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Facility Assessment Tool

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**Facility Assessment Tool**

# Requirement

Nursing facilities will conduct, document, and review a facility-wide assessment, which includes both their resident population and the resources the facility needs to care for their residents (42 CFR §483.71). The assessment will be reviewed annually and updated as needed. The requirement for the facility assessment may be found in Attachment 1.

# Purpose

The purpose of the assessment is to evaluate the resident population and determine what resources are necessary to care for residents competently during both day-to-day operations (including nights and weekends) and emergencies. Use this assessment to make decisions about your direct care staff needs (including those who provide services under contract and volunteers), as well as your capabilities to provide services to the residents in your facility, at least annually and as necessary, per the above requirement. Using evidence-based, data driven methods focuses on ensuring that each resident is provided care that allows the resident to maintain or attain their highest practicable physical, mental, and psychosocial well-being.

# Overview of the Assessment Tool

This is an optional template provided for nursing facilities, and if used, it needs to be modified to capture facility specific information. Each facility has flexibility to decide the best way to comply with this requirement.

The tool is organized in three parts:

1. **Resident profile** including numbers, diseases/conditions, physical/behavioral health needs, cognitive disabilities, acuity, and ethnic/cultural/religious factors that impact care
2. **Services and care offered** based on resident needs (includes types of care your resident population requires; the focus is not to include individual level care plans in the facility assessment)
3. **Facility resources needed** to provide competent care for residents, including staff, staffing plan (maximizing direct care staff recruitment and retention) staff training/education and competencies, physical environment and building needs, and other resources, including agreements with third parties, health information technology resources and systems, a facility-based and community-based risk assessment, and other information that you may choose

This assessment asks you to collect and use information from a variety of sources. Some of the sources may include but are not limited to MDS reports, Quality Measures, 671, 802 (Roster/Sample Matrix Form) reports, pharmacy reports, Payroll-Based Journal data or reports, and in-house developed reports (e.g., resident diagnosis and demographics, a 24-hour report, psychotropic medications use, pressure injuries, resident falls, behavior tracking and interventions, resident/family surveys, etc.).

*Disclaimer: Use of this tool is not mandated by the CMS, nor does it ensure regulatory compliance. 09/05/2024*

# Guidelines for Conducting the Assessment

1. To ensure the required thoroughness, individuals involved in the facility assessment should, at a minimum, include the administrator, a representative of the governing body, the medical director, the director of nursing, direct care staff, including but not limited to RNs, LPNs/LVNs, NAs, and representatives of the direct care staff, if applicable. The environmental operations manager and other department heads (e.g., the dietary manager, director of rehabilitation services, or other individuals including direct care staff) should be involved as needed. Facilities must seek input from residents, their representative(s), or families, and consider that information when formulating their assessment.
2. While a facility may include input from its corporate organization, the facility assessment must be conducted at the facility level.
3. The facility must review and update this assessment annually or whenever the facility implements or 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., meet the needs of those residents and any areas requiring attention, such as any training or supplies required to provide care.
   * It is not the intent that the organizational 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.
4. The facility assessment should drive staffing decisions and other resources and may include the operating budget necessary to carry out facility functions.
5. Appendix PP provides surveyor guidance through Interpretive Guidelines in the State Operations Manual. Regarding the facility assessment, Appendix PP indicates, “If systemic care concerns are identified that are related to the facility’s planning, review the facility assessment to determine if these concerns were considered as part of the facility’s assessment process. For example, if a facility recently started accepting bariatric residents, and concerns are identified related to providing bariatric services, did facility staff update its assessment before accepting residents with these needs to identify the necessary equipment, staffing, etc., needed to provide care that is effective and safe for the residents and staff?”
6. For a suggested process for conducting the assessment, including synthesis and use of findings, see Attachment 2

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# FACILITY ASSESSMENT TOOL

|  |  |
| --- | --- |
| **Facility Name** |  |
| **Persons (names/ titles) involved in the process and completing assessment** | Nursing Home Leadership and Management:   * Administrator: * Director of Nursing: * A member of the Governing Body: * Medical Director:   Other:   * Direct Care Staff; RNs, LPNs/LVNs, NA/CNA, and representatives  of the direct care staff, if applicable * Residents/resident representatives/family members   \**Solicit and consider input from residents/resident representative and family members (see QSO Memo: QSO-24-13-NH, page 7, or Appendix PP). Examples: suggestion boxes, distributing questionnaires addressing staffing, or annual notices seeking input prior to the annual review of the facility assessment*. |
| **Date(s) of assessment or**  **update** |  |
| **Date(s) assessment reviewed with QAA/QAPI committee** |  |

Part 1: Our Resident Profile

*Numbers*

* 1. Indicate the number of residents you are licensed to provide care for: (enter number of beds) .

Consider if it would also be helpful to 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).

* 1. Indicate your average daily census: (enter a range) \_ .

Consider if it would also be helpful to 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).

* + 1. Consider if it would be helpful to describe the number of persons admitted and discharged (i.e., each week, each month, throughout the year), as these processes can impact staffing needs.

|  |  |  |
| --- | --- | --- |
|  | **Number (enter average or range) of persons admitted (and specify timeframe)** | **Number (enter average or range) of persons discharged (and specify timeframe)** |
| Weekday |  |  |
| Weekend |  |  |

*Diseases/conditions, physical and cognitive disabilities, behavioral health needs, and overall acuity*

* 1. Indicate if you may accept residents with, or your residents may develop, the following **common** diseases, conditions, physical and cognitive disabilities, or combinations of conditions that require complex medical care and management.

