

**Standards for Licensed Assisted Living Facilities**  
**Effective February 1, 2018**  
**Questions and Answers**

**22 VAC 40-73-10. Definitions.**

Q: Please define “case manager.”

A: “Case manager” is defined in the ALF regulations as an employee of a public human services agency who is qualified and designated to develop and coordinate plans of care.

**22 VAC 40-73-30. Program of care.**

Q: (1) What would spiritual need look like on the service plan?

Q: Does this new regulation change indicate that spiritual needs have to be in the actual service plan or just offered in the program of care for the resident?

A: Spiritual needs are not just religious in nature; however, if an individual requires assistance with meeting their spiritual needs, this would need to be on the ISP.

Q: How will the inspectors inspect for meeting the spiritual needs of the residents?

A: The spiritual needs should reflect the residents’ personal preferences. Spiritual needs are not necessarily religious in nature.

**22 VAC 40-73-40. Licensee.**

Q: (B1) Licensee must give evidence of financial responsibility and solvency. What would this look like and would it be required more than the initial?

A: Look at it at the initial application, review the budget and credit reference. If there is a complaint or indication of a problem with finances, this would be reviewed again. Indications could include inability to pay bills or the building being in need of repairs.

Q: (B1) How should the licensee provide evidence of financial responsibility and solvency?

A: Depending on the specific circumstances, documents including but not limited to bank statements, bills and/or payment records may need to be reviewed by the licensing inspector.

Q: (B7) What about a social security payee?

A: This is not a matter of being a conservator or guardian. This is up to the Social Security Administration rules regarding payee situations.

Q: (D) What if the contact person is one of these people?

A: It is up to the facility to maintain the contact list, and they will need to understand the legality of the notification process.

Q: (D1) Has the notification time frame changed?

A: No.

**22 VAC 40-73-50. Disclosure.**

Q: Do we need to see the policy?

A: No, as there is no policy required.

**22 VAC 40-73-60. Electronic records and signatures.**

Q: (B1) Should the policy and procedures for electronic records include a copy of the Uniform Electronic Transactions Act.

A: That is not necessary.

Q: (B1) Should policy include verifying or conditions for accepting an electronic signature from doctors, hospital, etc.?

A: No.

Q: (C) What is acceptable for a backup system?

A: We do not need to define the providers backup system, all that matters is that one is in place.

**22 VAC 40-73-70. Incident reports.**

Q: (C7) If the actions to prevent recurrence don't work, what happens?

A: This is situational, and would need to be addressed on a case by case basis.

Q: Could the required information be provided to the licensing inspector by telephone, within 24 hours, to meet this part of the standard?

A: Yes, however, it is recommended that the licensee keep written documentation of the date and time of the telephone call.

**22 VAC 40-73-100. Infection control program.**

Q: How do you define "basic" infection prevention?

A: Basic infection prevention training would include an understanding and utilization of standard precautions. The CDC identifies standard precautions as practices to be used for **all** patient care. Practices are based on a risk evaluation and make use of common sense practices and personal protective equipment use that protect healthcare providers from infection and prevent the spread of infection from patient to patient.

Q: (A1&2) Which applicable guidelines and regulations?

A: Any state and federal regulations that apply.

Q: (A1 & A2) For the purpose of Infection Control, would an administrator be considered a licensed healthcare professional?

A: No, as infection control is not within the scope of a licensed assisted living facility administrator.

Q. (A1&2) What constitutes practicing within the scope of his profession?

A: This would refer back to the requirements of the identified profession.

Q: (A1&2&3) How do we verify that this person has been trained in basic infection protection?

A: Documentation should be available for review to demonstrate that the individual meets the requirement.

Q: (C2a) Define “acute infectious disease.”

A: Any illness that develops quickly is intense or severe and lasts a relatively short period of time. Ex.: Flu, Norovirus.

Q: (C2b) Should the use of safe injection practices and potential for exposure to blood or body fluids be based on staff “scope of practice”?

A: It is not necessary to include scope of practice here.

Q: (C2e) Does cleaning agents refer to type or specific name of cleaning supply?

A: The agent is just referring to what the product is; it is not specific to any specific product type.

Q: (C2e) How specific do you want the following “sanitation of rooms, cleaning and disinfecting procedures, agents and schedules?”

A: The procedure should address maintaining appropriate sanitation and cleanliness.

Q: (C2f) Other than blood pressure cuffs, what other types of medical equipment used on more than one resident do you think require sanitation? Why would a blood pressure cuff need to be sanitized, as that appears to be more than what our environment and this item and its use would require?

A: Refer to 22 VAC 40-73-100 C 2 f for clarification. Additional examples might include: Hoyer Lift, Geri Chairs, wheel chairs, chair tables, etc.

Q: (C3) Does the handwashing equipment and necessary personal protective equipment need to be indicated as to where it is located?

A: Yes.

Q: (D) Does the staff health program have to be in writing? What about updating the program?

A: Yes.

Q: (D.4) If the facility recommends that employees take the flu shot, is there a documentation requirement?

A: The ALF standard requires that the facility shall have a staff health program that includes documentation of screening and immunizations offered to, received by, or declined by employees in accordance with law, regulation, or recommendations of public health authorities.

Q: (E) How would you define an outbreak?

A: This would be defined in accordance with your local health department.

**22 VAC 40-73-120. Staff Orientation and initial training.**

Q: (B2) Will the requirement of staff being oriented to the facility's organizational structure be added to our form template?

A: All the forms will be updated.

Q: (B & C) Will the model form on the DSS website be updated to reflect the changes in the regulation about staff orientation?

A: Yes.

Q: (B & C) How many hours should staff orientation take?

A: The number of hours, for the orientation, is up to the facility. Please document the number of hours that the orientation takes, as this can be counted toward the required annual training for staff members.

