Introduction to the Facility Assessment

Facility Assessment

§483.70(e) F Tag 838

Introduction

The Requirements of Participation for Skilled Nursing Facilities **§483** (2016) includes a required facility assessment. The intent of this assessment is for the individual facility to evaluate its resident population and identify the resources needed to provide the necessary care and services the facility residents require. The facility assessment is intended to assist facility leadership to determine the appropriate resources to care for residents on a daily basis as well as in emergency situations.

As identified in **§483.70(e)** *F838***,** the facility assessment shall include specific evaluation of key areas such as:

- resident census
- facility capacity with imposed restrictions as applicable
- specific resident population demographics (i.e. specific diseases, diagnosis, cognitive conditions, specialty clinical populations, infections, behaviors, et al)
- number, types and training of staff necessary to provide the necessary care and services
- staff competencies – including nursing and non-nursing personnel as it relates to the resident population needs
- cultural, ethnic and religious needs
- specific services and resources for the provision of those services such as pharmacy, rehabilitation, behavioral health, respiratory and other special services
- other resources such as physical plant, equipment (medical and non-medical)
- access to services via third parties and correlating provisions of services day to day and in emergency situations, including the review of said agreements with provision inclusions
- training program evaluation
- health information technology and sharing of resident information
- completion of a community and facility risk assessment, utilizing an all hazards approach, in conjunction with the required emergency preparedness plan
- process for identification of gaps in performance related to adverse events
- integration into the facility Quality Assurance and Performance Improvement process
- monitoring of the plan and updating the plan on an annual basis or upon a change in the facility's operation that would require a substantial modification in the assessment and as needed.

The facility assessment is not to be a "cookie cutter" approach to documenting assessment findings, rather it should reflect the individuality of the facility's specific resident population,

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programs, and services. CMS guidance indicates that the facility assessment should be completed at the individual facility level rather than a document provided and completed at the corporate level. The assessment process and its findings are intended to provide the foundation for operational, clinical and resource allocations by facility leadership and current operations. It will provide the opportunity to evaluate operational plan and practices. It is important to note that the facility assessment will need to be accessible and available to the survey team within four hours of entrance to the facility.

It is important that the facility utilize available internal organization data to support the assessment, reflecting the resident population. Data can be derived from the Minimum Data Set (MDS) which can support information such as: cognitive conditions, care requirements, diagnosis, and more. As previously indicated, a specific methodology or reporting format has not been mandated, however there are best practice data collection tools and resources available to assist facilities in developing the facility assessment. Of primary importance is the accuracy of the data and its correlation to the specific assessment components identified.

Key implementation dates for the facility assessment

November 28, 2017 Facility Assessment Document Completed
November 28, 2019 Link of the Facility Assessment to Outcomes During Annual Survey

Navigating the expectations and intent of the Requirements of Participation for Skilled Nursing Facilities can be daunting and additional burdens on facility leaders. Many facilities have the processes in place to assess the resident population and the resources necessary to provide care and services to the population, however having a formal written articulated and documented system may not be in place.

The **RoP Facility Assessment Toolkit ©** is designed to assist leaders with the tools, resources and staff education to complete and support their individual facility assessment. This comprehensive Toolkit provides practical, step-by-step guidance for organizations as they work with their teams to evaluate the facility resident population, resource availability and allocation in accordance with resident care and service needs and the other required components to develop their written facility assessment.

The **RoP Facility Assessment Toolkit ©** is customizable to meet specific State and organization needs. It includes the following areas required for the Facility Assessment with corresponding resources and tools:

- **Leadership Implementation Strategies and Resources**
- **Facility Implementation Guide and Checklist**
  - A leader's guide for successful implementation.
- **Facility Assessment Policy and Procedure**
  - A detailed P&P that can be customized to meet your organization specific needs

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- **Organization Data Needs for the Facility Assessment**
    - Data sources
- **Facility Assessment Template and Tools** – How to Complete the Assessment
- **CMS Facility Assessment Resource Template**
- **Required Facility Assessment Components**
    - Facility Resident Population
        - Overview
        - Resident Demographics
        - Data Source and Collection
        - Tools, Templates and Resources
    - Personnel Resources
        - Overview
        - Review of Personnel Resources
        - Personnel and Resource Pyramid
        - Competencies – Tools, Resources and Templates
            - Non-Nursing Personnel
            - Nutritional Services
            - Nursing Services
    - Evaluation of Training Programs
        - Intent and Overview
        - Evaluation
            - Onboarding
            - Orientation
            - On the job training
            - Specialty programs
            - New Conditions and New Equipment Training
            - Gaps in competence related to adverse events
            - Annual
    - Infection Control
        - Infection Data Sources and Utilization for the Facility Assessment
        - Required components of Infection Prevention Program
        - Competencies needed for Infection prevention
        - Integration with FA and QAPI
    - Policy and Procedure Review Process
        - Intent and overview
        - F Tag and Policy and Procedure cross walk
    - Facility and Community Risk Assessment
        - Intent and Overview
        - HAV Template and how to use
        - Business Impact
        - Community and Regulatory Resources

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        - Facility Assessment and Emergency Preparedness plan coordination
        - E Tags Cross walk and Surveyor Guidance
        - Tools, Templates and Resources
    - Resources - Physical Plant and Equipment
        - Intent and Overview
        - Tools, Templates and Resources
            - Medical and Non-Medical
            - Vehicle
            - Buildings and Physical Plant
                - Building assessment and vulnerabilities
    - Health Information Technology
        - Intent and Overview
        - Tools, Templates and Resources
    - Third Party Agreements, Contracts, Memorandum of Understanding
        - Intent and Overviews
        - Tools, Templates and Resources
    - Quality Assurance and Performance Improvement (QAPI)
        - Intent and Overviews
        - Facility Assessment and QAPI coordination
        - Tools, Templates and Resources
- **Training Plan**
    - Designed for the facility assessment overview.
- **Competency Test**
    - Training Post-test.
- **Competency Test Answer Key**
    - Training Post-test Answer Key.
- **Education PowerPoint**
    - Comprehensive training already written for you and your team.
- **Trainer Notes**
    - PowerPoint Speaker Notes
- **Performance Improvement Resources**
    - Audit tools, Checklists, Data Collection, and more.

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Tool-
Facility Assessment Implementation Guide

State logo added here. If not, delete text box

Tool: Facility Assessment Implementation Guide

F838 §483.70(e) 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 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. 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.

The facility assessment must address or include:

§483.70(e)(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 considering the types of diseases, conditions, physical and cognitive disabilities, overall acuity, and other pertinent facts that are present within that population;
(iii) The staff competencies 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.

§483.70(e)(2) The facility's resources, including but not limited to,

(i) All buildings and/or other physical structures and vehicles;
(ii) Equipment (medical and non-medical);
(iii) Services provided, such as physical therapy, pharmacy, and specific rehabilitation therapies;
(iv) All personnel, including managers, 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, memorandums of understanding, or other agreements with third parties to provide services or equipment to the facility during both normal operations and emergencies; and

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(vi) Health information technology resources, such as systems for electronically managing patient records and electronically sharing information with other organizations.

§483.70(e)(3) A facility-based and community-based risk assessment, utilizing an all-hazards approach.

Purpose and Intent of §483.70(e)

The intent to develop of a facility assessment is to evaluate the resident population within the facility and identify the resources needed to provide the necessary care and services the facility residents require on a day to day basis and in emergency situations. The facility assessment must be conducted at the facility level including the administrator, medical director, a representative of the governing body, and the director of nursing at a minimum. The environment operations manager, other department heads, or direct care staff should be involved as needed.

The facility assessment shall enable the facility to thoroughly assess the needs of its resident population and required resources to provide the care and services the residents need – serving as a record for staff and management to understand the reasoning for decisions made regarding staffing and other resources. It may include the operating budget necessary to carry our facility functions.

The facility assessment serves as an evaluation of the overall number of staff needed for sufficient numbers of qualified competent staff available to meet resident needs. The facility assessment must be reviewed and updated: annually at a minimum, when there is a change that requires substantial modification (i.e. the facility begins to admit residents who have new tracheostomy or ventilator, etc.), based upon training program evaluation related to staff skills and competencies, and as necessary. 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.

To assist an individual facility in identifying all the required steps for the development and implementation of a Facility Assessment in accordance to the Requirements of Participation, the following checklist captures specific suggested action items for successful completion. The far left column represents the actual RoP language and the right column indicates suggested leadership strategies for successful completion and implementation of the facility assessment requirements. When preparing updated policies and procedures, it is recommended to include actual RoP language as applicable.

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Suggested Checklist:
Comprehensive Advance Directive Policy and Procedure

Regulation	Recommended Actions
F838 §483.70(e) 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 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.	☐ Develop, implement and train on a general facility assessment policy and procedure and how it is a foundation for care and service delivery direction in the organization. ☐ Define who is responsible for: ▪ Gathering the data for the assessment ▪ What tools/data sources will be used for the assessment completion ▪ Determination of data sources to be reviewed on a routine basis to determine if the assessment requires modifications ▪ Determination of the members of the assessment team to include at a minimum – NHA, DON, Medical Director, governing body representative ▪ The environmental operations manager, and other department heads (for example, the dietary manager, director of rehabilitation services, or other individuals including direct care staff should be involved as needed. ▪ Determination of roles and responsibilities related to the assessment process, data gathering, training, staff competencies, monitoring of outcomes and integration into the QAPI program ▪ Writing the overall assessment ▪ Determination of the facility assessment document that will be shared with survey team members per requirements ▪ Monitoring system which will facilitate assessment update ▪ Training evaluation process ▪ Review of the facility policy and procedure process on, at a minimum, annual basis

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Regulation	Recommended Actions
	☐ Provide education about the facility assessment, purpose and outcomes to all staff and their roles and responsibilities. ☐ Identify where the facility assessment will be stored within administration and accessibility off hours for survey team review. ☐ Integrate the facility assessment process and results into the facility QAPI plan. Best practice would also be to integrate/consider how facility assessment relates to the Infection Control program, Training Program, and Compliance & Ethics program and related policies & procedures, auditing and monitoring, and processes. ☐ Suggested update of the following policies and procedures (per current professional standards of practice) as it relates to the integration of the facility assessment and results for organization decision making (not an all-inclusive list): ▪ Budget process ▪ Capital budget process ▪ Abuse prevention ▪ Abuse, Neglect and Exploitation training ▪ Admission, PASARR ▪ Transfer and discharge ▪ Readmission to facility ▪ Comprehensive individualize care plan ▪ Resident assessment ▪ MDS/RAI process ▪ Activities of Daily Living ▪ Specialty programs – dementia, ERSD, TCU, Cardio-Pulmonary, etc. and identification of risk levels

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Regulation	Recommended Actions
	▪ Nursing P&P related to Change of Condition, special populations, cognitive impairment, and other DX/disease risk areas ▪ Infection Control ▪ Accidents and supervision ▪ Dementia/Cognitive impairment ▪ Pain management ▪ Wound management ▪ Physical Device ▪ Medication management ▪ Antipsychotic medication ▪ Resident Rights ▪ Resident Council ▪ Cultural competency ▪ Respiratory care ▪ Physician delegation of writing orders – dietary and therapist ▪ Nursing services, sufficient staff, staffing process ▪ Nurse competency ▪ Training program ▪ Nursing assistant training ▪ Annual training requirements ▪ Orientation program ▪ Onboarding process and screening process ▪ Staff competency per department ▪ Nutrition services o Qualified and competent staff o Sufficient staff o Menus and food procurement meeting residents ethnic, cultural, religious factors ▪ Preventative Maintenance Program ▪ Facility maintenance – grounds, vehicles, safety, security ▪ Equipment Management Program ▪ Equipment and adaptive equipment ▪ Medical supply procurement ▪ Pharmacy services ▪ Rehabilitation services

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Regulation	Recommended Actions
	▪ Third part agreements (services, equipment and supplies) and contract expectations as it relates to the facility assessment ▪ Behavioral health services ▪ Emergency preparedness ▪ Activity therapy ▪ Volunteers ▪ Social services – medically related social services specific to resident needs, demographics and access to services ▪ Grievance process ▪ Governing body and their role in the FA ▪ Medical Director role in FA ▪ QAPI policy and plan ▪ Data management plan ▪ Data security and privacy ▪ Health information technology - interoperability, privacy, and records management ▪ Medical records
The facility assessment must address or include: §483.70(e)(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 considering the types of diseases, conditions, physical and cognitive disabilities, overall acuity, and other pertinent facts that are present within that population; (iii) The staff competencies 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	☐ Determine and utilize a data collection process for organization specific information, including but not limited to: **Community Demographics** ▪ Resident demographics ▪ Number of residents – average daily census and capacity with self-imposed restrictions ▪ Diseases and conditions (diagnosis report for last year) as well as a review of active diagnosis from the MDS section I ▪ Physical Disabilities (CMS 672) ▪ Cognitive Disabilities (BIMS scores) ▪ Overall Acuity (average non-Medicare RUG distribution) ▪ Care considerations - considering the types of diseases, conditions, physical and cognitive disabilities, overall acuity, and

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Regulation	Recommended Actions
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.	other pertinent facts that are present within the resident population ▪ Potentially gather information with respect to care level and acuity perception from residents or representatives, direct care staff, and respective practitioners ▪ Ethnic and cultural considerations of the resident population **Facility Personnel and Nursing Services Competency** ▪ Staff competencies that are necessary to provide the level and types of care needed for the resident population (i.e. abuse prevention, behaviors, dementia, dual diagnosis, MI, infection control, communication disabilities, restorative needs, ADL decline, skin/wound care, tracheostomy, ERSD, disease specific, cultural competency, pain, incontinence, etc.) ☐ Development and implementation of nursing competency skills process and training ▪ Nurse competency considerations including nursing assessment, suctioning, dressing change, pain management, technology/equipment, transmission precautions, IV, phlebotomy, transfers, feeding, ADLs, change of condition, transition of care, communication, cultural competency, notification, etc) o Competency is a measurable pattern of knowledge, skills, abilities, behaviors and characteristics needed to perform the role or occupational function. This is not dependent solely upon qualifications or licensure. Examples include: lecture with return demonstration for physical

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Regulation	Recommended Actions
	tasks or activities, the ability to use tools, devices and equipment, an evaluation of adverse events to identify competency gaps and demonstrated ability to perform job functions. ☐ Development and implementation of competency skills process and training for non-nursing departments ☐ Development and implementation of competency skills process and training for vendors, contracted individuals who provide services and equipment for resident population ☐ Development and implementation of competency skills process and training for volunteers as applicable ☐ Development and implementation of a process to review training programs which include: onboarding, orientation, on the job training, specialty programs, new resident conditions, new equipment, gaps in competence related to adverse conditions and annual training plan review. ▪ Training programs to incorporate 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. ☐ Development and implementation of competency skills process and training for non-nursing departments ☐ Review of job descriptions to reflect the facility assessment findings related to respective roles and responsibilities based on the resident population

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Regulation	Recommended Actions
	☐ Development and implementation of competency skills process and training for governing body and leadership related to resident population, budget process, capital acquisition process, as well as provider knowledge and skill related to: • Knowledge of local culture • Respect shown to consumers • Beliefs about what consumers value • History / reputation in community • Availability of continuum of care • Education, competency, skills of staff • Evaluation of facility training program for staff and volunteers • Human resources • Insurance contracts – who can you take • Community Involvement
§483.70(e)(2) The facility's resources, including but not limited to, (i) All buildings and/or other physical structures and vehicles; (ii) Equipment (medical and non-medical); (iii) Services provided, such as physical therapy, pharmacy, and specific rehabilitation therapies; (iv) All personnel, including managers, 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, memorandums of understanding, or other agreements with third parties to provide services or equipment to the facility during both normal operations and emergencies; and	**Physical Plant and Equipment** ☐ Review and assessment of the physical plant – internal and external as well as all structures/buildings for potential risks and resident resource needs – including nonresident areas ☐ Review and assessment of facility vehicles for potential risks and resident resource needs ☐ Equipment (All departments) – medical and non-medical inventory with consideration to type, amount, condition and training related to care for the resident population (i.e. lifts, stands, wheel chairs, walkers, beds, specialty beds, bladder scanners, equipment used for resident care, dietary equipment, activity equipment, etc.) ☐ Equipment management program review

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Regulation	Recommended Actions
(vi) Health information technology resources, such as systems for electronically managing patient records and electronically sharing information with other organizations.	☐ Preventative Maintenance Program review and utilization in accordance to policy and procedure ☐ Assisted technology - medical and non-medical inventory with consideration to type, amount, condition and training related to care for the resident population ☐ Review of services provided: rehabilitation, pharmacy, respiratory, behavioral health, diagnostic, physician, etc. necessary to provide the level and types of care needed for the resident population ☐ Determine a process to review and evaluate external contracts, MOU's, third party agreements for the provision of equipment, goods and services for resident care both day-to-day and in emergencies ☐ Health Information technology – Evaluation process for managing health information – electronic health record, other electronic systems, sharing of resident information, privacy/safe guards, interoperability, interruption of services plan, back up energy source, etc.
§483.70(e)(3) A facility-based and community-based risk assessment, utilizing an all-hazards approach.	☐ Develop and implement a process to assess and document potential hazards within the facility, community and potential hazards and the vulnerabilities and challenges that may impact the facility in conjunction with the facility emergency preparedness plan such as a Hazard Vulnerability Assessment

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Regulation	Recommended Actions
	☐ Update the Emergency Preparedness Plan in conjunction with the completion of the facility assessment and vice versa as applicable ☐ Develop and implement a process to conduct a facility risk assessment which may include a review of clinical governance and leadership; ethics and resident rights; QAPI processes; resident safety and incident trends; and facility safety and emergency management.

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The below areas serve as a cross reference for facility leaders to conduct addition policy and procedure review across departments to incorporate the changes set forth in **§483.70(e) Facility Assessment.** This listing is not all encompassing however should serve as a resource for leaders as they update their internal policies, procedures and operational processes.

Cross Reference: (additional areas for review)

- Resident Rights
- Resident Postings
- CMS Definitions
- Admission Agreement
- Admission Policy
- Resident Education
- Resident Representative Education
- Transitions of Care Policies and Procedures
- Admission, transfer, discharge policies and procedures
- Change of Condition policies and procedures
- Notification policies and procedures
- Individualize Resident Assessment policies and procedures
- Comprehensive Person Centered Care Plan policies and procedures
- Physician Policies
- Medical Director Policies
- Resident Care Policies
- Infection Prevention and Control
- Interdisciplinary Department Policies and Procedures
- Clinical System Policies and Procedure
- Facility Training Program
- Life Safety, Physical Plant
- Emergency Preparedness Plan
- Preventative Maintenance Program
- Equipment Management Plan
- Volunteer Policies
- Contractual Services
- Governing Body Policies and Roles related to Facility Assessment
- Business Ethics and Corporate Compliance
- Operational Policies
- Hospital Transfer Agreements or Memorandum of Understanding
- Medical Records and Retention
- HIPPA and Privacy
- Employee Onboarding and Orientation
- Annual Training Requirements
- Quality Assurance and Performance Improvement

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Facility Assessment : Data in Health Care

Facility Assessment
Data: Utilization and Management

Data is the heart of strategic decision making in healthcare operations – clinical, financial, operational systems and quality outcomes. Many types of data are utilized daily in skilled nursing facilities across the nation deriving from the Minimum Data Set (MDS), billing practices (UB04), electronic health records, business software, and other assisted technologies. This data leads to insights – resident population demographics, resident acuity, resident conditions, resource utilization and allocation, financial performance and more.

Utilization of the data assists leaders in turning those insights into decisions and actions that improve operational and clinical outcomes. Organization data that is utilized for the facility assessment is also a great source for the data/feedback requirement of the Quality Assurance and Performance Improvement (QAPI) plan and program. Organization data is the foundation for assisting leaders is designing strategic clinical, operational, financial and performance improvement initiatives.

The **§483.70(e) Facility assessment** requires skilled nursing leaders to harness their organization data to determine trends, needs, performance improvement as well as resource needs and allocations needed provide the necessary care and services to the facility resident population in order to complete the facility assessment. Facility leadership and staff must assess and document the facilities' capabilities in providing care that allows each resident to attain and maintain their highest practicable physical, mental and psychosocial well-being, reflecting the individuality of the facility.

In the faced paced health care world, completion of the assessment may seem unnecessary, however harnessing the appropriate data, determining the facility's overall characteristics and needs, and identifying where resources need to be applied. Analyzing the data will help leaders determine patterns and trends that will drive strategic clinical and operational decisions which promote quality care and service delivery for the residents residing in their facility.

In developing the facility assessment, facilities should build upon existing tools and processes and avoid duplication of information – consider the input from current facility data sources. The following are examples of the supporting data that could be utilized in the development of the facility assessment document. It should be noted that these examples are not exhaustive, but are intended to reflect the types of data sources available to facilities in responding to the facility assessment requirements.

- Minimum Data Set
- Readmission tracking

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- Financial/Billing Software – UB04
- Operational Budget
- Capital Acquisition Plan
- Rehabilitation software
- Electronic Health Record
- Admission/Referral Software
- Hazard Vulnerability Assessment
- Emergency Preparedness Plan
- Safety Plan
- Preventative Maintenance Plan
- Equipment Management Plan
- Vendors and Contractual Service partners
- Staffing and Scheduling
- Human Resources and /or Payroll
- Training Plan and /or Software
- On Line Learning – Learning Management System
- Lab, Pharmacy, Infection Control
- Accident/Incident
    - Areas that are not readily available via the MDS or the CMS 672 form include falls, wandering/elopement, adverse events, etc.
- Complaint software/assessments
- Training plan and staff competencies
- QAPI

Numerous data sources are available to the facility and knowing how and where to obtain the necessary information is key for the successful evaluation of services and resources needed to provide care to the resident population. As indicated in the facility assessment requirement, a "thorough" assessment will require leaders to obtain the necessary information to complete the facility assessment.

Where to begin?

The power of data is that it can provide insights that can answer key questions and can be broken down into the areas that require assessment and evaluation.

1. **Understand** the §483.70(e) Facility assessment requirements
    a. Read and review the Interpretive Guidance with your team.

2. **Assemble a Team**
    a. Developing a Facility Assessment team is key to the thorough completion of this requirement. The §483.70(e) Facility assessment outlines that the

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assessment must be conducted at the facility level including a team comprised of: the administrator, medical director, a representative of the governing body, and the director of nursing at a minimum. The environment operations manager, other department heads, direct care staff, or others should be involved as needed.

b. Although it is not required, it is encouraged to seek input for the resident council, family council, residents or resident representatives, incorporating the information/input as applicable.

3. Identify Key Areas

a. The **RoP Facility Assessment Toolkit ©** outlines key areas (below) to be evaluated utilizing organization data and how to collect that information:
   i. Resident population served and care required
   ii. Specialty programs
   iii. Staff competencies necessary to provide care and services
   iv. Resources including physical environment, equipment, specialized services, contractual services
   v. Preferences – ethnic, cultural, religious needs
   vi. Training requirements
   vii. Behavioral health services
   viii. Infection prevention and control
   ix. Facility and community risk assessment
   x. Integration into the Quality Assurance and Performance Improvement plan

4. Develop a data strategy

a. Develop a strategy with your team on where to find the data, who is responsible to procure the data, data logistics (data range for analysis) and timeframe for data collection completion.
   i. The **RoP Facility Assessment Toolkit ©** outlines the recommended steps for each key area required in §483.70(e). These steps assist leaders in the formation of an organization data strategy.
   ii. Compile a list of questions that you would like answered by the data – these questions will inform leaders on how you choose the data solution to transform raw data into insights.

5. Determine Data Sources

a. It is recommended that facilities build upon existing tools and processes and avoid duplication of information – consider the input from current facility data sources..

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b. The **RoP Facility Assessment Toolkit ©** outlines data sources throughout each section of the toolkit – assisting leaders in compiling data from current facility sources.

6. **Collect, Review and Analyze Data**
   a. Collect – set up the processes and people who will gather and manage organization data.
   b. Analyze - Based upon the data collected, the team should review the raw data, analyze for trends and gaps and useful facility insights.
   c. Organize the data and trends to determine key business strategies. Review with team to determine next steps and completion of the written assessment.

7. **Present Findings**
   a. Based upon the data collection and the insights gather per analysis, complete the narrative facility assessment as outlined in the **RoP Facility Assessment Toolkit ©.**

8. **Monitor and Re-evaluate**
   a. Determine a process for ongoing data analysis to determine if the Facility Assessment requires updating or modification per requirements.
   b. Incorporate the Facility Assessment findings into the QAPI process.

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Facility Assessment Policy

Facility Assessment Policy

PREFACE

It is the policy of this facility that it must conduct and document an individualized facility-wide assessment to determine what resources are necessary to care for its residents competently during both day-to-day operations and emergencies. The facility assessment will be conducted at the facility level and may incorporate input from the governing body/ownership. The facility will review and update the facility assessment annually and as necessary whenever there is, or the facility plans for, any change that would require a substantial modification to any part of the assessment. The facility assessment will address or include the following per requirements:

- The facility's resident population
  - Number of residents and resident capacity
  - Care required by the resident population which considers:
    - Types of diseases
    - Conditions
    - Physical and cognitive disabilities
    - Overall acuity
    - Other pertinent facts that are present within the facility population

- The facility's resources, including but not limited to:
  - 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, 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; and
  - Health information technology resources, such as systems for electronically managing patient records and electronically sharing information with other organizations.

- A facility-based and community-based risk assessment, utilizing an all-hazards approach.

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OBJECTIVE OF FACILITY ASSESSMENT POLICY

The objective of the facility assessment is to evaluate the resident population and identify the resources needed to provide the necessary care and services the residents require. The facility assessment shall enable the facility to thoroughly assess the needs of its resident population and required resources to provide the care and services the residents need – serving as a record for staff and management to understand the reasoning for decisions made regarding staffing and other resources needed. The facility assessment will be conducted at the facility level including the administrator, medical director, a representative of the governing body, and the director of nursing at a minimum. The environment operations manager, other department heads, or direct care staff will be involved as needed.

CENTERS FOR MEDICAID AND MEDICARE SERVICES (CMS) – DEFINITIONS FOR THE FACILITY ASSESSMENT

The following are CMS definitions or clarifications from the State Operations Manual Appendix PP Interpretive Guidance:

"Competency" is a measurable pattern of knowledge, skills, abilities, behaviors, and other characteristics in performing that an individual needs to perform work roles or occupational functions successfully.

PROCEDURE

The facility will conduct and document a facility-wide assessment to determine the resources are necessary to care for its residents competently during both day-to-day operations and emergencies. The facility will follow the below process to complete the facility assessment:

1. Facility Assessment Team
    a. Under the direction of the administrator, the following team members, at a minimum, will participate in the completion of the facility assessment:
        i. Administrator
        ii. Medical Director
        iii. Representative from the Governing Body
        iv. Director of Nursing
    b. Additional team members for consideration may be needed or recommended, based upon facility resident population and service delivery. Incorporate the input as applicable. Other team members may include:
        i. Environmental services
        ii. Dietary services

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iii. Activity Therapy
iv. Social Services
v. Rehabilitation
vi. Direct Care Staff
vii. Financial Department
viii. Resident Council Representative
ix. Family Council Representative
x. Resident or Resident Representative

2. Organization Data
    a. The facility will collect facility data specific to the required elements of the facility assessment as required.
        i. Required Elements:
            1. The facility's resident population
                a. Number of residents and resident capacity
                b. Care required by the resident population which considers:
                i. Types of diseases
                ii. Conditions
                iii. Physical and cognitive disabilities
                iv. Overall acuity
                v. Other pertinent facts that are present within the facility population
            2. The facility's resources, including but not limited to:
                a. All buildings and/or other physical structures and vehicles
                b. Equipment (medical and non- medical)
                c. Services provided, such as physical therapy, pharmacy, and specific rehabilitation therapies
                d. All personnel, including managers, 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
                e. 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
                f. 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, utilizing an all-hazards approach.

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b. The facility will identify current data and existing tools to meet the above elements of the facility assessment.
c. Potential data sources may include, but are not limited to:
    i. Minimum Data Set
    ii. Financial/Billing Software – UB04
    iii. Operational Budget
    iv. Capital Acquisition Plan
    v. Rehabilitation software
    vi. Electronic Health Record
    vii. Admission/Referral Software
    viii. Hazard Vulnerability Assessment
    ix. Emergency Preparedness Plan
    x. Safety Plan
    xi. Preventative Maintenance Plan
    xii. Equipment Management Plan
    xiii. Vendors and Contractual Service partners
    xiv. Staffing and Scheduling
    xv. Human Resources and /or Payroll
    xvi. Training Plan and /or Software
    xvii. On Line Learning – Learning Management System
    xviii. Lab, Pharmacy, Infection Control
    xix. ((INSERT FACILITY SPECIFIC DATA SOURCES i.e. electronic health record software, etc))

3. Analysis and Evaluation
    a. The facility team will conduct thorough review, analysis and trending of the collected data to support the completion of the written facility assessment assessing resident's needs and identify resources needed for care and for future planning.
    b. The facility team will identify specific insights related to care and service delivery as well as resource needs to meet the needs of the resident population.
    c. The facility will correlate its analysis findings with the operating budget.
    d. The facility team will organize the data to determine key business strategies, determine applicable action steps and finalize the written facility assessment.
4. Written Facility Assessment
    a. Based upon the data collected and the insights gathered, the facility will complete a written summarization of key findings with respect to the required facility assessment elements as indicated in 2(a)(i).
    b. The written facility assessment will describe the resident population, the needs of the population and the required resources to provide the care and services the residents need. The assessment will serve as a foundation for the facility's staffing and resource allocation plan.

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c. See attached Facility Assessment Template
   i. **((Insert facility specific Facility Assessment Written Narrative Template))**

5. Quality Assurance and Performance Improvement
   a. The facility will incorporate the Facility Assessment process and findings into the overall facility quality assurance and performance improvement plan.
6. Facility Assessment Update
   a. The facility will review and update the facility assessment annually and as necessary whenever there is, or the facility plans for, any change that would require a substantial modification to any part of the assessment.
7. Location of the Facility Assessment
   a. The written facility assessment will be located **((INSERT FACILITY SPECIFIC INFORMATION HERE)) and will be accessible to ((INSERT FACILITY SPECIFIC INFORMATION HERE))**

References

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

- https://www.federalregister.gov/documents/2016/10/04/2016-23503/medicare-and-medicaid-programs-reform-of-requirements-for-long-term-care-facilities

CMS Memo Ref: S&C 17-36-NH: Revision to State Operations Manual (SOM) Appendix PP for Phase 2, F-Tag Revisions, and Related Issues

- https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/GuidanceforLawsAndRegulations/Downloads/Survey-and-Cert-Memo-Revision-SOM-Appendix-PP-Phase-2.pdf

CMS Transmittal 169-Advanced Copy Revision to State Operations Manual (SOM) Appendix PP for Phase 2, F-Tag Revisions, and Related Issues

- https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/GuidanceforLawsAndRegulations/Downloads/Advance-Appendix-PP-Including-Phase-2-.pdf

CMS Memo Ref: S&C 17-29-ALL: Advanced Copy- Appendix Z, Emergency Preparedness Final Rule Interpretive Guidelines and Survey Procedures

- https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/SurveyCertificationGenInfo/Downloads/Survey-and-Cert-Letter-17-29.pdf

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Facility Assessment:
Facility Assessment Template

Facility Assessment: Facility Assessment Template

Requirement

F838 §483.70(e) 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 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.

Facility Assessment Templates

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. There is no required format or template that the facility must use. The only requirements are the elements described in the regulation itself must be completed and documented.

Reminder: The Facility Assessment has to be completed, up-to date, in writing and accessible for review per the requirements and survey process.

The RoP Facility Assessment Toolkit © includes two sample templates that should be modified by the facility, based upon its' evaluation process and findings. These templates are not all encompassing, however they do direct the facility to input the specific facility assessment findings in a written narrative format.

Templates Included

- Facility Assessment Template – SAMPLE
  Facility Assessment Template with Data Insert Recommendations – SAMPLE
- QIO Facility Assessment Template
  Source: *http://qioprogram.org/facility-assessment-tool*

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Next Steps

- Review the templates understanding the necessary information needed to meet the required elements of the Facility Assessment
- Begin the evaluation/assessment process utilizing the instructions, tools and resources located in the specific sections of The RoP Facility Assessment Toolkit ©
- Finalize the written Facility Assessment utilizing one of the templates included in this toolkit

Facility Assessment Process

The below is a summary of guidelines related to the process for completing the Facility Assessment *(source Quality Improvement Organization, Facility Assessment Tool)*

Plan for the assessment

- Overseen by the Administrator
- Designate a leader to work with the team as required by the regulations
- Check in on the progress of the team's assignments
-

Complete the assessment process

Synthesize and use the findings

- Review the findings
- Remember the purpose and intent – make decisions about needed resources, including direct care staff needs as well as their capabilities to provide services and support to residents; identify opportunities for improvement
- Ask the following:
  - What has changed with our population?
  - Do we need to make any changes to staffing?
  - How do we know if we have sufficient staffing?
  - What training, education, competency needs do we have?
  - How can we better collaborate with medical practitioners?
  - Any infection control concerns?
  - Any QAPI opportunities?
  - Does our budget and capital plan include the resources that we need?

Evaluate the process and plan for future assessments

- Be prepared to respond to surveyor questions listed in the interpretive guidance
- Debrief with your team
- Establish and agree upon a process for updating the assessment per requirements

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References

State Operations Manual (SOM) Appendix PP for Phase 2, F-Tag Revisions, and Related Issues
www.cms.gov/Medicare/Provider-Enrollment-and-Certification/GuidanceforLawsAndRegulations/Downloads/Advance-Appendix-PP-Including-Phase-2-.pdf

Quality Improvement Organizations, Facility Assessment Tool (2017),
http://qioprogram.org/facility-assessment-tool

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Data Collection Tools and/or Resources

The following Tools and Resources are included in this Section of **The RoP Facility Assessment Toolkit ©**

Item	Description	Source *(If Applicable)*
Sample Written Narrative Template – draft	Sample Template – Narrative Format that is customizable for individual facility completion	Pathway Health
Sample Written Narrative Template with Instructions	Above Sample Template with instructions on what to include in the template – in specific fields	Pathway Health
QIO Sample Facility Assessment Template – Data Collection Format	QIO Facility Assessment Template – presented during MLN national call. Provides instructions and data source recommendations for Facility Assessment Completion	http://qioprogram.org/facility-assessment-tool

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Facility Assessment Template

- Order of Information
- Introduction
  - Intent
  - Facility Assessment Process
  - Facility Assessment and QAPI
- Facility Overview
  - Facility Description
  - Resident Profile
- Resident Demographics
  - Caring for Residents with Conditions not listed above
  - Resident Population Acuity
  - Resident Level of Independence to Dependence
  - Resident Preferences
  - Resident Care and Services Correlating to Resident Population
- Facility Resources
  - Facility Staff
  - Staffing Plan
  - Staff Education, Training and Competencies
  - Policies and Procedures for provision of care
- Resources for Resident Population Needs
  - Equipment, Supplies, Additional Services and Third Party Arrangements
- Health Information Technology
- Infection Control
- Facility and Community Risk Assessment
- Summary

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<< INSERT LOGO or NAME Of FACILITY>>

FACILITY ASSESSMENT

Insert Names and Titles of those completing the assessment

Team Members	*(Reminder required members are: Administrator, Director of Nursing, Medical Director, Governing Body rep)*
Assessment Completed	
QAA/QAPI Review Completed	

Date the Assessment was completed

Date QAA/QAPI reviewed and approved **Make sure reflected in QAPI Mtg Minutes

Introduction

The Facility Assessment is required by the nursing home Requirements of Participation to identify and analyze the facility's resident population and identify the personnel, physical plant, environmental and emergency response resources to needed to competently care for the residents during day to day operations and emergencies.

Insert a Description of the facility Philosophy of care or Mission Statement – This is an example

Intent

The facility provides person-centered, competent care that helps each person served to live their lives as they wish. The services and care provided assist people to reach their highest level of practicable potential and maintain their ability to participate in life activities as long as they are able. The facility offers comfort and compassionate care to those at the end of their lives.

The facility assessment serves as a resource to support decision-making regarding staffing and other resources.

Describe what you will do with the Facility Assessment – modify as needed – the language follows the requirements .

The Facility Assessment collects information about the facility's resident population to identify the number of residents; facility capacity; the care required; staff competencies; the ethnic, cultural and religious aspects of the unique resident population; physical; personnel resources needed; contractual agreements; health information technology resources; environment; equipment, supplies and other services utilized; and a facility and community based risk assessment utilizing an all hazards approach. The facility's resources are identified and evaluated to ensure that care can be provided to meet residents' needs during day to day and emergency operations.

Describe who developed the Facility Assessment and what was the process utilized

Facility Assessment Process

A Representative from the Governing Body, the Administrator, the Medical Director, Director of the Nursing, Therapy, *Social Work Services, Nutrition Services, Activity Services and Environmental Services* departments collaborated to develop and conduct the facility assessment with input from staff in each department.

Each department identified the relevant information to identify the resident population and the resources available within their departments to meet the residents' needs.

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Insert the examples of data used to develop the Facility Assessment. These are a few examples of data to use or list

Information sources such as the average daily census, CMS Resident Census and Condition report Quality Measure Facility Characteristics Report, Diagnosis reports, Facility equipment inventory, staff orientation plan and annual training plan, and others were used to develop the Facility Assessment.

Frequency of review

The Facility Assessment will be reviewed annually and if the resident population changes, new types of care and services are provided or new technology, equipment or other resources are introduced.

Describe how information is used for QAPI

Facility Assessment and QAPI

Information from the Facility Assessment is used to inform the Quality Assurance Performance Improvement (QAPI) process as indicated in the QAPI Plan. The identification of residents needs focuses the activities of the QAPI process. The description of care, services and resources available at the facility provides both areas for monitoring of processes and outcomes as well as information for investigation of root causes of adverse events and gaps in performance.

FACILITY OVERVIEW

Describe your Census and capacity

Facility Description

((facility name)) is a licensed *((skilled nursing, ….))* facility. The facility is licensed for _____ beds with an average daily census of _____. The facility provides *(((indicate or differentiate either by number or % - short term, long stay, memory care, specialty programming i.e. vents, bariatric, cardio rehab, ACO, etc))* .

> *Example - The facility has 100 beds available for resident use and has an average census of 80 residents. There is a 20 bed secured Memory Care unit and a 20 bed Short Term Transitional Care unit as well as 40 beds for long stay residents.*

The facility admits approximately _____ individuals and discharges _____ individuals on a monthly basis with an average length of stay of _____ days. Our average RUG level for the facility is _____. *((if applicable - separate out RUG level for specialty programs))*

Describe Physical Plant, structures, buildings and vehicles

The facility is located *((description of acreage, special location in community, etc))* with ((# of buildings, structures)), ((number of units or households)). Our facility also provides ((insert information on transportation vans, vehicles, walking trails, swimming pool, clinic, …)

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Narrative overview of your resident population. See examples

Resident Profile

The facility serves individuals who often times have one or more chronic or co-morbid conditions. Our overall resident population consists of …

Examples of resident population description

Narrative Examples:

The population of the facility is 90% female. The age range of residents in the Short Term Transitional Care unit is 50 – 90 years old. The average age of residents in the Memory Care unit and long term care units is 80 – 100 years old. Hospice services are typically provided for approximately 10% of the facility population. The resident population of the facility reflects the surrounding community with residents of various cultures and religions.

The residents of the facility have both chronic illnesses and post-acute conditions.

The residents of the 20 bed Short Term Transitional Care unit have some combination of post-surgical conditions and chronic diseases, such as COPD , CHF and Diabetes. Common admitting diagnoses include hip fracture, pneumonia, and exacerbation of COPD. The residents of the Short Term Transitional Care unit are admitted from the hospital and require skilled nursing skilled therapy services for recovery from surgery and illness. The average RUG level for these residents is RVB. Residents typically enter the facility with dependencies in ADL care and mobility and are discharged to the community at more independent levels of functioning.

The residents of the 20 bed Memory Care unit have a range of diseases with associated dementia symptoms, such as Parkinson's disease, Alzheimer's disease and residual effects of CVA. Approximately 50% of the residents living in the Memory Care unit have behaviors toward others, wandering or exit seeking behaviors. The average RUG level for the residents of the Memory Care unit is BA2. Residents of the Memory Care unit typically require supervision for mobility and need assistance with bathing, dressing and grooming. Approximately 50% of the residents require supervision and assistance with eating.

Residents living in long term care units typically have a number of chronic diseases. The most common are COPD (25%), CHF (10%), Diabetes (15%), Hypertension (80%) and Cancer (10%). The average RUG level for the long term care residents is CA1. 75% of these residents require assistance with mobility and 85% require assistance with bathing, dressing and grooming. Most residents (90%) can eat after staff set up their meals. 5% of the residents require enteral feedings. 55% of these residents are incontinent of bladder or bowel due to functional incontinence.

Residents of the facility are at risk for falls, pressure ulcers, infections, incontinence, increased disability, weight loss, depression and other potential areas of decline.

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Use data sources to gather information to describe. Identify the top 10 conditions

- **Resident Demographics – Diseases, conditions, physical and cognitive disabilities**

The following indicates the common diagnosis/conditions, physical and cognitive disabilities or a combination of these conditions. *((list top 10 conditions based on category))*

Category (system)	Common Diagnosis	% of Population

***Data Source** - The information about the resident population was derived from the CMS 672 Resident Census and Condition report, the CMS Quality Measure Facility Characteristics report, diagnosis and condition and MDS reports from the electronic health record.*

Modify for your facility and population you serve

- **Caring for Residents with Conditions not listed above**

Although the list above depicts the top common diseases and conditions that we serve, our facility has a comprehensive process in place to assess resident needs and determine the care and services required. The facility cares for residents with skilled needs. We utilize a comprehensive admission, readmission and required assessment process in which the interdisciplinary team identifies individualized resident care needs. Should an individual require care and services based upon a diagnosis or condition not typically serviced in our resident population, our team, in conjunction with our Medical Director and Director of nursing ((insert facility process))

- **Resident Population Acuity**

The facility reviews acuity within our resident population. The below outlines the resident population acuity within the past _____ months. *((the facility may wish to complete two grids if there are specific specialty programs which may alter the %))*

Modify for your facility and population you serve

RUG IV	% of Population

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Modify for your facility and population you serve

- **Resident Level of Independence to Dependence**

Indicate the data sources utilized to gather information

ADL Assistance	Independent %	Assist of 1-2 %	Dependent %
Dressing			
Bathing			
Transfer			
Eating			
Toileting			
	Independent %	**Asst Device Used to Ambulate**	**In Chair Most of Time**
Mobility			

***Data Source** - The information about the resident population was derived from the CMS 672 Resident Census and Condition report, the CMS Quality Measure Facility Characteristics report, diagnosis and condition and MDS reports from the electronic health record*

- **Resident Preferences**

The facility supports a culture of person centered care with respect to personal preferences. Our facility support this by our admission process as well as our day to day operations…

Indicate how your facility supports preferences – activities, food, space. Describe other pertinent facts or descriptions of the resident population that must be taken into account

Indicate facility specific information

- **Resident Care and Services Correlating to Resident Population**

The facility provides care and services based upon the needs of our resident population. Our facility embraces a person-centered care culture in which we provide care and services based upon our resident population, including the following:

- Assistance with activities of daily living
- Mobility assistance
- Incontinence prevention and care
- Medications and Medication Management
- Intravenous Therapy
- Behavioral health
- Psycho social support
- Clinical System - Pain, Wound Care, Pain Management…..
- Infection Control
- Rehabilitation
- Respiratory Therapy
- Therapeutic Recreation
- Special Care Needs including: _____
- Nutrition

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Examples of statements

A skilled rehabilitation program is offered with therapy available seven days per week.
Respiratory care and treatment are provided. Oxygen and respiratory treatments are provided. There is a consulting respiratory therapist available on-call from the hospital.
The licensed nursing staff provides IV therapy, medication by injection and inhalation and specialty wound care.
Residents requiring hemodialysis are treated at the Dialysis center in the community. Care and treatment for these residents is a joint effort of the facility and dialysis center staff.
The facility has agreements with two of the local Hospice agencies to provide services in the facility. The Administrator will be happy to arrange an agreement with other agencies as requested by the residents and their representatives.
The staff is capable to provide support, assistance and direct care as needed for activities of daily living, mobility and eating. Bathing is offered in the spa room and showers are available in residents' bathrooms. Residents are encouraged to establish their own daily routines and schedules.
The Restorative Nursing Program assists residents to reach higher levels of function and avoid decline in self-care abilities and mobility. The programs are implemented following an assessment of needs by a therapist or RN. Programs include range of motion, ambulation, transfer, strength and balance, bladder retraining and bowel retraining.
The facility has an agreement with the local psychology clinic. Therapists visit residents at the facility as needed, upon referral from their attending medical provider.
The facility offers on-site dental, podiatry and optometry services to meet residents' needs. Services may be requested by residents and their representatives or recommended by the staff.
Medication administration is offered by the nursing staff. Residents will be assessed for safe self-administration of medications upon request by residents and their representatives or recommendation by the staff. Medication management is provided by the Pharmacy. A consulting pharmacist reviews each resident's medication regimen monthly and collaborates with the nursing staff and medical provides for optimal medication therapies.
The nutrition services department provides nutritious and appetizing meals to meet each resident's dietary needs, based on assessment by the registered dietician. Staff serves meals in the three dining areas and can provide meals in residents' rooms. Nutrition services staff make every effort to provide for each resident's food preferences. Special meals are provided for religious holidays celebrated by the residents.
The Activities department provides a variety of activities based on the expressed preferences of the residents. Residents are supplies with reading materials, hand crafts and other hobby or activity supplies for use in their rooms.
The facility has routine clergy visits and religious services available in the facility from the Lutheran and Catholic churches in the community.

Facility Resources

Insert Specific Information

Facility Staff

The facility is managed by *((governing body, a Board of Directors, etc))* and Administrator. The Medical Director oversees medical practice and the clinical policies and programs of the facility. Each resident is supported to choose their own physician. There are ___ physicians and ____ nurse practitioners that visit the facility regularly to see residents. The facility collaborates medical practitioners as it relates to the care and service needs of the facility resident population.

Possibly insert overview Org Chart

The facility personnel consist of:

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Insert Specific Information

- licensed nurses, RN and LPN, certified nursing assistants, medication technicians,
- medical records staff,
- licensed social workers,
- a registered dietician and
- nutrition services staff,
- activities staff,
- maintenance, housekeeping and laundry staff, and
- staff in the business office.
- Each department is led by a department director.
- Therapy services are provided under contract and staff includes, licensed physical and occupational therapists and speech language pathologists.
- Volunteers
- Pharmacist
- Behavioral Health providers
- Support services
- Laboratory
- Diagnostic Services
- Other

Staffing Plan

The table below describes the number of staff available to meet residents' needs. Nursing, nutrition services and housekeeping staffing is evaluated at the beginning of each sift and adjusted as needed to meet the care needs and acuity of the resident population. Please see the posted nursing staffing hours for details.

Modify and Insert Specific Information

Position	FTEs
Licensed nurses	
Certified nursing assistants	
Medication techs	
Restorative nursing assistants	
Licensed social worker	
Dietician	
Nutrition services staff	
Social Services	
Activity Therapy	
Other Services	

Modify and Insert Specific Information . Describe how staff assignments are assigned to promote coordination and continuity of care.

Nursing staff is primarily assigned to care for the same residents. There are a few nursing staff who move between two primary units to fill in vacancies.

((Insert Information))

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Staff Education, Training and Competencies

Each job description identifies the required education and credentials for the job. Staff education and credentials are verified prior to hire.

Every staff member has knowledge competency in: abuse, neglect, exploitation and misappropriation; resident rights; identification of condition change; and resident preferences. Additional knowledge competencies for all staff include dementia management, infection transmission and prevention, immunization, QAPI, and OSHA hazard communication. Hand hygiene return demonstration competencies and observed knowledge competencies for emergency response are also required.

Modify and Insert Specific Information

Additional competencies are determined according to the amount of resident interaction required by the job role, job specific knowledge, skills and abilities and those needed to care for the resident population.

Certified nursing assistants have additional required competencies for

- *Person centered care*
- *Communication*
- *Basic nursing skills*
- *Basic restorative services*
- *Skin and wound care*
- *Medication management*
- *Pain management*
- *Additional Infection control topics*
- *Identification of changes in condition*
- *Cultural competency*

Competencies are based on current standards of practice and may include knowledge and a test, knowledge and return demonstration, knowledge and observed ability, knowledge and observed behavior and annual performance evaluation. Competencies are based on the care and services needed by the resident population. Please see the Resident Needs and Competencies worksheet for more details

Modify and Insert Specific Information

Competencies are verified upon orientation, least annually and as needed.

The facility provides education and training *((insert if in person, self directed, on line – what system, in-service…))* The staff training and education program is designed to ensure knowledge competency for all staff. Education is provided through the on-line learning system, peer mentoring and classroom sessions. The training program is reviewed and revised each time the Facility Assessment is reviewed and/or revised.

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Modify and Insert Specific Information

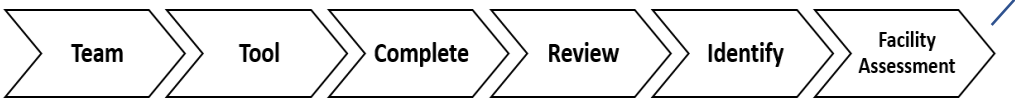
Policies and Procedures for provision of care

The care needs of the residents and the requirements of regulations rules and laws govern the needed policies and procedures.

Policies and procedures for care are reviewed and updated at least annually and as needed with the introduction of new resident care needs, new technology or equipment or a change in the physical plant or environmental hazards.

Resources for Resident Population Needs
Equipment, Supplies, Additional Services and Third Party Arrangements

Via a prescribed process, the facility evaluates the day to day and emergency provision of equipment (medical and non-medical), supplies, as well as additional services by providers via a contractual arrangement which is based upon the resident population care needs, annually or as needed. The following steps are utilized throughout the evaluation process:



Modify and Insert Specific Information

This process is conducted in conjunction with the facility assessment evaluation, per requirement, and the facility QAPI process.

Upon the evaluation process, it has been determined that the type and number of resources (i.e. equipment, supplies, other services) is adequate to meet the resident population care needs and services daily. The facility has reviewed the provision of resources in an emergency and determined that the type and number of resources, services and supplies are planned and applicable to the resident population. See the Emergency Preparedness Plan.

Modify and Insert Specific Information

Equipment and Supplies
The facility has a designee who oversees the procurement and maintenance of par levels for resident equipment and supplies based upon resident population needs.

((insert facility specific information – describing the facility process which reviews resident needs, par levels for adequate supplies and equipment))

Modify and Insert Specific Information

The facility utilizes the Preventative Maintenance Program to inventory equipment, physical plant and other physical plant needs and conduct maintenance prevention based upon the PMP plan.

The facility evaluates the physical environment, equipment (medical and non-medical), supplies, and additional services by providers via a contractual arrangement based upon the resident population needs for provision of care, annually or as needed.

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PATHWAY HEALTH
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Modify and Insert Specific Information

Third Party Agreements, Contracts, Memoranda of Understanding

Under the direction of the Administrator, the facility reviews all third-party agreements, contracts, and memoranda of understandings via a prescribed process which reviews the vendor arrangement, terms of contract and the provision of services on a daily or emergency need. These arrangements for the provision of services, equipment, and supplies to provide the level and types of care needed for the resident population.

Health Information Technology

The facility has a designee who oversees the health information technology resources including electronic health records and electronic sharing of resident information. The facility has a system to

Modify and Insert Specific Information

((insert facility specific information as it relates to interoperability, security, how information is exchanged with other providers – home care, assisted living, acute, physicians, receiving facility and resident/resident representative access of information))

Modify and Insert Specific Information

Infection Control

The facility has conducted an infection control risk assessment which evaluated and determined the risk or potential vulnerabilities within the resident population and the surrounding community. This process is integrated with the facility Infection Prevention and Control Program (IPCP). The IPCP is designed to meet current standards of practice and the needs of the facility population, staff and community. It is part of the QAPI program. The IPCP is reviewed at least annually and whenever the Facility Assessment is reviewed.

((Insert facility specific information if applicable))

Modify and Insert Specific Information

Facility and Community Risk Assessment

The facility has conducted a facility and community based risk assessment which document potential hazards within the geographic area of the facility, the facility physical plant and the vulnerabilities and challenges that may impact the facility utilizing an all hazards approach. In addition, the risk assessment evaluates the facility's ability to maintain continuity of operations, its ability to provide care and services, and its ability to secure required supplies and resources during an emergency or natural disaster. This risk assessment has been in incorporated Emergency Preparedness Plan.

Summary

Modify and Insert Specific Information

In summary, the facility

((Insert ending summary statement if applicable or desired))

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Facility Assessment Template

- Order of Information

- Introduction
  - Intent
  - Facility Assessment Process
  - Facility Assessment and QAPI

- Facility Overview
  - Facility Description
  - Resident Profile

- Resident Demographics
  - Caring for Residents with Conditions not listed above
  - Resident Population Acuity
  - Resident Level of Independence to Dependence
  - Resident Preferences
  - Resident Care and Services Correlating to Resident Population

- Facility Resources
  - Facility Staff
  - Staffing Plan
  - Staff Education, Training and Competencies
  - Policies and Procedures for provision of care

- Resources for Resident Population Needs
  - Equipment, Supplies, Additional Services and Third Party Arrangements

- Health Information Technology

- Infection Control

- Facility and Community Risk Assessment

- Summary

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<< INSERT LOGO or NAME Of FACILITY>>

FACILITY ASSESSMENT

Team Members	*(Reminder required members are: Administrator, Director of Nursing, Medical Director, Governing Body rep)*
Assessment Completed	
QAA/QAPI Review Completed	

Introduction

The Facility Assessment is required by the nursing home Requirements of Participation to identify and analyze the facility's resident population and identify the personnel, physical plant, environmental and emergency response resources to needed to competently care for the residents during day to day operations and emergencies.

Intent

The facility provides person-centered, competent care that helps each person served to live their lives as they wish. The services and care provided assist people to reach their highest level of practicable potential and maintain their ability to participate in life activities as long as they are able. The facility offers comfort and compassionate care to those at the end of their lives.

((Insert facility Mission or Philosophy of care))

The facility assessment serves as a resource to support decision-making regarding staffing and other resources.

((Describe what you will do with the Facility Assessment – modify as needed – the language follows the requirements))

The Facility Assessment collects information about the facility's resident population to identify the number of residents; facility capacity; the care required; staff competencies; the ethnic, cultural and religious aspects of the unique resident population; physical; personnel resources needed; contractual agreements; health information technology resources; environment; equipment, supplies and other services utilized; and a facility and community based risk assessment utilizing an all hazards approach. The facility's resources are identified and evaluated to ensure that care can be provided to meet residents' needs during day to day and emergency operations.

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Facility Assessment Process

A Representative from the Governing Body, the Administrator, the Medical Director, Director of the Nursing, *((Describe who developed the Facility Assessment and what was the process utilized Therapy, Social Work Services, Nutrition Services, Activity Services and Environmental Services departments))* collaborated to develop and conduct the facility assessment with input from staff in each department.

Each department identified the relevant information to identify the resident population and the resources available within their departments to meet the residents' needs.

Information sources such as *((Insert examples of data used to develop the Facility Assessment i.e. the average daily census, CMS Resident Census and Condition report Quality Measure Facility Characteristics Report, Diagnosis reports, Facility equipment inventory, staff orientation plan and annual training plan, and others))* were used to develop the Facility Assessment.

The Facility Assessment will be reviewed annually and if the resident population changes, new types of care and services are provided or new technology, equipment or other resources are introduced.

Facility Assessment and QAPI

Information from the Facility Assessment is used to inform the Quality Assurance Performance Improvement (QAPI) process as indicated in the QAPI Plan. The identification of residents needs focuses the activities of the QAPI process. The description of care, services and resources available at the facility provides both areas for monitoring of processes and outcomes as well as information for investigation of root causes of adverse events and gaps in performance.

((Insert specific information related to QAPI process and correlation to

Facility Assessment or modify the above))

FACILITY OVERVIEW

Facility Description

((facility name)) is a licensed *((skilled nursing, ….))* facility. The facility is licensed for _____ beds with an average daily census of _____. The facility provides *(((indicate or differentiate either by number or % - short term, long stay, memory care, specialty programming i.e. vents, bariatric, cardio rehab, ACO, etc))* .

> *((Example - The facility has 100 beds available for resident use and has an average census of 80 residents. There is a 20 bed secured Memory Care unit and a 20 bed Short Term Transitional Care unit as well as 40 beds for long stay residents))*

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The facility admits approximately _____ individuals and discharges _____ individuals on a monthly basis with an average length of stay of _____ days. Our average RUG level for the facility is _____. *((if applicable - separate out RUG level for specialty programs))*

The facility is located *((description of acreage, special location in community, etc))* with ((# of buildings, structures)), ((number of units or households)). Our facility also provides *((insert information on transportation vans, vehicles, walking trails, swimming pool, clinic, …)*

((Insert facility specific description of the facility or campus and surrounding area))

Resident Profile

The facility serves individuals who often times have one or more chronic or co-morbid conditions. Our overall resident population consists of …

((Insert a Narrative overview of your resident population. See examples of resident population description on Facility Template with Instructions))

- **Resident Demographics – Diseases, conditions, physical and cognitive disabilities**

The following indicates the common diagnosis/conditions, physical and cognitive disabilities or a combination of these conditions. *((list top 10 conditions based on category))*

Category (system)	Common Diagnosis	% of Population

***Data Source** – ((insert specific summary statement i.e. The information about the resident population was derived from the CMS 672 Resident Census and Condition report, the CMS Quality Measure Facility Characteristics report, diagnosis and condition and MDS reports from the electronic health record))*

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- **Caring for Residents with Conditions not listed above**

  Although the list above depicts the top common diseases and conditions that we serve, our facility has a comprehensive process in place to assess resident needs and determine the care and services required. The facility cares for residents with skilled needs. We utilize a comprehensive admission, readmission and required assessment process in which the interdisciplinary team identifies individualized resident care needs.

  ((Modify for your facility and population you serve))

  Should an individual require care and services based upon a diagnosis or condition not typically serviced in our resident population, our team, in conjunction with our Medical Director and Director of Nursing… ((insert facility process))

- **Resident Population Acuity**

  The facility reviews acuity within our resident population. The below outlines the resident population acuity within the past _____ months.

  ((the facility may wish to complete two grids if there are specific specialty programs which may alter the %))

RUG IV	% of Population

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- **Resident Level of Independence to Dependence**

ADL Assistance	Independent %	Assist of 1-2 %	Dependent %
Dressing			
Bathing			
Transfer			
Eating			
Toileting			
	Independent %	**Asst Device Used to Ambulate**	**In Chair Most of Time**
Mobility			

***Data Source** – ((Insert Summary statement – i.e. The information about the resident population was derived from the CMS 672 Resident Census and Condition report, the CMS Quality Measure Facility Characteristics report, diagnosis and condition and MDS reports from the electronic health record))*

- **Resident Preferences**
  The facility supports a culture of person centered care with respect to personal preferences. Our facility support this by our admission process as well as our day to day operations…

((Indicate how your facility supports preferences – activities, food, space. Describe other pertinent facts or descriptions of the resident population that must be taken into account))

- **Resident Care and Services Correlating to Resident Population**

The facility provides care and services based upon the needs of our resident population. Our facility embraces a person-centered care culture in which we provide care and services based upon our resident population, including the following:

((See example statements in the Facility Assessment Template with Instructions))

((Modify based upon resident population))

- Assistance with activities of daily living
- Mobility assistance
- Incontinence prevention and care
- Medications and Medication Management
- Intravenous Therapy
- Behavioral health
- Psycho social support

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- Clinical System - Pain, Wound Care, Pain Management…..
- Infection Control
- Rehabilitation
- Respiratory Therapy
- Therapeutic Recreation
- Special Care Needs including: _____
- Nutrition

Facility Resources

Facility Staff

The facility is managed by *((insert specific information -governing body, a Board of Directors, etc))* and Administrator. The Medical Director oversees medical practice and the clinical policies and programs of the facility. Each resident is supported to choose their own physician. There are ___ physicians and ____ nurse practitioners that visit the facility regularly to see residents. The facility collaborates medical practitioners as it relates to the care and service needs of the facility resident population.

((Insert overview organization chart if applicable))

The facility personnel consist of: *((insert specific information))*

- licensed nurses, RN and LPN, certified nursing assistants, medication technicians,
- medical records staff,
- licensed social workers,
- a registered dietician and
- nutrition services staff,
- activities staff,
- maintenance, housekeeping and laundry staff, and
- staff in the business office.
- Each department is led by a department director.
- Therapy services are provided under contract and staff includes, licensed physical and occupational therapists and speech language pathologists.

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- Volunteers
- Pharmacist
- Behavioral Health providers
- Support services
- Laboratory
- Diagnostic Services
- Other

Staffing Plan

The table below describes the number of staff available to meet residents' needs. Nursing, nutrition services and housekeeping staffing is evaluated at the beginning of each sift and adjusted as needed to meet the care needs and acuity of the resident population. Please see the posted nursing staffing hours for details.

((insert specific information))

Position	**FTEs**
Licensed nurses	
Certified nursing assistants	
Medication techs	
Restorative nursing assistants	
Licensed social worker	
Dietician	
Nutrition services staff	
Social Services	
Activity Therapy	
Other Services	

Nursing staff is primarily assigned to care for the same residents. There are a few nursing staff who move between two primary units to fill in vacancies.

((Insert Information -Describe how staff assignments are assigned for continuity of care))

Staff Education, Training and Competencies

Each job description identifies the required education and credentials for the job. Staff education and credentials are verified prior to hire.

Every staff member has knowledge competency in: *((insert specific information))* abuse, neglect, exploitation and misappropriation; resident rights; identification of condition change; and resident preferences. Additional knowledge competencies for all staff include dementia management, infection

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transmission and prevention, immunization, QAPI, and OSHA hazard communication. Hand hygiene return demonstration competencies and observed knowledge competencies for emergency response are also required.

Additional competencies are determined according to the amount of resident interaction required by the job role, job specific knowledge, skills and abilities and those needed to care for the resident population.

Certified nursing assistants have additional required competencies for *((insert specific information))*

- *Person centered care*
- *Communication*
- *Basic nursing skills*
- *Basic restorative services*
- *Skin and wound care*
- *Medication management*
- *Pain management*
- *Additional Infection control topics*
- *Identification of changes in condition*
- *Cultural competency*

Competencies are based on current standards of practice and may include knowledge and a test, knowledge and return demonstration, knowledge and observed ability, knowledge and observed behavior and annual performance evaluation. Competencies are based on the care and services needed by the resident population. Please see the Resident Needs and Competencies worksheet for more details

Competencies are verified upon orientation, least annually and as needed.

((Modify and insert specific information))

The facility provides education and training *((insert if in person, self directed, on line – what system, in-service…))* The staff training and education program is designed to ensure knowledge competency for all staff. Education is provided through the on-line learning system, peer mentoring and classroom sessions. The training program is reviewed and revised each time the Facility Assessment is reviewed and/or revised.

Policies and Procedures for Provision of Care

The care needs of the residents and the requirements of regulations rules and laws govern the needed policies and procedures.

((Modify and insert specific information))

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Policies and procedures for care are reviewed and updated at least annually and as needed with the introduction of new resident care needs, new technology or equipment or a change in the physical plant or environmental hazards.

Resources for Resident Population Needs

Equipment, Supplies, Additional Services and Third Party Arrangements

Via a prescribed process, the facility evaluates the day to day and emergency provision of equipment (medical and non-medical), supplies, as well as additional services by providers via a contractual arrangement which is based upon the resident population care needs, annually or as needed. The following steps are utilized throughout the evaluation process:

((Modify and insert specific information))

This process is conducted in conjunction with the facility assessment evaluation, per requirement, and the facility QAPI process.

Upon the evaluation process, it has been determined that the type and number of resources (i.e. equipment, supplies, other services) is adequate to meet the resident population care needs and services daily. The facility has reviewed the provision of resources in an emergency and determined that the type and number of resources, services and supplies are planned and applicable to the resident population. See the Emergency Preparedness Plan.

Equipment and Supplies

The facility has a designee who oversees the procurement and maintenance of par levels for resident equipment and supplies based upon resident population needs.

((Modify and insert specific information))

((insert facility specific information – describing the facility process which reviews resident needs, par levels for adequate supplies and equipment))

The facility utilizes the Preventative Maintenance Program to inventory equipment, physical plant and other physical plant needs and conduct maintenance prevention based upon the PMP plan.

((Modify and insert specific information))

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The facility evaluates the physical environment, equipment (medical and non-medical), supplies, and additional services by providers via a contractual arrangement based upon the resident population needs for provision of care, annually or as needed.

Third Party Agreements, Contracts, Memoranda of Understanding

Under the direction of the Administrator, the facility reviews all third-party agreements, contracts, and memoranda of understandings via a prescribed process which reviews the vendor arrangement, terms of contract and the provision of services on a daily or emergency need. These arrangements for the provision of services, equipment, and supplies to provide the level and types of care needed for the resident population.

((Modify and insert specific information))

Health Information Technology

The facility has a designee who oversees the health information technology resources including electronic health records and electronic sharing of resident information. The facility has a system to

((insert facility specific information as it relates to interoperability, security, how information is exchanged with other providers – home care, assisted living, acute, physicians, receiving facility and resident/resident representative access of information))

Infection Control

The facility has conducted an infection control risk assessment which evaluated and determined the risk or potential vulnerabilities within the resident population and the surrounding community. This process is integrated with the facility Infection Prevention and Control Program (IPCP). The IPCP is designed to meet current standards of practice and the needs of the facility population, staff and community. It is part of the QAPI program. The IPCP is reviewed at least annually and whenever the Facility Assessment is reviewed.

((Modify and insert specific information))

Facility and Community Risk Assessment

The facility has conducted a facility and community based risk assessment which document potential hazards within the geographic area of the facility, the facility physical plant and the vulnerabilities and challenges that may impact the facility utilizing an all hazards approach. In addition, the risk assessment evaluates the facility's ability to maintain continuity of operations, its ability to provide care and services, and its ability to secure required supplies and resources during an emergency or natural disaster. This risk assessment has been in incorporated Emergency Preparedness Plan.

((Modify and insert specific information))

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Summary

In summary, the facility

((Insert ending summary statement if applicable or desired))

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Facility Assessment Template

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- Health Information Technology

- Infection Control

- Facility and Community Risk Assessment

- Summary

<< INSERT LOGO or NAME Of FACILITY>>

FACILITY ASSESSMENT

Team Members	*(Reminder required members are: Administrator, Director of Nursing, Medical Director, Governing Body rep)*
Assessment Completed	
QAA/QAPI Review Completed	

Introduction

The Facility Assessment is required by the nursing home Requirements of Participation to identify and analyze the facility's resident population and identify the personnel, physical plant, environmental and emergency response resources to needed to competently care for the residents during day to day operations and emergencies.

Intent

The facility provides person-centered, competent care that helps each person served to live their lives as they wish. The services and care provided assist people to reach their highest level of practicable potential and maintain their ability to participate in life activities as long as they are able. The facility offers comfort and compassionate care to those at the end of their lives.

((Insert facility Mission or Philosophy of care))

The facility assessment serves as a resource to support decision-making regarding staffing and other resources.

((Describe what you will do with the Facility Assessment – modify as needed – the language follows the requirements))

The Facility Assessment collects information about the facility's resident population to identify the number of residents; facility capacity; the care required; staff competencies; the ethnic, cultural and religious aspects of the unique resident population; physical; personnel resources needed; contractual agreements; health information technology resources; environment; equipment, supplies and other services utilized; and a facility and community based risk assessment utilizing an all hazards approach. The facility's resources are identified and evaluated to ensure that care can be provided to meet residents' needs during day to day and emergency operations.

Facility Assessment Process

A Representative from the Governing Body, the Administrator, the Medical Director, Director of the Nursing, *((Describe who developed the Facility Assessment and what was the process utilized Therapy, Social Work Services, Nutrition Services, Activity Services and Environmental Services departments))* collaborated to develop and conduct the facility assessment with input from staff in each department.

Each department identified the relevant information to identify the resident population and the resources available within their departments to meet the residents' needs.

Information sources such as *((Insert examples of data used to develop the Facility Assessment i.e. the average daily census, CMS Resident Census and Condition report Quality Measure Facility Characteristics Report, Diagnosis reports, Facility equipment inventory, staff orientation plan and annual training plan, and others))* were used to develop the Facility Assessment.

The Facility Assessment will be reviewed annually and if the resident population changes, new types of care and services are provided or new technology, equipment or other resources are introduced.

Facility Assessment and QAPI

Information from the Facility Assessment is used to inform the Quality Assurance Performance Improvement (QAPI) process as indicated in the QAPI Plan. The identification of residents needs focuses the activities of the QAPI process. The description of care, services and resources available at the facility provides both areas for monitoring of processes and outcomes as well as information for investigation of root causes of adverse events and gaps in performance.

((Insert specific information related to QAPI process and correlation to

Facility Assessment or modify the above))

FACILITY OVERVIEW

Facility Description

((facility name)) is a licensed *((skilled nursing, ….))* facility. The facility is licensed for _____ beds with an average daily census of _____. The facility provides *(((indicate or differentiate either by number or % - short term, long stay, memory care, specialty programming i.e. vents, bariatric, cardio rehab, ACO, etc))* .

> *((Example - The facility has 100 beds available for resident use and has an average census of 80 residents. There is a 20 bed secured Memory Care unit and a 20 bed Short Term Transitional Care unit as well as 40 beds for long stay residents))*

The facility admits approximately _____ individuals and discharges _____ individuals on a monthly basis with an average length of stay of _____ days. Our average RUG level for the facility is _____. *((if applicable - separate out RUG level for specialty programs))*

The facility is located *((description of acreage, special location in community, etc))* with ((# of buildings, structures)), ((number of units or households)). Our facility also provides *((insert information on transportation vans, vehicles, walking trails, swimming pool, clinic, …)*

((Insert facility specific description of the facility or campus and surrounding area))

Resident Profile

The facility serves individuals who often times have one or more chronic or co-morbid conditions. Our overall resident population consists of …

((Insert a Narrative overview of your resident population. See examples of resident population description on Facility Template with Instructions))

- **Resident Demographics – Diseases, conditions, physical and cognitive disabilities**

The following indicates the common diagnosis/conditions, physical and cognitive disabilities or a combination of these conditions. *((list top 10 conditions based on category))*

Category (system)	Common Diagnosis	% of Population

***Data Source** – ((insert specific summary statement i.e. The information about the resident population was derived from the CMS 672 Resident Census and Condition report, the CMS Quality Measure Facility Characteristics report, diagnosis and condition and MDS reports from the electronic health record))*

- **Caring for Residents with Conditions not listed above**

Although the list above depicts the top common diseases and conditions that we serve, our facility has a comprehensive process in place to assess resident needs and determine the care

and services required. The facility cares for residents with skilled needs. We utilize a comprehensive admission, readmission and required assessment process in which the interdisciplinary team identifies individualized resident care needs.

((Modify for your facility and population you serve))

Should an individual require care and services based upon a diagnosis or condition not typically serviced in our resident population, our team, in conjunction with our Medical Director and Director of Nursing… ((insert facility process))

- **Resident Population Acuity**
  The facility reviews acuity within our resident population. The below outlines the resident population acuity within the past _____ months.

((the facility may wish to complete two grids if there are specific specialty programs which may alter the %))

RUG IV	% of Population

- **Resident Level of Independence to Dependence**

ADL Assistance	Independent %	Assist of 1-2 %	Dependent %

ADL Assistance	Independent %	Assist of 1-2 %	Dependent %
Dressing			
Bathing			
Transfer			
Eating			
Toileting			
	Independent %	**Asst Device Used to Ambulate**	**In Chair Most of Time**
Mobility			

***Data Source** – ((Insert Summary statement – i.e. The information about the resident population was derived from the CMS 672 Resident Census and Condition report, the CMS Quality Measure Facility Characteristics report, diagnosis and condition and MDS reports from the electronic health record))*

- **Resident Preferences**

  The facility supports a culture of person centered care with respect to personal preferences. Our facility support this by our admission process as well as our day to day operations…

((Indicate how your facility supports preferences – activities, food, space. Describe other pertinent facts or descriptions of the resident population that must be taken into account))

- **Resident Care and Services Correlating to Resident Population**

The facility provides care and services based upon the needs of our resident population. Our facility embraces a person-centered care culture in which we provide care and services based upon our resident population, including the following:

((See example statements in the Facility Assessment Template with Instructions))

((Modify based upon resident population))

- Assistance with activities of daily living
- Mobility assistance
- Incontinence prevention and care
- Medications and Medication Management
- Intravenous Therapy
- Behavioral health
- Psycho social support
- Clinical System - Pain, Wound Care, Pain Management…..
- Infection Control
- Rehabilitation

- Respiratory Therapy
- Therapeutic Recreation
- Special Care Needs including: _____
- Nutrition

Facility Resources

Facility Staff

The facility is managed by *((insert specific information -governing body, a Board of Directors, etc))* and Administrator. The Medical Director oversees medical practice and the clinical policies and programs of the facility. Each resident is supported to choose their own physician. There are ___ physicians and ____ nurse practitioners that visit the facility regularly to see residents. The facility collaborates medical practitioners as it relates to the care and service needs of the facility resident population.

((Insert overview organization chart if applicable))

The facility personnel consist of: *((insert specific information))*

- licensed nurses, RN and LPN, certified nursing assistants, medication technicians,
- medical records staff,
- licensed social workers,
- a registered dietician and
- nutrition services staff,
- activities staff,
- maintenance, housekeeping and laundry staff, and
- staff in the business office.
- Each department is led by a department director.
- Therapy services are provided under contract and staff includes, licensed physical and occupational therapists and speech language pathologists.
- Volunteers
- Pharmacist
- Behavioral Health providers
- Support services

- Laboratory
- Diagnostic Services
- Other

Staffing Plan

The table below describes the number of staff available to meet residents' needs. Nursing, nutrition services and housekeeping staffing is evaluated at the beginning of each sift and adjusted as needed to meet the care needs and acuity of the resident population. Please see the posted nursing staffing hours for details.

((insert specific information))

Position	**FTEs**
Licensed nurses	
Certified nursing assistants	
Medication techs	
Restorative nursing assistants	
Licensed social worker	
Dietician	
Nutrition services staff	
Social Services	
Activity Therapy	
Other Services	

Nursing staff is primarily assigned to care for the same residents. There are a few nursing staff who move between two primary units to fill in vacancies.

((Insert Information -Describe how staff assignments are assigned for continuity of care))

Staff Education, Training and Competencies

Each job description identifies the required education and credentials for the job. Staff education and credentials are verified prior to hire.

Every staff member has knowledge competency in: *((insert specific information))* abuse, neglect, exploitation and misappropriation; resident rights; identification of condition change; and resident preferences. Additional knowledge competencies for all staff include dementia management, infection transmission and prevention, immunization, QAPI, and OSHA hazard communication. Hand hygiene return demonstration competencies and observed knowledge competencies for emergency response are also required.

Additional competencies are determined according to the amount of resident interaction required by the job role, job specific knowledge, skills and abilities and those needed to care for the resident population.

Certified nursing assistants have additional required competencies for *((insert specific information))*

- *Person centered care*
- *Communication*
- *Basic nursing skills*
- *Basic restorative services*
- *Skin and wound care*
- *Medication management*
- *Pain management*
- *Additional Infection control topics*
- *Identification of changes in condition*
- *Cultural competency*

Competencies are based on current standards of practice and may include knowledge and a test, knowledge and return demonstration, knowledge and observed ability, knowledge and observed behavior and annual performance evaluation. Competencies are based on the care and services needed by the resident population. Please see the Resident Needs and Competencies worksheet for more details

Competencies are verified upon orientation, least annually and as needed.

((Modify and insert specific information))

The facility provides education and training *((insert if in person, self directed, on line – what system, in-service…))* The staff training and education program is designed to ensure knowledge competency for all staff. Education is provided through the on-line learning system, peer mentoring and classroom sessions. The training program is reviewed and revised each time the Facility Assessment is reviewed and/or revised.

Policies and Procedures for Provision of Care

The care needs of the residents and the requirements of regulations rules and laws govern the needed policies and procedures.

((Modify and insert specific information))

Policies and procedures for care are reviewed and updated at least annually and as needed with the introduction of new resident care needs, new technology or equipment or a change in the physical plant or environmental hazards.

Resources for Resident Population Needs

Equipment, Supplies, Additional Services and Third Party Arrangements

Via a prescribed process, the facility evaluates the day to day and emergency provision of equipment (medical and non-medical), supplies, as well as additional services by providers via a contractual arrangement which is based upon the resident population care needs, annually or as needed. The following steps are utilized throughout the evaluation process:

((Modify and insert specific information))

This process is conducted in conjunction with the facility assessment evaluation, per requirement, and the facility QAPI process.

Upon the evaluation process, it has been determined that the type and number of resources (i.e. equipment, supplies, other services) is adequate to meet the resident population care needs and services daily. The facility has reviewed the provision of resources in an emergency and determined that the type and number of resources, services and supplies are planned and applicable to the resident population. See the Emergency Preparedness Plan.

Equipment and Supplies

The facility has a designee who oversees the procurement and maintenance of par levels for resident equipment and supplies based upon resident population needs.

((Modify and insert specific information))

((insert facility specific information – describing the facility process which reviews resident needs, par levels for adequate supplies and equipment))

The facility utilizes the Preventative Maintenance Program to inventory equipment, physical plant and other physical plant needs and conduct maintenance prevention based upon the PMP plan.

((Modify and insert specific information))

The facility evaluates the physical environment, equipment (medical and non-medical), supplies, and additional services by providers via a contractual arrangement based upon the resident population needs for provision of care, annually or as needed.

Third Party Agreements, Contracts, Memoranda of Understanding

Under the direction of the Administrator, the facility reviews all third-party agreements, contracts, and memoranda of understandings via a prescribed process which reviews the vendor arrangement, terms of contract and the provision of services on a daily or emergency need. These arrangements for the provision of services, equipment, and supplies to provide the level and types of care needed for the resident population.

((Modify and insert specific information))

Health Information Technology

The facility has a designee who oversees the health information technology resources including electronic health records and electronic sharing of resident information. The facility has a system to

((insert facility specific information as it relates to interoperability, security, how information is exchanged with other providers – home care, assisted living, acute, physicians, receiving facility and resident/resident representative access of information))

Infection Control

The facility has conducted an infection control risk assessment which evaluated and determined the risk or potential vulnerabilities within the resident population and the surrounding community. This process is integrated with the facility Infection Prevention and Control Program (IPCP). The IPCP is designed to meet current standards of practice and the needs of the facility population, staff and community. It is part of the QAPI program. The IPCP is reviewed at least annually and whenever the Facility Assessment is reviewed.

((Modify and insert specific information))

Facility and Community Risk Assessment

The facility has conducted a facility and community based risk assessment which document potential hazards within the geographic area of the facility, the facility physical plant and the vulnerabilities and challenges that may impact the facility utilizing an all hazards approach. In addition, the risk assessment evaluates the facility's ability to maintain continuity of operations, its ability to provide care and services, and its ability to secure required supplies and resources during an emergency or natural disaster. This risk assessment has been in incorporated Emergency Preparedness Plan.

((Modify and insert specific information))

Summary

In summary, the facility

((Insert ending summary statement if applicable or desired))

Facility Assessment Tool

Requirement

Nursing facilities will conduct, document, and annually review a facility-wide assessment, which includes both their resident population and the resources the facility needs to care for their residents (§483.70(e)).

The requirement for the facility assessment may be found in Attachment 1.

Purpose

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

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

Overview of the Assessment Tool

This is an optional template provided for nursing facilities, and if used, it may be modified. 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 and 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, staff training/education and competencies, education and training, 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, 672 (Resident Census and Conditions of Residents) and/or 802 (Roster/Sample Matrix Form) reports, the Payroll-Based Journal, and in-house designed reports.

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, and the director of nursing. 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 are encouraged to 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 there is/the facility plans for any change that would require a modification to any part of this assessment. For example, if the facility decides to admit residents with care needs who were previously not admitted, such as residents on ventilators or dialysis, the facility assessment must be reviewed and updated to address how the facility staff, resources, physical environment, etc., 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 serve as a record for staff and management to understand the reasoning for decisions made regarding staffing and other resources, and may include the operating budget necessary to carry out facility functions.
5. Appendix PP provides 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 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.

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: Our Resident Profile

Numbers

1.1. 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).

1.2. 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).

1.2.a. Consider if it would be helpful to describe the number of persons admitted and discharged, as these processes can impact staffing needs.

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

Diseases/conditions, physical and cognitive disabilities

1.3. 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 in order 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, 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, CVA, 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 Resistant Organisms, Septicemia, Viral Hepatitis, *Clostridium difficile*, Influenza, Scabies, Legionellosis

Decisions regarding caring for residents with conditions not listed above

1.4. 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

1.5. 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 RUGs, MDS data, 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 your organization.* You may elect to use some or all of the tables below or choose your own methodology.

Example 1: Major RUG-IV Categories

Major RUG-IV Categories	**Number/Average or Range of Residents**
Rehabilitation Plus Extensive Services	
Rehabilitation	
Extensive Services	
Special Care High	
Special Care Low	
Clinically Complex	
Behavioral Symptoms and Cognitive Performance	
Reduced Physical Function	

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	

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			
Other care, describe:			
	Independent	**Assistive Device Used to Ambulate**	**In Chair Most of Time**
Mobility			

Ethnic, cultural, or religious factors

1.6. Describe ethnic, cultural, 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, languages, clothing preferences, access to religious services, or religious-based advanced directives.

Other

1.7. 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

2.1 List the types of care that your resident population requires and that you provide for your resident population. 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 in order 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), 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 gastroenteritis, 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
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 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 health care professionals, and medical practitioners that are needed to provide support and care for residents. Potential data sources include staffing records, organization chart, and Payroll-Based Journal reports.

Considering 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, 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, CNA or NAR, medication aide or technician, MDS nurse)
- Food and Nutrition Services (e.g., Director, support staff, registered dietician)
- Therapy Services (e.g., OT, OTA, PT, PTA, 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)

- Pharmacist
- Behavioral and mental health providers
- 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) psychiatric services and mental health providers

Staffing plan

3.2. 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.

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 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, for example, Nursing (F725), Behavioral Health (F741), Nutrition (F802), and Administration (F839). Enter number of staff needed or an average or range:

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	

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. For example:

Staff	**Plan**
Licensed Nurses (LN): RN, LPN, LVN	DON: 1 DON RN full-time Days; if has other responsibilities, add x more RN as Asst. DON to equal one FTE

providing direct care	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)
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 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).

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

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

- Communication – effective communications for direct care staff

- 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 – 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)

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, MRSA/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
- 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 implementing nonpharmacological interventions

Policies and procedures for provision of care

3.5. 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, 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 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 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 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	
Non-medical supplies (if applicable)	Soaps, body cleansing products, incontinence supplies, waste baskets, bed and bath linens, individual communication devices, computers	

Other

3.9. 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.

3.10. 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.

3.11. 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.

3.12. 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; Reform of Requirements for Long-Term Care Facilities
Federal Register / Vol. 81, No. 192 / Tuesday, October 4, 2016 / Rules and Regulations.

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

§483.70(e): 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 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. The facility assessment must address or include:
(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 considering the types of diseases, conditions, physical and cognitive disabilities, overall acuity, and other pertinent facts that are present within that population;
(iii) The staff competencies 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.
(2) The facility's resources, including but not limited to,
(i) All buildings and/or other physical structures and vehicles;
(ii) Equipment (medical and nonmedical);
(iii) Services provided, such as physical therapy, pharmacy, and specific rehabilitation therapies;
(iv) All personnel, including managers, 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, memorandums 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.
(3) A facility-based and community-based risk assessment, utilizing an all hazards approach.

Additional References to the Facility Assessment:

Nursing Services § 483.35 - 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 §483.70(e).

Behavioral Health Services § 483.40(a) - 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 §483.70(e).
-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 §483.70(e).

Food and Nutrition Services § 483.60(a) - 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 §483.70(e).

§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 §483.70(e) 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 §483.70(e).

Infection Control §483.80(a) - 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 §483.70(e) 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 § 483.70(e).

§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 §483.70(e).

§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 §483.70(e) 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:
    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. Do we need to update job descriptions to coincide with new competencies identified?

iv. 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?

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	

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.

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Facility Assessment: How to Use the Toolkit

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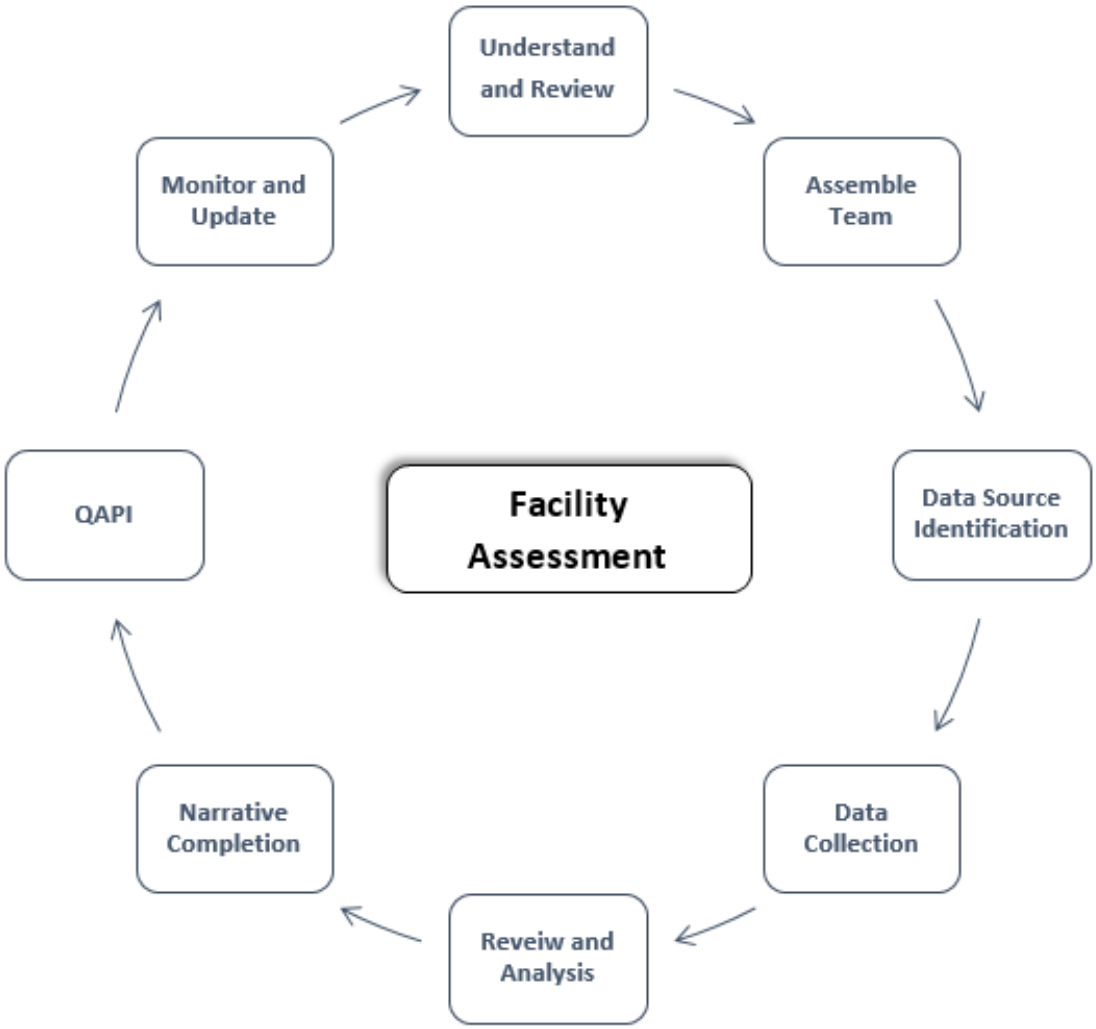
How to Use the Facility Assessment Toolkit

The **RoP Facility Assessment Toolkit ©** is designed to provide practical, step-by-step guidance for organizations as they evaluate their individual facility resident population, resource availability and allocation in accordance to resident care and service needs and other required elements in developing their written facility assessment. The following depicts the steps recommended when completing the Facility Assessment:



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Recommended Steps – Overview

1. **Understand and Review** the Intent of the Facility Assessment Requirements
   - ***Read and review*** the §483.70(e) Facility Assessment requirements and interpretive guidance with your team
   - *Inter-related* - the Facility Assessment, Quality Assurance and Performance Improvement plan and the Emergency Preparedness Plan are inter-related
   - *Other requirements* - The Facility Assessment is integrated into many areas of the Interpretive Guidance and will need to be appropriately addressed across departments within the facility. *See the *Facility Assessment F838 Crosswalk* resource tool located in the Resource Section of **The RoP Facility Assessment Toolkit ©**
   - *Review* the *Facility Assessment Implementation* Guide with your leadership team and determine necessary actions
   - *Develop and implement* a Facility Assessment Policy and Procedure (See: *Facility Assessment Policy and Procedure* Template)

2. **Assemble the Team**
   - *Required Team* - Led by the facility administrator , the minimum team requirements include:
     - Administrator
     - Director of Nursing
     - Medical Director
     - Governing Body representative
   - *Optional Team Members* as applicable
     - Environmental services
     - Plant operations
     - Social services
     - Activity therapy
     - Dietary
     - Direct care staff
     - Residents or representatives
     - Resident council
     - Family Council
     - Others
   - *Roles and Responsibilities*
     - List the team members on the *Facility Assessment Team Roster*
     - Determine roles and responsibilities
     - Set completion dates
     - Set meeting dates for review and analysis
     - Determine communication strategy related to findings and questions

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3. **Data Source Identification**
   - *Existing data sources* – utilize existing data sources for completion of the element requirements
   - *Determine data sources*
     - Review elements and correlate data sources
     - See **RoP Facility Assessment Toolkit ©** sections for recommended facility data sources

4. **Data Collection**
   - *Collect data* – team members to complete their assigned sections of the facility assessment
   - *Verify data* – verify the accuracy of the data thorough out the evaluation process.
     - If there are gaps in data or performance, review findings with leadership and initiate the appropriate improvement plan per facility policy
   - *Data sources and what to collect* are recommended in each section – correlating to the requirements as well as the QIO Facility Assessment Template.
   - *Summary initial findings* – team members will summarize their findings by utilizing the *Facility Assessment Worksheet* for each section of the **RoP Facility Assessment Toolkit ©**

5. **Review and Analysis**
   - *Analyze* - Based upon the data collected, the team should review the raw data, analyze for trends and gaps and useful facility insights. Utilize *the Facility Assessment Summary Worksheet* per section to help summarize the findings
   - *Organize* the data and trends to determine key business strategies
   - *Action* - Review with team to determine next steps, action steps related to gaps and needs identified, and roles and responsibilities for action step completion
   - *Present Findings* – review findings with facility leadership, correlate to facility operating budget, and strategic plan

6. **Narrative Completion**
   - *Collate* all worksheets
   - *Complete* the Facility Assessment Narrative Template – draft
   - *Review* the draft with team
   - *Prepare* the final narrative Facility Assessment (See Sample Template)
   - *Maintain* the official copy of the Facility Assessment per policy

7. **Quality Assurance and Performance Improvement (QAPI)**
   - *Incorporate* the Facility Assessment findings into the QAPI process.

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8. **<u>Monitor and Update</u>**
    - *Annual review* – complete an annual review of the Facility Assessment and corresponding processes per requirement
    - *Monitor* the facility assessment throughout the year via the QAPI process
    - *Update and revise* the Facility Assessment whenever this is or the facility plan for a change that would require a modification to any part of the assessment

How to get started - next steps – Begin using the **RoP Facility Assessment Toolkit ©** to develop your facility assessment.

1. Complete the Facility Assessment Team Roster
2. Review the contents of each section of the **RoP Facility Assessment Toolkit ©** with the assigned team member.
    a. Each section includes the following:
        i. Overview and intent of the specific required element
        ii. Data compilation worksheet
        iii. Recommended data sources
        iv. Data collection tools
        v. Resources
3. Complete the data collection process
4. Analyze and determine resources, training, competencies, physical plant and technology needed
5. Implement corresponding training
    a. Specific training based upon the assessment findings
    b. Overview of the facility assessment process to staff
6. Complete a training program evaluation
7. Complete respective policy and procedure updates
8. Determine Facility Assessment review process and annual review date

The process for completing the Facility Assessment appears overwhelming, however if broken down into specific tasks as outlined in the **RoP Facility Assessment Toolkit ©,** leaders efficiently can work side by side with their team using the Leadership *Quick*TIP to stay on track.

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Facility Assessment Team Roster

Required Element	Task	Team Member	Completion Date	Data Sources
Resident and Facility Population	Census and Capacity			
	Diseases and Conditions			
	Physical and Cognitive Disabilities			
	Other Pertinent Factors and Specialty Programs/Services			
	Overall Acuity			
	Staff Competencies Necessary per population			
	Ethnic, Cultural, Religious Factors including food, nutrition and activities			
	Assisted Technology			
	Individual Communication Devices			
	Physical Space – Resident Rooms, Common Areas, etc.			
Personnel Resources	Staffing Analysis and Ratios			
	Competency Based Training Plan			
	Personnel Listing, Resources and Competencies			
	Nutrition Services			
	Specialized Services			
	Contractual Services and Personnel			
	Volunteers			
	Training Plan Evaluation			

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Required Element	Task	Team Member	Completion Date	Data Sources
Physical Environment	Equipment - Medical			
	Equipment – Non Medical			
	Physical Plant – Buildings and Structures			
	Vehicles			
	Assisted Technologies			
Facility and Community Risk	Hazard Vulnerability Assessment			
	Integration - Emergency Preparedness Plan			
	Corporate Compliance, Ethics, Patient Safety			
Health Information Technology	Electronic Health Record, Resident software			
	Security and Exchange			
	Interruption of Services			
Third Party Agreements	Day to Day Provisions			
	Emergency Provisions			
	Training and Competency			
Infection Prevention	Tracking and Surveillance			
	Resident Population Considerations			
Policy and Procedures	Review of department policies and procedures			

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Facility Assessment
Leadership *Quick*TIP

Step	Action	Completed
Understand and Review	▪ Read and review the §483.70(e) Facility Assessment requirements and interpretive guidance	☐
	▪ Review the Facility Assessment F838 Crosswalk	☐
	▪ Review the Facility Assessment Implementation Guide	☐
	▪ Develop a Facility Assessment Policy and Procedure	☐
Assemble the Team	▪ Complete the Facility Assessment Team Roster	☐
Data Source	▪ Determine existing and needed data sources per required Facility Assessment element	☐
Data Collection	▪ Team members to collect assigned data using data collection tools	☐
	▪ Verify data	☐
	▪ Summarize initial findings on Facility Assessment Worksheets per element	☐
Review and Analysis	▪ Analyze and determine trends	☐
	▪ Determine key business strategies needed and resources needed	☐
	▪ Review initial findings as a team and correlate to operating budget and strategic plan	☐
Narrative Completion	▪ Complete the final narrative Facility Assessment	☐
QAPI	▪ Integrate the Facility Assessment into the facility QAPI process	☐
Monitor and Update	▪ Identify monitoring process with team	☐
	▪ Determine Annual review data	☐
	▪ Update and revise per requirement	☐
	▪ Update corresponding policies and procedures related to Facility Assessment requirement and evaluation findings.	☐

This tool is developed to serve as a quick checklist for Facility Assessment completion.