For example, start with this list and modify as needed. The intent is not to list every possible diagnosis or condition. Rather, it is to document common diagnoses or conditions to identify the types of human and material resources necessary to meet the needs of residents living with these conditions or combinations of these conditions. Use evidence-based, data driven methods (i.e., MDS, Care Area Assessment, EMR reports, fall risk assessment, Braden/Norton Assessment, Infection Control Assessment and Response tool).

|  |  |
| --- | --- |
| **Category** | **Common diagnoses** |
| Mental and Behavioral Health | Psychosis (Hallucinations, Delusions, etc.), Impaired Cognition, Mental Disorder, Depression, Bipolar Disorder (i.e., Mania/Depression), Schizophrenia, Post-Traumatic Stress Disorder, Anxiety Disorder, Behavior that Needs Interventions, Behavioral and Psychological Symptoms of Dementia (BPSD), Substance Use Disorder |
| 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), Pulmonary Thrombo-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, Down’s Syndrome, Autism, Huntington’s Disease, Tourette’s Syndrome, Aphasia, Cerebral Palsy, Progressive Neurological Conditions |
| Vision | Visual Loss, Cataracts, Glaucoma, Macular Degeneration |
| Hearing | Hearing Loss |
| Musculoskeletal System | Fractures, Osteoarthritis, Other Forms of Arthritis, Hip/Knee Replacement, Osteoporosis, Amputation |
| Neoplasm | Prostate Cancer, Breast Cancer, Lung Cancer, Colon Cancer |
| Metabolic Disorders | Diabetes, Thyroid Disorders, Hyponatremia, Hyperkalemia, Hyperlipidemia, Obesity, Morbid (severe) Obesity |
| Respiratory System | Chronic Obstructive Pulmonary Disease (COPD), Pneumonia,  Asthma, Chronic Lung Disease, Respiratory Failure |

|  |  |
| --- | --- |
| **Category** | **Common Diagnosis** |
| Genitourinary System | Renal Insufficiency, Nephropathy, Neurogenic Bowel or Bladder, Renal Failure, End Stage Renal Disease, Benign Prostatic Hyperplasia, Obstructive Uropathy, Urinary Incontinence |
| Diseases of Blood | Anemia |
| Digestive System | Gastroenteritis, Cirrhosis, Peptic Ulcers, Gastroesophageal Reflux, Ulcerative Colitis, Crohn’s Disease, Inflammatory Bowel Disease, Bowel Incontinence |
| Integumentary System | Skin Ulcers, Injuries |
| Infection Diseases | Skin and Soft Tissue Infections, Respiratory Infections, Tuberculosis, Urinary Tract Infections, Infections with Multi-Drug Resistant Organisms, Septicemia, Viral Hepatitis, *Clostridium difficile*, Influenza, Scabies, Legionellosis, COVID-19 |

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

* 1. Describe the process to make admission or continuing care decisions for persons that have diagnoses or conditions that you are less familiar with and have not previously supported. For example, how do you determine, if you have the opportunity to admit a person with a new diagnosis to your facility, or to continue caring for a person that has developed a new diagnosis, condition or symptom, if you have the resources, or how you might secure the resources, to provide care and support for the person?

*Acuity*

* 1. Describe your residents’ acuity levels that help you to understand potential implications regarding the intensity of care and services needed. The intent of this is to give an overall picture of acuity – **over the past year, or during a typical month**, for example. Potential data sources include case mix index, MDS data, PDPM, and resident/patient acuity tools.

Consider if it would also be helpful to 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).

Examples of different ways to look at acuity are provided using MDS data in the tables below*. Choose a methodology that works best for your organization.* You may elect to use some or all of the tables below or choose your own methodology. Please also refer to the most recent guidance available.

**Example 1:** PDPM Nursing Categories

| **PDPM Nursing Categories** | **Number/Average or Range of Residents** |
| --- | --- |
| Extensive Services  (ES3, ES2, ES1) |  |
| Special Care High  (HDE2, HDE1, HBC2, HBC1) |  |
| Special Care Low  (LDE2, LDE1, LBC2, LBC1) |  |
| Clinically Complex  (CDE2, CDE1, CBC2, CA2, CBC1, CA1) |  |
| Behavioral Symptoms and Cognitive Performance  (BAB2, BAB1) |  |
| Reduced Physical Function  (PDE2, PDE1, PBC2, PA2 PBC1, PA1) |  |

**Example 2:** Special Treatments and Conditions

| **Conditions** | **Special Treatments** | **Number/Average or Range of**  **Residents** |
| --- | --- | --- |
| Cancer Treatments | Chemotherapy |  |
|  | IV |  |
|  | Oral |  |
|  | Other |  |
|  | Radiation |  |
| Respiratory Treatments | Oxygen Therapy |  |
|  | Continuous |  |
|  | Intermittent |  |
|  | High-concentration |  |
|  | Suctioning |  |
|  | Scheduled |  |
|  | As Needed |  |
|  | Tracheostomy Care |  |
|  | Invasive Mechanical Ventilator |  |
|  | Non-invasive Mechanical  Ventilator |  |
|  | BiPAP |  |
|  | CPAP |  |
| Other | IV Medications |  |
|  | Vasoactive Medications |  |
|  | Antibiotics |  |
|  | Anticoagulants |  |
|  | Other |  |
|  | Transfusions |  |
|  | Dialysis |  |
|  | Hemodialysis |  |
|  | Peritoneal Dialysis |  |
|  | Hospice Care |  |
|  | Isolation or Quarantine for Active Infectious Disease |  |
|  | IV Access |  |
|  | Peripheral |  |
|  | Midline |  |
|  | Central |  |
|  | Injections |  |
|  | Transfusions |  |
|  | Respite Care |  |
| Mental Health | Behavioral Health Needs |  |
|  | Physical Behavioral Symptoms Directed Toward Others |  |
|  | Verbal Behavioral Symptoms  Directed Toward Others |  |
|  | Other Behavioral Symptoms  Directed Toward Others |  |
|  | Active or Current Substance Use Disorders |  |