**22 VAC 40-73-160. Administrator training.**

Q: (D) Does an administrator who supervises the RMAs need to be an RMA or nurse?

A: No. 22 VAC 40-73-160 D allows for an administrator that is not an RMA or nurse to supervise RMAs once they complete the 68-hour RMA training course.

Q: (D & E) Does the administrator training referenced in 160.D and 160.E apply to facilities that have a nurse that supervises RMAs?

A: If the facility has a full-time nurse that supervises the RMAs than the administrator is not required to complete medication aide training. Nor do they have to take the four hour refresher course.

Q: (D & E) Does the annual training in medication administration, referenced in 160E, apply to all administrators?

A: The four hours of annual training in medication administration only applies to administrators that supervise medication aides.

Q: (D & E) Would the administrator need the required training in medication administration, if the nurse that supervises RMAs quits and the position has not been filled yet?

A: Yes, if the administrator would be supervising the medication aides.

Q: (D & E) Would a consulting nurse, working a full-time schedule at the facility, be able to supervise RMAs?

A: Yes, as long as they worked a full-time schedule.

Q: (D & E) Would the administrator need the required medication training if they are also a nurse?

A: No

**22 VAC 40-73-200. Direct care staff qualifications.**

Q: (C) Would an individual that has a nursing license from another country be considered qualified direct care staff?

A: The credentials and training of the individual would need to be reviewed to ensure that they meet the criteria of the regulation.

**22 VAC 40-73-210. Direct care staff training.**

Q: (A & B) If a staff member is currently enrolled in a nursing program, how many hours of annual training would they need to complete?

A: The direct care staff person needs to complete the required training hours in either 210A or 210 B. The exception of only completing 12 hours of training does not apply to them if they are enrolled in a nursing program.

Q: (A & B) When would the 18 hour training requirement be effective? When would inspectors be citing staff members for not having the required 18 hours of training?

A: The 18-hour training requirement went into effect on February 1, 2018 and inspectors will begin citing for violations on April 1, 2018.

**22 VAC 40-73-220. Private duty personnel.**

Q: Would it be a violation of the ALF standard to use Nanny cams?

A: There are no applicable standards.

Q: (A3) Is it acceptable for the licensed home care agency to complete a TB screening for private duty personnel?

A: Yes. Documentation should be maintained by the facility or the licensed home care agency.

Q: Are background checks that are obtained through third party agencies acceptable for private duty personnel or does the background checks need to be obtained from the Virginia State Police and what is the timeframe in which the background check needs to be obtained?

A: Two part answer: (220 A) for private duty personnel from licensed home care organizations and (220 B) when a private duty person is not an employee of a licensed home care organization.

- (220 A)When private duty personnel from licensed home care organizations provide direct care or companion services to residents in an assisted living facility the licensed home care organization would be responsible for obtaining background checks as required by 12 VAC 5-381-110 which includes the following:

A. Section 32.1-162.9:1 of the Code of Virginia requires home care providers, as defined in § 32.1-162.7 of the Code of Virginia, to obtain a criminal record report on applicants for compensated employment from the Virginia Department of State Police. Section 32.1-162.9:1 of the Code of Virginia also requires that all applicants for employment in home care organizations provide a sworn disclosure statement regarding their criminal history.

E. No employee shall be permitted to work in a position that involves direct contact with a patient until an original criminal record report has been received by the home care organization or temporary staffing agency, unless such person works under the direct supervision of another employee for whom a background check has been completed in accordance with subsection B of this section.

- (220.A)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:
  - Prior to initiation of services, 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 date of the report must not be more than 90 days prior to the date of the beginning of services.

Q: (A) Does 220 apply to hospice organizations?

A: Yes.

Q: (A) For employees of a licensed home care organization (that have been working at the organization more than a year) but new to the ALF, does the ALF need a criminal history record report?

A: No, this would be handled by the licensed home care organization.

Q: (A) What type of orientation areas are required for private duty personnel?

A: Their orientation shall relate to their qualifications and duties performed at the facility.

Q: (A) Would private duty aides that only provide transportation need an orientation?

A: Yes.

Q: (A6) Does documentation of monitoring of private duty services need to be incorporated into the policy and procedure?

A: While not required to be included in the policy and procedures, best practice would dictate that the facility should have a means of documenting how they monitor private duty services.

Q: (B) How would you know if private duty personnel are qualified?

A: It is the responsibility of the facility to ensure that private duty personnel are qualified; the facility determines how to make that judgement, including, but not limited to a review of training documentation, license/registration, and/or credential check.

Q: (B) Is the criminal history record report only required for private duty personnel, who are not employees of a licensed home care organization?

A: The facility is required to review criminal history record reports for private duty personnel who are not from licensed home care organizations.

Q: (B) Is a criminal history record report required for paid family members?

A: Yes.

Q: (B) Can the cost of the required criminal history record report be passed on the resident/family that is receiving private duty services?

A: This is not a regulated action. Each facility can set its own policy.

Q: (B2) What would documentation look like to ensure private duty personnel are qualified for the types of direct care or companion services they are providing?

A: The facility is required to have processes in place to verify these service qualifications.

Q: (B2) Does the private duty personnel regulation apply to privately paid individuals not from a licensed home care organization?

A: Yes. It is the responsibility of the facility to determine if the private duty personnel is qualified to perform the duties for which they are hired.

Q: (B3c) Background checks/barrier crimes.

A: Formal TA will be issued on this.

Q: (B 3) Are current private duty personnel, who do not have a criminal history report, grandfathered in?

A: No.

## **22 VAC 40-73-240. Volunteers.**

Q: Do the volunteer requirements apply to members of the volunteer ombudsman program?

A: No.

Q: (A) Can a volunteer push a resident in a wheelchair?

A: They could push a wheel chair from place to place, but be cognizant of the volunteer's qualifications. Volunteers would not be able to provide assistance with transfers without being qualified and the qualification must be documented.

