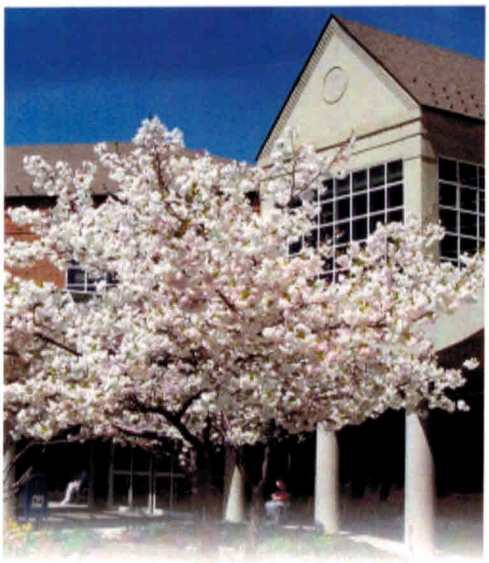


The Virginia Veterans Care Center

The Virginia Veterans Care Center opened on Veterans Day, 1992. We are proud to care for Virginia's veterans. Our staff is dedicated to giving the best quality of life to the veterans who served us.

Whether it's a short stay for rehab or for long-term care, the Virginia Veterans Care Center offers individualized services in a safe, caring, and professional environment.

Care Levels

- Assisted living
- Skilled nursing
- Intermediate nursing
- Alzheimer's/Dementia
- Hospice

Nursing Staff

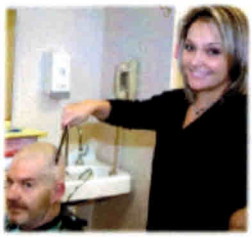
Registered Nurses, Licensed Practical Nurses, and Certified Nursing Assistants provide 24-hour care to our 240 residents

Virginia Veterans Care Center
4550 Shenandoah Avenue
Roanoke, VA 24017
(540) 982-2860 • 1-800-220-8387
(540) 982-1907 (fax)

Features

- In-house physical, occupational, and speech therapy
- Special veteran and patriotic programs throughout the year
- Events by local veteran service organizations
- Therapeutic activities such as pet therapy, bingo, fishing trips, and weekly shopping outings
- Transportation to community and sporting events, and medical appointments
- Support groups for families

Amenities



- Library
- Barber shop
- Chapel
- Paved wheelchair paths
- 20 acres of park-like grounds
- Nature trails

Eligibility

Eligibility requirements for admission include an honorable discharge from the U.S. Armed Forces and Virginia residency at the time of admission, or entry into the Armed Forces from Virginia. VVCC accepts payment from private insurers, Medicare and Medicaid. Most veterans also qualify for the VA per diem facility credit.

Virginia Veterans Care Center
Virginia Department of Veterans Services

Our residents and families say it all . . .

The second you walk through the doors, you can tell you are in a one-of-a-kind place.

—Annette, Reston, Virginia

It's definitely not the stereotypical nursing home. It is bright, open and airy with large rooms and many activities for the residents and their families.

—Vicki, Troutville, VA

We take great comfort in knowing Dad is receiving excellent care in a nurturing facility.

—Louise, Bethesda, MD

As difficult as it was to decide to have my husband cared for, it was the best decision. The caring personnel gave professional attention to my husband. This made it possible for me to leave him knowing he would be well looked after.

—Muriel, Roanoke, VA

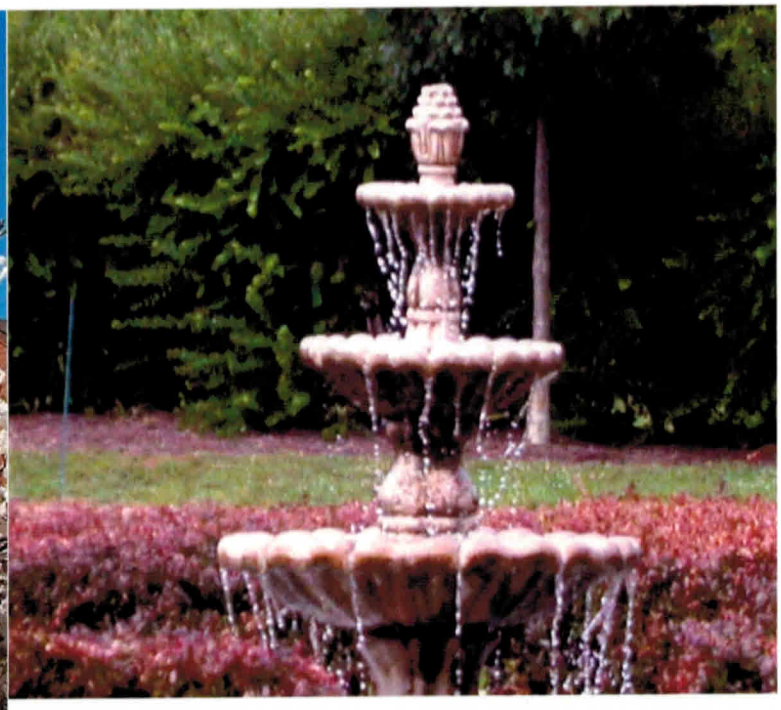
I am deeply grateful for the stability and peace VVCC provides not only to my father but also to me and the family.