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Facility Assessment: Section Overview

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Facility Assessment: Section Overview

The RoP Facility Assessment Toolkit © is divided into individual sections that correspond to **§483.70(e)** Facility assessment requirements. Below is an overview of the specific sections of the toolkit:

- **Facility and Resident Population**

  Topic Areas Included:
  - Census and capacity
  - Resident Population conditions, diseases, physical and cognitive disabilities, overall acuity, and other pertinent facts
  - Resident preferences
  - Facility capabilities

  Tools and Resources to support the completion of the facility assessment

- **Personnel Resources**

  Topic Areas Included:
  - Facility personnel
  - Nursing personnel
  - Nutrition personnel
  - Staff competencies
  - Staffing Analysis

  Tools and Resources to support the completion of the facility assessment

- **Training Program Evaluation**

  Topic Areas Included:
  - Overview of training components
  - Training evaluation process

  Tools and Resources to support the completion of the facility assessment

- **Infection Control**

  Topic Areas Included:
  - Overview of Infection Control
  - Correlation to facility assessment

  Tools and Resources to support the completion of the facility assessment

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- **Policy and Procedure Review**

  Topic Areas Included:
  - Overview and Intent of this element
  - Policy and Procedure update process
  - Cross Reference of SOM related to required policy and procedure update language

  Tools and Resources to support the completion of the facility assessment

- **Facility and Community Risk Assessment**

  Topic Areas Included:
  - Overview and Intent of this element
  - Completion of a facility and community risk assessment
  - Hazard Vulnerability Assessment

  Tools and Resources to support the completion of the facility assessment

- **Physical Plant and Equipment Resources**

  Topic Areas Included:
  - Overview and Intent of this element
  - Completion of physical plant and equipment resource evaluation

  Tools and Resources to support the completion of the facility assessment

- **Health Information Technology**

  Topic Areas Included:
  - Overview and Intent of this element

  Tools and Resources to support the completion of the facility assessment

- **Third Party Agreements and Other Services**

  Topic Areas Included:
  - Overview and Intent of the third party element
  - Overview and Intent of other services element

  Tools and Resources to support the completion of the facility assessment

- **Quality Assurance and Performance Improvement**

  Topic Areas Included
  - Overview and Intent of the correlation of QAPI and the facility assessment

  Tools and Resources to support the completion of the facility assessment

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- **Training Resources**

  Topic Areas Included

  - Facility Assessment Overview Training Plan
  - Facility Assessment Presentation and Speaker Notes
  - Facility Assessment Post Test
  - Facility Assessment Answer Key

  Tools and Resources to support the completion of the facility assessment

- **Resources**

  Additional Resource Links for consideration

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Facility Assessment: Facility Resident Population

Facility Assessment
Facility Resident Population

Reference - F838 *§483.70(e) 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 and emergencies. The facility assessment must address or include:

The facility's resident population, including, but not limited to,

- Both the number of residents and the facility's resident capacity;
- The care required by the resident population considering the types of diseases, conditions, physical and cognitive disabilities, overall acuity, and other pertinent facts that are present within that population;
- The staff competencies that are necessary to provide the level and types of care needed for the resident population;
- The physical environment, equipment, services, and other physical plant considerations that are necessary to care for this population; and
- 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.

I. Intent of the Facility Resident Population Section

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

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II. Number of Residents and Facility Resident Capacity

a. The Facility Assessment includes a variety of information to determine the needs of their resident population.

b. The first step in the Facility Assessment process is to identify the average daily resident census of the facility. Count residents who were present in the building, not those out on leave or in the hospital. Most clinical information about residents used in the Facility Assessment will be from the most recent quarter.

c. Report the average daily census for the most recent quarter unless there has been a change in the number of beds or units available for admission, such as a closed or new unit or wing, in the last year.

d. An average daily census report can typically be found in the electronic health record (EHR) system or billing software. Most information about residents used in the Facility Assessment will represent the most recent quarter.

e. The second step is to identify the facility resident capacity, or the total number of existing beds. Existing beds may be the total number of licensed beds, or the beds that the facility has available for admissions and current residents.
    i. Do not count beds on closed wings or unused areas of the facility. Some facilities have limited their census and admission pattern due to staffing or other considerations.
    ii. For the Facility Assessment, count only the existing beds that are available for admissions and current residents.
    iii. If that number has changed over the past year, reflect the current available beds in the Facility Assessment and explain the change in the narrative part of the Assessment.

f. If your facility has a specialty unit, break out the bed capacity and census by units so that the unique needs of the resident population for the specialty program can be explained.

III. Data Sources for Census and Capacity

a. Listed below are examples of where to find the Census and Capacity information for your facility.

b. Census Data Sources (Annual, Quarterly, Monthly and Average Daily Census)

c. Electronic Health Record

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i. The information for the EHR reports comes from different sources than the CMS 672 Resident Census and Conditions of Residents report.
ii. The EHR information is typically counted from the Admissions, Discharges and Transfers entered into the software.
iii. Reports will reflect the census on the day the reports are run or for the time frame you stipulate when you set up the reports.
iv. Each EHR software is different.
v. Read the background information about the reports to determine where the information comes from and follow the directions to run the reports.

d. d. Billing software

i. Billing software may also contain census information. Check this source if the billing software is separate from clinical software system.

ii. Ask the financial team to obtain the reports reflecting the data that you are seeking (i.e. average daily census, census trends quarterly – annually)

e. CMS 672 Resident Census and Conditions of Residents - Field F78 – total residents

i. The CMS 672 Resident Census and Conditions of Residents report is typically available in the MDS report area in your EHR.

ii. Field F78 of the report counts residents with a completed MDS in the EHR on the day the report is run and includes residents on bed-hold status.

iii. Important to note - In some software the report must be refreshed or updated to delete discharged residents and add new admissions.

iv. New admissions without a completed MDS will not be included.

v. Directions for the report indicate that all items must be independently verified by facility staff for accuracy.

For the narrative of the Facility Assessment, review the census information and describe the average census and total bed capacity in the Facility Assessment.

IV. Identify the Facility's Resident Population characteristics and ethnic, cultural, or religious factors

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a. The objective of this section of the Facility Assessment is to identify those needs and preferences that are unique to the facility in order to determine the appropriate level of resources needed to provide competent care for the residents while promoting their highest level of practicable function.

b. Each facility has a unique mix of residents that constitutes the culture of the facility. Some of the variables to explain the resident population may include the number of male and female residents, the age range of the residents, languages spoken by the residents, religious practices of the residents, and the ethnic origins of the resident population. There are many variables to consider.

c. **Data Sources for characteristics and ethnic, cultural, or religious factors**

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Listed below are examples of where to find characteristics and ethnic, cultural, or religious factors:

i. CASPER Quality Measure Facility Characteristics Report
   1. This report includes only data from MDS assessments submitted and accepted into the Quality Improvement and Evaluation System and the Assessment Submission and Processing System (QIES/ASAP) on the CASPER website.
   2. It includes MDS assessments for both short and long stay residents.
   3. MDS assessments are scanned for item information, starting with the most recent MDS and scanning backward to earlier MDS assessments to obtain the information for the report.
   4. The report contains information such as:
      a. residents' gender
      b. age ranges
      c. psychiatric diagnoses
      d. Intellectual Disability or Developmental disability conditions
      e. those currently on Hospice and with life expectancy less than 6 months,
      f. discharge plan in place
      g. referral for discharge planning
      h. admissions
      i. reentries
      j. type of facility the residents entered from
   5. Review the information for accuracy.

** The reports may not reflect the current resident population due to the time it takes to complete and submit admission and discharge MDS records.*

Quality Measure User Manual resources:
www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/NursingHomeQualityInits/Downloads/MDS-30-QM-Users-Manual-V11-Final.pdf

d. Resident Council Meeting Minutes

   i. The facility's resident council is a group meant to represent the resident population. The Council may discuss specific ethnic, cultural and religious preferences and ways in which the facility can support the residents'

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quality of life related to these areas. Often times these preferences are documented in the Resident Council Meeting Minutes

e. Activity Therapy
    i. Activity Therapy Assessment
    ii. Often times resident preferences as well as community integration are documented in the activity interests portion of the assessment process.
f. Activity Calendar
    i. The Activity calendar is planned by the Activities department with the lifestyle preferences and the residents' abilities in mind.
    ii. A review of the calendar will identify leisure pursuits that relate to the characteristics and preferences of the resident population.
g. Electronic Health Records – if the templates are set to run specific data point reports in your EHR, a specific report could be devised to pull resident population specific information
    i. MDS 3.0 Section F
    ii. Most EHR software can run reports for any MDS item. MDS item reports can include any specific item from the MDS.
    iii. Some MDS Item reports can combine a number of MDS items on one report, or summarize the number of residents with the item checked on the MDS, or group resident names together for a list of resident with the MDS item checked on the last assessment.
    iv. Consult your EHR report instructions to determine the reports available from your EHR software.
    v. Section F of the MDS captures information from resident, resident representative or staff interviews about residents' preferences for daily care, daily activities and lifestyle choices.
    vi. This information can identify trends and patterns of preferences and lifestyle choices that help describe the characteristics of the resident population.
h. Social Services
    i. Social History and Progress Notes
    ii. Often times resident preferences (cultural, religious, ethnic and characteristics) as well as community integration are documented in the social history portion of the assessment process and will be updated in the quarterly progress notes
i. Electronic Health Records – if the templates are set to run specific data point reports in your EHR, a specific report could be devised to pull resident population specific information
j. Admission/Readmission

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i. The admissions and readmission process will review resident preferences (cultural, religious, ethnic and characteristics) as well as community integration and involvement. If the preadmission and readmission process is electronically completed, a specific report could be devised to pull resident population specific information

V. The Facility Resident Population - Conditions, physical and cognitive disabilities, and other pertinent facts

a. The regulation requires that the residents' diseases, conditions, disabilities, acuity and other factors be assessed. Some facilities may choose to report the details of this information since the MDS 3.0 provides a high level of specific data about the level of physical and cognitive function.
b. Consider that the Facility Assessment is designed to guide us in an evaluation of the residents needs as they relate to the resources available at the facility to meet their needs, rather than to match specific care needs with specific resources.
c. Provide a clear description of a snapshot in time of the facility residents' care needs.
d. If the facility has one or more specialty units, it may be helpful to describe the resident conditions and care needs by unit.

VI. Data Sources for Conditions, physical and cognitive disabilities, and other pertinent facts

a. There are a number of sources for information about the resident population both in the electronic health record and in CMS reports. Remember to obtain this information from exiting reports rather than creating new processes for data gathering.
    i. CMS 672 Resident Census and Conditions of Residents
        1. The CMS 672 report uses MDS 3.0 data to counts residents by level of ADL dependence, Mobility, and Mental Status.
        2. The report also includes Bowel and Bladder status, Skin Integrity, Special care needs and Medications. Since the information is based on MDS data, it is critical to review the information for accuracy.
        3. Begin with a review of the ADL counts at the top of the report. Field F78 contains the Total resident population counted in the report.
        4. The ADL section counts residents by level of dependence as Independent, Assist of one or two staff and Dependent.

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5. The ADL categories include Bathing, Dressing, Transferring, Toilet Use and Eating. The total number across all three categories in each row should equal the total number of residents in field F78.

A blank copy and the instructions for the CMS 672 Resident Census and Conditions of Residents can be found here:
www.cms.gov/Medicare/CMS-Forms/CMS-Forms/downloads/cms672.pdf

ii. CMS 802 Roster Sample Matrix

1. Like the CMS 672 report, the CMS 802 Roster Sample Matrix report is typically available in the MDS report area in your EHR.
2. According to the CMS 802 report instructions, the form includes current residents and those on bed-hold on the day the report is run. The data is collected for the day the report is run.
3. CMS advises the facility check the report for accuracy to validate the information.
4. As with any report that uses MDS data, only those residents with a completed MDS assessment will be included.
5. Even if you refresh or update the report, new admissions with an MDS in progress or any other MDS assessments not yet completed, submitted and accepted will not be included in the report.
6. The report lists current residents with at least one completed MDS, and enters an "x" in any area included in the resident's MDS data which may impact your assessment of your resident population. Topics listed across the top columns of the report include:
    a. Pain
    b. Falls
    c. Pressure ulcers
    d. Restraints
    e. psychoactive medication use
    f. behavior symptoms
    g. Depression symptoms
    h. Infections,
    i. Indwelling catheters
    j. Urinary incontinence
    k. Weight loss
    l. Hospice
    m. Dialysis
    n. Admissions

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o. Language or communication needs
p. Range of motion deficits
q. Hydration
r. Swallowing or oral health issues
s. Specialized rehab services.
t. Review the report for accuracy. Add information for new admissions or changes in resident's status or conditions.
u. Ensure that discharged residents are not included in your description of resident's conditions and care needs.

A blank version of the CMS 802 Roster Sample Matrix can be found here:
www.cms.gov/Medicare/CMS-Forms/CMS-Forms/Downloads/CMS802.pdf
The instructions for the CMS 802 form can be found here:
www.cms.gov/Medicare/CMS-Forms/CMS-Forms/downloads/CMs802P.pdf

iii. MDS Item Reports

1. Most EHR software can run reports for any MDS item. MDS item reports can include any specific item from the MDS.
2. Some MDS Item reports can combine a number of MDS items on one report, or summarize the number of residents with the item checked on the MDS, or group resident names together for a list of resident with the MDS item checked on the last assessment.
3. Consult your EHR report instructions to determine the reports available from your EHR software.
4. MDS Items Report categories may include:
    a. MDS item A1000 - Race/Ethnicity
    b. A1100 - Need for interpreter
    c. A1550 Conditions related to ID/DD Status
    d. C0500 BIMS Summary Score
    e. F0400 Interview for Daily Preferences
    f. G0110 Activities of Daily Living Assistance
    g. GG0130 Self Care
    h. J1100 Shortness of breath
    i. M0210 Unhealed pressure ulcers
    j. O0100H IV medications

October 2016 MDS and draft October 1, 2017 item sets can be found here:

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www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/NursingHomeQualityInits/NHQIMDS30TechnicalInformation.html

iv. Facility tracking systems, tracking software or EHR modules
v. Other pertinent facts that are present within the population may be found in systems used by the facility to track specific topics, such as infection surveillance reports, pressure ulcer documentation systems, or incident tracking systems.
vi. Reports from these systems may be helpful to quantify and describe these specific resident needs.

VII. The Facility Resident Population - Types of diseases and conditions

a. Many facilities do not have professional medical records staff to code and manage diagnosis information. Diagnosis codes may be inaccurate, resolved conditions and diseases may remain on the resident diagnosis list and new conditions may not be added timely when a resident has a change in their health status. To use a diagnosis summary report to accurately describe the resident population for the Facility Assessment, the diagnoses should be accurately identified, coded and active.

b. The standard definition of an active diagnosis comes from the October 1, 2016 RAI manual for MDS 3.0, Section I, page I-3. Using this definition maintains a consistent framework for adding and inactivating diagnoses to a resident's diagnosis list.

ACTIVE DIAGNOSES

Physician-documented diagnoses in the last 60 days that have a direct relationship to the resident's current functional status, cognitive status, mood or behavior, medical treatments, nursing monitoring, or risk of death during the 7-day look-back period.

VIII. Data Sources for resident diagnosis information

a. Remember to obtain this information from exiting reports rather than creating new processes for data gathering.

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b. Electronic Health Record Diagnosis Reports
    i. Begin with a summary diagnosis report for the residents in the facility in the last quarter. Most EHR software has the ability to compile this report.
    ii. Configure the report with the most frequent diagnoses at the top of the list.
    iii. Before using a diagnosis report to define the care needs of the facility resident population, review the report to ensure that the information is accurate.

c. MDS Diagnosis Report
    i. Section I contains active diagnoses, listed by categories.
    ii. Section J captures information about pain, shortness of breath, current tobacco use and other problem conditions.
    iii. Section M contains information about pressure ulcers.
    iv. Section O captures information about special treatments, procedures and programs.
d. Most EHR software allows the facility to run reports about coded answers in specific MDS items.

October 2016 MDS and draft October 1, 2017 item sets can be found here: www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/NursingHomeQualityInits/NHQIMDS30TechnicalInformation.html

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X. The Facility Resident Population - Overall acuity

a. In skilled nursing facilities, resident acuity includes the number and stability of a resident's medical conditions and their physical and psychosocial care needs. These resident characteristics and services are represented by the Resource Utilization Groups, version IV (RUG IV) categories.
    i. Medicare Part A Fee-for-Service reimburses SNFs using a 66 RUG IV category system.
    ii. CMS also provides RUG 66, 57 and 48 categories for use by state Medicaid programs. RUG IV categories are derived from MDS 3.0 data.

b. Each completed MDS used for Medicare part payment contains both a Medicare Part A Health Insurance Prospective Payment System (HIPPS) code and a Medicare Part A non-therapy HIPPS code in Section Z of the MDS.
    i. The HIPPS code is composed of the RUG IV group and the MDS assessment type indicator. If RUG categories are used by the state for Medicaid reimbursement, a State Medicaid Billing RUG Case Mix Group is also calculated and found in Section Z of the MDS.

c. RUG IV categories are calculated using a combination of information coded on the MDS that indicates the resident's conditions and services provided in a specific time frame. Time frames vary by specific MDS sections.
d. The information used to calculate a RUG IV category includes therapy minutes provided, resident conditions and diagnoses, special treatments, depression symptoms, the provision of restorative nursing services and the resident's ADL needs and ADL support provided.
e. A few states use a different reimbursement category system, such as the Management Minutes Questionnaire in Massachusetts. The reimbursement categories are based on a combination of conditions and diagnoses and care provided during a specific time frame. Facilities typically have access to reports for information they have submitted for these programs.

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XI. Data Sources of acuity information

a. Remember to obtain this information from exiting reports rather than creating new processes for data gathering.

b. RUG category report and MDS item reports
   i. The RUG IV category, represented by the HIPPS code is available on each MDS used for payment can be obtained through an MDS item report from the EHR or through reports developed by the EHR software vendor.
   ii. A helpful report format will contain information about the RUG categories and the number of residents or resident days covered under each category.
   iii. It may be helpful to have individual residents identified by the report in each RUG category to make it easier to validate the accuracy of the information.

c. Monthly billing reports
   i. The facility's billing software may also contain reports about the number of residents or resident days billed under each RUG category.

d. State Medicaid reimbursement category reports
   i. If the state does not use RUG categories for billing, the billing office may be able to provide reports about the number of residents or resident days billed under each Medicaid reimbursement category.

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XIII. How to use data reports for the Facility Assessment: Facility Resident Population

a. The Facility Assessment is not intended to be a data collection tool. The facility needs to use the data collected about residents to identify the care required by the facility to provide the necessary care and services to the resident population. It is important to:

   i. Gather the data reports as described above.

   ii. Use the information to answer the questions in the *Facility Resident Population Guide* to write a narrative description of the facility resident population and their care needs.

   iii. Review the data for census and capacity and write a narrative description of your facility.

   iv. Review the resident characteristics, ethnic, cultural, or religious traits.

   v. Review the data about the resident population's conditions, physical and cognitive disabilities, and other pertinent

   vi. Review the data for residents' types of diseases and conditions

   vii. Write a narrative description of the facility's resident population

   viii. Incorporate your processes into your QAPI plan

   ix. Monitor the facility resident population data for changes which will warrant a modification to the Facility Assessment per requirements

See the Facility Assessment Template SAMPLE related to the inclusion of the necessary information obtained via this process for the completion of the Facility Assessment.

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Facility Resident Population Guide – TEMPLATE

Gather and review the data reports. Use the information to answer the questions in the Facility Resident Population Guide to write an outline for the narrative description of the facility resident population and their care needs.

Facility Census Capacity **The number of beds available for current residents and new admissions.** (Insert Facility Specific information here) If the facility has one or more specialty units, you may choose to answer the following questions for each unit.	
Data Sources	
(indicate the reports used or the location of the information used to describe this aspect of the Facility Assessment) *EXAMPLE:* *EHR Monthly census report* *EHR Average census report* *Billing software Average daily census* *CMS 672 Resident Census And Conditions of Residents - Field F78 – total residents*	
i) Review licensed bed information and answer the following questions	
How many beds are available for current resident and new admissions?	
Has the facility taken any beds, units or wings out of use in the last year?	
If yes, describe how many beds, units or wings were taken out of service, the date of the change and the reason.	
Has the facility added any beds, units or wings out of use in the last year?	
If yes, describe how many beds, units or wings were added, the date of the change and the reason. *(describe special programs later in the guide)*	
Is there a plan to take additional beds out of service or add beds in the coming year?	
If a change in bed capacity is planned, summarize the plan, timing and objectives.	

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Facility Average Census **The average number of residents staying in the facility.** (Insert Facility Specific information here) If the facility has one or more specialty units, you may choose to answer the following questions for each unit.	
Data Source *(indicate the reports used or the location of the information used to describe this aspect of the Facility Assessment)*	
EXAMPLE: *EHR Monthly census report* *EHR Average census report* *Billing software Average daily census* CMS 672 Resident Census And Conditions of Residents - Field F78 – total residents	
ii) Review the census information and answer the following questions	
What was the average daily census in the last quarter? *You may wish to break out the census by unit, wing or program*.	
Has the average census changed in the last year?	
If yes, explain the range of average daily census, the time frame and the cause if known.	
Is there a plan to take decrease the average daily census in the coming year?	
If a change in census is planned, summarize the plan, timing and objectives.	

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Resident Population Characteristics

The unique characteristics that make up the resident population and the facility culture.

(Insert Facility Specific information here) If the facility has one or more specialty units, you may choose to answer the following questions for each unit.

Data Sources for characteristics and ethnic, cultural, or religious factors *(indicate the reports used or the location of the information used to describe this aspect of the Facility Assessment)*

EXAMPLE:
CASPER Quality Measure Facility Characteristics Report
Resident Council minutes
Activity Calendar
MDS 3.0 Section F

Review the resident population characteristics information and answer the following questions

What is the **age range** of the resident population?	
How does the age range impact the needs of the resident population?	
What **percentage** of the resident population is **male** and what percentage is **female**?	
How does the gender mix impact the needs of the resident population?	
What **percentage** of the resident population is **receiving Hospice care** or has a **6 month life expectancy**?	
How does the percentage of resident receiving end of life care impact the needs of the resident population?	
What **percentage** of the resident population has a **psychiatric diagnosis**?	
How does the percentage of residents with psychiatric diagnoses impact the needs of the resident population?	
What **percentage** of the resident population has **intellectual or developmental disability**?	
How does the percentage of residents with intellectual or developmental disability impact the needs of the resident population?	

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What **percentage** of residents has **active discharge planning** occurring?	
How does this percentage of short stay residents impact the overall needs of the resident population?	
Are there any **ethnic or cultural** considerations for the resident population?	
How do these ethnic or cultural factors impact the needs of the resident population?	
Describe any other **unique characteristics** that impact the overall resident population?	

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Conditions, physical and cognitive disabilities, and other pertinent facts Specific diseases, conditions and care needs related to resident's disabilities (Insert Facility Specific information here) If the facility has one or more specialty units, you may choose to answer the following questions for each unit.	
Data Sources for characteristics and ethnic, cultural, or religious factors *(indicate the reports used or the location of the information used to describe this aspect of the Facility Assessment)* *EXAMPLES:* *CMS 672 Resident Census And Conditions of Residents* *CMS 802 Roster Sample Matrix* *MDS item reports, such as MDS item A1000 - Race/Ethnicity, A1100 - Need for interpreter, A1550 Conditions related to ID/DD Status, C0500 BIMS Summary Score, G0110 Activities of Daily Living Assistance, GG0130 Self Care, J1100 Shortness of breath, M0210 Unhealed pressure ulcers, O0100H IV medications,* *Facility tracking systems, tracking software or EHR modules*	
Review the resident conditions, physical and cognitive disabilities and other pertinent facts about the resident's care needs and answer the following questions	
What percentage of residents has **impaired communication and requires a communication device**?	
What percentage of residents is **cognitively impaired and dependent for daily decision-making**?	
What percentage of residents has **cognitive impairment and behaviors that affect others**?	
What percentage of residents has **cognitive impairment and wandering or exit seeking behaviors?**	
What percentage of residents is **totally dependent for bathing, grooming and dressing**?	
What percentage of residents is **totally dependent for transfers**?	
What percentage of residents **is totally dependent for other mobility**?	
What percentage of residents is **totally dependent for eating**?	
What percentage of residents is **totally dependent for toileting or incontinence care**?	

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What percentage of residents is **totally independent for bathing, grooming and dressing**?	
What percentage of residents is **totally independent for transfers**?	
What percentage of residents is **totally independent for other mobility**?	
What percentage of residents is **totally independent for eating**?	
What percentage of residents **is totally independent for toileting or incontinence care**?	
What percentage of residents has an **indwelling catheter**?	
What percentage of residents has a **feeding tube for more than 50% of their calorie intake**?	
What percentage of residents is **physically restrained for some part of the day or night**?	
What percentage of residents has a **current pressure ulcer**?	
What percentage of residents is on **resident-specific preventive skin program**?	
What percentage of **residents receives dialysis in the facility**?	
What percentage of **residents receives dialysis outside the facility**?	
What percentage of **residents receives chemotherapy outside the facility**?	
What percentage of **residents receives radiation therapy outside the facility**?	
What percentage of **residents receives tracheostomy care**?	
What percentage of **residents is on a ventilator**?	
What percentage of **residents receives ostomy care**?	
What percentage of **residents receives clean dressing changes?**	

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What percentage of **residents receives aseptic dressing changes?**	
What percentage of residents receives **PRN analgesics and non-pharmacologic pain management interventions**?	
What percentage of **residents receives respiratory therapy, suctioning or respiratory treatments from a licensed nurse**?	
What percentage of **residents receives medication by injection at least once per week?**	
What percentage of **residents receives IV hydration or medication at least once per day**?	
What percentage of **residents receives anticoagulant medication**?	
What percentage of **residents receives psychoactive (antipsychotic, antianxiety, hypnotic) medication**?	
What is the **average monthly UTI rate**?	
What is the **average monthly GI infection rate**?	
What is the **average monthly respiratory infection rate**?	
What is the **average monthly skin infection rate**?	
What is the **average monthly eye infection rate**?	
What is the **average monthly ear infection rate**?	
What is the **average number of resident with transmission-based precautions above standard precautions**?	
What percentage of residents has chosen to receive CPR, if needed?	

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Types of diseases and conditions ***(Insert Facility Specific information here) If the facility has one or more specialty units, you may choose to answer the following questions for each unit.***	
Data Sources for resident diseases and conditions *(indicate the reports used or the location of the information used to describe this aspect of the Facility Assessment)* *EXAMPLES:* *EHR Diagnosis Reports* *MDS Diagnosis Report*	
Review the resident diseases and conditions for the last quarter, and answer the following questions. Consider grouping diagnoses by categories with like care needs, such as bacterial and viral pneumonia counted in one group as Lower Respiratory infections	
What are the **top 10 most frequent** diagnoses categories?	
How many residents had a diagnosis of an **active drug resistant organism**?	
What percentage of residents had a diagnosis of **cancer** and was receiving cancer treatment?	
What percentage of residents had a **cardiac or circulatory diagnosis** (other than infection) and was receiving treatment or impacted their ADL or mobility needs?	
What percentage of residents had a **gastrointestinal diagnosis** (other than infection) and was receiving treatment or impacted their ADL or mobility needs?	
What percentage of residents had a **genitourinary diagnosis** (other than infection) and was receiving treatment or impacted their ADL or mobility needs?	
What percentage of residents had a **metabolic diagnosis** (other than infection) and was receiving treatment or impacted their ADL or mobility needs?	
What percentage of residents had a **musculoskeletal diagnosis** (other than infection) and was receiving treatment or impacted their ADL or mobility needs?	

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What percentage of residents had a **neurological diagnosis** (other than infection) and was receiving treatment or impacted their ADL or mobility needs?	
What percentage of residents had a **pulmonary diagnosis** (other than infection) and was receiving treatment or impacted their ADL or mobility needs?	
What percentage of residents had a **vision diagnosis** (other than infection) and was receiving treatment or impacted their ADL or mobility needs?	
What **other diagnoses** were residents treated for or diagnoses that impact their ADL or mobility needs?	

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Overall acuity (Insert Facility Specific information here) If the facility has one or more specialty units, you may choose to answer the following questions for each unit.	
Data Sources for resident acuity *(indicate the reports used or the location of the information used to describe this aspect of the Facility Assessment)* *EXAMPLES:* *RUG category reports* *MDS item reports* *Monthly billing reports for Medicare and Medicaid* *State Medicaid reimbursement category reports*	
Review the resident acuity reports for the last quarter, and answer the following questions.	
What average percentage of residents received skilled nursing level care?	
What were the common skilled nursing services provided?	
What average percentage of residents received skilled therapy level care?	
What were the common skilled therapy services provided?	
What average percentage of residents received restorative nursing services?	
What were the common restorative nursing services provided?	
What percentage of residents had a higher RUG level due to symptoms of depression?	
What percentage of residents was in a Behavioral Symptoms RUG level or equivalent?	
What is the average length of stay?	

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https://downloads.cms.gov/files/MDS-30-RAI-Manual-V114-October-2016.pdf

MDS 3.0 Quality Measure User's Manual version 11

www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/NursingHomeQualityInits/Downloads/MDS-30-QM-Users-Manual-V11-Final.pdf

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Facility Assessment: Facility Resident Population Probing Questions Template

LeadingAge®

LeadingAge® Illinois

Facility Assessment: Facility Resident Population

Facility Resident Population Probing Questions - TEMPLATE

Gather and review the data reports. Use the information to answer the questions in the Facility Resident Population Guide to write an outline for the narrative description of the facility resident population and their care needs.

Facility Census Capacity **The number of beds available for current residents and new admissions.** (Insert Facility Specific information here) If the facility has one or more specialty units, you may choose to answer the following questions for each unit.	
Data Sources	
(indicate the reports used or the location of the information used to describe this aspect of the Facility Assessment) *EXAMPLE:* *EHR Monthly census report* *EHR Average census report* *Billing software Average daily census* *CMS 672 Resident Census And Conditions of Residents - Field F78 – total residents*	
Review licensed bed information and answer the following questions	
How many **beds are available** for current resident and new admissions?	
Has the facility **taken any beds, units or wings out of use** in the last year?	
If yes, describe how many beds, units or wings were taken out of service, the date of the change and the reason.	
Has the facility **added any beds, units or wings** in the last year?	
If yes, describe how many beds, units or wings were added, the date of the change and the reason. *(describe special programs later in the guide)*	
Is there a **plan to take additional beds out of service or add beds** in the coming year?	
If a change in bed capacity is planned, summarize the plan, timing and objectives.	

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Facility Average Census **The average number of residents staying in the facility.** If the facility has one or more specialty units, you may choose to answer the following questions for each unit.	
Data Source *(indicate the reports used or the location of the information used to describe this aspect of the Facility Assessment)*	
EXAMPLE: *EHR Monthly census report* *EHR Average census report* *Billing software Average daily census* CMS 672 Resident Census And Conditions of Residents - Field F78 – total residents	
Review the census information and answer the following questions	
What was the **average daily census** in the last quarter? *You may wish to break out the census by unit, wing or program*.	
Has the average census changed in the last year?	
If yes, explain the range of average daily census, the time frame and the cause if known.	
Is there a **plan to take decrease the average daily census** in the coming year?	
If a change in census is planned, summarize the plan, timing and objectives.	

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Resident Population Characteristics ***The unique characteristics that make up the resident population and the facility culture.*** If the facility has one or more specialty units, you may choose to answer the following questions for each unit.	
Data Sources for characteristics and ethnic, cultural, or religious factors *(indicate the reports used or the location of the information used to describe this aspect of the Facility Assessment)* *EXAMPLE:* *CASPER Quality Measure Facility Characteristics Report* *Resident Council minutes* *Activity Calendar* *MDS 3.0 Section F*	
Review the resident population characteristics information and answer the following questions	
What is the **age range** of the resident population?	
How does the age range impact the needs of the resident population?	
What percentage of the resident population is **male** and what percentage is **female**?	
How does the gender mix impact the needs of the resident population?	
What percentage of the resident population is receiving **Hospice care or has a 6 month life expectancy**?	
How does the percentage of resident receiving end of life care impact the needs of the resident population?	
What percentage of the resident population has a **psychiatric diagnosis**?	
How does the percentage of residents with psychiatric diagnoses impact the needs of the resident population?	
What percentage of the resident population has **intellectual or developmental disability**?	
How does the percentage of residents with intellectual or developmental disability impact the needs of the resident population?	

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Resident Population Characteristics ***The unique characteristics that make up the resident population and the facility culture.*** If the facility has one or more specialty units, you may choose to answer the following questions for each unit.	
What percentage of residents has **active discharge planning occurring**?	
How does this percentage of short stay residents impact the overall needs of the resident population?	
Are there any **ethnic or cultural considerations** for the resident population?	
How do these ethnic or cultural factors impact the needs of the resident population?	
Describe any **other unique characteristics** that impact the overall resident population?	

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Conditions, physical and cognitive disabilities, and other pertinent facts Specific diseases, conditions and care needs related to resident's disabilities If the facility has one or more specialty units, you may choose to answer the following questions for each unit.	
Data Sources for characteristics and ethnic, cultural, or religious factors *(indicate the reports used or the location of the information used to describe this aspect of the Facility Assessment)* *EXAMPLES:* *CMS 672 Resident Census And Conditions of Residents* *CMS 802 Roster Sample Matrix* *MDS item reports, such as MDS item A1000 - Race/Ethnicity, A1100 - Need for interpreter, A1550 Conditions related to ID/DD Status, C0500 BIMS Summary Score, G0110 Activities of Daily Living Assistance, GG0130 Self Care, J1100 Shortness of breath, M0210 Unhealed pressure ulcers, O0100H IV medications,* *Facility tracking systems, tracking software or EHR modules*	
Review the resident conditions, physical and cognitive disabilities and other pertinent facts about the resident's care needs and answer the following questions	
What percentage of residents has **impaired communication and requires a communication device**?	
What percentage of residents is **cognitively impaired and dependent for daily decision-making**?	
What percentage of residents has **cognitive impairment and behaviors that affect others**?	
What percentage of residents has **cognitive impairment and wandering or exit seeking behaviors?**	
What percentage of residents is **totally dependent for bathing, grooming and dressing**?	
What percentage of residents is **totally dependent for transfers**?	
What percentage of residents **is totally dependent for other mobility**?	
What percentage of residents is **totally dependent for eating**?	
What percentage of residents is **totally dependent for toileting or incontinence care**?	

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Conditions, physical and cognitive disabilities, and other pertinent facts Specific diseases, conditions and care needs related to resident's disabilities If the facility has one or more specialty units, you may choose to answer the following questions for each unit.	
What percentage of residents is **totally independent for bathing, grooming and dressing**?	
What percentage of residents is **totally independent for transfers**?	
What percentage of residents is **totally independent for other mobility**?	
What percentage of residents is **totally independent for eating**?	
What percentage of residents **is totally independent for toileting or incontinence care**?	
What percentage of residents has an **indwelling catheter**?	
What percentage of residents has a **feeding tube for more than 50% of their calorie intake**?	
What percentage of residents is **physically restrained for some part of the day or night**?	
What percentage of residents has a **current pressure ulcer**?	
What percentage of residents is on **resident-specific preventive skin program**?	
What percentage of **residents receives dialysis in the facility**?	
What percentage of **residents receives dialysis outside the facility**?	
What percentage of **residents receives chemotherapy outside the facility**?	
What percentage of **residents receives radiation therapy outside the facility**?	
What percentage of **residents receives tracheostomy care**?	

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Conditions, physical and cognitive disabilities, and other pertinent facts Specific diseases, conditions and care needs related to resident's disabilities If the facility has one or more specialty units, you may choose to answer the following questions for each unit.	
What percentage of **residents is on a ventilator**?	
What percentage of **residents receives ostomy care**?	
What percentage of **residents receives clean dressing changes?**	
What percentage of **residents receives aseptic dressing changes?**	
What percentage of residents receives **PRN analgesics and non-pharmacologic pain management interventions**?	
What percentage of **residents receives respiratory therapy, suctioning or respiratory treatments from a licensed nurse**?	
What percentage of **residents receives medication by injection at least once per week?**	
What percentage of **residents receives IV hydration or medication at least once per day**?	
What percentage of **residents receives anticoagulant medication**?	
What percentage of **residents receives psychoactive (antipsychotic, antianxiety, hypnotic) medication**?	
What is the **average monthly UTI rate**?	
What is the **average monthly GI infection rate**?	
What is the **average monthly respiratory infection rate**?	
What is the **average monthly skin infection rate**?	
What is the **average monthly eye infection rate**?	

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Conditions, physical and cognitive disabilities, and other pertinent facts Specific diseases, conditions and care needs related to resident's disabilities If the facility has one or more specialty units, you may choose to answer the following questions for each unit.	
What is the **average monthly ear infection rate**?	
What is the **average number of resident with transmission-based precautions above standard precautions**?	
What percentage of residents has chosen to receive CPR, if needed?	

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Types of diseases and conditions If the facility has one or more specialty units, you may choose to answer the following questions for each unit.	
Data Sources for resident diseases and conditions *(indicate the reports used or the location of the information used to describe this aspect of the Facility Assessment)* *EXAMPLES:* *EHR Diagnosis Reports* *MDS Diagnosis Report*	
Review the resident diseases and conditions for the last quarter, and answer the following questions. Consider grouping diagnoses by categories with like care needs, such as bacterial and viral pneumonia counted in one group as Lower Respiratory infections	
What are the **top 10 most frequent** diagnoses categories?	
How many residents had a diagnosis of an active drug resistant organism?	
What percentage of residents had a diagnosis of cancer and was receiving cancer treatment?	
What percentage of residents had a cardiac or circulatory diagnosis (other than infection) and was receiving treatment or impacted their ADL or mobility needs?	
What percentage of residents had a gastrointestinal diagnosis (other than infection) and was receiving treatment or impacted their ADL or mobility needs?	
What percentage of residents had a genitourinary diagnosis (other than infection) and was receiving treatment or impacted their ADL or mobility needs?	
What percentage of residents had a metabolic diagnosis (other than infection) and was receiving treatment or impacted their ADL or mobility needs?	
What percentage of residents had a musculoskeletal diagnosis (other than infection) and was receiving treatment or impacted their ADL or mobility needs?	

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Types of diseases and conditions If the facility has one or more specialty units, you may choose to answer the following questions for each unit.	
What percentage of residents had a neurological diagnosis (other than infection) and was receiving treatment or impacted their ADL or mobility needs?	
What percentage of residents had a metabolic diagnosis and was receiving treatment or impacted their ADL or mobility needs?	
What percentage of residents had a pulmonary diagnosis (other than infection) and was receiving treatment or impacted their ADL or mobility needs?	
What percentage of residents had a vision diagnosis (other than infection) and was receiving treatment or impacted their ADL or mobility needs?	
What other diagnoses were residents treated for or diagnoses that impact their ADL or mobility needs?	

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Overall acuity The number and stability of a resident's medical conditions and their physical and psychosocial care needs If the facility has one or more specialty units, you may choose to answer the following questions for each unit.	
Data Sources for resident acuity *(indicate the reports used or the location of the information used to describe this aspect of the Facility Assessment)* *EXAMPLES:* *RUG category reports* *MDS item reports* *Monthly billing reports for Medicare and Medicaid* *State Medicaid reimbursement category reports*	
Review the resident acuity reports for the last quarter, and answer the following questions.	
What average percentage of residents received skilled nursing level care?	
What were the common skilled nursing services provided?	
What average percentage of residents received skilled therapy level care?	
What were the common skilled therapy services provided?	
What average percentage of residents received restorative nursing services?	
What were the common restorative nursing services provided?	
What percentage of residents had a higher RUG level due to symptoms of depression?	
What percentage of residents was in a Behavioral Symptoms RUG level or equivalent?	
What is the average length of stay?	

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Data Collection Tools and/or Resources

The following Tools and Resources are included in this Section of **The RoP Facility Assessment Toolkit ©**

Item	Description	Source *(If Applicable)*
Facility Resident Probing Questions	An example of a facility QAPI plan – customizable	Pathway Health
INTERACT Nursing Home Capabilities List– SAMPLE	SAMPLE of the INTERACT QIP tool which outlines nursing home capabilities – summary tool for the facility to use when determining this section of the requirement	The *"Interact Nursing Home Capabilities List"* document can be found at: http://www.pathway-interact.com/interact-tools/
CMS 672	CMS Tool – Resident Census and Conditions of Residents report	CMS. (2012). Resident Census and Conditions of Residents. Retrieved August, 2017, from https://www.cms.gov/Medicare/CMS-Forms/CMS-Forms/Downloads/CMS672.pdf
CSM CASPER Reporting User's Guide Section 1	CASPER Report – MDS Facility Characteristics Report	QTSO. (2015). MDS 3.0 Quality Measure (QM) Reports. Retrieved August, 2017, from www.qtso.com/download/guides/casper/cspr_sec11_mds_prvdr.pdf
CMM Matrix with Instructions 8/2017	CMS Roster Matrix with instructions	Entrance Conference and Facility Matrix https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/GuidanceforLawsAndRegulations/Downloads/LTC-Survey-Entrance-Conference-Provider-Matrix.zip
SWOT Summary Template	A Step by Step Guide to Implementing Quality Assurance and Performance Improvement (QAPI) in Your Nursing Home	
Facility Assessment Summary Worksheet	Template for team to use to summary findings and prepare for narrative Facility Assessment inclusion	Pathway Heath

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Nursing Home Capabilities List

INTERACT
Version 4.0 Tool

This list is for hospital emergency rooms, hospitalists, and case managers; and for physicians, NPs, and PAs who take off-hours call for the facility to assist with decisions about hospital admission or return to the facility.

Facility _____

Address _____

Tel (_____) _____ **Key Contact** _____

Circle 'Y' for yes or 'N' for no to indicate the availability of each item in your facility.

Capabilities	Yes	No
Primary Care Clinician Services		
At least one physician, NP, or PA in the facility three or more days per week	Y	N
At least one physician, NP, or PA in the facility five or more days per week	Y	N
Diagnostic Testing		
Stat lab tests with turnaround less than 8 hours	Y	N
Stat X-rays with turnaround less than 8 hours	Y	N
EKG	Y	N
Bladder Ultrasound	Y	N
Venous Doppler	Y	N
Cardiac Echo	Y	N
Swallow Studies	Y	N
Consultations		
Psychiatry	Y	N
Cardiology	Y	N
Pulmonary	Y	N
Wound Care	Y	N
Other Physician Specialty Consultations *specify:*	Y	N
Social and Psychology Services		
Licensed Social Worker	Y	N
Psychological Evaluation and Counseling by a Licensed Clinical Psychologist	Y	N
Therapies on Site		
Occupational	Y	N
Physical	Y	N
Respiratory	Y	N
Speech	Y	N

Capabilities	Yes	No
Nursing Services		
Frequent vital signs *(e.g. every 2 hrs)*	Y	N
Strict intake and output (I&O) monitoring	Y	N
Daily weights	Y	N
Accuchecks for glucose at least every shift	Y	N
INR	Y	N
O2 saturation	Y	N
Nebulizer treatments	Y	N
Incentive spirometry	Y	N
Interventions		
IV Fluids *(initiation and maintenance)*	Y	N
IV Antibiotics	Y	N
IV Meds – Other *(e.g. furosemide)*	Y	N
PICC Insertion	Y	N
PICC Management	Y	N
Total Parenteral Nutrition (TPN)	Y	N
Isolation *(for MRSA, VRE, etc…)*	Y	N
Surgical Drain Management	Y	N
Tracheostomy Management	Y	N
Analgesic Pumps	Y	N
Dialysis	Y	N
Advanced CPR *(ACLS capability)*	Y	N
Automatic Defibrillator	Y	N
Pharmacy Services		
Emergency kit with common medications for acute conditions available	Y	N
New medications filled within 8 hours	Y	N
Other Specialized Services *(specify)*		

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RESIDENT CENSUS AND CONDITIONS OF RESIDENTS

Provider No.	Medicare F75	Medicaid F76	Other F77	Total Residents F78

ADL	Independent	Assist of One or Two Staff	Dependent
Bathing	F79	F80	F81
Dressing	F82	F83	F84
Transferring	F85	F86	F87
Toilet Use	F88	F89	F90
Eating	F91	F92	F93

A. Bowel/Bladder Status

F94 ____ With indwelling or external catheter

F95 Of the total number of residents with catheters, how many were present on admission ____?

F96 ____ Occasionally or frequently incontinent of bladder

F97 ____ Occasionally or frequently incontinent of bowel

F98 ____ On urinary toileting program

F99 ____ On bowel toileting program

B. Mobility

F100____ Bedfast all or most of time

F101____ In a chair all or most of time

F102____ Independently ambulatory

F103____ Ambulation with assistance or assistive device

F104____ Physically restrained

F105 Of the total number of residents with restraints, how many were admitted or readmitted with orders for restraints ____?

F106____ With contractures

F107 Of the total number of residents with contractures, how many had a contracture(s) on admission ____?

C. Mental Status

F108-114 – indicate the number of residents with:

F108____ Intellectual and/or developmental disability

F109____ Documented signs and symptoms of depression

F110____ Documented psychiatric diagnosis (exclude dementias and depression)

F111____ Dementia: (e.g., Lewy-Body, vascular or Multi-infarct, mixed, frontotemporal such as Pick's disease; and dementia related to Parkinson's or Creutzfeldt-Jakob diseases), or Alzheimer's Disease

F112____ Behavioral healthcare needs

F113 Of the total number of residents with behavioral healthcare needs, how many have an individualized care plan to support them ____?

F114____ Receiving health rehabilitative services for MI and/or ID/DD

D. Skin Integrity

F115-118 – indicate the number of residents with:

F115____ Pressure ulcers (exclude Stage 1)

F116 Of the total number of residents with pressure ulcers excluding Stage 1, how many residents had pressure ulcers on admission ____?

F117____ Receiving preventive skin care

F118____ Rashes

RESIDENT CENSUS AND CONDITIONS OF RESIDENTS

E. Special Care

F119-132 – indicate the number of residents receiving:

Fl19 ____ Hospice care

F120____ Radiation therapy

F121____ Chemotherapy

F122____ Dialysis

F123____ Intravenous therapy, IV nutrition, and/or blood transfusion

F124____ Respiratory treatment

F125____ Tracheostomy care

F126____ Ostomy care

F127____ Suctioning

F128____ Injections (exclude vitamin B12 injections)

F129____ Tube feedings

Fl30____ Mechanically altered diets including pureed and all chopped food (not only meat)

F131____ Rehabilitative services (Physical therapy, speech-language therapy, occupational therapy, etc.) Exclude health rehabilitation for MI and/or ID/DD

F132____ Assistive devices with eating

F. Medications

F133-139 – indicate the number of residents receiving:

F133____ Any psychoactive medication

- **F134**____ Antipsychotic medications
- **F135**____ Antianxiety medications
- **F136**____ Antidepressant medications
- **F137**____ Hypnotic medications

F138____ Antibiotics

F139____ On pain management program

G. Other

F140____ With unplanned significant weight loss/gain

F141____ Who do not communicate in the dominant language of the facility (include those who use American sign language)

F142____ Who use non-oral communication devices

F143____ With advance directives

F144____ Received influenza immunization

F145____ Received pneumococcal vaccine

I certify that this information is accurate to the best of my knowledge.

Signature of Person Completing the Form	Title	Date

TO BE COMPLETED BY SURVEY TEAM

F146 Was ombudsman office notified prior to survey? ___ Yes ___ No

F147 Was ombudsman present during any portion of the survey? ___ Yes ___ No

F148 Medication error rate _____%

RESIDENT CENSUS AND CONDITIONS OF RESIDENTS
(use with Form CMS-672)

GENERAL INSTRUCTIONS:

THIS FORM IS TO BE COMPLETED BY THE FACILITY AND REPRESENTS THE CURRENT CONDITION OF RESIDENTS AT THE TIME OF COMPLETION

There is no federal requirement to automate the 672 form. A facility may use its MDS data to assist in completing the entry fields for the 672 form, however, facilities should ensure that the MDS information is not simply counted and copied over into the form. **All conditions noted on this form that are not identified on the MDS must be counted manually.** This information is designed to be a representation of the facility during survey; it does not directly correspond to the MDS data in every field. **The information entered on this form must be reflective of all residents as of the day of survey; therefore all information entered must be independently verified.**

Following certain entry fields, the related MDS 3.0 item(s) is noted. Remember, that although MDS items are noted for some fields, the field itself may need to be completed differently to reflect the current status of all residents as of the day of survey. The MDS items are provided only as a reference point, the form is to be completed using the time frames and other specific instructions as noted below.

Where a field refers to the "admission assessment," use only the counts from the first assessment since the most recent admission/entry or reentry (OBRA or Scheduled PPS, i.e., A0310A = 01 OR A0310B = 01 or 06 OR A0310E = 1 for each resident).

For the purpose of completing this form the terms: "facility" means certified beds (i.e., Medicare and/or Medicaid certified beds) and "residents" means residents in certified beds regardless of payer source.

INSTRUCTIONS AND DEFINITIONS:

Complete each field by specifying the number of residents in each category. If no residents fall into a category enter a "0".

Provider Number: Facility CMS certification provider number. A0100B; leave blank for initial certifications.

Block F75: Residents whose primary payer is Medicare.

Block F76: Residents whose primary payer is Medicaid.

Block F77: Residents whose primary payer is neither Medicare nor Medicaid.

Block F78: Residents for whom a bed is maintained on the day the survey begins, including those temporarily away in a hospital or on leave. This should be representative of residents in the nursing facility or those who have a bed-hold.

ADLS (F79 – F93): To determine resident status, unless otherwise noted, consider the resident's condition for the 7 days prior to the survey. Horizontal totals across the three columns (Independent, Assist of One or Two Staff, and Dependent) must equal the number in Block F78, Total Residents, for each of the ADL categories (Bathing, Dressing, Transferring, Toilet Use and Eating).

Bathing (F79 – F81): This includes a full-body bath/shower, sponge bath, and transfer into and out of tub or shower. G0120A = 0 for F79, G0120A = 1, 2, OR 3 for F80. OR G0120A = 4 for F81.

Facilities may provide "setup" assistance to residents such as drawing water for a tub bath or laying out clothes, bathing supplies/toiletries, etc. Also, a resident may only need assistance with washing their back or shampooing their hair. If either of these are the case, and the resident requires no other assistance, count the resident as independent.

Dressing (F82 – F84): How the resident puts on, and takes off all items of clothing, including donning/removing prostheses (e.g., braces and artificial limbs) or elastic stockings. G0110G1 = 0 for F82 OR G0110G1 = 1, 2, OR 3 for F83 OR G0110G1 = 4 for F84.

Facilities may set out clothes for residents. If this is the case and this is the only assistance the resident receives, count the resident as independent. However, if a resident receives assistance, such as with dressing, donning a brace, elastic stocking, a prosthesis , or securing fasteners, etc. count the resident as needing the assistance of 1 or 2 staff, as appropriate.

Transferring (F85 – F87): How the resident moves between surfaces, including, to or from bed, chair, wheelchair, or standing position. (EXCLUDES transfers to/from the bath/toilet). G0110B1 = 0 for F85 OR G0110B1 = 1, 2, or 3 for F86 OR G0110B1 = 4 for F87.

Facilities may provide "setup" assistance to residents, such as handing equipment (e.g., quad cane) to the resident. If this is the case and is the only assistance required, count the resident as independent.

Toilet Use (F88 – F90): How the resident uses the toilet, commode, bedpan, or urinal; transfers on/off toilet; cleanses self after elimination; changes pad(s); manages ostomy or catheter, and adjusts clothing. If all that is done for the resident is to open a package (e.g., a clean incontinence pad), count the resident as independent. G0110I1 = 0 for F88 OR G0110I1 = 1, 2, or 3 for F89 OR G0110I1 = 4 for F90.

Eating (F91 – F93): How a resident eats and drinks, regardless of skill. Do not include eating/drinking during medication pass. Includes intake of nourishment by other means (e.g., tube feeding, total parenteral nutrition, includes IV fluids administered for nutrition or hydration). Facilities may provide "setup" activities, such as opening containers, buttering bread, and organizing the tray; if this is the case and is the only assistance a resident needs, count this resident as independent. G0110H1 = 0 for F91 OR G0110H1 = 1, 2, or 3 for F92 OR G0110H1 = 4 for F93.

RESIDENT CENSUS AND CONDITIONS OF RESIDENTS
(use with Form CMS-672)

A. BOWEL/BLADDER STATUS (F94 – F99) - RESIDENTS

F94: With an indwelling or an external catheter: Whose urinary bladder is constantly drained by a catheter (e.g., an indwelling catheter, a suprapubic catheter or nephrostomy tube) or who wears an appliance that is applied over the penis and connected to a drainage bag to collect urine from the bladder (e.g., condom catheter or similar appliance). H0100A or B = checked.

F95: Of the total number of residents with catheters: Who had a catheter present on admission/entry or reentry. H0100A or B = checked. To complete this field use only the counts from the first assessment since the most recent admission/entry or reentry (OBRA or Scheduled PPS, i.e., A0310A = 01 OR A0310B = 01 or 06 OR A0310E = 1 for each resident).

F96: Occasionally or frequently incontinent of bladder: Who have an incontinent episode two or more times per week. Do not include residents with an indwelling or external catheter. H0100A and B = not checked AND H0300 =1, 2, or 3.

F97: Occasionally or frequently incontinent of bowel: Who have a loss of bowel control two or more times per week. H0400 = 2 or 3.

F98: On urinary toileting program: With a systematically implemented, individualized urinary toileting program (i.e. bladder rehabilitation/retraining, prompted voiding, habit training/scheduled voiding) to decrease or prevent urinary incontinence or minimizing or avoiding the negative consequences of incontinence (e.g., pelvic floor exercises). Count all residents on urinary training programs including those who are incontinent. H0200A = 1 OR H200C = 1 OR H0300 = 1, 2 or 3.

F99: On bowel toileting program: With a systematically implemented, individualized bowel toileting program to decrease or prevent bowel incontinence or minimizing or avoiding the negative consequences of incontinence (e.g., use of adequate fluid intake, fiber in the diet, exercise, and scheduled times to attempt bowel movement). Count all residents on toileting programs including those who are incontinent. H0400 = 2 or 3 OR H0500 OR H0600 = 1.

B. MOBILITY (F100 – F107) - RESIDENTS

Total for F100 – F103 should = the number in Block F78, Total Residents. Algorithm to force mutual exclusivity: Test for each resident. If F100 = 1 then add 1 to F100, and go to the next resident; If F101 = 1 then add 1 to F101 and go to the next resident; If F103 = 1 then add 1 to F103 and go to the next resident; If F102 = 1 then add 1 and go to the next resident.

F100: Bedfast all or most of time: Who are bedfast all or most of the time (e.g., in bed or geriatric chair/recliner) includes bedfast with bathroom privileges.

F101: In a chair all or most of time: Who depend on a chair for mobility includes those residents who can stand with assistance to pivot from bed to wheelchair or to otherwise transfer. The resident cannot take steps without extensive or constant weight-bearing support from others and is not bedfast all or most of the time. G0300A or E = 2 OR G0600C = checked.

F102: Independently ambulatory: Who require no help or oversight; or help or oversight was provided only 1 or 2 times during the past 7 days. Do not include residents who use a cane, walker or crutch. G0110C1 or G0110D1 = 0 or 7 and G0110C2 or G0110D2 = 0 or 1 AND G0600A and G0600B = not checked.

F103: Ambulation with assistance or assistive devices: Who require oversight, cueing, physical assistance or who use a cane, walker, or crutch. Count the use of lower leg splints, orthotics, and braces as assistive devices. G0110C1 or G0110D1 = 1, 2, or 3 AND G0110C2 or G0110D2 = 1, 2 or 3 OR G0600A and/or G0600B = checked.

F104: Physically restrained: For whom restraints were used. Restraints include any manual or physical method or mechanical device, material or equipment attached or adjacent to the resident's body in such a way that the individual cannot remove easily and it restricts freedom of movement or normal access to one's body. Do not include devices such as braces which are used for medical/clinical reasons. P0100A through H = 1 or 2.

F105: Of total number of restrained residents: On admission/entry or reentry with an order for restraint(s). P0100A through H = 1 or 2. To complete this field use only the counts from the first assessment since the most recent admission/entry or reentry (OBRA or Scheduled PPS, i.e., A0310A = 01 OR A0310B = 01 or 06 OR A0310E = 1 for each resident).

F106: With contractures: With a restriction of full passive range of motion of any joint due to deformity, disuse, pain, etc., includes loss of range of motion in neck, fingers, wrists, elbows, shoulders, hips, knees and ankles. G0400A and/or B = 1 or 2.

F107: Of the total number with contractures, those who had a contracture(s) on admission: To complete this field use only the counts from the first assessment since the most recent admission/entry or reentry (OBRA or Scheduled PPS, i.e., A0310A = 01 OR A0310B = 01 or 06 OR A0310E = 1 for each resident). (neck contractures not included in MDS data).

RESIDENT CENSUS AND CONDITIONS OF RESIDENTS
(use with Form CMS-672)

C. MENTAL STATUS (F108 – F114) - RESIDENTS

F108: With Intellectual Disability (ID) (Mental retardation as defined at 483.45(a)) or Developmental Disability (DD): In all of the categories of intellectual or developmental disability regardless of severity, as determined by the State Mental Health or State Mental Retardation Authorities. A1550A, B through E = checked.

F109: With documented signs and symptoms of depression: With documented signs and symptoms of depression. D0200A1 through D1 = 1 for any indicator present OR D0200I1 = 1OR D0200A2 through D2 = 2 or 3 for symptom frequency OR D0300 = 05 - 27 OR D0500A1 through D1 = 1 for any indicator present OR D0500I1 = 1 OR D0500A2 through D2 = 2 or 3 for symptom frequency OR D0600 = 05 - 30.

F110: With documented psychiatric diagnosis (exclude dementias and depression): With primary or secondary psychiatric diagnosis including:

- Schizophrenia
- Schizo-affective disorder
- Schizophreniform disorder
- Delusional disorder
- Anxiety disorder
- Psychotic mood disorders (including mania and depression with psychotic features, acute psychotic episodes, brief reactive psychosis and atypical psychosis). I5700, I5900, I5950, I6000 or I6100 = checked.

F111: Dementia: Non-Alzheimer's Dementia (e.g., Lewy-Body, vascular or Multi-infarct, mixed, frontotemporal such as Pick's disease; and dementia related to Parkinson's or Creutzfeldt-Jakob diseases), or Alzheimer's Disease: With a primary or secondary diagnosis of dementia or organic mental syndrome including, Non-Alzheimer's Dementia (e.g., Lewy-Body, vascular or Multi-infarct, mixed, frontotemporal such as Pick's disease; and dementia related to Parkinson's or Creutzfeldt-Jakob diseases). I4200 or I4800 = checked

F112: With behavioral health care needs: With one or more of the following indicator(s): wandering, verbally abusive, physically abusive, socially inappropriate/disruptive, and resistive to care. E0200A, B, or C = 1, 2, or 3 OR E0300 = 1 OR E0500A, B, or C = 1 OR E0600A, B, or C = 1 OR E0800 = 1, 2, or 3 OR E0900 = 1, 2, or 3 OR E1000A or B = 1.

F113: Of the total number with behavioral healthcare needs, those having an individualized care plan to support them: With behavior symptoms who are receiving an individualized care plan/program designed to support and manage behavioral needs (as noted in F112).

F114: Receiving health rehabilitative services for Mental Illness (MI) and/or ID/DD: Receiving health rehabilitative services for MI and/or ID/DD.

D. SKIN INTEGRITY (F115 – F118) - RESIDENTS

F115: With pressure ulcers: With localized injury to the skin and/or underlying tissue, usually over a bony prominence, as a result of pressure, or pressure in combination with shear and/or friction (exclude Stage I). M0300B1, M0300C1, M0300D1, M0300E1, M0300F1and/or M0300G1 > 0.

F116: Of the total number of residents with pressure ulcers (excluding Stage 1), those who had pressure ulcers on admission/entry or reentry: M0300B2, M0300C2, M0300D2, M0300E2, M0300F2 and/or M0300G2 > 0. To complete this field, use only the counts from the first assessment since the most recent admission/entry or reentry. (OBRA or Scheduled PPS, i.e., A0310A = 01 OR A0310B = 01 or 06 OR A0310E = 1 for each resident.)

F117: Receiving preventive skin care: Receiving non-routine skin care ordered by a physician, and/or included in the resident's comprehensive plan of care (e.g., hydrocortisone ointment to areas of dermatitis three times a day, granulex sprays, etc.). M1200A through I = checked.

Fl18: With rashes: Who have rashes which may or may not be treated with any medication or special baths, etc. (e.g., may include but are not limited to antifungals, corticosteroids, emollients, diphenhydramines or scabicides).

E. SPECIAL CARE (F119 – F132) - RESIDENTS

F119: Receiving hospice care: Who have elected or are currently receiving the hospice benefit. O0100K2 = checked.

F120: Receiving radiation therapy: Who are under a treatment plan involving radiation therapy. O0100B1 or O0100B2 = checked.

F121: Receiving chemotherapy: Who are under a treatment plan involving chemotherapy. O0100A1 or O0100A2 = checked.

F122: Receiving dialysis: Receiving hemodialysis or peritoneal dialysis either within the facility or offsite. O0100J1 or O0100J2 = checked.

F123: Receiving intravenous therapy, IV nutrition and/or blood transfusion: Receiving fluids, medications, all or most of their nutritional requirements and/or blood and blood products administered intravenously. K0510A2, O0100H2, or O0100I2 = checked.

F124: Receiving respiratory treatment: Resceiving treatment by the use of respirators/ventilators, oxygen, IPPB or other inhalation therapy, pulmonary toilet, humidifiers, and other methods to treat conditions of the respiratory tract. This does not include residents receiving tracheostomy care or respiratory suctioning. O0100C2, O0100F2, or O0100G2 = checked.

F125: Receiving tracheostomy care: Receiving care involved in maintenance of the airway, the stoma and surrounding skin, and dressings/coverings for the stoma. O0100E2 = checked.

F126: Receiving ostomy care: Receiving care for a colostomy, ileostomy, uretrostomy, or other ostomy of the intestinal and/or urinary tract. DO NOT include tracheostomy. H0100C = checked.

F127: Receiving suctioning: That require use of a mechanical device which provides suction to remove secretions from the respiratory tract via the oral cavity, nasal passage, or tracheostomy. O0100D2 = checked. (Note: O0100D2 does not include oral suctioning, so residents who receive oral suctioning will have to be counted separately.)

F128: Receiving injections: That have received one or more injections within the past 7 days. (Exclude injections of Vitamin B 12.) Review residents where N0300 > 0. Omit from the count any resident whose only injection currently is B12.

F129: Receiving tube feeding: Who receive all or most of their nutritional requirements via a feeding tube that delivers food/nutritional substances directly into the GI system (e.g., nasogastric tube, gastrostomy tube). K0510B2 = checked.

F130: Receiving mechanically altered diets: Receiving a mechanically altered diet including pureed and/or chopped foods (not only meat). K0510C2 = checked.

F131: Receiving rehabilitative services: Receiving care designed to improve functional ability provided by, or under the direction of a rehabilitation professional (physical therapist, occupational therapist, speech-language pathologist). Exclude health rehabilitation for MI and/or ID/DD. Any minutes > 0 entered in O0400.

F132: Assistive devices with eating: Who are using devices to maintain independence and to provide comfort when eating (i.e., plates with guards, large handled flatware, large handle mugs, extend hand flatware, etc.). O0500C or H > 0.

F. MEDICATIONS (F133 – F139) - RESIDENTS

F133: Receiving psychoactive medications: That receive medications classified as antipsychotics, anxiolytics, antidepressants, and/or hypnotics. Days entered > 0 for N0410A, B, C or D.

Use the following lists to assist you in determining the number of residents receiving psychoactive medications. These lists are **not meant** to be all inclusive; therefore, a resident receiving a psychoactive medication not on this list, should be counted under F133 and any other medication category that applies: F134, F135, F136, and/or F137.

F134: Antipsychotic medications: Days entered for N0410A > 0

- Clozapine
- Haloperidol
- Haloperiodal Deconate
- Droperidol
- Loxapine
- Thioridazine
- Molindone
- Theothixene
- Zyprexa
- Pimozide
- Fluphenazine Deconate
- Fluphenazine
- Quetiapine
- Risperidone
- Mesoridazine
- Promazine
- Trifluoperazine
- Chlorprothixene
- Chlorpromazine
- Acetophenazine
- Perphenazine

F135: Antianxiety medications (anxiolytics): Days entered for N0410B > 0

- Lorazepam
- Oxazepam
- Prazepam
- Diazepam
- Clonazepam
- Hydroxyzine
- Chlordiazepoxide
- Halazepam
- Alprazolam

F136: Antidepressant medications: Days entered for N0410C > 0

- Aripiprazole
- Amoxapine
- Nortriptyline
- Wellbutrin
- Trazodone
- Venlafaxine
- Amtriptyline
- Lithium
- Maprotiline
- Isocarboxazid
- Phenelzine
- Serzone
- Desipramine
- Tranylcypromine Paroxetine
- Fluoxetine
- Sertraline
- Doxepin
- Imipramine
- Protriptyline

F137: Hypnotic medications: Days entered for N0410D > 0
- Flurazepam
- Quazepam
- Estazolam
- Temazepam
- Triazolam
- Zolpidem

F138: Receiving antibiotics: Receiving antibacterial sulfonamides, antibiotics, etc., either for prophylaxis or treatment. Days entered for N0410F > 0.

F139: On a pain management program: With a specific plan for control of difficult to manage or intractable pain, which may include self medication pumps or regularly scheduled administration of medication alone or in combination with non-medication interventions (e.g., massages heat/cold, biofeedback, etc.). J0100A, B, or C = 1.

G. OTHER RESIDENT CHARACTERISTICS (F140 – F145)

F140: With unplanned significant weight loss/gain: Who have experienced unplanned weight loss/gain of > 5% in one month or > 10% over six months. K0300 or K0310 = 2.

F141: Who do not communicate in the dominant language at the facility: Who do not speak or understand the dominant language spoken in the facility and need or want an interpreter to communicate. A1100A = 1.

F142: Who use non-oral communication: Who communicate via non-oral methods, including, picture boards, computers, etc. A1100B, Preferred Language (e.g. American Sign Language).

F143: Who have advance directives: Who have advance directives, such as Physician's Orders for Life-Sustaining Treatment (POLST), a living will or durable power of attorney for health care, recognized under state law and relating to the provisions of care when the individual is incapacitated.

F144: Received influenza immunization: Who received the influenza immunization within the last 12 months. O0250A = 1.

F145: Received pneumococcal vaccine: Who received the pneumococcal vaccine. O0300A = 1.

LEAVE BLANK (F146-F148) – To Be Completed By Survey Team

F146: Ombudsman notice: Indicate whether or not the State Ombudsman was notified prior to the survey.

F147: Ombudsman presence: Indicate whether or not the State Ombudsman was present at any time during the survey.

F148: Medication error rate: Calculate and enter the medication error percentage of the facility.

Figure 11-3. MDS 3.0 Facility Characteristics Report

CASPER Report

Page 1 of 1

MDS 3.0 Facility Characteristics Report

Facility ID: [redacted]
CCN: [redacted]
Facility Name: [redacted]
City/State: [redacted]
Data was calculated on: 09/02/2012

Report Period: 03/01/11 - 08/31/11
Comparison Group: 07/01/11- 12/31/11
Run Date: 09/19/12
Report Version Number: 1.00

	Facility			Comparison Group	
	Num	Denom	Observed Percent	State Average	National Average
Gender					
Male	130	282	46.1%	34.2%	34.3%
Female	152	282	53.9%	59.8%	64.8%
Age					
<25 years old	1	282	0.4%	0.1%	1.2%
25-54 years old	53	282	18.8%	7.2%	5.6%
55-64 years old	69	282	24.5%	12.1%	13.5%
65-74 years old	61	282	21.6%	25.5%	21.0%
75-84 years old	57	282	20.2%	21.8%	24.4%
85+ years old	41	282	14.5%	33.4%	34.4%
Diagnostic Characteristics					
Psychiatric diagnosis	150	282	53.2%	43.1%	46.2%
Intellectual or Developmental Disability	2	282	0.7%	0.1%	1.8%
Hospice	0	282	0.0%	0.0%	4.6%
Prognosis					
Life expectancy of less than 6 months	7	282	2.5%	6.7%	4.2%
Discharge Plan					
Not already occurring	157	282	55.7%	81.7%	64.2%
Already occurring	120	282	42.6%	14.8%	31.7%
Referral					
Not needed	142	282	50.4%	15.6%	29.6%
Is or may be needed but not yet made	16	282	5.7%	6.5%	8.7%
Has been made	18	282	6.4%	4.8%	8.9%
Type of Entry					
Admission	216	282	76.6%	81.8%	70.5%
Reentry	66	282	23.4%	18.2%	29.5%
Entered Facility From					
Community	9	282	3.2%	24.6%	15.3%
Another nursing home	2	282	0.7%	9.6%	4.7%
Acute Hospital	265	282	94.0%	57.6%	74.9%
Psychiatric Hospital	0	282	0.0%	0.0%	0.4%
Inpatient Rehabilitation Facility	1	282	0.4%	2.1%	0.7%
ID/DD facility	0	282	0.0%	0.0%	0.0%
Hospice	0	282	0.0%	0.1%	0.3%
Long Term Care Hospital	0	282	0.0%	0.0%	0.0%
Other	5	282	1.8%	0.1%	1.7%

This report may contain privacy protected data and should not be released to the public.

The *Numerator* indicates the number of residents with the identified characteristic and the *Denominator* indicates the number of residents in the facility.

Simple average percentages are provided for each resident characteristic among all facilities in the state and nation for the selected *Comparison Group* period.

MATRIX INSTRUCTIONS FOR PROVIDERS

The Matrix is used to identify pertinent care categories for: 1) newly admitted residents in the last 30 days who are still residing in the facility, and 2) all other residents.

The facility completes the resident name, resident room number and columns 1-20, which are described in detail below. Blank columns are for Surveyor Use Only.

All information entered into the form should be verified by a staff member knowledgeable about the resident population. Information must be reflective of all residents as of the day of survey.

For each resident mark all columns that are pertinent.

1. ***Residents Admitted within the Past 30 days:*** Resident(s) who were admitted to the facility within the past 30 days and currently residing in the facility.

2. ***Alzheimer's/Dementia:*** Resident(s) who have a diagnosis of Alzheimer's disease or dementia of any type.

3. ***MD, ID or RC & No PASARR Level II:*** Resident(s) who have a serious mental disorder, intellectual disability or a related condition but does not have a PASARR level II evaluation and determination.

4. ***Medications:*** Resident(s) receiving any of the following medications: (I) = Insulin, (AC) = Anticoagulant (e.g. Direct thrombin inhibitors and low weight molecular weight heparin [e.g., Pradaxa, Xarelto, Coumadin, Fragmin]. Do not include Aspirin or Plavix), (ABX) = Antibiotic, (D) = Diuretic, (O) = Opioid, (H) = Hypnotic, (AA) = Antianxiety, (AP) = Antipsychotic, (AD) = Antidepressant, (RESP) = Respiratory (e.g., inhaler, nebulizer).

   NOTE: Record meds according to a drug's pharmacological classification, not how it is used.

5. ***Facility Acquired Pressure Ulcer(s) (any stage):*** Resident(s) who have a pressure ulcer at any stage, including suspected deep tissue injury (e.g., I, II, III, IV, unstageable, sDTI)

6. ***Worsened Pressure Ulcer(s) at any stage:*** Resident(s) with a pressure ulcer at any stage that have worsened.

7. ***Excessive Weight Loss without Prescribed Weight Loss program:*** Resident(s) with an unintended (not on a prescribed weight loss program) weight loss > 5% within the past 30 days or >10% within the past 180 days. Exclude residents receiving hospice services.

8. ***Tube Feeding:*** Resident(s) who receive enteral or parenteral feedings.

9. ***Dehydration:*** Resident(s) identified with **actual** hydration concerns (e.g., receives enteral, parenteral and/or IV feeding/fluids, or is dehydrated) takes in less than the recommended 1,500 ml of fluids daily (water or liquids in beverages and water in foods with high fluid content, such as gelatin and soups).

10. ***Physical Restraints:*** Resident(s) who have a physical restraint in use. A restraint is defined as the use of any manual method, physical or mechanical device, material or equipment attached or adjacent to the resident's body that the individual cannot remove easily which restricts freedom of movement or normal access to one's body (e.g., bed rail, trunk restraint, limb restraint, chair prevents rising, mitts on hands, confined to room, etc.). Do not code wander guards as a restraint.

11. ***Fall(s) (F) or Fall(s) with Injury (FI) or Major Injury (FMI):*** Resident(s) who have fallen since admission or within the past 90 days and have incurred an injury or not. A major injury includes bone fractures, joint dislocation, closed head injury with altered consciousness, subdural hematoma.

    Use **(F)** to identify residents with a fall(s), **(FI)** to identify a resident who has sustained an injury excluding major injury, and **(FMI)** to identify a resident who has sustained a fall(s) with Major Injury.

12. ***Indwelling Urinary Catheter:*** Resident(s) with an indwelling catheter (including suprapubic catheter and nephrostomy tube).

13. ***Dialysis:*** Resident(s) who are receiving **(H)** hemodialysis or **(P)** peritoneal dialysis either within the facility **(F)** or offsite **(O)**.

14. ***Hospice***: Resident(s) who have elected or are currently receiving hospice services.

15. ***End of Life/Comfort Care/Palliative Care:*** Resident(s) who are receiving end of life or palliative care (not including Hospice).

16. ***Tracheostomy:*** Resident(s) who have a tracheostomy.

17. ***Ventilator:*** Resident(s) who are receiving invasive mechanical ventilation.

18. ***Transmission-Based Precautions***: Resident(s) who are currently on Transmission-based Precautions.

19. ***Intravenous therapy***: Resident(s) who are receiving intravenous therapy through a central line, peripherally inserted central catheter, or other intravenous catheter.

20. ***Infections:*** Residents(s) who has a communicable disease/contagious infection (e.g., MDRO-M, pneumonia-P, tuberculosis-TB or viral hepatitis-VH, or c-diff-C) OR has a healthcare-associated infection (e.g., wound infection-WI or UTI).

MATRIX FOR PROVIDERS

	Resident Room Number	Date of Admission if Admitted within the Past 30 Days	Alzheimer's / Dementia	MD, ID or RC & No PASARR Level II	Medications: Insulin (I), Anticoagulant (AC), Antibiotic (ABX), Diuretic (D), Opioid (O), Hypnotic (H), Antianxiety (AA), Antipsychotic (AP), Antidepressant (AD), Respiratory (RESP)	Facility Acquired Pressure Ulcer(s) (any stage)	Worsened Pressure Ulcer(s) (any stage)	Excessive Weight Loss w/out Prescribed Weight Loss Program	Tube Feeding	Dehydration	Physical Restraints	Fall (F), Fall with Injury (FI), or Fall w/Major Injury (FMI)	Indwelling Catheter	Dialysis: Peritoneal (P), Hemo (H), in facility (F) or offsite (O)	Hospice	End of Life Care /Comfort Care/Palliative Care	Tracheostomy	Ventilator	Transmission-Based Precautions	Intravenous therapy	Infections (M,WI, P, TB, VH, C, UTI)	
Resident Name		1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21

8/2017

Strengths	Weaknesses
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
Opportunities	**Threats**
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Facility Assessment Worksheet Summary
Community Demographics

Current Population: _____

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Current Capacity: _____

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Insight | Expertise | Knowledge

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Wish list: _____

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Facility Assessment: Personnel Resources

Facility Assessment - Facility Personnel Resources

CMS State Operations Manual Appendix PP -Guidance to Surveyors for Long Term Care Facilities

F838
§483.70(e) 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 and emergencies. The facility assessment must address or include:

The facility's resident population, including, but not limited to,

- The staff competencies that are necessary to provide the level and types of care needed for the resident population;

The facility's resources, including but not limited to,

- All personnel, including managers, 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;

I. Intent of this section of the regulation

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

II. All Personnel

A. Personnel are the primary resource for meeting residents' care needs. Each staff member has a role in the facility's mission, operation, objectives and successes and residents' quality of life. Every staff member requires specific knowledge and skills to complete their job duties and function appropriately in the residents' environment, even if they do not provide direct care to the residents of the facility.

B. The number of staff and competencies needed for each type of staff in the facility varies according to the organization, the physical plant, required job duties and the unique needs of the facility resident population.

C. Although nursing facility federal regulations do not stipulate standard staffing levels, the Facility Assessment serves as a standardized tool to assist facilities to determine the

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number of staff needed according to the residents' needs and/or acuity. There are a number of F tags that describe staffing requirements, listed later in this section.

III. Four Steps to determine Facility Personnel Resources

1. The first step for determining the facility personnel resources is to quantify all personnel, including managers, staff (both employees and those who provide services under contract), and volunteers by job descriptions or roles as they interact with residents.

2. The second step will be to identify the credentials, and education related to resident care for each job category.

3. The third step is to identify the number and type of staff needed to meet the resident's needs.

4. The fourth step is the identification of staff competencies needed to provide the level and types of care needed for the resident population.

A. Step One – Quantify Facility Personnel

1. Data Sources To Identify All Facility Personnel

a. There are several sources of facility personnel information. Facility personnel is collected and tracked by the Human Resources department and the Payroll department. Each department also tracks and manages facility personnel information in order to assign and deploy staff to meet residents' needs.

b. CMS requires that payroll data be routinely submitted to the Payroll Base Journal (PBJ) system. The PBJ program has standardized definitions for each staff role. Hours worked by staff in each job category are routinely reported to CMS.

c. Use information about the hours worked by the staff, as reported in the PBJ submissions. Personnel information from the facility budget plans for the types and quantity of staff for the facility each year.

d. Data Source Examples for Step One

- PBJ reports
- Human Resources files
- Payroll files

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A. PBJ Reports

1. The PBJ program describes standard personnel job categories and job descriptions and collects the hours worked by each employee in each category for a defined period.

2. To use PBJ data for the Facility Assessment, obtain personnel data from PBJ submissions for the time period that you are using for the completion of the facility assessment, or you can annualize the payroll data based on the most recent quarter if the information is representative of the staffing hours worked.

3. PBJ information may be available from the payroll office, human resources department or the corporate offices of larger organizations.

4. Identify the number of Full Time Equivalent (FTE) positions, including personnel providing services to residents under contract, working in the facility during the last 90 days.

5. You will need to separately identify and quantify dietary services workers, as this job category is included in the "Other" category in PBJ submissions.

6. The Facility Assessment requires the volunteers to be included as personnel resources.

B. To calculate FTE

1. Full time equivalent = total number of hours worked per year divided by 2080 hours.

For example, an Administrator that works 40 hours per week would have hours equal to one FTE.

40 hrs. per week x 52 weeks = 2080 hours/ 2080 = 1 FTE

OR

480 hours this quarter = Average 40 hours per week

40 hours per week for 52 weeks = 2080 hours annually /2080 = 1 FTE

2. You may have a document or report that captures this information. If not, there is a Facility Personnel Workbook; an Excel workbook with three tabs, to document the information required for the Facility Personnel Resources section of the Facility Assessment

Below is an example of how to categorize facility job titles into PBJ job categories and list the number of FTE in each category.

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EXAMPLE of Facility Personnel listing based on PBJ data

PBJ Job Category	List facility job description titles counted in this category	# FTE in the facility
Administrator Administrative staff responsible for facility management as required under 483.75(d) such as the administrator and the assistant administrator.	Administrator Assistant Administrator	2 FTE (two full time positions)
Medical Director A physician designated as responsible for implementation of resident care policies and coordination of medical care in the facility in accordance with 483.75(i).	Medical Director	0.25 FTE (520 hours per year, or 10 hours per week)
Registered Nurse with Administrative Duties Nurses (RN) who, as either a facility employee or contractor, perform the Resident Assessment Instrument function in the facility and do not perform direct care functions. Also include other RNs whose principal duties are spent conducting administrative functions. For example, the Assistant Director of Nursing is conducting educational/in-service. Facilities with an RN waiver who do not have an RN as DON report all administrative nursing hours in this category.	Evening Supervisor MDS Coordinator Staff Development Coordinator	1.25 FTE (7 days per week) 1 FTE 0.6 FTE (3 days per week)

C. Human Resources and Payroll information

1. If PBJ information is not readily available or is difficult to decipher, the same information can be obtained from human resources and payroll files, comparative to the CMS PBJ requirements

2. Identify the job titles that meet the PBJ job categories listed above. Identify from payroll information, the number of hours worked in each job category in the last year and calculate the number of FTEs in each job category.

- ***Use the Facility Personnel Resources Workbook, Tab 1, <u>Personnel & Credentials</u> to enter the job categories and job titles of the facility's personnel.***

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B. Step Two – Credentials, and Education

1. Review the facility's job descriptions. Each job description will identify the required credentials and education for each job title.

2. The credentials and required education for some registered licensed or certified staff are defined by individual State laws and regulations. Others are determined by the organization or facility.

3. Use the credential title and education requirements for your specific state in the Facility Personnel Resources Workbook.

- ***Use the Facility Personnel Resources Workbook, Tab 1, Personnel & Credentials to enter required credential and required education.***

C. Step Three - Number of Staff Needed To Meet Residents' Needs

1. Review the residents' needs as identified in the Facility Resident Population section of the Facility Assessment.

2. For each broad area of care needs identify the number of FTE needed to provide the care.

3. Include consideration of contract staff and other staff contributing to the residents' care such as the Medical Director, Dentist and Psychologist.

- ***Use the Facility Personnel Resources Workbook, Tab 3, Resident Needs & Competencies or your organization's worksheets to identify the number of staff needed to meet each resident care need***

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D. Step Four - Competencies

1. There are competencies required by federal nursing home regulations and other governing organizations for persons working in healthcare organizations. Some of the organizations overseeing rules and laws that apply to staff and leaders include the Occupational Health and Safety Administration, the U.S. Equal Employment Opportunity Commission, Medicare and Medicaid integrity program, State and Federal labor laws, State and Federal Building codes, and practice rules for licensed, certified and registered professionals.

2. The Facility Assessment is focused on the competencies needed to provide appropriate care to residents.

- According to the State Operations Manual, Appendix PP,

  "Competency" is a measurable pattern of knowledge, skills, abilities, behaviors, and other characteristics that an individual needs to perform work roles or occupational functions successfully. This is not dependent solely upon qualifications or licensure.

3. All personnel who work in a nursing facility are required by the Requirements of Participation to have knowledge in specific topics including:
   a. Abuse, neglect, exploitation, and misappropriation of resident property (abuse prevention)
   b. Dementia management and
   c. Infection control
   d. Other areas as identified through the Facility Assessment.

   See §483.95(c)for more detailed information about the content of training for abuse prevention.

4. ***F 726 Nursing Services*** lists minimum competency requirements for nursing staff, as listed below.

   a. Competency in skills and techniques necessary to care for residents' needs includes but is not limited to competencies in areas such as;
   - Resident Rights;
   - Person centered care;
   - Communication;
   - Basic nursing skills;
   - Basic restorative services;
   - Skin and wound care;
   - Medication management;
   - Pain management;

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- Infection control;
- Identification of changes in condition;
- Cultural competency.

5. In ***F726 Nursing Services*** the surveyor is directed to determine if staff competencies are evaluated upon initial hire and routinely thereafter and when new technologies or equipment are put into use.

6. Competency is included in many areas of the Guidance to Surveyors.

7. Fundamentally, the facility must identify the residents' needs and determine, beyond the required topics, what knowledge, skills, abilities, behaviors, and other characteristics are needed.

- **Competency Levels**

1. One way to address competency needs is to determine the levels of competencies needed for each level of staff based on their interaction level with the residents. These are the topics covered in general orientation when staff from all departments is together for education. Think of competency requirements as an inverted pyramid (see below). The job categories requiring the fewest competencies are represented by the tip of the pyramid.

2. The next level of competencies is for staff that works in resident care areas, but do not provide direct care. Consider this to be Level II competencies.
    a. These staff must have the basic level competencies and additional knowledge and skills to appropriately and safely interact with residents. Those staff may include housekeepers, laundry staff, maintenance staff and volunteers, as well as others identified in your facility.

3. Level III of the competency pyramid is for direct care givers who do not have responsibility for assessment and treatment of residents. Nursing assistants will be the largest group in this level. Nursing assistants will need the Basic Level and Level II competencies, as well as a list required by the Requirements of Participation.

4. Continue to add levels and build on the competencies from prior levels as you define competencies needed for nurses, therapists, the consulting

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pharmacist and other professionals who provide care and services to the residents.

5. Include a competency level for staff that supervises other staff and oversee care, as well as participate in assessments of residents' needs and development of their care plans. Determine what knowledge, skills, abilities, behaviors, and other characteristics that these staff need to provide care to residents, including indirect care provided through others.

6. The largest number of competencies will be required for the positions that have responsibility and accountability for the systems, policies and procedures, protocols and standards for resident care across the entire facility. These positions will include the Medical Director, the Administrator, The Director of Nursing and others, as defined by your facility.

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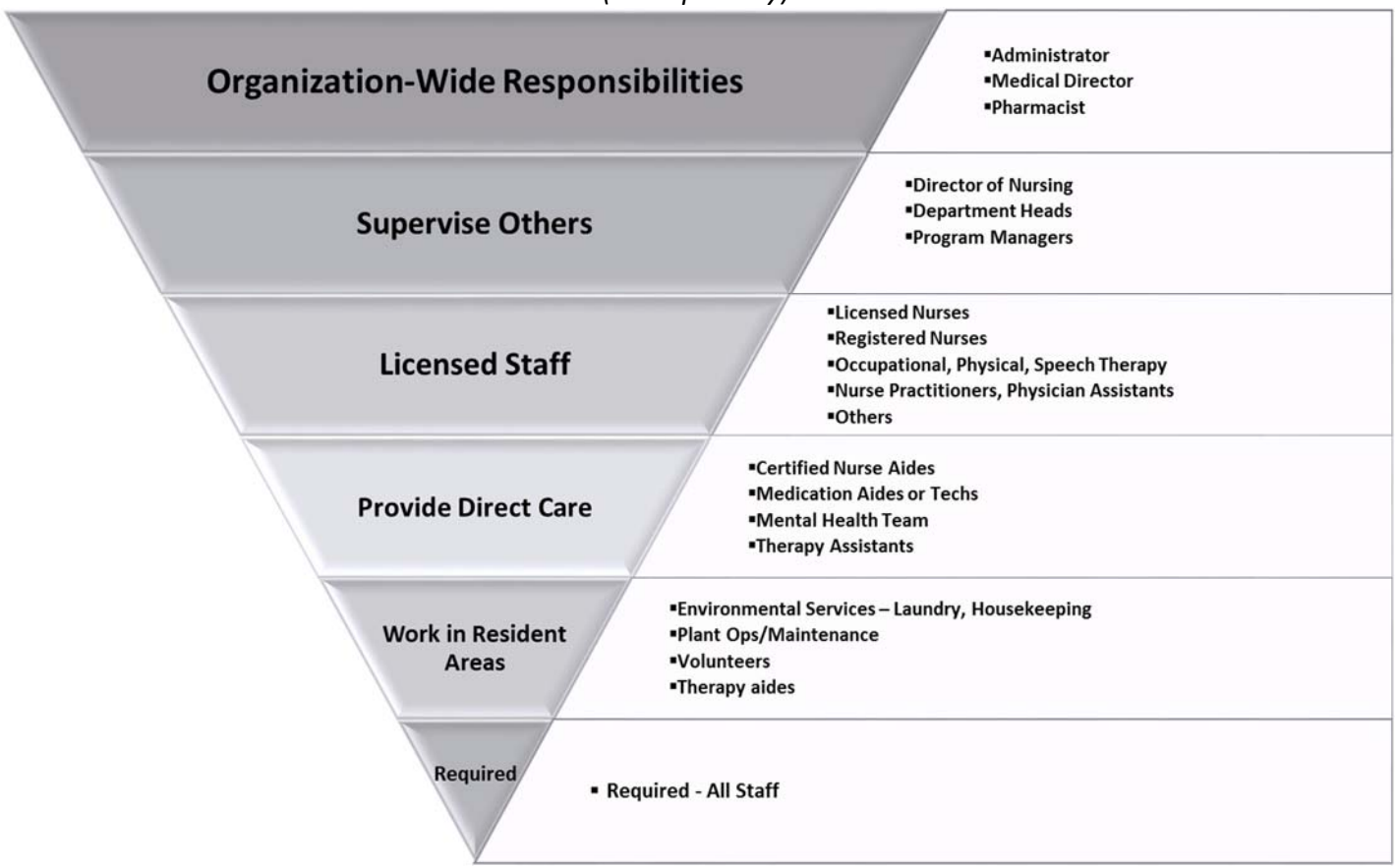
The Competency Pyramid

(example only)



The Guidance to Surveyors for Long Term Care Facilities does have a few areas of specific competencies required for some positions. See the lists below to include these in your library of competencies.

- **Level I - Basic Competencies for All Facility Staff**
  Identify the Basic competencies **required** for all staff who work in the facility. The regulations specify:
  - Abuse, neglect, exploitation, and misappropriation of resident property,
  - Dementia management and
  - Infection control
  - Other areas as identified through the Facility Assessment

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- You can add knowledge, skills and abilities required by other organizations, such as OSHA.

  Examples include:

  - OSHA Hazard communication
  - HIPPA,
  - QAPI

  Additional topics for all staff may include:

  - Response to Emergency Codes, such as fire

❖ **Level II - For staff that works in resident care areas, the competencies may include**

- Level I

  Consider these suggested topics and more:

  - Communication
  - Fall Prevention
  - Operation of exit alarms
  - Transmission-based precautions
  - Reporting changes in residents conditions
  - Job specific competencies
  - Competencies identified by the assessment of residents' needs

❖ **Level III – Direct Care Givers**

- Level I
- Level II

  Plus these *required* topics:

  - Person centered care
  - Communication
  - Basic nursing skills
  - Basic restorative services
  - Skin and wound care
  - Medication management
  - Pain management
  - Additional Infection control topics
  - Identification of changes in condition

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- Cultural competency
- Specific care skills as identified through the Facility Assessment

❖ **Level IV – Licensed Staff**

- Level I
- Level II
- Level III

Consider these topics and others identified though the assessment of residents' needs:

- Job specific evaluation and assessment skills
- Documentation
- Care plan development
- State and Federal Long Term Care requirements
- Standards of practice
- Specific care skills as identified through the Facility Assessment

❖ **Level V – Supervise Others**

- Level I
- Level II
- Level III
- Level IV

Consider these suggested topics and more:

- Delegation
- Effective communication for supervisors
- Task specific competencies, such as infection data collection
- Human Resources policies and procedures
- Develop and utilize competencies
- Effective staff performance evaluation
- State and Federal Long Term Care requirements
- Standards of practice

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- **Level VI – Facility-wide responsibilities**
  - All prior levels

    Consider these suggested topics and more:
    - Federal and State nursing home regulations
    - Nursing home survey process
    - Budgeting
    - Data collection, interpretation and management
    - Policy and procedure development and management
    - Role specific knowledge and skills

- ***Go to the Facility Personnel Resources Workbook to enter Required Competencies according to regulations, rules and state specific requirements on Tab 3 Competency Levels***

A. Competencies defined by the Resident population needs

1. Define the competencies that are needed to meet the residents' needs as you've identified them. List the major resident needs and define the knowledge, skills, abilities, attitudes and behaviors that staff needs to provide appropriate care and services.

2. There are several ways to demonstrate competency. CMS gives examples of in F 726.

F726 Nursing Services - Demonstration of Competency
Competency may not be demonstrated simply by documenting that staff attended training, listened to a lecture, or watched a video. A staff's ability to use and integrate the knowledge and skills that were the subject of the training, lecture or video must be assessed and evaluated by staff already determined to be competent in these skill areas.

Examples for evaluating competencies may include but are not limited to:

- Lecture with return demonstration for physical activities;
- A pre-and post-test for documentation issues;
- Demonstrated ability to use tools, devices, or equipment that were the subject of training and used to care for residents;
- Reviewing adverse events that occurred as an indication of gaps in competency; or
- Demonstrated ability to perform activities that is in the scope of practice an individual is licensed or certified to perform.

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3. Once you have identified the competencies needed to care for the residents, identify the type of competency demonstration that is appropriate for the task, skill, knowledge, ability or behavior.

4. Competency for high risk physical tasks, such as transferring a resident with a mechanical lift may require knowledge and a return demonstration, while competency for a nursing assessment may be knowledge and observed ability.

5. Document your decision-making process for the type of competency when you are categorizing the competency documentation needed. Consider the risk level of the activity, how frequently the activity is completed, the knowledge level of the staff completing the activity, and instances of adverse results from the activity at the facility.