Q: (A) Would it be appropriate to have volunteer qualifications included with their application?

A: This is a facility decision.

Q: (A) If a volunteer plays chess with a resident, do they need qualifications?

A: Only the basic requirements for a volunteer.

**22 VAC 40-73-260. First aid and CPR certification.**

Q: Do volunteers need to have certification in first aid and CPR?

A: There is no requirement in the ALF regulation for a volunteer to have certification in first aid and CPR.

Q: (A) Do certified nurse aides and registered medication techs need first aid training?

A: Yes.

Q: (A4&B1) Does this apply to units, i.e. does there need to be an additional person in a safe, secure unit?

A: Standard applies to "building" not "unit."

**22 VAC 40-73-270. Direct care staff training when aggressive or restrained residents are in care.**

Q: Can training direct care staff in methods of dealing with residents who have a history of aggressive behavior be conducted on-line?

A: Yes, however the practical experience portion must be face-to-face.

**22 VAC 40-73-290. Work schedule and posting.**

Q: (B) Is a written policy and procedure required along with the posting?

A: Procedure is required by the standard.

Q: (B) Does the procedure have to be posted?

A: The name of the current on-site person in charge must be posted. The procedure for doing this does not have to be posted.

Q: (B) If there is a general posting of staff members that could be in charge, is this acceptable to meet the requirement?



A: No, the standard requires that the name of the current on-site person in charge be posted in a conspicuous place.

**22 VAC 40-73-300. Communication among staff.**

Q: Can the communication among staff be documented electronically?

A: Yes, as long as it meets all of the documentation requirements of the standard.

**22 VAC 40-73-310. Admission and retention of residents.**

Q: Please define “agency staff.”

A: Agency staff of the home care agency.

Q: (G) Does “relinquish” rights as a condition of admission mean guardianship?

A: The facility cannot require a person to relinquish their rights, regardless if a guardian has been appointed.

Q: (M) Can the hospice plan be attached to the ISP in lieu of documenting each piece?

A: This will be addressed in the ISP staff training.

**22 VAC 40-73-325. Fall risk rating.**

Q: What are the qualifications needed for a person to be able to complete the fall risk rating?

A: There is no specific requirement in law or regulation. The facility must determine who is qualified and document the qualifications of the person determining the rating.

Q: Will DSS have a minimum number of falls per month?

A: A fall risk rating must be performed after each fall.

Q: Can fall risk assessments be done?

A: The standards require a fall risk rating. An assessment is more comprehensive. Unlicensed staff may not perform a fall risk assessment.

Q: Will there be a model form for fall risk rating?

A: No but we will try to provide examples.

Q: (A) Are you looking for the fall risk rating to be a numeric score? Will there be a model form?

A: The fall risk rating does not need to be a numeric score. No model form will be provided for the fall risk rating.

Q: (A) Does the fall risk rating also apply to residential living and/or independent living residents?

A: No, the fall risk rating only applies to residents who meet the criteria for assisted living care.

Q: (B) For residents that have frequent falls, how should documentation of the risks/interventions be completed without getting repetitive?

A: The facility should document what interventions can be put in place regarding each specific fall. There are a number of tools available for rating risk and planning appropriate interventions ranging from simply stated, user friendly documents to much more complex assessment tools. Some examples include: Morse Fall Scale and Briggs Fall Risk Assessment Tool.

The following is a website link to tools and suggestions from Centers for Disease Control and Prevention (CDC):

[https://www.cdc.gov/steady/pdf/STEADI\\_PocketGuide\\_1in4-print.pdf](https://www.cdc.gov/steady/pdf/STEADI_PocketGuide_1in4-print.pdf)

Q: (B) What if someone likes to sit on the floor?

A: This should be documented on the resident's ISP as a preference presuming the individual is capable of lowering himself to the floor with or without assistance. Staff must be made aware of any needs for assistance or monitoring related to this activity.

Q: (B & C) Will inspectors be looking for fall risk rating information, in addition to the nursing note?

A: Yes, documentation about the fall and the required information from 325.B and 325.C will be reviewed by the inspectors.

#### **22 VAC 40-73-340. Psychosocial and behavioral history.**

Q: (A) If a resident is coming from a mental health hospital, is a new mental health evaluation required?

A: No. The discharge summary or evaluation from the hospital may be used.

#### **22 VAC 40-73-350. Sex offender information.**

Q: For informing residents/families on how to research registered sex offenders, is this a one-time requirement or annual requirement?

A: The assisted living facility shall ensure that each resident or his legal representative is fully informed, prior to or at the time of admission and annually, that he should exercise whatever due diligence he deems necessary with respect to information on any sex offenders registered pursuant Chapter 9 (§ 9.1-900 et seq.) of Title 9.1 of the Code of Virginia, including how to obtain such information.

#### **22 VAC 40-73-360. Emergency placement.**

Q: What if the facility has not been able to obtain the UAI, physical, medication orders and other documents required for admission prior to the end of the seventh day that the individual is residing in the facility under an emergency placement?

A: All of the requirements for admission must be met or the resident may not be admitted to the facility.

**22 VAC 40-73-390. Resident agreement with facility.**

Q: For residents that have an auxiliary grant, does the local DSS assessor still need to complete the full UAI?

A: For residents receiving the auxiliary grant, the UAI needs to be completed by a case manager or qualified assessor as specified in 22 VAC 30-110.

Q: Is the liability insurance disclosure notification form new?

A: No, this has been in place since the notice dated 04/16.

**22 VAC 40-73-420. Acceptance back in facility.**

Q: (A) Must the facility take the person back? And then can discharge if need be?

A: Yes on both questions.

Q: (A) If a resident is not involuntarily committed, is it okay for the resident to return to the facility?

A: The regulation requires the facility to take the resident back.

