

STANDARDS FOR COMMUNITY LIVING CENTERS

1. SUMMARY OF MAJOR CHANGES: Major changes include:

a. Amendment dated January 29, 2024, includes:

(1) Clarification about a requirement that every Community Living Center (CLC) neighborhood participates in Process Improvement (PI) initiatives developed by the CLC QAPI Committee, as well as VA medical facility PI initiatives, when applicable (see paragraph 3).

(2) An addition of the Recreational Therapist or Creative Arts Therapist as a core member of the CLC Interdisciplinary Team rather than as additional ancillary staff (see paragraph 5).

b. Establishes responsibilities for the National Director, Facility-Based Care in Geriatrics and Extended Care; CLC Medical Director and the CLC Admissions Coordinator in paragraph 2.

c. Establishes and outlines the duties of the CLC Leadership Team and CLC Quality Assurance Performance Improvement (QAPI) Leadership Team in paragraph 3.

d. Explains the CLC delivery of care framework and outlines work, care and environmental practices to uphold the delivery of care framework in CLCs in paragraph 4.

e. Identifies core members and duties for CLC Interdisciplinary Teams in paragraph 5.

f. Outlines admission and discharge criteria to ensure consistency in the provision of care in CLCs in paragraph 6.

g. Outlines the Restorative Nursing Program component of CLCs in paragraph 9, defines restorative care in paragraph 14 and related responsibilities of the Restorative Care Coordinator in paragraph 2.

h. Describes the Resident Assessment Instrument/Minimum Data Set (RAI/MDS) used in CLCs in paragraph 8 and related responsibilities in paragraph 2.

i. Describes policy for granting authorized absences, passes and campus privileges for Veterans admitted to Department of Veterans Affairs (VA) CLCs for short-stay and for long-stay services in paragraph 7.

j. Changes the duration of short-stay services from 90 days to 100 days to align with Center for Medicare and Medicaid Services in paragraph 14.

2. RELATED ISSUES: VHA Directive 1140.11, Uniform Geriatrics and Extended Care Services in VA Medical Facilities, dated March 24, 2022; VHA Directive 1160.06, Uniform Mental Health Services in VHA Medical Points of Service, dated September 27, 2023 and VHA Directive 1170.03(1), Physical Medicine and Rehabilitation Service, dated November 5, 2019.

3. POLICY OWNER The Office of Geriatrics and Extended Care (12GEC) is responsible for the content of this directive. Questions may be addressed to the National Director, Facility-Based Care at vhagecfbc@va.gov.

4. RESCISSIONS: VHA Directive 1149, Criteria for Authorized Absence, Passes and Campus Privileges for Residents in VA Community Living Centers, dated June 1, 2017; VHA Handbook 1142.01, Criteria and Standards for Department of Veterans Affairs Community Living Centers (CLC), dated August 13, 2008; VHA Handbook 1142.02, Admissions Criteria, Service Codes and Discharge Criteria for Department of Veterans Affairs Community Living Centers, dated September 2, 2012; VHA Handbook 1142.03, Requirements for Use of the Resident Assessment Instrument (RAI) Minimum Data Set (MDS), dated January 4, 2013; VHA Memorandum 2022-11-05, Community Living Center Admission Practices (VIEWS 5778878), dated November 4, 2021; VHA Memorandum 2022-02-17, Community Living Centers Compliance with VHA Directive 1003.04, VHA Patient Advocacy (VIEWS 6876075), dated February 9, 2022; and VHA Memorandum 2022-05-09, Quality Assurance Performance Improvement in Community Living Centers (VIEWS 5913261), dated May 13, 2022, are rescinded.

5. RECERTIFICATION: This Veterans Health Administration (VHA) directive is scheduled for recertification on or before the last working day of October 2028. This VHA directive will continue to serve as national VHA policy until it is recertified or rescinded.

6. IMPLEMENTATION SCHEDULE: This directive is effective upon publication.

**BY DIRECTION OF THE OFFICE OF THE
UNDER SECRETARY FOR HEALTH:**

/s/ M. Christopher Saslo
DNS, ARNP-BC, FAANP
Assistant Under Secretary for Health
for Patient Care Services/CNO

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VHA DIRECTIVE 1142(1)

NOTE: *All references herein to VA and VHA documents incorporate by reference subsequent VA and VHA documents on the same or similar subject matter.*

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APPENDIX A

COMMUNITY LIVING CENTERS TREATING SPECIALTIESA-1

STANDARDS FOR COMMUNITY LIVING CENTERS

1. POLICY

It is Veterans Health Administration (VHA) policy that a standardized system of restorative, Veteran-centric care is implemented and maintained at all Department of Veterans Affairs (VA) Community Living Centers (CLCs) and is regularly evaluated for continuous process improvement in the delivery of care. **AUTHORITY:** 38 U.S.C. §§ 1710, 1710A, 1710B, 7301(b).

2. RESPONSIBILITIES

a. **Under Secretary for Health.** The Under Secretary for Health is responsible for ensuring overall VHA compliance with this directive.

b. **Assistant Under Secretary for Health for Patient Care Services/Chief Nursing Officer.** The Assistant Under Secretary for Health for Patient Care Services/Chief Nursing Officer (CNO) is responsible for:

(1) Supporting the Office of Geriatrics and Extended Care (GEC) with implementation and oversight of this directive.

(2) Approving decisions made by the Executive Director, GEC regarding requests from the National Director, Facility-Based Care (FBC), GEC to establish a new CLC, adjust bed numbers or close an existing CLC.

c. **Assistant Under Secretary for Health for Operations.** The Assistant Under Secretary for Health for Operations is responsible for:

(1) Communicating the contents of this directive to each of the Veterans Integrated Services Networks (VISNs).

(2) Assisting VISN Directors to resolve implementation and compliance challenges in all VA medical facilities within that VISN.

(3) Providing oversight of VISNs to ensure compliance with and effectiveness of this directive.

d. **Executive Director, Office of Geriatrics and Extended Care.** The Executive Director, GEC is responsible for:

(1) Developing national policy for CLC programs.

(2) Providing oversight for VISN and VA medical facility compliance with this directive and ensuring that corrective action is taken when non-compliance is identified.

(3) Collaborating with involved services and VHA program offices to develop ongoing CLC guidance as indicated.

(4) Reviewing and approving or denying requests from the National Director, FBC, GEC to establish a new CLC, adjust bed numbers or close an existing CLC in a particular area. **NOTE:** All decisions must also be approved by the Assistant Under Secretary for Patient Care Services.

e. **National Director, Facility-Based Care, Office of Geriatrics and Extended Care.** The National Director, FBC, GEC is responsible for:

(1) Coordinating with VA medical facility Directors, VISNs and the CLC Chief, GEC, to evaluate the need to establish a new CLC, adjust bed numbers or close an existing CLC in a particular area and communicating requests to the Executive Director, GEC, for approval or denial as outlined in paragraph 2.d.

(2) Promoting CLC development in VA medical facilities and VISNs through guidance, support, email groups, conference calls and educational programs.

(3) Approving any major renovation or construction of CLCs which must adhere to the Small House (SH) Model Design Guide available at <https://www.cfm.va.gov/til/dGuide.asp>.

(4) Collaborating with the VISN Rehabilitation and Extended Care (REC) Integrated Clinical Community (ICC) Lead to review Joint Patient Safety Reporting (JPSR) system data.

f. **Chief, Community Living Center, Office of Geriatrics and Extended Care.** The CLC Chief, GEC is responsible for:

(1) Providing operational and quality oversight of long-term care delivered in VA CLCs by reviewing data provided by CLCs (e.g., CLC Compare) and collaborating with the VISN Director to develop corrective action plans when necessary.

(2) Coordinating with VA medical facility Directors, VISNs and the National Director, FBC, to evaluate the need to establish a new CLC, adjust bed numbers or close an existing CLC in a particular area.

(3) Evaluating and ensuring appropriate bed utilization across VA CLCs.

(4) Maintaining communications and networking with CLC Leadership Teams through an interactive mail group and national monthly conference calls.

(5) Overseeing the CLC unannounced survey process.

g. **Veterans Integrated Service Network Director.** The VISN Director is responsible for:

(1) Ensuring that all VA medical facilities within the VISN comply with this directive and informing leadership when barriers to compliance are identified.

(2) Collaborating with the CLC Chief to develop corrective action plans when necessary.

(3) Ensuring that VA medical facility Directors appoint a CLC Medical Director (MD or DO) and an Associate Chief, Nursing Service (ACNS). **NOTE:** *If the CLC has less than 30 beds, a Nurse Leader can be appointed in lieu of an ACNS.*

(4) Ensuring that each CLC in the VISN has implemented a Quality Assurance Performance Improvement (QAPI) Committee and a Restorative Nursing Program. See paragraph 9 for additional information on Restorative Nursing Programs. **NOTE:** *Additional guidance regarding the QAPI Committee is available in the CLC QAPI Standard Operating Procedure (SOP), at:*

<https://dvagov.sharepoint.com/sites/vhacommunity-living-centers/Shared%20Documents/Forms/AllItems.aspx?id=%2Fsites%2Fvhacommunity%2Dliving%2Dcenters%2FShared%20Documents%2FCLC%20QAPI%20Training%20and%20Resources>. *This is an internal VA website that is not available to the public.*

(5) Appointing the VISN Resident Assessment Coordinator (RAC) Point of Contact (POC).

(6) Ensuring there is coordination between the VA medical facility Director, VISNs and GEC Program Office in evaluating the need to establish a new CLC, adjust bed numbers or close an existing CLC in a particular area.

h. Veterans Integrated Service Network Rehabilitation and Extended Care Integrated Clinical Community Lead. The VISN REC ICC Lead is responsible for:

(1) Acting as a liaison between VA medical facilities, CLCs and GEC Program Office.

