Proviso 31.48
Memory Care Study

South Carolina Department of Public Health

Report to the Senate Medical Affairs Committee and the House Medical, Military, Public and Municipal Affairs Committee

January 1, 2026

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Introduction

Background and Purpose of Report

Proviso 31.48 of the 2025-2026 Appropriations Act (2025 Act No. 69, H.4025) requires the South Carolina Department of Public Health (DPH) to conduct a study regarding memory care at community residential care facilities (CRCFs) and nursing homes and submit a report detailing the findings and recommendations of the study to the General Assembly. Specifically, Proviso 31.48 states:

> **31.48.** (DPH: Nursing Home Review) The Department of Public Health shall conduct a study regarding separate requirements for memory care facilities and assisted living facilities within nursing homes. Additionally, the department shall assess and recommend appropriate staff-to-resident ratios to ensure a sufficient number of staff are available at all times to provide necessary nursing care and related services to each resident. A report detailing the findings and recommendations shall be submitted to the Senate Medical Affairs Committee and the House Medical, Military, Public and Municipal Affairs Committee no later than January 1, 2026.

DPH is the state agency responsible for the regulation and licensure of CRCFs and nursing homes pursuant to the *State Health Facility Licensure Act*, S.C. Code Ann. Sections 44-7-110, et seq. *See* S.C. Code Ann. §§ 44-7-140, 44-7-250, 44-7-260(A)(2), and 44-7-260(A)(6). DPH has promulgated regulations for these facilities at Regulation 60-17, *Standards for Licensing Nursing Homes*, and Regulation 60-84, *Standards for Community Residential Care Facilities*. A CRCF is defined as:

> A facility which offers room and board and which, unlike a boarding house, provides/coordinates a degree of personal care for a period of time in excess of 24 consecutive hours for two or more persons, 18 years old or older, not related to the licensee within the third degree of consanguinity. It is designed to accommodate residents' changing needs and preferences, maximize residents' dignity, autonomy, privacy, independence, and safety, and encourage family and community involvement. Included in this definition is any facility (other than a hospital), which offers or represents to the public that it offers a beneficial or protected environment specifically for individuals who have mental illness or disabilities. These facilities may be referred to as "assisted living" provided they meet the above definition of community residential care facility.

S.C. Code Ann. Regs. 60-84 § 101.L. A nursing home is defined as:

> A facility with an organized nursing staff to maintain and operate organized facilities and services to accommodate two (2) or more unrelated individuals over a period exceeding twenty-four (24) hours which is operated either in connection with a hospital or as a freestanding facility for the express or implied purpose of providing intermediate or skilled care for persons who are not in need of hospital care.

S.C. Code Ann. Regs. 60-17 § 101.RR.

Regarding the current staffing requirements, Proviso 31.17 of 2025-2026 Appropriations Act sets forth the following provision regarding minimum nursing home staffing:

> Regulations for nursing home staffing for the current fiscal year must (1) provide a minimum of one and sixty-three hundredths (1.63) hours of direct care per resident per day from the non-licensed nursing staff; and (2) maintain at least one licensed nurse per shift for each staff work area. All other staffing standards and non-staffing standards

established in Standards for Licensing Nursing Homes: R61-17, Code of State Regulations, must be enforced.

The current staff-to-resident ratios for CRCFs are found in Regulation 60-84, Section 503.B which states, in part:

> . . . . The minimum number of staff members/direct care volunteers that shall be maintained in all facilities:
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> 1. In each building, there shall be at least one staff member/direct care volunteer for each eight (8) residents or fraction thereof on duty during all periods of peak hours.
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> 2. In each building, during non-peak hours, there shall be at least one staff member/volunteer on duty for each thirty (30) residents or fraction thereof. A staff member/volunteer shall be awake and dressed at all times. Staff member(s)/volunteer(s) shall be able to appropriately respond to resident needs during non-peak hours.
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> 3. In facilities that are licensed for more than 10 beds, and the facility is of multi-floor design, there shall be a staff member available on each floor at all times residents are present on that floor.