**22 VAC 40-73-430. Discharge of residents.**

Q: Please clarify the requirements for an emergency discharge. What if the resident's condition presents an immediate and serious risk to the health, safety, or welfare of the resident or others but the facility is unable to accomplish the discharge? Would the facility be responsible for providing 1:1 staff to resident care/supervision until discharge could be completed?

A: The facility must ensure that the health, safety and welfare of all residents are protected. That requirement may include, but is not limited to, 1:1 staff supervision.

Q: (A) What if a facility attempts to discharge a resident, but the resident refuses to leave or the family does not pick up the resident?

A: This question is outside the parameters of the regulation and fact-specific. The facility may want to consult with its legal counsel. The facility shall continue to document their attempts to discharge the resident.

Q: (H) Can email be used to provide the discharge statement to the resident and any other required individuals?

A: Yes, if that is an appropriate method of communication to the resident.

Q: (H) Does the discharge statement need to be provided to residents, even if they have severe dementia?

A: Yes.

**22 VAC 40-73-440. Uniform assessment instrument (UAI).**

Q: Is the UAI training on the public DSS website?

A: Yes, there is a link on the DSS website for: “Private Pay Uniform Assessment Instrument Online Training.”

**22 VAC 40-73-450. Individualized service plans.**

Q: Are the ALFs expected to go back and correct the ISP on existing residents immediately or as the client’s review date or need to modify the form arises?

A: As the review date or need to modify arises, the provider would be expected to add the column regarding the “Date Outcome Achieved”. However, for residents that are admitted after 2/1/18, their ISP should reflect this column immediately.

Q: Does the resident have to be given a copy of the ISP if they don’t want it? Can the resident sign a statement that they have been offered a copy and decline? Also, can a statement be included that Power of Attorney, Guardian or Responsible Party be included as persons that can receive a copy of the ISP? Can a statement be signed or initialed by the recipient(s) verifying the receipt of the ISP by the Resident?

A: If a resident refuses a copy of their ISP, documentation should be made to that effect. A copy of the ISP may be shared with Power of Attorney, Guardian or Responsible Party if the resident agrees to that; documentation of this agreement and receipt should be maintained.

Q: According to the addition in this standard a Licensed Health Care Professional can do ISP Training. Will there be a training document/guidance book and or workbooks for the Licensed Health Care Professional to use when training? Also, will there be a training session for these Licensed Health Care Professionals before they provide the ISP training?

A: Yes, a curriculum will be made available to those eligible to train later this year. Eligible trainers are not permitted to develop their own curriculum-there will be one approved curriculum. A decision has not yet been made as to a train-the-trainer course.

Q: Currently, we have resident, POA and others in service plan meeting sign a signature sheet. We would like to continue using this sheet as our method for capturing the required signature on the ISP. Is this acceptable? Is there a Model Form for preliminary ISPs?

A: Yes, it is acceptable to use a signature sheet. At this time there is no plan for a model form for preliminary IPSs.

Q: (A) What is included in the preliminary plan of care?

A: The preliminary plan of care should address the basic needs of the resident, which adequately protect his health, safety and welfare.

Q: (B) What type of training is required to complete the ISP?

A: Completion of the department-approved training.

Q: (B) Will more ISP training classes be available in the future?

A: The department is working to make ISP training more available to providers.

Q: (C) Please clarify the timeframes for completing the ISPs. Are 30-day ISPs still required?

A: If a preliminary plan of care is developed on or within seven days prior to admission, then a comprehensive ISP must be developed within 30 days.

Q: (E) What if the resident refuses to sign the ISP?

A: Document the resident's refusal to sign the ISP. The facility should investigate why the resident is refusing to sign the ISP, as this should not be a regular occurrence.

Q: (E) What should the facility do if a resident moves in to the facility and a change in care needs is noted and they update the ISP but the family will not come in to sign the changed ISP?

A: The family is not required to sign the ISP.

Q: (G) Do memory care residents need a copy of their ISP?

A: Yes.

Q: (G) If a resident has a care need that they do not want to have identified, does the complete ISP need to be provided to the resident?

A: Yes, the resident has the right to see their completed ISP. If there is a concern regarding a care need the facility should discuss this with the resident and alleviate their concerns in a manner that will preserve their dignity.

### **22 VAC 40-73-470. Health care services.**

Q: (D) During a recent DSS inspection, the inspector referenced that the facility needs to place all allergies on the ISP. Do all allergies have to be included on the ISP?

A: Regarding a resident's known allergy to food, medication, cleaning supplies, etc.; the need that must be included on the service plan is the need to protect the resident from the known allergy except that the allergy would not need to be on the ISP if:

- (i) The resident's allergy is clearly documented and readily available for staff to access without the assistance of contacting another person within the facility; and
- (ii) There are methods to ensure that the resident does not receive or is not exposed to substances to which the resident has a known allergy.

**Please Note:** 22 VAC 40-73-640.A.12 requires that the facility's medication management plan include methods to ensure that residents do not receive medications or dietary supplements to which they have known allergies. If the allergies related to medication are on the MAR, and if only those who are administering medications need to be aware of these allergies, then they do not need to be on the ISP.

Q: (E) If a resident cares for their own gastric tube, does the signed consent form and ISP documentation need to be completed?

A: No consent form would be required, but it would be best practice to document the resident's self-care of the gastric tube on the ISP.

Q: (E) Can medication aides administer medication via gastric tubes?

A: No. Medication aides are prohibited from administering medication via gastric tubes. The medication can only be administered by licensed personnel (e.g., a licensed practical nurse).

Q: (E) Please clarify the time frames for oversight of gastric tube care?

A: The registered nurse who is delegating care to direct care staff determines the frequency of oversight.

**22 VAC 40-73-490. Health care oversight.**

Q: (A) If the facility administrator is a licensed nurse, can they complete the health care oversight?

