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FOR
LICENSED ASSISTED LIVING FACILITIES
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COMMONWEALTH OF VIRGINIA

TECHNICAL ASSISTANCE

VIRGINIA DEPARTMENT OF SOCIAL SERVICES
STANDARDS FOR LICENSED ASSISTED LIVING FACILITIES
22 VAC 40-72

NAVIGATION NOTES (some of which are only available in the electronic version):

- Dates in the Table of Contents signify updates incorporated since the last revision.
- The number of "Q#"s corresponds to the number of updates to that section.
- The Table of Contents is hyperlinked to the corresponding section of the document.
- The numbers in the parentheses at the end of each answer are the Division of Licensing Programs' (DOLP) internal reference number and the answer's latest revision date.

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PART I. GENERAL PROVISIONS

22 VAC 40-72-10 Definitions (7/15-Q1)

22 VAC 40-72-10 Definition of assisted living facility

Question(Q1): *A provider may wish to request multiple nearby buildings under one license. When is it acceptable to have separate buildings under the same license?*
Answer: It is acceptable to have separate buildings under the same assisted living facility license when there is one licensee under the following circumstances:

- The buildings are located on a single campus (there could also be a licensed nursing home or unlicensed independent living buildings on the campus, but no other structures or businesses not related to the assisted living facility), or

- The buildings are on adjoining property, with no structures or businesses not related to the assisted living facility in between the buildings.

There could be unusual or extenuating circumstances where it is also acceptable to have separate buildings under the same license, which will be looked at on a case-by-case basis, with a recommendation by the appropriate regional licensing office to the Home Office. The Home Office will make the final decision in order to ensure consistency around the state. An example of unusual or extenuating circumstances might include buildings that are across the street from one another.

When there are multiple buildings under one license, each building must be noted on the license, with each building's licensed capacity included, as well as specific stipulations for the building that are appropriate to place on the license.

The premises is considered to be the single campus or in the case of buildings on adjoining property, the combined adjoining property. The premises includes the buildings and land. (0654 – 7/15)

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22 VAC 40-72-40 Program of care

22 VAC 40-72-40 Program of care

Question: *Is the assisted living facility required to have a separate and distinct written "program of care" document or is it sufficient for the facility's policies and procedures to reflect these regulatory provisions?*
Answer: This standard does not require the assisted living facility to have a separate and distinct written "program of care" document. Meeting the program of care provisions of this standard is reflected by the facilities policies and procedures, as well as compliance with other standards. The intent of the program of care requirement is to ensure that a definite pattern exists in the way care is provided that includes the required five elements specified in the standard. Please keep in mind that 22 VAC 40-72-60 A 4 g, as part of the disclosure statement, and 22 VAC 40-72-390 A

1 b, as part of the resident agreement, require a "description" of all accommodations, services, and care offered by the facility. (0602 - 6/08)

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PART II. ADMINISTRATION AND ADMINISTRATIVE SERVICES

22 VAC 40-72-50 Licensee

22 VAC 40-72-50 B 2 and 3 – Licensee

Question: *Is it sufficient for board members to only undergo a background check upon the initial application for licensure as an assisted living facility?*
Answer: According to § 63.2-1721 of the Code of Virginia, all applicants must undergo a background check. Background checks are not required for all board members, but only for those who are officers or agents. All officers must have a background check. In respect to agents, this is someone empowered to act on behalf of the unincorporated association, partnership, limited liability company, corporation or public agency in matters relating to the assisted living facility. An agent may or may not be a member of the board. The officers and agents must submit background checks at the time of initial application for licensure as an assisted living facility. For renewal applications, any officers or agents who have not previously submitted background checks must submit them. (0576 - 12/07)

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22 VAC 40-72-60 Disclosure

22 VAC 40-72-60 Disclosure

Question: *Can disclosure information be incorporated in the resident contract?*
Answer: Standard 60 requires that the disclosure information be on a disclosure form developed by the Department. Some of the information on the disclosure form is the same or similar to information required on the resident agreement with the facility required by Standard 390. (There is a model form, which may or may not be used, for the resident agreement.) The correct information must be reflected on both forms; the wording can even be the same when it fits appropriately. However, the two forms serve different purposes and each must be completed totally. There cannot just be a reference from one to the other. (0102 - 5/07)

22 VAC 40-72-60 B and C – Disclosure

Question: *Is a facility required to obtain written acknowledgement of the receipt of the disclosure statement from a member of the general public inquiring about the community who does not have a relationship and/or planned admission date with the facility?*
Answer: A facility is only required to obtain written acknowledgement of the receipt of the disclosure statement from a person (or his legal representative) who is admitted to the facility. It is not necessary for a facility to obtain written acknowledgement from a member of the general public at the time the disclosure statement is given to the person, but if he is admitted to the facility at a later date, the facility would then have to obtain written acknowledgement from him (or his legal representative) of receipt of the disclosure statement. (0577 - 6/08)

22 VAC 40-72-60 A 4 h and n, 150 A 3, 390 A 1 and 2 - Disclosure
There is an applicable question/answer under Standard **22 VAC 70-72-150-A-3**

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22 VAC 40-72-90 Infection control program (7/15-Q1)

22 VAC 40-72-90 A, B, C and 630 A Infection control program
Question(Q1): *I don't see where it says I have to provide single use, auto-retractable, disposable fingerstick devices for blood glucose monitoring. Why can't we just use penlets that the residents already have? Why can't they share glucometers?*
Answer: This regulation requires the facility to "establish and maintain" an effective infection control program. Implicit in that requirement is that the program changes as our knowledge base grows and acceptable procedures change. In the past, it was acceptable to re-cap needles, for example. As we learned more about accidental needle sticks and disease transmission, our practice changed and better and safer equipment also became available. Although the regulation doesn't state that needles are not to be re-capped, there is agreement based on science and research that this isn't acceptable in our setting, and this is reflected in current nursing and other curricula. Another example is the requirement that the facility establish procedures to "isolate the infecting organism." That part of the regulation doesn't spell out what type of isolation should be used for an infected wound, for example; that would be stated in the facility procedure and physician's order and would vary depending on the location, drainage, organism, etc. Isolation procedures have also changed greatly over the years as current knowledge, research and information has changed also.

There have been numerous incidents of disease transmission due to the improper use of fingerstick devices for blood glucose monitoring, including several that occurred in assisted living facilities in this state. Multiuse lancing devices (penlets) may harbor infected blood that can be transmitted to a second individual when used on more than one resident. They are more subject to human error than single use devices. Facilities have a regulatory duty to protect the physical well-being of their residents and their staff. Single use, auto-retractable disposable fingerstick devices ensure better protection for both residents and staff than multiuse lancing devices (penlets). Currently, *the only time multi-use fingerstick devices (penlets) may be used in assisted living facilities is if the resident is totally independent in all aspects of blood glucose monitoring.* Each piece of the individual's equipment must be labeled with his or her name regardless of where the equipment is stored.

In response to multiple cases of bloodborne disease transmission in this state and others, the Centers for Disease Control revised their recommendations for blood glucose monitoring. They are the authority on this issue. In addition, assisted living facilities must also comply with OSHA regulations and specifically, those addressing bloodborne pathogens. As noted, single use, auto-retractable disposable fingerstick devices provide enhanced protection against the transmission of bloodborne pathogens and thus better protect employees.

The CDC requirement regarding glucometers is based on more than one case of disease transmission from shared glucometers. The current requirement from the CDC regarding glucometers is as follows:

- Whenever possible, blood glucose meters should **not** be shared. If they must be shared, the device should be cleaned and disinfected after every use, per manufacturer's instructions. If the manufacturer does not specify how the device should be cleaned and disinfected then it should not be shared.
- Insulin pens and other medication cartridges and syringes are for single-patient-use only and should **never** be used for more than one person.

(Copied from the CDC website below)

http://www.cdc.gov/injectionsafety/blood-glucose-monitoring.html (10/9/14)

The facility must include a step-by-step blood glucose monitoring procedure document in either their infection control or medication management plan (or both if the facility so chooses) that is consistent with current practice recommendations. The document must be readily accessible by all staff responsible for performing this procedure and updated as needed. (0651-7/15)

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22 VAC 40-72-100 Incident reports (7/15-Q1, Q2)

22 VAC 40-72-100 Incident reports
Question: *Are the incident reports located in the licensing office available to the public upon request?*
Answer: Yes, the incident reports are available to the public upon request under the Freedom of Information Act. Names of persons and personal information would be removed from the reports before being made available to the public. (0431 - 6/08)

22 VAC 40-72-100 A – Incident reports
Question (Q1): *What is considered a major incident that has negatively affected or that threatens the life, health, safety or welfare of a resident that has to be reported?*
Answer: The following are considered to be major incidents that have negatively affected or that threaten the life, health, safety or welfare of any resident that must be reported as required by the standard:

1. Death – The death of a resident when the death is unanticipated.

2. Injury – *Any* injury to a resident that requires emergency treatment and/or admission to a hospital. This does not include minor injuries that require only first aid provided in the facility or minimal intervention by a licensed health care professional.

3. Any event requiring the application of emergency restraints.

4. The development of a pressure sore of Stage 2 or higher or stasis ulcers that are consistent with the description of a Stage 2 wound (refer to detailed answer for reporting pressure sores under this standard).

5. Abuse/neglect/exploitation – Suspected abuse, neglect, or exploitation of a resident that is required to be reported by mandated reporters (§ 63.2-1606 of the Code of Virginia) or is investigated by Adult Protective Services.

6. Absence/elopement –
   A. Residents with no serious cognitive impairment: Unanticipated absence/elopement of a resident from the facility must be reported when the following conditions are present: (i) the resident cannot be located; (ii) there is sufficient question as to the whereabouts of the resident; and (iii) there is deviation from the normal behavior/routine of the resident. This does not include situations where a resident without serious cognitive impairment is found within 24 hours, there has been no serious harm to the resident, and no laws have been broken.
   B. Residents with serious cognitive impairment who cannot recognize danger or protect their own safety and welfare: whether living in a mixed population or on a secure unit, an elopement when the resident actually exits the building without staff knowledge must be reported. (This does not include exiting to a *secured* outdoor area.) If a missing resident is located within the building, but more than an hour was required to locate the resident, this must also be reported.

7. Disaster – A fire, natural disaster or other occurrence that causes significant physical damage to the building in which the facility is located, or that results in the evacuation or partial evacuation of the building.

8. Incidents that require the assistance of an outside agency such as police, fire, rescue or emergency community service board contact. This does not include "routine" medical health issues.

There may be other circumstances or situations that are deemed by a facility to be a major incident to be reported. Providers are encouraged to contact their assigned inspector for additional questions regarding reportable incidents.

Please note that major incidents required to be reported by this standard may also need to be documented under other standards. For example, 22 VAC 40-72-330 B requires written communication to keep direct care staff on all shifts informed of significant happenings or problems experienced by residents. Most incidents addressed under 22 VAC 40-72-100 A would also have to be documented in the written communication required by 22 VAC 40-72-330 B, and in the individual resident record as indicated. (0086 – rev 7/15)

Question: *Is a facility required to submit an incident report to the licensing office when a resident falls? If not, is the facility required to take any other type of action, such as notifying the licensing office by phone?*
Answer: A facility is not required to submit an incident report to the licensing office when a resident falls, unless the fall meets the criteria for one or more of the categories listed as being a major incident that must be reported, i.e., death, injury, abuse/neglect/exploitation, absence/elopement, and disaster. Please see the technical assistance provided above on this standard (with a reference number of 0086-12/07 at the end of the answer). However, the facility

may deem the fall to be a major incident to be reported to the licensing office, i.e., it would be at the facility's discretion to make that determination.

Although the facility is not required to submit an incident report or notify the licensing office by phone, 22 VAC 40-72-450 G does require that the facility notify the next of kin, legal representative, designated contact person, or if applicable, any responsible social agency of any incident of a resident falling. Responsible social agency in this context might be a local department of social services, a community services board, etc., but it is not the licensing office. Moreover, 22 VAC 40-72-330 B requires a method of written communication to keep direct care staff on all shifts informed of significant happenings or problems experienced by residents, and depending upon the circumstances, this might include a fall. (0578 - 6/08)

Question: *Would a pressure ulcer be considered "a major incident that has negatively affected or that threatens the life, health, safety or welfare of a resident" that has to be reported?*
Answer: Yes. Pressure ulcers (sometimes called pressure sores, bedsores or decubitus ulcers) are areas of injury to skin and tissue that develop as the result of periods of constant pressure that cuts off circulation to vulnerable parts of the body. Without sufficient blood flow to these areas, the affected tissue dies. The facility must report pressure ulcers to the licensing inspector by the next day after they are identified. As required in 22 VAC 40-72-100.C.7, the report should include as much descriptive information as possible.
All direct care staff should be vigilant in efforts to identify and report potential causes and take necessary measures to reduce the risk of any resident developing a pressure ulcer. The following information is provided as a guide to reporting a pressure ulcer as part of an incident report:

- It is not necessary to report Stage 1 pressure ulcers as an incident. These are areas where the skin is unbroken but is persistently pink or red and may look like a mild sunburn. The resident may complain that the area is tender, painful or itchy. Other direct care staff, supervisors and/or primary care physicians should be notified and plans developed to reduce the risk that more serious wounds may develop.
- Stage 2, 3 & 4 ulcers **must be reported as an incident** whenever identified on or after admission to the facility. For those residents whose wounds have not been seen by a licensed health care professional (physician, nurse, wound care specialist) qualified to assess the stage of a wound, the following are simple descriptions:
    - Stage 2 – skin is broken and the second layer of tissue is involved. The area is red and painful, and there may be some swelling and/or some drainage oozing from the wound. In the early development of these wounds, they may be very small. It is important to take action and report any broken skin that may be a developing pressure ulcer (not to be confused with skin tears or incontinence injury).
    - Stage 3 – skin has broken down and the wound extends through all three layers of the skin into soft tissue. The pressure ulcer is deeper and very difficult to heal. The site now has the risk for serious infection to occur. In order for the resident to remain in the assisted living facility, wound assessment and treatment must be in compliance with 22 VAC 40-72-340.G.2 and H. The wound must be healing and periodic observation and treatment must be provided, as directed in the written treatment plan from a physician or other licensed prescriber. This care and treatment must be provided by a licensed health care professional employed

by or under contract with the facility, the resident, the responsible party or a home care agency licensed in Virginia.

  - Stage 4 – the wound extends into muscle and bone requiring extensive medical and/or surgical intervention and skilled observation and treatment due to the extreme risk of life-threatening infection. Because care of this level of pressure ulcer is prohibited by law in assisted living, the resident cannot be admitted to or retained in assisted living and must be transferred to a setting where appropriate services can be provided. In those rare occasions where the resident is an enrolled Hospice recipient and wishes to stay in the assisted living facility, the Hospice program is responsible for the skilled services, including the care of any Stage 4 ulcers.

    Note: necrotic or dead tissue may obscure the base of the wound making it difficult to differentiate a stage III from a stage IV wound. Necrotic tissue in the wound also predisposes a resident to infection.

- Clinical assessment is outside the scope of training and responsibility of unlicensed direct care staff, but they can report what they see. The acceptable description of the incident (the wound or wounds) as required at 22 VAC 40-72-100.C.7 will include, but is not limited to, the following:
  - Location of the wound(s) is usually, but not always, over a bony prominence
    - Shoulder
    - Hip
    - Tailbone
    - Buttocks
    - Heel and toes
    - Ankle
    - Elbow
    - Sides of knee
    - Ears, etc.
  - Approximation of size, width, length, depth even if a licensed health care professional has staged the wound.
  - Whether wound is draining/oozing.
  - Whether there is any unusual odor.
- Actions and outcomes as required at 22 VAC 40-72-100.C.9-10 will depend upon the extent of the clinical intervention, but at a minimum will include nurse and/or physician contacts, treatment orders, and any preventive measures undertaken as a result of the identification of any wound. (0613 - 3/09)

22 VAC 40-72-100 A, 201 B 1, 370 B, 640 D 2 and 930 F 2 – Incident reports

Question(Q2): *What is meant by the term "working day"?*

Answer: Working day" means a day between and including Monday to Friday, with the exception of federal, state, and major holidays when government agencies are closed. (0663-7/15)

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22 VAC 40-72-140 Resident accounts (7/15-Q1)

22 VAC 40-72-140 – Resident accounts
Question: *Do electronically recorded monthly statements and receipts have to go in the residents chart?*
Answer: No. 22 VAC 40-72-560 allows resident records to be kept electronically including monthly statements or itemized receipts. (0186 & 0189- 5/07)

Question: *Can the facility give the monthly statement or itemized receipt of the resident's account to a person who has power of attorney to handle the resident's finances, rather than to the resident?*
Answer: The facility must give the monthly statement or itemized receipt to the resident. The assisted living facility can *also* give the monthly statement or itemized receipt to a person who has power of attorney to handle the resident's finances when that person is executing the payments to the facility. The statement or receipt given to the person who has power of attorney may only include those items for which he or she is responsible for payment. (0435 - 12/07)

Question: *If a resident is confused, can the monthly statement or itemized receipt be given to someone else?*
Answer: The standard requires that a resident receive a monthly statement or itemized receipt unless the resident has a court appointed conservator or guardian. (0432 - 12/07)

Question(Q1): *Can the monthly statement or itemized receipt of the resident's account be provided electronically, rather than a hard copy, to the resident or the resident's conservator or guardian? The information can be obtained for each resident from the computer.*
Can the resident's detailed ledger account in an electronic accounting system be considered the resident's record or does a hard copy of each monthly statement need to be printed out and put in the resident's file?
Answer: The facility can provide the monthly statement or itemized receipt electronically to the resident or the resident's conservator or guardian if the resident/conservator/guardian has equipment and access to allow for electronic receipt and retention of the statement/receipt and gives written permission to have it provided in this manner; otherwise a hard copy would have to be provided.

The facility may maintain the accounting system electronically as long as the requirements for a resident's record are met, e.g., resident specific and easily located by resident name. If the requirements for a resident record are met, the electronic accounting system can be considered part of the resident's record and it would not be necessary to print a hard copy of each monthly statement. (0433 and 0434 – rev 7/15)

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22 VAC 40-72-150 Safeguarding residents' funds (7/15-Q1)

22 VAC 40-72-150 A 3, 390 A 1 and 2, 60 A 4 h and n - Safeguarding residents' funds
Question (Q1): *If a facility's accumulated residents' funds are maintained in a single account that bears interest, 150 A 3 requires that each resident receive interest proportionate to his*

average monthly account balance. In addition, 150 A 3 specifies that a facility may deduct a reasonable cost for administration of the account. Is it necessary to include either or both of these provisions in the resident agreement with the facility?
Answer: The resident agreement with the facility, in 390 A 2, is required to include special conditions, which are to be reviewed by the resident or his legal representative. Therefore, if each resident is to receive interest proportionate to his average monthly account balance, as required when accumulated residents' funds are in a single interest-bearing account, then this must be disclosed in the agreement. Also, the resident agreement with the facility, as per 390 A 1, is required to include a listing of charges for services provided by the facility. Therefore, if the facility deducts a cost for administration of the account, the cost must be included in the agreement.

In addition, both items, i.e., the proportionate interest and cost for account administration as noted above, are also to be included in the disclosure statement as specified in 60 A 4 h and n.

Please keep in mind that auxiliary grant recipients cannot be charged extra for administration of the account. As a result, the facility may not deduct a cost for account administration for residents receiving auxiliary grants. The auxiliary grant rate already covers the cost of care of personal funds. (0652-7/15)

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PART III. PERSONNEL

22 VAC 40-72-160 Personnel policies and procedures

22 VAC 40-72-160 B – Personnel policies and procedures

Question: *Does the organizational chart that employees are required to receive pertain just to that staffing unit? (Example: Administrator-nurse-direct care staff or Owner-Board Members-Licensee-Administrator-nurse-direct care staff).*
Answer: The organizational chart refers to employees working at the facility, starting with the administrator and including all other identified positions. (0161 - 5/07)

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22 VAC 40-72-170 Staff general qualifications

22 VAC 40-72-170, 180, and 290 – Staff general qualifications

Question: *What requirements must be met when a resident or family member hires a private duty person from a licensed home care agency to provide services to the resident?*
Answer: When a private duty person from a licensed home care organization, hired by a resident or family member, provides direct care or companion services to a resident in an assisted living facility, the following applies:

- Before direct care or companion services begin, the facility is to obtain, in writing, information on the type and frequency of the services to be delivered to the resident by the private duty person, review the information to determine if it is acceptable, and provide notification to the home care organization regarding any needed changes.

- The direct care or companion services provided by the private duty person to meet identified needs are to be reflected on the resident's individualized service plan.

- The facility is to ensure that the requirements of 22 VAC 40-72-290 D 1 – 4 regarding tuberculosis are applied to the private duty person and that the required reports are maintained by the facility or the licensed home care organization, based on written agreement between the two.

- The facility is to provide orientation and training to the private duty person regarding its policies and procedures related to the person's duties.

- The facility is to ensure that required documentation of resident care is maintained.

- The facility is to monitor the delivery of direct care and companion services to the resident by the private duty person.

The above requirements do not apply to private duty persons who only provide skilled nursing treatments as specified in 22 VAC 40-72-460 B. However, depending upon the circumstances, there may be other standards that apply in such cases, e.g., inclusion on the resident's individualized service plan. (0637-7/12)

Question: *What requirements must be met when a resident or family member hires a private duty person directly, i.e., the person is not an employee of a licensed home care agency, to provide services to the resident?*
Answer: When a private duty person who is not an employee of a licensed home care organization is hired by a resident or family member to provide direct care or companion services to a resident in an assisted living facility, the following applies:

- Before direct care or companion services begin, the facility is to obtain, in writing, information on the type and frequency of the services to be delivered to the resident by the private duty person, review the information to determine if it is acceptable, and provide notification to whoever has hired the private duty personnel regarding any needed changes.

- Before direct care or companion services begin, the facility is to review an original criminal record report issued by the Central Criminal Records Exchange, Virginia Department of State Police for the private duty person.

    - The report must be submitted by the private duty person prior to the beginning of services.

    - The date of the report must no more than 90 days prior to the date of the beginning of services.

- The administrator is to determine conformance to facility policy regarding private duty persons and criminal history to protect the welfare of residents. The policy must be in writing.

- The report and documentation that it was reviewed is to be maintained at the facility.

- The facility is to ensure that the private duty person is qualified for the types of direct care or companion services the person is responsible for providing to the resident and maintain documentation of the qualifications.

- The direct care or companion services provided by the private duty person to meet identified needs are to be reflected on the resident's individualized service plan.

- The facility is to ensure that the requirements of 22 VAC 40-72-290 D 1 – 4 regarding tuberculosis are applied to the private duty person and that the required reports are maintained by the facility.

- The facility is to provide orientation and training to the private duty person regarding its policies and procedures related to the person's duties.

- The facility is to ensure that required documentation of resident care is maintained.

- The facility is to monitor the delivery of direct care and companion services to the resident by the private duty person.