—Wendy, Alexandria, VA

From the start the dedicated staff has given dad the excellent care we know he deserves. Two years later we are still amazed that such a place exists.

—Donna, Salem, VA

A special place to call home . . .
exclusively for Virginia veterans



Admission Application

Dear Veteran:

Thank you for your interest in Virginia Veterans Care Center. We take great pride in caring for those who have cared for us!

By requesting this information, you have begun the Admission Process. In this package, you will find the information and forms necessary to continue your process.

Please fill out the following and return to us:

1. **The Application.** Please answer all the questions you can. Be sure to sign and fill in the back.

2. **A copy of your Honorable Discharge or a DD 214.** If you receive your medical care through the Veterans Administration, we can obtain this for you.

3. **A copy of your Medicare Card, Medicaid Card, Social Security and any additional insurance cards you have in effect.** Our Business Office will contact your insurance companies to investigate any benefits you may have.

4. **A copy of your Power of Attorney Papers.** If you do not have a power of attorney, please arrange for someone to assist you in financial and medical decisions.

5. **Medical History.** Contact your present Physician and request that he/she fax your medical information for the previous 12 months to (540) 982-1907.

6. **Physical Form.** There is also a Physical Form enclosed, but this physical must be done within 30 days of you Admission to Virginia Veterans Care Center. Please wait until we know you are going to be living here before you have a physical done.

If you are coming from a hospital or Nursing Home, your Social Worker will provide all the necessary information to us.. You will not need to fill out the above forms.

Please feel free to call me at 1-800-220-8387 or (540) 982-2860 if I can answer any questions. I will be happy to assist you anyway I can.

Sincerely,

Patti C. Smith

Patti Culver Smith
Director of Admission & Public Relations

E-mail: **patti.smith@dvs.virginia.gov**
Fax: (540) 982-1907
Phone: (540) 982-2860 Ext. 4107

Virginia Veterans Care Center
Virginia Department of Veterans Services

Virginia Veterans Care Center is a Smoke Free Facility. No smoking allowed on property.

Application For Admission

PERSONAL INFORMATION

Applicant's full name: _____
First Middle Last

Phone Number (_____) _____

Home Address _____ City _____ State ____ Zip _____

Virginia resident? ☐ Yes ☐ No How long? _____ ☐ Months ☐ Years

Date of Birth _____/_____/_____ Age _____ Sex _____ Social Security # _____-_____-_____

Marital Status ☐ Single ☐ Married ☐ Widowed ☐ Divorced ☐ Separated ☐ Never Married

Spouse's Name _____ ☐ Living ☐ Deceased

Applicant coming to VVCC from _____ Do you smoke? ☐ Yes ☐ No

Desired date arrival _____/____/_____ Residency sought: ☐ Temporary Residence ☐ Permanent Residence

Expected Level of Care: ☐ Assisted Living ☐ Nursing Home ☐ Dementia Care

MILITARY INFORMATION

Military Service: ☐ Coast Guard ☐ Army ☐ Navy ☐ Marine Corps ☐ Air Force

Service Number _____ Type of Discharge: _____

Date entered into service _____ Date separated from service _____

Have you received treatment at a VA Hospital? ☐ Yes ☐ No Where: _____

Are you Service Connected? ☐ Yes ☐ No What percentage? _____

What is your VA Priority Classification? _____

Have you given a Service Organization Power of Attorney (POA) to represent you with claims? ☐ Yes ☐ No

Were you a POW? ☐ Yes ☐ No Where? _____

HEALTH INFORMATION

Have you ever been treated for mental illness(es)? ☐ Yes ☐ No If yes, dates of treatment and name facility

_____

Have you ever been treated for drug or alcohol problems? ☐ Yes ☐ No If yes, dates of treatment and name facility

_____

Hospital stays during last 6 months? ☐ Yes ☐ No If yes, dates of treatment and name facility

_____

Resident of healthcare center in last year? ☐ Yes ☐ No If yes, dates of treatment and name facility

_____

FINANCIAL RESOURCES

APPLICANT'S PAYMENT SOURCE

☐ Private funds I have adequate personal funds available to cover at least _____ months of care.