A: Yes, as long as the person is a licensed health care professional, meets the qualifications for the administrator, and is not directly responsible for all or most of the functions being reviewed.

**22 VAC 40-73-510. Mental health services coordination and support.**

Q: (A) Would a neurologist be considered a qualified health care professional for the purpose of a resident needing mental health services?

A: Yes.

**22 VAC 40-73-540. Visiting in the facility.**

Q: With respect to visiting hours, it is acceptable for the facility to lock the doors at night?

A: Yes. There must be provisions for visitors to come in.

**22 VAC 40-73-550. Resident rights.**

Q: For notification of resident rights, can we add a signature for confirmation of receipt to the initial service plan meeting and then annual service plan meeting? Will this satisfy the requirement?

A: There should be a clear differentiation between the signature for the ISP and the signature for resident's rights. Licensee must ensure that resident rights are reviewed initially and annually.

Q: (F) The resident rights are now required to be printed in at least 14-point type. Is this change referring to the resident rights that are being posted or the resident agreement?

A: The change is being made in reference to the resident rights that are posted in the facility.

Q: (G) If the resident has dementia or has been found to be legally incompetent, how should a review of resident rights be conducted?

A: The review would be completed with the resident's legal representative. If the resident does not have a legal representative, then the review would be conducted with a responsible individual, of the resident's choice when possible, or with the resident if there is no legal representative or responsible individual. A resident is assumed capable of understanding and exercising resident rights unless a physician has determined otherwise.

Q: (H) If a family member is also a staff member, can they be the "responsible individual"?

A: No, the family member may not be the "responsible individual." The family member can be the legal representative.

#### **22VAC40-73-560. Resident records**

Q: Since new regulations say RMAs can sign one master list instead of each paper MAR, would that apply to ADL sheets? Can staff sign one master ADL sheet instead of each individual ADL sheet?

A: The regulations do not require specific ADL sheets/assignment sheets/etc. The facility can use whatever system they develop, but facility policy should address what they use and how it is used. If a facility uses a single ADL sheet, they would need to ensure that the master stayed up to date so that staff accountability can be reconciled when necessary. The regulation that would address that topic would fall under resident records so the new regulation would not impact an ADL sheet.

Q: (560.H) How long does the resident record need to be retained for a discharged resident?

A: The facility must retain the complete resident record for at least two years after the resident leaves the facility. For at least the first year, the record shall be retained at the facility; after the first year, the record may be retained off site in a safe, secure area and be available at the facility within 48 hours.

#### **22 VAC 40-73-590. Number of meals and availability of snacks.**

Q: (590.B) What if a resident(s) who has medical and/or mental health issues, attempts to eat all of the available snacks?

A: The standard requires that snacks shall be made available at all times for all residents or in accordance with their physician's or other prescriber's orders. Appropriate adjustments in the provision of snacks to a resident shall be made when orders from the resident's physician or other prescriber in the resident's record limits the receipt or type of snacks.

#### **22 VAC 40-73-610. Menus for meals and snacks.**

Q: (610.B) Do snack menus need to be posted?

A: Yes, menus for meals and snacks for the current week shall be dated and posted in an area conspicuous to residents.

**22 VAC 40-73-620. Oversight of special diets.**

Q: (B3) If the dietitian documents their visit in each individual resident record, is the report required?

A: Yes, a written report is required to be made to the administrator and shall be maintained at the facility for two years. Any specific recommendations regarding an individual resident must also be maintained in that resident's record.

**22 VAC 40-73-640. Medication management plan and reference materials.**

Q: What should the facility do if the insurance company will not cover the cost of a resident's prescribed medication? What if this happens on the weekend?

A: The facility would be expected to contact the prescriber to notify them that the resident will not receive their medication. It would be incumbent on the prescriber to give further direction to the facility.

Q: If a facility does not have a medication tech or nurse working the evening/night shift how will a facility ensure that the narcotic count is being done with two medication techs or nurses?

A: Any facility that has this scenario needs to ensure that their medication management plan clearly addresses how they will ensure counts and security for controlled medications.

Q: (A 2) If the facility's standard dosing schedule has to be documented in the medication management plan, does this mean that person centered care cannot be provided regarding resident medication?

A: Open med-passes work best in an environment that has already embraced culture change.

Standardized medication schedules, including open med-pass and other person centered medication management programs need to take into account both institutional and **individual needs**, including multiple drug therapies, drug-drug or drug-food compatibility, bioavailability of a drug, specific drug actions or interactions, and the effects of individual bio-rhythms; inappropriate changes may cause complications or adverse reactions. Thus, changes should be made only when the medication and the patient's condition don't require an exact schedule.

A couple of areas of caution: medications that are ordered for specific times of the day may not be liberalized. Certain medical diagnoses such as medications to control Parkinson's disease symptoms must be given as ordered. Staff needs to be very clear on those types of distinctions.

Decisions regarding open med-pass would be made with input from nursing, consulting pharmacist and physician. This would be based on both the individual resident and the specific medication.

Q: (A 10) Do licensed nurses who pass medication have to receive "periodic direct observation" of medication administration?



A: The medication management plan requires that the facility develop and implement methods to ensure that staff, including licensed nurses, who are responsible for administering medications are adequately supervised, including periodic direct observation of medication administration.

Q: (A 10) How is DSS defining periodic?

A: The individual facility determines the frequency as part of the medication management plan. The frequency will depend on such things as the number of residents, the number and complexity of medications being administered and the number of staff involved in the administration of the medications.

Q: Who can supervise the registered medication aid under the requirement for “periodic direct observation”?

A: Standard 670, Qualifications and supervision of staff administering medications answers this question in subpart 3.

**22 VAC 40-73-650. Physician’s or other prescriber’s order.**

Q: (F) How much time do facilities have to make contact with the primary physician, of a resident returning from the hospital, to inform them about the new medication orders?

A: Prior to or at the time the resident returns to the facility from the hospital.

