



## Documentation for Activity Team in Virginia Assisted Living and Nursing Facilities

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### Participants will:

Explore regulatory requirements for activity documentation in **Virginia** assisted living and nursing facilities

Examine commonalities and differences of activity documentation between assisted living facilities and nursing facilities

Explore “best practice” techniques for meeting activity documentation requirements

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## Activity Documentation

Assessments

Progress  
Notes

Treatment  
Records

Plans of Care

**Regulations and expectations vary according to the type of provider [ALF or NF] and to individual organization policy/procedures**

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## Required Interdisciplinary Assessments

### Assisted Living

- UAI - "Uniform Assessment Instrument"
- 2 versions – one for private pay residents and one for public pay residents
- Must be reviewed annually and with significant change

### Nursing Facility

- MDS 3.0
- Departmental [Activity] Assessment

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# UAI FORM

2 Versions

Private Pay

Public Pay

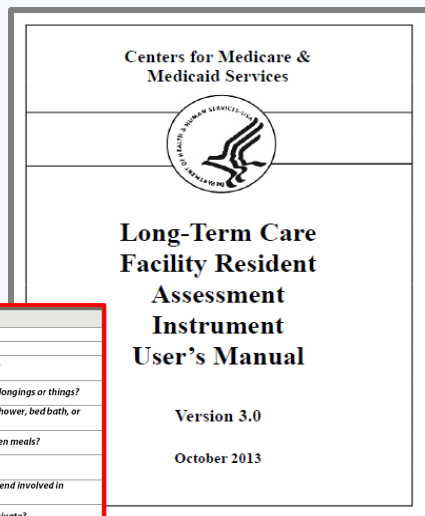
<https://www.dss.virginia.gov/>

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# MDS 3.0 - Minimum Data Set

- Comprehensive Assessment for NFs
- Version 3.0 implemented in October 2010; revised annually



**F0400. Interview for Daily Preferences**  
 Show resident the response options and say: "While you are in this facility..."

Enter Codes in Boxes

<input type="checkbox"/>	A. how important is it to you to choose what clothes to wear?
<input type="checkbox"/>	B. how important is it to you to take care of your personal belongings or things?
<input type="checkbox"/>	C. how important is it to you to choose between a tub bath, shower, bed bath, or sponge bath?
<input type="checkbox"/>	D. how important is it to you to have snacks available between meals?
<input type="checkbox"/>	E. how important is it to you to choose your own bedtime?
<input type="checkbox"/>	F. how important is it to you to have your family or a close friend involved in discussions about your care?
<input type="checkbox"/>	G. how important is it to you to be able to use the phone in private?
<input type="checkbox"/>	H. how important is it to you to have a place to lock your things to keep them safe?

**Coding:**  
 1. Very important  
 2. Somewhat important  
 3. Not very important  
 4. Not important at all  
 5. Important, but can't do or no choice  
 9. No response or non-responsive

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## Assessment Forms

Both forms [MDS/UAI] collect resident specific data including information on:

- Physical condition/limitations
- Cognitive status
- Need for assistances with ADLs
- Nutrition
- Behavior
- Medical conditions/diagnosis, etc.
- Past history

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## Principles of Assessment

Process includes

1. **Interview** with resident, family, and/or responsible party
2. **Chart review**
3. **Observation** (on admission and ongoing)
4. **Discussion** with other caregivers



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## Interview Suggestions

- Keep as informal as possible
- Choose time that is best for resident
- Listen and write as little as possible while with resident, keep it conversational
- Consult with family and significant others if cognition is a problem for resident



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## Activity Assessments

Requirement / Expectations that may vary

- Timeliness of completion
  - For NF certified for Medicaid: A thorough evaluation of an individual's interests, past hobbies, skills, physical and mental status, personal care requirements, and functional capabilities must be performed within 14 days of the individual's admission to the NF
- Frequency of completion / re-assessment
  - Varies – common practice is annually and with significant change in resident
- Format – hard copy or electronic record; format & content established by facility policy

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## Activity Assessment – Best Practice

- Age
- Health status
- Sensory deficits
- Lifestyle
- Ethnicity
- Religious affiliation
- Needs and/or Risks
- Values
- Experiences
- Interests and Preferences
- Abilities, and skills by providing opportunities for a variety of types of activities and levels of involvement

The form includes sections for:

- Personal Information:** Admission Date, Evaluation Type, Name, Sex, Birthdate, Language(s) Spoken, Last Place of Residence, Marital Status, Name of Spouse/Significant Other, Children, Level of Education, Former Occupation, Religion/Faith Identity, Church Affiliation, Active Participation, and Was church notified of admission?
- Activity Pursuit Patterns and Preferences:** A table with columns for Activity, IN, TYPE, and IMP. Activities listed include Animals/Pets, Arts/Crafts, Beauty/Barber, Bingo, Board Games, Cards, Community Outings, Computer, Cooking/Baking, Creative Writing, Cultural Events, and Current Events/News.
- Code Key:** Defines interest levels (1-5) and importance levels (1-5), as well as activity types (Individual, Group, Large Group) and frequencies (x per Week, x per Month, Not sure, N/A).