**Example 3**: Assistance with Activities of Daily Living – Section GG

| **Assistance with Activities of Daily Living** | **Independent** | **Setup or Clean-up Assistance** | **Supervision or Touching Assistance** | **Partial/ Moderate Assistance** | **Substantial/Maximal Assistance** | **Dependent** |
| --- | --- | --- | --- | --- | --- | --- |
| Eating |  |  |  |  |  |  |
| Dressing  (Upper and lower  body, footwear) |  |  |  |  |  |  |
| Transfer (Chair/bed to chair, toilet,  tub/shower) |  |  |  |  |  |  |
| Toileting Hygiene |  |  |  |  |  |  |
| Sit to Stand |  |  |  |  |  |  |
| Bed Mobility (Roll left and right, sit to lying, lying to sitting on  side of bed) |  |  |  |  |  |  |
| Walking With Assistive Device (10 feet, 50 feet with 2 turns, 150 feet) |  |  |  |  |  |  |
| Walking Without Assistive Device (10 feet, 50 feet  with 2 turns, 150  feet) |  |  |  |  |  |  |
| Wheelchair/ Scooter Manual (50 feet with 2  turns, 150 feet) |  |  |  |  |  |  |
| Wheelchair/ Scooter Motorized  (50 feet with 2  turns, 150 feet) |  |  |  |  |  |  |

*Ethnic, cultural, sexual orientation, and religious factors*

* 1. Describe ethnic, race, cultural, disability, socioeconomic or religious factors or personal resident preferences that may potentially affect the care provided to residents by your facility. Examples may include activities, food and nutrition services (e.g., diet preferences, therapeutic diets), languages, clothing preferences, gender identity, health literacy, access to religious services, or religious-based advanced directives.

*Other*

* 1. Describe other pertinent facts or descriptions of the resident population that must be taken into account when determining staffing and resource needs (e.g., residents’ preferences with regard to daily schedules, waking, bathing, activities, naps, food, going to bed, etc.)

# Part 2: Services and Care We Offer Based on our Residents’ Needs

*Resident support/care needs*

* 1. List the types of care that your resident population requires and that you provide for your resident population. This should be informed through resident assessments and care plans (see Attachment 1 483.71(a)(1)(ii)). List by general categories, adding specifics as needed. It is not expected that you quantify each care or practice in terms of the number of residents that need that care or enter an aggregate of all resident care plans here. The intent is to identify and reflect on resources needed (in Section 3) to provide these types of care.

For example, start with this list and modify as needed:

| **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 much of these activities by himself/herself |
| Mobility and fall/fall with injury prevention | Transfers, ambulation, restorative nursing, contracture prevention/care; supporting resident independence in doing as much 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 |
| Medications | Awareness of any limitations of administering medications Administration of medications that residents need  By route: oral, nasal, buccal, sublingual, topical, subcutaneous, rectal, intravenous (peripheral or central lines), intramuscular, inhaled (nebulizer, metered dose inhaler), vaginal, ophthalmic, etc.  Assessment/management of polypharmacy |
| Pain management | Assessment of pain, pharmacologic and nonpharmacological  pain management |
| Infection prevention and  control | Identification and containment of infections, prevention 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, chronic obstructive pulmonary disease (COPD), gastroenteritis, infections such as  UTI and pneumonia, hypothyroidism |
| Therapy | PT, OT, Speech/Language, Respiratory, Music, Art, management of braces, splints |
| Other special care needs | Dialysis, hospice, ostomy care, tracheostomy care, ventilator care, bariatric care, palliative care, end of life care, Medications for Opioid Use Disorder, Substance Use Disorder care |
| Nutrition | Individualized dietary requirements, liberal diets, specialized diets, IV nutrition, tube feeding, cultural or ethnic dietary needs, assistive devices, fluid monitoring or restrictions, hypodermoclysis |
| Provide person- centered/directed care: Psycho/social/spiritual support: | Build relationship with resident/get to know him/her; engage resident in conversation  Find out what resident’s preferences and routines are; what makes a good day for the resident; what upsets him/her and incorporate this information into the care planning process. Make sure staff caring for the resident have this information  Record and discuss treatment and care preferences  Support emotional and mental well-being; support helpful  coping mechanisms  Support resident having familiar belongings  Provide culturally competent care: learn about resident preferences, sexual orientation/gender identity and practices with regard to culture and religion; stay open to requests and preferences and work to support those as appropriate  Provide or support access to religious preferences, use or encourage prayer as appropriate/desired by the resident  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 |

# Part 3: Facility Resources Needed to Provide Competent Support and Care for our Resident Population During Day-to-Day Operations and During Emergencies

*Staff type*

* 1. Identify the type of staff members, other health care professionals, and medical practitioners that are needed to provide support and care for residents. Potential data sources include staffing records, organization charts, Payroll-Based Journal reports, and the Long-Term Care Policy Manual.

Consider the following type of staff and other professionals/practitioners, list (or refer to or provide a link to) your staffing data, directories, organization chart, or other lists that show the type of staff needed to care for your resident population.

* Administration (e.g., Administrator, Administrative Assistant, Staff Development, QAPI, Environmental Services, Social Services, Discharge Planning, Business Office, Finance, Human Resources, Compliance and Ethics)
  + - Nursing Services (e.g., DON, RN, LPN or LVN, CNA or NA, medication aide or technician, paid feeding assistant, MDS nurse, Infection Preventionist, Clinical Nurse Specialist and RN/LPN/LVN/s with administrative duties
    - Food and Nutrition Services (e.g., Director (who is a certified dietary manager, certified food service manager, etc.), support staff, registered dietitian)
    - Therapy Services (e.g., OT, OTA, PT, PTA, PT Aide, RT, RT tech, speech language pathology (SLP), recreation therapists, qualified activities professionals, other activities staff)
    - Medical/Physician Services (e.g., Medical Director, Attending Physician, Physician Assistant, Nurse Practitioner, Dentist, Podiatrist, Ophthalmologist, Audiologist, Optometrist)
    - Pharmacist
    - Behavioral and mental health providers, qualified and other social workers, mental health social workers
    - Support Staff (e.g., engineering, plant operations, information technology, custodians, housekeeping, maintenance staff, groundskeepers, laundry services)
    - Chaplain/Religious services
    - Volunteers, students
    - Other (vocational services worker, clinical laboratory services worker, diagnostic X-ray services worker, blood services worker/phlebotomist, psychiatric services and mental health providers, transportation aides/providers, hospice workers)

*Staffing plan*

* 1. Based on your resident population and their needs for care and support, describe your general approach to staffing to ensure that you have sufficient staff to meet the needs of the residents at any given time. The facility assessment must include an evaluation of the overall number of facility staff needed to ensure enough qualified staff are available to meet each resident’s needs as identified through resident assessments and care plans.