Q: (F) If a resident is discharged from the hospital with new medications or changed doses and the primary physician can’t be reached, can the new medication be administered by the facility?

A: Yes. The new orders would be valid, if signed by the hospital physician. The facility is responsible for documenting that it has informed the primary physician about the new orders.

**22 VAC 40-73-660. Storage of medications.**

Q. How does the provider store morphine when it comes from the pharmacy in pre-loaded syringes which are not individually labeled but are in a zip lock type baggie that is labeled with the resident name and contains multiple pre-loaded syringes? (the facility gets the medication from the pharmacy this way).

A: Morphine is a Schedule II drug and is required to be kept in a separate locked storage compartment (e.g. locked cabinet within a locked storage area or a locked container within a locked cabinet or cart). Pre-loaded morphine is often prescribed for patients enrolled in hospice and the syringe is too small for the full pharmacy label. It is not a violation of pharmacy regulation to label in this manner; however some pharmacies do not consider it best practice. Providers can ask the pharmacy to add a small label to the syringe with some identifying data of the resident if they consider this to be a risk for medication error. Licensed medication staff must ensure that syringes remain in the labeled pharmacy container until removed for administration.

Q: (B) What suggestions do you have to evaluate the ability of residents who self-administer medications to be able to continue to do so?

A: The regulation does not dictate the process; however, there are various resources to assist a provider in doing this. This should be included within the medication management plan.

**22 VAC 40-73-680. Administration of medications and related provisions.**

Q: (D) What is the requirement if physician orders are not clear?

A: Call the prescriber and get clarification.

Q: (I 14) Does the MAR master list need to be done monthly?

A: 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.

Q: (I) Must every MAR include the full name of the staff person administering medications?

A: The full name of the staff person must be included, whether it be on individual MAR or on a master list.

Q: (J) What is the requirement if a wrong medication is administered to a resident?

A: Administering the wrong medication is a medication error. 680.J provides the specific requirements of what to do in the event of an adverse drug reaction or a medication error. The error must be documented on the MAR.

**22 VAC 40-73-690. Medication review.**

Q: (E 7) How does a provider show a “gradual dose reduction of antipsychotic medications”?

A: The licensed healthcare professional conducting the medication reviews will include this observation/consideration as a part of the medication review for residents with diagnoses of dementia with no diagnosis of a primary psychiatric disorder. As noted in 690 G, action taken in response to the recommendations noted in subsection F of this section shall be documented in the resident’s record.

Q: (E 7) What if antipsychotic medications cannot be reduced in order for the person to function independently – can they note no reduction due to that at this time?

A: The review has to include “consideration” of a gradual dose reduction of antipsychotic medications. If the licensed health care professional conducting the review determines that the medication should not be reduced for that reason at this time, 690 G specifies that this is to be so noted.

**22 VAC 40-73-700. Oxygen therapy.**

Q: Do we need to continue to post oxygen in use signs on apartment doors of residents?

A: The facility shall post “No Smoking-Oxygen In Use” signs and enforce the smoking prohibition in any room of a building where oxygen is in use.

Q: If the facility does not allow smoking in any building, may the facility simply put a sign at each entrance which indicates the facility is a No Smoking facility, rather than posting a sign at each resident's room?

A: Even if the facility has a sign at each entrance which indicates the facility is a No Smoking facility, the facility must still post "No Smoking-Oxygen in Use" signs in any room of a building where oxygen is in use.

**22 VAC 40-73-710. Restraints.**

Q: Are Halos considered restraints?

A: See answer below.

Q: Regarding the use of side rails - I currently have a resident that has a neuromuscular degenerating disease and is not able to lift himself due to weakness in his upper body. He currently has a hospital bed and the side rail helps him reposition himself and assist with sitting up. He has 24 hour private duty care and will continue to have this care. Please advise if having a sitter right next to the bed for 24 hour care would be acceptable enough for him to continue to use the side rail?

A: See answer below.

Q: Are there any medical conditions that would permit the use of side rail for repositioning and if so, would they be required to have a sitter all day every day?

A: See answer below.

Q: I know what the new regulations add in reference to restraints. Where does it say that you may not use a ½ rail with a hospital bed? There was talk of NO hospital beds with ½ rails at all and only low beds with floor mats. If a resident is asked to demonstrate how to release a rail; that has always been the regulation (with no cognitive impairment) with a cognitive impairment - they may-not be able to complete the task. This is very confusing.

A: See answer below.

Q: Are half-rails considered restraints; can we still use them?

A: If a resident is able to use the half or quarter side rail independently to reposition himself, it does not restrict freedom of movement, and he is safety aware, then the rail would be considered an adaptive device to support his mobility and not a restraint. The use of a private duty staff is determined by the resident, responsible party, and facility. If the sitter is there to assist with hands on care including repositioning and is appropriately trained to provide that level of care, he or she would serve as an additional safety measure in the use of the device.

Q: Are there any forms that would help to assess whether a bed rail/device would be considered a restraint?

A: The simple answer to this question is that no form can be all inclusive. It is imperative that direct care staff know the residents and each resident's individual needs. Whether the device or

equipment is being used to intentionally restrain the individual or not, staff must be able to determine whether it is actually restraining.

Any number of devices that are used with a purpose of improving the quality of life or safety for a resident may at the same time be restraining. Even bedside mats, lap buddies, low bed positions, wedge cushions, seat belts, scoop mattresses and reclining chairs can be restraints depending on the individual's functional abilities and capabilities.

A low bed position for the person who can normally swing his legs over the side of the bed and stand can be restraining. A bedside mat used to protect an individual from rollovers from bed at night is restraining if it keeps the individual from approaching his own bed with a walker or wheelchair.

