



# *Individualized Service Plan (ISP) Training Participant Packet*

Approved by the Virginia Department of Social Services

**Division of Licensing Programs**

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VIRGINIA DEPARTMENT OF  
SOCIAL SERVICES

# Individualized Service Plan Training: Participant Packet

## Background

This training is provided by the Virginia Department of Social Services (VDSS) Division of Licensing Programs (DOLP). The mission of VDSS is to design and deliver high-quality human services that help Virginians achieve safety, independence and overall well-being. DOLP protects the safety, health, and well-being of vulnerable children and adults through comprehensive regulatory oversight and provider services in day facilities and residential and assisted living programs.

## Purpose

This participant packet contains resources for learning participants that are referenced throughout the ISP training. Your trainer will guide you through the use of these references.

## Prerequisite for Participation

Completion of the *state-approved private pay uniform assessment instrument (UAI) training* is a required prerequisite for all participants before taking this course on ISPs. This training program will not provide an in-depth review of UAI completion. Participants needing an in-depth review of UAI completion should review a state-approved private pay UAI training prior to participation in this ISP training.

## Preparing for Training

Prior to the start of training, ensure that you have a way to take notes and that you have access to printed or downloaded/electronic copies of the following:

- The *Standards for Licensed Assisted Living Facilities*
- The VDSS model ISP form or your facility-specific ISP forms
- The private pay UAI and public pay UAI

# Individualized Service Plans (ISPs): Training Outline

## Introduction

- Title Slide
- VDSS Mission Statement
- Introductions & Ice Breakers
- Learning Objectives

## Module 1: Introduction to the Individualized Service Plan (ISP)

- Regulations & Code References Applicable to ISPs
- Defining ISPs
- ISP Guiding Principles
- ISP Required Components
- VDSS ISP Model Form
- Requirements for Development of ISPs
- Format and Access to ISPs
- Common Problem

## Module 2: Identifying Needs

- Overview of Sources for Identifying Needs
- UAI
- Admission Physical Examination
- Interview with Resident
- Fall Risk Rating
- Psychological, Behavioral, Emotional Functioning Assessment
- Other Sources
- Mrs. Simms – Case Study Example

## Module 3: Services & Goal Setting

- ISP in Plain Language
- Supporting Principles
- Selecting Services & Writing Service Statements
- Selecting Goals & Writing Expected Outcomes
- Planning for Teamwork

## Module 4: Putting It Together

- Lifecycle of an ISP
- Effective ISPs
- Leveraging Teamwork

## Module 5: Case Studies & Practice Examples

## **Mrs. Arlene Simms: Initial Case Study Information**

Mrs. Arlene Simms is a 78-year-old woman who has been a widow for 12 years. She was married 46 years to a small-town businessman who also became Mayor of their town. She has been a volunteer during her married life and since being widowed, she never had paid work outside the home and had no children.

### **History & Physical:**

Mrs. Simms had a Cerebral Vascular Accident (stroke) six months ago. She attended rehab but she has permanent right-sided weakness. She has had several unwitnessed falls at home within the past three months. She had cataract surgery ten years ago, which was successful, but she is still nearsighted and requires glasses, at all times. Needs daily assistance.

### **UAI - ADL Function:**

Mrs. Simms generally wears stretchy clothes like knits and jogging suits and can manage these types of clothes on her own. She needs assistance with bras, stockings, zippers, and similar dressing functions. She has an extended shoehorn and a button hook but often can't find them when she needs them. She also needs a quad cane when walking, for safety. She can go up a flight of stairs, but slowly, and with the use of handrails. She never climbs stairs without someone accompanying her and always takes an elevator when one is available.

### **UAI - IADLs**

She enjoys cooking but can no longer open packages or operate kitchen equipment, independently. She can make salads & sandwiches from fresh ingredients & soft spreads. Mrs. Simms likes a tidy living space. She dusts and polishes in her apartment, but thorough cleaning is done by a cleaning service, twice weekly. She needs glasses but often forgets to put them on when dressing in the morning, and when she remembers to wear them, they are often smudged with fingerprints making them less effective.

### **UAI & Interview - Psychosocial:**

Mrs. Simms is very social. She enjoys the company of others and doesn't enjoy spending time alone. She is an active member of a local church and attends regularly. She has been volunteering in her church food pantry, assisting with packaging, and distributing food to people who come to the pantry for food. This is very important to her and wishes to continue.

### **Resident Interview - Hobbies & Enjoyment:**

She enjoys knitting, going to church, volunteering, watching NASCAR races and has held season tickets to the Commanders' games for more than 15 years.

## **Mrs. Arlene Simms: Annual Review Case Study Information**

One year after the initial ISP was created, you are conducting your annual review of Mrs. Simms' ISP.

You have received input from Mrs. Simms, a direct care staff member who often cares for Mrs. Simms and Mrs. Simms' primary care provider.

Based on this input, you have determined the following:

Her needs in the following areas are unchanged, and the services described and the expected outcomes for those services continue to be appropriate:

- Assistance with dressing
- Assistance with walking
- Use of glasses during waking hours
- DNR status

Her need for social interaction is unchanged, however:

- She has been consistently attending group activities four or more times per week, meeting and exceeding her goal.
- She has expressed a desire to participate in more social outings outside of the facility.

**INDIVIDUALIZED SERVICE PLAN**

RESIDENT'S NAME: Arlene Simms

NAME OF ALF: Rainbow Assisted Living

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

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

Description of Needs and Date Identified	Description of Services to be Provided	Persons Who will Provide Services	When and Where Services will be Provided	Expected Outcomes and Time Frame	Date Outcomes Achieved
5/1/25 Needs physical and mechanical assistance with dressing due to right-side weakness	-Hand Mrs. Simms her shoehorn and button hook when needed -Assist with hooking bra, zippers, and pulling up stockings if she is unable or requests assistance	-Direct Care Staff -Nursing Staff	-Daily with AM & PM care and as needed -In the resident's apartment	5/1/27 YNH 5/1/26-Resident will be dressed in clean clothing of her choosing, daily -Resident will dress in pullover shirts and elastic waist pants with minimal assistance, when they are chosen to wear	
5/1/25 Needs mechanical assistance with walking due to right-sided weakness	-Ensure that cane is always kept within easy reach of Mrs. Simms -Ensure safety by checking cane tip pads daily	-Direct Care Staff -Nursing Staff	-At all times when ambulating	5/1/27 YNH 5/1/26-Resident will use cane for all ambulation -Resident will maintain safety during walking	
5/1/25 Needs glasses during waking hours due to nearsightedness	-Provide verbal cues to clean glasses and place on bedside table each night before bed -Provide verbal cue to wear glasses when awake	-All Staff -Direct Care Staff & Nursing Staff	-At all times when awake throughout facility -Daily HS in resident's room	5/1/27 YNH 5/1/26-Resident will be able to navigate the environment safely when awake -Resident will engage in meaningful activities daily	
5/1/25 Resident has a signed DNR	-Resuscitation/CPR will not be performed in the event the resident's heart or breathing stops	-All staff certified in CPR	-At all times, wherever the resident is located	5/1/27 YNH 5/1/26-Resident's DNR will be honored	
5/1/25 Needs social interaction in group settings	-Remind Mrs. Simms when group activities are occurring -Provide positive enforcement for attendance by thanking her for coming	-Direct Care Staff -Activities Staff	-Throughout facility as resident wishes to participate	5/1/26-Resident will attend at least three group activities weekly	05/01/2026

Description of Needs and Date Identified	Description of Services to be Provided	Persons Who will Provide Services	When and Where Services will be Provided	Expected Outcomes and Time Frame	Date Outcomes Achieved
5/1/26 Needs social interaction in group settings	-Remind Mrs. Simms when group activities and outings are occurring -Provide positive reinforcement by thanking her for coming when she attends	-Direct Care Staff -Activities Staff	-Throughout facility and during outings as resident wishes to participate	5/1/27-Resident will attend at least four group activities weekly -Resident will attend at least two outings monthly	

