Facility Assessment Tool

Requirement

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).

The regulatory requirement for the Facility Assessment is found in Attachment 1.

Purpose

Use this assessment to make decisions about the facility's direct care staff member needs and their capabilities to provide services to the residents in the facility. Using evidence-based, data-driven methods and a competency-based approach focuses on ensuring that each resident is provided care that allows the resident to maintain or attain his or her highest practicable physical, mental, and psychosocial well-being. The Facility Assessment is the foundation for the facility to assess its resident population and determine the direct care staffing and other resources to provide the required care to their residents.

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 assessment helps ensure that facilities have an efficient process for consistently assessing and documenting the necessary resources and staff that the facility requires to provide ongoing care for its population that is based on the specific needs of its residents.

Overview of the Assessment Tool

This is an optional tool provided for nursing facilities and, if used, it may be modified. Each facility has the flexibility to decide the best way to comply with this requirement to ensure the needs of its unique resident population are met.

The tool is organized in three parts:

1. Resident profile including:
    - The number of residents and the facility's capacity.
    - The care required by the resident population using evidence-based, data-driven methods that consider the types of diseases and 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 assessments.
    - Staff competencies and skill sets necessary to provide the level and types of care needed.

- The physical environment, equipment, services, and other physical plant considerations that are necessary to care for this population.
- 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.

2. Facility resources including:
   - All buildings and/or other physical structures and vehicles.
   - Equipment (medical and non-medical).
   - Services provided, such as physical therapy, pharmacy, and specific rehabilitation therapies.
   - 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.
   - Contracts, memorandums of understanding, or other agreements with third parties to provide services or equipment to the facility during both normal operations and emergencies.
   - Health information technology resources, such as systems for electronically managing patient records and electronically sharing information with other organizations.

3. A facility-based and community-based risk assessment, using an all-hazards approach.
   - Risk assessment is general terminology that is within the emergency preparedness regulations and preamble to the Final Rule (81 Fed. Reg. 63860, Sept. 16, 2016), which describes a process facilities are to use to assess and document potential hazards within their areas and the vulnerabilities and challenges which may impact the facility. Additional terms currently used by the industry are all-hazards risk assessments, also referred to as Hazard Vulnerability Assessments (HVAs) or all-hazards self- assessments. For the purposes of these guidelines, the term "risk assessment," may include a variety of current industry practices used to assess and document potential hazards and their impacts.

This assessment asks the facility to collect and use information from various sources. Some of the sources may include, but are not limited to, Minimum Data Set (MDS) reports, Quality Measures, 802 (Roster/Sample Matrix Form) reports, the Payroll Based Journal (PBJ), and in-house designed reports.

Guidelines for Conducting the Assessment

1. To ensure the required thoroughness, individuals actively involved in the Facility Assessment process must include, but are not limited to:
   a) Nursing home leadership (including a member of the governing body and the medical director) and management (including the administrator, and the director of nursing [DON]).
   b) Direct care staff including, but not limited to registered nurses (RNs), licensed practical and vocational nurses (LPN/LVNs), nursing assistants (NAs), and representatives of the direct care staff, if applicable.
   c) The environmental operations manager, and other department heads (for example, dietary manager, director of rehabilitation services, or other individuals) should be involved as needed.
   d) The facility must also solicit and consider input received from residents, resident representatives, family members, and representatives of direct care staff.
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, as necessary, the Facility Assessment at least annually using evidenced-based, data-driven methods that consider the needs of the residents, and the competencies of their staff.
    a) It is not the intent that the organizational assessment be updated for every new person who moves into the nursing home but rather for significant changes, such as when the facility begins admitting residents who require substantially different care or changes in staffing patterns or needs.
4. The Facility Assessment will be used to:
    a) Inform staffing decisions to ensure that there are a sufficient number of staff with the appropriate competencies and skill sets necessary to care for the residents' needs as identified through the resident assessment and plan of care.
    b) Consider specific staffing needs for each resident unit in the facility and adjust as necessary based on changes to the resident population.
    c) Consider the specific staffing needs for each shift, such as day, evening, night, and adjust as necessary based on any changes to the resident population.
    d) Develop and maintain a plan to maximize recruitment and retention of direct care staff.
    e) Inform contingency planning for events that do not require activation of the facility 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.
5. Appendix PP surveyor guidance through Interpretive Guidelines in the State Operations Manual. With regard to the Facility Assessment, Appendix PP states, "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 members 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 members?"
6. For a suggested assessment process, including synthesis and use of findings, see Attachment 2.