EXAMPLE
For example, there are 10 residents who require a mechanical lift for transfers. The appropriate roles to provide that care are: Nursing Assistant, LPN, RN, PT, and OT. There are 8 FTE of LPN, 12 FTE of Nursing Assistants, 3 FTE of RN and 2 FTE of PT and OT. The competency documentation required for this high risk activity is Knowledge and a Return Demonstration for safe use of the mechanical lift.

Resident care need	**Average % residents**	**Appropriate position or role** **RN** – Registered Nurse **LPN/LVN** – Licensed Practical Nurse **CNA** - Certified Nursing Assistant **VOL** - Volunteer **PFA** - Paid Feeding Assistant **TMA**- Trained medication aide **OT** –Occupational Therapist **PT** – Physical Therapist **ST** – Speech Langauge Pathologist	**# FTE available**	*Type of competency* documentation needed* **RD** – Knowledge & Return demo **KT -** Knowledge & test **OA** - Knowledge & Observed ability **OB** - Knowledge & Observed behavior **PR** - Knowledge & Performance review
EXAMPLE Transfer with mechanical lift	*4%*	*CNA* *LPN* *RN* *OT* *PT*	*12* *8* *3* *2* *2*	*RD*

- ***Review the Resident Care Needs from the prior section of the Facility Assessment***
- ***Identify the types of Competencies needed to meet those needs and organize them into levels for use of explanation and use. See Tab 2 Competency Levels of the Facility Personnel Resources Workbook.***
- ***Use the Facility Personnel Resources Workbook, Tab 4, Needs and Competencies to document the type and amount of staff and appropriate competency documentation.***

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Narrative Template ***Example***

Section II Services and Care We Offer Based on Our Residents' Needs

Insert mission statement here?

Facility Name provides care in a culture of respect and dignity for all people we serve. *Our primary goal is to offer compassionate support to help people live the lives they desire to and are capable of living. The residents of this community have unique needs which we serve with a person-centered philosophy that maintains the person as decision-maker or promotes the involvement of a resident selected representative when needed.*

Discuss ADL needs here

Based on a review of the resident populations' needs, the **facility** hires and maintains a qualified workforce with up to date knowledge and skills.

A full program of leisure activities is offered at ***Facility Name*** , based on the residents' preferences and designed to supports each resident's quality of life. Activities are modified to meet the needs of residents with physical, cognitive, psychosocial and mental impairments and conditions. 7**0% of the resident require assistance with mobility** and staff from the activities and nursing departments are available to provide assistance. Supplies and resources are offered to residents that prefer to do some activities in their own rooms. Assistive devices, such as amplification devices, wheelchair height games and large print books offer support for the **15% of the residents with hearing deficits**, **35% that primarily use a wheelchair for mobility** and **12% with visual deficits**.

Discuss ADL needs here

All residents are provided with assistance with bathing, grooming, dressing and personal hygiene as needed. **88% of residents require help with bathing**. One or more nursing assistants accompanies each resident that needs assistance with bathing in the spa room. ***Facility Name*** provides staff assistance with self-care for resident's at each resident's preferred schedule. **90% of the 100** residents require some assistance with dressing grooming and personal hygiene. There are **30 FTE** of nursing assistants who work across all three shift to provide care the residents that require assistance.

Discuss programs that apply to all residents here

Between **70 and 85% of the residents** at ***Facility Name*** are **at risk for skin breakdown and at risk for falls**. The facility provides resident-specific preventive measures for these risk areas, based on an individualized assessment and in accordance with the residents' treatment goals and preferences. There are Preventive Skin Program and Fall Prevention Program resources available to staff. An interdisciplinary approach is used to develop a resident-centered care plan with input from the resident, the nurse and nursing assistant, the medical providers, PT and OT , the registered dietician and the social worker.

Discuss the most prevalent diagnoses and conditions here

The licensed nurses provide care and treatments to residents based on their medical needs. **30%** of the residents have a **diagnosis of diabetes**. Nurses monitor and treat residents' symptoms and collaborate with the residents and medical providers to maintain consistent blood sugar levels for these residents.

At Facility Name, 60% of the residents have a diagnosis of ***cardiopulmonary disease***. ***Facility Name*** provides a ***Cardiac Rehab Program*** with a Restorative Nursing to assist residents with cardiopulmonary conditions to reach and maintain their highest level of function and well-being. The program includes appropriate staff from the ***Therapy department, registered and licensed nurses, a registered dietician,***

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restorative nursing assistants, social workers, and activity department staff with the knowledge and credentials to meet those residents' needs.

Approximately ***20%*** of the resident population at ***Facility Name*** have a medical condition with related dementia symptoms, some of who have behaviors toward others. ***Facility Name*** provides a secured memory care unit for people with dementia who can benefit from a secured environment and the special social programming offered for this population. There is a dedicated staff of nursing staff, the social worker and activities staff that are consistently assigned to work with these residents.

Nursing staff assignments are reviewed and adjusted as needed before each shift to meet residents' needs. While most staff has a consistent assignment and work with the same residents each day, a few nursing staff move between two of the four units to fill in for vacancies.

Discuss approaches to staffing here

When vacancies cannot be covered by scheduled staff, other facility staff are contacted to work and existing licensed nurse staff may be assigned to provide ADL care for a group of residents. Supervisory and administrative nurses then assume the duties of the licensed nurse staff as needed.

Staff are vetted for appropriate education and credentials prior to hire and attend both general and role specific orientation. Orientation assesses staff knowledge and skill levels and provides education about the expected standards of care at ***Facility Name.*** Before new staff work with residents they are required to complete the orientation and specified competencies, according to their role.

All facility staff have knowledge competencies in Abuse, Neglect, Exploitation and misappropriation of resident property. Basic infection control knowledge competencies include transmission of infections, immunizations, employee health and are required to complete return demonstration for hand hygiene. All staff have knowledge competency about dementia symptoms, including communicating with people with dementia symptoms and safety protocols for residents that are exit seeking. Staff have knowledge and return observed competencies in emergency response for fire, weather, missing resident, and active shooter scenarios. Knowledge competency is also required for all staff for OSHA hazard communication.

Discuss the Basic competencies here

Additional competencies are based on the amount of interaction with residents, the skills required to complete their role, their responsibility for providing and managing the residents' care and for supervising others.

Competencies are evaluated upon hire, when a new type of resident condition is present, a new type of equipment is introduces or there is a programmatic or policy change at the facility. Evaluation of competencies based on observed abilities and observed behaviors are reviewed at least annually as art of the annual performance evaluation process and more frequently in response to actual or potential adverse outcomes to residents.

Discuss frequency of competency evaluations here

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❖ F Tags Related To Staffing, Credentials and Education

F689

§483.12 Freedom from Abuse, Neglect, and Exploitation

The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms.

§483.12(a) The facility must—

§483.12(a)(1) Not use verbal, mental, sexual, or physical abuse, corporal punishment, or involuntary seclusion;

TYPES OF ABUSE

Identified facility characteristics [1,2] that could increase the risk for abuse include, but are not limited to:

- Chronic staffing problems;
- Neglect of goods or services may occur when staff are aware, or should be aware, of residents' care needs, based on assessment and care planning, but are unable to meet the identified needs due to other circumstances, such as lack of training to perform an intervention (e.g., suctioning, transfers, use of equipment), lack of sufficient staffing to be able to provide the services, lack of supplies, or staff lack of knowledge of the needs of the resident

For specific allegations of abuse, the surveyor should review:

- For allegations of staff to resident abuse, staffing rosters to determine staffing at the time of the alleged abuse, timecards for staff on duty at the time, and conduct staff interviews to determine whether there was adequate monitoring and supervision of staff at the time of the allegation.

F689

§483.25(d) Accidents. The facility must ensure that –

§483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and

§483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents.

"Risk" refers to any external factor, facility characteristic (e.g., staffing or physical environment) or characteristic of an individual resident that influences the likelihood of an accident.

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"Supervision/Adequate Supervision" refers to an intervention and means of mitigating the risk of an accident. Facilities are obligated to provide adequate supervision to prevent accidents. Adequate supervision is determined by assessing the appropriate level and number of staff required, the competency and training of the staff, and the frequency of supervision needed. This determination is based on the individual resident's assessed needs and identified hazards in the resident environment.

F695
§483.25(i) Respiratory care, including tracheostomy care and tracheal suctioning.

The facility must ensure that a resident who needs respiratory care, including tracheostomy care and tracheal suctioning, is provided such care, consistent with professional standards of practice, the comprehensive person-centered care plan, the residents' goals and preferences, and 483.65 of this subpart.
Refer to §483.65 specialized rehabilitative services, for review of provision of services by qualified personnel. When providing respiratory care, the facility must, based on professional standards of practice:

- Have sufficient numbers of trained, competent, qualified staff, consistent with State practice acts/laws; and
- Identify who is authorized to perform each type of respiratory care service, such as responding to mechanical ventilator alarms, suctioning and tracheostomy care.

F715
§483.30(e)(2) A resident's attending physician may delegate the task of writing dietary orders, consistent with §483.60, to a qualified dietitian or other clinically qualified nutrition professional who—

(i) Is acting within the scope of practice as defined by State law; and
(ii) Is under the supervision of the physician.

§483.30(e)(3) A resident's attending physician may delegate the task of writing therapy orders, consistent with §483.65, to a qualified therapist who—

(i) Is acting within the scope of practice as defined by State law; and
(ii) Is under the supervision of the physician

DEFINITIONS §483.30(e)(2)-(3)
"Qualified dietitian" – is defined in §483.60 as follows: §483.60(a)(1) A qualified dietitian or other clinically qualified nutrition professional either full-time, part-time, or on a consultant basis. A qualified dietitian or other clinically qualified nutrition professional is one who—

i. Holds a bachelor's or higher degree granted by a regionally accredited college or university in the United States (or an equivalent foreign degree) with completion of the academic requirements of a program in nutrition or dietetics accredited

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by an appropriate national accreditation organization recognized for this purpose.

ii. Has completed at least 900 hours of supervised dietetics practice under the supervision of a registered dietitian or nutrition professional.

iii. Is licensed or certified as a dietitian or nutrition professional by the State in which the services are performed. In a State that does not provide for licensure or certification, the individual will be deemed to have met this requirement if he or she is recognized as a "registered dietitian" by the Commission on Dietetic Registration or its successor organization, or meets the requirements of paragraphs (a)(1)(i) and (ii) of this section.

iv. For dietitians hired or contracted with prior to November 28, 2016, meets these requirements no later than 5 years after November 28, 2016 or as required by state law.

"Qualified therapist" – professional staff, licensed, certified or registered to provide specialized therapy/rehabilitative services in accordance with State laws. Includes: Physical, Occupational, and Respiratory therapists and Speech-Language Pathologists.

F715
§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 §483.70(e).

Always, review nursing services requirements under §483.35 during a standard or extended survey, when a waiver of RN and/or licensed nurse (RN/LPN) staffing has been requested or granted, or if a complaint has been received regarding nursing services.

F725

§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

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number, acuity and diagnoses of the facility's resident population in accordance with the facility assessment required at §483.70(e).

§483.35(a) Sufficient Staff.

§483.35(a)(1) The facility must provide services by sufficient numbers of each of the following types of personnel on a 24-hour basis to provide nursing care to all residents in accordance with resident care plans:

(i) Except when waived under paragraph (e) of this section, licensed nurses; and
(ii) Other nursing personnel, including but not limited to nurse aides.

§483.35(a)(2) Except when waived under paragraph (e) of this section, the facility must designate a licensed nurse to serve as a charge nurse on each tour of duty.

Many factors must be considered when determining whether or not a facility has sufficient nursing staff to care for residents' needs, as identified through the facility assessment, resident assessments, and as described in their plan of care. A staffing deficiency under this requirement may or may not be directly related to an adverse outcome to a resident's care or services. It may also include the **potential** for physical or psychosocial harm.

PROCEDURES AND PROBES: §§483.35(a)(1)-(2)
Although federal regulations do not define minimum nursing staff ratios, many States do. If a facility does not meet State regulations for staffing, do NOT cite that as a deficiency here, refer to Administration, F836, §483.70(b). In addition, if a facility meets the State's staffing regulations that is not, by itself, sufficient to demonstrate that the facility has sufficient staff to care for its residents

F727

§483.35(b) Registered nurse §483.35(b)(1) Except when waived under paragraph (e) or (f) of this section, the facility must use the services of a registered nurse for at least 8 consecutive hours a day, 7 days a week.

§483.35(b)(2) Except when waived under paragraph (e) or (f) of this section, the facility must designate a registered nurse to serve as the director of nursing on a full time basis.

§483.35(b)(3) The director of nursing may serve as a charge nurse only when the facility has an average daily occupancy of 60 or fewer residents.

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F731

§483.35(e) Nursing facilities Waiver of requirement to provide licensed nurses on a 24-hour basis. To the extent that a facility is unable to meet the requirements of paragraphs (a)(2) and (b)(1) of this section, a State may waive such requirements with respect to the facility if—

§483.35(*e*)(1) The facility demonstrates to the satisfaction of the State that the facility has been unable, despite diligent efforts (including offering wages at the community prevailing rate for nursing facilities), to recruit appropriate personnel;

§483.35(e)(2) The State determines that a waiver of the requirement will not endanger the health or safety of individuals staying in the facility;

§483.35(e)(3) The State finds that, for any periods in which licensed nursing services are not available, a registered nurse or a physician is obligated to respond immediately to telephone calls from the facility;

§483.35(e)(4) A waiver granted under the conditions listed in paragraph (e) of this section is subject to annual State review;

§483.35(e)(5) In granting or renewing a waiver, a facility may be required by the State to use other qualified, licensed personnel;

§483.35(e)(6) The State agency granting a waiver of such requirements provides notice of the waiver to the Office of the State Long-Term Care Ombudsman (established under section 712 of the Older Americans Act of 1965) and the protection and advocacy system in the State for individuals with a mental disorder who are eligible for such services as provided by the protection and advocacy agency; and

§483.35(e)(7) The nursing facility that is granted such a waiver by a State notifies residents of the facility and their resident representatives of the waiver.

§483.35(f) SNFs Waiver of the requirement to provide services of a registered nurse for more than 40 hours a week.

§483.35(f)(1) The Secretary may waive the requirement that a SNF provide the services of a registered nurse for more than 40 hours a week, including a director of nursing specified in paragraph (b) of this section, if the Secretary finds that—

> **(i) The facility is located in a rural area and the supply of skilled nursing facility services in the area is not sufficient to meet the needs of individuals residing in the area;**
> **(ii) The facility has one full-time registered nurse who is regularly on duty at the facility 40 hours a week; and**
> **(iii) The facility either—**
> **(A) Has only patients whose physicians have indicated (through physicians' orders or admission notes) that they do not require the services of a registered nurse or a physician for a 48-hours period or;**

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(B) Has made arrangements for a registered nurse or a physician to spend time at the facility, as determined necessary by the physician, to provide necessary skilled nursing services on days when the regular full-time registered nurse is not on duty;

(iv) The Secretary provides notice of the waiver to the Office of the State Long-Term Care Ombudsman (established under section 712 of the Older Americans Act of 1965) and the protection and advocacy system in the State for individuals with developmental disabilities or mental disorders; and

(v) The facility that is granted such a waiver notifies residents of the facility and their resident representatives of the waiver.

§483.35(f)(2) A waiver of the registered nurse requirement under paragraph (f)(1) of this section is subject to annual renewal by the Secretary.

F732

§483.35(g) Nurse Staffing Information.

§483.35(g)(1) Data requirements. The facility must post the following information on a daily basis:

(i) Facility name.

(ii) The current date.

iii) The total number and the actual hours worked by the following categories of licensed and unlicensed nursing staff directly responsible for resident care per shift:

(A) Registered nurses.

(B) Licensed practical nurses or licensed vocational nurses (as defined under State law).

(C) Certified nurse aides.

(iv) Resident census.

§483.35(g)(2) Posting requirements.

(i) The facility must post the nurse staffing data specified in paragraph (g)(1) of this section on a daily basis at the beginning of each shift.

(ii) Data must be posted as follows:

(A) Clear and readable format.

(B) In a prominent place readily accessible to residents and visitors.

§483.35(g)(3) Public access to posted nurse staffing data. The facility must, upon oral or written request, make nurse staffing data available to the public for review at a cost not to exceed the community standard.

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§483.35(g)(4) Facility data retention requirements. The facility must maintain the posted daily nurse staffing data for a minimum of 18 months, or as required by State law, whichever is greater.

Staffing must include all nursing staff that are paid by the facility (including contract staff). The nursing home would not include in the posting staff paid for through other sources; examples include hospice staff covered by the hospice benefit, or individuals hired by families to provide companionship or assistance to a specific resident.

F741

§483.40(a) 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 §483.70(e). 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 §483.70(e),

INVESTIGATIVE PROTOCOL §483.40(a), (a)(1) & (a)(2)
Determination of Sufficient Staffing
One factor used to determine sufficiency of staff (including both quantity and competency of staff) is the facility's ability to provide needed care for residents as determined by resident assessments and individual care plans. A staffing deficiency must be supported by examples of care deficits caused by insufficient quantity or competency of staff. The surveyor's investigation will include whether inadequate quantity or competency of staff prevented residents from reaching the highest practicable level of well-being.

A deficiency of insufficient staffing is determined through observations, interviews, and/or record reviews. Information gathered through these sources will help the surveyor in determining non-compliance. Concerns such as expressions or indications of distress by residents or family members, residents living with mental, psychosocial, and/or substance use disorders who lack care plan interventions to address their individual needs, lack of resident engagement, and the incidence of elopement and resident altercations, can also offer insight into the sufficiency and competency of staff and the adequacy of training provided to them to care for residents with behavioral health needs.

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F801

§483.60(a) 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 §483.70(e)

This includes:

§483.60(a)(1) A qualified dietitian or other clinically qualified nutrition professional either full-time, part-time, or on a consultant basis. A qualified dietitian or other clinically qualified nutrition professional is one who—

(i) Holds a bachelor's or higher degree granted by a regionally accredited college or university in the United States (or an equivalent foreign degree) with completion of the academic requirements of a program in nutrition or dietetics accredited by an appropriate national accreditation organization recognized for this purpose.

(ii) Has completed at least 900 hours of supervised dietetics practice under the supervision of a registered dietitian or nutrition professional.

(iii) Is licensed or certified as a dietitian or nutrition professional by the State in which the services are performed. In a State that does not provide for licensure or certification, the individual will be deemed to have met this requirement if he or she is recognized as a "registered dietitian" by the Commission on Dietetic Registration or its successor organization, or meets the requirements of paragraphs (a)(1)(i) and (ii) of this section.

(iv) For dietitians hired or contracted with prior to November 28, 2016, meets these requirements no later than 5 years after November 28, 2016 or as required by state law.

§483.60(a)(2) If a qualified dietitian or other clinically qualified nutrition professional is not employed full-time, the facility must designate a person to serve as the director of food and nutrition services who—

(i) For designations prior to November 28, 2016, meets the following requirements no later than 5 years after November 28, 2016, or no later than 1 year after November 28, 2016 for designations after November 28, 2016, is:

(A) A certified dietary manager; or

(B) A certified food service manager; or

(C) Has similar national certification for food service management and safety from a national certifying body; or

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D) Has an associate's or higher degree in food service management or in hospitality, if the course study includes food service or restaurant management, from an accredited institution of higher learning; and

(ii) In States that have established standards for food service managers or dietary managers, meets State requirements for food service managers or dietary managers, and

(iii) Receives frequently scheduled consultations from a qualified dietitian or other clinically qualified nutrition professional.

F802

§483.60(a) 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 §483.70(e).

§483.60(a)(3) Support staff. The facility must provide sufficient support personnel to safely and effectively carry out the functions of the food and nutrition service.

§483.60(b) A member of the Food and Nutrition Services staff must participate on the interdisciplinary team as required in § 483.21(b)(2)(ii).

DEFINITION §483.60(a)(3)-(b) "**Sufficient support personnel**" means having enough dietary and food and nutrition staff to safely carry out all of the functions of the food and nutrition services. This does not include staff, such as licensed nurses, nurse aides or paid feeding assistants, involved in assisting residents with eating.

F850 §483.70(p) Social worker. *Any* facility with more than 120 beds must employ a qualified social worker on a full-time basis. A qualified social worker is:

§483.70(p)(1) An individual with *a minimum of* a bachelor's degree in social work or a bachelor's degree in a human services field including, but not limited to, sociology, *gerontology,* special education, rehabilitation counseling, and psychology; and

§483.70(p)(2) One year of supervised social work experience in a health care setting working directly with individuals.

GUIDANCE §483.70(p)
The regulations do not require a Social Worker when a facility has equal to or less than 120 beds.

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If the facility has more than 120 beds and its full-time social worker does not provide on-site coverage on a full-time basis determine how these services are provided to meet the individual needs of the resident whenever needed. If social services deficiencies are identified refer to §483.40(d), F745, regardless of the number of beds.

F851

§483.70(q) Mandatory submission of staffing information based on payroll data in a uniform format. Long-term care facilities must electronically submit to CMS complete and accurate direct care staffing information, including information for agency and contract staff, based on payroll and other verifiable and auditable data in a uniform format according to specifications established by CMS.

❖ F tags related to competency

F607 §483.12(b) The facility must develop and implement written policies and procedures that:
***§483.12(b)(1) P*rohibit *and prevent* abuse, neglect, *and exploitation* of residents and misappropriation of resident property,**

GUIDANCE
The facility must develop and implement policies and procedures that include the *following* seven components:

I. Screening:

In addition, a facility must develop and implement policies and procedures to prohibit and prevent both abuse and neglect. This would include screening prospective residents to determine whether the facility has the capability and capacity to provide the necessary care and services for each resident admitted to the facility. The facility's written procedures may include, but are not limited to:

- For prospective residents, reviewing:

o An assessment of the individual's functional and mood/behavioral status;
o Medical acuity; and
o Special needs (e.g., mechanical ventilation care, dialysis, hospice).

The facility can then determine whether – in consideration of current staffing patterns, staff qualifications, competency and knowledge, clinical resources, physical environment, and equipment-it can safely and competently provide the necessary care to meet the resident's needs.

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VII. Reporting/Response:
The facility must have written procedures that must include

- Taking all necessary actions as a result of the investigation, which may include, but are not limited to, the following:

    - Analyzing the occurrence(s) to determine why abuse, neglect, misappropriation of resident property or exploitation occurred, and what changes are needed to prevent further occurrences;
    - Defining how care provision will be changed and/or improved to protect residents receiving services;
    - Training of staff on changes made and demonstration of staff competency after training is implemented;

F689

§483.25(d) Accidents. The facility must ensure that – §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and

§483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents.

"Supervision/Adequate Supervision" refers to an intervention and means of mitigating the risk of an accident. Facilities are obligated to provide adequate supervision to prevent accidents. Adequate supervision is *determined by assessing the appropriate level and number of staff required, the competency and training of the staff, and the frequency of supervision needed. This determination is based on the* individual resident's assessed needs and identified hazards in the resident environment. Adequate supervision may vary from resident to resident and from time to time for the same resident.

A systematic approach *enables the facility to evaluate safety throughout its environment and among all staff, and make appropriate adjustments in training and competency testing as required*

Ongoing staff training, competencies and supervision, including how to approach a resident who may be agitated, combative, verbally or physically aggressive, or anxious, and how and when to obtain assistance in managing a resident with behavior symptoms

Factors that may influence a resident's risk of accident during transfer include staff availability, resident abilities, staff training and competency

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F694
§ 483.25(h) Parenteral Fluids. Parenteral fluids must be administered consistent with professional standards of practice and in accordance with physician orders, the comprehensive person-centered care plan, and the resident's goals and preferences.
Competency of staff to:
o Use infusion equipment;
o Accurately perform IV insertion, and maintain vascular access; and
o Assess for complications

F695
§483.25(i) Respiratory care, including tracheostomy care and tracheal suctioning. The facility must ensure that a resident who needs respiratory care, including tracheostomy care and tracheal suctioning, is provided such care, consistent with professional standards of practice, the comprehensive person-centered care plan, the residents' goals and preferences, and 483.65 of this subpart

Emergency care which includes staff training and competency for implementation of emergency interventions for, at a minimum, cardiac/respiratory complications, and include provision of appropriate equipment at the resident's bedside for immediate access, such as for unplanned extubation;

F698
§483.25(l) Dialysis. The facility must ensure that residents who require dialysis receive such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences.

Dialysis in a Nursing Home: Receive home hemodialysis (HHD) or peritoneal dialysis (PD) treatments in the nursing home, by trained and qualified staff who have received training and competency from the dialysis facility.
The dialysis facility is responsible for providing training and assuring the competency of staff or individuals that are allowed to initiate, access and discontinue dialysis treatments. The nursing home must maintain documentation of completion of training/competency for staff or other individuals providing the dialysis treatments.

F726
§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 §483.70(e).

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§483.35(a)(3) The facility must ensure that licensed nurses have the specific competencies and skill sets necessary to care for residents' needs, as identified through resident assessments, and described in the plan of care.

§483.35(a)(4) Providing care includes but is not limited to assessing, evaluating, planning and implementing resident care plans and responding to resident's needs.

§483.35(c) Proficiency of nurse aides. The facility must ensure that nurse aides are able to demonstrate competency in skills and techniques necessary to care for residents' needs, as identified through resident assessments, and described in the plan of care.

INTENT §483.3*5(a)(3)-(4),*(c)
To assure that *all* nursing staff possess *the competencies and skill sets necessary to provide nursing and related services* to meet the residents' needs *safely and in a* manner that promotes each resident's *rights,* physical, mental and psychosocial well-being.

All nursing staff must also meet the specific competency requirements as part of their license and certification requirements defined under State law or regulations.

Many factors must be considered when determining whether or not facility staff have the specific competencies and skill sets necessary to care for residents' needs, as identified through the facility assessment, resident-specific assessments, and described in their plan of care. A staff competency deficiency under this requirement may or may not be directly related to an adverse outcome to a resident's care or services. It may also include the **potential** for physical and psychosocial harm.

As required under F838, §483.70(e), the facility's assessment must address/include an evaluation of staff competencies that are necessary to provide the level and types of care needed for the resident population. Additionally, staff are expected to demonstrate competency with the activities listed in the training requirements per §483.95, such as preventing and reporting abuse, neglect, and exploitation, dementia management, and infection control. Also, nurse aides are expected to demonstrate competency with the activities and components that are required to be part of an approved nurse aide training and competency evaluation program, per §483.152.

Staff Competencies in Identifying Changes in Condition
A key component of competency is a nurse's (CNA, LPN, RN) ability to identify and address a resident's change in condition. Facility staff should be aware of each resident's current health status and regular activity, and be able to promptly identify changes that may indicate a change in health status. Once identified, staff should demonstrate effective actions to address a change in condition, which may vary depending on the staff who is involved. For example, a CNA who identifies a change in condition may document the change on a short form and report it to the RN manager. Whereas an RN who is informed of a change in condition may conduct an in-depth assessment, and then call the attending practitioner.

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These competencies are critical in order to identify potential issues early, so interventions can be applied to prevent a condition from worsening or becoming acute. Without these competencies, residents may experience a decline in health status, function, or need to be transferred to a hospital. Not all conditions, declines of health status, or hospitalizations are preventable.

Demonstration of Competency

Competency may not be demonstrated simply by documenting that staff attended a training, listened to a lecture, or watched a video. A staff's ability to use and integrate the knowledge and skills that were the subject of the training, lecture or video must be assessed and evaluated by staff already determined to be competent in these skill areas.

Examples for evaluating competencies may include but are not limited to:

- Lecture with return demonstration for physical activities;
- A pre-and post-test for documentation issues;
- Demonstrated ability to use tools, devices, or equipment that were the subject of training and used to care for residents;
- Reviewing adverse events that occurred as an indication of gaps in competency; or
- Demonstrated ability to perform activities that is in the scope of practice an individual is licensed or certified to perform.

Nursing leadership with input from the Medical Director should delineate the competencies required for all nursing staff to deliver, individualize, and provide safe care for the facility's residents. There should also be a process to evaluate staff skill levels, and to develop individualized competency-based training, that ensure resident safety and quality of care and service being delivered. A competency-based program might include the following elements:

a. Evaluates current staff training programming to ensure nursing competencies (e.g. skills fairs, training topics, return demonstration).

b. Identifies gaps in education that is contributing to poor outcomes (e.g. potentially preventable re-hospitalization) and recommends educational programing to address these gaps.

c. Outlines what education is needed based on the resident population (e.g. geriatric assessment, mental health needs) with delineation of licensed nursing staff verses non-licensed nursing and other staff member of the facility.

d. Delineates what specific training is needed based on the facility assessment (e.g. ventilator, IV's, trachs).

e. Details the tracking system or mechanism in place to ensure that the competency-based staffing model is assessing, planning, implementing, and evaluating effectiveness of training.

f. Ensures that competency-based training is not limited to online computer based but should also test for critical thinking skills as well as the ability to manage care in complex environments with multiple interruptions.

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***§483.35(d) Requirement for facility hiring and use of nurse aides*§483.*35*(*d*)(*1)* General rule. A facility must not use any individual working in the facility as a nurse aide for more than 4 months, on a full-time basis, unless—**

(i) That individual is competent to provide nursing and nursing related services; and

(ii)(A) That individual has completed a training and competency evaluation program, or a competency evaluation program approved by the State as meeting the requirements of §483.151 through §483.154; or

(B) That individual has been deemed or determined competent as provided in §483.150(a) and (b).

§483.*35(d)(2)* Non-permanent employees. A facility must not use on a temporary, per diem, leased, or any basis other than a permanent employee any individual who does not meet the requirements in paragraphs (d)(1)(i) and (ii) of this section.

§483.*35*(*d*)(*3*) *Minimum* Competency A facility must not use any individual who has worked less than 4 months as a nurse aide in that facility unless the individual—
(i) Is a full-time employee in a State-approved training and competency evaluation program;
(ii) Has demonstrated competence through satisfactory participation in a State-approved nurse aide training and competency evaluation program or competency evaluation program; or
(iii) Has been deemed or determined competent as provided in §483.150(a) and (b).

F729

§483.*35*(*d*)(*4*) Registry verification. Before allowing an individual to serve as a nurse aide, a facility must receive registry verification that the individual has met competency evaluation requirements unless—

(i) The individual is a full-time employee in a training and competency evaluation program approved by the State; or

(ii)The individual can prove that he or she has recently successfully completed a training and competency evaluation program or competency evaluation program approved by the State and has not yet been included in the registry. Facilities must follow up to ensure that such an individual actually becomes registered.

§483.*35*(*d*)*(5*) Multi-State registry verification. Before allowing an individual to serve as a nurse aide, a facility must seek information from every State registry established under sections 1819(e)(2)(A) or 1919(e)(2)(A) of the Act *that* the facility believes will include information on the individual.

§483.*35*(*d*)(*6*) Required retraining. If, since an individual's most recent completion of a training and competency evaluation program, there has been a continuous period of 24 consecutive months during none of which the individual provided nursing or nursing-related services for monetary compensation, the individual must complete a new training and competency evaluation program or a new competency evaluation program.

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F741

§483.40(a) 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 §483.70(e). 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 §483.70(e), and

§483.40(a)(2) Implementing non-pharmacological interventions.

Skill and Competency of Staff

The facility must identify the skills and competencies needed by staff to work effectively with residents (both with and without mental disorders and psychosocial disorders). Staff need to be knowledgeable about implementing non-pharmacological interventions. The skills and competencies needed to care for residents should be identified through an evidence-based process that could include the following: an analysis of Minimum Data Set (MDS) data, review of quality improvement data, resident-specific and population needs, review of literature, applicable regulations, etc. Once identified, staff must be aware of those disease processes that are relevant to enhance psychological and emotional well-being. Competency is established by observing the staff's ability to use this knowledge through the demonstration of skill and the implementation of specific, person-centered interventions identified in the care plan to meet residents' behavioral health care needs. Additionally, competency involves staff's ability to communicate and interact with residents in a way that promotes psychosocial and emotional well-being, as well as meaningful engagements.

Under §483.152 Requirements for approval of a nurse aide training and competency evaluation program, nurse aides are required to complete and provide documentation of training that includes, but is not limited to, competencies in areas such as:

- Communication and interpersonal skills;
- Promoting residents' independence;
- Respecting residents' rights;
- Caring for the residents' environment;
- Mental health and social service needs; and
- Care of cognitively impaired residents.

In phases one and two of implementation of the Reform of Requirements for Long-term Care Facilities, it is the expectation that all facility staff members, including non-nurse aide staff, assisting

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residents living with behavioral health needs, be competent in care areas, such as those mentioned previously.

F755

§483.*45* Pharmacy Services The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.*70*(*g*). The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse.

§483.*45*(a) Procedures. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident.

- Develop intravenous (IV) therapy procedures if used within the facility (consistent with state requirements) which may include: determining competency of staff and facility-based IV admixture procedures that address sterile compounding, dosage calculations, IV pump use, and flushing procedures;

F826
§483.65(b) Qualifications Specialized rehabilitative services must be provided under the written order of a physician by qualified personnel.

In addition to meeting the specific competency requirements as part of their license and certification requirements defined under State law or regulations, these personnel must have the training, competencies and skill sets to care for residents as identified through resident assessments, and described in the plan of care.

F880 §483.*80* Infection Control The facility must establish and maintain an infection *prevention and* control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of *communicable* diseases and infections.

§483.*80(a)* Infection *prevention and* control program.

Education and competency assessment: facilities must ensure staff follow the IPCP's standards, policies and procedures. Therefore, staff must be informed and competent. Knowledge and skills pertaining to the IPCP's standards, policies and procedures are needed by all staff in order to follow proper infection control practices (e.g., hand hygiene and appropriate use of personal protective equipment) while other needs are specific to particular roles, responsibilities, and situations (e.g., injection safety and point of care testing)

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SYSTEM OF SURVEILLANCE: DATA ANALYSIS, DOCUMENTATION AND REPORTING

How the data will be used and shared with appropriate individuals (e.g., staff, medical director, director of nursing, quality assessment and assurance committee-QAA), when applicable, to ensure that staff minimize spread of the infection or disease (e.g., require revision of staff education and competency assessment).

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References

State Operations Manual (SOM) Appendix PP for Phase 2, F-Tag Revisions, and Related Issues
www.cms.gov/Medicare/Provider-Enrollment-and-Certification/GuidanceforLawsAndRegulations/Downloads/Advance-Appendix-PP-Including-Phase-2-.pdf

Long Term Care Facility Resident Assessment Instrument 3.0 User's Manual version 1.14

https://downloads.cms.gov/files/MDS-30-RAI-Manual-V114-October-2016.pdf

MDS 3.0 Quality Measure User's Manual version 11

www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/NursingHomeQualityInits/Downloads/MDS-30-QM-Users-Manual-V11-Final.pdf

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Data Collection Tools and/or Resources

The following Tools and Resources are included in this Section of **The RoP Facility Assessment Toolkit ©**

This section of the Toolkit offers multiple samples of tools for facility use to evaluate staffing and staff competencies.

Item	Description	Source *(If Applicable)*
Comprehensive Facility Personnel Resources Workbook	Sample Template – This tool assists individual facility to review their personnel resources across departments with acuity considerations and other considerations in correlation with the Facility Assessment requirements	Pathway Health
Facility Personnel – Non Detailed	Sample Template – This tool assists the facility in identifying current personnel resources	Pathway Health
EXAMPLE Staffing Analysis Tool	A Template for the facility to conduct an analysis of the staffing model	Pathway Health
Nutrition Services Personnel Workbook	Sample – Streamlined tool to evaluate nutrition services resources	Pathway Health
Facility Assessment Staffing Tool to Meet Resident Needs	Sample Template – this tool is one component of the Comprehensive Facility Personnel Resources Workbook	Pathway Health
Licensed Nurse Competency Template	Sample Template – For Licensed Nurse Competency – Customizable	Pathway Health
CMS 671	CMS 671 Form and Directions – utilized by the facility to evaluate the resident population and align resources accordingly	CMS. (2002). Long Term Care Facility Application for Medicare and Medicaid. Retrieved August, 2017, from https://www.cms.gov/Medicare/CMS-Forms/CMS-Forms/Downloads/CMS671.pdf
CMS-20062 Sufficient and Competent Staff	CMS - Sufficient and Competent Nurse Staffing Review Tool used during survey process.	Critical Element (CE) Pathways and Facility Tasks https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/GuidanceforLawsAndRegulations/Downloads/LTC-Survey-Pathways.zip

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Return Demonstration - PeriCare	Sample Template of a return demonstration checklist for competency evaluation	Pathway Health
Facility Assessment Summary Worksheets	Tools to be utilized by team members upon the completion of data collection to determine trends and improvement opportunities. Finalization of information to enter into the facility assessment template	Pathway Health

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The information entered in italics are examples

PBJ Job Category

Administrator

Medical Director

Other Physician

Physician Assistant

Registered Nurse Director of Nursing

RN with Administrative Duties

Registered Nurse

LPN/LVN with Administrative Duties

Licensed Practical/Vocational Nurse

Certified Nurse Aide

Nurse Aide in Training

Medication Aide/Technician

Nurse Practitioner

Clinical Nurse Specialist

Pharmacist

Dietitian

Paid Feeding Assistant

Occupational Therapist

Occupational Therapy Assistant

Occupational Therapy Aide

Physical Therapist

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Physical Therapy Assistant

Physical Therapy Aide

Respiratory Therapist

Respiratory Therapy Technician

Speech/Language Pathologist

Therapeutic Recreation Specialist

Qualified Activities Professional

Other Activities Staff

Qualified Social Worker

Other Social Worker

Dentist

Podiatrist

Mental Health Service Worker

Vocational Service Worker

Clinical Laboratory Service Worker

Diagnostic X-ray Service Worker

Blood Service Worker

Housekeeping Service Worker

Other Service Worker

Dietary Services Workers

Volunteer Director or Manager

Volunteer

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List facility job description titles counted in this category *(EXAMPLES)*	**# FTE worked** (# hrs worked in 1 year/2080)	**Required Credentials State or organization** *(EXAMPLES)*
Administrator		
Assistant Administrator	*2.0*	*Licensed in state*
LTC Medical Director		*MD license in the state*
TCU Medical Director	*0.8*	*Board certified Gerontology*
Wound Care Consultant	*1.0*	*MD or DO license in the state*
Urology PA	*0.2*	*PA*
Director of Clinical Services	*1.0*	*Registered Nursing in the State*
MDS Coordinator		
Infection Preventionist	*2.5*	*RN*

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Required Education
State or organization *(EXAMPLES)*

BA in Healthcare Administration

Medical education as accepted for licensure in the state
Medical education as accepted for licensure in the state
Successful completion of PA course in the state

BSN

RAC-CT for MDS
Infection Control Education for Infection Preventionist

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PBJ Job Category
Administrator
Medical Director
Other Physician
Physician Assistant
Registered Nurse Director of Nursing
Registered Nurse with Administrative Duties
Registered Nurse
Licensed Practical/Vocational Nurse with Administrative Duties
Licensed Practical/Vocational Nurse
Certified Nurse Aide
Nurse Aide in Training
Medication Aide/Technician
Nurse Practitioner
Clinical Nurse Specialist
Pharmacist
Dietitian

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Paid Feeding Assistant
Occupational Therapist
Occupational Therapy Assistant
Occupational Therapy Aide
Physical Therapist
Physical Therapy Assistant
Physical Therapy Aide
Respiratory Therapist
Respiratory Therapy Technician
Speech/Language Pathologist
Therapeutic Recreation Specialist
Qualified Activities Professional
Other Activities Staff
Qualified Social Worker
Other Social Worker
Dentist
Podiatrist

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Mental Health Service Worker
Vocational Service Worker
Clinical Laboratory Service Worker
Diagnostic X-ray Service Worker
Blood Service Worker
Housekeeping Service Worker
Other Service Worker
Categories below are not defined by PBJ
Dietary Services Workers
Volunteer Director or Manager
Volunteer

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PBJ Job Category Description
Administrative staff responsible for facility management as required under 483.75(d) such as the administrator and the assistant administrator.
A physician designated as responsible for implementation of resident care policies and coordination of medical care in the facility in accordance with 483.75(i).
A salaried physician, other than the medical director, who supervises the care of residents when the attending physician is unavailable, and/or a physician(s) available to provide emergency services 24 hours a day.
A graduate of an accredited educational program for physician assistants who provides healthcare services typically performed by a physician, under the supervision of a physician.
Professional registered nurse(s) administratively responsible for managing and supervising nursing services within the facility. Do not additionally reflect these hours in any other category.
Nurses (RN) who, as either a facility employee or contractor, perform the Resident Assessment Instrument function in the facility and do not perform direct care functions. Also include other RNs whose principal duties are spent conducting administrative functions. For example, the Assistant
Those persons licensed to practice as registered nurses in the State where the facility is located. Includes geriatric nurse practitioners and clinical nurse specialists who primarily perform nursing, not physician-delegated tasks. Do not include Registered Nurses' hours reported elsewhere.
Those persons licensed to practice as licensed practical/vocational nurses in the State where the facility is located, and do not perform direct care functions. Also include other nurses whose principal duties are spent conducting administrative functions. For example, the LPN Charge Nurse is conducting
Those persons licensed to practice as licensed practical/vocational nurses in the State where the facility is located. Do not include those hours of LPN/LVNs reported elsewhere.
Individuals who have completed a State approved training and competency evaluation program, or competency evaluation program approved by the State, or have been determined competent as provided in 483.150 and who are providing nursing or nursing-related services to residents. Do not
Individuals who are in the first 4 months of employment and who are receiving training in a State approved Nurse Aide training and competency evaluation program and are providing nursing or nursing-related services for which they have been trained and are under the supervision of a licensed or registered nurse. Do not include volunteers.
Individuals, other than a licensed professional, who fulfill the State requirement for approval to administer medications to residents.
A registered nurse with specialized graduate education who is licensed by the state to diagnose and treat illness, independently or as part of a healthcare team.
A registered nurse with specialized graduate education who provides advanced nursing care.
The licensed pharmacist(s) who a facility is required to use for various purposes, including providing consultation on pharmacy services, establishing a system of records of controlled drugs, overseeing records and reconciling controlled drugs, and/or performing a monthly drug regimen review for each resident.
A person(s), employed full, part-time or on a consultant basis, who is either registered by the Commission of Dietetic Registration of the American Dietetic Association, or is qualified to be a dietitian on the basis of experience in identification of dietary needs, planning and implementation of dietary programs.

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Person who meets the requirements specified in C.F.R. Section 483.35(h)(2) and who is paid to feed residents by a facility, or who is used under an arrangement with another agency or organization. Paid feeding assistants can only feed residents who do not have complicated feeding problems that would require the training of a nurse or nurse aide. Paid feeding assistants must not feed any residents with complicated feeding problems or perform any other nursing or nursing related tasks.
Persons licensed/registered as occupational therapists according to State law in the State in which the facility is located. Include OTs who spend less than 50 percent of their time as activities therapists.
Person(s) who, in accord with State law, have licenses/certification and specialized training to assist a licensed/certified/registered Occupational Therapist (OT) to carry out the OT's comprehensive plan of care, without the direct supervision of the therapist. Include OT Assistants who spend less than 50 percent of their time as Activities Therapists.
Person(s) who have specialized training to assist an OT to carry out the OT's comprehensive plan of care under the direct supervision of the therapist, in accord with State law.
Persons licensed/registered as physical therapists, according to State law where the facility is located.
Person(s) who, in accord with State law, have licenses/certification and specialized training to assist a licensed/certified/registered Physical Therapist (PT) to carry out the PT's comprehensive plan of care, without the direct supervision of the PT.
Person(s) who have specialized training to assist a PT to carry out the PT's comprehensive plan of care under the direct supervision of the therapist, in accordance with State law.
Persons(s) who are licensed under state law (except in Alaska) as Respiratory Therapist
Person(s) who provide respiratory care under the direction of respiratory therapists and physicians
Persons licensed/registered, according to State law where the facility is located, to provide speech therapy and related services (e.g., teaching a resident to swallow).
Person(s) who, in accordance with State law, are licensed/registered and are eligible for certification as a therapeutic recreation specialist by a recognized accrediting body.
Person(s) who meet the definition of activities professional at 483.15(f)(2)(i)(A) and (B) of 483.15(f)(2)(ii) or (iii) or (iv) and who are providing an on-going program of activities designed to meet residents' interests and physical, mental or psychosocial needs. Do not include hours reported as Therapeutic Recreation Specialist, Occupational Therapist, OT Assistant, or other categories listed.
Persons providing an on-going program of activities designed to meet residents' needs and interests. Do not include volunteers or hours reported elsewhere.
Person licensed to practice social work in the State where the facility is located, or if licensure is not required, persons with a bachelor's degree in social work, a bachelor's degree in a human services field including but not limited to sociology, special education, rehabilitation counseling and psychology, and one year of supervised social work experience in a health care setting working directly with elderly
Person(s) other than the qualified social worker who are involved in providing medical social services to residents. Do not include volunteers.
Persons licensed as dentists, according to State law where the facility is located, to provide routine and emergency dental services.
Persons licensed/registered as podiatrists, according to State law where the facility is located, to provide podiatric care.

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Staff (excluding those included under therapeutic services) who provide programs of services targeted to residents' mental, emotional, psychological, or psychiatric well-being and which are intended to: • Diagnose, describe, or evaluate a resident's mental or emotional status; • Prevent deviations from mental or emotional well-being from developing; or • Treat the resident according to a planned regimen to assist him/her in regaining, maintaining, or increasing emotional abilities to function. Among the specific services included are psychotherapy and counseling, and administration and
Evaluation and training aimed at assisting the resident to enter, re-enter, or maintain employment in the labor force, including training for jobs in integrated settings (i.e., those which have both disabled and nondisabled workers) as well as in special settings such as sheltered workshops.
Entities that provide laboratory services and are approved by Medicare as independent laboratories or hospitals.
Radiology services, ordered by a physician, for diagnosis of a disease or other medical condition.
Blood bank and transfusion services.
Services, including those of the maintenance department, necessary to maintain the environment. Includes equipment kept in a clean, safe, functioning and sanitary condition. Includes housekeeping
Record total hours worked for all personnel not already recorded (For example, librarian).
Staff who order, receive, prepare and serve food for residents and those who clean the kitchen areas and dining and cooking equipment, utensils, pans, dishware, etc.
Persons that manages and supervises the activities and scheduling of volunteers who provide unpaid services to the residents
Persons that provide unpaid services to the residents

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Facilities with an RN waiver who do not have an RN as DON report all administrative nursing hours in this category.

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Level I - Basic - *EXAMPLES*

All facility personnel

Abuse, neglect, exploitation and misappropriate of resident property
Dementia management
Infection Control
QAPI
OSHA Hazard communication
Emergency Response

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Level II - *EXAMPLES*

Those working in resident care areas

Level I plus

Communication

Fall Prevention

Operation of exit alarms

Transmission-based precautions

Reporting changes in residents conditions

Job specific competencies

Competencies identified by the assessment of residents' needs.

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Level III - EXAMPLES

Direct Care Givers

Level I plus

Level II plus

- Person centered care
- Communication
- Basic nursing skills
- Basic restorative services
- Skin and wound care
- Medication management
- Pain management
- Additional Infection control topics
- Identification of changes in condition
- Cultural competency
- Specific care skills from the Facility Assessment

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Level IV - EXAMPLES

Licensed Staff

Level I

Level II

Level III Plus

- Job specific evaluation and assessment skills
- Documentation
- Care plan development
- Specific care skills from the Facility Assessment

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Level V - EXAMPLES
Supervisors and Department Heads
Level I
Level II
Level III
Level IV Plus
Delegation
Effective communication for supervisors
Task specific competencies, e.g. infection data collection
Human Resources policies and procedures
Develop and utilize competencies
Effective staff performance evaluation

Level VI -EXAMPLES
Facility-Wide Responsibilites
Level I
Level II
Level III
Level IV
Level V Plus
Federal nursing home regulation
Nursing home survey process
Budgeting
Data collection, interpretation a
Policy and procedure developme
Role specific knowledge and skill

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Resident care need	Average % residents
Communication and Cognition	
Communication device	
Dependent for daily decision-making	
Behaviors that affect others	
Wandering or exit seeking behaviors	
ADLs	
Totally dependent for bathing, grooming and dressing	
Totally dependent for transfers	
Totally dependent for other mobility	
Totally dependent for eating	
Totally dependent for toileting or incontinence care	
Totally independent for bathing, grooming and dressing	
Totally independent for transfers	
Totally independent for other mobility	
Totally independent for eating	
Totally independent for toileting or incontinence care	
Toileting program	
Pressure ulcer/injury prevention	
ADLs for residents with transmission-based precautions	
Restorative Nursing programs (incl. braces, splints and prostheses)	
Indwelling catheter care	
Care Requiring assessment/Evaluation	
Symptom management for end of life care	

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Admission assessments	
Assessment for change in condition	
Scheduled re-evaluations	
Condition specific assessment and treatment	
Assessment and management of skin impairment	
Care and Treatments	
Blood sugar testing and management	
Indwelling catheter	
Feeding tube for more than 50% of their calorie intake	
Pphysically restrained for some part of the day or night	
Current pressure ulcer	
Resident-specific preventive skin program	
Dialysis in the facility	
Dialysis outside the facility	
Chemotherapy outside the facility	
Radiation therapy outside the facility	
Tracheostomy care	
Ventilator	
Other respiratory care	
Ostomy care	
Clean dressing changes	
Aseptic dressing changes	
PRN analgesics and non-pharmacologic pain management interventions	
Respiratory therapy, suctioning or respiratory treatments from a licensed nurse	
Medication by injection at least once per week	
IV hydration or medication at least once per day	
Anticoagulant medication	
Psychoactive (antipsychotic, antianxiety, hypnotic) medication	
Average monthly UTI rate	
Average monthly GI infection rate	
Average monthly respiratory infection rate	
Average monthly skin infection rate	
Average monthly eye infection rate	

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Average monthly ear infection rate	
Average number of transmission-based precautions above standard precautions	
Chosen to receive CPR, if needed (Full Code)	
Other	
Other	
Other	

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Appropriate position or role RN – Registered Nurse LPN/LVN – Licensed Practical/Vocation Nurse CNA - Certified Nursing Assistant VOL - Volunteer PFA - Paid Feeding Assistant TMA- Trained medication aide OT-Occupational Therapist PT- Physical Therapist ST –Speech Language Pathologist	# FTE needed	Type of competency* documentation needed RD - Knowledge & Return demo KT - Knowledge & test OA -Knowledge &Observed ability OB - Knowledge &Observed behavior PR - Knowledge & Performance review

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FACILITY PERSONNEL

Managers, employees, contract staff, volunteers

Name	Position	Credentials	Education	Training and Competencies related to resident care
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(EXAMPLE) Workforce Planning - Staffing Analysis

Date: _____

Facility Name:_____

Total # of beds:
Beds STR/TCU/Rehab:
Beds MC/Dementia:
Beds CC/LTC:

Attendance
Call ins per day:
Call ins per week:
Call ins per month:

Hours Per Day	***Nursing Department Hours***
CNA/NAR:	Director of Nursing:
TMA:	Clinical Resource Nurse:
LPN:	Education:
RN:	Nurse Manager:
Total:	MDS Coordinator:
Do staff work a 7.5 or 8 hour day?	Restorative Nurse:
	RN:
	LPN:
	TMA:
	CNA/NAR:
	HIM/MedRec:
	Staffing:
	CSR:
	Admin Asst:

Name of Unit/Hall/Household	
A.	# Beds:
B.	# Beds:
C.	# Beds:
D.	# Beds:

Agency Staff per day
CNA/NAR:
TMA:
LPN:
RN:

Number of FT staff:

Number of PT staff:

Nursing Hours by Shift				***Total $***
CNA/NAR	Days:	PMs:	NOCs:	
TMA	Days:	PMs:	NOCs:	
LPN	Days:	PMs:	NOCs:	
RN	Days:	PMs:	NOCs:	

What is your PPD for NPH? $_____

What is your cost per patient day for nursing? $ _____

What is your budgeted PPD for nursing? $_____

Are there short shifts / partial shifts? If yes, what are they?

What are the shift start and end times? Are there different start/end times?	
A. 6-2:30 nsg asst	E. 7-3:30 nurse
B. 2-10:30 nsg asst	F. 3-11:30 nurse
C. 10-6:30 nsg asst	G. 11-7:30 nurse
D. 11-2 nsg asst (short shift)	H. 4-9 nsg asst (short shift)

Admissions:	***Discharges:***	***Restorative Aide:***
Monthly:	Monthly:	
Weekly:	Weekly:	

Ratios of staff to residents:	
Nursing Assistants:	**Nurses:**
Days:	Days:
PM's:	PM's:
NOC's:	NOC's:

PNH:
Daily Productive Nursing Hours:
with restorative aide:

Documents requested: 1) 7 daily staffing patterns 2) master schedule 3) attendance policy 4) Absenteeism for last six months (monthly)

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Nutrition Services Workforce Planning Review

Shift start and end times			
	Day	Afternoon	Evening
Cook			
Aide			
Dish			
Other			
Dietitian			
Diet Tech			
Director			
Asst. Director			

Hours scheduled per day by shift				
	Day	Afternoon	Evening	Total
Cook				
Aide				
Dish				
Other				
Dietitian				
Diet Tech				
Director				
Asst. Director				
			Total	

Additional Information:

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Date:

Dining Rooms	
A.	# Residents
B.	# Residents
C.	# Residents
D.	# Residents

Number of Kitchens:
Number of Kitchenettes:
Scratch vs prepared food:
Ethnic foods prepared:
Special diets prepared:
# of room trays:
Type of service: steam table or trayline:

Budgeted PPD for dietary: $
Actual PPD for dietary: $
Cost per meal: $
Cost per patient day: $

Tube Feeding:
Mechanically Altered Diets:
Thickened Liquids:
Other:

Total # of beds:
Beds STR/TCU/Rehab:
Beds MC/Dementia:
Beds CC/LTC:

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STAFFING TO MEET RESIDENTS NEEDS

Document the average number of residents in the last year with these care needs, based on CMS 672, CMS 802 and _____ reports.

Resident care need	Average # residents / year	Appropriate position or role **RN** – Registered Nurse **LPN/LVN** – Licensed Practical/Vocation Nurse **CNA** - Certified Nursing Assistant **VOL** - Volunteer **PFA** - Paid Feeding Assistant **TMA**- Trained medication aide	# needed AM shift PM shift NOC shift	Type of competency* documentation needed **RD** - Return demo **KT -** Knowledge test **OA** - Observed ability **OB** - Observed behavior **PR** - Performance review *see page 3 for CMS definitions
EXAMPLE **Transfer with staff assist**	**30**	**CNA** LPN & CNA on noc shift	**AM shift 3-4** **PM shift 3-4** **Noc shift 2**	**OA, PR,** **RD for lifts and resident specific interventions**
ADLs				
Transfer with staff assist			AM shift PM shift Noc shift	
Staff assist for eating			AM shift PM shift Noc shift	
Bed Mobility with staff assist			AM shift PM shift Noc shift	
Incontinence care			AM shift PM shift Noc shift	
Toileting program			AM shift PM shift Noc shift	
Ambulation with staff assist			AM shift PM shift Noc shift	
Behavior monitoring and documentation			AM shift PM shift Noc shift	
Pressure ulcer/injury prevention			AM shift PM shift Noc shift	
ADLs for residents with transmission-based precautions			AM shift PM shift Noc shift	
Restorative Nursing programs (incl. braces, splints and prostheses)			AM shift PM shift Noc shift	
Indwelling catheter care			AM shift PM shift Noc shift	

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Resident care need	Average # residents / year	Appropriate position or role **RN** – Registered Nurse **LPN/LVN** – Licensed Practical/Vocation Nurse **CNA** - Certified Nursing Assistant **VOL** - Volunteer **PFA** - Paid Feeding Assistant **TMA**- Trained medication aide	# needed AM shift PM shift NOC shift	Type of competency* documentation needed **RD** - Return demo **KT -** Knowledge test **OA** - Observed ability **OB** - Observed behavior **PR** - Performance review *see page 3 for CMS definitions
Care involving evaluation and assessment				
Symptom management for end of life care			AM shift PM shift Noc shift	
Post - dialysis care			AM shift PM shift Noc shift	
Post – radiation care			AM shift PM shift Noc shift	
Post - chemotherapy care			AM shift PM shift Noc shift	
Admission assessments			AM shift PM shift Noc shift	
Assessment for change in condition			AM shift PM shift Noc shift	
Scheduled re-evaluations			AM shift PM shift Noc shift	
Condition specific assessment and treatment			AM shift PM shift Noc shift	
Assessment and management of skin impairment			AM shift PM shift Noc shift	
Care and Treatments				
Blood sugar testing and management			AM shift PM shift Noc shift	
Dressing changes and wound management			AM shift PM shift Noc shif	
Trach care			AM shift PM shift Noc shift	

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Suctioning			AM shift PM shift Noc shift	
Other respiratory treatments			AM shift PM shift Noc shift	
IV therapy, parenteral nutrition			AM shift PM shift Noc shift	
Tube feedings and management NG, GT, J/G-tube			AM shift PM shift Noc shift	
Ostomy care			AM shift PM shift Noc shift	
Routine Medication administration			AM shift PM shift Noc shift	
PRN medication administration			AM shift PM shift Noc shift	
Injections			AM shift PM shift Noc shift	
Topical Treatment administration			AM shift PM shift Noc shift	
Other			AM shift PM shift Noc shift	
Other			AM shift PM shift Noc shift	
Other			AM shift PM shift Noc shift	

Competency – measureable pattern of knowledge, skills, abilities, behaviors and other characteristics needed to perform the role or occupational function. This is not dependent solely upon qualifications or licensure.
Examples include lecture with return demonstration for physical tasks or activities, the ability to use tools, devices and equipment, an evaluation of adverse events to identify competency gaps and demonstrated ability.

CMS Surveyor Training: https://surveyortraining.cms.hhs.gov/pubs/ClassInformation.aspx?cid=0CMSLTCSME_VID

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LICENSED NURSE COMPETENCY ASSESSMENT

Name: _____ Job Title: _____ Date of Hire _____

Assessment of competency for the following policy and procedure:

Competency Statement:
Licensed nurses will display consistent competency proficiency when providing care and services to residents and managing the residents' care processes**.**

Instructions:
Nurse: Complete the self-assessment portion of this document using the key for each step of the procedure.
Evaluator: Complete the Evaluator's Assessment portion of this document using the key for each step of the procedure. Collaborate with the nurse to describe an improvement or knowledge plan, as needed, based on the assessment.

Assessment Key:	**Method of Evaluation:**	**Learning Resources**
1- Needs skills Improvement 2- Needs increased knowledge 3 - Can perform competently 3 - Can perform independently and evaluate others	SA – Self assessment S- Simulation DO- Direct Observation RD- Return demonstration KT– Knowledge Test	☐ Observed peer mentor ☐ Computer-based learning and test ☐ Formal class ☐ Other:

Performance Criteria *Document the steps of the facility procedure here*	**Self-Assessment** **Use Assessment Key (See legend)** **Add comments as needed**			**Evaluator's Assessment** **Use Assessment Key (See legend)** **Add comments as needed**		
Procedure steps	Method Code	Assessment Key	Comment	*Method Code*	*Assessment Key*	*Comment*
1.						
2.						
3.						
4.						
5.						
6.						
7.						
8.						
9.						
10.						
11.						
12.						
13.						
14.						
15.						
16.						
17.						
18.						
19.						
20.						

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Performance Criteria *Document the steps of the facility procedure here*	**Self-Assessment** **Use Assessment Key (See legend)** **Add comments as needed**			**Evaluator's Assessment** **Use Assessment Key (See legend)** **Add comments as needed**		
Procedure steps	Method Code	Assessment Key	Comment	*Method Code*	*Assessment Key*	*Comment*
21.						
22.						
23.						
24.						
25.						

Employee signature **date**
Both sign here when employee meets competency

Evaluator signature **date**

☐ **Competency Met**

☐ **Knowledge Plan –** see below **Knowledge Plan completed on** _____ ☐ **Competency Met after knowledge plan completed** ***(Sign above)***

☐ **Improvement Plan** - see below **Improvement Plan completed on** _____ ☐ **Competency Met after improvement plan completed** ***(Sign above)***

Knowledge or Improvement Plan Steps Initiated on ***(date)***	**Resources**	**Target date for completion**

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LONG TERM CARE FACILITY APPLICATION FOR MEDICARE AND MEDICAID

Standard Survey
From: F1 ☐☐ ☐☐ ☐☐ To: F2 ☐☐ ☐☐ ☐☐
MM DD YY MM DD YY

Extended Survey
From: F3 ☐☐ ☐☐ ☐☐ To: F4 ☐☐ ☐☐ ☐☐
MM DD YY MM DD YY

Name of Facility	Provider Number	Fiscal Year Ending: F5 ☐☐ ☐☐ ☐☐ MM DD YY

Street Address	City	County	State	Zip Code

Telephone Number: F6	State/County Code: F7	State/Region Code: F8

A. F9 ☐☐

01 Skilled Nursing Facility (SNF) - Medicare Participation
02 Nursing Facility (NF) - Medicaid Participation
03 SNF/NF - Medicare/Medicaid

B. Is this facility hospital based? F10 Yes ☐ No ☐

If yes, indicate Hospital Provider Number: F11 ☐☐☐☐☐☐

Ownership: F12 ☐☐

For Profit	**NonProfit**	**Government**	
01 Individual	04 Church Related	07 State	10 City/County
02 Partnership	05 Nonprofit Corporation	08 County	11 Hospital District
03 Corporation	06 Other Nonprofit	09 City	12 Federal

Owned or leased by Multi-Facility Organization: F13 Yes ☐ No ☐

Name of Multi-Facility Organization: F14

Dedicated Special Care Units (show number of beds for all that apply)

F15 ☐☐☐ AIDS
F16 ☐☐☐ Alzheimer's Disease
F17 ☐☐☐ Dialysis
F18 ☐☐☐ Disabled Children/Young Adults
F19 ☐☐☐ Head Trauma
F20 ☐☐☐ Hospice
F21 ☐☐☐ Huntington's Disease
F22 ☐☐☐ Ventilator/Respiratory Care
F23 ☐☐☐ Other Specialized Rehabilitation

Does the facility currently have an organized residents group?	F24	Yes ☐	No ☐
Does the facility currently have an organized group of family members of residents?	F25	Yes ☐	No ☐
Does the facility conduct experimental research?	F26	Yes ☐	No ☐
Is the facility part of a continuing care retirement community (CCRC)?	F27	Yes ☐	No ☐

If the facility currently has a staffing waiver, indicate the type(s) of waiver(s) by writing in the date(s) of last approval. Indicate the number of hours waived for each type of waiver granted. If the facility does not have a waiver, write NA in the blanks.

Waiver of seven day RN requirement. Date: F28 ☐☐ ☐☐ ☐☐ Hours waived per week: F29_____
Waiver of 24 hr licensed nursing requirement. Date: F30 ☐☐ ☐☐ ☐☐ Hours waived per week: F31_____
MM DD YY

Does the facility currently have an approved Nurse Aide Training and Competency Evaluation Program? F32 Yes ☐ No ☐

FACILITY STAFFING

		A			B					C					D				
	Tag Number	Services Provided			Full-Time Staff (hours)					Part-Time Staff (hours)					Contract (hours)				
		1	2	3															
Administration	F33																		
Physician Services	F34																		
Medical Director	F35																		
Other Physician	F36																		
Physician Extender	F37																		
Nursing Services	F38																		
RN Director of Nurses	F39																		
Nurses with Admin. Duties	F40																		
Registered Nurses	F41																		
Licensed Practical/ Licensed Vocational Nurses	F42																		
Certified Nurse Aides	F43																		
Nurse Aides in Training	F44																		
Medication Aides/Technicians	F45																		
Pharmacists	F46																		
Dietary Services	F47																		
Dietitian	F48																		
Food Service Workers	F49																		
Therapeutic Services	F50																		
Occupational Therapists	F51																		
Occupational Therapy Assistants	F52																		
Occupational Therapy Aides	F53																		
Physical Therapists	F54																		
Physical Therapists Assistants	F55																		
Physical Therapy Aides	F56																		
Speech/Language Pathologist	F57																		
Therapeutic Recreation Specialist	F58																		
Qualified Activities Professional	F59																		
Other Activities Staff	F60																		
Qualified Social Workers	F61																		
Other Social Services	F62																		
Dentists	F63																		
Podiatrists	F64																		
Mental Health Services	F65																		
Vocational Services	F66																		
Clinical Laboratory Services	F67																		
Diagnostic X-ray Services	F68																		
Administration & Storage of Blood	F69																		
Housekeeping Services	F70																		
Other	F71																		

Name of Person Completing Form	Time
Signature	Date

GENERAL INSTRUCTIONS AND DEFINITIONS

(use with CMS-671 Long Term Care Facility Application for Medicare and Medicaid)

This form is to be completed by the Facility

For the purpose of this form "the facility" equals certified beds (i.e., Medicare and/or Medicaid certified beds).

Standard Survey - LEAVE BLANK - Survey team will complete
Extended Survey - LEAVE BLANK - Survey team will complete

INSTRUCTIONS AND DEFINITIONS

Name of Facility - Use the official name of the facility for business and mailing purposes. This includes components or units of a larger institution.

Provider Number - Leave blank on initial certifications. On all recertifications, insert the facility's assigned six-digit provider code.

Street Address - Street name and number refers to physical location, not mailing address, if two addresses differ.

City - Rural addresses should include the city of the nearest post office.

County - County refers to parish name in Louisiana and township name where appropriate in the New England States.

State - For U.S. possessions and trust territories, name is included in lieu of the State.

Zip Code - Zip Code refers to the "Zip-plus-four" code, if available, otherwise the standard Zip Code.

Telephone Number - Include the area code.

State/County Code - LEAVE BLANK - State Survey Office will complete.

State/Region Code - LEAVE BLANK - State Survey Office will complete.

Block F9 - Enter either 01 (SNF), 02 (NF), or 03 (SNF/NF).

Block F10 - If the facility is under administrative control of a hospital, check "yes," otherwise check "no."

Block F11 - The hospital provider number is the hospital's assigned six-digit Medicare provider number.

Block F12 - Identify the type of organization that controls and operates the facility. Enter the code as identified for that organization (e.g., for a for profit facility owned by an individual, enter 01 in the F12 block; a facility owned by a city government would be entered as 09 in the F12 block).

Definitions to determine ownership are:

FOR PROFIT - If operated under private commercial ownership, indicate whether owned by individual, partnership, or corporation.

NONPROFIT - If operated under voluntary or other nonprofit auspices, indicate whether church related, nonprofit corporation or other nonprofit.

GOVERNMENT - If operated by a governmental entity, indicate whether State, City, Hospital District, County, City/County, or Federal Government.

Block F13 - Check "yes" if the facility is owned or leased by a multi-facility organization, otherwise check "no." A Multi-Facility Organization is an organization that owns two or more long term care facilities. The owner may be an individual or a corporation. Leasing of facilities by corporate chains is included in this definition.

Block F14 - If applicable, enter the name of the multi-facility organization. Use the name of the corporate ownership of the multi-facility organization (e.g., if the name of the facility is Soft Breezes Home and the name of the multi-facility organization that owns Soft Breezes is XYZ Enterprises, enter XYZ Enterprises).

Block F15 – F23 - Enter the number of beds in the facility's Dedicated Special Care Units. These are units with a specific number of beds, identified and dedicated by the facility for residents with specific needs/diagnoses. They need not be certified or recognized by regulatory authorities. For example, a SNF admits a large number of residents with head injuries. They have set aside 8 beds on the north wing, staffed with specifically trained personnel. Show "8" in F19.

Block F24 - Check "yes" if the facility currently has an organized residents' group, i.e., a group(s) that meets regularly to discuss and offer suggestions about facility policies and procedures affecting residents' care, treatment, and quality of life; to support each other; to plan resident and family activities; to participate in educational activities or for any other purposes; otherwise check "no."

Block F25 - Check "yes" if the facility currently has an organized group of family members of residents, i.e., a group(s) that meets regularly to discuss and offer suggestions about facility policies and procedures affecting residents' care, treatment, and quality of life; to support each other, to plan resident and family activities; to participate in educational activities or for any other purpose; otherwise check "no."

GENERAL INSTRUCTIONS AND DEFINITIONS

(use with CMS-671 Long Term Care Facility Application for Medicare and Medicaid)

Block F26 - Check "yes" if the facility conducts experimental research; otherwise check "no." Experimental research means using residents to develop and test clinical treatments, such as a new drug or therapy, that involves treatment and control groups. For example, a clinical trial of a new drug would be experimental research.

Block F27 - Check "yes" if the facility is part of a continuing care retirement community (CCRC); otherwise check "no." A CCRC is any facility which operates under State regulation as a continuing care retirement community.

Blocks F28 – F31 - If the facility has been granted a nurse staffing waiver by CMS or the State Agency in accordance with the provisions at 42CFR 483.30(c) or (d), enter the last approval date of the waiver(s) and report the number of hours being waived for each type of waiver approval.

Block F32 - Check "yes" if the facility has a State approved Nurse Aide Training and Competency Evaluation Program; otherwise check "no."

FACILITY STAFFING

GENERAL INSTRUCTIONS

This form requires you to identify whether certain services are provided and to specify the number of hours worked providing those services. Column A requires you to enter "yes" or "no" about whether the services are provided onsite to residents, onsite to nonresidents, and offsite to residents. Columns B-D requires you to enter the specific number of hours worked providing the service. To complete this section, base your calculations on the staff hours worked in the most recent complete pay period. If the pay period is more than 2 weeks, use the last 14 days. For example, if this survey begins on a Tuesday, staff hours are counted for the previous complete pay period.

Definition of Hours Worked - Hours are reported rounded to the nearest whole hour. Do not count hours paid for any type of leave or non-work related absence from the facility. If the service is provided, but has not been provided in the 2-week pay period, check the service in Column A, but leave B, C, or D blank. If an individual provides service in more than one capacity, separate out the hours in each service performed. For example, if a staff person has worked a total of 80 hours in the pay period but has worked as an activity aide and as a Certified Nurse Aide, separately count the hours worked as a CNA and hours worked as an activity aide to reflect but not to exceed the total hours worked within the pay period.

Completion of Form

Column A - Services Provided - Enter Y (yes), N (no) under each sub-column. For areas that are blocked out, do not provide the information.

Column A-1 - Refers to those services provided onsite to residents, either by employees or contractors.

Column A-2 - Refers to those services provided onsite to non-residents.

Column A-3 - Refers to those services provided to residents offsite/or not routinely provided onsite.

Column B - Full-time staff, C - Part-time staff, and D - Contract - Record hours worked for each field of full-time staff, part-time staff, and contract staff (do not include meal breaks of a half an hour or more). Full-time is defined as 35 or more hours worked per week. Part-time is anything less than 35 hours per week. Contract includes individuals under contract (e.g., a physical therapist) as well as organizations under contract (e.g., an agency to provide nurses). If an organization is under contract, calculate hours worked for the individuals provided. Lines blocked out (e.g., Physician services, Clinical labs) do not have hours worked recorded.

REMINDER - Use a 2-week period to calculate hours worked.

DEFINITION OF SERVICES

Administration - The administrative staff responsible for facility management such as the administrator, assistant administrator, unit managers and other staff in the individual departments, such as: Health Information Specialists (RRA/ARTI), clerical, etc., who do not perform services described below. Do not include the food service supervisor, housekeeping services supervisor, or facility engineer.

Physician Services - Any service performed by a physician at the facility, except services performed by a resident's personal physician.

Medical Director - A physician designated as responsible for implementation of resident care policies and coordination of medical care in the facility.

Other Physician - A salaried physician, other than the medical director, who supervises the care of residents when the attending physician is unavailable, and/or a physician(s) available to provide emergency services 24 hours a day.

Physician Extender - A nurse practitioner, clinical nurse specialist, or physician assistant who performs physician delegated services.

Nursing Services - Coordination, implementation, monitoring and management of resident care plans. Includes provision of personal care services, monitoring resident responsiveness to environment, range-of-motion exercises, application of sterile dressings, skin care, naso-gastric tubes, intravenous fluids, catheterization, administration of medications, etc.

GENERAL INSTRUCTIONS AND DEFINITIONS

(use with CMS-671 Long Term Care Facility Application for Medicare and Medicaid)

Director of Nursing - Professional registered nurse(s) administratively responsible for managing and supervising nursing services within the facility. Do not additionally reflect these hours in any other category.

Nurses with Administrative Duties - Nurses (RN, LPN, LVN) who, as either a facility employee or contractor, perform the Resident Assessment Instrument function in the facility and do not perform direct care functions. Also include other nurses whose principal duties are spent conducting administrative functions. For example, the Assistant Director of Nursing is conducting educational/in-service, or other duties which are not considered to be direct care giving. Facilities with an RN waiver who do not have an RN as DON report all administrative nursing hours in this category.

Registered Nurses - Those persons licensed to practice as registered nurses in the State where the facility is located. Includes geriatric nurse practitioners and clinical nurse specialists who primarily perform nursing, not physician-delegated tasks. Do not include Registered Nurses' hours reported elsewhere.

Licensed Practical/Vocational Nurses - Those persons licensed to practice as licensed practical/vocational nurses in the State where the facility is located. Do not include those hours of LPN/LVNs reported elsewhere.

Certified Nurse Aides - Individuals who have completed a State approved training and competency evaluation program, or competency evaluation program approved by the State, or have been determined competent as provided in 483.150(a) and (3) and who are providing nursing or nursing-related services to residents. Do not include volunteers.

Nurse Aides in Training - Individuals who are in the first 4 months of employment and who are receiving training in a State approved Nurse Aide training and competency evaluation program and are providing nursing or nursing-related services for which they have been trained and are under the supervision of a licensed or registered nurse. Do not include volunteers.

Medication Aides/Technicians - Individuals, other than a licensed professional, who fulfill the State requirement for approval to administer medications to residents.

Pharmacists - The licensed pharmacist(s) who a facility is required to use for various purposes, including providing consultation on pharmacy services, establishing a system of records of controlled drugs, overseeing records and reconciling controlled drugs, and/or performing a monthly drug regimen review for each resident.

Dietary Services - All activities related to the provision of a nourishing, palatable, well-balanced diet that meets the daily nutritional and special dietary needs of each resident.

Dietitian - A person(s), employed full, part-time or on a consultant basis, who is either registered by the Commission of Dietetic Registration of the American Dietetic Association, or is qualified to be a dietitian on the basis of experience in identification of dietary needs, planning and implementation of dietary programs.

Food Service Workers - Persons (excluding the dietitian) who carry out the functions of the dietary service (e.g., prepare and cook food, serve food, wash dishes). Includes the food services supervisor.

Therapeutic Services - Services, other than medical and nursing, provided by professionals or their assistants, to enhance the residents' functional abilities and/or quality of life.

Occupational Therapists - Persons licensed/registered as occupational therapists according to State law in the State in which the facility is located. Include OTs who spend less than 50 percent of their time as activities therapists.

Occupational Therapy Assistants - Person(s) who, in accord with State law, have licenses/certification and specialized training to assist a licensed/certified/registered Occupational Therapist (OT) to carry out the OT's comprehensive plan of care, without the direct supervision of the therapist. Include OT Assistants who spend less than 50 percent of their time as Activities Therapists.

Occupational Therapy Aides - Person(s) who have specialized training to assist an OT to carry out the OT's comprehensive plan of care under the direct supervision of the therapist, in accord with State law.

Physical Therapists - Persons licensed/registered as physical therapists, according to State law where the facility is located.

Physical Therapy Assistants - Person(s) who, in accord with State law, have licenses/certification and specialized training to assist a licensed/certified/registered Physical Therapist (PT) to carry out the PT's comprehensive plan of care, without the direct supervision of the PT.

Physical Therapy Aides - Person(s) who have specialized training to assist a PT to carry out the PT's comprehensive plan of care under the direct supervision of the therapist, in accord with State law.

Speech-Language Pathologists - Persons licensed/registered, according to State law where the facility is located, to provide speech therapy and related services (e.g., teaching a resident to swallow).

GENERAL INSTRUCTIONS AND DEFINITIONS

(use with CMS-671 Long Term Care Facility Application for Medicare and Medicaid)

Therapeutic Recreation Specialist - Person(s) who, in accordance with State law, are licensed/registered and are eligible for certification as a therapeutic recreation specialist by a recognized accrediting body.

Qualified Activities Professional - Person(s) who meet the definition of activities professional at 483.15(f)(2)(i)(A) and (B) or 483.15(f)(2)(ii) or (iii) or (iv) and who are providing an on-going program of activities designed to meet residents' interests and physical, mental or psychosocial needs. Do not include hours reported as Therapeutic Recreation Specialist, Occupational Therapist, OT Assistant, or other categories listed above.

Other Activities Staff - Persons providing an on-going program of activities designed to meet residents' needs and interests. Do not include volunteers or hours reported elsewhere.

Qualified Social Worker(s) - Person licensed to practice social work in the State where the facility is located, or if licensure is not required, persons with a bachelor's degree in social work, a bachelor's degree in a human services field including but not limited to sociology, special education, rehabilitation counseling and psychology, and one year of supervised social work experience in a health care setting working directly with elderly individuals.

Other Social Services Staff - Person(s) other than the qualified social worker who are involved in providing medical social services to residents. Do not include volunteers.

Dentists - Persons licensed as dentists, according to State law where the facility is located, to provide routine and emergency dental services.

Podiatrists - Persons licensed/registered as podiatrists, according to State law where the facility is located, to provide podiatric care.

Mental Health Services - Staff (excluding those included under therapeutic services) who provide programs of services targeted to residents' mental, emotional, psychological, or psychiatric well-being and which are intended to:

- Diagnose, describe, or evaluate a resident's mental or emotional status;
- Prevent deviations from mental or emotional well-being from developing; or
- Treat the resident according to a planned regimen to assist him/her in regaining, maintaining, or increasing emotional abilities to function.

Among the specific services included are psychotherapy and counseling, and administration and monitoring of psychotropic medications targeted to a psychiatric diagnosis.

Vocational Services - Evaluation and training aimed at assisting the resident to enter, re-enter, or maintain employment in the labor force, including training for jobs in integrated settings (i.e., those which have both disabled and nondisabled workers) as well as in special settings such as sheltered workshops.

Clinical Laboratory Services - Entities that provide laboratory services and are approved by Medicare as independent laboratories or hospitals.

Diagnostic X-ray Services - Radiology services, ordered by a physician, for diagnosis of a disease or other medical condition.

Administration and Storage of Blood Services - Blood bank and transfusion services.

Housekeeping Services - Services, including those of the maintenance department, necessary to maintain the environment. Includes equipment kept in a clean, safe, functioning and sanitary condition. Includes housekeeping services supervisor and facility engineer.

Other - Record total hours worked for all personnel not already recorded, (e.g., if a librarian works 10 hours and a laundry worker works 10 hours, record 00020 in Column C).

Sufficient and Competent Nurse Staffing Review

Surveyors should evaluate if the facility has sufficient and competent nursing staff 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. States who have mandatory nurse-to-resident ratios are not exempt from this regulation.

Coordination:

☐ Every surveyor assesses the facility for compliance with the requirements for sufficient and competent nursing staffing throughout the survey.

☐ At the end of each day, one surveyor consolidates the information related to staffing from other surveyors. This shall include information obtained from any observation or interview conducted as part of the activities in this task listed below, or based on other activities such as general resident interviews or investigations. Information obtained shall include examples that demonstrate a lack of sufficient and/or competent staff. with either:

- the potential for negative outcomes or harm, or
- actual negative outcomes or harm.

☐ After consolidating this information, the surveyor assigned to this task then evaluates the information and determines further actions or investigations.

General Observation and Interview Concepts to Consider When Considering Compliance:

- Odors, call-lights, census, and staff's ability to complete assignments are used to assess if the facility has sufficient staff to meet the residents' needs.
- The Facility Assessment is used to assess if the facility appropriately considers the facility's census and residents' acuity to determine the number and competency of staff required to meet each resident's needs.
- The use of position-change alarms, devices that may restrict a resident's movement, and medications that subdue or sedate residents are used to assess if the facility is using these items as potential restraints because they don't have sufficient staff to monitor each resident effectively.
- Hospitalizations and the staff's ability to identify and address residents' changes in condition are used to assess if the facility's staff possess the required competencies to care for each resident.
- Agency staff are used to assess if agency staff possess the required competencies to care for each resident.
- Trainings are used to assess if staff retained the information provided by training to maintain the required competencies to meet each resident's needs.
- Turnover and QAA are used to assess if the facility is operating an effective QAA process.

List of Observations Made While Completing the Initial Pool Process and/or Investigations: During team meetings, the team should discuss whether any of the areas listed below were concerns to alert the team of potential concerns with sufficient or competent staff.

☐ Are there offensive odors? If so, what is the source?

Sufficient and Competent Nurse Staffing Review

- ☐ If mid-morning (e.g., 9-11 a.m.) or later, are residents still in bed and not dressed?
- ☐ Are residents sitting around the nurse's station, in the hallways, or in front of the television without any interaction from staff?
- ☐ Are call lights and alarms responded to timely?
- ☐ Are residents displaying behavioral or pain concerns such as being combative, yelling, or crying out?
- ☐ Are residents who wander unsupervised and susceptible to, or creating, issues?
- ☐ Do staff appear rushed when providing resident care? Do licensed nurses help nursing aides when asked for assistance?
- ☐ Are residents provided assistance with eating during meals and are nursing staff monitoring the dining area during meals?
- ☐ Potential use of restraints:
  - Are residents subdued or sedated, indicating the potential use of chemical restraints; or
  - Are there devices or practices in use that restrict residents' freedom of movement indicating the potential use of physical restraints?
- ☐ Are residents' choices honored and their dignity maintained? For example:
  - Do residents remain unkempt or unclean for extended periods of time (e.g., after sleeping or eating); or
  - Are residents woken up and assisted with activities, such as eating, bathing, or dressing at times that is convenient for staff (e.g., during shift change), rather than at the residents' preference (within reason)?
- ☐ Is there a delay in residents receiving their medications timely?
- ☐ Are residents repositioned or turned timely in accordance with their plan of care?
- ☐ Is there a high incidence of position-change alarm use?
- ☐ Do staff explain to residents what they are doing when assisting or providing services to the resident?
- ☐ Are residents experiencing avoidable accidents (e.g., falls), elopements, or incidences of resident-to-resident altercations or abuse?
- ☐ If concerns about staff responsiveness exist, the surveyor should activate the call light and record the response time of the staff.
- ☐ When observing care or services provided to residents by nursing staff, determine if they demonstrate competency. Such as, their abilities to provide care according to professional standards in the following areas: Refer to other regulations and IGs as appropriate.
  - Inability for staff to identify any obvious signs of residents' change in condition;
  - Transfers and Positioning (e.g., use of mechanical lifts, bed to chair);
  - Infection Control Techniques, including wound care and residents on isolation precautions;
  - Tracheostomy, Ventilator care, or Tube feeding; and
  - Incontinence, including Catheter care.

Sufficient and Competent Nurse Staffing Review

INTERVIEWS:

Residents/Resident Representatives or Family Members:

Staff Sufficiency (list of probes addressed during the initial pool process): During team meetings, the team should discuss whether any of the areas listed below were concerns to alert the team of potential concerns with sufficient or competent staff.

- ☐ Do you feel that there is enough staff to meet your needs and concerns, such as answering your call light timely or responding quickly to your alarm if you have one? If not, why, and what care or services do you feel are not provided, such as receiving or refilling a cup of water, toileting, dressing, eating, going to activities? Is there a specific time of day or weekends that are more problematic?
- ☐ Has anything occurred because you had to wait for staff to respond and assist you, such as being incontinent, missing a shower, or falling? How often does this occur?
- ☐ Do you routinely eat in your room? If so, is this your choice and if needed, is assistance provided to help you? Are room trays delivered timely?
- ☐ Are you able to wake, dress, eat, or engage in other activities at times that are preferable to you?
- ☐ Does staff interact with you and explain to you what care or services they are providing and why? Does staff rush you when they provide care?
- ☐ Do you get your medications on time?
- ☐ Do you now or have you ever had a position-change alarm used -- for example, a device that makes a sound when you change your position while sitting or in bed? If so, do you know why these alarms are used for you?
- ☐ Do you receive medications that make you sleepy, tired, lethargic, or sedated?

Staff Competency (surveyors should ask residents about staff competency throughout the survey):

- ☐ Do you feel safe and comfortable when staff assist you?
- ☐ Do you think the nursing staff are experienced and knowledgeable when providing your care? If not, what concerns have you experienced?
- ☐ Do you recall a time when you didn't feel well? Did you tell a staff member? What happened? For example, did you get better or worse?
- ☐ Have you been transferred to the hospital? For what reason?

Nursing Aide and Licensed Nurse Interview: If concerns are identified with sufficient or competent staff, complete the following interviews.

Staff Sufficiency:

- ☐ How many residents are you responsible for on a regular basis during your shift?
- ☐ Do you have enough time to complete your required assignments each day? If not, why not, and what assignments are you not able to complete? How often does this occur?

Sufficient and Competent Nurse Staffing Review

- ☐ How often are you asked to stay late, come in early, or work overtime?
- ☐ Do you use position-change alarms? Why?
- ☐ Are there any devices used to help keep residents from falling, moving in certain ways, or wandering into certain areas? If so, why? Which residents?
- ☐ Are you able to complete rehabilitation services as ordered for the residents?
- ☐ How are current staffing needs determined? Does management ask for your input into their facility assessment for sufficient staffing? If so, can you provide some examples of what you provided and if you know whether or not these were considered?

Staff Competency:

- ☐ How are you made aware of the care and services the residents require as directed in their plan of care and what their individual choices are?
- ☐ How do you identify a resident's change in condition? Can you provide some examples?
- ☐ How are changes in a residents' care communicated to you and how do you communicate a resident's change in condition or concerns to other staff? Is there a structured tool (e.g., INTERACT or a process for identifying, communicating, and caring for changes in a resident's condition)?
- ☐ How often are residents sent to the hospital? For what reasons? Which residents have recently been transferred?
- ☐ How have you been trained to provide care, use equipment, and ensure proper infection control techniques are used?
- ☐ Do you receive periodic evaluations on your skills, knowledge, and abilities? If so, how often? For what areas have you been assessed? What areas do you believe you need more assistance or training?
- ☐ Do you have regular in-services on abuse, resident rights, dementia care, and specific resident needs (e.g., ventilators, dialysis, hospice, medication side effects, pain, or changes in condition)? Are you provided training on each resident? How often?
- ☐ Does your facility use agency staff? If so, how does that impact your daily activities? Do you have any concerns about resident care when agency staff are used?

DON and Staff Development Coordinator Interviews: If concerns are identified with sufficient or competent staff, complete the following interviews.

- ☐ Does the facility assessment include a determination of the level and competency of staff needed to meet each resident's needs each day and during emergencies? If so, what does this assessment include? How do you have input into this assessment? How often is this assessment updated?
- ☐ How is the residents' acuity, needs, and diagnoses considered when determining staffing requirements and assignments?

Sufficient and Competent Nurse Staffing Review

Staff Sufficiency:

- ☐ How does the facility's census impact staffing levels? For example, are staffing assignments routinely changed based on census? If so, how do you accommodate for the changes and for weekend staffing adjustments? How do you handle call-ins?
- ☐ Do staff, residents, or families bring workload concerns to you? How do you handle the concerns? Is there a system in place to address these concerns?
- ☐ What is your turn-over rate? Do you conduct exit interviews with staff? Do you report interview findings to your QA&A meeting?
- ☐ Do you use position-change alarms? Why?
- ☐ Are there any devices used to help keep residents from falling, moving in certain ways, or wandering into certain areas? If so, why? Which residents?

Staff Competency:

- ☐ How do staff identify residents' changes in condition and what process should they follow if they identify something (e.g., INTERACT, facility-developed tool or process)?
- ☐ What are the most common reasons why residents are transferred to the hospital?
- ☐ How do you assure that staff are appropriately assigned to meet the needs of residents and are implementing care-planned approaches for each resident on each shift and unit?
- ☐ Do you use temporary/contract staff? If so, how often and why? How do you ensure these staff are competent and have the knowledge and skills to care for residents? What is covered in your agreement with the staffing agency regarding the skill set of contract staff? How do you ensure the work assigned to contract staff is within their skill set?
- ☐ Is ongoing training provided for all staff, (permanent, temporary/contracted, etc.)? If not, why not? If yes, how often is this conducted and what areas are covered?
- ☐ Who is responsible for competency oversight? How often is staff evaluated to access their competencies, skills, and knowledge? What type of education or training has been provided based on the outcomes of these reviews?

RECORD REVIEW: If there are any concerns identified by the observations or interviews noted above, it may be necessary to validate/verify this information by conducting a review of records. Such as:

Resident Record

- ☐ For residents with position-change alarms, does the record document the rationale for the alarm and the impact on the resident?
- ☐ Is the resident receiving any medications that have a sedating, subduing effect? What documentation supports the use of the medication?

Sufficient and Competent Nurse Staffing Review

- ☐ Did the resident experience any changes in condition? If so, was the change identified quickly, reported, and monitored? Were conditions appropriately addressed to prevent further decline in status?
- ☐ Was the resident transferred to the hospital for a decline in condition that could have been avoided?

Facility Documents/Records

- ☐ Review the Facility Assessment: Does the facility assessment include a determination for the level and competency of staff needed to meet each resident's needs each day and during emergencies? For example, is staffing based on the census, resident's acuity, resident assessments, plans of care, needs, diagnoses, and the skill sets of the staff? How does the facility assessment compare to the observations of the resident population, staffing structure, and competency of staff?
- ☐ Review the staffing schedule, including call-ins and staff postings for the past month. Depending on identified concerns, it may be necessary to expand your review.
- ☐ Review the list of nursing staff compared to the staffing schedule the facility provided/posted. If there are discrepancies between the duty roster and the staff observed onsite, ask the person in charge to explain the discrepancies.
- ☐ Review specific policies related to resident rights, quality of life, quality of care concerns identified (e.g., change of condition, position-change alarms, assessments, pressure ulcers, incontinence care, ADLs).
- ☐ Are hospital transfers occurring for conditions that should be identified and addressed earlier that would avoid the need for a transfer? Review transfer log if one exists.
- ☐ Staff evaluations and/or training records, including in-services that may demonstrate an assessment of nurse staffing competencies, skills, and knowledge.
- ☐ Based on identified concerns, consider reviewing documents such as nurse aide assignment schedule, resident care sheets, or resident-specific information like care plans, bathing records, restorative schedule, toileting, and behavior monitoring.

Other Requirements

- ☐ Does the nursing schedule reflect the following required coverage:
  - 24-hour licensed nurse;
  - 8-hour registered nurse, 7 days a week; and
  - Full-time DON.
- ☐ Is nursing staffing posted daily?

Sufficient and Competent Nurse Staffing Review

1. **Does the facility have sufficient nursing staff on a 24-hour basis to care for residents' needs, as identified through resident assessments and the plan of care (not including #3 below)?** ☐ Yes ☐ **No F725**

2. **Does the facility's nursing staff have the competencies required to care for residents' needs, as identified through resident assessments and the plan of care (not including #3 below)?** ☐ Yes ☐ **No F726**

3. **Does the facility's nursing staff have sufficient and competent staff to provide the necessary behavioral health, psychosocial, and dementia care to residents?** ☐ Yes ☐ **No F741**

4. **Unless the facility has a waiver, has the facility designated a licensed nurse to serve as a charge nurse on each tour of duty?** ☐ **Yes** ☐ **No F727**

5. **Unless the facility has a waiver, does the facility have an RN at least 8 hours a day, 7 days a week?** ☐ Yes ☐ **No F727**

6. **Unless the facility has a waiver, does the facility have a registered nurse to serve as the DON on a full time basis?** ☐ Yes ☐ **No F727**

7. **Did the facility ensure the DON served as a charge nurse only when the facility had an average daily occupancy of 60 or fewer residents?** ☐ Yes ☐ **No F727**

8. **Have nurse aides demonstrated competency in skills and techniques necessary to care for residents' needs, as identified through resident assessments, and described in their care plans?** ☐ Yes ☐ **No F726**

9. **Are nurse aides re-trained either by completing (1) a new training and competency evaluation program or (2) a new competency evaluation program, if there has been a continuous period of 24 consecutive months during none of which the individual provided nursing or nursing-related services for monetary compensation?** ☐ Yes ☐ **No F729**

10. **Does the facility ensure full-time nurse aides have become certified within 4 months of nurse aide training?** ☐ Yes ☐ **No F728**

11. **Does the facility provide nurse aide in-services, at least 12 hours in a year, including dementia training, abuse prevention training, areas of weakness as determined in the nursing aides' performance reviews, facility assessment, special needs of residents determined by facility staff, and care of the cognitively impaired resident for those nursing aides providing cares for individuals with cognitive impairments?** ☐ Yes ☐ **No F730**

Sufficient and Competent Nurse Staffing Review

12. If the facility has a waiver to provide licensed nurses on a 24 hour basis, is there evidence that it is approved and reviewed by the state annually and has the facility notified the residents or representatives of the waiver? ☐ Yes ☐ **No F731** ☐ NA

13. For SNFs, if the facility has a waiver to provide a registered nurse for more than 40 hours a week, is there evidence that it is approved and reviewed by the state annually and has the facility notified the residents or representatives of the waiver?
☐ Yes ☐ **No F731** ☐ NA

14. Is nurse staffing posted daily? ☐ Yes ☐ **No F732**

15. Does the facility have sufficient and competent direct care staff to provide nursing and related services to meet the behavioral health needs of the residents as determined by resident assessments, care plans, and facility assessment? ☐ Yes ☐ **No F741**

16. Does the facility have an annual documented facility assessment, and does the facility assessment include information on the level and competency of staff needed to meet the needs of each resident? ☐ Yes ☐ **No F838**

Other Tags, Care Areas (CA) and Tasks (Task) to Consider: Pressure Ulcer (CA), Bladder and Bowel (CA), Dental (CA), Positioning/Mobility/ROM (CA), Accidents (CA), Nutrition (CA), Catheter/UTI (CA), Tube Feeding (CA), Respiratory (CA), ADLs (CA), Environment (Task), Abuse (CA), Neglect (CA), Physical Restraints (CA), Chemical Restraints F605, Behavioral-Emotional Status (CA), Infection Control (Task), Required In-Service Training Nurse Aides F947, QAA/QAPI (Task).