**SIGNATURES:**

**I. DEVELOPMENT OF PLAN:**

Your Name Here 05/01/2025 Arlene Simms 05/01/2025  
 Staff Person Who Developed Plan Date Plan Completed Resident or Resident's Legal Representative Date

PCP Signature, MD | Physician 5/1/25 \_\_\_\_\_  
 Other, if any, Involved in Plan Development Date  
 (Specify Title/Relationship to Resident) (Specify Title/Relationship to Resident)

**II. SUBSEQUENT REVIEW/UPDATE OF PLAN:**

Your Name Here 05/01/2026 Arlene Simms 05/01/2026  
 Staff Person Who Reviewed/Updated Plan Date Reviewed/Updated Resident or Resident's Legal Representative Date

PCP Signature, MD | Physician 5/1/26 \_\_\_\_\_  
 Other, if any, Involved in Plan Review/Update Date  
 (Specify Title/Relationship to Resident) (Specify Title/Relationship to Resident)

**NOTE:** Any time changes are made in the plan, the place where the change is made should be initialed and dated by the staff person making the change and by the resident/legal representative. In addition, the staff person and the resident/legal representative must sign in Part II above.

## Virginia “Vee” Jones Case Study Information



For the purposes of this activity, the current date is February 16, 2025, and the resident is being admitted to your facility today.

Virginia “Vee” Jones is 82 years old. She prefers to be called “Vee” rather than “Mrs. Jones” or “Virginia”. She lived alone until February 2025. She had a stroke in December 2024, spending two weeks at the University of Virginia Medical Center, and was then transferred to Sun Beach Nursing and Rehabilitation, a local facility in Charlottesville, for rehabilitative therapy. She no longer requires continuous nursing care, but she is still unable to care for herself at home.

She was widowed 10 years ago after 52 years of marriage. She has a daughter, Patricia, who currently lives in Charlottesville who helps her care for her home and money. Patricia’s husband has recently taken a job in Williamsburg, and they plan to move there soon. Flora does not wish to move to Williamsburg. She has a son, James, who lives in Colorado and, though they call and write, they cannot afford to visit often. Vee had a second daughter was killed in an accident 15 years ago.

In her late 20’s, she was diagnosed with bipolar disorder and takes lithium carbonate to control the symptoms. Vee’s mental status is fairly stable. She sometimes experiences episodes of anxiety and depression and has difficulty sleeping. She tends to isolate herself from others. Sometimes she is disoriented to time and place but is generally oriented and aware of her surroundings. She has some short-term memory loss and hearing loss. She appears to become confused at times due in part to her hearing difficulty.

She is forgetful enough that her daughter recently bought her a “medication reminder” device to help her remember to take her medications on time which is something that has been a problem for her. In the NF the nurses have been providing all medications.

Vee likes quilting, making pottery, and playing and listening to music. She dislikes crowds. She is a devoted reader, and a favorite pastime is sitting in the sun to read. She also enjoys watching news programs on television. For years she has been staying up late and getting up around 8:00 or 9:00 AM. She naps frequently during the day. Vee has outlived most of her friends and family, but she enjoys visiting with some members of the local potter’s club that she was active in until arthritis and her stroke prevented her from using the potter’s wheel. She was once an active member of a nearby Methodist church but has not attended regularly for three years. Prior to her marriage, she was a music teacher. She was a stay-at-home mother after her children were born. She returned to teaching after her children left home.

Vee has lost some mobility as a result of the stroke. She walks with the help of a walker but has a fear of falling. She requires frequent prompting to encourage her to walk. She also has some slurring of speech, which causes her some embarrassment and contributes to self-isolation. In October 2024, she had cataract surgery on her right eye and the cataract was successfully removed. She does wear glasses and must have them for reading.

She can no longer drive and is dependent on others for transportation. She visits several doctors frequently for her medical conditions which include arthritis, congestive heart failure, and bipolar disorder. She has been receiving occupational and physical therapy since her stroke and has made good progress in regaining mobility. She was a heavy drinker and smoker in the past but has not smoked or drank for many years. She is allergic to nuts. She is typically continent of bowel and bladder but must be reminded to urinate often and sometimes has minor bladder “leaks” upon exertion, when she sneezes, or laughs hard.

Vee has no advance directive, or living will and is listed as “Full Code” status on hospital and nursing facility documentation.

# VIRGINIA UNIFORM ASSESSMENT INSTRUMENT

**Dates:**Screen: 2 /4/25Assessment: 2 /6/25Reassessment:  / /

## IDENTIFICATION/BACKGROUND

### Name & Vital Information

Client Name: Jones Virginia B Client SSN: 222-8A-9879  
(Last) (First) (Middle Initial)  
Address: 2904 Makepeace Road Charlottesville VA 22901  
(Street) (City) (State) (Zip Code)  
Phone: 434-982-2793 City/County Code: 999

**Directions to House:**West on Main Street, East on Downing Street, six blocks.  
Makepeace is a pedestrian only street next to 10 Downing Street

Pets? No

### Demographics

Birthdate: 04 / 10 /1942 Age: 82 Sex: Male Female  
(Month) (Day) (Year) 0 X 1  
Marital Status: Married Widowed Separated Divorced Single Unknown  
0 X 1 2 3 4 9

**Race:**

White 0  
 Black/African American 1  
 American Indian 2  
 Oriental/Asian 3  
 Alaskan Native 4  
 Unknown 9

**Education:**

Less than High School 0  
 Some High School 1  
 High School Graduate 2  
 Some College 3  
 College Graduate 4  
 Unknown 9

**Communication of Needs:**

Verbally, English 0  
 Verbally, Other Language 1  
Specify: \_\_\_\_\_  
 Sign Language/Gestures/Device 2  
 Does Not Communicate 3  
Hearing Impaired? \_\_\_\_\_

Ethnic Origin: \_\_\_\_\_

Specify: \_\_\_\_\_

### Primary Caregiver/Emergency Contact/Primary Physician

Name: Patricia Johnson Relationships: Daughter  
Address: 408 Colonial Road, Charlottesville, VA 22901 Phone: (H) 434-438-2997 (W) 434-299-4356  
Name: James Jones Relationship: Son  
Address: 211 Bow Street, Edgewood, CO 89677 Phone: (H) 978-457-9796 (W) 978-598-6712  
Name of Primary Physician: Dr. Herbert Ransom, MD Phone: 434-971-2387  
Address: 750 Pantops Road, Charlottesville, VA 22901

### Initial Contact

Who called: Patricia Johnson Daughter 434-438-2997  
(Name) (Relation to Client) (Phone)

**Presenting Problem/Diagnosis:**

Mrs. Jones was in Sun Beach NF for 1 month following her stroke. She wanted to return home, but due to left-sided weakness she is unable to care for herself. Mrs. Jones and her daughter are requesting ALF placement for Mrs. Jones.

Client Name: Virginia Jones

Client SSN: 222-8A-9879

### Current Formal Services

Do you currently use any of the following types of services?

No 0	Yes 1	(Check All Services That Apply)	Provider/Frequency:
X		Adult Day Care	
X		Adult Protective	
	X	Case Management	Blue Mountain Behavioral Services-monthly
X		Chore/Companion/Homemaker	
X		Congregate Meals/Senior Center	
X		Financial Management/Counseling	
X		Friendly Visitor/Telephone Reassurance	
X		Habilitation/Supported Employee	
X		Home Delivered Meals	
X		Home Health/Rehabilitation	
X		Home Repairs/Weatherization	
X		Housing	
X		Legal	
	X	Mental Health (Inpatient/Outpatient)	Blue Mountain Behavioral Services-Outpatient-monthly
X		Mental Retardation	
	X	Personal Care	Daily, assistance by NF staff
X		Respite	
X		Substance Abuse	
X		Transportation	
X		Vocational Rehab/Job Counseling	
X		Other:	

### Financial Resources

Where are you on the scale for annual (monthly) family income before taxes?

