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**Disclaimer**

This Facility Assessment template is presented as a model only by way of illustration. It has not been reviewed by counsel. Before applying a form to specific use within your organization, it should be reviewed by a counsel knowledgeable in applicable federal and state health care laws, rules and regulations.

The Facility Assessment template should not be used or relied upon in any way without consultation with and supervision by qualified physicians and other health care professionals who have full knowledge of each resident's case history and medical conditions.

The Facility Assessment Template is offered to nursing facilities as a guide for developing individualized Facility Assessment plans, and for information and educational purposes only.

The development process included a review of government regulations, literature review, expert opinions and consensus. The guidelines strive to be consistent with these principles:

* Evidence-based criteria
* Consistent with statutory and regulatory requirements
* Use of federal and state government terminology, definitions and data collection

Staff, residents and families should be involved in Facility Assessment development to ensure efficient and appropriate implementation.

**Introduction to the Facility Assessment**

**Purpose**

The purpose of the assessment is to determine what resources are necessary to care for residents competently during both day-to-day operations and emergencies. Use this assessment to make decisions about your direct care staff needs, as well as your capabilities to provide services to the residents in your facility. Using a competency-based approach focuses on ensuring each resident is provided care that allows the resident to maintain or attain their highest practicable physical, mental and psychosocial well-being.

The intent of the facility assessment is for the facility to evaluate its resident population and identify the resources needed to provide the necessary person-centered care and services the residents require.

The facility assessment will be used to create a contingency plan for events that do not require the activation of the facility emergency plan but have the potential to impact resident care, such as the availability of direct care nurse staffing or other resources needed for care of residents. For example, the use of contract licensed nurses to cover several shifts during a holiday. The facility assessment will be used to develop and maintain a plan to maximize direct care staff recruitment and retention. It will serve as a record for staff and management to understand the reasoning for decisions made regarding staffing and other resources and may include the operating budget necessary to carry out facility functions.

**Guidelines for Conducting the Assessment**

1. To ensure the required thoroughness, the following need to be involved in the process:
* Nursing home leadership and management including, but not limited to, the administrator, a representative of the governing body, the medical director, the director of nursing and
* Direct care staff including, but not limited to, registered nurses (RNs), licensed practical nurses/licensed vocational nurses (LPNs/LVNs) and nursing assistants.
* The facility must also solicit and consider input received from residents, resident representatives and family members.
1. While a facility may include input from its corporate organization, the facility assessment must be conducted at the facility level.
2. The facility must review and update this assessment annually or whenever there is change and/or when the facility plans for any change that would require a modification to any part of this assessment. For example, if the facility decides to admit residents with care needs who were previously not admitted, such as residents on ventilators or dialysis, the facility assessment must be reviewed and updated to address how the facility staff, resources, physical environment, etc., meets the needs of those residents and any areas requiring attention, such as any training or supplies required to provide care.
3. The facility assessment should serve as a record for staff and management to understand the reasoning for decisions made regarding staffing and other resources and may include the operating budget necessary to carry out facility functions.

For refence: [QSO-24-13-NH: Revised Guidance for Long-Term Care Facility Assessment Requirements](https://www.cms.gov/files/document/qso-24-13-nh.pdf)

**Facility Assessment Template Instructions**

1. Review the entire document. You will note yellow highlighted areas throughout the document as you review. These are the areas you will need to revise and update with your facility-specific information.
2. Follow instructions and/or recommendations and fill out/update information where you see yellow highlight. As you fill out this information, feel free to delete the instructions provided and remove the yellow highlight.
3. Delete this page when complete.
4. This document may also serve as a resource guide to review and update an existing Facility Assessment.

**FACILITY**

**ASSESSMENT**

Add your facility logo and/or photo

**Introduction**

Facility Name:

Mission Statement:

Vision Statement:

Guiding Principles:

Facility Assessment (FA) Plan

Use of the facility assessment will demonstrate a “good faith effort” by the facility to evaluate necessary resources to care for residents competently during both day-to-day operations (including nights and weekends) and emergencies.

