USER'S MANUAL: VIRGINIA UNIFORM ASSESSMENT INSTRUMENT (UAI)

FOR PRIVATE PAY RESIDENTS OF ASSISTED LIVING FACILITIES

Commonwealth of Virginia
Department of Social Services
Division of Family Services, Adult Services Program
7 North Eighth Street
Richmond, Virginia 23219

Revised July 2005

TABLE OF CONTENTS

Virginia Department of Social Services' regulation at 22 VAC 40-71-170 specifies that facilities opting to complete the Uniform Assessment Instrument (UAI) for Private Pay Individuals (in lieu of the full UAI) must ensure that the information is obtained as required by 22 VAC-745-10 et seq., Assessment in Adult Care Residences. This User's Manual contains the necessary information for complying with these requirements. If clarification is needed beyond the contents of this manual, please refer to the User's Manual: Virginia Uniform Assessment Instrument. Both manuals and the UAI forms are available from the Virginia Department of Social Services, Adult Services Program, 7 North Eighth Street, Richmond, Virginia 23219 or 804-726-7533.

SUMMARY OF MANUAL CHANGES

The following is a summary of changes that have been made to this revision of the *User's Manual: Virginia Uniform Assessment Instrument for Private Pay Residents of Assisted Living Facilities*. All changes are minor, non-substantive editing revisions and do not affect the assessment process or the Private Pay Uniform Assessment Instrument. The June 2005 revisions replace the April 2001 version. Please discard any copies of previous assessment manuals.

Additional copies of this manual and the *Virginia Uniform Assessment Instrument for Private Pay Residents of Assisted Living Facilities* may be plain-paper copied as needed, or additional copies may be requested from the Virginia Department of Social Services, Adult Services Program, 7 North Eighth Street, Richmond, VA 23219 or by calling the VDSS Adult Services Program at (804) 726-7533. The *Virginia Uniform Assessment Instrument for Private Pay Residents of Assisted Living Facilities* may also be downloaded from http://www.dss.virginia.gov/form/index.html

Please note that no changes have been made to the private pay or public pay *Virginia Uniform Assessment Instrument*. These documents are used by all public human services agencies' long-term care programs.

- Revision of the address and phones numbers of the Adult Services Program at the Virginia Department of Social Services.
- Updated dates.
- Revised pagination and Table of Contents.
- Reference to the Adult Services and Virginia Department of Social Services websites for downloading forms and manuals.
- Revised formatting and typo corrections.

SECTION I: GENERAL INFORMATION

BACKGROUND

In 1992, the Joint Legislative Audit and Review Commission (JLARC) report, *Follow-up Review of Homes for Adults*, included recommendations in response to its findings that the current statutory and regulatory systems were not providing sufficient safeguards for the diverse physically and mentally impaired populations served by the homes. Changes recommended by JLARC included modification of the regulatory system to address levels of care and the linking of the Auxiliary Grant (AG) payments to these regulations.

Following the JLARC report, the Homes for Adult Task Force, with representatives from the major stakeholder groups, convened to examine options for implementing the JLARC recommendations. In 1992, the Homes for Adult Task Force proposed the implementation of tiered licensure in assisted living facilities (ALFs), formerly known as homes for adults (HFAs) or adult care residences (ACRs). The 1993 and 1995 Sessions of the General Assembly passed legislation that established the framework for:

- Two-tiered licensing (residential and assisted living);
- Uniform assessment of all individuals, regardless of payment source;
- Restructuring of AG payments; and
- Intensity of service needs survey of the residents of ALFs.

To implement the legislation, the State Board of Social Services adopted the final regulations concerning the Auxiliary Grants program, standards for licensed assisted living facilities, and assessments in ALFs on November 16, 1995. These regulations became effective February 1, 1996. The Virginia Department of Social Services (VDSS) is responsible for licensing ALFs, monitoring compliance with standards, and ensuring all individuals are assessed. VDSS continues to coordinate the Assisted Living Facility Advisory Committee that includes representatives from providers, state agencies, and other interested parties to assist the Department with changes to regulations and policy. The Department of Medical Assistance Services (DMAS) is responsible for those aspects of the legislation related to payment for assessments, targeted case management, and assisted living services for AG residents of ALFs.

PURPOSE OF THIS MANUAL

This manual provides guidance related to the implementation of assessment of all private pay residents and applicants to ALFs and describes how to administer the Virginia Uniform Assessment Instrument for Private Pay Residents of Assisted living facilities. (A copy of this assessment form is found in Appendix A.) This is an alternate version of the full Virginia Uniform Assessment Instrument (UAI) and contains only the information

necessary to determine whether the resident meets the level of care criteria for residential or assisted living. It continues to use the common definitions associated with the full UAI.

The purpose of the private pay version of the UAI is to assist the ALF provider with gathering information for the determination of an individual's care needs and to ensure that these needs match the level of care which the ALF is licensed to provide. Virginia regulations at 22 VAC 40-71-150 (*Standards and Regulations for Adult Care Residences*) and 22 VAC 40-745-10 *et seq*. (*Assessment in Adult Care Residences*) require that no resident be admitted or retained for whom the ALF cannot provide or secure appropriate care, or who requires a level of service or type of service for which the ALF is not licensed, or if the ALF does not have the staff appropriate in numbers and with the appropriate skill to provide such services. In addition to the completed UAI, the ALF must ensure that, for admission, there is a physical examination report for the individual, and an interview between the administrator or a designee responsible for admission and retention decisions and the resident and his or her personal representative, if any, must take place. The ALF must make any admission decision based on the completed private pay UAI, the physical examination, and the interview.

Assessors should become familiar with this manual and use it as a reference document. The general principle that should guide the assessor is to obtain the best, most complete, and most accurate information in every case. This manual provides general instructions regarding the use of the private pay UAI, followed by specific instructions for the administration of each question.

VIRGINIA UNIFORM ASSESSMENT INSTRUMENT (UAI)

An assessment is a standardized approach using common definitions to gather sufficient information on applicants to and residents of ALFs to determine their care needs. A 1993 study of residents in Virginia's ALFs found that the UAI provides a framework for determining an individual's care needs because it contains measurable and common definitions for rating how individuals function in their daily lives. As of July 1, 1994, all publicly funded health and human services agencies in Virginia are using the UAI to gather information for the determination of an individual's care needs, for service eligibility, and for planning and monitoring care needs across agencies and services.

Across the country, there is considerable consensus that measures of functioning in Activities of Daily Living (ADLs) are an extremely effective approach for assessing the need for long-term care. An emphasis on functioning taps into the behavioral consequences of chronic disease or ill health, rather than focusing on the disease itself. Therefore, the use of ADLs was the main approach used for defining the ALF levels of care criteria (see Appendix B).

WHO NEEDS TO BE ASSESSED?

All residents of and applicants to ALFs, regardless of payment status or anticipated length of stay, must be assessed using the UAI, or the alternate version for private pay residents, to determine the need for residential or assisted living. Except in the event of a documented emergency, all individuals must be assessed as follows:

- Prior to admission for all new residents;
- At least every twelve months (reassessment); or
- Whenever a change in the resident's level of care appears to warrant a change in the resident's approved level of care.

WHO CAN COMPLETE THE PRIVATE PAY ASSESSMENTS?

A qualified individual may complete assessments for private pay individuals if he or she meets one of the following criteria:

- **Qualified staff of the ALF.** The qualifications for an employee of an ALF to complete the assessment include documented training in the completion of the private pay UAI and appropriate application of level of care criteria. Documentation of training must be placed in the ALF employee's personnel record. ALF staff training in the private pay UAI may be documented in one of the following three ways:

  - A certificate from the Virginia Commonwealth University/Virginia Institute of Social Services Activities (VISSTA) for completion of the VISSTA course on the Virginia UAI for Private Pay Residents of Assisted Living Facilities;

  - A certificate from UAI training offered by a state agency (such as VDSS or DMAS); or

  - In writing, a description of the content of the training, the name of the trainer and his or her qualifications to provide UAI training, the agency or facility from which the trainer came, the date of the training, and the length of the training. For example, if an ALF staff member has attended one of the UAI training sessions offered by a state agency, and has documentation of such training, he or she may train other staff members on completing the UAI. The documentation of the UAI training must be maintained in the employee's personnel record. Private pay UAIs that are completed by qualified staff of the ALF must be approved and signed by the administrator or the administrator's designated representative.

- **An independent private physician.** The responsibilities of physicians may be implemented by nurse practitioners or physicians' assistants as assigned by the supervising physician and within the parameters of professional licensing.

- **A public agency case manager or other qualified assessor.** A specified fee may be charged for their services in the assessment of private pay residents not to exceed the charge for public pay assessments. Payment is the responsibility of the resident. Public human services agency assessors are not required to assess private pay individuals.

HOW TO GET TRAINING

One-day courses are offered periodically statewide through Area Training Centers (ATCs) for a nominal fee. For information on the schedule of trainings, call VISSTA at:

Eastern/Central ATC (Hampton):	757-727-1884
Northern ATC (Fairfax):	703-324-7836
Piedmont ATC (Roanoke):	540-853-6380
Western ATC (Abingdon):	540-623-0134

VISSTA also has a website with course information at www.vcu.edu/vissta. To access training information, click on the region in which training is desired. Courses for the Virginia UAI for Private Pay Residents of assisted living facilities may be listed under "Adult Services Programs."

ANNUAL REASSESSMENTS

Reassessments of private pay residents of ALFs must be conducted at least annually. A reassessment is an update of information at a later point in time from the previous assessment. It is a formal review of the resident's status to determine whether the resident's situation and/or functioning have changed.

When a reassessment is performed, there are three options for completing the reassessment as follows:

- Mark only those items that have changed from the previous assessment. The assessor *clearly* updates the previous assessment and marks the reassessment information by crossing out old information and initialing and dating all changes. The assessor then signs and dates the UAI and marks the front of the instrument as a reassessment.

- For private pay residents for whom there have been no changes in the items listed on the private pay UAI since the immediately preceding assessment, it is sufficient

to have the assessor indicate "no change" on the private pay UAI. It is not necessary to individually answer each item listed on the assessment for the reassessment. The assessor must sign and date the UAI to indicate when the reassessment occurred.

- Begin a new assessment on a new private pay UAI form.

CHANGES IN LEVEL OF CARE

A new or updated private pay UAI is required whenever a change in the resident's condition appears to warrant a change in the resident's approved level of care. **Temporary changes in a resident's condition that can be reasonably expected to last less than thirty days do not require a new assessment or update.** Examples are short-term changes that resolve with or without intervention, changes that arise from easily reversible causes such as a medication change, short-term acute illness or episodic event, and a well-established, predictive, cyclic pattern of signs and symptoms associated with a previously diagnosed condition when an appropriate course of treatment is in progress.

At the request of the ALF, the resident's representative, the resident's physician, VDSS, or the local department of social services, an independent assessment using the private pay or full UAI may be completed to determine whether a resident's care needs are being met in the current placement. An independent assessment is an assessment completed by an entity other than the original assessor; this may be another assessor within the same agency. If the request is for a private pay resident, and the independent assessment confirms the resident's placement is appropriate, then the entity requesting the independent assessment is responsible for payment of the assessment, if applicable.

EMERGENCY PLACEMENTS

In emergency placements, the private pay UAI must be completed within seven working days from the date of placement. An emergency is a situation in which an adult is living in conditions that present a clear and substantial risk of death or immediate and serious physical harm to self or others. Prior to placement, the need for an emergency placement must be documented and approved by a Virginia adult protective services (APS) worker or an independent physician. *This is the **only** instance in which an individual may be placed in an ALF without first having been assessed to determine if he or she meets ALF level of care criteria.*

OUT-OF-STATE INDIVIDUALS

Individuals who reside out-of-state and seek admission to a Virginia ALF must be assessed following the process for assessing private pay individuals as described herein.

