

VIRGINIA

Licensure Terms

Assisted Living Facilities

General Approach

The Virginia Department of Social Services licenses two levels of care in assisted living facilities (ALFs): residential living care (minimal assistance) or assisted living care (at least moderate assistance). Facilities licensed to provide assisted living care may also provide residential care. Excluded from this licensure category are facilities licensed by the Virginia Department of Behavioral Health and Developmental Services, and housing for persons age 62 or older that is financed by state or federal funds (e.g., by the U.S. Department of Housing and Urban Development).

Facilities that care for adults with serious cognitive impairments who cannot recognize danger or ensure their own safety or welfare, must meet additional requirements; these requirements apply whether the facility serves only such individuals or when the resident population is mixed. Facilities licensed for ten or fewer residents, or that house no more than three residents with a serious cognitive impairment, are exempt from the requirements.

Adult Foster Care (AFC). AFC is a program that provides room and board, supervision, and other services for up to three adults who have a physical or mental health condition, including an emotional or behavioral health issue. This setting is regulated through the Department for Aging and Rehabilitative Services, Adult Protective Services Division. *Regulatory provisions for AFC are not included in this profile but a link to the provisions can found at the end.*

This profile includes summaries of selected regulatory provisions for ALFs. The complete regulations are online at the links provided at the end.

Definitions

Assisted living facility means a non-medical group residential setting that provides or coordinates personal and health care services, 24-hour supervision, and assistance for the care of four or more adults who are aged, infirm, or disabled.

Residential living care is a level of service defined as minimal assistance with activities of daily living (ADLs) and/or medication administration. Minimal assistance

means dependency in only one ADL or one or more instrumental activities of daily living. Minimal assistance includes services provided by the facility to individuals who are assessed as capable of maintaining themselves in an independent living status.

Assisted living care is a level of service defined as moderate assistance with ADLs. Moderate assistance is provided to persons who are dependent in two or more ADLs and/or who are dependent in behavior patterns (e.g., abusive, aggressive, disruptive) as documented on a uniform assessment instrument (UAI).

Resident Agreements

The agreement, signed by the resident or appropriate legal representative and by the licensee or administrator, must describe financial arrangements, including specific charges for accommodations, services, and care; payment and refund policies; policies related to charge increases; and rules for resident conduct.

Residents must receive information about bed hold, transfer, and discharge policies; weapons policies; residents' rights and responsibilities; grievance policies; the right to form or participate in a Residence Council; smoking policies; and medications and dietary supplement storage and administration policies. The resident agreement must include an acknowledgement that all required information was provided.

Disclosure Provisions

Facilities must provide a statement to prospective residents and their legal representatives (if any) that discloses information about the facility, including several of the topics required for the resident agreement, as well as:

- Ownership structure and the management company, if other than the licensee.
- Licensed capacity and characteristics of the resident population.
- General number, functions, and qualifications of staff on each shift.
- A description of all basic and optional accommodations, services, and care offered, and their cost.

Admission and Retention Policy

Before admitting a prospective resident, the facility must interview the individual and his/her representative (if any), conduct an assessment, receive a physical examination report from a physician, and conduct a mental health screening, if needed.

Facilities may not admit or retain individuals with certain serious medical conditions and extensive nursing needs, including: (1) ventilator dependency; (2) some Stage III and all Stage IV dermal ulcers; (3) intravenous (IV) therapy or injections directly into the

vein; (4) nasogastric and gastric tubes; (5) continuous nursing care; and (6) individuals who present a danger to themselves or others; require maximum physical assistance; meet Medicaid nursing facility level of care criteria; or whose health care needs cannot be met as determined by the facility. Private pay residents who require IV therapy or gastric tubes may be retained if their physician approves and they receive care from a licensed physician or nurse.

To reside in a secure unit that cares for residents with serious cognitive impairments, an individual must have a primary diagnosis of dementia. This rule is waived for a spouse, parent, adult sibling, or adult child who wishes to live with the individual. Before a resident with dementia is placed in a secure unit, written approval must be obtained from the resident (if possible) or from (in order of priority) a guardian or legal representative, family member, or a physician. A physician or clinical psychologist must conduct an initial assessment and the licensee/administrator or designee must conduct periodic reviews to assess the appropriateness of the placement.

