Virginia Department of Behavioral Health & Developmental Services

Children in Nursing Facilities Annual Report

Activities 2014 – June 2026

Children in Nursing Facilities Reporting:

The Preadmission Screening and Resident Review (PASRR) process is a federal requirement put in place to help ensure that individuals (adults and children) with intellectual/developmental disabilities and serious mental illness are not inappropriately placed in nursing facilities for long-term care.

In 2016, the Commonwealth worked with the Department of Medical Assistance Services to determine the number of children in nursing facilities as of July 2015. This group of children became the baseline for tracking future disposition of these children. The number of Baseline Children in Nursing Facilities (Table 1) was recorded to be 50 children on July 1, 2015. This report shows children no longer under review and their disposition (discharged, deceased, or persistent vegetative state). As of June 2026, 15 of these children are still residing in a nursing facility setting while 35 are no longer under review. Of those 35 no longer under review, 2 have gone into a persistent vegetative state, 10 have passed away, and 23 have discharged to a lesser restrictive community environment.

Table 1

Baseline Children in NF						
Fiscal Year	Baseline Children in NF as of Mar 2016	Children No Longer Under Review	PVS	Deceased	Discharged	Number of Children Still Under Review *as of June 2026
2026	50	35	2	10	23	15
2025	50	35	2	10	23	15
2024	50	34	2	10	22	16
2023	50	31	2	10	19	19
2022	50	28	2	9	17	22
2021	50	27	2	9	16	23
2020	50	24	2	7	15	26
2019	50	22	1	6	15	28

The Children Identified or Children Found (Table 2) report was also created in 2016. This report tracks any children that were not identified in the baseline but were later determined to have a developmental disability and reside in a nursing facility. These children sometimes get the diagnosis of ID/DD later in life, to be able to fully complete all the testing needed to ensure a proper lifelong diagnosis. As of June 2026, this report shows 70 children who have been identified as residing in a nursing facility after March 2016 and were not identified in the baseline group. As of June 2026, of this group of 70 children, 22 children remain in a nursing facility receiving regular resident reviews, 2 are diagnosed in persistent vegetative state (PVS), 12 are deceased, and 33 have moved to a lesser restrictive community environment.

Table 2

Children Identified in NF						
Fiscal Year	Children Identified in NF after Mar 2016	Children No Longer Under Review	PVS	Deceased	Discharged	Number of Children Still Under Review *as of June 2026
2026	70	47	2	12	33	22
2025	65	45	2	11	31	20
2024	61	36	2	8	26	25
2023	57	31	2	6	23	26
2022	52	28	1	6	21	24
2021	45	26	1	5	20	19
2020	42	21	1	4	16	21
2019	37	12	1	1	10	25

In 2014, a report of children with developmental disabilities referred for nursing facility placement through Preadmission Screening and Resident Review (PASRR) (Table 3) was created to identify and track individuals receiving a pre-admission screening prior to admission to a nursing facility. As of June 2026, 126 children have gone through the PASRR screening process. Of those 126 children, 56 children have been admitted and 70 have been diverted from nursing facility placement. Of the 56 children admitted to a nursing facility, 52 were admitted for medical rehabilitation (services to help a person keep, get back, or improve skills and functioning for daily living that have been lost or impaired because of illness, injury, or disability; these services may include physical or occupational therapy, speech-language pathology, etc.), 1 for hospice (services that provide support and comfort for persons near end-of-life and their families), 2 for respite services (provides short-term relief for primary caregivers), and 1 for long term residential at the request of the mother (this child has since discharged). Of the 56 children admitted for nursing facility placement, 34 have since discharged to a less restrictive environment, and 24 remain in a nursing facility setting.