	\$20,000 or More	(\$1,667 or more ) 0
	\$15,000 - 19,999	(\$1,250 - \$1,666) 1
	\$11,000 - 14,999	(\$ 917 - \$1,249) 2
	\$ 9,500 - 10,999	(\$ 792 - \$ 916) 3
	\$ 7,000 - 9,499	(\$ 583 - \$ 791) 4
X	\$ 5,500 - 6,999	(\$ 458 - \$ 582) 5
	\$ 5,499 or Less	(\$ 457 or Less ) 6
	Unknown 9	

Number in Family unit: 1  
Optional: Total monthly family income: \_\_\_\_\_

Do you currently receive income from...?

No 0	Yes 1	Optional: Amount
X		Black Lung
X		Pension
	X	Social Security
	X	SSI/SSDI
X		VA Benefits
X		Wages/Salary
X		Other

Does anyone cash your check, pay your bills or manage your business?

No 0	Yes 1	Names
X		Legal Guardian
X		Power of Attorney
X		Representative Payee
X	X	Other Patricia Johnson

Do you receive any benefits or entitlements?

No 0	Yes 1	
X		Auxiliary Grant
	X	Food Stamps
	X	Fuel Assistance
X		General Relief
X		State and Local Hospitalization
X		Subsidized Housing
X		Tax Relief

What types of health insurance do you have?

No 0	Yes 1	
	X	Medicare, # 222-8A-9879 A
	X	Medicaid, # 888 888888
		Pending: No 0 Yes 1
		QMB/SLMB: No 0 Yes 1
X		All Other Public/Private: _____

Client Name: Virginia Jones

Client SSN: 222-8A-9879

**Physical Environment**

**Where do you usually live? Does anyone live with you?**

	Alone <sup>1</sup>	Spouse <sup>2</sup>	Other <sup>3</sup>	Names of Persons in Household	
<input type="checkbox"/> House: Own <sup>0</sup>					
<input type="checkbox"/> House: Rent <sup>1</sup>					
<input type="checkbox"/> House: Other <sup>2</sup>					
<input type="checkbox"/> Apartment <sup>3</sup>					
<input type="checkbox"/> Rented Room <sup>4</sup>					
	Name of Provider (Place)			Admission Date	Provider Number (If Applicable)
<input type="checkbox"/> Adult Care Residence <sup>50</sup>					
<input type="checkbox"/> Adult Foster <sup>60</sup>					
<input checked="" type="checkbox"/> Nursing Facility <sup>70</sup>	Sun Beach NH			1/4/25	0382752
<input type="checkbox"/> Mental Health/Retardation Facility <sup>80</sup>					
<input type="checkbox"/> Other <sup>90</sup>					

**Where you usually live are there any problems?**

No <sup>0</sup>	Yes <sup>1</sup>	(Check All Problems That Apply)	Describe Problems:
<input checked="" type="checkbox"/>	<input type="checkbox"/>	Barriers to Access	
<input checked="" type="checkbox"/>	<input type="checkbox"/>	Electric Hazards	
<input checked="" type="checkbox"/>	<input type="checkbox"/>	Fire Hazards/No Smoke Alarm	
<input checked="" type="checkbox"/>	<input type="checkbox"/>	Insufficient Heat/Air Conditioning	
<input checked="" type="checkbox"/>	<input type="checkbox"/>	Insufficient Hot Water/Water	
<input checked="" type="checkbox"/>	<input type="checkbox"/>	Lack of/Poor Toilet Facilities (Inside/Outside)	
<input checked="" type="checkbox"/>	<input type="checkbox"/>	Lack of/Defective Stove, Refrigerator, Freezer	
<input checked="" type="checkbox"/>	<input type="checkbox"/>	Lack of/Defective Washer/Dryer	
<input checked="" type="checkbox"/>	<input type="checkbox"/>	Lack of/Poor Bathing Facilities	
<input checked="" type="checkbox"/>	<input type="checkbox"/>	Structural Problems	
<input checked="" type="checkbox"/>	<input type="checkbox"/>	Telephone Not Accessible	
<input checked="" type="checkbox"/>	<input type="checkbox"/>	Unsafe Neighborhood	
<input checked="" type="checkbox"/>	<input type="checkbox"/>	Unsafe/Poor Lighting	
<input checked="" type="checkbox"/>	<input type="checkbox"/>	Unsanitary Conditions	
<input checked="" type="checkbox"/>	<input type="checkbox"/>	Other: _____	

Client Name: Virginia Jones

Client SSN: 222-8A-9879



**FUNCTIONAL STATUS** (Check only one block for each level of functioning.)

ADLS	Needs Help?	
	No <sup>00</sup>	Yes
Bathing		X
Dressing		X
Toileting	X	
Transferring		X
Eating/Feeding	X	

Continence	Needs Help?	
	No <sup>00</sup>	Yes
Bowel	X	
Bladder	X	

Ambulation	Needs Help?	
	No <sup>00</sup>	Yes
Walking		X
Wheeling	X	
Stairclimbing		X
Mobility		X

IADLS	Needs Help?	
	No <sup>0</sup>	Yes <sup>1</sup>
Meal Preparation		X
Housekeeping		X
Laundry		X
Money Mgmt.		X
Transportation		X
Shopping		X
Using Phone	X	
Home Maintenance		X

MH Only 10 Mechanical Help	HH Only 2 Human Help		MH & HH 3		Performed by Others 40	Is Not Performed 50
	Supervision 1	Physical Assistance 2	Supervision 1	Physical Assistance 2		
		X				
		X				
		X				
					Spoon Fed 1	Syringe/ Tube Fed 2
						Fed by IV 3

Incontinent Less than Weekly 1	Ext. Device/ Indwelling/ Ostomy Self Care 2	Incontinent D Weekly or More 3	External Device Not Self Care 4	Indwelling D Catheter Not Self Care 5	Ostomy D Not Self Care 6

MH Only 10 Mechanical Help	HH Only 2 Human Help		MH & HH 3		Performed by Others 40	Is Not Performed 50
	Supervision 1	Physical Assistance 2	Supervision 1	Physical Assistance 2		
			X			
		X				
	X				<b>Confined</b> Moves About	<b>Confined</b> Does Not Move About

Comments:

**Outcome: Is this a short assessment?**

X No, Continue with Section 3 (0) \_\_\_\_\_ Yes, Service Referrals (1) \_\_\_\_\_ Yes, No Service Referrals (2)

Screener: Pamela Court Agency: DSS

Client Name: Virginia Jones

Client SSN: 222-8A-9879

### PHYSICAL HEALTH ASSESSMENT

#### Professional Visits/Medical Admissions

Doctor's Name(s) (List all)	Phone	Date of Last Visit	Reason for Last Visit
Herbert Ransom	434-971-2387	1/30/24	CVA

#### Admission: In the past 12 months have you been admitted to a . . . for medical or rehabilitation reasons?

No 0	Yes 1		Name of Place	Admit Date	Length of Stay/Reason
	X	Hospital	UVA Medical Center	12/21/24	CVA-2 weeks
	X	Nursing Facility	Sun Beach NF	1/12/25	CVA
X		Adult Care Residence			

#### Do you have any advance directives such as... (Who has it...Where is it...)?

No 0	Yes 1	Location
X		Living Will, _____
X		Durable Power of Attorney for Health Care, _____
X		Other, _____

#### Diagnoses & Medication Profile

#### Do you have any current medical problems, or a known or suspected diagnosis of mental retardation or related conditions, such as ... (Refer to the list of diagnoses)?