Facility Assessment Tool

Facility Name:	
Persons (names/ titles) involved in completing assessment	Administrator: Director of Nursing: Governing Body Rep: Medical Director: Other:
Date(s) of assessment or update:	
Date(s) assessment reviewed with QAA/QAPI committee:	

Part 1: The Facility's Resident Population

Numbers

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

Recommend differentiating between long-stay and short-stay residents or other categories (e.g., unit floors or specialty areas or units, such as those that provide care and support for persons with dementia or using ventilators).

1.2. Indicate your average daily census: (enter a range) _____.

Recommend differentiating between long-stay and short-stay residents or other categories (e.g., unit floors or specialty areas or units, such as those that provide care and support for persons with dementia or using ventilators). Consider if it would be helpful to describe the number of persons admitted and discharged, including high-peak times or shifts for admissions and discharges, as these processes can impact staffing needs. Use evidence-based, data-driven methods to capture the information needed.

1.3. Indicate the facility's demographics of its residents, including age range, gender, and race.

	Number (enter average or range) of persons admitted	Number (enter average or range) of persons discharged
Weekday		
Weekend		

Diseases/conditions, physical and cognitive disabilities, and behavioral health needs

1.4. Indicate if the facility accepts residents with or currently care for, or facility 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 to identify the resident population cared for by the facility to include types of disease, conditions, physical and behavioral health needs, cognitive disabilities, overall acuity, and other pertinent faction that are present. 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 resident's living with these conditions or combinations of these conditions.

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 (PTSD), anxiety disorder, behavior that needs interventions
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, cerebrovascular accident (CVA), transient ischemic attack (TIA), stroke, traumatic brain injuries, neuropathy, Down's syndrome, autism, Huntington's disease, Tourette's syndrome, aphasia, cerebral palsy
Vision	Visual loss, cataracts, glaucoma, macular degeneration
Hearing	Hearing loss
Musculoskeletal System	Fractures, osteoarthritis, other forms of arthritis
Neoplasm	Prostate cancer, breast cancer, lung cancer, colon cancer
Metabolic Disorders	Diabetes, thyroid disorders, hyponatremia, hyperkalemia, hyperlipidemia, obesity, morbid obesity
Respiratory System	Chronic obstructive pulmonary disease (COPD), pneumonia, asthma, chronic lung disease, respiratory failure
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
Infectious Diseases	Skin and soft tissue infections, respiratory infections, tuberculosis, urinary tract infections, infections with multi-drug

Category	Common Diagnoses
	resistant organisms, septicemia, viral hepatitis, Clostridioides difficile infection (CDI), influenza, scabies, legionellosis

Decisions regarding caring for residents with conditions not listed above

1.5. Describe the process to make admission or continuing care decisions for persons with diagnoses or conditions the facility is less familiar with or has not previously supported. For example, how does the facility determine if it has the opportunity to admit a person with a new diagnosis to the facility or to continue caring for a person who has developed a new diagnosis, condition, or symptom if the facility has the resources or how it might secure the resources, to provide care and support for the person? Consider describing conditions or diagnoses you may not be able to appropriately care for in your facility, whether due to staff training, equipment and resources, or acuity. If an existing resident develops these conditions, describe your transfer/discharge process.

Acuity

1.6. Describe the facility residents' acuity levels using evidence-based, data-driven methods consistent with the resident assessments that help the facility to understand potential implications regarding the intensity of care, staffing considerations, and employee skill set. and other 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, use evidence-based data from the MDS; other potential data sources, include Patient-Driven Data Model (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 in the tables below. Choose a methodology that works best for the facility. Use some or all of the tables below or choose a different preferred method.