The above requirements do not apply to private duty persons who only provide skilled nursing treatments as specified in 22 VAC 40-72-460 B. However, depending upon the circumstances, there may be other standards that apply in such cases, e.g., inclusion on the resident's individualized service plan. (0638-7/12)

22 VAC 40-72-170 A 5 and 290 C 9 – Staff general qualifications
Question: *Do staff, including administrators, who are hired prior to 07/01/92 need criminal record checks?*
Answer: An assisted living facility is not required to obtain background checks on employees, including administrators, hired prior to 07/01/92 who have been continuously employed, but may do so if the facility wishes. Background checks for employees of ALFs include a criminal history record check and a sworn disclosure statement. In 1993, in the Code of Virginia, the words "On or after July 1, 1992" were struck from the requirement that an ALF (then known as a home for adults) shall not hire for compensated employment persons who have been convicted of specified barrier crimes. The reason that employees hired prior to 07/01/92 do not need to have background checks is that hiring is a one time event, not a continuous state. Therefore, employees who were already hired prior to 07/01/92 and have continuous employment at the ALF are not included in the population needing a background check. Supporting this is another requirement in the Code that specifies that the ALF shall obtain the criminal history record (or clearance) "within 30 days of employment." This requirement also indicates the one time nature

of the mandate. Please note that the answer to this question applies to § 63.2-1720 (formerly § 63.1-173.2) of the Code, which relates to employees. It does not apply to § 63.2-1721, which relates to applicants for licensure. (0105 - 5/07)

Question: *Do people who come into an ALF to do staff training need to have a criminal record check?*
Answer: No. Unless the trainer is hired as an employee of the facility, he does not have to have a criminal record check. (0223 - 12/07)

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22 VAC 40-72-180 Staff orientation

22 VAC 40-72-180, 170, and 290 – Staff orientation
There is an applicable question/answer under Standard **22VAC 40-72-170.**

22 VAC 40-72-180 A – Staff orientation
Question: *Do part-time employees have to meet the 7-day period in meeting the training requirement?*
Answer: Yes. (0224 - 12/07)

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22 VAC 40-72-190 (Repealed)

22 VAC 40-72-190 E Exception 2 - Administrator provisions and responsibilities
Question and Answer # 0568 deleted 9/09.

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22 VAC 40-72-191 Administrator qualifications

22 VAC 40-72-191 D – Administrator qualifications
Question: *Is the Assisted Living Federation of America (ALFA) considered a department-approved course? Virginia has an ALFA affiliate, which is VAALFA.*
Answer: The ALFA course provides an insufficient amount of training to satisfy the requirements. (0107 - 5/07)

Question: *Do the new ALF standards allow for assistant administrators to be "grandfathered" as well?*
Answer: The ALF standards provide for the following:
In facilities licensed for residential living care only, an assistant administrator is "grandfathered" if:

1) he was employed as an ALF assistant administrator prior to 12/28/06;
2) when he was employed, he met the qualifications in effect at that time for an ALF administrator; and
3) he has been continuously employed as an ALF assistant administrator.
(0139 – rev 09/09)

Question: *Is there a department-approved course specific to the administration of an ALF available?*
Answer: Yes, currently one course specific to the administration of an ALF has been approved by the department. (0099 – rev 09/09)

Question: *Will administrators who were "grandfathered" in with the 2/96 regulations be "grandfathered" in to meet the new ALF standard requirements?*
Answer: Administrators of facilities licensed for residential living care only who were "grandfathered" in with the 2/96 regulations and who meet the requirement for continuous employment as an ALF administrator are "grandfathered" in. (0095 – rev 09/09)

Question: Can a grandfathered assistant administrator become a grandfathered administrator?
Answer: No. (0472 - 6/08)

22 VAC 40-72-191 D Exception 3 – Administrator qualifications
Question: *Does "continuously employed as an assisted living facility administrator" mean continuous employment at the same ALF or does it also include an administrator who left one ALF and became the administrator of another ALF without a break in employment?*
Answer: "Continuously employed as an assisted living facility administrator" allows for an administrator to leave one ALF and become the administrator of another ALF as long as employment is continuous. The exceptions regarding continuous employment relate to the person's position as ALF administrator, not to a specific facility. Therefore, an ALF administrator can remain at the same ALF or can leave one ALF and become the administrator of another ALF, as long as the person is continuously employed as an ALF administrator. Exception 3 for 200 D applies under both of these circumstances. (0575 - 12/07)

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22 VAC 40-72-200 (Repealed)

22 VAC 40-72-200 E – Administrator qualifications
Question and Answer # 0096 deleted 9/09.

22 VAC 40-72-200 E and F – Administrator qualifications
Question and Answer # 0085 and 0108 deleted 9/09.

22 VAC 40-72-200 F – Administrator qualifications
Question and Answer # 0016, 0034, 0046, 0088, 0089, 0122 and 0193 deleted 9/09.

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22 VAC 40-72-201 Administrator provisions and responsibilities (7/15-Q1)

22 VAC 40-72-201 B - Administrator provisions and responsibilities
Question: *What is a "qualified acting administrator''?*
Answer: It is important to understand that an "administrator" and a "qualified acting administrator" are not the same and each has its own separate qualifications.

A person may become a "qualified acting administrator" only when the administrator of an ALF dies, resigns, is discharged, or becomes unable to perform his duties, and another administrator is not immediately employed. When this occurs, the standard allows for a "qualified acting administrator" for a specified interim period of time. A "qualified acting administrator" is not required to be licensed.

For facilities licensed for residential living care only, the determination of whether a person has the qualifications to be a "qualified acting administrator" is based on the definition of "qualified" in 22 VAC 40-72-10. This definition is as follows: " 'Qualified' means having appropriate training and experience commensurate with assigned responsibilities; or if referring to a professional, possessing an appropriate degree or having documented equivalent education, training or experience." Therefore, whether a person is "qualified" to be an acting administrator in these facilities must be determined on a case-by-case basis by the facility, following a review of his or her education, training and experience specifically related to administrator responsibilities.

For facilities licensed for both residential and assisted living care, the qualifications for an acting administrator are specified in 22 VAC 40-72-201 B 4, i.e., qualified by education for an approved administrator-in-training program and at least one year of administrative or supervisory experience in a health care or long-term care facility or completion of such a program and awaiting licensure.

A currently serving administrator of an assisted living facility who did not become licensed by January 2, 2009, cannot simply be reclassified as an "acting administrator" as he or she has not terminated employment (neither can the person be terminated and rehired by the same facility as the "acting administrator.") In an ALF that serves both levels of care, the person no longer qualifies to be the administrator.

Your licensing inspector is available to provide assistance in determining whether a person has the qualifications to be a "qualified acting administrator." (0615 – Rev 7/12)

22 VAC 40-72-201 B Exception - Administrator provisions and responsibilities
Question: *What does "awaiting the results of the national examination" mean, i.e., can the acting administrator wait and take the exam during the 30-day extension?*
Answer: "Awaiting the results of the national examination" means that the acting administrator has already taken the examination prior to a 30-day extension and is waiting for the results. An extension could not be granted if the person had not yet taken the exam. (0629 - Rev 7/12)

22 VAC 40-72 201 B 1, 370 B, 640 D 2, 930 F 2 and 100 A – Administrator provisions and responsibilities
There is an applicable question/answer under Standard 22 VAC 40-72-100 A

22 VAC 40-72-201 B 2 – Administrator provisions and responsibilities
Question: *What is the contact information for the Virginia Board of Long-Term Care Administrators that the acting administrator uses to notify them that the facility is operating without a licensed administrator?*
Answer: The acting administrator shall notify the Virginia Board of Long-Term Care Administrators that the facility is operating without a licensed administrator in one of the following ways:

- Email: ltc@dhp.virginia.gov
- Phone: (804) 367-4595
- Fax: (804) 527-4413
- Mailing address: Virginia Board of Long-Term Care Administrators
  Perimeter Center
  9960 Mayland Drive, Suite 300
  Henrico, Virginia 23233-1463

The above contact information is also available on the website of the Board of Long-Term Care Administrators at http://www.dhp.state.va.us/nha/. (0631 – 3/10)

22 VAC 40-72-201 C – Administrator provisions and responsibilities
Question: *Is a written plan required that explains how the administrator directs operations?*
Answer: This standard does not require a written plan for how the administrator directs operations. (0008 - 5/07)

22 VAC 40-72-201 F – Administrator provisions and responsibilities
Question(Q1): *When a licensed administrator of a facility licensed for both residential and assisted living care goes on a vacation or leave of absence, is the facility required to have another licensed administrator or a qualified acting administrator?*
Answer: If the vacation or leave of absence exceeds a three week period, i.e., 21 consecutive calendar days, the facility would then be required to have another licensed administrator or a qualified acting administrator. A qualified acting administrator would have to meet the requirements of 22 VAC 40-72-201 B 4.

During the three week period, there would always have to be a staff person in charge. This person could be another licensed administrator or qualified acting administrator, but this would not be required during that period. The person in charge could be a designated direct care staff member as per 22 VAC 40-72-240. During the 21 day period, the administrator who is on vacation or leave of absence would still be the administrator of record.

During the three week period, the person in charge would be responsible for ensuring that the health, safety and welfare of residents continue to be protected and the individualized needs of residents continue to be met.

The three week period is the maximum amount of time before another licensed administrator or a qualified administrator would be required, but this technical assistance also applies for a vacation or leave of absence that is less than 21 days. (0660 - 7/15)

22 VAC 40-72-201 B - Administrator provisions and responsibilities
Question and Answer # 0630 deleted 3/12.

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22 VAC 40-72-210 Administrator training

22 VAC 40-72-210 – Administrator training
Question: *Regarding administrator training, will the number of trainings be increased in order to meet the new requirements for all staff involved?*
Answer: Administrators and other staff can continue to meet training requirements through department sponsored events, in-service trainings, and independently offered trainings. (0035 - 5/07)

22 VAC 40-72-210 A – Administrator training
Question: *If a current employee is promoted to administrator, which date of hire is used to calculate the 12 month training cycle-the original hire date or the promotion date?*
Answer: The date an employee becomes the administrator would be used to calculate the 12 month training cycle as this standard requires training specific to an administrator. (0007 - 5/07)

Question: *Do the 5 hours of training if there are mentally impaired residents refer to residents who have some level of dementia or residents with a MH diagnosis and/or diagnosis of dementia?*
Answer: The 5 hours of training annually are needed by an administrator of a facility where residents who are mentally impaired (have any disability which reduces their ability to reason or make decisions) reside. These would include primarily MH or MR diagnoses, but could also include diagnoses of cognitive deficits. The additional requirements for facilities that care for adults with serious cognitive impairments who cannot recognize danger or protect their own safety and welfare include additional one-time-only training requirements for administrators if the facility cares for residents with serious cognitive impairments. (0214 - 12/07)

Question: *Licensed nursing home administrators are required to get a certain number of CEUs annually to be recertified. Would these hours count toward the training requirement?*
Answer: Yes. (0216 - 12/07)

Question: *Where will the training for administrators required by this standard be offered to meet the 20 hour requirement?*
Answer: One source would be Department-sponsored through provider fees. Training may also be available through community colleges. Facilities need to identify their own sources in addition to the above. (0215 - 12/07)

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22 VAC 4-72-210 B Exception – Administrator training
Question: *If an administrator was employed prior to 12/28/06 as administrator at one assisted living facility (ALF) and after 12/28/06 leaves the facility to become administrator at another ALF, is he then required to have the training?*

Answer: No. Since the administrator was employed as an ALF administrator prior to 12/28/06, and then after 12/28/06 left that facility in which he was employed to become administrator of another ALF, he does not have to complete the training required by 22 VAC 40-72-210 B. In other words, this person meets the specifications of the exception. (0606 - 6/08)

22 VAC 40-72-210 C – Administrator training
Question: *Does the requirement for completion of the training within two months of employment as administrator (if not previously completed) also apply to acting administrators? The two month time frame in this standard could fall within the 90 day acting time frame specified in 22 VAC 40-72-201 B.*
Answer: Yes. An acting administrator must complete the training within two months of employment as the acting administrator (if not previously completed). (0625 – 12/09)

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22 VAC 40-72-220 Shared administrator for smaller facilities

22 VAC 40-72-220 – Shared administrator for smaller facilities
Question: *Regarding a shared administrator for smaller facilities, can one of the two facilities be a non-medical hospital and the other an ALF?*
Answer: No, one of the two cannot be a non-medical hospital. The facilities to which the standard refers and applies are assisted living facilities only. (0126 - 5/07)

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22 VAC 40-72-230 Administrator of both assisted living facility and nursing home

22 VAC 40-72-230 B 2 – Administrator of both assisted living facility and nursing home
Question: *What does "direct management of the assisted living facility" mean?*
Answer: The administrator is providing "direct management of the assisted living facility" if he is directly responsible for overseeing the care and supervision of the residents and as specified in Standard 190 D, the day-to-day operation of the facility. (0218 - 6/08)

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22 VAC 40-72-250 Direct care staff qualifications (7/15-Q1)

22 VAC 40-72-250 B – Direct care staff qualifications
Question(Q1): *Can direct care staff be trained by someone to provide health care for certain ALF residents with care needs and conditions not taught in the direct care staff curriculum? What health care needs may direct care staff be trained to* perform for residents?
Answer: Direct care staff may be trained to provide care for conditions not covered in the direct care staff curriculum under certain circumstances. An example of care that staff may be trained to do is the care of the skin for a resident with a gastrostomy site for tube feedings when training has occurred that is consistent with this guidance. The training and care provided must meet the conditions as stated in current nursing regulations that describe delegation of nursing tasks. Nurse delegation may only be done by a *registered nurse;* licensed practical nurses *may not* delegate tasks. The nurse must determine if the resident's needs are appropriate for delegation and must develop a delegation plan in accordance with 18 VAC 90-20-430 A. Criteria for

delegation are described in 18 VAC 90-20-430 B. In addition, the nurse must assess both the resident's needs and the competency of the direct care staff to provide the care. The last component of the regulation that must be met describes the supervisory responsibilities of the RN. The nurse is responsible for the performance of the delegated task by direct care staff and must determine the method and frequency of supervision based on the resident's individual needs.

There are a few critical points that should be considered when determining if delegation is appropriate (although every part of the nurse delegation regulations must be met). The delegated task(s) "d. Do not require repeated performance of nursing assessments; e. Utilize a standard procedure in which the tasks or procedures can be performed according to exact, unchanging directions; and f. Have predictable results and for which the consequences of performing the task or procedures improperly are minimal and not life threatening." For example, a resident with a complex wound where the characteristics of the wound are evolving and require on-going assessment and change in treatment and procedure would not be appropriate for delegation. Tasks that fall into "skilled" areas such as the care of a PICC (Peripherally Inserted Central Catheter) line may only be performed by licensed staff with specialized training in that area. Many types of care and treatment do not meet criteria for delegation and should only be performed by staff with appropriate licensure.

The facility must be able to identify the delegating RN, and to demonstrate how the plan was communicated to staff. The delegating RN retains responsibility and accountability for the nursing care of the resident, "…including nursing assessment, planning, evaluation, documentation and supervision." The delegating registered nurse must be employed by, or under contract with, the assisted living facility. Whether or not the delegating registered nurse has to be on-site during care provided by the unlicensed staff is dependent upon the nurse's assessment of both the resident's care needs and the unlicensed staff members' competencies as documented by the nurse in the staff members' files.

The requirements of the nurse delegation regulation apply to all direct care staff that perform procedures that are outside of the curriculum requirements, or for registered medication aides, that fall outside of that curriculum. Certified nursing assistants have training in skills not included in the direct care staff curriculum and so may be qualified to provide some types of care that other direct care staff may not. The facility may choose to hire licensed health care professionals in lieu of using RN delegation for tasks and procedures that fall outside of current, relevant curricula. The facility must be able to identify residents for whom nurse delegation is being utilized and must be able to demonstrate how the requirements of the regulations are met. Records of staff training must be detailed and carefully documented to include a description of the training content and retained at the facility.

We do not provide a list of procedures that direct care staff may perform since the decision is based on the availability and willingness of an RN to delegate, the background and training of the staff employed by the facility, and many other factors that the facility staff must consider that vary from one situation to another. The decision must be made by the facility's administrator in conjunction with the RN, the resident and as appropriate, others. (0659 – 7/15)

22 VAC 40-72-250 C – Direct care staff qualifications
Question: *How would staff who are EMTs be considered for direct care staff under Standard 250 C? This training is not specifically addressed so would they have to complete Standard 250 C 5, department-approved direct care staff training?*
Answer: EMTs would have to go through the department-approved direct care staff training unless they also meet Standard 250 C 1, 2, 3, or 4. (0474 - 6/08)

22 VAC 40-72-250 C 1 – Direct care staff qualifications
Question: *Can CMAs (Certified Medical Assistants) be used instead of CNAs in ALFs?*
Answer: No. Virginia does not regulate CMA programs or their graduates. In general, these programs appear to offer a focus on functions in a clinical setting (physician's office, laboratory, wellness center, etc.) where a nurse, physician or other licensed health care professional is always present to directly oversee the function of the individual on a day-to-day basis. Training and services are task specific with little focus on direct care, activities of daily living, or general oversight of the elderly or disabled individual. (0461 - 6/08)

22 VAC 40-72-250 E – Direct care staff qualifications
Question: *Will the skills checklist referenced in this standard carry over from one facility to another?*
Answer: No. The skills checklist was used to "grandfather" in existing direct care staff employed prior to February 1, 1996. If a staff person has been continuously employed as direct care staff in the same facility in which he was "grandfathered," he does not have to complete a training program required by 22 VAC 40-72-250 C. However, if the person leaves the facility in which he was "grandfathered" and is employed by another facility, the person is no longer "grandfathered" and must meet the requirements of 22 VAC 40-72-250 C. (0469 - 6/08)

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22 VAC 40-72-260 Direct care staff training (7/15-Q1)

22 VAC 40-72-260 – Direct care staff training
Question: *What period of time should be looked at for annual training - calendar year, license year, employment year?*
Answer: The employment year is to be used to comply with the annual training requirement. This means that the eight hours of training must be obtained within one year from the date the staff person began employment. In subsequent years, the hours of required annual training would always be based on the anniversary of the date the person started to work at the assisted living facility. For example if the staff person began to work on February 15, each year the staff person would need to obtain the required hours of training between February 15 of one year and February 14 of the next year. (0226 - 12/07)

Question: *Can some of this required annual training for direct care staff be delivered by videotape with a facilitator instead of a live presenter for every in-service?*
Answer: Yes. Some of the annual training can be delivered by a videotape with a facilitator as long as the facilitator has verifiable expertise on the topic and can provide guidance as needed. The facilitator or administrator should determine the number of training hours to be credited to

staff for the training and certificates or some type of documentation should be provided to staff trained. (0225 - 12/07)

Question: *When there is a change of licensee, what is considered the employment date of a direct care staff person for the purpose of the annual training requirement?*
Answer: If the person is continuously employed at the facility, the employment date of a direct care staff person used to determine the employment year for the annual training requirement does not change when there is a change of licensee. In other words, the staff person's employment date for the purposes of this standard remains the same, even though there is a new licensee. The employment year is to be used to comply with the annual training requirement, as specified in the above technical assistance under this standard. (0612 - 3/09)

Question(Q1): *Does an activity director who transports residents in wheelchairs to doctor's offices, etc., on a regular basis need direct care staff training?*
Answer: No. Transporting residents in wheelchairs does not make an activity director a direct care staff person, and therefore direct care staff training would not be needed. By definition, direct care staff are those staff persons who assist residents in the performance of personal care or daily living activities. Merely providing transportation is neither assisting in the performance of personal care or daily living activities.

However, if an activity director is transferring a resident, such as from a wheelchair to a chair or an examining table, he would then be considered direct care staff because transferring is one of the activities of daily living. Under such circumstances, since he would then be direct care staff, the activity director would need direct care staff training. (0661 – 7/15)

22 VAC 40-72-260 A – Direct care staff training
Question: *The wording on this standard ("in addition to required first aid and CPR training") sounds like all direct care staff are required to have first aid and CPR training, however, Standard 300 states that all direct care staff must have first aid but not CPR. Can you clarify?*
Answer: 22 VAC 40-72-260 A (facilities licensed for residential living care only) and 22 VAC 40-72-260 B (facilities licensed for residential and assisted living care) refer to the training hours required for direct care staff and clarifies through the language "(in addition to required first aid and CPR training)" that any first aid and CPR training that may be required of the direct care staff under 22 VAC 40-72-300 would not count toward the training hours required in 22 VAC 40-72-260. (0056 & 0063 - 5/07)

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22 VAC 40-72-280 Volunteers

22 VAC 40-72-280 G – Volunteers
Question: *Why is it required to have a staff directly present when a volunteer is doing a program and residents are present? This would reduce the offering of free programs. Why have a volunteer call bingo if we have to have a staff present?*
Answer: Standard 280 G requires that a volunteer be directly supervised by a staff person when residents are present. This requirement provides protection for the safety and welfare of the residents, the volunteer, and the facility because of several factors that are often the case in respect to the use of volunteers. In general, volunteers do not know the residents as well as those

regularly filling staff positions, and therefore may inadvertently run into difficulty with certain residents and then not be able to adequately resolve matters. Also, residents may not be as comfortable with a volunteer whom they don't know. Moreover, there may not be the consistency of qualifications for volunteers as is found for paid staff. In addition, it may be problematic if a facility comes to rely on volunteers, who may not have the same commitment to work as a paid employee. These concerns can be avoided or alleviated by requiring a staff person to be present. (0094 - 5/07)

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22 VAC 40-72-290 Staff records and health requirements

22 VAC 40-72-290, 480 and 620 G – Staff records and health requirements
Question: *Does a licensed health care professional, dietitian or nutritionist hired on a contractual basis have to meet the requirements for staff, such as references, staff records, tuberculosis screening?*
Answer: An individual hired on a contractual basis, such as a licensed health care professional, dietitian or nutritionist, does not have to meet the requirements for staff when all of the following conditions are met:

- The individual is hired on a contractual basis to perform a specific, limited function;
- The individual does not perform any direct care staff functions;
- The individual is present at the facility on an infrequent or occasional basis; and
- The individual works under the supervision of the administrator or his designee who meets the requirements for staff.

There is an exception to the above regarding background checks. Please see the Technical Assistance for Regulation for Background Checks for Assisted Living Facilities and Adult Day Care Centers, 22 VAC 40-90-10, Definitions: "Employee."

Please note that a person is not excluded from meeting the requirements of his profession, such as those for a Registered Nurse or Licensed Practical Nurse. (0477 - 06/09)

22 VAC 40-72-290, 170, and 180 – Staff records and health requirements
There is an applicable question/answer under Standard **22 VAC 40-72-170**.

22 VAC 40-72-290 C 6 – Staff records and health requirements
Question: *What is the "organizational chart"? Do you have to give it to each new employee and can this be done during Orientation?*
Answer: An organizational chart is a graphic representation of the structural relationships within and among all components of an organization, including the lines of authority and areas of responsibility for individuals or categories of positions. Standard 290 C 6 specifies that the staff person's record contain verification that he received a copy of the organizational chart (and also his job description). Standard 160 B requires that each staff person be given a copy of the facility's current organizational chart (and also his current job description). Each new employee must receive the organizational chart and job description, both of which are to be given to them prior to or during orientation. Moreover, if the organizational chart or job description changes,

the employee must be given a copy of the revised document(s) so he always has the current version. (0071 - 5/07)

22 VAC 40-72-290 C 8 – Staff records and health requirements
Question: *What kind of references would suffice to meet the requirement for two references? Often the only information an employer will give is the job title, dates of employment, and sometimes salary information.*
Answer: An ALF is required to obtain at least two references, but if all that an employer will give as a reference is job title and dates of employment, and the date of the reference and the source are included, this would be acceptable to meet the requirement. Of course, the references need to be obtained prior to employment. (0648 - 7/14)

22 VAC 40-72-290 C 9 and 170 A 5 – Staff records and health requirements
There is an applicable question/answer under Standard **22 VAC 40-72-170 A 5**.