(2) Collaborating with the CLC Leadership Team to determine the frequency of the Interim Quality Oversight Survey and develop, document and implement an Interim Quality Oversight Survey plan. Findings from the Interim Quality Oversight Survey must be shared with the CLC Leadership Team as outlined in paragraph 3. **NOTE:** *The Interim Quality Oversight Survey is an individualized process that VA medical facilities use to assess CLC unannounced survey readiness. Interim quality oversight can include record review, on-site or virtual. Record review includes but is not limited to medical record review, reviewing the accuracy of RAI/MDS documentation and review of quality metrics.*

(3) Uploading the interrater reliability quarterly summary report, provided by the CLC Nurse Leader or CLC-designated individual, to the GEC Program Office Action SharePoint Site, at:

<https://dvagov.sharepoint.com/sites/VACOVHADUSHOM/10NC/GEC>. **NOTE:** *This is an internal VA website that is not available to the public.*

(4) Collaborating with the National Director, FBC, GEC, to review JPSR system data.

i. **Veterans Integrated Service Network Resident Assessment Coordinator Point of Contact.** VISN RAC POC is responsible for:

- (1) Assisting with the orientation and education for all new RACs in CLCs.
- (2) Serving as the resource point of contact and assisting CLC RACs with troubleshooting issues with software, coding or scheduling.

j. **VA Medical Facility Director.** The VA medical facility Director is responsible for:

(1) Ensuring overall VA medical facility compliance with the directive and appropriate corrective action is taken if non-compliance is identified.

(1) Assigning a CLC Medical Director (MD or DO) and an ACNS. **NOTE:** *If the CLC has less than 30 beds, a Nurse Leader can be appointed in lieu of an ACNS.*

(2) Ensuring designated CLC beds are not used for observation care, temporary lodging (“Hoptel”) or other services not specifically designated as CLC beds without prior approval by GEC and submission of an appropriate bed request.

(3) Coordinating with VISNs the National Director, FBC and the CLC Chief to evaluate the need to establish a new CLC, adjust bed numbers or close an existing CLC in a particular area.

(4) Reviewing reports of CLC-specific process and quality improvement initiatives from the CLC QAPI Leadership Team and ensuring CLC QAPI initiatives are incorporated into the overall VA medical facility quality management (QM) plan. See paragraph 3 for additional information on CLC QAPI.

(5) Assigning a Quality Consultant to work with the CLC Leadership Team on CLC QAPI initiatives.

k. **Community Living Center Medical Director.** The CLC Medical Director is responsible for:

(1) Ensuring that all ethical and legal rights of CLC residents (also referred to as residents in this directive) and rights of families of residents, as it relates to the resident, are respected by CLC staff. including the right of residents to receive care that aligns with their values and goals, which includes the right to request that health care providers limit, withhold or withdraw treatments.

(2) Identifying resources that can assist in resolving health care ethics issues in conjunction with the VA medical facility Ethics Consultation Service and legal issues in conjunction with the appropriate Office of Chief Counsel in the District. **NOTE:** *A list of Offices of Chief Counsel in the Districts is available at: <https://www.va.gov/OGC/DistrictOffices.asp>.*

(3) In collaboration with the CLC Nurse Leader, overseeing the CLC admissions process and facilitating appropriate admissions into the CLC in accordance with paragraph 6. This includes, but is not limited to, ensuring the primary discharge destination and type of service needed are documented and TS codes are determined when the admission decision is made. For additional information on CLC TS, see Appendix A. **NOTE:** Residents are permitted to dispute discharge decisions. The CLC Medical Director must ensure that review and final determination of the dispute aligns with the clinical appeals process outlined in VHA Directive 1041, Appeal of Veterans Health Administration Clinical Decisions, dated September 28, 2020.

(4) Assisting with identification, evaluation and resolution of medical and clinical concerns and issues that:

(a) Affect resident care, medical care or quality of life; or

(b) Are related to the provision of services by physicians and other licensed health care providers.

(5) Ensuring CLCs implement and follow VHA Directive 1003.04, VHA Patient Advocacy, dated February 7, 2018, for documenting complaints and tracking and resolution within the Patient Advocate Tracking System. Additional information regarding is available at: <https://dvagov.sharepoint.com/sites/PATS-R554/SitePages/PATS-R.aspx>. **NOTE:** This is an internal VA website that is not available to the public.

(6) Organizing, coordinating and overseeing CLC provider services, including those of MDs, DOs, nurse practitioners, physician assistants and others.

(7) Participating in or designating a participant in interdisciplinary committees, meetings with CLC resident family members and similar activities as appropriate.

(8) Assisting health care providers and other staff to identify and access relevant geriatric expertise and educational resources.

(9) Ensuring all authorized absences, passes and campus privileges meet all requirements as outlined in paragraph 7.

(10) Participating in the CLC Leadership Team and ensuring all members of the Leadership Team are adhering to their duties as outlined in paragraph 3.

(11) Adhering to Centers for Medicare and Medicaid Services (CMS) standards for medical leadership and the role of the Medical Director in U.S. nursing homes. **NOTE:** See the CMS State Operations Manual at: <https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Internet-Only-Manuals-IOMs>.

I. **Community Living Center Nurse Leader.** The CLC Nurse Leader or equivalent (i.e., ACNS, Chief Nurse or Director of Clinical Services) is responsible for:

(1) Collaborating and coordinating with VA medical facility leadership to promote learning experiences and improve performance of nursing personnel in CLCs.

(2) Ensuring the CLC has a Restorative Nursing Program as described in paragraph 9 and overseeing the delivery of nursing care in the CLC, including the administrative management and leadership of nursing staff to create an environment that facilitates the delivery of restorative nursing care in CLCs while remaining resident-centered; see paragraph 4 for additional information on the CLC delivery of care framework. **NOTE:** *Every CLC must have a Restorative Nursing Program. The VA medical facility ACNS or Nurse Leader may delegate oversight of the Restorative Nursing Program to a CLC Nurse Manager.*

(3) Ensuring that standards of nursing professional practice, accrediting bodies and applicable law and policy are implemented throughout the CLC.

(4) Participating in the CLC Leadership Team and QAPI Leadership Team as outlined in paragraph 3.

(5) In collaboration with the CLC Medical Director, overseeing the CLC admissions process and facilitating appropriate admissions into the CLC in accordance with paragraph 6. This includes, but is not limited to, ensuring the primary discharge destination and type of service needed are documented and Treatment Specialty (TS) codes are determined when the admission decision is made. For additional information on CLC TS, see Appendix A. **NOTE:** *Residents are permitted to dispute discharge decisions. The CLC Medical Director must ensure that review and final determination of the dispute aligns with the clinical appeals process outlined in VHA Directive 1041.*

(6) Assisting with writing position descriptions and functional statements and identifying performance standards and competencies for CLC nursing staff across CLC TS.

(7) Ensuring that CLC staffing levels, assignments and clinical competencies are appropriate for the practice area.

(8) Ensuring the CLC has, at a minimum, one designated full-time RAC to function as the Facility Administrator of the RAI/MDS program and MDS software.

(9) Ensuring documentation completed by CLC nursing staff is standardized to meet regulatory requirements.

(10) Ensuring nursing documentation and VHA RAI/MDS requirements are completed and contain high-quality, comprehensive and concise resident-centered information. **NOTE:** *For more information on RAI/MDS requirements, see: <https://dva.gov.sharepoint.com/sites/vhacommunity-living-centers/RAIMDS>. CLC documentation guidelines are available at: <https://dva.gov.sharepoint.com/sites/vhacommunity-living-centers/Shared%20Documents/Forms/AllItems.aspx?csf=1&web=1&e=U4mEfx&cid=65a2414d%20Db7f9%20D4a6e%20Daccf%20D007bf3fa5d46&RootFolder=%2Fsites%2Fvhac>*

[ommunity%2Dliving%2Dcenters%2FShared%20Documents%2FCLC%20SOP%2FCLC%20SOP%27s%20for%201142&FolderCTID](#). These websites are internal VA website and are not available to the public.

(11) Ensuring that interrater reliability reviews are conducted at a minimum, quarterly, by the CLC Interdisciplinary Team members identified by the CLC RAC. **NOTE:** Interrater reliability reviews assess the accuracy of the RAI/MDS Assessment and report trends of errors identified. These reviews must include a representative sample of RAI/MDS Assessments that were completed in the quarter under review. The sample size is determined by the VISN REC ICC Lead.

(12) Ensuring that discrepancies in coding or documentation noted during the interrater reliability review are communicated to the CLC RAC, as well as the clinician responsible for the error.

(13) Ensuring the interrater reliability quarterly reports are reported to the CLC Leadership Team for development of corrective action. **NOTE:** The corrective action is provided on a summary report completed by the Nurse Leader or designee which is forwarded to the VISN REC ICC Lead who has the responsibility to upload the interrater reliability report to the GEC Program Office Action SharePoint Site at: <https://dvagov.sharepoint.com/sites/VACOVHADUSHOM/10NC/GEC>. This is an internal VA website that is not available to the public.

(14) Ensuring corrections are made immediately to RAI/MDS Assessments that have not been transmitted to the Austin Information Technology Center by the CLC RAC. **NOTE:** Corrections to transmitted assessments must be made as outlined in the RAI/MDS User's Manual available at: <https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/NursingHomeQualityInits/MDS30RAIManual>.

m. **Community Living Center Quality Consultant.** The Quality Consultant who works in conjunction with the CLC is responsible for:

(1) Providing expertise and knowledge of current Federal regulations and standards, quality assurance and performance improvement and for the annual unannounced survey process and Interim Quality Oversight Survey readiness for the CLC. **NOTE:** See paragraph 4.b. and <https://dvagov.sharepoint.com/sites/vhacommunity-living-centers/survey/SitePages/Unannounced-Survey-Homepage.aspx> for additional information on unannounced surveys. This is an internal VA website that is not available to the public.

(2) Assisting the CLC Leadership Team and VISN REC ICC Lead with developing and implementing an Interim Quality Oversight Survey plan, documenting Interim Quality Oversight Survey results and sharing findings with the CLC Leadership Team as outlined in paragraph 3. **NOTE:** See paragraph 4.b. and <https://dvagov.sharepoint.com/sites/vhacommunity-living-centers/survey/SitePages/Unannounced-Survey-Homepage.aspx> for additional

information on unannounced surveys. This is an internal VA website that is not available to the public.

(3) Assisting CLC staff with interpretation of and compliance with CMS and VHA standards and guidelines.