Example 1: Skilled Acuity

Acuity	Number of Residents
Major joint replacement or spinal surgery	
Non-orthopedic surgery and acute neurologic	
Other orthopedic	
Medical management	
Function score: 0–5	
Function score: 6–9	
Function score: 10–23	
Function score: 24	
Mechanically altered diet or swallowing disorder	
Extensive services	
Special care high	
Special care low	
Clinically complex	

Behavioral symptoms and cognitive performance	
Reduced physical functioning	
Non-therapy ancillary (NTA) Score: 12+	
NTA Score: 9–11	
NTA Score: 6–8	
NTA Score: 3–5	
NTA Score: 1–2	
NTA Score: 0	

Example 2: Special Treatments and Conditions

	Special Treatments	Number/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	
	Transfusions	
	Dialysis	
	Ostomy Care	
	Hospice Care	
	Respite Care	
	Isolation or Quarantine for Active Infectious Disease	
	Wound Care	
	Pain management	
	Tube feedings/parenteral nutrition	

Example 3: Assistance with Activities of Daily Living

Assistance with Activities of Daily Living	Independent	Assist of 1 2 Staff	Dependent
Dressing			
Bathing			
Transfer			
Eating			
Toileting			
Mobility			
Behavioral symptoms			
Other care, describe:			

Ethnic, cultural, or religious factors

1.7. Describe ethnic, cultural, religious factors or personal resident preferences that may potentially affect the care provided to residents by the facility. Examples may include activities, food and nutrition services, languages, clothing preferences, access to religious services, or religious-based advance directives.

1.8. Facilities must use their Facility Assessment to identify resident populations having unique cultural characteristics, such as language (including American Sign Language), religious or cultural practices, values, and preferences. This facilitates a facility-wide and department-wide understanding of cultural differences and how to approach the provision of care and services with dignity and respect for the individual.

Other

1.9. Describe other pertinent facts or descriptions of the resident population that must be considered when determining staffing and resource needs (e.g., residents' preferences with regard to daily schedules, waking, bathing, activities, naps, food, meal times, going to bed, etc.).

1.10. Examples of other pertinent information about the resident population the facility serves may include race, ethnicity, disability, sexual orientation, gender identity, socioeconomic status, preferred language, health literacy, or other factors that affect access to care and health outcomes related to health equity.

Part 2: Services and Care We Offer Based on Our Residents' Needs

Resident support/care needs

2.1 List the types of care that the facility resident population requires and that the facility provides for its resident population – a list by general categories, adding specifics, as needed. The facility is not expected to 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, IV (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	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, COPD, gastroenteritis, infections such as urinary tract infection (UTI) and gastroenteritis, pneumonia, hypothyroidism
Therapy	Physical therapy (PT), occupational therapy (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
Nutrition	Individualized dietary requirements, liberal diets, specialized diets, IV nutrition, tube feeding, cultural or ethnic dietary

General Care	Specific Care or Practices
	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 the 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 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 Every Day and During Emergencies

Staff type

3.1 Identify the type of staff members, other healthcare professionals, and medical practitioners that are needed to provide support and care for residents. Potential data sources include staffing records, organization chart, and PBJ reports. The facility must use the Facility Assessment to ensure 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.

Considering the following type of staff members and other professionals/practitioners. List (or refer to or provide a link to) the facility's staffing data, directories, organization chart, or other lists that show the type of staff members needed to care for the facility's resident population. Include other relevant information pertaining to each type of staff member.

- Administration (e.g., administrator, administrative assistant, staff development, QAPI, infection control and prevention, environmental services, social services, discharge planning, business office, finance, human resources, compliance and ethics)
- Nursing services (e.g., DON, RN, LPN or LVN, certified NA [CNA] or NA-registered [NAR], medication aide or technician, MDS nurse)
- Food and nutrition services (e.g., director, cooks, dietary aides, registered dietician)
- Therapy services (e.g., OT, OT assistant [OTA], PT, PT assistant [PTA], respiratory therapy [RT], RT tech, speech language pathology, audiologist, optometrist, activities professionals, other activities staff, social worker, mental health social worker)
- Medical/physician services (e.g., medical director, attending physician, physician assistant, nurse practitioner, dentist, podiatrist, ophthalmologist)
- Social services (director, discharge planner, mental health professional)
- Activities (director, staff, volunteers)
- Pharmacist (pharmacy consultants, pharmacy technicians)
- Behavioral and mental health providers (psychiatrists, psychologists, licensed counselors)
- Support staff members (e.g., engineering, plant operations, information technology, custodians, housekeeping, maintenance staff, groundskeepers, laundry services, van driver)
- Chaplain/religious services
- Students
- Other (vocational services worker, clinical laboratory services worker, diagnostic X-ray services worker, blood services worker) psychiatric services and mental health providers

Staffing plan

3.2. Based on the facility's resident population and their needs for care and support, describe the facility's general approach to staffing to ensure that it has sufficient staff members with the appropriate competencies and skill sets to meet the needs of the residents, as identified through resident assessments and care plans at any given time. Review PBJ data
Examples of two different ways to look at the facility's staffing plan are provided in the following tables. Choose a methodology that works best for the organization. Facilities may use one or both

tables below or choose their preferred methods. It may be helpful to review specific staffing references in the regulation regarding the Facility Assessment (see attachment 1). For a discussion on determining
sufficient staffing, see Attachment 2, section 7.b.