Many things are situational and are dependent upon an individual assessment and the person's interaction with any device. Consideration of the purpose/function relationship to the individual's health, safety and independence is critical. The key to all of this, besides knowing the residents and the devices, is clearly documenting the intended use, any safety precautions and any additional measures required to maintain the well-being of the individual on the service plan. Once documented, direct care staff must be made aware of and held accountable for the provision of those services and oversight.

Q: Are chair alarms considered restraints?

A: Chair and bed alarms can be considered restraints if the individual becomes programmed to restrict his or her movement in order not to hear, be startled by, or risk inconveniencing others by triggering the alarm. Studies have shown actual decline in mobility levels and greater risk of falls as a result.

Q: What if the resident's family wants the resident restrained; can this be a family decision?

A: Whether restraints will be used is not a family decision.

**22 VAC 40-73-720. Do not resuscitate orders.**

Q: Can you confirm that Virginia is now able to honor DNR orders from another state?

A: Yes. Virginia now honors DNRs executed in accordance with the laws of another state in which such order was executed. See § 54.1-2987.1 of the Code of Virginia.

Q: (F) Why would a facility not honor a DNR?

A: Because the facility has a policy to that effect and informed residents of the policy prior to or at the time of their admission.

**22 VAC 40-73-740. Personal possessions.**

Q: (D) What if the resident agreement states that the facility is not responsible for lost or stolen items?

A: The facility may not have a policy that conflicts with a standard, as this would seem to.

Q: Is there a specific time frame for notifying the resident of the results of investigation of missing items?

A: No, but the response should be provided within a timely manner.

Q: (D) If a resident regularly reports that something is missing (ex: bar of soap) and this is documented on the ISP as a pattern of behavior, is an investigation/report necessary for each report of the missing item?

A: No. This should be documented on the ISP as a behavior pattern.

Q: (D) Do the written results of the missing item investigation have to be kept in the resident record?

A: No, there is no requirement to maintain the documentation in the resident's record but the facility must maintain the documentation at the facility for at least two years.

**22 VAC 40-73-750. Resident rooms.**

Q: (C) What if a family member does not want an item in the resident rooms; especially in the memory care unit?

A: If the family member is the resident's legal representative they have the same legal standing as the resident and can speak for the resident.

Q: (C) Does the resident's written request, about the exclusion of certain bedroom items, need to be on the ISP?

A: No.

Q: (C) Will there be a model form to document that a resident does not want certain items in their room?

A: No.

**22 VAC 40-73-780. Laundry and linens.**

Q: Please clarify what is meant by the part of the standard that reads, "...sorted by individual resident."

A: Each individual resident shall receive their own personal clothing and personal linens back after they are laundered.

**22 VAC 40-73-830. Resident councils.**

Q: (E) How should the facility provide a written response to the recommendations that were made during a resident council?

A: There must be a written response. The responses could be provided by different means, such as posted in a conspicuous place, included in the meeting minutes, or a facility newsletter.

**22 VAC 40-73-860. General requirements.**

Q: (D 3) What would be considered an operable window, what about a window that has been secured to prevent it from opening?

A: An operable window is a window that can be opened. If the window has been secured to prevent it from being opened at all, the window would not be considered operable. The facility should ensure that securing the window is not a fire or building code issue.

Q: (I) What is the definition of hazardous materials?

A: 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
- Safety Data Sheet (SDS)

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 SDS for many, and probably most, cleaning supplies and other materials that contain chemical ingredients. A SDS 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 SDS 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."

Q: (J) If a resident has dementia, but is capable of independently using Polident, would this be allowable?

A: A determination needs to be made, under subpart J, whether the resident has a “serious cognitive impairment” because this subpart only applies if the resident does not have a serious cognitive impairment. Therefore, assuming the resident does not have a serious cognitive impairment, the resident may use the Polident.

Q: (J) Does the facility have the option to prohibit residents from keeping cleaning supplies or other hazardous materials in their room, when the resident does not have a serious cognitive impairment?

A: Yes, the facility may have its own policy prohibiting cleaning supplies in resident rooms.

Q: (J) Is MSDS required for resident’s products?

A: No.

**22 VAC 40-73-880. Heating, ventilation, and cooling.**

Q: (B3) Can the temperature in the facility be warmer than 72°F?

A: Yes, the standard requires a temperature of at least 72°F during the day when residents are normally awake but the temperature may not exceed 80°F pursuant to 22 VAC 40-73-880 C 1.

**22 VAC 40-73-925. Toilet, face/hand washing, and bathing supplies.**

Q: Can the facility charge private pay residents for toilet paper, soap and paper towels?

A: You can charge private pay residents for supplies in their rooms but not at common sinks and commodes.

**22 VAC 40-73-930. Provisions for signaling and call systems.**

Q: When the licensing inspector is conducting an inspection, what kind of documentation will they be looking for?

A: The standard requires a written log.

Q: (C & D) Can the documentation of the change in round frequency be made on a progress note?

A: No, the standard requires a written agreement.

Q: (C & D) Does the facility need to have a policy specifying the start and end time of the rounds?

A: No, a policy is not required.

Q: (D) Does a signaling device need to be provided, if a resident is unable to use it?

A: Yes, every resident in the facility needs to have a signaling device.

Q: (D) A resident has a chair alarm and it is included in their ISP, would this qualify as a signaling device?

A: No, a chair alarm is not a signaling device.

Q: (D) Does this apply to residents on the special care unit as well?

A: Yes.

Q: (D) Regarding the rounds to monitor for emergencies or other unanticipated resident needs, for residents that are unable to use the signaling device, can the log of rounds be kept electronically?

A: Yes, if the electronic record keeps all of the required information.

Q: (D) Does each round have to be documented?

A: Yes, the documentation requires the name of the resident, the date of the round, the time of the round, and the staff person that made the round.

Q: (D) What if the family of a resident would like a resident to receive a check more frequently than every two hours?

A: The standard states that the resident may request a change in frequency. It is recommended that any agreement for a change in frequency should be documented.