(4) Participating in the CLC Leadership Team and CLC QAPI Leadership Team as outlined in paragraph 3 in this directive.

n. **Community Living Center Resident Assessment Coordinator.** The CLC RAC is responsible for:

(1) Leading the CLC RAI/MDS program as outlined in paragraph 8, which includes serving as the Facility Administrator of the RAI/MDS program and MDS software and promoting the application of the RAI/MDS Assessment for resident care planning.

(2) Directing the RAI/MDS Nurse who is responsible for coding for nursing assigned sections and Care Area Assessments (CAAs). For further information regarding CAAs, see paragraph 10.

(3) Identifying CLC Interdisciplinary Team members to conduct the interrater reliability reviews, which must be conducted, at a minimum, quarterly.

(4) Collaborating with the ACNS or CLC Nurse Leader to support the CLC Interdisciplinary Team members conducting the interrater reliability review, at a minimum, quarterly, which assesses the accuracy of the RAI/MDS Assessment and reporting trends of errors identified.

(5) Completing the interrater reliability quarterly report and submitting it to the CLC Leadership Team. **NOTE:** *In the absence of a CLC MDS Nurse, the CLC RAC must document and take corrective action when notified by the CLC Nurse Leader of any discrepancies in coding or documentation during the interrater reliability review.*

(6) Transmitting RAI/MDS Assessments to the Austin Information Technology Center.

(7) Communicating CMS guidelines changes, educational sessions, MDS coding changes and RAI/MDS program updates to CLC staff and developing and implementing educational plans for CLC staff to ensure ongoing education for the completion of the RAI/MDS process and software.

(8) Ensuring, in accordance with current CMS and VHA requirements, completion of the RAI/MDS Assessment by the CLC Interdisciplinary Team and providing recommendations, developing and updating procedures related to the RAI/MDS process. **NOTE:** *Additional information on RAI/MDS Assessments is available at: <https://dvagov.sharepoint.com/sites/vhacommunity-living-centers/RAIMDS>. This is an internal VA website that is not available to the public.*

(9) Collaborating with the CLC MDS Nurse to educate CLC staff on the RAI/MDS process to ensure appropriate completion. This includes, but is not limited to, providing educational sessions related to RAI/MDS software, MDS coding changes and program updates as needed.

(10) Serving as an expert consultant in identifying quality of care deficiencies and assisting the CLC Quality Consultant with performance improvement projects related to QM and CLC Compare. See paragraph 8 for additional information regarding CLC Compare.

(11) Downloading, validating and distributing QM and Resource Utilization Group (RUG) reports and distributing them to the CLC Interdisciplinary Team and leadership. See paragraphs 8 and 14 for additional information on RUG reports.

(12) Assisting with continued survey readiness for the annual unannounced survey process and Interim Quality Oversight survey readiness for the CLC. **NOTE:** See <https://dvagov.sharepoint.com/sites/vhacommunity-living-centers/survey/SitePages/Unannounced-Survey-Homepage.aspx> for additional information on CLC survey readiness. *This is an internal VA website that is not available to the public.*

(13) Ensuring the CLC meets regulatory guidelines for scheduling quarterly and comprehensive MDS assessments as outlined in the MDS guidelines available at: <https://dvagov.sharepoint.com/sites/vhacommunity-living-centers/Shared%20Documents/Forms/AllItems.aspx?csf=1&web=1&e=U4mEfx&cid=65a2414d%2Db7f9%2D4a6e%2Daccf%2D007bf3fa5d46&RootFolder=%2Fsites%2Fvhacommunity%2Dliving%2Dcenters%2FShared%20Documents%2FCLC%20SOP%2FCLC%20SOP%27s%20for%201142&FolderCTID>. **NOTE:** *This is an internal VA website that is not available to the public.*

(14) Participating in the CLC Leadership Team as outlined in paragraph 3.

o. **Community Living Center Minimum Data Set Nurse.** **NOTE:** *The MDS assessment is an interdisciplinary tool intended for use by all CLC nursing staff providing care to CLC residents. The CLC MDS Nurse is responsible for:*

(1) Coding the sections of the RAI/MDS Assessments and CAAs that are assigned to nursing, adhering to current CMS and VHA timeframes of assessment completion. For further information regarding CAAs, see paragraph 10. **NOTE:** *Every CLC is encouraged to have a MDS Nurse(s) in a designated position for coding the assigned nursing sections in the RAI/MDS Assessment. A MDS Nurse in such a designated position is only responsible for the completion of assigned nursing sections in the RAI/MDS Assessment.*

(2) Participating in CLC Interdisciplinary Team care plan meetings and reviewing, communicating and monitoring the residents' care plan.

(3) Collaborating with the CLC RAC to educate CLC staff on the completion of the RAI/MDS process; this includes but is not limited to documentation requirements for accurate MDS data entry, educational sessions pertaining to RAI/MDS software and program updates as needed.

(4) Supporting quality improvement activities based on CLC QM data.

(5) Participating in ongoing survey readiness activities in the CLC.

(6) Documenting and taking corrective action when notified by the CLC Nurse Leader or designee of any discrepancies in coding or documentation of RAI/MDS Assessments and CAAs reported during the interrater reliability review. See paragraph 10 for additional information on RAI/MDS Assessments and CAAs.

p. **Community Living Center Admissions Coordinator.** The CLC Admissions Coordinator must be a Registered Nurse (RN) or Licensed Independent Practitioner. **NOTE:** *In the absence of a CLC Admissions Coordinator, the CLC Nurse Leader must designate an individual to complete the duties outlined below.* The CLC Admissions Coordinator is responsible for:

(1) Coordinating with the appropriate service line to ensure availability of the National Consult Tool for CLC admission applications.

(2) Supporting the CLC Medical Director and CLC Nurse Leader in assessing the availability of CLC beds, appropriateness of Veteran admission to the CLC or the need to refer the Veteran to home-based or community-based services for prospective CLC residents.

(3) Utilizing Bed Management System (BMS) Patient Pending Bed Placement for Veteran's denied admission due to no bed availability.

q. **Community Living Center Restorative Care Coordinator.** **NOTE:** *The CLC Restorative Care Coordinator (RCC) must be an RN.* The CLC RCC is responsible for:

(1) Evaluating restorative nursing interventions and making necessary changes to a residents' restorative nursing care plan based on significant changes to the residents' condition to ensure the best outcomes, maintain function and prevent decline of the resident. Restorative nursing interventions include, but are not limited to, bowel and bladder retraining, communication and cognition retraining and splint and brace assistance.

(2) Assisting the CLC Nurse Leader with facilitation of the Restorative Nursing Program. See paragraph 9 for additional information on Restorative Nursing Programs. This includes, but is not limited to:

(a) Conducting an initial Restorative Nursing Program Assessment for newly admitted CLC residents and developing an individualized restorative care plan for every CLC resident enrolled in the Restorative Nursing Program within 7 days of admission to

a CLC. **NOTE:** *The restorative care plan must be incorporated into the resident's comprehensive care plan and overall interdisciplinary care planning process.*

(b) Ensuring ongoing evaluation and documentation in the Electronic Health Record (EHR) of resident progress in the Restorative Nursing Program as outlined in paragraph 9. **NOTE:** *CLC residents concurrently enrolled in a Restorative Nursing Program must be reassessed by the CLC RCC at minimum, quarterly, or when there is a significant change in resident status.*

(c) Overseeing the implementation of Restorative Nursing Program services by trained restorative aides, restorative nursing staff or nursing staff trained in restorative care and communicating with the VA medical facility ACNS or CLC Nurse Leaders regarding staff performance within the Restorative Nursing Program.

(d) Coordinating nursing staff training and continuing education related to the Restorative Nursing Program.

3. COMMUNITY LIVING CENTER LEADERSHIP TEAM AND QUALITY ASSURANCE PERFORMANCE IMPROVEMENT LEADERSHIP TEAM

a. **Community Living Center Leadership Teams.** The CLC Leadership Team is an integral part of the interdisciplinary services provided at CLCs.

(1) Each VA medical facility CLC Leadership Team must meet, at a minimum, quarterly, and be comprised of the following:

(a) The CLC Medical Director.

(b) An ACNS, or CLC Nurse Leader for CLCs that have less than 30 beds.

(c) The CLC Quality Consultant.

(d) A CLC RAC.

(2) The CLC Leadership Team is structured to be collaborative and employ the specific skillset of each member while simultaneously having an equitable distribution of duties. For CLCs to provide adequate resident-centered care, the CLC Leadership Team must:

(a) Be actively engaged to unify the VA medical facility under the mission of person-centered care by facilitating successful negotiation of the interplay between the CLC and the VA medical facility rules and procedures that directly and indirectly affect the life and work experiences of residents and staff.

(b) Promote an organizational environment and leadership structure designed to embrace and support an interdisciplinary approach to person-centered care. This includes, but is not limited to:

1. Actively supporting and modelling cultural transformation. CLC leaders must recognize that a high-quality working environment is one of the most important facilitators of successful cultural transformation. Additional information can be found in paragraph 4.

2. Engaging in consistent efforts to improve the quality of staff working conditions, such as creating regular and impromptu opportunities for multidisciplinary staff to share and discuss resident issues and ideas for improving resident care.

3. Providing opportunities for all staff to engage as leaders and affect change.

4. Encouraging CLC staff to obtain specialty care certifications, in their care area or areas of specialty. Households are defined in paragraph 14 and additional information is available in the Small House (SH) Model Design Guide available at <https://www.cfm.va.gov/til/dGuide.asp>.

(3) Additionally, each CLC Leadership Team member must be a part of:

(a) Administrative decision making.

(b) Recommending and approving relevant CLC medical emergency equipment, medications and supplies.

(c) Supporting the Restorative Nursing Program; see paragraph 9 for additional information.

(d) Assisting with developing and writing VA medical facility procedures and processes required for or impacting the CLC.

(e) Developing corrective actions for the quarterly interrater reliability reviews that are received from CLC Nurse Leaders.

(f) Creating opportunities for professional development through self-directed and continuing education in topics relevant to the resident census in the CLC, regulatory environment, administration and clinical care for all CLC staff.

(g) Promoting the use of telehealth and other virtual technology to increase residents' choice and access to specialty or other health care providers.