**The facility assessment is organized into three main components/sections:**

1. Resident profile including, but not limited to, the numbers, diseases/conditions, physical and cognitive disabilities, decisions regarding caring for residents with conditions not listed and acuity and ethnic/cultural/religious factors which impact care.
2. Services and care offered including but not limited to, care needed by the resident population using evidence-based, data-driven methods which consider types of diseases, conditions, physical and behavioral needs, cognitive disabilities, overall acuity and any other pertinent facts present within the population (consistent with residents’ assessments).
3. Facility resources needed including, but not limited to, providing competent care for residents, including facility staff, staffing plan, staff training/education and competencies, individual staff assignments, policies and procedures for provision of care, working with medical practitioners, physical environment, equipment, technology, communication, building needs and other resources.

**The facility assessment was conducted utilizing the following guidelines:**

1. Active involvement of participants to ensure required thoroughness. Individuals involved in the facility assessment should include, but is not limited to, nursing home leadership and management, i.e., a member of the governing body, the medical director, administrator and director of nursing. Also, direct care staff including, but not limited to, RNs, LPNs/LVNs, nursing assistants and representatives of direct care if applicable. The facility will include other participants as needed such as the environmental operations manager and department heads. The facility must also solicit and consider input received from residents, resident representatives and family members.
2. Staffing decisions are determined at the facility level (corporate input may be included) to ensure there are enough staff with appropriate competencies and skill sets necessary to care for its residents’ needs as identified through resident assessments and plans of care. The facility will consider staffing needs for each shift, such as day, evening and night, and will adjust as necessary based on any changes to its resident population. The facility will develop and maintain a plan to maximize recruitment and retention of direct care staff. The facility will have contingency planning for events that do not require activation of the facility’s emergency plan, but do have the potential to affect resident care, such as, but not limited to, the availability of direct care nurse staffing or other resources as needed for resident care.
3. Data was collected and analyzed from various sources which may include Minimum Data Set (MDS) reports, Quality Measures, RUGS/PDPM data and/or 802 (Roster/Sample Matrix Form) reports, electronic medical record (EMR), UB-04, preadmission assessment, acuity tools, staffing and scheduling and risk assessments, Payroll-Based Journal, and in-house designed reports.
4. The facility will review and update this facility assessment annually or whenever there are plans for any change that would require a modification to any part of this assessment.
	* + - *Please note it is not the intent that the facility assessment is updated for every new person that moves into the nursing home, but rather for significant changes such as when the facility begins admitting residents that require substantially different care. Likewise, hiring new staff or a director of nursing or even remodeling should not require an update of the facility assessment, unless these are actions that the facility assessment indicated the facility needed to do.*

|  |  |
| --- | --- |
| **Facility Name** | Name |
| **Facility Address** | Address |
| **Individuals (titles/names) and/or process involved in completing FA** | Administrator:Director of Nursing:Governing Body Representative:Medical Director:Direct Care Representative:*(Please note: we recommend adding 1 RN/LPN and 1 CNA/STNA)*Resident Representative: *(Or describe how this will be completed)*Family Representative: *(Or describe how this will be completed)*Other: |
| **Date(s) original FA was completed** | Insert date your original facility assessment was completed |
| **Date(s) FA was revised** | Insert date this document was completed |
| **Date(s) assessment reviewed with QAA/QAPI committee** | Insert date |

**Section 1: Resident Profile/Resident Population**

**Numbers**

Our facility has a license to provide care for # residents, including:

|  |  |  |
| --- | --- | --- |
| Type | # | Payor Type |
| Short-stay (skilled) beds |  |  |
| Long-stay beds |  |  |
| Special unit beds |  |  |
| Other |  |  |

Our average daily census (ADC):

(Enter an ADC for an identified period of time (i.e., 6 months). Differentiate between long-stay and short-stay residents or other categorizations (e.g., unit floors or specialty areas or units, such as those that provide care and support for persons living with dementia or using ventilators). Insert data below – these processes can impact staffing needs.