CHANGES IN FINANCIAL ELIGIBILITY STATUS OF AN ALF RESIDENT

When a Private Pay Resident Becomes an AG Recipient

When a private pay resident becomes an Auxiliary Grant (AG) recipient, the local department of social services (LDSS) eligibility worker will advise the resident of program requirements which include the need for an assessment. All assessment procedures must be followed. The public human services agency providing the assessment will be reimbursed at the initial assessment rate of $25 for a short assessment and $100 for a full assessment. The eligibility worker will advise the applicant to which agency to go for an assessment using the 12-paged public pay UAI. The eligibility worker must be provided with a copy of the Long-Term Care Preadmission Screening Authorization (DMAS-96) for verification of the assessment. If there is a full UAI on record (not the two-paged private pay version) that is less than twelve months old, the resident does not need to be reassessed unless there is indication that his or her level of care has changed.

When an AG Recipient Becomes a Private Pay Resident

If the resident becomes ineligible for an AG based on income or countable resources, the eligibility worker will issue a notice of adverse action to the recipient 11 days in advance of the action to terminate the AG. The ALF and the resident must determine whether the former AG recipient continues to reside in the ALF. If there is an ongoing case manager, the case manager would participate in the discharge planning process, if appropriate, and then terminate case management services. If ongoing case management is not being provided, the agency completing the level of care assessment should assist the ALF, if necessary, in discharge planning. If the resident continues to reside in the ALF as a private pay resident, assessment requirements for private pay residents must be followed.

RECORD RETENTION

All private pay UAI forms must be retained in the resident's file for review by the VDSS Division of Licensing Programs' staff. Assessments and related documentation must be legible and maintained in accordance with accepted professional standards and practices. All UAIs must be signed in ink with the name and professional title of the assessor and completely dated with month, day, and year. Resident records must be maintained in accordance with the Department of Social Services' regulations (22 VAC 40-71-180).

WHERE TO GET FORMS

Plain paper copies of both this manual and the *Virginia UAI for Private Pay Residents of Assisted Living Facilities* form may be made as needed. Copies are also available from:

Virginia Department of Social Services

Adult Services Program
7 North Eighth Street
Richmond, Virginia 23219
Telephone: 804-726-7533
Fax: 804-726-7895

SUMMARY OF ALF RESPONSIBILITIES RELATED TO ASSESSMENTS

The ALF staff must:

- Ensure that assessments are completed prior to admission, at least every twelve months, and whenever there is a significant, permanent (i.e., expected to last more than 30 days) change in the resident's level of care.

- Know the criteria for levels of care (found in Appendix B) and the prohibited conditions (described later in this manual) and arrange for the discharge of the resident whenever the resident does not meet, either upon admission or at any later time, the criteria for level of care for which the ALF is licensed.

- Be knowledgeable of and comply with all regulatory and policy requirements.

- Make available residents' records, including the UAI, to VDSS staff upon request.

SECTION II: COMPLETING THE PRIVATE PAY UAI

INTERVIEWING PROCESS

Prior to beginning the interview, the assessor should establish rapport with the individual being assessed. If the individual feels comfortable, he or she will speak more openly, allowing the assessor to gather valuable, necessary information. Developing rapport will also result in a better understanding of the individual, which will help to direct the conversation.

In some situations (such as a cognitively impaired individual), it may be necessary to use other sources of information such as family members, friends, facility staff, and/or individual records. It is important to note on the form when sources other than the individual are used to gather information and to obtain valid and reliable assessment information. When asking questions, the following suggestions will help to ensure accurate and useful responses:

- Always remain neutral.

- Do not make statements or offer nonverbal cues that might suggest a particular response is correct or incorrect, unusual or inappropriate, or similar to or different from others.

Many times respondents say they do not know the answer to a question when they are still thinking about it. At other times, they give answers that do not seem to fit the question or give general answers when a more specific response is required. On these occasions, use a neutral probe to help the respondent answer. Neutral probes are questions or actions that are meant to encourage a more complete response without suggesting what the answer should be. The following ways of providing neutral probes may be useful:

- Repeat all questions that are misunderstood or that lead to "don't know" responses.

- If the question has specific response categories, read the categories and ask the respondent which is more appropriate to him or her or which fits him or her best.

- Ask a neutral question, such as "Do you have more to say about that?" or "Is there anything else?" Probes that begin with "Don't you think. . ." or "Most people have said. . ." or "I assume what you're trying to get at is . . ." all serve to direct respondents toward particular answers, and the respondents are less likely to express their true feelings.

ASSESSMENT GUIDELINES

The private pay version of the UAI contains an essential set of **minimum** data to be recorded in the spaces provided. These data are important because the completed UAI will be reviewed by Department of Social Services licensing staff to ensure that the individual meets the level of care the ALF has a license to provide. Assessors may wish to use the comment section to record additional information. Some specific points about completing the assessment are listed below.

- All of the questions are closed-ended with a fixed set of responses. Only "codable" responses are acceptable, and assessors may have to probe respondents for answers.

- All questions call for one answer; if two or more are given, probe for the response that comes closest in the individual's view.

- Use a check "√" or an "X" to mark the appropriate response.

- Read the response choices to familiarize the respondent with the range of responses.

- Make sure every question has the appropriate number of responses recorded.

IDENTIFICATION INFORMATION

- **Date**: In the upper right-hand corner of the UAI is space to record the date of the assessment and date of the reassessment. The assessment date is when the initial assessment is done. The reassessment date is the date when the individual is reassessed. This date will always be later than the assessment date.

- **Name:** Record the full name of the individual (last, first, middle initial).

- **Social Security Number (SSN):** The purpose of requesting the individual's social security number (SSN), a nine-digit number, is so every person has a ***unique*** number to identify the resident's records. **For private pay individuals, a facility identification number will also be acceptable in lieu of the Social Security Number**. Most individuals should have a SSN, but the assessor will find that many females use their Medicare number as their SSN and/or their husband's SSN as their own. Medicare numbers are SSNs with an additional letter added. A Medicare number ending with the letters A, J, M, or T is equal to the female's own SSN. However, a Medicare number ending in B or D is the husband's SSN. B means the husband is still alive and D means the husband is deceased. Assessors can use the Medicare number ending in D as the wife's SSN since the husband is deceased.

- **Current Address:** The full current address (street, city, state, and zip) of the applicant. If the person assessed is a current ALF resident, the name and location of the ALF is all that is required.

- **Telephone:** The telephone number recorded on the form should be the number where the individual can be reached. This may be the ALF's telephone number.

- **Birth Date:** Record the individual's date of birth (month, day and year).

- **Sex:** Record the individual's gender.
- **Marital Status:** Choose the answer that describes the person's current status relative to the civil rite or legal status of marriage, as reported by the person.

    - **Married** includes those who have been married only once and have never been widowed or divorced, as well as those currently married persons who remarried after having been widowed or divorced.

    - **Widowed** includes individuals whose most recent spouse has passed away.

    - **Separated** includes legally separated, living apart, or deserted.

    - **Divorced** means a marital dissolution by court decree of competent jurisdiction.

    - **Single** includes never married, annulled marriage and individuals who claim a common law marriage, which is not recognized as a legal status in Virginia.

FUNCTIONAL STATUS

Components of Functional Status

Measurements of functional status are commonly used across the country as a basis for differentiating among levels of long-term caregiving. Functional status is the degree of independence with which an individual performs Activities of Daily Living (ADLs), Ambulation, and Instrumental Activities of Daily Living (IADLs).

- **ADLs** indicate a person's ability to perform daily personal care tasks. They include: bathing, dressing, toileting, transferring, eating/feeding, and bowel and bladder control (continence).

- **Ambulation** is the person's ability to get around indoors and outdoors, climb stairs, and use a wheelchair.

- **IADLs** indicate the person's ability to perform certain social tasks that are not necessarily done every day, but which are critical to living independently. The

IADLs used in determining ALF level of care criteria include **Meal Preparation, Housekeeping, Laundry, and Money Management**.

There are three important points to remember when assessing functional status:

- **First,** functional status is a measure of the individual's impairment level **and** need for personal assistance. In many cases, impairment level and need for personal assistance are described by the help received, but this could lead to an inaccurate assessment. For example, a disabled person **needs** help to perform an activity in a safe manner, but he or she lives alone, has no formal supports and "receives no help." Coding the person's performance as "independent" because no help is received is very misleading in terms of the actual impairment level. In order to avoid this type of distortion, interpret the ADLs in terms of what is usually needed to safely perform the entire activity.
- **Second,** an assessment of functional status is based on what the person is **able** to do, not what he or she prefers to do. In other words, assess the person's *ability* to do particular activities, even if he or she doesn't usually do the activity. Lack of capacity should be distinguished from lack of motivation, opportunity or choice. This is particularly relevant for the IADLs. For example, when asking someone if he or she can prepare light meals, the response may be "no," he or she does not prepare meals, even though he or she may be able to do so. This person should be coded as not needing help. If someone refuses to perform an activity, thus putting self at risk, it is important to probe for the reason why the person refuses in order to code the activity correctly. *The emphasis in this section is on assessing whether ability is impaired.* Physical health, mental health, cognitive, or functional disability problems may manifest themselves as the inability to perform ADL, Ambulation, and IADL activities. If a person is mentally and physically free of impairment, there is no safety risk to the individual, and the person chooses not to complete an activity due to personal preference or choice, indicate that the person does not need help.

- **Third,** the emphasis of the measurement of each of the functional activities should be *how the individual usually performed the activity over the past two weeks.* For example, if an individual *usually* bathes self with no help, but on the date of the interview requires some assistance with bathing, code the person as requiring no help unless the person's ability to function on the date of the assessment accurately reflects ongoing need.

There are several components to each functional activity, and the coded response is based on the person's ability to perform **all** of the components. For example, when assessing the ability to bathe, it is necessary to ask about the person's ability to do all of the bathing activities such as getting in and out of the tub, preparing the bath, washing, and towel drying. Interviewers will need to probe in detail in order to establish actual functional level. The definitions of each ADL and other functional activities that follow should serve as a guide when probing for additional information.

Self-reporting on ADLs and other functional activities should be verified by observation or reports of others. This is especially critical when individuals report that they do activities by themselves, but performance level or safety of the individual is in question.

Some questions in this section are personal and the individual may feel somewhat embarrassed to answer (e.g., toileting, bladder and bowel control). Ask these questions in a straightforward manner and without hesitation. If the assessor asks the questions without embarrassment or hesitation, the person will more likely feel comfortable. If the individual is embarrassed, it is the assessor's responsibility to reassure him or her that it is O.K. and that the assessor understands how he or she could feel that way. Let the individual know that answers to these questions are important because they will help the assessor better understand his or her needs and provide a care plan that is right for the individual.

Because each item in the functional status section is critical to determining level of care needs, every functional question in this section must have a valid answer. No "Unknown" responses are allowed.

Dependence: "Big D's and Little d's"

Dependence in functional status is used to differentiate among levels of long-term care. The total number of dependencies an individual has will determine the type of care appropriate to meet his or her needs. Dependence includes a continuum of assistance that ranges from minimal to total.

Independent: Independent means an individual usually completes an activity without assistance (i.e., mechanical or human) **(Independent=I).**

Semi-dependence: Semi-dependence means an individual needs only mechanical help in a functional area **(semi-dependent=d)**. No human help or supervision is needed.

Dependence: Dependence means an individual needs at least the assistance of another person (human help only) OR needs at least the assistance of another person and equipment or a device (mechanical help and human help) to safely complete the activity. Human assistance includes supervision (verbal cues, prompting) or physical assistance (set-up, hands-on care). See scoring options below for the correct way to define supervision and physical assistance **(Dependence=D).**

Total Dependence: An individual is considered **totally dependent (TD)** in each level of the seven ADLs when the individual is entirely unable to participate or assist in the activity performed. This scoring level may also be seen as "DD", another designation for totally dependent. For the purpose of an ALF assessment, "D," "TD," and "DD" all indicate dependence or "D." An individual who can participate in any way with the performance of the activity is not considered to be totally dependent.