☐ Medicare (number) _____

☐ Medicare Supplemental insurance (name of carrier) _____

☐ Medicaid (number) _____

APPLICANT'S SOURCE OF MONTHLY INCOME

☐ Retirement/Pension $_____

☐ Social Security Income (SSA) $ _____

☐ Veterans benefits $ _____

☐ Supplemental Security Income (SSI) $ _____

☐ Other (identify) _____ $ _____

APPLICANT'S ASSETS

☐ Real estate (type/location/value) _____

_____

☐ Bank accounts (checking, savings, CDs, IRAs, other) (value) _____

_____

☐ Life Insurance policies

Type/carrier _____ Cash value $ _____

Type/carrier _____ Cash value $ _____

☐ Burial and /or Irrevocable Trust ☐ Yes ☐ No

Has applicant transferred ownership of any type of assets in the past 5 years? ☐ Yes ☐ No

If yes, asset and date of transfer _____

Social Security check is made payable to the applicant? ☐ Yes ☐ No

If no, name of representative payee _____ Relationship _____

Representative's address: _____

City _____ State _____ Zip _____

RESPONSIBLE PARTY

A Responsible Party is held responsible for paying for the Veteran's stay with the Residents Funds.

Responsible Party_____
First Middle Last

Relationship to Applicant: _____

Address _____ City _____ State _____ Zip _____

Telephone (home) _____(cell)_____ (work) _____

Power of Attorney (POA)? ☐ Yes ☐ No (If yes, include copy with application packet)
Are you a Court Appointed Guardian? ☐ Yes ☐ No (If yes, include copy with application packet)

POA Name _____

POA Address _____ City _____ State _____ Zip _____

POA Telephone (home) _____(cell)_____(work) _____

I/We hereby confirm that all information stated herein is current and correct to the best of my/our knowledge, and no requested information has been withheld or misrepresented. I/We authorize Virginia Veterans Care Center to verify any of the information herein. I/We understand that falsification of the stated information may jeopardize admission into the VVCC. I/We understand that all information will be kept confidential by Virginia Veterans Care Center and will not be released without my/our written permission.

_____ _____
Applicant's or Authorized Representative's Signature Date

REQUIRED ADMISSION SUPPLEMENTS

To start the application process, the following documents are also required:

1. The last 6 months of the applicant's medical history, faxed from all the applicant's health providers. Ask Dr's office or VA to f ax information to (540) 982-1907.

2. A copy of the applicant's Social Security card, as well as copies of all insurance cards, e.g., Medicare, Medicaid and Blue Cross/Blue Shield.

3. A copy of Veteran's DD-214 or Honorable Discharge.

4. A copy of any legal guardianship papers or Power of Attorney documentation.

Please mail Application and Additional Supplements to:
Virginia Veterans Care Center
Admissions Director
4550 Shenandoah Ave.
Roanoke, VA 24017

Have questions or need assistance?
Call 540-982-2860
Ask For
The Admissions Department

VIRGINIA VETERANS CARE CENTER

DAILY ROOM RATES

Effective 5/1/2014

Level Of Care	Semi-Private Room Rate	Private Room Rate	VA Per Diem Facility Credit	Resident Cost Semi Private Room After Credit*	Resident Cost For Private Room After Credit*
Domiciliary Assisted Living	$131.32	$156.32	$43.32	$88.00 *	$113.00 *
Nursing Facility	$223.37	$259.37	$100.37	$123.00 *	$159.00 *
Alzheimer Special Care Unit	$223.37	$259.37	$100.37	$123.00 *	$159.00 *

** A FACILITY CREDIT MAY BE APPLIED TO THE ACCOUNTS OF ELIGIBLE RESIDENTS.*

Virginia Veterans Care Center is a "SMOKE FREE" facility. No smoking is allowed on the property.