22 VAC 40-72-290 C 12 – Staff records and health requirements
Question: *Performance evaluations must be in employee file or may they be kept in a separate file but available?*
Answer: Performance evaluations must be included in the staff record. However, the record may be kept in more than one place, as long as it is identified and easily located by staff name. As required by Standard 290 B, the record must be retained at the facility, treated confidentially, kept in a locked area, and made available for inspection by the department's representative upon request. (There is an exception providing that emergency contact information also be kept in an easily accessible place.) (0125 – 12/07)

22 VAC 40-72-290 D – Staff records and health requirements
Question: *Does the reference to household members in this standard mean those related or otherwise connected to staff or those related or otherwise connected to residents?*
Answer: Household member is defined in Standard 10 as any person domiciled in an assisted living facility other than residents or staff. As such, the definition applies to household members related or otherwise connected to either staff or residents. (0110 - 5/07)

Question: *Can a risk assessment for TB be completed by a licensed nurse of the facility without oversight by a physician? (Not the PPD test, but just the screening risk assessment)*
Answer: No. Whether screening or testing, there must be a qualified health professional (MD, DO, Nurse Practitioner, Physician's Assistant) willing and able to assume responsibility for assisting with the development of the facility's protocols and ultimately for the final decision related to outcome of any screening or testing. (0133 - 5/07)

22 VAC 40-72-290 D and 350 A 8 and C – Staff records and health requirements.
Question: *How can I determine appropriate TB testing/screening for staff and applicants for employment, residents, and applicants for admission?*
Answer: The Virginia Department of Health Office of TB Control and Prevention advised VDSS that the general content included in the guidance document titled "TB screening/testing TA for ALFs and ADCCs" that was issued in February 2005 remains unchanged. While the regulatory references have changed, the stipulations regarding the screening process

requirements are the same. Anyone needing a copy of this guidance should contact the facility's assigned inspector. (0607 - 6/08)

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22 VAC 40-72-300 First aid and CPR certification

22 VAC 40-72-300 E – First aid and CPR certification

Question: *Do we have to post all of the names of the first aid and CPR certified staff for the public?*

Answer: No. The facility will be in compliance with this regulation as long as the information is current, complete and readily accessible to all staff in case of an emergency. (0592 - 12/07)

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22 VAC 40-72-310 Direct care staff training when aggressive or restrained residents are in care

22 VAC 40-72-310 – Direct care staff training when aggressive or restrained residents are in care

Question: *What are the qualifications needed for training on aggressive behavior? Can ALF staff who were trained to be trainers continue to train on this topic?*

Answer: The trainer for aggressive behavior must be a qualified health professional. Qualified health professional is defined here as a R.N., L.P.N., psychologist, social worker, counselor, or other health professional who has knowledge of and experience working with people with aggressive behaviors. This professional does not have to be licensed. This professional does not have to have been trained as a trainer using an aggressive behavior curriculum. The Department offered a train-the-trainer series on aggressive behavior in 1991. Apparently it was not required that the people attending this training be qualified health professionals, however the standard at the time clearly stated that trainers had to be qualified health professionals. If current staff of ALFs who are not qualified health professionals were trained as trainers and are currently providing training to staff, they may request an allowable variance to continue conducting the training. (0441 - 12/07)

Question: *Restraint training for staff - can it be done by an RN on staff?*

Answer: Restraint training must be provided by a qualified health professional. An RN is a health professional. If the RN on staff has expertise in applying restraints, he/she could provide the training to staff. (0442 - 12/07)

Question: *Do you have to provide training if restraints are not used?*

Answer: Restraint training must be provided to staff only if they are involved in the care of residents for whom restraints may be used. (0443 - 12/07)

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PART IV. STAFFING AND SUPERVISION

22 VAC 40-72-320 Staffing

22 VAC 40-72-320 – Staffing

Question: *Who will be gathering the information to complete the new tool(s) designed to help determine numbers and types of staff required to meet the identified needs of the residents?*
Answer: The tools will be utilized by licensing inspectors to record information which should already be available in a variety of forms in the facility, including assessments of residents' needs, individualized service plans, current staffing schedules, staff qualifications and the facility's written staffing plan. If the facility does not have specific information on file, the inspectors may enlist staff assistance in collecting necessary data. Inspectors will also interview facility staff, residents and family members as a part of the process of determining whether the facility has staff sufficient in numbers and qualifications to provide the services to appropriately meet the needs of the residents. (0141 - 5/07)

22 VAC 40-72-320 E – Staffing

Question: *Can the facility scratch through the name of the assigned person(s) and write in the name of the individual(s) who actually worked that shift?*
Answer: The standard requires that absences and substitutions be indicated on the written work schedules. A single line through the name of the scheduled staff with the addition of the name of the substitute is the appropriate method to indicate these changes. Best practice would be for the individual making such a change to initial and date the change. (0092 - 5/07)

Question: *Do we have to post our staffing schedule where it is accessible to the public?*
Answer: No. There is no posting requirement for staffing schedules in the regulations. (0591 - 12/07)

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PART V. ADMISSION, RETENTION AND DISCHARGE OF RESIDENTS

22 VAC 40-72-340 Admission and retention of residents (7/15-Q1)

22 VAC 40-72-340, 380, 390, 430 and 440 Admission and retention of residents

Question(Q1): *We are seeking clarification regarding documentation required for respite care residents. When first admitted, it is assumed that all admission requirements apply. Once admitted for respite care, with the exception of the physical examination report, which is valid for six months per 350 B, does the admission process need to be completed each time they return, e.g., resident agreement, UAI, ISP?*
Answer: It is correct that when first admitted, all admission requirements apply to respite care residents. It would have to be clear in the resident agreement that the person is receiving respite care. Once admitted, unless the facility discharges the resident, the resident receiving respite care would not be considered discharged from the facility in between his/her stays. Since such person would continue to be considered a resident when present at the facility, the admission process would not need to be completed each time the person returns to the facility, with the exception, as applicable, for the physical examination report as per 350 B. Therefore, there

would not need to be a new agreement, UAI, ISP, etc., each time such respite care resident returns. However, the requirements related to all residents who are retained in the facility would be applicable. If there are significant changes in the resident's condition when the person returns, the UAI and ISP would have to be updated. It is the responsibility of the facility to ascertain whether there are significant changes. Moreover, if a year has passed since the last reassessment or review/update of the service plan, a UAI annual reassessment or annual review/update of the ISP respectively would be required. (0656-7/15)

22 VAC 40-72-340 A and G 9. Admission and retention of residents
Question: *Can a resident with a colostomy be admitted to or retained in an ALF?*
Answer: It is possible for a resident with a colostomy to be admitted to or retained in an ALF although there are many factors to consider. New colostomies are not appropriate in an ALF setting since they require adjustments in diet, types of supplies and of course, monitoring and assessment for healing and potential complications at the site, and this would require continuous licensed nursing care. Residents who are capable and willing to provide care for their colostomy may be admitted or retained in ALFs as long as the colostomy is well healed and diet and elimination patterns are stable, and the resident remains independent in this aspect of their care.

Residents who require assistance with colostomy care may be admitted or retained in an ALF if: a registered nurse willing to delegate care of the colostomy is available, all direct care staff who may care for the resident have received resident specific training in the care of the particular colostomy, and the training content is thoroughly documented for each staff person. The RN willing to delegate colostomy care must meet the relevant regulations as found in Regulations Governing the Practice of Nursing, 18 VAC 90-20-420 through 18 VAC 90-20-460. In the event a facility may have more than one resident with a colostomy, training must be completed and documented for each resident as colostomies vary in position, characteristics and care. In addition, there must be a "hands-on," observed demonstration of proper care and technique by each staff person who has received the training. The colostomy care must also be addressed on the resident's ISP (including type of supplies, changes that should be reported, contact information for the delegating RN, special dietary needs, etc.). The degree of assistance provided by staff to the resident will vary with the individual but might include emptying the colostomy bag, applying a new device, and recording the appearance of the site. "Assessment" in any form is not appropriate for staff other than a registered nurse. Irrigations may not be done by anyone other than licensed staff. Colostomy care may be provided by licensed nursing staff, but they may also need refresher training in colostomy care since this is a specific skill and it is not unusual for nurses to have little experience in caring for residents with ostomies. It is a specialized area in nursing. (0639 - 7/14)

22 VAC 40-72-340 A 1 – Admission and retention of residents
Question: *Are we expecting everyone with a primary "psychiatric" diagnosis to be followed by a mental health professional?*
Answer: No, the standards do not require this. This recommendation should come from a qualified mental health professional. (0514 - 12/07)

22 VAC 40-72-340 B – Admission and retention of residents
Question: *Must a resident be discharged and then re-admitted to an ALF when the person goes to a nursing home for a short stay for rehabilitation, for instance? If re-admitted after discharge, would it be necessary to repeat all of the admission requirements? If discharge/readmission is not necessary and the resident has a bed hold at the ALF, must there be a new UAI (to ensure care needs at the ALF can be met), an updated ISP and new MD orders?*
Answer: There is no requirement in the ALF standards for a resident to be discharged and re-admitted when the person goes to a nursing home, rehabilitation center, or hospital for a short stay. If an ALF allows for temporary movement of a resident with agreement to hold a bed, it must develop and follow a bed hold policy, as specified in 22 VAC 40-72-410 B. When there is a bed hold policy, it is the decision of the facility whether or not, and under what circumstances, a resident will be discharged, as long as there is compliance with all ALF standards.

If a resident is discharged from the ALF, he or she would then have to be re-admitted to the facility. In such cases, all the requirements for admission would have to be met. The same requirements would apply to this person as would apply to an individual who had never been a resident of the ALF. The only things that could be used from the previous admission would be those that fall into a timeframe allowed by a standard for the current admission, such as a physical exam that had been done within 30 days prior to the re-admission.
If the resident is not discharged from the facility, then there is no need to be re-admitted and the admission requirements would not apply. However, the requirements affecting retention of residents would be applicable. If there is a significant change in the resident's condition, a new or updated UAI would have to be completed. The ISP would have to be updated as needed, if the condition of the resident has changed. Since the admission requirements do not apply, the facility would not be required to obtain a new physical examination. However, if the ISP must be updated, it is to be updated in conjunction with health care providers, as appropriate.

22 VAC 40-72-640 E specifies that if a resident was admitted to a hospital for treatment, new orders for all medications and treatments must be obtained prior to or at the time the resident returns to the facility. Old orders may no longer be used. Even if a resident returned to the ALF directly from a nursing home or rehabilitation center, if the stay away from the facility involved admittance to a hospital for treatment, then new orders for medications and treatment would be required. Of course, this assumes that the resident needs medications and treatment, which may not be the case. (0616 - 06/09)

22 VAC 40-72-340 B 3 – Admission and retention of residents
Question: *Are there specific guidelines on this interview? What should be covered? How in depth? 5 minute discussion vs. 45 minute? Specific topics to review/discuss with prospective residents?*
Answer: The interview is one of the tools to be used by a facility to determine whether or not it can meet the needs of a prospective resident. The facility is to decide on the topics to be covered in the interview based on what is important to know to make a decision regarding whether it has the appropriate services/care provisions to protect the health, safety and welfare of the individual. The length of time necessary to make this determination may vary from person to person. Of course, the ALF may also use the interview to provide an opportunity for the

prospective resident to ask questions about the facility, but this is not required by the standard. (0070 - 5/07)

Question: *Can the written assurance be used instead of the pre-admission interview?*
Answer: The written assurance cannot be used instead of the pre-admission interview. The written assurance, as required by 340 D, ensures that both the facility and the resident know that the level of care (residential living care or residential and assisted living care) for which the facility is licensed is appropriate for meeting the resident's needs at the time of admission. The pre-admission interview goes beyond determining whether the facility has the appropriate license for being able to meet the resident's needs. Facilities licensed for the same level of care do not necessarily provide the same services or provide the same type of care. The interview is to be used to determine whether a given facility has the appropriate services and care provisions to meet the needs of a given resident. (0137 - 12/07)

22 VAC 40-72-340 D – Admission and retention of residents
Question: *Is the "written assurance" the agreement between prospective residents and the facility?*
Answer: The "written assurance" and the agreement between (prospective) residents and the facility are not the same. The "written assurance" is a written statement made by the assisted living facility administrator, which is provided to the resident, that the facility has the appropriate license to meet the care needs of the resident at the time of admission. If it so desires, the facility can choose to include the assurance in the written agreement/acknowledgment of notification between the resident and the licensee or administrator as long as the requirements for the written assurance are met. (0268 - 6/08)

22 VAC 40-72-340 G – Admission and retention of residents.
Question: *Can a resident with an indwelling urinary catheter be admitted or retained in an ALF?*
Answer: Yes. This condition is not prohibited in an assisted living facility. However, it is important to note that urinary catheters must be inserted under sterile conditions by a licensed health care professional. Care of the catheter is critical. There must be careful observation for signs and symptoms of disease, or other complications, by an individual trained to do so. Daily catheter care is also necessary and can be done by a trained Certified Nurses Assistant or trained direct care staff person. If these measures are not taken, life-threatening infections can result. Thus, these residents cannot be admitted or retained unless the facility is fully prepared to meet their specialized health care needs. (0297 - 6/08)

Question: *Wouldn't a permanent indwelling catheter (Foley) be a condition that would be required to have "continuous nursing care 24 hours a day?" Also, would a resident who required in and out catheterization two or three times per day, and who may or may not always do this himself, come under "continuous nursing care?"*
Answer: A permanent indwelling catheter (Foley) would not require continuous nursing care 24 hours a day. The catheter must be inserted by a licensed health care professional. If there is no evidence to indicate the need for earlier intervention, the catheter must be changed, at prescribed intervals, by a licensed health care professional. These catheters do require special daily care and close observation by trained direct care staff as complications can be life-threatening.

If a resident requires "in and out" catheterization one or more times per day and is unable to perform this task independently, it must be done by a licensed health care professional. This would not require continuous nursing care. (0307 - 6/08)

Question: *There are questions about antibiotic resistant infections such as MRSA, GRE, VRE and whether they are "prohibited conditions" in ALFs. It is said they are not airborne infections.*
Answer: Although these infections are not "prohibited conditions" in ALFs, they are extremely serious and require special handling by knowledgeable staff. The University of Virginia uses Contact Isolation for patients with Vancomycin resistant Enterococci (VRE) which means the staff must wear gowns and gloves when caring for these patients. For patients infected with Methicillin resistant Staphylococcus aureus (MRSA) in the lungs they use Contact and Droplet Isolation, which includes gowns, gloves and masks, and is recommended by the Centers for Disease Control and Prevention.

The Virginia Department of Health Office of Epidemiology gave the following information:

> These infections are not prohibited --- the key is hand washing and using the appropriate barriers (gloves, gowns, masks). Don't put them in a room with someone who is severely immunosuppressed or with someone who has an open wound. If there are others with the same infection then putting them in the same room is an option for room assignment.

Although not a prohibited condition, an individual with an antibiotic resistant infection cannot be admitted or retained in an ALF unless his specialized health care needs can be met in the facility. (0298 - 6/08)

Question: *Regarding intravenous therapy, does a nurse have to be in the building around the clock?*
Answer: Continuous intravenous therapy must be administered directly by a licensed physician or a licensed nurse, including a nurse from a licensed home care organization, under a physician's treatment plan. A licensed physician or licensed nurse must be in the assisted living facility for the duration of the intravenous therapy.
Intermittent intravenous therapy must be provided by a licensed health care professional, acting within the scope of his/her profession. The licensed health care professional must initiate the infusion, remain in the assisted living facility until it is infused, then discontinue the infusion.

Note: See exception in Standard 340.J. for recipients of auxiliary grants. (0301 - 6/08)

22 VAC 40-72-340 G 5 – Admission and retention of residents
Question: *What if the examining physician refuses to address this item on the physical examination form, because he has no knowledge or has not prescribed any psychotropic medications?*
Answer: The physical examination form is a model form. If documentation is available that addresses this item someplace else, then that is acceptable. (0274 - 12/07)

Question: *Does this diagnosis and treatment plan have to come from a psychiatrist?*
Answer: No. (0275 - 12/07)

Question: *Can a medical physician provide a psychiatric diagnosis and a treatment plan?*
Answer: Yes. (0276 - 12/07)

Question: *Does this include all psychotropic meds? Sleepers? Hypnotics?*
Answer: Yes. (0277 - 12/07)

Question: *If a resident is already on psychotropic drugs without a diagnosis should we contact the doctor and get a diagnosis?*
Answer: Yes. The doctor should be requested to provide a proper diagnosis and to determine whether the resident still requires psychotropic medication. (0272 - 12/07)

22 VAC 40-72-340 G 9 and A – Admission and retention of residents
There is an applicable question/answer under Standard 22 VAC 40-72-340 A

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22 VAC 40-72-350 Physical examination and report (7/15-Q1)

22 VAC 40-72-350 A – Physical examination and report
Question: *Could the physical exam form be modified to include a question about whether an individual has a serious cognitive impairment and cannot recognize danger or protect own safety/welfare?*
Answer: No, the physical exam form currently only asks for information that is required in the standards. Having a doctor's statement that a resident has a serious cognitive impairment and cannot recognize danger or protect own safety/welfare is NOT required except for a resident with a primary psychiatric diagnosis of dementia in special care unit.
A model form has been developed for the assessment required by 700.C.1 (Assessment of Serious Cognitive Impairment [032-05-078/2]). (0374 - 12/07)

22 VAC 40-72-350 A 7 – Physical examination and report
Question: *Is "diet as tolerated" allowed in ALFs? Can this be accepted as the type of diet from the physician?*
Answer: This is acceptable; however, the more accurate order would be "Regular Diet as tolerated." Unless otherwise stipulated, "diet as tolerated" implies that the resident will receive a healthy, well-balanced diet that is appropriate for his/her age and activity levels and takes into consideration his/her likes and dislikes. (0064 - 5/07)

22 VAC 40-72-350 A 8 – Physical examination and report
Question: *Who can sign off on the risk assessments (screenings) for tuberculosis?*
Answer: Only a representative from the Department of Health or the examining physician or his designee can sign the results of the risk screening. If a physician has worked with a facility to develop screening/testing protocols and is willing/able to assume responsibility for direction and oversight of the licensed nurse(s) working in the facility, the physician may identify those nurses as his/her designee in the facility. (0147 - 5/07)

22 VAC 40-72-350 A 8 and C and 290 D – Physical examination and report
There is an applicable question/answer under Standard **22 VAC 40-72-290 D**.

22 VAC 40-72-350 A 10 – Physical examination and report
Question: *If a person has a serious cognitive impairment and cannot recognize danger or protect own safety/welfare, could he be considered ambulatory if he is physically and mentally capable of self-preservation by evacuating in response to an emergency with a single verbal command?*
Answer: Probably most of these individuals would be considered non-ambulatory, but there could be the exception of a person who is capable of self-preservation by evacuating in response to an emergency with a single verbal command even though the individual has a serious cognitive impairment and cannot recognize danger or protect own safety/welfare. (0375 - 12/07)

22VAC 40-72-350 B - Physical examination and report
Question(Q1): *When someone comes to an ALF for respite care, and the physical, TB, and all other admission requirements are met, do they need all new documents if they are permanently admitted during the six-month respite period?*
Answer: No (0657 - 7/15)

22 VAC 40-72-350 C 1 - Physical examination and report
Question: *Does each resident need to have an annual risk assessment (screening) by a physician?*
Answer: The standard requires that each resident have an annual risk assessment for tuberculosis. Only a representative from the Department of Health or the examining physician or his designee can sign the results of the risk screening. If a physician has worked with a facility to develop screening/testing protocols and is willing/able to assume responsibility for direction and oversight of the licensed nurse(s) working in the facility, the physician may identify those nurses as his/her designee in the facility. (0195 - 5/07)

22 VAC 40-72-350 D – Physical examination and report
Question: *As necessary to determine whether a resident's needs can continue to be met in the ALF, the department may request a current physical examination, including diagnosis and assessments. Can a provider request this evaluation/assessment through the department to be completed before a resident is considered ready to return from a hospital stay? Can a provider decline to accept a resident back into care without a satisfactory evaluation?*
Answer: The department does not arrange for or coordinate to have assessments conducted to determine whether a resident's needs can continue to be met in an ALF. If a facility has determined that it can no longer meet the needs of a resident, the facility must initiate discharge planning in accordance with 22 VAC 40-72-420. The department shall review specifically 420 H, *Discharge Statement,* to ensure that the facility conscientiously considered all relevant information before arriving at the decision to discharge. (0010 - 5/07)

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22 VAC 40-72-360 Mental health screening

22 VAC 40-72-360 – Mental health screening

Question: *What if you think a resident needs a mental health screening but the resident's primary care physician doesn't agree and says he can handle it? Assuming he does so successfully, would we be cited for not having the resident seen by a mental health professional?*
Answer: A primary care physician's medical license authorizes him or her to assess and treat mental diseases, i.e., treatment of mental diseases does not require licensure as, for example, a psychiatrist, clinical psychologist/social worker or other specialist acting within the scope of that license. If the facility is satisfied that the primary care physician's treatment is effectively addressing the resident's symptoms in a way that abates risks to self/others, as this question states, there would be no reason to cite the facility because it has met the intent of the standard. On the other hand, if the facility remains concerned, it should promptly contact the primary care physician about its observations and concerns, which might prompt the physician to make a referral or to change the resident's treatment regimen. If the facility is not satisfied that the resident's treatment is abating risks to self/others, it has the responsibility to seek a second opinion, presumably with a qualified assessor or psychiatric specialist. A clear failure to monitor and deal with a situation of this type in a timely and responsible manner would be cited as a violation. The ALF licensee remains ultimately responsible for determining whether the facility can adequately and safely serve each resident and for maintaining a safe environment for all residents and personnel. (0120 - 5/07)

Question: *Are specific content items and format required for the mental health screening? Standard 360 E, states that if mental health services are recommended by the screening, the facility must notify the community services board, behavioral health authority, or other appropriate licensed provider. Please clarify who these agencies and providers are.*
Answer: The department does not require that a specific format be used by the Qualified Mental Health Professional (QMHP) to prepare the mental health screening report. The format of the areas covered in a mental health screening is determined by the standards as practiced by the QMHP's profession. Generally, a mental health screening will provide information about, e.g., the recent history and current status of a person's mental, emotional, and behavioral functioning; complaints or concerns identified by the person being examined and/or by the referring party; and concluding statements by the QMHP regarding whether the person may present concerns for the safety of himself and/or others, and interventions recommended to address whatever concerns were identified. Community services boards (CSBs) and behavioral health authorities (BHAs) are community-based mental health clinics that are required by law to offer services to the public, at a cost based on income, in the areas of mental illness, mental retardation, substance abuse, and behavioral disorders. Other appropriate licensed professionals who could provide mental health services in their privately owned businesses are, for examples, psychiatrists, psychologists, social workers, psychiatric nurse practitioners, etc. (0129 - 5/07)

Question: *Will VDSS provide a model form for the mental health screening used to determine the need for a referral to a qualified mental health professional?*
Answer: The department will not develop a form for the mental health screening used to determine the need for a referral to a qualified mental health professional. Instead, the department supports using the *Psychosocial Assessment, Part IV,* and the *Appendix K* of the

Uniform Assessment Instrument (UAI) for this purpose. While the facility is free to use its own screening tool for private-pay residents, the department does recommend that the information provided by any optional tool address, at a minimum, the areas covered by the *Psychosocial Assessment, Part IV* of the UAI. (0173 - 5/07)

Question: *What information is to be on the mental health screening?*
Answer: The information provided by the *Psychosocial Assessment, Part 4* and the *Appendix K* of the *Uniform Assessment Instrument* is required to be used for public-pay residents to determine whether a referral needs to be made to a qualified mental health professional. For private-pay residents, while the facility is free to use its own preliminary screening tool, it is recommended that the information provided by the tool be similar to the information provided by the *Psychosocial Assessment* of the UAI for public-pay residents. Regarding the information contained in the mental health screening instrument prepared by the qualified mental health professional, the areas covered in this screening will be consistent with the standards of his professional practice. (0069 - 5/07)

Question: *Is there a particular DSS form to be used for the mental health screening? Is this the same as the Assessment of Serious Cognitive Impairment?*
Answer: DSS does not have a model form for the mental health screening. To determine the need for a referral to a qualified mental health professional, the facility may (1) use its own mental health screening tool or complete the *Psychosocial Assessment* section and the Appendix K of the UAI for private-pay residents, (2) request a person who is eligible to complete the *Psychosocial Assessment* section and the Appendix K of the UAI for public-pay residents, or (3) rely on an assessment by another health care professional. The mental health screening that is conducted by the qualified mental health professional will utilize the format in accordance with the standards of his professional practice. This screening is not the same as the assessment to determine serious cognitive impairments for persons diagnosed with dementia. (0047 - 5/07)

Question: *Will the latest psychological evaluation be enough for a mental health screening?*
Answer: As it relates to the appropriateness of a prospective admission, the purpose of a psychological evaluation or screening is to address concerns raised by a facility, an assessor using the uniform assessment instrument, or other health care professional who observes (within the six months prior to the date of being considered for admission into an assisted living facility) behaviors or patterns of behaviors that might be indicative of mental illness, mental retardation, substance abuse, or behavioral disorders. Therefore, if the "latest psychological evaluation" does not address the concerns regarding the appropriateness of the admission of a prospective resident and/or it was performed prior to the six month time period, then it would not meet the intent of Standard 360. (0055 - 5/07)

Question: *Would a resident who is a wanderer or who talks to himself need a mental health screening?*
Answer: The question that must be asked is whether the observed behaviors or patterns of behaviors are believed to place the resident or others at risk for harm. Not all behaviors or patterns of behaviors warrant mental health intervention, especially if there are no apparent indications that the display is a threat to the safety of the resident or others, or if the professional health care provider who is overseeing the mental health care of the resident is already aware that

the behaviors are occurring. Instead, it may be appropriate to seek medical attention in order to rule out a medical cause. Precaution, nevertheless, should be taken when a resident is exhibiting behaviors seen for the first time or considered "out of character" for that particular resident. In this case, if wandering or talking to oneself is a behavior that is considered "out of character" for a resident or is a behavior that the professional health care provider is not aware of, then it would be proper to seek professional intervention. (0121 - 5/07)

Question: *If a resident is admitted to an ALF prior to getting the results of a mental health screening from a qualified mental health professional, and it is subsequently revealed from the screening that the resident is assessed as a risk to self and/or others, can you then discharge the resident based on being unable to meet their needs?*
Answer: Yes. However, the facility must explain specifically why it is not able to meet the needs of the resident. Simply stating, "The facility is unable to meet the needs of the residents," is not a reason…it is a conclusion. The facility must state the reasons, conditions, or circumstances that prevent it from being able to provide the scope of services required by the resident. If the resident presents a high risk to self and/or others, the facility must be able to provide sufficient information about the behavior(s) and existing circumstances to clearly demonstrate the basis for which a discharge decision was made. For instance, if the resident is prone to self-injurious behaviors, the facility may state that its staff is not adequate in number to provide intense supervision nor do they have adequate training specific to being able to therapeutically intervene when such behaviors occur. (0150 - 5/07)

Question: *If a prospective resident needs a mental health screening, will VDSS pay to have it done? If so, who should be contacted to arrange this?*
Answer: The department neither arranges nor pays for the mental health screening required by Standard 360 and §63.2-1805.b of the Code of Virginia. For public-pay residents, the initial screening that is conducted to determine the need for a referral to a qualified mental health professional (QMHP) must be performed by a qualified assessor (an employee of a public human services agency trained in the completion of the Uniform Assessment Instrument). There is no charge to the resident or facility for this screening. If a referral to a QMHP for a screening is indicated for a public-pay resident, the screening performed by the local CSB, behavioral health authority, or a Medicaid-approved provider will be paid for by Medicaid. For private-pay residents, the initial screening to determine the need for a referral to a QMHP may be performed by a qualified assessor (staff member of the facility trained in the completion of the Uniform Assessment Instrument) or an independent private physician selected by the facility or the resident. If a referral for a screening by a QMHP is indicated for a private-pay resident, the facility or resident may use any independent private QMHP. The cost for the screening is assumed by the resident or his health care plan. (0152 - 5/07)

22 VAC 40-72-360 and 365 – Mental health screening
Question: *Would there be a conflict of interest with a local CSB or behavioral health authority in conducting the mental health screening or providing the psychosocial and behavioral history for a resident who resides in an ALF it operates?*
Answer: The department does not consider any public agency (federal, state, or local) to be subject to the conflict of interest requirement as stated at 360 C. (0060 - 5/07)

Question: *Do Standards 360 and 365 apply to residents with dementia?*
Answer: Having a diagnosis of dementia, alone, would not necessarily require attention under the standards related to mental health services, coordination, and support. What determines the need is whether the behaviors of the person with dementia place himself or others at risk for harm, e.g., exhibiting a problem with aggression or depression. The behavior of wandering is not one that would typically warrant mental health interventions. However, if any behavior is observed, even wandering, that is considered not normal for a particular person, then it would be appropriate to seek a professional opinion. In fact, it may be necessary to seek professional help in order to rule out a medical cause for the behavior. (0041 - 5/07)

22 VAC 40-72-360 and 500 – Mental health screening
Question: *If an ALF is associated with a hospital that has mental health professionals, e.g., M.D., case managers, CSW, etc., can they be used to provide mental health services to residents in the ALF?*
Answer: The question does not specify the way in which the "ALF is associated with a hospital" or the specific mental health services needed by the ALF, and the answers would depend on those factors.
If the ALF has no financial ties to the hospital:

- The ALF may make a referral to a mental health professional employed by the hospital to complete the initial mental health screening as required by 360 C., and, to provide other mental health services, except for evaluations for involuntary commitments, which are restricted by law to community services boards and behavioral health authorities.