ADL SCORING OPTIONS

Needs Help means whether or not the individual needs help (equipment or human assistance) to perform the activity. If the individual does need help, score the specific type of help on the UAI in the boxes to the right.

Mechanical Help Only means the individual needs equipment or a device to complete the activity, but does not need assistance from another human **(d=semi-dependent)**.

Human Help Only means the individual needs help from another person, but does not need to use equipment in order to perform the activity. A need for human help exists when the individual is unable to complete an activity due to cognitive impairment, functional disability, physical health problems or safety. An unsafe situation exists when there currently is a negative consequence from not having help (e.g., falls, skin rash or breakdown, weight loss, exacerbation of a diabetic condition as a result of an inadequate diet), or when there is the potential for a negative consequence to occur within the next 3 months without additional help. The decision that potential exists must be based on some present condition, such as a situation where the individual has never fallen when transferring, but shakes or has difficulty completing the activity. The assessor should not assume that any person over 60 and without help has the potential for negative consequences. Within the human help category, specify whether the assistance needed is supervision or physical assistance. If both supervision and physical assistance are required, the category that should be used is the one reflecting the greatest degree of need, physical assistance **(D=Dependent).**

- **Supervision (Verbal Cues, Prompting).** The individual is able to perform the activity without hands-on assistance of another person, but must have another person present to prompt and/or remind him or her **to safely perform the complete activity.** This code should only be used when the only way the activity gets completed is through this supervision. For example, if an individual is not likely to put on all the necessary clothes without prompting, this code should be used. Another example is when an individual requires supervision while bathing to ensure that the task is completed and that they remain safe. This code often pertains to people with cognitive impairment, but may include those who need supervision for other reasons.

- **Physical Assistance (Set-Up, Hands-On Care)**. Physical assistance means hands-on help by another human, including assistance with set-up of the activity.

Mechanical Help and Human Help means the individual needs equipment or a device and the assistance of another person to complete the activity. For this category, specify whether human help is supervision or physical assistance as defined above **(D=Dependent).**

Performed by Others means another person completes the entire activity and the individual does not participate in the activity at all **(D=Dependent/Totally Dependent).**

Is Not Performed means that neither the individual nor another person performs the activity **(D=Dependent/Totally Dependent).**

ADL: BATHING

Bathing: Getting in and out of the tub, preparing the bath (e.g., turning on the water), actually washing oneself, and towel drying. Some individuals may report various methods of bathing that constitute their usual pattern. For example, they may bathe themselves at a sink or basin five days a week, but take a tub bath two days of the week when an aide assists them. The questions refer to the method used **most or all of the time** to bathe the entire body.

Does Not Need Help. Individual gets in and out of the tub or shower, turns on the water, bathes entire body, or takes a full sponge bath at the sink and does not require immersion bathing, without using equipment or the assistance of any other person.

Mechanical Help Only Individual usually needs equipment or a device such as a shower/tub chair/stool, grab bars, pedal/knee-controlled faucet, long-handled brush and/or a mechanical lift to complete the bathing process **(d=semi-dependent)**.

Human Help Only (D=Dependent)

- **Supervision**. Individual needs prompting and/or verbal cues to safely complete washing the entire body. This includes individuals who need someone to teach them how to bathe.

- **Physical Assistance.** Someone fills the tub or brings water to the individual, washes part of the body, helps the individual get in and out of the tub or shower, and/or helps the individual towel dry. Individuals who only need human help to wash their backs or feet would not be included in this category. Such individuals would be coded as "Does Not Need Help".

Mechanical and Human Help. Individual usually needs equipment or a device and requires assistance of others to bath **(D=Dependent).**

Performed by Others. Individual is completely bathed by other persons and does not take part in the activity at all **(D=Dependent/Totally Dependent).**

ADL: DRESSING

Dressing: Getting clothes from closets and/or drawers, putting them on, fastening and taking them off. Clothing refers to clothes, braces, and artificial limbs worn daily.

Does Not Need Help. Individual usually completes the dressing process without help from others. If the individual only receives help tying shoes, do not count as needing assistance.

Mechanical Help Only. Individual usually needs equipment or a device such as a long-handled shoe horn, zipper pulls, specially designed clothing or a walker with an attached basket to complete the dressing process **(d=semi-dependent)**.

Human Help Only (D=Dependent).

- **Supervision**. Individual usually requires prompting and/or verbal cues to complete the dressing process. This category also includes individuals who are being taught to dress.

- **Physical Assistance.** Individual usually requires assistance from another person who helps in obtaining clothing, fastening hooks, putting on clothes or artificial limbs, etc.

Mechanical and Human Help. Individual usually needs equipment or a device and requires assistance of another person(s) to dress **(D=Dependent).**

Performed by Others. Individual is completely dressed by another individual and does not take part in the activity at all **(D=Dependent/Totally Dependent).**

Is Not Performed. Refers only to bedfast individuals who are considered not dressed **(D=Dependent/Totally Dependent).**

ADL: TOILETING

Toileting: Ability to get to and from the bathroom, get on/off the toilet, clean oneself, manage clothes and flush.

Does Not Need Help. Individual uses the bathroom, cleans self, and arranges clothes, and flushes without help.

Mechanical Help Only. Individual needs grab bars, raised toilet seat or transfer board and manages these devices without the aid of others. Includes individuals who use handrails, walkers or canes for support to complete the toileting process **(d=semi-dependent)**.

Human Help Only (D=Dependent).

- **Supervision**. Individual requires verbal cues and/or prompting to complete the toileting process.

- **Physical Assistance.** Individual usually requires assistance from another person who helps in getting to/from the bathroom, adjusting clothes, transferring on and off the toilet, or cleansing after elimination. The individual participates in the activity.

Mechanical and Human Help. Individual usually needs equipment or a device *and* requires assistance of others to toilet **(D=Dependent).**

Performed by Others. Individual does use the bathroom, but is totally dependent on another's assistance. Individual does **not** participate in the activity at all **(D=Dependent/Totally Dependent).**

Is Not Performed. Individual does not use the bathroom **(D=Dependent/Totally Dependent)** .

ADL: TRANSFERRING

Transferring: Measures the level of assistance an individual needs to move between the bed, chair and/or wheelchair. If a person needs help with some transfers but not all, code assistance at the highest level.

Does Not Need Help. Individual usually completes the transferring process without human assistance or use of equipment.

Mechanical Help Only. Individual usually needs equipment or a device, such as lifts, hospital beds, sliding board, pulleys, trapezes, railings, walkers or the arm of a chair, to safely transfer, and individual manages these devices without the aid of another person **(d=semi-dependent)**.

Human Help Only (D=Dependent).

- **Supervision.** Individual usually needs verbal cues or guarding to safely transfer.

- **Physical Assistance.** Individual usually requires the assistance of another person who lifts some of the individual's body weight and provides physical support in order for the individual to safely transfer.

Mechanical and Human Help. Individual usually needs equipment or a device and requires the assistance of another to transfer **(D=Dependent).**

Performed By Others. Individual is usually lifted out of the bed and/or chair by another person and does not participate in the process. If the individual does not bear weight on any body part in the transferring process he or she is not participating in the transfer. Individuals who are transferred with a mechanical or Hoyer lift are included in this category **(D=Dependent/Totally Dependent).**

Is Not Performed. The individual is confined to the bed **(D=Dependent/Totally Dependent).**

ADL: EATING/FEEDING

Eating/Feeding: The process of getting food/fluid by any means into the body. This activity includes cutting food, transferring food from a plate or bowl into the individual's mouth, opening a carton and pouring liquids, and holding a glass to drink. This activity is the process of eating food after it is placed in front of the individual.

Does Not Need Help. Individual is able to perform all of the activities without using equipment or the supervision or assistance of another.

Mechanical Help Only. Individual usually needs equipment or a device, such as adapted utensils, hand splint and/or nonskid plates, in order to complete the eating process. Individuals needing mechanically adjusted diets (pureed food) and/or food chopped are included in this category **(d= semi-dependent)**.

Human Help Only (D=Dependent).

- **Supervision**. Individual feeds self, but needs verbal cues and/or prompting to complete the eating process.

- **Physical Assistance**. Individual needs assistance to bring food to the mouth, cut meat, butter bread, open cartons and/or pour liquid due to an actual physical or mental disability (e.g., severe arthritis, Alzheimer's disease). This category must **not** be checked if the individual is able to feed self, but it is completed by the caregiver/staff instead.

Mechanical and Human Help. Individual usually needs equipment or a device and requires assistance of others to eat **(D=Dependent).**

Performed By Others. Includes individuals who are spoon fed, fed by syringe or tube, or individuals who are fed intravenously (IV). *Spoon fed* means the individual does not bring any food to his mouth and is fed completely by others. *Fed by syringe or tube* means the individual usually is fed a prescribed liquid diet via a feeding syringe, NG-tube (tube from the nose to the stomach) or G-tube (opening into the stomach). *Fed by I.V.* means the individual usually is fed a prescribed sterile solution intravenously **(D=Dependent/Totally Dependent).**

ADL: CONTINENCE

Continence is the ability to control urination (bladder) and elimination (bowel). Incontinence may have one of several different causes, including specific disease processes and side-effects of medications. Helpful questions include, "Do you get to the bathroom on time?"; "How often do you have accidents?"; and "Do you use pads or Depends?"

ADL: Continence of Bowel

Bowel: The physiological process of elimination of feces.

Does Not Need Help. The individual voluntarily controls the elimination of feces.

Incontinent Less Than Weekly. The individual has involuntary elimination of feces less than weekly (e.g., every other week) **(d=semi-dependent).**

Ostomy - Self-Care. The individual has an artificial anus established by an opening into the colon (colostomy) or ileum (ileostomy) and he or she completely cares for the ostomy. Individuals who use pads or adult diapers and correctly dispose of them without assistance should be coded here **(d=semi-dependent).**

Incontinent Weekly or More. The individual has involuntary elimination of feces at least once a week. Individuals who use pads or adult diapers and do not correctly dispose of them should be coded here **(D=Dependent).**

Ostomy - Not Self-Care. The individual has an artificial anus established by an opening into the colon (colostomy) or ileum (ileostomy) and another person cares for the ostomy: stoma and skin cleansing, dressing, application of appliance, irrigations, etc. **(D=Dependent/Totally Dependent).**

ADL: Continence of Bladder

Bladder: The physiological process of elimination of urine.

Does Not Need Help. The individual voluntarily empties his or her bladder without help.

Incontinent Less Than Weekly. The individual has involuntary emptying or loss of urine less than weekly **(d=semi-dependent).**

External/Indwelling Device (e.g., Catheter or Ostomy) - Self-Care. The individual has a urosheath or condom with a receptacle attached to collect urine (external catheter); a hollow cylinder passed through the urethra into the bladder (internal catheter) or a surgical procedure that establishes an external opening into the ureter(s) (ostomy). The individual

completely cares for urinary devices (changing the catheter or external device, irrigates as needed, empties and replaces the receptacle) and the skin surrounding the ostomy. Individuals who use pads or adult diapers and correctly dispose of them should be coded here **(d=semi-dependent).**

Incontinent Weekly or More. The individual has involuntary emptying or loss of urine at least once a week. Individuals who use pads or adult diapers and do not dispose of them should be coded here **(D=Dependent).**

External Device - Not Self-Care. Individual has a urosheath or condom with a receptacle attached to collect urine. Another person cares for the individual's external device. This code should never be used with individuals who only use pads or adult diapers **(D=Dependent/Totally Dependent).**

Indwelling Catheter - Not Self-Care. Individual has a hollow cylinder passed through the urethra into the bladder. Another person cares for the individual's indwelling catheter **(D=Dependent/Totally Dependent).**

Ostomy - Not Self Care. Individual has a surgical procedure that establishes an external opening into the ureter(s). Another person cares for the individual's ostomy **(D=Dependent/Totally Dependent).**

INSTRUMENTAL ACTIVITIES OF DAILY LIVING (IADLs)

IADLs are more complex than activities related to personal self-care. Personal motivation plays an important role in a person's ability to perform IADLs. For example, a depressed person may easily neglect activities such as cooking and cleaning. IADLs also measure a person's social situation and environment rather than ability level. For example, the inability to cook, for one who has never cooked, does not necessarily reflect impaired capacity. In both of these situations, the assessor should probe to get information about the type of help needed to do the activity.