Examples of two different ways to look at your staffing plan are provided in the tables below. Choose a methodology that works best for your organization. You may elect to use one or both tables below or choose your own methodology. It may be helpful to review specific staffing references in the regulation regarding the facility assessment (see attachment 1). For a discussion on how to determine sufficient staffing, see Attachment 2, section 7.b.

**Example 1.** 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. Refer to the guidance in the various tags that have requirements for staffing to be based on/in accordance with the facility assessment (refer to the [CMS Website](https://www.cms.gov/medicare/provider-enrollment-and-certification/guidanceforlawsandregulations/nursing-homes) for the latest F-Tag revisions and information and refer to QSO Memo: QSO-24-13-NH). Enter number, average, or range of staff needed below, considering staffing needs for each shift and for each resident unit in the facility:

| **Position** | **Total Number Needed or Average or Range** |
| --- | --- |
| Licensed nurses (RN, LPN, LVN) providing direct care |  |
| Nurse aides |  |
| Other nursing personnel (e.g., those with administrative duties) |  |
| In addition to nursing staff, other staff needed for behavioral healthcare and services (list other staff positions/roles): |  |
| Dietitian or other clinically qualified nutrition professional to serve as the director of food and nutrition services |  |
| Food and nutrition services staff |  |
| Therapy services staff; PT, OT, SLP, PT aide, OT aide, RT |  |

**Example 2.** Describe your general staffing plan to ensure that you have sufficient staff to meet the needs of the residents at any given time. Consider if and how the degree of fluctuation in the census and acuity levels impact staffing needs. In addition, consider specific staffing needs for each shift (e.g., day, evening, night, weekend shifts) and for each resident unit in the facility based on changes to resident population. For example:

| **Staff** | **Plan** |
| --- | --- |
| Licensed Nurses (LN): RN, LPN, LVN  providing direct care | DON: 1 DON RN full-time Days; if has other responsibilities, add x more RN as Asst. DON to equal one FTE  RN or LPN Charge Nurse: 1 for each shift 1-x residents DON may be Charge Nurse  1:x LN ratio Days (consider breaking this down by RN and LPN/LVN per shift and unit)  1:x LN ratio Evenings (consider breaking this down by RN and LPN/LVN per shift and unit)  1:x LN ratio Nights (consider breaking this down by RN and LPN/LVN per shift and unit)  Note: Please refer to the most up to date CMS guidance regarding minimum staffing requirements |
| All direct care staff (includes LN, CNA,) | 1:x ratio Days (total licensed) 1:x ratio Days (total certified)  1:x ratio Evenings (total licensed) 1:x ratio Evenings (total certified) 1:x ratio Nights (total licensed) 1:x ratio Nights (total certified)  Or  x hours per resident days (HPRD) indicating a) total number of licensed nurse staff hours per resident per day, b) RN hours per resident per day,  c) LPN/LVN hours per resident per day, d) Certified Nursing Assistant hours per resident per day.  Note: Comparative data for HPRD are available on Nursing Home Care Compare. Please refer to the most up to date CMS guidance regarding minimum staffing requirements. |
| Therapy (PT, OT, SLP, RT, RT Tech, PTA, PT Aide, OTA, and OT Aide) |  |
| Other (e.g., department heads, nurse educator, quality assurance, ancillary  staff in maintenance, housekeeping, dietary, laundry) |  |

*Contingency staffing plan*

* 1. Describe your contingency staffing plan for events that do not require the activation of the facility emergency plan, but do have the potential to impact resident care, such as the availability of direct care nurse staffing, or other resources needed for resident care (e.g. using contract/agency nurses to cover several shifts during a holiday, covering shifts for staff that call-out).

*Individual staff assignment*

* 1. Describe how you determine and review individual staff assignments for coordination and continuity of care for residents within and across these staff assignments (i.e., various shifts, resident units, etc.).

*Develop and maintain a plan to maximize recruitment and retention of direct care staff*

* 1. Provide a detailed description of how you plan to maximize recruitment and retention of direct care staff that includes the methods and strategies you are using or plan to use. Data collection for your recruitment and retention efforts is critical to evaluate and monitor its effectiveness.

[The](https://www.federalregister.gov/d/2024-08273/p-758) staff involved in developing this plan will vary by the type of care and services provided by the individual facilities. When developing a recruitment and retention plan, we encourage LTC facilities to include participation and input from the various types of direct care staff in their facilities and representatives of these workers.

Start by reviewing examples of strategies below, and modify as needed

|  |  |
| --- | --- |
| **Current/Future Staff Recruitment Strategies** | **Current/Future Staff Retention Strategies** |
| Utilize technology and data to analyze workforce supply and demand, assess gaps, and short and long term needs; partner with local nursing schools to host clinicals and career fairs; work with community partners to develop CNA career ladder apprenticeship programs; offer tuition reimbursement; use social media for advertising positions; ensure wages are within the market standard and compensation packages are competitive, with tuition reimbursement opportunities; use an automated application/hiring process; hold virtual interviews. | Develop a robust onboarding training program that includes checking in on new hires; consider having a mentor and supervisors completing reviews at 30/60/90-day intervals; deploy and analyze employee satisfaction surveys and identify how to strengthen practices and workplace culture while promoting diversity, equity and inclusion;  offer career ladders and paid training/education opportunities. |

*Staff training/education and competencies*

3.6 Describe the staff training/education and competencies that are necessary to provide the level and types of support and care needed for your resident population. Include staff certification requirements as applicable. Potential data sources include hiring, education, training, competency instruction, and testing policies.

It may be helpful to review specific references in the regulation regarding the facility assessment (see Attachment 1).