If the ALF has a financial relationship with the hospital, the ALF:

- May use a hospital employee to perform only the initial screening, which is conducted to determine whether a referral needs to be made for a formal mental health screening by a qualified mental health professional. That is, only a provider with no financial relationship with the ALF can perform the formal mental health screening.
- May use the hospital's mental health professionals to provide emergency and non-*emergency* mental health care and treatment, unless
    - an evaluation is for purposes of obtaining an involuntary psychiatric admission, in which case the CSB or behavioral health authority must perform the evaluation, or,
    - another regulation or law applicable to licensed ALFs requires that the evaluator be independent of the facility in which the resident resides, e.g., an evaluator who conducts an assessment to admit a resident to a safe, secure environment (or special care unit) must be independent of the ALF. (0142 - 5/07)

22 VAC 40-72-360 A – Mental health screening
Question: *What is the intent of Standard 360 A?*
Answer: Because ALFs are not designed to be able to provide the same level of care that a mental health facility can provide, assurance is needed that any prospective resident or one already residing in an ALF, with a recent history of a mental, emotional, substance abuse, or a behavioral disorder, can safely reside in the facility. It is not intended that all individuals with a recent history of these problems be subject to an assessment by a qualified mental health professional. Rather, it is intended that professional intervention be pursued when there are

observations about the person that lead one to have concern for the safety of that person and/or others. (0175 - 5/07)

22 VAC 40-72-360 B – Mental health screening

Question: *If a resident had to be hospitalized due to dangerous behavior and is expected to return to the ALF, will the discharging psychiatric hospital conduct a mental health screening or would the facility need to request it?*

Answer: A written assessment of a resident's functioning and appropriate diagnosis is a standard practice for a hospital. Additionally, a discharge summary is typically prepared which, in part, describes the identified problem(s), services provided, status of the problem(s) at discharge, and any recommended aftercare services. The assessment and discharge summary should provide sufficient information in order for the ALF to determine whether the needs of the resident, at the time of discharge from the hospital, exceed the abilities of the ALF to care for the resident. However, the availability of the written assessment and summary at the time the resident is deemed ready to return to the ALF could be delayed. If this is the case, then the facility is advised to obtain and document as much information as possible verbally from the mental health provider (or designee) involved in treating the resident in the hospital. (0032 - 5/07)

22 VAC 40-72-360 C – Mental health screening

Question: *Can we use the geropsychiatrist that we contract with under 40-72-500 to provide services to our residents to complete the mental health screenings under 40-72-360?*

Answer: For the purpose of admission, the screening that is conducted to determine only the need for a referral to a qualified mental health professional may be performed by a geropsychiatrist or other qualified health care provider who has a contract with the facility for services specified in 500. However, in accordance with Standard 360 C, when a person has a direct or indirect financial interest in the facility or who is an owner, officer, employee, or is an independent contractor with the facility, this person cannot be the one who will actually conduct the mental health screening to meet the requirements of 360 A, B, and E. Standard 360 C is consistent with the definition of "financial interest" and "investment interest" and the intent of avoiding a conflict of interest as conveyed by that section under § 37.2-809. (0127 - 5/07)

22 VAC 40-72-360 E 1 and 2 – Mental health screening

Question: *Can the required notifications regarding the resident's need for mental health, mental retardation, substance abuse, or behavioral disorder services be verbal or must they be written down in the chart?*

Answer: The required notifications that the resident has been assessed as needing services may be given verbally and/or may be sent in writing. Either method of notification must be documented in the resident's file to reflect the name and affiliation of the person contacted, date and time of contact, and a brief statement of the information shared with the person(s) contacted. (0151 - 5/07)

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22 VAC 40-72-365 Psychosocial and behavioral history

22 VAC 40-72-365 – Psychosocial and behavioral history

Question: *Regarding the psychosocial and behavioral history, how are you going to cite on something that is so totally subjective? Is there no model form? Are we to have mental health services for every resident with dementia?*
Answer: The requirement is to determine compliance on whether the facility has obtained and has used the information in a psychosocial and behavioral history in considering the appropriateness of admission and in developing the individualized service plan. It is not expected that a determination regarding the quality of the content be made. Part II of the ***Mental Health Screening Determination Form*** is being made available to ALFs in order to document their efforts to comply with Standard 365. Whether a resident with dementia should receive mental health services is a determination that can only be made by a clinician trained in diagnosing and treating mental and behavioral disorders. A clinician should be involved in any case where the behavior so warrants. If a recommendation has been made by a qualified mental health professional that a person with dementia may benefit from some form of psycho-pharmacological and/or behavioral treatment, then it would be expected that the effort be made to secure these services. (0168 - 5/07)

Question: *Do Standards 365 and 360 apply to residents with dementia?*
Answer: Having a diagnosis of dementia, alone, would not necessarily require attention under the standards related to mental health services, coordination, and support. What determines the need is whether the behaviors of the person with dementia place himself or others at risk for harm, e.g., exhibiting a problem with aggression or depression. The behavior of wandering is not one that would typically warrant mental health interventions. However, if any behavior is observed, even wandering, that is considered not normal for a particular person, then it would be appropriate to seek a professional opinion. In fact, it may be necessary to seek professional help in order to rule out a medical cause for the behavior. (0041 - 5/07)

22 VAC 40-72-365 and 360 – Psychosocial and behavioral history

There is an applicable question/answer under Standard **22 VAC 40-72-360**.

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22 VAC 40-72-367 Sex offender screening

22 VAC 40-72-367 - Sex offender screening

Question: *For the screening required by this standard, is it acceptable to use the National Sex Offender Registry sponsored by the U.S. Department of Justice as opposed to using the Virginia Sex Offender Registry sponsored by the Virginia Department of State Police?*
Answer: It is acceptable to use either the National Sex Offender Public Website (NSOPW) sponsored by the U.S. Department of Justice or the Virginia Sex Offender Registry sponsored by the Virginia Department of State Police for conducting the search required by this standard. The NSOPW is not actually a separate registry, but is a search of databases as noted below.

The U.S. Department of Justice National Sex Offender Public Website (NSOPW) states that it "…is a cooperative effort between Jurisdictions hosting public sex offender registries ("Jurisdictions") and the federal government. These Jurisdictions include the 50 states, Puerto Rico, Guam, the District of Columbia, and participating tribes. This Website is a search tool

allowing a user to submit a single national query to obtain information about sex offenders ….." The same website states that "…NSOPW primarily uses Web services to search the individual databases of the Jurisdictions in real time when a search is conducted. This method ensures that NSOPW is returning the most current information." (0628 – 3/10)

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22 VAC 40-72-370 Emergency placement

22 VAC 40-72-370 B – Emergency placement

Question: *Which admissions requirements may be delayed when an emergency placement occurs in an ALF?*

Answer: The standard specifies that when an emergency placement occurs, the person may remain in the ALF for no longer than seven working days unless all the requirements for admission have been met and the person has been admitted. An emergency placement is defined in 22 VAC 40-72-10 as the temporary status of a person in an ALF when the person's health and safety would be jeopardized by denying entry into the facility until the requirements for admission have been met. Thus, an emergency placement is not an "admission" to an ALF; rather it is the temporary status of a person who has entered into the facility. Since, during temporary placement, the person has not been admitted, the admission requirements do not have to be met for the person to remain in temporary status for the allowed seven working day period. For example, to stay in temporary status, the UAI does not have to be completed and the sex offender screening does not have to take place. However, for the person to remain in the ALF, the person would have to meet all the requirements for admission and be admitted by the eighth day. The facility must take into consideration that some of the standards relating to admission have requirements that must be met "prior to admission."

There is one exception to the above regarding admission requirements and that relates to 22 VAC 40-72-340 E, i.e., the age of an individual. Because an ALF by definition is a setting that cares for adults, a person under the age of 18 cannot enter the facility as an emergency placement or be admitted to the facility.

Please note that all standards apply that do not directly relate to the requirements for admission to an ALF. A person who has entered the ALF as an emergency placement is still considered a resident, as the definition of resident in 22 VAC 40-72-10 is any adult residing in an ALF for the purpose of receiving maintenance or care. 22 VAC 40-72-50 B 4 requires the licensee to protect the physical and mental well-being of all residents. Please note that the facility must gather enough information about the person to be able to provide this protection. A more specific example of a standard that would apply relates to the administration of medication, i.e., in order for the ALF to administer medications to a resident, whether or not the person has entered the facility as an emergency placement, there must be a valid order from a physician or other prescriber, as required by 22 VAC 40-72-640 A.

Please keep in mind that for an emergency placement to occur, the emergency must be documented and approved as specified in 22 VAC 40-72-370 A. (0627 – 3/10)

22 VAC 40-72- 370 B, 640 D 2, 930 F 2, 100 A and 201 B 1 – Emergency placement
There is an applicable question/answer under Standard 22 VAC 40-72-100 A

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22 VAC 40-72-380 Resident personal and social information

22 VAC 40-72-380 and 390 – Resident personal and social information
Question: *"Prior to or at the time of admission" - do individuals who were residents prior to the effective date of new standards have to have additional information required by these two standards that was not required when they became residents?*
Answer: Individuals who were residents prior to the effective date of new standards do not have to have additional information required by the above two standards that was not required by the standards in effect when they became residents. However, it is advisable that any additional information specified in the two standards be obtained for these residents, since this would benefit both the facility and the residents. These residents do have to have all the information required by standards in effect when they became residents. (0484 - 6/08)

22 VAC 40-72-380, 340, 390, 430 and 440 – Resident personal and social information
There is an applicable question/answer under Standard 22 VAC 40-72-340

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22 VAC 40-72-390 Resident agreement with facility (7/15-Q1)

22 VAC 40-72-390 and 380 – Resident agreement with facility
There is an applicable question/answer under Standard **22 VAC 40-72-380**.

22 VAC 40-72-390, 340, 380, 430 and 440 – Resident agreement with facility
There is an applicable question/answer under Standard **22 VAC 40-72-340**

22 VAC 40-72-390 A 1 and 2, 60 A 4 h and n and 150 A 3 - Resident agreement with facility
There is an applicable question/answer under Standard **22 VAC 70-72-150-A-3**

22 VAC 40-72-390 B Resident agreement with facility
Question(Q1): *Can the copy of the signed resident agreement provided to the resident, and as appropriate, his legal representative, be provided electronically?*
Answer: Yes, the signed resident agreement could be provided electronically to the resident or his legal representative if they have equipment and access to allow for electronic receipt and retention of the document and give written permission to have it provided in this manner; otherwise a hard copy would have to be provided. (0664 - 7/15)

22 VAC 40-72-390 C Resident agreement with facility
Question: *Can a facility change its requirements regarding smoking that are in the resident agreement?*
Answer: The facility can change the requirements governing resident conduct. For example, the facility can change the agreement so that a resident is no longer permitted to smoke on a patio, and is only allowed to smoke on the premises in a designated outside area(s). As per 22 VAC 40-72-390 C, the agreement must be updated regarding this change and then signed by the

licensee or administrator and the resident or his legal representative. If the resident does not wish to agree to the change, he can choose to leave the facility. If such is the case, it would be advisable, but not required, that under the circumstances, the facility not penalize the resident for not giving the required notice for moving. (0640 - 7/14)

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22 VAC 40-72-410 Acceptance back in facility

22 VAC 40-72-410 – Acceptance back in facility

Question: *Please clarify the provider's responsibility to accept a resident back into the facility when he is sent out by an emergency custody order (ECO) or temporary detention order (TDO) but the resident is not committed.*

Answer: If a resident is not involuntarily committed to an in-patient treatment facility, pursuant to §37.2-808 (ECO) and §37.2-809 (TDO) of the Code of Virginia, then the facility must have procedures in place to accept the resident back in the facility. The resident must also be accepted back in the facility if the facility has a policy that permits the holding of a resident's bed if the resident is away from the facility on a temporary transfer. A facility still has the responsibility under Standard 420, however, to initiate discharge procedures if it concludes that a resident's needs exceed its ability to safely and adequately care for him. In making that decision, the facility should carefully weigh its own capabilities against the care demands reflected in the totality of relevant circumstances surrounding that individual's residency, including but not limited to symptoms, response to emergency or non-emergency treatment, and availability of supplemental resources. (0030 - 5/07)

Question: *If a resident is temporarily detained but not committed and if that resident has been disruptive to others in the facility before being detained, without indication that the therapy has been effective, why would the facility have to ensure it would take the resident back? Would that not be a quality of life issue for the remaining residents?*

Answer: The intent of the standard is that the person who is not committed has a place to return to and that he is not discharged from the facility without a good reason and without an orderly process. Should the person return to the facility and continue to be disruptive with no indication that therapy has been effective, and his condition presents an immediate and serious risk to the health, safety or welfare of himself or others, an emergency discharge may be in order.
(0285 - 12/07)

Question: *This standard refers to Code Sections 37.2-808 and 37.2-809 and 37.2-814 thru 816. What are these sections, what do they reference?*

Answer: These are sections of the Code of Virginia relevant to Title 37.2, *Mentally Health, Mental Retardation, and Substance Services.* Section 37.2-808 pertains to the issuance of an *emergency custody order* by the magistrate and executed by the local law-enforcement office to transport a person to a convenient location to be assessed for the need of emergency psychiatric treatment, either on an out-patient or in-patient basis.

Section 37.2-809 pertains to the issuance of an *involuntary temporary detention order* by the magistrate to have a person assessed based upon the sworn petition by an employee or a designee of the local community services board or behavioral health authority that the person (i) has mental illness, (ii) presents an imminent danger to himself or others as a result of mental illness or is so seriously mentally ill as to be substantially unable to care for himself, (iii) is in need of

hospitalization or treatment, and (iv) is unwilling to volunteer or incapable of volunteering for hospitalization or treatment. The duration of the temporary detention may not exceed 48 hours following the issuance by the magistrate.

Sections 37.2-814-816 pertain to the commitment hearing process for a person who has been temporarily detained and evaluated for hospitalization. A judge or special justice will determine the need for hospitalization within 48 hours following the execution of the temporary detention order. (0286 - 12/07)

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22 VAC 40-72-420 Discharge of residents

22 VAC 40-72-420 H – Discharge of residents
Question: *Does the discharge statement pertain to a discharge initiated by a resident, as well as one initiated by a facility? Does the discharge statement pertain when a resident passes away?*
Answer: The discharge statement is required for both facility initiated and resident initiated discharges. The discharge statement does not pertain when a resident passes away. (0621-06/09)

22 VAC 40-72-420 J – Discharge of residents
Question: *Since some residents have moved to places hours away, is the facility responsible for paying the freight charges to send property or things of value held in trust or custody by the facility?*
Answer: The facility is not responsible for paying the freight charges to send the items. However, the facility is to assist the resident or his legal representative in making appropriate plans to have property or things of value held by the facility returned to the resident. Please note 22 VAC 40-72-420 D, which speaks to assisting the resident and his legal representative in the discharge process and notes that "primary responsibility for transporting the resident and his possessions rests with the resident or his legal representative." (0309 - 6/08)

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PART VI. RESIDENT CARE AND RELATED SERVICES

22 VAC 40-72-430 Uniform assessment instrument (UAI)

22 VAC 40-72-430 – Uniform assessment instrument (UAI)
Question: *On the private Pay UAI under psychosocial status, abusive/aggressive/disruptive less than weekly is D=Dependent. However, under the Nursing Home Pre-Admission Screening Manual (3-19-94), page 4, under 8) Behavior Pattern & Orientation of "Abusive/Aggressive/Disruptive < weekly + Oriented or Disoriented" is rated "d" meaning semi-dependent. Which standard will apply?*
Answer: For ALFs, abusive/aggressive/disruptive less than weekly is D=Dependent.(0312 - 12/07)

22 VAC 40-72-430, 440, 340, 380 and 390 – Uniform assessment instrument (UAI)
There is an applicable question/answer under Standard 22 VAC 40-72-340

22 VAC 40-72-430 A – Uniform assessment instrument (UAI)
Question: *I manage an ALF operated by CSB. Can I, my staff or case managers of the CSB complete the UAI of my residents? Clarification of the question: Assuming that CSB has contract with DMAS to complete UAI for current and prospective ALF (AG) residents, would it be a conflict of interest for CSB to complete initial UAI on residents of the ALF operated by the CSB?*
Answer: ALF direct care staff who are also CSB employees can perform assessments on AG residents, provided that the CSB is the licensee of the ALF and individual is a qualified assessor. The department does not consider any public agency (federal, state, local) to be subject to conflict of interest regarding this standard. (0318 - 12/07)

Question: *If a CSB operates an ALF, can the CSB case managers complete the UAIs on the residents in the facility?*
Answer: Yes, if they are qualified. (0319 - 12/07)

Question: *Does the UAI supervision definition mean that mental health/mental retardation (MHMR) diagnosis should automatically place a resident at assisted living care level?*
Answer: No. The definition does not automatically place the resident at any level. On page 22 of the *User's Manual: Virginia Uniform Assessment Instrument (UAI)*, March July 2005, supervision is defined to mean that the client is able to perform the activity without hands-on assistance of another person, but must have another person present to prompt and/or remind him to safely perform the complete activity. The definition of supervision *often* pertains to people with cognitive impairment, but not always, and may include those who need supervision for other reasons. (0342 - 12/07)

22 VAC 40-72-430 A and 440 A – Uniform assessment instrument (UAI)
Question: *Must a uniform assessment instrument (UAI) and an individualized service plan be completed for a respite care resident?*
Answer: Yes. A respite care resident must have both a UAI and an individualized service plan. The UAI must be completed prior to admission and the service plan must be completed within 30 calendar days after admission. However, the service plan to address the immediate needs of the resident must be completed within 72 hours of admission. (0364 - 6/08)

22 VAC 40-72-430 A 1 – Uniform assessment instrument (UAI)
Question: *Can a licensed nurse (either RN or LPN) who is a staff person at an ALF be able to do private pay UAIs?*
Answer: An ALF staff person, including a licensed nurse, who has successfully completed state-approved training on the UAI and level of care criteria, with documentation of such maintained by the facility, can complete the private pay UAI. A licensed nurse would not be exempt from this training. (0346 - 6/08)

22 VAC 40-72- 430 A 1 a – Uniform assessment instrument (UAI)
Question: *Can the facility charge private pay residents for completion of the UAI by a facility staff person who has the training as required by the standard?*
Answer: Yes. This is not addressed by regulation. (0315 - 6/08)

Question: *Can a facility employee who has successfully completed state-approved training on the UAI and level of care criteria contract with several facilities to complete the UAI for their private pay residents or can the employee only complete the UAI for the residents of the facility of which he is a regular employee?*
Answer: A facility employee who has successfully completed the state-approved training on the UAI and level of care criteria can contract with several facilities to complete the UAI for their private pay residents. The employee is not limited to his place of primary employment. However, the employee must be hired, either directly or through a contract, by any assisted living facility that wishes to have him complete the private pay UAI for its residents, i.e., the person must be an employee of that facility for that purpose. (0326 - 6/08)

Question: *Can a person who is not employed by any facility but who wants to contract with several facilities to do their UAIs for private pay do so? If he enters into a contract with a facility, can he do the UAIs? Can he do this for a number of facilities if he has contracts with them?*
Answer: This standard and 22 VAC 40-745-20 (in regulations entitled "Assessment in Assisted Living Facilities") allow for qualified staff of the ALF to complete the UAI for private pay individuals. A qualified staff person of the ALF is an employee who has successfully completed state-approved training on the UAI and level of care criteria. A qualified staff person can contract with several facilities to complete the UAI for private pay residents. The individual must be employed by the facilities for which he or she completes private pay UAIs, either directly or through a contract. In other words, an individual who has contracts with several facilities to complete UAIs for private pay residents is considered a staff person or employee of those facilities for the purpose of completing the UAIs. (0347 - 6/08)

Question: *Can the administrator make the person who completes the UAI the designee to approve and sign?*
Answer: A facility employee cannot be the administrator's designated representative who approves and signs a UAI for a UAI that the employee himself completed. However, the employee may be the administrator's designated representative for UAIs completed by other facility employees. (0348 - 6/08)

Question: *Can the administrator designate more than one representative to approve and sign completed UAIs?*
Answer: Yes. (0353 - 6/08)

22 VAC 40-72-430 D – Uniform assessment instrument (UAI)
Question: *Does a history of aggressive behavior require a resident to be placed at the assisted living care level?*
Answer: No. A history of aggressive behavior does not automatically place the resident at any level. Each assessment of a resident must consider the resident's behavior at the point in time in which he or she is assessed. (0343 - 12/07)

Question: *Does a "big D" on the orientation (of the UAI) place a resident in the population of residents with serious cognitive deficits?*

Answer: If a person is dependent in orientation ("big D") or has other cognitive deficits due to a primary psychiatric diagnosis of dementia and is unable to recognize danger or protect his own safety and welfare, then he meets the criteria for placement in a safe, secure environment (or special care unit). If residing in a mixed population, there are certain services requirements applicable only to persons having one or more serious cognitive deficits due to dementia, or to some other cause, who is unable to recognize danger or protect his own safety and welfare. However, if residing in a mixed population and a person with one or more serious cognitive deficit is able to recognize danger and protect his own safety and welfare, then those special services requirements would not apply to him. The person meeting this latter condition would, however, require that an individualized service plan address any needs identified as a result of one or more cognitive deficits. (0363 - 6/08)

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22 VAC 40-72-440 Individualized service plans

22 VAC 40-72-440, 340, 380, 390 and 430 – Individualized service plans
There is an applicable question/answer under Standard 22 VAC 40-72-340

22 VAC 40 -72-440 A – Individualized service plans
Question: *Do licensed nurses doing the ISPs have to complete the DSS approved ISP training?*
Answer: Yes, licensed nurses must complete an ISP training program approved by the department in order to develop ISPs. (0124 - 12/07)

Question: *Can the person completing the individualized service plan (ISP) and the health care oversight person be one and the same?*
Answer: Yes, the person completing the ISP and the health care oversight person may be one and the same. However, if practicable, it would be better to have one person completing the ISP and a different person providing the health care oversight. (0355 - 6/08)

22 VAC 40-72-440 A and 430 A – Individualized service plans
There is an applicable question/answer under Standard **22 VAC 40-72-430 A**.