Scoring Options

Does Not Need Help means the individual does not require personal assistance from another to complete the entire activity in a safe manner. Individuals who need equipment but receive no personal assistance are included in this category.

Does Need Help means the individual needs personal assistance, including supervision, cueing, prompts, set-up and/or hands-on help to complete the entire activity in a safe manner **(D=Dependent).**

Activities

Meal Preparation: The ability to plan, prepare, cook and serve food. If it is necessary for someone to bring meals to the individual which he or she reheats, this is considered needing help.

Housekeeping: The ability to do light housework such as dusting, washing the dishes, making the bed, vacuuming, cleaning floors, and cleaning the kitchen and bathroom.

Laundry: Washing and drying clothes. This includes putting clothes in and taking them out of the washer/dryer, and folding and putting clothes away. If the individual lives with others and does not do his or her own laundry, be sure to ask whether he or she *could* do laundry.

Money Management: This does not refer to handling complicated investments or taxes. It refers to the individual's ability to manage day-to-day financial matters such as paying bills, writing checks, handling cash transactions, and making change.

AMBULATION

Ambulation is the ability to get around indoors and outdoors, climb stairs, and wheel. Ambulation is not part of the ALF level of care criteria, but provides information on the resident's ability to exit the facility in event of an emergency. Specific information for each ambulation activity is reported below.

Walking: The process of moving about indoors on foot or on artificial limbs.

Does Not Need Help. Individual usually walks steadily more than a few steps without the help of another person or the use of equipment.

Mechanical Help Only. Individual usually needs equipment or a device to walk. Equipment or device includes braces and/or splints, canes and/or crutches, special shoes, walkers, handrails and/or furniture.

Human Help Only

- **Supervision**. Individual usually requires the assistance of another person who provides verbal cues or prompting.

- **Physical Assistance**. Individual usually requires assistance of another person who provides physical support, guarding, guiding or protection.

Mechanical and Human Help. Individual usually needs equipment or a device *and* requires assistance of others to walk.

Is Not Performed. The individual does not usually walk. Individuals who are bedfast would be coded here. Individual may be able to take a few steps from bed to chair with support, but this alone does not constitute walking and should be coded as **Is Not Performed**.

Wheeling: The process of moving about by using a wheelchair.

Does Not Need Help. The individual usually walks, or the individual uses a wheelchair and independently propels the device unaided. Includes individuals who usually do not use a wheelchair to move about. Do not code individuals confined to a bed or chair here.

Mechanical Help Only. Individual usually needs a wheelchair equipped with adaptations, such as an electric chair, amputee chair, one-arm drive, and removable arm chair.

Human Help Only

- **Supervision**. Individual usually needs a wheelchair and requires the assistance of another person who provides prompting or cues.

- **Physical Assistance**. Individual usually needs a wheelchair and requires assistance of another person to wheel.

Mechanical and Human Help. Individual usually needs an adapted wheelchair and requires assistance of others to wheel.

Performed By Others. Individual is transported in a wheelchair and does not propel or guide it. The individual may wheel a few feet within his or her own room or within an activity area, but this alone does not constitute wheeling.

Is Not Performed. The individual is confined to a chair or wheelchair that is not moved, or the individual is bedfast.

Stair Climbing: The process of climbing up and down a flight of stairs from one floor to another. If the individual does not live in a dwelling unit with stairs, ask whether he or she can climb stairs if necessary.

Does Not Need Help. Individual usually climbs up and down a flight of stairs steadily on his or her own.

Mechanical Help Only. Individual usually needs equipment or a device to climb stairs. Equipment or device includes leg braces and/or splints, special shoes and/or canes, crutches and/or walkers, and special hand railings. Regular hand railings are considered equipment if the person is dependent upon them to go up or down the stairs.

Human Help Only

- **Supervision**. Individual usually requires assistance such as guarding and guiding from another person.

- **Physical Assistance**. Individual usually requires assistance from another person who physically supports the individual climbing up or down the stairs.

Mechanical and Human Help. Individual usually needs equipment or a device and requires assistance of others to climb stairs.

Is Not Performed. The individual does not usually climb a flight of stairs due to mental or physical disabilities.

Mobility: The extent of the individual's movement outside of his or her usual living quarters. Evaluate the individual's ability to walk steadily and level of endurance.

Does Not Need Help. Individual usually goes outside of his or her residence on a routine basis. If the only time the individual goes outside is for trips to medical appointments or treatments by ambulance, car, or van, do not code here because this is not considered going outside. These individuals would be coded either in the "confined - moves about" or "confined - does not move about" categories.

Mechanical Help Only. Individual usually needs equipment or a device to go outside. Equipment or device includes splints, leg braces, crutches, special shoes, canes, walkers, handrails, wheelchairs, chair lifts, and special ramps.

Human Help Only

- **Supervision (verbal cues, prompting)**. Individual usually requires the assistance of another person who provides supervision, cues or coaxing to go outside.

- **Physical Assistance (set-up, hands-on care)**. Individual usually requires assistance of another person who physically supports or steadies the individual to go outside.

Mechanical and Human Help - Individual usually needs equipment or a device and requires assistance of other(s) to go outside.

Confined - Moves About. Individual does not customarily go outside of his or her residence, but does go outside of his or her room.

Confined - Does Not Move About. The individual usually stays in his or her room.

MEDICATION ADMINISTRATION

Assess the capability of the individual to take his or her medicine. Focus on ability (what the individual **can** do) rather than biases imposed by the environment. For example, an individual who is able to take his or her medicine without any help, but who uses help because it is available, should be coded as *Without Assistance*. For those needing some type of assistance taking medicine, use the space provided to record the type of help and the name of the helper.

Without Assistance means the individual takes medication without any assistance from another person.

Administered/Monitored by lay person(s) means the individual needs assistance of a person without pharmacology training to either administer or monitor medications **(D=Dependent)**.

Administered/Monitored by Professional Nursing Staff means the individual needs licensed or professional health personnel to administer or monitor some or all of the medications **(D=Dependent).**

PSYCHOSOCIAL STATUS

The presence of cognitive problems and mental impairments can have an impact on the ability of an individual to live independently. Cognitive problems are caused by a variety of diseases and conditions. Of all the losses suffered by a individual, cognition is the most difficult to assess and handle, and it has the most pervasive effect on overall functioning. Cognitive impairments can affect a person's memory, judgment, conceptual thinking, and orientation. These can limit the ability to perform ADLs and IADLs. When assessing individuals for cognitive impairment, distinguish between minor losses in intellectual functioning which occur among many elderly persons, and the more severe intellectual impairments caused by cognitive disorders such as Alzheimer's Disease or Organic Brain Syndrome (OBS). Some intellectual dysfunction may be caused by a physical disorder or by side effects or interactions of medications.

The assessor may ask the cognitive questions at the beginning of the interview, especially when it becomes apparent during the initial time with the individual that he or she may not be capable of participating in the full assessment process or that the assessor may not be able to obtain meaningful information directly from the individual.

Cognitive function questions should be approached in a very matter-of-fact manner. The interviewer should read the following instructions: "Sometimes people have trouble remembering things. If you do not know the answers to some of the next questions, that's okay. On the other hand, some of the answers may seem obvious." Do not make the individual think that answering the questions is a pass/fail situation. If individuals seem upset by the questions, try to reassure them that they are doing fine. Then go on quickly to the next question. If the assessor indicates to the individual that his or her answers are correct or incorrect, increased anxiety may cause the individual to miss other questions. Do not assume the assessor knows the individual's answer to a particular question if the assessor has not asked the question.

The assessor should pay attention to the individual's appearance, behavior and way of talking throughout the complete interview. This may give clues about cognitive and emotional functioning. This section includes two required questions as noted on the private pay UAI: behavior pattern and orientation.

BEHAVIOR PATTERN

This question is not designed to be asked directly of the individual. The answer is based on the assessor's judgment based on observation and information gathered about the individual.

This question assesses the way the individual conducts self in his or her environment, and it taps three types of behavior: wandering, agitation, and aggressiveness. Other things to consider include whether the individual:

- ever engages in intrusive or dangerous wandering that results in trespassing, getting lost or going into traffic;
- gets easily agitated (overwhelmed and upset, unpleasantly excited) by environmental demands;
- becomes verbally or physically aggressive when frustrated; or
- becomes resistive or combative toward the caregiver when assisted with ADLs.

If several of the responses could describe the individual, code the most dependent. *Specify the type of inappropriate behavior and the source of the information in the space provided.*

- **Appropriate** means the individual's behavior pattern is suitable to the environment and adjusts to accommodate expectations in different environments and social circumstances.
- **Wandering/Passive - Less than Weekly** means the individual physically moves about aimlessly, is not focused mentally, or lacks awareness or interest in personal matters and/or in activities taking place in close proximity (e.g., the failure to take medications or eat, withdrawal from self-care or leisure activities). The individual's behavior does not present major management problems and occurs less than weekly.
- **Wandering/Passive - Weekly or More** means the individual wanders and is passive (as above), but the behavior does not present major management problems and occurs weekly or more **(d=semi-dependent).**
- **Abusive/Aggressive/Disruptive - Less than Weekly** means the individual's behavior exhibits acts detrimental to the life, comfort, safety and/or property of the individual and/or others. The behavior occurs less than weekly **(D=Dependent).**
- **Abusive/Aggressive/Disruptive - Weekly or More** means the abusive, aggressive or disruptive behavior occurs at least weekly **(D=Dependent).**

- **Comatose** refers to the semi-conscious or unconscious state **(D=Dependent/Totally Dependent).**

ORIENTATION

Ask the questions related to person, place, and time in order to evaluate orientation, or the individual's awareness of his or her environment.

Person: "Please tell me your full name so that I can make sure our record is correct." Alternative questions to assess orientation to person are "Please tell me the name of your next door neighbor" or "Please tell me the name of the person who takes care of you."

Place: For orientation to place, ask "Where are we now?" or "What is the name of this place?" The complete mailing address, excluding zip code, is preferred. It may be necessary to probe for more details when individuals give vague answers such as "my house" or "my room". Ask for the state, county, town, street name and number or box number. For individuals residing in an ALF, the facility name and floor is also considered correct.

Time: For orientation to time, the month, day and year are required. Ask "Would you tell me the date today?"

Based on the individual's answers to the questions on Person, Place, and Time, code his or her level of orientation/disorientation. An individual is considered disoriented if he or she is unable to answer any of the questions. In order to code the specific type of disorientation, it may be necessary to consult a caregiver about the spheres affected and the frequency (i.e., some of the time or all of the time). *Use the space provided to record the spheres in which the individual is disoriented.*

- **Oriented** means the individual has no apparent problems, is aware of who he or she is, where he or she is, the day of the week, the month, and people around him or her.