|  |  |  |
| --- | --- | --- |
| Short-stay (skilled beds) | Average # residents admitted within past 6 months | Average # residents discharged within past 6 months |
| Weekday day  | # | # |
| Weekday evening  | # | # |
| Weekday night | # | # |
| Weekend day | # | # |
| Weekend evening | # | # |
| Weekend night | # | # |

|  |  |  |
| --- | --- | --- |
| Long-stay beds | Average # residents admitted within past 6 months | Average # residents discharged within past 6 months |
| Weekday day  | # | # |
| Weekday evening  | # | # |
| Weekday night | # | # |
| Weekend day | # | # |
| Weekend evening | # | # |
| Weekend night | # | # |

|  |  |  |
| --- | --- | --- |
| Special unit beds | Average # residents admitted within past 6 months | Average # residents discharged within past 6 months |
| Weekday day  | # | # |
| Weekday evening  | # | # |
| Weekday night | # | # |
| Weekend day | # | # |
| Weekend evening | # | # |
| Weekend night | # | # |

|  |  |  |
| --- | --- | --- |
| Other | Average # residents admitted within past 6 months | Average # residents discharged within past 6 months |
| Weekday day  | # | # |
| Weekday evening  | # | # |
| Weekday night | # | # |
| Weekend day | # | # |
| Weekend evening | # | # |
| Weekend night | # | # |

Describe analysis of admission and/or discharge trends and any next steps.

**Diseases/conditions, physical and cognitive disabilities**

Our facility may accept residents with, or residents who may develop, the following common diseases, conditions, physical and cognitive disabilities, or combinations of conditions that require complex medical care and management. This is not an inclusive list.

Please review the diagnoses below and remove any which your facility cannot care for.

|  |  |
| --- | --- |
| Category  | Common diagnoses |
| Psychiatric/Mood Disorders | Psychosis (Hallucinations, Delusions, etc.), Impaired Cognition, Mental Disorder, Depression, Bipolar Disorder (i.e., Mania/Depression), Schizophrenia, Post-Traumatic Stress Disorder, Anxiety Disorder, Behavioral Health, and substance use disorders (SUD)  |
| Heart/Circulatory System | Congestive Heart Failure, Coronary Artery Disease, Angina, Dysrhythmias, Hypertension, Orthostatic Hypotension, Peripheral Vascular Disease, Risk for Bleeding or Blood Clots, Deep Venous Thrombosis (DVT), and Pulmonary Thrombi-Embolism (PTE) |
| Neurological System  | Parkinson’s Disease, Hemiparesis, Hemiplegia, Paraplegia, Quadriplegia, Multiple Sclerosis, Alzheimer’s Disease, Non-Alzheimer’s Dementia, Seizure Disorders, CVA, TIA, Stroke, Traumatic Brain Injuries, Neuropathy, Huntington’s Disease, Tourette’s Syndrome, Aphasia, and Cerebral Palsy |
| Vision | Visual Loss, Cataracts, Glaucoma, and Macular Degeneration |
| Hearing | Hearing Loss and Deafness |
| Musculoskeletal System | Fractures, Osteoarthritis, Other Forms of Arthritis, Amputations, Contractures, Weakness or General Debility  |
| Neoplasm  | Blood, Brain, Bone, Organ, and Soft Tissue Cancers such as Prostate Cancer, Breast Cancer, Lung Cancer, Colon Cancer, and Active Cancer Requiring Treatment  |
| Metabolic Disorders  | Diabetes, Thyroid Disorders, Electrolyte Imbalances, Hyperlipidemia, Obesity, and Morbid Obesity |
| Respiratory System | Chronic Obstructive Pulmonary Disease (COPD), Pneumonia, Asthma, Chronic Lung Disease, Respiratory Failure, and New or Established Tracheostomy |
| Genitourinary System | Renal Insufficiency, Nephropathy, Neurogenic Bowel or Bladder, Renal Failure, End Stage Renal Disease, Benign Prostatic Hyperplasia, Obstructive Uropathy, and Urinary Incontinence |
| Diseases of Blood  | Anemias and Sickle Cell Anemia |
| Digestive System | Gastroenteritis, Cirrhosis, Peptic Ulcers, Gastro Esophageal Reflux, Ulcerative Colitis, Crohn’s Disease, Inflammatory Bowel Disease, Bowel Incontinence, Celiac disease and Dysphagia |
| Integumentary System | Skin Ulcers, Diabetic or Venous Ulcers, Pressure Injuries, dermatitis and moisture-associated skin damage (MASD) |
| Infectious Diseases  | Skin and Soft Tissue Infections, Respiratory Infections, Covid, Tuberculosis, Urinary Tract Infections, Infections with Multi-Drug Resistant Organisms, Septicemia, Viral Hepatitis, *Clostridium difficile*, Influenza, Scabies, Legionellosis and Sexually Transmitted Infections |