22 VAC 40-72-440 A and I – Individualized service plans
Question: *What if a family or legal representative does not participate in ISP plan or review?*
Answer: Standards 440 A and I require that the resident's family and legal representative be involved in the development and review of the ISP "as appropriate." This means that if the facility's attempts to involve these individuals at each development/review stage prove to be unsuccessful, then it is not required that the family or legal representative be involved in the ISP development/review. The ALF is to make reasonable attempts to contact these persons at each development/review stage, and even if they cannot be physically present at the facility, try to involve them in the development/review of the ISP through other means, such as the phone, email, fax, etc. There may be instances where a resident has no family or legal representative, or for whatever reason, the family or legal representative does not wish to be involved with the development/review of the plan, and if such is the case, this is acceptable. In such cases, the facility should document all efforts made to involve the family or legal representative at each development/review stage. (0036 - 5/07)

Question: *When and where will there be available DSS approved training for ISPs?*
Answer: There are two curriculums currently approved by the department for the ISP training. One is offered by Virginia Commonwealth University Department of Gerontology. The website address is www.sahp.vcu.edu/gerontology/html/dss/home.html and the phone number is 804-828-9060. The training is also available from Virginia Adult Care Education. The website address is www.VACEtraining.com and the phone number is 434-978-4619. Please check the website addresses or call the phone numbers for information on the schedules and locations of training. (0043 - 3/15)

Question: *What is defined as the immediate needs of a resident in relationship to his or her individualized service plan (ISP)?*
Answer: Since the comprehensive ISP does not have to be completed until 30 days after admission (although, of course, it may be completed earlier), the "immediate needs" must be addressed in the plan within 72 hours of admission to ensure that the health, safety, and welfare of the resident are not endangered during the time when there is not a comprehensive plan. The immediate needs would be those identified needs (see 440 B 1) that would present a risk of harm to the resident if not addressed right away. What the specific immediate needs are would vary from resident to resident, depending upon conditions, circumstances, capabilities, etc. that apply to an individual. (0100 - 5/07)

22 VAC 40-72- 440 B – Individualized service plans
Question: *Can the comprehensive plan be completed within 72 hours to eliminate the "immediate needs" service plan?*
Answer: For the most part, the comprehensive plan can be completed within 72 hours. In essence, the "immediate needs" service plan would be incorporated into the comprehensive plan, but would not be separately distinguishable. However, more than 72 hours is needed to determine how the resident is adjusting and for facility staff to get to better know the resident. During the first month, additions or other changes to the ISP would have to be made, as appropriate, based upon increased knowledge of the resident and his needs. (0574 - 12/07)

Question: *Can there be portions of an individualized service plan (ISP) that are preprinted so that the staff completing the plan circles/checks the most appropriate choice(s)?*
Example: Bathing: Services to be provided

- *Total assistance*
- *Partial assistance*
- *Prompting*
- *Monitoring water temperature*
- *Other* _____

Answer: Yes, portions can be preprinted so that staff can mark the appropriate choice(s) as long as it is clear that this is the method being used and the choices are specific enough. In the above example, for instance, "partial assistance" does not adequately describe the service to be provided. Staff would have to describe the type and extent of assistance required by the individual. The other choices seem sufficient. (0360 - 6/08)

22 VAC 40-72-440 B 1 – Individualized service plans

Question: *In identifying the needs on the individualized service plan, do the IADLs have to be included?*

Answer: Yes. Whenever an instrumental activity of daily living (IADL) is identified as a need of an individual, it must be included on the person's individualized service plan (ISP). This is required by both this standard and 22 VAC 40-72 440 C, which states that "the individualized service plan shall reflect the resident's assessed needs...." If a resident's need in respect to a particular IADL does not exceed a service that is routinely provided by the facility, then after a description of the need on the ISP, it is acceptable to make reference to another document (or documents) that explains the service and includes the other information required by 22 VAC 40-72-440 B. The relevant parts of these other documents must be available to all direct care staff to assist them in understanding the overall service needs of the residents.

An example would be if a facility provides housekeeping services to all residents twice a week and this service is adequate to meet a particular resident's housekeeping needs. Such being the case, then after the need for housekeeping is noted on the resident's ISP, a reference may be made to documents such as the resident agreement and/or the facility's housekeeping schedule as long as these documents include the required information. In such a case , it would not be necessary to include specific information regarding the delivery of the housekeeping service on the ISP itself. However, if the resident has an allergy to certain cleaning products and as a result special cleaning supplies have to be used, this need and the specific way it is to be met must be detailed on the ISP.

Please note that the above answer applies only to IADLs and only under the described circumstances. (0358 - 6/08)

22 VAC 40-72-440 B 4 – Individualized service plans

Question: *Regarding the individualized service plan, under expected outcomes, is the term "to maintain status" ok?*

Answer: No. Under some circumstances it may be apparent that aggressive services are being provided with the outcome/goal of preventing or slowing further deterioration. To establish an outcome/goal of "maintaining the status quo," however, runs the risk of allowing or expecting deterioration, which will likely occur without a plan to combat it. (0359 - 6/08)

22 VAC 40-72-440 E – Individualized service plans

Question: *Is it necessary for a health care oversight person to sign ISPs?*

Answer: Standard 440 E requires the ISP to be signed and dated by the person who has developed the plan, by the resident or legal representative, and by any others who contributed to the development of the plan. This requirement also applies to reviews and updates of the plan. The reviews and updates are those referred to in Standard 440 I, that is, the formal reviews that occur at least once every 12 months and as needed as the condition of the resident changes. It is not necessary for the licensed health care professional providing health care oversight, as required by Standard 480, to sign the ISP, unless the health care professional directly participates in the development, formal review, or update of the plan. If the health care professional only recommends (to the appropriate facility staff) changes to a resident's ISP when it does not

appropriately address current health care needs, as required by 480 B 1, but is not involved any further, then the health care professional would not be required to sign the ISP. (0057 - 5/07)

Question: *Is a typed name acceptable as a signature on the individualized service plan?*
Answer: A typed name is not acceptable as a signature on the individualized service plan, even if the person initials next to his or her name. (0620 - 06/09)

Question: *The standard requires that the ISP be signed and dated by specific persons. By when must this be done?*
Answer: For the ISP to be considered complete, it must be signed and dated by the persons who are required to do so. 22 VAC 40-72-440 B specifies that the ISP is to be completed within 30 days after admission. Therefore, the ISP must be signed and dated by the persons required to do so within 30 days after admission of the resident. The immediate needs service plan noted in 22 VAC 40-72-440 B must be signed and dated within the 72 hour time frame by those who are required to do so. Please keep in mind that there is an exception to 22 VAC 40-72-440 E that pertains to individuals who contributed to the plan without being present at the facility. Also, please note that the signatures of those who contributed to the ISP indicate that they participated in the development of the plan, not that they necessarily agree with everything in the plan. (0626 - 12/09)

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22 VAC 40-72-450 Personal care services and general supervision and care

22 VAC 40-72-450 G – Personal care services and general supervision and care
Question: *Can a resident refuse to allow the facility to notify his next of kin?*
Answer: Standard 450 G requires that at least one of the listed entities, that is, next of kin, legal representative, designated contact person, or responsible social agency, be notified of an incident of a resident falling or wandering. Being that only one has to be so notified, the resident can refuse to have the next of kin notified, and instead select one of the others to be notified of an incident of falling or wandering. This information should be placed in the resident's record. Included in the personal and social information on a resident, as found in Standard 380, is information regarding a designated contact person or persons authorized by the resident (or legal representative, if appropriate) for notification purposes. (0031- 5/07)

Question: *Does "responsible social agency" refer to the Division of Licensing Programs, Virginia Department of Social Services and if not, to which agency or agencies does it refer? What does "if applicable" mean? Does the 24-hour notification include week-ends?*
Answer: "Responsible social agency" as used in this standard does not refer to the Division of Licensing Programs, Virginia Department of Social Services. In respect to this standard, responsible social agencies include, but are not limited to, local social services departments, community services boards, behavioral health authorities, and private social services agencies. "If applicable" means that the agency provides the type of service to the resident for which it would be relevant to know about falls or wandering, which may include, among other services, guardianship, case work or case management. The notification required by the standard must occur within 24 hours of the time of initial discovery or knowledge of the incident, with a requirement for immediate notification under specified circumstances. Week-ends are not excluded from the 24 hour requirement. Please note that, depending upon the situation, the

facility may have to report an incident of a resident falling or wandering to the licensing office as required by 22 VAC 40-72-100 or report it for suspected abuse or neglect to Adult Protective Services (APS). (0024 - 6/08)

22 VAC 40-72-450 J and K – Personal care services and general supervision and care
Question: *Do residents have the right to refuse full or partial bath or shower after incontinence? Do they have the right to refuse clean clothing? What recourse does the facility have if residents do refuse?*
Answer: A resident does have the right to refuse full or partial baths after incontinence. He also has the right to refuse clean clothing. The facility, which has responsibility for the health, safety and well-being of the resident, is obligated to explore with him the reason for refusal of a bath or clean clothing. Perhaps a male resident is uncomfortable getting assistance for bathing or dressing from a female staff member. Perhaps the temperature of the water is too cool or too hot. There could be any number of reasons why the resident is refusing a bath or clean clothes. The facility may well be able to make adjustments in care to overcome the resistance of the resident.

However, there may be situations where the resident still refuses a bath or clean clothes. This should be documented by the facility. The facility must make a determination as to whether this is or could be detrimental to the health, safety or well-being of the resident. If the resident's refusal reaches the point of endangering his welfare and his needs cannot be met, discharge from the facility would be appropriate. (0115 - 12/07)

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22 VAC 40-72-460 Health care services

22 VAC 40-72-460 D 1 – Health care services
Question: *If unlicensed staff are providing gastric tube care, does the RN responsible for training and oversight have to be on staff? On-site during care?*
Answer: The delegating registered nurse must be employed by, or under contract with, the assisted living facility. Whether or not the delegating registered nurse has to be on-site during care provided by the unlicensed staff is dependent upon the nurse's assessment of both the resident's care needs and the unlicensed staff members' competencies as documented by the nurse in the staff members' files. (0021 - 5/07)

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22 VAC 40-72-480 Health care oversight (7/15-Q1)

22 VAC 40-72-480 – Health care oversight
Question: *Can the licensed health care professional referenced in this standard be the facility administrator?*
Answer: Yes, as long as the person is a licensed health care professional as defined in 22 VAC 40-72-10, meets the qualifications for the administrator, and is not directly responsible for all or most of the functions being reviewed. (0462 - 12/07)

Question: *Can an LPN or RN employed by the facility be the licensed health care professional to provide the health care oversight?*
Answer: Yes, as long as the person is not directly responsible for all or most of the functions being reviewed. (0463 - 12/07)

Question: *The nurse, an LPN, in a small home completes the ISP, keeps records, directs the staff, is the owner/administrator, and then also is the licensed health care professional reviewing all the things that she has done. Is this acceptable?*
Answer: In a situation such as this, when one person is directly responsible for all or most of the functions being reviewed by the licensed health care professional, it would not be acceptable for that person to be the licensed health care professional who provides the health care oversight. (0470 - 12/07)

Question: *If a facility is staffed with LPNs and RNs, is it necessary to have health care oversight?*
Answer: Yes. The intent of this regulation is that, in conducting the health care oversight, the licensed health care professional helps the facility to recognize and improve problem areas. As noted in the answer above, when one person is directly responsible for all or most of the functions being reviewed by the licensed health care professional, it would not be acceptable for that person to be the licensed health care professional who provides the health care oversight. It is possible for those facilities that have multiple licensed staff to develop written policies and procedures that allow some degree of peer review and an over all facility operation review that will address all required elements of health care oversight and meet the intent of the regulation. Such policy should be submitted through the assigned inspector for review/approval in order to avoid unnecessary confusion at the time of inspection. (0597 - 12/07)

Question: *Does the licensed health care professional conducting health care oversight have to write comments for each responsibility or function required by the regulation.*
Answer: No. Comments and/or recommendations are only required when the licensed health care professional (LCHP) observes something or reviews documentation that warrants comment or recommendation. However, the licensed health care professional must certify in writing that all the requirements of subdivisions 1 through 9 were met. The accountability of the LCHP would come into question if inspectors find significant areas of non-compliance which have not been addressed. (0598 - 12/07)

22 VAC 40-72-480, 620 G and 290 – Health care oversight
There is an applicable question/answer under Standard **22 VAC 40-72-290**.

22 VAC 40-72-480 A 1 and 2 - Health care oversight
Question(Q1): *Does the licensed health care professional responsible for the health care oversight every 3 months for the assisted living level of care or every 6 months for the residential living level of care have to be in the facility to the day every 90 days and every 180 days respectively?*
Answer: No. The current regulation stipulates "at least" every 3 months or "at least" every 6 months, but this does not mean that it has to be "to the day." As long as the oversight is provided at approximate equal intervals and is within the three month or six month period respectively, this would be within the timeframes established by the regulation. Every effort should be made to schedule, conduct and complete the required oversight within 1-2 weeks of the date that would be 90 or 180 days after the last oversight, keeping in mind that the oversight would have to take place within the respective three or six month period. (0665 – 7/15)

22 VAC 40-72-480 A 2 – Health care oversight
There is an applicable question/answer under Standard **22 VAC 40-72-480 A 1**

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22 VAC 40-72-500 Mental health services coordination, support, and agreement

22 VAC 40-72-500 – Mental health services coordination, support, and agreement
Question: *In the past the CSB refused involvement with the "stated intent to harm self" as well as the Sheriff's Dept. Both said the act had to actually occur, is this still the case? We wanted to act before resident did harm to herself.*
Answer: Actual harm or injury does not need to occur before a request can be made to the local law-enforcement agency or to the local CSB (or behavioral health authority) to assist with a person experiencing a psychiatric emergency. The following section of the Code of Virginia cites the specific conditions that authorize the law-enforcement agency and the CSB or behavioral health authority to intervene during a psychiatric emergency:
§ 37.2-808 - Emergency custody; issuance and execution of order. (see also § 37.2-809 - Involuntary temporary detention; issuance and execution of order.)
A.. Any magistrate may issue, upon the sworn petition of any responsible person or upon his own motion, an emergency custody order when he has probable cause to believe that any person within his judicial district (i) has mental illness, (ii) presents an imminent danger to himself or others as a result of mental illness or is so seriously mentally ill as to be substantially unable to care for himself, (iii) is in need of hospitalization or treatment, and (iv) is unwilling to volunteer or incapable of volunteering for hospitalization or treatment.
B. Any person for whom an emergency custody order is issued shall be taken into custody and transported to a convenient location to be evaluated to assess the need for hospitalization or treatment. The evaluation shall be made by a person designated by the community services board or behavioral health authority who is skilled in the diagnosis and treatment of mental illness and who has completed a certification program approved by the Department.
C. The magistrate issuing an emergency custody order shall specify the primary law-enforcement agency and jurisdiction to execute the emergency custody order and provide transportation. Transportation under this section shall include transportation to a medical facility as may be necessary to obtain emergency medical evaluation or treatment. This evaluation or treatment shall be conducted immediately in accordance with state and federal law. (0190 - 5/07)

Question: *What if you have requested a different mental health professional for a resident because your documentation shows that the resident's mental illness is not improving but you are refused a different doctor?*
Answer: This situation may reflect a conflict with the rights of a resident to have the freedom of choice, as determined by the resident or by the individual having the appropriate authority to act in behalf of the resident. If the matter cannot be resolved in the best interest of the resident, it would then be appropriate to involve the local Ombudsman and/or the Virginia Office for Protection and Advocacy. (0081 - 5/07)

Question: *If a private-pay resident needs in-patient mental health care, can the resident's doctor have him admitted?*
Answer: Yes, provided that the resident is willing to accept a voluntary admission. If, however, the resident is either unwilling or unable to accept a voluntary admission, then pursuant to §37.2-

808-§37.2-816 of the Code of Virginia, the facility would need to contact its local community services board or behavioral health authority in order to have the resident evaluated and, if necessary, transported under a temporary detention order to be involuntarily admitted to a psychiatric facility or unit. (0042 - 5/07)

22 VAC 40-72-500 and 360 – Mental health services coordination, support, and agreement
There is an applicable question/answer under Standard **22 VAC 40-72-360.**

22 VAC 40-72-500 C – Mental health services coordination, support, and agreement
Question: *Standard 500 C specifies that an ALF enter into a written agreement with all providers of mental health services utilized by residents. What if a resident, as is their right, obtains services from a mental health provider that has not signed an agreement with the facility, or one the facility does not have an agreement with? For example, the residents seeks out the services they want, but does not necessarily tell the facility, and then the facility finds out, are they required to obtain a written agreement?*
Answer: The facility must make the effort to obtain a written agreement with each public or private mental health services provider utilized by residents in the facility, therefore, when the facility becomes aware that a resident is receiving mental health services from a provider, the facility must make an effort to secure an agreement. As stated in 500 C 4, if the facility is unable to secure an agreement, it must document the reason for the failure and all efforts made to secure the agreement. (0128 - 5/07)

22 VAC 40-72-500 C and D – Mental health services coordination, support, and agreement
Question: *If an MR resident does not need mental health services, does he need a mental health agreement in his case record?*
Answer: A mental health services agreement is required when a resident is actively receiving mental health services, which will include residents receiving only case management services. The agreement must be maintained on file at the ALF, but is not required to be in the resident's record. (0158 - 5/07)

22 VAC 40-72-500 D – Mental health services coordination, support, and agreement
Question: *Are progress reports needed if a resident sees a psychiatrist only for medication management and review, not for therapy?*
Answer: Medication services are a type of service which may be received from the local community mental health, mental retardation and substance abuse services board, or a public or private mental health clinic, treatment facility or agent. As such, the standard requires written progress reports for a resident who sees a psychiatrist only for medication management and review. (0500 - 12/07)

22 VAC 40-72-500 E – Mental health services coordination, support, and agreement
Question: *If a facility contacts a CSB to have a resident evaluated for emergency psychiatric services and the CSB does not come out to evaluate the resident, will the facility be cited for not meeting that particular need of the resident even though it is the responsibility of the CSB to address that particular need?*
Answer: If a CSB (or behavioral health authority) fails to respond to a facility's request to evaluate a resident whom the facility thinks is in need of emergency psychiatric services, and the

event is clearly documented in the resident's record, then the facility will not be cited. However, if the facility has determined that there is a threat of imminent harm to the resident of concern and/or others and the CSB (or behavioral health authority) does not respond, the facility is to call the local police to secure an emergency custody order, pursuant to §37.2-808 of the Code of Virginia. (0037 - 5/07)

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22 VAC 40-72-520 Activity/recreational requirements

22 VAC 40-72-520 – Activity/recreational requirements
Question: *If a resident with mental illness goes to a day support program, does that count toward the 14 hours of required activities? Also, is what the resident does while attending the day support program important in determining whether the program counts toward the 14 hours of scheduled activities per week?*
Answer: If all residents are attending activities away from the ALF each day, then time may be counted toward meeting the 14 hours of required activities. However, this does not mean that if the residents were able to obtain the 14 hours of scheduled activities within, e.g., 2 or 3 days, that the ALF does not need to provide at least one hour of scheduled activities each day, as required by Standard 520.B. Nor does it mean that the facility is not responsible for providing the required hours of scheduled activities when one or more residents do not attend activities sponsored by an independent agency or organization and choose to remain in the ALF.

Regarding what qualifies a day support program to count, there must be structured activities for the residents to participate in with the goal of re-learning or acquiring new knowledge and/or skills. (0485 - 12/07)

22 VAC 40-72-520 B – Activity/recreational requirements
Question: *Is what the resident does while attending the day support program important in determining whether the program counts toward the 14 hours of scheduled activities per week?*
Answer: Yes, in order for the program to count, there must be structured activities for the residents to participate in with the goal of re-learning or acquiring new knowledge and/or skills. (0486 - 12/07)

22 VAC 40-72-520 C and G 2 b and 22 VAC 40-72-1100 A – Activity/recreational requirements
Question: *Do we have to code our activities schedules or in some way identify which category each activity falls under? How is "category" distinguished from "type" of activity?*
Answer: The categories as required by 22 VAC 40-72-520 C and 22 VAC 40-72-1100 A do not have to be identified on the written activity schedule. However, the facility is responsible for ensuring that the activities offered each week include at least those from every category specified. If an inspector is unable to discern, from the schedule, whether all required categories are addressed by one or more activities or what any one activity is, the facility must provide any needed clarification.

The "type" of activity, which must be included on the schedule as required by 22 VAC 40-72-520 G 2 b, refers to the classification of the activity, such as gardening, exercise, bingo, arts and crafts, etc. The "name" of the activity, which must also be included on the schedule as required

by 22 VAC 40-72-520 G 2 b, may be whatever the facility chooses to call it and may be a catchy title, such as "Fun in the Sun." Although this title may be appealing, it does not describe the activity, which may be gardening, an outdoor exercise class, a picnic, etc., which would be the "type" of activity. The "name" and "type" need not be different, and then would only have to be included once, such as if gardening is just called gardening. In other words, if the "name" is self-explanatory, it does not need to be repeated as "type." (0590 - 12/07)

22 VAC 40-72-520 C – Activity/recreational requirements

Question: *Does the activity person need to be trained in "physical, cognitive, productive, sensory, reflective, outdoor, and nature" and will the STATE offer such trainings for the activity director/staff?*

Answer: There is no requirement for the activity director or staff to have training in these specific topic areas. However, 22 VAC 40-72-520 D requires that activities shall be planned under the supervision of the administrator or other qualified staff person. Also, 22 VAC 40-72-520 L requires that the staff person or volunteer leading an activity have a general understanding of: 1. attention spans and functional levels of the residents; 2. methods to adapt the activity to meet the needs and abilities of the residents; 3. various methods of engaging and motivating individuals to participate; and 4. the importance of providing appropriate instruction, education and guidance throughout the activity. DSS develops and offers activities-based training in cooperation with both the Virginia Geriatric Education Center and the Alzheimer's Association. (0187 - 5/07)

22 VAC 40-72-520 D – Activity/recreational requirements

Question: *Define "qualified staff person."*

Answer: The term "qualified" is defined in 22 VAC 40-72-10 as "having appropriate training and experience commensurate with assigned responsibilities; or if referring to a professional, possessing an appropriate degree or having documented equivalent education, training or experience." In addition, the staff person is required to meet any statutory or regulatory requirements that may apply (e.g., licensed health care professional, registered medication aide, etc.). (0148 - 5/07)

22 VAC 40-72-520 G-Activity/recreational requirements.

Question: *This standard states: "There shall be a written schedule of activities that meets the following criteria:*

1. The schedule of activities shall be developed at least monthly.
2. The schedule shall include:
a. Group activities for all residents or small groups of residents; and
b. The name, type, date and hour of the activity."

Are the "types" of activities required to be coded on the activity schedule in accordance with the categories outlined in 22 VAC 40-72-520 (C), e.g., physical, social, cognitive? Including this type of information on the schedule may confuse residents about the available activities.