- **Disoriented, Person, Place, <u>or</u> Time, Some of the Time** means the individual sometimes has problems with one or two of the three cognitive spheres. *Some of the Time* means there are alternating periods of awareness-unawareness **(d=semi-dependent).**

- **Disoriented, Person, Place, <u>or</u> Time, All of the Time** means the individual is disoriented in one or two of the three cognitive spheres, and this is the individual's usual state **(d=semi-dependent).**

- **Disoriented, Person, Place, <u>and</u> Time, Some of the Time** means the individual is disoriented to person, place, and time some of the time **(D=Dependent).**

- **Disoriented, Person, Place, and Time, All of the Time** means the individual is disoriented to person, place, and time all of the time **(D=Dependent).**

- **Comatose** refers to the semi-conscious or unconscious state **(D=Dependent/Totally Dependent).**

BEHAVIOR PATTERN AND ORIENTATION (used for determining criteria for intensive assisted living (IAL) for private pay ALFs only)

- Behavior is appropriate or wandering/passive less than weekly + Oriented **(Independent).**
- Behavior is appropriate or wandering/passive less than weekly + Disoriented some spheres **(Independent).**
- Behavior is wandering/passive weekly or more + Oriented **(Independent).**
- Behavior is appropriate or wandering/passive less than weekly + Disoriented all spheres **(d=semi-dependent).**
- Behavior is wandering/passive weekly or more + Disoriented some or all spheres **(d=semi-dependent).**
- Behavior is abusive/aggressive/disruptive less than weekly + Oriented or Disoriented **(d=semi-dependent).**
- Behavior is abusive/aggressive/disruptive weekly or more + Oriented **(d=semi-dependent).**
- Behavior is abusive/aggressive/disruptive weekly or more + Disoriented **(D=Dependent).**

PSYCHIATRIC/PSYCHOLOGICAL EVALUATION

The assessor must indicate whether a psychiatric or psychological evaluation is needed according to 22 VAC 40-71-660 of the *Standards and Regulations for Licensed Adult Care Residences*. When determining the appropriateness of admission for applicants with serious mental illness, mental retardation, or a history of substance abuse, a current psychiatric or psychological evaluation may be needed. The need for this evaluation must be indicated on the UAI or based upon the recommendation of the resident's case manager or other assessor. A current evaluation for an applicant with mental illness or a history of substance abuse can be no more than 12 months old unless a more recent evaluation is recommended. A current evaluation for a person with mental retardation can be no more than three years old unless a more recent evaluation is recommended. *The evaluation must have been completed by a person having no financial interest in the ALF, directly or indirectly as an owner, officer, employee, or as an independent contractor with the facility.* A copy of the evaluation must be filed in the resident's record.

ASSESSMENT SUMMARY

PROHIBITED CONDITIONS

Assessors must determine whether individuals have any of the prohibited conditions listed below before authorizing placement in an ALF. (Bold text is used to indicate language from the law.) State law prohibits placement or retention of individuals in an ALF when they have any of the following conditions or care needs:

1. **Ventilator dependency**: A situation where a ventilator is used to expand and contract the lungs when a person is unable to spontaneously breathe on his or her own. Some individuals require the ventilator for all of their respirations, while others require in the event that they are unable to breathe on their own.

2. **Dermal ulcers stage III and IV, except those stage III ulcers which are determined by an independent physician to be healing** and care is provided by a licensed health care professional under a physician's treatment plan. Dermal ulcers include pressure ulcers (i.e., bed sores, decubitus ulcers) which may be caused by pressure resulting in damage of underlying tissues and stasis ulcers (also called venous ulcer or ulcer related to peripheral vascular disease) which are open lesions, usually in the lower extremities, caused by a decreased blood flow from chronic venous insufficiency. The following is a summary of dermal ulcer stages:

   i. *Stage I:* A persistent area of skin redness, without a break in the skin, that does not disappear when pressure is relieved.

   ii. *Stage II:* A partial thickness loss of skin layers that present clinically as an abrasion, blister, or shallow crater.

   iii. *Stage III:* A full thickness of skin lost, exposing the subcutaneous tissues; presents as a deep crater with or without undermining adjacent tissue.

   iv. *Stage IV:* A full thickness of skin and subcutaneous tissue is lost, exposing muscle or bone.

3. **Intravenous therapy or injection directly into the vein for intermittent intravenous therapy managed by a health care professional licensed in Virginia.** If the course of treatment extends beyond a two-week period, an evaluation by the licensed health care professional is required every two weeks. Intravenous (IV) therapy means that a fluid or drug is administered directly into the vein. Examples may include the infusion of liquids for hydration, antibiotics, chemotherapy, narcotics for pain, and total parenteral nutrition (TPN). Intermittent intravenous therapy may be provided for a limited period of time on a daily or periodic basis by a licensed health care professional under a physician's treatment

plan. When a course of treatment is expected to be ongoing and extends beyond a two-week period, evaluation is required at two-week intervals by the licensed health care professional.

4. **Airborne infectious disease in a communicable state that requires isolation of the individual or requires special precautions by the caretaker to prevent transmission of the disease, including diseases such as tuberculosis and excluding infections such as the common cold.**

5. **Psychotropic medications without appropriate diagnosis and treatment plans.** Psychopharmacological or psychotropic drugs include any drug prescribed or administered with the intent of controlling mood, mental status, or behavior. They include such drug classes as antipsychotic, antidepressants, and the anti-anxiety/hypnotic class. Please see Appendix D for examples of these medications.

6. **Nasogastric tubes**: A nasogastric (NG) tube is a feeding tube inserted into the stomach through the nose. It is used when the individual is unable to manage oral nutrition or feeding.

7. **Gastric tubes except when the individual is capable of independently feeding himself or herself and caring for the tube.** Gastric tube feeding is the use of any tube that delivers food, nutritional substances, fluids, or medications directly into the gastrointestinal system. Examples include, but are not limited to, gastrostomy tube (GT), jejunostomy tube (JT), and percutaneous endoscopic gastrostomy tube (PEG).

8. **Individuals presenting an imminent physical threat or danger to self or others.** Imminent physical threat cannot be classified by a diagnosis; the determination is made based upon the behavior of the individual.

9. **Individuals requiring continuous licensed nursing care (seven days a week, twenty-four hours a day).** Continuous licensed nursing care means around-the-clock observation, assessment, monitoring, supervision, or provision of medical treatment by a licensed nurse. Individuals requiring continuous licensed nursing care may include:

    i. Individuals who have a medical instability due to complexities created by multiple, interrelated medical conditions; or

    ii. Individuals with a health care condition with a high potential for medical instability.

10. **Individuals whose physician certifies that placement is no longer appropriate.**

11. **Unless the individual's independent physician determines otherwise, individuals who require maximum physical assistance as documented by the**

UAI and meet Medicaid nursing facility level of care criteria as defined in the State Plan for Medical Assistance. Maximum physical assistance means that an individual has a rating of total dependence in four or more of the seven activities of daily living as documented on the UAI. An individual who can participate in any way with the performance of the activity is not considered to be totally dependent.

12. **Individuals whose health care needs cannot be met in the specific assisted living facility as determined by the residence.**

Exceptions to the above: At the request of the private pay individual, care for the conditions or care needs specified in (3) and (7) above may be provided to a individual in an ALF by a physician licensed in Virginia, a nurse licensed in Virginia under a physician's treatment plan, or by a home care organization licensed in Virginia when the resident's independent physician determines that such care is appropriate for the resident. These exceptions do not apply to AG recipients. When care for a resident's special medical needs is provided by licensed staff of a home care agency, the ALF staff may receive training from the home care agency staff in appropriate treatment monitoring techniques regarding safety precautions and actions to take in case of emergency.

In the block on the private pay UAI for prohibited conditions, check whether the individual has a prohibited condition as described above. Briefly describe if a prohibited condition is present.

LEVEL OF CARE APPROVED

Using the level of care criteria for ALFs as found in Appendix B, the assessor must determine whether the private pay individual meets residential living, assisted living, or intensive assisted living and indicate on the UAI the level of care for which approval is given. The ALF must be licensed to provide the level of care that the individual needs.

***Important! The Virginia Medicaid Intensive Assisted Living (IAL) Waiver was not renewed by the Health Care Financing Administration (HCFA). The IAL waiver is no longer available as a Medicaid-funded alternative to nursing facility placement after March 17, 2000, for new applicants. <u>There are now only two levels of care recognized for ALFs: residential care and assisted living.</u> Please note that the intensive assisted living category can be used ONLY for private pay residents of an ALF; this level of care is NOT an option for public pay applicants to or residents of an ALF.**

ASSESSMENT COMPLETED BY

The assessor must record his or her name (printed and signature), the provider for whom he or she works, and the date the assessment is completed. Comments may be added if necessary. If the assessor is an ALF employee, the administrator or his or her designee must signify approval by signing and dating in the designated space on the UAI.

APPENDIX A

VIRGINIA UNIFORM ASSESSMENT INSTRUMENT (UAI) FOR PRIVATE PAY RESIDENTS OF ASSISTED LIVING FACILITIES

VIRGINIA UNIFORM ASSESSMENT INSTRUMENT
For Private Pay Residents of Assisted Living Facilities

Dates: Assessment: ____/____/____
Reassessment: ____/____/____

1. IDENTIFICATION

Name: _____ **Social Security Number**: _____
(Last) (First) (Middle Initial)

Current Address: _____
(Street) (City) (State) (Zip Code)

Phone: (____)_____

Birth date: _____/_____/_____ **Sex:** ___Male $_0$ ___Female $_1$
(Month) (Day) (Year)

Marital Status: __Married $_0$ __Widowed $_1$ __Separated $_2$ __Divorced $_3$ __Single $_4$ __Unknown $_9$

2. FUNCTIONAL STATUS (Check only one block for each level of functioning) D = Dependent or Totally Dependent (TD or DD)

	Needs Help?		d **Mechanical Help Only** 10	D **Human Help Only** 2		D **Mechanical & Human Help** 3		D/TD **Performed by Others** 40			D/TD **Is Not Performed** 50
	No 00	If Yes Check Type of Help		Supervision 1	Physical Assistance 2	Supervision 1	Physical Assistance 2				
Bathing											
Dressing											
Toileting											
Transferring											
								Spoon Fed 1	Syringe/ Tube Fed 2	Fed by IV 3	
Eating/Feeding											

Continence	**Needs Help?**		d **Incontinent** Less than Weekly 1	d **Ext. Device/ Indwelling/ Ostomy** Self Care 2	D **Incontinent** Weekly or More 3	D/TD **External Device** Not Self Care 4	D/TD **Indwelling Catheter** Not Self Care 5	D/TD **Ostomy** Not Self Care 6
	No 00	If Yes Check Type of Help						
Bowel								
Bladder								

AMBULATION	**Needs Help?**		**Mechanical Help Only** 10	**Human Help Only** 2		**Mechanical & Human Help** 3		**Performed by Others** 40	**Is Not Performed** 50
	No 00	If Yes Check Type of Help		Supervision 1	Physical Assistance 2	Supervision 1	Physical Assistance 2		
Walking									
Wheeling									
Stairclimbing									
								Confined Moves About	Confined Does Not Move About
Mobility									

2. FUNCTIONAL STATUS *(Continued)*

D = Dependent

IADLS	Needs Help?	
	No 0	D Yes 1
Meal Prep		
Housekeeping		
Laundry		
Money Mgmt.		

Medication Administration
How can you take your medicine?
_____ Without assistance 0
_____ Administered/monitored by lay person 1 D
_____ Administered/monitored by professional nursing staff 2 D
Describe help/Name of helper:

3. PSYCHO-SOCIAL STATUS

Behavior Pattern		Orientation
_____ Appropriate 0 _____ Wandering/Passive - Less than weekly 1 _____ Wandering/Passive - Weekly or more 2 d _____ Abusive/Aggressive/Disruptive - Less than weekly 3 D _____ Abusive/Aggressive/Disruptive - Weekly or more 4 D _____ Comatose 5 D		_____ Oriented 0 _____ Disoriented - Some spheres, some of the time 1 d _____ Disoriented - Some spheres, all the time 2 d _____ Disoriented - All spheres, some of the time 3 D _____ Disoriented - All spheres, all of the time 4 D _____ Comatose 5 D
Type of inappropriate behavior:		Spheres affected:
Current psychiatric or psychological evaluation needed? _____ No 0 _____ Yes 1		

4. ASSESSMENT SUMMARY

Prohibited Conditions

Does applicant/resident have a prohibited condition? _____ No 0 _____ Yes 1
Describe:

Level of Care Approved

1) Residential Living _____ 2) Assisted Living _____ 3) Intensive Assisted Living _____
(for private pay residents only; not for Auxiliary Grant recipients)

Assessment Completed by:

Assessor	Assessor's Signature	Agency/Assisted Living Facility Name	Date

If the assessor is an assisted living facility employee, the administrator or designee must signify approval by signing below:

_____ _____ _____
Administrator or Designee Signature Title Date

_____ _____ _____
Administrator or Designee Signature Title Date

Comments:

Note: Form must be filed in private pay resident's record upon completion.