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PERINEAL CARE RETURN DEMONSTRATION

Check if completed correctly	Procedure Steps
	Knocked on door. Screened resident. Pulled window curtain if necessary.
	Addressed resident, introduced self and explained what was being done.
	Gathered equipment
	Washed hands and put on gloves (universal precautions).
	Removed soiled incontinence product and disposed of properly (put in trash bag, tied shut).
	Did not put soiled incontinence product or linen on floor.
	Told resident before using wipes/washcloth/perineal wash, "Wipe may feel cold."
	Used clean section for each wipe/washcloth or used a new wipe/washcloth each time.
	Used correct technique for peri-care on female vs. male residents. • Female: Spread labia, wipe one side, then the other, and then the middle, wiping toward the rectal are and never wiping back and forth. Proceed to clean the rectal and buttocks area. • Male: Pull foreskin back if resident is uncircumcised. Clean the tip of the penis using a circular motion starting at the urethra and working outward. Clean shaft of the penis with firm downward strokes. Clean the scrotum.
	Used no other products unless resident has order.
	Removed gloves before touching clothing, bed rail, cubicle curtain, etc.
	Washed hands before leaving room.
	Correctly disposed of incontinence product in soiled utility room or if in isolation in red barrel in room.
	Used proper body mechanics and proper positioning for resident during entire procedure.
	Maintained resident dignity and privacy throughout entire procedure.

☐ **Met competency**

☐ **Knowledge Plan –** see back **Knowledge Plan completed on** _____
☐ **Competency Met after knowledge plan completed** ***(Sign above)***

☐ **Improvement Plan** - see back **Improvement Plan completed on** _____
☐ **Competency Met after improvement plan completed** ***(Sign above)***

Staff Signature:_____ **Date**_____

Staff Name:_____

Evaluator Signature:_____ **Date:**_____

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PERINEAL CARE RETURN DEMONSTRATION

Knowledge or Improvement Plan

Knowledge or Improvement Plan Steps Initiated on *(date)*	Resources	Target date for completion

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Facility Assessment Worksheet Summary
Facility Personnel

Governance: _____

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Organization Chart: _____

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Personnel: _____

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Facility Assessment Worksheet Summary
Nutrition Services

Cultural Preference: _____

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Religious Preference: _____

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Ethnic Preference: _____

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Facility Assessment Worksheet Summary
Nursing Services

Nursing Management: _____

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Licensed Staff: _____

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Direct Caregivers: _____

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Facility Assessment: Training Program Evaluation

Facility Assessment: Training Program Evaluation

Reference F Tags

F725 and F726

§483.35, 483.35(a), and 483.35(c) Sufficient and Competent Staff

F741

§483.40(a) Sufficient Number of staff with appropriate competencies

F838

§483.70(e) Facility assessment interpretive guidance
The assessment must **include or address an evaluation of the facility's training program** to ensure any training needs are met for all new and existing staff, individuals providing services under a contractual arrangement, and volunteers, consistent with their expected roles. The assessment should also include an evaluation of what policies and procedures may be required in the provision of care and that these meet current professional standards of practice. If there are any concerns regarding training refer to §483.95 Training.

F940

§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 § 483.70(e). Training topics must include but are not limited to— [§483.95 will be implemented beginning November 28, 2019 (Phase 3)]

F943 Training

§483.95(c) and §483.95(c)(1-2) Abuse, neglect, and exploitation.
§483.95(c)(3) dementia management and abuse prevention

Staff includes for the purposes of the training guidance, all facility staff, (direct and indirect care and auxiliary functions) contractors, and volunteers.

GUIDANCE §483.95(c)
All facilities must develop, implement and permanently maintain an effective training program for all staff, which includes, at a minimum, training on abuse, neglect,

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exploitation, misappropriation of resident property, and dementia management, that is appropriate and effective, as determined by staff need and the facility assessment (as specified at §483.70(e)).

Changes to the facility's resident population, staff turnover, the facility's physical environment, and modifications to the facility assessment may necessitate ongoing revisions to the facility's training program.
There are a variety of methods that could be used to provide training. For example, staff training may be facilitated through any combination of in-person instruction, webinars and/or supervised practical training hours.
Supervised practical training means training in a setting in which instruction and oversight are provided by a person who has relevant education and/or experience specific to the subject of the training being provided.

All training should support current scope and standards of practice through curricula which detail learning objectives, performance standards and evaluation criteria, and addresses potential risks to residents, staff and volunteers if procedures are not followed. There should be a process in place to track staff participation in the required trainings.

F947

§483.95(g) Required in-service training for nurse aides.
§483.95(g)(3) Address areas of weakness as determined in nurse aides' performance reviews and facility assessment at § 483.70(e) and may address the special needs of residents as determined by the facility staff.

GUIDANCE §483.95(g)
All facilities must develop, implement and permanently maintain an in-service training program for nurse aides that is appropriate and effective, as determined by nurse aide evaluation or the facility assessment as specified at §483.70(e). Changes to the facility's resident population, the facility's physical environment, staff turnover, and modifications to the facility assessment may necessitate ongoing revisions to the facility's training program.

There are a variety of methods that could be used to provide training. For example, nurse aide training may be facilitated through any combination of in-person instruction, webinars and/or supervised practical training hours. Supervised practical training means training in a setting in which instruction and oversight are provided by a person who has relevant education and/or experience specific to the subject of the training being provided.

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All training should support current scope and standards of practice through curricula which detail learning objectives, performance standards and evaluation criteria, and addresses potential risks to residents, staff and volunteers if procedures are not followed. There should be a process in place to track nurse aide participation in the required trainings.

The adequacy of the in-service education program may be measured not only by documentation of hours of completed in-service education, but also by demonstrated competencies of nurse aide staff through written exam and/or in consistently applying the interventions necessary to meet residents' needs as identified in the facility assessment. Observations of nurse aides that indicate deficiencies in their nurse aide skills may be the result of an inadequate training program and/or inadequate performance review …

INTENT OF THE TRAINING PROGRAM EVALUATION SECTION

The facility training program must include trainings provided for competencies and skills that correlate with the resident needs identified in the facility assessment. An evaluation of the training program needs to be conducted per the requirements. The overall intent of conducting an evaluation of a facility training program is to determine the effectiveness of the facility training programs and how the facility is meeting its' objectives per the facility assessment. The evaluation is a process by which a facility can observe what they and others are doing and learn how to improve these activities when necessary.

There are numerous methods that providers may use to evaluate the progress of individual trainings as well as the overall outcomes of their facility training program. The intent of evaluating the training program can be conducted in two phases:

1. At different stages whether daily, weekly or monthly after a specific training, which may include evaluating the individual's response to training or the effectiveness or the training/trainer as deemed applicable and/or;
2. Evaluation of the facility's overall training program annually or as needed based upon performance outcomes which correlate with the facility assessment.

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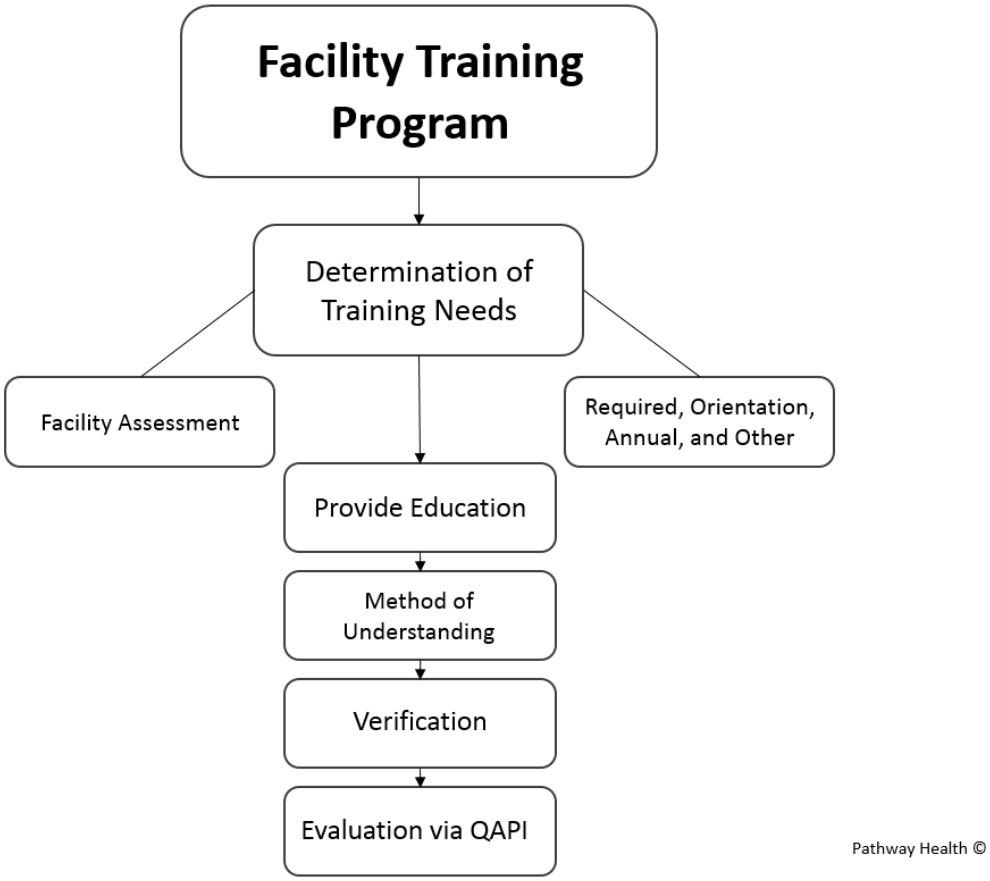
TRAINING PROGRAM EVALUATION PROCESS

Evaluating a training program is a means for a facility to gather information that can be reviewed and interpreted to make decisions regarding learning and development that aligns with standards of practice, professional scope of practice, requirements, staff knowledge and competencies and correlation with the facility assessment. The following depicts a process to evaluate a facility training program utilizing the facility Quality Assurance and Performance Improvement process.



1. <u>Determination of Training Needs</u>
    a. The facility will incorporate the required training components into their orientation program, annual training plan, professional/certification requirements, facility assessment findings, as well as other clinical and operational needs.

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b. Specific elements and criteria in a facility training plan should include, but not limited to:

   i. Evidenced based practice
   ii. Standards of practice
   iii. Regulatory requirements (federal, state, and local)
   iv. Scope of practice
   v. Specialty program requirements
   vi. Facility policies and procedures
   vii. Facility expectations
   viii. Facility assessment results
   ix. Staff learning needs and competencies
   x. Past training needs
   xi. Other areas determined by operational, clinical, and organization needs

c. Additional determination of training needs includes any identified areas of deficit or opportunities for improvement based upon quality assurance and performance improvement findings

2. <u>Provide Education</u>
   a. Development of specific training/education programs should provide evidence of learning needs and overall objectives. Specific components may include, but are not limited to:
      i. Training description or summary of educational content
      ii. Learning objectives
      iii. Methodology – Method of instruction such as:
         1. Lecture
         2. Demonstration
         3. Protocol or procedure review
         4. Self-Learning package
         5. On-line
         6. Skills Fair
         7. Simulation
         8. Clinical practice
         9. Other
      iv. Handouts
      v. Method of understanding to demonstrate learner knowledge post training

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3. Method of Understanding
    a. There are numerous methods to determine a learner's understanding of the training program, such as:
        1. Written post-test
        2. Oral post-test
        3. Return demonstration
        4. Skills check/competency check
        5. Verbal review
        6. Observation of performance
        7. Sign in sheets verbalizing the understanding of the material
        8. Other

    b. There are many methods to assess knowledge and performance and a facility may choose one or a combination of methods based upon the learning objectives and process needs.

    c. It is important to discuss observations and evaluations with the learner. Feedback assists the learner to see their progress and how they can improve. Acknowledge and give support for good results, and provide recommendations for improvement or individualized training to achieve the expected outcomes.

4. Verification or Evaluation
    a. Upon the completion of individual training programs, the facility is responsible for the adherence to the training objectives – training into facility practice. There are various methods that a facility may choose to verify and validate the training objectives and facility practice, including:
        i. Observation – care and practice
        ii. Walking rounds
        iii. Interviews
        iv. Medical record review
        v. Verbal review
        vi. Monitoring audits
        vii. Annual performance evaluation

    b. Document results

5. Evaluation via Quality Assurance and Performance Improvement process
    a. Review verification results via the QAPI process which provides the facility the opportunity to analyze and interpret data (findings) to assess performance and support improvement initiatives.

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i. From the identified opportunities for improvement, the facility will systematically and objectively prioritize the opportunities in order to determine the necessary action steps. This process takes into consideration input from multiple disciplines, facility assessment findings, residents and families.

b. The facility will document its overall evaluation of individual training programs, and the overall facility training program per QAPI protocols.
   i. This can be accomplished by adding the training evaluation overview and results into the QAPI Committee Meeting Minutes. This can serve as verification of your evaluation process.

HOW TO INCORPORATE INTO THE FACILITY ASSESSMENT

Per **§483.70(e), t**he facility assessment must include or address an evaluation of the facility's training program to ensure any training needs are met for all new and existing staff, individuals providing services under a contractual arrangement, and volunteers, consistent with their expected roles. Therefore, it is important to:

- Gather the outcomes data related to facility training programs reports as described above.
- Use the information to answer the questions:
  - Does the facility have a process to identify gaps and provide targeted training for staff to meet the resident population needs as identified in the facility assessment?
  - Has the facility outlined what education is needed based upon the resident population?
  - Does the facility conduct the verification/evaluation process of training programs, reporting results per the QAPI process?
  - Are there any training, education and/or competency needs based on resident data, staff knowledge data, or trends identified in the Facility Assessment?
  - Does our current direct care training program correlate with resident population based upon the Facility Assessment?
- Incorporate your processes into your QAPI plan
- Monitor the facility assessment annually or upon a change in the facility's operation that would require a substantial modification in the assessment and adjust the facility training plan accordingly.
- Write a narrative description of the facility's training evaluation process for inclusion, see below, into the narrative Facility Assessment. See the Facility Assessment Template

See the Facility Assessment Template SAMPLE related to the inclusion of the necessary information obtained via this process for the completion of the Facility Assessment.

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References

State Operations Manual (SOM) Appendix PP for Phase 2, F-Tag Revisions, and Related Issues www.cms.gov/Medicare/Provider-Enrollment-and-Certification/GuidanceforLawsAndRegulations/Downloads/Advance-Appendix-PP-Including-Phase-2-.pdf

Quality Improvement Organizations, Facility Assessment Tool (2017) http://qioprogram.org/facility-assessment-tool

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Sample

Individual Training Program Evaluation Summary

Education Topic	Method of Teaching	Date of Education
Instructor	**Teaching Methodology** (Circle One)	
	Lecture **D**emonstration **P**rotocol or procedure review **S**elf-Directed **O**n-line **S**kills Fair **S**imulation **C**linical practice **O**ther:	
Course Description		
Objectives		
Handouts – Attached		

Method of Understanding	Verification or Evaluation Conducted
☐ Written post-test ☐ Oral post-test ☐ Return demonstration ☐ Skills check/competency check ☐ Verbal review ☐ Sign in sheets verbalizing the understanding of the material ☐ Other	*Utilize applicable monitoring data collect method* ☐ Observation – care and practice ☐ Walking rounds ☐ Interviews ☐ Medical record review ☐ Verbal review ☐ Monitoring audits ☐ Other

Evaluation Results:

☐ Analysis conducted to determine trend and potential performance improvement needs
☐ Correlate training evaluation findings with Facility Assessment
☐ Included in QAPI process

_____ _____

Evaluator **Date Completed**

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Facility Assessment Worksheet Summary
Training Program Evaluation

Training Program Review: _____

_____

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Annual, Orientation, Required, Competency, Performance Review Outcomes: _____

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Summary of Outcomes: _____

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Facility Assessment: Infection Control Intent and Overview

Facility Assessment – Infection Control

RELATED REQUIREMENTS

F838 §483.70(e) 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 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. The facility assessment must address or include:

§483.70(e)(1) The facility's resident population, including, but not limited to,

- Both the number of residents and the facility's resident capacity;
- The care required by the resident population considering the types of diseases, conditions, physical and cognitive disabilities, overall acuity, and other pertinent facts that are present within that population;
- The staff competencies that are necessary to provide the level and types of care needed for the resident population;
- The physical environment, equipment, services, and other physical plant considerations that are necessary to care for this population; and

§483.70(e)(3) A facility-based and community-based risk assessment, utilizing an all-hazards approach.

F880 §483.80 Infection Control

The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections.

§483.80(a) 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:

§483.80(a)(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 §483.70(e) and following accepted national standards;

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§483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to:

(i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility;

(ii) When and to whom possible incidents of communicable disease or infections should be reported;

(iii) Standard and transmission-based precautions to be followed to prevent spread of infections;

(iv)When and how isolation should be used for a resident; including but not limited to:

(A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and

(B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances.

(v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and

(vi)The hand hygiene procedures to be followed by staff involved in direct resident contact.

§483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility.

§483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection.

§483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary.

INTENT OF INFECTION CONTROL AND THE FACILITY ASSESSMENT

The overall intent of the facility assessment is for a facility to evaluate its resident population and identify the resources needed to provide the care and services the residents require. The facility assessment will include a review of potential hazards and risks as well as the resources necessary to care for the resident populations during day to day operations and in emergencies.

Infection Control related to the Facility Assessment

A comprehensive Infection Prevention and Control program (IPCP) includes identification, tracking and management of resident and employee infections and their treatment. It describes

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the training and competencies needed by staff related to infection prevention and control and addresses the appropriate services needed in the residents' environment to prevent and manage infections. The IPCP includes information about identification, reporting and management of infection outbreaks for the safety of residents, staff and others who enter the facility.

The specific program requirements are described in the regulations earlier in this document. This segment of the Facility Assessment will tie the IPCP to the Facility Assessment (i.e. *"Indicate if the facility 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"* such as communicable diseases and infection control vulnerabilities) Source: QIO Facility Assessment

Common Diagnosis

Infectious 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

Source: QIO Facility Assessment

Infection Prevention and Control Program

Both the Facility Assessment and the IPCP require that residents' and employees' infections be identified. The numbers and types of infections found in the resident population help describe the types of diseases, conditions, and overall acuity, to assist the facility to identify residents' care needs.

The Resident Population Probing Questions from the Resident Population section of the Facility Assessment asks for information about the percentage of infections by broad categories as well as the percent of residents that required transmission precautions above Standard Precautions. This information is collected as part of the facility's Infection Surveillance program.

Infection Surveillance

The intent of surveillance is to identify possible clusters, changes in prevalent organisms, or increases in the rate of infection in a timely manner. The results should be used to plan infection control activities, direct in-service education, and identify individual resident problems in need of intervention.

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Essential elements of an infection surveillance system include:

- Standardized definitions and listings of the symptoms of infections,
- Use of surveillance tools such as surveys and data collection templates, walking rounds throughout the healthcare facility;
- Identification of resident populations at risk for infection;
- Identification of the processes or outcomes selected for surveillance;
- Statistical analysis of data that can uncover an outbreak; and
- Feedback of results to the primary caregivers so that they can continually assess the residents' physical condition for signs of infection.

The infection surveillance process identifies the location that the infection was acquired. When planning for infection prevention resources, consider the percentage of infections that are community acquired and those that are facility acquired. Each of these sources for infections will require different types of resources for monitoring, aggregating data and managing infections. Address the resources needed to identify and manage infections from both sources in the Facility Assessment narrative.

Infection Reporting

Nurses and other licensed professionals need knowledge and skills for identifying infections that may be communicable and reporting them in accordance with State/Local Regulations. Review the facility's IPCP to identify the policies and procedures needed to educate nurses about infection outbreaks and the appropriate steps to take to report and control them. This may be considered a knowledge and test type of competency.

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Standard and Transmission-based Precautions

Facility staff and volunteers that work in resident care areas need to have up to date knowledge about standard and transmission-based precautions. Standard precautions are typically included in general orientation for staff and a review of the information is offered at least annually. This information is vital for those who work in resident care areas, even if they do not provide direct care. Review the facility's policy for Standard Precautions to ensure that there are processes to educate and evaluate the practices of staff who work in resident care areas.

Volunteers also need an understanding of communicable infections and precautions when they assist in resident care areas.

When residents are diagnosed with a communicable infection, the Infection Preventionist, or another nurse, will determine if an additional level of precautions is needed. Transmission precautions include the additional of personal protective equipment when entering a resident's room or providing care for the resident with a communicable infection. The amount and type of personal protective equipment varies with the type of infection and the ease with which the infection can spread.

Review the IPCP to ensure that there are processes to identify the types of precautions needed for various types of infections. Review the orientation and ongoing education materials for staff and volunteers to assure that the facility's policies and procedures for transmission-based precautions are included for staff at the appropriate level of information for the role.

Knowledge competency about transmission-based precautions may be appropriate for those not providing direct care. Return demonstration is appropriate for the donning and doffing of personal protective equipment, based on the frequency of transmission-based precautions identified in the Resident Population area of the Facility Assessment.

Monitoring Staff Practices

Another aspect of the IPCP is the appropriate practices of facility staff related to infection prevention and control. Include the facility's experience with practice monitoring (audits) to assist with the development and implementation of staff education programs and competency documentation.

> For example, hand hygiene is a topic usually covered for all staff in a facility. Consider return demonstration competencies for hand hygiene as this task happens frequently and poses some risk for residents if it is done incorrectly.
>
> Additional considerations when reviewing staff practices may include non-direct care activities such as activities with snacks/food, birthday events, passing of trays at events etc.

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The Facility Assessment is required to be reviewed at least annually and updates with changes in the resident population or the care and services provided by the facility. Use infection surveillance information and data from monitoring staff practices to identify a potential need to review the Facility Assessment due to new types of infections or an increased prevalence of infections because of a change in the resident population being served.

Infection as a Risk Factor

Employee health is a required element of an IPCP. The program must contain policies and procedures for monitoring employee health and identifying potentially communicable conditions in order to prevent exposure of the residents and others to the illnesses. Review the facility's experience with employee illnesses to identify characteristics of the facility that may impact the resources needed to care for the residents.

> For example, if a large number of staff decline immunizations for religious or cultural reasons, the residents may be at higher risk for exposure to certain conditions and the facility will need resources to carefully monitor for signs and symptoms of employee illness related to the declined immunization.

Wide-spread infections also present a risk for residents and facility staff. Review the facility's Hazard Risk assessment to identify and plan for potential exposure to an outbreak of a communicable infection. Implement policies and practices to prevent and monitor for those conditions.

HOW TO INCORPORATE INTO THE FACILITY ASSESSMENT

Per F838 §483.70(e) Facility Assessment, the facility must include and address what resources are necessary to care for its resident population competently during both day-to-day operations and emergencies, which includes the evaluation of risks and vulnerabilities of the resident population and community related to infections. Therefore, it is important to:

- Gather the outcomes data related to infection prevention risk assessment and surveillance as described above.
    - Review the facility's infection surveillance information, employee health information and results from practice observations to describe the residents' care needs related to infections and the competencies needed by various staff for infection prevention and control.
    - Review the communicable illness experience of the facility and include the information in the facility Hazard Risk Assessment or HVA
- Use information to answer the questions:

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- Are their trends identified in the facility surveillance data?
- Have you completed a IC risk assessment outlining potential vulnerabilities and risks associated with your resident population and prevalence in your community? (MDRO's, TB, etc.)
- Have you identified your staffing needs based upon your experience and current resident population? (# of residents with transmission based precautions, time for care based upon infection concerns, etc.)
- Have you designed your education based upon your assessed risks and identified unique infection characteristics in your resident population and community in order to competently and safely provide care and prevention to other residents, staff and visitors?
- Have you identified your capacity to accept residents with special considerations related to communicable infections?
- Have you determined a contingency strategy for staffing needs in the event of an outbreak?
- Incorporate your findings and processes into the facility QAPI plan

See the Facility Assessment Template SAMPLE related to the inclusion of the necessary information obtained via this process for the completion of the Facility Assessment.

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References

CDC resources for infection control in nursing homes

www.cdc.gov/longtermcare/index.html

APIC Resources

http://community.apic.org/sierra/resources/overview

CDC: The Core Elements of Antibiotic Stewardship for Nursing Homes:

https://www.cdc.gov/longtermcare/prevention/antibiotic-stewardship.html

AHRQ-Nursing Home Antimicrobial Stewardship Guide:

https://www.ahrq.gov/nhguide/index.html

"Surveillance Definitions of Infections in Long-Term Care Facilities: Revisiting the McGeer Criteria"

https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3538836/

Toolkit to Reduce CAUTI and Other HAIs in Long-Term Care Facilities (AHRQ)

https://www.ahrq.gov/professionals/quality-patient-safety/quality-resources/tools/cauti-ltc/index.html?utm_source=ahrq&utm_medium=en2&utm_term=&utm_content=2&utm_campaign=ahrq_en5_23_2017

Diagnosis, Prevention and Treatment of C. difficile: Current State of the Evidence (AHRQ) May 30, 2017

https://www.effectivehealthcare.ahrq.gov/search-for-guides-reviews-and-reports/?pageaction=displayproduct&productID=2476&utm_source=ahrq&utm_medium=en5&utm_term=&utm_content=5&utm_campaign=ahrq_en5_23_2017

QIO Sample Facility Assessment Template

http://qioprogram.org/facility-assessment-tool

State Operations Manual (SOM) Appendix PP for Phase 2, F-Tag Revisions, and Related Issues

www.cms.gov/Medicare/Provider-Enrollment-and-Certification/GuidanceforLawsAndRegulations/Downloads/Advance-Appendix-PP-Including-Phase-2-.pdf

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Data Collection Tools and/or Resources

The following Tools and Resources are included in this Section of **The RoP Facility Assessment Toolkit ©**

Item	Description	Source *(If Applicable)*
Monthly Infection Prevention Log	Sample – This is a template for organizations to include into their overall Infection Prevention and Control Plan (IPCP)	Pathway Health
Employee Infection Line List	Sample – This is a template for organizations to use to track employee illness per requirements. Part of a comprehensive IPCP	Pathway Health
Facility Assessment Summary Worksheet	Tool to be utilized by team members upon the completion of data collection to determine trends and improvement opportunities. Finalization of information to enter into the facility assessment template	Pathway Heatlh

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MONTHLY INFECTION CONTROL LOG (LINE LIST)

Unit:_____ **Month/Year:**_____ **Date Reported to QA/CQI or Other Committee:**_____

Total # of Infections:_____ **# HAI's:**_____ **# Prophylactic ABX TX:**_____ **Reporting Period:**_____ **to** _____

Types of Infection: **UTI w/cath:**_____ **UTI no cath:**_____ **URI:**_____ **LRI:**_____ **Surgical Wound:**_____ **Pressure Ulcer:**_____ **Stasis Ulcer:**_____

Scabies:_____ **Shingles:**_____ **Other skin:**_____ **Eye:**_____ **GI:**_____ **Sepsis:**_____ **Other:**_____

 # New cases infected with antibiotic resistant organisms:_____

 # New cases colonized (not infected) with antibiotic resistant organisms:_____

				INFECTION			CULTURE			ANTIBIOTIC				CLASSIFICATION				
Resident Name	Admit Date	Room #	Unit	Type	Body Site (catheter?)	Date of Onset	Date Taken	Organism(s)	Antibiotic Resistant (Y/N)	Type	Start Date	Infection Definition Met? (Y/N)	Resident for ≥48 hours? (Y/N)	Not Infected	Community	HAI's	Date Resolved	Isolated? (Type)

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EMPLOYEE INFECTION LINE LIST/LOG

DATE: _____

DATE	EMPLOYEE NAME	UNIT WORKED	SYMPTOMS OR COMPLAINTS (Nausea, vomiting, diarrhea, fever, cough, sore throat, infected skin lesions, etc.)	SEEN BY PHYSICIAN (Y/N)	CONFIRMED INFECTION (MD OR LAB)	DATE/TIME OF ONSET OF SYMPTOMS	NUMBER OF HOURS WITH NO SYMPTOMS	RETURN TO WORK DATE

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Facility Assessment Worksheet Summary
Infection Control

Policies: _____

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Risk Assessment: _____

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Facility Assessment: Policy and Procedure Evaluation Process

Facility Assessment: Policy and Procedure Evaluation

Reference F Tag

F838 §483.70(e) 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 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.

Guidance
The assessment must include or address an evaluation of the facility's training program to ensure any training needs are met for all new and existing staff, individuals providing services under a contractual arrangement, and volunteers, consistent with their expected roles. The assessment should also include an evaluation of what policies and procedures may be required in the provision of care and that these meet current professional standards of practice. If there are any concerns regarding training refer to §483.95 Training.

INTENT OF POLICY AND PROCEDURE PROCESS

The intent of this element of the facility assessment reflects the need for a facility to evaluate their policies and procedures that may be required to direct the provision of care. The policies need to meet current professional standards of practice.

POLICY AND PROCEDURE REVISION AND REVIEW

Evaluating the facility's policies and procedures that correlate to clinical and resident care practices is recommended to be part of the quality assurance and performance improvement (QAPI) process, annually or as needed. This process should include the following:

- Evaluation process
- Development based on the reference to evidence based standard of practice
- Determination of when new or updated policies are required
- Approval process for policies
- Training plan for new or revised policies

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HOW TO INCORPORATE INTO THE FACILITY ASSESSMENT

Per **§483.70(e), t**he facility assessment must include or address an evaluation of the facility's policies and procedures as it relates to the care and services provided to the resident population as indicated in the requirements.

Therefore, it is important to:

- Develop a policy and procedure revision process which is incorporated into the QAPI plan

- Use the information to answer the questions:
  - How does the facility review and revise policies and procedures required for the provision of care?
  - How do we ensure that those policies meet current professional standards of practice?
  - What is our process in determining the need for a new policy or revision of a policy required for the provision of care and service?

- Incorporate your processes into your QAPI plan.

- Monitor the facility assessment annually or upon a change in the facility's operation that would require a substantial modification in the assessment and adjust the policy and procedure revision process accordingly.

- Write a narrative description of the facility's process to evaluate what policies and procedures may be required in the provision of care and services and how the facility will add new policies or revise policies based upon resident population needs and standards of practice.

- See the Facility Assessment Template.

See the Facility Assessment Template SAMPLE related to the inclusion of the necessary information obtained via this process for the completion of the Facility Assessment.

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Quality Improvement Organizations, Facility Assessment Tool (2017),
http://qioprogram.org/facility-assessment-tool

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Data Collection Tools and/or Resources

The following Tools and Resources are included in this Section of **The RoP Facility Assessment Toolkit ©**

Item	Description	Source *(If Applicable)*
Policy and Procedure Review Checklist	Sample Template – This is a comprehensive excel spreadsheet the facility can use to track their policies and procedures, as well as proof of evaluation and update of policies	Pathway Health
Policies and Procedures in RoP	This tool is a cross walk which indicates every F Tag and guidance that specifically describes a need for a policy and procedure. This is NOT all encompassing, however serves as a foundational tool for the facility	Pathway Health
Facility Assessment Summary Worksheet	Template for team to use to summary findings and prepare for narrative Facility Assessment inclusion	Pathway Heath

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Policies in italics are referenced in the Guidance to Surveyors, Appendix PP A

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August 2018

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SECTION ONE

Policies in italics are referenced in the Guidance

Administration

Policy Description	Policy Number	Review Date	QAPI Approval
Mission Statement			
Governing Body			
Addendum: Governing Body Members*			
Administrative Qualifications and Responsibilities			
Administrator reports to and held accountable by Governing Body			
Conflict of Interest			
Public Disclosure Statement			
Designation of Individual in Absence of Executive Director/Administrator*			
Regulatory Compliance			
Addendum: Additional State Requirements*			
Development of Policies and Procedures			
Addendum: Policy Renewal/Revision Flow Sheet*			
Clinical Policies and Procedures management			
Use of Organizational Chart			
Addendum: Organizational Charts*			
Uniform Quality of Care			
Experimental Research and Investigational Studies			
Organizational Planning			
Telemedicine Program			
Financial Responsibility and Medicare Written Notices			
Program Planning			
Marketing Plan			
Communication with Family and Resident Groups			
Physician Licensure Verification			
Emergency resident transfer policy			

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to Surveyors, Appendix PP August 2018

Board Approval

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SECTION TWO

Policies in italics are referenced in the Guidance to Surveyors, Appendi

Financial Management

	Policy Number	Review Date	QAPI Approval	Board Approval
Annual Operating Budget				
Capital Expenditure Plan				
Financial Management and Control				
Financial Reports				
Billing and Collections				
Accounts Receivable Review				
Bad Debt Policy				
Contractual Allowances				
Cash Receipts				
Purchasing Authorization and Accounts Payable*				
Fixed Assets and Depreciation				
Payroll Processing				
Donated Funds				
Certificates of Insurance				

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SECTION Three

Policies in italics are referenced in the Guida

Quality Assurance Performance Improvement

	Policy Number	Review Date	QAPI Approval
Improving Organizational Performance			
Design and Scope of Program			
Governance and Leadership			
Feedback, Data Systems ad Monitoring			
*Addendum: Prioritization of Important Processes**			
Patient and Family/Caregiver Experience of Care Survey			
Addendum: Policy for Patient and Family/Caregiver Experience of Care Survey			
Incident Reporting			
Serious Adverse Events			
Root Cause Analysis/Action Plan			
Addendum: Root Cause Analysis/Action Plan Form			
Aggregation of Data/Information			
External Databases			
Performance Improvement Projects (PIPs)			
Systematic Analysis and Systemic Action			
Annual Program Evaluation			

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SECTION Four

Policies in italics

Personnel Policies

	Policy Number
Personnel Policies	
Human Resources	
Recruitment, Retention, Development, and Continuing Education	
Categories/Qualifications/Education of Personnel	
Selection/Hiring of Personnel	
Licensure/Certification/Registration	
Background screening and credentials verification	
Equal Opportunity Employer	
Job Descriptions	
Termination	
Personnel Turnover	
Attendance and Absenteeism	
Personnel Grievance Process	
Personal Vehicle Use/Mileage Reimbursements	
Dress and Appearance	
Sexual Harassment	
Standards of Conduct/Ethical Behavior	
Personnel Record Contents	
Performance Evaluations	
Progressive Discipline Policy	

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SECTION FIVE

Policies in italics

Job Descriptions

	Policy Number
Policy Statement	
Addendum: Job Description (Template)	
Addendum: Physical Requirements	
Professional Services Agreement for Medical Director	
Addendum: Professional Services Agreement for Medical Director (Sample)	
Executive Director/Administrator	
Finance Director	
Controller	
Human Resources Director	
Information Systems Director	
Marketing/Community Relations Director	
Director of Nursing Services	
Clinical Records Manager	
Clinical Supervisor	
Case Management Coordinator	
Referral/Intake Supervisor	
Performance Improvement Coordinator	
MDS Coordinator	
Registered Nurse	
Addendum: Performance Evaluation for the Registered Nurse	
Licensed Practical/Vocational Nurse	
Addendum: Performance Evaluation for the Licensed Practical/Vocational Nurse	
Certified Nursing Assistant	
Addendum: Performance Evaluation for the Certified Nursing Assistant	
Rehabilitation Supervisor	
Physical Therapist	
Physical Therapy Assistant	
Speech-Language Pathologist	
Occupational Therapist	
Certified Occupational Therapy Assistant	
Medical Social Worker	
Registered Dietician	
Secretary/Receptionist	
Billing Manager	
Data Entry/Computer Operator	
Billing/Collections Clerk	
Office Manager	
Payroll and Benefits Coordinator	

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SECTION SIX

Clinical Competency Program

Scope of the Program/Process Methodology
Competency Based Orientation
Orientation
Addendum: Personnel General Orientation Checklist
Abuse, neglect, exploitation, misappropriation prohibited
Personnel Development
Addendum: Personnel Development/Inservice Needs Assessment
Resource Information
Competency Program
Competency Assessments
Responsibilities/Supervision of Clinical Services
Training/Inservice Education
Certified Nursing Assistant Training
Specialized Services
Requirements for Supervisors/Preceptors
Addendum: Performance Observation Report (Sample)
Report to the Governing Body
Addendum: Organization Competence Report (Sample)
Addendum: Initial Competency Assessment Skills Checklist – Registered Nurse
Addendum: Initial Competency Assessment Skills Checklist – Licensed Practical/Vocational Nurse
Addendum: Initial Competency Assessment Skills Checklist – Infusion Nurse
Addendum: Initial Competency Assessment Skills Checklist – Nursing Assistant
Addendum: Initial Competency Assessment Skills Checklist – Physical Therapist
Addendum: Initial Competency Assessment Skills Checklist – Physical Therapy
Addendum: Initial Competency Assessment Skills Checklist – Physical Therapy Assistant
Addendum: Initial Competency Assessment Skills Checklist – Speech-Language Pathologist
Addendum: Initial Competency Assessment Skills Checklist – Occupational Therapist
Addendum: Initial Competency Assessment Skills Checklist – Occupational Therapy Assistant
Addendum: Initial Competency Assessment Skills Checklist – Medical Social Worker
Addendum: Initial Competency Assessment Skills Checklist – Registered Dietician
Level I Basic Competency Skills
Annual Competence Evaluation
Paid feeding assistant, how to obtain emergency assistance
Paid feeding assistant, verification of completion of state approved program

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SECTION Seven

Policies in italics are referenced

Residents Rights

	Policy Number	Review Date
Availability of Services		
Equal access to care		
Patient Bill of Rights		
Admission Criteria and Process		
Admission Documents		
Share pertinent policies at admission		
Limited conditions for transfer/discharge		
Room change		
Safeguard personal property & document high value property		
Informed Consent/Refusal of Treatment		
Addendum: Sample Informed Consent for Medical Photography		
Visitation Rights		
Resident or Representative Financial Responsibility		
Grievance Process		
Patient Privacy Rights		
Addendum: Notice of Privacy Practices*		
Criteria for admission to secured/locked unit		
Prohibit infection isolation as seclusion		
Initiate emergency restraints		
Minimum Necessary Requests For PHI		
Advance Directives		
Addendum: Advance Directive Information Statement		
Addendum: Durable Power of Attorney for Health Care*		
Bed Hold and Return		
Prevention of Abuse, Neglect, Exploitation and Misappropriation of Property		
Identification and reporting		
Investigation		

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Protecting residents		
Preventing retaliation		
Root cause analysis		
When and how to determine capacity to consent to sexual contact (prohibited with staff)		
Drug diversion as potential resident misappropriation		
Reporting of crimes		
Training		
Annual written notice of obligations		
Ethical Issues		
Organization List of Interpreters Language		
Social Media		
Addendum: Social Media and Blog Guidelines*		

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SECTION Eight

Social Services

Notification of state mental health organization for Level II PASARR change of status
Coordination of services with Hospice
Circumstances for facility responsibility for lost or broken dentures

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SECTION Eight

Policies in italics are referenced i

Social Services

	Policy Number	Review Date
Food ordering and recovering		
Food storage		
Cold food storage		
Facility Gardens		
Food handling and preparation		
Cleaning kitchen and food service equipment		
Pot luck events		
Food brought by visitors		
Staff assistance with food brought by visitors		
Resident personal food storage		
Resident personal refrigerator		
Sufficient staffing		
Nutrition employee illness		

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SECTION Ten

Policies in italic

Clinical Services and Programs

	Policy Number
Standards of Care, Service, and Practice	
Scope of Assessments	
Addendum: Drug Information for the Nurse	
Addendum: Medications Approved/Not Approved for Intravenous Administration*	
Addendum: Oral Dosage Forms That Should Not Be Crushed*	
Administration and Documentation of Medications	
Advance Directive, Do Not Resuscitate/Do Not Intubate Orders	
Assessment of Resident Change in Condition	
Assessment, RAI Process	
Assessment, Routine scheduled and as needed	
Assessments, Ongoing	
Behavior management, behaviors toward others	
Behavior management, exit seeking	
Behavior management, resident to resident altercation	
Behavior Management, wandering	
Care Conference/Progress Summary	
Care plan, Coordination of Services With Other Providers	
Care Plan, Interdisciplinary Person-Centered	
Care Plan, Nurse Aide Plan of Care	
Care Plan, Physician Participation	
CPR, Cardiopulmonary Resuscitation	
CPR, Staffing with CPR skills	
Discharge AMA	
Discharge Community Resources	
Discharge Criteria and Process	
Discharge Plan, Patient Education	
Discharge Planning	
Discharge Referral Process	

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Discharge Summary	
Educational Resources	
End of Life, Care of the Dying Resident	
Fall Reduction Program	
Hazardous Waste, Identification, Handling, and Disposal	
Infection Control Program	
Medication Error	
Medication Labeling	
Medication Monitoring	
Medication Reconciliation	
Medication, Adverse Drug Reactions	
Medication, Anaphylaxis Protocol	
Medication, Disposal of Controlled Substances	
Medication, Drug – Food Interactions	
Medication, Intravenous Administration of Medications/Solutions	
Medication, Intravenous insertion, maintenance and discontinuation	
Medication, Intravenous prevention of infection	
Medication, Intravenous Care and use of equipment	
Medication, Investigational Medications	
Medication, Patient Self-Administration	
Medication, Pulse Rate Determination With Certain Drugs	
Medications, Safe/Effective Use	
Medications, Storage of meds and Nutritional Products	
Notification of Changes in Care, resident, medical provider, representative	
Nursing Admission Process	
Pain management	
Pharmacy, Drug Regimen Review	
Physical restraint, Appropriate Use	
Restorative Nursing Program and Techniques	
Restorative nursing equipment use, cleaning, storage	
Safe/Effective Use of Equipment and Supplies	
Safety, resident smoking	
Skin integrity, Pressure Ulcer Prevention and Management Program	

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Skin integrity, treatment protocols approved by Medical Director	
Storage, Handling, and Access to Supplies and Gases	
Transfer Summary	
Transfer/Referral Process	
Verification of Physician Orders	
Catheter Care	
Infection control, collecting urine specimen	
Feeding tube, care	
Feeding tube, medication administration	
Feeding tube, change or replace	
Feeding tube, monitor for complications	
Feeding tube, verifying placement	
Respiratory Care and services	
Respiratory Care and services, pre-admission screening	
Dialysis, monitoring access site	
Dialysis, post-dialysis assessment	
Dialysis, communication with dialysis center	
Dialysis, response to complication or emergency	
Dialysis, cancelled or unable to attend dialysis	
Safety, physical device assessment bed rails and mattress	
Blood Transfusions, prevent transfusion reactions	
Blood Transfusions, identification of blood component prior to transfusion	

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SECTION Twelve

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Infection Control

	Policy Number	Review Date	QAPI AC Approval
Surveillance			
Identification and reporting communicable conditions			
Standard and Transmission-based Precautions			
Addendum: Standard Precautions Information for Personnel			
Personal Protective Equipment			
Addendum: Protective Device Checklist			
Addendum: Required Personal Protective Equipment Form			
Hand Hygiene			
Clean vs. Aseptic Technique			
Infection Control/Expanded Precautions			
Addendum: Bed Bug Guidance*			
Contaminated Waste Disposal			
Hazardous Waste Handling			
Addendum: Hazardous Waste Disposal State and Local Regulations*			
Accidental Exposure to Blood			
Evaluating and Maintaining Records of Infections Among Patients			
Addendum: Infection Identification—Patient Report			
Evaluating and Maintaining Records of Infections Among Personnel			
Addendum: Infection Identification—Personnel Report			
Reporting of Communicable Diseases			
Tuberculosis Exposure Control Plan			
Bloodborne Pathogens and Hepatitis B Exposure Control Plan			
Addendum: Hepatitis B Vaccination Documentation Form			
Addendum: Hepatitis B Vaccination Declination Form			
Addendum: Recognizing the Dangers			
Addendum: Occupational Exposure Risk By Job Classification			
Storage of Medications and Nutritional Therapies			
Glucose Monitoring and treatment			

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Linen handling			
Influenza and pneumococcal vaccines			

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SECTION Twelve

Safety

Record Keeping
Occupational Exposure Information and Training
Communication of Hazards to Personnel
Management of Exposures in Personnel
Environmental Safety Program
Addendum: Environment Checklist
Fire Safety
Utilities Management
Equipment Management
Environmental Safety—
Medical Equipment Malfunction
Safe Medical Device Act
Organization Personnel Safety—Personal Safety
Vehicle Accident Reporting
Waived Testing
Addendum: Organization List and Criteria for Waived Test Performed*
Safe and Appropriate Use of Home Medical Equipment and Supplies

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SECTION Thirteen

Pharmacy Services

Consulting pharmacist
System for receipt and disposition of controlled drugs
System for ordering, receipt and administering controlled medications
Controlled drug inventory discrepancy
Process for limited access to controlled drugs
Procedure to secure controlled drugs for self-administration
Medication regiment review
time frames
steps for communicating irregularities
MRR for short stay residents < 30 days
MRR for resident acute change in condition
Process for medical provider disagreement with recommendations
Procedure when attending physician is the Medical Director
Medication management, stop orders
Medication management, continuing antibiotics beyond recommended clinical guidelines
Medication management, dosing schedules
Medication management, process for identifying residents
Medication management, communicating physician orders, transfer orders to pharmacy
Medication management, communicating physician orders, telephone orders to pharmacy
Medication management, communicating physician orders, admission orders to pharmacy
Medication management, communicating physician orders, order renewals to pharmacy
Medication management, storage of medications

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SECTION Fourteen

Policies in italics

Pharmacy Services

	Policy Number
Physician visit, frequency	
Physician visit, delegation to Nurse Practitioner or Physician Assistant	
Physician visit, Electronic and rubber stamp signatures	
Physician visit, NP to conduct required visits	
Physician visit, off-site visits	
Physician services, Standing orders	
Physician services, 24 hour coverage	
Physician services, delegation of orders to registered dietician (state specific)	
Physician services, delegation of orders to qualified therapist (state specific)	

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SECTION Fifteen

Policies in italics

Diagnostic Services

	Policy Number
Laboratory, quality and timeliness of services	
Laboratory, reporting results outside the clinical reference range	
Laboratory, system for monitoring effectiveness of communication of lab findings	
Laboratory, arranging transport of specimens	
Radiology, definition of findings requiring reporting to the provider	
Radiology, system for monitoring effectiveness of communication of x-ray findings	

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SECTION Sixteen

Policies in italics

Environmental Services

	Policy Number
Bed frame and mattress inspection	

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SECTION Seventeen

Contracted resources

Job description or policy, effectively implement resident care policies and coordinate medical care
Process to address any performance issues if also attending MD
Participate in facility-specific policy and procedure development
Monitor other health professionals, communicates and resolves issues
Hospice agreements
orientation to facility policies

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SECTION Eighteen

Policies in italics are referenced ir

Emergency Response Plan

	Policy Number	Review Date
Contingency Planning		
Contingency Plan if Organization Closes		
Branch/Subunit Documentation Control		
Natural Disasters/Emergencies		
Addendum: Guidelines for Emergency Management*		
Emergency Management Plan		
Addendum: Pyramid Phone Communication Plan*		
Addendum: Weather Report/Road Conditions*		
Missing Resident		
Emergency water supply		

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SECTION Nineteen

Policies in italics are referenced in

Health Information Management

	Policy Number	Review Date
Contents of Clinical Record		
Record Retention		
Assembly of Clinical Record		
Abbreviations and Symbols		
Clinical/Service Data Collection		
Access to Information		
Principles of Information Management		
Privacy of Health Information of Deceased Individuals		
Patient Requests for Privacy Restrictions		
Patient Requests for Confidential Communications		
Patient Requests for Access to PHI		
Patient Requests for Accounting of PHI Disclosures		
Fundraising and PHI		
Marketing and PHI		
Privacy Training		
Enforcement for Privacy and Security Violations		
Identity Theft Prevention Program		
Safeguarding/Retrieval of Clinical/Service Record		
Computer Access to Information		
Business Associates		
Privacy of PHI		
Breach Analysis		
Breach Notification		
Security Management Process		
Workforce Security		
Information Access Management		
Security Awareness and Training		
Security Incident Procedures		
Workstation Use and Security		
Device and Media Controls		
Access Controls: Technical Safeguards		
HIPAA Security Audit Controls		
Integrity Controls		
Transmission Security		
Whistleblower Protection		
Electronic storage of MDS and Care Plan		
Electronic signatures		
Computer/Server Access security		
Privacy of records		

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SECTION Twenty

Corporate Compliance

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	Policy Number	Review Date
Corporate Compliance Plan		
Corporate Compliance Officer		
Internal Control Systems/Accountabilities		

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Policy and Procedures Required in the State Operations Manual, Appendix PP Reflecting Draft F tags effective November 28, 2017

F-Tags	Policy/Procedure/Process
563	Visitation rights of residents-reasonable clinical and safety restrictions/visitor access
565	Policy for how resident and family groups will be informed of facility policies and changes
572	Share pertinent policies at admission
578	Resident's rights to formulate an advance directive, refuse medical/surgical treatment. The policy delineates the steps necessary to promote these rights
580	Notification of changes: accident with injury, change in status, need to alter treatment, decision to transfer, room or roommate change, change in rights
583	Protecting resident privacy and confidentiality. (Social media, photographs)
585	Grievance Policy
600	Abuse-policy to identify when, how and by whom determination of capacity to consent to a sexual contact will be made and where this document will be recorded. Prohibit, Identify, report abuse Policy for Abuse prevention training Policy r/t aspects of Quality of Life and/or care, Advance directive, intimacy and relationships Policies re: care & services per current standards of practice
602	Policy for investigation of drug diversion as misappropriation of resident property
603	Secured locked units-including criteria for placement Policy for placement of residents for transmission precautions related to seclusion in the room
604	Policy re: wo can initiate emergency restraint
606	Screening procedures prior to employment
607	Prohibit and prevent abuse, neglect and exploitation and misappropriation Policies to investigate allegations Policy and procedure for training new and existing NH staff and in-service training for NA Prevention prohibit all types of abuse Written procedures to assist staff in identifying abuse, neglect Procedures for investigation Written procedures for protecting residents Written procedures for reporting allegations
608	Ensure reporting of crimes-including examples of crimes Written procedure notifying covered individuals annually of their obligation P&P promote culture of safety and open communication in the work environment Posting a conspicuous notice of employee rights Prohibiting and preventing retaliation
620	Admissions policy-stipulate limited conditions for transfer or discharge For room changes P&P to safeguard resident's personal property Process to document high-value personal property
621	Equal access to care and identical policies regarding transfer regardless of payment
625	Policy holding resident bed during periods of absence
626	Policy permitting resident to return to the facility
639	Policy for electronic storage of MDS with hard to copy to surveyors upon request

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Policy and Procedures Required in the State Operations Manual, Appendix PP
Reflecting Draft F tags effective November 28, 2017

F-Tags	Policy/Procedure/Process
642	Policy for electronic signatures- computer security measures
646	Process to notify appropriate state mental health or intellectual disability authority when a resident with a Level II PASARR has a significant change in mental or physical status
660	Process for discharge Against Medical Advice
678	CPR Systems and processes for Adequate # of staff present at all times who are properly trained Procedure to document a resident's choices regarding issues like CPR Code status
684	Care policies that are consistent with current professional standards of practice not only pain management about symptom control, but for assessing resident's physical, intellectual, emotional, social, and spiritual needs as appropriate. Policies must identify the ongoing collaboration and communication process between the nursing home and hospice
686	Skin Integrity Treatment protocols with Medical Director approval
688	Resident care policies restorative/rehab tx/services, also equipment use, cleaning and storage
689	Safety policies with input from staff Wandering/elopement Smoking Plan to locate missing resident Disaster and emergency preparedness
690	Catheter care and services Policy obtaining urine for culture
693	P&P Monitoring feeding tube Care of feeding tube Feeding tube replacement Complications
694	IV's - Policies for preparation, insertion administration, maintenance and discontinuance of IV as well as prevention of infection at site to extent possible. Care and use of all IV equipment, such a pumps, tubing, syringes, fluids
695	Respiratory-P&P for respiratory care and services prior to admission of a resident requiring specific types of respiratory care and services
698	Dialysis-monitoring of access site Types of dialysis that are provided in NH are consistent with current standards Cleaning policies if dialysis in-house Emergency meds for in-house dialysis
700	Process for scheduling for routine maintenance of beds and bed rails correct use
711	Facility practice of progress notes written, signed and dated at each physician visit in a chart of HER Policy for standing orders for influenza and pneumococcal vaccine

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Reflecting Draft F tags effective November 28, 2017

F-Tags	Policy/Procedure/Process
	Use of rubber stamp signatures
712	Policy if the resident leaves the grounds for medical care – (expectation that visit occurs at the facility) Policy for NP to conduct required visits
713	Agreement with another MD to provide physician services in the absence of the attending physician
714	Physician delegation of tasks to NP, CS, PA
715	Policy allowing physician to delegate the task of writing orders to qualified dietitian and qualified therapist-according to stat e law - how does the facility ensure the physician supervision of individuals performs these tasks
755	Policy for consulting pharmacist System of records of receipt and disposition of all controlled drugs Procedure acquiring controlled drugs process for medication orders, receiving and administering medications including transfer orders, admission orders, telephone orders order renewals and the MAR Policy for reporting controlled med count discrepancy
756	Drug Regimen Review –time frames for the different steps in the process and steps the pharmacist must take when irregularities require urgent action to protect the resident MRR for residents who are anticipated to stay < 30 days MRR for residents who experience an acute change of condition Procedure to resolve situation where physician does not concur with or take action on identified irregularities Procedure to resolve situation where the attending physician is the Medical Director
758	Med Management Stop orders for certain meds Policy for continuing antibiotic beyond recommended clinical guideline
759	Policy for checking feeding tube placement before med administration Policy for medication dosing schedules Policy for identification of residents prior to med admin
760	Policy or system for identification of resident system to limit who has security access and when access is used for controlled meds (scheduled II-IV) Procedure for control and safe storage of meds for those who can self-administer medication Procedures that address and monitor safe storage and handling of medications
761	Policies for quality and timeliness of Lab services
770	Labs-P&P for the quality and timeliness of services whether services are provided by the facility or an outside service
771	Prevent transfusion reactions Positive ID of blood components
773	P&P defining categories that are considered outside clinical reference ranges for lab values, the urgency of reporting values and a process for monitoring the effectiveness of communication

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Policy and Procedures Required in the State Operations Manual, Appendix PP
Reflecting Draft F tags effective November 28, 2017

F-Tags	Policy/Procedure/Process
774	Procedure for making transportation arrangements to and from source of service
777	Radiology-procedure for defining categories where follow-up is required, the urgency of reporting specific concerns and a process for monitoring the effectiveness of communication to ensure that communication was received and delegation by the ordering provider
790	Dental Services-identification of circumstances when the loss or damage of dentures is the facility's responsibility and may not charge a resident
811	Paid Feeding Assistants-Knowledge on how to obtain assistance in an emergency Process for verification of state approved training course
812	Food receiving and storage- Maintaining and harvesting the gardens, including ensuring manufacturer's instructions are followed if any pesticides, fertilizers or other topical or root-based plant preparations are applied Process for monitoring temperatures for refrigerators P&P to prevent the spread of foodborne illness and minimize food storage, preparation and handling practices that could cause food contamination and could compromise food and safety Cleaning schedule for kitchen and food service equipment Pot luck events Food from visitors Sufficient staffing No sick employees to work
813	Use and storage of personal food items-give to families and residents Personal refrigerator Food brought to residents by family and other visitors Staff assisting residents in accessing and consuming the food
837	Governing Body- Process by which administrator reports to governing body, the method of communication, how the governing body responds back How the administrator is held accountable and reports information Active governing body that is responsible for establishing and implementing policies regarding management of the facility
840	Timeliness of outside resources
841	Medical Director- Job description or policy for how Med Director will carry out responsibilities to effectively implement resident care policies and coordinate medical care If the medical director is also an attending physician there should be a process to ensure there are no concerns with the individual's performance as a physician-facility must have a process how to address this situation. Be involved in corporate policies and facility unique policy development Show participation in policy development System development to monitor performance of health care practitioners including mechanism for communicating and resolving issues r/t medical care and other licensed practitioners act within scope of practice

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Policy and Procedures Required in the State Operations Manual, Appendix PP Reflecting Draft F tags effective November 28, 2017

F-Tags	Policy/Procedure/Process
842	Electronic Signatures- P&P maintaining confidentiality of resident records Storage including archiving
843	Emergency resident transfer policy
846	Facility Closure-P&P must be in place at all time Administrator's duties and responsibilities Communication to receiving entities Roles and responsibilities of owners Provisions of ongoing operations during closure process Interview of residents and their legal for goals, preferences, offering community options, providing residents with information, access of another entity(s)
849	Hospice-written agreement Orientation of Hospice staff to facility policies
865	QAPI
866	Program feedback, data systems and monitoring Systems to obtain and use feedback Maintenance of effective system to identify, collect and use data and information Methodology and frequency for development, monitoring and evaluation of data
867	Use of a systematic approach to determine underlying causes of problems impacting larger systems Development of corrective actions that will be designed to effect change at the system level to prevent quality of care, quality of life or safety problems How the facility will monitor the effectiveness of its performance improvement activities to ensure that improvements are sustained
868	If Medical Director not present at QAA the process of communication of the content of the meeting to the Medical Director with his/her acknowledgement of the information
880	Infection Control System of surveillance When and to whom possible incidents of communicable disease or infections should be reported Standard and transmission-based precautions When and how isolation should be used The circumstances under which the facility must prohibit employees with a communicable disease Hand hygiene procedures to be followed P&P safe use of insulin pens Laundry Services-including off-site
881	Antibiotic Stewardship
883	Influenza and pneumococcal immunizations
895	Phase 3-compliance and ethics program
908	P&P for inspection of equipment, mattresses

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Policy and Procedures Required in the State Operations Manual, Appendix PP
Reflecting Draft F tags effective November 28, 2017

F-Tags	Policy/Procedure/Process
922	Procedure to ensure water is available to essential areas when there is a loss of normal water supply
926	Smoking policies
945	Train about Infection control policies

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Facility Assessment Worksheet Summary
Policy and Procedure Review Process

Resident Care: _____

_____

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Operations: _____

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Financial: _____

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Facility Assessment: Facility and Community Risk

Facility Assessment: Facility-Based and Community-Based Risk Assessment

Reference F Tags

F838 §483.70(e) Facility assessment
§483.70(e)(3) A facility-based and community-based risk assessment, utilizing an all-hazards approach.

Guidance
The facility based and community-based risk assessment, utilizing an all-hazards approach must evaluate the facility's ability to maintain continuity of operations and its ability to secure required supplies and resources during an emergency or natural disaster.

For example, if the facility is located in a flood zone, the risk assessment must include an evaluation of how residents will be kept safe and needs met during a flood affecting the facility.

Facility staff should consider involving their local/county Office of Emergency Preparedness when conducting this community based risk assessment. The facility's emergency preparedness plans as required under **§483.73 (Emergency Preparedness)** should be integrated and compatible with the facility assessment. As one is updated, so should the other.

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, we are using the term "risk assessment," which may include a variety of current industry practices used to assess and document potential hazards and their impacts. Hazard Vulnerability Assessments (HVAs) are systematic approaches to identifying hazards or risks that are most likely to have an impact on a healthcare facility and the surrounding community. The HVA describes the process by which a provider or supplier will assess and identify potential gaps in its emergency plan(s).

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Potential loss scenarios should be identified first during the risk assessment. Once a risk assessment has been conducted and a facility has identified the potential hazards/risks they may face, the organization can use those hazards/risks to conduct a Business Impact Analysis.

This guidance is not specifying which type of generally accepted emergency preparedness risk assessment facilities should have, as the language used in defining risk assessment activities is meant to be easily understood by all providers and suppliers that are affected by this final rule and is aligned with the national preparedness system and terminology (81 Fed. Reg. 63860, at 63875). However, facilities are expected to conduct a full assessment of hazards based on geographical location and the individual facility dynamics, such as patient population.

INTENT OF THE FACILITY-BASED AND COMMUNITY BASED-RISK ASSESSMENT

The intent of the all hazards approach to assessing risk, Facility-Based and Community-Based Risk Assessment is to assess and document potential hazards within the geographic area of the facility, the facility physical plant and the vulnerabilities and challenges that may impact the facility. The risk assessment will evaluate the facility's ability to maintain continuity of operations, its ability to provide care and services, and its ability to secure required supplies and resources during an emergency or natural disaster. Based upon these assessments, the facility will identify hazards and risks for residents and that information shall be incorporated into the Facility Assessment and Emergency Preparedness Plan.

CMS DEFINITIONS

CMS' Emergency Preparedness Appendix Z regulations contain specific terminology for which many providers requested clarification. The following definitions are contained in a Frequently Asked Questions (FAQs) document which can be downloaded from https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/SurveyCertEmergPrep/Emergency-Prep-Rule.html.

- **"All-Hazards Approach"** 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 internal emergencies and a man-made emergency (or both) or natural disaster. This approach is specific to the location of the provider or supplier and considers the particular type of hazards most likely to occur in their areas. These may include, but are 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

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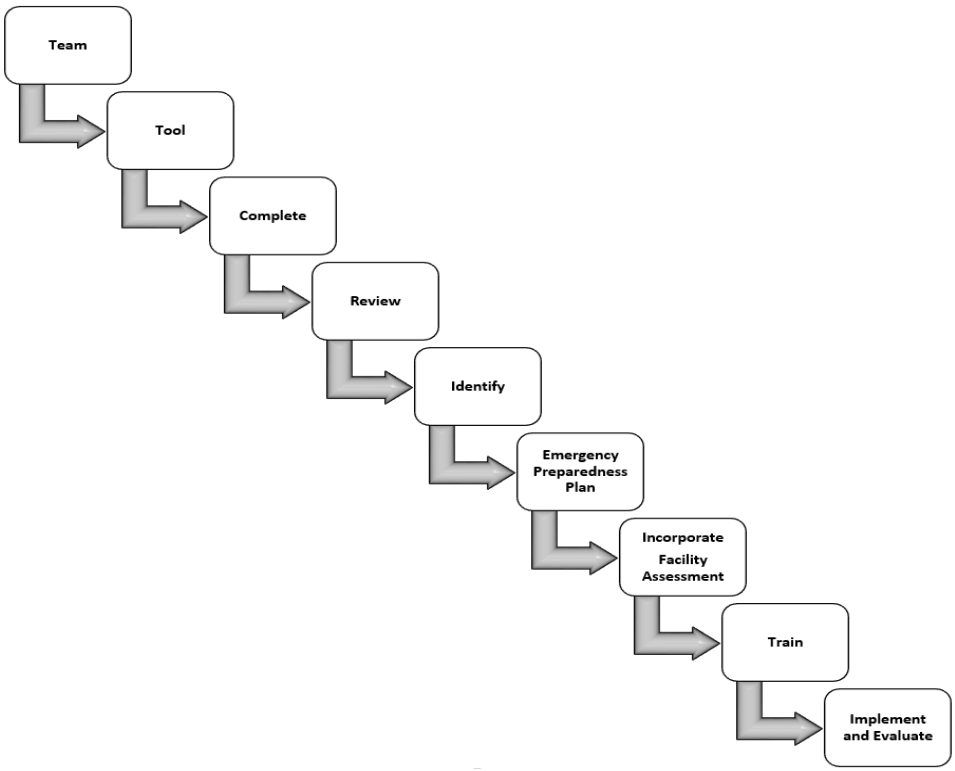
interruptions in the normal supply of essentials such as water and food. Rather than managing planning initiatives for a multitude of threat scenarios all-hazards planning focuses on developing capacities and capabilities that are critical to preparedness for a full spectrum of emergencies or disasters. Thus, all-hazards planning does not specifically address every possible threat but ensures those hospitals and all other providers and suppliers will have the capacity to address a broad range of related emergencies.

FACILITY-BASED AND COMMUNITY BASED-RISK ASSESSMENT PROCESS

The facility based and community-based risk assessment process is a team approach. Led by the facility administrator, the team will utilize an all hazards approach to complete the risk assessment in conjunction with the facility Emergency Preparedness Plan. The purpose of an all hazards risk assessment is to assist facilities in identifying the greatest threats and vulnerabilities within the facility and the community. Based upon the assessment, the resource or knowledge gaps can be addressed, correlate the findings with the Facility Assessment and complete the Emergency Preparedness Plan.

The following process is recommended for the completion of the Facility-Risk and Community-Risk assessment:



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1. **Team**
    a. Assemble a team led by the facility Administrator
    b. Specific team members as indicated and required
    c. Possible inclusion local/county Office of Emergency Management and other organizations as appropriate
2. **Tool**
    a. Determine the all hazards tool for team completion
    b. Recommend utilizing a Hazard Vulnerability Assessments (HVAs)
        i. Purpose of the HVA is to assist the facility in identifying the greatest threats and vulnerabilities within your facility or local community, as well as using the tool to plan for emergencies and address resource gaps
3. **Complete**
    a. Complete the all hazards tool per guidelines

4. **Review**
    a. Review and analyze the findings of the HVA
    b. Summarize the findings with the Team
    c. Focus on potential high volume, high risk areas

5. **Identify**
    a. Identify Hazards
        i. Hazards that may cause:
            1. Injury
            2. Property damage
            3. Business disruption
            4. Environmental impact
    b. Identify Vulnerabilities
    c. Determine potential Business Impact
        i. Lost revenue and billing capabilities
        ii. Labor costs – overtime and accessibility
        iii. Third party agreements and contingencies
        iv. Regulatory implications
        v. Recovery strategies and costs
        vi. Identification, document and recovery needs of key business functions and processes
        vii. Potential relocation plan (See Admission, transfer, discharge policies)
        viii. Insurance policies
    d. Community risk may include:
        i. Knowledge and skill of your community and of yourself as a provider in the community

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ii. Knowledge of the facility's consumers and local community residents
iii. Knowledge of the facility's capacity and capabilities

e. Determine and implement necessary actions related to hazards and vulnerabilities that are not addressed in the Emergency Preparedness Plan

6. **Emergency Preparedness**
   a. Plans for should identify threats or hazards, opportunities for prevention and risk mitigation

7. **Incorporate into Facility Assessment**
   a. Incorporate findings into the applicable sections of the written narrative Facility Assessment
   b. Refer to the Risk Assessment of the Emergency Preparedness Plan

8. **Train**
   a. Provide training to all staff as required
   b. Provide training to facility leadership as it relates to their respective roles and responsibilities *See facility Emergency Preparedness Plan

9. **Implement and Evaluate**
   a. Follow Emergency Preparedness Plan drill and implementation requirements
   b. The findings of the risk assessment should be integrated and compatible with the Facility Assessment and the Emergency Preparedness Plan.
      i. As one is updated, so should the other.
   c. The Facility Assessment, including the all hazards risk assessment, should be reviewed annually or updated per requirements

HOW TO INCORPORATE INTO THE FACILITY ASSESSMENT

Per §483.70(e)(3) the facility assessment must include or address an facility-based and community-based risk assessment, utilizing an all-hazards approach. Therefore, it is important to:

- Gather the outcomes data related to the all hazards approach risk assessment as described above.

- Use the information to answer the questions:
  - Has the facility identified potential hazards that may impede resident care delivery, day to day operations or operations during an emergency situation?
  - Has the facility identified potential vulnerabilities that may impede resident care delivery, day to day operations or operations during an emergency situation

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  - Has the facility determined the business impact of an emergency and incorporated a plan into the Emergency Preparedness Plan?
  - Has the facility identified the resource or knowledge gaps and correlate the findings with the Facility Assessment and complete the Emergency Preparedness Plan?

- Incorporate your processes into your QAPI plan.

- Monitor the facility assessment annually or upon a change in the facility's operation that would require a substantial modification in the assessment and adjust the facility training plan accordingly.

- Write a narrative description of the facility's facility-based and community-based risk assessment for inclusion, see below, into the narrative Facility Assessment. See the Facility Assessment Template.

- It is acceptable to refer to the risk assessment including in the emergency preparedness plan pursuant to 483.75

See the Facility Assessment Template SAMPLE related to the inclusion of the necessary information obtained via this process for the completion of the Facility Assessment.

References

State Operations Manual (SOM) Appendix PP for Phase 2, F-Tag Revisions, and Related Issues www.cms.gov/Medicare/Provider-Enrollment-and-Certification/GuidanceforLawsAndRegulations/Downloads/Advance-Appendix-PP-Including-Phase-2-.pdf

CMS Ref: S&C 17-29-ALL Advanced Copy – Appendix Z, Emergency Preparedness Final Rule Interpretive Guidelines and Survey Procedures https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/SurveyCertificationGenInfo/Downloads/Survey-and-Cert-Letter-17-29.pdf

Quality Improvement Organizations, Facility Assessment Tool (2017), http://qioprogram.org/facility-assessment-tool

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Data Collection Tools and/or Resources

The following Tools and Resources are included in this Section of **The RoP Facility Assessment Toolkit ©**

Item	Description	Source *(If Applicable)*
Hazard Vulnerability Assessment	This template will assist the facility complete their HVA to identify potential vulnerabilities. Search local state Emergency Preparedness Website for potential state specific HVA tools and resources	
S&C Memo 17-29 Emergency Preparedness	Advanced Copy – Appendix Z Emergency Preparedness Final Rule Interpretive Guidelines and Survey Procedures	CMS S&C Memo 17-29. (2017, June 2). Retrieved August, 2017, from https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/SurveyCertificationGenInfo/Downloads/Survey-and-Cert-Letter-17-29.pdf
S&C Emergency Preparedness Checklist	CMS Checklist to assist with the development and implementation of an Emergency Preparedness Plan – also includes Resource Links for provider use	Emergency Preparedness Checklist Recommended Tool for Effective Health Care Facility Planning. (2013). Retrieved August, 2017, from https://www.cms.gov/medicare/provider-enrollment-and-certification/surveycertemergprep/downloads/sandc_epchecklist_provider.pdf
CMS Emergency Preparedness Rule – Website Resources	CMS Resource List for health care providers	www.cms.gov/Medicare/Provider-Enrollment-and-Certification/SurveyCertEmergPrep/Downloads/General-Resources-for-Emergency-Preparedness.pdf
CMS Survey Tool for the E Tags – Post Acute Care	This is a cross walk interactive tool which walks through each E Tag and interpretive guidance	CMS E-Tags for LTC Emergency Preparedness. (2017). Retrieved August, 2017, from https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/SurveyCertEmergPrep/Emergency-Prep-Rule.html
Sample Transfer Agreement – CMS	Sample Transfer Agreement with Emergency Preparedness updates – CMS	https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/SurveyCertEmergPrep/Emergency-Prep-Rule.html
CMS – Health Coalition By State	CMS Resource List – Health Coalition - serve as resource for completion of HVA	www.cms.gov/Medicare/Provider-Enrollment-and-Certification/SurveyCertEmergPrep/Downloads/By-Name-by-State-Healthcare-Coalitions.pdf
Facility Assessment Summary Worksheet	Template for team to use to summary findings and prepare for narrative Facility Assessment inclusion	Pathway Heath

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HAZARD VULNERABILITY ASSESSMENT

Hazard identification and risk assessment provides a step by step, factual basis for activities proposed in the identification of risks and strategies for hazard mitigation. Hazard vulnerability analysis (HVA) and risk assessment are systematic approaches to identifying hazards or risks that are most likely to have an impact on a healthcare facility and the surrounding community.

An effective risk assessment informs proposed actions by focusing attention and resources on the greatest risks. The four basic components of a risk assessment are:

1. Hazard identification
2. Profiling of hazard events Inventory of assets
3. Estimation of potential human and economic losses based on the exposure and vulnerability of people, buildings, and infrastructure.

There are multiple tools (HVA's) and resources available to help facilities prioritize their planning efforts based on these identified hazards. Each state, through their Emergency Preparedness Coalition has tools, resources and training available for health care organizations.

Hazard Vulnerability Analysis Tool Examples

Kaiser Permanente has developed a Hazard Vulnerability Analysis tool which is available as a downloadable planning resource. Organizations using this tool are solely responsible for any hazard assessment, compliance with applicable regulations and laws as well as facility identification of hazards and vulnerabilities. This tool It can be accessed at:

The U.S. Department of Health & Human Services at
https://asprtracie.hhs.gov/technical-resources/resource/250/kaiser-permanente-hazard-vulnerability-analysis-hva-tool

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The Kaiser Permanente HVA tool, depicted below, is downloadable and customizable for your individual organization's needs.

1. Fill in facility specific information

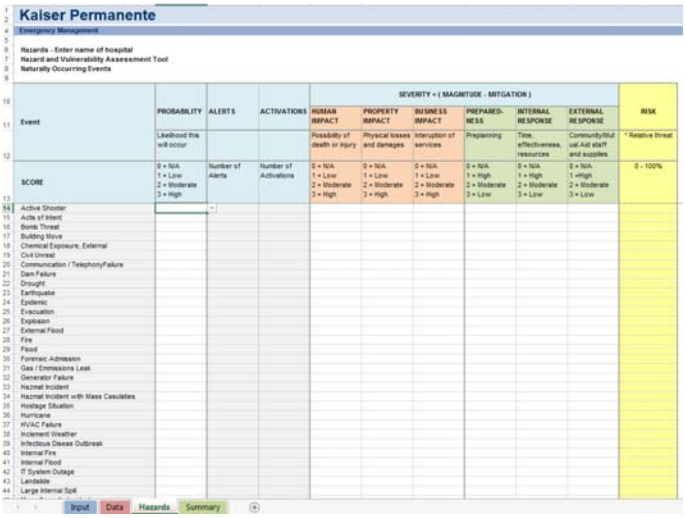
Kaiser Permanente

Emergency Management

Input

Report Year	
Last Saved	Thursday, January 05, 2017 at 01:58 PM
Report For	Enter name of hospital

2. Conduct your analysis with your team and complete the data collection section – including the type of hazard, impact, probability, response and risk level.



Kaiser Permanente

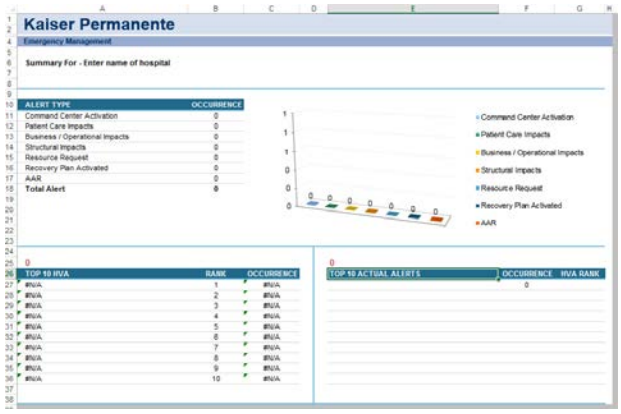
Emergency Management

Hazards - Enter name of hospital
Hazard and Vulnerability Assessment Tool
Naturally Occurring Events

Event	PROBABILITY	ALERTS	ACTIVATIONS	SEVERITY = (MAGNITUDE - MITGATION) HUMAN IMPACT	PROPERTY IMPACT	BUSINESS IMPACT	PREPARED-NESS	INTERNAL RESPONSE	EXTERNAL RESPONSE	RISK
	Likelihood this will occur			Possibility of death or injury	Physical losses and damages	Interuption of services	Preplanning	Time, effectiveness, resources	Community/Mutual Aid staff and supplies	* Relative threat
SCORE	0 = N/A 1 = Low 2 = Moderate 3 = High	Number of Alerts	Number of Activations	0 = N/A 1 = Low 2 = Moderate 3 = High	0 = N/A 1 = Low 2 = Moderate 3 = High	0 = N/A 1 = Low 2 = Moderate 3 = High	0 = N/A 1 = High 2 = Moderate 3 = Low	0 = N/A 1 = High 2 = Moderate 3 = Low	0 = N/A 1 =High 2 = Moderate 3 = Low	0 - 100%
Active Shooter										
Acts of Intent										
Bomb Threat										
Building Move										
Chemical Exposure, External										
Civil Unrest										
Communication / TelephonyFailure										
Dam Failure										
Drought										
Earthquake										
Epidemic										
Evacuation										
Explosion										
External Flood										
Fire										
Flood										
Forensic Admission										
Gas / Emmissions Leak										
Generator Failure										
Hazmat Incident										
Hazmat Incident with Mass Casualties										
Hostage Situation										
Hurricane										
HVAC Failure										
Inclement Weather										
Infectious Disease Outbreak										
Internal Fire										
Internal Flood										
IT System Outage										
Landslide										
Large Internal Spill										

Input | Data | Hazards | Summary

3. Summarizes your individual facility information, identifying the specific trends as required.



Kaiser Permanente

Emergency Management

Summary For - Enter name of hospital

ALERT TYPE	OCCURRENCE
Command Center Activation	0
Patient Care Impacts	0
Business / Operational Impacts	0
Structural Impacts	0
Resource Request	0
Recovery Plan Activated	0
AAR	0
Total Alert	0

Command Center Activation
Patient Care Impacts
Business / Operational Impacts
Structural Impacts
Resource Request
Recovery Plan Activated
AAR

TOP 10 HVA	RANK	OCCURRENCE
#N/A	1	#N/A
#N/A	2	#N/A
#N/A	3	#N/A
#N/A	4	#N/A
#N/A	5	#N/A
#N/A	6	#N/A
#N/A	7	#N/A
#N/A	8	#N/A
#N/A	9	#N/A
#N/A	10	#N/A

TOP 10 ACTUAL ALERTS	OCCURRENCE	HVA RANK
	0	

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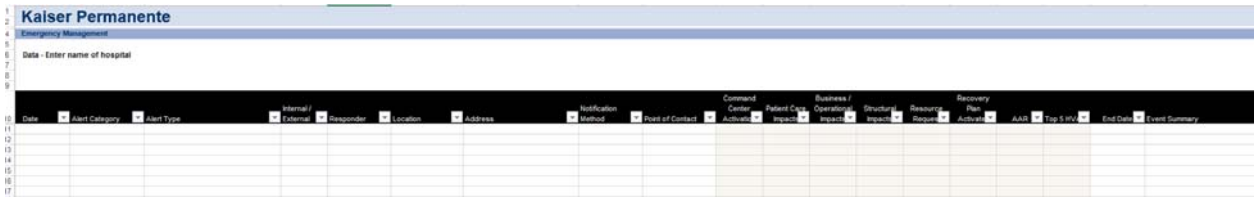
4. Should an incident occur, it provides a log to document your organization's response and correlates back to your HVA analysis.



Kaiser Permanente

Emergency Management

Data - Enter name of hospital

Date	Alert Category	Alert Type	Internal / External	Responder	Location	Address	Notification Method	Point of Contact	Command Center Activated	Patient Care Impacts	Business / Operational Impacts	Structural Impacts	Resource Request	Recovery Plan Activated	AAR	Top 5 HVA	End Date	Event Summary

ACCESS STATE AND LOCAL SPECIFIC RESOURCES

All State Health Care Coalition Listing

https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/SurveyCertEmergPrep/Downloads/By-Name-by-State-Healthcare-Coalitions.pdf

Additional Resources related to HVA

U.S. Department of Health & Human Services – Emergency Response
https://asprtracie.hhs.gov/technical-resources

Long Term Care HVA Resources
Department of Health and Human Services
https://asprtracie.hhs.gov/technical-resources/52/long-term-care-facilities/47

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DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
7500 Security Boulevard, Mail Stop C2-21-16
Baltimore, Maryland 21244-1850

Center for Clinical Standards and Quality/Survey & Certification Group

Ref: S&C 17-29-ALL

DATE: **June 02, 2017**

TO: State Survey Agency Directors

FROM: Director
Survey and Certification Group

SUBJECT: Advanced Copy- Appendix Z, Emergency Preparedness Final Rule Interpretive Guidelines and Survey Procedures

Memorandum Summary

- **Advanced Copy of Interpretive Guidelines:** The Centers for Medicare & Medicaid Services (CMS) is releasing a new Appendix Z of the State Operations Manual (SOM) which contains the interpretive guidelines and survey procedures for the Emergency Preparedness Final Rule.
- **Affects all 17 providers and suppliers:** Appendix Z applies to all 17 providers and suppliers included in the Final Rule.

Background

On September 16, 2016, the final rule on Emergency Preparedness Requirements for Medicare and Medicaid Participating Providers and Suppliers was published (Federal Register Vol. 81, No. 180). This rule affects all 17 provider and supplier types eligible for participation in Medicare. The rule became effective on November 15, 2016 and will be implemented on November 15, 2017.

Interpretive Guidance

An advanced copy of the interpretive guidelines and survey procedures is available and will be incorporated into the SOM under Appendix Z and applies to all 17 provider and supplier types. Since the Conditions of Participation (CoPs), Conditions for Coverage (CfCs) and requirements apply across providers and suppliers and only vary slightly, CMS has compiled the requirements under one appendix.

Note: For ease of understanding the guidelines, we have kept this copy as a clean copy without red italics. The final version that will be incorporated into the on-line SOM may vary slightly. The final SOM version is the final policy.

Understanding the Tags for Surveyors

Similar to how Life Safety Code (LSC) requirements have a set of K-Tags that are utilized for citations for multiple provider and supplier types, the emergency preparedness requirements will have a set of tags that will be utilized to cite non-compliance for all 17 provider and supplier types included in the final rule. The tags for emergency preparedness will be "E" Tags and accessible to both health and safety surveyors and LSC Surveyors. State survey agencies will have discretion regarding whether the LSC or health and safety surveyors will conduct the emergency preparedness surveys. **Note: Surveying for compliance with the emergency preparedness requirements does not begin before November 15, 2017.**

The current survey processes and enforcement procedures for each provider and supplier type will remain the same.

We will also be posting an Excel Spreadsheet in which surveyors may filter by their provider/supplier types by selecting "yes" to determine which tags apply to which provider. The location of the document will be https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/SurveyCertEmergPrep/Emergency-Prep-Rule.html, under downloads.

Contact: For questions regarding the Emergency Preparedness Rule, please contact SCGEmergencyPrep@cms.hhs.gov.

Effective Date: Immediately. This policy should be communicated with all survey and certification staff, their managers and the State/Regional Office training coordinators within 30 days of this memorandum.

/s/
David R. Wright

Attachment- Advanced Copy Appendix Z, Emergency Preparedness Interpretive Guidelines

cc: Survey and Certification Regional Office Management

The contents of this letter support activities or actions to improve patient or resident safety and increase quality and reliability of care for better outcomes.

State Operations Manual
Appendix Z- Emergency Preparedness for All Provider and Certified Supplier Types Interpretive Guidance
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(Rev. XXXX, TBD)

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Introduction

The "Medicare and Medicaid Programs; Emergency Preparedness Requirements for Medicare and Medicaid Participating Providers and Suppliers" Final Rule (81 FR 63860, Sept. 16, 2016) ("Final Rule") establishes national emergency preparedness requirements for participating providers and certified suppliers to plan adequately for both natural and man-made disasters, and coordinate with Federal, state, tribal, regional and local emergency preparedness systems. The Final Rule also assists providers and suppliers to adequately prepare to meet the needs of patients, clients, residents, and participants during disasters and emergency situations, striving to provide consistent requirements across provider and supplier-types, with some variations. The new emergency preparedness Final Rule is based primarily off of the hospital emergency preparedness Condition of Participation (CoP) as a general guide for the remaining providers and suppliers, then tailored based to address the differences and or unique needs of the other providers and suppliers (e.g. inpatient versus out-patient providers). The requirements are focused on three key essentials necessary for maintaining access to healthcare during disasters or emergencies: safeguarding human resources, maintaining business continuity, and protecting physical resources. The interpretive guidelines and survey procedures in this appendix have been developed to support the adoption of a standard all- hazards emergency preparedness program for all certified providers and suppliers while similarly including appropriate adjustments to address the unique differences of the other providers and suppliers and their patients. Successful adoption of these requirements will enable all providers and suppliers wherever they are located to better anticipate and plan for needs, rapidly respond as a facility, as well as integrate with local public health and emergency management agencies and healthcare coalitions' response activities and rapidly recover following the disaster.

Because the individual regulations for each specific provider and supplier share a majority of standard provisions, we have developed this Appendix Z to provide consistent interpretive guidance and survey procedures located in a single document Unless otherwise indicated, the general use of the terms "facility" or "facilities" in this Appendix refers to all provider and suppliers addressed in the Final Rule and in this appendix. Additionally, the term "patient(s)" within this appendix includes patients, residents and clients unless otherwise stated. Finally, as some specific citations between providers vary, but the language is the same, we have inserted the citation to reflect as [(z) or (y), (x)] as the only the citation number varies by provider or supplier type.

Survey Protocol

These Conditions of Participation (CoP), Conditions for Coverage (CfC), Conditions for Certification and Requirements follow the standard survey protocols currently in place for each facility type and will be assessed during initial, revalidation, recertification and complaint surveys as appropriate. Compliance with the Emergency Preparedness requirements will be determined in conjunction with the existing survey process for health and safety compliance surveys or Life Safety Code (LSC) surveys for each provider and supplier type.

Important Note: Unless otherwise indicated, the general use of the terms "facility" or "facilities" in this Appendix refers to all provider and suppliers addressed in this appendix. This is a generic moniker used in lieu of the specific provider or supplier noted in the regulations. For varying requirements, the specific regulation for that provider/supplier will be noted as well. This Appendix annotates under the Interpretive Guidelines sections for which providers or suppliers the specific standard does not apply to, unless the standard only applies to one provider or supplier type.

Definitions

Emergency/Disaster: An event that can affect the facility internally as well as the overall target population or the community at large or community or a geographic area.

Emergency: A hazard impact causing adverse physical, social, psychological, economic or political effects that challenges the ability to respond rapidly and effectively. It requires a stepped-up capacity and capability (call-back procedures, mutual aid, etc.) to meet the expected outcome, and commonly requires change from routine management methods to an incident command process to achieve the expected outcome (see "disaster" for important contrast between the two terms).
Reference: Assistant Secretary for Preparedness and Response (ASPR) *2017-2022 Health Care Preparedness and Response Capabilities Document (ICDRM/GWU Emergency Management Glossary of Terms)* (November 2016).

Disaster: A hazard impact causing adverse physical, social, psychological, economic or political effects that challenges the ability to respond rapidly and effectively. Despite a stepped-up capacity and capability (call-back procedures, mutual aid, etc.) and change from routine management methods to an incident command/management process, the outcome is lower than expected compared with a smaller scale or lower magnitude impact (see "emergency" for important contrast between the two terms).
Reference: Assistant Secretary for Preparedness and Response (ASPR) *2017-2022 Health Care Preparedness and Response Capabilities Document (ICDRM/GWU Emergency Management Glossary of Terms)* (November 2016).

Emergency Preparedness Program: The Emergency Preparedness Program describes a facility's comprehensive approach to meeting the health, safety and security needs of the facility, its staff, their patient population and community prior to, during and after an emergency or disaster. The program encompasses four core elements: an Emergency Plan

that is based on a Risk Assessment and incorporates an all hazards approach; Policies and Procedures; Communication Plan; and the Training and Testing Program.

Emergency Plan: An emergency plan provides the framework for the emergency preparedness program. The emergency plan is developed based on facility- and community-based risk assessments that assist a facility in anticipating and addressing facility, patient, staff and community needs and support continuity of business operations.

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. All facilities must develop an all-hazards emergency preparedness program and plan.

Facility-Based: We consider the term "facility-based" to mean the emergency preparedness program is specific to the facility. It includes but is not limited to hazards specific to a facility based on its geographic location; dependent patient/resident/client and community population; facility type and potential surrounding community assets- i.e. rural area versus a large metropolitan area.

Risk Assessment: The term risk assessment describes a process facilities use to assess and document potential hazards that are likely to impact their geographical region, community, facility and patient population and identify gaps and challenges that should be considered and addressed in developing the emergency preparedness program. The term risk assessment is meant to be comprehensive, and may include a variety of methods to assess and document potential hazards and their impacts. The healthcare industry has also referred to risk assessments as a Hazard Vulnerability Assessments or Analysis (HVA) as a type of risk assessment commonly used in the healthcare industry.

Full-Scale Exercise: A full scale exercise is an operations-based exercise that typically involves multiple agencies, jurisdictions, and disciplines performing functional (for example, joint field office, emergency operation centers, etc.) and integration of operational elements involved in the response to a disaster event, i.e. ''boots on the ground'' response activities (for example, hospital staff treating mock patients).

Table-top Exercise (TTX): A tabletop exercise involves key personnel discussing simulated scenarios in an informal setting. TTXs can be used to assess plans, policies, and procedures. A tabletop exercise is a discussion-based exercise that involves senior staff, elected or appointed officials, and other key decision making personnel in a group discussion centered on a hypothetical scenario. TTXs can be used to assess plans, policies, and procedures without deploying resources.

Staff: The term "staff" refers to all individuals that are employed directly by a facility. The phrase "individuals providing services under arrangement" means services furnished under arrangement that are subject to a written contract conforming with the requirements specified in section 1861(w) of the Act.

E-0001
(Issued XX-XX-17)

§403.748, §416.54, §418.113, §441.184, §460.84, §482.15, §483.73, §483.475, §484.22, §485.68, §485.625, §485.727, §485.920, §486.360, §491.12

The [*facility*, except for Transplant Center] must comply with all applicable Federal, State and local emergency preparedness requirements. The [*facility*] must establish and maintain a [comprehensive] emergency preparedness program that meets the requirements of this section.* The emergency preparedness program must include, but not be limited to, the following elements:

* (*Unless otherwise indicated, the general use of the terms "facility" or "facilities" in this Appendix refers to all provider and suppliers addressed in this appendix. This is a generic moniker used in lieu of the specific provider or supplier noted in the regulations. For varying requirements, the specific regulation for that provider/supplier will be noted as well.*)

*[*For hospitals at §482.15:*] **The hospital must comply with all applicable Federal, State, and local emergency preparedness requirements. The hospital must develop and maintain a comprehensive emergency preparedness program that meets the requirements of this section, utilizing an all-hazards approach. The emergency preparedness program must include, but not be limited to, the following elements:**

*[*For CAHs at §485.625:*] **The CAH must comply with all applicable Federal, State, and local emergency preparedness requirements. The CAH must develop and maintain a comprehensive emergency preparedness program, utilizing an all-hazards approach. The emergency preparedness program must include, but not be limited to, the following elements:**

Interpretive Guidelines applies to: §403.748, §416.54, §418.113, §441.184, §460.84, §482.15, §483.73, §483.475, §484.22, §485.68, §485.625, §485.727, §485.920, §486.360, §491.12.

Note: This does not apply to Transplant Centers.
Note: The word comprehensive is not used in the language for ASCs.

Under this condition/requirement, facilities are required to develop an emergency preparedness program that meets all of the standards specified within the condition/requirement. The emergency preparedness program must describe a facility's comprehensive approach to meeting the health, safety, and security needs of their staff and patient population during an emergency or disaster situation. The program must also address how the facility would coordinate with other healthcare facilities, as well as the

whole community during an emergency or disaster (natural, man-made, facility). The emergency preparedness program must be reviewed annually.

A comprehensive approach to meeting the health and safety needs of a patient population should encompass the elements for emergency preparedness planning based on the "all-hazards" definition and specific to the location of the facility. For instance, a facility in a large flood zone, or tornado prone region, should have included these elements in their overall planning in order to meet the health, safety, and security needs of the staff and of the patient population. Additionally, if the patient population has limited mobility, facilities should have an approach to address these challenges during emergency events. The term "comprehensive" in this requirement is to ensure that facilities do not only choose one potential emergency that may occur in their area, but rather consider a multitude of events and be able to demonstrate that they have considered this during their development of the emergency preparedness plan.

Survey Procedures

- Interview the facility leadership and ask him/her/them to describe the facility's emergency preparedness program.
- Ask to see the facility's written policy and documentation on the emergency preparedness program.
- For hospitals and CAHs only: Verify the hospital's or CAH's program was developed based on an all-hazards approach by asking their leadership to describe how the facility used an all-hazards approach when developing its program.

E-0002

(Issued XX-XX-17)

§482.78 Condition of participation: Emergency preparedness for transplant centers. A transplant center must be included in the emergency preparedness planning and the emergency preparedness program as set forth in § 482.15 for the hospital in which it is located. However, a transplant center is not individually responsible for the emergency preparedness requirements set forth in § 482.15.

Interpretive Guidelines for §482.78.

A representative from each transplant center must be actively involved in the development and maintenance of the hospital's emergency preparedness program, as required under §482.15(g)(1).

Transplant centers would still be required to have their own emergency preparedness policies and procedures as required under §482.78(a), as well as participate in mutually-agreed upon protocols that address the transplant center, hospital, and OPO's duties and responsibilities during an emergency.

Survey Procedures

- Verify that a representative from the transplant center was included in the planning of the emergency preparedness program of the hospital in which the transplant center is located.

E-0003
(Issued XX-XX-17)

§494.62 Condition for Coverage: The dialysis facility must comply with all applicable Federal, State, and local emergency preparedness requirements. These emergencies include, but are not limited to, fire, equipment or power failures, care related emergencies, water supply interruption, and natural disasters likely to occur in the facility's geographic area.

The dialysis facility must establish and maintain an emergency preparedness program that meets the requirements of this section. The emergency preparedness program must include, but not be limited to, the following elements:

Interpretive Guidelines for §494.62.

Under this condition, the ESRD facility is required to develop and update an emergency preparedness program that meets all of the standards contained within the condition. The emergency preparedness program must describe a facility's comprehensive approach to meeting the health and safety needs of their patient population during an emergency; as well as the whole community during and surrounding an emergency event (natural or man-made).

Survey Procedures
- Ask to see written or electronic documentation of the program.

E-0004
(Issued XX-XX-17)

§403.748(a), §416.54(a), §418.113(a), §441.184(a), §460.84(a), §482.15(a), §483.73(a), §483.475(a), §484.22(a), §485.68(a), §485.625(a), §485.727(a), §485.920(a), §486.360(a), §491.12(a), §494.62(a).

The [*facility*] must comply with all applicable Federal, State and local emergency preparedness requirements. The [*facility*] must develop establish and maintain a comprehensive emergency preparedness program that meets the requirements of this section.

***** [*For hospitals at §482.15 and CAHs at §485.625(a)*:] **The [*hospital or CAH*] must comply with all applicable Federal, State, and local emergency preparedness requirements. The [*hospital or CAH*] must develop and maintain a comprehensive emergency preparedness program that meets the requirements of this section, utilizing an all-hazards approach.**

The emergency preparedness program must include, but not be limited to, the following elements:]

(a) Emergency Plan. **The [*facility*] must develop and maintain an emergency preparedness plan that must be [reviewed], and updated at least annually. The plan must do all of the following:**

* [*For ESRD Facilities at §494.62(a)*:] **Emergency Plan**. **The ESRD facility must develop and maintain an emergency preparedness plan that must be [evaluated], and updated at least annually.**

Interpretive Guidelines applies to: §403.748(a), §416.54(a), §418.113(a), §441.184(a), §460.84(a), §482.15(a), §483.73(a), §483.475(a), §484.22(a), §485.68(a), §485.625(a), §485.727(a), §485.920(a), §486.360(a), §491.12(a), §494.62(a).