Services

Facilities are permitted but are not required to offer all services as long as they provide services that are appropriate for the needs of current residents. Skilled nursing services--except continuous skilled nursing--may be provided by a facility nurse or a nurse contracted from a licensed home care agency. Eleven hours of activities per week for residential living care and 14 hours for assisted living care must be scheduled. The facility may include informal caregivers who wish to be included in the service delivery plan. A facility's program of care must:

- Meet residents' physical, mental, emotional, and psychosocial needs.
- Provide protection, guidance, and supervision.
- Promote a sense of security and self-worth.
- Promote the resident's involvement with appropriate community resources.
- Meet the service plan objectives.

Facilities must also provide periodic health care and oversight through a licensed health care professional--either directly employed or retained on a contractual basis. Residents at the residential care level must be evaluated every 6 months and assisted living care residents every 3 months. When on-site, the health care professional must perform a range of activities, including the following:

- Reviewing service plans and recommending needed changes.
- Monitoring direct care staff's performance of health activities, providing consultation and technical assistance to staff as needed, and recommending topics for staff training as needed.

- Reviewing documentation of health care services, including medication and treatment records, to determine that services correspond with physicians' and other prescribers' orders.
- Assessing residents for whom restraints are in use.
- Monitoring the facility's medication management plan and infection control plans.

Secure dementia units must provide at least 16 hours per week of scheduled activities, including cognitive stimulation, physical functioning (involving both gross and fine motor skills), and sensory, social, reflective, and natural world activities, such as interaction with pets or having a picnic.

Service Planning

The facility must complete an assessment with the Department's UAI for all residents prior to admission, every 12 months, and following a significant change in condition. The assessment is used to develop a care plan with the input of the resident, family, direct care staff, case manager, and health care providers, as relevant.

Residents eligible for public programs, must be assessed by a case manager or other qualified individual who is a trained employee of a public human services agency. Assessments for private pay residents may also be completed by an independent physician, or an employee of the facility who has documented training in the completion of the UAI. Assessments completed by facility staff must be signed by the administrator or designated representative.

Third-Party Providers

If residents need skilled nursing treatments they must be provided by a licensed nurse--through direct or contractual employment. For each resident requiring mental health services, appropriate services based on an assessment must be secured from a mental health provider.

Medication Provisions

The facility must have a medication management plan that is reviewed and approved by the Department. The rules provide detailed requirements for providers' orders, storage, staff qualifications, administration, medication review, and oxygen therapy.

Residents may self-administer medications if they are capable of doing so and their rooms have a secure place for storing medications.

Medications may be administered by licensed individuals or by medication aides who have successfully completed a Board of Nursing-approved training program, have passed a competency evaluation, and are registered with the Virginia Board of Nursing.

At the residential living care level, a licensed health care professional must annually review all residents' medications (except for those who self-administer all of their medications). This review is required every 6 months for residents at the assisted living care level.

Food Service and Dietary Provisions

Three nutritious meals must be provided each day, and bedtime and between meal snacks must be available. Periodic oversight of special diets by a dietitian or nutritionist, either through direct or contractual employment, is required, and religious dietary practices respected.

Staffing Requirements

Type of Staff. The facility must have an *administrator* who is responsible for the facility's general administration and management, and who oversees its day-to-day operation. Facilities may share an administrator if specified conditions are met. *Direct care staff* provide personal care services. *Medication aides* are certified to administer medications.

A *licensed health care professional* must be hired or under contract to monitor direct care staff performance of health-related activities, including the identification of any significant gaps in the staff person's ability to function competently; advise the administrator of the need for staff training; provide consultation and technical assistance to staff; and recommend in writing any needed changes in the care provided or in residents' individual service plans. The licensed health care professional must be on site to evaluate residents who are at the assisted living level of care at least quarterly, and every 6 months for residents who are at the residential living level of care.

Staff Ratios. *No minimum ratios.* Facility staff must be present in sufficient numbers to provide services to help residents attain and maintain their physical, mental, and psychosocial well-being, as determined by resident assessments and service plans, and to implement the fire and emergency evacuation plan. At least one staff member must be awake and on-duty at all times in each building that houses at least 20 residents. A staff member with a current first-aid certificate and cardiopulmonary resuscitation (CPR) certification must be on site at all times, unless the facility has an on-duty registered nurse (RN) or licensed practical nurse (LPN). Facilities licensed for more than 100 residents must have at least one additional employee with current CPR certification for every 100 residents or portion thereof.

Training Requirements

All staff must complete an orientation within 1 week of employment. In addition, each direct care staff member, unless he/she is an RN or LPN, must receive certification in the provision of first-aid within 60 days of employment and then maintain current certification. Medication aides must meet continuing education requirements of the Board of Nursing.