Current Diagnoses	Date of Onset	Diagnoses:
CVA (Stroke)	12/21/24	Alcoholism/Substance Abuse (01) Blood-Related Problems (02) Cancer (03) Cardiovascular Problems Circulation (04) Heart Trouble (05) High Blood Pressure (06) Other Cardiovascular Problems (07)
Congestive Heart Failure	2019	Dementia Alzheimer's (08) Non-Alzheimer's (09)
Cataract Surgery (Right Eye); developing cataract on left eye	10/2024	Developmental Disabilities Mental Retardation (10) Related Conditions Autism (11) Cerebral Palsy (12) Epilepsy (13) Friedreich's Ataxia (14) Multiple Sclerosis (15) Muscular Dystrophy (16) Spina Bifida (17)
Bipolar Disorder	~1965	Digestive/Liver/Gall Bladder (18) Endocrine (Gland)Problems Diabetes (19) Other Endocrine Problem (20) Eye Disorders (21) Immune System Disorders (22) Muscular/Skeletal Arthritis/Rheumatoid Arthritis (23) Osteoporosis (24) Other Muscular/Skeletal Problems (25)
Enter Codes for 3 Major, Active Diagnoses: _____ None00 <u>28</u> DX1 <u>05</u> DX2 <u>31</u> DX3		
Current Medications (Include Over-the-Counter)	Dose, Frequency, Route	Reason(s) Prescribed
1. Plavix	75mg, po, Daily AM	CHF
2. Lithium Carbonate	300 mg, po, BID	Bipolar Disorder
3. Hydrochlorothiazide	25 mg PO, Daily AM	CHF
4.		
5.		
6.		
7.		
8.		
9.		
10.		
Total No. of Medications: <u>3</u>	(If 0, skip to Sensory Function)	Total No. of Tranquilizer/Psychotropic Drugs: <u>1</u>
Do you have any problems with medicine(s)...?	How do you take your medications?	
No 0    Yes 1	_____ Without assistance 0	
X _____ Adverse reactions/allergies	_____ Administered/monitored by lay person 1	
X _____ Cost of medication	X _____ Administered/monitored by professional nursing staff 2	
X _____ Getting to the pharmacy	Describe help: <u>Administered</u>	
_____ X Taking them as instructed/prescribed	Name of helper: <u>Nurses in NF</u>	
_____ X Understanding directions/schedule		
_____ History of refusing to take medications		

Client Name: Virginia Jones

Client SSN: 222-8A-9879

### Sensory Functions

#### How is your vision, hearing, and speech?

	No Impairment <sub>0</sub>	Impairment		Complete Loss <sub>3</sub>	Date of Last Exam
		Record Date of Onset/Type of Impairment			
		Compensation <sub>1</sub>	No Compensation <sub>2</sub>		
Vision		X (glasses; cataract surgery 10/2024)			11/2024
Hearing	X				
Speech		X			12/03

### Physical Status

#### Joint Motion: How is your ability to move your arms, fingers, and legs?

Within normal limits or instability corrected <sub>0</sub>

Limited motion <sub>1</sub>

Instability uncorrected or immobile <sub>2</sub>

#### Have you ever broken or dislocated any bones ... Ever had an amputation or lost any limbs ... Lost voluntary movement of any part of your body?

Fractures/Dislocations	Missing Limbs	Paralysis/Paresis
<input checked="" type="checkbox"/> None 000	<input checked="" type="checkbox"/> None 000	<input type="checkbox"/> None 000
<input type="checkbox"/> Hip Fracture 1	<input type="checkbox"/> Finger(s)/Toe(s) 1	<input checked="" type="checkbox"/> Partial 1
<input type="checkbox"/> Other Broken Bone(s) 2	<input type="checkbox"/> Arm(s) 2	<input type="checkbox"/> Total 2
<input type="checkbox"/> Dislocation(s) 3	<input type="checkbox"/> Leg(s) 3	Describe: <u>Right-sided weakness</u>
<input type="checkbox"/> Combination 4	<input type="checkbox"/> Combination 4	
<b>Previous Rehab Program?</b>	<b>Previous Rehab Program?</b>	<b>Previous Rehab Program?</b>
<input type="checkbox"/> No/Not Completed 1	<input type="checkbox"/> No/Not Completed 1	<input type="checkbox"/> No/Not Completed 1
<input type="checkbox"/> Yes 2	<input type="checkbox"/> Yes 2	<input checked="" type="checkbox"/> Yes 2
<b>Date of Fracture/Dislocation?</b>	<b>Date of Amputation?</b>	<b>Onset of Paralysis?</b>
<input type="checkbox"/> 1 Year or Less 1	<input type="checkbox"/> 1 Year or Less 1	<input checked="" type="checkbox"/> 1 Year or Less 1
<input type="checkbox"/> More than 1 Year 2	<input type="checkbox"/> More than 1 Year 2	<input type="checkbox"/> More than 1 Year 2

### Nutrition

Height: 5'3" Weight: 140 Recent Weight Gain/Loss:  No <sub>0</sub>  Yes <sub>1</sub>  
 (Inches) (lbs.) Describe: \_\_\_\_\_

Are you on any special diet(s) for medical reasons?	Do you have any problems that make it hard to eat?
<input type="checkbox"/> None 0	No <sub>0</sub> Yes <sub>1</sub>
<input type="checkbox"/> Low Fat/Cholesterol 1	<input checked="" type="checkbox"/> Food Allergies
<input checked="" type="checkbox"/> No/Low Salt 2	<input checked="" type="checkbox"/> Inadequate Food/Fluid Intake
<input type="checkbox"/> No/Low Sugar 3	<input checked="" type="checkbox"/> Nausea/Vomiting/Diarrhea
<input type="checkbox"/> Combination/Other 4	<input checked="" type="checkbox"/> Problems Eating Certain Foods
	<input checked="" type="checkbox"/> Problems Following Special Diets
<b>Do you take dietary supplements?</b>	<input type="checkbox"/> Problems Swallowing
<input checked="" type="checkbox"/> None 0	<input checked="" type="checkbox"/> Taste Problems
<input type="checkbox"/> Occasionally 1	<input checked="" type="checkbox"/> Tooth or Mouth Problems
<input type="checkbox"/> Daily, Not Primary Source 2	<input checked="" type="checkbox"/> Other: _____
<input type="checkbox"/> Daily, Primary Source 3	
<input type="checkbox"/> Daily, Sole Source 4	

Client Name: Virginia Jones

Client SSN: 222-8A-9879

### Current Medical Services

#### Rehabilitation Therapies: Do you get any therapy prescribed by a doctor, such as...?

No 0	Yes 1	Frequency
	<input checked="" type="checkbox"/>	Occupational 3 times weekly
	<input checked="" type="checkbox"/>	Physical 3 times weekly
<input checked="" type="checkbox"/>		Reality/Remotivation
<input checked="" type="checkbox"/>		Respiratory
<input checked="" type="checkbox"/>		Speech
<input checked="" type="checkbox"/>		Other

#### Special Medical Procedures: Do you receive any special nursing care, such as ...?

No 0	Yes 1	Site, Type, Frequency
<input checked="" type="checkbox"/>		Bowel/Bladder Training
<input checked="" type="checkbox"/>		Dialysis
<input checked="" type="checkbox"/>		Dressing/Wound Care
<input checked="" type="checkbox"/>		Eye care
<input checked="" type="checkbox"/>		Glucose/Blood Sugar
<input checked="" type="checkbox"/>		Injections/IV Therapy
<input checked="" type="checkbox"/>		Oxygen
<input checked="" type="checkbox"/>		Radiation/Chemotherapy
<input checked="" type="checkbox"/>		Restraints (Physical/Chemical)
	<input checked="" type="checkbox"/>	ROM Exercise
<input checked="" type="checkbox"/>		Trach Care/Suctioning
<input checked="" type="checkbox"/>		Ventilator
<input checked="" type="checkbox"/>		Other:

#### Do you have pressure ulcers?

	None 0	Location/Size
<input checked="" type="checkbox"/>		
<input checked="" type="checkbox"/>	Stage I 1	
<input checked="" type="checkbox"/>	Stage II 2	
<input checked="" type="checkbox"/>	Stage III 3	
<input checked="" type="checkbox"/>	Stage IV 4	

### Medical/Nursing Needs

Based on client's overall condition, assessor should evaluate medical and/or nursing needs.