Table 3

Children Referred for NF Placement through PASRR Dec 2014-June 2026									
Fiscal Year	Number of Children Referred for Level II for Preadmisison to NF as of December 2014	Total Number Admitted	Number Admitted for Med Rehab	Number Admitted for Hospice	Number Admitted for Respite	Number Admitted for Long Term Residential	Number Diverted from NF	Number Discharged Since Admission	Number Remain in NF
2026	126	56	52	1	2	1	70	34	24
2025	120	53	49	1	2	1	67	30	22
2024	106	47	43	1	2	1	59	29	18
2023	87	45	41	1	2	1	42	27	18
2022	79	39	35	1	2	1	40	26	13
2021	66	34	30	1	2	1	32	25	9
2020	52	28	25	1	2	0	24	20	8
2019	44	25	22	1	2	0	19	16	9

Outreach to Nursing Facilities

In 2017, the Registered Nurse Community Integration Consultant and the Community Transition Nurse within the Office of Integrated Health (OIH) at DBHDS began close work with the two children's nursing facilities in Virginia, to offer assistance in facilitating children's discharges to a less restrictive community environment. The assistance provided includes ensuring that 1) the child's home Community Service Board (CSB) is notified when a child from their catchment area is admitted to a nursing facility and when the formal discharge planning process begins; and 2) families of children admitted and/or seeking admission are provided information about community-based resources. When a child is admitted to a nursing facility, the Community Transition Nurse sends an Awareness Letter to the child's home Community Service Board. This letter is to inform the CSB, a child from their catchment area has been admitted to a nursing facility to allow them the opportunity to become involved in that child's care to begin discharge planning as early as possible.

- **Involvement of Community Service Boards (CSB)**
- **The Action Letter**

In March of 2018, the Office of Integrated Health, Registered Nurse Community Integration Consultant, and the Community Transition Nurse, created a protocol to ensure CSBs are notified of children working towards discharging from nursing facilities to a community setting, and offered 120 days of state funding to support case management transition activities. This funding is supplemental to the 30 days of Medicaid funded case management. When the Community Transition Nurse (CTN) is notified that a child is in an "active discharge status" (or within 90 days of proposed discharge date), the CTN will send an Action Letter to the CSB. This Action Letter explains the availability of additional funding to assist with the work involved in discharging a child to a less restrictive community environment.

Along with the letter is an Individualized Status Report form that a representative of the CSB will fill out and send back to DBHDS if they plan to request funding. There have been 37 action letters sent (one sent twice due to a delayed discharge) and nine CSBs have requested state funding. Whether or not the CSB accepts the discharge funding, they remain involved during the discharge process and follow up with the family post-discharge from a nursing facility.

- **Family Outreach**

Beginning in April/May 2019, the DBHDS Office of Integrated Health began a process of Family Outreach to families/guardians/authorized representatives of children less than 22 years of age who resided in nursing facility settings. The protocol requires the Community Transition Nurse (CTN) to send an initial contact letter and a copy of the Community Transition Guide to the family/guardian/authorized representative of those children receiving nursing facility care as an informational resource.

The Community Transition Guide is a resource that provides children and their families, who are preparing for transition from the nursing facility to a community setting. The Guide offers information on different community options, waiver options, information about the Office of Integrated Health, and different community service options. After the initial letter is mailed to the family/guardian/authorized representative of the child, a Registered Nurse Care Consultant (a nurse within the Office of Integrated Health who works in the community) will call to discuss the Community Transition Guide to ensure the family is aware of services available to the child in the community and to answer any questions that may have come up after their review of the Community Transition Guide. The Registered Nurse Care Consultant (RNCC) will attempt to reach the family/guardian/authorized representative three times to discuss the letter and Community Transition Guide. If the family/guardian/authorized representative requests further information, CTN will then work to connect the family/guardian/authorized representative to the social worker at the nursing facility and to the CSB. In the Outreach to Families in November/December 2024, there were 25 letters and Community Transition Guides mailed. It is important to note, there are three attempts made before a family is placed in the "no answer" result category. They will be resent the letter and Community Transition Guide and receive phone calls in the next Outreach to Families. The table below reflects the most recent outcomes (Table 4) of Family Outreach.

Table 4

Family Outreach- November/December 2025	
Result Categories	**Number of Families**
Community Transition Guide and Letters Sent	**27**
No Answer After Three Attempts	17
Not Interested in Transition, Remain on List	10
Requested to be Removed from List	0
Not Interested in Transition	0
Requested packet be resent by mail	0
Requested packet be resent by email	0
Requested more information/Interested in Transition*	10
Additional Breakdown	
Number of Individulas 10 years and younger	11
Number of Individuals 11 to 18 years old	11
Number of Individuals 19 years old and up	5

*Per results submitted by the RNCC, no families requested more information. CTN will continue to follow and provide materials with the Fall 2026 Outreach.