Note: This does not apply to Transplant Centers.

Facilities are required to develop and maintain an emergency preparedness plan. The plan must include all of the required elements under the standard. The plan must be reviewed and updated at least annually. The annual review must be documented to include the date of the review and any updates made to the emergency plan based on the review. The format of the emergency preparedness plan that a facility uses is at its discretion.

An emergency plan is one part of a facility's emergency preparedness program. The plan provides the framework, which includes conducting facility-based and community-based risk assessments that will assist a facility in addressing the needs of their patient populations, along with identifying the continuity of business operations which will provide support during an actual emergency. In addition, the emergency plan supports, guides, and ensures a facility's ability to collaborate with local emergency preparedness officials. This approach is specific to the location of the facility and considers particular hazards most likely to occur in the surrounding area. These include, but are not limited to:

- Natural disasters
- Man-made disasters,
- Facility-based disasters that include but are not limited to:
    - Care-related emergencies;
    - Equipment and utility failures, including but not limited to power, water, gas, etc.;
    - Interruptions in communication, including cyber-attacks;
    - Loss of all or portion of a facility; and
    - Interruptions to the normal supply of essential resources, such as water, food, fuel (heating, cooking, and generators), and in some cases, medications and medical supplies (including medical gases, if applicable).

When evaluating potential interruptions to the normal supply of essential services, the facility should take into account the likely durations of such interruptions. Arrangements or contracts to re-establish essential utility services during an emergency should describe the timeframe within which the contractor is required to initiate services after the start of the emergency, how they will be procured and delivered in the facility's local area, and that the contractor will continue to supply the essential items throughout and to the end of emergencies of varying duration.

Survey Procedures

- Verify the facility has an emergency preparedness plan by asking to see a copy of the plan.
- Ask facility leadership to identify the hazards (e.g. natural, man-made, facility, geographic, etc.) that were identified in the facility's risk assessment and how the risk assessment was conducted.
- Review the plan to verify it contains all of the required elements
- Verify that the plan is reviewed and updated annually by looking for documentation of the date of the review and updates that were made to the plan based on the review

E-0005

(Issued XX-XX-17)

§482.78(a) Standard: Policies and procedures. A transplant center must have policies and procedures that address emergency preparedness. These policies and procedures must be included in the hospital's emergency preparedness program.

Interpretive Guidelines for §482.78(a).

Transplant centers must be actively involved in their hospital's emergency planning and programming under §482.15(g). The transplant center's emergency preparedness plans must be included in the hospital's emergency plans. All of the Medicare-approved transplant centers are located within certified hospitals and, as part of the hospital, must be included in the hospital's emergency preparedness plans. The transplant center needs to be involved in the hospital's risk assessment because there may be risks to the transplant center that others in the hospital may not be aware of or appreciate. However, most of the risk assessment of the hospital and transplant center would be the same since the transplant center is located within the hospital. Therefore a separate risk assessment would be unnecessary and overly burdensome.

Survey Procedures

- Verify the transplant center has emergency preparedness policies and procedures.
- Verify that the transplant center's emergency preparedness policies and procedures are included in the hospital's emergency preparedness program.

E-0006

(Issued XX-XX-17)

§403.748(a)(1)-(2), §416.54(a)(1)-(2), §418.113(a)(1)-(2), §441.184(a)(1)-(2), §460.84(a)(1)-(2), §482.15(a)(1)-(2), §483.73(a)(1)-(2), §483.475(a)(1)-(2), §484.22(a)(1)-(2), §485.68(a)(1)-(2), §485.625(a)(1)-(2), §485.727(a)(1)-(2), §485.920(a)(1)-(2), §486.360(a)(1)-(2), §491.12(a)(1)-(2), §494.62(a)(1)-(2)

[(a) Emergency Plan. **The [*facility*] must develop and maintain an emergency preparedness plan that must be reviewed, and updated at least annually. The plan must do the following:]**

(1) Be based on and include a documented, facility-based and community-based risk assessment, utilizing an all-hazards approach.*
*[*For LTC facilities at §483.73(a)(1):*] **(1) Be based on and include a documented, facility-based and community-based risk assessment, utilizing an all-hazards approach, including missing residents.**

*[*For ICF/IIDs at §483.475(a)(1):*] **(1) Be based on and include a documented, facility-based and community-based risk assessment, utilizing an all-hazards approach, including missing clients.**

(2) Include strategies for addressing emergency events identified by the risk assessment.

* [*For Hospices at §418.113(a)(2)*:] **(2) Include strategies for addressing emergency events identified by the risk assessment, including the management of the consequences of power failures, natural disasters, and other emergencies that would affect the hospice's ability to provide care.**

Interpretive Guidelines applies to: §403.748(a)(1)-(2), §416.54(a)(1)-(2), §418.113(a)(1)-(2), §441.184(a)(1)-(2), §460.84(a)(1)-(2), §482.15(a)(1)-(2), §483.73(a)(1)-(2), §483.475(a)(1)-(2), §484.22(a)(1)-(2), §485.68(a)(1)-(2), §485.625(a)(1)-(2), §485.727(a)(1)-(2), §485.920(a)(1)-(2), §491.12(a)(1)-(2), §494.62(a)(1)-(2).

Note: This does not apply to Transplant Centers.

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. Facilities must document both risk assessments. 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. This approach is specific to the location of the facility considering the types of hazards most likely to occur in the area. 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. Facilities are encouraged to utilize the concepts outlined in the

National Preparedness System, published by the United States Department of Homeland Security's Federal Emergency Management Agency (FEMA), as well as guidance provided by the Agency for Healthcare Research and Quality (AHRQ).

"Community" is not defined in order to afford facilities the flexibility in deciding which healthcare facilities and agencies it considers to be part of its community for emergency planning purposes. However, the term could mean entities within a state or multi-state region. The goal of the provision is to ensure that healthcare providers collaborate with other entities within a given community to promote an integrated response. Conducting integrated planning with state and local entities could identify potential gaps in state and local capabilities that can then be addressed in advance of an emergency.

Facilities may rely on a community-based risk assessment developed by other entities, such as public health agencies, emergency management agencies, and regional health care coalitions or in conjunction with conducting its own facility-based assessment. If this approach is used, facilities are expected to have a copy of the community-based risk assessment and to work with the entity that developed it to ensure that the facility's emergency plan is in alignment.

When developing an emergency preparedness plan, facilities are expected to consider, among other things, the following:

- Identification of all business functions essential to the facility's operations that should be continued during an emergency;
- Identification of all risks or emergencies that the facility may reasonably expect to confront;
- Identification of all contingencies for which the facility should plan;
- Consideration of the facility's location;
- Assessment of the extent to which natural or man-made emergencies may cause the facility to cease or limit operations; and,
- Determination of what arrangements may be necessary with other health care facilities, or other entities that might be needed to ensure that essential services could be provided during an emergency.

In situations where the facility does not own the structure(s) where care is provided, it is the facility's responsibility to discuss emergency preparedness concerns with the landlord to ensure continuation of care if the structure of the building and its utilities are impacted.

For LTC facilities and ICF/IIDs, written plans and the procedures are required to also include missing residents and clients, respectively, within their emergency plans.

Facilities must develop strategies for addressing emergency events that were identified during the development of the facility- and community-based risk assessments. Examples of these strategies may include, but are not limited to, developing a staffing strategy if staff shortages were identified during the risk assessment or developing a surge capacity strategy if the facility has identified it would likely be requested to accept additional

patients during an emergency. Facilities will also want to consider evacuation plans. For example, a facility in a large metropolitan city may plan to utilize the support of other large community facilities as alternate care sites for its patients if the facility needs to be evacuated. The facility is also expected to have a backup evacuation plan for instances in which nearby facilities are also affected by the emergency and are unable to receive patients

Hospices must include contingencies for managing the consequences of power failures, natural disasters, and other emergencies that would affect the hospice's ability to provide care.

Survey Procedures

- Ask to see the written documentation of the facility's risk assessments and associated strategies.
- Interview the facility leadership and ask which hazards (e.g. natural, man-made, facility, geographic) were included in the facility's risk assessment, why they were included and how the risk assessment was conducted.
- Verify the risk-assessment is based on an all-hazards approach specific to the geographic location of the facility and encompasses potential hazards.

E-0007

(Issued XX-XX-17)

§403.748(a)(3), §416.54(a)(3), §418.113(a)(3), §441.184(a)(3), §460.84(a)(3), §482.15(a)(3), §483.73(a)(3), §483.475(a)(3), §484.22(a)(3), §485.68(a)(3), §485.625(a)(3), §485.727(a)(3), §485.920(a)(3), §491.12(a)(3), §494.62(a)(3).

[(a) Emergency Plan. **The [*facility*] must develop and maintain an emergency preparedness plan that must be reviewed, and updated at least annually. The plan must do the following:]**

(3) Address patient/client population, including, but not limited to, persons at-risk; **the type of services the [*facility*] has the ability to provide in an emergency; and continuity of operations, including delegations of authority and succession plans.****

Note*: ["Persons at risk" does not apply to*: **ASC, hospice, PACE, HHA, CORF, CMCH, RHC/FQHC, or ESRD facilities.]**

Interpretive Guidelines applies to: §403.748(a)(3), §416.54(a)(3), §418.113(a)(3), §441.184(a)(3), §460.84(a)(3), §482.15(a)(3), §483.73(a)(3), §483.475(a)(3), §484.22(a)(3), §485.68(a)(3), §485.625(a)(3), §485.727(a)(3), §485.920(a)(3), §491.12(a)(3), §494.62(a)(3).

Note: This does not apply to Transplant Centers and OPOs.

The emergency plan must specify the population served within the facility, such as inpatients and/or outpatients, and their unique vulnerabilities in the event of an emergency or disaster. A facility's emergency plan must also address persons at-risk, except for plans of ASCs, hospices, PACE organizations, HHAs, CORFs, CMHCs, RHCs/FQHCs and ESRD facilities. As defined by the Pandemic and All-Hazards Preparedness Act (PAHPA) of 2006, members of at-risk populations may have additional needs in one or more of the following functional areas: maintaining independence, communication, transportation, supervision, and medical care. In addition to those individuals specifically recognized as at-risk in the PAHPA (children, senior citizens, and pregnant women), "at-risk populations" are also individuals who may need additional response assistance including those who have disabilities, live in institutionalized settings, are from diverse cultures and racial and ethnic backgrounds, have limited English proficiency or are non-English speaking, lack transportation, have chronic medical disorders, or have pharmacological dependency. At-risk populations would also include, but are not limited to, the elderly, persons in hospitals and nursing homes, people with physical and mental disabilities as well as others with access and functional needs, and infants and children.

Mobility is an important part in effective and timely evacuations, and therefore facilities are expected to properly plan to identify patients who would require additional assistance, ensure that means for transport are accessible and available and that those involved in transport, as well as the patients and residents are made aware of the procedures to evacuate. For outpatient facilities, such as Home Health Agencies (HHAs), the emergency plan is required to ensure that patients with limited mobility are addressed within the plan.

The emergency plan must also address the types of services that the facility would be able to provide in an emergency. The emergency plan must identify which staff would assume specific roles in another's absence through succession planning and delegations of authority. Succession planning is a process for identifying and developing internal people with the potential to fill key business leadership positions in the company. Succession planning increases the availability of experienced and capable employees that are prepared to assume these roles as they become available. During times of emergency, facilities must have employees who are capable of assuming various critical roles in the event that current staff and leadership are not available. At a minimum, there should be a qualified person who "is authorized in writing to act in the absence of the administrator or person legally responsible for the operations of the facility."

In addition to the facility- and community-based risk assessment, continuity of operations planning generally considers elements such as: essential personnel, essential functions, critical resources, vital records and IT data protection, alternate facility identification and location, and financial resources. Facilities are encouraged to refer to and utilize resources from various agencies such as FEMA and Assistant Secretary for Preparedness and Response (ASPR) when developing strategies for ensuring continuity of operations. Facilities are encouraged to refer to and utilize resources from various agencies such as FEMA and ASPR when developing strategies for ensuring continuity of operations.

Survey Procedures
Interview leadership and ask them to describe the following:

- The facility's patient populations that would be at risk during an emergency event;
- Strategies the facility (except for an ASC, hospice, PACE organization, HHA, CORF, CMHC, RHC/FQHC and ESRD facility) has put in place to address the needs of at-risk or vulnerable patient populations;
- Services the facility would be able to provide during an emergency;
- How the facility plans to continue operations during an emergency;
- Delegations of authority and succession plans.

Verify that all of the above are included in the written emergency plan.

E-0008
(Issued XX-XX-17)

§486.360(a)(3) Condition for Participation:
[(a) Emergency Plan. **The OPO must develop and maintain an emergency preparedness plan that must be reviewed, and updated at least annually. The plan must do the following:]**

(3) Address the type of hospitals with which the OPO has agreements; the type of services the OPO has the capacity to provide in an emergency; and continuity of operations, including delegations of authority and succession plans.

Interpretive Guidelines for §486.360(a)(3).

The emergency plan must address the type of hospitals with which the OPO has agreements and the types of services that the OPO would be able to provide in an emergency. The emergency plan must also identify which staff would assume specific roles in another's absence through succession planning and delegations of authority. Succession planning is a process for identifying and developing staff with the potential to fill key business leadership positions in the company. Succession planning increases the availability of experienced and capable employees that are prepared to assume these roles as they become necessary. During times of emergency, facilities must have internal employees who are capable of assuming various critical roles in the event that current staff and leaders are not available. At a minimum, facilities should designate a qualified person who is authorized in writing to act in the absence of the administrator or person legally responsible for the operations of the facility.

In addition to the facility- and community-based risk assessment, continuity of operations planning generally considers elements such as: essential personnel, essential functions, critical resources, vital records and IT data protection, alternate facility identification and location, and financial resources. Facilities are encouraged to refer to and utilize

resources from various agencies such as FEMA and ASPR when developing strategies for ensuring continuity of operations.

Survey Procedures
Interview leadership and ask them to describe the following:

- Services the OPO would be able to provide during an emergency;
- How the OPO plans to continue operations during an emergency;
- Delegations of authority and succession plans.
- How the OPO has included/addressed all of the hospitals with which it has agreements into its emergency plan.

Verify that all of the above are included in the written emergency plan.

E-0009
(Issued XX-XX-17)

§403.748(a)(4), §416.54(a)(4), §418.113(a)(4), §441.184(a)(4), §460.84(a)(4), §482.15(a)(4), §483.73(a)(4), §483.475(a)(4), §484.22(a)(4), §485.68(a)(4), §485.625(a)(4), §485.727(a)(5), §485.920(a)(4), §486.360(a)(4), §491.12(a)(4), §494.62(a)(4)

[(a) Emergency Plan. **The [*facility*] must develop and maintain an emergency preparedness plan that must be reviewed, and updated at least annually. The plan must do the following:]**

(4) Include a process for cooperation and collaboration with local, tribal, regional, State, and Federal emergency preparedness officials' efforts to maintain an integrated response during a disaster or emergency situation, including documentation of the facility's efforts to contact such officials and, when applicable, of its participation in collaborative and cooperative planning efforts. **

* [*For ESRD facilities only at §494.62(a)(4)*]: **(4) Include a process for cooperation and collaboration with local, tribal, regional, State, and Federal emergency preparedness officials' efforts to maintain an integrated response during a disaster or emergency situation, including documentation of the dialysis facility's efforts to contact such officials and, when applicable, of its participation in collaborative and cooperative planning efforts. The dialysis facility must contact the local emergency preparedness agency at least annually to confirm that the agency is aware of the dialysis facility's needs in the event of an emergency.**

Interpretive Guidelines applies to: §403.748(a)(4), §416.54(a)(4), §418.113(a)(4), §441.184(a)(4), §460.84(a)(4), §482.15(a)(4), §483.73(a)(4), §483.475(a)(4), §484.22(a)(4), §485.68(a)(4), §485.625(a)(4), §485.727(a)(5), §485.920(a)(4), §486.360(a)(4), §491.12(a)(4), §494.62(a)(4).

Note: This does not apply to Transplant Centers.

While the responsibility for ensuring a coordinated disaster preparedness response lies upon the state and local emergency planning authorities, the facility must document its efforts to contact these officials to engage in collaborative planning for an integrated emergency response. The facility must include this integrated response process in its emergency plan. Facilities are encouraged to participate in a healthcare coalition as it may provide assistance in planning and addressing broader community needs that may also be supported by local health department and emergency management resources.

For ESRD facilities, §494.120(c)(2) of the ESRD Conditions for Coverage on Special Purpose Dialysis Facilities describes the requirements for ESRD facilities that are set up in an emergency (i.e., an emergency circumstance facility) which are issued a unique CMS Certification Number (CCN). ESRD facilities must incorporate these specific provisions into the coordination requirements under this standard.

Survey Procedures
Interview facility leadership and ask them to describe their process for ensuring cooperation and collaboration with local, tribal, regional, State, and Federal emergency preparedness officials' efforts to ensure an integrated response during a disaster or emergency situation.

- Ask for documentation of the facility's efforts to contact such officials and, when applicable, its participation in collaborative and cooperative planning efforts.
- For ESRD facilities, ask to see documentation that the ESRD facility contacted the local public health and emergency management agency public official at least annually to confirm that the agency is aware of the ESRD facility's needs in the event of an emergency and know how to contact the agencies in the event of an emergency.

E-0010
(Issued XX-XX-17)

§485.727(a)(4) Condition for Participation:
[(a) Emergency Plan. **The Clinics, Rehabilitation Agencies, and Public Health Agencies as Providers of Outpatient Physical Therapy and Speech-Language Pathology Services ("Organizations") must develop and maintain an emergency preparedness plan that must be reviewed, and updated at least annually. The plan must do the following:]**

(4) Address the location and use of alarm systems and signals; and methods of containing fire.

Interpretive Guidelines for §485.727(a)(4).

The Organizations' emergency plan must address the location and use of alarm systems and signals. The plan must also include the methods used for containing fires, such as fire extinguishers, sprinkler systems and other current methods used. The National Fire

Protection Association (NFPA) at section A.20.1.1.1.6, recognizes that certain functions necessary for the life safety of building occupants, such as the closing of corridor doors, the operation of manual fire alarm devices, and the removal of patients from the room of fire origin, require the intervention of facility staff. Therefore, the plan should follow guidelines set forth by the NFPA.

Survey Procedures

- Ask facility leadership to show the section of the plan which addresses location(s) and use of fire alarms.
- Ask facility staff to describe the facility's current procedure for containing fires.

E-0011

(Issued XX-XX-17)

§485.68(a)(5) Condition for Participation:
[(a) Emergency Plan. **The Comprehensive Outpatient Rehabilitation Facility (CORF) must develop and maintain an emergency preparedness plan that must be reviewed, and updated at least annually. The plan must do the following:]**

(a)(5) Be developed and maintained with assistance from fire, safety, and other appropriate experts.

§485.727(a)(6) Condition for Participation:
[(a) Emergency Plan. **The Clinics, Rehabilitation Agencies, and Public Health Agencies as Providers of Outpatient Physical Therapy and Speech-Language Pathology Services ("Organizations") must develop and maintain an emergency preparedness plan that must be reviewed, and updated at least annually. The plan must do the following:]**

(a)(6) Be developed and maintained with assistance from fire, safety, and other appropriate experts.

Interpretive Guidelines applies to: §485.68(a)(5), §485.727(a)(6).

The CORF and Clinics, Rehabilitation Agencies, and Public Health Agencies as Providers of Outpatient Physical Therapy and Speech-Language Pathology Services must collaborate with fire, safety and other appropriate experts to develop and maintain its emergency plan. They must document their collaboration with these experts and include them in the annual review of the plan.

Survey Procedures

- Ask for a list of/documentation for which experts were collaborated with to develop and maintain its plan.

E-0012

(Issued XX-XX-17)

§ 482.78 Condition of participation: Emergency preparedness for transplant centers. A transplant center must be included in the emergency preparedness planning and the emergency preparedness program as set forth in § 482.15 for the hospital in which it is located. However, a transplant center is not individually responsible for the emergency preparedness requirements set forth in § 482.15.

(a) ***Standard: Policies and procedures.***
A transplant center must have policies and procedures that address emergency preparedness. These policies and procedures must be included in the hospital's emergency preparedness program.

(b) ***Standard: Protocols with hospital and OPO.*** **A transplant center must develop and maintain mutually agreed upon protocols that address the duties and responsibilities of the transplant center, the hospital in which the transplant center is operated, and the OPO designated by the Secretary, unless the hospital has an approved waiver to work with another OPO, during an emergency.**

Interpretive Guidelines applies to: §482.78(a), and §482.78(b).

Hospitals which have transplant centers must include within their emergency planning and preparedness process one representative, at minimum, from the transplant center. If a hospital has multiple transplant centers, each center must have at least one representative who is involved in the development and maintenance of the hospital's emergency preparedness process. The hospital must include the transplant center in its emergency preparedness plan policies and procedures, communication plans, as well is the training and testing programs.

Both the hospital and the transplant center are required to demonstrate during a survey that they have coordinated in planning and the development of the emergency program. Both are required to have written documentation of the emergency preparedness plans. However, the transplant center is not individually responsible for the emergency preparedness requirements under §482.15.

Survey Procedures

- Verify the hospital has written documentation to demonstrate that a representative of each transplant center participated in the development of the emergency program.
- Ask to see documentation of emergency protocols that address transplant protocols that include the hospital, the transplant center and the associated OPOs.

E-0013

(Issued XX-XX-17)
§403.748(b), §416.54(b), §418.113(b), §441.184(b), §460.84(b), §482.15(b), §483.73(b), §483.475(b), §484.22(b), §485.68(b), §485.625(b), §485.727(b), §485.920(b), §486.360(b), §491.12(b), §494.62(b).

(b) Policies and procedures. [*Facilities*] must develop and implement emergency preparedness policies and procedures, based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, and the communication plan at paragraph (c) of this section. The policies and procedures must be reviewed and updated at least annually.

**Additional Requirements for PACE and ESRD Facilities:*

*[*For PACE at §460.84(b):*] **Policies and procedures. The PACE organization must develop and implement emergency preparedness policies and procedures, based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, and the communication plan at paragraph (c) of this section. The policies and procedures must address management of medical and nonmedical emergencies, including, but not limited to: Fire; equipment, power, or water failure; care-related emergencies; and natural disasters likely to threaten the health or safety of the participants, staff, or the public. The policies and procedures must be reviewed and updated at least annually.**

*[*For ESRD Facilities at §494.62(b):*] **Policies and procedures. The dialysis facility must develop and implement emergency preparedness policies and procedures, based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, and the communication plan at paragraph (c) of this section. The policies and procedures must be reviewed and updated at least annually. These emergencies include, but are not limited to, fire, equipment or power failures, care-related emergencies, water supply interruption, and natural disasters likely to occur in the facility's geographic area.**

Interpretive Guidelines applies to: §403.748(b), §416.54(b), §418.113(b), §441.184(b), §460.84(b), §482.15(b), §483.73(b), §483.475(b), §484.22(b), §485.68(b), §485.625(b), §485.727(b), §485.920(b), §486.360(b), §491.12(b), §494.62(b).

Note: This does not apply to Transplant Centers.

Facilities must develop and implement policies and procedures per the requirements of this standard. The policies and procedures are expected to align with the identified hazards within the facility's risk assessment and the facility's overall emergency preparedness program.

We are not specifying where the facility must have the emergency preparedness policies and procedures. A facility may choose whether to incorporate the emergency policies and procedures within their emergency plan or to be part of the facility's Standard Operating Procedures or Operating Manual. However, the facility must be able to demonstrate compliance upon survey, therefore we recommend that facilities have a central place to house the emergency preparedness program documents (to include all policies and procedures) to facilitate review.

Survey Procedures
Review the written policies and procedures which address the facility's emergency plan and verify the following:

- Policies and procedures were developed based on the facility- and community-based risk assessment and communication plan, utilizing an all-hazards approach.
- Ask to see documentation that verifies the policies and procedures have been reviewed and updated on an annual basis.

E-0014
(Issued XX-XX-17)

§482.78(b) Standard: Protocols with hospital and OPO. A transplant center must develop and maintain mutually agreed upon protocols that address the duties and responsibilities of the transplant center, the hospital in which the transplant center is operated, and the OPO designated by the Secretary, unless the hospital has an approved waiver to work with another OPO, during an emergency.

Interpretive Guidelines for §482.78(b).

Transplant centers must be involved in the development of mutually agreed upon protocols that address the duties and responsibilities of the hospital, transplant program and the designated OPO during emergencies.

All transplant centers are located within Medicare participating hospitals. Any hospital that furnishes organ transplants and other medical and surgical specialty services for the care of transplant patients is defined as a transplant hospital (42 CFR 482.70). Therefore, transplant centers must meet all hospital CoPs at §§482.1 through 482.57 (as set forth at §482.68(b)), and the hospitals in which they are located must meet the provisions of § 482.15, however, a transplant center is not individually responsible for the emergency preparedness requirements in §482.15.

The hospital in which a transplant center is located (i.e., a transplant hospital) would be responsible for ensuring that the transplant center is involved in the development of an emergency preparedness program. This requirement does not oblige a transplant center that agrees to care for another transplant center's patients during an emergency to put those patients on its waiting lists. We anticipate that most emergencies would be of short duration and that the transplant center that is affected by an emergency will resume its normal operations within a short period of time. However, if a transplant center does arrange for its patients to be transferred to another transplant center during an emergency, both transplant centers would need to determine what care would be provided to the transferring patients, including whether and under what circumstances the patients from the transferring transplant center would be added to the receiving center's waiting lists.
Survey Procedures

- Verify the transplant center has developed mutually agreed upon protocols that address the duties and responsibilities of the transplant center, the hospital in which the transplant center is operated, and the designated OPO.
- Ask to see documentation of the protocols.

E-0015

(Issued XX-XX-17)

§403.748(b)(1), §418.113(b)(6)(iii), §441.184(b)(1), §460.84(b)(1), §482.15(b)(1), §483.73(b)(1), §483.475(b)(1), §485.625(b)(1)

[(b) Policies and procedures. [*Facilities*] must develop and implement emergency preparedness policies and procedures, based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, and the communication plan at paragraph (c) of this section. The policies and procedures must be reviewed and updated at least annually.] At a minimum, the policies and procedures must address the following:

(1) The provision of subsistence needs for staff and patients whether they evacuate or shelter in place, include, but are not limited to the following:

> **(i) Food, water, medical and pharmaceutical supplies**
> **(ii) Alternate sources of energy to maintain the following:**
> **(A) Temperatures to protect patient health and safety and for the safe and sanitary storage of provisions.**
> **(B) Emergency lighting.**
> **(C) Fire detection, extinguishing, and alarm systems.**
> **(D) Sewage and waste disposal.**

*[*For Inpatient Hospice at §418.113(b)(6)(iii):*] **Policies and procedures.**
(6) The following are additional requirements for hospice-operated inpatient care facilities only. The policies and procedures must address the following:

> **(iii) The provision of subsistence needs for hospice employees and patients, whether they evacuate or shelter in place, include, but are not limited to the following:**
>
> > **(A) Food, water, medical, and pharmaceutical supplies.**
> > **(B) Alternate sources of energy to maintain the following:**
> > > **(1) Temperatures to protect patient health and safety and for the safe and sanitary storage of provisions.**
> > > **(2) Emergency lighting.**
> > > **(3) Fire detection, extinguishing, and alarm systems.**
> > **(C) Sewage and waste disposal.**

Interpretive Guidelines applies to: §403.748(b)(1), §418.113(b)(6)(iii), §441.184(b)(1), §460.84(b)(1), §482.15(b)(1), §483.73(b)(1), §483.475(b)(1), §485.625(b)(1).

Note: This does not apply to ASCs, Outpatient Hospice Providers [applies to inpatient hospices], Transplant Centers, HHA, CORFs, CMHCs, RHCs/FQHCs, ESRD facilities.

Facilities must be able to provide for adequate subsistence for all patients and staff for the duration of an emergency or until all its patients have been evacuated and its operations cease. Facilities have flexibility in identifying their individual subsistence needs that would be required during an emergency. There are no set requirements or standards for the amount of provisions to be provided in facilities, Provisions include, but are not limited to, food, pharmaceuticals and medical supplies. Provisions should be stored in an area which is less likely to be affected by disaster, such as storing these resources above ground-level to protect from possible flooding. Additionally, when inpatient facilities determine their supply needs, they are expected to consider the possibility that volunteers, visitors, and individuals from the community may arrive at the facility to offer assistance or seek shelter.

Alternate sources of energy depend on the resources available to a facility, such as battery-operated lights, or heating and cooling, in order to meet the needs of a facility during an emergency. Facilities are not required to upgrade their electrical systems, but after review of their risk assessment, facilities may find it prudent to make any necessary adjustments to ensure that occupants health and safety needs are met, and that facilities maintain safe and sanitary storage areas for provisions.

This specific standard does not require facilities to have or install generators or any other specific type of energy source. (However, for hospitals at §482.15(e), CAHs at §485.625(e) and LTC facilities at §483.73(e) please also refer to Tag E-0041 for Emergency and Stand-by Power Systems.) It is up to each individual facility, based on its risk assessment, to determine the most appropriate alternate energy sources to maintain temperatures to protect patient health and safety and for the safe and sanitary storage of provisions, emergency lighting, fire detection, extinguishing, and alarm systems and sewage and waste disposal. Whatever alternate sources of energy a facility chooses to utilize must be in accordance with local and state laws as well as relevant LSC requirements.
Facilities must establish policies and procedures that determine how required heating and cooling of their facility will be maintained during an emergency situation, as necessary, if there were a loss of the primary power source.

If a facility determines the best way to maintain temperatures, emergency lighting, fire detection and extinguishing systems and sewage and waste disposal would be through the use of a portable generator, then the Life Safety Code (LSC) provisions, such as generator testing and fuel storage, etc. outlined under the NFPA guidelines would not be applicable. Portable generators should be operated, tested, and maintained in accordance with manufacturer, local and/or State requirements. If a facility, however, chooses to utilize a permanent generator to maintain emergency power, LSC provisions such as

generator testing and maintenance will apply and the facility may be subject to LSC surveys to ensure compliance is met.

As an example, some ESRD facilities have contracted services with companies who maintain portable emergency generators for the facilities off-site. In the event of an emergency where the facility is unable to reschedule patients or evacuate, the generators are brought to the location in advance to assist in the event of loss of power. Facilities who are not specifically required by the EP Final Rule to have a generator, but are required to meet provision for an alternate sources of energy, may consider this approach for their facility.

Facilities are encouraged to confer with local health department and emergency management officials, as well as and healthcare coalitions, where available, to determine the types and duration of energy sources that could be available to assist them in providing care to their patient population during an emergency. As part of the risk assessment planning, facilities should determine the feasibility of relying on these sources and plan accordingly.

Facilities are not required to provide onsite treatment of sewage but must make provisions for maintaining necessary services. For example, LTC facilities are already required to meet Food Receiving and Storage provisions at §483.35(i) Sanitary Conditions, which contain requirements for keeping food off the floor and clear of ceiling sprinklers, sewer/waste disposal pipes, and vents can also help maintain food quality and prevent contamination. Additionally, ESRD facilities under current CfCs at §494.40(a)(4) are also required to have policies and procedures for handling, storage and disposal of potentially infectious waste. We are not specifying any required provisions regarding treatment of sewage and necessary services under this tag; however, facilities are required to follow their current facility-type requirements (e.g., CoPs/CfCs, Requirements) which may address these areas. Additionally, we would expect facilities under this requirement to ensure current practices are followed, such as those outlined by the Environmental Protection Agency (EPA) and under State-specific laws. Maintaining necessary services may include, but are not limited to, access to medical gases; treatment of soiled linens; disposal of bio-hazard materials for different infectious diseases; and may require additional assistance from transportation companies for safe and appropriate disposal in accordance with nationally accepted industry guidelines for emergency preparedness.

Survey Procedures

- Verify the emergency plan includes policies and procedures for the provision of subsistence needs including, but not limited to, food, water and pharmaceutical supplies for patients and staff by reviewing the plan.
- Verify the emergency plan includes policies and procedures to ensure adequate alternate energy sources necessary to maintain:
    - Temperatures to protect patient health and safety and for the safe and sanitary storage of provisions;
    - Emergency lighting; and,

    - Fire detection, extinguishing, and alarm systems.
- Verify the emergency plan includes policies and procedures to provide for sewage and waste disposal.

E-0016
(Issued XX-XX-17)

§418.113(b)(1): Condition for Participation:
[(b) Policies and procedures. The hospice must develop and implement emergency preparedness policies and procedures, based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, and the communication plan at paragraph (c) of this section. The policies and procedures must be reviewed and updated at least annually.] At a minimum, the policies and procedures must address the following:

(1) Procedures to follow up with on duty staff and patients to determine services that are needed, in the event that there is an interruption in services during or due to an emergency. The hospice must inform State and local officials of any on-duty staff or patients that they are unable to contact.

Interpretive Guidelines for §418.113(b)(1).

Hospices have the flexibility to determine how best to develop these policies and procedures. For administrative purposes, all hospices should already have some mechanism in place to keep track of patients and staff contact information. However, the information regarding patient services that are needed during or after an interruption in their services and on-duty staff and patients that were not able to be contacted must be readily available, accurate, and shareable among officials within and across the emergency response system, as needed, in the interest of the patient.

Survey Procedures

- Review the emergency plan to verify it includes policies and procedures for following up with staff and patients.
- Interview a staff member or leadership and ask them to explain the procedures in place in the event they are unable to contact a staff member or patient.

E-0017
(Issued XX-XX-17)

§484.22(b)(1) Condition for Participation:
[(b) Policies and procedures. The HHA must develop and implement emergency preparedness policies and procedures, based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, and the communication plan at paragraph (c) of this section. The policies and procedures must be reviewed and updated at least annually.]
At a minimum, the policies and procedures must address the following:]

(1) The plans for the HHA's patients during a natural or man-made disaster. Individual plans for each patient must be included as part of the comprehensive patient assessment, which must be conducted according to the provisions at §484.55.

Interpretive Guidelines for §484.22(b)(1).

HHAs must include policies and procedures in its emergency plan for ensuring all patients have an individualized plan in the event of an emergency. That plan must be included as part of the patient's comprehensive assessment.

For example, discussions to develop individualized emergency preparedness plans could include potential disasters that the patient may face within the home such as fire hazards, flooding, and tornados; and how and when a patient is to contact local emergency officials. Discussions may also include patient, care providers, patient representative, or any person involved in the clinical care aspects to educate them on steps that can be taken to improve the patient's safety. The individualized emergency plan should be in writing and could be as simple as a detailed emergency card to be kept with the patient. HHA personnel should document that these discussions occurred and also keep a copy of the individualized emergency plan in the patient's file as well as provide a copy to the patient and or their caregiver.

Survey Procedures

- Through record review, verify that each patient has an individualized emergency plan documented as part of the patient's comprehensive assessment.

E-0018

(Issued XX-XX-17)

§403.748(b)(2), §416.54(b)(1), §418.113(b)(6)(ii) and (v), §441.184(b)(2), §460.84(b)(2), §482.15(b)(2), §483.73(b)(2), §483.475(b)(2), §485.625(b)(2), §485.920(b)(1), §486.360(b)(1), §494.62(b)(1).

[(b) Policies and procedures. The [*facilities*] must develop and implement emergency preparedness policies and procedures, based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, and the communication plan at paragraph (c) of this section. The policies and procedures must be reviewed and updated at least annually.] At a minimum, the policies and procedures must address the following:]

[(2) or (1)] A system to track the location of on-duty staff and sheltered patients in the [*facility's*] care during an emergency. If on-duty staff and sheltered patients are relocated during the emergency, the [*facility*] must document the specific name and location of the receiving facility or other location.

*[*For PRTFs at §441.184(b), LTC at §483.73(b), ICF/IIDs at §483.475(b), PACE at §460.84(b):*] **Policies and procedures. (2) A system to track the location of on-duty staff and sheltered residents in the [*PRTF's, LTC, ICF/IID or PACE*] care during and after an emergency. If on-duty staff and sheltered residents are relocated during the emergency, the [*PRTF's, LTC, ICF/IID or PACE*] must document the specific name and location of the receiving facility or other location.**

*[*For Inpatient Hospice at §418.113(b)(6):*] **Policies and procedures.**
(ii) Safe evacuation from the hospice, which includes consideration of care and treatment needs of evacuees; staff responsibilities; transportation; identification of evacuation location(s) and primary and alternate means of communication with external sources of assistance.
(v) A system to track the location of hospice employees' on-duty and sheltered patients in the hospice's care during an emergency. If the on-duty employees or sheltered patients are relocated during the emergency, the hospice must document the specific name and location of the receiving facility or other location.

*[*For CMHCs at §485.920(b):*] **Policies and procedures. (2) Safe evacuation from the CMHC, which includes consideration of care and treatment needs of evacuees; staff responsibilities; transportation; identification of evacuation location(s); and primary and alternate means of communication with external sources of assistance.**

*[*For OPOs at § 486.360(b):*] **Policies and procedures. (2) A system of medical documentation that preserves potential and actual donor information, protects confidentiality of potential and actual donor information, and secures and maintains the availability of records.**

*[*For ESRD at § 494.62(b):*] **Policies and procedures. (2) Safe evacuation from the dialysis facility, which includes staff responsibilities, and needs of the patients.**

Interpretive Guidelines applies to: §403.748(b)(2), §416.54(b)(1), §418.113(b)(6)(ii) and (v), §441.184(b)(2), §460.84(b)(2), §482.15(b)(2), §483.73(b)(2), §483.475(b)(2), §485.625(b)(2), §485.920(b)(1), §486.360(b)(1), §494.62(b)(1).

Note: This does not apply to Transplant Centers, HHAs, Clinics, Rehabilitation Agencies, and Public Health Agencies as Providers of Outpatient Physical Therapy and Speech-Language Pathology Services, RHCs/FQHCs.

Facilities must develop a means to track patients and on-duty staff in the facility's care during an emergency event. In the event staff and patients are relocated, the facility must document the specific name and location of the receiving facility or other location for sheltered patients and on-duty staff who leave the facility during the emergency.

CMHCs, PRTF's, LTC facilities, ICF/IIDs, PACE organizations and ESRD Facilities are required to track the location of sheltered patients and staff during and *after* an emergency.

We are not specifying which type of tracking system should be used; rather, a facility has the flexibility to determine how best to track patients and staff, whether it uses an electronic database, hard copy documentation, or some other method. However, it is important that the information be readily available, accurate, and shareable among officials within and across the emergency response systems as needed in the interest of the patient. It is recommended that a facility that is using an electronic database consider backing up its computer system with a secondary source, such as hard copy documentation in the event of power outages. The tracking systems set up by facilities may want to consider who is responsible for compiling/securing patient records and what information is needed during tracking a patient throughout an evacuation. A number of states already have such tracking systems in place or under development and the systems are available for use by health care providers and suppliers. Facilities are encouraged to leverage the support and resources available to them through local and national healthcare systems, healthcare coalitions, and healthcare organizations for resources and tools for tracking patients.

Facilities are not required to track the location of patients who have voluntarily left on their own, or have been appropriately discharged, since they are no longer in the facility's care. However, this information must be documented in the patient's medical record should any questions later arise as to the patient's whereabouts.

Note: If an ASC is able to cancel surgeries and close (meaning there are no patients or staff in the ASC), this requirement of tracking patients and staff would no longer be applicable. Similarly to ESRD standard practices, if an emergency was imminent and able to be predicted (i.e. inclement weather conditions, etc.) we would expect that ASCs cancel surgeries and cease operations, which would eliminate the need to track patients and staff.

Survey Procedures

- Ask staff to describe and/or demonstrate the tracking system used to document locations of patients and staff.
- Verify that the tracking system is documented as part of the facilities' emergency plan policies and procedures.

E-0019

(Issued XX-XX-17)

§418.113(b)(2), §460.84(b)(4), §484.22(b)(2)

[(b) Policies and procedures. The [*facilities*] must develop and implement emergency preparedness policies and procedures, based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, and the communication plan at paragraph (c) of this section. The policies and procedures must be reviewed and updated at least annually.] At a minimum, the policies and procedures must address the following:]

**[For homebound Hospice at §418.113(b)(2), PACE at §460.84(b)(4), and HHAs at §484.22(b)(2):]*
The procedures to inform State and local emergency preparedness officials about [*homebound Hospice, PACE or HHA*] patients in need of evacuation from their residences at any time due to an emergency situation based on the patient's medical and psychiatric condition and home environment.

Interpretive Guidelines applies to: §418.113(b)(2), §460.84(b)(4), §484.22(b)(2).

Note: The regulatory language for hospices under §418.113(b)(2) does not include the terms "emergency preparedness" when describing officials.

Note: This only applies to homebound Hospice, PACE and HHAs.

Home bound hospices, HHAs and PACE organizations are required to inform State and local emergency preparedness officials of the need for patient evacuations. These policies and procedures must address when and how this information is communicated to emergency officials and also include the clinical care needed for these patients. For instance, in the event an in-home hospice, PACE organization or HHA patient requires evacuation, the responsible agency should provide emergency officials with the appropriate information to facilitate the patient's evacuation and transportation. This should include, but is not limited to, the following:

- Whether or not the patient is mobile.
- What type of life-saving equipment does the patient require?
- Is the life-saving equipment able to be transported? (E.g., Battery operated, transportable, condition of equipment, etc.)
- Does the patient have special needs? (E.g., Communication challenges, language barriers, intellectual disabilities, special dietary needs, etc.)

Since such policies and procedures include protected health information of patients, facilities must also ensure they are in compliance with applicable the Health Insurance Portability and Accountability Act (HIPAA) Rules at 45 CFR parts 160 and 164, as appropriate. See (81 FR 63879, Sept. 16, 2016).

Survey Procedures

- Review the emergency plan to verify it includes procedures to inform State and local emergency preparedness officials about patients in need of evacuation from their residences at any time due to an emergency situation based on the patient's medical and psychiatric condition and home environment.

E-0020
(Issued XX-XX-17)

§403.748(b)(3), §416.54(b)(2), §418.113(b)(6)(ii), §441.184(b)(3), §460.84(b)(3), §482.15(b)(3), §483.73(b)(3), §483.475(b)(3), §485.68(b)(1), §485.625(b)(3), §485.727(b)(1), §485.920(b)(2), §491.12(b)(1), §494.62(b)(2)

[(b) Policies and procedures. The [*facilities*] must develop and implement emergency preparedness policies and procedures, based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, and the communication plan at paragraph (c) of this section. The policies and procedures must be reviewed and updated at least annually. At a minimum, the policies and procedures must address the following:]

[(3) or (1), (2), (6)] Safe evacuation from the [*facility*], which includes consideration of care and treatment needs of evacuees; staff responsibilities; transportation; identification of evacuation location(s); and primary and alternate means of communication with external sources of assistance.

*[*For RNHCs at §403.748(b)(3) and ASCs at §416.54(b)(2):]*
Safe evacuation from the [*RNHCI or ASC*] which includes the following:

(i) Consideration of care needs of evacuees.
(ii) Staff responsibilities.
(iii) Transportation.
(iv) Identification of evacuation location(s).
(v) Primary and alternate means of communication with external sources of assistance.

* [*For CORFs at §485.68(b)(1), Clinics, Rehabilitation Agencies, OPT/Speech at §485.727(b)(1), and ESRD Facilities at §494.62(b)(2):*]
Safe evacuation from the [*CORF; Clinics, Rehabilitation Agencies, and Public Health Agencies as Providers of Outpatient Physical Therapy and Speech-Language Pathology Services; and ESRD Facilities*], which includes staff responsibilities, and needs of the patients.

* [*For RHCs/FQHCs at §491.12(b)(1):]* **Safe evacuation from the RHC/FQHC, which includes appropriate placement of exit signs; staff responsibilities and needs of the patients**.

Interpretive Guidelines applies to: §403.748(b)(3), §416.54(b)(2), §418.113(b)(6)(ii), §441.184(b)(3), §460.84(b)(3), §482.15(b)(3), §483.73(b)(3), §483.475(b)(3), §485.68(b)(1), §485.625(b)(3), §485.727(b)(1), §485.920(b)(2), §491.12(b)(1), §494.62(b)(2)

Note: Note this does not apply to HHAs, OPOs, and Transplant Centers.

Note: The requirements under §418.113(b)(6)(ii) is not a requirement for outpatient hospice providers.

Facilities must develop policies and procedures that provide for the safe evacuation of patients from the facility and include all of the requirements of this standard. RHCs and FQHCs must also place exit signs to guide patients and staff in the event of an evacuation from the facility.

Facilities must have policies and procedures which address the needs of evacuees. The facility should also consider in development of the policies and procedures, the evacuation protocols for not only the evacuees, but also staff members and families/patient representatives or other personnel who sought potential refuge at the facility. Additionally, the policies and procedures must address staff responsibilities during evacuations. Facilities must consider the patient population needs as well as their care and treatment. For example, if an evacuation is in progress and the facility must evacuate, leadership should consider the needs for critically ill patients to be evacuated and accompanied by staff who could provide care and treatment enroute to the designated relocation site, in the event trained medical professionals are unavailable by the transportation services.

Facilities must consider in their development of policies and procedures, the needs of their patient population and what designated transportation services would be most appropriate. For instance, if a facility primarily cares for critically ill patients with ventilation needs and life-saving equipment, the transportation services should be able to assist in evacuation of this special population and be equipped to do so. Additionally, facilities may also find it prudent to consider alternative methods for evacuation and patient care and treatment, such as mentioned above to have staff members evacuate with patients in given situations.

Additionally, facilities should consider their triaging system when coordinating the tracking and potential evacuation of patient/residents/clients. For instance, a triaging system for evacuation may consider the most critical patients first followed by those less critical and dependent on life-saving equipment. Considerations for prioritization may be based on, among other things, acuity, mobility status (stretch-bound/wheelchair/ambulatory), and location of the unit, availability of a known transfer destination or some combination thereof. Included within this system should be who (specifically) will be tasked with making triage decisions. Following the triaging system, staff should consider the communication of patient care requirements to the in-taking facility, such as attaching hard copy of standard abbreviated patient health condition/history, injuries, allergies, and treatment rendered. On the same method for communicating this information, a facility could consider color coordination of triage level (i.e. green folder with this information is for less critical patients; red folders for critical and urgent evacuated patients, etc.). Additionally, this hard copy could include family member/representative contact information.

Finally, facilities policies and procedures must outline primary and alternate means for communication with external sources for assistance. For instance, primarily methods may be considered via regular telephone services to contact transportation companies for evacuation or reporting evacuation needs to emergency officials; whereas alternate means

account for loss of power or telephone services in the local area. In this event, alternate means may include satellite phones for contacting evacuation assistance.

Survey Procedures

- Review the emergency plan to verify it includes policies and procedures for safe evacuation from the facility and that it includes all of the required elements.
- When surveying an RHC or FQHC, verify that exit signs are placed in the appropriate locations to facilitate a safe evacuation.

E-0021

(Issued XX-XX-17)

§484.22(b)(3) Condition of Participation:
[(b) Policies and procedures. The HHA must develop and implement emergency preparedness policies and procedures, based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, and the communication plan at paragraph (c) of this section. The policies and procedures must be reviewed and updated at least annually.] At a minimum, the policies and procedures must address the following:]

(3) The procedures to follow up with on-duty staff and patients to determine services that are needed, in the event that there is an interruption in services during or due to an emergency. The HHA must inform State and local officials of any on-duty staff or patients that they are unable to contact.

Interpretive Guidelines for §484.22(b)(3).

HHAs must include in its emergency plan, procedures required of this standard. During an emergency, if a patient requires care that is beyond the capabilities of the HHA, there is an expectation that care of the patient would be rearranged or suspended for a period of time, as most HHAs in general would not necessarily transfer patients to other HHAs during an emergency.

HHAs policies and procedures should clearly outline what surrounding facilities, such as a hospital or a nursing home, it has a transfer arrangement with to ensure patient care is continued. Additionally, these policies and procedures should outline timelines for transferring patients or under what conditions patients would need to move. For instance, if the emergency is one which only is anticipated to have one or two days of disruption and does not pose immediate threat to patient health or safety (in which then the HHA should immediately transfer the patient); the HHA may rearrange services, whereas if a disaster is anticipated to last over one week or more, the HHA may need to initiate transfer of a patient as soon as possible. The policies and procedures should address these events. Additionally, the HHAs' policies and procedures must address what actions would be required due to the inability to make contact with staff or patients and reporting capabilities to the local and State emergency officials.

Survey Procedures

- Verify that the HHA has included in its emergency plan these procedures to follow-up with staff and patients and to inform state and local authorities when they are unable to contact any of them.
- Verify that the HHA has procedures in its emergency plan to follow up with on-duty staff and patients to determine the services that are needed, in the event that there is an interruption in services during or due to an emergency.
- Ask the HHA to describe the mechanism to inform State and local officials of any on-duty staff or patients that they are unable to contact.

E-0022

(Issued XX-XX-17)

§403.748(b)(4), §416.54(b)(3), §418.113(b)(6)(i), §441.184(b)(4), §460.84(b)(5), §482.15(b)(4), §483.73(b)(4), §483.475(b)(4), §485.68(b)(2), §485.625(b)(4), §485.727(b)(2), §485.920(b)(3), §491.12(b)(2), §494.62(b)(3).

(b) Policies and procedures. The [*facilities*] must develop and implement emergency preparedness policies and procedures, based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, and the communication plan at paragraph (c) of this section. The policies and procedures must be reviewed and updated at least annually.] At a minimum, the policies and procedures must address the following:]

[(4) or (2),(3),(5),(6)] A means to shelter in place for patients, staff, and volunteers who remain in the [*facility*].

*[*For Inpatient Hospices at §418.113(b):*] **Policies and procedures.**
(6) The following are additional requirements for hospice-operated inpatient care facilities only. The policies and procedures must address the following:

> **(i) A means to shelter in place for patients, hospice employees who remain in the hospice.**

Interpretive Guidelines applies to: §403.748(b)(4), §416.54(b)(3), §418.113(b)(6)(i), §441.184(b)(4), §460.84(b)(5), §482.15(b)(4), §483.73(b)(4), §483.475(b)(4), §485.68(b)(2), §485.625(b)(4), §485.727(b)(2), §485.920(b)(3), §491.12(b)(2), §494.62(b)(3).

Note: This does not apply to Transplant Centers, HHAs or OPOs.

Emergency plans must include a means for sheltering all patients, staff, and volunteers who remain in the facility in the event that an evacuation cannot be executed. . In certain disaster situations (such as tornadoes) , sheltering in place may be more appropriate as opposed to evacuation and would require a facility to have a means to shelter in place for such emergencies. Therefore, facilities are required to have policies and procedures for sheltering in place which align with the facility's risk assessment.

Facilities are expected to include in their policies and procedures the criteria for determining which patients and staff that would be sheltered in place. When developing policies and procedures for sheltering in place, facilities should consider the ability of their building(s) to survive a disaster and what proactive steps they could take prior to an emergency to facilitate sheltering in place or transferring of patients to alternate settings if their facilities were affected by the emergency. For example, if it is dangerous to evacuate or the emergency affects available sites for transfer or discharge, then the patients would remain in the facility until it was safe to effectuate transfers or discharges. The plan should take into account the appropriate facilities in the community to which patients could be transferred in the event of an emergency. Facilities must determine their policies based on the type of emergency and the types of patients, staff, volunteers and visitors that may be present during an emergency. Based on its emergency plan, a facility could decide to have various approaches to sheltering some or all of its patients and staff.

Survey Procedures

- Verify the emergency plan includes policies and procedures for how it will provide a means to shelter in place for patients, staff and volunteers who remain in a facility.
- Review the policies and procedures for sheltering in place and evaluate if they aligned with the facility's emergency plan and risk assessment.

E-0023

(Issued XX-XX-17)

§403.748(b)(5), §416.54(b)(4), §418.113(b)(3), §441.184(b)(5), §460.84(b)(6), §482.15(b)(5), §483.73(b)(5), §483.475(b)(5), §484.22(b)(4), §485.68(b)(3), §485.625(b)(5), §485.727(b)(3), §485.920(b)(4), §486.360(b)(2), §491.12(b)(3), §494.62(b)(4).

[(b) Policies and procedures. The [*facilities*] must develop and implement emergency preparedness policies and procedures, based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, and the communication plan at paragraph (c) of this section. The policies and procedures must be reviewed and updated at least annually.] At a minimum, the policies and procedures must address the following:]

[(5) or (3),(4),(6)] A system of medical documentation that preserves patient information, protects confidentiality of patient information, and secures and maintains availability of records.

*[*For RNHCIs at §403.748(b):*] **Policies and procedures. (5) A system of care documentation that does the following:**

(i) Preserves patient information.
(ii) Protects confidentiality of patient information.
(iii) Secures and maintains the availability of records.

*[*For OPOs at §486.360(b):*] **Policies and procedures. (2) A system of medical documentation that preserves potential and actual donor information, protects confidentiality of potential and actual donor information, and secures and maintains the availability of records.**

Interpretive Guidelines applies to: §403.748(b)(5), §416.54(b)(4), §418.113(b)(3), §441.184(b)(5), §460.84(b)(6), §482.15(b)(5), §483.73(b)(5), §483.475(b)(5), §484.22(b)(4), §485.68(b)(3), §485.625(b)(5), §485.727(b)(3), §485.920(b)(4), §486.360 (b)(2), §491.12(b)(3), §494.62(b)(4).

Note: This does not apply to Transplant Centers.

In addition to any existing requirements for patient records found in existing laws, under this standard, facilities are required to ensure that patient records are secure and readily available to support continuity of care during emergency. This requirement does not supersede or take away any requirements found under the provider/supplier's medical records regulations, but rather, this standard adds to such policies and procedures. These policies and procedures must also be in compliance with the Health Insurance Portability and Accountability Act (HIPAA), Privacy and Security Rules at 45 CFR parts 160 and 164, which protect the privacy and security of individual's personal health information.

Survey Procedures

- Ask to see a copy of the policies and procedures that documents the medical record documentation system the facility has developed to preserves patient (or potential and actual donor for OPOs) information, protects confidentiality of patient (or potential and actual donor for OPOs) information, and secures and maintains availability of records.

E-0024

(Issued XX-XX-17)

§403.748(b)(6), §416.54(b)(5), §441.184(b)(6), §460.84(b)(7), §482.15(b)(6), §483.73(b)(6), §483.475(b)(6), §484.22(b)(5), §485.68(b)(4), §485.625(b)(6), §485.727(b)(4), §485.920(b)(5), §491.12(b)(4), §494.62(b)(5).

[(b) Policies and procedures. The [*facilities*] must develop and implement emergency preparedness policies and procedures, based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, and the communication plan at paragraph (c) of this section. The policies and procedures must be reviewed and updated at least annually.] At a minimum, the policies and procedures must address the following:]

(6) [*or (4), (5), or (7) as noted above*] The use of volunteers in an emergency or other emergency staffing strategies, including the process and role for integration of State

and Federally designated health care professionals to address surge needs during an emergency.

*[*For RNHCIs at §403.748(b):*] **Policies and procedures. (6) The use of volunteers in an emergency and other emergency staffing strategies to address surge needs during an emergency.**

Interpretive Guidelines applies to: §403.748(b)(6), §416.54(b)(5), §418.113(b)(4), §441.184(b)(6), §460.84(b)(7), §482.15(b)(6), §483.73(b)(6), §483.475(b)(6), §484.22(b)(5), §485.68(b)(4), §485.625(b)(6), §485.727(b)(4), §485.920(b)(5), §491.12(b)(4), §494.62(b)(5).

Note: This does not apply to Hospices, Transplant Centers, or OPOs.

During an emergency, a facility may need to accept volunteer support from individuals with varying levels of skills and training. The facility must have policies and procedures in place to facilitate this support. In order for volunteering healthcare professionals to be able to perform services within their scope of practice and training, facilities must include any necessary privileging and credentialing processes in its emergency preparedness plan policies and procedures. Non-medical volunteers would perform non-medical tasks. Facilities have flexibility in determining how best to utilize volunteers during an emergency as long as such utilization is in accordance with State law, State scope of practice rules, and facility policy. These may also include federally designated health care professionals, such as Public Health Service (PHS) staff, National Disaster Medical System (NDMS) medical teams, Department of Defense (DOD) Nurse Corps, Medical Reserve Corps (MRC), or personnel such as those identified in federally designated Health Professional Shortage Areas (HPSAs) to include licensed primary care medical, dental, and mental/behavioral health professionals. Facilities are also encouraged to integrate State-established volunteer registries, and where possible, State-based Emergency System for Advanced Registration of Volunteer Health Professionals (ESAR-VHP).

Facilities are expected to include in its emergency plan a method for contacting off-duty staff during an emergency and procedures to address other contingencies in the event staff are not able to report to duty which may include, but are not limited to, utilizing staff from other facilities and state or federally-designated health professionals.

Survey Procedures

- Verify the facility has included policies and procedures for the use of volunteers and other staffing strategies in its emergency plan.

E-0025

(Issued XX-XX-17)

§403.748(b)(7), §418.113(b)(5), §441.184(b)(7), §460.84(b)(8), §482.15(b)(7), §483.73(b)(7), §483.475(b)(7), §485.625(b)(7), §485.920(b)(6), §494.62(b)(6).

[(b) Policies and procedures. The [*facilities*] must develop and implement emergency preparedness policies and procedures, based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, and the communication plan at paragraph (c) of this section. The policies and procedures must be reviewed and updated at least annually.] At a minimum, the policies and procedures must address the following:]

*[*For Hospices at §418.113(b), PRFTs at §441.184,(b) Hospitals at §482.15(b), and LTC Facilities at §483.73(b):*] **Policies and procedures. (7) [or (5)] The development of arrangements with other [*facilities*] [and] other providers to receive patients in the event of limitations or cessation of operations to maintain the continuity of services to facility patients.**

*[*For PACE at §460.84(b), ICF/IIDs at §483.475(b), CAHs at §486.625(b), CMHCs at §485.920(b) and ESRD Facilities at §494.62(b):*] **Policies and procedures. (7) [or (6), (8)] The development of arrangements with other [*facilities*] [or] other providers to receive patients in the event of limitations or cessation of operations to maintain the continuity of services to facility patients.**

*[*For RNHCIs at §403.748(b):*] **Policies and procedures. (7) The development of arrangements with other RNHCIs and other providers to receive patients in the event of limitations or cessation of operations to maintain the continuity of non-medical services to RNHCI patients.**

Interpretive Guidelines applies to: §403.748(b)(7), §418.113(b)(5), §441.184(b)(7), §460.84(b)(8), §482.15(b)(7), §483.73(b)(7), §483.475(b)(7), §485.625(b)(7), §485.920(b)(6), §494.62(b)(6).

Note: The differences for some providers and suppliers between "and" and "or" are referenced above. Additionally, the there are differences between continuity of "operations" and "services" within the regulatory language.

Note: This does not apply to ASCs, Transplant Centers, HHAs, CORFs, Clinics, Rehabilitation Agencies and Public Health Agencies as Providers of Outpatient Physical Therapy and Speech-Language Pathology Services, OPOs, RHCs/FQHCs.

Facilities are required to have policies and procedures which include prearranged transfer agreements, which may include written agreements or contracted arrangements with other facilities and other providers to receive patients in the event of limitations or cessation of operations to maintain the continuity of services to facility patients. Facilities should consider all needed arrangements for the transfer of patients during an evacuation. For example, if a CAH is required to evacuate, policies and procedures should address what facilities are nearby and outside the area of disaster which could accept the CAH's patients. Additionally, the policies and procedures and facility agreements should include pre-arranged agreements for transportation between the

facilities. The arrangements should be in writing, such as Memorandums of Understanding (MOUs) and Transfer Agreements, in order to demonstrate compliance.

For RNHCIs, at § 403.748(b)(7), the term "non-medical" is added in order to accommodate the uniqueness of the RNHCI non-medical care.

Survey Procedures

- Ask to see copies of the arrangements and/or any agreements the facility has with other facilities to receive patients in the event the facility is not able to care for them during an emergency.
- Ask facility leadership to explain the arrangements in place for transportation in the event of an evacuation.

E-0026

(Issued XX-XX-17)

§403.748(b)(8), §416.54(b)(6), §418.113(b)(6)(C)(iv), §441.184(b)(8), §460.84(b)(9), §482.15(b)(8), §483.73(b)(8), §483.475(b)(8), §485.625(b)(8), §485.920(b)(7) §494.62(b)(7).

[(b) Policies and procedures. The [*facilities*] must develop and implement emergency preparedness policies and procedures, based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, and the communication plan at paragraph (c) of this section. The policies and procedures must be reviewed and updated at least annually.] At a minimum, the policies and procedures must address the following:]

(8) [(6), (6)(C)(iv), (7), or (9)] The role of the [*facility*] under a waiver declared by the Secretary, in accordance with section 1135 of the Act, in the provision of care and treatment at an alternate care site identified by emergency management officials.

*[*For RNHCIs at §403.748(b):*] **Policies and procedures.** (**8) The role of the RNHCI under a waiver declared by the Secretary, in accordance with section 1135 of Act, in the provision of care at an alternative care site identified by emergency management officials.**

Interpretive Guidelines applies to: §403.748(b)(8), §416.54(b)(6), §418.113(b)(6)(C)(iv), §441.184(b)(8), §460.84(b)(9), §482.15(b)(8), §483.73(b)(8), §483.475(b)(8), §485.625(b)(8), §485.920(b)(7), §494.62(b)(7)

Note: This does not apply to Transplant Centers, HHAs, CORFs, Clinics, Rehabilitation Agencies and Public Health Agencies as Providers of Outpatient Physical Therapy and Speech-Language Pathology Services, OPOs, RHCs/FQHCs.

Facilities must develop and implement policies and procedures that describe its role in providing care at alternate care sites during emergencies. It is expected that state or local emergency management officials might designate such alternate sites, and would plan jointly with local facilities on issues related to staffing, equipment and supplies at such alternate sites. This requirement encourages providers to collaborate with their local emergency officials in such proactive planning to allow an organized and systematic response to assure continuity of care even when services at their facilities have been severely disrupted.

Facility's policies and procedures must specifically address the facility's role in emergencies where the President declares a major disaster or emergency under the Stafford Act or an emergency under the National Emergencies Act, and the HHS Secretary declares a public health emergency Examples of 1135 waivers include some of the existing CoPs; Licensure for Physicians or others to provide services in the affected State; EMTALA; Medicare Advantage out of network providers and HIPAA.

Facilities policies and procedures should address what coordination efforts are required during a declared emergency in which a waiver of federal requirements under section 1135 of the Act has been granted by the Secretary. For example, if due to a mass casualty incident in a geographic location, an 1135 waiver may be granted to waive licensure for physicians in order for these individuals to assist at a specific facility where they do not normally practice, then the facility should have policies and procedures which outline the responsibilities during the duration of this waiver period. For instance, the policies may establish a lead person in charge for accountability and oversight of assisting physicians not usually under contract with the facility.

Additionally, facilities should also have in place policies and procedures which address emergency situations in which a declaration was not made and where an 1135 waiver may not be applicable, such as during a disaster affecting the single facility. In this case, policies and procedures should address potential transfers of patients; timelines of patients at alternate facilities, etc.

For additional 1135 Waiver information, the SCG Emergency Preparedness Website has resources.

Survey Procedures

- Verify the facility has included policies and procedures in its emergency plan describing the facility's role in providing care and treatment (except for RNHCI, for care only) at alternate care sites under an 1135 waiver.

E-0027

(Issued XX-XX-17)

§494.62(b)(8) Condition for Coverage:
[(b) Policies and procedures. The dialysis facility must develop and implement emergency preparedness policies and procedures, based on the emergency plan set

forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, and the communication plan at paragraph (c) of this section. The policies and procedures must be reviewed and updated at least annually.] At a minimum, the policies and procedures must address the following:]

(8) How emergency medical system assistance can be obtained when needed.

Interpretive Guidelines for §494.62(b)(8).

ESRD facilities must include in its emergency plan, policies and procedures for obtaining emergency medical assistance when needed. Medical system assistance can be considered but not limited to, outside assistance such as from a nearby hospital. Additionally, this can mean assistance from other ESRD facilities including personnel to assist during a single-facility disaster.

Survey Procedures

- Verify the ESRD facility has included in its emergency plan, policies and procedures for obtaining emergency medical assistance when needed.

E-0028

(Issued XX-XX-17)

§494.62(b)(9) Condition for Coverage:
[(b) Policies and procedures. The dialysis facility must develop and implement emergency preparedness policies and procedures, based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, and the communication plan at paragraph (c) of this section. The policies and procedures must be reviewed and updated at least annually.] At a minimum, the policies and procedures must address the following:]

(9) A process by which the staff can confirm that emergency equipment, including, but not limited to, oxygen, airways, suction, defibrillator or automated external defibrillator, artificial resuscitator, and emergency drugs, are on the premises at all times and immediately available.

Interpretive Guidelines for §494.62(b)(9).

ESRD facilities must include policies and procedures in its emergency plan that address a process that confirms that the specific requirements listed under this standard are on the premises at all times and immediately available in the event of an emergency. The process must be in writing. It is the facilities responsibility to determine what equipment is should on the premises and available during an emergency to assist patients in an emergency. Additionally, it is the responsibility of the facility to ensure that all necessary equipment identified in this area, should-be in working order at all times in accordance with the manufacturer instructions. Emergency drugs should not be out of date and should be stored and maintained based on the manufacturer instructions. The facility is in

the best position to determine what emergency equipment it needs to have available. In addition, dialysis facilities need to be able to manage care-related emergencies during an emergency when other assistance, emergency medical services systems, may not be immediately available to them.

Survey Procedures

- Verify the dialysis facility has a process in place by which its staff can confirm that emergency equipment is on the premises and immediately available.
- Verify that the process includes at least the listed emergency equipment within its emergency plan by asking to see a copy of the written processes/ policy on emergency equipment and medications.
- Check to see that all of the above equipment is available and in working order. Ask to see procedures/checklist for ensuring equipment is checked
- Check to see that all emergency drugs are not out of date.

E-TAG NON-CITABLE (No assigned tags)
Reference Only (PACE)
(Issued XX-XX-17)

§460.84(b)(10) Requirement:
[(b) Policies and procedures. The PACE organization must develop and implement emergency preparedness policies and procedures, based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, and the communication plan at paragraph (c) of this section. The policies and procedures must be reviewed and updated at least annually.] The policies and procedures must address management of medical and non-medical emergencies, including, but not limited to: Fire; equipment, power, or water failure; care-related emergencies; and natural disasters likely to threaten the health or safety of the participants, staff, or the public. Policies and procedures must be reviewed and updated at least annually. At a minimum, the policies and procedures must address the following:

(10)(i) Emergency equipment, including easily portable oxygen, airways, suction, and emergency drugs.
(ii) Staff who know how to use the equipment must be on the premises of every center at all times and be immediately available.
(iii) A documented plan to obtain emergency medical assistance from outside sources when needed.

Interpretive Guidelines for §460.84(b)(10).

PACE organizations must include policies and procedures in its emergency plan to address the requirements of this standard.

E-0029

(Issued XX-XX-17)

§403.748(c), §416.54(c), §418.113(c), §441.184(c), §460.84(c), §482.15(c), §483.73(c), §483.475(c), §484.22(c), §485.68(c), §485.625(c), §485.727(c), §485.920(c), §486.360(c), §491.12(c), §494.62(c).

(c) The [*facility*] must develop and maintain an emergency preparedness communication plan that complies with Federal, State and local laws and must be reviewed and updated at least annually.

Interpretive Guidelines applies to: §403.748(c), §416.54(c), §418.113(c), §441.184(c), §460.84(c), §482.15(c), §483.73(c), §483.475(c), §484.22(c), §485.68(c), §485.625(c), §485.727(c), §485.920(c), §486.360(c), §491.12(c), §494.62(c).

Note: This does not apply to Transplant Centers.

Facilities must have a written emergency communication plan that contains how the facility coordinates patient care within the facility, across healthcare providers, and with state and local public health departments. The communication plan should include how the facility interacts and coordinates with emergency management agencies and systems to protect patient health and safety in the event of a disaster. The development of a communication plan will support the coordination of care. The plan must be reviewed annually and updated as necessary. We are allowing facilities flexibility in how they formulate and operationalize the requirements of the communication plan.

Facilities in rural or remote areas with limited connectivity to communication methodologies such as the Internet, World Wide Web, or cellular capabilities need to ensure their communication plan addresses how they would communicate and comply with this requirement in the absence of these communication methodologies. For example, if a facility is located in a rural area, which has limited or no Internet and phone connectivity during an emergency, it must address what alternate means are available to alert local and State emergency officials. Optional communication methods facilities may consider include satellite phones, radios and short wave radios.

Survey Procedures

- Verify that the facility has a written communication plan by asking to see the plan.
- Ask to see evidence that the plan has been reviewed (and updated as necessary) on an annual basis.

E-0030

(Issued XX-XX-17)

§403.748(c)(1), §416.54(c)(1), §418.113(c)(1), §441.184(c)(1), §460.84(c)(1), §482.15(c)(1), §483.73(c)(1), §483.475(c)(1), §484.22(c)(1), §485.68(c)(1),

§485.625(c)(1), §485.727(c)(1), §485.920(c)(1), §486.360(c)(1), §491.12(c)(1), §494.62(c)(1).

[(c) The [*facility,* except RNHCIs, hospices, transplant centers, and HHAs] must develop and maintain an emergency preparedness communication plan that complies with Federal, State and local laws and must be reviewed and updated at least annually.] The communication plan must include all of the following:]

(1) Names and contact information for the following:
- **(i) Staff.**
- **(ii) Entities providing services under arrangement.**
- **(iii) Patients' physicians**
- **(iv) Other [facilities].**
- **(v) Volunteers.**

*[*For Hospitals at §482.15(c) and CAHs at §485.625(c)]* **The communication plan must include all of the following:**
(1) Names and contact information for the following:
- **(i) Staff.**
- **(ii) Entities providing services under arrangement.**
- **(iii) Patients' physicians**
- **(iv) Other [hospitals and CAHs].**
- **(v) Volunteers.**

*[*For RNHCIs at §403.748(c):*] **The communication plan must include all of the following:**
- **(1) Names and contact information for the following:**
  - **(i) Staff.**
  - **(ii) Entities providing services under arrangement.**
  - **(iii) Next of kin, guardian, or custodian.**
  - **(iv) Other RNHCIs.**
  - **(v) Volunteers.**

*[*For ASCs at §416.45(c):*] **The communication plan must include all of the following:**
- **(1) Names and contact information for the following:**
  - **(i) Staff.**
  - **(ii) Entities providing services under arrangement.**
  - **(iii) Patients' physicians.**
  - **(iv) Volunteers.**

*[*For Hospices at §418.113(c):*] **The communication plan must include all of the following:**
- **(1) Names and contact information for the following:**
  - **(i) Hospice employees.**
  - **(ii) Entities providing services under arrangement.**

(iii) Patients' physicians.
(iv) Other hospices.

*[*For OPOs at §486.360(c):*] **The communication plan must include all of the following:**

(1) Names and contact information for the following:
- **(i) Staff.**
- **(ii) Entities providing services under arrangement.**
- **(iii) Volunteers.**
- **(iv) Other OPOs.**
- **(v) Transplant and donor hospitals in the OPO's Donation Service Area (DSA).**

Interpretive Guidelines applies to: §403.748(c)(1), §416.54(c)(1), §418.113(c)(1), §441.184(c)(1), §460.84(c)(1), §482.15(c)(1), §483.73(c)(1), §483.475(c)(1), §484.22(c)(1), §485.68(c)(1), §485.625(c)(1), §485.727(c)(1), §485.920(c)(1), §486.360(c)(1), §491.12(c)(1), §494.62(c)(1).

Note: This does not apply to Transplant Centers.

A facility must have the contact information for those individuals and entities outlined within the standard. The requirement to have contact information for "other facilities" requires a provider or supplier to have the contact information for another provider or supplier of the same type as itself. For instance, hospitals should have contact information for other hospitals and CORFs should have contact information for other CORFs, etc. While not required, facilities may also find it prudent to have contact information for other facilities not of the same type. For instance a hospital may find it appropriate to have the contact information of LTC facilities within a reasonable geographic area, which could assist in facilitating patient transfers. Facilities have discretion in the formatting of this information, however it should be readily available and accessible to leadership and staff during an emergency event. Facilities which utilize electronic data storage should be able to provide evidence of data back-up with hard copies or demonstrate capability to reproduce contact lists or access this data during emergencies. All contact information must be reviewed and updated as necessary at least annually. Contact information contained in the communication plan must be accurate and current. Facilities must update contact information for incoming new staff and departing staff throughout the year and any other changes to information for those individuals and entities on the contact list.

Transplant Centers should be included in the development of the hospitals communication plans. In the case of a Medicare-approved transplant center, a communication plan needs to be developed and disseminated between the hospitals, OPO, and transplant patients. For example, if the transplant program is planning to transfer patients to another transplant center due to an emergency, the communication plan between the hospitals, the OPO, and the patient should include the responsibilities of each of the facility types to ensure continuity of care. During an emergency, should an

organ offer become available at the time the patient is at the "transferred hospital," the OPO's emergency preparedness communication plan should address how this information will be communicated to both the OPO and the patient of where their care will be continued.

Survey Procedures

- Verify that all required contacts are included in the communication plan by asking to see a list of the contacts with their contact information.
- Verify that all contact information has been reviewed and updated at least annually by asking to see evidence of the annual review.

E-0031

(Issued XX-XX-17)

§403.748(c)(2), §416.54(c)(2), §418.113(c)(2), §441.184(c)(2), §460.84(c)(2), §482.15(c)(2), §483.73(c)(2), §483.475(c)(2), §484.22(c)(2), §485.68(c)(2), §485.625(c)(2), §485.727(c)(2), §485.920(c)(2), §486.360(c)(2), §491.12(c)(2), §494.62(c)(2).

[(c) The [*facility*] must develop and maintain an emergency preparedness communication plan that complies with Federal, State and local laws and must be reviewed and updated at least annually] The communication plan must include all of the following:

(2) Contact information for the following:

(i) Federal, State, tribal, regional, and local emergency preparedness staff.
(ii) Other sources of assistance.

*[*For LTC Facilities at §483.73(c):*] **(2) Contact information for the following:**

(i) Federal, State, tribal, regional, or local emergency preparedness staff.
(ii) The State Licensing and Certification Agency.
(iii) The Office of the State Long-Term Care Ombudsman.
(iv) Other sources of assistance.

*[*For ICF/IIDs at §483.475(c):*] **(2) Contact information for the following:**

(i) Federal, State, tribal, regional, and local emergency preparedness staff.
(ii) Other sources of assistance.
(iii) The State Licensing and Certification Agency.
(iv) The State Protection and Advocacy Agency.

Interpretive Guidelines applies to: §403.748(c)(2), §416.54(c)(2), §418.113(c)(2), §441.184(c)(2), §460.84(c)(2), §482.15(c)(2), §483.73(c)(2), §483.475(c)(2), §484.22(c)(2), §485.68(c)(2), §485.625(c)(2), §485.727(c)(2), §485.920(c)(2), §486.360(c)(2), §491.12(c)(2), §494.62(c)(2).

Note: This does not apply to Transplant Centers.

A facility must have the contact information for those individuals and entities outlined within the standard. Facilities have discretion in the formatting of this information, however it should be readily available and accessible to leadership during an emergency event. Facilities are encouraged but not required to maintain these contact lists both in electronic format and hard-copy format in the event that network systems to retrieve electronic files are not accessible. All contact information must be reviewed and updated at least annually.

Survey Procedures

- Verify that all required contacts are included in the communication plan by asking to see a list of the contacts with their contact information.
- Verify that all contact information has been reviewed and updated at least annually by asking to see evidence of the annual review.

E-0032

(Issued XX-XX-17)

§403.748(c)(3), §416.54(c)(3), §418.113(c)(3), §441.184(c)(3), §460.84(c)(3), §482.15(c)(3), §483.73(c)(3), §483.475(c)(3), §484.22(c)(3), §485.68(c)(3), §485.625(c)(3), §485.727(c)(3), §485.920(c)(3), §486.360(c)(3), §491.12(c)(3), §494.62(c)(3).

[(c) The [*facility*] must develop and maintain an emergency preparedness communication plan that complies with Federal, State and local laws and must be reviewed and updated at least annually.] The communication plan must include all of the following:

(3) Primary and alternate means for communicating with the following:

(i) [*Facility*] staff.

(ii) Federal, State, tribal, regional, and local emergency management agencies.

*[*For ICF/IIDs at §483.475(c):*] **(3) Primary and alternate means for communicating with the ICF/IID's staff, Federal, State, tribal, regional, and local emergency management agencies.**

Interpretive Guidelines applies to: §403.748(c)(3), §416.54(c)(3), §418.113(c)(3), §441.184(c)(3), §460.84(c)(3), §482.15(c)(3), §483.73(c)(3), §483.475(c)(3), §484.22(c)(3), §485.68(c)(3), §485.625(c)(3), §485.727(c)(3), §485.920(c)(3), §486.360(c)(3), §491.12(c)(3), §494.62(c)(3).

Note: This does not apply to Transplant Centers.

Facilities are required to have primary and alternate means of communicating with staff, Federal, State, tribal, regional, and local emergency management agencies. Facilities

have the discretion to utilize alternate communication systems that best meets their needs. However, it is expected that facilities would consider pagers, cellular telephones, radio transceivers (that is, walkie-talkies), and various other radio devices such as the NOAA Weather Radio and Amateur Radio Operators' (HAM Radio) systems, as well as satellite telephone communications systems. We recognize that some facilities, especially in remote areas, may have difficulty using some communication systems, such as cellular phones, even in non-emergency situations, which should be outlined within their risk assessment and addressed within the communications plan. It is expected these facilities would address such challenges when establishing and maintaining a well-designed communication system that will function during an emergency.

The communication plan should include procedures regarding when and how alternate communication methods are used, and who uses them. In addition the facility should ensure that its selected alternative means of communication is compatible with communication systems of other facilities, agencies and state and local officials it plans to communicate with during emergencies. For example, if State X local emergency officials use the SHAred RESources (SHARES) High Frequency (HF) Radio program and facility Y is trying to communicate with RACES, it may be prudent to consider if these two alternate communication systems can communicate on the same frequencies.

Facilities may seek information about the National Communication System (NCS), which offers a wide range of National Security and Emergency Preparedness communications services, the Government Emergency Telecommunications Services (GETS), the Telecommunications Service Priority (TSP) Program, Wireless Priority Service (WPS), and SHARES. Other communication methods could include, but are not limited to, satellite phones, radio, and short wave radio. The Radio Amateur Civil Emergency Services (RACES) is an integral part of emergency management operations.

Survey Procedures

- Verify the communication plan includes primary and alternate means for communicating with facility staff, Federal, State, tribal, regional and local emergency management agencies by reviewing the communication plan.
- Ask to see the communications equipment or communication systems listed in the plan.

E-0033

(Issued XX-XX-17)

§403.748(c)(4)-(6), §416.54(c)(4)-(6), §418.113(c)(4)-(6), §441.184(c)(4)-(6), §460.84(c)(4)-(6), §441.184(c)(4)-(6), §460.84(c)(4)-(6), §482.15(c)(4)-(6), §483.73(c)(4)-(6), §483.475(c)(4)-(6), §484.22(c)(4)-(5), §485.68(c)(4), §485.625(c)(4)-(6), §485.727(c)(4), §485.920(c)(4)-(6), §491.12(c)(4), §494.62(c)(4)-(6).

[(c) The [*facility*] must develop and maintain an emergency preparedness communication plan that complies with Federal, State and local laws and must be

reviewed and updated at least annually.] The communication plan must include all of the following:

(4) A method for sharing information and medical documentation for patients under the [*facility's*] care, as necessary, with other health providers to maintain the continuity of care.

(5) A means, in the event of an evacuation, to release patient information as permitted under 45 CFR 164.510(b)(1)(ii). [*This provision is not required for HHAs under §484.22(c), CORFs under §485.68(c)*]

(6) [(4) or (5)]A means of providing information about the general condition and location of patients under the [*facility's*] care as permitted under 45 CFR 164.510(b)(4).

*[*For RNHCIs at §403.748(c):*] **(4) A method for sharing information and care documentation for patients under the RNHCI's care, as necessary, with care providers to maintain the continuity of care, based on the written election statement made by the patient or his or her legal representative.**

*[For *RHCs/FQHCs at §491.12(c):*] **(4) A means of providing information about the general condition and location of patients under the facility's care as permitted under 45 CFR 164.510(b)(4).**

Interpretive Guidelines applies to: §403.748(c)(4)-(6), §416.54(c)(4)-(6), §418.113(c)(4)-(6), §441.184(c)(4)-(6), §460.84(c)(4)-(6), §482.15(c)(4)-(6), §441.184(c)(4)-(6), §460.84(c)(4)-(6), §483.73(c)(4)-(6), §483.475(c)(4)-(6), §484.22(c)(4)-(5), §485.68(c)(4), §485.625(c)(4)-(6), §485.727(c)(4), §485.920(c)(4)-(6), §491.12(c)(4), §494.62(c)(4)-(6).

Note: For RHCs/FQHC's the regulatory language differs under (c)(4). Additionally, a method for sharing information and medical documentation for patients under the RHC/FQHC's care, as necessary, with other health providers to maintain the continuity of care and a means of providing information about the general condition and location of patients does not apply.

Note: This does not apply to Transplant Centers.

Facilities are required to develop a method for sharing information and medical (or for RNHCIs only, care) documentation for patients under the facility's care, as necessary, with other health care providers to maintain continuity of care. Such a system must ensure that information necessary to provide patient care is sent with an evacuated patient to the next care provider and would also be readily available for patients being sheltered in place. While the regulation does not specify timelines for delivering patient care information, facilities are expected to provide patient care information to receiving facilities during an evacuation, within a timeframe that allows for effective patient

treatment and continuity of care. Facilities should not delay patient transfers during an emergency to assemble all patient reports, tests, etc. to send with the patient. Facilities should send all necessary patient information that is readily available and should include at least, patient name, age, DOB, allergies, current medications, medical diagnoses, current reason for admission (if inpatient), blood type, advance directives and next of kin/emergency contacts. There is no specified means (such as paper or electronic) for how facilities are to share the required information.

Facilities (with the exception of HHAs, RHCs/FQHCs, and CORFs) are also required to have a means, in the event of an evacuation, to release patient information as permitted under 45 CFR 164.510 and a means of providing information about the general condition and location of patients under the facility's care as permitted under 45 CFR 164.510(b)(4). Thus, facilities must have a communication system in place capable of generating timely, accurate information that could be disseminated, as permitted under 45 CFR 164.510(b)(4), to family members and others. Facilities have the flexibility to develop and maintain their own system in a manner that best meets its needs.

HIPAA requirements are not suspended during a national or public health emergency. However, the HIPAA Privacy Rule specifically permits certain uses and disclosures of protected health information in emergency circumstances and for disaster relief purposes. Section 164.510 ‘‘Uses and disclosures requiring an opportunity for the individual to agree to or to object,’’ is part of the ‘‘Standards for Privacy of Individually Identifiable Health Information,’’ commonly known as ‘‘The Privacy Rule.’’ HIPAA Privacy Regulations at 45 CFR 164.510(b)(4), ‘‘Use and disclosures for disaster relief purposes,’’ establishes requirements for disclosing patient information to a public or private entity authorized by law or by its charter to assist in disaster relief efforts for purposes of notifying family members, personal representatives, or certain others of the patient’s location or general condition.

Survey Procedures

- Verify the communication plan includes a method for sharing information and medical (or for RNHCIs only, care) documentation for patients under the facility's care, as necessary, with other health (or care for RNHCIs) providers to maintain the continuity of care by reviewing the communication plan.
    - For RNCHIs, verify that the method for sharing patient information is based on a requirement for the written election statement made by the patient or his or her legal representative.
- Verify the facility has developed policies and procedures that address the means the facility will use to release patient information to include the general condition and location of patients, by reviewing the communication plan

E-0034

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§403.748(c)(7), §416.54(c)(7), §418.113(c)(7) §441.184(c)(7), §482.15(c)(7), §460.84(c)(7), §483.73(c)(7), §483.475(c)(7), §484.22(c)(6), §485.68(c)(5),

§485.68(c)(5), §485.727(c)(5), §485.625(c)(7), §485.920(c)(7), §491.12(c)(5), §494.62(c)(7).

[(c) The [*facility*] must develop and maintain an emergency preparedness communication plan that complies with Federal, State and local laws and must be reviewed and updated at least annually.] The communication plan must include all of the following:

(7) [(5) or (6)] A means of providing information about the [*facility's*] occupancy, needs, and its ability to provide assistance, to the authority having jurisdiction, the Incident Command Center, or designee.

*[*For ASCs at 416.54(c)*]: **(7) A means of providing information about the ASC's needs, and its ability to provide assistance, to the authority having jurisdiction, the Incident Command Center, or designee.**

*[*For Inpatient Hospice at §418.113(c):*] **(7) A means of providing information about the hospice's inpatient occupancy, needs, and its ability to provide assistance, to the authority having jurisdiction, the Incident Command Center, or designee**.

Interpretive Guidelines applies to: §403.748(c)(7), §416.54(c)(7), §418.113(c)(7), §441.184(c)(7), §460.84(c)(7), §482.15(c)(7), §483.73(c)(7); §483.475(c)(7); §484.22(c)(6); §485.68(c)(5), §485.625(c)(7); §485.727(c)(5); §485.920(c)(7); §491.12 (c)(5), §494.62(c)(7).

Note: This does not apply to outpatient hospices or Transplant Centers.

Facilities, except for transplant centers, must have a means of providing information about the facility's needs and its ability to provide assistance to the authority having jurisdiction (local and State emergency management agencies, local and state public health departments, the Incident Command Center, the Emergency Operations Center, or designee). For hospitals, CAHs, RNHCIs, inpatient hospices, PRTFs, LTC facilities, and ICF/IIDs, they must also have a means for providing information about their occupancy.

Occupancy reporting is considered, but not limited to, reporting the number of patients currently at the facility receiving treatment and care or the facility's occupancy percentage. The facility should consider how its occupancy affects its ability to provide assistance. For example, if the facility's occupancy is close to 100% the facility may not be able to accept patients from nearby facilities. The types of "needs" a facility may have during an emergency and should communicate to the appropriate authority would include but is not limited to, shortage of provisions such as food, water, medical supplies, assistance with evacuation and transfers, etc.

Note: The authority having jurisdiction varies by local, state and federal emergency management structures as well as the type of disaster. For example, in the event of a multi-state wildfire, the jurisdictional authority who would take over the Incident

Command Center or state-wide coordination of the disaster would likely be a fire-related agency.

We are not prescribing the means that facilities must use in disseminating the required information. However, facilities should include in its communication plan, a process to communicate the required information.

Note: As defined by the Federal Emergency Management Administration (FEMA), an Incident Command System (ICS) is a management system designed to enable effective and efficient domestic incident management by integrating a combination of facilities, equipment, personnel, procedures, and communications operating within a common organizational structure. (FEMA, 2016). The industry, as well as providers/suppliers, use various terms to refer to the same function and we have used the term ‘‘Incident Command Center’’ to mean ‘‘Emergency Operations Center’’ or ‘‘Incident Command Post.’’ Local, State, Tribal and Federal emergency preparedness officials, as well as regional healthcare coalitions, can assist facilities in the identification of their Incident Command Centers and reporting requirements dependent on an emergency.

Survey Procedures

- Verify the communication plan includes a means of providing information about the facility’s needs, and its ability to provide assistance, to the authority having jurisdiction, the Incident Command Center, or designee by reviewing the communication plan.
- For hospitals, CAHs, RNHCIs, inpatient hospices, PRTFs, LTC facilities, and ICF/IIDs, also verify if the communication plan includes a means of providing information about their occupancy.

E-0035
(Issued XX-XX-17)

§483.73(c)(8); §483.475(c)(8)

*[*For LTC Facilities at §483.73(c) and ICF/IIDs at §483.475(c) :*]
[(c) The [*LTC facility and ICF/IID*] must develop and maintain an emergency preparedness communication plan that complies with Federal, State and local laws and must be reviewed and updated at least annually.] The communication plan must include all of the following:

(8) A method for sharing information from the emergency plan, that the facility has determined is appropriate, with residents [*or clients*] and their families or representatives.

Interpretive Guidelines for §483.73(c)(8) and §483.475(c)(8).

Note: This ONLY applies to LTC Facilities and ICF/IIDs.

LTC facilities and ICF/IIDs are required to share emergency preparedness plans and policies with family members and resident representative s or client representatives, respectively. Facilities have flexibility in deciding what information from the emergency plan should be shared, as well as the timing and manner in which it should be disseminated. While we are not requiring facilities take specific steps or utilize specific strategies to share this information with residents or clients and their families or representatives, we would recommend that facilities provide a quick "Fact Sheet" or informational brochure to the family members and resident or client representatives which may highlight the major sections of the emergency plan and policies and procedures deemed appropriate by the facility. Other options include providing instructions on how to contact the facility in the event of an emergency on the public website or to include the information as part of the facility's check-in procedures. The facility may provide this information to the surveyor during the survey to demonstrate compliance with the requirement.

Survey Procedures

- Ask staff to demonstrate the method the facility has developed for sharing the emergency plan with residents or clients and their families or representatives.
- Interview residents or clients and their families or representatives and ask them if they have been given information regarding the facility's emergency plan.
- Verify the communication plan includes a method for sharing information from the emergency plan, and that the facility has determined it is appropriate with residents or clients and their families or representatives by reviewing the plan.

E-0036

(Issued XX-XX-17)

§403.748(d), §416.54(d), §418.113(d), §441.184(d), §460.84(d), §482.15(d), §483.73(d), §483.475(d), §484.22(d), §485.68(d), §485.625(d), §485.727(d), §485.920(d), §486.360(d), §491.12(d), §494.62(d).

(d) Training and testing. The [*facility*] must develop and maintain an emergency preparedness training and testing program that is based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, policies and procedures at paragraph (b) of this section, and the communication plan at paragraph (c) of this section. The training and testing program must be reviewed and updated at least annually.

*[*For ICF/IIDs at §483.475(d):*] **Training and testing. The ICF/IID must develop and maintain an emergency preparedness training and testing program that is based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, policies and procedures at paragraph (b) of this section, and the communication plan at paragraph (c) of this section. The training and testing program must be reviewed and updated at least annually. The ICF/IID must meet the requirements for evacuation drills and training at §483.470(h).**

*[*For ESRD Facilities at §494.62(d):*] **Training, testing, and orientation. The dialysis facility must develop and maintain an emergency preparedness training, testing and patient orientation program that is based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, policies and procedures at paragraph (b) of this section, and the communication plan at paragraph (c) of this section. The training, testing and orientation program must be reviewed and updated at least annually.**

Interpretive Guidelines applies to: §403.748(d), §416.54(d), §418.113(d), §441.184(d), §482.15(d), §460.84(d), §483.73(d), §483.475(d), §484.22(d), §485.68(d), §485.625(d), §485.727(d), §485.920(d), §486.360(d), §491.12(d), §494.62(d).

Note: This does not apply to Transplant Centers.

Note: The citation to §483.470(h) referenced in §483.475(d) for ICF/IIDs requirements is incorrect as this was a technical error made within the Final Rule.

An emergency preparedness training and testing program as specified in this requirement must be documented and reviewed and updated on at least an annual basis. The training and testing program must reflect the risks identified in the facility's risk assessment and be included in their emergency plan. For example, a facility that identifies flooding as a risk should also include policies and procedures in their emergency plan for closing or evacuating their facility and include these in their training and testing program. This would include, but is not limited to, training and testing on how the facility will communicate the facility closure to required individuals and agencies, testing patient tracking systems and testing transportation procedures for safely moving patients to other facilities. Additionally, for facilities with multiple locations, such as multi-campus or multi-location hospitals, the facility's training and testing program must reflect the facility's risk assessment for each specific location.

Training refers to a facility's responsibility to provide education and instruction to staff, contractors, and facility volunteers to ensure all individuals are aware of the emergency preparedness program. Testing is the concept in which training is operationalized and the facility is able to evaluate the effectiveness of the training as well as the overall emergency preparedness program. Testing includes conducting drills and/or exercises to test the emergency plan to identify gaps and areas for improvement.

Survey Procedures

- Verify that the facility has a written training and testing (and for ESRD facilities, a patient orientation) program that meets the requirements of the regulation.
- Verify the program has been reviewed and updated on, at least, an annual basis by asking for documentation of the annual review as well as any updates made.
- Verify that ICF/IID emergency plans also meet the requirements for evacuation drills and training at §483.470(i).

E-0037

(Issued XX-XX-17)

§403.748(d)(1), §416.54(d)(1), §418.113(d)(1), §441.184(d)(1), §460.84(d)(1), §482.15(d)(1), §483.73(d)(1), §483.475(d)(1), §484.22(d)(1), §485.68(d)(1), §485.625(d)(1), §485.727(d)(1), §485.920(d)(1), §486.360(d)(1), §491.12(d)(1).

(1) ***Training program*****. The [*****facility*****, except Hospices, PRTFs, PACE organizations, Hospitals, CAHs, RHCs/ FQHCs, and dialysis facilities] must do all of the following:**

> **(i) Initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected role.**
> **(ii) Provide emergency preparedness training at least annually.**
> **(iii) Maintain documentation of all emergency preparedness training.**
> **(iv) Demonstrate staff knowledge of emergency procedures.**

*[*For Hospitals at §482.15(d) and RHCs/FQHCs at §491.12:*] **(1) Training program. The [Hospital or RHC/FQHC] must do all of the following:**

> **(i) Initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing on-site services under arrangement, and volunteers, consistent with their expected roles.**
> **(ii) Provide emergency preparedness training at least annually.**
> **(iii) Maintain documentation of the training.**
> **(iv) Demonstrate staff knowledge of emergency procedures.**

*[*For Hospices at §418.113(d):*] **(1) Training. The hospice must do all of the following:**

> **(i) Initial training in emergency preparedness policies and procedures to all new and existing hospice employees, and individuals providing services under arrangement, consistent with their expected roles.**
> **(ii) Demonstrate staff knowledge of emergency procedures.**
> **(iii) Provide emergency preparedness training at least annually.**
> **(iv) Periodically review and rehearse its emergency preparedness plan with hospice employees (including nonemployee staff), with special emphasis placed on carrying out the procedures necessary to protect patients and others.**

*[*For PRTFs at §441.184(d):*] **(1) Training program. The PRTF must do all of the following:**

> **(i) Initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected roles.**
> **(ii) After initial training, provide emergency preparedness training at least annually.**
> **(iii) Demonstrate staff knowledge of emergency procedures.**
> **(iv) Maintain documentation of all emergency preparedness training.**

*[*For PACE at §460.84(d):*] **(1) The PACE organization must do all of the following:**

(i) Initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing on-site services under arrangement, contractors, participants, and volunteers, consistent with their expected roles.