"Peak hours" refers to "[t]hose hours from 7 a.m. to 7 p.m., or as otherwise approved in writing by the Department." S.C. Code Ann. Regs. 60-84 § 101.LL. Moreover, CRCF staff are required to receive training regarding, among other things, dementia, if the residents admitted/retained by the CRCF have dementia or other memory care diagnoses.

Additionally, the Alzheimer's Special Care Disclosure Act, S.C. Code Ann. Sections 44-36-510, et seq., prescribes certain requirements for licensed CRCFs, nursing homes, and day care facilities for adults that offer to provide or provide an Alzheimer's special care unit or program. Section 44-36-520 of the S.C. Code of Laws states:

> A nursing home, community residential care facility, or day care facility for adults licensed by the Department of Health and Environmental Control which offers to provide or provides an Alzheimer's special care unit or program must include in its policies and procedures and disclose to the responsible party seeking a placement within the Alzheimer's special care unit or program, the form of care or treatment provided that distinguishes it as being especially applicable to or suitable for persons with Alzheimer's disease. The information that distinguishes the form of care or treatment shall include criteria for admission, transfer, and discharge; care planning; staffing patterns; staff training; physical environment; resident and participant activities; family role in care; and unique costs to the resident or participant associated with specialized service delivery.

Scope of Study

As part of the study required by Proviso 31.48 and in order to obtain comprehensive information on the provision of memory care in South Carolina, DPH sought to involve the public and applicable stakeholders. DPH surveyed existing licensed facilities and invited comments from the public. DPH appreciates the substantial input it received from the facilities as well as the public. Moreover, DPH sought and received information from the National Governors Association Center for Best Practices regarding States' Approaches to Memory Care Regulations. DPH's study and findings are further described below.

Nursing Home and CRCF Survey Results

Overview

DPH conducted a statewide survey of all licensed community residential care facilities (CRCFs) and nursing homes, a total of 629 facilities,[1] to obtain feedback and recommendations related to memory care,[2] with a particular focus on staffing ratios. A total of 137 facilities responded, including 114 CRCFs and 23 nursing homes. Among respondents, 80 percent reported providing or offering to provide care for residents or patients with Alzheimer's disease or other dementia diagnosis, representing approximately 3,177 individuals statewide. Of the facilities that reported offering or providing memory care, 67 indicated they have an Alzheimer's special care unit or program,[3] while 42 indicated they do not.

CRCFs

Among responding CRCFs, the most commonly recommended minimum staffing ratio for Alzheimer's special care units during peak hours was **1:6 staff-to-resident** (33 responses). This was followed by **1:8** (30 responses), which is the current regulatory requirement, and **1:4** (19 responses).

For non-peak hours, most respondents recommended a **1:15 staff-to resident** ratio (31 responses). Other common recommendations included **1:8** (17 responses) and **1:10** (11 responses). The current requirement of **1:30** was selected by seven respondents.

Respondents identified **resident acuity and level of care needed** (83 responses) and **safety considerations**, such as risks of elopement and falls (74 responses), as the primary factors influencing their recommended staffing levels. **Staff availability** was noted by 20 respondents as another significant factor.

Nursing Homes

When asked about the most appropriate minimum licensed nurse staffing level per work area per shift for Alzheimer's special care units, most nursing home respondents recommended **two licensed nurses** (11 responses). The current requirement of **one licensed nurse** received five responses.

For non-licensed nursing staffing, respondents were divided between the current requirement of **1.63 hours of direct care per resident per day** (10 responses) and a higher staffing level (12 responses). Those recommending increased staffing suggested levels ranging from **1.85 and 3.5 hours**, with five respondents specifically recommending **two hours** of direct care per resident per day.