APPENDIX B
LEVEL OF CARE CRITERIA

CRITERIA FOR ASSISTED LIVING FACILITY PLACEMENTS

AUTHORIZATION OF SERVICES TO BE PROVIDED

The assessor is responsible for authorizing the individual for the appropriate level of care for admission to and continued stay in an ALF. The ALF must be knowledgeable of the criteria for level of care in an ALF and is responsible for discharge of the resident whenever a resident does not meet the criteria for level of care in an ALF upon admission or at any later time. The appropriate level of care must be documented based on the completion of the Uniform Assessment Instrument (UAI) and definitions of activities of daily living and directions provided in the *User's Manual: Virginia Uniform Assessment Instrument*.

CRITERIA FOR RESIDENTIAL LIVING IN AN ALF

Individuals meet the criteria for residential living as documented on the UAI when at least one of the following describes their functional capacity:

1. Rated dependent in only one of seven ADLs; OR

2. Rated dependent in one or more of four selected IADLs; OR

3. Rated dependent in medication administration.

CRITERIA FOR ASSISTED LIVING IN AN ALF

Individuals meet the criteria for assisted living as documented on the UAI when at least one of the following describes their functional capacity:

1. Rated dependent in two or more of seven ADLs; OR

2. Rated dependent in behavior pattern.

CRITERIA FOR INTENSIVE ASSISTED LIVING IN AN ALF (to be used for private pay residents only)*

Private pay individuals meet the criteria for intensive assisted living as documented on the UAI when at least one of the following describes their functional capacity:

1. Rated dependent in four or more of seven ADLs; OR

2. Rated dependent in two or more ADLs and rated as semi-dependent or dependent in a combination of behavior pattern and orientation; OR

3. Rated semi-dependent in two or more ADLs and rated as dependent in a combination of behavior pattern and orientation.

***Important! The Intensive Assisted Living (IAL) Waiver was not renewed by the Health Care Financing Administration. The IAL waiver is no longer available as a Medicaid-funded alternative to nursing facility placement, after March 17, 2000, for new applicants. There are now only two levels of care recognized for ALFs: residential care and assisted living.**

Individuals who previously would have been assessed at the IAL level of care may reside in an ALF if all three of the following conditions are met:

- The individual does not have a prohibited condition;
- The ALF is licensed at the assisted living level; and,
- The ALF is willing and able to meet all of the individual's care needs, including personal care and any mental health and/or mental retardation needs that may exist.

Documentation on the Virginia UAI (Uniform Assessment Instrument), either the public or private pay version, must continue to clearly and accurately describe the care needs of the individual.

For public pay residents, if the individual was receiving IAL services on or before March 17, 2000, he or she will continue to be funded at the IAL rate, but through State funds, not federal, as long as he or she continues to meet criteria. DMAS is continuing to review IAL recipients, and, as long as the facility accepts the additional $180 per month for "grandfathered" residents, will expect to see the care provided in the IAL Waiver before it was not renewed. No applicant or resident may be assessed at the IAL level of care after March 17, 2000.

IAL was a payment level, not a licensure level. Licensing standards were structured for two-level licensure, meaning:

- Licensing regulations have always required and continue to require ALFs to meet the identified needs of residents admitted or retained in care regardless of the source of payment and regardless of whether the needs were identified in the UAI or by other reports or observations.
- Only one licensing rule (22 VAC 40-71-630, J.5) mentions IAL and can no longer be enforced as written because the regulation did not define IAL. This rule requires the health care professional who oversees facilities licensed for assisted living to directly observe all residents whose care needs are equivalent to IAL on each visit and to provide written recommendations for any needed changes in care. This rule further requires that all subsidized IAL residents will be monitored in accordance with DMAS specifications.
- The protections contained in J.5., are also implicit or explicit in the full body of the rule, which remains enforceable (e.g., health oversight at least quarterly) and more often as needed, monitoring service performance and recommending changes in service plans and care. While J.5. was the only rule component explicitly requiring "direct observation," observation is implicit in the remaining components and, indeed, some of the requirements could not be met without observation of residents.

NURSING FACILITY CRITERIA

The criteria for assessing an individual's eligibility for Medicaid payment of nursing home care consist of two components:

1. Functional capacity (the degree of assistance an individual requires to complete activities of daily living); and

2. Medical or nursing needs.

To qualify for Medicaid payment for nursing home care, an individual must meet both functional capacity requirements and have a medical condition that requires ongoing medical or nursing management. An exception may be made when the individual does not meet the functional capacity requirement but the individual does have a health condition that requires the daily direct services of a licensed nurse that cannot be managed on an outpatient basis.

The criteria for assessing an individual's eligibility for Medicaid payment of community-based care consist of the following components:

1. Functional capacity (the degree of assistance an individual requires to complete activities of daily living);

2. Medical or nursing needs; and

3. The individual's risk of nursing home placement in the absence of community-based waiver services.

In order to qualify for Medicaid payment for community-based care, an individual must meet both the functional and medical components of the nursing home criteria. In addition, the individual must be determined to be at risk of nursing home placement unless services under the waiver are offered. Functional dependency alone is not sufficient to demonstrate the need for nursing home care or placement.

Except as provided for individuals who require the daily direct services of a licensed nurse that cannot be managed on an outpatient basis, an individual may only be considered to meet the nursing home criteria when both the functional capacity of the individual and his or her medical or nursing needs meet the following requirements. Even when an individual meets nursing home criteria, placement in a noninstitutional setting shall be evaluated before actual nursing home placement is considered.

Functional Capacity

Functional capacity must be documented on the *Virginia Uniform Assessment Instrument*, completed in a manner consistent with the definitions of activities of daily living and directions provided by DMAS for the rating of those activities. (See the *User's Manual: Virginia Uniform Assessment Instrument* for complete definitions.) Individuals may be considered to meet the functional capacity requirements for nursing home care when one of the following describes their functional capacity:

1. Rated dependent in two to four of the Activities of Daily Living, and also rated semi-dependent or dependent in Behavior Pattern and Orientation, and semi-dependent in Joint Motion or semi-dependent in Medication Administration; OR

2. Rated dependent in five to seven of the Activities of Daily Living and also rated dependent in Mobility; OR

3. Rated semi-dependent in two to seven of the Activities of Daily Living and also rated dependent in Mobility and in Behavior Pattern and Orientation.

The rating of functional dependencies on the preadmission screening assessment instrument must be based on the individual's ability to function in a community environment, not including any institutionally induced dependence.

Medical and Nursing Needs

An individual with medical or nursing needs is an individual whose health needs require medical or nursing supervision or care above the level which could be provided through assistance with Activities of Daily Living, Medication Administration, and general supervision and is not primarily for the care and treatment of mental diseases. Medical or nursing supervision or care beyond this level is required when any one of the following describes the individual's need for medical or nursing supervision:

1. The individual's medical condition requires observation and assessment to assure evaluation of the person's need for modification of treatment or additional medical procedures to prevent destabilization and the person has demonstrated an inability to self-observe and/or evaluate the need to contact skilled medical professionals; or

2. Due to the complexity created by the person's multiple, interrelated medical conditions, the potential for the individual's medical instability is high or medical instability exists; or

3. The individual requires at least one ongoing medical or nursing service. The following is a non-inclusive list of medical/nursing services that may, but need not necessarily, indicate a need for medical or nursing supervision or care:

    a) Application of aseptic dressings;
    b) Routine catheter care;
    c) Respiratory therapy;
    d) Supervision for adequate nutrition and hydration for individuals who show clinical evidence of malnourishment or dehydration or have a recent history of weight loss or inadequate hydration which, if not supervised, would be expected to result in malnourishment or dehydration;
    e) Therapeutic exercise and positioning;
    f) Routine care of colostomy or ileostomy or management of neurogenic bowel and bladder;
    g) Use of physical (e.g., side rails, poseys, locked wards) and/or chemical restraints;
    h) Routine skin care to prevent pressure ulcers for individuals who are immobile;
    i) Care of small uncomplicated pressure ulcers and local skin rashes;
    j) Management of those with sensory, metabolic, or circulatory impairment with demonstrated clinical evidence of medical instability;
    k) Chemotherapy;
    l) Radiation;
    m) Dialysis;

n) Suctioning;
o) Tracheostomy care;
p) Infusion therapy; and
q) Oxygen.

Even when an individual meets nursing home criteria, provision of services in a noninstitutional setting should be considered before nursing facility placement is sought.

APPENDIX C
LEVEL OF CARE WORKSHEET
(Optional)

WORKSHEET TO DETERMINE ASSISTED LIVING FACILITY LEVEL OF CARE

(The use of this worksheet is optional.)

Resident's Name: _____

STEP 1: Based on the completed UAI, complete sections below. Refer to the *User's Manual: Virginia Uniform Assessment Instrument (UAI) for Private Pay Residents of Assisted Living Facilities* for information.

ADLs	Check if Dependent (D)
Bathing	
Dressing	
Toileting	
Transferring	
Eating/Feeding	
Bowel	
Bladder	

Selected IADLs	Check if Dependent (D)
Meal Preparation	
Housekeeping	
Laundry	
Money Management	

Number of ADL Dependencies: _____ *Number of IADL Dependencies:* _____

Medication Administration: Check here if Dependent _____

Behavior Pattern: Check here if Dependent _____

Behavior Pattern and Orientation: Check here if Semi-Dependent or Dependent _____

STEP 2: Apply the above responses to the criteria below to determine the individual's level of care.

RESIDENTIAL LIVING LEVEL OF CARE IN AN ALF:

1. Rated dependent in only one of seven ADLs; OR
2. Rated dependent in one or more of four selected IADLs; OR
3. Rated dependent in medication administration.

REGULAR ASSISTED LIVING LEVEL OF CARE IN AN ALF:

1. Rated dependent in two or more of seven ADLs; OR
2. Rated dependent in behavior pattern.

INTENSIVE ASSISTED LIVING LEVEL OF CARE IN AN ALF (for private pay individuals ONLY!):

1. Rated dependent in four or more of seven ADLs; OR
2. Rated dependent in two or more ADLs and rated as semi-dependent or dependent in a combination of behavior pattern and orientation; OR
3. Rated semi-dependent in two or more ADLs and rated as dependent in a combination of behavior pattern and orientation.

APPENDIX D
PSYCHOTROPIC MEDICATIONS

(Used by permission of and with gratitude to Dr. Steven Eisenstein of Piedmont Geriatric Hospital, Burkeville, VA)

PSYCHOTROPIC MEDICATIONS

INTRODUCTION

In the United States, persons over the age of 65 account for 25 percent of all prescription drug use, and psychotropic drug use is on the rise in this population. Many more options are now available to clinicians to treat older persons with mental disorders. Yet, many factors impact the way in which psychotropic medications actual work and how aging affects the way in which the body can handle medications.

There are four classes of psychotropic medications:

- Antidepressant
- Antianxiety or anxiolytic
- Antipsychotic
- Mood-stabilizing agents.