**Decisions regarding caring for residents with conditions not listed above**

At our facility, we review potential admissions so we can make a good faith effort to determine continuing care arrangements for persons with diagnoses or conditions we may be less familiar with and have not previously supported. If we can admit a person with a new diagnosis to our facility or continue caring for a person that has developed a new diagnosis, condition, or symptom, we evaluate the resident to make an effort to have the resources, or plan how we might secure the needed resources, to provide care and support for the resident. We educate our staff to meet residents’ needs (competencies and skill sets).

List/describe any conditions that are not able to be cared for or services that cannot be provided. Examples may include dangerous physical aggression, excessive verbal abuse of the residents, staff and/or visitors, behaviors that place others or self at risk (i.e., failure to adhere to smoking policy, etc.), active substance abuse, criminal activity, active psychosis, vegan diet, kosher/halal diet, IV nutrition, new tracheostomy, ventilators, morbid obesity greater than xx pounds, mental health concerns that create a risk to self or others, infectious diseases requiring air borne precautions, in-house dialysis care, etc.

**Acuity Data**

Our facility reviews our residents’ acuity levels to understand potential implications regarding the intensity and complexity of care and services needed. We differentiate between long-stay and short-stay residents or other categorizations (e.g., unit floors or specialty areas or units, such as those that provide care and support for persons living with dementia or using ventilators). Our facility assessment includes an evaluation of the overall number of facility staff needed to ensure a sufficient number of qualified staff are available to meet each resident’s needs as identified through resident assessments and care plans. This is not an inclusive list.

When determining resident acuity, it may be helpful to differentiate between long-stay and short-stay residents and/or other categories (e.g., units, floors, specialty areas, secured units, vents). Describe these areas here. You may wish to include PDPM data for your Medicare residents or Medicaid RUGs data for your Medicaid residents.

**Special Treatments and Conditions**

|  |  |  |
| --- | --- | --- |
|  |  Special Treatments  | Average # or Range of Residents |
| Cancer Treatments | Chemotherapy | # |
| Radiation | # |
| Respiratory Treatments  | Oxygen therapy | # |
| Suctioning | # |
| Tracheostomy Care | # |
| Ventilator or Respirator | # |
| BIPAP/CPAP | # |
| Mental Health  | Behavioral Health Needs | # |
| Active or Current Substance Use Disorders | # |
| Other  | IV Medications | # |
| Injections | # |
| Enteral Feedings | # |
| Palliative Care | # |
| Transfusions | # |
| Dialysis | # |
| Ostomy Care | # |
| Hospice Care | # |
| Respite Care | # |
| Transmission Based Precautions for Active Infectious Disease | # |
| Wound Care | # |

**Ethnic, cultural or religious factors**

At our facility, we respect ethnic, cultural or religious factors or personal resident preferences which may potentially affect the care provided to our residents. Some examples may include activities, food and nutrition services, languages, clothing preferences, access to religious services or religious-based advanced directives.

Describe what you have identified and implemented upon evaluating your resident population/profile. Examples include cultural, ethnic and spiritual preferences and how they are integrated into facility services.

**Other**

Describe other pertinent facts or descriptions of the resident population that must be considered when determining staffing and resource needs. Examples of other pertinent information about the resident population the facility serves may include race, ethnicity, disability, sexual orientation, gender identity, preferred language, health literacy or other factors that affect access to care and health outcomes related to health equity, residents’ preferences about daily schedules, waking, bathing, activities, naps, food, going to bed and preference for either male or female caregivers.