(ii) Provide emergency preparedness training at least annually.

(iii) Demonstrate staff knowledge of emergency procedures, including informing participants of what to do, where to go, and whom to contact in case of an emergency.

(iv) Maintain documentation of all training.

[For CORFs at §485.68(d):]***(1) Training. The CORF must do all of the following:**

(i) Provide initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected roles.

(ii) Provide emergency preparedness training at least annually.

(iii) Maintain documentation of the training.

(iv) Demonstrate staff knowledge of emergency procedures. All new personnel must be oriented and assigned specific responsibilities regarding the CORF's emergency plan within 2 weeks of their first workday. The training program must include instruction in the location and use of alarm systems and signals and firefighting equipment.

*[*For CAHs at §485.625(d):*] **(1) Training program. The CAH must do all of the following:**

(i) Initial training in emergency preparedness policies and procedures, including prompt reporting and extinguishing of fires, protection, and where necessary, evacuation of patients, personnel, and guests, fire prevention, and cooperation with firefighting and disaster authorities, to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected roles.

(ii) Provide emergency preparedness training at least annually.

(iii) Maintain documentation of the training.

(iv) Demonstrate staff knowledge of emergency procedures.

*[*For CMHCs at §485.920(d):*] **(1) Training. The CMHC must provide initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected roles, and maintain documentation of the training. The CMHC must demonstrate staff knowledge of emergency procedures. Thereafter, the CMHC must provide emergency preparedness training at least annually**.

Interpretive Guidelines applies to: §403.748(d)(1), §416.54(d)(1), §418.113(d)(1), §441.184(d)(1), §460.84(d)(1), §482.15(d)(1), §483.73(d)(1), §483.475(d)(1),

§484.22(d)(1), §485.68(d)(1), §485.625(d)(1), §485.727(d)(1), §485.920(d)(1), §486.360(d)(1), §491.12(d)(1)

Note: This does not apply to Transplant Centers or ESRD facilities.

Facilities are required to provide initial training in emergency preparedness policies and procedures that are consistent with their roles in an emergency to all new and existing staff, individuals providing services under arrangement, and volunteers. This includes individuals who provide services on a per diem basis such as agency nursing staff and any other individuals who provide services on an intermittent basis and would be expected to assist during an emergency.

PACE organizations and CAHs have additional requirements. PACE organizations must also provide initial training to contractors and PACE participants. CAHs must also include initial training on the following: prompt reporting and extinguishing of fires; protection; and where necessary, evacuation of patients, personnel, and guests, fire prevention, and cooperation with firefighting and disaster authorities.

Facilities should provide initial emergency training during orientation (or shortly thereafter) to ensure initial training is not delayed. With the exception of CORFs which must complete initial training within the first two weeks of employment, we recommend initial training be completed by the time the staff has completed the facility's new hire orientation program. Additionally, in the case of facilities with multiple locations, such as multi-campus hospitals, staff, individuals providing services under arrangement, or volunteers should be provided initial training at their specific location and when they are assigned to a new location.

Facilities have the flexibility to determine the focus of their annual training, as long as it aligns with the emergency plan and risk assessment. Ideally, annual training should be modified each year, incorporating any lessons learned from the most recent exercises, real-life emergencies that occurred in the last year and during the annual review of the facility's emergency program. For example, annual training could include training staff on new evacuation procedures that were identified as a best practice and documented in the facility "After Action Report" (AAR) during the last emergency drill and were incorporated into the emergency plan during the program's annual review.

While facilities are required to provide annual training to all staff, it is up to the facility to decide what level of training each staff member will be required to complete each year based on an individual's involvement or expected role during an emergency. There may be core topics that apply to all staff, while certain clinical staff may require additional topics. For example, dietary staff who prepare meals may not need to complete annual training that is focused on patient evacuation procedures. Instead, the facility may provide training that focuses on the proper preparation and storage of food in an emergency. In addition, depending on specific staff duties during an emergency, a facility may determine that documented external training is sufficient to meet some or all of the facility's annual training requirements. For example, staff who work with

radiopharmaceuticals may attend external training that teach staff how to handle radiopharmaceutical emergencies. It is up to the facility to decide if the external training meets the facility's requirements.

Facilities must maintain documentation of the annual training for all staff. The documentation must include the specific training completed as well as the methods used for demonstrating knowledge of the training program. Facilities have flexibility in ways to demonstrate staff knowledge of emergency procedures. The method chosen is likely based on the training delivery method. For example: computer-based or printed self-learning packets may contain a test to demonstrate knowledge. If facilities choose instructor-led training, a question and answer session could follow the training. Regardless of the method, facilities must maintain documentation that training was completed and that staff are knowledgeable of emergency procedures.

Survey Procedures

- Ask for copies of the facility's initial emergency preparedness training and annual emergency preparedness training offerings.
- Interview various staff and ask questions regarding the facility's initial and annual training course, to verify staff knowledge of emergency procedures.
- Review a sample of staff training files to verify staff have received initial and annual emergency preparedness training.

E-0038

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§494.62(d)(1): Condition for Coverage:

(d)(1) ***Training program.*** **The dialysis facility must do all of the following:**

(i) Provide initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected roles.

(ii) Provide emergency preparedness training at least annually. Staff training must:

(iii) Demonstrate staff knowledge of emergency procedures, including informing patients of—

(A) What to do;

(B) Where to go, including instructions for occasions when the geographic area of the dialysis facility must be evacuated;

(C) Whom to contact if an emergency occurs while the patient is not in the dialysis facility. This contact information must include an alternate emergency phone number for the facility for instances when the dialysis facility is unable to receive phone calls due to an emergency situation (unless the facility has the ability to forward calls to a working phone number under such emergency conditions); and

(D) How to disconnect themselves from the dialysis machine if an emergency occurs.

(iv) Demonstrate that, at a minimum, its patient care staff maintains current CPR certification; and
(v) Properly train its nursing staff in the use of emergency equipment and emergency drugs.
(vi) Maintain documentation of the training.

Interpretive Guidelines for §494.62(d)(1).

The ESRD facility is required to train new and existing staff on their emergency preparedness policies and procedures on an annual basis. Additionally, individuals providing services under arrangement and volunteers are required to undergo the training as applicable to their roles and responsibilities within the facility.

Many large ESRD Networks already implement trainings for staff regarding evacuation procedures of the facilities. Through this requirement, all facilities are required to demonstrate upon survey that that staff know the current evacuation plans, alternate locations as well as their emergency contacts. Among the training, ESRD staff must be able to demonstrate knowledge on procedures for informing patients on how to disconnect themselves from a dialysis machine in the event of a disaster.

The ESRD facility must train staff on informing patients on whom to contact if the facility is closed and cannot provide treatment due to an emergency situation and how they can locate an alternate dialysis facility (e.g. Kidney Community Emergency Response Program (KCER)) or hospital that can assist them.

The ESRD facilities are expected to rearrange patient appointments if a disaster or emergency is forecasted through emergency notification channels, such as national weather forecasts. For instance, for inclement weather such as a snow storm which could cause community-wide closures and dangerous road conditions, we would expect the facility to make the appropriate arrangements for patients to receive their dialysis or be transferred into an inpatient setting to be provided with the appropriate care. Therefore, ESRD facilities may gear their training and testing program to include evacuation procedures in the event the facility is unable to close prior to an emergency.

All ESRD facility patient care staff are required to maintain current CPR certifications and all nursing staff are required to be properly trained in clinical emergency protocols that include the use of emergency equipment and emergency drugs. The training and CPR certifications must be documented and maintained on file.

Survey Procedures

- Verify the facility has an emergency preparedness training program and that it is updated annually.
- Interview staff and ask them to describe the evacuation procedures and plan.
- Verify current copies of CPR certifications for all patient care staff are on file.

E-0039

(Issued XX-XX-17)

§416.54(d)(2), §418.113(d)(2), §441.184(d)(2), §460.84(d)(2), §482.15(d)(2), §483.73(d)(2), §483.475(d)(2), §484.22(d)(2), §485.68(d)(2), §485.625(d)(2), §485.727(d)(2), §485.920(d)(2), §491.12(d)(2), §494.62(d)(2).

(2) ***Testing.*** **The [*facility*, except for LTC facilities, RNHCIs and OPOs] must conduct exercises to test the emergency plan at least annually. The [*facility*, except for RNHCIs and OPOs] must do all of the following:**

[For LTC Facilities at §483.73(d):]* **(2) Testing. The LTC facility must conduct exercises to test the emergency plan at least annually, including unannounced staff drills using the emergency procedures. The LTC facility must do all of the following:]

(i) Participate in a full-scale exercise that is community-based or when a community-based exercise is not accessible, an individual, facility-based. If the [facility] experiences an actual natural or man-made emergency that requires activation of the emergency plan, the [*facility*] is exempt from engaging in a community-based or individual, facility-based full-scale exercise for 1 year following the onset of the actual event.

(ii) Conduct an additional exercise that may include, but is not limited to the following:

(A) A second full-scale exercise that is community-based or individual, facility-based.

(B) A tabletop exercise that includes a group discussion led by a facilitator, using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan.

(iii) Analyze the [*facility's*] response to and maintain documentation of all drills, tabletop exercises, and emergency events, and revise the [facility's] emergency plan, as needed.

*[*For RNHCIs at §403.748 and OPOs at §486.360*] **(d)(2) Testing. The [*RNHCI and OPO*] must conduct exercises to test the emergency plan. The [*RNHCI and OPO*] must do the following:**

(i) Conduct a paper-based, tabletop exercise at least annually. A tabletop exercise is a group discussion led by a facilitator, using a narrated, clinically relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan.

(ii) Analyze the [*RNHCI's and OPO's*] response to and maintain documentation of all tabletop exercises, and emergency events, and revise the [*RNHCI's and OPO's*] emergency plan, as needed.

Interpretive Guidelines applies to: §403.748(d)(2), §416.54(d)(2), §418.113(d)(2), §441.184(d)(2), §460.84(d)(2), §482.15(d)(2), §483.73(d)(2), §483.475(d)(2),

§484.22(d)(2), §485.68(d)(2), §485.625(d)(2), §485.727(d)(2), §485.920(d)(2), §486.360(d)(2)§491.12(d)(2), §494.62(d)(2)

Note: This does not apply to Transplant Centers.

Note: RNHCIs and OPOs are only required to annually conduct paper-based tabletop exercises to test the emergency plan. They are not required to conduct individual facility based and full-scale community-based exercises.

Facilities must on an annual basis conduct exercises to test the emergency plan, which for LTC facilities also includes unannounced staff drills using the emergency procedures. Specifically, facilities are required to conduct a tabletop exercise and participate in a full-scale community-based exercise or conduct an individual facility exercise if a community-based exercise is not available. As the term full-scale exercise may vary by sector, facilities are not required to conduct a full-scale exercise as defined by FEMA or DHS's Homeland Security Exercise and Evaluation Program (HSEEP). For the purposes of this requirement, a full scale exercise is defined and accepted as any operations-based exercise (drill, functional, or full-scale exercise) that assesses a facility's functional capabilities by simulating a response to an emergency that would impact the facility's operations and their given community. A full-scale exercise is also an operations-based exercise that typically involves multiple agencies, jurisdictions, and disciplines performing functional or operational elements. There is also definition for "community" as it is subject to variation based on geographic setting, (e.g. rural, suburban, urban, etc.), state and local agency roles and responsibilities, types of providers in a given area in addition to other factors. In doing so, facilities have the flexibility to participate in and conduct exercises that more realistically reflect the risks and composition of their communities. Facilities are expected to consider their physical location, agency and other facility responsibilities and needs of the community when planning or participating in their exercises. The term could, however, mean entities within a state or multi-state region.

In many areas of the country, State and local agencies (emergency management agencies and health departments) and some regional entities, such as healthcare coalitions may conduct an annual full-scale, community-based exercise in an effort to more broadly assess community-wide emergency planning, potential gaps, and the integration of response capabilities in an emergency. Facilities should actively engage these entities to identify potential opportunities, as appropriate, as they offer the facility the opportunity to not only assess their emergency plan but also better understand how they can contribute to, coordinate with, and integrate into the broader community's response during an emergency. They also provide a collective forum for assessing their communications plans to ensure they have the appropriate contacts and understand how best to engage and communicate with their state and local public health and emergency management agencies and other relevant partners, such as a local healthcare coalition, during an emergency.

Facilities are expected to contact their local and state agencies and healthcare coalitions, where appropriate, to determine if an opportunity exists and determine if their participation would fulfill this requirement. In doing so, they are expected to document the date, the personnel and the agency or healthcare coalition that they contacted. It is also important to note that agencies and or healthcare coalitions conducting these exercises will not have the resources to fulfill individual facility requirements and thus will only serve as a conduit for broader community engagement and coordination prior to, during and after the full-scale community-based exercise. Facilities are responsible for resourcing their participation and ensuring that all requisite documentation is developed and available to demonstrate their compliance with this requirement.

Facilities are encouraged to engage with their area Health Care Coalitions (HCC) (partnerships between healthcare, public health, EMS, and emergency management) to explore integrated opportunities. Health Care Coalitions (HCCs) are groups of individual health care and response organizations who collaborate to ensure each member has what it needs to respond to emergencies and planned events. HCCs plan and conduct coordinated exercises to assess the health care delivery systems readiness. There is value in participating in HCCs for participating in strategic planning, information sharing and resource coordination. HCC's do not coordinate individual facility exercises, but rather serve as a conduit to provide an opportunity for other provider types to participate in an exercise. HCCs should communicate exercise plans with local and state emergency preparedness agencies and HCCs will benefit the entire community's preparedness. In addition, CMS does not regulate state and local government disaster planning agencies. It is the sole responsibility of the facility to be in compliance.

Facilities that are not able to identify a full-scale community-based exercise, can instead fulfill this part of their requirement by either conducting an individual facility-based exercise, documenting an emergency that required them to fully activate their emergency plan, or by conducting a smaller community-based exercise with other nearby facilities. Facilities that elect to develop a small community-based exercise have the opportunity to not only assess their own emergency preparedness plans but also better understand the whole community's needs, identify critical interdependencies and or gaps and potentially minimize the financial impact of this requirement. For example, a LTC facility, a hospital, an ESRD facility, and a home health agency, all within a given area, could conduct a small community-based exercise to assess their individual facility plans and identify interdependencies that may impact facility evacuations and or address potential surge scenarios due to a prolonged disruption in dialysis and home health care services. Those that elect to conduct a community-based exercise should make an effort to contact their local/state emergency officials and healthcare coalitions, where appropriate, and offer them the opportunity to attend as they can provide valuable insight into the broader emergency planning and response activities in their given area.

Facilities that conduct an individual facility-based exercise will need to demonstrate how it addresses any risk(s) identified in its risk assessment. For example, an inpatient facility might test their policies and procedures for a flood that may require the evacuation of patients to an external site or to an internal safe "shelter-in-place" location (e.g. foyer,

cafeteria, etc.) and include requirements for patients with access and functional needs and potential dependencies on life-saving electricity-dependent medical equipment. An outpatient facility, such as a home health provider, might test its policies and procedures for a flood that may require it to rapidly locate its on-duty staff, assess the acuity of its patients to determine those that may be able to shelter-in-place or require hospital admission, communicate potential evacuation needs to local agencies, and provide medical information to support the patient's continuity of care.

Each facility is responsible for documenting their compliance and ensuring that this information is available for review at any time for a period of no less than three (3) years. Facilities should also document the lessons learned following their tabletop and full-scale exercises and real-life emergencies and demonstrate that they have incorporated any necessary improvements in their emergency preparedness program. Facilities may complete an after action review process to help them develop an actionable after action report (AAR). The process includes a roundtable discussion that includes leadership, department leads and critical staff who can identify and document lessons learned and necessary improvements in an official AAR. The AAR, at a minimum, should determine 1) what was supposed to happen; 2) what occurred; 3) what went well; 4) what the facility can do differently or improve upon; and 5) a plan with timelines for incorporating necessary improvement. Lastly, facilities that are a part of a healthcare system, can elect to participate in their system's integrated and unified emergency preparedness program and exercises. However, those that do will still be responsible for documenting and demonstrating their individual facility's compliance with the exercise and training requirements.

Finally, an actual emergency event or response of sufficient magnitude that requires activation of the relevant emergency plans meets the annual exercise requirements and exempts the facility for engaging in the required exercises for one year following the actual event; and facility's must be able to demonstrate this through written documentation.

For additional information and tools, please visit the CMS Survey & Certification Emergency Preparedness website at: https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/SurveyCertEmergPrep/index.html or ASPR TRACIE.

Survey Procedures

- Ask to see documentation of the annual tabletop and full scale exercises (which may include, but is not limited to, the exercise plan, the AAR, and any additional documentation used by the facility to support the exercise.
- Ask to see the documentation of the facility's efforts to identify a full-scale community based exercise if they did not participate in one (i.e. date and personnel and agencies contacted and the reasons for the inability to participate in a community based exercise).
- Request documentation of the facility's analysis and response and how the facility updated its emergency program based on this analysis.

E-0040
(Issued XX-XX-17)

§494.62(d)(3) Condition for Coverage:
Patient orientation: Emergency preparedness patient training. The dialysis facility must provide appropriate orientation and training to patients, including the areas specified in paragraph (d)(1) of this section.

Interpretive Guidelines for §494.62(d)(3).

ESRD facilities are required to implement an orientation and training program which educates patients on the emergency preparedness policies and procedures of the facility, including the requirements of the ESRD facility's emergency preparedness training program under §494.62(d)(1). For instance, the orientation and training program should include how patients would be notified of an emergency; what particular procedures they are expected to follow; communication protocols for contacting the ESRD facility and identifying an alternate location for their treatment in the event of a facility closure as well as shelter-in place.

Additionally, patients should be oriented to how they would evacuate the facility (if required) and the location of potential transfer sites or services. For instance, if an emergency situation required evacuation during a dialysis treatment, the facility must train the patient on how to safely disconnect from the machine. Additionally, in this example, if the patient was disconnected, the patient should be informed that he or she will be transferred to another facility or hospital to complete the dialysis (if required).

Ultimately, the emergency preparedness orientation and training for patients should adequately address scenarios which were identified in the ESRD facility's risk assessment and address specific actions required for the emergency situation. The orientation and training program is intended to ensure patients are informed, ready to assist themselves, and are aware of the facility procedures and resources (e.g. KCER) that can provide up to date information during and after an emergency.

Survey Procedures

- Verify the ESRD facility has implemented their policies and procedures and are actively providing orientation and training of all their patients for the emergency preparedness program.
- Interview a patient and ask them to describe their orientation to the facility in terms of emergency protocols and procedures.

E-0041
(Issued XX-XX-17)

§482.15(e) Condition for Participation:
(e) *Emergency and standby power systems.* The hospital must implement emergency and standby power systems based on the emergency plan set forth in paragraph (a)

of this section and in the policies and procedures plan set forth in paragraphs (b)(1)(i) and (ii) of this section.

§483.73(e), §485.625(e)
(e) ***Emergency and standby power systems.*** **The [*LTC facility and the CAH*] must implement emergency and standby power systems based on the emergency plan set forth in paragraph (a) of this section.**

§482.15(e)(1), §483.73(e)(1), §485.625(e)(1)
Emergency generator location. **The generator must be located in accordance with the location requirements found in the Health Care Facilities Code (NFPA 99 and Tentative Interim Amendments TIA 12–2, TIA 12–3, TIA 12–4, TIA 12–5, and TIA 12–6), Life Safety Code (NFPA 101 and Tentative Interim Amendments TIA 12–1, TIA 12–2, TIA 12–3, and TIA 12–4), and NFPA 110, when a new structure is built or when an existing structure or building is renovated.**

482.15(e)(2), §483.73(e)(2), §485.625(e)(2)
Emergency generator inspection and testing. **The [*hospital, CAH and LTC facility*] must implement the emergency power system inspection, testing, and [maintenance] requirements found in the Health Care Facilities Code, NFPA 110, and Life Safety Code.**

482.15(e)(3), §483.73(e)(3), §485.625(e)(3)
Emergency generator fuel. **[*Hospitals, CAHs and LTC facilities*] that maintain an onsite fuel source to power emergency generators must have a plan for how it will keep emergency power systems operational during the emergency, unless it evacuates.**

*[*For hospitals at §482.15(h), LTC at §483.73(g), and CAHs §485.625(g):]*
The standards incorporated by reference in this section are approved for incorporation by reference by the Director of the Office of the Federal Register in accordance with 5 U.S.C. 552(a) and 1 CFR part 51. You may obtain the material from the sources listed below. You may inspect a copy at the CMS Information Resource Center, 7500 Security Boulevard, Baltimore, MD or at the National Archives and Records Administration (NARA). For information on the availability of this material at NARA, call 202–741–6030, or go to: *http://www.archives.gov/federal_register/code_of_federal_regulations/ibr_locations.html*.
If any changes in this edition of the Code are incorporated by reference, CMS will publish a document in the Federal Register to announce the changes.

(1) National Fire Protection Association, 1 Batterymarch Park, Quincy, MA 02169, *www.nfpa.org*, 1.617.770.3000.

(i) NFPA 99, Health Care Facilities Code, 2012 edition, issued August 11, 2011.

(ii) Technical interim amendment (TIA) 12–2 to NFPA 99, issued August 11, 2011.

(iii) TIA 12–3 to NFPA 99, issued August 9, 2012.

(iv) TIA 12–4 to NFPA 99, issued March 7, 2013.
(v) TIA 12–5 to NFPA 99, issued August 1, 2013.
(vi) TIA 12–6 to NFPA 99, issued March 3, 2014.
(vii) NFPA 101, Life Safety Code, 2012 edition, issued August 11, 2011.
(viii) TIA 12–1 to NFPA 101, issued August 11, 2011.
(ix) TIA 12–2 to NFPA 101, issued October 30, 2012.
(x) TIA 12–3 to NFPA 101, issued October 22, 2013.
(xi) TIA 12–4 to NFPA 101, issued October 22, 2013.
(xiii) NFPA 110, Standard for Emergency and Standby Power Systems, 2010 edition, including TIAs to chapter 7, issued August 6, 2009.

Interpretive Guidelines applies to: 482.15(e), §485.625(e), §483.73(e).

Note: For CAHs under §485.625(e)(2) "maintenance" is not included in the regulatory language.

Note: This provision for hospitals, CAHs and LTC facilities requires these facility types to base their emergency power and stand-by systems on their emergency plan, risk assessment and policies and procedures. The determination for a generator should be made through the development of the facility's risk assessment and policies and procedures. If these facilities determine that no generator is required to meet the emergency power and stand-by systems requirements, then §§482.15(e)(1) and (2), §483.73(e)(1) and (2), §485.625(e)(1) and (2), would not apply.
However, these facility types are must continue to meet the existing provisions and requirements for their provider/supplier types under physical environment CoPs or any existing LSC guidance.

Emergency and standby power systems

CMS requires Hospitals, CAHs and LTC facilities to comply with the 2012 edition of the National Fire Protection Association (NFPA) 101 – *Life Safety Code* (LSC) and the 2012 edition of the NFPA 99 – *Health Care Facilities Code* in accordance with the Final Rule (CMS–3277–F**)**. NFPA 99 requires Hospitals, CAHs and certain LTC facilities to install, maintain, inspect and test an Essential Electric System (EES) in areas of a building where the failure of equipment or systems is likely to cause the injury or death of patients or caregivers. An EES is a system which includes an alternate source of power, distribution system, and associated equipment that is designed to ensure continuity of electricity to elected areas and functions during the interruption of normal electrical service. The EES alternate source of power for these facility types is typically a generator. (Note: LTC facilities are also expected to meet the requirements under Life Safety Code and NFPA 99 as outlined within the LTC Appendix of the SOM). In addition, NFPA 99 identifies the 2010 edition of NFPA 110 – *Standard for Emergency and Standby Power Systems* as a mandatory reference, which addresses the performance requirements for emergency and standby power systems and includes installation, maintenance, operation, and testing requirements.

In addition to the LSC, NFPA 99 and NFPA 110 requirements, the Emergency Preparedness regulation requires all Hospitals, CAHs, and LTC facilities to implement emergency and standby power systems based upon a facility's established emergency plan, policies, and procedures. Emergency preparedness policies and procedures (substandard (b) of the emergency preparedness requirements) are required to address the subsistence needs of staff and residents, whether the facility decides to evacuate or shelter in place. Subsistence needs include, but are not limited to, food, water, medical, and pharmaceutical supplies, and alternate sources of energy to maintain: temperatures to protect patient/resident health and safety and sanitary storage of provisions; emergency lighting; fire detection, extinguishing, and alarm systems; and sewage and waste disposal.

NFPA 99 contains emergency power requirements for emergency lighting, fire detection systems, extinguishing systems, and alarm systems. But, NFPA 99 does not specify emergency power requirements for maintaining supplies, and facility temperature requirements are limited to heating equipment for operating, delivery, labor, recovery, intensive care, coronary care, nurseries, infection/isolation rooms, emergency treatment spaces, and general patient/resident rooms. In addition, NFPA 99 does not require heating in general patient rooms during the disruption of normal power where the outside design temperature is higher than 20 degrees Fahrenheit or where a selected room(s) is provided for the needs of all patients (where patients would be internally relocated), then only that room(s) needs to be heated. Therefore, EES in Hospitals, CAHs and LTC facilities should include consideration for design to accommodate any additional electrical loads the facility determines to be necessary to meet all subsistence needs required by emergency preparedness plans, policies and procedures, unless the facility's emergency plans, policies and procedures required under paragraph (a) and paragraph (b)(1)(i) and (ii) of this section determine that the hospital, CAH or LTC facility will relocate patients internally or evacuate in the event of an emergency. Facilities may plan to evacuate all patients, or choose to relocate internally only patients located in certain locations of the facility based on the ability to meet emergency power requirements in certain locations. For example, a hospital that has the ability to maintain temperature requirements in 50 percent of the inpatient locations during a power outage, may develop an emergency plan that includes bringing in alternate power, heating and/or cooling capabilities, and the partial relocation or evacuation of patients during a power outage instead of installing additional power sources to maintain temperatures in all inpatient locations. Or a LTC facility may decide to relocate residents to a part of the facility, such as a dining or activities room, where the facility can maintain the proper temperature requirements rather than the maintaining temperature within the entire facility. It is up to each facility to make emergency power system decisions based on its risk assessment and emergency plan.

Emergency generator location

NFPA 110 contains minimum requirements and considerations for the installation and environmental conditions that may have an effect on Emergency Power Supply System (EPSS) equipment, including, building type, classification of occupancy, hazard of contents, and geographic location. NFPA 110 requires that EPSS equipment, including

generators, to be designed and located to minimize damage (e.g., flooding). NFPA 110 requires emergency power supply systems to be permanently attached, therefore portable and mobile generators would not be permitted as an option to provide or supplement emergency power to Hospitals, CAHs or LTC facilities.

Under emergency preparedness, the regulations require that the generator and its associated equipment be located in accordance with the LSC, NFPA 99, and NFPA 110 when a new structure is built or an existing structure or building is renovated. Therefore, new structures or building renovations that occur after November 15, 2016, the effective date of the Emergency Preparedness Final Rule must consider NFPA requirements to ensure that the EPSS equipment is in a location to minimize damage.

Emergency generator inspection and testing

NFPA 110 contains routine maintenance and operational testing requirements for emergency and standby power systems, including generators. Emergency generators required by NFPA 99 and the Emergency Preparedness Final Rule must be maintained and tested in accordance with NFPA 110 requirements, which are based on manufacture recommendations, instruction manuals, and the minimum requirements of NFPA 110, Chapter 8.

Emergency generator fuel

NFPA 110 permits fuel sources for generators to be liquid petroleum products (e.g., gas, diesel), liquefied petroleum gas (e.g., propane) and natural or synthetic gas (e.g., natural gas). Generators required by NFPA 99 are designated by Class, which defines the minimum time, in hours, that an EES is designed to operate at its rated load without having to be refueled. Generators required by NFPA 99 for Hospitals, CAHs and LTC facilities are designated Class X, which defines the minimum run time as being "other time, in hours, as required by application, code or user." However, NFPA 110 does require facilities considering seismic events to maintain a minimum 96 hour fuel supply. NFPA 110 also requires that generator installations in locations where the probability of interruption of off-site (e.g., natural gas) fuel supplies is high to maintain onsite storage of an alternate fuel source sufficient to allow full output of the ESS for the specified class.

The Emergency Preparedness Final Rule requires Hospitals, CAHs and LTC facilities that maintain onsite fuel sources (e.g., gas, diesel, propane) to have a plan to keep the EES operational for the duration of emergencies as defined by the facilities emergency plan, policy and procedures, unless it evacuates. This would include maintaining fuel onsite to maintain generator operation or it could include making arrangements for fuel delivery for an emergency event. If fuel is to be delivered during an emergency event, planning should consider limitations and delays that may impact fuel delivery during an event. In addition, planning should ensure that arranged fuel supply sources will not be limited by other community demands during the same emergency event. In instances when a facility maintains onsite fuel sources and plans to evacuate during an emergency,

a sufficient amount of onsite fuel should be maintained to keep the EES operational until such time the building is evacuated.

Survey Procedures

- Verify that the hospital, CAH and LTC facility has the required emergency and standby power systems to meet the requirements of the facility's emergency plan and corresponding policies and procedures
- Review the emergency plan for "shelter in place" and evacuation plans. Based on those plans, does the facility have emergency power systems or plans in place to maintain safe operations while sheltering in place?
- For hospitals, CAHs and LTC facilities which are under construction or have existing buildings being renovated, verify the facility has a written plan to relocate the EPSS by the time construction is completed

For hospitals, CAHs and LTC facilities with generators:

- For new construction that takes place between November 15, 2016 and is completed by November 15, 2017, verify the generator is located and installed in accordance with NFPA 110 and NFPA 99 when a new structure is built or when an existing structure or building is renovated. The applicability of both NFPA 110 and NFPA 99 addresses only new, altered, renovated or modified generator locations.
- Verify that the hospitals, CAHs and LTC facilities with an onsite fuel source maintains it in accordance with NFPA 110 for their generator, and have a plan for how to keep the generator operational during an emergency, unless they plan to evacuate.

E-0042

(Issued XX-XX-17)

§416.54(e), §418.113(e), §441.184(e), §460.84(e), §482.15(f), §483.73(f), §483.475(e), §484.22(e), §485.68(e), §485.625(f), §485.727(e), §485.920(e), §486.360(f), §491.12(e), §494.62(e).

(e) [or (f)]Integrated healthcare systems. If a [*facility*] is part of a healthcare system consisting of multiple separately certified healthcare facilities that elects to have a unified and integrated emergency preparedness program, the [*facility*] may choose to participate in the healthcare system's coordinated emergency preparedness program.
If elected, the unified and integrated emergency preparedness program must- [do all of the following:]

(1) Demonstrate that each separately certified facility within the system actively participated in the development of the unified and integrated emergency preparedness program.

(2) Be developed and maintained in a manner that takes into account each separately certified facility's unique circumstances, patient populations, and services offered.

(3) Demonstrate that each separately certified facility is capable of actively using the unified and integrated emergency preparedness program and is in compliance [with the program].

(4) Include a unified and integrated emergency plan that meets the requirements of paragraphs (a)(2), (3), and (4) of this section. The unified and integrated emergency plan must also be based on and include the following:

> **(i) A documented community-based risk assessment, utilizing an all-hazards approach.**
>
> **(ii) A documented individual facility-based risk assessment for each separately certified facility within the health system, utilizing an all-hazards approach.**

(5) Include integrated policies and procedures that meet the requirements set forth in paragraph (b) of this section, a coordinated communication plan, and training and testing programs that meet the requirements of paragraphs (c) and (d) of this section, respectively.

Interpretive Guidelines Applies to: §482.15(f), §416.54(e), §418.113(e), §441.184(e), §460.84(e), §482.78(f), §483.73(f), §483.475(e), §484.22(e), §485.68(e), §485.625(f), §485.727(e), §485.920(e), §486.360(f), §491.12(e), §494.62(e).

***** *[For ASCs at §416.54, PRTFs at §418.113, PACE organizations at §460.84, ICF/IIDs at §483.475, HHAs at §484.22, CORFs at §485.68, Clinics and Rehab facilities at §485.727, CMHCs at §485.920, RHCs/FQHCs at §491.12, and ESRD facilities at §494.62],* the requirements for **Integrated health systems are cited as substandard (e), not (f).**

Note: This does not apply to Transplant Centers.

Healthcare systems that include multiple facilities that are each separately certified as a Medicare-participating provider or supplier have the option of developing a unified and integrated emergency preparedness program that includes all of the facilities within the healthcare system instead of each facility developing a separate emergency preparedness program. If an integrated healthcare system chooses this option, each certified facility in the system may elect to participate in the system's unified and integrated emergency program or develop its own separate emergency preparedness program. It is important to understand that healthcare systems are not required to develop a unified and integrated emergency program. Rather it is a permissible option. In addition, the separately certified facilities within the healthcare system are not required to participate in the

unified and integrated emergency preparedness program. It is simply an option for each facility. If this option is taken, the healthcare system's unified emergency preparedness program should be updated each time a facility enters or leaves the healthcare system's program.

If a healthcare system elects to have a unified emergency preparedness program, the integrated program must demonstrate that each separately certified facility within the system that elected to participate in the system's integrated program actively participated in the development of the program. Therefore, each facility should designate personnel who will collaborate with the healthcare system to develop the plan. The unified and integrated plan should include documentation that verifies each facility participated in the development of the plan. This could include the names of personnel at each facility who assisted in the development of the plan and the minutes from planning meetings. All components of the emergency preparedness program that are required to be reviewed and updated at least annually must include all participating facilities. Again, each facility must be able to prove that it was involved in the annual reviews and updates of the program. The healthcare system and each facility must document each facility's active involvement with the reviews and updates, as applicable.

A unified program must be developed and maintained in a manner that takes into account the unique circumstances, patient populations, and services offered at each facility participating in the integrated program. For example, for a unified plan covering both a hospital and a LTC facility, the emergency plan must account for the residents in the LTC facility as well as those patients within a hospital, while taking into consideration the difference in services that are provided at a LTC facility and a hospital. The unique circumstances that should be addressed at each facility would include anything that would impact operations during an emergency, such as the location of the facility, resources such as the availability of staffing, medical supplies, subsistence, patients' and residents' varying acuity and mobility at the different types of facilities in a unified healthcare system, etc.

Each separately certified facility must be capable of demonstrating during a survey that it can effectively implement the emergency preparedness program and demonstrate compliance with all emergency preparedness requirements at the individual facility level. Compliance with the emergency preparedness requirements is the individual responsibility of each separately certified facility.

The unified emergency preparedness program must include a documented community–based risk assessment and an individual facility-based risk assessment for each separately certified facility within the health system, utilizing an all-hazards approach. This is especially important if the facilities in a healthcare system are located across a large geographic area with differing weather conditions.

Lastly, the unified program must have a coordinated communication plan and training and testing program. For example, if the unified emergency program incorporates a central point of contact at the "system" level who assists in coordination and

communication, such as during an evacuation, each facility must have this information outlined within its individual plan.

This type of integrated healthcare system emergency program should focus the training and exercises to ensure communication plans and reporting mechanisms are seamless to the emergency management officials at state and local levels to avoid potential miscommunications between the system and the multiple facilities under its control.

The training and testing program in a unified emergency preparedness program must be developed considering all of the requirements of each facility type. For example, if a healthcare system includes, hospitals, LTC facilities, ESRD facilities and ASCs, then the unified training and testing programs must meet all of the specific regulatory requirements for each of these facility types.

Because of the many different configurations of healthcare systems, from the different types of facilities in the system, to the varied locations of the facilities, it is not possible to specify how unified training and testing programs should be developed. There is no "one size fits all" model that can be prescribed. However, if the system decides to develop a unified and integrated training and testing program, the training and testing must be developed based on the community and facility based hazards assessments at each facility that is participating in the unified emergency preparedness program. Each facility must maintain individual training records of staff and records of all required training exercises.

Survey Procedures

- Verify whether or not the facility has opted to be part of its healthcare system's unified and integrated emergency preparedness program. Verify that they are by asking to see documentation of its inclusion in the program.
- Ask to see documentation that verifies the facility within the system was actively involved in the development of the unified emergency preparedness program.
- Ask to see documentation that verifies the facility was actively involved in the annual reviews of the program requirements and any program updates.
- Ask to see a copy of the entire integrated and unified emergency preparedness program and all required components (emergency plan, policies and procedures, communication plan, training and testing program).
- Ask facility leadership to describe how the unified and integrated emergency preparedness program is updated based on changes within the healthcare system such as when facilities enter or leave the system.

EP-043
(Issued XX-XX-17)

§482.15(g)
(g) *Transplant hospitals.* If a hospital has one or more transplant centers (as defined in § 482.70)—

(1) A representative from each transplant center must be included in the development and maintenance of the hospital's emergency preparedness program; and

(2) The hospital must develop and maintain mutually agreed upon protocols that address the duties and responsibilities of the hospital, each transplant center, and the OPO for the DSA where the hospital is situated, unless the hospital has been granted a waiver to work with another OPO, during an emergency.

Interpretive Guidelines for §482.15(g).

Hospitals which have transplant centers must include within their emergency planning and preparedness process one representative, at minimum, from the transplant center. If a hospital has multiple transplant centers, each center must have at least one representative who is involved in the development and maintenance of the hospital's emergency preparedness process. The hospital must include the transplant center in its emergency plan's policies and procedures, communication plans, as well is the training and testing programs.

The hospital must also collaborate with each OPO in its designated service area (DSA) or other OPO if the hospital was granted a waiver to develop policies and procedures (protocols) that address the duties and responsibilities of each entity during an emergency.

Both the hospital and the transplant center are required to demonstrate during a survey that they have collaborated in the planning and development of the emergency program. Both are required to have written documentation of the emergency preparedness plans. However, the transplant center is not individually responsible for the emergency preparedness requirements under §482.15 (see tag [INSERT] at §482.78).

Survey Procedures

- Verify the hospital has written documentation to demonstrate that a representative of each transplant center participated in the development of the emergency program.
- Ask to see documentation of emergency protocols that address transplant protocols that include the hospital, the transplant center and the associated OPOs.

EP-044

(Issued: 09-16-16; Effective Date 11-15-16; Implementation Date: 11-15-17)

§486.360(e)

(e) ***Continuity of OPO operations during an emergency.*** **Each OPO must have a plan to continue operations during an emergency.**

(1) The OPO must develop and maintain in the protocols with transplant programs required under § 486.344(d), mutually agreed upon protocols that address the duties and responsibilities of the transplant program, the hospital in which the transplant program is operated, and the OPO during an emergency.

(2) The OPO must have the capability to continue its operation from an alternate location during an emergency. The OPO could either have:

(i) An agreement with one or more other OPOs to provide essential organ procurement services to all or a portion of its DSA in the event the OPO cannot provide those services during an emergency;

(ii) If the OPO has more than one location, an alternate location from which the OPO could conduct its operation; or

(iii) A plan to relocate to another location as part of its emergency plan as required by paragraph (a) of this section.

Interpretive Guidelines for §486.360(e).

An OPO may choose to relocate to an alternate location within its DSA. For instance, if a tornado threat or major flooding was anticipated within one area, however there is another location 20 miles away for the OPO to relocate to, we would anticipate the OPO would address this within its emergency plan. Additionally, OPOs must develop mutually-agreed upon protocols that address the duties and responsibilities of the hospital, transplant center and OPO during emergencies as previously outlined (Reference Tags: 0002, 0012, 0014, 0042). Therefore, these three facility types must work together to develop and maintain policies and programs which address emergency preparedness.

Survey Procedures

- Verify that the OPO has mutually-agreed upon protocols with every certified transplant program it is associated with which includes the duties and responsibilities of the hospital, transplant program and OPO during emergencies.
- Verify that the OPO has a plan in place to ensure continuity of its operation from an alternate location during an emergency.

Survey & Certification

Emergency Preparedness for Every Emergency

EMERGENCY PREPAREDNESS CHECKLIST
RECOMMENDED TOOL FOR EFFECTIVE HEALTH CARE FACILITY PLANNING

Not Started	In Progress	Completed	Tasks
			• **Develop Emergency Plan:** Gather all available relevant information when developing the emergency plan. This information includes, but is not limited to: - Copies of any state and local emergency planning regulations or requirements - Facility personnel names and contact information - Contact information of local and state emergency managers - A facility organization chart - Building construction and Life Safety systems information - Specific information about the characteristics and needs of the individuals for whom care is provided
			• **All Hazards Continuity of Operations (COOP) Plan:** Develop a continuity of operations business plan using an all-hazards approach (e.g., hurricanes, floods, tornadoes, fire, bioterrorism, pandemic, etc.) that could potentially affect the facility directly and indirectly within the particular area of location. Indirect hazards could affect the community but not the facility and as a result interrupt necessary utilities, supplies or staffing. Determine all essential functions and critical personnel.
			• **Collaborate with Local Emergency Management Agency:** Collaborate with local emergency management agencies to ensure the development of an effective emergency plan.
			• **Analyze Each Hazard:** Analyze the specific vulnerabilities of the facility and determine the following actions for each identified hazard: - Specific actions to be taken for the hazard - Identified key staff responsible for executing plan - Staffing requirements and defined staff responsibilities - Identification and maintenance of sufficient supplies and equipment to sustain operations and deliver care and services for 3-10 days, based on each facility's assessment of their hazard vulnerabilities. (Following experiences from Hurricane Katrina, it is generally felt that previous recommendations of 72 hours may no longer be sufficient during some wide-scale disasters. However, this recommendation can be achieved by maintaining 72-hours of supplies on hand, and holding agreements with suppliers for the remaining days.). - Communication procedures to receive emergency warning/alerts, and for communication with staff, families, individuals receiving care, before, during and after the emergency - Designate critical staff, providing for other staff and volunteer coverage and meeting staff needs, including transportation and sheltering critical staff members' family
			• **Collaborate with Suppliers/Providers:** Collaborate with suppliers and/or providers who have been identified as part of a community emergency plan or agreement with the health care facility, to receive and care for individuals. A surge capability assessment should be included in the development of the emergency plan. Similarly, evidence of a surge capacity assessment should be included if the supplier or provider, as part of its emergency planning, anticipates the need to make housing and sustenance provisions for the staff and or the family of staff.

Note: Some of the recommended tasks may exceed the facility's minimum Federal regulatory requirements

***** Task may not be applicable to agencies that provide services to clients in their own homes

EMERGENCY PREPAREDNESS CHECKLIST RECOMMENDED TOOL FOR EFFECTIVE HEALTH CARE FACILITY PLANNING			
Not Started	In Progress	Completed	**Tasks**
			• **Decision Criteria for Executing Plan:** Include factors to consider when deciding to evacuate or shelter in place. Determine who at the facility level will be in authority to make the decision to execute the plan to evacuate or shelter in place (even if no outside evacuation order is given) and what will be the chain of command.
			• **Communication Infrastructure Contingency:** Establish contingencies for the facility communication infrastructure in the event of telephone failures (e.g., walkie-talkies, ham radios, text messaging systems, etc.).

			• **Develop Shelter-in-Place Plan:** Due to the risks in transporting vulnerable patients and residents, evacuation should only be undertaken if sheltering-in-place results in greater risk. Develop an effective plan for sheltering-in-place, by ensuring provisions for the following are specified: *
			- Procedures to assess whether the facility is strong enough to withstand strong winds, flooding, etc.
			- Measures to secure the building against damage (plywood for windows, sandbags and plastic for flooding, safest areas of the facility identified.
			- Procedures for collaborating with local emergency management agency, fire, police and EMS agencies regarding the decision to shelter-in-place.
			- Sufficient resources are in supply for sheltering-in-place for at least 7 days, including:
			  - Ensuring emergency power, including back-up generators and accounts for maintaining a supply of fuel
			  - An adequate supply of potable water (recommended amounts vary by population and location)
			  - A description of the amounts and types of food in supply
			  - Maintaining extra pharmacy stocks of common medications
			  - Maintaining extra medical supplies and equipment (e.g., oxygen, linens, vital equipment)
			- Identifying and assigning staff who are responsible for each task
			- Description of hosting procedures, with details ensuring 24-hour operations for minimum of 7 days
			- Contract established with multiple vendors for supplies and transportation
			- Develop a plan for addressing emergency financial needs and providing security

			• **Develop Evacuation Plan:** Develop an effective plan for evacuation, by ensuring provisions for the following are specified: ***** - Identification of person responsible for implementing the facility evacuation plan (even if no outside evacuation order is given) - Multiple pre-determined evacuation locations (contract or agreement) with a “like” facility have been established, with suitable space, utilities, security and sanitary facilities for individuals receiving care, staff and others using the location, with at least one facility being 50 miles away. A back-up may be necessary if the first one is unable to accept evacuees. - Evacuation routes and alternative routes have been identified, and the proper authorities have been notified Maps are available and specified travel time has been established - Adequate food supply and logistical support for transporting food is described.

Note: Some of the recommended tasks may exceed the facility’s minimum Federal regulatory requirements
***** Task may not be applicable to agencies that provide services to clients in their own homes

EMERGENCY PREPAREDNESS CHECKLIST RECOMMENDED TOOL FOR EFFECTIVE HEALTH CARE FACILITY PLANNING			
Not Started	In Progress	Completed	**Tasks**
			- The amounts of water to be transported and logistical support is described (1 gal/person). - The logistics to transport medications is described, including ensuring their protection under the control of a registered nurse. - Procedures for protecting and transporting resident/patient medical records. - The list of items to accompany residents/patients is described. - Identify how persons receiving care, their families, staff and others will be notified of the evacuation and communication methods that will be used during and after the evacuation - Identify staff responsibilities and how individuals will be cared for during evacuation and the back-up plan if there isn't sufficient staff. - Procedures are described to ensure residents/patients dependent on wheelchairs and/or other assistive devices are transported so their equipment will be protected and their personal needs met during transit (e.g., incontinent supplies for long periods, transfer boards and other assistive devices). - A description of how other critical supplies and equipment will be transported is included. - Determine a method to account for all individuals during and after the evacuation - Procedures are described to ensure staff accompany evacuating residents. - Procedures are described if a patient/resident becomes ill or dies in route. - Mental health and grief counselors are available at reception points to talk with and counsel evacuees. - Procedures are described if a patient/resident turns up missing during an evacuation: • Notify the patient/resident's family • Notify local law enforcement • Notify Nursing Home Administration and staff - Ensure that patient/resident identification wristband (or equivalent identification) must be intact on all residents. - Describe the process to be utilized to track the arrival of each resident at the destination. - It is described whether staff's family can shelter at the facility and evacuate.
			• **Transportation & Other Vendors:** Establish transportation arrangements that are adequate for the type of individuals being served. Obtain assurances from transportation vendors and other suppliers/contractors identified in the facility emergency plan that they have the ability to fulfill their commitments in case of disaster affecting an entire area (e.g., their staff, vehicles and other vital equipment are not "overbooked," and vehicles/equipment are kept in good operating condition and with ample fuel.). Ensure the right type of transportation has been obtained (e.g., ambulances, buses, helicopters, etc.). *

Note: Some of the recommended tasks may exceed the facility's minimum Federal regulatory requirements
***** Task may not be applicable to agencies that provide services to clients in their own homes

Survey & Certification
Emergency Preparedness for Every Emergency

EMERGENCY PREPAREDNESS CHECKLIST RECOMMENDED TOOL FOR EFFECTIVE HEALTH CARE FACILITY PLANNING			
Not Started	In Progress	Completed	**Tasks**
			• **Train Transportation Vendors/Volunteers:** Ensure that the vendors or volunteers who will help transport residents and those who receive them at shelters and other facilities are trained on the needs of the chronic, cognitively impaired and frail population and are knowledgeable on the methods to help minimize transfer trauma. *
			• **Facility Reentry Plan**: Describe who will authorizes reentry to the facility after an evacuation, the procedures for inspecting the facility, and how it will be determined when it is safe to return to the facility after an evacuation. The plan should also describe the appropriate considerations for return travel back to the facility. *
			• **Residents & Family Members:** Determine how residents and their families/guardians will be informed of the evacuation, helped to pack, have their possessions protected and be kept informed during and following the emergency, including information on where they will be/go, for how long and how they can contact each other.
			• **Resident Identification:** Determine how residents will be identified in an evacuation; and ensure the following identifying information will be transferred with each resident: - Name - Social security number - Photograph - Medicaid or other health insurer number - Date of birth, diagnosis - Current drug/prescription and diet regimens - Name and contact information for next of kin/responsible person/Power of Attorney) Determine how this information will be secured (e.g., laminated documents, water proof pouch around resident's neck, water proof wrist tag, etc.) and how medical records and medications will be transported so they can be matched with the resident to whom they belong.
			• **Trained Facility Staff Members:** Ensure that each facility staff member on each shift is trained to be knowledgeable and follow all details of the plan. Training also needs to address psychological and emotional aspects on caregivers, families, residents, and the community at large. Hold periodic reviews and appropriate drills and other demonstrations with sufficient frequency to ensure new members are fully trained.
			• **Informed Residents & Patients:** Ensure residents, patients and family members are aware of and knowledgeable about the facility plan, including: - Families know how and when they will be notified about evacuation plans, how they can be helpful in an emergency (example, should they come to the facility to assist?) and how/where they can plan to meet their loved ones. - Out-of-town family members are given a number they can call for information. Residents who are able to participate in their own evacuation are aware of their roles and responsibilities in the event of a disaster.

Note: Some of the recommended tasks may exceed the facility's minimum Federal regulatory requirements
***** Task may not be applicable to agencies that provide services to clients in their own homes

Survey & Certification

Emergency Preparedness for Every Emergency

EMERGENCY PREPAREDNESS CHECKLIST RECOMMENDED TOOL FOR EFFECTIVE HEALTH CARE FACILITY PLANNING			
Not Started	In Progress	Completed	**Tasks**
			• **Needed Provisions:** Check if provisions need to be delivered to the facility/residents -- power, flashlights, food, water, ice, oxygen, medications -- and if urgent action is needed to obtain the necessary resources and assistance.
			• **Location of Evacuated Residents:** Determine the location of evacuated residents, document and report this information to the clearing house established by the state or partnering agency.
			• **Helping Residents in the Relocation:** Suggested principles of care for the relocated residents include: - Encourage the resident to talk about expectations, anger, and/or disappointment - Work to develop a level of trust - Present an optimistic, favorable attitude about the relocation - Anticipate that anxiety will occur - Do not argue with the resident - Do not give orders - Do not take the resident's behavior personally - Use praise liberally - Include the resident in assessing problems - Encourage staff to introduce themselves to residents - Encourage family participation
			• **Review Emergency Plan:** Complete an internal review of the emergency plan on an annual basis to ensure the plan reflects the most accurate and up-to-date information. Updates may be warranted under the following conditions: - Regulatory change - New hazards are identified or existing hazards change - After tests, drills, or exercises when problems have been identified - After actual disasters/emergency responses - Infrastructure changes - Funding or budget-level changes Refer to FEMA (Federal Emergency Management) to assist with updating existing emergency plans. Review FEMA's new information and updates for best practices and guidance, at each updating of the emergency plans.
			• **Emergency Planning Templates:** Healthcare facilities should appropriately complete emergency planning templates and tailor them to their specific needs and geographical locations.
			• **Collaboration with Local Emergency Management Agencies and Healthcare Coalitions:** Establish collaboration with different types of healthcare providers (e.g. hospitals, nursing homes, hospices, home care, dialysis centers etc.) at the State and local level to integrate plans of and activities of healthcare systems into State and local response plans to increase medical response capabilities. *

Note: Some of the recommended tasks may exceed the facility's minimum Federal regulatory requirements

***** Task may not be applicable to agencies that provide services to clients in their own homes

Survey & Certification

Emergency Preparedness for Every Emergency

EMERGENCY PREPAREDNESS CHECKLIST RECOMMENDED TOOL FOR EFFECTIVE HEALTH CARE FACILITY PLANNING			
Not Started	In Progress	Completed	**Tasks**
			• **Communication with the Long-Term Care Ombudsman Program:** Prior to any disaster, discuss the facility's emergency plan with a representative of the ombudsman program serving the area where the facility is located and provide a copy of the plan to the ombudsman program. When responding to an emergency, notify the local ombudsman program of how, when and where residents will be sheltered so the program can assign representatives to visit them and provide assistance to them and their families.
			• **Conduct Exercises & Drills:** Conduct exercises that are designed to test individual essential elements, interrelated elements, or the entire plan: - Exercises or drills must be conducted at least semi-annually - Corrective actions should be taken on any deficiency identified.
			• **Loss of Resident's Personal Effects**: Establish a process for the emergency management agency representative (FEMA or other agency) to visit the facility to which residents have been evacuated, so residents can report loss of personal effects. *

Note: Some of the recommended tasks may exceed the facility's minimum Federal regulatory requirements

***** Task may not be applicable to agencies that provide services to clients in their own homes

Emergency Preparedness Rule (CMS 3178-F)
Website Resources
(To include on SCG EP Website in lieu of in Interpretive Guidelines)

World Health Organization (WHO). (2011). Hospital Emergency Response Checklist. *An All-Hazards Tool for Hospital Administrators and Emergency Managers*. http://www.euro.who.int/__data/assets/pdf_file/0008/268766/Hospital-emergency-response-checklist-Eng.pdf

The document provides key components of command control, communication, safety and security, triage, surge capacity and continuity of operations in preparation and during an emergency within a hospital setting. This document provides checklists and recommendations to facilities to guide the emergency preparedness plan and considerations to take when preparing the elements of the emergency plan and communication plans.

Health Lawyers' Public Information Series. (2004). *Emergency Preparedness, Response & Recovery Checklist: Beyond the Emergency Management Plan*. http://www.in.gov/isdh/files/AHLAEmergency_Preparedness_Checklist.pdf

This emergency preparedness guiding document provides information and questions to consider for facilities in planning for emergencies. Additionally, the document provides a review of key positions within the National Incident Command System (i.e. Incident Commander; Public Information Officer; Liaison Officer; Communication Officer; etc.) and what questions should be considered in the planning stages. The questions posed within this document can provide areas of consideration to guide an emergency plan, policies and procedures and the communication plan.

Murray, Rick; Elmes, Pat; Fly, Deb. American College of Emergency Physicians (ACEP). Hospital Disaster Preparedness Self-Assessment Tool. http://www.acep.org/content.aspx?id=91205

This assessment tool can allow hospitals and other facilities to begin self-assessing their current emergency preparedness capabilities and identify additional areas which would need to be addressed in emergency planning and the creation of the emergency preparedness plans. The document provides sample checklists which could be changes to adapt to any facility and provides areas of considerations for planning and preparedness. Additionally, the self-assessment tool provides key areas of consideration, to include but not limited to the bed capacity; security and safety; logistics and emergency power; and succession planning.

The National Association for Home Care & Hospice (2008). *Emergency Preparedness Packet for Home Health Agencies*. http://www.nahc.org/assets/1/7/ep_binder.pdf

This document provides a basic overview and considerations for Home Health Agencies to consider when organizing the emergency preparedness plans. The document itself includes checklists; areas for consideration in assigning roles and responsibilities as well as a sample Emergency Preparedness Plan. Additionally, the plan provides an ability for Home Health Agencies to consider potential hazards and threats given their geographical locations, which could assist in providing planning considerations in high hazard areas, such as winter storm affected areas. Agencies could use this to begin prioritizing their planning and needs assessments.

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South Carolina Department of Health and Environmental Control in Coordination with the South Carolina Emergency Management Division. (2013). *Emergency Operations Plan Development Guide and Template for Extended Care Facilities.* https://www.scdhec.gov/health/docs/hlgeop.pdf

The resource developed by the state of South Carolina, provides a detailed overview for long-term care facilities to consider when preparing their emergency and communication plans, as well as outlining policies in procedures. The document not only provides potential situations to consider in planning, but also provides the Federal Emergency Management Agency (FEMA) critical areas of preparedness, planning, mitigation, response, and recovery. Additionally, the documents appendices provide sample checklists for long-term care facilities to be able to consider in preparation of their own plans.

Guenther, Robin, FAIA; Balbus, John, MD. *Primary Protection: Enhancing Health Care Resilience for a Changing Climate*. (2014). Department of Health and Human Services. http://toolkit.climate.gov/topics/human-health/building-climate-resilience-health-sector.

The resource provides extensive research and a tool kit for providers, primarily hospital settings, in establishing the framework for emergency preparedness and planning for severe weather incidents. The website and documents, including the toolkit, provide groundwork for common understanding of climate changes; adverse events and challenges that this poses to the health care community and provides a suite of online tools and resources that highlight emerging best practices for developing sustainable and climate-resilient health care facilities.

Resources provided by National Center for Disaster Medicine & Public Health

Several online lessons for health professionals:
Tracking and Reunification of Children in Disasters
Psychosocial Impacts of Disasters on Children
Radiation Issues in Children: Knowledge Check, Primer, & Case-Based Activity

Caring for Older Adults in Disasters: A Curriculum for Health Professionals. Developed through the support of the U.S. Department of Veterans Affairs, the Caring for Older Adults in Disasters (COAD) curriculum is comprised of 24 lessons in 7 modules covering topics ranging from special considerations for older adults in specific types of disasters to ethical and legal issues related to the care of the senior population during a disaster. The COAD curriculum's lessons range from 30 to 120 minutes in length based on the particular learning context. They include suggested learning activities for educators to engage their learners, as well as required and supplemental readings for both learners and educators. The curriculum can be used in its entirety, teaching all lessons in the order provided, or trainers may select individual lessons or portions of lessons most relevant to their learners. The curriculum's material can be adapted to best meet a specific setting and learner needs by substituting resources, modifying activities, or augmenting content.

A video series (currently two videos) on healthcare professionals working with individuals with access and functional needs for disaster preparedness.

- To access the first video in this series, click here: It's Empowering the Community
- The second video in the series: Everyone in the Community Involved

Transfer Agreement Example

This agreement is made and entered into by and between YOUR FACILITY NAME, CITY, STATE, a nonprofit corporation (hereinafter called "YOUR FACILITY") and RECEIVING FACILITY NAME, CITY, STATE, a nonprofit corporation, (hereinafter called "RECEIVING FACILITY"):

WHEREAS, both YOUR FACILITY and RECEIVING FACILITY desire, by both means of this Agreement, to assist physicians and the parties hereto in the treatment of trauma patients (e.g., burn, traumatic brain injuries, spinal cord injuries, pediatrics); and whereas the parties specifically wish to facilitate: (a) the timely transfer of patients and information necessary or useful in the care and treatment of trauma patients transferred, (b) the continuity of the care and treatment appropriate to the needs of trauma patients, and (c) the utilization of knowledge and other resources of both facilities in a coordinated and cooperative manner to improve the professional health care of trauma patients.

IT IS, THEREFORE, AGREED by and between the parties as follows:

1. PATIENT TRANSFER: The need for transfer of a patient from YOUR FACILITY to RECEIVING FACILITY shall be determined and recommended by the patient's attending physician in such physician's own medical judgment. When a transfer is recommended as medically appropriate, a trauma patient at YOUR FACILITY shall be transferred and admitted to RECEIVING FACILITY as promptly as possible under the circumstances, provided that beds and other appropriate resources are available. Acceptance of the patient by RECEIVING FACILITY will be made pursuant to admission policies and procedures of RECEIVING FACILITY.

2. YOUR FACILITY agrees that it shall:

    a. Notify RECEIVING FACILITY as far in advance as possible of transfer of a trauma patient.
    b. Transfer to RECEIVING FACILITY the personal effects, including money and valuables and information relating to same.
    c. Make every effort within its resources to stabilize the patient to avoid all immediate threats to life and limbs. If stabilization is not possible, YOUR FACILITY shall either establish that the transfer is the result of an informed written request of the patient or his or her surrogate or shall have obtained a written certification from a physician or other qualified medical person in consultation with a physician that the medical benefits expected from the transfer outweigh the increased risk of transfer.
    d. Affect the transfer to RECEIVING FACILITY through qualified personnel and appropriate transportation equipment, including the use of necessary and medically appropriate life support measures.

3. YOUR FACILITY agrees to transmit with each patient at the time of transfer, or in the case of emergency, as promptly as possible thereafter, pertinent medical information and records necessary to continue the patient's treatment and to provide identifying and other information.

4. RECEIVING FACILITY agrees to state where the patient is to be delivered and agrees to provide information about the type of resources it has available.

5. Bills incurred with respect to services preformed by either party to the Agreement shall be collected by the party rendering such services directly from the patient, third party, and neither party shall have any liability to the other for such charges.

6. This agreement shall be effective from the date of execution and shall continue in effect indefinitely. Either party may terminate this agreement on thirty (30) days notice in writing to the other party. If either party shall have its license to operate revoked by the state, this Agreement shall terminate on the date such revocation becomes effective.

7. Each party to the Agreement shall be responsible for its own acts and omissions and those of their employees and contractors and shall not be responsible for the acts and omissions of the other institutions.

8. Nothing in this Agreement shall be construed as limiting the right of either to affiliate or contract with any hospital or nursing home on either a limited or general basis while this agreement is in effect.

9. Neither party shall use the name of the other in any promotional or advertising material unless review and written approval of the intended use shall first be obtained from the party whose name is to be used.

10. This agreement shall be governed by the laws of the State of INSERT STATE. Both parties agree to comply with the Emergency Medical Treatment and Active Labor Act of 1986, and the Health Insurance Portability and Accountability Act of 1996 and the rules now and hereafter promulgated thereunder.

11. This Agreement may be modified or amended from time to time by mutual agreement of the parties, and any such modification or amendment shall be attached to and become part of the Agreement.

YOUR FACILITY	RECEIVING FACILITY
SIGNED BY:	SIGNED BY:
DATE:	DATE:

Sig #	Title	Effective Date	Deemed	Ch.	Survey	Source CFR Citations Plus Subsect	Top Text (Regulatory Text)	Supporting Guidelines - Text on Appendix A of SOW	Does this sig be deemed on this survey? (Yes, No, Not Sure)	Do we have a survey process	Do we have a template to use	Does this sig qualify for MQ? (Yes, No, Not Sure, Not Quality, RR only, DNS)
1001	Establishment of an Emergency Program (EP)	11/13/2017	No	Yes	Yes	42CFR 482.41(c)(1) 42CFR 482.15(b) 42CFR 482.15(b)(1) 42CFR 482.15(b)(2) 42CFR 482.15(b)(3) 42CFR 482.15(b)(4) 42CFR 482.15(b)(5) 42CFR 482.15(b)(6)	The Facility, except for Transplant Centers must comply with all applicable Federal, and local emergency preparedness requirements. The Facility must establish and maintain a comprehensive emergency preparedness program that meets the requirements of the section, using an all-hazards approach. The program must be tailored to, but not limited to, the following elements: The Facility must comply with all applicable Federal, State, and local emergency preparedness requirements. The hospital must develop and maintain a comprehensive emergency preparedness program that meets the requirements of this section, utilizing an all-hazards approach. (For CAHs at §485.625) The CAH must comply with all applicable Federal, State, and local emergency preparedness requirements. The CAH must develop and maintain a comprehensive emergency preparedness program, utilizing an all-hazards approach.	Under the conditions/requirements, Facilities are required to develop an emergency preparedness program that meets all of the standards specified within the conditions/requirements. The emergency preparedness program must describe a facility's comprehensive approach to meeting the health, safety, and security needs of their staff and patient population during an emergency or disaster situation. The program must be based on a hazard vulnerability analysis (HVA) and include a process for mitigation, preparedness, response, and recovery during an emergency or disaster (natural, man-made, hybrid). The emergency preparedness program must be reviewed annually. A comprehensive approach to meeting the health and safety needs of a patient population should encompass the elements for emergency preparedness planning, including the provision of medical care, mitigation, preparedness, response, and recovery. The health and safety of patients, or remain prime focus, should focus included those elements in their overall planning in order to meet the health, safety, and security needs of the staff and of the patient population. Additionally, if the patient population has limited mobility, Facilities should focus on providing services to patients with functional needs during an emergency. Facilities should focus on providing services to patients who do not only, choose one potential emergency, that may occur in their area, but rather consider a multitude of events and the ability to provide services to patients during and after the event, including, but not limited to, the following elements: Survey Procedures: • review the facility leadership and ask how/when/how to describe the facility's emergency preparedness program. • ask to see the facility's written policy and documentation on the emergency preparedness program. • review the facility's HVA, EP, and EM plans. Ask how the facility incorporated the Hospital Preparedness Program approach by asking how/when/why to describe how the facility used an all-hazards approach when developing its program. Transplant centers would be required to have their own emergency preparedness policies and procedures on hospital-wide EMC Plans, as well as participate in mutually agreed-upon protocols that address the transplant center, hospital, and OPO's duties and responsibilities during an emergency. Survey Procedures: • verify that a representative from the transplant center was included in the planning of the emergency preparedness program of the hospital, and participated in the exercises. Under the condition, the DNHC facility is required to develop and update an emergency preparedness program that meets all of the standards contained within the condition. The emergency preparedness program must describe a facility's comprehensive approach to meeting the health, safety, and security needs of their staff and patient population during an emergency, as well as the whole community, during and concluding an emergency, on-site (natural or man-made). Survey Procedures: • ask to see written or electronic documentation of the program.	No	No	No
1002	Establishment of an EP Program Templates	11/13/2017	No	No	No	482.70	482.70 Condition of participation: Emergency preparedness for transplant centers. A transplant center must be included in the emergency preparedness planning and the hospital-wide emergency preparedness plan of the hospital in which it is located. Include in a transplant center in the inter-facility requirements for the emergency preparedness requirements set forth in § 482.15.	Transplant centers would be required to have their own emergency preparedness policies and procedures on hospital-wide EMC Plans, as well as participate in mutually agreed-upon protocols that address the transplant center, hospital, and OPO's duties and responsibilities during an emergency. Survey Procedures: • verify that a representative from the transplant center was included in the planning of the emergency preparedness program of the hospital, and participated in the exercises.	No	No	No
1003	Establishment of an EP Program Data-on	11/13/2017	No	No	No	1000.02	1000.02 Condition for Coverage: The DNH-or facility must comply with all applicable Federal, State, and local emergency preparedness requirements. These emergencies include, but are not limited to, fire, flood, hurricane, tornado, earthquake, terrorism, emergency, water supply interruption, and natural disasters likely to occur in the facility's geographic area. The DNH-or facility must establish and maintain an emergency preparedness program that meets the requirements of this section. The emergency preparedness program must include, but not limited to, the following elements:	Under the condition, the DNHC facility is required to develop and update an emergency preparedness program that meets all of the standards contained within the condition. The emergency preparedness program must describe a facility's comprehensive approach to meeting the health, safety, and security needs of their staff and patient population during an emergency, as well as the whole community, during and concluding an emergency, on-site (natural or man-made). Survey Procedures: • ask to see written or electronic documentation of the program.	No	No	No
1004	Develop and Maintain EP Program	11/13/2017	No	Yes	Yes	482.15(b)(1) 482.15(b)(2) 482.15(b)(3) 482.15(b)(4) 482.15(b)(5) 482.15(b)(6) 482.15(b)(7) 482.15(b)(8) 482.15(b)(9) 482.15(b)(10) 482.15(b)(11) 482.15(b)(12) 482.15(b)(13) 482.15(b)(14) 482.15(b)(15) 482.15(b)(16) 482.15(b)(17) 482.15(b)(18) 482.15(b)(19) 482.15(b)(20)	The Facility must comply with all applicable Federal, State and local emergency preparedness requirements. The Facility must develop and maintain a comprehensive emergency preparedness program that meets the requirements of this section, using an all-hazards approach. The emergency preparedness program must include, but not limited to, the following elements: (For Hospitals at §482.15 and CAHs at §485.625(a)) The Hospital or CAH must develop and maintain a comprehensive emergency preparedness program that meets the requirements of this section, using an all-hazards approach. The emergency preparedness program must include, but not limited to, the following elements: (For ESRD Facilities at §494.62(a)) Emergency Plan: The ESRD facility must develop and maintain emergency preparedness plan that must be (re-tested), and updated at least annually. (For ESRD Facilities at §494.62(a)) Emergency Plan: The ESRD facility must develop and maintain emergency preparedness plan that must be (re-tested), and updated at least annually.	The facility is required to develop and maintain an emergency preparedness plan. The plan must include all of the required elements under the conditions. The plan must be (re-tested) and updated annually. The plan must also be developed to include the risks of the area and any updates made to the emergency plan based on the review. The format of the emergency preparedness plan that a facility uses is at its discretion. An emergency plan is also part of a facility's emergency preparedness program. The plan provides the framework, which includes procedures, for a facility to maintain its operations and services during an emergency. It also provides the framework for protecting patients, staff, visitors, and assisting the community of business operations which will provide support during an actual emergency. In addition, the plan should include procedures for a facility to maintain its operations and services during an emergency. The plan should include an approach to access to the location of the facility, and consider particular hazards most likely to occur in the surrounding area. These hazards may include: • Natural disaster • Man-made disasters, • Facility-specific hazards that include but are not limited to: • Care-related emergencies, • Facility-related emergencies, including but not limited to power, water, gas, etc., • Interruptions in communication, including cyber-attacks, • Loss of a critical vendor/supplier, • Interruptions in the normal supply of essential resources, such as water, food, fuel (heating, cooking, and generators), and in some cases, medications and medical supplies (including medical gases, if applicable). When evaluating potential interruptions in the normal supply of essential services, the facility should take into account the likely dynamics of the community in which it operates. Facilities should also consider the impact of the loss of a critical vendor/supplier, including the emergency action which the contractor is required to initiate services after the start of the emergency. Has they will be procured and delivered to the facility, and how will the facility be able to continue to provide services if the contract is terminated or the vendor is unable to fulfill its contractual obligations in the normal supply of essential resources, such as water, food, fuel (heating, cooking, and generators), and in some cases, medications and medical supplies (including medical gases, if applicable).	No	No	No
1005	Transport EP Patients Included in Hospital	11/13/2017	No	No	No	1000.70(a)	1000.70(a) Standard: Policies and procedures. A transplant center must have policies and procedures that address emergency preparedness. These policies and procedures must be included in the hospital's emergency preparedness program.	Transplant centers would be required to have their own emergency preparedness policies and procedures on hospital-wide EMC Plans, as well as participate in mutually agreed-upon protocols that address the transplant center, hospital, and OPO's duties and responsibilities during an emergency. The transplant center must be included in the hospital's emergency plan. All of the Medicare-approved transplant centers are required to have a written agreement with a hospital in order to provide services to Medicare beneficiaries. The transplant center must be included in the hospital's risk assessment because there may be risks to the transplant center that others in the hospital may not be aware of or appreciate. However, most of the risk assessment of the hospital and transplant center would be the same. The transplant center is located within the hospital, therefore a separate risk assessment would be redundant, and inefficient. Survey Procedures: • verify that the transplant center has emergency preparedness policies and procedures. • verify that the transplant center's emergency preparedness policies and procedures are included in the hospital's emergency preparedness program.	No	No	No
1006	Develop and Review EP Updates	11/13/2017	No	Yes	Yes	1000.70(b)(1) 1000.70(b)(2) 1000.70(b)(3) 1000.70(b)(4) 1000.70(b)(5) 1000.70(b)(6) 1000.70(b)(7) 1000.70(b)(8) 1000.70(b)(9) 1000.70(b)(10) 1000.70(b)(11) 1000.70(b)(12) 1000.70(b)(13) 1000.70(b)(14) 1000.70(b)(15) 1000.70(b)(16) 1000.70(b)(17) 1000.70(b)(18) 1000.70(b)(19) 1000.70(b)(20) 1000.70(b)(21) 1000.70(b)(22) 1000.70(b)(23) 1000.70(b)(24) 1000.70(b)(25) 1000.70(b)(26) 1000.70(b)(27) 1000.70(b)(28) 1000.70(b)(29) 1000.70(b)(30) 1000.70(b)(31) 1000.70(b)(32) 1000.70(b)(33) 1000.70(b)(34) 1000.70(b)(35) 1000.70(b)(36) 1000.70(b)(37) 1000.70(b)(38) 1000.70(b)(39) 1000.70(b)(40)

2020	EP Support Memo Template	11/13/2021	Yes	Yes	No	[MHC Hospital], [MHC Hospital], [MHC Critical], [MHC Critical], [MHC Hospital], [MHC Hospital], [MHC Hospital], [MHC Hospital], [MHC Hospital], [MHC Critical], [MHC Hospital], [MHC Critical], [MHC Hospital], [MHC Critical], [MHC Hospital], [MHC Hospital], [MHC Critical], [MHC Critical], [MHC Hospital], [MHC Hospital], [MHC Critical], [MHC Critical], [MHC Hospital], [MHC Hospital], [MHC Critical], [MHC Critical], [MHC Hospital], [MHC Hospital], [MHC Critical], [MHC Critical]	(a) Emergency Plan. The Facility must develop and maintain an emergency preparedness plan that must be reviewed, and updated at least annually. The plan must include, but not limited to, the following: (i) Hazard assessment parameters, including, but not limited to, persons at-risk, the care and services they require, and the Facility's ability to care for these persons during all operations, including delegations of authority and succession plans. Note: ("Persons at-risk" does not apply to: ASC, Hospice, PACE, RHA, CORF, CMHC, RNC, FQHC, or ESRD facilities.)	The emergency plan must specify the operations around which the facility, such as inpatient care or outpatient care, will be in place (collaboration to the extent of an emergency or disaster. A facility's emergency plan must also address persons at-risk, except for plans of ASC, Hospice, PACE, RHA, CORF, CMHC, RNC, FQHC, or ESRD facilities. Per Centers for Medicare & Medicaid Services Hospice Preparedness Act (PHSPA) of 2006, inclusion of at-risk populations may have additional needs in one or more of the following: functional areas: maintaining independence, communication, transportation, supplies-care, and medical care. In addition to these mild-to-moderate needs, persons at-risk may also include persons who require medical care, services, or supplies on a regular basis to sustain their health and who may need additional resources accessing housing and care, especially, but not exclusively, in institutionalized settings, and from devices (utilizing electricity, batteries, or other power sources) to sustain life, such as, but not limited to, persons who are ventilator-dependent, persons who are dialysis-dependent, or who are pharmacological dependency. At-risk populations would also include, but are not limited to, the elderly, persons in institutional nursing homes, persons with physical and mental disabilities as well as persons with acute and chronic needs, and chronic and complex. Mobility is an important part of efficient and timely evacuations, and Medicare facilities are expected to properly plan to identify patients who will require additional assistance, ensure that means for transport are accessible and available and that they are kept in transport condition. Facilities are also expected to have a plan for the care of patients who are in the facility when a disaster or emergency occurs. Depending upon the agency (ies) involved, the emergency plan is required to ensure that patients with limited mobility, are addressed within the plan. The emergency plan must also address the types of services that the facility would be able to provide in an emergency. The emergency plan must identify which staff would assume specific roles in worker's absence through succession planning and delegations of authority. Succession planning is a process for identifying and developing internal people with the potential to fill key leadership positions in the company. Succession planning increases the availability of organized and capable employees that are prepared to assume these roles as they become available. Succession planning is also a process of identifying critical positions in the company and the critical competencies needed to perform those roles. In the event that current staff and leadership are not available, in a crisis, there should be a qualified person who is authorized to acting in or in the absence of the administrator or person legally responsible for the operations of the facility.				
2019	Compliance of the EP Regular (HP)	11/13/2021	Yes	No	No	[HPR Billing/A],	[HPR Billing/A] Condition for Participation (a) Emergency Plan. The Facility must develop and maintain an emergency preparedness plan that must be reviewed, and updated at least annually. The plan must do the following: (1) Assess the type of hospitals with which the CRTA has agreements, the type of services that the CRTA has the capacity to provide in an emergency, and continuity of operations, including delegations of authority and succession plans.	The emergency plan must address the type of hospitals with which the CRTA has agreements and the types of services that the CRTA would be able to provide during an emergency. The emergency plan must identify which staff would assume specific roles in worker's absence through succession planning and delegations of authority. Succession planning is a process for identifying and developing internal people with the potential to fill key leadership positions in the company. Succession planning increases the availability of organized and capable employees that are prepared to assume these roles as they become available. Succession planning is also a process of identifying critical positions in the company and the critical competencies needed to perform those roles. In the event that current staff and leadership are not available, in a crisis, there should be a qualified person who is authorized to acting in or in the absence of the administrator or person legally responsible for the operations of the facility. In addition to the facility, and continually based risk assessment, continuity of operations planning generally considers elements such as: • Identification of critical business functions, • Critical service and IT disaster recovery, alternate facility identification and backup, and financial resources. Facilities are encouraged to refer and utilize resources from contract agencies such as Ready and ASPR when developing strategies for ensuring continuity of operations. Survey Procedures: • Review the facility's plan and ask them to describe the following: • Services the CRTA would be able to provide during an emergency; • Succession planning for critical staff during an emergency; • Delegations of authority and succession plans; • How the CRTA has included/addressed all of the hospitals with which it has agreements into its emergency plan				
2018	Provide Full EP Collaboration	11/13/2021	Yes	Yes	Yes	[MHC Hospital], [MHC Hospital], [MHC Critical], [MHC Critical], [MHC Hospital], [MHC Hospital], [MHC Hospital], [MHC Hospital], [MHC Critical], [MHC Critical], [MHC Hospital], [MHC Hospital], [MHC Critical], [MHC Critical], [MHC Hospital], [MHC Hospital], [MHC Critical], [MHC Critical], [MHC Hospital], [MHC Hospital], [MHC Critical], [MHC Critical], [MHC Hospital], [MHC Hospital], [MHC Critical], [MHC Critical], [MHC Hospital], [MHC Hospital], [MHC Critical], [MHC Critical]	(a) Emergency Plan. The Facility must develop and maintain an emergency preparedness plan that must be reviewed, and updated at least annually. The plan must do the following: (a) Include a process for cooperation and collaboration with local, tribal, regional, State, and Federal emergency preparedness officials' activities to ensure an integrated response during a disaster or emergency, caused, including documentation of the facility's efforts to contact such officials and, when applicable, of its participation in collaborative and cooperative planning efforts. (1) In CMS Facilities, (as, at, MHC/Hospital), (2) Include a process for cooperation and collaboration with local, tribal, regional, State, and Federal emergency preparedness officials' activities to ensure an integrated response during a disaster or emergency, caused, including documentation of the facility's efforts to contact such officials and, when applicable, of its participation in collaborative and cooperative planning efforts. (3) In CMS Facilities, and in no way accountable that the CMS Facility, contracted the local public health and emergency management agency, or facilities, to assist in the development of the facility's plan. Facilities are encouraged to contact the agency (ies) at least annually to confirm that the agency is aware of the obligation facility's obligation to provide the agency(ies) with a copy of the plan.	While the responsibility, for ensuring a coordinated disaster preparedness response lies upon the state and local emergency planning authorities, the facility must be prepared to cooperate with these authorities and participate in coordinated disaster preparedness and response activities. The facility must include the integrated response process in its emergency plan. Facilities are encouraged to participate in a local/regional emergency preparedness committee, or similar forum, and addressing broader community needs that may also be supported by local health department and emergency management resources. For CMS Facilities, MHC (HSLD) of the CMS Conditions for Coverage on Special Purpose Hospital Facilities describes the requirements. For CMS Facilities that are not up to an emergency (i.e. an emergency circumstance facility) which are issued a unique CMS CoP/Cases Specific Waiver, the CMS Facility is not required to meet the requirements of the emergency preparedness requirements under (MHC). Survey Procedures: • Review the facility's plan and ask them to describe the process for including cooperation and collaboration with the local, tribal, regional, State, and Federal emergency preparedness officials' efforts to ensure an integrated response during a disaster or emergency, caused, including documentation of the facility's efforts to contact such officials and, when applicable, its participation in collaborative and cooperative planning efforts. • For CMS Facilities, and in no way accountable that the CMS Facility, contracted the local public health and emergency management agency, or facilities, to assist in the development of the facility's plan. Facilities are encouraged to contact the agency (ies) at least annually to confirm that the agency is aware of the CMS Facility's needs in the event of an emergency, and know how to contact the agency(ies) in the event of an emergency.				
2016	Clinic location and use of alarms, etc.	11/13/2021	Yes	No	No	[MHC TC/Hp/A]	(a) Emergency Plan. The Clinic, Rehabilitation Agencies, and Public Health Agencies Providers of Outpatient Physical Therapy, and Speech-Language Pathology Services, must develop and maintain an emergency preparedness plan that must be reviewed, and updated at least annually. The plan must do the following: (a) Address the location and use of alarm systems and signals, and methods of contacting him.	(a) Organizations emergency plan must address the location and use of alarm systems and signals. The plan must also include the methods used for contacting him, such as the microphones, landline systems and other current methods used. The Medicare Conditions of Participation (CoP) for Rehabilitation Agencies, and Public Health Agencies Providers of Outpatient Physical Therapy, and Speech-Language Pathology Services, requires the clinic/agency to develop a plan for the care of patients from the care of the agency, regardless the clinic/agency of facility, staff. Therefore, the plan should follow guidelines set forth by the HCFA. Survey Procedures: • Review the facility's plan to ensure the version of the plan which addresses location(s) and use of fire alarms. • Ask facility staff to describe the facility's current procedure for contacting him.				
2011	CMS/CMC Compliance Not Fully Met	11/13/2021	Yes	No	No	[HPR Billing/A], [HPR TC/Hp/A],	[HPR Billing/A] Condition for Participation (a) Emergency Plan. The Clinic, Rehabilitation Agencies, or Outpatient Rehabilitation Facility, (CORF) must develop and maintain an emergency preparedness plan that must be reviewed, and updated at least annually. The plan must do the following: [(a)(3) Be developed and maintained with assistance from fire, safety, and other appropriate suppliers. [HPR TC/Hp/A] Condition for Participation (a) Emergency Plan. The Clinics, Rehabilitation Agencies, and Public Health Agencies as Providers of Outpatient Physical Therapy, and Speech-Language Pathology Services, (Organizations") must develop and maintain an emergency preparedness plan that must be reviewed, and updated at least annually. The plan must do the following: [(a)(3) Be developed and maintained with assistance from fire, safety, and other appropriate suppliers.	The CORF and Clinics, Rehabilitation Agencies, and Public Health Agencies as Providers of Outpatient Physical Therapy, and Speech-Language Pathology Services, must have a plan for the care of patients from the care of the agency, regardless the clinic/agency of facility. The plan must address the collaboration with fire/ambulance/rescue and include them in the annual review of the plan. Survey Procedures: • Ask to see a list of documentation for which aspects were collaborated with to develop and maintain its plan.				
2012	Hospitals EP Patients - Included in Hospital	11/13/2021	No	No	No	[HPR TC/Hp], [HPR TC/Hp],	(a)(4) Be evaluated of participation. Emergency preparedness for transplant centers. If transplant center must be included in the emergency preparedness planning and the emergency preparedness plan, and procedures, and communication plans, as well as the training and drills. However, if a transplant center is not individually responsible for the emergency preparedness requirements under (MHC) (1) (2) (3) (4) (5) (6) (7) (8) (9) (10) (11) (12) (13) (14) (15) (16) (17) (18) (19) (20) (21) (22) (23) (24) (25) (26) (27) (28) (29) (30) (31) (32) (33) (34) (35) (36) (37) (38) (39) (40)

2012	Development of all Policies and Procedures	11/15/2011	Fac	Fac	§483.73(b), §483.73(d), §483.73(e), §483.73(f), §483.470(a), §483.470(b), §483.470(c), §483.470(d), §483.470(e), §483.470(f), §483.470(g), §483.470(h), §483.470(i), §483.470(j), §483.470(k), §483.470(l), §483.470(m), §483.470(n), §483.470(o), §483.470(p), §483.470(q), §483.470(r), §483.470(s), §483.470(t), §483.470(u), §483.470(v), §483.470(w), §483.470(x), §483.470(y), §483.470(z), §483.470(aa), §483.470(ab), §483.470(ac), §483.470(ad), §483.470(ae), §483.470(af), §483.470(ag), §483.470(ah), §483.470(ai), §483.470(aj), §483.470(ak), §483.470(al), §483.470(am), §483.470(an), §483.470(ao), §483.470(ap), §483.470(aq), §483.470(ar), §483.470(as), §483.470(at), §483.470(au), §483.470(av), §483.470(aw), §483.470(ax), §483.470(ay), §483.470(az), §483.470(ba), §483.470(bb), §483.470(bc), §483.470(bd), §483.470(be), §483.470(bf), §483.470(bg), §483.470(bh), §483.470(bi), §483.470(bj), §483.470(bk), §483.470(bl), §483.470(bm), 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§483.470(xg), §483.470(xh), §483.470(xi), §483.470(xj), §483.470(xk), §483.470(xl), §483.470(xm), §483.470(xn), §483.470(xo), §483.470(xp), §483.470(xq), §483.470(xr), §483.470(xs), §483.470(xt), §483.470(xu), §483.470(xv), §483.470(xw), §483.470(xx), §483.470(xy), §483.470(xz), §483.470(ya), §483.470(yb), §483.470(yc), §483.470(yd), §483.470(ye), §483.470(yf), §483.470(yg), §483.470(yh), §483.470(yi), §483.470(yj), §483.470(yk), §483.470(yl), §483.470(ym), §483.470(yn), §483.470(yo), §

EM.P.04	Facility Emergency Equipment	2/23/2010	Pre	Pre	Pre	NFPA 101(LSC)	NFPA 101(LSC) Guidance: (1) For Group (a) Policies and procedures. The plan(s) for facility must develop and implement emergency preparedness policies and procedures, including the process for ongoing maintenance and testing, as described in paragraph (e)(1) of this section, the assessment at paragraph (e)(2) of this section, and the communication plan at paragraph (c) of this section. The policies and procedures must address the following: (1) Equipment. The facility must ensure that all equipment, including but not limited to, the systems and procedures must address the following: (i) A process by which the staff can confirm that emergency equipment, including, but not limited to, fire extinguishers, AED units, oxygen, suctioning equipment, medical equipment, and emergency drugs, are in the premises at all times and immediately available. (ii) Staff training on how to use equipment. (iii) Equipment needs are based on the facility's emergency plan, risk to care procedures/interventions for ensuring equipment is charged. (iv) Staff training on how to use equipment. (v) Staff that all emergency drugs are not out of date.	Health facilities must include policies and procedures in its emergency plan that address a process that confirms that the specific, diagnostically tested units that established are in the premises at all times and immediately available in the event of an emergency. The facility must have a process in place that ensures that staff can confirm that emergency equipment is ready to be used in an emergency. Additionally, it is the responsibility of the facility to ensure that all necessary equipment is maintained in the area, should be in working order at all times in accordance with the manufacturer instructions. Emergency drugs should not be out of date and should be available in the premises at all times and immediately available in the event of an emergency. Equipment that is not in working order and emergency equipment is needed is here to be available. In addition, they(or facility) need to be able to manage case-related emergencies/interventions, when other assistance, emergency medical service systems, may not be immediately available to them. Survey Procedures Verify the deficient facility has a process in place by which its staff can confirm that emergency equipment is in the premises and immediately available. Verify that the deficient facility accurately at least the basal emergency equipment when its emergency plan by aiming to use a copy of the whole emergency plan, or emergency equipment and medications. Verify that the deficient facility has a process in place for managing case, risk to care procedures/interventions for ensuring equipment is charged. Verify that the deficient facility has a process in place for ensuring that staff are trained on how to use equipment.									
EM.P.05	Communication Plan	2/23/2010	Pre	Pre	Pre	NFPA 99(HCF) 4-3.5(1), 4-3.5(2), 4-3.5(3), 4-3.5(4), 4-3.5(5), 4-3.5(6), 4-3.5(7), 4-3.5(8), 4-3.5(9), 4-3.5(10), 4-3.5(11), 4-3.5(12), 4-3.5(13), 4-3.5(14), 4-3.5(15), 4-3.5(16), 4-3.5(17), 4-3.5(18), 4-3.5(19), 4-3.5(20), 4-3.5(21), 4-3.5(22), 4-3.5(23), 4-3.5(24), 4-3.5(25), 4-3.5(26), 4-3.5(27), 4-3.5(28), 4-3.5(29), 4-3.5(30), 4-3.5(31), 4-3.5(32), 4-3.5(33), 4-3.5(34), 4-3.5(35), 4-3.5(36), 4-3.5(37), 4-3.5(38), 4-3.5(39), 4-3.5(40),

2009	Transport Health Systems	11/9/2011	Yes	Yes	42CFR482.41(b)(1), 42CFR482.41(b)(2), 42CFR482.41(b)(3), 42CFR482.41(b)(4), 42CFR482.41(b)(5), 42CFR482.41(b)(6), 42CFR482.41(b)(7), 42CFR482.41(b)(8), 42CFR482.41(b)(9), 42CFR482.41(b)(10), 42CFR482.41(b)(11), 42CFR482.41(b)(12), 42CFR482.41(b)(13), 42CFR482.41(b)(14), 42CFR482.41(b)(15), 42CFR482.41(b)(16), 42CFR482.41(b)(17), 42CFR482.41(b)(18), 42CFR482.41(b)(19), 42CFR482.41(b)(20), 42CFR482.41(b)(21), 42CFR482.41(b)(22), 42CFR482.41(b)(23), 42CFR482.41(b)(24), 42CFR482.41(b)(25), 42CFR482.41(b)(26), 42CFR482.41(b)(27), 42CFR482.41(b)(28), 42CFR482.41(b)(29), 42CFR482.41(b)(30), 42CFR482.41(b)(31), 42CFR482.41(b)(32), 42CFR482.41(b)(33), 42CFR482.41(b)(34), 42CFR482.41(b)(35), 42CFR482.41(b)(36), 42CFR482.41(b)(37), 42CFR482.41(b)(38), 42CFR482.41(b)(39), 42CFR482.41(b)(40),

Awardee	Coalition Name	Website
Alabama	PUBLIC HEALTH AREA 10 HEALTHCARE COALITION	http://www.adph.org/CEP/
Alabama	PUBLIC HEALTH AREA 11 HEALTHCARE COALITION	http://www.adph.org/CEP/
Alabama	PUBLIC HEALTH AREA 8 HEALTHCARE COALITION	http://www.adph.org/CEP/
Alabama	PUBLIC HEALTH AREA 5 HEALTHCARE COALITION	http://www.adph.org/CEP/
Alabama	PUBLIC HEALTH AREA 4 HEALTHCARE COALITION	http://www.adph.org/CEP/
Alabama	PUBLIC HEALTH AREA 9 HEALTHCARE COALITION	http://www.adph.org/CEP/
Alabama	PUBLIC HEALTH AREA 1 HEALTHCARE COALITION	http://www.adph.org/CEP/
Alabama	PUBLIC HEALTH AREA 7 HEALTHCARE COALITION	http://www.adph.org/CEP/
Alabama	PUBLIC HEALTH AREA 6 HEALTHCARE COALITION	http://www.adph.org/CEP/
Alabama	PUBLIC HEALTH AREA 3 HEALTHCARE COALITION	http://www.adph.org/CEP/
Alabama	PUBLIC HEALTH AREA 2 HEALTHCARE COALITION	http://www.adph.org/CEP/
Alaska	Alaska Healthcare Coalition	http://dhss.alaska.gov/dph/Emergency/Pages/prepared/default.aspx
American Samoa	ESF 8	Unable to locate
Arizona	ARIZONA COALITION FOR HEALTHCARE EMERGENCY RESPONSE - CENTRAL (AZCHER – CENTRAL)	http://www.azdhs.gov/preparedness/emergency-preparedness/
Arizona	COYOTE CRISIS COLLABORATIVE	http://www.azdhs.gov/preparedness/emergency-preparedness/
Arizona	ARIZONA COALITION FOR HEALTHCARE EMERGENCY RESPONSE – SOUTHERN (AzCHER-SOUTHERN)	http://www.azdhs.gov/preparedness/emergency-preparedness/
Arizona	ARIZONA COALITION FOR HEALTHCARE EMERGENCY RESPONSE - NORTHERN (AzCHER-NORTHERN)	http://www.azdhs.gov/preparedness/emergency-preparedness/
Arizona	ARIZONA COALITION FOR HEALTHCARE EMERGENCY RESPONSE - WESTERN (AzCHER-WESTERN)	http://www.azdhs.gov/preparedness/emergency-preparedness/
Arkansas	AR VALLEY REGION	http://www.healthy.arkansas.gov/programsServices/preparedness/Pages/default.aspx
Arkansas	METRO REGION	http://www.healthy.arkansas.gov/programsServices/preparedness/Pages/default.aspx