Answer: A description of the type of activity must be included on the written schedule. The type of activities that may be offered are not limited to those listed in 22 VAC 40-72-520 C. The facility should identify the activities in a manner that is understandable to the resident.
(0581 - 6/08)

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22 VAC 40-72-530 Freedom of movement

22 VAC 40-72-530 – Freedom of movement
Question: *What would be on the UAI to indicate an individual has a serious cognitive impairment and cannot recognize danger or protect own safety/welfare?*
Answer: There are some indicators in Section 3 (Psycho-Social Status) of the Private Pay UAI and even more in Section 4 (Psycho-Social Assessment) of the Public Pay UAI. However, neither of these sections specifically addresses a resident's ability to recognize danger or protect one's own safety and welfare. Rather, they are intended to yield sufficient information to the UAI assessor to support a referral to a physician or licensed clinical psychologist who is qualified to conduct a formal assessment to determine the extent of the person's cognitive impairment. (0373 - 12/07)
Question: *Are ALFs allowed to lock doors to prevent access into the facility from the outside?*
Answer: A facility may lock doors to prevent access into the facility as long as residents inside a facility (except those in a special care unit) are not locked in. (0378 - 12/07)

Question: *May a facility have a locked perimeter fence?*
Answer: Only a special care unit may have a locked perimeter fence, as provided for in 22 VAC 40-72-1130 A and 1140. (0381 - 6/08)

Question: *Are ALFs allowed to lock doors to prevent access into the facility from the outside?*
Answer: Yes. A facility may lock doors to prevent access into the facility as long as residents inside a facility are not locked in or prevented from freely leaving the facility (except as noted in 22 VAC 40-72-1020 A and 22 VAC 40-72-1130 A). (0378 - 6/08)

Question: *If a person has a serious cognitive impairment and cannot recognize danger or protect own safety/welfare, could he be considered ambulatory if he is physically and mentally capable of self-preservation by evacuating in response to an emergency with a single verbal command?*
Answer: Probably most of these individuals would be considered non-ambulatory, but there could be the exception of a person who is capable of self-preservation by evacuating in response to an emergency with a single verbal command even though the individual has a serious cognitive impairment and cannot recognize danger or protect own safety/welfare. (0375 - 6/08)

22 VAC 40-72-530 A – Freedom of movement
Question: *What would be on the UAI to indicate an individual has a serious cognitive impairment and cannot recognize danger or protect own safety/welfare?*
Answer: There are some indicators in Section 3 (Psycho-Social Status) of the Private Pay UAI and even more in Section 4 (Psycho-Social Assessment) of the Public Pay UAI although neither of these sections specifically address a resident's ability to recognize danger or protect own safety/welfare. The indicators in Sections 3 and 4 of the UAI are intended to be used to determine whether a more formal assessment is needed. (0373 - 6/08)

22 VAC 40-72-530 C – Freedom of movement
Question: *Does this standard also apply to special care units?*

Answer: Yes, all residents shall be allowed access to common areas and their personal spaces. No resident shall be locked out of or inside his room. (0376 - 12/07)

Question: *If a resident is in his room, may he lock his door?*
Answer: He may lock the door while inside the room if:

- the lock conforms to the Uniform Statewide Building Code;
- locking the door does not infringe upon the rights of a roommate;
- a key is readily available to allow staff access to the room; and
- locking the door does not prevent staff from providing proper supervision; and
- he is not a resident with a serious cognitive impairment who cannot recognize danger or protect his own safety and welfare.(0379 - 12/07)

Question: *If a resident is outside his room, may he lock his door?*
Answer: He may lock the door when he leaves the room if:

- the lock conforms to the Uniform Statewide Building Code;
- locking the door does not infringe upon the rights of a roommate;
- a key is readily available to allow staff access to the room; and
- locking the door does not prevent staff from providing proper supervision. (0380 - 12/07)

Question: *Does "personal spaces" mean residents' assigned rooms?*
Answer: Personal spaces would include residents' assigned rooms and other areas such as a shared bathroom between two rooms. (0377 - 6/08)

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22 VAC 40-72-550 Resident rights

22 VAC 40-72-550 C – Resident rights
Question: *Is use of reverse peepholes in doors of residents' rooms permissible? A facility wishes to use reverse peepholes to monitor the residents on a dementia unit at night when they are asleep.*
Answer: A reverse peephole allows a staff person, or anyone else for that matter, to look into a resident's room without the resident having any control over when a person is looking in. The *Code of Virginia*, § 63.2-1808.A.17 (resident rights), states that each resident of an assisted living facility must be "… accorded respect for ordinary privacy in every aspect of daily living…." Reverse peepholes are a violation of this right and are therefore not permitted in assisted living facilities. (0371 - 6/08)

22 VAC 40-72-550 C and Code of Virginia, § 63.2-1808 A 8 – Resident rights
Question: *Are pharmacies included in the definition of health care services as referenced in § 63.2-1808 A 8 of the Code of Virginia? If the answer is yes, is it acceptable for an ALF to ask residents to waive their right to select a reasonably available pharmacy? Can an ALF require that a particular medication system be used?*

Answer: Yes, pharmacies are included in the definition of health care services as referenced in § 63.2-1808 A 8 of the Code of Virginia. This section of the Code specifies the rights and responsibilities of residents of ALFs.

ALFs cannot ask, coerce or require residents to waive any of the rights provided to them in the Code of Virginia. An ALF cannot have an admissions policy that requires waiving any of these rights as a condition of admission. § 63.2-1808 A 8 of the Code states that any resident of an ALF "is free to select health care services from reasonably available resources." Therefore, a facility cannot require that residents obtain their medications from a specific pharmacy, even if the facility contracts with that pharmacy for services. The ALF must make it clear to residents that they have a choice of reasonably available pharmacies. Should a resident choose a different pharmacy, the facility may charge a reasonable fee if additional time and effort is required on the facility's part.

There is a distinction between choice of a pharmacy and the method used by the facility to manage medications. A facility does have the right to select a medication system. In an effort to reduce errors during medication passes, many facilities have instituted unit dose systems. An ALF can require that all residents get their medications packaged for the system chosen by the facility.

If the pharmacy the resident has selected does not package medications consistent with the system chosen by the ALF, the ALF's servicing pharmacy may repackage medications dispensed by another pharmacy. The facility or the ALF's servicing pharmacy may charge a reasonable fee for the repackaging.

It is possible that an ALF may allow for a different system than the facility has chosen, but the resident may be charged a reasonable fee for the additional time and effort this would take the facility, if such is the case. (0650 – 7/14)

22 VAC 40-72-550 D – Resident rights

Question: *Must the facility have written policies and procedures for implementing each of the resident rights or is an overall summary of policy and procedures regarding resident rights as a whole acceptable?*

Answer: The facility must have written policies and procedures for implementing each of the rights and responsibilities of residents specified in § 63.2-1808 of the Code of Virginia. In other words, there must be policies and procedures that address each of the rights and responsibilities; an overall general summary is not acceptable. However, how the policies and procedures are organized is up to the facility; i.e., they all may be in one document, they may be in several documents, they may be organized by topic areas, etc. Policies provide general guidance that captures beliefs or principles, whereas procedures provide action steps or prescribed rules for implementation. Procedures should be clear and specific, as well as reasonable and practical. Please go to the Department's public website, which is http://www.dss.virginia.gov, to see *Model Policies with Suggested Procedures for the Implementation of Section 63.2-1808: A Technical Assistance Manual for Operators of Licensed Assisted Living Facilities*. (0601 - 6/08)

22 VAC 40-72-550 E – Resident rights
Question: *"The rights and responsibilities of residents shall be printed in at least 12-point type and posted conspicuously in a public place in all assisted living facilities." What is "posted conspicuously?"*
Answer: The rights and responsibilities of residents must be displayed in such a way as to be easily located and read. (0372 - 6/08)

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22 VAC 40-72-560 Resident records (7/15-Q1)

22VAC 40-72-560 Resident Records
Question(Q1): *When a document is completed and retained electronically, what is acceptable regarding any required signatures?*
Answer: When a document is completed and retained electronically, signatures and any accompanying dates can be entered either electronically or placed on paper. All applicable assisted living facility standards apply. Use of electronic signatures and records must also comply with the provisions of the Uniform Electronic Transactions Act, §§ 59.1-479 through 59.1-501 of the Code of Virginia.

In addition, if electronic signatures are used, the licensee must:

1. Develop, implement, and maintain specific policies and procedures for the use of electronic signatures;

2. Ensure that each electronic signature identifies the individual signing the document by name and title;

3. Ensure that the document cannot be altered after the signature has been affixed;

4. Ensure that access to the code or key sequence is limited;

5. Ensure that all users have signed statements that they alone have access to and use the key or computer password for their signature and will not share their key or password with others; and

6. Ensure that strong and substantial evidence exists that would make it difficult for the signer or the receiving party to claim the electronic representation is not valid.

When the document is electronic and the required signatures and dates are placed on paper, which obviously is separate from the electronic document, there must be clear notation of the specific document to which the signatures are related and clear indication that the individuals have reviewed, agreed with, participated in, etc., the document, depending upon the requirements of the standard for that document. The paper with the signatures and any accompanying dates must be maintained with the document, which would either involve scanning the paper or utilizing other technology to place the paper with the electronic document. In other words, the complete content of the document, which includes the signatures, must be kept together.

For example, the resident agreement/acknowledgment of notification must be dated and signed by the resident/applicant for admission or the appropriate legal representative, and by the licensee or administrator. The agreement/acknowledgment may be completed electronically, including electronic signatures/dates, or the signatures/dates may be placed on paper. No matter which way it is done, all items required in the agreement/acknowledgment, including the signatures/dates, must be kept together. If a facility does not have the technology to do that electronically, then a hard copy of the electronic version would have to be maintained. (0662 – 7/15)

22 VAC 40-72-560 D – Resident records
Question: *Must the department's model forms be used by an assisted living facility?*
Answer: No. A facility may use its own forms rather than the department's model forms as long as all the information required by a standard is included. The model forms are designed to assist the facility, but are not required to be used. The fact that the document is a model form is so noted at the top of the form, and each form has a reference number at the bottom. Please note that if a form is mandated, such as the Disclosure Statement required by 22 VAC 40-72-60, it must be used by the facility. (0331 - 6/08)

22 VAC 40-72-560 I – Resident records
Question: *Do family members and those with power of attorney have access to a resident's record?*
Answer: If a person is a legal representative of the resident, that person has access to the resident's record or part of the record as allowed by the scope of the representative's legal authority. The definition of "legal representative" is found in 22 VAC 40-72-10. (0366 - 6/08)

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22 VAC 40-72-580 Food service and nutrition

22 VAC 40-72-580 – Food service and nutrition
Question: *Can a family member who wants to feed a resident in his room be allowed to do so?*
Answer: If a family member routinely or regularly feeds a resident in his room, the facility would have to comply with the requirements of 580 B 1 a or b. If a family member occasionally feeds a resident in his room, the facility would have to comply with 580 B 2. The fact that a family member is assisting at mealtime does not eliminate the responsibility of the facility staff for monitoring intake as required by 580 F. (0072 - 5/07)

22 VAC 40-72-580 B 1 and F – Food service and nutrition
Question: *If we are to give residents a choice of eating privately in their rooms (with a plan) how can we monitor their food consumption, etc. if we have 200 residents who might opt for dining in their room?*
Answer: 580 B 1 does not require the facility to offer residents this option unless routine or regular room service is part of the facility's policy and procedure. If the facility chooses to offer this option and "200 residents" choose to exercise the option, the facility is responsible for developing and implementing a monitoring plan consistent with the requirements outlined in 580 F. (0028 - 5/07)

22 VAC 40-72-580 F – Food service and nutrition
Question: *Can you clarify monitoring meal consumption? Does this mean meal attendance or % of meal eaten?*
Answer: The standard requires the facility to develop and implement a policy to monitor each resident's food consumption. Estimating what percentage of the food served was actually consumed is one method that can be used because it allows staff to be aware of significant changes that may indicate developing physical or mental problems. (0073 - 5/07)

Question: *Does the facility have to document the percentages of food consumed by the residents?*
Answer: It is not necessary for the facility to document what percentage of the food that is served is consumed as long as the facility has a policy that establishes another method for monitoring consumption that is understood and implemented by facility staff. Inspectors will review policy and may question staff and residents to determine what and how successfully methods are being used. (0091 - 5/07)

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22 VAC 40-72-610 Number of meals

22 VAC 40-72-610 A – Number of meals
Question: *Must a facility provide three meals a day to all residents, or if a facility charges separately for meals, can residents choose to pay for and thus receive only two meals a day?*
Answer: The standard requires that the facility provide at least three meals a day to each resident, unless contraindicated by the attending physician, or unless a resident with independent living status has opted to obtain some or all meals from another source as allowed in 22 VAC 40-72-580 C. A facility can use whatever method it prefers regarding charges or fees for services and care, but it cannot provide fewer than three meals a day to residents, unless one of the two exceptions noted above applies. Please note that for residents receiving an auxiliary grant, the three meals must be included in the facility's rate.

This does not exempt the facility from meeting the requirements of 22 VAC 40-72-610 B, i.e., snacks must be made available for all residents desiring them, including residents with independent living status who have opted to obtain some or all meals from another source, or in accordance with their physician's or other prescriber's orders. (0649 - 7/14)

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22 VAC 40-72-620 Menus for meals and snacks

22 VAC 40-72-620 B – Menus for meals and snacks
Question: *Regarding posted menus (in a secured unit) is it necessary to have a weekly/monthly menu posted? Some residents become confused with a weekly/monthly menu. What if a facility posts a daily menu with each meal on an individual 8½ x 11 sheet of paper with the meal (breakfast, lunch, and dinner) on it as well as the time it will be served and what will be served. Is this individualizing/tailoring causing the facility to be out of compliance with the standards?*
Answer: The standard requires that the menus be dated and posted for the current week. It does not require a particular format as long as the meal plans for the week are readily accessible to those residents and families/friends who prefer to know what is scheduled ahead of time. It

would be acceptable to post an optional daily menu in addition to the required weekly menu if a facility chooses to do so. (0140 - 5/07)

22 VAC 40-72-620 F – Menus for meals and snacks

Question: *Can an ALF determine that they are not going to offer special diets? (information would need to be shared in disclosure to prospective residents).*

Answer: While there is nothing in the standards to prevent a facility from doing this, it poses a problem if a resident's physician determines that the resident needs a special diet (no added sugar, low sodium, low fat, mechanically altered, etc.) The facility would have to make special arrangements to meet the identified need until such time as discharge arrangements can be made for the resident. (0119 - 5/07)

Question: *Why would "no added salt" and "no concentrated sweets" diets be considered special diets?*

Answer: These diets are ordered for the treatment of conditions such as diabetes and hypertension. They require planning beyond withholding sugar and desserts or table salt. Certain prepared foods, such as canned soups and sweetened cereals, some vegetables which are high in natural salts and sugars, and many processed meats must be used in moderation or not at all. The residents require evaluation of the meal plan and its effectiveness in meeting their individual needs. (0180 - 5/07)

22 VAC 40-72-620 F and G – Menus for meals and snacks

Question: *What is considered a "special diet"? Anything other than regular? Please include examples.*

Answer: "Special diets, medical nutrition therapy, diet therapy, therapeutic diets" are defined for our purposes as any diet ordered by a physician as part of treatment for a disease or clinical condition (e.g., no concentrated sweets for a diabetic), or to eliminate or decrease specific nutrients in the diet (e.g., sodium), or to increase specific nutrients in the diet (e.g., potassium), or to provide food the resident is able to eat (e.g., a mechanically altered diet). A mechanically altered diet is one in which the texture of a diet is altered. When the texture must be modified when prepared, the type of texture modification must be specified in the physicians' order. [This does not include cutting meats, vegetables or fruit for residents who simply need some assistance after the meal is served.] The more common practice amongst physicians and dietitians in long term care is to liberalize the diet (e.g., a physician order for Regular Diet) to increase acceptance of the meal. A well balanced regular diet such as that which is promoted through MyPyramid.gov can be considered appropriate/sufficient for most individuals as long as weight gain or loss and general physical condition are monitored. If an individual's diagnosis or clinical condition is determined to require stricter management of dietary intake, the physician and dietitian will determine which special diet is appropriate. (0134 - 5/07)

22 VAC 40-72-620 G, 480 and 290 – Menus for meals and snacks

There is an applicable question/answer under Standard **22 VAC 40-72-290**.

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22 VAC 40-72-630 Medication management plan and reference materials

22 VAC 40-72-630 A and 90 A, B, C – Medication management plan and reference materials
There is an applicable question/answer under Standard 22 VAC 40-72-90A,B,C

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22 VAC 40-72-640 Physician's or other prescriber's order

22 VAC 40-72-640 B and D - Physician's or other prescriber's order
Questiion: *Can a facility accept an oral order directly from a pharmacist – is the pharmacist an authorized agent of the physician? If so, who is responsible for having the order signed? Also, may the physician's nurse call and give an oral order to another nurse or medication aide?*
Answer: Yes, it is acceptable for a pharmacist to give the medication aide or nurse an oral order the pharmacist has received from the physician. Per the Board of Pharmacy, the pharmacist is considered to be an "authorized agent" of the physician. The oral order must still be signed by the physician within the 10 day time frame and it is the responsibility of the facility to see that the order is signed. The facility (nurse or registered medication aide) may also accept an oral order from the physician's licensed nurse who is acting as an "authorized agent" of the physician. Please refer to the reference below from the Virginia Board of Pharmacy per email on May 15, 2013: "…A pharmacist may serve as an authorized agent of the prescriber in compliance with §54.1-3408.01." §54.1-3408.01 C. states: "The oral prescription referred to in § 54.1-3408 shall be transmitted to the pharmacy of the patient's choice by the prescriber or his authorized agent. For the purposes of this section, an authorized agent of the prescriber shall be an employee of the prescriber who is under his immediate and personal supervision, or if not an employee, an individual who holds a valid license allowing the administration or dispensing of drugs and who is specifically directed by the prescriber." (0641 - 7/14)

22 VAC 40-72-640 B and D – Physician's or other prescriber's order
There is an applicable question/answer under Standard **22 VAC 40-72-640 D**

22 VAC 40-72-640 D 1 b – Physician's or other prescriber's order
Question: *Can medication aides accept oral orders from an MD? I did not think they were allowed to do that.*
Answer: Medication aides can accept oral (verbal, telephone) orders from physicians or other prescribers **to administer** the prescribed medication. [The documentation of the oral order must be reviewed and signed by the physician or other prescriber within 10 working days as required in 640 D 2.] Medication aides are required to advise the prescriber that they are not nurses and therefore cannot transmit the order to the pharmacy. The prescriber or his/her designee must contact the pharmacy with the prescription order to be filled. (0076 - 5/07)

22 VAC 40-72-640 D 2, 930 F 2, 100 A, 201 B 1 and 370 B – Physician's or other prescriber's order
There is an applicable question/answer under Standard 22 VAC 40-72-100 A

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22 VAC 40-72-650 Storage of medications

22 VAC 40-72-650 B - Storage of medications
Question: *A couple shares an apartment in an ALF. The husband is assessed as independent living, and the wife is assessed as assisted living level of care. He leaves his medications unsecured on a table top, accessible to his wife. The facility does not administer the medication to the husband. Is this acceptable?*
Answer: ALF standard 22 VAC 40-72-660 requires that "staff" who administer medications in an ALF "shall be authorized" by § 54.1-3408 of the VA Drug Control Act. Is a staff hired at the ALF facility as direct care and who is currently a student in a medication aide training program owned by the ALF's administrator (a BON approved instructor for the med aide training curriculum), required to have a provisional letter prior to actually administering medications as a skill practice at the ALF? Should the med aide in training sign and initial the MAR when he/she administers meds or does the trainer supervisor observing the trainee initial and sign his/her own name in place of the med aide trainee?
No. Since the couple resides together in the licensed ALF, both are considered to be residents. Therefore, the requirements of this standard apply and the medications that belong to the husband need to be in a "secure place" and "not accessible to other residents." (0647 - 7/14)

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22 VAC 40-72-660 Qualifications and supervision of staff administering medications (7/15-Q1)

22 VAC 40-72-660 Qualifications and supervision of staff administering medications
Question(Q1): *ALF standard 22 VAC 40-72-660 requires that "staff" who administer medications in an ALF "shall be authorized" by § 54.1-3408 of the VA Drug Control Act. Is a staff hired at the ALF facility as direct care and who is currently a student in a medication aide training program owned by the ALF's administrator (a BON approved instructor for the med aide training curriculum), required to have a provisional letter prior to actually administering medications as a skill practice at the ALF? Should the med aide in training sign and initial the MAR when he/she administers meds or does the trainer supervisor observing the trainee initial and sign his/her own name in place of the med aide trainee?*
Answer: If the direct care staff person in training for the position of med aide is being directly supervised (one on one supervision) by the authorized trainer as part of the clinical practice component of this training, then that staff person may administer medications (see 18 VAC 90-60-60. Requirements for the program curriculum.). The medication aide in training may not administer medications in the facility under any other circumstances until the individual obtains a provisional license issued by the Department of Health Professions.

The med aide in training needs to sign and initial the MAR. It is customary, *but not regulatory*, for the student to sign the MAR as "med aide student" and to use the designation (m.a.s.) following their personal initials. The instructor isn't required to sign but has to keep records of the clinical portion of the training (which is regulatory). (0666 -7/15)

22 VAC 40-72-660 and 670 - Qualifications and supervision of staff administering medications

Question: *Can family members, friends or privately hired caregivers administer medications to a resident in an assisted living facility if they do not hold a current license or registration permitting them to administer medications?*

Answer: No. The portion of the *Code of Virginia* known as the *Drug Control Act* dictates who can administer medications to residents while they are in an assisted living facility. In addition to licensed health care professionals who may administer medications as a part of the scope of their professional practice, the *Code of Virginia,* § 54.1-3408.M. permits only registered medication aides to administer medications to residents in licensed assisted living facilities. (0635 - 7/12)

22 VAC 40-72-660 and 670 - Qualifications and supervision of staff administering medications

Question and Answer # 0622 deleted 07/12 (replaced with new numbers 0635 & 0636).

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22 VAC 40-72-670 Administration of medications and related provisions (7/15-Q1, Q2)

22 VAC 40-72-670 and 660 - Administration of medications and related provisions

There is an applicable question/answer under Standard **22 VAC 40-72-660**.

22 VAC 40-72-670 - Administration of medications and related provisions

Question: *What is required of the facility if a resident has family members, friends or privately hired caregivers who do have a current license or registration permitting them to administer medications and who administer medications to a resident in the assisted living facility?*

Answer: In order for anyone other than facility staff to administer medications to residents, the assisted living facility must request and receive approval for a resident-specific Allowable Variance (AV) for 22 VAC 40-72-670. The information that must be submitted as a part of the request includes, but is not limited to, the following:

- There must be validation that the individual has current license or registration as a health care professional permitted by law to administer medications (examples include nurse, pharmacist, physician, registered medication aide, etc.)
- There must be facility approved back-up plans such as additional qualified family members or a written agreement with the facility to ensure that someone is ready, willing and able to provide the service in case the family member, friend or hired caregiver is suddenly unable to perform the tasks.
- There must be a written agreement between the facility and the party/parties assuming this responsibility.
- The agreement must acknowledge the fact that the facility must be provided with current and complete information related to prescribed and administered medications, including over-the-counter medications and supplements, in case of a medical emergency. While the family member(s) are not required to use an MAR, some form of documentation that identifies what medications were administered and what time they were administered must be maintained for monitoring purposes and in case of an emergency.

It will be the facility's responsibility to ensure that the resident's Individualized Service Plan accurately reflects the involvement and the responsibilities for meeting the resident's medication administration needs.

The family, the physician and the ALF must understand that any indications that this plan is placing the resident's health, safety and welfare at risk must be addressed immediately with family, physician, Adult Protective Services and/or assigned Licensing Inspector as appropriate. (Letters of approval for the AV will specify that the AV can be revoked at any time there is evidence that the intent of the regulations is not being met. (0636 – 7/12)

22 VAC 40-72-670 C – Administration of medications and related provisions
Question: *Do all meds have to be witnessed as taken when administered by ALF staff?*
Answer: Yes. If the resident is assessed as incapable of self-administering medication or the facility has policy that assumes responsibility for providing medications and treatments for all residents, the medication staff must witness the resident taking his medication or treatment as prescribed. (0403 - 6/08)

Question: *Can a resident be both "self-administer" for some medications and "facility administer" for other M.D. ordered medications? Would this have to be assessed as part of the UAI?*
Answer: Yes, it is possible for a resident to be able to self-administer some medications, but need facility medication staff to administer other medications. This would have to be assessed and documented on the UAI. In such a case, the most restrictive or limiting option is to be selected, that is, "Administered/monitored by lay person" or "Administered/monitored by professional nursing staff" (whichever is appropriate) would have to be checked. Since only one option is to be selected, the option of "Without assistance" is not to be checked under these circumstances. A note is to be made that the resident is able to self-administer certain medication(s) as approved by the physician and the approved medication(s) must be specified. (0421 - 6/08)

22 VAC 40-72-670 E - Administration of medications and related provisions
Question: *What can med staff do if the prescribing physician sends sample medication(s) that have not been labeled as required by this regulation?*
Answer: Since facilities must have an order from the prescriber to administer the medication(s) as required in 22 VAC 40-72-640, the Board of Pharmacy has advised us that ALF med staff may attach a copy of the prescriber's order for the sample medications, i.e., rubber banding, taping to one corner of the sample package, as long as the package labeling is not obscured. (0632 – 3/10)

22 VAC 40-72-670 F - Administration of medications and related provisions
Question: *Do med staff have to label packages of over-the-counter medications with all of the information that the pharmacy puts on their labels?*
Answer: No. The standard requires only that, if not repackaged by the pharmacy, the medication must remain in the original packaging and be labeled with the resident's name. (0633 – 3/10)

22 VAC 40-72-670 F & K - Administration of medications and related provisions
Question: *Do recent changes in the Board of Pharmacy regulations mean that ALFs can now have floor stock of over-the-counter medications?*
Answer: No. While the changes in the pharmacy regulations make it possible for the pharmacy to provide long term care facilities with OTC products as floor stock, the activity is prohibited in ALFs by VDSS licensure regulations. (0634 – 3/10)

22 VAC 40-72-670 H – Administration of medications and related provisions
Question: *How long is a facility required to keep a resident's medication administration record (MAR)?*
Answer: The MAR is a permanent part of each resident's record and as such must be maintained for at least two years after the resident leaves the facility as required in 560 J. Typically, the standard of practice is to maintain the MAR forms for the most recent 3-6 months in the resident's current file. Older forms may be kept properly labeled and stored with archived files but must be available upon request if needed for inspection or other investigative purposes. (0090 - 5/07)

22 VAC 40-72-670 H 11 – Administration of medications and related provisions
Question: *What steps do we have to take to comply with this regulation when a resident refuses a dose of medicine or misses a dose because he or she is off the premises and does not return in time for safe administration before the next scheduled dose?*
Answer: There are a number of appropriate methods for handling the described scenario depending upon the drug and any relevant implications described in the reference materials, any written understanding with the attending physician and any written facility policy. In the absence of physician orders and/or a written facility policy related to missed doses, physician notification with actions based on subsequent physician orders and documentation of the circumstances and follow-up will satisfy the regulatory requirement. (0589 - 12/07)

22VAC 40-72-670 H 14 – Administration of medications and related provisions
Question(Q2): *Staff responsible for administering meds sign and initial one sheet that is placed in the front of each MAR book, instead of all staff signing and initialing monthly on the backs of all residents' MARs. The signature sheet is kept in the front of the MAR. Is this acceptable?*
Answer: Yes, the facility may use a master list of all staff administering medications. The list must be kept in the appropriate MAR notebook at all times and must be kept accurate and up-to-date. Depending on the system the facility uses, a copy of the master signature sheet must be placed either with the monthly MARs when they are removed from the current record, or in each record for each individual resident, and retained as required by other regulations. (0658 – 7/15)

22 VAC 40-72-670 J – Administration of medications and related provisions
Question (Q1): *What is acceptable for "comfort kit" medications ordered for residents who are in hospice? Must they be kept in the medication cart? Are they considered "stat" boxes? Is it OK for a hospice provider to send a list of these medications on a "med sheet" without a physician's signature?*
Answer: Comfort kits typically contain a selection of medications commonly used in hospice care. For example, you might see Ativan, Morphine, Phenergan, or others for symptom relief. Comfort kits may be found in the refrigerator since the medications they contain usually require

this (manufacturer's recommendations for storage are to be followed). See 22 VAC 40-72-650 A 6 regarding requirements for storage of refrigerated medications.