Review current regulations and list all staff training and competencies needed by type of staff, including managers, nursing, and other direct care staff, as well as individuals providing services under a contractual arrangement and volunteers. Consider if it would be helpful to indicate which competencies are reviewed at the time the staff member is hired, and cadence of subsequent reviews.

Consider the following **training topics** (this is not an inclusive list):

* Communication – effective communications for direct care staff, including communicating with residents who speak another language by using interpreter services, communication board, etc.
* Resident’s rights and facility responsibilities – ensure that 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 on— (1) Activities that constitute abuse, neglect, exploitation, and misappropriation of resident property; (2)

Procedures for reporting incidents, of abuse, neglect, exploitation, or the misappropriation of resident property; and (3) Care/management for persons with dementia and resident abuse prevention

* Infection control – a facility must include as part of its infection prevention and control program mandatory training that includes the written standards, policies, and procedures for the program
* Culture change (that is, person-centered and person-directed care)
* 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.
  + For nurse aides providing services to individuals with cognitive impairments, also address the care of the cognitively impaired.
* Required training of feeding assistants, if applicable – through a State-approved training program for feeding assistants
* Identification of resident changes in condition, including 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 improve quality of life
* Cultural competency (ability of organizations to effectively deliver health care services that meet the social, cultural, and linguistic needs of residents)
* Trauma-informed care – ensure residents who are trauma survivors receive culturally competent, trauma-informed care in accordance with professional standards of practice and accounting for residents’ experiences and preferences in order to eliminate or mitigate triggers that may cause re-traumatization of the resident
* Dementia care – provide care for persons living with dementia that focuses holistically on the needs of the resident living with dementia, as well as the needs of the other residents in the nursing home

Consider the following **competencies** (this is not an inclusive list):

* Person-centered care – This should include but not be limited to person-centered care planning, education of 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 – 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, using mechanic lifts, adaptive equipment, orthotics
* Disaster planning and procedures – active shooter, elopement, fire, flood, power outage, tornado, hurricane, cyber-attacks, pandemic
* Infection control – hand hygiene, isolation, standard universal precautions including use of personal protective equipment, COVID/MRSA/VRE/CDI precautions, environmental cleaning (please visit [CDC.gov](https://www.cdc.gov/long-term-care-facilities/about/index.html) for the latest guidance)
* Medication administration – injectable, oral, subcutaneous, topical, intravenous, ophthalmic, inhaled
* Measurements – 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, urine test for glucose/acetone
* Resident assessment and examinations – admission assessment, skin assessment, pressure injury assessment, neurological check, lung sounds, nutritional check, observations of response to treatment, pain assessment
* Caring for persons with Alzheimer’s or other dementia by supporting residents through the implementation of individualized approaches to care (including direct care and activities) that are directed toward understanding, preventing, relieving, and/or accommodating a resident’s distress or loss of abilities
* Specialized care – 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
* Caring for residents with mental and psychosocial disorders, as well as residents with a history of trauma and/or post-traumatic stress disorder and substance use disorder, and implementing nonpharmacological interventions
* Communication – effectively communicating with residents who speak another language than the staff person’s first language

*Policies and procedures for provision of care*

* 1. Describe how you evaluate what policies and procedures may be required in the provision of care, and how you ensure those meet current professional standards of practice. Include, for example, your process to determine if new or updated policies are needed, and how they are developed or updated. Examples of policies and procedures include pain management, IV therapy, fall prevention, skin and wound care, restorative nursing, specialized respiratory care for tracheostomy or ventilator, storage of medications and biologicals, staffing, and transportation.

*Working with medical practitioners*

* 1. 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/patients, including how you will collaborate with them to ensure that the facility has appropriate medical practices for the needs and scope of your population.
  2. 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 that are 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, building/plant needs, and emergency preparedness plan*

* 1. List (or refer to or provide a link to inventory) physical resources for the following categories. Review the resources in the example below and modify as needed. If applicable, describe your processes to ensure adequate supplies and to ensure equipment is maintained to protect and promote the health and safety of residents.

| **Physical Resource Category** | **Resources** | **If applicable, process to ensure adequate supply, appropriate maintenance, replacement** |
| --- | --- | --- |
| Buildings and/or other  structures | Building description, garage, storage shed |  |
| Vehicles | Transportation van |  |
| Physical equipment | Bath benches, shower chairs, bathroom safety bars, bathing tubs, sinks for residents and for staff, scales, bed scales, ventilators, wheelchairs and associated positioning devices, bariatric beds, bariatric wheelchairs, lifts, lift slings, bed frames, mattresses, room and common space furniture, exercise equipment, therapy tables/equipment, walkers, canes, nightlights, steam table, oxygen tanks and  tubing, dialysis chair and station, ventilators |  |
| Services | Waste management, hazardous waste management, telephone, HVAC, dental, barber/beauty, pharmacy, laboratory, radiology, occupational, physical, respiratory, and speech therapy, gift shop,  religious, exercise, recreational music, art therapy, café/snack bar/bistro |  |
| Other physical plant needs | Sliding doors, ADA compliant entry/exit ways, nourishment accessibility, nurse call system, emergency power/generator,  elopement devices |  |
| Medical supplies (if applicable) | Blood pressure monitors, compression garments, gloves, gowns, hand sanitizer, gait belts, infection control products, heel and elbow suspension products, suction equipment, thermometers, urinary catheter supplies, wound care supplies, ostomy supplies, oxygen,  oxygen saturation machine, Bi-PAP, bladder scanner, PPE (face shields, goggles, Isolation  gowns, shoe covers) |  |
| Non-medical supplies (if applicable) | Soaps, body cleansing products, incontinence supplies, waste baskets, bed and bath linens, individual communication devices, computers, assisted technology |  |

*Other*

* 1. List contracts, memoranda of understanding, or other agreements with third parties to 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.
  2. List health information technology resources, such as systems for electronically managing patient 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.
  3. 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 follow accepted national standards. See the [CDC’s Core Elements of Antibiotic Stewardship for Nursing Homes](https://www.cdc.gov/antibiotic-use/hcp/core-elements/nursing-homes-antibiotic-stewardship.html?CDC_AAref_Val=https://www.cdc.gov/antibiotic-use/core-elements/nursing-homes.html) for more information.
  4. Provide your facility-based and community-based risk assessment, 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). Note that it is acceptable to refer to the risk assessment of your emergency preparedness plan (§483.73), and focus on high-volume, high-risk areas.