(h) Collaborating with the Infection Prevention and Control team at the VA medical facility to ensure infection control practices are consistent with commonly accepted standards.

(i) Reviewing Joint Patient Safety Reporting at least monthly in collaboration with other CLC leaders or staff to identify trends and patterns that pose risks to resident or staff safety.

(j) Facilitating the successful negotiation of the interplay between the CLC and the VA medical facility rules and procedures that directly and indirectly affect the life and work experiences of residents and staff.

(k) Collaborating with the VISN REC ICC Lead to develop and implement an Interim Quality Oversight Survey plan, review survey documentation, assess findings and take corrective action. **NOTE:** For additional information on unannounced surveys, see paragraph 4.b. and <https://dvagov.sharepoint.com/sites/vhacommunity-living-centers/survey/SitePages/Unannounced-Survey-Homepage.aspx>. This is an internal VA website that is not available to the public.

(l) Reviewing the quarterly CLC Compare report and developing a plan to mitigate any issues found in the report; reporting findings and plan of correction to the CLC QAPI Committee. See paragraph 8 for additional information on CLC Compare. **NOTE:** Refer to <https://dvagov.sharepoint.com/sites/vhacommunity-living-centers> under the “Quick Links” heading for CLC Compare reports. This is an internal VA website that is not available to the public.

(m) Collaborating with the CLC Interdisciplinary Team and CLC residents to identify and provide activities considered to be meaningful use of time for residents.

(n) Being active members of the CLC QAPI Leadership Team. This includes, but is not limited to, the development and implementation of the CLC QAPI Committee and CLC QAPI action plans.

b. **CLC QAPI Leadership Team.** The CLC QAPI Leadership Team is an entity within the VA medical facility CLC QAPI Committee as required by the CLC QAPI SOP available at <https://dvagov.sharepoint.com/sites/vhacommunity-living-centers/Shared%20Documents/Forms/AllItems.aspx?id=%2Fsites%2Fvhacommunity%2Dliving%2Dcenters%2FShared%20Documents%2FCLC%20QAPI%20Training%20and%20Resources>. **NOTE:** This is an internal VA website that is not available to the public. CLC QAPI Leadership must report CLC-specific processes and quality improvement initiatives to the VA medical facility Director for incorporation into the VA medical facility’s overall QM plan; see paragraph 2.j. Every CLC neighborhood is required to participate in Process Improvement (PI) initiatives developed by the CLC QAPI Committee, as well as VA medical facility PI initiatives, when applicable. See paragraph 14 for additional information on CLC neighborhoods.

(1) The CLC QAPI Leadership Team must adhere to responsibilities outlined in the CLC QAPI SOP available at <https://dvagov.sharepoint.com/sites/vhacommunity-living-centers/Shared%20Documents/Forms/AllItems.aspx?id=%2Fsites%2Fvhacommunity%2Dliving%2Dcenters%2FShared%20Documents%2FCLC%20QAPI%20Training%20and%20Resources>. **NOTE:** This is an internal VA website that is not available to the public.

(2) The CLC QAPI Leadership Team must, at a minimum, include CLC Leadership Team members listed in paragraph 3.a.(1). The CLC QAPI Leadership Team oversees

the CLC QAPI Committee, is involved in developing and implementing process improvement initiatives developed by the CLC QAPI Committee and ensures CLC QAPI initiatives and assessments are reported to the VA medical facility Quality Committee.

(3) The CLC QAPI Leadership Team, in conjunction with the CLC QAPI Committee, must develop, implement and maintain the CLC QAPI program, which must include a written plan with performance-based outcomes for the CLC and strategies for maximizing residents' quality of life, quality of care and residents' choice. A member of the CLC QAPI Leadership Team leads the implementation of the CLC QAPI written plan. **NOTE:** For further details regarding QAPI plan elements, see the QAPI SOP at <https://dvagov.sharepoint.com/sites/vhacommunity-living-centers/Shared%20Documents/Forms/AllItems.aspx?id=%2Fsites%2Fvhacommunity%2Dliving%2Dcenters%2FShared%20Documents%2FCLC%20QAPI%20Training%20and%20Resources>. This is an internal VA website that is not available to the public.

4. COMMUNITY LIVING CENTERS DELIVERY OF CARE FRAMEWORK

a. The mission of CLCs is to restore the resident to the highest practicable level of well-being and maximum function and independence, while preventing a decline in health and providing comfort and dignity to all CLC residents.

b. The unannounced survey process that assesses CLC compliance with Federal regulations, follows CMS processes for surveying Long-Term Care (LTC) facilities (see CMS State Operations Manual, Appendix PP specific to requirements for State and LTC facilities; 42 C.F.R. part 483), and integrates applicable VHA regulations and procedures into the CMS survey process. The annual unannounced survey written reports reflect a CLC's integration of the Holistic Approach to Transformational Change (HATCh) model. The HATCh model, designed by CMS, is an approach to nursing home care that supports quality of life and quality of care.

c. The CLC delivery of care framework utilizes the HATCh model as a guide for resident-centered care and to employ cultural transformation in CLCs. Resident-centered care and cultural transformation are defined in paragraph 14 of this directive. The resident is at the center of the HATCh model. The HATCh model considers six inter-related domains that are necessary for a transformation from institutional to individualized care. VA CLCs emphasize the following inter-dependent domains from the HATCh model, as they have the largest impact on residents and staff:

(1) **Work Practices.** The routines, work processes, procedures and schedules in the CLC must revolve around the needs of the resident. The resident's stated preferences and needs are the foundation for making shared, informed decisions involving the resident, family or friends and CLC staff. Additional guidance can be found in "Resident-Centered Care: An Introduction to VA CLCs" available in the "Quick Links" section at: <https://dvagov.sharepoint.com/sites/vhacommunity-living-centers>. **NOTE:** This is an internal VA website that is not available to the public. The following examples of resident-centered work practices in CLCs are required practices across VA CLCs:

(a) Alterations in shifts and work schedules for all disciplines, the empowerment of direct care staff and no restriction on visiting hours.

(b) Direct care staff are consistently assigned to care for the same residents.

(c) All staff must be given opportunities to act as leaders. Nursing assistants must be involved in resident assessment and care planning meetings and decision making by making contributions to the discussions based on their personal knowledge and experience with the resident.

(2) **Care Practices.** CLC care practices must respect the resident and invite the resident to be an active participant in their own care. VA CLCs must provide a supportive, interdisciplinary care environment which engages employees in all aspects of decision-making and information sharing. Care practices must be team-based, not discipline-based and involve the resident and family to the extent possible and as needed. Additional guidance can be found in “Resident-Centered Care: An Introduction to VA CLCs” available in the “Quick Links” section at: <https://dvagov.sharepoint.com/sites/vhacommunity-living-centers>. **NOTE:** *This is an internal VA website that is not available to the public.*

(a) Care plans, processes and resident routines must be individualized to each resident and must meet the age-appropriate, cultural and religious needs and preferences of each resident to enhance quality of life for the resident. This includes, but is not limited to, assessment of resident priorities, preferred learning modalities and barriers to learning.

1. Respect, Dignity and Diversity. All CLC staff members must provide clinically appropriate, comprehensive, resident-centered care with respect and dignity to Lesbian, Gay, Bisexual, Transgender, Queer and other non-heteronormative identities (LGBTQ+) residents and their spouses, significant others and families.

2. Clinically appropriate care includes assessment of sexual health as indicated with all residents and attention to health disparities experienced by LGBTQ residents.

3. A resident’s gender identity must be respected and not be made contingent on whether the person has gone through particular medical interventions or a legal name change.

4. A resident’s sexual orientation or gender identity must be kept confidential. Disclosure of this information by CLC staff to other residents is prohibited without resident consent. CLCs must provide care for the resident that affirms their sexual orientation or gender identity.

5. Residents must be addressed based upon their self-identified gender identity; the use of resident’s preferred name and pronoun is required including in conversation and clinical notes, even when this is not their legal name.

6. CLCs must ensure that room assignments and access to facilities for which gender is a consideration (e.g., restrooms) give preference to self-identified gender, irrespective of appearance or surgical state.

(b) CLCs must, to the extent possible, creatively enhance dining practices, liberalize diets and allow resident choice in regard to activities of daily living (ADLs) and instrumental activities of daily living (IADLs). ADLs and IADLs are defined further in paragraph 14.

1. Upon admission to a CLC, CLC staff must consult with the resident on their preferences for ADLs and IADLs. CLC staff must use an interdisciplinary approach to incorporate opportunities for residents to practice and participate in ADLs and IADLs, which must be individualized to the needs and preferences of the resident and best prepare the resident for discharge into the community once goals of care have been achieved. In short-stay skilled nursing or rehabilitation focused settings, performance of these activities is critical to the discharge planning process. In long-stay settings participation to the level of a resident's maximal ability is an important aspect in quality of life, meaningful use of time, determining need for skilled rehabilitation services and planning recreation activities. **NOTE:** *Staff must encourage and assist all residents to be out of bed and out of their bedrooms for most of the day unless clinical status warrants bedrest or on an occasion when a resident prefers to remain in bed or stay in their bedroom all day. In these cases, staff must make every effort to encourage and assist residents out of their bedrooms for short periods of time each day.*

2. Speech-language pathologists must evaluate and treat residents with communication (speech, language and cognitive) disorders or dysphagia and swallowing disorders. Occupational therapists must be consulted for recommendations for ADL and IADL performance and provision of appropriate adaptive equipment and positioning devices; see VHA Directive 1171, Swallowing (Oropharyngeal Dysphagia) and Feeding Disorders, dated December 28, 2022, for additional guidance.

(c) CLCs must have a process for educating residents and family members, when applicable, on the rights and responsibilities of CLC residents; see <https://www.va.gov/health/rights/patientrights.asp> for additional information.

(d) CLC's must have integrated psychological services and access to psychopharmacological care.