The pharmacy labels are usually placed on the outside of the box and not on each individual medication. We do not allow the placement of the kit in an ALF without the appropriate labels and orders. Each individual medication must be labeled in accordance with the requirements under 22 VAC 40-72-670 D. The hospice provider has to meet all of our regulations regarding packaging, labeling and proper format for PRN medications for any hospice resident in our facilities.

The physician orders must meet our criteria for the use of any PRN. Some hospice residents might be sufficiently alert and oriented to meet the criteria under 670 J.1, or there may be facilities that use only licensed health care professionals for *medication administration* in which case the more stringent requirement under 670 J.3 wouldn't apply. Otherwise, the PRN orders for medications in the comfort care kit must meet 670 J.3.

Comfort kits are not the same as "stat-drug boxes" (refer to 22 VAC 40-72-670 L. for regulations addressing the use of stat-drug boxes).

Hospice nurses operate under the supervision of a physician; comfort kits and the related orders are similar to "standing orders" used in some facilities. These orders are typically initiated by the nurse when the resident elects the hospice benefit although *they are physician orders and are usually electronically signed*. The inspector can accept hospice orders initiated by the nurse as a "physician order" that meets the requirement of 22 VAC 40-72-640 B. "Med sheets" are simply lists of a resident's medications and are not acceptable as physician's orders or MARs. (0655 – 7/15)

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22 VAC 40-72-680 Medication review

22 VAC 40-72-680 – Medication review
Question: *Does the licensed health care professional conducting the medication review have to write comments for each element listed in the regulation?*
Answer: Only those elements for which there are significant findings need to be specifically addressed in writing, but there needs to be an indication in writing that all elements were reviewed. The licensed health care professional conducting these reviews is accepting responsibility for accountability with his/her signature on whatever reporting form they and/or the facility have chosen to use. Their accountability becomes an issue for licensing if the inspector becomes aware of significant circumstances that would indicate that they did not look at particular elements or follow through with appropriate recommendations to the facility and or the physician. (0599 - 12/07)

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22 VAC 40-72-700 Restraints

22 VAC 40-72-700 A – Restraints
Question: *Please provide clarification on whether Geri chairs are allowed in ALFs. Are Geri chairs restraints when used in assisted living?*

Answer: ALF regulations don't prohibit the use of Geri chairs in ALFs. As with any device, in order to determine if the device is actually a restraint, it must always be evaluated within the context of the definition of restraint and the physical, functional and cognitive abilities of the specific resident. A device such as a Geri chair might be a restraint for one individual and not another. First consider the definition of a restraint: "Physical restraint means any manual method or physical or mechanical device, material, or equipment attached or adjacent to the resident's body that the resident cannot remove easily, which restricts freedom of movement or access to his body." So, if the resident is ambulatory with a diagnosis of dementia with poor safety awareness, unable to follow directions and wandering, and the facility uses the Geri chair to keep the resident in the chair and "safe," then the chair would constitute a restraint for that resident since it meets the definition (restricts the ability of the resident to ambulate). All of the additional requirements under 22 VAC 40-72-700 B and C would apply. However, if the resident is unable to ambulate but has a medical symptom such as poor trunk control due to the latent effect of a stroke, and the Geri chair and locking tray top are used only for positioning during meals and do not restrict the resident's usual freedom of movement, then the device *might* be considered an assistive device, rather than a restraint, for that resident.

Geri chairs should be used with caution as they are frequently not the best choice for ALF residents. Many of them can be uncomfortable and may add to pressure over bony prominences. Preventive care (pressure relief, toileting, etc.) should be provided for *any* resident using a Geri chair and should be included on the resident's ISP. (0646 - 7/14)

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PART VII. RESIDENT ACCOMMODATIONS AND RELATED PROVISIONS

22 VAC 40-72-730 Resident rooms

22 VAC 40-72-730 – Resident rooms

Question: *When residents furnish their own rooms must the facility dictate to residents that each of these items be bought, even when they would not have chosen to do so?*
Answer: Standard 730 A provides that the resident is to be encouraged to furnish or decorate his room as space and safety considerations allow and in accordance with the regulations. Standard 730 B specifies the items to be contained in each bedroom. Whether a bedroom is furnished by the facility or by the resident, the items specified in the standard must be included. If the resident does not wish to buy a particular item himself, then the facility must furnish it. (0056 - 5/07)

22 VAC 40-72-730 B – Resident rooms

Question: *A facility making application for ALF licensure plans to require residents to bring their furniture or rent it from the facility. The facility will serve private pay residents only. Is there anything that prohibits the facility from renting the furniture?*
Answer: The facility is not prohibited from renting the furniture to private pay residents. The facility is responsible, however, for making sure that bedrooms contain the items required by the standards. In all cases a resident's room must meet all applicable standards related to the type and condition of furnishings. The facility must make it clear in the written agreement that residents must bring their furniture or rent it from the facility and it must be clear what they have chosen to do. In addition, any specific conditions of the arrangement, including charges

involved, must be specified in the written agreement. (See Standard 390 regarding the written agreement.)

Whether the furniture is provided, rented, or brought by the resident, it must meet the regulations, including being kept clean and in good repair.

Please note that a furnished room is included as a mandated covered service under the Auxiliary Grants Program. Therefore, a facility cannot rent furniture to public pay residents, but must provide to them the items required for bedrooms by the ALF standards under its established Auxiliary Grant rate.(0368 - 6/08)

22 VAC 40-72-730 D – Resident rooms
Question: *Does the standard require that ALF facilities purchase and provide linens for residents' use? Some facilities specify that the resident or his family must bring linens to the facility for the resident's use, and do not purchase or provide linens for residents.*
Answer: The facility has the responsibility to assure that residents have clean linens that are kept in good repair. The facility may specify that the resident or his family supply the linens required by the standard. However, if the resident or his family does not do this, the facility must supply the linens. Except for public pay residents, the facility may charge an additional fee for the provision of linens. (0367 - 6/08)

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22 VAC 40-72-760 Laundry and linens

22 VAC 40-72-760 A – Laundry and linens
Question: *Residents are responsible for their own clothing - if someone becomes unable to maintain clean clothing, can an additional charge be made to those whose clothing is being cleaned by the staff?*
Answer: The home has the responsibility to assure that residents' clothing is kept clean and in good repair. Exclusive of public pay residents, the facility sets its fees. (For public pay residents, the regulation for the Auxiliary Grants Program sets a limit on the amount a facility may charge for laundry to be paid from the personal needs allowance.) (0369 - 6/08)

22 VAC 40-72-760 E and 840 G – Laundry and linens
Question: *If residents have access to a laundry room (they are capable of doing their own laundry), does the water temperature for laundry still remain at 140 degrees? The tap is set between 105 -120 degrees. The facility uses the same washer and dryer to wash linens that residents use to wash personal clothes.*
Answer: Standard 760 E requires that bed, bath, table and kitchen linens be washed in water temperature above 140ºF or the dryer must heat the linens above 140ºF or a sanitizing agent must be used. This standard does not apply to the personal clothes of residents, which may be washed and dried at a lower temperature, with no sanitizing agent required. Standard 840 G requires a range of 105º to 120º for hot water at taps available to residents. This standard applies to sinks and showers, not the washing machine. (0039 - 5/07)

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22 VAC 40-72-810 Resident councils

22 VAC 40-72-810 D – Resident councils
Question: *Regarding Resident Council in a dementia unit, what would be the TA for 22 VAC 40-72-810 D, "without the presence of any facility staff" if they are unable to do due to cognitive impairment?*
Answer: If arrangements cannot be made to meet the requirement to allow at least part of each meeting to be conducted without the presence of a staff person, the facility should consider requesting an allowable variance. (0045 - 5/07)

22 VAC 40-72-810 F – Resident councils
Question: *Annual reminder of Council – Does facility need to document that annual reminders were given to residents?*
Answer: Standard 810 requires annual reminders be given to residents regarding a resident council, if there is no council. The standard does not require documentation of these annual reminders. Although not required, it would be advisable for a facility to keep a record of residents who received annual reminders, so there is no question of who received the reminders and so there is no doubt as to when the next reminders must be given. (097 - 5/07)

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22 VAC 40-72-820 Pets living in the assisted living facility

22 VAC 40-72-820 3 – Pets living in the assisted living facility
Question: *Does this include birds, fish, hamsters, guinea pigs…?*
Answer: Facilities will need to consult with their local animal control office or a local veterinarian to determine what immunizations are required for each type of pet that is being considered for residency within the facility and then ensure that the appropriate immunizations have been administered and that the pet is free of diseases transmittable to humans. (0075 - 5/07)

22 VAC 40-72-820 4 a – Pets living in the assisted living facility
Question: *What is expected in the regular examination of pets?*
Answer: Facilities will need to consult with their local animal control office or a local veterinarian to determine the examination requirements for each type of pet that is being considered for residency within the facility. (0156 - 5/07)

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PART VIII. BUILDINGS AND GROUNDS

22 VAC 40-72-840 General requirements (7/15-Q1)

22 VAC 40-72-840 A – General requirements
Question: *Does changing from the I-1 Use Group to the I-2 Use Group constitute a change of Use Group?*
Answer: Yes. (0445 - 12/07)

Question: *If an assisted living facility classified in the R Use Group is sold would it have to be re-classified into the I-1 Use Group?*

Answer: It would not have to be reclassified into the I-1 Use Group if it continues as an assisted living facility and no renovations are made that would affect the Use Group classification. (0446 - 12/07)

22 VAC 40-72-840 B – General requirements
Question: *Do all newly constructed assisted living facilities have to have a sprinkler system?*
Answer: Yes. (0447 - 12/07)

22 VAC 40-72-840 G and 760 E – General requirements
There is an applicable question/answer under Standard **22 VAC 40-72-760 E.**

22 VAC 40-72-840 I – General requirements
Question(Q1): *Why can't assisted living facility residents who do not have a diagnosis of dementia have items such as soap powder and glass cleaner in their rooms?*
Answer: The standards do not prohibit residents who do not have a cognitive impairment that might cause them to ingest or otherwise misuse cleaning supplies or other hazardous materials from keeping these items in their rooms. However, in order to prevent other residents, who may have a serious cognitive impairment, from having access to hazardous materials, these items must be stored in a locked area. This can be a locked container, cabinet, drawer, or closet in the resident's room. Please see another technical assistance response under 22 VAC 40-72-840 I for assistance in determining which materials are considered hazardous.

Please note that the requirement for storing cleaning supplies and other hazardous materials in a locked area is optional in an independent living environment. (0618 – rev 7/15)

Question: *What are considered "cleaning supplies and other hazardous materials"? Can you develop a list of them?*
Answer: Materials that, if ingested or otherwise misused by a resident, could cause significant harm to the resident would be considered hazardous. Developing a list of such materials is not feasible, as there could be thousands of items on the list and it would still be incomplete. However, there are various indicators and resources that may be used to assist in making a decision regarding whether a material is hazardous. These include, but are not limited to:

- Manufacturer's instructions and recommendations
- Warning labels and other cautionary language
- Manufacturer's notations regarding use
- Listed ingredients
- U.S. Department of Health and Human Services Household Products Database
- Material Safety Data Sheet (MSDS)

The U.S. Department of Health and Human Services Household Products Database contains information on many categories of products. The Personal Care category includes antiperspirant, hairspray, makeup, shampoo, soap, and many other items. The Inside the Home category includes, among many other items, air freshener, bleach, and cleaners. Plus, there are several other categories, e.g., Auto Products, Pesticides, and Home Maintenance. The Household

Products Database contains information that includes product health effects, handling/disposal, and ingredients. The database website address is http://householdproducts.nlm.nih.gov.

There is a MSDS for many, and probably most, cleaning supplies and other materials that contain chemical ingredients. A MSDS for a product contains information such as hazards identification, handling, personal protection, etc., regarding the product. It may be obtained on the website for the manufacturer/product or by calling the phone number listed on the product. Sometimes the MSDS is included with the product when buying material in bulk.

Unless there are extenuating circumstances, many personal care products, including but not limited to, common toiletry items, such as deodorant and toothpaste, would not be considered "hazardous materials." (0619 – rev 7/14)

22 VAC 40-72-840 J – General requirements
Question: *Do you have a formal list of what you consider as a weapon?*
Answer: No. (0449 - 12/07)

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22 VAC 40-72-850 Maintenance of building and grounds (7/15-Q1)

22 VAC 40-72-850 A - Maintenance of building and grounds
Question(Q1): *The standard requires that all buildings be maintained in good repair. What is considered to be "maintained in good repair"?*
Answer: The following factors are applicable in determining whether or not a building is maintained in good repair.

- Risk to individuals inside or outside the building, including residents, staff, visitors, etc. If the problem is likely to present a risk to the health, safety or welfare of residents, staff, etc., then the building is not being maintained in good repair. Examples would be water leaks that cause or might cause slippery floors, and cracked ceiling plaster that causes or might cause the plaster to fall down.
- Extent of damage on an item or a few items. If the extent of the problem is significant, then the building is not being maintained in good repair. Examples would be a large number of stained ceiling tiles, many areas with peeling paint, and a roof with many missing shingles.
- Extent of damage on several items. If the cumulative damage on several items is significant, then the building is not being maintained in good repair. In this case, each of the items does not have extensive damage, but there are several items in poor condition. An example would be if several of the following items were present: a couple of doors that don't close properly, a couple of rooms with a hole in the wall, a few broken floor tiles, a couple of rooms with peeling wallpaper, missing baseboard in a few places.

Please keep in mind that the examples included here are given for clarification purposes. There are many other items that also need to be considered in determining whether or not a building is in good repair. (0667-7/15)

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22 VAC 40-72-860 Heating, ventilation, and cooling

22 VAC 40-72- 860 C – Heating, ventilation, and cooling

Question: *If a facility has a heating system, but some residents want their room to be warmer, can the facility provide them with a space heater that has been approved by the fire marshal?*
Answer: Standard 860 C 1 requires that heat be supplied from a central heating plant or by an approved electrical heating system. Standard 860 C 2 allows the use of space heaters only to provide or supplement heat in the event of a power failure or similar emergency. (The installation or operation of these space heaters must have the approval of the state or local building or fire authorities, and the space heaters must be used in accordance with the manufacturer's instructions.) The facility cannot provide residents with a space heater to make the room warmer, except in the event of a power failure or similar emergency. (0067 - 12/07)

22 VAC 40-72-860 D 6 and 7 – Heating, ventilation, and cooling

Question: *This applies to a resident's private bedroom. What if the resident chooses to have their room temperature exceed 80ºF?*
Answer: Once the standard is in effect for a facility, if a resident wishes to have his or her bedroom temperature exceed 80ºF, the facility should request an allowable variance for the temperature in that resident's room. (0001 - 5/07)

22 VAC 40-72-860 D 7 – Heating, ventilation, and cooling

Question: *Are hallways considered "common areas" and therefore, must they have air conditioning by December 28, 2012? Also, although this standard does not address ventilation, are there specific ventilation requirements?*
Answer: The standard requires that all areas used by residents must be part of the facility's air conditioning system by 12/28/12. Therefore, it is not only bedrooms and common areas used by residents that are included in this requirement, but any areas in the building used by residents, including hallways. Regarding ventilation, 22 VAC 40-72-840 E requires that enclosed walkways between residents' rooms and dining and sitting areas be adequately ventilated, and 22 VAC 40-72-850 C requires that all buildings be well-ventilated. (0600 - 6/08)

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22 VAC 40-72-880 - Sleeping areas

22 VAC 40-72-880 2- Sleeping areas

Question: *Does the higher square footage requirement apply only to renovated/new bedrooms approved for construction or change in use and occupancy classification, or does the higher square footage apply to all bedrooms whenever there is renovation/construction in any part of the facility that involves approval/change in use?*
Answer: The higher square footage requirement applies only to those bedrooms that were renovated or newly built and that required approval for construction or had a change in use and occupancy classification. If, for example, an addition was built to a facility to accommodate new bedrooms or a new common area, the square footage requirement for the older existing bedrooms would not be affected. (0614 - 06/09)

22 VAC 40-72-880 5 a and 890 A 1 and 3 – Sleeping areas

Question: *These standards refer to "buildings approved for construction or change in use and occupancy classification." Does "approved for construction" refer only to "new" from the ground up or does it mean any construction activity for which a building permit has been issued, such as for renovation or addition?*

Answer: "Approved for construction" includes any construction activity for which a building permit has been issued, including renovations and additions, as well as "new" construction. (0611 - 3/09)

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22 VAC 40-72-890 Toilet, face/hand washing and bathing facilities

22 VAC 40-72-890 A and B – Toilet, face/hand washing and bathing facilities

Question: *If additional bedrooms are built on a floor of an ALF or there are other changes on the floor requiring building official approval, does the facility then have to go to the one to four for toilets and sinks and one to seven for tubs instead of the old requirement?*

Answer: The ratio for toilets, sinks and bathtubs to residents for the older existing bedrooms, built prior to December 28, 2006, would remain the same, i.e., for toilets and sinks, at least one for each seven persons, and for bathtubs/showers, at least one for each 10 persons. The ratio for toilets, sinks and bathtubs/showers for the new additional bedrooms or for renovated bedrooms that require building official approval would be for toilets and sinks, at least one for each four persons, and for bathtubs/showers, at least one for each seven persons. To determine the total number of toilets, sinks and bathtubs/showers required, the number needed for the older existing bedrooms and the number needed for the new or renovated bedrooms would be added together. The number of toilets, sinks and bathtubs/showers would first be calculated separately for each group. Then the number of toilets for each group would be added together to determine the total number of toilets required, likewise for the required number of sinks and bathtubs/showers. Please see the example below.

The following is an example of how to determine the correct number of toilets, sinks and bathtubs/showers.

35 residents in the older existing bedrooms:
5 toilets and 5 sinks (35 ÷ 7 = 5) and 4 bathtubs/showers (35 ÷ 10 = 3.5 or 4)
10 residents in the new or renovated bedrooms:
3 toilets and 3 sinks (10 ÷ 4 = 2.5 or 3) and 2 bathtubs/showers (10 ÷ 7 – 1.4 or 2)
Total number required on the floor:
8 toilets and 8 sinks (5 + 3) and 6 bathtubs/showers (4 + 2).

In this example, the ALF would be in compliance with the standard if it had at least eight toilets and eight sinks and at least six bathtubs/showers on the floor.

If there are other changes on the floor, such as an addition to the dining area, the number of required toilets, sinks and bathtubs/showers would not be affected. (0617 - 06/09)

22 VAC 40-72-890 A 1 c and d – Toilet, face/hand washing and bathing facilities
Question: *Is this reasonable when central bathing/shower areas are used for resident/staff safety, when showers are given throughout the day – as care planned and scheduled? As written, 6 showers or tubs would be needed for 40 people. Then to designate one of those areas for "men" when it is possible that 2-3 men reside in that area? This should be "outcome driven." Are the residents clean and well groomed? If not, the number of showers is most likely not the issue, rather staffing, resident performance, etc.*
Answer: Standard 890 A 1 c, which requires one bathtub/shower for each seven persons or portion thereof, applies for buildings approved for construction or change in use and occupancy classification on or after 12/28/06. Otherwise, one bathtub or shower is required for each 10 persons or portion thereof. The lower ratio allows for greater flexibility and increased opportunity for resident choice in scheduling baths or showers. The lower ratio supports the principles of individuality, personal dignity and freedom of choice. Standard 890 A 1 d provides for separate rooms for bathtubs/showers (as well as toilets and sinks) for men and women where more than four persons live on a floor. This applies for buildings approved for construction or change in use and occupancy classification on or after 12/28/06. Otherwise, separate rooms for bathtubs/showers (as well as toilets and sinks) are required where more than seven persons live on a floor. Separate rooms for bathtubs/showers allow for gender privacy, which provides a level of comfort and avoidance of confusion, embarrassment and possibly inappropriate behavior. If circumstances warrant, an allowable variance may be requested. (0038 - 5/07)

22 VAC 40-72-890 A1 and 3 and 880 5a – Toilet, face/hand washing and bathing facilities
There is an applicable question/answer under Standard **22 VAC 40-72-880 5a.**

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22 VAC 40-72-900 Toilet and face/hand washing sink supplies (7/15-Q1)

22 VAC 40-72-900 – Toilet and face/hand washing sink supplies
Question: *On a secured dementia unit, what kind of soap is recommended to address the risk of ingestion? Chemicals, etc., are supposed to be secured.*
Answer: There are a number of non-toxic soap products that, if ingested, would not pose harm to the person. The gentle forms of commercial soaps used in typical wall-mounted dispensers meet the requirements of this standard as well as the intent of 1050 B. The intent of 1050 B is to avoid bar soaps that an impaired resident may pick up and eat and bottles of liquid soap that the resident may open and drink. (0019 - 5/07)

22 VAC 40-72-900 A - Toilet and face/hand washing sink supplies
Question(Q1): *Does a private pay facility have to provide toilet paper and soap to their residents in their individual bathrooms? Or does the facility just have to provide it if the resident runs out?*
Answer: The private pay facility can have a policy that residents are to provide their own toilet paper and soap in their individual bathrooms or the facility can choose to provide these supplies to all residents. Another possibility is letting residents decide which way they prefer, and then providing toilet paper and soap to those residents who choose that option, with the other residents providing their own. However, the facility is responsible for ensuring that there is toilet paper accessible to

each commode and soap accessible to each sink. So if a private pay resident who provides his own toilet paper and soap runs out of either or both, the facility must provide it.

The resident agreement and the disclosure statement would have to reflect any additional fees that the facility charges for toilet paper and soap, if such fees are charged. (0653 – 7/15)

22 VAC 40-72-900 B – Toilet and face/hand washing sink supplies
Question: *Define "common face/hand washing sinks."*
Answer: It is easier to define "common face/hand washing sinks" by what they are not than by what they are. A sink that is accessible only to residents of one or two bedrooms with no more than a total of four residents or a sink that is in a private apartment is not a common face/hand washing sink. All other sinks are considered to be common face/hand washing sinks.
(0453 - 6/08)

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22 VAC 40-72-910 Provisions for signaling/call systems

22 VAC 40-72-910 – Provisions for signaling/call systems
Question: *Can ALFs with 20 or more beds use hourly rounds in place of a signaling device that terminates at a central location?*
Answer: ALFs with 20 or more beds under one roof cannot use hourly rounds in place of a signaling device that terminates at a central location. (0040 - 5/07)

Question: *For facilities having 19 or fewer residents, if the residents' ISPs indicate that an awake staff is not needed, do rounds still have to be made?*
Answer: If the residents' ISPs indicate that an awake staff is not needed, Standard 910 would still apply. As required by subsection C of the standard, rounds have to be made at least once each hour during the specified time period to monitor for emergencies or other unanticipated resident needs, unless the signaling system meets the specifications of subsection B of the standard. If awake staff is not needed, depending upon the length of time it takes to make rounds, the staff person may be able to sleep between the rounds.
To meet the provisions of subsection B, the signaling device must terminate at a central location that is continuously staffed and permits staff to determine the origin of the signal or the signaling device must be audible and visible in a manner that permits staff to determine the origin of the signal. If awake staff is not needed at night in a facility having 19 or fewer residents, the staff person could be asleep as long as the provisions of subsection B are met and the staff person would be immediately awakened by the signaling device. (0112 - 5/07)

22 VAC 40-72-910 A – Provisions for signaling/call systems
Question: *Is the required signaling device per room rather than per resident?*
Answer: The standard requires that a signaling device be easily accessible to the resident in his bedroom or a connecting bathroom. A signaling device may be shared by residents in a room as long as the device is easily accessible to each of the residents who are sharing it. The accessibility depends upon the location of the signaling device and the condition of the resident. What may be easily accessible to one resident may not be to another, depending upon the residents' condition. The answer to this question is not simply that the signaling device is required per room or per resident. The following examples demonstrate how the location or condition of the resident affects the accessibility of the signaling device.