Are there ongoing medical/nursing needs?  No 0  Yes 1

#### If yes, describe ongoing medical/nursing needs:

- Evidence of medical instability.
- Need for observation/assessment to prevent destabilization.
- Complexity created by multiple medical conditions.
- Why client's condition requires a physician, RN, or trained nurse's aide to oversee care on a daily basis.

**Comments:** Needs assistance and encouragement with ROM exercises/ambulation.

Optional: Physician's Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Others: \_\_\_\_\_ Date: \_\_\_\_\_

(Signature/Title)

# 4 PSYCHO-SOCIAL ASSESSMENT

## Cognitive Function

**Orientation** (Note: Information in italics is optional and can be used to give a MMSE Score in the box to the right.)

**Person:** Please tell me your full name (so that I can make sure our record is correct).  
**Place:** Where are we now (*state, county, town, street/route number, street name/box number*)? Give the client 1 point for each correct response.  
**Time:** Would you tell me the date today (*year, season, date, day, month*)?

Oriented 0  
 Disoriented – Some spheres, some of the time 1  
 \_\_\_\_\_ Disoriented – Some spheres, all the time 2  
 \_\_\_\_\_ Disoriented – All spheres, some of the time 3  
 \_\_\_\_\_ Disoriented – All spheres, all of the time 4  
 \_\_\_\_\_ Comatose 5

Spheres affected: Place, time

Optional: MMSE Score
(5)
(5)
(3)
(5)
Total:
<b>Note:</b> Score of 14 or below implies cognitive impairment.

## Recall/Memory/Judgment

**Recall:** I am going to say three words. And I want you to repeat them after I am done ( House, Bus, Dog). \* Ask the client to repeat them. Give the client 1 point for each correct response on the first trial. \* Repeat up to 6 trials until client can name all 3 words. Tell the client to hold them in his mind because you will ask him again in a minute or so what they are.

**Attention/ Concentration:** Spell the word "WORLD". Then ask the client to spell it backwards. Give 1 point for each correctly placed letter (DLROW).

**Short-Term:** \* Ask the client to recall the 3 words he was to remember.

**Long-Term:** When were you born ( What is your date of birth)?

**Judgment:** If you needed help at night, what would you do?

No 0 Yes 1  
 \_\_\_\_\_  Short-Term Memory Loss?  
 \_\_\_\_\_ Long-Term Memory Loss?  
 \_\_\_\_\_ Judgment Problems?

## Behavior Pattern

**Does the client ever wander without purpose (trespass, get lost, go into traffic, etc...) or become agitated and abusive?**

\_\_\_\_\_ Appropriate 0  
 \_\_\_\_\_ Wandering/Passive – Less than weekly 1  
 \_\_\_\_\_ Wandering/Passive – Weekly or more 2  
 \_\_\_\_\_ Abusive/Aggressive/Disruptive – Less than weekly 3  
 \_\_\_\_\_ Abusive/Aggressive/Disruptive – Weekly or more 4  
 \_\_\_\_\_ Comatose 5

Type of inappropriate behavior: \_\_\_\_\_ Source of Information: \_\_\_\_\_

## Life Stressors

**Are there any stressful events that currently affect your life, such as ...?**

No 0	Yes 1	No 0	Yes 1	No 0	Yes 1
<input checked="" type="checkbox"/>	_____	<input checked="" type="checkbox"/>	_____	<input checked="" type="checkbox"/>	_____
_____	_____	_____	_____	_____	_____
<input checked="" type="checkbox"/>	_____	<input checked="" type="checkbox"/>	_____	_____	<input checked="" type="checkbox"/>
<input checked="" type="checkbox"/>	_____	_____	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	_____

Change in work/employment      Financial problems      Victim of a crime  
 Death of someone close      Major illness- family/friend      Failing health  
 Family conflict      Recent move/relocation      Other: \_\_\_\_\_

Client Name: Virginia Jones

Client SSN: 222-8A-9879

**Emotional Status**

In the past month, how often did you ...?	Rarely/ Never 0	Some of the Time 1	Often 2	Most of the Time 3	Unable to Assess 9
Feel anxious or worry constantly about things?			X		
Feel irritable, have crying spells or get upset over little things?		X			
Feel alone and that you don't have anyone to talk to?			X		
Feel like you didn't want to be around other people?			X		
Feel afraid that something bad was going to happen to you and/or feel that others were trying to take things from you or trying to harm you?		X			
Feel sad or hopeless?				X	
Feel that life is not worth living ... or think of taking your life?		X			
See or hear things that other people did not see or hear?	X				
Believe that you have special powers that others do not have?	X				
Have problems falling or staying asleep?			X		
Have problems with your appetite ... that is, eat too much or too little?		X			

Comments:

**Social Status**

Are there some things that you do that you especially enjoy?

No 0	Yes 1		Describe
<input type="checkbox"/>	<input checked="" type="checkbox"/>	Solitary Activities,	Reading
<input type="checkbox"/>	<input checked="" type="checkbox"/>	With Friends/Family,	Visiting
<input type="checkbox"/>	<input checked="" type="checkbox"/>	With Groups/Clubs,	Quilting
<input type="checkbox"/>	<input checked="" type="checkbox"/>	Religious Activities,	Attending church

How often do you talk with your children family or friends either during a visit or over the phone?

Children	Other Family	Friends/ Neighbors
<input type="checkbox"/> No Children 0	<input checked="" type="checkbox"/> No Other Family 0	<input type="checkbox"/> No Friends/Neighbors 0
<input type="checkbox"/> Daily 1	<input type="checkbox"/> Daily 1	<input type="checkbox"/> Daily 1
<input checked="" type="checkbox"/> Weekly 2	<input type="checkbox"/> Weekly 2	<input checked="" type="checkbox"/> Weekly 2
<input type="checkbox"/> Monthly 3	<input type="checkbox"/> Monthly 3	<input type="checkbox"/> Monthly 3
<input type="checkbox"/> Less than Monthly 4	<input type="checkbox"/> Less than Monthly 4	<input type="checkbox"/> Less than Monthly 4
<input type="checkbox"/> Never 5	<input type="checkbox"/> Never 5	<input type="checkbox"/> Never 5

Are you satisfied with how often you see or hear from your children other family and/or friends?

No 0       Yes 1

Client Name: Virginia Jones

Client SSN: 222-8A-9879

**Hospitalization/Alcohol – Drug Use**

**Have you been hospitalized or received inpatient/outpatient treatment in the last 2 years for nerves emotional/mental health alcohol or substance abuse problems?**

No  Yes

Name of Place	Admit Date	Length of stay/Reason
Blue Mountain Behavioral Services	?	

**Do (did) you ever drink alcoholic beverages?**

Never

At one time, but no longer  1

Currently  2

How much: Beer-six pack; Bourbon

How often: 6 pack/day; pint Bourbon weekly

**Do (did) you ever use non-prescription, mood altering substances?**

Never  0

At one time, but no longer  1

Currently  2

How much: \_\_\_\_\_

How often: \_\_\_\_\_

*If the client has never used alcohol or other non-prescription, mood altering substances, skip to the tobacco question.*

Have you, or someone close to you, ever been concerned about your use of alcohol/other mood altering substances?	Do (did) you ever use alcohol/other mood-altering substances with ...	Do (did) you ever use alcohol/other mood-altering substances to help you ...
No <input type="checkbox"/> Yes <input type="checkbox"/>	No <input type="checkbox"/> Yes <input type="checkbox"/>	No <input type="checkbox"/> Yes <input type="checkbox"/>
<b>Describe concerns:</b>	<input type="checkbox"/> Prescription drugs?	<input type="checkbox"/> Sleep?
	<input type="checkbox"/> OTC medicine?	<input type="checkbox"/> Relax?
	<input type="checkbox"/> Other substances?	<input type="checkbox"/> Get more energy?
	<b>Describe what and how often:</b>	<input type="checkbox"/> Relieve worries?
		<input type="checkbox"/> Relieve physical pain?
		<b>Describe what and how often:</b>

**Do (did) you ever smoke or use tobacco products?**

Never

At one time, but no longer  1

Currently  2

How much: 2 packs-cigarettes

How often: Per day

**Is there anything we have not talked about that you would like to discuss?**

Client states "I don't like to be called Mrs. Jones and I don't like to be called Virginia. Vee is what I like to be called, it's what my friends and family have always called me. Please call me Vee."