**Section 2: Services and Care We Offer Based on Residents’ Needs**

**Resident support/care needs**

Our facility cares for many different residents with various types of care. The list below is designated by general categories; we have added specifics pertinent to reflect the needs of our resident population. This is not an inclusive list. Review “Specific Care or Practices” below and add or remove any your facility does not provide.

|  |  |
| --- | --- |
| General Care | Specific Care or Practices |
| Activities of Daily Living | Bathing, showers, oral/denture care, dressing, eating, support with needs related to hearing/vision/sensory impairment, supporting resident independence in doing as many of these activities by himself/herself  |
| Mobility and Fall/Fall with Injury Prevention | Transfers, ambulation, restorative nursing, contracture prevention/care; amputation/prostheses care; supporting resident independence in doing as many of these activities by himself/herself  |
| Bowel/Bladder | Bowel/bladder toileting programs, incontinence prevention and care, intermittent or indwelling or other urinary catheter, ostomy, responding to requests for assistance to the bathroom/toilet promptly to maintain continence and promote resident dignity |
| Skin Integrity  | Pressure injury prevention and care, skin care, wound care (surgical, other skin wounds)  |
| Mental Health and Behavior  | Manage the medical conditions and medication-related issues causing psychiatric symptoms and behavior, identify and implement interventions to help support individuals with issues such as dealing with anxiety, care of someone with cognitive impairment, care of individuals with depression, trauma/PTSD, other psychiatric diagnoses, intellectual or developmental disabilities, SUD, traumatic brain injury |
| Medications  | Awareness of any limitations of self-administering medications, administration of medications that residents need by route – including oral, nasal, buccal, sublingual, topical, subcutaneous, rectal, intravenous (peripheral or central lines), intramuscular, inhaled (nebulizer), vaginal, ophthalmic, etc., assessment/management of polypharmacy |
| Pain Management  | Assessment of pain, pharmacologic and nonpharmacological pain management  |
| Infection Prevention and Control  | Prevention, identification and containment of infections  |
| Management of Medical Conditions | Assessment, early identification of problems/deterioration, management of medical and psychiatric symptoms and conditions such as heart failure, diabetes hypothyroidism, chronic obstructive pulmonary disease (COPD), gastroenteritis, infections such as UTI, gastroenteritis and pneumonia  |
| Therapy | Physical, occupational, speech/language, respiratory, music, art, management of braces, splints and assistive devices  |
| Other Special Care Needs  | Dialysis (in-house or coordinated outpatient), hospice, ostomy care, tracheostomy care, ventilator care, bariatric care, palliative care, end of life care, Dementia care, amputation care |
| Nutrition | Individualized dietary requirements, liberal diets, specialized diets, mechanically altered, thickened liquids, IV nutrition and hydration, tube feeding, cultural or ethnic dietary needs, assistive devices, fluid monitoring or restrictions, hypodermoclysis |
| Provide Person-Centered/Directed Care including Psycho/Social/Spiritual Support | Build relationship with resident/get to know him/her, then engage resident/representatives in conversation to find out what resident’s preferences and routines are, what makes a good day for the resident, and what upsets him/her. Incorporate this information into the care planning process, ensure staff caring for the resident/representative have this information, and record and discuss treatment and care preferences. Support emotional and mental well-being and helpful coping mechanisms. Support resident having familiar belongings. Provide culturally competent care; learn about resident preferences and practices about culture and religion; stay open to requests and preferences and work to support those as appropriate. Provide or support access to religious and spiritual preferences. Provide opportunities for social activities/life enrichment (individual, small group, community). Support community integration if resident desires. Prevent abuse and neglect. Identify hazards and risks for residents. Offer and assist resident and family caregivers (or other proxy as appropriate) to be involved in person-centered care planning and advance care planning. Provide family/representative support. |

**Section 3: Facility Resources Needed to Provide Competent Support and Care for our Resident Population Every Day and During Emergencies**

**Facility staff**

At our facility, we utilize information collected in the resident profile to identify the care and services needed to care for our residents. We evaluate the type of staff members, other health care professionals and medical practitioners needed to provide support and care for our residents. Below is a list of staff identified as needed to care for our resident population. This is not an inclusive list. Please review the areas below and add or remove any that your facility does not provide. In addition, identify if services are performed remotely or are contracted through an outside entity.