Attachment 1

Medicare and Medicaid Programs; Minimum Staffing Standards for Long-Term Care Facilities and Medicaid Institution Payment Transparency Reporting

For additional information, see Survey & Certification [Memos](https://www.cms.gov/medicare/health-safety-standards/quality-safety-oversight-general-information/policy-memos-states-and-cms-locations) including QSO 24-13-NH and Appendix PP in the State Operations Manual, which can be found on the [CMS Home Page.](https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/GuidanceforLawsAndRegulations/Nursing-Homes)

§483.71 Facility Assessment

The facility must conduct and document a facility-wide assessment to determine what resources are necessary to care for its residents competently during both day-to- day operations *(including nights and weekends)* and emergencies. The facility must review and update that assessment, as necessary, and at least annually. The facility must also review and update this assessment whenever there is, or the facility plans for, any change that would require a substantial modification to any part of this assessment.

§483.71(a)The facility assessment must address or include the following:

§483.71(a)(1) The facility’s resident population, including, but not limited to,

* 1. Both the number of residents and the facility’s resident capacity;
  2. The care required by the resident population using evidenced-based, data driven methods that consider the types of diseases, conditions, physical and behavioral health needs, cognitive disabilities, overall acuity, and other pertinent facts that are present within that population, consistent with and informed by individual resident assessment as required under §483.20;
  3. The staff competencies and skill sets that are necessary to provide the level and types of care needed for the resident population;
  4. The physical environment, equipment, services, and other physical plant considerations that are necessary to care for this population; and
  5. Any ethnic, cultural, or religious factors that may potentially affect the care provided by the facility, including, but not limited to, activities and food and nutrition services.

§483.71(a)(2) The facility’s resources, including but not limited to, the following:

1. All buildings and/or other physical structures and vehicles;
2. Equipment (medical and nonmedical);
3. Services provided, such as physical therapy, pharmacy, behavioral health, and specific rehabilitation therapies;
4. All personnel, including managers, nursing and other direct care staff (both employees and those who provide services under contract), and volunteers, as well as their education and/or training and any competencies related to resident care;
5. Contracts, memorandums of understanding, or other agreements with third parties to provide services or equipment to the facility during both normal operations and emergencies; and
6. Health information technology resources, such as systems for electronically managing patient records and electronically sharing information with other organizations.

§483.71(a)(3) A facility-based and community-based risk assessment, utilizing an all-hazards approach as required in §483.73(a)(1).

§483.71(b) In conducting the facility assessment, the facility must ensure:

§483.71(b)(1) Active involvement of the following participants in the process:

1. Nursing home leadership and management, including but not limited to, a member of the governing body, the medical director, an administrator, and the director of nursing; and
2. Direct care staff, including but not limited to, RNs, LPNs/LVNs, NAs, and representatives of the direct care staff, if applicable.
3. The facility must also solicit and consider input received from residents, resident representatives, and family members.

§483.71(c) The facility must use this facility assessment to:

§483.71(c)(1) Inform staffing decisions to ensure that there are a sufficient number of staff with the appropriate competencies and skill sets necessary to care for its residents' needs as identified through resident assessments and plans of care as required in § 483.35(a)(3).

§483.71(c)(2) Consider specific staffing needs for each resident unit in the facility and adjust as necessary based on changes to its resident population.

§483.71(c)(3) Consider specific staffing needs for each shift, such as day, evening, night, and adjust as necessary based on any changes to its resident population.

§483.71(c)(4) Develop and maintain a plan to maximize recruitment and retention of direct care staff.

§483.71(c)(5) Inform 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 needed for resident care.

Additional References to the Facility Assessment:

§483.35 Nursing Services - The facility must have sufficient nursing staff with the appropriate competencies and skills sets to provide nursing and related services to assure resident safety and attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care and considering the number, acuity and diagnoses of the facility’s resident population in accordance with the facility assessment required at §483.71.

§483.40(a) Behavioral Health Services - The facility must have sufficient staff who provide direct services to residents with the appropriate competencies and skills sets to provide nursing and related services to assure resident safety and attain or maintain the highest practicable physical, mental and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care and considering the number, acuity and diagnoses of the facility’s resident population in accordance with §483.71.

-These competencies and skills sets include, but are not limited to, knowledge of and appropriate training and supervision for: 483.40(a)(1) Caring for residents with mental and psychosocial disorders, as well as residents with a history of trauma and/or post-traumatic stress disorder, that have been identified in the facility assessment conducted pursuant to §483.71.

§483.60(a) Food and Nutrition Services - Staffing. The facility must employ sufficient staff with the appropriate competencies and skills sets to carry out the functions of the food and nutrition service, taking into consideration resident assessments, individual plans of care and the number, acuity and diagnoses of the facility’s resident population in accordance with the facility assessment required at §483.71.

§483.75(c) QAPI Program feedback, data systems, and monitoring. The policies and procedures must include, at a minimum, the following: … (2) Facility maintenance of effective systems to identify, collect, and use data and information from all departments, including but not limited to the facility assessment required at §483.71 and including how such information will be used to develop and monitor performance indicators.

§483.75(e) QAPI Program activities …. (3) … The number and frequency of improvement projects conducted by the facility must reflect the scope and complexity of the facility's services and available resources, as reflected in the facility assessment required at §483.71.

§483.80(a) Infection Control - Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: (1) A system 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 based upon the facility assessment conducted according to §483.71 and following accepted national standards.

§483.95 Training Requirements - A facility must develop, implement, and maintain an effective training program for all new and existing staff; individuals providing services under a contractual arrangement; and volunteers, consistent with their expected roles. A facility must determine the amount and types of training necessary based on a facility assessment as specified at §483.71.

§483.95(i) Behavioral health - A facility must provide behavioral health training consistent with the requirements at §483.40 and as determined by the facility assessment at §483.71.