Example 1.
Evaluation of the overall number of facility staff members is needed to ensure a sufficient number of qualified staff members 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/by the Facility Assessment. For example, nursing (F725), behavioral health (F741), nutrition (F802), and administration (F839). Enter several staff members needed or an average or range, taking into consideration the specific needs for each shift, such as day, evening, and night, and adjust as necessary.

Position	Total Number Needed or Average or Range
Licensed nurses 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):	
Dietician or other clinically qualified nutrition professional to serve as the director of food and nutrition services	
Food and nutrition services staff	
Respiratory care services staff; PT, OT, ST, PTA, OTA	

Example 2.
Describe the facility's general staffing plan to ensure that it has sufficient staff members with the appropriate competencies and skill sets necessary to meet the needs of the residents at any given time, as identified through resident assessments and care plans. Consider if and how the degree of fluctuation in the census and acuity levels impact staffing needs across all shifts and days of the week, including weekends. 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 and evenings (consider breaking this down by RN and LPN per shift) 1:x LN ratio Nights (consider breaking this down by RN and LPN per shift)

Staff	Plan
Direct care staff	1:x ratio days (total licensed or certified) 1:x ratio evenings 1:x ratio nights 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 e) physical therapy staff hours per resident per day Note: comparative data for HPRD are available on Nursing Home Compare
Other (e.g., department heads, nurse educator, quality assurance, ancillary staff in maintenance, housekeeping, dietary, laundry)	

Individual staff assignment

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

Staff training/education and competencies

3.4. Describe the staff members' training/education/skill set and competencies necessary to provide the level and types of support and care needed for the facility's resident population as identified through resident assessments and care plans. Include staff member 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).

List (or refer to or provide a link to) all staff members' training and competencies needed by type of staff member. Consider if it would be helpful to indicate which competencies are reviewed when the staff member is hired and how often they are reviewed.

Consider the following **training topics** (this is not an inclusive list, review federal and state requirements):

- Communication
- Resident's rights
- Abuse, neglect, and exploitation

- Infection control
- Infection control
- QAPI
- Compliance and ethics
- Behavioral health
- Emergency preparedness
- 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 identified through resident assessment and plans of care
    - Address the care of the cognitively impaired for nurse aides providing services to individuals with cognitive impairments
- Required training of feeding assistants through a state-approved training program
- • 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).

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
- Disaster planning and procedures–active shooter, elopement, fire, flood, power outage, tornado
- Infection control- hand hygiene, isolation, standard universal precautions including use of personal protective equipment, Methicillin-resistant Staphylococcus aureus (MRSA)/Vancomycin-resistant Enterococci (VRE)/CDI precautions, environmental cleaning
- Medication administration – injectable, oral, subcutaneous, topical
- 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
- Behavioral health

- 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 PTSD, and implementing nonpharmacological interventions.

Policies and procedures for provision of care

3.5. Describe how the facility evaluates what policies and procedures may be required in providing care and how it ensure those meet current professional standards of practice. Include, for example, the facility's 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 ventilators, storage of medications and biologicals, and transportation.

Working with medical practitioners

3.6. 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.

3.7. Describe how the management and staff members 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 the facility's resident population. For example, does the facility share expectations for providers who see residents in its nursing home using standards, protocols, or other information developed by the facility's medical director? Do facility representatives discuss what providers and staff members expect of each other regarding the care delivery process and clinical reasoning essential to providing high-quality care?

Physical environment and building/plant needs

3.8. 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 Resource Category	Resources	If applicable, process to ensure adequate supply, appropriate maintenance, replacement
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	
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, 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	

Other

3.9. The Facility Assessment must be used to develop and maintain a plan to maximize direct care staff recruitment and retention.