(3) **Environment of Care.** CLC environment and practices must be designed to support the needs of the residents and must be flexible to meet residents' individual preferences. Enhancing the environment of CLCs to improve quality of life for residents is an important aspect of cultural transformation; additional guidance can be found in "Resident-Centered Care: An Introduction to VA CLCs" in the "Quick Links" section at: <https://dvagov.sharepoint.com/sites/vhacommunity-living-centers>. **NOTE:** *This is an internal VA website that is not available to the public.* Examples of a resident-centered environment of care include, but are not limited to:

(a) Residents having access to outdoor spaces, children and animals, as appropriate. Specific guidance related to animal-assisted activities and animal-assisted therapy in VA medical facilities is outlined in VHA Directive 1178(1), Animal-Assisted Activities and Animal-Assisted Therapy, dated September 14, 2018.

(b) Replacing nursing stations with communal spaces for residents and staff to interact with one another, when possible. Every CLC must have designated neighborhoods and if possible, create households. Neighborhoods and households are defined in paragraph 14. Additional information on neighborhoods and households is also available in the SH Model Design Guide available at <https://www.cfm.va.gov/til/dGuide.asp>.

(c) Adhering to the to the SH Model Design Guide available at <https://www.cfm.va.gov/til/dGuide.asp>. Architectural designs and furnishings must consider the unique needs of the populations served, including age and gender cohorts and cultural, regional, physical and psychosocial differences, which may vary depending on the Treatment Specialty (TS) and geographic location of the CLC. For additional information on TS, see Appendix A. **NOTE:** *All major renovation plans must be approved by the National Director, FBC, GEC prior to final design and construction.*

1. VA CLCs should have designated spaces for a living room, kitchen and bedroom to reflect a home atmosphere and greater attention to privacy and comfort.

2. The physical space of a CLC must give staff and residents cues on how to use and live in the CLC as a home rather than a hospital or acute care setting.

(4) **Family Involvement and Community Engagement.** A resident's family, which includes, but is not limited to, blood relatives, next-of-kin and friends, is a crucial aspect of resident-centered care that must be incorporated into the treatment of all residents at VA CLCs. Additionally, VA considers a Veteran or CLC resident's family to include anyone related to the Veteran or CLC resident in any way (e.g., biologically or legally) and anyone whom the Veteran or CLC resident considers to be family. LGBTQ+ families are included in this definition with VA recognizing family members that the Veteran identifies (e.g., partner; children), even without biologic or legal ties. Additional information on the Rights and Responsibilities of Family Members of VA Patients and Residents of CLCs is available at: <https://www.va.gov/health/rights/familyrights.asp>. VA CLCs must take the following measures to foster family and community involvement, to align with the resident's wishes:

(a) Encouraging the resident's family to be as closely involved in all activities and planning pertaining to the resident's quality of life and care plan as is appropriate, feasible and consistent with resident preferences. **NOTE:** *For the purposes of this directive, family is defined by the resident and CLC staff must make provisions for the active participation of individuals considered family by the resident. For example, the resident could consider a friend or neighbor to be their family.*

(b) Every VA CLC must have a Resident Council and hold regular meetings in accordance with local procedures. **NOTE:** *Resident Council meetings may serve a number of purposes that include information sharing, education, opportunities for support, discussion among family members and family involvement in social and or recreation activities with the resident, volunteers and staff. Additional information regarding CLC Resident Councils is in Resident Centered Care: An Introduction to VA Community Living Centers, available at: <https://dvagov.sharepoint.com/sites/vhacommunity-living-centers>. This is an internal VA website that is not available to the public.*

(c) CLCs must provide options to the resident to participate in a wide array of activities that are considered meaningful use of time for residents. These activities must, to the extent possible, be provided by different disciplines, in a team approach and on different days and times to give residents the choice to participate. CLC staff must involve residents in the identification of activities to be provided at the CLC when possible. **NOTE:** *Activities that are considered a meaningful use of time must be identified based on resident assessments completed by the CLC Interdisciplinary Team and CLC staff.*

(d) Specialized rehabilitative therapy (RT) treatment helps improve function and ability and the use of meaningful activities ensures life satisfaction, engagement and wellness for the residents.

5. COMMUNITY LIVING CENTER INTERDISCIPLINARY TEAMS

a. Every neighborhood within a VA CLC must have an Interdisciplinary Team. CLC Interdisciplinary Teams consist of both required, core Interdisciplinary Team members and ancillary team members. Neighborhoods are defined in paragraph 14; additional information on CLC neighborhoods is available in the SH Model Design Guide at <https://www.cfm.va.gov/til/dGuide.asp>.

b. The core CLC Interdisciplinary Team must consist of:

(1) The CLC Medical Director.

(2) A CLC RN that is not the CLC Nurse Leader.

(3) A CLC Psychologist, in alignment with VHA Directive 1160.01, Uniform Mental Health Services in VHA Medical Points of Service, dated September 27, 2023.

(4) A CLC Social Worker.

(5) A CLC Dietitian.

(6) A CLC Nursing Assistant.

(7) Recreational Therapist or Creative Arts Therapist.

c. The following CLC staff must participate in the CLC Interdisciplinary Team, but are not designated as core team members:

- (1) A CLC RAC.
- (2) A CLC MDS Nurse.

d. Additional ancillary staff participate in CLC Interdisciplinary Teams on an as-needed basis determined by the needs of the CLC residents and care plan. Ancillary staff includes but is not limited to a CLC RCC, clinical pharmacist, physical therapist, speech-language pathologist, occupational therapist, kinesiotherapist or chaplain service.

e. For CLCs to provide resident-centered care, all CLC Interdisciplinary Team members must work collaboratively to:

(1) Schedule routine treatment planning meetings when all core CLC Interdisciplinary Team members are able to participate. **NOTE:** *Each clinical discipline represented in the core CLC Interdisciplinary Team must be present for a treatment planning meeting to occur. Specific individuals within the core CLC Interdisciplinary Team are permitted to assign a CLC Interdisciplinary Team designee, who must be a clinician within the same discipline as the core Interdisciplinary Team member. This discipline-specific designee may attend treatment planning meetings when the original core CLC Interdisciplinary Team member is unavailable.*

(2) Create and revise every CLC resident's care plan throughout the resident's tenure at the CLC. The CLC Interdisciplinary Team must make every effort to involve the resident in developing and revising the care plan. See paragraph 10 for further information on the CLC care planning process. **NOTE:** *The resident's care plan must be reviewed after each MDS assessment as required by 42 C.F.R § 483.20. Every clinical discipline involved in a resident's care must be involved in developing and revising the care plan for that resident. The CLC Interdisciplinary Team must reassess the resident's care plan and adjust goals and interventions as clinically indicated when a resident is not progressing towards goals outlined in the care plan.* The CLC Interdisciplinary Team must include the following information in every resident's care plan:

- (a) The reasons for admission to the CLC.
- (b) The resident's personal preferences.
- (c) The services and interventions that are designed to help the resident achieve goals for care. Documentation of the Restorative Nursing care plans must be incorporated into the Comprehensive Care Plan for residents concurrently receiving restorative nursing care.
- (d) A plan for resident discharge to the next appropriate care setting, which includes home and community-based care. Residents receiving hospice care must be provided

support to include identifying preferences for death, burial and end-of-life decision making.

(3) Complete the RAI/MDS interdisciplinary process as outlined in paragraph 8, in accordance with current CMS and VHA requirements.

(4) Instruct and aid CLC residents in performance of self-care skills consistent with interventions outlined in the resident's care plan.

(5) Participate in QAPI program processes and conducting interrater reliability reviews. **NOTE:** *Interrater reliability reviews must be conducted at a minimum, quarterly.*

(6) Direct hospice and palliative care services for Veterans with terminal conditions that have become advanced, progressive or incurable and are expected to result in death within 6 months.

(7) Goals of care conversations must be conducted and LTC plans documented within 7 days of all CLC admissions for residents that meet high-risk criteria.).

(8) Collaborate with the CLC Leadership Team and CLC residents to identify and provide activities considered to be meaningful use of time for residents.

(9) Contact Spinal Cord Injury and Disorder (SCI/D) Centers for consultation for all residents with SCI/D in alignment with VHA Directive 1176(2), Spinal Cord Injuries and Disorders System of Care, dated September 30, 2019.

6. ADMISSION AND DISCHARGE CRITERIA

a. The CLC Medical Director in collaboration with the Nurse Leader oversees the CLC admissions process as stated in paragraph 2.k. of this directive to make final determinations on CLC applications for admission. See paragraphs 2.n. and paragraph 5 for additional information.

b. **CLC Eligibility Guidelines.** CLCs must provide care to eligible Veterans as outlined in VHA Directive 1601A.02(4), Eligibility Determination, dated July 6, 2020. Additional eligibility requirements for CLC admission are:

(1) The prospective resident is enrolled in the VA health care system.

(2) The provision of care and treatment needed by the resident can be provided by the CLC. Either the service must already be common practice in the CLC, or training must be provided to ensure staff has the necessary competencies and does not compromise Veteran safety. **NOTE:** *A CLC may deny admission to a Veteran if it is determined by the CLC Nurse Leader that staff competencies at the CLC do not meet the needs of the prospective resident.*

(3) The Veteran must be medically and psychiatrically stable.

(4) The CLC Admissions Coordinator or CLC-designated equivalent reviews the CLC admissions application using the National Consult Tool in the EHR and makes an initial determination of Veteran appropriateness for admission to the CLC. The following information must be obtained to determine the Veteran's appropriateness for CLC admission and identification of appropriate TS as outlined in Appendix A, should the Veteran be admitted to a CLC:

1. Reason for admission and services needed.
2. Expected duration of CLC residency.
3. Veteran discharge goals.

c. Admissions Application Review and Final Admissions Determination.

(1) If the Veteran is considered appropriate for CLC admission as determined by the CLC Admissions Coordinator, the CLC admissions application is reviewed by the CLC Interdisciplinary Team for review and final determination of Veteran admission to the CLC.

(2) Upon admission to a CLC, the following must occur concurrently:

(a) TS are reviewed and the appropriate TS must be assigned to the Veteran in the EHR. See Appendix A for a list of TS provided at VA CLCs.

(b) The newly admitted CLC resident undergoes an RAI/MDS Assessment as outlined in paragraph 8. The CLC Interdisciplinary Team develops care plans for the resident based on results from the RAI/MDS and CAA as outlined in paragraph 10.