Client Name: Virginia Jones

Client SSN: 222-8A-9879

## Assessment Summary

*Indicators of Adult Abuse and Neglect: While completing the assessment, if you suspect abuse, neglect or exploitation, you are required by Virginia law, Section 63.1-55.3, to report this to the Department of Social Services, Adult Protective Services.*

### Caregiver Assessment

#### Does the client have an informal caregiver?

No 0 (Skip to Section on Preferences)  Yes 1

#### Where does the caregiver live?

- With client 0  
 Separate residence, close proximity 1  
 Separate residence, over 1 hour away 2

#### Is the caregiver's help ...

- Adequate to meet the client's needs? 0  
 Not adequate to meet the client's needs? 1

#### Has providing care to client become a burden for the caregiver?

- Not at all 0  
 Somewhat 1  
 Very much 2

#### Describe any problems with continued caregiving:

### Preferences

Client's preference for receiving needed care: ALF

Family/Representative's preference for client's care: ALF

Physician's comments (if applicable): Resident's needs can be met in ALF.

Client Name: Virginia Jones

Client SSN: 222-8A-9879

**Client Case Summary**

Mrs. Jones is dependent in 3 of 7 ADLs. She has need for prompting to walk and complete range of motion exercises. Due to history of bipolar disorder and recent stroke, she needs emotional support and encouragement.

She is dependent (prompting) on others for assistance with medication administration.

**Unmet Needs**

No <sub>0</sub> Yes <sub>1</sub> (Check All That Apply)

X \_\_\_\_\_ Finances  
\_\_\_\_\_ X Home/Physical Environment  
\_\_\_\_\_ X ADLS  
\_\_\_\_\_ X IADLS

No <sub>0</sub> Yes <sub>1</sub> (Check All That Apply)

\_\_\_\_\_ X Assistive Devices/Medical Equipment  
\_\_\_\_\_ X Medical Care/Health  
\_\_\_\_\_ X Nutrition  
\_\_\_\_\_ X Cognitive/Emotional  
X \_\_\_\_\_ Caregiver Support

**Assessment Completed By:**

Assessor's Name	Signature	Agency/Provider Name	Provider #	Section(s) Completed
Pamela Court	<i>Pamela Court</i>	ABC County DSS	437.10	All

Optional: Case assigned to: \_\_\_\_\_ Code #: \_\_\_\_\_

**RESIDENT - PERSONAL/SOCIAL DATA**  
(See 22 VAC 40-73-380)

<b>Name:</b> Virginia "Vee" Jones		<b>Admission Date:</b> 02/16/2025		<b>Marital Status:</b> <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Divorced <input checked="" type="checkbox"/> Widowed	
<b>Last Home Address:</b> 2904 Markepeace Rd Charlottesville, VA 22903			<b>Address From Which Received (if different):</b> Sun Beach Nursing and Rehabilitation		
<b>Date of Birth:</b> 04/01/1942 <b>Estimated Age (if DOB unknown):</b>		<b>Birth Place:</b> Williamsburg, VA		<b>Allergies:</b> Penicillin, Sulfa Drugs, Peanuts	
<b>Interests/Hobbies:</b> Quilting, playing piano/music, visiting with friends, attending church		<b>Lifetime vocation, career or primary role:</b>		<b>Information on advance directives, Do Not Resuscitate (DNR) orders, or organ donation, if applicable:</b>	
		<b>Service in Armed Forces, if applicable:</b>			
<b>Legal Representative, if any (attach documents)</b>			<b>Designated Contact Person</b>		
<b>Name:</b> Patricia Johnson			<b>Name:</b> Patricia Johnson		
<b>Address:</b> 408 Colonial Rd, Charlottesville, VA 22901			<b>Address:</b> 408 Colonial Rd, Charlottesville, VA 22901		
<b>Phone:</b>			<b>Phone:</b>		
<b>Cell Phone:</b> 434-438-2997			<b>Cell Phone:</b> 434-438-2997		
<b>Responsible Individual (reg. 550 H), if needed</b>			<b>Clergyman/Place of Worship, if applicable</b>		
<b>Name:</b>			<b>Name:</b> Dr. Howard Hill		
<b>Address:</b>			<b>Address:</b> 2525 Vine St, Charlottesville, VA 22901		
<b>Phone:</b>			<b>Phone:</b> 434-912-3698		
<b>Cell Phone:</b>			<b>Cell Phone:</b> 434-882-3598		
			<b>Place of Worship:</b> Forest Hills United Methodist Church		
<b>Next of Kin, if known</b>			<b>Next of Kin, if known</b>		
<b>Name:</b> Patricia Johnson			<b>Name:</b> James Jones		
<b>Address:</b> 408 Colonial Rd, Charlottesville, VA 22901			<b>Address:</b> 211 Bow St, Edgewood, CO 89677		
<b>Phone:</b>			<b>Phone:</b>		
<b>Cell Phone:</b> 434-438-2997			<b>Cell Phone:</b> 978-457-9796		

Personal Physician	Personal Dentist
<b>Name:</b> Herbert Ransom, MD	<b>Name:</b> John James, DDS
<b>Address:</b> 750 Pantops Rd, Charlottesville, VA 22901	<b>Address:</b> 7569 Greene Ave, Charlottesville, VA 22901
<b>Phone:</b> 434-971-2387	<b>Phone:</b> 434-876-0322
<b>Cell Phone:</b>	<b>Cell Phone:</b>
Local Department of Social Services, if applicable	Other Agency, if applicable
<b>Name:</b>	<b>Name:</b>
<b>Address:</b>	<b>Address:</b>
<b>Phone:</b>	<b>Phone:</b>
<b>Cell Phone:</b>	<b>Cell Phone:</b>
<b>Case Manager or Caseworker:</b>	<b>Case Manager or Caseworker:</b>
<p><b>Previous mental health or intellectual disability services history, if any, and if applicable for care or services:</b>  <input type="checkbox"/> Not Applicable    <input checked="" type="checkbox"/> Yes, Explain Below</p> <p>-Diagnosis of bipolar disorder, receiving monthly services from Blue Mountain Behavioral Health Services for medication review and case management.</p> <p>-Numerous hospitalizations for depressive episodes, throughout adulthood.</p>	
<p><b>Current behavioral and social functioning:</b> Frequently avoids socialization due to feelings of embarrassment related to her speech. Tends to isolate during depressive episodes.</p> <p><b>Strengths:</b> Enjoys quiet activities and small groups. Prior to stroke, met several times per week with neighbors to quilt. Played piano and continues to enjoy reading.</p> <p><b>Problems:</b> Has not been attending church due to mobility problems from stroke. Since her stroke, speech is somewhat slurred and she is occasionally disoriented to time.</p>	
<p><b>Substance abuse history if applicable for care or services:</b>    <input checked="" type="checkbox"/> Not Applicable    <input type="checkbox"/> Yes, Explain Below</p> <p>_____</p> <p>_____</p> <p>_____</p>	

### REPORT OF RESIDENT PHYSICAL EXAMINATION

(Examination is to be completed by an independent physician within 30 days preceding the person's admission to the assisted living facility. Report of the examination is to be kept at the facility as part of the resident's record.)