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[1] Twenty-two percent of licensed facilities responded to the survey. As of November 25, 2025, there are 629 licensed facilities, including 437 CRCFs and 192 nursing homes.
[2] "Memory care" refers to care provided to residents/patients with Alzheimer's or other dementia diagnosis, for purposes of the survey.
[3] "Alzheimer's special care unit program" refers to a facility or area within a facility providing a secure, special program or unit for residents/patients with a diagnosis of probable Alzheimer's disease and/or related dementia to prevent or limit access by a resident/patient outside the designated or separated areas, and that advertises, markets, or otherwise promotes the facility as providing specialized care/services for persons with Alzheimer's disease and/or related dementia or both, for the purposes of the survey.

Similar to CRCFs, nursing homes identified **resident acuity and safety concerns**, such as risks of elopement and falls (19 responses), as the primary drivers of their recommendations cited by 19 and 17 respondents, respectively. **Staffing availability** was again a key consideration (7 responses).

Suggestions

Facilities offered comments and suggestions for improving memory care services. These included:

- **Increased staffing**, including additional direct care staff (29 responses);
- **Enhanced and specialized training** for staff (17 responses);
- **Acuity-based staffing models** (14 responses);
- **Additional funding and career pathways** to support workforce development (3 responses); and
- **Physical plant or security measures**, such as locked exit requirements (1 response).

Conclusion

The survey responses indicate that both CRCFs and nursing homes view resident acuity, behavioral and safety risks, and the specialized nature of dementia care as central considerations in determining minimum staffing requirements for Alzheimer's special care units. Across facility types, a majority of respondents recommended staffing levels that exceed current regulatory minimums during both peak and non-peak hours. Many CRCFs supported ratios between 1:4 and 1:8 during peak hours and between 1:8 and 1:15 during non-peak hours, compared to the current 1:8 and 1:30 requirements. Nursing home respondents similarly indicated a preference for higher licensed nurse coverage, most often two nurses per work area per shift, and increased non-licensed direct care hours beyond the current 1.63 hours per resident per day.

Respondents also identified several operational considerations that affect the feasibility of staffing changes, including workforce availability, the need for specialized dementia-specific training, and the financial impact of increased staffing. Facilities further noted that variations in resident acuity and facility design may warrant flexibility or the use of acuity-based staffing models rather than a single statewide minimum.

Taken together, these survey results show a clear pattern of facilities recommending higher staffing levels for memory care units than those currently required, while also acknowledging constraints that may limit implementation. These findings will serve as a key component of DPH's broader assessment, alongside public comments and an examination of other states' approaches, to inform our recommendations to the General Assembly regarding memory care.

Public Comments

Overview

After DPH completed its statewide study of Proviso 31.48 and memory care requirements in licensed CRCFs and nursing homes, DPH requested feedback from the public. On Nov. 4, 2025, DPH issued a news release inviting public comment through Nov. 15, 2025. In total, DPH received responses from 14 members of the public outlining concerns and suggestions for improving care.

Suggestions

Commenters highlighted several key concerns, including severe understaffing, inadequate staff training, and serious safety risks such as resident elopement and frequent falls, especially falls from beds. To address these issues, commenters suggested measures such as increasing staffing levels at all times, raising minimum non-peak staffing hours to support a 1:15 staff-to-resident ratio, requiring specialized staff training, installing cameras in common areas and at exit doors, establishing distinct regulations for memory care facilities, and strengthening inspections and enforcement efforts.

Additional concerns and suggestions included permitting cameras in residents' rooms to monitor for abuse, neglect, elopement, and theft; ensuring staffing ratios count only direct-care personnel; and assigning a social services employee to each memory care resident.

Conclusion

The public feedback collected by DPH identified three primary areas of concern in memory care: staffing shortages, insufficient training, and preventable safety risks. The commenters emphasized a need for increased staffing, specialized staff training, and clearer standards to ensure the safety of individuals in memory care settings. These comments reflect a desire for more practical solutions that address the unique needs of memory care residents.