(c) The CLC RCC conducts a Restorative Nursing Program assessment as outlined in paragraph 9 and determines resident appropriateness for enrollment in the CLC Restorative Nursing Program.

d. Admission Considerations for Special Circumstances. The following circumstances of Veteran admission to a CLC have additional admissions qualifications:

(1) Veterans admitted directly to a CLC from a Patient Aligned Care Team (PACT), Geri-PACT, Community-Based Outpatient Clinic, Home-Based Primary Care or community care setting must already be known to the CLC providers or CLC Interdisciplinary Team or the Veteran has been previously assessed within the past 30 days and approved for admission by a CLC Admissions Coordinator and CLC Interdisciplinary Team.

(2) Veterans must not be admitted directly to a CLC from the Emergency Department (ED) except for those who are designated as receiving or needing hospice services.

(3) Veterans admitted directly to CLC hospice services from community hospice care through the VA medical facility ED must already be known to the CLC providers or the Hospice and Palliative Care Team or the Veteran was evaluated in the ED by the CLC or Hospice and Palliative Care Team and deemed appropriate for admission to the CLC. The CLC must be able to provide and safely care for the resident.

e. **Admissions Outside Normal Working Hours.** *NOTE: Admission of a Veteran into a CLC outside of normal working hours must be made when it is least disruptive to the Veteran.* CLCs are permitted to admit Veterans outside of normal working hours on a case-by-case basis only if the resident meets the eligibility criteria outlined in paragraph 6.b., above, and if the following requirements have been met:

(1) The CLC Admission Coordinator must evaluate the Veteran for appropriateness of admission and determine that the CLC has the nursing, clinical resources (including, but not limited to, pharmacy services and equipment) and provision of care competencies to accept the admission outside of normal working hours. *NOTE: Depending on the reason for admission and needs of the Veteran, relevant CLC Interdisciplinary Team members must be available or on call.*

(2) A CLC medical health care provider is readily available to receive CLC residents outside of normal working hours.

(3) The CLC must have a written admission order specifically for CLC admission occurring outside of normal working hours. *NOTE: Due to the variation in services provided by CLCs and resident demographics, written admissions orders for CLC admissions outside of normal working hours will vary from CLC to CLC.*

(4) The CLC has the nursing competencies and infrastructure including pharmacy services, equipment and other resources to serve the Veteran.

f. **Changes in Service Needs After Admission.** When there are changes in service needs after CLC admission, the MDS and Resource Utilization Group (RUG) must be updated to reflect these changes and additional therapies ordered. CLCs must have a process to ensure orders are not discontinued when residents are transferred to a different CLC TS. Examples in which changes in service needs after admission occur include, but are not limited to:

(1) A resident is initially admitted for long-stay continuing care and develops a need for rehabilitation services or short-term skilled nursing.

(2) A resident requires multiple services and has reached the TS goals to meet the resident's highest level of primary needs. For example, a resident with both rehabilitation and skilled care needs is initially admitted to rehabilitation services. Upon completion of rehabilitation goals, the resident will require a change in service needs to be admitted to skilled care services.

g. **Discharge Criteria.** Discharge to the least restrictive environment is the goal in the CLC. Each resident must have either a defined discharge destination to prepare the

resident for living in an appropriate community setting or a plan for long-stay continuing care in the CLC. A resident may be discharged from the CLC when:

(1) The resident has met treatment goals, no longer requires skilled level of care and is sufficiently independent in functional status for discharge to the community setting.

(2) The CLC can no longer accommodate the resident due to change in service needs.

(3) The resident shows flagrant disregard for the procedures or rules of resident conduct of the VA medical facility after being appropriately advised of such procedures and rules. Consultations with the VA medical facility Ethics Consultation Service should be requested when necessary. If the resident has continuing medical needs, the VA medical facility must transfer the resident to an appropriate alternative site of care in accordance with VHA Directive 1094, Inter-Facility Transfer Policy, dated January 11, 2017.

(4) A Veteran described in 38 U.S.C. § 1710A(a) who continues to need nursing home care must not, after placement in a CLC, be transferred from the facility without the consent of the Veteran, or in the event the Veteran cannot provide informed consent, the representative of the Veteran. Long-stay residents may be discharged if the resident no longer requires CLC or nursing home level of care.

(5) Discharge decisions may be disputed by the resident; review and final determination of the dispute must be in alignment with the clinical appeals process outlined in VHA Directive 1041.

h. Re-Admission of a Recently Discharged Veteran from a VA Community Living Center. For residents discharged from the CLC to a different level of care that are readmitted to the CLC within 30 days for the same or a related problem:

(1) The CLC health care provider must conduct an interval physical exam reflecting any changes to the resident's health since initial discharge, provided the physical exam information from the residents most recent CLC admissions assessment is readily available in the residents' EHR.

(2) A new comprehensive admission assessment is not required for a resident discharged from the CLC to a different level of care that is readmitted to the CLC within 30 days for the same or a related problem, unless there is evidence of significant change in circumstances from the original comprehensive admission assessment.

(3) For residents discharged from the CLC to a different level of care that are readmitted to the CLC within 30 days for the same or a related problem, whose readmission was not anticipated, RAI/MDS instructions must be followed for MDS completion. For residents discharged from the CLC to a different level of care that are readmitted to a VA medical facility or ED, the CLC is not required to complete a new RAI/MDS Assessment.

7. PASSES AND ABSENCES

The CLC Medical Director, as outlined in paragraph 2.k., must ensure that authorized passes and absences administered to CLC residents meet the following requirements:

a. All authorized absences, passes and campus privileges must have accompanying health care provider orders and documentation specifying details and therapeutic indication documented in individualized care plans. Authorized passes and absences are defined in paragraph 14.

b. Authorized absences and passes for CLC residents receiving short-stay services are only permitted when therapeutically indicated or considered necessary for personal business. Authorized absences for CLC residents receiving short-stay services must be limited to 3 days.

c. Authorized absences and passes for CLC residents receiving long-stay services must be limited to 15 days per calendar year.

d. All determination of use, frequency and extension of authorized absences and passes are restricted or allowed, only after careful evaluation of the resident's ability to function safely when unattended by CLC staff and in a less restrictive community. CLC residents frequently utilizing authorized passes or extended authorized absences must be evaluated to receive care in a less restrictive community care setting.

8. RESIDENT ASSESSMENT INSTRUMENT MINIMUM DATA SET

a. The RAI/MDS is a standardized assessment and treatment planning instrument established by CMS. VA uses this standardized assessment and treatment instrument for its CLC program to ensure consistency with national nursing home standards and to facilitate comparisons between VA CLCs and nursing homes in the community or private sector.

b. The RAI/MDS assigns each resident to a RUG and case mix. RUGs identify CLC residents' treatment needs and the resources required to provide that care. RUGs are used in the nurse staffing methodology to determine the amount and type of nursing staff necessary to provide the appropriate level of care. RUGs and Bed Days of Care are the basis for Veterans Equitable Resource Allocation classification in VA CLCs. Case mix is a weighted average of RUGs in a neighborhood or in the CLC. Neighborhoods are defined in paragraph 14 of this directive and additional information is available in the SH Model Design Guide at <https://www.cfm.va.gov/ti/dGuide.asp>.

c. The RAI/MDS is an interdisciplinary process. MDS assessments may only be completed by health care providers serving residents in the CLCs. Completion of the entire RAI/MDS Assessment is not meant to be assigned to any single discipline. Coding of the RAI/MDS Assessment results must be completed as outlined in paragraph 2.o.

d. The MDS-based QMs are a data source to identify potential care problems in the CLC and to provide the CLC with performance measures required for VHA quality improvement activities. The QMs are used for monitoring VA CLC quality of care at the VA medical facility, VISN and national levels. In addition, QMs are utilized in the CLC Compare Tool. CLC Compare is an external benchmarking system that uses CMS comparative data and methods to compare CLC performance against that of for-profit nursing homes. CLC Compare provides nursing home consumers and other stakeholders a tool to understanding the quality of care provided in the CLCs. **NOTE:** *CLCs are subject to the laws and policies governing nursing home care in VA CLCs (see 38 U.S.C. §§ 101(28), 1710, 1710A and 1710B).*

e. The national software package has a care-planning component that builds from the RAI/MDS, which VA medical facility staff can adapt to VA's interdisciplinary care-planning processes. The Care Plan library is a part of the national software package and must be edited at the VA medical facility level to enhance individualization of the care plans.

9. RESTORATIVE NURSING

The Restorative Nursing Program incorporates goal-directed nursing techniques and care to promote the resident's ability to adapt and adjust to living as independently and safely as possible. Restorative care is a critical component of the nursing care provided in every CLC. Each CLC selects its own guides for education, implementation and maintenance of restorative care nursing practice. **NOTE:** *The Restorative Nursing SOP is available at: <https://dvagov.sharepoint.com/sites/vhacommunity-living-centers/Shared%20Documents/Forms/AllItems.aspx?csf=1&web=1&e=U4mEfx&cid=65a2414d%2Db7f9%2D4a6e%2Daccf%2D007bf3fa5d46&RootFolder=%2Fsites%2Fvhacommunity%2Dliving%2Dcenters%2FShared%20Documents%2FCLC%20SOP%2FCLC%20SOP%27s%20for%201142>. This is an internal VA website that is not available to the public.*

a. Restorative Nursing Program Assessment.

(1) The CLC Resident Care Coordinator (RCC) must assesses each resident for restorative nursing needs and appropriateness for participation in a Restorative Nursing Program within 7 days of admission.

(2) CLC residents concurrently enrolled in a Restorative Nursing Program must be re-assessed by the CLC RCC at a minimum, quarterly, when there is a significant change in status or upon recommendation from a therapy service.

(a) Restorative nursing does not require a physician's order.

(b) Trained restorative aides, nurses trained in restorative care or restorative nursing staff implement the Restorative Nursing Program. Restorative nursing staff providing the care must document interventions in the resident's EHR.

(3) For residents enrolled in Restorative Nursing Program(s):

(a) An individualized Restorative Nursing care plan must be developed to identify the problem or need, approaches to care and measurable objectives and goals for the CLC resident. The Restorative Nursing care plan must be incorporated into the Comprehensive Care Plan developed by the CLC Interdisciplinary Team and communicated to nursing and interdisciplinary staff members.