* Administration (e.g., Administrator, Administrative Assistant, Staff Development, Quality Assurance – Performance Improvement [QAPI], Infection Control and Preventionist, Environmental Services, Social Services, Activities, Discharge Planning, Business Office, Finance, Human Resources, Compliance and Ethics)
* Nursing Services (e.g., DON, RN, LPN/LVN, CNA/STNA, Medication Aide or Technician, MDS Nurse)
* Food and Nutrition Services (e.g., Director, Support Staff, RD)
* Therapy Services (e.g., OT, OTA, PT, PTA, RT, RT Tech, Speech Language Pathologist)
* Medical/Physician Services (e.g., Medical Director, Attending Physician, Physician Assistant, Nurse Practitioner, Dentist, Podiatrist, Ophthalmologist, Audiologist, Optometrist, Psychiatrist/Psychology)
* Pharmacist
* Behavioral and Mental Health Providers
* Support Staff (e.g., Engineering, Plant Operations, Information Technology, Custodians, Housekeeping, Maintenance, Groundskeepers, Laundry, Transport, etc.)
* Chaplain/Religious Services
* Volunteers
* Students
* Other (Vocational Services, Clinical Laboratory Services, Diagnostic X-ray Services, Blood Services, Beautician/Barber)

Describe how the facility solicits and considers input received from direct care staff (including, but not limited to, RNs, LPNs/LVNs, nursing assistants and representatives of direct care staff such as a third party, if applicable).

Staff directories, organizational charts, etc., may be referred to and attached here.

**Staffing plan**

\*Facility leadership to determine if and how they will include staffing levels in facility assessment.

Based on our resident population and their needs for care and support, we have made a good faith effort and approach to ensure we have sufficient staff to meet the needs of our residents at any given time.

At our facility, we make a good faith effort to evaluate the overall number of facility staff needed to ensure enough qualified staff are available to meet each resident’s needs. This is not an all-inclusive list. Please refer to the organizational chart.

Sample staffing charts below. This example uses Hours Per Resident Days (HPRD) as it is publicly available on Care Compare.

|  |  |
| --- | --- |
| All Staff (as noted above) | Current # |
| Full-time staff | # |
| Part-time staff | # |
| PRN staff | # |

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| Hours Per a Resident Days (HPRD) | RN | LPN | CNA/STNA | Other |
| Days | # | # | # | # |
| Evenings | # | # | # | # |
| Nights | # | # | # | # |

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| Direct Care Staff for Specialty Units, i.e., Behavioral Health, Memory Care, Secured Unit (Insert data for each unit separately if applicable) HPRD | RN | LPN | CNA/STNA | Other/Admin |
| Days | # | # | # | # |
| Evenings | # | # | # | # |
| Nights | # | # | # | # |

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| Dietary Staff HPRD  | Cook | Aides | Dietary Manager | Other i.e. Registered Dietitian |
| Days | # | # | # | # |
| Evenings | # | # | # | # |

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| Rehab Care Staff HPRD  | PT | OT | ST | PTA | OTA |
| Days | # | # | # | # | # |

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| Other Staff HPRD  | Maintenance | Ancillary | Laundry | Housekeeping | Other |
| Days | # | # | # | # | # |
| Evenings | # | # | # | # | # |
| Nights | # | # | # | # | # |

**Individual staff assignment**

Describe how you determine and review individual staff assignments for coordination and continuity of care for residents within and across these staff assignments.

Describe how staffing needs for each shift are determined and adjusted as necessary based on changes to resident population during normal operations and emergencies.

**Recruitment and retention of direct care staff**

Describe your current recruitment and retention processes/practices and highlight applicable areas below.

|  |  |  |
| --- | --- | --- |
| Activity | Type | Process |
| Social Media | FacebookInstagramTikTokLinkedInOther | Describe process for posting on these sites and content of postings (i.e., resident activities, employee culture/retention, “we are hiring,” etc. |
| Job boards and job sites | IndeedGlassdoorLinkedInFacebookOther | Describe process for posting on job boards and job sites |
| Community connections for recruitment opportunities | Community centersJob fairsChurchesTech schoolsHigh schoolsNursing schoolsSTNA schoolsLPN schoolsCollege campusesGovernment programsOther | Describe process for utilizing these connections and which are available/actively being used |
| Career ladder/growth opportunities | Tuition reimbursementPaid certificationsOther | Describe opportunities you provide to staff for professional growth |
| Benefits | Healthcare401(k)Daily payMental healthPTO/sick daysBonuses  | Describe current benefits offered to employees |
| Technology | Applicant tracking systemScheduling appElectronic on-boardingOther | Describe technology/programs utilized to increase the candidate experience and streamline processes |
| Retention activities | Employee appreciationFocus groupsFeedback surveysOther | Describe retention activities and, if applicable, how the activities are followed-up on (surveys) |

**Contingency plan for staffing**

Describe processes for planning for events that do not require activation of an emergency plan but do have the potential to affect resident care, including:

* How the facility accounts for staff call-offs and process for covering shifts
* Med and non-med supply management and how to ensure supplies are available
* Other

**Staff training/education and competencies**

Our facility makes a good faith effort to provide the staff training/education and competencies necessary to provide the level and types of support and care needed for our resident population. Describe staff certification requirements as applicable. Potential data sources include hiring, education, training, competency instruction and testing policies.