All personnel must be sufficiently educated regarding relevant laws, regulations, the facility's policies and procedures, and other topics, including:

- Specific duties and requirements of their positions.
- Emergency and disaster plans, including those for evacuating residents.
- Hand-washing techniques, standard precautions, and infection risk reduction behavior.
- Procedures for detecting suspected abuse, neglect, or exploitation of residents and reporting and documenting incidents.
- Residents' rights and responsibilities.
- Confidential treatment of personal information.

Administrators must attend at least 20 hours of annual training related either to resident-specific needs or to the management and operation of a residential facility for adults. When adults with mental impairments reside in the facility, at least 5 hours of training must focus on their needs.

Direct care staff at the residential living care level must complete at least 8 hours of training annually in addition to first-aid and CPR training and, for medication aides, continuing education required by the Board of Nursing. If any residents have mental impairments, 2 of the 8 hours of training must be devoted to mental impairment.

Direct care staff in facilities licensed for both residential living and assisted living levels of care must complete at least 16 hours of training annually in addition to first-aid and CPR training and medication aide training. If any residents have mental impairments, 4 of the 16 hours of training must be devoted to care of individuals with mental impairments. Direct care workers who are licensed health care professionals or certified nurse aides may complete 12 hours of training annually.

All direct care staff who care for residents who meet the criteria for assisted living care must have satisfactorily completed an approved training program prior to employment, or within 30 days of employment they must enroll in and successfully complete the program within 2 months of employment. Licensed health care professionals are exempt from this training requirement. Examples of approved training programs are:

- A Virginia Board of Nursing-approved educational curriculum from a Virginia Board of Nursing accredited institution--or a Department-approved educational curriculum for nursing assistants, geriatric assistants, or home health aides.
- A personal care aide training program approved by the Virginia Department of Medical Assistance Services.
- The Department-approved 40-hour direct care staff training provided by a licensed health care professional.

Staff who serve residents who are--or may be--aggressive or need restraints must receive additional training that covers self-protection, and the prevention and de-escalation of aggressive behavior. Training to serve residents who are restrained must cover proper techniques for applying and monitoring restraints; skin care and active assisted range of motion exercises; assessment of blood circulation; turning and positioning; provision of sufficient bed clothing and covering to maintain body temperature; provision of additional attention to meet the physical, mental, emotional, and social needs of restrained residents; and awareness of possible risks, and methods of reducing or eliminating such risks.

Provisions for Apartments and Private Units

Apartment-style units are not required. Facilities constructed or modified after 2006 can have up to two occupants per room; those constructed before that time may have up to four occupants. Facilities built or modified after 2006 must provide one toilet and sink for every four residents and one bathtub or shower for every seven residents.

Provisions for Serving Persons with Dementia

Dementia Care Staff. At least two direct care staff must be awake and on-duty at all times in each secure special care unit (SCU) when residents are present.¹ During trips away from the facility, sufficient direct care staff must be available to provide “sight and sound” supervision to all residents who cannot recognize danger or ensure their own safety and welfare. A designated staff person who is responsible for managing or coordinating the structured activities program must be on site at least 20 hours a week.

Dementia Staff Training. In facilities that serve a mixed population, commencing immediately upon employment and within 3 months, the administrator must complete 12 hours of training in cognitive impairment; and commencing immediately upon

¹ Only one direct care staff member has to be awake and on-duty in the unit if sufficient to meet the needs of the residents, and if: (1) no more than five residents are present in the unit; and (2) at least two other direct care staff members are present in the building, one of whom is readily available to assist with emergencies in the SCU, provided that supervision necessary to ensure that the health, safety, and welfare of residents throughout the building is not compromised.

employment and within 4 months, direct care staff must complete 4 hours of training in cognitive impairment. The training curriculum for direct care staff and administrators must be developed by a qualified health professional or by a licensed social worker and be relevant to the population in care. Topics must include but are not limited to: (1) an overview of cognitive impairments; (2) resident care techniques; (3) behavior management; (4) communication skills; (5) activity planning; and (6) safety.

In secure SCU s, commencing immediately upon employment and within 2 months, the administrator and direct care staff must attend at least 4 hours of training in cognitive impairments due to dementia, and at least 6 more hours of training within the first year. The training must be developed by a licensed health care professional who has at least 12 hours of training in the care of individuals with dementia; or a person who has been approved by the Department to develop the training.