Awardee	Coalition Name	Website
Arkansas	NORTH CENTRAL REGION	http://www.healthy.arkansas.gov/programsServices/preparedness/Pages/default.aspx
Arkansas	NORTHEAST REGION	http://www.healthy.arkansas.gov/programsServices/preparedness/Pages/default.aspx
Arkansas	NORTHWEST REGION	http://www.healthy.arkansas.gov/programsServices/preparedness/Pages/default.aspx
Arkansas	SOUTHEAST REGION	http://www.healthy.arkansas.gov/programsServices/preparedness/Pages/default.aspx
Arkansas	SOUTHWEST REGION	http://www.healthy.arkansas.gov/programsServices/preparedness/Pages/default.aspx
California	SANTA CLARA COUNTY INPATIENT HOSPITALS EMERGENCY PREPAREDNESS PARTNERSHIP	http://www.cdph.ca.gov/programs/Pages/EmergencyPreparednessOffice.aspx
California	ALAMEDA COUNTY DISASTER PREPAREDNESS HEALTH COALITION/ALAMEDA	http://www.cdph.ca.gov/programs/Pages/EmergencyPreparednessOffice.aspx
California	ALPINE COUNTY HPP COALITION	http://www.cdph.ca.gov/programs/Pages/EmergencyPreparednessOffice.aspx
California	AMADOR COUNTY PUBLIC HEALTH	http://www.cdph.ca.gov/programs/Pages/EmergencyPreparednessOffice.aspx
California	BUTTE	http://www.cdph.ca.gov/programs/Pages/EmergencyPreparednessOffice.aspx
California	CALAVERAS CO EMER PREPAREDNESS HEALTHCARE COALITION	http://www.cdph.ca.gov/programs/Pages/EmergencyPreparednessOffice.aspx
California	COLUSA COUNTY	http://www.cdph.ca.gov/programs/Pages/EmergencyPreparednessOffice.aspx
California	CONTRA COSTA COUNTY MED/HEALTH FORUM	http://www.cdph.ca.gov/programs/Pages/EmergencyPreparednessOffice.aspx
California	COUNTY OF SAN DIEGO	http://www.cdph.ca.gov/programs/Pages/EmergencyPreparednessOffice.aspx
California	DEL NORTE COUNTY	http://www.cdph.ca.gov/programs/Pages/EmergencyPreparednessOffice.aspx
California	EL DORADO COUNTY HPP COALITION	http://www.cdph.ca.gov/programs/Pages/EmergencyPreparednessOffice.aspx
California	EMERGENCY PREPAREDNESS/PANDEMIC INFLUENZA COMMITTEE	http://www.cdph.ca.gov/programs/Pages/EmergencyPreparednessOffice.aspx
California	FRESNO COUNTY DEPARTMENT OF PUBLIC HEALTH STAKEHOLDER GROUP	http://www.cdph.ca.gov/programs/Pages/EmergencyPreparednessOffice.aspx
California	GLENN COUNTY HEALTHCARE PARTNERSHIP	http://www.cdph.ca.gov/programs/Pages/EmergencyPreparednessOffice.aspx
California	HUMBOLDT COUNTY HPP PARTNERSHIP	http://www.cdph.ca.gov/programs/Pages/EmergencyPreparednessOffice.aspx
California	IMPERIAL COUNTY PUBLIC HEALTH DEPARTMENT	http://www.cdph.ca.gov/programs/Pages/EmergencyPreparednessOffice.aspx
California	INLAND COUNTIES EMERGENCY MEDICAL AGENCY (ICEMA)	http://www.cdph.ca.gov/programs/Pages/EmergencyPreparednessOffice.aspx
California	INYO COUNTY HPP COLLABORATION	http://www.cdph.ca.gov/programs/Pages/EmergencyPreparednessOffice.aspx
California	KERN PUBLIC HEALTH HPP PARTNERSHIP COORDINATOR	http://www.cdph.ca.gov/programs/Pages/EmergencyPreparednessOffice.aspx
California	KINGS COUNTY HPP PARTNERSHIP	http://www.cdph.ca.gov/programs/Pages/EmergencyPreparednessOffice.aspx
California	LAKE COUNTY	http://www.cdph.ca.gov/programs/Pages/EmergencyPreparednessOffice.aspx
California	LASSEN COUNTY HPP	http://www.cdph.ca.gov/programs/Pages/EmergencyPreparednessOffice.aspx

Awardee	Coalition Name	Website
California	MADERA COUNTY PUBLIC HEALTH DEPARTMENT	http://www.cdph.ca.gov/programs/Pages/EmergencyPreparednessOffice.aspx
California	MARIN HEALTHCARE PREPAREDNESS PROGRAM	http://www.cdph.ca.gov/programs/Pages/EmergencyPreparednessOffice.aspx
California	MARIPOSA COUNTY	http://www.cdph.ca.gov/programs/Pages/EmergencyPreparednessOffice.aspx
California	MENDOCINO HPP PARTNERSHIP	http://www.cdph.ca.gov/programs/Pages/EmergencyPreparednessOffice.aspx
California	MERCED COUNTY DEPARTMENT OF PUBLIC HEALTH	http://www.cdph.ca.gov/programs/Pages/EmergencyPreparednessOffice.aspx
California	MODOC COUNTY HEALTHCARE COALITION	http://www.cdph.ca.gov/programs/Pages/EmergencyPreparednessOffice.aspx
California	MONO COUNTY	http://www.cdph.ca.gov/programs/Pages/EmergencyPreparednessOffice.aspx
California	MONTEREY COUNTY HEALTHCARE EMERGENCY RESPONSE COALITION (HERC)	http://www.cdph.ca.gov/programs/Pages/EmergencyPreparednessOffice.aspx
California	NAPA HPP COMMITTEE	http://www.cdph.ca.gov/programs/Pages/EmergencyPreparednessOffice.aspx
California	NEVADA COUNTY HPP PARTNERSHIP	http://www.cdph.ca.gov/programs/Pages/EmergencyPreparednessOffice.aspx
California	ORANGE COUNTY	http://www.cdph.ca.gov/programs/Pages/EmergencyPreparednessOffice.aspx
California	PLACER COUNTY HEALTHCARE PREPAREDNESS PARTNERSHIP	http://www.cdph.ca.gov/programs/Pages/EmergencyPreparednessOffice.aspx
California	PLUMAS COUNTY EMERGENCY PREPAREDNESS/EMCC	http://www.cdph.ca.gov/programs/Pages/EmergencyPreparednessOffice.aspx
California	SACRAMENTO COUNTY HPP PARTNERSHIP	http://www.cdph.ca.gov/programs/Pages/EmergencyPreparednessOffice.aspx
California	SAN BENITO COUNTY HPP GROUP	http://www.cdph.ca.gov/programs/Pages/EmergencyPreparednessOffice.aspx
California	SAN FRANCISCO DEPARTMENT OF PUBLIC HEALTH-HEALTH PREPAREDNESS PARTNERSHIP	http://www.cdph.ca.gov/programs/Pages/EmergencyPreparednessOffice.aspx
California	SAN JOAQUIN COUNTY EMERGENCY PREPREDNESS COMMITTEE	http://www.cdph.ca.gov/programs/Pages/EmergencyPreparednessOffice.aspx
California	SAN LUIS OBISPO COUNTY PUBLIC HEALTH EMERGENCY PREPAREDNESS	http://www.cdph.ca.gov/programs/Pages/EmergencyPreparednessOffice.aspx
California	SAN MATEO COUNTY	http://www.cdph.ca.gov/programs/Pages/EmergencyPreparednessOffice.aspx
California	SANTA BARBARA HEALTHCARE PARTNERS	http://www.cdph.ca.gov/programs/Pages/EmergencyPreparednessOffice.aspx
California	SANTA CRUZ HEALTHCARE EMERGENCY PREPAREDNESS COALITION	http://www.cdph.ca.gov/programs/Pages/EmergencyPreparednessOffice.aspx
California	SHASTA COUNTY HPP	http://www.cdph.ca.gov/programs/Pages/EmergencyPreparednessOffice.aspx
California	SISKIYOU COUNTY MEDICAL HEALTH	http://www.cdph.ca.gov/programs/Pages/EmergencyPreparednessOffice.aspx

Awardee	Coalition Name	Website
	EMERGENCY PREPAREDNESS	
California	SOLANO PUBLIC HEALTH AND SAFETY PREPAREDNESS AND RESPONSE (PHASPAR)	http://www.cdph.ca.gov/programs/Pages/EmergencyPreparednessOffice.aspx
California	SONOMA COUNTY HEALTHCARE DISASTER PLANNING FORUM	http://www.cdph.ca.gov/programs/Pages/EmergencyPreparednessOffice.aspx
California	STANISLAUS COUNTY HEALTHCARE EMERGENCY PREPAREDNESS COUNCIL	http://www.cdph.ca.gov/programs/Pages/EmergencyPreparednessOffice.aspx
California	SUTTER COUNTY HPP PARTNERSHIP	http://www.cdph.ca.gov/programs/Pages/EmergencyPreparednessOffice.aspx
California	TEHAMA CO. HPP PARTNERSHIP	http://www.cdph.ca.gov/programs/Pages/EmergencyPreparednessOffice.aspx
California	TRINITY INPATIENT HOSPITALS (MOUNTAIN COMMUNITIES HEALTHCARE DIST.)	http://www.cdph.ca.gov/programs/Pages/EmergencyPreparednessOffice.aspx
California	TULARE COUNTY PHEP ADVISORY COMMITTEE (PHEP-AC)	http://www.cdph.ca.gov/programs/Pages/EmergencyPreparednessOffice.aspx
California	TUOLUMNE COUNTY EMERGENCY PREPAREDNESS ADVISORY COMMITTEE	http://www.cdph.ca.gov/programs/Pages/EmergencyPreparednessOffice.aspx
California	VENTURA COUNTY HEALTH CARE COALITION (VCHCC)	http://www.vchca.org/ems/emergency-preparedness/vchcc
California	WESTERN / EASTERN RIVERSIDE EMERGENCY COUNCIL	http://www.cdph.ca.gov/programs/Pages/EmergencyPreparednessOffice.aspx
California	YOLO HEALTHCARE PREPAREDNESS COALITION (HPC)	http://www.cdph.ca.gov/programs/Pages/EmergencyPreparednessOffice.aspx
California	YUBA COUNTY HPP PARTNERSHIP	http://www.cdph.ca.gov/programs/Pages/EmergencyPreparednessOffice.aspx
Colorado	BACA COUNTY HEALTH	https://www.colorado.gov/pacific/cdphe/public-health-emergency-preparedness-program
Colorado	PARTNERS IN PREPAREDNESS (CHEYENNE COUNTY HCC)	https://www.colorado.gov/pacific/cdphe/public-health-emergency-preparedness-program
Colorado	DENVER HEALTHCARE COALITION	https://www.colorado.gov/pacific/cdphe/public-health-emergency-preparedness-program
Colorado	EAGLE COUNTY PUBLIC SAFETY COUNCIL	https://www.colorado.gov/pacific/cdphe/public-health-emergency-preparedness-program
Colorado	FOOTHILLS HEALTHCARE COALITION	https://www.colorado.gov/pacific/cdphe/public-health-emergency-preparedness-program
Colorado	GARFIELD COUNTY ESF8/HCC	https://www.colorado.gov/pacific/cdphe/public-health-emergency-preparedness-program
Colorado	GRAND COUNTY HCC	https://www.colorado.gov/pacific/cdphe/public-health-emergency-preparedness-program
Colorado	HAMR PARTNERSHIP	https://www.colorado.gov/pacific/cdphe/public-health-emergency-preparedness-program
Colorado	JACKSON COUNTY HEALTHCARE COALITION	https://www.colorado.gov/pacific/cdphe/public-health-emergency-preparedness-program
Colorado	KIOWA COUNTY HEALTH CARE COALITON	https://www.colorado.gov/pacific/cdphe/public-health-emergency-preparedness-program

Awardee	Coalition Name	Website
Colorado	KIT CARSON COUNTY HEALTHCARE COALITION	https://www.colorado.gov/pacific/cdphe/public-health-emergency-preparedness-program
Colorado	LARIMER COUNTY EMERGENCY HEALTHCARE COALITION	https://www.colorado.gov/pacific/cdphe/public-health-emergency-preparedness-program
Colorado	LASST COALITION	https://www.colorado.gov/pacific/cdphe/public-health-emergency-preparedness-program
Colorado	LINCOLN COUNTY EMERGENCY MANAGEMENT HEALTHCARE COALITION	https://www.colorado.gov/pacific/cdphe/public-health-emergency-preparedness-program
Colorado	LOGAN COUNTY ESF8 COMMITTEE	https://www.colorado.gov/pacific/cdphe/public-health-emergency-preparedness-program
Colorado	MESA COUNTY ESF8	https://www.colorado.gov/pacific/cdphe/public-health-emergency-preparedness-program
Colorado	MOFFAT COUNTY HEALTHCARE COALITION	https://www.colorado.gov/pacific/cdphe/public-health-emergency-preparedness-program
Colorado	MONTELORES HEALTH CARE COALITION	https://www.colorado.gov/pacific/cdphe/public-health-emergency-preparedness-program
Colorado	MORGAN COUNTY HEALTHCARE COALITION	https://www.colorado.gov/pacific/cdphe/public-health-emergency-preparedness-program
Colorado	PHILLIPS CTY HEALTHCARE	https://www.colorado.gov/pacific/cdphe/public-health-emergency-preparedness-program
Colorado	South Central Healthcare Coalition	https://www.colorado.gov/pacific/cdphe/public-health-emergency-preparedness-program
Colorado	PITKIN COUNTY HEATLH CARE COALITION	https://www.colorado.gov/pacific/cdphe/public-health-emergency-preparedness-program
Colorado	PROWERS COUNTY HEALTHCARE COALITION, SEHC, BENT COUNTY HEALTH CARE ADVISORY BOARD	https://www.colorado.gov/pacific/cdphe/public-health-emergency-preparedness-program
Colorado	RIO BLANCO COUNTY HEALTHCARE COALITION	https://www.colorado.gov/pacific/cdphe/public-health-emergency-preparedness-program
Colorado	ROUTT COUNTY EMERGENCY RESPONSE COALITION	https://www.colorado.gov/pacific/cdphe/public-health-emergency-preparedness-program
Colorado	SAN LUIS VALLEY EAST HEALTHCARE COALITION	https://www.colorado.gov/pacific/cdphe/public-health-emergency-preparedness-program
Colorado	SAN LUIS VALLEY WEST HEALTHCARE COALITION (SLVWHCC)	https://www.colorado.gov/pacific/cdphe/public-health-emergency-preparedness-program
Colorado	SEDGWICK COUNTY HEALTHCARE COALITION	https://www.colorado.gov/pacific/cdphe/public-health-emergency-preparedness-program
Colorado	SOUTH EAST HEALTHCARE COALITION (SEHC)	https://www.colorado.gov/pacific/cdphe/public-health-emergency-preparedness-program
Colorado	SOUTH REGION HEALTHCARE COALITION	https://www.colorado.gov/pacific/cdphe/public-health-emergency-preparedness-program
Colorado	SUMMIT COUNTY HEALTH CARE COALITION	https://www.colorado.gov/pacific/cdphe/public-health-emergency-preparedness-program
Colorado	TCHD HEALTHCARE COALITION	https://www.colorado.gov/pacific/cdphe/public-health-emergency-preparedness-program

Awardee	Coalition Name	Website
Colorado	WELD COUNTY ESF 8 HEALTHCARE COALITION	https://www.colorado.gov/pacific/cdphe/public-health-emergency-preparedness-program
Colorado	WEST REGION HCC	https://www.colorado.gov/pacific/cdphe/public-health-emergency-preparedness-program
Colorado	Y-W ESF 8 HEALTHCARE COALITION	https://www.colorado.gov/pacific/cdphe/public-health-emergency-preparedness-program
Connecticut	REGION 1 HEALTHCARE ORGANIZATION COALITION	http://www.ct.gov/dph/taxonomy/ct_taxonomy.asp?DLN=46945&dphNav_GID=1601
Connecticut	REGION 2 HEALTHCARE ORGANIZATION COALITION	http://www.ct.gov/dph/taxonomy/ct_taxonomy.asp?DLN=46945&dphNav_GID=1601
Connecticut	REGION 3 HEALTHCARE ORGANIZATION COALITION	http://www.ct.gov/dph/taxonomy/ct_taxonomy.asp?DLN=46945&dphNav_GID=1601
Connecticut	REGION 4 HEALTHCARE ORGANIZATION COALITION	http://www.ct.gov/dph/taxonomy/ct_taxonomy.asp?DLN=46945&dphNav_GID=1601
Connecticut	REGION 5 HEALTHCARE ORGANIZATION COALITION	http://www.ct.gov/dph/taxonomy/ct_taxonomy.asp?DLN=46945&dphNav_GID=1601
Delaware	Healthcare Preparedness Coalition	http://www.dhss.delaware.gov/dhss/dph/php/
District of Columbia	DC Health and Medical Coalition (DC HMC)	http://doh.dc.gov/page/health-emergency-preparedness-and-response-administration
Florida	BROWARD COUNTY HEALTHCARE COALITION	http://www.floridahealth.gov/programs-and-services/emergency-preparedness-and-response/index.html
Florida	Northeast Florida Healthcare Coalition	http://www.floridahealth.gov/programs-and-services/emergency-preparedness-and-response/index.html
Florida	HERC-PALM BEACH COUNTY	http://www.floridahealth.gov/programs-and-services/emergency-preparedness-and-response/index.html
Florida	MIAMI-DADE COUNTY HEALTHCARE PREPAREDNESS COALITION	http://www.floridahealth.gov/programs-and-services/emergency-preparedness-and-response/index.html
Florida	KEYS HEALTH READY COALITION	http://www.floridahealth.gov/programs-and-services/emergency-preparedness-and-response/index.html
Florida	Emerald Coast Healthcare Coalition	http://www.floridahealth.gov/programs-and-services/emergency-preparedness-and-response/index.html
Florida	North Central Florida Health Care Coalition	http://www.floridahealth.gov/programs-and-services/emergency-preparedness-and-response/index.html
Florida	Region 4 Health and Medical Coalition (R4-HMC)	http://www.floridahealth.gov/programs-and-services/emergency-preparedness-and-response/index.html
Florida	Central Florida Disaster Medical Coalition	http://www.floridahealth.gov/programs-and-services/emergency-preparedness-and-response/index.html
Florida	Suncoast Disaster Healthcare Coalition	http://www.floridahealth.gov/programs-and-services/emergency-preparedness-and-response/index.html
Florida	Big Bend Healthcare Coalition	http://www.floridahealth.gov/programs-and-services/emergency-preparedness-and-response/index.html
Florida	Coalition of Health and Medical Preparedness(CHAMP)	http://www.floridahealth.gov/programs-and-services/emergency-preparedness-and-response/index.html
Florida	Southwest Florida Healthcare Preparedness Coalition	http://www.floridahealth.gov/programs-and-services/emergency-preparedness-and-response/index.html
Florida	Heartland Healthcare Coalition	http://www.floridahealth.gov/programs-and-services/emergency-preparedness-and-response/index.html
Florida	Collier Healthcare Emergency Preparedness Coalition	http://www.floridahealth.gov/programs-and-services/emergency-preparedness-and-response/index.html
Georgia	REGION A	http://dph.georgia.gov/environmental-health-emergency-preparedness

Awardee	Coalition Name	Website
Georgia	REGION B	http://dph.georgia.gov/environmental-health-emergency-preparedness
Georgia	REGION C	http://dph.georgia.gov/environmental-health-emergency-preparedness
Georgia	REGION D	http://dph.georgia.gov/environmental-health-emergency-preparedness
Georgia	REGION E	http://dph.georgia.gov/environmental-health-emergency-preparedness
Georgia	REGION F	http://dph.georgia.gov/environmental-health-emergency-preparedness
Georgia	REGION G	http://dph.georgia.gov/environmental-health-emergency-preparedness
Georgia	REGION H	http://dph.georgia.gov/environmental-health-emergency-preparedness
Georgia	REGION I	http://dph.georgia.gov/environmental-health-emergency-preparedness
Georgia	REGION J	http://dph.georgia.gov/environmental-health-emergency-preparedness
Georgia	REGION K	http://dph.georgia.gov/environmental-health-emergency-preparedness
Georgia	REGION L	http://dph.georgia.gov/environmental-health-emergency-preparedness
Georgia	REGION M	http://dph.georgia.gov/environmental-health-emergency-preparedness
Georgia	REGION N	http://dph.georgia.gov/environmental-health-emergency-preparedness
Guam	GUAM EMERGENCY MANAGEMENT HEALTHCARE COALITION	http://www.gmha.org/gmha_new/DEPARTMENTAL%20POLICIES%202010/DEPARTMENTAL%20POLICIES%202010/CURRENT%20-%20ALL%20DEPTS/EPManual%20-%20CURRENT/Emergency%20Preparedness%20Manual%20Policy%20Repository%20DatabaseAUG2012.htm
Hawaii	HAH EMERGENCY SERVICES COALITION	http://health.hawaii.gov/docd/php/
Idaho	CENTRAL DISTRICT HEALTH DEPARTMENT	http://healthandwelfare.idaho.gov/Health/ReadyIdaho/tabid/1613/Default.aspx
Idaho	EASTERN IDAHO PUBLIC HEALTH DISTRICT	http://healthandwelfare.idaho.gov/Health/ReadyIdaho/tabid/1613/Default.aspx
Idaho	PANHANDLE HEALTH DISTRICT	http://healthandwelfare.idaho.gov/Health/ReadyIdaho/tabid/1613/Default.aspx
Idaho	PUBLIC HEALTH – IDAHO NORTH CENTRAL DISTRICT	http://healthandwelfare.idaho.gov/Health/ReadyIdaho/tabid/1613/Default.aspx
Idaho	SOUTH CENTRAL PUBLIC HEALTH DISTRICT	http://healthandwelfare.idaho.gov/Health/ReadyIdaho/tabid/1613/Default.aspx
Idaho	SOUTHEASTERN IDAHO PUBLIC HEALTH	http://healthandwelfare.idaho.gov/Health/ReadyIdaho/tabid/1613/Default.aspx
Idaho	SOUTHWEST DISTRICT HEALTH	http://healthandwelfare.idaho.gov/Health/ReadyIdaho/tabid/1613/Default.aspx
Illinois	CHICAGO HEALTHCARE COALITION FOR PREPAREDNESS AND RESPONSE (CHSCPR)	http://www.cityofchicago.org/city/en/depts/cdph/supp_info/public_health_preparedness/hospital_and_healthcaresystempreparednessprogram.html
Illinois	Northwest Illinois Preparedness and Response Coalition	http://dph.illinois.gov/topics-services/emergency-preparedness-response/public- health-care-system-preparedness
Illinois	REGION II HEALTH CARE COALITION	http://dph.illinois.gov/topics-services/emergency-preparedness-response/public- health-care-system-preparedness
Illinois	Springfield Region Public Health and Medical Emergency Response Region	http://dph.illinois.gov/topics-services/emergency-preparedness-response/public- health-care-system-preparedness
Illinois	REGION IV HEALTH CARE COALITION	http://dph.illinois.gov/topics-services/emergency-preparedness-response/public-health-care-system-preparedness
Illinois	Region IX Medical Disaster Preparedness and Response Coalition	http://dph.illinois.gov/topics-services/emergency-preparedness-response/public-health-care-system-preparedness
Illinois	Shawnee Preparedness and Response Coalition	http://dph.illinois.gov/topics-services/emergency-preparedness-response/public-health-care-system-preparedness

Awardee	Coalition Name	Website
Illinois	Champaign Regional Healthcare Coalition	http://dph.illinois.gov/topics-services/emergency-preparedness-response/public- health-care-system-preparedness
Illinois	REGION VII HEALTH CARE COALITION	http://dph.illinois.gov/topics-services/emergency-preparedness-response/public- health-care-system-preparedness
Illinois	Region VIII Coalition for Preparedness and Response	http://dph.illinois.gov/topics-services/emergency-preparedness-response/public- health-care-system-preparedness
Illinois	Region X Disaster Healthcare Coalition	http://dph.illinois.gov/topics-services/emergency-preparedness-response/public-health-care-system-preparedness
Indiana	DISTRICT 1	https://secure.in.gov/isdh/17855.htm
Indiana	DISTRICT 10	https://secure.in.gov/isdh/17855.htm
Indiana	DISTRICT 2	https://secure.in.gov/isdh/17855.htm
Indiana	DISTRICT 3	https://secure.in.gov/isdh/17855.htm
Indiana	DISTRICT 4	https://secure.in.gov/isdh/17855.htm
Indiana	DISTRICT 5	https://secure.in.gov/isdh/17855.htm
Indiana	DISTRICT 6	https://secure.in.gov/isdh/17855.htm
Indiana	DISTRICT 7	https://secure.in.gov/isdh/17855.htm
Indiana	DISTRICT 8	https://secure.in.gov/isdh/17855.htm
Indiana	DISTRICT 9	https://secure.in.gov/isdh/17855.htm
Iowa	ADAIR-GUTHRIE PREPARES	http://idph.iowa.gov/BETS/preparedness
Iowa	ADAMS COUNTY HEALTHCARE COALITION	http://idph.iowa.gov/BETS/preparedness
Iowa	ALLAMAKEE COUNTY HEALTHCARE COALITION	http://idph.iowa.gov/BETS/preparedness
Iowa	CALHOUN COUNTY HEALTHCARE COALITION	http://idph.iowa.gov/BETS/preparedness
Iowa	CARROLL COUNTY PREPAREDNESS COALITION	http://idph.iowa.gov/BETS/preparedness
Iowa	CASS COUNTY HEALTHCARE COALITION	http://idph.iowa.gov/BETS/preparedness
Iowa	CEDAR VALLEY HEALTH CARE COALITION	http://idph.iowa.gov/BETS/preparedness
Iowa	CENTRAL IOWA COORDINATED RESPONSE COALITION	http://idph.iowa.gov/BETS/preparedness
Iowa	CHEROKEE COUNTY COALITION	http://idph.iowa.gov/BETS/preparedness
Iowa	CLARKE COUNTY HEALTHCARE COALITION	http://idph.iowa.gov/BETS/preparedness
Iowa	CLAY COUNTY HEALTH CARE COALITION	http://idph.iowa.gov/BETS/preparedness
Iowa	CLAYTON COUNTY HEALTHCARE COALITION	http://idph.iowa.gov/BETS/preparedness
Iowa	CORNER 3 COALITION	http://idph.iowa.gov/BETS/preparedness
Iowa	CRAWFORD COUNTY HEALTHCARE AND	http://idph.iowa.gov/BETS/preparedness

Awardee	Coalition Name	Website
	PREPAREDNESS COALITION	
Iowa	DELAWARE COUNTY EMERGENCY PREPAREDNESS COALITION	http://idph.iowa.gov/BETS/preparedness
Iowa	DES MOINES COUNTY HEALTH CARE COALITION	http://idph.iowa.gov/BETS/preparedness
Iowa	DICKINSON COUNTY HEALTHCARE COALITION	http://idph.iowa.gov/BETS/preparedness
Iowa	DUBUQUE COUNTY HEALTHCARE PREPAREDNESS COALITION	http://idph.iowa.gov/BETS/preparedness
Iowa	EMMET COUNTY FIRST RESPONDERS COALITION	http://idph.iowa.gov/BETS/preparedness
Iowa	GATEWAY AREA HEALTHCARE COALITION	http://idph.iowa.gov/BETS/preparedness
Iowa	GREENE COUNTY HEALTHCARE COALITION	http://idph.iowa.gov/BETS/preparedness
Iowa	HEALTH EMERGENCY COALITION OF BUCHANAN COUNTY	http://idph.iowa.gov/BETS/preparedness
Iowa	HENRY COUNTY HEALTHCARE COALITION	http://idph.iowa.gov/BETS/preparedness
Iowa	HOWARD COUNTY HEALTH CARE COALITION	http://idph.iowa.gov/BETS/preparedness
Iowa	HUMBOLDT COUNTY COALITION	http://idph.iowa.gov/BETS/preparedness
Iowa	IDA COUNTY HEALTHCARE COALITION	http://idph.iowa.gov/BETS/preparedness
Iowa	JACKSON COUNTY COALITION	http://idph.iowa.gov/BETS/preparedness
Iowa	JASPER COUNTY EMERGENCY RESPONSE COALITION	http://idph.iowa.gov/BETS/preparedness
Iowa	EAST CENTRAL PREPAREDNESS COALITION	http://idph.iowa.gov/BETS/preparedness
Iowa	KEPT (KOSSUTH EMERGENCY PLANNING TEAM) HEALTHCARE COALITION	http://idph.iowa.gov/BETS/preparedness
Iowa	LEE COUNTY HEALTH CARE COALITION	http://idph.iowa.gov/BETS/preparedness
Iowa	LINN COUNTY HEALTHCARE PREPAREDNESS COALITION	http://idph.iowa.gov/BETS/preparedness
Iowa	LOESS HILLS HEALTHCARE COALITION	http://idph.iowa.gov/BETS/preparedness
Iowa	LUCAS COUNTY HEALTHCARE PREPAREDNESS COALITION	http://idph.iowa.gov/BETS/preparedness

Awardee	Coalition Name	Website
Iowa	LYON COUNTY EMERGENCY HEALTH CARE COALITION	http://idph.iowa.gov/BETS/preparedness
Iowa	MAHASKA COUNTY HEALTHCARE PREPAREDNESS COALITION	http://idph.iowa.gov/BETS/preparedness
Iowa	MARION COUNTY EMERGENCY RESPONSE COALITION	http://idph.iowa.gov/BETS/preparedness
Iowa	MESKWAKI, MARSHALL, POWESHIEK AND TAMA (MMPT) COUNTIES HEALTHCARE COALITION	http://idph.iowa.gov/BETS/preparedness
Iowa	MUSCATINE COUNTY HEALTH CARE PREPAREDNESS COALITION	http://idph.iowa.gov/BETS/preparedness
Iowa	OSCEOLA COUNTY HEALTHCARE PREPAREDNESS COALITION	http://idph.iowa.gov/BETS/preparedness
Iowa	PLYMOUTH COUNTY HEALTHCARE COALITION	http://idph.iowa.gov/BETS/preparedness
Iowa	POCAHONTAS COUNTY HEALTHCARE COALITION	http://idph.iowa.gov/BETS/preparedness
Iowa	PREPAREDNESS ADVISORY GROUP	http://idph.iowa.gov/BETS/preparedness
Iowa	SCOTT COUNTY HEALTHCARE COALITION	http://idph.iowa.gov/BETS/preparedness
Iowa	SHELBY COUNTY EMERGENCY PLANNING AND PREPAREDNESS COALITION	http://idph.iowa.gov/BETS/preparedness
Iowa	SIOUX COUNTY EMERGENCY PREPAREDNESS COALITION	http://idph.iowa.gov/BETS/preparedness
Iowa	CBS-HELPs	http://idph.iowa.gov/BETS/preparedness
Iowa	WAPELLO COUNTY HEALTHCARE COALITION	http://idph.iowa.gov/BETS/preparedness
Iowa	WASHINGTON COUNTY HEALTHCARE PREPAREDNESS COALITION	http://idph.iowa.gov/BETS/preparedness
Iowa	WAYNE COUNTY HEALTHCARE PREPAREDNESS COALITION	http://idph.iowa.gov/BETS/preparedness
Iowa	WEBSTER COUNTY HEALTHCARE COALITION	http://idph.iowa.gov/BETS/preparedness
Iowa	WINNESHIEK HEALTHCARE EMERGENCY PREPAREDNESS COALITION	http://idph.iowa.gov/BETS/preparedness
Iowa	WOODBURY COUNTY PREPAREDNESS	http://idph.iowa.gov/BETS/preparedness

Awardee	Coalition Name	Website
	HEALTHCARE COALITION	
Iowa	WRIGHT COUNTY HEALTHCARE PREPAREDNESS AND RESPONSE COALITION	http://idph.iowa.gov/BETS/preparedness
Iowa	Iowa County Health Care Coalition	http://idph.iowa.gov/BETS/preparedness
Iowa	Madison County Cares: Health Care Coalition	http://idph.iowa.gov/BETS/preparedness
Iowa	Decatur County Healthcare Coalition	http://idph.iowa.gov/BETS/preparedness
Iowa	OBrien County Healthcare Coalition	http://idph.iowa.gov/BETS/preparedness
Iowa	Butler, Franklin, Floyd Health Care Preparedness Coalition	http://idph.iowa.gov/BETS/preparedness
Iowa	Union County Healthcare Coalition	http://idph.iowa.gov/BETS/preparedness
Kansas	KANSAS CITY, KS HEALTHCARE COALITION	http://www.kdheks.gov/cphp/
Kansas	NORTH CENTRAL KANSAS HEALTHCARE COALITION	http://www.kdheks.gov/cphp/
Kansas	NORTHEAST KANSAS HEALTHCARE COALITION	http://www.kdheks.gov/cphp/
Kansas	NORTHWEST KANSAS HEALTHCARE COALITION	http://www.kdheks.gov/cphp/
Kansas	SOUTH CENTRAL KANSAS HEALTHCARE COALITION	http://www.kdheks.gov/cphp/
Kansas	SOUTHEAST KANSAS HEALTHCARE COALITION	http://www.kdheks.gov/cphp/
Kansas	SOUTHWEST KANSAS HEALTHCARE COALITION	http://www.kdheks.gov/cphp/
Kentucky	HEALTHCARE EMERGENCY AREA 4 RESPONSE TEAM (HEART)	http://chfs.ky.gov/dph/epi/preparedness/
Kentucky	HEALTHCARE EMERGENCY RESPONSE ASSOCIATION (HERA) REGION VI	http://chfs.ky.gov/dph/epi/preparedness/
Kentucky	REGION 1 HPC	http://chfs.ky.gov/dph/epi/preparedness/
Kentucky	REGION 10 HPC	http://chfs.ky.gov/dph/epi/preparedness/
Kentucky	REGION 12 HPC	http://chfs.ky.gov/dph/epi/preparedness/
Kentucky	REGION 13 HPC	http://chfs.ky.gov/dph/epi/preparedness/
Kentucky	REGION 15 HPC	http://chfs.ky.gov/dph/epi/preparedness/
Kentucky	REGION 2 HPC	http://chfs.ky.gov/dph/epi/preparedness/
Kentucky	REGION 3 HPC	http://chfs.ky.gov/dph/epi/preparedness/
Kentucky	REGION 5 HPC	http://chfs.ky.gov/dph/epi/preparedness/
Kentucky	REGION 7 HPC	http://chfs.ky.gov/dph/epi/preparedness/
Kentucky	REGION 8 EMERGENCY PREPAREDNESS GROUP	http://chfs.ky.gov/dph/epi/preparedness/

Awardee	Coalition Name	Website
Kentucky	Region 14 Healthcare Preparedness Coalition	http://chfs.ky.gov/dph/epi/preparedness/
Los Angeles	LOS ANGELES COUNTY (LAC) HEALTHCARE COALITION	http://publichealth.lacounty.gov/eprp/
Louisiana	LA ESF 8 HEALTH AND MEDICAL	http://dhh.louisiana.gov/index.cfm/subhome/17/n/173
Louisiana	REGION 1 ESF 8 PARTNERSHIP	http://dhh.louisiana.gov/index.cfm/subhome/17/n/173
Louisiana	REGION 2 ESF 8 PARTNERSHIP	http://dhh.louisiana.gov/index.cfm/subhome/17/n/173
Louisiana	REGION 3 ESF 8 PARTNERSHIP	http://dhh.louisiana.gov/index.cfm/subhome/17/n/173
Louisiana	REGION 4 ESF 8 PARTNERSHIP	http://dhh.louisiana.gov/index.cfm/subhome/17/n/173
Louisiana	REGION 5 ESF 8 PARTNERSHIP	http://dhh.louisiana.gov/index.cfm/subhome/17/n/173
Louisiana	REGION 6 ESF 8 PARTNERSHIP	http://dhh.louisiana.gov/index.cfm/subhome/17/n/173
Louisiana	REGION 7 ESF 8 PARTNERSHIP	http://dhh.louisiana.gov/index.cfm/subhome/17/n/173
Louisiana	REGION 8 ESF 8 PARTNERSHIP	http://dhh.louisiana.gov/index.cfm/subhome/17/n/173
Louisiana	REGION 9 ESF 8 PARTNERSHIP	http://dhh.louisiana.gov/index.cfm/subhome/17/n/173
Maine	Central Maine Healthcare Preparedness Coalition	http://www.maine.gov/dhhs/mecdc/public-health-systems/phep/
Maine	NORTHEASTERN MAINE REGIONAL RESOURCE CENTER	http://www.maine.gov/dhhs/mecdc/public-health-systems/phep/
Maine	SOUTHERN MAINE REGIONAL RESOURCE CENTER	http://www.maine.gov/dhhs/mecdc/public-health-systems/phep/
Maryland	DELMARVA REGIONAL HEALTHCARE MUTUAL AID GROUP (DRHMAG)	http://preparedness.dhmh.maryland.gov/Pages/Home.aspx
Maryland	REGION III HEALTH AND MEDICAL COALITION	http://preparedness.dhmh.maryland.gov/Pages/Home.aspx
Maryland	REGION V EMERGENCY PREPAREDNESS COALITION	http://preparedness.dhmh.maryland.gov/Pages/Home.aspx
Maryland	REGIONS I AND II HEALTH CARE COUNCIL	http://preparedness.dhmh.maryland.gov/Pages/Home.aspx
Massachusetts	BOSTON HEALTHCARE COALITION, REGION 4C	http://www.mass.gov/eohhs/gov/departments/dph/programs/emergency-prep/
Massachusetts	METROWEST MA HEALTHCARE COALITION, REGION 4AB	http://www.mass.gov/eohhs/gov/departments/dph/programs/emergency-prep/
Massachusetts	NORTHEAST MA HEALTHCARE COALITION, REGION 3	http://www.mass.gov/eohhs/gov/departments/dph/programs/emergency-prep/
Massachusetts	PARTNERSHIP FOR THE ENHANCEMENT OF REGIONAL PREPAREDNESS, REGION 2	http://www.mass.gov/eohhs/gov/departments/dph/programs/emergency-prep/
Massachusetts	SOUTHEAST MA HEALTHCARE COALITION, REGION 5	http://www.mass.gov/eohhs/gov/departments/dph/programs/emergency-prep/
Massachusetts	WESTERN MA HEALTHCARE COALITION, REGION 1	http://www.mass.gov/eohhs/gov/departments/dph/programs/emergency-prep/
Michigan	REGION 5 HEALTHCARE COALITION	http://www.michigan.gov/mdhhs/0,5885,7-339-71548_54783_54826---,00.html

Awardee	Coalition Name	Website
Michigan	REGION 1 HEALTHCARE COALITION	http://www.michigan.gov/mdhhs/0,5885,7-339-71548_54783_54826---,00.html
Michigan	REGION 8 HEALTHCARE COALITION	http://www.michigan.gov/mdhhs/0,5885,7-339-71548_54783_54826---,00.html
Michigan	REGION 2 NORTH HEALTHCARE COALITION	http://www.michigan.gov/mdhhs/0,5885,7-339-71548_54783_54826---,00.html
Michigan	REGION 2 SOUTH HEALTHCARE COALITION	http://www.michigan.gov/mdhhs/0,5885,7-339-71548_54783_54826---,00.html
Michigan	REGION 3 HEALTHCARE COALITION	http://www.michigan.gov/mdhhs/0,5885,7-339-71548_54783_54826---,00.html
Michigan	REGION 6 HEALTHCARE COALITION	http://www.michigan.gov/mdhhs/0,5885,7-339-71548_54783_54826---,00.html
Michigan	REGION 7 HEALTHCARE COALITION	http://www.michigan.gov/mdhhs/0,5885,7-339-71548_54783_54826---,00.html
Micronesia	FSM Healthcare Coalition	Unable to locate
Minnesota	CENTRAL MINNESOTA HEALTHCARE SYSTEM PREPAREDNESS PROGRAM	http://www.health.state.mn.us/macros/topics/emergency.html
Minnesota	METRO	http://www.health.state.mn.us/macros/topics/emergency.html
Minnesota	NORTHEAST MINNESOTA HEALTHCARE SYSTEM PREPAREDNESS PROGRAM	http://www.health.state.mn.us/macros/topics/emergency.html
Minnesota	NORTHWEST MINNESOTA HEALTH COMPACT	http://www.health.state.mn.us/macros/topics/emergency.html
Minnesota	SOUTH CENTRAL	http://www.health.state.mn.us/macros/topics/emergency.html
Minnesota	SOUTH EAST MINNESOTA	http://www.health.state.mn.us/macros/topics/emergency.html
Minnesota	SOUTHWEST EMERGENCY PREPAREDNESS TEAM (SWEPT)	http://www.health.state.mn.us/macros/topics/emergency.html
Minnesota	WEST CENTRAL MINNESOTA HEALTHCARE SYSTEM PREPAREDNESS PROGRAM	http://www.health.state.mn.us/macros/topics/emergency.html
Mississippi	Mississippi ESF-8 Healthcare Coalition	http://msdh.ms.gov/msdhsite/_static/44,0,122.html
Missouri	REGION A	http://health.mo.gov/emergencies/index.php
Missouri	REGION B	http://health.mo.gov/emergencies/index.php
Missouri	REGION C	http://health.mo.gov/emergencies/index.php
Missouri	Southeast HCC	http://health.mo.gov/emergencies/index.php
Missouri	REGION F	http://health.mo.gov/emergencies/index.php
Missouri	REGION H	http://health.mo.gov/emergencies/index.php
Missouri	SOUTHWEST HCC	http://health.mo.gov/emergencies/index.php
Montana	MONTANA HEALTHCARE Partners	http://dphhs.mt.gov/publichealth/phep
N. Mariana Islands	THE COMMONWEALTH OF MARIANAS HEALTHCARE COALITION	http://chcc.gov.mp/

Awardee	Coalition Name	Website
Nebraska	LINCOLN METROPOLITAN MEDICAL RESPONSE SYSTEM	http://dhhs.ne.gov/Pages/emergency_preparedness.aspx
Nebraska	OMAHA METROPOLITAN MEDICAL REPONSE SYSTEM	http://dhhs.ne.gov/Pages/emergency_preparedness.aspx
Nebraska	PANHANDLE REGION MEDICAL RESPONSE SYSTEM	http://dhhs.ne.gov/Pages/emergency_preparedness.aspx
Nebraska	RURAL REGION ONE MEDICAL RESPONSE SYSTEM	http://dhhs.ne.gov/Pages/emergency_preparedness.aspx
Nebraska	SOUTHEAST NEBRASKA HEALTHCARE COALITION	http://dhhs.ne.gov/Pages/emergency_preparedness.aspx
Nebraska	TRICITIES MEDICAL RESPONSE SYSTEM	http://dhhs.ne.gov/Pages/emergency_preparedness.aspx
Nebraska	NEBRASKA PLAINS HEALTHCARE COALITION	http://dhhs.ne.gov/Pages/emergency_preparedness.aspx
Nevada	DOUGLAS COUNTY HEALTHCARE COALITION (DC HCC)	http://dpbh.nv.gov/Programs/Preparedness/
Nevada	INTER-HOSPITAL COORDINATING COUNCIL (IHCC)	http://dpbh.nv.gov/Programs/Preparedness/
Nevada	RURAL HEALTHCARE PREPAREDNESS PARTNERS (RHPP) - A sub-committee of the Nevada Hospital Association	http://dpbh.nv.gov/Programs/Preparedness/
Nevada	SOUTHERN NEVADA HEALTHCARE PREPAREDNESS COALITION (SNHPC)	http://dpbh.nv.gov/Programs/Preparedness/
New Hampshire	CAPITAL AREA PUBLIC HEALTH NETWORK	http://www.dhhs.nh.gov/esu/index.htm
New Hampshire	CARROLL COUNTY PUBLIC HEALTH NETWORK	http://www.dhhs.nh.gov/esu/index.htm
New Hampshire	GREATER DERRY PUBLIC HEALTH NETWORK	http://www.dhhs.nh.gov/esu/index.htm
New Hampshire	GREATER MANCHESTER PUBLIC HEALTH NETWORK	http://www.dhhs.nh.gov/esu/index.htm
New Hampshire	GREATER MONADNOCK PUBLIC HEALTH NETWORK	http://www.dhhs.nh.gov/esu/index.htm
New Hampshire	GREATER NASHUA PUBLIC HEALTH NETWORK	http://www.dhhs.nh.gov/esu/index.htm
New Hampshire	CENTRAL NH PUBLIC HEALTH NETWORK	http://www.dhhs.nh.gov/esu/index.htm
New Hampshire	GREATER SULLIVAN COUNTY PUBLIC HEALTH NETWORK	http://www.dhhs.nh.gov/esu/index.htm
New Hampshire	WINNIPESAUKEE PUBLIC HEALTH NETWORK	http://www.dhhs.nh.gov/esu/index.htm

Awardee	Coalition Name	Website
New Hampshire	NORTH COUNTRY PUBLIC HEALTH NETWORK	http://www.dhhs.nh.gov/esu/index.htm
New Hampshire	SEACOAST PUBLIC HEALTH NETWORK	http://www.dhhs.nh.gov/esu/index.htm
New Hampshire	STRAFFORD COUNTY PUBLIC HEALTH NETWORK	http://www.dhhs.nh.gov/esu/index.htm
New Hampshire	UPPER VALLEY PUBLIC HEALTH NETWORK	http://www.dhhs.nh.gov/esu/index.htm
New Jersey	NEW JERSEY CE REGION	http://www.state.nj.us/health/er/index.shtml
New Jersey	NEW JERSEY CW REGION	http://www.state.nj.us/health/er/index.shtml
New Jersey	NEW JERSEY NE REGION	http://www.state.nj.us/health/er/index.shtml
New Jersey	NEW JERSEY NW REGION	http://www.state.nj.us/health/er/index.shtml
New Jersey	NEW JERSEY SOUTH REGION	http://www.state.nj.us/health/er/index.shtml
New Mexico	Albuquerque Regional Coalition for Healthcare Preparedness (ARCH-P)	https://nmhealth.org/about/erd/bhem/
New Mexico	Region III - Eastern New Mexico Healthcare Coalition	https://nmhealth.org/about/erd/bhem/
New Mexico	Region I - Northern New Mexico Healthcare Coalition	https://nmhealth.org/about/erd/bhem/
New Mexico	Region II - Southern New Mexico Healthcare Coalition	https://nmhealth.org/about/erd/bhem/
New York	CAPITAL DISTRICT REGIONAL OFFICE (CDRO)	http://www.health.ny.gov/environmental/emergency/
New York	CENTRAL NEW YORK REGIONAL OFFICE (CNYRO)	http://www.health.ny.gov/environmental/emergency/
New York	METROPOLITAN AREA REGIONAL OFFICE (MARO)	http://www.health.ny.gov/environmental/emergency/
New York	WESTERN REGIONAL OFFICE (WRO)	http://www.health.ny.gov/environmental/emergency/
New York City	NEW YORK CITY HEALTH CARE COALITION	http://www1.nyc.gov/site/doh/providers/emergency-prep/hospitals.page
North Carolina	CAPITAL REGIONAL ADVISORY COMMITTEE (CAPRAC)	https://www2.ncdhhs.gov/dhsr/EMS/aspr/index.html http://nchealthcarecoalitions.org/
North Carolina	Duke Healthcare Preparedness Coalition	https://www2.ncdhhs.gov/dhsr/EMS/aspr/index.html http://nchealthcarecoalitions.org/
North Carolina	EASTERN HEALTHCARE PREPAREDNESS COALITION (EHPC)	https://www2.ncdhhs.gov/dhsr/EMS/aspr/index.html http://nchealthcarecoalitions.org/
North Carolina	METROLINA HEALTHCARE PREPAREDNESS COALITION	https://www2.ncdhhs.gov/dhsr/EMS/aspr/index.html http://nchealthcarecoalitions.org/
North Carolina	MID CAROLINA REGIONAL HEALTHCARE COALITION	https://www2.ncdhhs.gov/dhsr/EMS/aspr/index.html http://nchealthcarecoalitions.org/
North Carolina	MOUNTAIN AREA TRAUMA REGIONAL ADVISORY COMMITTEE	https://www2.ncdhhs.gov/dhsr/EMS/aspr/index.html http://nchealthcarecoalitions.org/

Awardee	Coalition Name	Website
	(MATRAC)- MISSION HOSPITAL	
North Carolina	SOUTHEASTERN REGIONAL ADVISORY COMMITTEE (SERAC)	https://www2.ncdhhs.gov/dhsr/EMS/aspr/index.html http://nchealthcarecoalitions.org/
North Carolina	TRIAD HEALTHCARE PREPAREDNESS COALITION (HPC)	https://www2.ncdhhs.gov/dhsr/EMS/aspr/index.html http://nchealthcarecoalitions.org/
North Dakota	ND HEALTH CARE Coalition	https://www.health.nd.gov/EPR/
Ohio	DISASTER PREPAREDNESS Committee	http://www.odh.ohio.gov/healthpreparedness/emergencypreparedness.aspx
Ohio	DOMESTIC PREPAREDNESS COMMITTEE	http://www.odh.ohio.gov/healthpreparedness/emergencypreparedness.aspx
Ohio	Northwest Ohio Healthcare Emergency Management Coalition	http://www.odh.ohio.gov/healthpreparedness/emergencypreparedness.aspx
Ohio	METROPOLITAN MEDICAL RESPONSE COMMITTEE	http://www.odh.ohio.gov/healthpreparedness/emergencypreparedness.aspx
Ohio	NORTHEAST CENTRAL OHIO REGIONAL STEERING COMMITTEE	http://www.odh.ohio.gov/healthpreparedness/emergencypreparedness.aspx
Ohio	Central Ohio Healthcare Coalition	http://www.odh.ohio.gov/healthpreparedness/emergencypreparedness.aspx
Ohio	SOUTHEAST OHIO HOSPITAL DISASTER PREPAREDNESS COMMITTEE	http://www.odh.ohio.gov/healthpreparedness/emergencypreparedness.aspx
Oklahoma	REGION 1 - REGIONAL MEDICAL PLANNING GROUP (RMPG)	https://www.ok.gov/health/Disease_Prevention_Preparedness/Emergency_Preparedness_and_Response/
Oklahoma	REGION 2 - REGIONAL MEDICAL PLANNING GROUP (RMPG)	https://www.ok.gov/health/Disease_Prevention_Preparedness/Emergency_Preparedness_and_Response/
Oklahoma	REGION 3 - REGIONAL MEDICAL PLANNING GROUP (RMPG)	https://www.ok.gov/health/Disease_Prevention_Preparedness/Emergency_Preparedness_and_Response/
Oklahoma	REGION 4 - REGIONAL MEDICAL PLANNING GROUP (RMPG)	https://www.ok.gov/health/Disease_Prevention_Preparedness/Emergency_Preparedness_and_Response/
Oklahoma	REGION 5 - REGIONAL MEDICAL PLANNING GROUP (RMPG)	https://www.ok.gov/health/Disease_Prevention_Preparedness/Emergency_Preparedness_and_Response/
Oklahoma	REGION 6/8 - REGIONAL MEDICAL PLANNING GROUP (RMPG)	https://www.ok.gov/health/Disease_Prevention_Preparedness/Emergency_Preparedness_and_Response/
Oklahoma	REGION 7 - REGIONAL MEDICAL PLANNING GROUP (RMPG)	https://www.ok.gov/health/Disease_Prevention_Preparedness/Emergency_Preparedness_and_Response/
Oregon	REGION 1-NORTHWEST OREGON HEALTH PREPAREDNESS ORGANIZATION	https://public.health.oregon.gov/Preparedness/Pages/index.aspx
Oregon	REGION 2 - HEALTHCARE COALITION	https://public.health.oregon.gov/Preparedness/Pages/index.aspx
Oregon	REGION 3 - HEALTHCARE COALITION	https://public.health.oregon.gov/Preparedness/Pages/index.aspx
Oregon	REGION 5 - HEALTHCARE COALITION	https://public.health.oregon.gov/Preparedness/Pages/index.aspx

Awardee	Coalition Name	Website
Oregon	REGION 6 - HEALTHCARE COALITION	https://public.health.oregon.gov/Preparedness/Pages/index.aspx
Oregon	REGION 7 - HEALTHCARE COALITION	https://public.health.oregon.gov/Preparedness/Pages/index.aspx
Oregon	REGION 9 - HEALTHCARE COALITION	https://public.health.oregon.gov/Preparedness/Pages/index.aspx
Palau	EMERGENCY PREPAREDNESS COALITION	http://www.palauhealth.org/default.aspx
Pennsylvania	EAST CENTRAL COALITION	http://www.health.pa.gov/My%20Health/Emergency%20Preparedness/Pages/Health-Care-Coalition-HCC-Preparedness.aspx#.WWYlyKPD-M_
Pennsylvania	NORTH CENTRAL COALITION	http://www.health.pa.gov/My%20Health/Emergency%20Preparedness/Pages/Health-Care-Coalition-HCC-Preparedness.aspx#.WWYlyKPD-M_
Pennsylvania	NORTH EAST COALITION	http://www.health.pa.gov/My%20Health/Emergency%20Preparedness/Pages/Health-Care-Coalition-HCC-Preparedness.aspx#.WWYlyKPD-M_
Pennsylvania	NORTH WEST CENTRAL COALITION	http://www.health.pa.gov/My%20Health/Emergency%20Preparedness/Pages/Health-Care-Coalition-HCC-Preparedness.aspx#.WWYlyKPD-M_
Pennsylvania	NORTH WEST COALITION	http://www.health.pa.gov/My%20Health/Emergency%20Preparedness/Pages/Health-Care-Coalition-HCC-Preparedness.aspx#.WWYlyKPD-M_
Pennsylvania	SOUTH CENTRAL COALITION	http://www.health.pa.gov/My%20Health/Emergency%20Preparedness/Pages/Health-Care-Coalition-HCC-Preparedness.aspx#.WWYlyKPD-M_
Pennsylvania	SOUTH CENTRAL MOUNTAIN COALITION	http://www.health.pa.gov/My%20Health/Emergency%20Preparedness/Pages/Health-Care-Coalition-HCC-Preparedness.aspx#.WWYlyKPD-M_
Pennsylvania	SOUTH EAST COALITION	http://www.health.pa.gov/My%20Health/Emergency%20Preparedness/Pages/Health-Care-Coalition-HCC-Preparedness.aspx#.WWYlyKPD-M_
Pennsylvania	SOUTH WEST COALITION	http://www.health.pa.gov/My%20Health/Emergency%20Preparedness/Pages/Health-Care-Coalition-HCC-Preparedness.aspx#.WWYlyKPD-M_
Puerto Rico	CAGUAS HCC (DAVID SANTOS)	www.salud.gov.pre
Puerto Rico	MAYAGUEZ/ AGUADILLA HCC (CLAUDIA DE FERIA)	www.salud.gov.pre
Puerto Rico	FAJARDO HCC (DAVID SANTOS)	www.salud.gov.pre
Puerto Rico	METRO HCC (MARI A. LAGO)	www.salud.gov.pre
Puerto Rico	BAYAMON HCC (DAVID SANTOS)	www.salud.gov.pre
Puerto Rico	ARECIBO HCC (CLAUDIA DE FERIA)	www.salud.gov.pre
Puerto Rico	PONCE HCC (MARI A. LAGO)	www.salud.gov.pre
Rhode Island	THE HEALTHCARE COALITION OF RHODE ISLAND	http://www.health.ri.gov/emergency/

Awardee	Coalition Name	Website
South Carolina	SOUTH CAROLINA UPSTATE REGION HEALTHCARE COALITION	http://www.scdhec.gov/HomeAndEnvironment/DisasterPreparedness/
South Carolina	SOUTH CAROLINA MIDLANDS REGION HEALTHCARE COALITION	http://www.scdhec.gov/HomeAndEnvironment/DisasterPreparedness/
South Carolina	SOUTH CAROLIN PEE DEE INLAND HEALTHCARE COALITION	http://www.scdhec.gov/HomeAndEnvironment/DisasterPreparedness/
South Carolina	SOUTH CAROLINA PEE DEE COASTAL HEALTHCARE COALITION	http://www.scdhec.gov/HomeAndEnvironment/DisasterPreparedness/
South Carolina	SOUTH CAROLINA LOWCOUNTRY REGION HEALTHCARE COALITION	http://www.scdhec.gov/HomeAndEnvironment/DisasterPreparedness/
South Dakota	SOUTH DAKOTA REGION 1	http://doh.sd.gov/providers/preparedness/
South Dakota	SOUTH DAKOTA REGION 2	http://doh.sd.gov/providers/preparedness/
South Dakota	SOUTH DAKOTA REGION 3	http://doh.sd.gov/providers/preparedness/
South Dakota	SOUTH DAKOTA REGION 4	http://doh.sd.gov/providers/preparedness/
Tennessee	Knox/East Tennessee Healthcare Coalition	http://tn.gov/health/topic/cedep-emergency-preparedness
Tennessee	Upper Cumberland Healthcare Preparedness Coalition	http://tn.gov/health/topic/cedep-emergency-preparedness
Tennessee	Region 7 Healthcare Coalition	http://tn.gov/health/topic/cedep-emergency-preparedness
Tennessee	Northeast/Sullivan Healthcare Coalition	http://tn.gov/health/topic/cedep-emergency-preparedness
Tennessee	South Central Region Healthcare Coalition	http://tn.gov/health/topic/cedep-emergency-preparedness
Tennessee	Southeast/Hamilton Regional Healthcare Coalition	http://tn.gov/health/topic/cedep-emergency-preparedness
Tennessee	Mid South Healthcare Coalition	http://tn.gov/health/topic/cedep-emergency-preparedness
Tennessee	Tennessee Highland Rim Healthcare Coalition	http://tn.gov/health/topic/cedep-emergency-preparedness
Texas	ABILENE TSA	http://dshs.texas.gov/preparedness/e-prep_public.shtm
Texas	BRYAN/COLLEGE STATION TSA	http://dshs.texas.gov/preparedness/e-prep_public.shtm
Texas	CAPITAL AREA TSA	http://dshs.texas.gov/preparedness/e-prep_public.shtm
Texas	CENTRAL TEXASTSA	http://dshs.texas.gov/preparedness/e-prep_public.shtm
Texas	COASTAL BEND TSA	http://dshs.texas.gov/preparedness/e-prep_public.shtm
Texas	CONCHO VALLEY TSA	http://dshs.texas.gov/preparedness/e-prep_public.shtm
Texas	DEEP EAST TEXAS TSA	http://dshs.texas.gov/preparedness/e-prep_public.shtm
Texas	EAST TEXAS GULF COAST TSA	http://dshs.texas.gov/preparedness/e-prep_public.shtm
Texas	FAR WEST TEXAS & SOUTHERN NEW MEXICO TSA	http://dshs.texas.gov/preparedness/e-prep_public.shtm
Texas	GOLDEN CRESCENT TSA	http://dshs.texas.gov/preparedness/e-prep_public.shtm

Awardee	Coalition Name	Website
Texas	HEART OF TEXAS TSA	http://dshs.texas.gov/preparedness/e-prep_public.shtm
Texas	HOSPITAL PREPAREDNESS COUNCIL OF NORTH TEXAS	http://dshs.texas.gov/preparedness/e-prep_public.shtm
Texas	LAREDO TSA	http://dshs.texas.gov/preparedness/e-prep_public.shtm
Texas	LOWER RIO GRANDE VALLEY TSA	http://dshs.texas.gov/preparedness/e-prep_public.shtm
Texas	LUBBOCK TSA	http://dshs.texas.gov/preparedness/e-prep_public.shtm
Texas	MIDLAND/ODESSA TSA	http://dshs.texas.gov/preparedness/e-prep_public.shtm
Texas	NORTH CENTRAL TEXAS TSA	http://dshs.texas.gov/preparedness/e-prep_public.shtm
Texas	NORTHEAST TEXAS TSA	http://dshs.texas.gov/preparedness/e-prep_public.shtm
Texas	PANHANDLE TSA	http://dshs.texas.gov/preparedness/e-prep_public.shtm
Texas	PINEY WOODS TSA	http://dshs.texas.gov/preparedness/e-prep_public.shtm
Texas	SOUTHEAST TEXAS TSA	http://dshs.texas.gov/preparedness/e-prep_public.shtm
Texas	SOUTHWEST TEXAS TSA	http://dshs.texas.gov/preparedness/e-prep_public.shtm
Utah	CENTRAL REGION HEALTHCARE COALITION	http://health.utah.gov/preparedness/
Utah	HEALTHCARE PREPAREDNESS COALITION OF UTAH/WASATCH COUNTIES	http://health.utah.gov/preparedness/
Utah	NORTHERN UTAH HEALTHCARE COALITION	http://health.utah.gov/preparedness/
Utah	SALT LAKE, SUMMIT, AND TOOELE HEALTHCARE PREPAREDNESS COALITION	http://health.utah.gov/preparedness/
Utah	SOUTHEASTERN UTAH HEALTHCARE PREPAREDNESS COALITION	http://health.utah.gov/preparedness/
Utah	SOUTHWEST UTAH HEALTHCARE PREPAREDNESS COALITION	http://health.utah.gov/preparedness/
Utah	UINTAH BASIN REGION HEALTHCARE PREPAREDNESS COALITION	http://health.utah.gov/preparedness/
Vermont	VERMONT HOSPITAL EMERGENCY PREPAREDNESS COMMITTEE (VHEPC)	http://www.healthvermont.gov/e_ready.aspx
Virgin Islands	USVI– HPP HEALTHCARE COALITION	Http://doh.vi.gov
Virginia	CENTRAL VIRGINIA HEALTHCARE COALITION	http://www.vdh.virginia.gov/OEP/
Virginia	EASTERN REGION HEALTHCARE	http://www.vdh.virginia.gov/OEP/

Awardee	Coalition Name	Website
	PREPAREDNESS COORDINATING GROUP	
Virginia	FAR SOUTHWEST REGION HEALTHCARE PREPAREDNESS COORDINATING GROUP	http://www.vdh.virginia.gov/OEP/
Virginia	NEAR SOUTHWEST REGION HEALTHCARE PREPAREDNESS COORDINATING GROUP	http://www.vdh.virginia.gov/OEP/
Virginia	Northern Virginia Hospital Alliance (NVHA)	http://www.vdh.virginia.gov/OEP/
Virginia	NORTHWEST REGION HEALTHCARE PREPAREDNESS COORDINATING GROUP	http://www.vdh.virginia.gov/OEP/
Washington	REGION 1 HEALTHCARE COALITION – ISLAND SAN JUAN; SKAGIT; SNOHOMISH; WHATCOM COUNTIES	http://www.doh.wa.gov/AboutUs/PublicHealthSystem/RegionalHealthcareCoalitionLeads
Washington	REGION 2 HEALTHCARE COALITION – CLALLAM; JEFFERSON; KITSAP COUNTIES	http://www.doh.wa.gov/AboutUs/PublicHealthSystem/RegionalHealthcareCoalitionLeads
Washington	REGION 3 HEALTHCARE COALITION – GRAYS HARBOR; LEWIS; MASON; PACIFIC; THURSTON COUNTIES	http://www.doh.wa.gov/AboutUs/PublicHealthSystem/RegionalHealthcareCoalitionLeads
Washington	REGION 4 HEALTHCARE COALITION – CLARK; COWLITZ; SKAMANIA; WAHKIAKUM COUNTIES	http://www.doh.wa.gov/AboutUs/PublicHealthSystem/RegionalHealthcareCoalitionLeads
Washington	REGION 5-6 HEALTHCARE COALITION – KING COUNTY	http://www.doh.wa.gov/AboutUs/PublicHealthSystem/RegionalHealthcareCoalitionLeads
Washington	REGION 7 HEALTHCARE COALITION – CHELAN; DOUGLAS; GRANT; KITTITAS; OKANOGAN COUNTIES	http://www.doh.wa.gov/AboutUs/PublicHealthSystem/RegionalHealthcareCoalitionLeads
Washington	REGION 8 HEALTHCARE SYSTEMS COALITION – BENTON; FRANKLIN; KLICKITAT; WALLA WALLA; YAKIMA COUNTIES	http://www.doh.wa.gov/AboutUs/PublicHealthSystem/RegionalHealthcareCoalitionLeads
Washington	REGION 9 HEALTHCARE COALITION – ADAMS; ASOTIN; COLUMBIA; FERRY; GARFIELD; LINCOLN; PEND OREILLE; SPOKANE; STEVENS; WHITMAN COUNTIES	http://www.doh.wa.gov/AboutUs/PublicHealthSystem/RegionalHealthcareCoalitionLeads
West Virginia	REGION 1 WV HOSPITAL ASSOCIATION REGION	http://www.dhhr.wv.gov/healthprep/programs/publichealth/Pages/default.aspx
West Virginia	REGION 10/11 WV HOSPITAL ASSOCIATION REGION	http://www.dhhr.wv.gov/healthprep/programs/publichealth/Pages/default.aspx
West Virginia	REGION 2 WV HOSPITAL ASSOCIATION REGION	http://www.dhhr.wv.gov/healthprep/programs/publichealth/Pages/default.aspx

Awardee	Coalition Name	Website
West Virginia	REGION 3/4 WEST- WV HOSPITAL ASSOCIATION REGION/REGION 3/4 EAST - H.A. REGION	http://www.dhhr.wv.gov/healthprep/programs/publichealth/Pages/default.aspx
West Virginia	REGION 5 MEDICAL SURGE CAPACITY COUNCIL	http://www.dhhr.wv.gov/healthprep/programs/publichealth/Pages/default.aspx
West Virginia	REGION 5 WV HOSPITAL ASSOCIATION REGION	http://www.dhhr.wv.gov/healthprep/programs/publichealth/Pages/default.aspx
West Virginia	REGION 6/7 WV HOSPITAL ASSOCIATION REGION	http://www.dhhr.wv.gov/healthprep/programs/publichealth/Pages/default.aspx
West Virginia	REGION 8/9 WV HOSPITAL ASSOCIATION REGION	http://www.dhhr.wv.gov/healthprep/programs/publichealth/Pages/default.aspx
Wisconsin	WHEPP LEADERSHIP (STATEWIDE COALITION)	https://www.dhs.wisconsin.gov/preparedness/index.htm
Wisconsin	WISCONSIN REGION 1 COALITION	https://www.dhs.wisconsin.gov/preparedness/index.htm
Wisconsin	WISCONSIN REGION 2 COALITION	https://www.dhs.wisconsin.gov/preparedness/index.htm
Wisconsin	WISCONSIN REGION 3 COALITION	https://www.dhs.wisconsin.gov/preparedness/index.htm
Wisconsin	WISCONSIN REGION 4 COALITION	https://www.dhs.wisconsin.gov/preparedness/index.htm
Wisconsin	WISCONSIN REGION 5 COALITION	https://www.dhs.wisconsin.gov/preparedness/index.htm
Wisconsin	WISCONSIN REGION 6 COALITION	https://www.dhs.wisconsin.gov/preparedness/index.htm
Wisconsin	WISCONSIN REGION 7 COALITION	https://www.dhs.wisconsin.gov/preparedness/index.htm
Wyoming	REGION 1	https://health.wyo.gov/publichealth/preparedness/
Wyoming	REGION 2	https://health.wyo.gov/publichealth/preparedness/
Wyoming	REGION 3	https://health.wyo.gov/publichealth/preparedness/
Wyoming	REGION 4	https://health.wyo.gov/publichealth/preparedness/
Wyoming	REGION 5	https://health.wyo.gov/publichealth/preparedness/

PATHWAY HEALTH
Insight | Expertise | Knowledge

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Facility Assessment Worksheet Summary
Facility and Community Risk

Facility and Community Risk: _____

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Community Risk: _____

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Emergency Prep Plan: _____

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Facility Assessment: Resources – Physical Plant and Equipment

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Facility Assessment: Resources - Physical Plant and Equipment

Reference F Tag

F838 §483.70(e) 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 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. The facility assessment must address or include:
§483.70(e)(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 considering the types of diseases, conditions, physical and cognitive disabilities, overall acuity, and other pertinent facts that are present within that population;
(iii) The staff competencies 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.
§483.70(e)(2) The facility's resources, including but not limited to,
(i) All buildings and/or other physical structures and vehicles;
(ii) Equipment (medical and non- medical);
(iii) Services provided, such as physical therapy, pharmacy, and specific rehabilitation therapies;
(iv) All personnel, including managers, 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, memorandums 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.
§483.70(e)(3) A facility-based and community-based risk assessment, utilizing an all-hazards approach.

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INTENT OF THE RESOURCES - PHYSICAL PLANT AND EQUIPMENT

Long term care facilities strive to create safe, secure and positive environments to support resident care, health and welfare on a daily basis. The intent of the Physical Plant and Equipment resources elements in the facility assessment requirements is to address or include and evaluate the physical environment, equipment (medical and non-medical), services and other physical plant considerations that are necessary to care for our population every day and during emergencies.

When conducting the assessment, the facility must include or address the facility's resources which include but are not limited to:

- The facility's operating budget
- Supplies
- Equipment (medical and non-medical)
- Other services necessary to provide for the needs of residents *(See Third Party Agreement and Other Services Section of **The RoP Facility Assessment Toolkit ©**)*

Additionally, the facility assessment must include an evaluation of the physical environment necessary to meet the needs of the residents.

- This must include an evaluation of how the facility is equipped and maintained to protect and promote the health and safety of residents.
- This should also include an evaluation of building maintenance capital improvements, or structures, vehicles, or medical and non-medical equipment and supplies.

RESOURCES - PHYSICAL PLANT AND EQUIPMENT PROCESS

Evaluating the facility's physical plant, equipment (medical and non-medical), supplies and supporting maintenance process and financial processes (operating budget and capital improvements) is a means for a facility to gather information that can be reviewed and interpreted to make decisions regarding: resource needs, physical plant needs, capital needs, and improvement needs which correlate with the facility assessment findings. The following depicts a process to evaluate physical plant and equipment resources utilizing the facility Quality Assurance and Performance Improvement process.

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1. **Team**
    a. Assemble a team, overseen by facility administration
    b. Determine a team member to serve as the lead to address or include and evaluate the physical environment, equipment (medical and non-medical), and other physical plant considerations per the facility assessment requirements
        i. Determine applicable team members to assist with the process
        ii. Divide into two or three sub-teams to complete the evaluation of:
            1. Physical plant, buildings and vehicles
            2. Equipment and Supplies – Medical
            3. Equipment and Supplies – Nonmedical
        iii. Example of areas/items to address for the facility assessment –*(Source: Quality Improvement Organization – Facility Assessment Tool*

Physical Resource Category	Resources – Examples	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	
Other physical plant needs	Sliding doors, ADA compliant entry/exit ways, nourishment accessibility, nurse call system, emergency power, alarm systems – wander alerts	

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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	
Non-medical supplies (if applicable)	Soaps, body cleansing products, incontinence supplies, waste baskets, bed and bath linens, individual communication devices, computers	

2. **Tool**
    a. Determine and review the data collection tools needed to collect the applicable data for each area identified
    b. Review the purpose and intent of this process and how to complete the tools with the applicable teams
    c. Set timelines for completion

3. **Complete**
    a. Conduct the data collection process
        i. Remember to use internal resources to gather and verify data and inventory, such as:
            1. Preventative maintenance program
            2. Equipment inventory
            3. Equipment management plans with inventory
            4. Facility par levels for supplies and equipment
            5. Partner vendors may have par levels and inventories with records of purchasing/trends
            6. Emergency Preparedness Plan
            7. Hazard Vulnerability Assessments (HVAs)
            8. Safety Plan

4. **Review**
    a. Review and analyze the findings of the data
    b. Summarize the findings with the Team

5. **Identify**
    a. Determine trends, if identified, of potential vulnerabilities and improvement opportunities
    b. Summarize the findings with the team

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c. Determine and implement applicable actions related to the physical plant, supplies and equipment evaluation as it relates to the resident population care and service needs

6. **Facility Assessment**
   a. Incorporate findings into the applicable sections of the written narrative Facility Assessment.
      i. Findings should be integrated and compatible with the Facility Assessment and correlating internal programs (i.e. preventative maintenance, equipment management, vendor supply software, etc.)
   b. Utilize the QAPI process

HOW TO INCORPORATE INTO THE FACILITY ASSESSMENT

Per **§483.70(e), t**he facility assessment must include or address an evaluation of the facility's resources related to physical plant, equipment, supplies and other considerations as indicated in the requirements. Therefore, it is important to:

- Gather the outcomes data related to:
  - Physical plant, buildings and vehicles
  - Equipment and Supplies – Medical
  - Equipment and Supplies – Nonmedical
- Use the information to answer the questions:
  - How did the facility determine what equipment, supplies, and physical environment would be required to meet all resident needs?
  - Can we describe our physical plant layout, lay out of our building, any other physical structures and vehicles
  - What types of equipment do we have or need to care for our resident population?
  - Have we conducted a physical inventory of our _____?
  - Do we have enough equipment and is our equipment in good repair to care for our resident population? (i.e. lifts, slings,
  - What types of services do we obtain, provide or access to care for our resident population?
  - Are there any other physical plant considerations (i.e. small therapy gym however not a private space to provide speech therapy,
  - Do we have adequate areas to provide activities and a meaningful dining experience?
  - Do we have an effective Preventative Maintenance Program? (i.e. detailed which includes equipment management program, work order communication and documentation of PMP process)

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- Incorporate your processes into your QAPI plan
- Monitor the facility assessment annually or upon a change in the facility's operation that would require a substantial modification in the assessment and adjust the facility training plan accordingly.
- Write a narrative description of the facility's training evaluation process for inclusion, see below, into the narrative Facility Assessment. See the Facility Assessment Template.
- List (or refer to or provide a link to inventory) physical resources. 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.

See the Facility Assessment Template SAMPLE related to the inclusion of the necessary information obtained via this process for the completion of the Facility Assessment.

References

State Operations Manual (SOM) Appendix PP for Phase 2, F-Tag Revisions, and Related Issues
www.cms.gov/Medicare/Provider-Enrollment-and-Certification/GuidanceforLawsAndRegulations/Downloads/Advance-Appendix-PP-Including-Phase-2-.pdf

Quality Improvement Organizations, Facility Assessment Tool (2017) http://qioprogram.org/facility-assessment-tool

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Data Collection Tools and/or Resources

The following Tools and Resources are included in this Section of **The RoP Facility Assessment Toolkit ©**

Item	Description	Source *(If Applicable)*
Physical Plant Equipment Supplies and Other Services Worksheet	Sample Template – With instructions to complete the evaluation or inventory of resources related to physical plant, equipment, supplies and other considerations as indicated in the requirements.	Pathway Health
Facility Assessment Summary Worksheets	Worksheets designed for team to summarize findings and plan for written narrative portion of the facility Assessment	Pathway Health

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Resources: Physical Plant, Supplies, Medical and Non-Medical Equipment, Other Services

Physical Resource Category (indicate below)	Location or Department	Item	Quantity	Ownership	Supplier	Maintained By	Overall Status	Process in Place to Maintain Supply	Comments
B=Buildings **O**=Other Structures' **V**=Vehicles **P**=Physical Equipment **S**=Services **OP**=Other Physical Plant Needs **M**=Medical Supplies **NM**=Non-Medical Supplies	Indicate Below	Type or Name	Total	R=Rented L=Leased O= Owned	Name of Vendor	F=Facility V=Vendor	G=Good Repair R=Replacement	D= Day to Day E=Emergency B=Both	

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	
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	
Non-medical supplies (if applicable)	Soaps, body cleansing products, incontinence supplies, waste baskets, bed and bath linens, individual communication devices, computers	

Source: QIO Facility Assesement Tool Template

Other

3.9. 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.

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.

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Facility Assessment Worksheet Summary
Physical Plant

Building Structures/Vehicles: _____

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Floor Plans: _____

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Preventive Maintenance Plan: _____

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Facility Assessment Worksheet Summary
Equipment Summary

Medical Equipment: _____

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Non-Medical Equipment: _____

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Summary: _____

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Facility Assessment Worksheet Summary
Other Services

Resident Direct Care: _____

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Non-Direct Care: _____

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Summary: _____

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Facility Assessment: Health Information Technology

Facility Assessment: Health Information Technology

Reference F Tag

F838 §483.70(e) 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 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. The facility assessment must address or include:

§483.70(e)(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 considering the types of diseases, conditions, physical and cognitive disabilities, overall acuity, and other pertinent facts that are present within that population;
- (iii) The staff competencies 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.

§483.70(e)(2) The facility's resources, including but not limited to,
- (i) All buildings and/or other physical structures and vehicles;
- (ii) Equipment (medical and non- medical);
- (iii) Services provided, such as physical therapy, pharmacy, and specific rehabilitation therapies;
- (iv) All personnel, including managers, 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, memorandums 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.

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§483.70(e)(3) A facility-based and community-based risk assessment, utilizing an all-hazards approach.

The facility's health information technology resources, such as systems for electronically managing patient records and electronically sharing information with other organizations.

- The types of systems are used to manage resident health information
- 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

INTENT OF THE HEALTH INFORMATION TECHNOLOGY SECTION

The intent of the health information technology section of the facility assessment is for the facility to evaluate its health information technology resources to ensure that resident protected health information is managed in a secure environment and how the facility will transfer health information to other providers utilizing health information exchange.

How Health Information is Managed

A nursing home may utilize several different types of technology to manage health information. Besides the electronic health record there may be other systems used such as point of care documentation software for documenting activities of daily living, billing software, risk management software, pharmacy software for drug regimen review, referral management software, skin and wound care software, therapy services software, MDS/RAI software and others.

Consider that the Facility Assessment is designed to guide us in an evaluation of the facility needs as they relate to the health information technology resources available at the facility and what resources the facility is lacking or may need to obtain.

PROCESS: DETERMINE AND IDENTIFY HEALTH INFORMATION TECHNOLOGY RESOURCES

1. Review the facility inventory to identify the facility resources for health information technology.

2. List the health information technology resources on the data collection tool.
    a. Example: systems for electronically managing patient records and electronically sharing information with other organizations.
    b. Remember to correlate the technology list with the facility Emergency Preparedness Plan
3. Write a narrative description of your electronic health record system.

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4. Describe any other types of software used to manage resident health information. 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.

5. Write a narrative description of the facility's health information exchange program if utilized, adding information on HIPAA security policies, software and hardware testing that has been completed to ensure a secure environment.

HOW TO INCORPORATE INTO THE FACILITY ASSESSMENT

Per **§483.70(e), t**he facility assessment must include or address an evaluation of the facility's health information technology resources as indicated in the requirements. Therefore, it is important to:

- Gather the necessary information as indicated above
- Use the information to answer the questions:
  - How do we manage patient records in our organization such as what type of electronic health record software do we use?
  - Are we paper, electronic or a combination of both?
  - If we participate in HIE, what is our system for electronically sharing HI with other organizations?
- Incorporate your processes into your QAPI plan
- Monitor the facility assessment annually or upon a change in the facility's operation that would require a substantial modification in the assessment and adjust the facility training plan accordingly.
- Write a narrative description of the facility's health information technology resources for inclusion, see below, into the narrative Facility Assessment. See the Facility Assessment Template.

See the Facility Assessment Template SAMPLE related to the inclusion of the necessary information obtained via this process for the completion of the Facility Assessment.

References

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www.cms.gov/Medicare/Provider-Enrollment-and-Certification/GuidanceforLawsAndRegulations/Downloads/Advance-Appendix-PP-Including-Phase-2-.pdf

CMS – EHR Incentive Programs
https://www.cms.gov/Regulations-and-Guidance/Legislation/EHRIncentivePrograms/2016ProgramRequirements.html

HIPAA Security Rule
https://www.hhs.gov/hipaa/for-professionals/security/laws-regulations/index.html

Guide to Reducing Unintended Consequences of Electronic Health Records
https://www.healthit.gov/unintended-consequences/

Quality Improvement Organizations, Facility Assessment Tool (2017),
http://qioprogram.org/facility-assessment-tool

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Data Collection Tools and/or Resources

The following Tools and Resources are included in this Section of **The RoP Facility Assessment Toolkit ©**

Item	Description	Source *(If Applicable)*
HIT Evaluation Worksheet	A template worksheet to assist the facility in inventorying their HIT and the required elements for the facility assessment	Pathway Health
Sample HIT/EHR Policy and Procedure	A sample policy and procedure for the electronic health record – including HIPAA, security information and requirements. Customizable for facility use	Pathway Health
Facility Assessment Summary Worksheet	Template for team to use to summary findings and prepare for narrative Facility Assessment inclusion	Pathway Heath

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Health Information Technology
Resource and Evaluation

HIT Software	Provider	Use of Software

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Applicable Use					
Daily	Emergency	Security Protcols HIPAA HITECH	Inter - operability	Back Up System	P&P Updated

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Comments/Actions

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Facility Assessment Worksheet Summary
Health Information Technology

Current HIT: _____

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Back-Up Systems: _____

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Policies: _____

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Facility Assessment: Third Party Agreements, Memorandum of Understanding, Contracts And Other Services

Facility Assessment: Contracts, Third Party Agreements, Memorandums of Understanding and Other Services

Reference F Tag

F838 §483.70(e) 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 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. The facility assessment must address or include:

§483.70(e)(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 considering the types of diseases, conditions, physical and cognitive disabilities, overall acuity, and other pertinent facts that are present within that population;
- (iii) The staff competencies 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.

§483.70(e)(2) The facility's resources, including but not limited to,
- (i) All buildings and/or other physical structures and vehicles;
- (ii) Equipment (medical and non- medical);
- (iii) Services provided, such as physical therapy, pharmacy, and specific rehabilitation therapies;
- (iv) All personnel, including managers, 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, memorandums 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.

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§483.70(e)(3) A facility-based and community-based risk assessment, utilizing an all-hazards approach.

Guidance
The assessment must include or address the facility's resources which include but are not limited to a facility's operating budget, supplies, equipment or other services necessary to provide for the needs of residents

The facility assessment must include an evaluation of any contracts, memorandums of understanding including third party agreements for the provision of goods, services or equipment to the facility during both normal operations and emergencies. The facility assessment must address their process for overseeing these services and how those services will meet resident needs and regulatory, operational, maintenance, and staff training requirements.

> For example, if the facility contracts for language translation, the assessment must address how those contractors will ensure services are provided both during normal operational hours and during emergencies.

INTENT OF THIRD PARTY AGREEMENT, CONTRACT, MOU

The intent of the third party agreement, contract or memorandums of understanding evaluation is to address the provision of goods, services, or equipment to the facility during both normal operations and emergencies.

THIRD PARTY AGREEMENT, CONTRACTS AND MEMORANDUMS OF UNDERSTANDING PROCESS AND OTHER SERVICES

Evaluating the facility's contracts, third party agreements and memorandums of understanding for the provision of goods, services or equipment to the facility during both normal operations and emergencies is a required element for the successful completion of the facility assessment. This process will include a review of said agreements from multiple departments within the organization. Based upon the assessment, the resource and service gaps can be addressed through the facility's Quality Assurance and Performance Improvement process.

The following process and corresponding data collection tools are recommended for the completion of the Third Party Agreement, Contracts and Memorandums of Understanding element of the facility assessment:

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1. **Team**
    a. Assemble a team, underneath the direction of the facility Administrator
    b. Identify specific team members to gather the applicable information

2. **Tool**
    a. Determine the documentation tool for the evaluation review
        i. Include:
            1. Service provider name
            2. Type of service provided
            3. Day to day provision
            4. Emergency provision
            5. Date of renewal
            6. Business Associates Agreement in place
            7. Evaluate that the agreement includes language of the provision of qualified staff, competency, etc. as applicable - which is a way to indicate that they provider will provide qualified and competent staff

3. **Complete**
    a. Complete the review all agreements, MOUs, contracts – including those for other services across all departments
    b. Suggested areas for review include:
        i. Medical Director
        ii. Management Agreement/Governing Body
        iii. Pharmacy
        iv. IV
        v. Beds
        vi. Therapy
        vii. Laboratory
        viii. Radiology
        ix. Dental
        x. Podiatry
        xi. Optometrists
        xii. Audiology
        xiii. Temporary Agency Staff
        xiv. Medical Supplies
        xv. Equipment
        xvi. Specialty devices(beds, devices, etc)
        xvii. Oxygen, Respiratory
        xviii. Food and Nutrition
        xix. Dietitian

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xx. Wound Consultation
xxi. Waste management
xxii. Hazardous waste
xxiii. Telephone
xxiv. Transfer Agreements
xxv. Hospice
xxvi. Home Care
xxvii. Software
xxviii. Technology
xxix. Wander alarm system
xxx. Resident Call system
xxxi. Emergency services (water, waste, medical waste, etc)
xxxii. Religious
xxxiii. Maintenance agreements – (elevator, boiler, fire suppression system, etc)
xxxiv. Lawn care, snow removal
xxxv. Transportation companies
xxxvi. Water contingency
xxxvii. HVAC
xxxviii. Accounting
xxxix. Payroll
xl. Learning Management System
xli. Security
xlii. Dialysis
xliii. Pest Control
xliv. Barber/beauty
xlv. Religious
xlvi. Activity therapy
xlvii. Massage therapy
xlviii. Café or other store arrangements

4. **Review**
    a. Review and analyze the findings with the team
    b. Summarize the findings with the team
    c. Focus on areas of potential vulnerabilities and the appropriate actions for improvement

5. **Identify**
    a. Determine trends, if identified, of potential vulnerabilities and improvement opportunities
    b. Summarize the findings and actions with the team

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c. Determine and implement applicable actions related to the third party agreement, contract or memorandums of understanding evaluation is to address the provision of goods, services, or equipment to the facility during both normal operations and emergencies as it relates to the resident population care and service needs

6. **Facility Assessment**
   a. Incorporate findings into the applicable sections of the written narrative Facility Assessment.
      i. Findings should be integrated and compatible with the Facility Assessment and correlating internal programs (i.e. preventative maintenance, equipment management, vendor supply software, emergency preparedness, safety plan, staffing plan etc.)
   b. Utilize the QAPI process

HOW TO INCORPORATE INTO THE FACILITY ASSESSMENT

Per **§483.70(e), t**he facility assessment must include or address an evaluation of the facility's third party agreement, contract or memorandums of understanding evaluation, the provision of goods, services, or equipment to the facility during both normal operations and emergencies as it relates to the resident population care and service needs as indicated in the requirements.

Therefore, it is important to:

- Gather the necessary information as indicated above
- Use the information to answer the questions:
- How did the facility determine what equipment, supplies, and physical environment would be required to meet all resident needs?
  - What are the major services that we provide to residents
    - Any time someone is in contact with a residents – beauty shop, religious,
  - Do our agreements include language that they will provide personnel to provide the services with appropriate credentials or licensure
  - Do our agreements state that the services are provided day to day, in emergencies or both?
  - Do our agreements have breach of contract language and indemnification
  - Do we have Business Associate Agreements to protect resident health information
  - Do you have a plan or a process to handle a breach of contract?
  - Do we have a process to review our agreements via a process?
- Incorporate your processes into your QAPI plan

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- Monitor the facility assessment annually or upon a change in the facility's operation that would require a substantial modification in the assessment and adjust the facility training plan accordingly.
- Write a narrative description of the facility's third party agreements, contract, memorandum of understandings or other services, see below, into the narrative Facility Assessment. Refer to the 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 the facility process for overseeing these services and how those services will meet resident needs and regulatory, operational, maintenance, and staff training requirements.

- See the Facility Assessment Template.

See the Facility Assessment Template SAMPLE related to the inclusion of the necessary information obtained via this process for the completion of the Facility Assessment.

References

State Operations Manual (SOM) Appendix PP for Phase 2, F-Tag Revisions, and Related Issues
www.cms.gov/Medicare/Provider-Enrollment-and-Certification/GuidanceforLawsAndRegulations/Downloads/Advance-Appendix-PP-Including-Phase-2-.pdf

Quality Improvement Organizations, Facility Assessment Tool (2017), http://qioprogram.org/facility-assessment-tool

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Data Collection Tools and/or Resources

The following Tools and Resources are included in this Section of **The RoP Facility Assessment Toolkit ©**

Item	Description	Source *(If Applicable)*
Third Party Agreement, et.al Evaluation Worksheet	This template will assist the facility in identifying and evaluating third party agreements, contracts, MOUs addressing the provision of goods, services, or equipment to the facility during both normal operations and emergencies	Pathway Health
Facility Assessment Summary Worksheet	Template for team to use to summary findings and prepare for narrative Facility Assessment inclusion	Pathway Heath

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Third Party Agreements

Contracts, memorandum of understanding, letters of agreement for the provision of goods, services or equipment

Service Provider Name	Type of Services	Day to Day	Emergency	Date of Renewal	BAA	Services Meet Resident Needs and Regulatory Requirements

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Facility Assessment Worksheet Summary
Third Party Agreements

Who You Contract With: _____

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Agreements in Place: _____

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Training: _____

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Facility Assessment: Quality Assurance Performance Improvement

Facility Assessment: QAPI Integration

Reference F Tags

F838
§483.70(e) 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 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. The facility assessment must address or include:

§483.70(e)(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 considering the types of diseases, conditions, physical and cognitive disabilities, overall acuity, and other pertinent facts that are present within that population;
(iii) The staff competencies 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.

§483.70(e)(2) The facility's resources, including but not limited to,

(i) All buildings and/or other physical structures and vehicles;
(ii) Equipment (medical and non-medical);
(iii) Services provided, such as physical therapy, pharmacy, and specific rehabilitation therapies;
(iv) All personnel, including managers, 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, memorandums 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.

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§483.70(e)(3) A facility-based and community-based risk assessment, utilizing an all-hazards approach.

INTENT §483.70(e)
The intent of the facility assessment is for the facility to evaluate its resident population and identify the resources needed to provide the necessary care and services the residents require.

F865
§483.75(a) Quality assurance and performance improvement (QAPI) program. [§483.75 and all subparts will be implemented beginning November 28, 2019 (Phase 3), unless otherwise specified] Each LTC facility, including a facility that is part of a multiunit chain, must develop, implement, and maintain an effective, comprehensive, data-driven QAPI program that focuses on indicators of the outcomes of care and quality of life. The facility must:

§483.75(a)(1) Maintain documentation and demonstrate evidence of its ongoing QAPI program that meets the requirements of this section. This may include but is not limited to systems and reports demonstrating systematic identification, reporting, investigation, analysis, and prevention of adverse events; and documentation demonstrating the development, implementation, and evaluation of corrective actions or performance improvement activities;

§483.75(a)(2) Present its QAPI plan to the State Survey Agency no later than 1 year after the promulgation of this regulation; [§483.75(a)(2) implemented November 28, 2017 (Phase 2)]

§483.75(a)(3) Present its QAPI plan to a State Survey Agency or Federal surveyor at each annual recertification survey and upon request during any other survey and to CMS upon request; and

§483.75(a)(4) Present documentation and evidence of its ongoing QAPI program's implementation and the facility's compliance with requirements to a State Survey Agency, Federal surveyor or CMS upon request.

§483.75(b) Program design and scope. A facility must design its QAPI program to be ongoing, comprehensive, and to address the full range of care and services provided by the facility. It must:

§483.75(b)(1) Address all systems of care and management practices;

§483.75(b)(2) Include clinical care, quality of life, and resident choice;

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§483.75(b)(3) Utilize the best available evidence to define and measure indicators of quality and facility goals that reflect processes of care and facility operations that have been shown to be predictive of desired outcomes for residents of a SNF or NF.

§483.75(b (4) Reflect the complexities, unique care, and services that the facility provides.

§483.75(f) Governance and leadership. The governing body and/or executive leadership (or organized group or individual who assumes full legal authority and responsibility for operation of the facility) is responsible and accountable for ensuring that:

§483.75(f)(1) An ongoing QAPI program is defined, implemented, and maintained and addresses identified priorities.

§483.75(f)(2) The QAPI program is sustained during transitions in leadership and staffing;

§483.75(f)(3) The QAPI program is adequately resourced, including ensuring staff time, equipment, and technical training as needed;

§483.75(f)(4) The QAPI program identifies and prioritizes problems and opportunities that reflect organizational process, functions, and services provided to residents based on performance indicator data, and resident and staff input, and other information.

§483.75(f)(5) Corrective actions address gaps in systems, and are evaluated for effectiveness; and

§483.75(f)(6) Clear expectations are set around safety, quality, rights, choice, and respect.

§483.75(h) Disclosure of information**.**

Each nursing home, including facilities which are a part of a multi-chain organization, should tailor its QAPI plan to reflect the specific units, programs, departments, and unique population it serves, as identified in its facility assessment.

§483.75(c)(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 §483.70(e) and including how such information will be used to develop and monitor performance indicators.

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§483.75(e)(3) As part of their performance improvement activities, the facility must conduct distinct performance improvement projects. 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 §483.70(e). Improvement projects must include at least annually a project that focuses on high risk or
problem-prone areas identified through the data collection and analysis described in paragraphs (c) and (d) of this section

INTENT OF THE QAPI SECTION

Each facility must have a QAPI Plan developed by November 28, 2018. The QAPI pan focus should be based on the scope and complexity of services defined by the Facility Assessment. The overall intent of the review of the facility assessment for development of the QAPI plan is to identity the high risk, problem prone and high volume areas to evaluate for improvement and identify, collect and use data relevant to the unique characteristic and needs of the residents.

QAPI PLAN USING THE FACILITY ASSESSMENT

Development of the QAPI plan includes a description of how the plan will address the facility's clinical care, resident quality of life and residents' choice. Development of the QAPI plan is based on the same data used to develop the Facility Assessment.

I. Data used for the Facility Assessment and the QAPI plan
    a. Number of residents and resident capacity
        i. Describe the census and bed capacity to define the scope and breadth of the QAPI plan
    b. Care required by the facility's resident population
        i. Describe the unique characteristics of the resident populations and data, standards and benchmarks to use to monitor quality and focus improvement efforts.
        ii. Use the Facility Assessment information about the resident's needs to identify the areas to monitor and measure
            1. Diseases and conditions
            2. Physical and cognitive disabilities

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3. Overall acuity
4. Other pertinent facts

c. Staff competencies

i. Describe in the QAPI plan the methods to validate and update staff competencies at the time of hire and periodically

1. Routine monitoring of competencies as a measure of care quality

2. Competency testing to identify gaps in knowledge, skills and abilities when there are identified issues, adverse outcomes or measures that exceed desired benchmarks

d. Physical environment

i. The QAPI plan must encompass all aspects of the facility's operations. Include processes for monitoring and improving aspects of the physical environment on a routine basis and when there are identified issues, or adverse outcomes.

1. Equipment
2. Services
3. Other physical plan considerations

e. Ethnic, cultural and religious considerations

i. The QAPI Plan encompasses resident quality of life. Ensure that residents provide input into the QAPI Plan to prioritize the areas to monitor and measure that reflect the resident's preferences, ethnic, cultural and religious considerations.

f. Facility Resources

i. One aspect of the QAPI plan is to improve areas where there are issues, adverse events or quality measured at a lower than desired benchmark. Routine review of the physical structures, buildings and vehicles can establish the baseline for the facility structures and identify and investigate problems using root cause analysis.

1. Buildings and physical structures and vehicles

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2. Preventive maintenance is part of quality assurance. When there are identified issues or an improvement is desired the facility will use the performance improvement process as described by the QAPI plan to address equipment, both medical and non-medical.

ii. Services provided under contract

1. The contracted service providers should participate in the QAPI process but contributing data and information and collaborating for root cause analysis and performance improvement. Describe the roles of the major contracted providers in the QAPI plan.