If there are two residents in a room, it would not be acceptable to have only one signaling device that is located above the bed of one resident. The device would not be easily accessible to the other resident.

If a resident needs the assistance of a staff person to transfer, he would not have access to a signaling device located across the room, in a connecting bathroom, or possibly even on the wall behind the bed. (0624 – 12/09)

22 VAC 40-72-910 C– Provisions for signaling/call systems
Question: *Does this standard apply when a facility is licensed for a total of 20 or more residents, but there are two buildings, each of which is licensed to care for 19 or fewer residents?*
Answer: Yes. 22 VAC 40-72-910 C applies to each of the two buildings. The total capacity of the facility is not the issue in respect to this standard, but rather the licensed capacity for each building. (0604 - 6/08)

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PART IX. EMERGENCY PREPAREDNESS

22 VAC 40-72-930 Emergency preparedness and response plan

22 VAC 40-72-930 C-Emergency preparedness and response plan
Question: *Are the staff, residents, and volunteers required to provide written acknowledgement that they received emergency preparedness and response information/materials or is it sufficient for the facility to document that the information was provided?*
Answer: The standard itself does not require written acknowledgement or documentation. However, in order to keep track of when the orientation/reviews are done and demonstrate compliance with the standard, the facility should keep documentation of the orientation/reviews. (0585 - 6/08)

22 VAC 40-72-930 F 2, 100 A, 201 B 1, 370 B and 640 D 2 – Emergency preparedness and response plan
There is an applicable question/answer under Standard 22 VAC 40-72-100 A

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22 VAC 40-72-940 Fire and emergency evacuation plan

22 VAC 40-72-940 B – Fire and emergency evacuation plan
Question: *Please define "areas of refuge" and "assembly areas".*
Answer: "Areas of refuge" is defined in the Virginia Statewide Fire Prevention Code as: "an area where persons unable to use stairways can remain temporarily to await instructions or assistance during emergency evacuation." This definition is found in Chapter 10: Means of Egress, page 97. "Assembly areas" is not formally defined in the Virginia Statewide Fire Prevention Code, although it is referenced several times as a safe area to be designated for people to gather during an evacuation process that keeps them safe from the emergency and allows for accountability of those being evacuated. (0184 - 5/07)

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22 VAC 40-72-950 Fire and emergency evacuation drills

22 VAC 40-72-950 - Fire and emergency evacuation drills
Question: *Please clarify the use of the word "evacuation" which is found throughout the standard. Please also clarify the requirement that fire and emergency evacuation drills be conducted three times per quarter, one on each shift.*
Answer: The Division of Licensing Programs consulted with the State Fire Marshal and determined that it was appropriate to use the language referenced in the Virginia Statewide Fire Prevention Code and rename standard 950 "Fire and emergency evacuation drills." The change in terminology refers directly to the language used in the Virginia Statewide Fire Prevention Code. Facilities will need to work with their local fire official to determine if they are required to evacuate residents during drills as determined by the use and occupancy classification requirements of the Virginia Statewide Fire Prevention Code. Per the Virginia Statewide Fire Prevention Code, fire and emergency evacuation drills are required to take place quarterly on each shift. If a facility operates on a schedule that includes three shifts, each shift would have to complete one drill during the quarter, thereby equaling three drills per quarter. The drills cannot take place within the same month. (0065 - 5/07)

Question: *In a fire-drill must we evacuate all residents? Remember this is a drill. Potential for injury is a major factor.*
Answer: The Division of Licensing Programs consulted with the State Fire Marshal and determined that it was appropriate to use the language referenced in the Virginia Statewide Fire Prevention Code and rename standard 950 "Fire and emergency evacuation drills." The change in terminology refers directly to the language used in the Virginia Statewide Fire Prevention Code. Facilities will need to work with their local fire official to determine if they are required to evacuate residents during drills as determined by the use and occupancy classification requirements of the Virginia Statewide Fire Prevention Code. (0082 - 5/07)

Question: *Regarding fire and emergency evacuation drills-must the residents be evacuated to the outdoors or is evacuation to another section of the building (behind a fire wall) acceptable?*
Answer: Facilities must work with their local fire officials to determine if they are required to evacuate residents during drills as determined by the use and occupancy classification requirements of the Virginia Statewide Fire Prevention Code. (0188 - 5/07)

22 VAC 40-72-950 E 5-Fire and emergency evacuation drills.
Question: *What is the rationale for recording the weather conditions during a drill?*
Answer: This is required by the Virginia Statewide Fire Prevention Code (13 VAC 5-51). (0586 - 6/08)

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22 VAC 40-72-960 Emergency equipment and supplies

22 VAC 40-72-960 D – Emergency equipment and supplies
Question: *The standard requires that the facility be able to connect to a temporary emergency electrical power source for the provision of electricity during an interruption of the normal electric power supply. What does the electricity have to be able to do, i.e., to what extent do we have to be able to power the facility in an emergency when the normal electric power supply is interrupted?*

Answer: The facility must be able to meet the provisions of its emergency preparedness and response plan, which is required by 22 VAC 40-72-930. The plan requires that procedures be developed for sheltering in place (as well as for evacuation and relocation). The facility is responsible for protecting the life safety of residents, staff, volunteers and visitors, and for protecting essential equipment, medications, and vital records. There must be adequate electricity or other resources available to meet this responsibility. The emergency preparedness and response plan must address, for example, how the facility will ensure that residents will not be endangered by extreme heat or cold, how lighting will be sufficient to avoid harm, how medications that need refrigeration will be preserved, and how necessary medical equipment will be operated. The determination of the amount of electricity necessary to power the facility in an emergency will depend upon what the plan includes for which electricity is needed. The plan may include other methods for meeting needs in an emergency, such as wood burning stoves to provide heat, as allowed for in 22 VAC 40-72-860 C 2. If, for instance, heat was provided by wood burning stoves, the amount of electricity otherwise necessary would be reduced. Please note that whether the facility chooses to have enough emergency power for the whole building or only for part of it, the protection of residents, staff, etc., is essential. (0610 - 3/09)

22 VAC 40-72-960 G – Emergency equipment and supplies

Question: *Is a facility required to have the specified supply of emergency food, drinking water, and oxygen (if residents use oxygen) on-site or is it sufficient for the facility to contract with a company that can provide supplies in the event of an emergency?*

Answer: A facility does not have to keep the supply of emergency food, drinking water, and oxygen (if residents use oxygen) on-site if the facility has a written agreement with a supplier to provide these items in an emergency. Since the facility must take appropriate action in an emergency to protect the health, safety, and welfare of residents, any agreement should specify a reasonable amount of time in which the supplies must be provided. It is recommended that a facility keep at least some of the emergency food, water, and oxygen (if applicable) on-site. (0587 - 6/08)

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22 VAC 40-72-970 Plan for resident emergencies and practice exercise

22 VAC 40-72-970 B – Plan for resident emergencies and practice exercise

Question: *Does "all staff on each shift" mean those working at the time of the "emergency" exercise or every single employee of the facility? Is there a requirement of 100% participation in the actual exercise twice a year?*

Answer: "All staff on each shift" would apply to every employee (100%) in the facility participating in an exercise in which the procedures for resident emergencies are practiced at least once every six months. This will allow for all staff, regardless of what shift or day they may be working, to be knowledgeable in these procedures. (0083 - 5/07)

Question: *Does the exercise to be completed every 6 months mean that a practice is required for each of the different emergencies i.e. missing persons, medical etc.?*

Answer: Yes, the exercise must address the procedures for handling each of the identified emergencies and notifications. (0080 - 5/07)

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22 VAC 40-72-980 Subjectivity

22 VAC 40-72-980, 990, 1060 and 1070 – Subjectivity

Question: *Can the Assessment of Serious Cognitive Impairment model form, 032-05-0078-04-eng (9/13), be used to determine whether a resident in an ambulatory-only ALF has a serious cognitive impairment due to a primary psychiatric diagnosis of dementia with an inability to recognize danger or protect his own safety and welfare is actually non-ambulatory and, therefore, inappropriate for an ambulatory-only facility ? The situation: an inspector found evidence in a resident record (in an ambulatory-only ALF) that the resident has a serious cognitive impairment, and requested an evaluation of this to determine if this was still a correct placement. This particular facility is unable to become a mixed facility because of the ambulatory-only restriction.*

Answer: The Assessment of Serious Cognitive Impairment model form, 032-05-0078-04-eng (9/13), is the assessment form used by a qualified assessor to determine whether a person being considered for admission to a safe, secure environment has a serious cognitive impairment due to a primary psychiatric diagnosis of dementia with an inability to recognize danger or protect his own safety and welfare. The form may also be used for a resident in a mixed population. Unless a restriction has been stipulated by the local building official, the state building code allows for up to five non-ambulatory individuals in an ambulatory-only ALF. Therefore, a person determined to be non-ambulatory must be counted among the five non-ambulatory residents in the ALF and can be retained at the facility if the facility can meet the needs of the resident. In respect to mixed populations, the facility must be in compliance with all the standards in Article 2 regarding mixed populations if they do not meet the exception found in 22 VAC 40-72-990. Please note that a facility is not prevented from having a policy that does not allow admission or retention of any non-ambulatory residents. (0642 - 7/14)

Question: *Is it ever permissible to use the Assessment of Serious Cognitive Impairment model form, 032-05-0078-04-eng (9/13), for anything other than for determining the appropriateness of placement in a safe, secure unit?*

Answer: The Assessment of Serious Cognitive Impairment model form, 032-05-0078-04-eng (9/13), was specifically developed for determining whether a person has a serious cognitive impairment due to a primary psychiatric diagnosis of dementia with an inability to recognize danger or protect his own safety. While the facility may use this form for a resident in a mixed population suspected of having a serious cognitive impairment, it is not required. The assessment form was not developed for any purpose other than to determine the appropriateness for a safe, secure environment. (0643 - 7/14)

Question: *On the Assessment of Serious Cognitive Impairment model form, 032-05-0078-04-eng (9/13), under the questions "Does the individual named above have a serious cognitive impairment due to a primary psychiatric diagnosis of dementia and Is the individual named above unable to recognize danger or protect his/her own safety and welfare?," if "Yes" is checked for both, does that force the resident to be transferred to a safe, secure unit (as described under Article 3 of 22 VAC 40-72, Safe, Secure Environment), or is it ok for the resident to go to a mixed population facility (as described under Article 2 of 22 VAC 40-72, Mixed Population) if the family still wants the resident in an ALF? The situation: The facility in question did use this form (a previous version) to determine that a resident does have a serious*

cognitive impairment. Does this mean the resident must be discharged from the ambulatory-only ALF, or does this mean that the resident must be placed in a safe, secure unit? Since the form has been completed, is a mixed population facility permissible?
Answer: In light of the allowance by the state building code for an ambulatory-only facility to have up to five non-ambulatory residents, unless stipulated otherwise by the local building official, if the person in question becomes the sixth non-ambulatory person in the ambulatory-only facility, this resident cannot be retained at the facility. While this person may not be retained in an ambulatory-only facility, this does not mean that the individual must be admitted to a facility with a safe, secure environment. Such a person can be placed in a facility with a mixed population provided that the facility can meet the care, supervision, and safety needs. In other words, placement of a person with a serious cognitive impairment due to a primary psychiatric diagnosis of dementia with an inability to recognize danger or protect his own safety and welfare in a safe, secure environment is not mandatory. (0644 - 7/14)

Question: *If a licensing representative suspects that due to diminished cognitive functioning, the needs of a resident cannot be met in the current environment within an ALF, can the licensing representative require the facility to use the Assessment of Serious Cognitive Impairment model form, 032-05-0078-04-eng (9/13), to determine whether the resident is non-ambulatory or has a primary diagnosis of dementia?*
Answer: No. The department does not have the authority to require that the facility have a resident assessed using the model form for assessment. However, in accordance with 22 VAC 40-72-350.D, the department may request a current physical examination or psychiatric evaluation, including diagnosis and assessments. (0645 - 7/14)

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PART X. ADDITIONAL REQUIREMENTS FOR FACILITIES THAT CARE FOR ADULTS WITH SERIOUS COGNITIVE IMPAIRMENTS WHO CANNOT RECOGNIZE DANGER OR PROTECT THEIR OWN SAFETY AND WELFARE

22 VAC 40-72-990 Applicability

22 VAC 40-72-990 – Applicability
Question: *Can a "mixed population" include a resident who has a primary psychiatric diagnosis of dementia who cannot recognize danger/protect self?*
Answer: Yes. (0520 - 12/07)

Question: *Does the resident with a diagnosis of dementia in a mixed population have to have a physician's assessment?*
Answer: No. (0521 - 12/07)

22 VAC 40-72-990 - Applicability
There is an applicable question/answer under Standard 22 VAC 40-72 980, 1060 and 1070.

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22 VAC 40-72-1000 Staffing

22 VAC 40-72-1000 A - Staffing

Question: *A facility has a 4th floor that houses a mixed population, does not have "locking devices" on the doors/elevators from the floor, has "wanderguard" monitors on exits/elevators from the floor. Are two direct care staff required on such floors or only two staff in the building at all times?*
Answer: Two direct care staff are required in the building, but the ALF must assure appropriate staffing to meet the needs of the residents as required by 22 VAC 40-72-320. (0522 - 12/07)

Question: *If a facility has only residents with serious cognitive impairments who CAN recognize danger, are a minimum of 2 direct care staff members required to be in each building?*
Answer: It would be rare for a facility to have only residents with serious cognitive impairments who CAN recognize danger, but if that is the case, 2 direct care staff persons are NOT required in each building. The ALF must assure appropriate staffing to meet the needs of the residents as required by 22 VAC 40-72-320. (0524 - 12/07)

Question: *If an ALF has only one resident with a serious cognitive impairment, are two direct care staff required in the building at all times?*
Answer: Yes, if it has been determined that the resident cannot recognize danger/protect self. (0523 - 12/07)

Question: *Does this requirement for 2 staff include while the residents are sleeping?*
Answer: Yes. (0505 - 12/07)

Question: *During the night, can one of the direct care staff members be awake and one asleep?*
Answer: Both of the direct care staff members must be awake at all times. Should a facility believe that circumstances warrant allowing one of the staff members to be asleep at night, an allowable variance may be requested. (0511 - 12/07)

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22 VAC 40-72-1010 Staff training

22 VAC 40-72-1010 A – Staff training

Question: *Do administrators who have been such for a number of years need to have the 12 hours training for mixed population residents?*
Answer: Yes, commencing immediately upon employment and within three months, the administrator shall attend 12 hours of training in cognitive impairment that meets the requirements of 22 VAC 40-72-1010 C. This training is counted toward the annual training requirement for the first year. Previous training that meets the requirements of 22 VAC 40-72-1010 C and was completed in the year prior to employment is transferable if there is documentation of the training. The documented previous training is counted toward the required 12 hours but not toward the annual training requirement. (0506 - 12/07)

22 VAC 40-72-1010 B – Staff training

Question: *Does the Department's training on dementia count toward this requirement? What about area Alzheimer Association training or other resource? How would we know if the curriculum has been developed by a health professional if given by a community group?*

Answer: The Department has approved the following curricula offered by the Alzheimer's Association: 1) Special Care for Special Persons: Basic Skill Building for Caregivers of People with Cognitive Impairment; 2) Building Your Skills for Dementia Care: A Person Centered Approach; and 3) Quality Activity Service Delivery for Persons with Dementia. The best way to determine if training meets this standard is to call the sponsoring group for the training or the trainer and ask about the curriculum development and delivery. It is advisable to also check with the licensing inspector for the acceptability of training to meet a specific standard requirement. (0504 - 12/07)

Question: *Can video tape series count as training?*
Answer: Yes. A video tape series can count as training as long as it is facilitated by someone with verifiable expertise on the course topic and who can provide guidance as needed. The video tape series must have been developed by a qualified health professional or by a licensed social worker, must be relevant to the population in care and shall include, but need not be limited to the following topics: 1) explanation of cognitive impairments; 2) resident care techniques; 3) behavior management; 4) communication skills; 5) activity planning; and 6) safety considerations. The training must be documented. (0501 - 12/07)

Question: *Can this be in-service by the home's administrator?*
Answer: Yes, however, the curriculum used by the administrator must meet the criteria listed in 22 VAC 40-72-1010 C and be developed by a qualified health professional or by a licensed social worker. (0502 - 12/07)

22 VAC 40-72-1010 C – Staff training
Question: *Do the curriculum requirements in 22 VAC 40-72-1010 C apply to 22 VAC 40-72-1010 A & D?*
Answer: The curriculum requirements in 22 VAC 40-72-1010 C refer to 22 VAC 40-72-1010 A&B. 22 VAC 40-72-1010 D requires one hour of orientation for new staff on the nature and needs of residents with cognitive impairments relevant to the population in care. (0503 - 12/07)

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22 VAC 40-72-1020 Doors and windows

22 VAC 40-72-1020 – Doors and windows
Question: *Would locks that prevent the windows from being opened enough for a resident to crawl through present a problem in regard to exiting the building in the event of fire or other emergency?*
Answer: Before installing any protective devices on bedroom or bathroom windows of residents, licensees should consult with the local building official. This consultation is necessary because Section 1010.4 of the BOCA National Building Code/1993 requires that every sleeping room below the fourth story in occupancies in Use Groups R and I-1 shall have at least one operable window or exterior door approved for emergency exit or rescue. The units shall be operable from the inside without the use of special knowledge, separate tools or force greater than that which is required for normal operation or rescue. Bars, grilles or screens placed over emergency escape windows shall be releasable or removable from the inside without the use of a key, tool or force greater than that which is required for normal operation of the window. Other requirements apply to occupancies in Use Group I-2. (0509 - 12/07)

Question: *In a mixed population, what if SOME but not all doors in the mixed population area are locked at night with a magnetic lock? Those doors can be opened using a keypad or emergency button (labeled "push to exit"), and the doors open automatically if the fire alarm is triggered. Other doors leading to the outside from the same area are NOT locked. Would this be acceptable? (There is a separate safe, secure unit on the third floor.)*
Answer: This would not be acceptable. 22 VAC 40-72-530 states "doors leading to the outside shall not be locked…." The keypad and the emergency button are locks. (0525 - 12/07)

22 VAC 40-72-1020 A – Doors and windows
Question: *A facility with a mixed population has a system in which residents with serious cognitive impairments who cannot recognize danger/protect self wear bracelets that trigger a lock when they go near a door. Would this be acceptable?*
Answer: This would not be acceptable. 22 VAC 40-72-530 states "doors leading to the outside shall not be locked…." If the bracelet triggered a delayed egress mechanism, this would be acceptable because a delayed egress mechanism is not a lock. (0526 - 12/07)

Question: *What constitutes a door alarm? Must it be audible in a particular place?*
Answer: The alarm can be any device audible to the staff person responsible for monitoring the alarm. (0527 - 12/07)

22 VAC 40-72-1020 B – Doors and windows
Question: *If an ALF has only one resident with a serious cognitive impairment who cannot recognize danger/protect self, must there be protective devices on all the windows?*
Answer: No, only on that resident's bedroom and bathroom windows and on windows in common areas accessible to that resident. (0528 - 12/07)

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22 VAC 40-72-1060 Applicability

22 VAC 40-72-1060 – Applicability
Question: *Does a special care unit require a separately designated manager?*
Answer: No. (0532 - 12/07)

Question: *Can a safe, secure environment (special care unit) have a mixed population?*
Answer: No, a facility that represents itself to the public as having a special care unit must comply with the requirements of Article 3. Special care units may only house residents with serious cognitive impairments due to a primary diagnosis of dementia who cannot recognize danger or protect their own safety and welfare. (See exception to this standard)
(0533 - 12/07)

Question: *Does the exception for facilities licensed for 10 or fewer residents apply to special care units?*
Answer: The exception does not apply to a special care unit, but does apply to a facility with a mixed population. (0531 - 12/07)

22 VAC 40-72-1060 - Applicability
There is an applicable question/answer under Standard 22 VAC 40-72 980, 990 and 1070.

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22 VAC 40-72-1070 Assessment

22 VAC 40-72-1070 A – Assessment
Question: *What is meant by "primary" psychiatric diagnosis? Does that mean it must be the first diagnosis listed? If there are several diagnoses, which one is primary?*
Answer: The primary diagnosis is the diagnosis given the greatest amount of attention when a particular intervention is being proposed. For example: A resident with a serious cognitive impairment due to mental retardation has been diagnosed with Alzheimer's Disease. The resident has begun to wander due to dementia and needs a safe, secure environment. The primary psychiatric diagnosis is dementia since it is due to this diagnosis that an intervention is necessary. (0534 - 12/07)

Question: *May a nurse practitioner or physician assistant complete the assessment?*
Answer: In the definition section (10) of the standards, the definition of licensed health care professional includes a statement that "responsibilities of physicians referenced in this chapter may be implemented by nurse practitioners or physician assistants in accordance with their protocols or practice agreements with their supervising physicians and in accordance with the law." The other provisions of the standard would still have to be met. (0513 - 12/07)

22 VAC 40-72-1070 - Assessment
There is an applicable question/answer under Standard 22 VAC 40-72 980, 990 and 1060.

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22 VAC 40-72-1080 Approval

22 VAC 40-72-1080 A – Approval
Question: *If the resident's wife was not willing to give written approval, but allowed an adult child to give written approval for the resident to be admitted to a special care unit and then the wife changes her mind and wants the resident moved out of the unit, can she override the adult child's decision?*
Answer: Yes. (0516 - 12/07)

Question: *What if two adult children disagree over giving the written approval?*
Answer: As long as the facility has the written approval from someone in the correct order of priority, the approval is valid. The facility would only have to discharge the resident from the special care unit if someone higher in the order of priority disapproves of the continued placement in the special care unit. (0517 - 12/07)

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22 VAC 40-72-1100 Activities

22 VAC 40-72-1100 A – Activities

Question: *Must all activity categories listed be included in each week's activities?*
Answer: Yes. (0518 - 12/07)

22 VAC 40-72-1100 A and 22 VAC 40-72-520 C and G 2 b – Activities

There is an applicable question/answer under Standard **22 VAC 40-72-520 C** .

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22 VAC 40-72-1130 Doors and windows

22 VAC 40-72-1130 A – Doors and windows

Question: *Building officials have approved locked doors in assisted living facilities located in residential use group buildings. These buildings do not house residents with serious cognitive impairments due to dementia who cannot recognize danger or protect own safety/welfare. Can a locked door that prevents egress in a mixed population area be allowed if a building official approves the locking mechanism?*
Answer: The Virginia Uniform Statewide Building Code does allow locking devices on the doors of a single family dwelling in a residential use group building. A building official may have approved or will approve such locking devices in an assisted living facility located in a residential use group building.
However, according to the Standards for Licensed Assisted Facilities, ONLY facilities that meet the requirements of 1060 may have locked doors (doors that are not readily opened from inside the building without the use of a key or special knowledge) in a special care unit. So a facility with a mixed population may not have locked doors (even though the building official has given his approval). (0556 - 12/07)

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22 VAC 40-72-1160 Environmental precautions

22 VAC 40-72-1160 B – Environmental precautions

Question: *Should silverware be locked up? Should pre-setting the table be prohibited?*
Answer: This depends on the characteristics of the resident population and the amount of staff supervision. If a resident has exhibited behavior that indicates that silverware or dinnerware may be used in a harmful manner, it is the responsibility of the ALF to recognize the risk and take the appropriate measures to eliminate the danger. (0529 - 12/07)

Question: *"When there are indications…." Does this mean the resident has to have actually demonstrated behavior in which ordinary materials or objects have been misused? What if a resident has a history of aggressive behavior?*
Answer: If the resident has a history of behavior or has made statements indicating that ordinary objects or materials may be used in harmful ways, these objects or materials shall be inaccessible except under staff supervision. (0530 - 12/07)

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