NAME OF PERSON EXAMINED: Virginia Jones DATE OF EXAMINATION: 02/04/2025

ADDRESS: 2904 Makepeace Rd, Charlottesville, VA 22901

TELEPHONE: 434-982-2793

Height: 5' 3"

Weight: 140 lbs

BP: 130/78

**Significant Medical History:**

Appendectomy 1992

Cataract surgery (right eye) 10/2024

CVA, 12/21/2024

Congestive Heart Failure (CHF) 2019

**General physical condition, including systems review as is medically indicated:**

82 year old female, alert and oriented x2 (disoriented to time). Ambulates with use of a walker, due to impaired mobility from her stroke.

**Allergies (food, medicine, or other) and description of the person's reactions:**

Penicillin (rash), Sulfa drugs (rash), peanuts (rash, hives, swelling of lips and tongue)

**Is this person:**

**Ambulatory (physically and mentally capable of self-preservation by evacuating in response to an emergency to a refuge area as defined by the Uniform Statewide Building Code without the assistance of another person, or from the structure itself without the assistance of another person if there is no such refuge area within the structure, even if such person may require the assistance of a wheelchair, walker, cane, prosthetic device, or a single verbal command to evacuate).**

**Nonambulatory (by reason of physical or mental impairment is not capable of self-preservation without the assistance of another person).**

Person's Name Virginia Jones

Is this person capable of self-administering medication?  Yes  No

Does this individual have any of the following conditions or care needs?

Condition/Care Need	Yes	No	Comment
Ventilator dependency		X	
Dermal ulcers III and IV		X	If stage III, is ulcer healing?
Intravenous therapy or injections directly into the vein		X	If intermittent therapy, please note and indicate expected time period.
Airborne infectious disease in a communicable state that requires isolation or special precautions to prevent transmission		X	
Psychotropic medications without appropriate diagnosis and treatment plans		X	
Nasogastric tubes		X	
Gastric tubes		X	If yes, is person capable of independently feeding himself and caring for the tube?
Presents imminent physical threat or danger to self or others		X	
Requires continuous licensed nursing care		X	

Person's Name Virginia Jones

**Diagnosis or significant problems:**

CVA

Developing cataract on left eye

Congestive heart failure

Bipolar disorder

**Recommendations for care:**

**Medications:** Plavix (clopidogrel) 75 mg PO daily AM

Lithium carbonate 300 mg PO BID

Hydrochlorothiazide 25 mg PO daily AM

**Diet:** No nuts or nut oils

Low Sodium

**Therapy:** Physical therapy and speech therapy evaluation

Mental health services

**Other:** \_\_\_\_\_

**Screening for Tuberculosis:**

Results of a risk assessment documenting the absence of tuberculosis in a communicable form as evidenced by the completion of the current screening form published by the Virginia Department of Health or a form consistent with it. A Report of TB Screening form, which may be used, is attached.

Name of Physician: (print) Dr. Herbert Ransom

Name of Designee, if applicable: (print) Type text here

Signature of Physician or Designee: Herbert Ransom, MD Date: 02/02/2025

Address: (Street, City, State, Zip Code) 750 Pantops Rd, Charlottesville, VA 22901

Telephone: 434-971-2387

# Virginia Tuberculosis (TB) Screening and Risk Assessment Tool

For use in individuals 6 years and older

Use this tool to identify asymptomatic **individuals 6 years and older** for latent TB infection (LTBI) testing.

- The symptom screen and risk factor assessment may be conducted by a licensed healthcare provider (MD, PA, NP, RN, LPN). If a symptom or risk factor for TB is identified, further evaluation should also be performed by a licensed healthcare provider (MD, PA, NP, RN, LPN), however an RN or an LPN conducting evaluations must have an order by healthcare personnel with prescriptive authority consistent with Virginia professional practice acts for [medicine](#) and [nursing](#).
- Re-testing should only be done in persons who previously tested negative and have new risk factors since the last assessment.
- A negative Tuberculin Skin Test (TST) or Interferon Gamma Release Assay (IGRA) does not rule out active TB disease.

First screen for TB Symptoms:  None (If no TB symptoms present → Continue with this tool)

Cough  Hemoptysis (coughing up blood)  Fever  Weight Loss  Poor Appetite  Night Sweats  Fatigue

If TB symptoms present → Evaluate for active TB disease

Check appropriate risk factor boxes below.

TB infection testing is recommended if any of the risks below are checked.

If TB infection test result is positive and active TB disease is ruled out, TB infection treatment is recommended.

Birth, travel, or residence in a country with an elevated TB rate  $\geq$  3 months

- Includes countries other than the United States (U.S.), Canada, Australia, New Zealand, or Western and North European countries
- IGRA is preferred over TST for non-U.S.-born persons  $\geq$  2 years old
- Clinicians may make individual decisions based on the information supplied during the evaluation. Individuals who have traveled to TB-endemic countries for the purpose of medical or health tourism  $<$  3 months may be considered for further screening based on the risk estimated during the evaluation.

Medical conditions increasing risk for progression to TB disease

Radiographic evidence of prior healed TB, low body weight (10% below ideal), silicosis, diabetes mellitus, chronic renal failure or on hemodialysis, gastrectomy, jejunioileal bypass, solid organ transplant, head and neck cancer

Immunosuppression, current or planned

HIV infection, injection drug use, organ transplant recipient, treatment with TNF-alpha antagonist (e.g., infliximab, etanercept, others), steroids (equivalent of prednisone  $\geq$ 15 mg/day for  $\geq$ 1 month) or other immunosuppressive medication

Close contact to someone with infectious TB disease at any time

None; no TB testing indicated at this time

Patient Name Virginia Jones

Date of Birth 04 / 10 / 1942

Name of Person Completing Assessment Dr. Herbert Ransom Signature of Person Completing Assessment \_\_\_\_\_

Title/Credentials of Person Completing Assessment Physician Assessment Date 02 / 04 / 2025

# Virginia Tuberculosis Screening and Risk Assessment User Guide

## Symptoms that should trigger evaluation for active TB disease

Patients with any of the following symptoms that are otherwise unexplained should be evaluated for active TB disease: cough for more than 2-3 weeks, fevers, night sweats, poor appetite, weight loss, fatigue, and hemoptysis.

## How to evaluate for active TB disease

Evaluate for active TB disease with a chest x-ray (CXR), symptom screen, and if indicated, sputum acid-fast bacilli (AFB) smears, cultures and nucleic acid amplification testing. A negative tuberculin skin test (TST) or interferon gamma release assay (IGRA) does not rule out active TB disease.

## Negative test for TB infection does not rule out active TB disease

It is important to remember that a negative TST or IGRA result does not rule out active TB disease. In fact, a negative TST or IGRA in a patient with active TB disease can be a sign of extensive disease and poor outcome.

## Avoid testing persons at low risk

Routine testing of low-risk populations is not recommended and may result in unnecessary evaluations and treatment because of falsely positive test results.

### Prioritize persons with risks for progression

Prioritize patients with at least one of the following medical risks for progression:

- diabetes mellitus
- smoker within past 1 year
- end stage renal disease
- leukemia or lymphoma
- silicosis
- cancer of head or neck
- intestinal bypass/gastrectomy
- chronic malabsorption
- low body weight (10% below ideal)
- history of chest x-ray findings suggestive of previous or inactive TB (no prior treatment). Includes fibrosis or non-calcified nodules, but does not include solitary calcified nodule or isolated pleural thickening. In addition to LTBI testing, evaluate for active TB disease.

## U.S. Preventive Services Task Force recommendations

The USPSTF has recommended testing persons born in, or former residents of, a country with an elevated tuberculosis rate and persons who live in, or have lived in, high-risk Congregate settings such as homeless shelters and correctional facilities. Because the increased risk of exposure to TB in congregate settings varies substantially by facility and local health jurisdiction, clinicians are encouraged to follow local recommendations when considering testing among persons from these congregate settings. USPSTF did not review data supporting testing among close contacts to persons with infectious TB or among persons who are immunosuppressed because these persons are recommended to be screened by public health programs or by clinical standard of care.