Psychotropics work by altering the brain chemistry and then, in turn, upon the older person's psychological state, mood, and thoughts. Not all medications are listed here; psychotropics that are more likely to be prescribed to older persons are discussed here. **As new medications are constantly entering the market, if you are unsure whether a medication is a psychotropic or not, please consult the individual's physician or pharmacist.**

PHARMACODYNAMICS

Apart from the concentration level of a particular drug in the blood are the effects of a medication on the target organs of the body. This is referred to as "pharmacodynamics," Greek for "drug" and "power." Older persons have a tendency to experience an increased response of a given psychotropic drug even when the drug is present at the same level as younger patients. Side effects like drug-induced sedation tend to be more pronounced. This is due to complex age-related changes at the tissue and cellular elves at receptor sites. As we age, we become more sensitive to any medication, a concern that can be magnified by a disease that alters the elimination process or the body's response to the drug. This leads to concerns over tolerance (or the diminishing of the drug's effectiveness) and withdrawal (what happens when a drug that an older person is dependent upon is removed). Older adults must also be clearly monitored by a physician when any type of psychotropic drug is discontinued. Certain agents have shorter half-lives (e.g., Paxil®) that can heighten potentially unpleasant side effects.

ADVERSE DRUG EVENTS

Simply stated, older persons tend to have more adverse drug reactions because they take more medications. The risk factor for adverse reactions increases greatly with each drug added to the regimen. One of the shortcomings in drug therapy is the potential for misuse or heavy reliance on medications, particularly tranquilizers. This is a special concern in nursing homes as numerous reports have indicated excessive reliance on antipsychotics and other psychotropic agents.

It is critically important to consider the distribution and impact upon the body of psychotropics. Medications for things such as anxiety and depression are more likely to cause adverse effects as the

person ages. This points to the need for caution on the part of the physician and vigilance on the part of staff of a long-term care facility, social service workers, and family members.

POLYPHARMACY

Older persons are more likely than other adults to be medicated with multiple agents, both prescriptions and over-the-counter medications. Polypharmacy refers to the use of more than one psychotropic drug concurrently for treatment of the same ailment. It can result in drug-to-drug interactions and decreasing effectiveness of one or both agents. Polypharmacy is generally viewed as a danger, yet may not always present a negative situation for the older person. The strict decision rule can be relaxed, especially when a physician finds a combination of drugs that work to help unresponsive patients. The administration of two antipsychotic agents for persistent psychosis or an antidepressant and an antianxiety agent for clinical depression may work well for the individual. As always, a review of all current medications, vigilant monitoring, and follow-up for adverse events is indicated.

EXAMPLES OF PSYCHOTROPIC MEDICATIONS

BRAND NAME	*GENERIC NAME*
Adapin	Doxepin HCl
Anafranil	Fluoxetine
Aricept	Donepezil
Asendin	Amoxapine
Ativan	Lorazepam
Aventyl	Nortriptyline
Buspar	Buspirone HCl
Centrax	Prazepam
Clozaril	Clozapine
Cognex	Tacrine
Dalmane	Flurazepam HCl
Desyrel	Trazodone
Doral	Quazepam
Effexor	Venlafaxine
Elavil	Amitriptyline
Endep	Amitriptyline
Halcion	Triazolam
Haldol	Haloperidol
Janimine	Imipramine
Klonopin	Clonazepam
Librium	Chlordiazepoxide HCl
Lithium	Lithium Carbonate (tablet) or Lithium Citrate (liquid)
Loxitane	Loxapine
Ludiomil	Mapizotiline
Luvox	Fluvoxamine
Mellaril	Thioridazine
Moban	Molidone
Nardil	Phenelzine Sulfate
Navane	Thiothixene
Norpramin	Desipramine
Pamelor	Nortriptyline
Parnate	Tranylcypromine Sulfate
Paxil	Paroxetine
Permitil	Fluphenazine HCl
Pertofrane	Desipramine
Prolixin	Fluphenazine
ProSom	Estazolam
Prozac	Fluoxetine
Remeron	Mirtazapine
Restoril	Temazepam

Risperdal	Risperidone
Serax	Oxazepam
BRAND NAME	*GENERIC NAME*
Serentil	Mesoridazine
Seroquel	Quetiapine
Serzone	Nefazodone
Sinequan	Doxepin HCl
Stelazine	Trifluoperazine
Taractan	Chlorprothiene
Thorazine	Chorpromazine
Tofranil	Imipramine
Tranxene	Clorazepate dipotassium
Trilafon	Perphenazine
Valium	Diazepam
Vivactil	Protryptyline
Wellbutrin	Bupropion HCl
Xanax	Alprazolam
Zoloft	Sertraline HCl
Zyprexa	Olanzapine

NOTE: As new medications are constantly entering the market, if you are unsure whether a medication is a psychotropic or not, please consult the individual's physician or pharmacist.

APPENDIX E

INDICATORS FOR REFERRAL OF ABUSE, NEGLECT, AND EXPLOITATION TO ADULT PROTECTIVE SERVICES/ VIRGINIA DEPARTMENT OF SOCIAL SERVICES

INDICATORS FOR REFERRAL OF ABUSE, NEGLECT, AND EXPLOITATION TO ADULT PROTECTIVE SERVICES

INDICATORS OF NEGLECT

Definition: Failure by a caregiver to provide an older or incapacitated adult with the necessities of life or failure of an older or incapacitated adult to provide necessities for himself or herself.

Inadequate Hygiene
Odorous/not bathed/dirty hair/body
Uncut hair/unshaven
Overgrown toe/finger nails
Not receiving mouth care

Nutrition
Dehydrated/malnourished
Constantly hungry
Not fed/inadequate meals

Physical Care
Inadequate/inappropriate/dirty clothing/shoes
Inadequate supervision
Lying in feces/urine/old food

Behavior of Victim
Begs for food/steals food
Eats meals alone in room
Picks at sores
Scratches self with nails/instruments

Condition of Home
Home in disrepair
Extremely dirty/garbage piled up
Severe pest/rodent infestation
Animal waste or smell/offensive odors
Inadequate heat/no fuel
Electricity cut off
Inadequate/contaminated water supply
No refrigerator/stove
Homeless

Social Isolation
Victim feels rejected
Victim is left alone
No opportunity to be with others
No planned activities
No cognitive stimulation

Medical Care of Victim
Not receiving needed medical care
No walking aids when needed
Special diet not allowed
No false teeth when needed/decayed teeth
No glasses or broken glasses
No hearing aid or broken hearing aid
Untreated mental health problems

Skin
Abrasions/lesions
Pressure sores/untreated sores
Insect bites
Dry, scaly/rash

Behavior of Abuser
Withholds food or medication
Does not assist with toileting
Does not assist with eating when needed
Call bell out of reach/does not answer call
Uses multiple medical facilities
Ignores/does not talk to victim
Does not allow victim to see others alone
Refuses to hire needed assistance
Inadequate supervision

INDICATORS OF PHYSICAL ABUSE

Definition: The infliction of physical pain or injury to the older person or the incapacitated adult.

Injuries
Cuts
Bites
Punctures
Abrasions
Lacerations
Bleeding
Sprains, dislocations
Bone fracture
Bruises
Burns
Scratches

Pattern of Injuries
Repeated
Frequent
Unusually placed
Several at one time
Various stages of healing
Bilateral, upper arms
Clustered
Shape of familiar object

Violent Actions
Pushed, shoved
Grabbed, shaken
Choked
Slapped
Punched, hit
Kicked, beaten
Cut
Shot
Handled roughly
Force fed
Scratched
Poked

Medical Evidence
Skeletal injuries
Retinal hemorrhages/detachment
Unset bones
Duodenal/jejunal hematomas
Ruptured inferior vena cava
Peritonitis
Internal injuries

INDICATORS OF UNREASONABLE CONFINEMENT

Definition: Use of physical or chemical restraints for reasons other than the adult's safety or well-being or without medical orders.

Inappropriate Physical Restraint
Handcuffed
Tied to furniture
Gagged
Locked in room
No adequate padding
Restrained only for confusion
Without medical orders
Without trying alternatives
Not periodically checked
Not permitted to leave house
Restrained person cannot get to phone
Phone out of reach

Inappropriate Chemical Restraint
Over medicated
Not checked for side effects of medication
Too much alcohol
Medicated without reason

INDICATORS OF EMOTIONAL ABUSE

Definition: Pain or distress that results from verbal or behavioral activity directed at the older or incapacitated adult.

Behavior of Victim
Depression
Self-destructive behavior
Intense fear
Intense sadness
Tearful without apparent reason
Overreacts to sound of abuser=s voice

Actions of Abuser
Uses harsh tone of voice
Swears at person
Talks of person's death
Talks of person as a burden
Makes derogatory remarks
Threatens person with:
- violence
- institutionalization
- guardianship
- abandonment
- isolation
- premature discharge
- eviction

Insults person
Humiliates person
Calls person names
Treats person as a child
Overcritical of person
Does not allow person visitors

INDICATORS OF SEXUAL ABUSE

Definition: Touching, fondling, or any sexual activities with an older or incapacitated person when the older or incapacitated person is unable to understand or give consent or is forced to engage in sexual behavior.

Medical Evidence
Presence of semen
Presence of a sexually transmitted disease
Genital or urinary irritation, injury
Prolapsed uterus
Frequent, unexplained physical illness
Phobic behavior
Depression

Behavior of Victim
Intense fear reaction to one or more people
Mistrust of others
Nightmares, sleep disturbances
Extreme upset when changed or bathed
Regressive behaviors
Aggressive behaviors
Self-destructive behaviors

Violent Actions
Voyeurism
Exhibitionism
Inflicting pornography on victim
Sexual assault
Forced to perform oral sex
Force to fondle or touch abuser sexually
Forced to engage in sexual activity

Behavior of Abuser
Discussion of sexual activity
Sexual interest in victim's body
Sexual jokes/comments
Sexual harassment

INDICATORS OF FINANCIAL ABUSE

Indicators are signs, symptoms, or clues that suggest that abuse has occurred or is likely to occur. While there is no litmus test for identifying abuse, the presence of any of these conditions may warrant concern and further investigation.

- Bank activity that is erratic, unusual, or uncharacteristic of the person.
- Bank activity that is inconsistent with the person's abilities (e.g., the person's automatic teller card is used when the person is unable to use it).
- Recent, new acquaintances, particularly those who take up residence with the person.
- Changes in the person's property titles, will, or other documents, particularly if the person is confused and/or the documents favor new acquaintances.
- A power of attorney is executed by a confused person.
- Lack of amenities when the person can afford them.
- Missing property.
- Suspicious activity on credit card accounts.
- Forged or suspicious signatures on documents.
- Failure to receive services that have been paid for.
- The person is being evicted or having utilities disconnected.
- The person is uncared for when arrangements have been made for providing care.
- The person's documents are missing.
- The person's mail has been redirected to a different address.

Virginia Adult Protective Services
24-Hour Toll-free Hotline:
1-888-83ADULT

APPENDIX F

INDICATORS FOR REFERRAL TO THE DEPARTMENT OF MENTAL HEALTH, MENTAL RETARDATION AND SUBSTANCE ABUSE SERVICES

You will obtain important direct and indirect information from other sections of the instrument which can be used to complete the mental health assessment. Pay particular attention to the following aspects of the individual's appearance and behavior during the total interview with the client and/or caregiver for pertinent information about a person's cognitive and emotional behavior.

Demographic: Can the client accurately give information about address, telephone number, date of birth, etc.?

Physical Environment: Is the living area cluttered, unclean, with spoiled food around, or numerous animals not well cared for? Is there evidence of pests?

Appearance: Does the client have soiled clothing and poor hygiene?

Functional Status: Does the client have difficulty with physical/maintenance of activities of daily living (ADLs)? Does a once routine activity now seem too complex to the client? (This may indicate dementia.) Does the client start an activity and then stop in the middle of it? Does the client walk with unsteady gait, have trouble with balance, appear awkward? Does the client have slowed movements, everything seems an effort, tired, weak? Any of these may indicate depression or the need for further evaluation.