At a minimum, the training must include: (1) information about cognitive impairment (e.g., cause, progression, behaviors, and management of the condition); (2) communicating with the resident; (3) managing dysfunctional behavior; (4) identifying and alleviating safety risks to residents with cognitive impairment; (5) assessing resident needs and capabilities and understanding and implementing service plans; (6) resident care techniques for persons with physical, cognitive, behavioral and social disabilities; (7) creating a therapeutic environment; (8) promoting resident dignity, independence, individuality, privacy and choice; (9) communicating with families and other persons interested in the resident; (10) planning and facilitating activities appropriate for each resident; and (11) common behavioral problems and behavior management techniques.

Within the first month of employment, in both mixed population facilities and in secure SCU s, staff other than the administrator and direct care staff must complete 1 hour of training on the nature and needs of residents with cognitive impairments, relevant to the population in care.

Dementia Facility Requirements. A facility may have one or more self-contained SCU s or an entire facility may be a SCU. Exit doors must be monitored or secured unless they lead to protected areas. Staff-supervised or secure outdoor areas must be available. Protective devices must be in place on bedroom and bathroom windows and on common area windows that are accessible to residents with dementia. Unrestricted access to an indoor area for walking must be provided. Facilities must take precautions to limit environmental hazards for residents who cannot recognize danger.

Background Checks

A separate regulatory document describes background check requirements. Staff must submit a sworn statement disclosing criminal convictions or pending charges. False statements are a Class 1 misdemeanor. For all employees, the facility must

obtain original criminal records checks from the Virginia State Police Central Criminal Records Exchange.

Inspection and Monitoring

An inspection has six components: (1) an initial meeting with the inspection team and facility staff; (2) a facility tour; (3) interviews with residents, family members, and staff; (4) observations of staff activities, including medication administration; (5) a review of documentation; and (6) an exit interview. Unannounced inspections are conducted at least annually.

Public Financing

A Medicaid 1915(c) waiver program--Virginia Alzheimer's Assisted Living--serves up to 200 assisted living residents with Alzheimer's disease. To be eligible, residents must meet the state's nursing facility/waiver level of care criteria and be receiving the state supplement to the federal Supplemental Security Income (SSI) payment.

Room and Board Policy

The state provides an optional state supplement (OSS) through its Auxiliary Grant Program to needy aged, blind, and disabled persons who live in an ALF or in an approved AFC home and who are eligible for federal SSI benefits or would be eligible except for excess income.² The grant program is administered by the Department for Aging and Rehabilitative Services.

The state establishes an SSI standard from which the federal SSI payment (\$721 in 2014) minus a personal needs allowance (\$82 in 2014) and any countable income are deducted; the remainder is the amount of the auxiliary grant (the OSS). Providers serving residents who receive auxiliary grants may not charge more than the total SSI payment. In 2011, the maximum auxiliary grant was \$686 in Northern Virginia and \$519 in the rest of the state.³

Family supplementation is not allowed to pay for the cost of a private room but is allowed to pay for goods and services beyond those covered by the total SSI payment.

² Facilities can use the grant to cover room, board, basic supportive services, and supervision.

³ Social Security Administration. *State Assistance Programs for SSI Recipients*, January 2011. http://www.socialsecurity.gov/policy/docs/progdesc/ssi_st_asst/2011/va.html. Current information about the state's SSI payment was not available online or from other sources.

Location of Licensing, Certification, or Other Requirements

Virginia Department of Social Services website: Assisted Living Facilities with information and links to the regulations and other provider resources.

<http://www.dss.virginia.gov/facility/alf.cgi>

Virginia Department of Social Services website: Adult Services information, including AFC, assisted living and other adult services, and links to resources.

<http://www.dss.virginia.gov/family/as/servtoadult.cgi>

Virginia Department of Social Services website: Auxiliary Grant information and links to rules and resources.

<http://www.dss.virginia.gov/family/as/auxgrant.cgi>

Information Sources

Beverley Soble
Virginia Health Care Association

Judith McGreal
Virginia Department of Social Services

Tishaun Harris Ugworji
Virginia Department for Aging and Rehabilitative Services

Steve Ankiel
Virginia Department of Medical Assistance Services

COMPENDIUM OF RESIDENTIAL CARE AND ASSISTED LIVING REGULATIONS AND POLICY: 2015 EDITION

Files Available for This Report

FULL REPORT

| | |
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| Executive Summary | http://aspe.hhs.gov/execsum/compendium-residential-care-and-assisted-living-regulations-and-policy-2015-edition-executive-summary |
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SEPARATE STATE PROFILES

[**NOTE:** These profiles are available in the full HTML and PDF versions, as well as each state available as a separate PDF listed below.]

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