## Virginia Department of Health recommendations

This risk assessment has been customized according to the Virginia Department of Health's (VDH) TB Program recommendations. Providers should check with local TB control programs, or the VDH TB Program at (804) 864-7906 for local recommendations.

## Mandated testing and other risk factors

Several risk factors for TB that have been used to select patients for TB screening historically or in mandated programs are not included among the components of this risk assessment. This is purposeful in order to focus testing on patients at highest risk. However, certain populations may be mandated for testing by statute, regulation, or policy. This risk assessment does not supersede any mandated testing. Examples of these populations include: healthcare workers, residents or employees of correctional institutions, substance abuse treatment facilities, homeless shelters, and others.

## Age as a factor

Age (among adults) is not considered in this risk assessment. However, younger adults have more years of expected life during which progression from latent infection to active TB disease could develop. Some programs or clinicians may additionally prioritize testing of younger, non-U.S.-born persons when all non-U.S.-born are not tested. An upper age limit for testing has not been established but could be appropriate depending on individual patient TB risks, comorbidities, and life expectancy.

Flora Adams  
**Virginia Tuberculosis Screening and Risk Assessment User Guide**

**Young children**

This risk assessment tool is intended for individuals ≥ 6 years old. A risk assessment tool created for use in children < 6 years old can be found on the VDH website:

<https://www.vdh.virginia.gov/tuberculosis/screening-testing/>

**When to repeat a test**

Re-testing should only be done in persons who previously tested negative, and have new risk factors since the last assessment. In general, this would include new close contact with an infectious TB case or new immunosuppression, but could also include foreign travel in certain circumstances.

**When to repeat a risk assessment**

The risk assessment should be administered at least once. Persons can be assessed for new risk factors at subsequent preventive health visits.

**IGRA preference in BCG vaccinated**

Because the IGRA has increased specificity for TB infection in persons vaccinated with Bacillie Calmette-Guerin vaccine (BCG), IGRA is preferred over the TST in these persons. Most persons born outside the US have been vaccinated with BCG.

**Previous or inactive tuberculosis**

Chest radiograph findings consistent with previous or inactive TB include fibrosis or non-calcified nodules, but do not include a solitary calcified nodule or isolated pleural thickening. Persons with a previous chest radiograph showing findings consistent with previous or inactive TB should be tested for TB infection. In addition to TB infection testing, evaluate for active TB disease.

**A decision to test is a decision to treat**

**Emphasis on short course for treatment of TB infection**

Shorter regimens for treating TB infection have been shown to be more likely to be completed and the 3-month 12-dose regimen has been shown to be as effective as 9 months of isoniazid. Use of these shorter regimens is preferred in most patients. Drug-drug interactions and contact to drug-resistant TB are typical reasons these regimens cannot be used.

**Shorter duration TB infection treatment regimens**

Medication	Frequency	Duration
Rifampin	Daily	4 months
Isoniazid + Rifapentine*	Weekly	12 weeks**
Isoniazid + Rifampin	Daily	3 months

\*VDH recommends Directly Observed Therapy (DOT)

\*\*11-12 doses in 16 weeks required for completion

**Patient refusal of TB infection treatment**

Refusal should be documented. Offers of treatment should be made at future encounters with medical services. Annual chest radiographs are not recommended in asymptomatic persons. If treatment is later accepted, TB disease should be excluded and CXR repeated if it has been > 3 months from the initial evaluation.

## Mental Health Screening Determination Form

(See 22 VAC 40-73-310, 330 and 340)

<b>Resident's Name:</b> Virginia Jones	<b>Referred for Admission by:</b> Dr. Herbert Ransom
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<b>Date Resident Interviewed for Admission:</b> 02/03/2025	<b>Date Resident Admitted:</b> 02/16/2025
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**Part I. Mental Health Screening**

Date mental health screening was recommended for admission or retention, if applicable: \_\_\_\_\_  
 Date mental health screening was completed for admission or retention: 02/03/2025  
 Date mental health screening was reviewed by facility: 02/05/2025

1) Based on all sources of information gathered for determining the appropriateness of admission or retention, has a recommendation been made, if appropriate, to have the (prospective) resident referred to a qualified mental health professional (QMHP) to determine whether the person presents a risk of harm to self and/or others? [Circle one: Yes /  No] If a recommendation for a screening was made but a referral was not done, explain:

2) If a mental health screening was recommended but there will be a delay in having it completed and the results made available to the facility, explain the reason for the delay and the expected length of the delay.

3) If a mental health screening was recommended and the results were made available to the facility, did the facility use the information to help determine whether the facility can meet or continue to meet the needs of the individual, such as equipping staff with specialized training, providing a higher level of supervision, offering psychosocial activities, or providing a type of physical environment that will enhance protection? [Circle one:  Yes / No]

4) If there are special considerations for the facility to help support meeting the mental health needs of the (prospective) resident, what are they?

**Socialization in small groups and management of medications.**

5) If a QMHP completed a mental health screening for a (prospective) resident and a recommendation for mental health services was made, have the resident, a mental health services provider, the authorized contact person, the physician of record, and, if applicable, the legal representative been notified? [Circle one:  Yes / No] If not, explain:

**Part II. Psychosocial and Behavioral History**

1) If there are indications of mental health problems within the past six months, has the referring party provided a documented psychosocial and behavioral history that describes the prospective resident's psychological, social, emotional, and behavioral functioning (if the party is a family member, a significant other, friend, or physician, the information may be obtained by interview and documented by the facility)? [Circle one: Yes /  No]

2) Did the facility consider the information contained in the psychosocial and behavioral history in making a decision about whether the facility can meet the needs of the individual? [Circle one: Yes /  No] Date History Reviewed:

3) Does the psychosocial and behavioral history indicate special considerations for the facility to help meet the mental health needs of the prospective resident [Circle one: Yes /  No] If so, what are they?

4) If the person is admitted, was the psychosocial and behavioral history used in the development of the individualized service plan? [Circle one: Yes / No]

**Additional Comments Regarding Admission/Retention:** Mrs. Adams requires medication review and case management. She also suffers from episodes of depression

<b>Signature of Facility Administrator (or Designee):</b> <u>Moira Simpson</u>	<b>Date:</b> 02/16/2025
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## INDIVIDUALIZED SERVICE PLAN

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

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

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

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

RESIDENT'S NAME: \_\_\_\_\_

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

**SIGNATURES:**

**I. DEVELOPMENT OF PLAN:**

Staff Person Who Developed Plan \_\_\_\_\_ Date Plan Completed \_\_\_\_\_ Resident or Resident's Legal Representative \_\_\_\_\_ Date \_\_\_\_\_

Other, if any, Involved in Plan Development (Specify Title/Relationship to Resident) \_\_\_\_\_ Date \_\_\_\_\_ Other, if any, Involved in Plan Development (Specify Title/Relationship to Resident) \_\_\_\_\_ Date \_\_\_\_\_

**II. SUBSEQUENT REVIEW/UPDATE OF PLAN:**

Staff Person Who Reviewed/Updated Plan \_\_\_\_\_ Date Reviewed/Updated \_\_\_\_\_ Resident or Resident's Legal Representative \_\_\_\_\_ Date \_\_\_\_\_

Other, if any, Involved in Plan Review/Update (Specify Title/Relationship to Resident) \_\_\_\_\_ Date \_\_\_\_\_ Other, if any, Involved in Plan Review/Update (Specify Title/Relationship to Resident) \_\_\_\_\_ Date \_\_\_\_\_

**NOTE:** Any time changes are made in the plan, the place where the change is made should be initialed and dated by the staff person making the change and by the resident/legal representative. In addition, the staff person and the resident/legal representative must sign in Part II above.

## INDIVIDUALIZED SERVICE PLAN

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

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

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

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

## INDIVIDUALIZED SERVICE PLAN

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

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

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

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