Our facility has identified the following training topics that may be utilized by our staff including managers, nursing, direct care staff, contracted individuals and volunteers consistent with their expected roles. This is not an inclusive list.

* Communication: effective communications for direct care staff
* Resident’s rights and facility responsibilities: staff members are educated on the rights of the resident and the responsibilities of a facility to properly care for its residents
* Abuse, neglect and exploitation: training that, at a minimum, educates staff regarding:
	+ Activities which constitute abuse, neglect, exploitation and misappropriation of resident property.
	+ Procedures for reporting incidents of abuse, neglect, exploitation or the misappropriation of resident property; and
	+ Care/management for persons with dementia and resident abuse prevention.
* Infection control: includes the written standards, policies and procedures for the program
* Required in-service training for nurse aides. In-service training must:
	+ Be sufficient to ensure the continuing competence of nurse aides but must be no less than 12 hours per year
	+ Include dementia management training and resident abuse prevention training
	+ Address areas of weakness as determined in nurse aides’ performance reviews and facility assessment and may address the special needs of residents as determined by the facility staff; and
	+ For nurse aides providing services to individuals with cognitive impairments, also address the care of the cognitively impaired.
* Required training of feeding assistants: through a state-approved training program for feeding assistants (if applicable)
* Identification of changes in resident condition: includes how to identify medical issues appropriately, how to determine if symptoms represent problems in need of intervention, how to identify when medical interventions are causing rather than helping relieve suffering and how to improve quality of life
* Cultural competency: includes ability to effectively deliver healthcare services that meet the social, cultural, and linguistic needs of residents including resident-centered care
* Quality Assurance Performance Improvement (QAPI)
* Emergency preparedness
* Wound/pressure injury prevention
* Behavioral health, i.e., substance use disorder
* Other – describe, if applicable

Our facility has identified the following competencies that may be utilized by our staff. This is not an inclusive list.

* Person-centered care: includes, but is not limited to, person-centered care planning, education to resident and family/resident representative about treatments and medications, documentation of resident treatment preferences, end-of-life care and advance care planning
* Activities of daily living: includes bathing (e.g., tub, shower, sitz, bed), bed-making (occupied and unoccupied), bedpan, dressing, feeding, nail and hair care, perineal care (female and male), mouth care (brushing teeth or dentures), providing resident privacy, range of motion (upper or lower extremity), transfers, using gait belt and using mechanic lifts
* Disaster planning and procedures: includes emerging infections, active shooter, elopement, fire, flood, power outage and weather
* Infection control: includes hand hygiene, isolation, standard universal precautions including use of personal protective equipment, multidrug resistant organisms (MDROs) precautions and environmental cleaning
* Medication administration: includes injectable, oral, subcutaneous and topical
* Measurements: includes blood pressure, orthostatic blood pressure, body temperature, urinary output including urinary drainage bags, height and weight, radial and apical pulse, respirations, recording intake and output and urine test for glucose/acetone
* Resident assessment and examinations: includes admission assessment, skin assessment, pressure injury assessment, neurological check, lung sounds, nutritional check, observations of response to treatment and pain assessment
* Memory care: includes caring for persons with Alzheimer’s or other dementia
* Specialized care: includes catheterization insertion/care, colostomy care, diabetic blood glucose testing, oxygen administration, suctioning, pre-op and post-op care, trach care/suctioning, ventilator care, tube feedings, wound care/dressings, dialysis care, and IV placement, use and care
* Behavioral health: includes caring for residents with mental and psychosocial disorders and residents with a history of trauma and/or post-traumatic stress disorder and implementing nonpharmacological interventions
* Resident safety
* Pressure injury preventions
* Abuse prevention and reporting
* Other – describe, if applicable

**Policies and procedures for provision of care**

Our facility utilizes the data collected in the review of our resident profile/resident population to evaluate what policies and procedures may be required in the provision of care, and to ensure the policies and procedures meet current professional standards of practice. Describe how you evaluate what policies/procedures are needed as well as how they will be developed, written, and/or updated, and provide source references.

