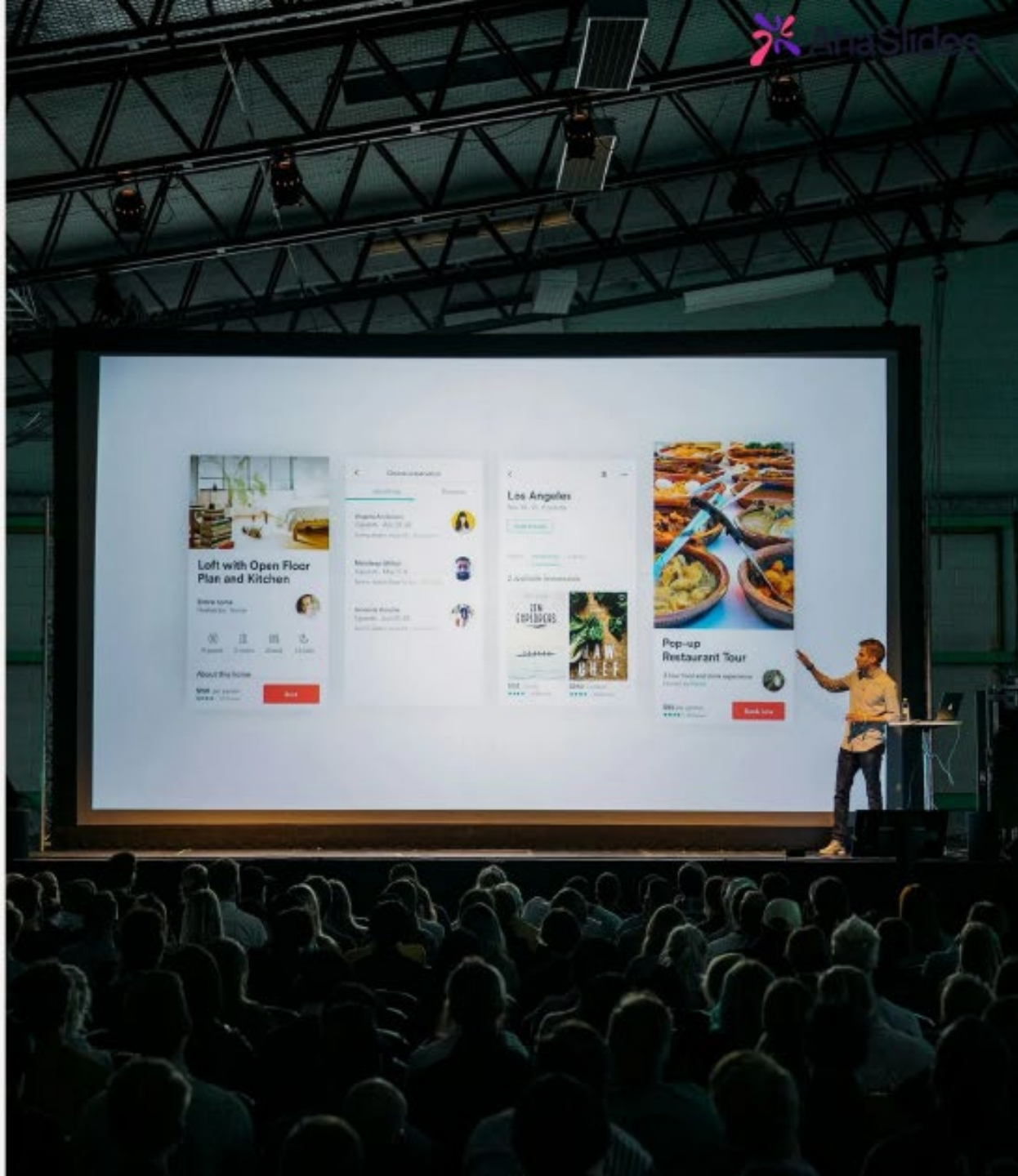
Take a picture, then build

AhaSlides

Scan this QR code to join

The Training Toolbox

What works now



Questions?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