§483.95(g) Required in-service training for nurse aides - In-service training must—§483.95(g)(3) Address areas of weakness as determined in nurse aides' performance reviews and facility assessment at §483.71 and may address the special needs of residents as determined by the facility staff.

# Attachment 2

Sample Process for Conducting the Facility Assessment

## Plan for the Assessment

* 1. The administrator or designated individual assigns a person to lead the facility assessment process.
  2. The facility assessment leader:
     1. Reviews the regulation for the facility assessment requirements.
     2. Reviews the Interpretive Guidelines, Appendix PP for F838 Facility Assessment, and other areas that refer to the Facility Assessment.
     3. Reviews this optional facility assessment tool and/or your organization’s facility assessment template.
  3. The leader identifies and invites team members to be on the assessment team, including the administrator, a member of the governing body, medical director, director of nursing, direct care staff (RNs, LPNs/LVNs, NAs), and representatives of the direct care staff, if applicable. In addition, solicit and consider input received from residents, resident representatives, and family members.
     1. Consider and plan for how you will get input and participation from residents, their representatives and/or family members throughout the assessment process. This could include

a) distributing a questionnaire related to staffing to residents/families; b) placing convenient suggestion boxes throughout the facility for anonymous input; c) providing annual notices for soliciting input to residents and families prior to conducting the annual review and update of the facility assessment; d) asking for input from both the resident council and the family council (if there is one; if not, a meeting of families could be held to obtain such input); e) getting feedback from the local long-term care ombudsman program; and f) involving residents, their representatives, and/or family members as part of the facility assessment team (for instance, the president of the resident council could represent residents.

* + 1. Consider and plan for how you will get input from direct care staff (RNs, LPNs/LVNs, NAs). This could include involving direct care staff as part of the facility assessment team.
    2. Consider and plan for how you will engage the medical director and medical practitioners in discussing the entire approach to, and ability to care for, residents/patients.
  1. The leader convenes a team to work on the assessment, and with the team:
     1. Review and discuss the requirement.
     2. Review the process with the team; discuss and clarify steps needed.
     3. Discuss and establish a timeline for the assessment.
        1. Consider if the facility assessment timing should align with the budgeting process.
     4. Discuss and decide how the assessment will be completed.
        1. One person takes the lead on the first draft, or
        2. Assign persons to complete different sections.

## Complete the Facility Assessment

* 1. The team leader and others assigned complete the assessment.
  2. Team leader and others completing the assessment check-in as needed to discuss any questions or barriers that are coming up to completing the assessment. Create a timeline for completion and the team leader holds teammates accountable.

## Synthesize and Use the Assessment Findings

* 1. Review the findings of your assessment as a leadership team and discuss the following questions. The goal is to make decisions about needed resources, including direct care staff needs, as well as their capabilities to provide services to the residents in the facility. This step in the process is to use the assessment findings to ensure you are providing competent care to residents every day and during emergencies, and work to continuously identify and act on opportunities for improvement.

Documentations of discussions or responses to the questions below are intended for facility use. Consider the questions below:

* + 1. How has the resident population – diseases, conditions, acuity, etc. changed since the last assessment?
    2. Do we need to make any changes in staffing?
       1. Based on resident number/average daily census, acuity, and diagnoses of resident population and our current level of staffing, do we have sufficient nursing staff (nurses and CNAs) with the appropriate competencies and skills?

How do we determine if we have sufficient staffing? Consider the following:

* + - * + Gather input from residents, family members, and/or resident representatives, CNAs, licensed nurses providing direct care, and the local long-term care ombudsman about how well the current staffing plan has been working and any concerns, and make sure to consider this information when developing the staffing plan.
        + Calculate the type of staff and the amount of staff time needed to meet residents’ daily needs, preferences, and routines in order to help each resident attain or maintain the highest practicable physical, mental, and psychosocial well-being.
        + Review expectations for minimum staffing requirements at the federal and state level. Federal law requires nursing homes to have sufficient staff to meet the needs of residents, to use the services of a registered nurse for at least 8 consecutive hours a day, 7 days a week. §483.35(b)(1) and must designate a licensed nurse to serve as a charge nurse on each tour of duty (§483.35(a)(2). Review the [Final Rule Fact Sheet](https://www.cms.gov/newsroom/fact-sheets/medicare-and-medicaid-programs-minimum-staffing-standards-long-term-care-facilities-and-medicaid-0) for information regarding the minimum staffing standards for long-term care facilities. Refer to your state regulations for any additional minimum staffing standards.
        + Review comparative data (at the nursing home, state and national level) available on the staff measure on Nursing Home Care Compare. Ask how do we compare, and if we have different HRPD from other homes, the state, and nation, why? What might that mean and how might it inform our staffing plan? Note that the Nursing Home Care Compare staffing rating takes into account differences in the levels of residents' care needs in each nursing home. For example, a nursing home with residents that have more health problems would be expected to have more nursing staff than a nursing home where the residents need less health care.
      1. Based on resident number, acuity, and diagnoses of resident population, do we have sufficient staff with the appropriate skills and competencies to carry out functions of food and nutrition services; for example, dietitian?
    1. Are there any training, education and/ or competency needs based on resident and/or staff data or trends identified in the Facility Assessment?
       1. Does our current behavioral health training sufficiently address our resident population, as identified by the Facility Assessment?
       2. Does our current CNA training program sufficiently address our resident population as identified by the Facility Assessment?
       3. Are agency staff sufficiently trained to address needs of resident population?
       4. Do we need to update job descriptions to coincide with new competencies identified?
       5. Are new requirements incorporated into our annual performance evaluation process?
    2. What opportunities do we have to further collaborate closely with our medical practitioners to enhance our approaches to resident/patient care?
    3. Are there any infection control issues (e.g., increase in or new infectious diseases, surveillance needs) that require a change in our infection prevention resources and methods?
    4. What opportunities exist for quality initiatives (QAA/QAPI) as a result of what we learned from the Facility Assessment to improve our facility’s services and resources?
       1. Do the trends identified in the Facility Assessment suggest areas where we need to improve the quality of our care, quality of life for our residents and/or quality of our services, including staff recruitment and retention plans?
       2. What findings in the assessment indicate a need for us to collect and use additional data to inform decision making for future care and improvement?
    5. Are there any other resources we need to care for residents competently during day-to-day operations and emergencies, based on the Facility Assessment?
    6. Has our facility’s anticipated income been evaluated with relation to anticipated needs in the coming year, as identified in the assessment? Are adjustments needed in our operating budget to address any gaps in resource needs?
    7. Have you completed a Hazard Vulnerability Assessment? Are adjustments needed to minimize risk? See examples from [Kaiser Permanente,](https://www.telligenqiconnect.com/resource/kaiser-permanente-hazard-vulnerability-analysis-emergency-risk-assessment-tool/) [Leading Age Minnesota,](https://www.leadingagemn.org/inc/data/LTCPreparednessToolkit.pdf) and the [California](https://www.cahfdisasterprep.com/hva) [Association of Health Facilities.](https://www.cahfdisasterprep.com/hva)