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## Activity Progress Note

- The activity record documentation for each resident must include the resident's participation or refusal to participate in the activities and efforts to motivate the uninvolved, as well as the progress toward meeting these established measurable goals within realistic time frames.
- For NF certified for Medicaid
  - **Progress notes must be written as needed and every 90 days when the POC is updated and reviewed.**
- Frequency of required activity notes may vary across organizations / providers but "PRN" [as needed] notes should be written for unusual circumstances

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# Activity Treatment Record

- No required format
- Related regulations require documentation of services offered, provided, and of resident's response
- Consideration must be given for:
  - Self-initiated
  - Off – hours activities
  - 1:1 activities
  - Group activities
  - Activities facilitated by others

# Activity – Plans of Care

Care Plan or ISP  
[Individualized Service Plan]



## Plans of Care - Commonalities

**Uses fundamental information gathered by the assessment and investigative process**

**Applies “critical thinking” through linking other related factors**

**Develops a blueprint for meeting the needs of the individual resident**

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## Plans of Care - Commonalities

**Must evaluate treatment objectives and outcomes**

**Must respect the right to refuse**

**Must offer alternatives**

**Must use interdisciplinary approach to care**

**Must involve family and others in care planning**

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## ALFs – Individualized Service Plans

- ❑ The service plan to address the immediate needs of the resident **must be completed within 72 hours of admission**
- ❑ The individualized service plan shall reflect the resident's:
  - ❑ assessed needs and
  - ❑ **support the principles of individuality, personal dignity, freedom of choice and home-like environment** and
  - ❑ shall include other formal and informal supports that may participate in the delivery of services. Whenever possible, residents shall be given a choice of options regarding the type and delivery of services

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## ALFs Individualized Service Plans

The individualized service plan shall be signed and dated by the licensee/administrator or designee, i.e., the person who has developed the plan, and by the resident or his legal representative.

The plan shall also be signed and dated by any other individuals who contributed to the development of the plan.

Each person signing the plan shall note his/her title or relationship to the resident next to his/her signature. These requirements shall also apply to reviews and updates of the plan.

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## ALFs – Individualized Service Plans

The master service plan shall be filed in the resident's record.



A current copy shall be maintained in an easily accessible location for direct care staff but, must be in an area that protects the confidentiality of the contents of the service plan.



Extracts from the plan may be filed in locations specifically identified for their retention, e.g., dietary plan in kitchen.

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## ALFs – Individualized Service Plans

The facility shall ensure that the care and services specified in the individualized service plan are provided to each resident.

Outcomes shall be noted on the individualized plan or on a separate document as outcomes are achieved, and progress toward reaching expected outcomes shall be noted on the service plan or other document at least annually. Personnel making such notes shall sign and date them.

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# ALFs – Individualized Service Plans

Individualized service plans shall be reviewed and updated **at least once every 12 months** and as needed as the condition of the resident changes.

The review and update shall be performed by a staff person who has completed an ISP training program approved by the department, in conjunction with the resident, and as appropriate, with the resident’s family, legal representative, direct care staff, case manager, health care providers, qualified mental health professionals, etc.

# Sample DSS ISP Form

VDSS MODEL FORM - ALF

**INDIVIDUALIZED SERVICE PLAN**

RESIDENT'S NAME: \_\_\_\_\_ NAME OF ALF: \_\_\_\_\_

*Description of needs is based upon the (i) UAI; (ii) medical reports; (iii) interview with the resident; (iv) fall risk rating, if appropriate; (v) assessment of psychological, behavioral and emotional functioning, if appropriate; and (vi) any additional information necessary to meet the care needs of the resident.*

For a facility licensed for residential living care only, if the resident lives in a building that houses 19 or fewer residents, does the resident need to have a staff member awake and on duty at night?  Yes  No

Description of Needs and Date Identified	Description of Services to be Provided	Persons Who will Provide Services	When and Where Services will be Provided	Expected Outcomes and Time Frame	Date Outcomes Achieved

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## Nursing Facility Care Plans

The care plan must describe the following:

- (i) The **services that are to be furnished** to attain or maintain the resident’s highest practicable physical, mental, and psychosocial well-being; and
- (ii) Any services that would otherwise be required under §483.25 but, are not provided due to the resident’s exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4).

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## Sample NF Care Plan

DATE	PROBLEM/CONCERN	GOAL/OBJECTIVE	APPROACH	RESPONSIBLE DISCIPLINE(S)	REVIEW DATE
	Resident ___ has actual ___ is at risk for social/diversion activity deficit related to: ___ cognitive loss ___ loss/change in physical functioning ___ mood/behavioral disturbance ___ change in living environment/socialization ___ change in medical status Explain: _____ ___ communication problems As evidenced by: ___ decreased ability to participate in referred/usual activities ___ loss of interest in socialization/diversion ___ inability to leave room for activities. Explain: _____ ___ expressed dissatisfaction with current activities ___ disruptive behavior in activities. Explain: _____ ___ reluctance/unwillingness to participate ___ other (specify): _____	Resident will attend at least ___ group activities/week. Goal date: _____ ___ Resident will participate in at least ___ 1:1 weekly. Goal date: _____ ___ Resident will verbalize/ demonstrate increased satisfaction with types of activities and activity involvement. Goal date: _____ ___ Other	___ Review activity calendar with resident. Arrange with resident/staff for attendance at activities of interest/ choice. ___ Introduce to other residents and encourage socialization. ___ Invite to /engage resident in activities of known interest. Past/current interests include, but are not limited to: _____ _____ _____ Provide 1:1 visit Frequency: _____ Therapeutic goal: _____ ___ See ADL care plan. ___ See restorative care plan. ___ See pain management care plan ___ See nutrition care plan ___ See Quality of Life: Psychosocial, mood and behavior care plan. ___ See Quality of Life: Cognition, communication and vision care plan ___ When available use volunteers for additional activity support ___ Provide assistive devices to promote participation in activities of choice/interest ___ Encourage family and friend supports/visit ___ Encourage resident to participate in LOAs as available and approved by physician ___ Other		

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## Wrap UP

What challenges / barriers do you see to documentation?  
How will you change the way that you document?

# Thank You

I will gladly try to answer any questions



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