Review of Other States

Overview

DPH asked the National Governors Association Center for Best Practices ("NGA Center") to provide examples of how other states regulate memory care programs for people with Alzheimer's and dementia.[4] The memo outlines common regulatory approaches in four areas: facilities and infrastructure; staffing and training; patient care and planning; and recent legislation.

Facilities and Infrastructure

Approaches to memory care oversight vary by state, with some states regulating the memory care program itself and others regulating the facilities where it is provided. Many states require specialized building features to prevent resident wandering (elopement) and support safety, such as the following: secured outdoor areas and walkways; high-contrast visual design inside facilities; and infrastructure tailored to dementia-specific needs.

[4] The information provided by the NGA Center had the following disclaimer: "The following document is for the sole and exclusive use of the members of the National Governors Association and staff from the State of South Carolina. This document is not an exhaustive list. Such document primarily draws from publicly available information and, therefore, may not fully reflect the policy or practices of states and jurisdictions referenced herein. The NGA Center makes no endorsements or recommendations of any proposal or legislation that is described in this memorandum."

Staffing and Training

Staffing and training standards vary widely. For assisted living communities holding themselves out as providing additional/specialized care to persons with probable diagnosis of Alzheimer's Disease or other dementia, Georgia requires such facilities to meet certain minimum staffing requirements (e.g., one dementia trained direct care staff for every 12 residents on-site during all waking hours and for every 15 residents during all non-waking hours based on a monthly average). Georgia also requires orientation and 16 hours of specialized training for direct care staff, plus yearly refresher training. Washington requires six hours of continuing education annually. Arizona and Ohio require more extensive and state-approved dementia care training requirements, including communication skills, behavior management, and safety.

Patient Care and Planning

Other states regulate the following: resident assessment and admission criteria; activity programming tailored to cognitive and physical abilities; and protocols to prevent and respond to elopement. Georgia and Arizona provide detailed requirements for therapeutic and daily engagement activities to support memory, mobility, and social interaction.

Recent Legislation

Several states have updated memory care related regulations within the past two years. Arizona recently added a new licensing and training approval system. Delaware, Kansas, Oklahoma, and Oregon developed new standards for staffing, disclosure of care, resident advocacy groups, and/or training for facility staff and oversight agencies. Washington recently added a new certification requirement for all memory care facilities, including 24/7 staffing.

Conclusion

Several other states are actively strengthening memory care oversight, focusing on: standardized definitions; stricter and more specialized staff training; enhanced infrastructure for safety; and more transparency and resident rights.

Recommendations

Based upon the input received from the licensed facilities, the general public, and our review of other states' statutes and regulations concerning memory care, DPH makes the recommendations below.

Increase minimum staffing ratios

There was general consensus among surveyed facilities and the public that increasing staffing ratios would improve the quality of memory care provided at licensed facilities. Increased staffing ratios for specific types of facility staff (e.g., nurses), during specific times of the day (e.g., non-peak hours), and/or based upon the acuity of the residents being cared for may be reasonable approaches to addressing minimum staffing requirements. However, this must be balanced with the existing and expected resources of licensed facilities.

Require enhanced memory care training

Similar to the above, there was agreement that enhanced training focused on residents with memory care diagnoses would improve quality of care and reduce poor outcomes. This may include requiring specific training by recognized organizations that specialize in providing care to persons with memory care diagnoses. Moreover, it may include requiring such training be provided at more frequent intervals.

Augment resources/infrastructure for workforce

The long-term care industry, like many healthcare industries, faces significant obstacles in developing and maintaining a stable workforce (e.g., thin margins, high turnover, burnout staff, shrinking staffing pools). Additional support to facilities, schools/universities, and other involved organizations may assist in improving the quality of care at these facilities, in particular for the care of residents with memory care diagnoses.