3.10. List contracts, memoranda of understanding, or other agreements with third parties to provide services or equipment to the facility during normal operations and emergencies. Consider including a description of the facility's process for overseeing these services, how these services will meet resident needs, and regulatory, operational, maintenance, and staff member training requirements.

3.11. List health information technology resources, such as systems for electronically managing patient records and 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(s) can access their records upon request and obtain copies within the required timeframes.

3.12. Describe how the facility evaluates if its infection prevention and control program includes effective systems for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff members, volunteers, visitors, and other individuals providing services under a contractual arrangement, that follow accepted national standards.

3.13. Provide the facility-based and community-based risk assessment using 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 the facility's emergency preparedness plan (§483.73) and focus on high-volume, high-risk areas.

Part 3: Facility Resources Needed to Provide Competent Support and Care for Our Resident Population Every Day and During Emergencies

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

Risk Assessments Using All-Hazards Approach

Facilities are expected to develop an emergency preparedness plan that is based on the facility-based and community-based risk assessment using an "all-hazards" approach. Though a format is not specified, facilities must document the risk assessment. An example consideration may include, but is not limited to, natural disasters prevalent in a facility's geographic region, such as wildfires, tornados, flooding, etc. An all-hazards approach is an integrated approach to emergency preparedness planning that focuses on capacities and capabilities that are critical to preparedness for a full spectrum of emergencies or disasters, including pandemics and emerging infectious diseases (EIDs) as noted under E-0004. This approach is specific to the location of the facility considering the types of hazards most likely to occur in the area, but should also include unforeseen, widespread communicable diseases. Thus, all-hazards planning does not specifically address every possible threat or risk but ensures the facility will have the capacity to address a broad range of related emergencies.

All-Hazards Approach

An all-hazards approach is an integrated approach to emergency preparedness that focuses on identifying hazards and developing emergency preparedness capacities and capabilities that can address those as well as a wide spectrum of emergencies or disasters. This approach includes preparedness for natural, man-made, and or facility emergencies that may include, but is not limited to: care-related emergencies; equipment and power failures; interruptions in communications, including cyber-attacks; loss of a portion or all of a facility; and, interruptions in the normal supply of essentials, such as water and food. Planning for using an all-hazards approach should also include EID threats. Examples of EIDs include influenza, Ebola, zika virus, and others. All facilities must develop an all-hazards emergency preparedness program and plan.

The Facility Assessment must 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.
**Disclaimer: Review Appendix Z for all Emergency Preparedness guidance.*

Attachment 1 - Medicare and Medicaid Programs; Reform of Requirements for Long-Term Care Facilities

Federal Register / Vol. 81, No. 192 / Tuesday, October 4, 2016 / Rules and Regulations.
Federal Register/Vol. 89, No. 92/Friday May 10, 2024/Rules and Regulations.

Also see Survey & Certification memos and Appendix PP in the State Operations Manual for additional information.

§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: (i) Both the number of residents and the facility's resident capacity; (ii) The care required by the resident population, using evidence-based, data-driven methods that considering 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 assessments as required under §483.20; (iii) The staff competencies and skill sets that are necessary to provide the level and types of care needed for the resident population; (iv) The physical environment, equipment, services, and other physical plant considerations that are necessary to care for this population; and (v) 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: (i) All buildings and/or other physical structures and vehicles; (ii) Equipment (medical and non- medical); (iii) Services provided, such as physical therapy, pharmacy, behavioral health, and specific rehabilitation therapies; (iv) 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; (v) Contracts, memoranda of understanding, or other agreements with third parties to provide services or equipment to the facility during both normal operations and emergencies; and (vi) 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, using an all-hazards approach as required in §483.73(a)(1). § 483.71(b) In conducting the Facility Assessment, the facility must ensure: ADVANCED COPY Page 6 of 11 § 483.71(b)(1) Active involvement of the following participants in the process: (i) Nursing home leadership and management, including but not limited to, a member of the governing body, the medical director, an administrator, and the DON; and (ii) Direct care staff, including but not limited to, RNs, LPNs/LVNs, NAs, and representatives of the direct care staff, if applicable. (iii) 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.