**22 VAC 40-73-950. Emergency preparedness and response plan.**

Q: (A) Does the local emergency coordinator need to sign the emergency preparedness and response plan annually?

A: No, the standard requires facilities to document their initial and annual contact with the local emergency coordinator regarding the required information but no signatures or approvals are required.

Q: (C) Can staff members, residents, and volunteers simply sign the (dated) attendance sheet for the semi-annual review on the emergency preparedness plan?

A: Yes.

Q: (C) Please clarify the time frames for orientation and semi-annual review of the emergency preparedness and response plan for staff, residents, and volunteers.

A: Orientation to the emergency preparedness and response plan should occur as required by the specific standards for staff, residents, and volunteers. The facility is then required to conduct a review of the emergency preparedness and response plan on a semi-annual basis.

**22 VAC 40-73-980. Emergency equipment and supplies.**

Q: This standard adds that the “Temporary emergency electrical power source must be capable of providing power to required circuits when connected and sufficient to implement the EP & R plan”. How is the facility expected to ensure this and how is the inspector to determine this? Does the facility have to have a generator?



A: The facility is not required to have a generator. The amount of power needed is directly related to what is stated in the EP&R plan. For example, if the facility intends to power all electricity in the facility, it will need to have a system/resources that can do that. If the facility intends to power the kitchen and heat/air system, it would need a system/resources for that. It is recommended that the facility consult with an electrician or building specialist to determine what type of system/resources it would need for what it intends to power. If necessary, inspectors would do the same.

Q: (A) Can facilities use a crash cart as an alternative to the first aid kit?

A: Yes, as long as it is easily accessible to staff and they can verify that the required items are kept in the cart.

Q: (G) Can the emergency food supply be stored in the same location as the regular everyday food supply?

A: Yes, however, you will need to be able to show what food supplies constitute the 48-hour emergency food supply.

Q: (G) If an ALF is located on the same campus with a nursing home, does the emergency food and water need to be designated as being for ALF only?

A: There would need to be an identifiable supply of emergency food and water designated for the ALF residents.

#### **22 VAC 40-73-990. Plan for resident emergencies and practice exercise.**

Q: (C) Please clarify the requirements for the exercise for resident emergencies that is to be done at least once every six months.

A: The exercise must address the procedures for handling each of the identified emergencies and notifications as listed in the standard.

Q: (C) What is the definition of a staff member?

A: "Staff" or "staff person" mean personnel working at a facility who are compensated or have a financial interest in the facility, regardless of role, service, age, function, or duration of employment at the facility. "Staff" or "staff person" also includes those individuals hired through a contract with the facility to provide services for the facility.

#### **22 VAC 40-73-1020. Staffing.**

Q: (A) Is two direct care staff enough for an ALF that has a mixed population?

A: At least 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 40-73-280.

#### **22 VAC 40-73-1050. Outdoor access.**

Q: (B) How will inspectors determine if residents with serious cognitive impairments are reminded of the opportunity to be outdoors on a daily basis (weather permitting); do we need to keep a log?

A: No, the facility does not need to keep a log. Inspectors will speak with staff, residents, and families regarding the opportunities for residents to go outdoors.

**22 VAC 40-73-1120. Activities.**

Q: (B) Would it count to have residents in the secure unit and the regular assisted living unit have mixed activities?

A: Yes.

Q: For activities in the safe and secure units, do the required 2 hours each day need to be physically located in the safe/secure unit? Can they be at other locations in the building?

A: No, all activities do not need to take place on the safe/secure unit. Yes, the activities can take place in other areas of the building.

Q: How do we interpret the regulations about who is in charge of the twenty hours and who needs to be present to conduct the activity?

A: There shall be a designated staff person responsible for managing or coordinating the structured activities program who meets the requirements of 1120 F. The designated staff person is not required to conduct all activities. Activities may be conducted by any knowledgeable staff.

**22 VAC 40-73-1130. Staffing**

Q: Does the ratio in the safe, secure unit, apply to mixed populations?

A: No.

Q: We have a 30-bed special care unit, which means we will need 3 direct care staff members in this unit during the 11-7 shift. This will be extremely impactful on the remainder of the building, as we will have to pull one of the two direct care staff members from the regular side of the building for 1 and ½ hours to cover breaks in the special care unit. Would it be acceptable, per this regulation, to maintain 2 direct care staff members in the special care unit and a “floater” for the building as a whole that would serve as the “one of whom is readily available to assist with emergencies in the special care unit”?

A: No, you cannot use a floater. A facility must have staff to cover the number of residents in the unit.

Q: (A) Does the requirement for staffing ratios for a safe, secure unit, apply to each separately locked unit?

A: Yes.

Q: (A) In memory care, is the care staff allowed to take a 15 min break or 30 minute meal break off the unit one at a time, even if that puts the unit below the staffing ratio? Example, if a unit

has 30 residents, and 3 staff are required, can 1 take a break off the unit, leaving only 2, or will that be in violation of the minimum staffing regulation?

A: There are no exceptions to the staffing requirements. If a person takes a break, there must be another staff person to take their place.

Q: (A) What would be considered a unit?

A: There are many configurations for secure units. Questions should be directed to your inspector.

**22 VAC 40-73-1140. Staff training.**

Q: If an administrator changes communities but is current on all SCU training hours would he/she have to complete 12 more hours of dementia training again or is this per calendar year?

A: No, provided the training was completed within the year prior to employment. Training is based on hire date, not calendar year.

Q: What if the administrator or direct care staff person is a certified Dementia Practitioner or something similar but certification is two years old – some of the programs give you two to five years to renew, so it may not be 12 month current – do they have to go through it again?

A: The standard allows completion of the training in the year prior to employment. So, yes, if it is not within this period of time, they would need to go through the training again, even though their certification may not yet be up for renewal.