**Working with medical practitioners**

Describe your plan to recruit and retain enough medical practitioners (e.g., physicians, nurse practitioners) who are adequately trained and knowledgeable in the care of your residents, including how you will collaborate with them to ensure that the facility has appropriate medical practices for the needs and scope of your population. Discuss how you integrate with in-house practitioners and external, and their backgrounds – i.e., nurse practitioner, certified would nurse consultants, geriatricians, mental health professionals, etc.

Describe how the management and staff familiarize themselves with what they should expect from medical practitioners and other healthcare professionals related to standards of care and competencies necessary to provide the level and types of support and care needed for your resident population. For example, do you share expectations for providers that see residents in your nursing home on the use of standards, protocols, or other information developed by your medical director? Do you have discussions on what providers and staff expect of each other in terms of the care delivery process and clinical reasoning essential to providing high quality care?

**Physical environment and building/plant needs**

Our facility collects data related to resources which may be needed to meet the residents' needs based on our resident profile/resident population. Physical environment, equipment, services, and other physical plant considerations are reviewed to assure we meet the care needs of our residents.

Describe your processes to ensure adequate supplies and to ensure equipment (medical and non-medical) is maintained to protect and promote the health and safety of residents (secure unit, mechanical lifts, bariatric needs, etc.) Describe some routine preventive measures used to promote resident safety such as monitoring water temperatures, conducting fire drills, generator testing, etc. Include an evaluation of building maintenance capital improvements, structures and vehicles.

**Other**

Describe how the facility solicits and considers input received from staff, residents, resident representatives and family members. Examples may include compliance hot lines, resident/family customer service interviews/surveys, management of grievance process, resident and family councils, staff meetings, staff satisfaction surveys, suggestion boxes and staff/residents/family participation in QAPI activities.

Our facility reviews contracts, memorandums of understanding and other agreements with third parties that provide services or equipment to the facility during both normal operations and emergencies. Consider including a description of your process for overseeing these services and how those services will meet resident needs and regulatory, operational, maintenance and staff training requirements. Examples may include Quality Improvement Organization (QIO), heartcare coalitions, etc.

List health information technology resources, such as systems for electronically managing resident records and electronically sharing information with other organizations. Consider including a description of a) how the facility will securely transfer health information to a hospital, home health agency, or other providers for any resident transferred or discharged from the facility; b) how downtime procedures are developed and implemented; and c) how the facility ensures that residents and their representative can access their records upon request and obtain copies within required timeframes.

Describe how you evaluate if your infection prevention and control program includes effective systems for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors and other individuals providing services under a contractual arrangement that follows accepted national standards. For example, local health department, state health department, or QIO. An example of an infection risk assessment is the Centers for Disease Control (CDC) [Infection Control Risk Assessment](https://view.officeapps.live.com/op/view.aspx?src=https%3A%2F%2Fwww.cdc.gov%2Flong-term-care-facilities%2Fmedia%2Fexcel%2FIPC-RiskAssessment.xlsx&wdOrigin=BROWSELINK).

**Facility-based and community-based risk assessment**

Our facility has conducted a Hazards Vulnerability Assessment (HVA), utilizing an all-hazards approach (an integrated approach focusing on capacities and capabilities critical to preparedness for a full spectrum of emergencies and natural disasters). Our facility utilizes this information along with information we have collected in our Facility Assessment to make a good faith effort to focus on high-volume, high-risk areas. An example of a HVA is the Kaiser Permanente Hazard Vulnerability Analysis.

Please refer to the facility Emergency Preparedness Plan (EPP).

**Additional Supporting Activity**

Fill out this chart below with opportunities you have identified from the Facility Assessment process and current actions taken.

|  |  |
| --- | --- |
| Opportunities | Actions Taken: |
|  | Training and competencies | Referred to QAPI | Added to Policy and Procedures |
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