|  |  |
| --- | --- |
| **Areas Facility Assessment Informed** | **Action To Be Taken/Already Taken This Year** |
| Staffing |  |
| Infection Prevention/Control |  |
| Training, Competencies |  |
| QAPI Initiatives/Performance Improvement Projects |  |
| Business Strategy |  |
| Hazard Vulnerability |  |
| Staff Recruitment and Retention |  |

## Evaluate Your Process and Plan for Future Assessments

* 1. Review the facility assessment requirements and guidance at F838. Be prepared to respond to the surveyor on the following questions.
     1. Does the facility assessment include an evaluation of the resident population, and its needs (e.g., acuity) based on evidence-based, data-driven methods? Does this reflect the population observed? Does it address the facility’s resident capacity?
     2. Does the facility assessment include information on the staffing level(s) needed for specific shifts, such as day, evening, and night? And are they adjusted as necessary based on changes in the resident population?
     3. Does the facility assessment address what skills and competencies are required by those providing care?
     4. Was the facility assessment conducted with input from the individuals stated in regulation (483.71(b))?
     5. Does the facility assessment indicate what resources, including but not limited to, equipment, supplies, services, personnel, health information technology, and physical environment are required to meet all resident needs?
     6. Does the facility have a plan for maximizing recruitment and retention of direct care staff?
     7. Does the facility assessment include a contingency plan that is informed by the facility assessment?
  2. Evaluate with your team the process to conduct the assessment and use the findings. What went well? What will you do differently next time?
  3. Establish a process for updating the assessment in one year (within 12 months) or earlier if there are substantive changes.

Attachment 3

Example of Evidenced Based Sources:

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Name** | **Link** | **Training** | **Retention** | **Recruitment** |
| Agency for Healthcare Research and Quality | [https://www.ahrq.gov/patient-](https://www.ahrq.gov/patient-safety/settings/long-term-care/resource/index.html) [safety/settings/long-term-](https://www.ahrq.gov/patient-safety/settings/long-term-care/resource/index.html)  [care/resource/index.html](https://www.ahrq.gov/patient-safety/settings/long-term-care/resource/index.html) | X | X |  |
| SAMHSA- Evidence- Based Practice  Resource Center | [https://www.samhsa.gov/resource-](https://www.samhsa.gov/resource-search/ebp) [search/ebp](https://www.samhsa.gov/resource-search/ebp) | X | X |  |
| Center of Excellence for the Behavioral Health in Nursing  Facilities | [https://nursinghomebehavioralhealth.org/ab](https://nursinghomebehavioralhealth.org/about-us/) [out-us/](https://nursinghomebehavioralhealth.org/about-us/) | X | X |  |
| Centers for Disease Control and Prevention (CDC) | CDC Home page: <https://www.cdc.gov/index.html> CDC Train:  <https://www.train.org/cdctrain/welcome> | X |  |  |
| National Pressure  Injury Advisory Panel | [https://npiap.com/#](https://npiap.com/) | X |  |  |
| INTERACT® | <https://pathway-interact.com/> |  |  |  |
| The Society for Post- Acute and Long-Term Care Medicine™ | <https://paltc.org/> | X |  |  |
| Pioneer Network | <https://www.pioneernetwork.net/> | X | X |  |
| CMS Quality, Safety & Education Portal (QSEP) COVID-19 and  Hand in Hand, Quality  in Focus | [https://qsep.cms.gov/ProvidersAndOthers/h](https://qsep.cms.gov/ProvidersAndOthers/home.aspx) [ome.aspx](https://qsep.cms.gov/ProvidersAndOthers/home.aspx) | X |  |  |
| Civil Money Penalty Reinvestment Program Toolkits | [https://www.cms.gov/medicare/health-](https://www.cms.gov/medicare/health-safety-standards/quality-safety-oversight-general-information/civil-money-penalty-reinvestment-program) [safety-standards/quality-safety-oversight-](https://www.cms.gov/medicare/health-safety-standards/quality-safety-oversight-general-information/civil-money-penalty-reinvestment-program) [general-information/civil-money-penalty-](https://www.cms.gov/medicare/health-safety-standards/quality-safety-oversight-general-information/civil-money-penalty-reinvestment-program) [reinvestment-program](https://www.cms.gov/medicare/health-safety-standards/quality-safety-oversight-general-information/civil-money-penalty-reinvestment-program) | X | X |  |
| Health Resources and Services Administration (HRSA) | <https://www.hrsa.gov/> |  |  | X |
| American Job Centers | [https://www.dol.gov/general/topic/training/](https://www.dol.gov/general/topic/training/onestop) [onestop](https://www.dol.gov/general/topic/training/onestop) |  |  | X |
| Nursing Home Trade Association Members | [https://www.ahcancal.org/Pages/default.asp](https://www.ahcancal.org/Pages/default.aspx) [x](https://www.ahcancal.org/Pages/default.aspx)  <https://leadingage.org/> | X | X | X |