VIRGINIA VETERANS CARE CENTER

RESTRAINT POLICY

It is the philosophy of Virginia Veterans Care Center to promote a restraint free environment. When use of a restraint is medically necessary, the least restrictive alternative available will be used. All residents have the right to be free from physical and chemical restraints. It is our position that restraints may interfere with the quality of life for our Veterans.

The use of physical restraints can contribute to a decline in overall health status to include, but not limited to:

Pressure Sores
Confusion and Agitation
Pneumonia
Urinary Tract Infections
Dehydration
Skin Tears
Falls
Decline of Physical Mobility
Loss of Dignity

A restraint free environment promotes Quality of Life for our Veterans!

Virginia Veterans Care Center
Nutrition Plan Jan. 2007

VVCC has adopted a liberalized diet philosophy that supports the quality of life and nutritional status of residents in long term care. We use "qualified dietetics professional to assess, monitor, and evaluate the need for medical nutritional therapy based on each individual's needs and rights" as recommended by the American Dietetics Association. Concerns are addressed promptly with the primary care physician.

For nursing home, residents receive meal trays individually prepared based on VVCC Standing Orders for conversion of outside orders to standard house diets.

For assisted living, the same menu selections are served cafeteria style in a central dining room. Residents receive education as needed to support healthy menu choices, but ultimately each resident selects menu items without interference from staff. Residents also choose snacks from those available from dietary and those they purchase independently. Our menu selections include items appropriate for residents who should limit sodium, cholesterol, and calories. This encourages residents to actively participate in healthy living.

REPORT OF PHYSICAL EXAMINATION FOR PLACEMENT

Must be completed by physician within 30 days prior to admission.
If admission is delayed beyond 30 days, addendum will be requested.

NAME _____ PHONE _____ DATE OF EXAM _____
ADDRESS _____
_____

Resident's Height _____ Weight _____ BP _____

Current Diagnoses/Problems

_____
_____
_____
_____
_____
_____
_____

Significant Medical History

_____
_____
_____
_____

General physical condition/systems review:

_____
_____
_____
_____
_____
_____
_____
_____

Is this person:

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

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

REPORT OF PHYSICAL EXAMINATION FOR PLACEMENT

Name _____

Diet Education Needed: _____

Current Activity _____

Current Treatment Orders _____

ALLERGIES (medication, food, other): _____

_____

Current Scheduled Medications (including OTC products):

List PRN medications on page 3 or 4.

Name	Dose	Route	Frequency	Reason for prescribing

Unless VVCC is notified of changes, these orders will be used for admission orders.

Signature of MD _____ Date _____

REPORT OF PHYSICAL EXAMINATION FOR PLACEMENT
PRN MEDICATIONS

Name _____

PRN medications must include symptoms/indication for use, exact timeframes the medication is to be given in a 24-hour period, and directions for what to do if symptoms persist. All PRN medications must be available individually for each resident.

VVCC has adopted the following **over the counter medications** to alleviate symptoms of temporary conditions. If symptoms are not relieved or worsen, the PCP or VAMC ER physician will be notified. Please check approved orders or write in others.

1. For mild pain or temp. of 101° or higher:
   - ☐ Tylenol 650 mg. PO every four hours PRN. Maximum of 6 doses per 24 hours.
   - ☐ _____
2. For constipation:
   - ☐ Milk of Magnesia 30 ml. PO daily PRN
   - ☐ _____
   - ☐ Fleet's enema x 1 PRN
3. For diarrhea:
   - ☐ Licensed nurse to check for fecal impaction.
   - ☐ If none present, may give Imodium AD 2 caplets PO. May repeat 1 caplet after each loose stool up to a maximum dose of 16 mg. (8 caplets) within a 24 hour period.
   - ☐ _____
4. For nausea, vomiting, acid indigestion, or upset stomach:
   - ☐ Mylanta 15 ml. PO every 2 hours PRN for acid indigestion.
   - ☐ _____
   - ☐ Emetrol 15 ml. every 15 minutes PRN for nausea and vomiting up to a maximum of 5 doses in 24 hours.
   - ☐ _____
5. For cough/cold symptoms:
   - ☐ Guaifenesin-DM Sugar-Free 10ml. PO every 4 hours PRN. Maximum of 4 doses in 24 hour period.
   - ☐ _____
6. For difficulty sleeping:
   - ☐ Benadryl 25mg. PO at bedtime PRN
   - ☐ _____
7. For minor skin tears and abrasions:
   - ☐ Clean area with Normal Saline daily until healed. Apply Bacitracin Ointment and clean dry dressing daily.
   - ☐ _____
8. For shortness of breath:
   - ☐ Check vital signs and pulse ox, start O2 at 2 LPM, and notify MD.
   - ☐ _____

Unless VVCC is notified of changes, these orders will be used for admission orders.