(b) For residents not progressing toward restorative goals, the CLC Interdisciplinary Team must reassess the resident care plan or adjusts goals and interventions as clinically indicated.

b. Criteria for Change in Restorative Care Plan.

(1) Resident is exceeding initial goal (e.g., ambulation distance or endurance is increasing).

(2) Resident is unable to physically perform current program and requires modification to interventions or goals.

c. Criteria for Discontinuing a Restorative Nursing Program.

(1) Resident is unable to physically perform the current program.

(2) Resident refuses to participate or perform the current program.

(3) Resident's medical condition indicates they are no longer able to perform the current program.

(4) Resident achieves independence or no longer needs a restorative program to maintain the ability to function safely.

(5) Attempts to modify the resident's program are unsuccessful.

10. CARE PLANNING

a. **Care Area Assessments.** The resident's care plan is based on the MDS assessment and identification of resident problems through the Care Area Assessments (CAA) process. The CAA identifies actual and potential problems which require designated interdisciplinary involvement in order to develop a person-centered care plan for residents admitted to the CLC. It is important that all CLC staff, disciplines, resident and designated resident representative participate in the resident's care-planning process. CAAs are part of the RAI/MDS Assessment requirements; access to and completion of CAAs is triggered by completion of the RAI/MDS Assessment.

b. **Baseline Care Plan.** The CLC must develop and implement a Baseline Care Plan for the resident within 48 hours of CLC admission that includes the instructions needed to provide effective and person-centered care of the resident that meets professional standards of care (42 C.F.R. § 483.21(a)). **NOTE:** *Additional guidance for creating a Baseline Care Plan is located in the documents folder at:*

<https://dvagov.sharepoint.com/sites/vhacommunity-living-centers/RAIMDS>. This is an internal VA website that is not available to the public

(1) The Baseline Care Plan must address resident-specific health and safety concerns to prevent decline or injury and identify needs for supervision, behavioral interventions and assistance with ADLs, as necessary.

(2) A Baseline Care Plan summary must be provided to the resident or the representative within 48 hours of admission to the CLC. In instances where the resident is incapable of participating in the care planning process, the resident representative must be provided the opportunity to receive a copy of the Baseline Care Plan. The Baseline Care Plan summary must include:

(a) Initial goals for the resident.

(b) A list of current medications and dietary instructions.

(c) Services and treatments to be administered by the VA medical facility and personnel acting on the behalf of the VA medical facility.

c. Comprehensive Care Plan.

(1) The resident's Comprehensive Care Plan must be developed by the CLC Interdisciplinary Team within 7 days of the initial RAI/MDS Assessment and CAA for a newly admitted CLC resident. The Comprehensive Care Plan must be reviewed after each MDS assessment as required by 42 C.F.R. § 483.20.

(2) Comprehensive Care Plans must be revised based on the changing goals, preferences and needs of the resident and results of services and treatments included in the Baseline Care Plan. **NOTE:** *The Discharge portion of the Comprehensive Care Plan should only be updated when the discharge plan for the resident changes.*

(3) For residents concurrently enrolled in a Restorative Nursing Program, the Comprehensive Care Plan must include the Restorative Nursing care plan developed by the CLC RCC.

d. Hospice Care Plan.

(1) Hospice and palliative care services are directed by the CLC Interdisciplinary Team. CLCs must have clinicians and staff trained in end-of-life care.

(2) Goals of care must be discussed following a hospice admission and after each illness or transition and must be documented in the resident's medical record per VHA Handbook 1004.03(3), Life-Sustaining Treatment Decisions: Eliciting Documenting and Honoring Patients' Values, Goals and Preferences, dated January 11, 2017. The resident's values, goals and preferences for care, including decisions regarding palliative care and end-of-life care, must be identified in these discussions. Life-

sustaining treatment plans must be completed within 7 days of admission as outlined in VHA Handbook 1004.03(3).

(3) CLCs are strongly encouraged to have bereavement activities and resources readily available for residents' families and staff. Examples include, but are not limited to, opportunities and rituals for remembrance and mourning of the resident, affording everyone a tangible space for paying respects. Institute practices that serve as a respectful way to mark the passing of a resident, rather than having fellow residents, staff and visitors being greeted with an empty bed. Chaplain Services, Social Workers and Mental Health providers can assist in facilitating activities.

11. TRAINING

There are no formal training requirements associated with this directive.

12. RECORDS MANAGEMENT

All records regardless of format (e.g., paper, electronic, electronic systems) created by this directive shall be managed per the National Archives and Records Administration (NARA) approved records schedules found in VHA Records Control Schedule 10-1. Questions regarding any aspect of records management should be addressed to the appropriate Records Officer.

13. BACKGROUND

a. VA-owned and operated nursing homes are referred to as CLCs. CLCs provide resident-centered geriatrics and extended care services to Veterans in residential settings with the purpose of restoring residents to the highest practicable level of well-being, maximizing function and independence, preventing declines in health and providing comfort at the end-of-life. Each CLC is unique in the services provided; not every CLC provides every service. CLCs may provide a variety of specialty programs for Veterans needing short and long-stay services; TS that may be provided are listed in Appendix A. CLCs are structured to resemble a home environment as much as possible as outlined in paragraph 4.

b. Resident-centered care is a component of VA's efforts to transform the delivery of health care to Veterans from the traditional model of health care to a personalized, proactive and patient-driven model of care. Personalizing the delivery of care also transforms the culture of nursing home care and requires that health care providers, CLC leadership and VA medical facility leadership deinstitutionalize care, workplace practices and the environment of care itself. Culture transformation refers to the change that nursing homes are making from a medical model of care to a resident-centered model of care. Culture transformation emphasizes resident participation in decisions about their care and routines; the facility environment, policies and practices are designed to support the needs of the resident and are flexible to meet the resident's individual preference. This directive highlights VA's core values of I CARE (Integrity, Commitment, Advocacy, Respect and Excellence) and its other initiatives to provide Veteran-centered care. The I CARE core values are available at:

<https://www.va.gov/icare/>. See paragraph 4 for additional information on the delivery of care framework in CLCs. **NOTE:** *It is important that the VA CLC Program is able to provide a broad range of services needed by Veterans. If the CLC is unable to provide a particular service, it is advisable that the VA medical facility arrange for the service to be provided elsewhere in the VA system or in the community as authorized under 38 U.S.C. § 1720. Not every CLC will be able to provide the entire array of CLC services. For legal purposes, CLCs are subject to the laws and policies governing nursing home care in VA nursing homes as outlined in paragraph 1.*

14. DEFINITIONS

a. **Activities of Daily Living.** ADLs are specific personal care activities or tasks required for daily maintenance and sustenance. Residents may require the assistance of others to complete these essential activities. ADLs include, but are not limited to, activities such as grooming, bathing, dressing, personal hygiene, toileting, eating and mobility.

b. **Authorized Absences.** Authorized absences are resident absences from a CLC for therapeutic reasons for greater than 24 hours. Authorized absences for each CLC resident are determined by the CLC Interdisciplinary Team.

c. **Authorized Passes.** Authorized passes are formal permissions granted to CLC residents to leave the CLC and VA campus for less than 24 hours, including one overnight. Authorized passes for each CLC resident are determined by the CLC Interdisciplinary Team.

d. **Family.** Family includes next-of-kin and close friends, as defined in 38 C.F.R. § 17.32. Family as defined by the resident and the CLC must honor the resident's choices.

(1) **Close Friend.** A close friend is any person (18 years of age or older) who has shown care and concern for the resident's welfare and is familiar with the resident's activities, health, religious beliefs and values. This may include, but is not limited to, the resident's significant other(s).

(2) **Next-of-Kin.** Next-of-kin is a relative (18 years of age or older) of the resident who may act as a surrogate in the following order of priority: spouse, child, parent, sibling, grandparent, grandchild.

e. **Hospice.** Hospice is a mode of palliative care for those residents diagnosed with a known terminal condition who are expected to live less than 6 months and no longer seek aggressive and curative care.

f. **Household.** Household, for the purposes of this directive, is based on the "household model" of nursing home care and refers to a long-term nursing facility in which care is organized around a kitchen and great room that services 10 to 12 residents. Additional information on CLC neighborhoods is available in the SH Model Design Guide at <https://www.cfm.va.gov/til/dGuide.asp>.

g. **Instrumental Activities of Daily Living.** IADLs are complex activities or tasks that a person does to maintain independence in the home and community. IADLs include, but are not limited to, activities such as: cooking, laundry, shopping, management of finances, making and keeping appointments, answering the telephone and planning activities.

h. **Long-stay Services.** Long-stay services are those where, on admission, the Veteran's expected length of stay is greater than 100 days.

i. **Neighborhood.** For the purposes of this directive, neighborhood refers to a grouping of three households within a CLC. Additional information on CLC neighborhoods is available in the SH Model Design Guide at <https://www.cfm.va.gov/til/dGuide.asp>.

j. **Palliative Care.** Palliative care includes hospice care and other care that emphasizes symptom control. It does not necessarily require the presence of an imminently terminal condition, a time-limited prognosis or exclusion of all aggressive or curative therapies. Palliative care aims to relieve symptoms and may include both comfort measures and curative interventions.

k. **Quality Measures.** QMs are tools that help measure or quantify health care processes, outcomes, resident perceptions, organizational structure or systems that are associated with the ability to provide high-quality health care or that relate to one or more quality goals for health care.

l. **Resident.** A resident is a Veteran residing in the CLC.

m. **Resident Assessment Instrument/Minimum Data Set.** The RAI/MDS is a standardized assessment and treatment planning instrument established by CMS designed to identify the functional and health care needs of the residents and to help develop a care plan where services are individualized. **NOTE:** *VA is not required to follow CMS standards but has voluntarily chosen to operate consistent with those CMS standards.*

n. **Resident-Centered Care.** Resident-centered care is an approach to care whereby the treatment plan reflects the specific needs of the resident (i.e., Veteran) and decisions are driven by the wishes, preferences and lifelong habits of the resident. Resident-centered care is individualized to each resident and the resident is a participant in their own care in whatever way is possible. Attention is paid to ensure that care meets the age-appropriate, gender-appropriate, cultural, social and religious needs and preferences of each Veteran.

o. **Resource Utilization Group.** RUG is a category-based classification system in which nursing facility residents classify into one of 66 RUG-IV groups. Residents in each group utilize similar quantities and patterns of resources. Assignment of a resident to a RUG-IV group is based on certain item responses on the MDS 3.0.

p. **Short-stay Services.** Short-stay services are those where, on admission, the

Veteran's expected length of stay in the CLC is 100 days or less.