IADLs: Does the client have diminished or absent ability to do instrumental ADLs?

Health Assessment: Does the client have somatic concerns: complain of headaches, dizziness, shortness of breath, heart racing, faintness, stomach or bowel disturbances (may indicate depression)? Does the client have trouble falling asleep awakening early or awakens for periods in the middle of the night? This may also indicate depression or the need for further evaluation.

Medication: Is there inappropriate use or misuse of prescribed and/or over-the-counter medications?

Speech: Are there speech difficulties, slurring, word-finding problems, can't get ideas across? (may indicate dementia).

Fractures/Dislocations: Does the client have fractures/bruises and is hesitant to give the cause?

Nutrition: Does the client have problems with appetite--eating too much or too little? Does the client have an unhealthy diet?

Hospitalization/Alcohol Use: Does the client have problematic alcohol use?

Cognitive: Does the client appear confused, bewildered, confabulates answers, speaks irrelevantly or bizarrely to the topic? Is the client easily distracted, has poor concentration, responds inconsistently when questioned? Is the client aware of surroundings, time, place, and situation? Does the client misplace/lose personal possessions? (may or may no complain of this) Does the client have angry outbursts and agitation? Does the client have decreased recognition of family and familiar places?

Emotional/Social: Does the client appear sad, blue, or despondent? Has crying spells, complains of feeling sad or blue, speaks and moves slowly, suffers significant appetite and sleep habit changes, has vague/somatic complaints and complains of memory impairments without objective impairment? (may indicate depression) Does the client appear unusually excited or emotionally high? Show pressured, incessant and rapid speech? Brag, talk of unrealistic plans, show a decreased need for food or sleep? (may indicate grandiosity, euphoria, mania) Does the client appear to be hallucinatory? Hear or see things that aren't there? Talk, mutter, or mumble to him/herself? Giggle or smile for no apparent reason? (may indicate hallucinations) Does the client

appear to be suspicious, feel that others are against him/her? Out to get him/her? Feel others are stealing from him/her? Feel he/she is being persecuted or discriminated against? Believe has special qualities/power? (may indicate delusions) Does client feel life is not worth living? Has she/he given up on self/ Does individual feel those who care about him/her have given up on him/her? Has the client ever considered ending his/her life? (may indicate suicidal thoughts, ideation, or gestures) Has the client ever considered harming someone? (may indicate homicidal ideation) Is the client fidgety, nervous, sweating, fearful, pacing, agitated, frightened, panicky? (may indicate fearfulness, anxiety, or agitation)

Inappropriate and disturbing (disruptive) behavior, particularly when it is more problematic for caretakers than the client (take note of how often the behavior occurs, when it began, and how much it currently upsets people in the immediate environment):

- Being suspicious and accusatory
- Verbally threatening to harm self or others
- Yelling out, screaming, cursing
- Taking others' things, hiding/hoarding possessions
- Being agitated, uncooperative and resistive with necessary daily routines
- Being a danger to self or others
- Exhibiting inappropriate sexual behavior
- Inappropriately voiding of urine or feces (voiding in non-bathroom locations)
- Being unaware of need to use bathroom or problems locating a bathroom
- Exhibiting intrusive or dangerous wandering (danger of getting lost, entering/damaging others' property, wandering into traffic)
- Exhibiting poor impulse control
- Exhibiting impaired judgment

Based on your assessment, if the client is currently exhibiting any of the following, a referral to the local CSB or other mental health professional should be considered:

Behavior	*Thinking*	*Affective/Feelings*
Aggressive/combative Destructive to self, others, or property Withdrawn/social isolation Belligerence/hostility Anti-social behavior Appetite disturbance Sleep disturbance Problematic substance abuse Sets fires	Hallucinations Delusions Disoriented Seriously impaired judgment Suicidal/homicidal thoughts, ideat gestures Cannot communicate basic needs Unable to understand simple commands Suspicion/persecution Memory loss Grandiosity/euphoria	Helplessness, hopelessness, feel worthless Sadness Crying spells Depressed Agitation Anxiety

If an individual is dangerous to self or others or is suicidal, an immediate referral should be made to the local CSB or other mental health professional.

Substance Abuse: A referral to the CSB should be considered when:

- A client reports current drinking of more than 2 drinks of alcohol per day. Further exploration of the usage is suggested; or
- Any current use of non-prescription mood-altering substances (e.g., marijuana, amphetamines).

Mental Retardation/Developmental Disability

Mental Retardation:

Diagnosis if:

- The person's intellectual functioning is approximately 70 to 75 or below;
- There are related limitations in two or more applicable adaptive skills areas; and
- The age of onset is 18 or below.

Use these questions or observations to assess undiagnosed but suspected MR:

- Did you go to school?
- What grade did you complete in school?
- Did you have special education?
- Does the individual have substantial functioning limitations in two or more of the following adaptive skill areas: communication, self-care, home living, social skills, community use, self-direction, health and safety, functional academics, leisure, and work?

If a person meets the above definition of mental retardation, a referral should be made to the local CSB.

Developmental Disability

Definition: A severe, chronic disability of a person that:

- Is attributable to a mental or physical impairment or combination of mental or physical impairments;
- Is manifest before age 22;
- Is likely to continue indefinitely; and
- Results in substantial functional limitations in three or more of the following areas of major life activity: self-care, receptive and expressive language; mobility; self-direction and capacity for independent living or economic self-sufficiency; or reflects the need for a combination and sequence of special interdisciplinary or generic care, treatment, or other services which are lifelong or extended duration and are individually planned and coordinated.

Developmental disability includes, but is not limited to, severe disabilities attributable to autism, cerebral palsy, epilepsy, spina bifida, and other neurological impairment where the above criteria are met.

People who have mental health, mental retardation, or substance abuse problems should be assisted to achieve the highest level of recovery, empowerment, and self-determination that is possible for them. In order to achieve this, applications to and residents of facilities such as assisted living facilities may need mental health, mental retardation, or substance abuse services. If a need for these services if identified, the client should be referred to the CSB, behavior health authority (BHA), or other appropriate licensed provider that serves the locality in which the person resides. It is not necessary to make a diagnosis or to completed a clinical assessment to make a referral to a CSB/BHA/licensed provider, but it is important to describe the behavior and/or symptoms that are observed on the screening matrix.

The screening matrix should be included with the UAI when it is forwarded to the provider who will care for the individual.

SCREENING FOR MENTAL HEALTH/MENTAL RETARDATION/SUBSTANCE ABUSE NEEDS

CONCERNS/ SYMPTOMS/ BEHAVIORS	REFER TO CSB/BHA OR OTHER APPROPRIATE LICENSED PROVIDER FOR MH SERVICES	REFER TO CSB/BHA OR OTHER APPROPRIATE LICENSED PROVIDER FOR MR SERVICES	REFER TO CSB/BHA OR OTHER APPROPRIATE LICENSED PROVIDER FOR SA SERVICES	REFER FIRST TO PCP FOR MEDICAL SCREENING/ SERVICES	PLEASE RECORD INFO. ON THE MOST APPROPRIATE UAI SECTIONS NOTED BELOW
1. Received a diagnosis of mental retardation, originating before the age of 18 years, which is characterized by significant sub-average intellectual functioning as demonstrated by performance on a standardized measure of intellectual functioning (IW test) that is at least two standard deviations below the mean and significant limitations in adaptive behavior as expressed in conceptual, social, and practical skills.		X			#1-Demographic Info/Education #1-Current Formal Services #2-Functional Status-Comments #3-Diagnoses #5- Client Case Summary
2. Currently engaging in I.V. drug abuse and is willing to seek treatment.			X		#4-Drug Use #5-Client Case Summary
3. Currently pregnant and engaging in substance abuse to the degree that the health/welfare of the baby is seriously compromised, and is willing to seek treatment.			X		#4-Drug Use #5-Client Case Summary
4. Currently expressing thoughts about wanting to die or to harm self or others.	X Call immediately				#4-Emotional Status #5-Client Case Summary
5. Currently under the care of a psychiatrist and taking medications prescribed for serious mental health disorders (e.g., schizophrenia, bi-polar, or major affective disorders.)	X				#1-Current Formal Services #3-Physical Health #4-Emotional Status #4-Hospitalization #5-Client Case Summary
6. Past history of psychiatric treatment (outpatient and/or hospitalizations) for serious mental health disorders) (e.g., schizophrenia, bi-polar, or major affective disorders.)	X				#4-Hospitalization #5-Client Case Summary
• Currently exhibiting the following behaviors that are not due to medical or organic causes:	X				#3-Sensory Functions #4-Emotional Status

CONCERNS/ SYMPTOMS/ BEHAVIORS	REFER TO CSB/BHA OR OTHER APPROPRIATE LICENSED PROVIDER FOR MH SERVICES	REFER TO CSB/BHA OR OTHER APPROPRIATE LICENSED PROVIDER FOR MR SERVICES	REFER TO CSB/BHA OR OTHER APPROPRIATE LICENSED PROVIDER FOR SA SERVICES	REFER FIRST TO PCP FOR MEDICAL SCREENING/ SERVICES	PLEASE RECORD INFO. ON THE MOST APPROPRIATE UAI SECTIONS NOTED BELOW
• Reports hearing voices, and/or talks to self, giggles/smiles at inappropriate times).					#5-Client Case Summary
• Reports seeing thing that are not present.	X				#3-Sensory Functions #4-Emotional Status #5-Client Case Summary
• Inflicting harm on self by cutting, burning, etc.	X Call immediately				#4-Emotional Status #5-Client Case Summary
• Has difficulty staying physically immobile, insists on constantly moving physically within the environment, paces rapidly, and/or talks in a very rapid fashion, and may express grandiose and obsessive thoughts.	X				#3-Sensory Functions #4- Behavior Pattern #4-Emotional Status #5-Client Case Summary
• Confused, not oriented/aware of person, place, and time; may wander in or outside of facility/home.				X	#4-Cognitive Functions #4-Behavior Pattern #5-Client Case Summary
• Significant mood changes occur rapidly within one day and are not related to the environment.	X				#4-Emotional Status #5-Client Case Summary
• Becomes easily upset and agitated, exhibits behaviors others find intimidating, threatening, or provocative, may destroy property, and may feel others are "out to hurt him."	X				#4-Emotional Status #5-Client Case Summary
• Cries often, appears consistently sad, and exhibits very few other emotions.				X	#4-Emotional Status #5-Client Case Summary
• Has little appetite or energy, consistently sleeps more than 9-10 hours /day, or has problems sleeping, and has little interest in social activities.				X	#3-Nutrition #4-Emotional Status #4-Social Status #5-Client Case Summary
• Level of personal hygiene and grooming has significantly declined.				X	#3-Functional Status #5-Client Case Summary

CONCERNS/ SYMPTOMS/ BEHAVIORS	REFER TO CSB/BHA OR OTHER APPROPRIATE LICENSED PROVIDER FOR MH SERVICES	REFER TO CSB/BHA OR OTHER APPROPRIATE LICENSED PROVIDER FOR MR SERVICES	REFER TO CSB/BHA OR OTHER APPROPRIATE LICENSED PROVIDER FOR SA SERVICES	REFER FIRST TO PCP FOR MEDICAL SCREENING/ SERVICES	PLEASE RECORD INFO. ON THE MOST APPROPRIATE UAI SECTIONS NOTED BELOW
7. Displaying behaviors that are considered very unusual in the general population and a medical exam has found no physical basis (i.e., Alzheimer's Disease, brain injury, MR, etc.) Behaviors may include:	X				#5-Client Case Summary
• Eating non-food items	X				#5-Client Case Summary
• Voiding (urine and/or feces) in inappropriate places and/or inappropriately handling/disposing of these items.	X				#5-Client Case Summary
• Inappropriate sexual aggression or exploitation.	X				#5-Client Case Summary
• Combatively engaging in odd, ritualistic behaviors.	X				#5-Client Case Summary