QSO-24-13-NH (cms.gov)

- F639, §483.21(b)(3), Comprehensive person-centered care planning
- F725 or 726, §483.35(a),(c) for any nursing services not related to behavioral health care or dementia care
- F741, §483.40 for any staff caring for residents with dementia or a history of trauma and/or PTSD
- F801, §483.60(a) for food and nutrition staff; ADVANCED COPY Page 11 of 11
- F826, §483.65(b), Specialized rehabilitative services
- F839, §483.70(e), Staff qualifications
- F837, §483.70(d), Governing body

It is recommended that facilities stay up-to-date with state and federal agencies to ensure they have the most current regulatory guidelines for compliance.

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:
    a. Reviews the regulation for the facility assessment requirements.
    b. Reviews the Interpretive Guidelines, Appendix PP for F838 Facility Assessment, and other areas that refer to the Facility Assessment.
    c. Reviews the optional tool made available by CMS.
3. The leader identifies and invites team members to be on the assessment team, including the administrator, representative of the governing body, medical director, and director of nursing, and considers other persons to be on the team.
    a. Consider and plan for how you will get input and participation from residents, their representatives and/or family members and CNAs (who provide most of the hands-on care) throughout the assessment process. This could include a) 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); b) getting feedback from the local long-term care ombudsman program; and c) involving residents, their representatives, and/or family members and CNAs as part of the facility assessment team (for instance, the president of the resident council could represent residents.
    b. 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.
4. The leader convenes a team to work on the assessment, and with the team:
    a. Review and discuss the requirement.
    b. Review the process with the team; discuss and clarify steps needed.
    c. Discuss and establish a timeline for the assessment.
        i. Consider if the facility assessment timing should align with the budgeting process.
    d. Discuss and decide how the assessment will be completed.
        i. One person takes the lead on the first draft, or
        ii. Assign persons to complete different sections.

Complete the Facility Assessment

5. The team leader and others assigned complete the assessment.
6. 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.

Synthesize and Use the Assessment Findings

7. 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:

a. How has the resident population- diseases, conditions, acuity, etc. changed since the last assessment?
b. Do we need to make any changes in staffing?
    i. Based on resident number, 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). However, there is no current federal requirement for specific nursing home staffing levels.
       - Review comparative data (at the nursing home, state and national level) available on the staff measure on Nursing Home 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 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.

    ii. 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?
c. Are there any training, education and/or competency needs based on resident and/or staff data or trends identified in the Facility Assessment?
    i. Does our current behavioral health training sufficiently address our resident population, as identified by the Facility Assessment?
    ii. Does our current CNA training program sufficiently address our resident population as identified by the Facility Assessment?
    iii. Ensure agency staff sufficiently trained to address needs of resident population.
    iv. Do we need to update job descriptions to coincide with new competencies identified?

v. Are new requirements incorporated into our annual performance evaluation process?

d. What opportunities do we have to further collaborate closely with our medical practitioners to enhance our approaches to resident/patient care?
e. 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?
f. 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?
    i. 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?
    ii. 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?
g. Are there any other resources we need to care for residents competently during day-to-day operations and emergencies, based on the Facility Assessment?
h. 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?
i. Have you completed a Hazard Vulnerability Assessment? Are adjustments needed to minimize risk? See examples from Kaiser Permanente, Leading Age Minnesota, and the California Association of Health Facilities.

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

Evaluate Your Process and Plan for Future Assessments

8. Review the facility assessment requirements and guidance at F838. Be prepared to respond to the surveyor on the following questions:
    a. How did the facility assess the resident population? Does this reflect the population observed?
    b. How did the facility determine the acuity of the resident population?
    c. How did the facility determine the staffing level?
    d. How did the facility determine what skills and competencies would be required by those providing care?
    e. Who was involved in conducting the facility assessment?
    f. How did the facility determine what equipment, supplies, and physical environment would be required to meet all resident needs?

    g. How did the facility develop its emergency plan?
9. Evaluate with your team the process to conduct the assessment and use the findings. What went well? What will you do differently next time?
10. Establish a process for updating the assessment in one year or earlier of there are substantive changes.

Sourced from HSAG. This material was prepared by Qsource, a/an Network of Quality Improvement and Innovation Contractors under contract with the Centers for Medicare & Medicaid Services (CMS), an agency of the U.S. Department of Health and Human Services (HHS). Views expressed in this document do not necessarily reflect the official views or policy of CMS or HHS, and any reference to a specific product or entity herein does not constitute endorsement of that product or entity by CMS or HHS. 24.QIO1.08.046