15. REFERENCES

- a. 38 U.S.C. §§ 101(28), 1710, 1710A, 1710B, 1720, 7301(b).
- b. 38 C.F.R. § 17.32.
- c. 42 C.F.R. part 483.
- d. VHA Directive 1003.04, VHA Patient Advocacy, dated February 7, 2018.
- e. VHA Directive 1041, Appeal of Veterans Health Administration Clinical Decisions, dated September 28, 2020.
- f. VHA Directive 1094, Inter-Facility Transfer Policy, dated January 11, 2017.
- g. VHA Directive 1160.01, Uniform Mental Health Services in VHA Medical Points of Service, dated September 27, 2023.
- h. VHA Directive 1171, Swallowing (Oropharyngeal Dysphagia) and Feeding Disorders, dated December 28, 2022.
- i. VHA Directive 1176(2), Spinal Cord Injuries and Disorders System of Care, dated September 30, 2019.
- j. VHA Directive 1601A.02(4), Eligibility Determination, dated July 6, 2020.
- k. VHA Handbook 1004.03(3), Life-Sustaining Treatment Decisions: Eliciting Documenting and Honoring Patients' Values, Goals and Preferences, dated January 11, 2017.
- l. CLC Quality Assurance Performance Improvement (SOP-GEC-FBC-CLC-02), dated May 12, 2022. <https://dvagov.sharepoint.com/sites/vhacommunity-living-centers>. **NOTE:** This is an internal VA website that is not available to the public.
- m. VA CLC SharePoint website and related content (e.g., HATCh Model Overview; HATCh Model Fact Sheet, Unannounced Surveys, RAI/MDS Guidance, Baseline Care Plan Guidance, CLC SOPs and Resident-Centered Care: An Introduction to VA Community Living Centers). <https://dvagov.sharepoint.com/sites/vhacommunity-living-centers>. **NOTE:** This is an internal VA website that is not available to the public.
- n. VA I CARE Core Values. <https://www.va.gov/icare/>.
- o. VA Office of Construction & Facilities Management. Small House Model Design Guide. <https://www.cfm.va.gov/til/dGuide.asp>.
- p. VA Offices of Chief Counsel in the Districts. <https://www.va.gov/OGC/DistrictOffices.asp>.

q. VA Patient Advocacy Tracking System Replacement (PATS-R) Homepage. <https://dvagov.sharepoint.com/sites/PATS-R554/SitePages/PATS-R.aspx>. **NOTE:** *This is an internal VA website that is not available to the public.*

r. VA SCI/D Services Intranet. <http://vaww.sci.va.gov>. **NOTE:** *This is an internal VA website that is not available to the public.*

s. VHA GEC SharePoint website. <https://dvagov.sharepoint.com/sites/VACOVHADUSHOM/10NC/GEC>. **NOTE:** *This is an internal VA website that is not available to the public. Individuals must request access.*

t. VHA Rights and Responsibilities of Family Members of VA Patients and Residents of CLCs. <https://www.va.gov/health/rights/familyrights.asp>.

u. VHA Rights and Responsibilities of VA Patients and Residents of CLCs. <https://www.va.gov/health/rights/patientrights.asp>.

v. CMS RAI/MDS User's Manual: <https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/NursingHomeQualityInits/MDS30RAIManual>.

w. CMS State Operations Manual: <https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Internet-Only-Manuals-IOMs>.

COMMUNITY LIVING CENTERS TREATING SPECIALTIES

The following treating specialties (TS) are services provided to residents across Department of Veterans Affairs (VA) Community Living Centers (CLCs). Short-stay and long-stay services are defined in paragraph 14 in the body of this directive. The TS must be included in the Electronic Health Record for all CLC residents.

The primary resources for care include activities such as rehabilitative therapy (RT), social work, nursing, and psychology or psychiatry. Veterans receiving this level of care may benefit from supportive or episodic rehabilitation, as indicated, with at least one therapy intervention such as physical therapy, occupational therapy, kinesiotherapy and speech-language pathology based on identified needs. Mental health providers (psychology and psychiatry) must also be available and part of the overall interdisciplinary care team to help address challenging dementia-related behaviors and other mental health issues that may arise in Veterans cared for in this setting. The focus of care and therapy needs to include activities that enhance physical strength and mobility and promote maximal psychological functioning to allow the Veteran to maintain the highest practicable level of well-being and overall function.

1. SHORT-STAY REHABILITATION

CLCs providing short-stay rehabilitation services provide care in a home environment to enhance preparation for discharge and ready the resident to function in a non-institutional setting. Short-stay rehabilitation provides time-limited, goal-directed care for the purpose of returning the Veteran to functioning as independently as possible. Services are rendered and goals achieved by an interdisciplinary effort to improve function.

2. SHORT-STAY SKILLED NURSING

CLCs providing short-stay skilled nursing care provide care in a home environment to enhance preparation for discharge and ready the resident to function in a non-institutional setting. Short-stay skilled nursing care services are limited to CLC residents with specific conditions or interventions that require daily assistance from a Registered Nurse or a licensed nurse (Licensed Practical Nurse or Licensed Vocational Nurse).

3. SHORT-STAY GERIATRICS EVALUATION AND MANAGEMENT PROGRAM

CLCs with a short-stay Geriatrics Evaluation and Management Program provide comprehensive evaluation of a resident's health status, management of chronic stable conditions and recommend interventions to prepare the resident for continued living in the community.

4. SHORT-STAY RESTORATIVE CARE

CLCs providing short-stay restorative care services utilize restorative interventions to facilitate resident's highest practicable level of independence, well-being and function. Short-stay restorative care is a transitional service to assist CLC residents prior to discharge to a non-institutional setting that is most appropriate for the resident.

5. SHORT-STAY CONTINUING CARE

CLCs with short-stay continuing care services provide care for residents awaiting alternative placement (for instance, to a community nursing home, State Veterans Home or other community-based setting).

6. SHORT-STAY MENTAL HEALTH RECOVERY

CLCs with short-stay mental health recovery services provide mental health evaluation and management (i.e., medical adjustment and evidence-based psychosocial behavioral interventions), for residents with exacerbation of medical or behavioral symptoms that can be managed in a non-psychiatric inpatient setting, with the goal of receiving this level of care returning to their previous living arrangements upon discharge.

7. SHORT-STAY DEMENTIA CARE

Short-stay dementia care for CLC residents is intended to stabilize symptoms while developing a long-term care plan within the secure environment of an existing dementia program that supports the residents return to their previous living arrangements upon discharge. Veterans receiving this level of care are expected to return to their previous living arrangements upon discharge. Therefore, the household environment provides cues for resident behavior management and functional improvements. The family, or significant other, need to be involved in learning about safe and effective care practices in the home, resources for continued support, access to home telehealth and other services that support the Veteran and assist the family, or significant other, to continue to care for the Veteran at home. This program may offer family, or significant other, behavior management skills and opportunities to practice skills while the Veteran is in the CLC.

8. HOSPICE AND PALLIATIVE CARE.

CLCs providing hospice and palliative care services provide comprehensive management of the physical, psychological, social, cultural, spiritual and emotional needs of the resident with terminal conditions that have become advanced, progressive or incurable and are expected to result in death within 6 months. CLC hospice and palliative care must be provided in alignment with VHA Handbook 1004.03(3), Life-Sustaining Treatment Decisions: Eliciting Documenting and Honoring Patients' Values, Goals and Preferences, dated January 11, 2017.

9. RESPITE CARE

Respite care is part of the VA medical benefits package and must be available to every CLC-enrolled resident for whom it is determined by appropriate health care professionals that the service is needed to promote, preserve and restore the health of the individual in accord with generally accepted standards of medical practice.

10. LONG-STAY DEMENTIA CARE

CLCs providing long-stay dementia care must do so in a CLC environment where the safety of the resident is protected or in a dementia-specific household. Dementia-specific care focuses on the respectful management of challenging behaviors, functional and cognitive improvement, meaningful use of time and resident and caregiver education and support.

11. LONG-STAY CONTINUING CARE

CLCs providing long-stay continuing care assist residents maintain the highest practicable level of well-being and function and prevention of further decline. Examples of long-stay continuing care may include, but are not limited to, care for:

- a. CLC residents with long-standing chronic functional disabilities for whom active rehabilitation is no longer an option.
- b. CLC residents who require assistance with basic activities of daily living, medication administration and general supervision and who do not require direct skilled nursing services; or
- c. CLC residents who require skilled nursing interventions that extend beyond the short-stay limit.

12. LONG-STAY MENTAL HEALTH RECOVERY

Long-stay mental health recovery services assist residents with chronic stable mental illness coupled with geriatric or other syndromes that render them less able to function in non-institutional settings maintain the highest practicable level of well-being and function and prevention of further decline. Primary resources for care include, but are not limited to, RT, social work, psychology and psychiatry.

13. LONG-STAY SPINAL CORD INJURY AND DISORDERS

CLCs providing long-stay Spinal Cord Injury and Disorders (SCI/D) services provide care to residents with a primary diagnosis of SCI/D with significant functional impairments that render them less able to function in non-institutional settings due to the level of assistance required. Additional guidance is available in VHA Directive 1176(2), Spinal Cord Injuries and Disorders System of Care, dated September 30, 2019.

a. These residents must also be offered annual evaluations in a SCI/D Center each year.

b. The CLC must contact the closest SCI/D Center for consultation in the care of all residents with SCI/D and review the SCI/D Services Intranet site at: <http://vaww.sci.va.gov> for care of the unique needs of these residents. **NOTE:** *This is an internal VA website that is not available to the public.*