Signature of MD _____ Date _____

REPORT OF PHYSICAL EXAMINATION FOR PLACEMENT
OTHER SCHEDULED OR PRN MEDICATIONS

Name ____

Name	Dose	Route	Frequency/Max per 24 hour period
Specific indication for use		If symptoms persist	

Name	Dose	Route	Frequency/Max per 24 hour period
Specific indication for use		If symptoms persist	

Name	Dose	Route	Frequency/Max per 24 hour period
Specific indication for use		If symptoms persist	

Name	Dose	Route	Frequency/Max per 24 hour period
Specific indication for use		If symptoms persist	

Name	Dose	Route	Frequency/Max per 24 hour period
Specific indication for use		If symptoms persist	

Name	Dose	Route	Frequency/Max per 24 hour period
Specific indication for use		If symptoms persist	

Name	Dose	Route	Frequency/Max per 24 hour period
Specific indication for use		If symptoms persist	

Name	Dose	Route	Frequency/Max per 24 hour period
Specific indication for use		If symptoms persist	

Name	Dose	Route	Frequency/Max per 24 hour period
Specific indication for use		If symptoms persist	

Unless VVCC is notified of changes, these orders will be used for admission orders.

Signature of MD ____ Date _____________

REPORT OF PHYSICAL EXAMINATION FOR PLACEMENT

Name _____

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

Condition/Care Need	Yes	No	Comment
Ventilator dependency			
Pressure Ulcer, Stage III or IV			If stage III ulcer, is it healing?
IV therapy or IV injections			If intermittent IV therapy , check yes and indicate expected time period
Airborne infectious disease that requires isolation or special precautions			
Psychotropic medications without appropriate diagnosis and treatment plans			
Nasogastric tubes			
Gastric tubes			If yes, is the person capable of independently feeding himself and caring for the tube and site?
Presents imminent physical threat or danger to self or others			In need of immediate assessment by a qualified mental health professional.
Requires continuous licensed nursing care			Licensed nurse must provide specific needed care each shift.

Does applicant have a history of mental health problems requiring intervention in the past year?

_____

Has the applicant exhibited any of these behavior(s) in the past year requiring assessment, treatment, or monitoring? Yes _____ No_____ If yes, check behaviors identified:

- ☐ Physically assaulting others
- ☐ Gesturing a threat of assault
- ☐ Verbalizing a threat of harm to self or others
- ☐ Suicidal ideation or attempts
- ☐ Verbalizing an unrealistic fear of being harmed by others
- ☐ Destroying property that exposes self or others to harm
- ☐ Wandering inside or outside current residence
- ☐ Being intrusive in the personal space of others
- ☐ Putting objects or liquids in the mouth that are mistaken as food or consumable fluids
- ☐ Increased physical activity such as floor pacing that might indicate anxiety or stress
- ☐ Increased or confusing speech pattern or communications that might indicate a disorder of thought process
- ☐ Decreased physical activity such as staying in bed, not eating, or not communicating that might indicate depression
- ☐ Self-neglect – bathing, grooming, clean clothing, clean environment
- ☐ Pattern of alcohol abuse
- ☐ Pattern of drug abuse or misuse
- ☐ Compulsive behavior patterns
- ☐ Other _____

Is applicant capable of making financial decisions? _____, Medical decisions? _____

Signature of MD _____ Date _____

REPORT OF PHYSICAL EXAMINATION FOR PLACEMENT
TUBERCULOSIS SCREENING EVALUATION

Name _____

Date of most recent Mantoux tuberculin skin test _____

Result: mm of induration _____

- ☐ Applicant previously tested positive
- ☐ Previously treated_____

Is person exhibiting any TB-like symptoms? Yes _____ No _____

If TB skin test is 10mm or greater (5mm in HIV infected), previously positive, or if TB-like symptoms exist, respond to the following:

Date of last chest x-ray _____ (Attach report)

Was chest x-ray suggestive of active TB? Yes_____ No ____

If yes, were sputum smears collected for AFB? Yes ____ No ____

Were three consecutive smears negative for AFB? Yes ___ No ___

Based on the above, is this individual free of communicable TB? Yes ___ No ____

Name of licensed MD, nurse practitioner, or local health department official completing evaluation.

Print Name _____ Phone _____

Signature _____ Date _____