2. Review the contracts and letters of agreement for contracted service providers to ensure that they are obligated to participate in QAPI. Providers may include:

    a. Physical Therapy
    b. Pharmacy
    c. Other rehab services
    d. Dentist
    e. Podiatrist
    f. Hospice
    g. Diagnostic services

iii. Facility personnel

1. The Facility Assessment identifies the numbers, credentials and competencies needed to meet the needs of the facility resident population. Describe how the QAPI plan will use this information to monitor staff quality and investigate adverse events. Include all staff: managers, staff and contract staff and volunteers.

2. Competency validation is key to assuring quality care and services. Review the plan for competency validation and testing at least annually in the QAPI Committee meeting to ensure that competencies are met and new competencies are added to the program as needed.

iv. Health information technology

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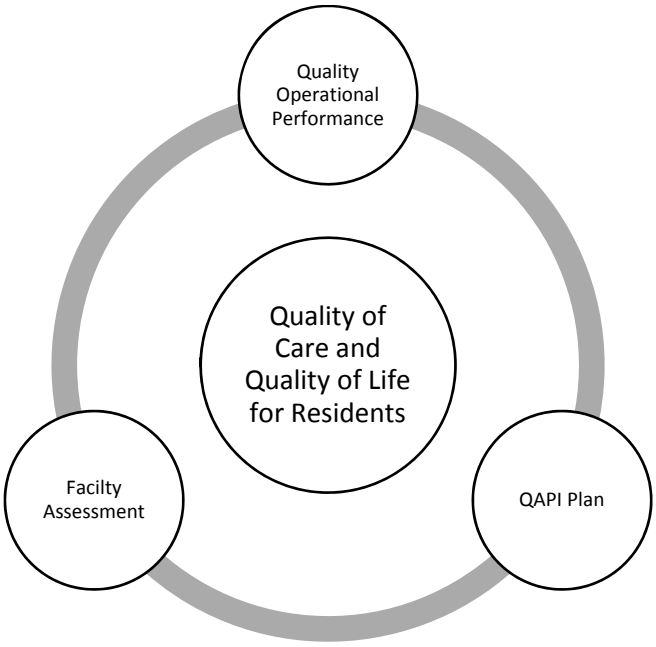
1. The QAPI plan should address how the systems to manage records will be defined and periodically reviewed. Describe how the QAPI plan will monitor the HIM systems for effectiveness and security.

v. Facility-based and community-based risk assessment utilizing an all-hazards approach

1. Describe in the QAPI plan the mechanism for conducting the Hazard Risk Assessment. Include the findings of major risk areas and how the Committee will assure that the risks are addressed.



See the Facility Assessment Template SAMPLE related to the inclusion of the necessary information obtained via this process for the completion of the Facility Assessment.

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References

State Operations Manual (SOM) Appendix PP for Phase 2, F-Tag Revisions, and Related Issues www.cms.gov/Medicare/Provider-Enrollment-and-Certification/GuidanceforLawsAndRegulations/Downloads/Advance-Appendix-PP-Including-Phase-2-.pdf

Quality Improvement Organizations, Facility Assessment Tool (2017) http://qioprogram.org/facility-assessment-tool

The *"QAPI Guide for Developing a QAPI Plan"*

https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/QAPI/downloads/QAPIPlan.pdf

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Data Collection Tools and/or Resources

The following Tools and Resources are included in this Section of **The RoP Facility Assessment Toolkit ©**

Item	Description	Source *(If Applicable)*
Sample QAPI Plan	An example of a facility QAPI plan – customizable	Pathway Health
QAPI Five Elements	Overview of the Five Elements required in a QAPI Plan	CMS. (2017). QAPI Five Elements. Retrieved August, 2017, from https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/QAPI/downloads/qapifiveelements.pdf
Guide for Developing a QAPI Plan	Provides a walkthrough of the key components in developing a QAPI Plan	CMS. (2017). QAPI Guide for Developing a QAPI Plan. Retrieved August, 2017, from https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/QAPI/downloads/QAPIPlan.pdf
Process Tool Framework	QAPI Resource Guide - Provides links to assist organization's in the understanding and completion of the QAPI plan, including training and tools	CMS. (2017). QAPI Process Tool Framework. Retrieved August, 2017, from https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/QAPI/Downloads/ProcessToolFramework.pdf
Root Cause Analysis Worksheet	A customizable worksheet to assist organizations determine root cause with possible solutions	Pathway Health
QAPI at a Glance	A Step by Step Guide to Implementing Quality Assurance and Performance Improvement (QAPI) in Your Nursing Home	CMS. (2017). QAPI at a Glance. Retrieved August, 2017, from https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/QAPI/Downloads/QAPIAtaGlance.pdf
Facility Assessment Summary Worksheet	Template for team to use to summary findings and prepare for narrative Facility Assessment inclusion	Pathway Heath

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QUALITY ASSURANCE PERFORMANCE IMPROVEMENT PROGRAM

Preface

Per the QAPI New Brief published by CMS in 2013, Quality Assurance Performance Improvement (QAPI) is the merger of two approaches to monitor and improve quality.

Quality Assurance is a process of meeting quality standards and assuring that care reaches an acceptable level. Nursing homes typically set QA thresholds to comply with regulations. They may also create standards that go beyond regulations. QA is a reactive, retrospective effort to examine why a facility failed to meet certain standards. QA activities do improve quality, but efforts frequently end once the standard is met.

PI (also called Quality Improvement - QI) is a proactive and continuous study of processes with the intent to prevent or decrease the likelihood of problems by identifying areas of opportunity and testing new approaches to fix underlying causes of persistent/systemic problems. PI in nursing homes aims to improve processes involved in health care delivery and resident quality of life. PI can make good quality even better

Regulations require that a facility's QAPI program be ongoing, comprehensive and address the full range of care and services provided by the facility. The program must address all systems of care and management practices. The program utilizes the best available evidence to define and measure indicators of clinical care, quality of life, resident choice. The facility's goals reflect care processes and facility operations that have been shown to be predictive of desired outcomes for residents of SNFs and NFs. The program reflects each facility's complexities, unique residents and care and services provided.

A comprehensive QAPI program involves all staff. Residents and residents' representatives are knowledgeable of the facility's QAPI activities.

Regulations

§483.75(a) Quality assurance and performance improvement (QAPI) program.

Each LTC facility, including a facility that is part of a multiunit chain, must develop, implement, and maintain an effective, comprehensive, data-driven QAPI program that focuses on indicators of the outcomes of care and quality of life. The facility must:

(1) Maintain documentation and demonstrate evidence of its ongoing QAPI program that meets the requirements of this section. This may include but is not limited to systems and reports demonstrating systematic identification, reporting, investigation, analysis, and

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prevention of adverse events; and documentation demonstrating the development, implementation, and evaluation of corrective actions or performance improvement activities;

(2) Present its QAPI plan to the State Survey Agency no later than 1 year after the promulgation of this regulation; **[§483.75(a)(2) will be implemented beginning November 28, 2017 (Phase 2)]**

(3) Present its QAPI plan to a State Survey Agency or Federal surveyor at each annual recertification survey and upon request during any other survey and to CMS upon request; and

(4) Present documentation and evidence of its ongoing QAPI program's implementation and the facility's compliance with requirements to a State Survey Agency, Federal surveyor or CMS upon request.

§483.75(b) Program design and scope.

A facility must design its QAPI program to be ongoing, comprehensive, and to address the full range of care and services provided by the facility. It must:

(1) Address all systems of care and management practices;

(2) Include clinical care, quality of life, and resident choice;

(3) Utilize the best available evidence to define and measure indicators of quality and facility goals that reflect processes of care and facility operations that have been shown to be predictive of desired outcomes for residents of a SNF or NF.

(4) Reflect the complexities, unique care, and services that the facility provides.

§483.75(c) Program feedback, data systems and monitoring.

A facility must establish and implement written policies and procedures for feedback, data collections systems, and monitoring, including adverse event monitoring. The policies and procedures must include, at a minimum, the following:

(1) Facility maintenance of effective systems to obtain and use of feedback and input from direct care staff, other staff, residents, and resident representatives, including how such information will be used to identify problems that are high risk, high volume, or problem-prone, and opportunities for improvement.

(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 §483.70(e) and including how such information will be used to develop and monitor performance indicators.

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(3) Facility development, monitoring, and evaluation of performance indicators, including the methodology and frequency for such development, monitoring, and evaluation.

(4) Facility adverse event monitoring, including the methods by which the facility will systematically identify, report, track, investigate, analyze and use data and information relating to adverse events in the facility, including how the facility will use the data to develop activities to prevent adverse events.

§483.75 (d) Program systematic analysis and systemic action.

(§483.75 (d) will be implemented during Phase 3)

(1) The facility must take actions aimed at performance improvement and, after implementing those actions, measure its success, and track performance to ensure that improvements are realized and sustained.

(2) The facility will develop and implement policies addressing: (i) How they will use a systematic approach to determine underlying causes of problems impacting larger systems;

(ii) How they will develop corrective actions that will be designed to effect change at the systems level to prevent quality of care, quality of life, or safety problems; and
(iii) How the facility will monitor the effectiveness of its performance improvement activities to ensure that improvements are sustained.

§483.75(e) Program activities.

(1) The facility must set priorities for its performance improvement activities that focus on high-risk, high-volume, or problem-prone areas; consider the incidence, prevalence, and severity of problems in those areas; and affect health outcomes, resident safety, resident autonomy, resident choice, and quality of care.

(2) Performance improvement activities must track medical errors and adverse resident events, analyze their causes, and implement preventive actions and mechanisms that include feedback and learning throughout the facility.

(3) As part of their performance improvement activities, the facility must conduct distinct performance improvement projects. 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 §483.70(e). Improvement projects must include at least annually a project that focuses on high risk or problem-prone

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areas identified through the data collection and analysis described in paragraphs (c) and (d) of this section

§483.75(f) Governance and leadership.
The governing body and/or executive leadership (or organized group or individual who assumes full legal authority and responsibility for operation of the facility) is responsible and accountable for ensuring that:
(1) An ongoing QAPI program is defined, implemented, and maintained and addresses identified priorities.
(2) The QAPI program is sustained during transitions in leadership and staffing;
(3) The QAPI program is adequately resourced, including ensuring staff time, equipment, and technical training as needed;
(4) The QAPI program identifies and prioritizes problems and opportunities that reflect organizational process, functions, and services provided to residents based on performance indicator data, and resident and staff input, and other information.
(5) Corrective actions address gaps in systems, and are evaluated for effectiveness; and
(6) Clear expectations are set around safety, quality, rights, choice, and respect.

§483.75(g) Quality assessment and assurance.

[§483.75(g)(1)(i)-(iii) will be implemented beginning November 28, 2016 (Phase 1)]

(1) A facility must maintain a quality assessment and assurance committee consisting at a minimum of:

(i) The director of nursing services;

(ii) The Medical Director or his/her designee;

(iii) At least three other members of the facility's staff, at least one of who must be the administrator, owner, a board member or other individual in a leadership role; and

(iv) The infection control and prevention officer.

(2) The quality assessment and assurance committee reports to the facility's governing body, or designated person(s) functioning as a governing body regarding its activities, including implementation of the QAPI program required under *paragraphs (a) through (e) of this section. The* committee must:

(i) Meet at least quarterly and as needed to coordinate and evaluate activities under the QAPI program, such as identifying issues with respect to which quality assessment and assurance activities, including performance improvement projects required under the QAPI program, are necessary

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(ii) Develop and implement appropriate plans of action to correct identified quality deficiencies;

(iii) Regularly review and analyze data, including data collected under the QAPI program and data resulting from drug regimen reviews, and act on available data to make improvements.

§483.75(h) Disclosure of information.
A State or the Secretary may not require disclosure of the records of such committee except in so far as such disclosure is related to the compliance of such committee with the requirements of this section.

§483.75(i) Sanctions.
Good faith attempts by the committee to identify and correct quality deficiencies will not be used as a basis for sanctions.

[§483.75(h)(i)) will be implemented beginning November 28, 2016 (Phase 1)]

Definitions

• **"Quality Assessment"** is an evaluation of a process and/or outcomes of a process to determine if a defined standard of quality is being achieved.

• "**Quality Assurance"** is the organizational structure, processes, and procedures designed to ensure that care practices are consistently applied and the facility meets or exceeds an expected standard of quality. Quality assurance includes the implementation of principles of continuous quality improvement.

• **"Quality Deficiencies"** are potential markers of quality that the facility considers to be in need of investigating and which, after investigation, may or may not represent a deviation from quality that results in a potential or actual undesirable outcome. The term "quality deficiency" in this regulation is meant to describe a deficit or an area for improvement. This term is not synonymous with a deficiency cited by surveyors.

• **"Quality Improvement (QI)"** is an ongoing interdisciplinary process that is designed to improve the delivery of services and resident outcomes

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Sample

ABC Facility

Quality Assurance/Assessment and Performance Improvement Plan

Purpose

Example: The Quality Assurance/Assessment and Performance Improvement (QAPI) Program is to utilize an on-going, data driven, pro-active approach to advance the quality of life and quality of care for all residents at ABC Facility. Quality Assurance and Performance Improvement principles will drive our facilities decision making to promote excellence in all resident and staff related areas. All facility staff, families and residents will be encouraged to be involved in identifying opportunities for improvement, partake in QAPI teams, imbed QAPI activities in all core processes and provide ongoing feedback.

Mission

Example: To provide superior quality health care services and to be the facility of choice where our clients see themselves not as patients but rather as members of our extended family

Vision

Example: To be recognized leaders for excellence in healthcare with innovative services for improved resident and client outcomes.

Guiding Principles

Guiding Principle #1: Our organization makes quality improvement decisions based on data analysis with input from residents, families, staff and the community

Guiding Principle #2: Our organization uses quality assurance and performance improvement (QAPI) principles to address systems of care

Guiding Principle #3: In our organization, …

Guiding Principle #4:

Guiding Principle #5:

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Design and Scope

Each facility's program will be on-going, comprehensive and reflect the resident population, staff community, care and services provided by the facility and the resources available and reflect the Service Standards of ABC Facility.

Example: The QAPI program at ABC Facility encompasses post-acute care, long term care and outpatient therapy. The QAPI committee consists of representatives from all departments including nursing, food and nutrition, laundry, maintenance, health information technology, therapeutic recreation, therapy, business office and administration. Involvement will be varied by topic and may include committee, sub-committee or verbal/written input. Our service areas will work together to best meet the needs of the individuals living in our care center. All departments and services along with families, residents, volunteers, board members and contract staff will be educated on the principles of QAPI. All resident directed decisions will be focused on retaining autonomy, encouraging individualized choices and preserving the highest attainable quality of life and quality of care. PIPs will be implemented when an opportunity for improvement is identified. These PIPs may apply to processes or systems at all levels of the organization.

The QAPI program is ongoing, comprehensive and addresses the full range of care and services provided at ABC Facility.

> *Clinical Care* – example: data will be obtained from the following reports: QI/QM, infection, medication error, pressure injuries, falls, health department surveys, CASPER and pain. Licensed nursing staff will receive up-to-date education on best practice and clinical guidelines to promote the highest attainable level of clinical care. The team will meet monthly with the Medical Director to achieve desirable outcomes for the residents. Results will be shared with the QAPI Steering Committee on a quarterly basis.
>
> *Quality of Life* - example: the best available evidence will be utilized to define and measure indicators of quality including but not limited to resident and family satisfaction surveys, resident council meetings, health department surveys and grievances/concerns. The team will meet monthly to review findings and concerns, and prioritize activities. Results will be shared with the QAPI Steering Committee on a quarterly basis.
>
> *Resident Choice* – example: individualized plans of care are developed with input from resident and family members. Plans of care are reviewed at care conferences and choices are offered with care options throughout the day. Residents or resident representatives are encouraged to direct their clinical care with staff member guidance to assure safety and informed decision making.

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ABC Facility is unique in the population served as we have a ventilator unit with medically complex residents requiring nursing staff with specialized training. Education and competency training are performed on a regular basis. Other service areas include: memory care, short term rehab, long term care, hospice, and respite care.

The services available at ABC Facility include:

Skilled Nursing
Long-Term Care
Post-acute care
Dialysis
Hospice/Palliative Care
Pharmacy

Therapy
Outpatient
Physical
Occupational
Respiratory
Speech Language pathology
Alzheimer's/Memory Care
Skilled Rehabilitation

Dietary
Dining
Dietitian

Social Services
Care Coordination
Mental Health

Activities

Housekeeping
Laundry
Janitorial

Maintenance
Building
Landscaping/Grounds keeping
Equipment

Health Information Services
Electronic Health Record
Electronic Medical Record
Minimum Data Set

Business Office
Staffing
Billing
Human Resources

Organizational Resources include:

Staff Education

On-line LMS

On-boarding and Orientation

Internal Continuing Education

External Continuing Education, (Conferences, Symposiums, etc.)

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Governance and Leadership

Example: The Nursing Home Administrator (NHA) and Board of Directors are responsible and accountable for the development, implementation and monitoring of the QAPI program.

- The Quality Assessment and Assurance (QAA) Committee consists of the Director of Nursing Services, the Medical Director, the Administrator, at least two other members of the facility staff, and the infection control and prevention officer.
- The QAA Committee meets at least quarterly to coordinate and evaluate the activities under the QAPI program.
- A QAPI Steering Committee is appointed by the NHA and the Executive leadership team and is interdisciplinary with at least two non-licensed staff who provide direct care or service to the residents. This may include nursing assistants, food and nutrition staff, housekeeping staff, maintenance and laundry staff.
- Non-licensed staff will serve on the Committee for one year and then rotate out so additional staff have the opportunity to service on the Committee.
- The QAPI Steering Committee, which includes the Medical Director as co-chair, meets monthly and is accountable for the continuous improvement in Quality of Life and Quality of Care. Minutes are recorded and shared with staff verbally and posted in staff areas for review.
- The QAPI Steering Committee collects data from sub committees (pain, falls, weight loss) and includes the data in their quarterly reports to the QAA Committee /NHA/Board of Directors.
- The QAA Committee completes an annual assessment of the program with report to the governing body/Board of Directors.
- A Quality Management Coordinator is appointed by the NHA and Executive Leadership team and is responsible for ongoing QAPI activities including development of a facility dashboard to display current goals and progress toward those goals.
- On a quarterly basis, the NHA will report on all current QAPI activities and outcomes to the Board of Directors.
- Annually, Executive Leadership will report on the status of the current QAPI plan and outline plans for the upcoming year. This information will be shared with the Board of Directors, management team, staff, and resident/family councils.
- The Executive Leadership team will support and advise the QAPI Steering Committee.

Budget: The Nursing Home Administrator works with the Board of Directors to create a budget for QAPI to assure that resources are available for the ongoing activities of the QAPI Committee. Resources include but are not limited to time for education, staff time for meetings, equipment, technology needs, software, supplies, improvement projects, etc. The

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NHA and Quality Management Coordinator will review the budget on a monthly basis and revise as necessary to assure ongoing success of the QAPI program.

Education: All staff including contracted staff are educated on the principles of QAPI. QAPI is included in orientation of new employees and in the annual education that all staff are required to attend. Education includes the use of visual aide tools, posters, pay-check stuffers, text alerts, small group exercises, department meetings, all staff meetings, change of shift reports, facility newsletter, etc. Staff will be trained on using QAPI principles, identifying areas for improvement, and how they can be involved in the QAPI process including participation on a PIP team. The QAPI program is sustained during transitions in leadership and staffing through all-staff education and involvement in the QAPI process.

Residents and families are also informed of the QAPI plan and are encouraged to share their insights, concerns and opportunities for improvement. QAPI will be discussed at resident council meetings and family council meetings. Involvement of residents and family members on a PIP team may be considered.

Culture: ABC Facility believes in providing a non-punitive environment where managers encourage all staff involvement in bringing forward concerns, areas for improvement, reporting mistakes, and reporting quality issues. Managers will respond respectfully and timely to maintain an environment where staff have no fear of reprisal.

Feedback, Data Systems, and Monitoring

Example: ABC Facility will monitor multiple data sources and performance indicators in determining areas of concern, gaps and opportunities and also to determine effectiveness of system modifications and other interventions. All data will be reviewed against state, national or organization benchmarks or thresholds as appropriate and will be reported to the Board of Directors on a quarterly basis.

Data for adverse events and medical errors will be tracked, causes analyzed and preventative actions and mechanisms put into place. Feedback will be provided to staff and education provided as needed.

Potential sources of data may include:

- Survey outcomes
- Complaints
- Near misses
- Input from staff, residents, families and volunteers
- CMS Quality Measures

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- Medication Errors
- Rehospitalization Rates
- Staff hours per day
- Staff retention
- Case Mix findings
- Pharmacist reports
- CASPER report
- Behavioral Health reports
- Satisfaction survey outcomes
- Billing audits
- Five Star report

Data may be collected weekly, monthly or quarterly depending on frequency of data updates from each source. The QAPI Management Coordinator oversees the maintenance of the QAPI dashboard, monthly reports/graphs, QAPI logs, and minutes of all meetings. The QAPI Steering Committee will utilize CMS's *Measure/Indicator Development worksheet* and CMS's *Measure/Indicator Collection and Monitoring Plan* to assist with program development.

Insert facility specific table here with data source, frequency of data collection, who reviews the information and how the information is disseminated.

Performance Improvement Projects (PIPs)

Example: ABC Facility will review the designated sources of data; identify areas where gaps in performance may negatively affect resident or staff outcomes. Where opportunities for improvement are detected, the QAPI Steering Committee with input from the Leadership Team will prioritize focus areas for PIP development. In prioritizing activities, the team will consider:

- high-risk to residents and/or staff,
- high-volume or problem-prone areas,
- health outcomes,
- resident safety,
- resident autonomy,
- resident choice,
- cost,
- feasibility,
- relevance,
- responsiveness,

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- areas not outside of benchmarks but of importance to the resident population we serve.

The CMS publication *Prioritizing Worksheet for Performance Improvement Projects* may be utilized to assist with prioritizing potential areas of concern.

At least annually a project that focuses on high risk or problem-prone areas will be addressed through the QAPI program including PIP development. As defined in the facility assessment required at §483.70(e) our facility's services and resources will be taken into account when determining how many PIPs to support at one time. A minimum of one PIP and a maximum of four PIPs will occur simultaneously.

A *project charter* which establishes the goals, scope, timing, milestones, and team's roles and responsibilities will be developed for each PIP. CMS's form, *Worksheet to Create a Performance Improvement Project Charter* may be utilized by the QAPI Steering Committee to provide guidance to the PIP team.

The *PIP team* will be assembled by the QAPI Steering Committee and the QAPI Quality Manager. The team will be interdisciplinary with staff representing each job role affected by the project and may include resident and/or family representation when appropriate. Direct care staff will be replaced at their work station so that resident care is not interrupted. A *project lead* will be selected and will be responsible for coordinating, organizing and directing the activities of that specific PIP team.

The PIP Team will identify the information needed to evaluate the problem at hand, supplies required, staff participation, and any equipment needs. The project lead will communicate any identified resource needs to the QAPI Quality Manager. The team will utilize root cause analysis to identify the cause of the problem and any contributing factors. PDSA will also be used and is further described in the next section – Systematic Analysis and Systemic Action. The PIP team will develop an action plan with identified problem statement, causes, goals, interventions, staff responsible, and due dates.

The following forms may be utilized for PIP Action Plans:

Insert facility specific form here

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PIP Action Plan

Problem Statement with Causes (related to)	Goal (Corrected Problem Statement)	Interventions to Address Causes & Achieve Goal	Responsible Staff	Due Date	Completion Date & Comments

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The following form may be utilized in developing and monitoring Action Plans:

Insert facility specific form here

QAPI ACTION PLAN

Location		Date:	Team Members
Concern			
Root Cause Analysis			
Goals			

Action Items	Responsible Team Member(s)	Start Date	Estimated Completion Date	Actual Completion Date	Comments

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PIP activities will be reported to residents, families and staff at least one time during the PIP. More frequent communication may be required as determined by the QAPI Quality Manager. Communication may occur via posters, bulletin boards, newsletters, and/or meetings with residents, family, staff and board members. To monitor the status of PIPs within our building, we will utilize CMS *Performance Improvement Project (PIP) Inventory*.

The project lead will also provide verbal and written documentation at the monthly QAPI Committee meetings. Meeting minutes will include information shared.

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Systematic Analysis and Systemic Action

Example: ABC Facility uses a systematic approach to determining the root cause of an issue and any contributing factors. Facility staff and management have been trained on Root Cause Analysis. The PIP team identifies the root cause through utilization of many different tools, including:

- Fishbone Diagram
- Five Whys
- Cause and Effect Diagram
- Healthcare Failure Mode and Effect analysis (HFMEA)

The team considers the implications of any interventions or changes to systems for potential negative outcomes in other areas. The team will determine whether a pilot test or facility wide change is appropriate based on the facts gathered.

We utilize Plan-Do-Study-Act (PDSA) as our rapid-cycle improvement strategy with outcomes reported ongoing to the QAPI Quality Manager and quarterly to the QAPI Steering Committee.

Each PIP team determines the timing for conduction of periodic measurements and reviews to evaluate whether new actions/interventions are being followed/performed consistently. If any backsliding has occurred, the team will continue with the PDSA cycle with changes in processes/procedures as required.

Evaluation

The QAPI program will be evaluated annually by the QAPI Steering Committee with input from the Leadership Team/Executive Leadership. This review will include whether goals were met, if standards of practice are being followed, any training needs will be identified and addressed, and staff opinion on the QAPI process will be obtained via survey. Current trends in long term care will be considered along with strategic plans for ABC Facility. Any variances in systems and processes will be identified and included in the coming year's QAPI plan.

This plan was established on August 14, 2017 and will be revisited and revised as needed annually at a minimum.

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Resources

Measure/Indicator Development Worksheet. (2016). Retrieved December 7, 2016, from https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/QAPI/downloads/MeasIndicatDevWksdebedits.pdf

Measure/Indicator Collection and Monitoring Plan. (2016). Retrieved December 7, 2016, from https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/QAPI/downloads/MeasIndCollectMtrPlandebedits.pdf

Prioritizing Worksheet for Performance Improvement Projects. (2016). Retrieved December 7, 2016, from https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/QAPI/downloads/PIPCharterWkshtdebedits.pdf

Worksheet to Create a Performance Improvement Project Charter. (2016). Retrieved December 7, 2016, from https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/QAPI/downloads/PIPCharterWkshtdebedits.pdf

CMS PIP Inventory. (2016). Retrieved 2017, January 12 from https://www.cms.gov/medicare/provider-enrollment-and-certification/qapi/downloads/pipinventorydebedits.pdf

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Five Elements

Element 1: Design and Scope

A QAPI program must be ongoing and comprehensive, dealing with the full range of services offered by the facility, including the full range of departments. When fully implemented, the QAPI program should address all systems of care and management practices, and should always include clinical care, quality of life, and resident choice. It aims for safety and high quality with all clinical interventions while emphasizing autonomy and choice in daily life for residents (or resident's agents). It utilizes the best available evidence to define and measure goals. Nursing homes will have in place a written QAPI plan adhering to these principles.

Element 2: Governance and Leadership

The governing body and/or administration of the nursing home develops a culture that involves leadership seeking input from facility staff, residents, and their families and/or representatives. The governing body assures adequate resources exist to conduct QAPI efforts. This includes designating one or more persons to be accountable for QAPI; developing leadership and facility-wide training on QAPI; and ensuring staff time, equipment, and technical training as needed. The Governing Body should foster a culture where QAPI is a priority by ensuring that policies are developed to sustain QAPI despite changes in personnel and turnover. Their responsibilities include, setting expectations around safety, quality, rights, choice, and respect by balancing safety with resident-centered rights and choice. The governing body ensures staff accountability, while creating an atmosphere where staff is comfortable identifying and reporting quality problems as well as opportunities for improvement.

Element 3: Feedback, Data Systems and Monitoring

The facility puts systems in place to monitor care and services, drawing data from multiple sources. Feedback systems actively incorporate input from staff, residents, families, and others as appropriate. This element includes using Performance Indicators to monitor a wide range of care processes and outcomes, and reviewing findings against benchmarks and/or targets the facility has established for performance. It also includes tracking, investigating, and monitoring Adverse Events that must be investigated every time they occur, and action plans implemented to prevent recurrences.

Element 4: Performance Improvement Projects (PIPs)

A Performance Improvement Project (PIP) is a concentrated effort on a particular problem in one area of the facility or facility wide; it involves gathering information systematically to clarify issues or problems, and intervening for improvements. The facility conducts PIPs to examine and improve care or services in areas that the facility identifies as needing attention. Areas that need attention will vary depending on the type of facility and the unique scope of services they provide.

Element 5: Systematic Analysis and Systemic Action

The facility uses a systematic approach to determine when in-depth analysis is needed to fully understand the problem, its causes, and implications of a change. The facility uses a thorough and highly organized/ structured approach to determine whether and how identified problems may be caused or exacerbated by the way care and services are organized or delivered. Additionally, facilities will be expected to develop policies and procedures and demonstrate proficiency in the use of Root Cause Analysis. Systemic Actions look comprehensively across all involved systems to prevent future events and promote sustained improvement. This element includes a focus on continual learning and continuous improvement.

QAPI

Guide for Developing a QAPI Plan

DIRECTIONS:

The QAPI plan will guide your organization's performance improvement efforts. Prior to developing your plan, complete the *Guide to Develop Purpose, Guiding Principles, and Scope for QAPI.* Your QAPI plan is intended to assist you in achieving what you have identified as the purpose, guiding principles and scope for QAPI, therefore this information is needed before you begin working on your plan. This is a living document that you will continue to refine and revisit. Use these step-by-step instructions to create your QAPI plan. This plan should reflect input from caregivers representing all roles and disciplines within your organization.

I. QAPI Goals

Based on the *Guide to Develop Purpose, Guiding Principles, and Scope for QAPI*, indicate the QAPI goals that your plan will strive to meet. Goals should be specific, measurable, actionable, relevant, and have a time line for completion. (See *Goal Setting Worksheet*).

II. Scope

a. Describe how QAPI is integrated into all care and service areas of your organization.

b. Describe how the QAPI plan will address:

   i. Clinical care

   ii. Quality of life

   iii. Resident choice (i.e., individualized goals for care)

c. Describe how QAPI will aim for safety and high quality with all clinical interventions while emphasizing autonomy and choice in daily life for residents (or resident's agents).

d. Describe how QAPI will utilize the best available evidence (e.g., data, national benchmarks, published best practices, clinical guidelines) to define and measure goals.

III. Guidelines for Governance and Leadership

a. Describe how QAPI is integrated into the responsibilities and accountabilities of top-level management and the Board of Directors (if applicable).

b. Describe how QAPI will be adequately resourced.

   i. Designate one or more persons to be accountable for QAPI leadership and for coordination.

   ii. Indicate the plan for developing leadership and facility-wide training on QAPI.

   iii. Describe the plan to provide caregivers time, equipment, and technical training as needed for QAPI.

   iv. Indicate how you will determine if resources are adequate for QAPI.

   v. Describe how your caregivers will become and remain proficient with process improvement tools and techniques. How will you assess their level of proficiency?

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c. QAPI Leadership

   i. While everyone in the organization is involved in QAPI, you will likely have a small group of individuals who will provide the backbone or structure for QAPI in your organization. Who will be part of this group? Many of these individuals may be on your current QAA committee.

   ii. Describe how this group of people will work together, communicate, and coordinate QAPI activities. This could include but is not limited to:

   - Establishing a format and frequency for meetings
   - Establishing a method for communication between meetings
   - Establishing a designated way to document and track plans and discussions addressing QAPI.

   iii. Describe how the QAPI activities will be reported to the governing body; i.e., Board of Directors, owner.

IV. Feedback, Data Systems, and Monitoring

a. Describe the overall system that will be put in place to monitor care and services, drawing data from multiple sources.

b. Identify the sources of data that you will monitor through QAPI

   i. Input from caregivers, residents, families, and others

   ii. Adverse events

   iii. Performance indicators

   iv. Survey findings

   v. Complaints

c. Describe the process for collecting the above information.

d. Describe the process for analyzing the above information, including how findings will be reviewed against benchmarks and/or targets established by the facility.

e. Describe the process to communicate the above information. What types of reports will be used? One way to accomplish this is to use a dashboard or dashboards for individual performance improvement projects.

f. Identify who will receive this information (i.e., executive leadership, QAPI leadership, resident/family council, and a center's caregivers), in what format, and how frequently information will be disseminated.

V. Guidelines for Performance Improvement Projects (PIPs)

a. Describe the overall plan for conducting PIPs to improve care or services.

   i. Indicate how potential topics for PIPs will be identified.

   ii. Describe criteria for prioritizing and selecting PIPs: areas important and meaningful for the specific type and scope of services unique to the facility, requires a concentrated effort on a particular problem in one area of the facility or facility wide.

   iii. Indicate how and when PIP charters will be developed.

   iv. Describe the process for reporting the results of PIPs. Identify who will receive this information (i.e., quality committee, resident/family council, and a center's caregivers), in what format, and how frequently information will be disseminated.

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b. Describe how to designate PIP teams and establish and describe a process for assembling teams to work on specific PIPs.

c. Define the required characteristics for any PIP team. This may include that the team be interdisciplinary (i.e., representing each of the job roles affected by the project), that it include resident representation (as appropriate), and that a qualified team leader is selected (i.e., ability to coordinate, organize and direct all activities of the project team). Describe how PIP teams should document and report their work.

d. Describe your process for documenting PIPs, including highlights, progress, and lessons learned. For example, what project documentation templates will you use consistently and file electronically in a standardized fashion for future reference.

VI. Systematic Analysis and Systemic Action

a. Any change that is made has the potential to have broader impact than intended. If you are trying to make a change to a specific system or process, it is important to recognize any "unintended" consequences of your actions. Describe how your organization will identify these consequences which may be either positive or negative.

b. Describe the process you will use to ensure you are getting at the underlying causes of issues, rather than applying quick fixes that address symptoms only.

c. Describe how you will monitor to ensure that interventions or actions are implemented and effective in making and sustaining improvements.

VII. Communications

Outline the audiences for QAPI communications and the frequency and format of these communications.

VIII. Evaluation

a. Describe the process for assessing QAPI in your organization on an ongoing basis. (See *QAPI Self-Assessment Tool*.)

b. Describe the purpose of this evaluation – to help your organization to expand your skills in QAPI and increase the impact of QAPI in your organization.

IX. Establishment of Plan

a. Date your plan.

b. Determine when you will revisit the plan (i.e., at least annually).

c. Determine how you will track revisions or updates to the plan.

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QAPI Five Elements	Goals	Tools
Element 1 – Design and Scope	**Learn the basics of QAPI** • Review QAPI five elements • Understand how QAPI coordinates with QAA	QAPI Five Elements QAPI at a Glance QAPI News Brief - Volume 1
	Assess QAPI in your organization	QAPI Self-Assessment Tool
	Create a structure and plan to support QAPI	Guide to Developing Purpose, Guiding Principles and Scope for QAPI Guide for Developing a QAPI Plan
Element 2 – Governance and Leadership	**Understand the QAPI business case**	CMS Video: Nursing Home QAPI – What's in it for you?
	Promote a fair and open culture where staff are comfortable identifying quality problems and opportunities • Know your current culture • Assess your individual skills, practice, attitude • Create a learning organization that drives and reinforces a process for organizational change • Distinguish between human error, at risk, and reckless behavior, and respond differently/ appropriately to each	QAPI at a Glance QAPI News Brief - Volume 1

QAPI Five Elements	Goals	Tools
Element 2 – Governance and Leadership	**Create a Culture that embraces the principles of QAPI**	QAPI at a Glance QAPI News Brief - Volume 1 QAPI Leadership Rounding Tool
	Promote engagement and commitment of staff, residents and families in QAPI	QAPI at a Glance QAPI News Brief - Volume 1 Examples of Performance Objectives for Job Descriptions and Performance Reviews
	Involve residents and families • Focus on the customer needs and expectations	QAPI at a Glance QAPI News Brief - Volume 1
Element 3 – Feedback, Data Systems and Monitoring	**Use and make data meaningful** • Identify what you need to monitor • Collect, track, and monitor measures/indicators • Set goals, benchmarks, thresholds • Identify gaps and opportunities • Prioritize what you will work to improve • Use data to drive decisions	Measure/Indicator Development Worksheet Measure/Indicator Collection and Monitoring Plan Instructions to Develop a Dashboard Goal Setting Worksheet Prioritization Worksheet for Performance Improvement Projects

QAPI Five Elements	Goals	Tools
Element 4 – Performance Improvement Projects	**Implement performance improvement projects** • Focus on topics that are meaningful and address the needs of residents and staff • Charter PIP teams • Support staff in being effective PIP team members. Use tools that support effective teamwork. • Plan, implement, measure, monitor, and document changes, using a structured PI approach	Worksheet to Create a PIP Charter PIP Launch Checklist: Helpful hints for project leaders, managers, and coordinators Plan-Do-Study-Act (PDSA) Cycle Template PIP Inventory Sustainability Decision Guide Brainstorming, Affinity Grouping, and Multi-Voting Tool
	Enhance QAPI communications	QAPI at a Glance Communications Plan Worksheet Storyboard Guide for PIPs Improvement Success Story Template
Element 5 – Systematic Analysis and Systemic Action	**Understand and focus on organizational processes and systems** • Model and promote systems thinking • Practice RCA – get to the root of problems • Take action at the systems-level	Guidance for Failure Mode and Effects Analysis (FMEA) Guidance for Root Cause Analysis (RCA) Flowcharting Five Whys Fishbone Diagram

Facility:

Pathway Health Services
Root Cause Analysis Worksheet

Date:_____

Issue/Problem				Likely Root Cause			Possible Solutions					
Decription	Source	Criticality		Description	Likelihood (H/M/L)	Info/Tests to Clarify	Description	Risks			Measure of Success	
		Level (H/M/L)	Rationale					Description	Likelihood	Mitigation	Test	Results
Client is not aware of project status	Client	Medium	Doesn't affect delivery but damaging to account	Status reports not being issued weekly becuz of lack of info from PM	High	Check with office/supervisor to ensure they are aware	Simplify info required for report so it is less time consuming	Client feels reports lack detail	Medium	Agree - detail level could be less for client report	Check with client after 4 weeks	TBA

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Transforming the lives of nursing home residents through continuous attention to quality of care and quality of life

QAPI *at a Glance:*

A Step by Step Guide to Implementing Quality Assurance and Performance Improvement (QAPI) in Your Nursing Home

CMS
CENTERS FOR MEDICARE & MEDICAID SERVICES

UNIVERSITY OF MINNESOTA

StratisHealth

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Introduction: Why This Guide?

As you use this guide, please take note of the following:

- The term "Caregiver" refers to individuals who provide care in nursing homes.
- The tool icon: indicates that there is a QAPI tool associated with that concept in Appendix A of this guide. Click the tool icon to access the corresponding QAPI tool.
- Words underlined in **bold blue** are defined in Appendix B. Click the underlined word icon to be automatically linked to the definitions listed in Appendix B.

Effective Quality Assurance and Performance Improvement (QAPI) is critical to our national goals to improve care for individuals and improve health for populations, while reducing per capita costs in our healthcare delivery system. We have the opportunity to accomplish these goals in each local nursing home with the aid of QAPI tools and the establishment of an effective QAPI foundation. Nursing homes are in the best position to assess, evaluate, and improve their care and services because each home has first-hand knowledge of their own organizational systems, culture, and history. Effective QAPI leverages this knowledge to maximize the return on investments made in care improvement. This *QAPI at a Glance* guide is a resource for nursing homes striving to embed QAPI principles into their day to day work of providing quality care and services.

Nursing homes in the United States will soon be required to develop QAPI plans. QAPI will take many nursing homes into a new realm in quality—a systematic, comprehensive, data-driven, proactive approach to performance management and improvement. This guide provides detailed information about the "nuts and bolts" of QAPI. We hope that *QAPI at a Glance* conveys a true sense of QAPI's exciting possibilities. Once launched, an effective QAPI plan creates a self-sustaining approach to improving safety and quality while involving all nursing home caregivers in practical and creative problem solving. Your QAPI results are generated from your own experiences, priority-setting, and team spirit.

The Affordable Care Act of 2010 requires nursing homes to have an acceptable QAPI plan within a year of the promulgation of a QAPI regulation. However, a more basic reason to build care systems based on a QAPI philosophy is to ensure a systematic, comprehensive, data-driven approach to care. When nursing home leaders promote such an approach, the results may prevent adverse events, promote safety and quality, and reduce risks to residents and caregivers. This effort is not only about meeting minimum standards—it is about continually aiming higher. Many nursing homes are already demonstrating leadership in developing and implementing effective QAPI plans.

We encourage nursing home leaders to use *QAPI at a Glance* as a reference as they examine their own activities in the context of the goals and expectations for QAPI and sustainable improvement. You can also visit the QAPI website at http://go.cms.gov/Nhqapi, which we will update regularly as new materials and resources become available.

WHAT IS QAPI?

QAPI is the merger of two complementary approaches to quality management, Quality Assurance **(QA)** and Performance Improvement **(PI)**. Both involve using information, but differ in key ways:

- QA is a process of meeting quality standards and assuring that care reaches an acceptable level. Nursing homes typically set QA thresholds to comply with regulations. They may also create standards that go beyond regulations. QA is a reactive, retrospective effort to examine why a facility failed to meet certain standards. QA activities do improve quality, but efforts frequently end once the standard is met.
- PI (also called Quality Improvement - QI) is a pro-active and continuous study of processes with the intent to prevent or decrease the likelihood of problems by identifying areas of opportunity and testing new approaches to fix underlying causes of persistent/systemic problems. PI in nursing homes aims to improve processes involved in health care delivery and resident quality of life. PI can make good quality even better.

The chart below was adapted from the Health Resources and Services Administration (HRSA)[1] and shows some key differences between QA and PI efforts.

	QUALITY ASSURANCE	PERFORMANCE IMPROVEMENT
Motivation	Measuring compliance with standards	Continuously improving processes to meet standards
Means	Inspection	Prevention
Attitude	Required, reactive	Chosen, proactive
Focus	Outliers: *"bad apples"* Individuals	Processes or Systems
Scope	Medical provider	Resident care
Responsibility	Few	All

QA + PI = QAPI

QA and PI combine to form QAPI, a comprehensive approach to ensuring high quality care.

QAPI is a data-driven, proactive approach to improving the quality of life, care, and services in nursing homes. The activities of QAPI involve members at all levels of the organization to: identify opportunities for improvement; address gaps in systems or processes; develop and implement an improvement or corrective plan; and continuously monitor effectiveness of interventions.

[1] U.S. Department of Health and Human Services, Health Resources and Services Administration. Quality Improvement adapted from http://www.hrsa.gov/healthit/toolbox/HealthITAdoptiontoolbox/QualityImprovement/whataredifffbtwqinqa.html

WHY QAPI IS IMPORTANT

Once QAPI is launched and sustained, many people report that it is a rewarding and even an enjoyable way of working. The rewards of QAPI include:

- Competencies that equip you to solve quality problems and prevent their recurrence;
- Competencies that allow you to seize opportunities to achieve new goals;
- Fulfillment for caregivers, as they become active partners in performance improvement; and
- Above all, better care and better quality of life for your residents.

Being new at QAPI is like being a new driver…

A new driver must coordinate so many actions and pay attention to so many cues that driving feels awkward, confusing, and almost impossible at first. Yet when it suddenly comes together, it becomes automatic and ushers in new horizons for that driver. In the same way, once you get some QAPI experience, it will come together, seem automatic, and will take you to new places in your quality management.

In the following pages, we discuss QAPI and its inter-related components (QA and PI), and emphasize how it can readily fit into your nursing home. Launching QAPI is not necessarily easy or quick, but it has a compelling logic and it is feasible for all nursing homes, beginning wherever your nursing home is right now.

QAPI Builds on QA&A

QAPI is not entirely new. It uses the existing QA&A, or Quality Assessment and Assurance regulation and guidance as a foundation. Maybe you recognize some of the statements below as things you are already doing:

- You create systems to provide care and achieve compliance with nursing home regulations.
- You track, investigate, and try to prevent recurrence of adverse events.
- You compare the quality of your home to that of other homes in your state or company.
- You receive and investigate complaints.
- You seek feedback from residents and front-line caregivers.
- You set targets for quality.
- You strive to achieve improvement in specific goals related to pressure ulcers, falls, restraints, or permanent caregiver assignment; or other areas; (for example by joining the Advancing Excellence Campaign).
- You are committed to balancing a safe environment with resident choice.
- You strive for deficiency-free surveys.
- You assess residents' strengths and needs to design, implement, and modify person-centered, measurable and interdisciplinary care plans.

You are already partly there. All of this is part of QAPI.

QAPI Features

> *"Not all change is improvement, but all improvement is change."*
>
> *Donald Berwick, MD*
> *Former CMS Administrator*

QAPI includes components that may be new for many nursing homes. It emphasizes improvements that can not only elevate the care and experience of all residents, but also improve the work environment for caregivers. With QAPI, your organization will use a systems approach to actively pursue quality, not just respond to external requirements. Look at the following list of QAPI features. How many are you already using?

- Using data to not only identify your quality problems, but to also identify other opportunities for improvement, and then setting priorities for action
- Building on residents' own goals for health, quality of life, and daily activities
- Bringing meaningful resident and family voices into setting goals and evaluating progress
- Incorporating caregivers broadly in a shared QAPI mission
- Developing Performance Improvement Project **(PIP)** teams with specific "charters"
- Performing a **Root Cause Analysis** to get to the heart of the reason for a problem
- Undertaking systemic change to eliminate problems at the source
- Developing a feedback and monitoring system to sustain continuous improvement

Illustrating QAPI in Action

The scenario below illustrates how a QAA committee might develop a plan of correction in response to deficiencies identified during an annual survey. The example shows how facilities often react to regulatory non-compliance with a "band-aid" approach. The activities described are representative of the types of plans of corrections that are often submitted to Survey Agencies and accepted. It addresses the immediate problem, and then takes steps assumed to prevent recurrence of the problem.

Scenario 1

The Issue: Your nursing home, Whistling Pines, received deficiencies during their annual survey because residents had unexplained weight loss, and weights and food intake were not accurately and consistently documented.

What Whistling Pines did: The QA Committee developed a Plan of Correction, which contained the following components: Re-weighing all residents, and updating the weight records for the affected residents; in-servicing the Nursing Department on obtaining and documenting weights and intake. They stated they would conduct 3 monthly audits of weight and intake records, with results reported to the QA committee.

This plan of correction was accepted by the State Survey Agency.

The next case study shows a facility with effective QAPI systems in place to identify issues proactively, before trends become serious problems. A nursing home chooses a limited number of PIP projects in "high-risk, high volume, problem-prone" areas.

Scenario 2

The Issue: During the monthly QAPI meeting at Whistling Pines, staff discovered a trend of unexplained weight loss among several residents over the last two months. During the discussion, a representative from dining services noted that there had been an increase in the amount of food left on plates, as well as an increase in the amount of supplements being ordered. Although other issues and opportunities for improvement were identified at the meeting, the QAPI Steering Committee decided to launch a Performance Improvement Project (PIP) on the weight loss trend because unexplained weight loss posed a high-risk problem for residents.

What Whistling Pines did: The QAPI Steering Committee chartered a PIP team composed of a certified nursing assistant (CNA), charge nurse, social worker, dietary worker, registered dietitian, and a nurse practitioner. The team studied the issue, and then performed a root cause analysis (RCA) to help direct a plan of action. The RCA revealed several underlying factors, which included:

- No process existed for identifying and addressing risks for weight loss such as dental condition, diagnosis, or use of appetite suppressing medications;
- No system existed to ensure resident preferences are honored;
- Staff lacked an understanding of how to document food intake percentages; and
- Residents reported the food was not appetizing.

Based on the identified underlying causes, the PIP team recommended the following interventions:

- Development of a protocol for identifying residents at risk for weight loss to be done on admission and with each care plan. This protocol included a review of medications (appetite suppressants), new diagnoses, and resident assessments, including dental issues;
- Development of standing orders for residents identified as "at risk" for weight loss. These would include bi-weekly weights, referral to attending physician and dietitian for assessment, and documentation of meal percentages;
- Development of a new program for CNAs to be "Food Plan Leads" for at risk residents. The program would include identification of food preferences and accurate documentation of meals - laminated badge cards with pictures of meal percentages were distributed to all CNAs; and
- Revision of the menu to focus on favorite foods, adding finger foods and increasing choices outside of mealtimes.

The interventions were implemented in one area of the building that was home to 25 residents. The PIP team collected data from dietary (food wasted and supplement use), CNAs (observation of resident satisfaction and meal percentages), residents (satisfaction surveys), and weights.

After 3 months, they found that 5 residents gained weight,15 remained stable, and 5 lost weight, but the weight loss was not unexpected and consistent with their clinical condition. Food costs did not increase and supplement costs decreased by 12%.

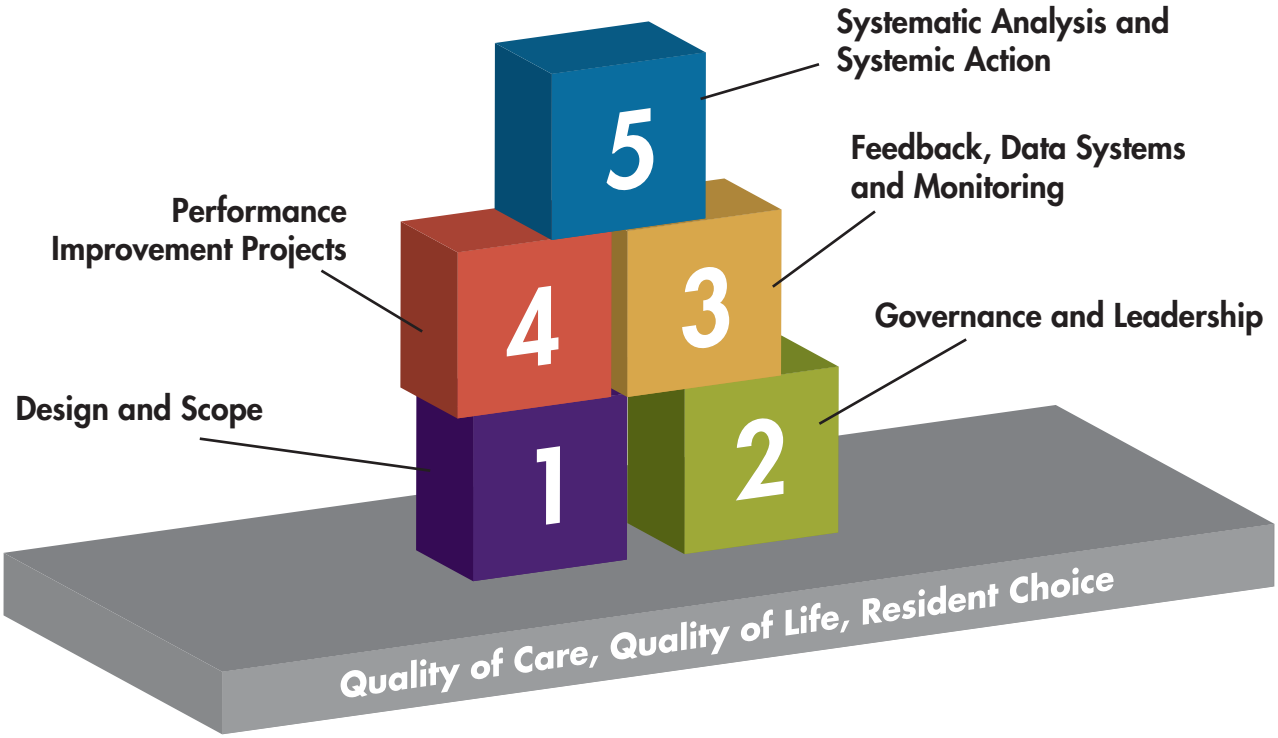
Whistling Pines decided to adopt and expand the changes to other areas of the facility. They received no deficiencies in the areas of nutrition on their annual survey. Using QAPI allowed them to identify and correct developing issues before they escalated to larger problems.

Many of the QAPI action steps discussed in this guide are found in the second scenario. Here are some of the key highlights:

- The facility had a structured Steering Committee for directing the QAPI activities (Step 1).
- The facility established performance measures and was conducting routine monitoring (Step 6).
- The facility used data to identify gaps or opportunities for improvement (Step 8).
- The QAPI Steering Committee used prioritization to decide when to conduct PIPs (Step 9).
- The QAPI Steering Committee created an interdisciplinary team, and as seen in this example, each discipline in the team brought a unique perspective that contributed to a balanced and comprehensive analysis (Step 2).
- The QAPI Steering Committee gave each team member real responsibility to study the issue, analyze the data, and recommend corrective actions (Step 2).
- The PIP team explored the issue, and designed interventions using a Plan-Do-Study-Act (PDSA) model (Steps 9 and 10).
- The PIP team's investigation revealed several underlying systemic issues and made recommendations that addressed those systems, rather than focusing on individual behavior (Step 12).

Five Elements for Framing QAPI in Nursing Homes

CMS has identified five strategic elements that are basic building blocks to effective QAPI. These provide a framework for QAPI development.



The 5 elements are your strategic framework for developing, implementing, and sustaining QAPI. In doing so, keep the following in mind:

- Your QAPI plan should address all five elements.
- The elements are all closely related. You are likely to be working on them all at once—they may all need attention at the same time because they will all apply to the improvement initiatives you choose.
- Your plan is based on your own center's programs and services, the needs of your particular residents, and your assessment of your current quality challenges and opportunities.

THE FIVE ELEMENTS ARE:

Element 1: Design and Scope

A QAPI program must be ongoing and comprehensive, dealing with the full range of services offered by the facility, including the full range of departments. When fully implemented, the QAPI program should address all systems of care and management practices, and should always include clinical care, quality of life, and resident choice. It aims for safety and high quality with all clinical interventions while emphasizing autonomy and choice in daily life for residents (or resident's agents). It utilizes the best available evidence to define and measure goals. Nursing homes will have in place a written QAPI plan adhering to these principles.

Element 2: Governance and Leadership

The governing body and/or administration of the nursing home develops a culture that involves leadership seeking input from facility staff, residents, and their families and/or representatives. The governing body assures adequate resources exist to conduct QAPI efforts. This includes designating one or more persons to be accountable for QAPI; developing leadership and facility-wide training on QAPI; and ensuring staff time, equipment, and technical training as needed. The Governing Body should foster a culture where QAPI is a priority by ensuring policies are developed to sustain QAPI despite changes in personnel and turnover. Their responsibilities include, setting expectations around safety, quality, rights, choice, and respect by balancing safety with resident-centered rights and choice. The governing body ensures staff accountability, while creating an atmosphere where staff are comfortable identifying and reporting quality problems as well as opportunities for improvement.

Element 3: Feedback, Data Systems and Monitoring

The facility puts in place systems to monitor care and services, drawing data from multiple sources. Feedback systems actively incorporate input from staff, residents, families, and others as appropriate. This element includes using Performance Indicators to monitor a wide range of care processes and outcomes, and reviewing findings against benchmarks and/or targets the facility has established for performance. It also includes tracking, investigating, and monitoring Adverse Events that must be investigated every time they occur, and action plans implemented to prevent recurrences.

Element 4: Performance Improvement Projects (PIPs)

A Performance Improvement Project (PIP) is a concentrated effort on a particular problem in one area of the facility or facility wide; it involves gathering information systematically to clarify issues or problems, and intervening for improvements. The facility conducts PIPs to examine and improve care or services in areas that the facility identifies as needing attention. Areas that need attention will vary depending on the type of facility and the unique scope of services they provide.

Element 5: Systematic Analysis and Systemic Action

The facility uses a systematic approach to determine when in-depth analysis is needed to fully understand the problem, its causes, and implications of a change. The facility uses a thorough and highly organized/ structured approach to determine whether and how identified problems may be caused or exacerbated by the way care and services are organized or delivered. Additionally, facilities will be expected to develop policies and procedures and demonstrate proficiency in the use of Root Cause Analysis. Systemic Actions look comprehensively across all involved systems to prevent future events and promote sustained improvement. This element includes a focus on continual learning and continuous improvement.

Action Steps to QAPI

The next few sections detail action steps that may help you on your road to implementing QAPI. They do not need to be achieved sequentially, but each step builds on other QAPI principles.

The most important aspect of QAPI is effective implementation. Learning and understanding the principles is just the first step.

STEP 1: Leadership Responsibility and Accountability

Creating a culture to support QAPI efforts begins with leadership. Support from the top is essential, and that support should foster the active participation of every caregiver. The administrator and senior leaders must create an environment that promotes QAPI and involves all caregivers.

Executive leadership sets the tone and provides resources. Their challenge is to help leadership flourish in each home.

Put a Personal Face on Quality Issues

Leadership should:

- give residents, family and staff the opportunity to meet board members and executive leaders to generate support for QAPI.
- tour the organization regularly, meeting with residents and caregivers where they live and work.
- choose the person or persons who will be the QAPI lead in conjunction with top management—QAPI needs champions.

Here are some ways leadership can take action:

- Develop a steering committee, a team that will provide QAPI leadership:
  - The steering committee has overall responsibility to develop and modify the plan, review information, and set priorities for PIPs. The steering committee charters teams to work on particular problems. It reviews results and determines the next steps. The steering committee must learn and use systems thinking—a nursing home has many competing interests and needs. Top leadership such as the Administrator and the Director of Nursing must be part of this structure.
  - It is also important to have a medical director who is actively engaged in QAPI. It is possible to adapt your Quality Assurance committee to become your "Steering committee" to oversee QAPI. For this to work, the QA Committee may need to meet more often, include more people, and establish permanent and time-limited workgroups that report to it.
- Provide resources for QAPI—including equipment and training:
  - Caregivers may need time to attend team meetings during working hours, requiring others to cover their clinical duties for a period of time.
  - Equipment might include anything from additional computers, to low-cost supplies like posters to create story boards, or multiple copies of resource books or CDs.
  - Leadership may want to consider sending one or more team members to a specialized training.

- Establish a climate of open communication and respect. Leadership may wish to consider:
  - Having an open-door policy to communicate with staff and caregivers.
  - Emphasizing communication across shifts and between department heads.
  - Creating an environment where caregivers feel free to bring quality concerns forward without fear of punishment.
  - Understand your home's current culture and how it will promote performance improvement:
  - Create the expectation that everyone in your nursing home is working on improving care and services.
  - Establish an environment where caregivers, residents, and families feel free to speak up to identify areas that need improvement.
  - Expect and build effective teamwork among departments and caregivers.

STEP 2: Develop a Deliberate Approach to Teamwork

Teamwork is a core component of QAPI and too often it is taken for granted. You will hear and read that you should discuss a situation with "your team," or that the opinion of "everyone on the team" is valued. The word "teamwork" may have different meanings. Many people work together without being a designated or formal "team."

Characteristics of an effective team include the following:

- Having a clear purpose
- Having defined roles for each team member to play
- Having commitment to active engagement from each member

The roles of team workers may grow out of their original discipline (e.g., nurse, social worker, physical therapist) or their defined job responsibilities.

QAPI relies on teamwork in several ways:

- Task-oriented teams may be specially formed to look into a particular problem and their work may be limited and focused.
- PIP teams are formed for longer-term work on an issue.
- When chartering a PIP, careful consideration must be given to the purpose of the PIP and type of members needed to achieve that purpose. Here are some examples:
  - A PIP team with the goal of helping residents go outside more often decided that grounds personnel needed to be on that team so that procedures for snow removal, sun protection, and outdoor seating could be considered.
  - Another PIP team working at simplifying medication regimens included a pharmacist, even though the time needed to be added to the consultant contract.
  - After a PIP team began working on the problem of anxiety among residents, the members realized that many of the affected residents reported reassurance from the pastor and asked the QA committee to add him to the team that was planning the approach.
  - A PIP team working on reducing falls asked that the housekeeping department be involved as it considered root causes of falls and realized that equipment in the corridors and clutter in the bathrooms contributed.

Note: Generally, each team should be composed of interdisciplinary members. For example, a concern with medication administration should include nursing and pharmacy team members. However, even other disciplines or family members may bring a different perspective to understanding this issue and should be considered for this type of team.

- Family members and residents may be team members, though for confidentiality reasons, they may not review certain data or information that identifies individuals.
- PIP teams need to plan for sufficient communication—including face-to-face meetings to get to know each other and plan the work. The team should also plan for the way each team member will review information that emerges from the PIP.
- Leadership needs to convey that being on a PIP team is an important part of the job—not something to put aside if other things come up. They must also support this idea through action and resources to enable staff to complete daily assignments, provide clinical care and also participate on QAPI teams.

STEP 3: Take your QAPI "Pulse" with a Self-Assessment

In order to establish QAPI in your organization, it is helpful to conduct a self-assessment in your organization. As you continue implementing the action steps outlined in this guide, you should periodically evaluate QAPI in your organization – see how far you've come.

To get you started, we've developed a self-assessment tool to take your QAPI "pulse." It will assist you in evaluating the extent to which components of QAPI are in place within your organization and identifying areas requiring further development. It will help you determine how you really know whether QAPI is taking hold.

You may use the self-assessment tool as you begin work on QAPI and then for annual or semiannual evaluation of your organization's progress. You should complete the tool with input from the entire QAPI team and organizational leadership. This is meant to be an honest reflection of your progress with QAPI. The results of this assessment will direct you to areas you need to work on in order to establish QAPI in your organization.

Click here to go to the QAPI Self-Assessment Tool in Appendix A

STEP 4: Identify Your Organization's Guiding Principles

It is important to lay a foundation that will help you think about what principles will guide your decision making and help you set priorities.

Nursing homes are complex organizations, with numerous departments performing different functions that interact with and depend on each other. Establishing a purpose and guiding principles will unify the facility by tying the work being done to a fundamental purpose or philosophy. These principles will help guide your facility in determining programmatic priorities.

Use the Guide for Developing Purpose, Guiding Principles, and Scope for QAPI to establish the principles that will give your organization direction. The team completing this assignment should include senior leadership. Taking time to articulate the purpose, develop guiding principles, and define the scope will help you to understand how QAPI will be used and integrated into your organization. This information will also help your organization to develop a written QAPI plan.

Click here to go to the Guide for Developing Purpose, Guiding Principles, and Scope for QAPI in Appendix A

STEP 5: Develop Your QAPI Plan

Your plan will assist you in achieving what you have identified as the purpose, guiding principles and scope for QAPI. This is a living document that you may revisit as your facility evolves.

A written QAPI plan guides the nursing home's quality efforts and serves as the main document to support implementation of QAPI. The plan describes guiding principles that will be used in QAPI as well as the scope QAPI will have based on the unique characteristics and services of the nursing home. The QAPI plan should be something that is actually used and not viewed as a task that must be completed. You should continually review and refine your QAPI plan.

- Tailor the plan to fit your nursing home including all units, programs, and resident groups (for example, your sub-acute care unit, your dementia care unit, or your palliative care program). Think also of the range of residents. Do you have some younger residents? You may need to consciously develop a distinct plan to create quality of life for those residents.
- Some large organizations or corporations may choose to develop a general plan for all nursing homes in the group—in fact many multi-home organizations already have a corporate quality plan. Flexibility must be built in because individual nursing homes must have a plan that works for them. Leaders at the facility level need flexibility to develop plans for the priorities that fit their needs.

You may use the Guide for Developing a QAPI Plan to help you create a comprehensive plan that addresses the full range and scope of care and services provided by your organization.

Click here to go to the Guide for Developing a QAPI Plan in Appendix A

STEP 6: Conduct a QAPI Awareness Campaign

COMMUNICATE WITH ALL CAREGIVERS

- Let everyone know about your QAPI plan—often and in multiple ways.
- Plan ongoing caregiver education beyond single exposures—the goal is widespread awareness of QAPI initiatives.
- Train through dialogue, examples, and exercises. Transform the material in this guide into smaller pieces and easily understood ideas. Use your home's own experiences with certain caregivers or residents as part of the learning materials.
- Convey the message that QAPI is about systems of care, management practices, and business practices—systems should support quality and/or acceptable business practices, or they must change. Use examples to get the message across, and ask caregivers to think of examples of their own.
- Be sure consultants, contractors, and collaborating agencies are also aware of your QAPI approach. Maybe you have several hospice organizations coming in and out of your home. You may work with a podiatrist who visits regularly. They each have a role in your system.
- Convey the message that any and every caregiver is expected to raise quality concerns, that it is safe to do so, and that everyone is encouraged to think about systems.

- Discuss the hard questions—what is meant by a culture of safety here in our nursing home? How does the nursing home try to balance issues of safety and resident choice/autonomy? These types of questions often do not have easy answers but QAPI opens up these types of issues for discussion and deeper thinking.

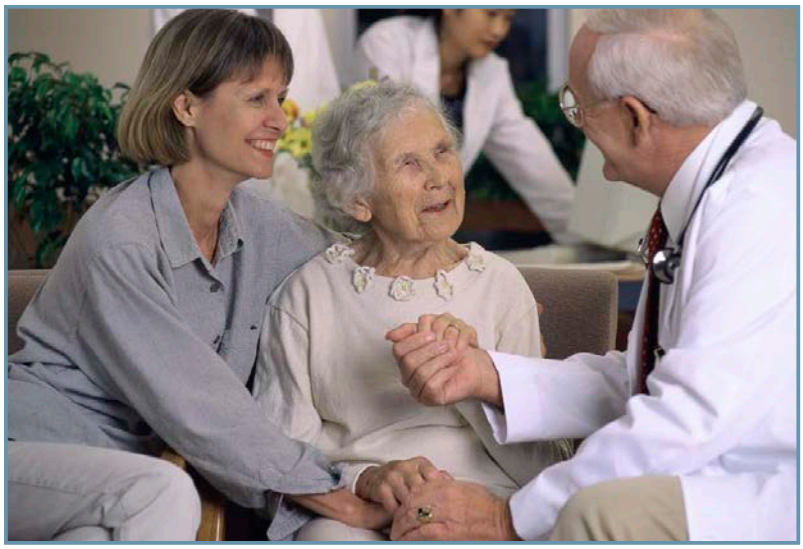
Try this:

An exercise where groups that cross disciplines and roles brainstorm the various ways their work influences the work of others. For example, activities personnel may find that their events are cut short because no one is available to help residents to and from activity areas. Also seek examples where resident choice did not prevail. For instance, evening caregivers may say residents cannot be up and out of their rooms after 9:30 pm because no one will be able to help them to bed after 10:00 pm. Brainstorm how to solve problems like these, even if jobs and routines would change.

If systems don't exist, they may need to be developed. If systems impede quality, they must be changed.

COMMUNICATE WITH RESIDENTS AND FAMILIES

- Make sure all residents and families know that their views are sought, valued, and considered in facility decision-making and process improvements by announcing and discussing QAPI in resident and family councils and other venues.
- Ask residents and family members to tell you about their quality concerns. Many facilities today are using some type of customer-satisfaction survey—results should be used to identify opportunities for improvement that will proactively have an impact on all residents and their families.
- Try to view concerns through residents' eyes. For example, getting back to a resident in 10 minutes may seem responsive, but may feel like an eternity to the resident. How would that feel to a resident waiting an answer to a call light or for help to the bathroom?
- Consider including QAPI information in routine communications to families.



Family and resident complaints are often underused, and yet they are a valuable way of identifying more general problems.

STEP 7: Develop a Strategy for Collecting and Using QAPI Data

Your team will decide what data to monitor routinely. Areas to consider may include:

- Clinical care areas, e.g., pressure ulcers, falls, infections
- Medications, e.g., those that require close monitoring, antipsychotics, narcotics
- Complaints from residents and families
- Hospitalizations and other service use
- Resident satisfaction
- Caregiver satisfaction
- Care plans, including ensuring implementation and evaluation of measurable interventions
- State survey results and deficiencies
- Results from MDS resident assessments
- Business and administrative processes—for example, financial information, caregiver turnover, caregiver competencies, and staffing patterns, such as permanent caregiver assignment. Data related to caregivers who call out sick or are unable to report to work on short notice, caregiver injuries, and compensation claims may also be useful.

This data will require systematic organization and interpretation in order to achieve meaningful reporting and action. Otherwise, it would only be a collection of unrelated, diverse data and may not be useful.

Compare this to an individual resident's health—you must connect many pieces of information to reach a diagnosis. You also need to connect many pieces of information to learn your nursing home's quality baseline, goals, and capabilities.

- Your team should set targets for performance in the areas you are monitoring. A target is a goal, usually stated as a percentage. Your goal may be to reduce restraints to zero; if so, even one instance will be too many. In other cases, you may have both short and longer-term goals. For example, your immediate goal may be reducing unplanned rehospitalizations by 15 percent, and then subsequently by an additional 10 percent. Think of your facility or organization as an athlete who keeps beating his or her own record.

- Identifying benchmarks for performance is an essential component of using data effectively with QAPI. A benchmark is a standard of comparison. You may wish to look at your performance compared to nursing homes in your state and nationally using Nursing Home Compare (www.medicare.gov/nhcompare); some states also have state report cards. You may compare your nursing home to other facilities in your corporation, if applicable. But generally, because every facility is unique, the most important benchmarks are often based on your own performance. For example, seeking to improve hand-washing compliance to 90 percent in 3 months based on a finding of 66 percent in the prior quarter. After achieving 90 percent for some period of time, the benchmark can be raised higher as part of ongoing, continuous improvement.

- It may be helpful to monitor what happens when residents leave the nursing home or come back, including discharges to the hospital or home. You may examine discharge rates from your post-acute care area, preventable hospitalizations (i.e., hospitalizations that can be avoided through good clinical care), and what happens after the resident returns from the hospital.

- You'll want to develop a plan for the data you collect. Determine who reviews certain data, and how often. Collecting information is not helpful unless it is actually used. Be purposeful about who should review certain data, and how often—and about the next steps in interpreting the information.

STEP 8: Identify Your Gaps and Opportunities

This step involves reviewing your sources of information to determine if gaps or patterns exist in your systems of care that could result in quality problems. Or, are there opportunities to make improvements?

Potential areas to consider when reviewing your data:

- MDS data for problem patterns.
- Nursing Home Compare (provides quality information about every certified nursing home in the country).
- State survey results and plans of correction.
- Resident care plans for documented progress towards specified goals.
- Trends in complaints.
- Resident and family satisfaction for trends.
- Patterns of caregiver turnover or absences.
- Patterns of ER and/or hospital use.

During this step, you may decide to spend more time discussing the quality themes you have identified with residents and caregivers. They may pick up patterns you have not yet identified, and they may have ideas about what is at the root of the problem. Consider hosting a series of small group meetings with your caregivers, and arrange to meet with your Resident Council. You may wish to provide refreshments and have an informal discussion.

This step should lead to the next steps involving PIPs. Such projects are expected to be chosen to deal with "high risk, high volume, problem-prone areas" related to quality of care or quality of life. Take time to notice the things you are doing well—that's important too, and deserves recognition.

But while you are celebrating accomplishments, you can also begin to set priorities for improvement around issues that the team identifies.

STEP 9: Prioritize Quality Opportunities and Charter PIPs

Prioritizing opportunities for improvement is a key step in the process of translating data into action.

As you continue to implement QAPI, you and your team will:

- Prioritize opportunities for more intensive improvement work. Problems versus opportunities are a matter of perspective and often require discussion.
- Choose problems or issues that you consider important (consider if the issue is high risk, high frequency, and/or problem prone). Remember that problems affecting psychosocial well-being and the ability of residents to exercise choice should also be considered as they may lead to resident suffering.
- Consider which problems will become the focus for a PIP.

- All identified problems need attention—and usually from more than one person, but they do not all require PIPs.
- Begin some PIPs with problems you think you can solve relatively easily. A quick win is worthwhile.

Charter PIP teams:

We use the word "charter" on purpose. A PIP is more than a casual effort - it entails a specific written mission to look into a problem area. The PIP team should include people in a position to explore the problem (usually direct caregivers, such as nursing assistants, are needed). If the problem being addressed involves, for example, dietary choices, then someone from the dietary department should also be on the PIP team.

Chartering implies that the team has been entrusted with a mission, and that it reports back to the Steering Committee at intervals. Being part of a formally chartered PIP team must be interpreted as an important assignment that team members and their supervisors must take seriously. The development of a charter adds strength, importance, and formality to the PIP process. The team typically has a leader—either chosen in the charter or by the team itself. Soon after it begins its work, the PIP should develop a proposed time line, and indicate the budget that is needed.

Use the Goal Setting Worksheet to help your PIP team establish appropriate goals for organizational quality measures, informal improvement initiatives, and PIPs.

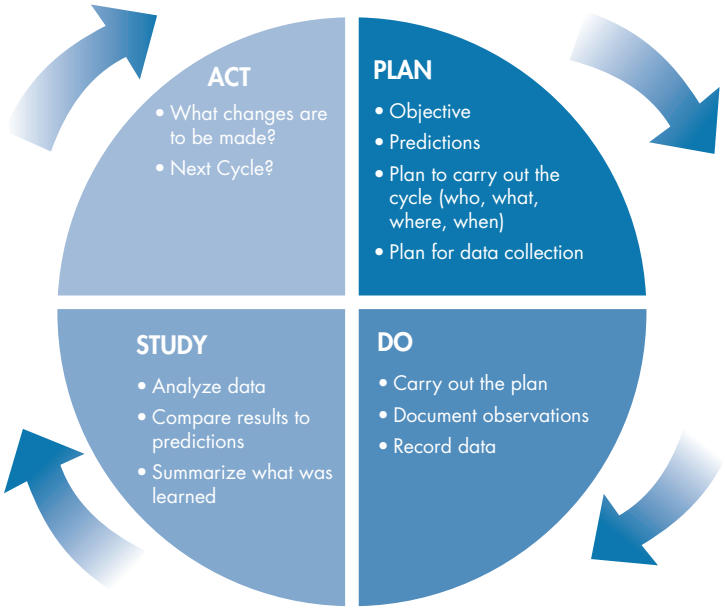
Click here to go to the Goal Setting Worksheet in Appendix A

STEP 10: Plan, Conduct and Document PIPs

Careful planning of PIPs includes identifying areas to work on through your comprehensive data review which are meaningful and important to your residents. It is important to focus your PIPs by defining the scope, so they do not become overwhelming.

You and your team may:

- consider each PIP a learning process.
- determine what information you need for the PIP.
- determine a timeline and communicate it to the Steering Committee.
- identify and request any needed supplies or equipment.
- select or create measurement tools as needed;
- prepare and present results.
- use a problem solving model like PDSA (Plan-Do-Study-Act).
- report results to the Steering Committee.



PDSA MODEL

PLAN-DO-STUDY-ACT (PDSA) CYCLE

During a PIP you will try out some changes and then see whether or not they made a difference in the area you were trying to improve. In the PLAN stage, the team learns more about the problem, plans for how improvement would be measured, and plans for any changes that might be implemented. In the DO stage, the plan is carried out, including the measures that are selected. In the STUDY phase, the team summarizes what was learned. In the ACT phase, the team and leadership determine what should be done next. The change can be adapted (and re-studied), adopted (perhaps expanded to other areas), or abandoned. That decision determines the next steps in the cycle.

STEP 11: Getting to the "Root" of the Problem

A major challenge in process improvement is getting to the heart of the problem or opportunity.

There is danger in starting with a solution without thoroughly exploring the problem. Multiple factors may have contributed, and/or the problem may be a symptom of a larger issue. What seems like a simple issue may involve a number of departments.

Root Cause Analysis (RCA) is a term used to describe a systematic process for identifying contributing causal factors that underlie variations in performance. This structured method of analysis is designed to get to the underlying cause of a problem –which then leads to identification of effective interventions that can be implemented in order to make improvements.

RCA helps teams understand that the most immediate or seemingly obvious reason for the problem or an event may not be the real reason that an event occurred. The RCA process leads to digging deeper and deeper—looking for the reasons behind the reasons. This process will generally lead to the identification of more than one root cause. The root cause(s) and any contributing factors can then be sorted into categories to facilitate the identification of various actions that can be taken to make improvements.

RCA focuses primarily on systems and processes, not individual performance.

The RCA process takes practice, but can be a valuable tool for performance improvement. In order to get familiar with RCA you and your team may consider:

- studying case examples of RCA.
- applying RCA to an adverse event and discussing this technique with the team.
- building RCA examples into training opportunities.

STEP 12: Take Systemic Action

Identifying root causes is only the first step in improving performance. Next you will want to implement changes or corrective actions that will result in improvement or reduce the chance of the event recurring. This is often the most challenging step in the process. Common solutions such as providing more training/education or asking clinicians to "be more careful" do not change the process or system. These proposed solutions are based on two assumptions: lack of knowledge contributed to the event, and if a person is educated or trained, the mistake won't happen again.

Choosing actions that are tightly linked to the root causes and that lead to a system or process change are considered to have a higher likelihood of being effective. Actions that simply support the current process are considered "weaker" and should not be selected as the sole intervention. The goal is to make changes that will result in lasting improvement. Avoiding quick fixes and weak actions is vital to achieving that goal.

To be effective, interventions or corrective actions should target the elimination of root causes, offer long term solutions to the problem, and have a greater positive than negative impact on other processes. In addition, interventions must be achievable, objective, and measurable.

Pilot Test:

Think about testing or "piloting" changes in one area of your facility before launching throughout. Some changes have unintended consequences.

The Department of Veterans Affairs National Center for Patient Safety's Hierarchy of Actions[2] classifies corrective actions as:

Weak: Actions that depend on staff to remember their training or what is written in the policy. Weak actions enhance or enforce existing processes.

Examples of weak actions:

- double checks
- warnings/labels
- new policies/procedures/memoranda
- training/education
- additional study

Intermediate: Actions are somewhat dependent on staff remembering to do the right thing, but they provide tools to help staff to remember or to promote clear communication. Intermediate actions modify existing processes.

Examples of intermediate actions:

- decrease workload
- software enhancements/modifications
- eliminate/reduce distraction
- checklists/cognitive aids/triggers/prompts
- eliminate look alike and sound alike
- read back
- enhanced documentation/communication
- build in redundancy

[2]U.S. Department of Veterans Affairs. National Center for Patient Safety Root Cause Analysis Tools. Retrieved from http://www.patientsafety.gov/CogAids/RCA/index.html#page+page-1.

Strong: Actions that do not depend on staff to remember to do the right thing. The action may not totally eliminate the vulnerability but provides strong controls. Strong actions change or re-design the process. They help detect and warn so there is an opportunity to correct before the error reaches the patient. They may involve hard stops which won't allow the process to continue unless something is corrected or gives the chance to intervene to prevent significant harm.

Examples of strong actions:

- physical changes: grab bars, non slip strips on tubs/showers
- forcing functions or constraints: design of gas lines so that only oxygen can be connected to oxygen lines; electronic medical records – cannot continue charting unless all fields are filled in
- simplifying: unit dose

Prevent future problems by developing and testing strong actions.

QAPI Principles Summarized

- All of QAPI may not be new to your facility. You already have a Quality Assessment and Assurance program—consider beginning by evaluating or re-evaluating that program and then conducting a self evaluation using the QAPI Self Assessment Tool.
- QAPI leadership starts at the top with executive management and the Board of Directors, Owners, or Trustees, and includes top management in each home.
- Three important principles of QAPI are Systems, Systems, and Systems. Start using systems thinking as you assess your own QAPI efforts, and develop a QAPI plan moving forward. Think of your entire center or community as you plan for monitoring, as you conduct PIPs, and particularly as you think about the way problems might be caused and how care is organized.
- Involve the people directly working in a process in order to improve that process. These are the people who really know what happens at any point in the process. It is crucial to focus on organization-wide inclusion, not for the sake of inclusion, but to truly understand what is going on in any given process.
- Communication about QAPI should be continuous throughout the whole organization. QAPI principles and ongoing training should be built into a facility-wide educational effort that involves all caregivers, residents, and families.
- Residents' perspectives need to be considered in setting QAPI priorities. Solicit residents' viewpoints and talk to residents and families about quality as they experience it.
- Two important components of your QAPI plan will be setting priorities and chartering PIP teams. Everyone should have an opportunity to participate in these activities.
- Create a record of QAPI activities. Consider using past experience as a resource as you move ahead. Keeping an ongoing record of QAPI achievements may help to sustain the improvements regardless of crises or changes in leadership. Build it into your plan.
- Celebrate and reward successes.

How to Learn More

Our QAPI website: http://go.cms.gov/Nhqapi

An excellent resource on QAPI in Nursing Homes is CMS' QAPI website. It contains a number of tools and resources including:

- Learning modules complete with videos, QAPI Process Tools and how to use them, case study examples, best practices information, sections to help engage consumers, and much more
- Downloadable QAPI process tools with instructions for their use
- Best practice examples organized by topic
- QAPI tools for specific topics and purposes with links to many related resources
- Special resources for you in your particular practice role in the "Communities of Practice" section
- News Briefs on QAPI implementation

QAPI Tools and Related Resources

QAPI PROCESS TOOLS

These are tools that help make QAPI processes work. They may include:

- checklists
- templates
- flow charts
- reporting forms or outlines
- worksheets

QAPI process tools are important to:

- organize multiple tasks.
- enhance communication within and across teams.
- help generate ideas and reach decisions.
- keep information organized and accessible.
- track successes and challenges using data.

QAPI is largely about well-functioning and tightly coordinated systems that can identify, solve, and prevent problems effectively. Using QAPI can improve diverse aspects of care and services as well as resident, family, caregiver, and staff experience and satisfaction. **TOOLS CAN HELP.**

QAPI TOPIC TOOLS

QAPI Topic Tools are used to study and improve particular topic areas. Many tools are available to assess care processes and outcomes and to allow you to follow progress in areas you want to track and/or improve. Topic tools can take many forms, ranging from simple to complex, and they use multiple sources of information.

- Checklists or audits completed by caregivers and practitioners. Checklists can be used to review records of various kinds to determine that all steps have been taken. For example, an admission or fall prevention checklist.
- Rating forms completed by caregivers. For example,residents' mood states are rated when residents cannot respond to direct questions.
- Structured observation (e.g., observations of interactions among residents and caregivers or of physical environments). Observations are objective and made at specific times and places; later they may be summarized into a score.
- Direct interviews with residents and family. Such tools, sometimes called resident self-report tools, may be related to single areas of functioning.
- Protocols to guide caregivers' behavior to improve quality in a particular area. Such protocols may include procedures and forms meant to shape caregiver behavior around pressure ulcer prevention, respecting residents' rights, etc. This comprehensive set of tools could be considered a QAPI process toolkit as well.

Nursing homes may wish to select established tools that have been tested and use them consistently.

QAPI RESOURCES FOR PROVIDERS

Each state is served by a Quality Improvement Organization that offers resources and tools for nursing homes. To find your Quality Improvement Organization, visit http://www.qualitynet.org/dcs/ContentServer?c=Page&pagename=QnetPublic%2FPage%2FQnetTier2&cid=1144767874793

RESOURCES AND TOOLS AVAILABLE THROUGH QIOS

Oklahoma Foundation for Medical Quality
Provides tools and resources for nursing homes.
http://www.ofmq.com/nhtoolsandresources Improvement basics for nursing homes, Change management, and Facilitating group agreement.

Stratis Health
The following recorded webinars cover some basic principles of QI and can be used for caregiver education: http://www.stratishealth.org/events/recorded.html

WEBSITES ON SELECTED QUALITY TOPICS

Advancing Excellence in America's Nursing Homes
Supported by CMS, the Commonwealth Fund, and others, The Advancing Excellence Campaign provides tools and resources to improve nursing home care in clinical and organizational areas.
http://www.nhqualitycampaign.org/

Agency for Healthcare Research and Quality
The Department of Defense and the Agency for Healthcare Research and Quality developed the Team STEPPS program to optimize performance among teams of healthcare professionals and improve collaboration and communication. The Long-Term Care version addresses issues specific to nursing homes: http://www.ahrq.gov/professionals/education/curriculum-tools/teamstepps/ltc/index.html.

Department of Veterans Affairs
National Center for Patient Safety supports and leads the patient safety activities for all VA medical centers and has developed tools including Root Cause Analysis investigations: http://www.patientsafety.gov/CogAids/RCA/.

Getting Better All the Time: Working Together for Continuous Improvement
The Isabella Geriatric Center and Cobble Hill Health Center have developed a web manual on quality improvement approaches as a guide for nursing home caregivers. This is a particularly practical and lively resource that explains and illustrates performance monitoring and improvement approaches in ways that are understandable to most nursing home caregivers. *Getting Better All the Time* was written by Ann Wyatt, a social worker and nursing home administrator; it aims to present a model of quality improvement that integrates quality of care and quality life.
http://www.susanwehrymd.com/files/gettingbetterall-the-time.pdf

Interact II
An example of a more extensive set of tools, INTERACT II is a system of tools to improve how nursing home caregivers communicate around change in resident condition. This comprehensive set of tools could be considered a QAPI process toolkit as well. www.interact2.net

Institute for Health Care Improvement (IHI)
IHI uses the Model for Improvement as the framework to guide improvement work. The Model for Improvement, developed by Associates in Process Improvement, is a simple, yet powerful tool for accelerating improvement. Learn about the fundamentals of the Model for Improvement and testing changes on a small scale using Plan-Do-Study-Act (PDSA) cycles.
http://www.ihi.org/knowledge/Pages/HowtoImprove/default.aspx

WEBSITES ON PERSON-CENTERED CARE

Implementing Change in Long-Term Care: A Practical Guide to Transformation
This resource was prepared by Barbara Bowers and others with a grant from the Commonwealth Fund to the Pioneer Network. Although it deals with implementing culture change (not QAPI), it is a good resource on the change process.
http://www.pioneernetwork.net/Data/Documents/Implementation_Manual_ChangeInLongTermCare%5B1%5D.pdf

Picker Institute Publications
These include a *Long-Term Care Improvement Guide*, commissioned in 2010 and a *Patient-Centered Care Improvement Guide*, commissioned in 2008, both by Susan Frampton and others. The website also carries information on current books related to person centered care that Picker Institute recommends.
http://pickerinstitute.org/publications-and-resources/

Appendix A: QAPI Tools

Disclaimer: Use of these tools is not mandated by CMS for regulatory compliance nor does their completion ensure regulatory compliance.

QAPI Self-Assessment Tool

Directions: Use this tool as you begin work on QAPI and then for annual or semiannual evaluation of your organization's progress with QAPI. This tool should be completed with input from the entire QAPI team and organizational leadership. This is meant to be an honest reflection of your progress with QAPI. The results of this assessment will direct you to areas you need to work on in order to establish QAPI in your organization. You may find it helpful to add notes under each item as to why you rated yourself a certain way.

Date of Review:_____ Next review scheduled for:_____

Rate how closely each statement fits your organization	Not started	Just starting	On our way	Almost there	Doing great
Our organization has developed principles guiding how QAPI will be incorporated into our culture and built into how we do our work. For example, we can say that QAPI is a method for approaching decision making and problem solving rather than considered as a separate program. Notes:					
Our organization has identified how all service lines and departments will utilize and be engaged in QAPI to plan and do their work. For example, we can say that all service lines and departments use data to make decisions and drive improvements, and use measurement to determine if improvement efforts were successful. Notes:					
Our organization has developed a written QAPI plan that contains the steps that the organization takes to identify, implement and sustain continuous improvements in all departments; and is revised on an ongoing basis. For example, a written plan that is done purely for compliance and not referenced would not meet the intent of a QAPI plan. Notes:					
Our board of directors and trustees (if applicable) are engaged in and supportive of the performance improvement work being done in our organization. For example, it would be evident from meeting minutes of the board or other leadership meetings that they are informed of what is being learned from the data, and they provide input on what initiatives should be considered. Other examples would be having leadership (board or executive leadership) representation on performance improvement projects or teams, and providing resources to support QAPI. Notes:					

Rate how closely each statement fits your organization	Not started	Just starting	On our way	Almost there	Doing great
QAPI is considered a priority in our organization. For example, there is a process for covering caregivers who are asked to spend time on improvement teams. Notes:					
QAPI is an integral component of new caregiver orientation and training. For example, new caregivers understand and can describe their role in identifying opportunities for improvement. Another example is that new caregivers expect that they will be active participants on improvement teams. Notes:					
Training is available to all caregivers on performance improvement strategies and tools. Notes:					
When conducting performance improvement projects, we make a small change and measure the effect of that change before implementing more broadly. An example of a small change is pilot testing and measuring with one nurse, one resident, on one day, or one unit, and then expanding the testing based on the results. Notes:					
When addressing performance improvement opportunities, our organization focuses on making changes to systems and processes rather than focusing on addressing individual behaviors. For example, we avoid assuming that education or training of an individual is the problem, instead, we focus on what was going on at the time that allowed a problem to occur and look for opportunities to change the process in order to minimize the chance of the problem recurring. Notes:					
Our organization has established a culture in which caregivers are held accountable for their performance, but not punished for errors and do not fear retaliation for reporting quality concerns. For example, we have a process in place to distinguish between unintentional errors and intentional reckless behavior and only the latter is addressed through disciplinary actions. Notes:					

Rate how closely each statement fits your organization	Not started	Just starting	On our way	Almost there	Doing great
Leadership can clearly describe, to someone unfamiliar with the organization, our approach to QAPI and give accurate and up-to-date examples of how the facility is using QAPI to improve quality and safety of resident care. For example, the administrator can clearly describe the current performance improvement initiatives, or projects, and how the work is guided by caregivers involved in the topic as well as input from residents and families. Notes:					
Our organization has identified all of our sources of data and information relevant to our organization to use for QAPI. This includes data that reflects measures of clinical care; input from caregivers, residents, families, and stakeholders, and other data that reflects the services provided by our organization. For example, we have listed all available measures, indicators or sources of data and carefully selected those that are relevant to our organization that we will use for decision making. Likewise, we have excluded measures that are not currently relevant and that we are not actively using in our decision making process. Notes:					
For the relevant sources of data we identify, our organization sets targets or goals for desired performance, as well as thresholds for minimum performance. For example, our goal for resident ratings for recommending our facility to family and friends is 100% and our threshold is 85% (meaning we will revise the strategy we are using to reach our goal if we fall below this level). Notes:					
We have a system to effectively collect, analyze, and display our data to identify opportunities for our organization to make improvements. This includes comparing the results of the data to benchmarks or to our internal performance targets or goals. For example, performance improvement projects or initiatives are selected based on facility performance as compared to national benchmarks, identified best practice, or applicable clinical guidelines. Notes:					
Our organization has, or supports the development of, employees who have skill in analyzing and interpreting data to assess our performance and support our improvement initiatives. For example, our organization provides opportunities for training and education on data collection and measurement methodology to caregivers involved in QAPI. Notes:					

Rate how closely each statement fits your organization	Not started	Just starting	On our way	Almost there	Doing great
From our identified opportunities for improvement, we have a systematic and objective way to prioritize the opportunities in order to determine what we will work on. This process takes into consideration input from multiple disciplines, residents and families. This process identifies problems that pose a high risk to residents or caregivers, is frequent in nature, or otherwise impact the safety and quality of life of the residents. Notes:					
When a performance improvement opportunity is identified as a priority, we have a process in place to charter a project. This charter describes the scope and objectives of the project so the team working on it has a clear understanding of what they are being asked to accomplish. Notes:					
For our Performance Improvement Projects, we have a process in place for documenting what we have done, including highlights, progress, and lessons learned. For example, we have project documentation templates that are consistently used and filed electronically in a standardized fashion for future reference. Notes:					
For every Performance Improvement Project, we use measurement to determine if changes to systems and process have been effective. We utilize both process measures and outcome measures to assess impact on resident care and quality of life. For example, if making a change, we measure whether the change has actually occurred and also whether it has had the desired impact on the residents. Notes:					
Our organization uses a structured process for identifying underlying causes of problems, such as Root Cause Analysis. Notes:					

Rate how closely each statement fits your organization	Not started	Just starting	On our way	Almost there	Doing great
When using Root Cause Analysis to investigate an event or problem, our organization identifies system and process breakdowns and avoids focus on individual performance. For example, if an error occurs, we focus on the process and look for what allowed the error to occur in order to prevent the same situation from happening with another caregiver and another resident. Notes:					
When systems and process breakdowns have been identified, we consistently link corrective actions with the system and process breakdown, rather than having our default action focus on training education, or asking caregivers to be more careful, or remember a step. We look for ways to assure that change can be sustained. For example, if a policy or procedure was not followed due to distraction or lack of caregivers, the corrective action focuses on eliminating distraction or making changes to staffing levels. Notes:					
When corrective actions have been identified, our organization puts both process and outcome measures in place in order to determine if the change is happening as expected and that the change has resulted in the desired impact to resident care. For example, when making a change to care practices around fall prevention there is a measure looking at whether the change is being carried out and a measure looking at the impact on fall rate. Notes:					
When an intervention has been put in place and determined to be successful, our organization measures whether the change has been sustained. For example, if a change is made to the process of medication administration, there is a plan to measure both whether the change is in place, and having the desired impact (this is commonly done at 6 or 12 months). Notes:					

Guide for Developing Purpose, Guiding Principles, and Scope for QAPI

Directions: Use this tool to establish the purpose, guiding principles and scope for QAPI in your organization. The team completing this worksheet should include senior leadership. Taking time to articulate the purpose, develop guiding principles, and define the scope will help you to understand how QAPI will be used and integrated into your organization. This information will also help your organization to develop a written QAPI plan. Use these step-by-step instructions to create a separate document that may be used as a preamble to your QAPI plan.

STEP 1. LOCATE OR DEVELOP YOUR ORGANIZATION'S VISION STATEMENT

A **vision statement** is sometimes called a picture of your organization in the future; it is your inspiration and the framework for your strategic planning. Consider involving staff in the development of your vision statement. Post it for everyone to view.

For example, the vision of the Good Samaritan Society is to create an environment where people are loved, valued and at peace.

STEP 2. LOCATE OR DEVELOP YOUR ORGANIZATION'S MISSION STATEMENT

A **mission statement** describes the purpose of your organization. The mission statement should guide the actions of the organization, spell out its overall goal, provide a path, and guide decision-making. It provides the framework or context within which the company's strategies are formulated. As above, get caregivers involved in establishing your organizations mission.

For example, Meadowlark Hills is each resident's home. We are committed to enhancing quality of life by nurturing individuality and independence. We are growing a value-driven community while leading the way in honoring inherent senior rights and building strong and meaningful relationships with all whose lives we touch.

STEP 3. DEVELOP A PURPOSE STATEMENT FOR QAPI

A **purpose statement** describes how QAPI will support the overall vision and mission of the organization. If your organization does not have a vision or mission statement, the purpose statement can still be written and would state what your organization intends to accomplish through QAPI.

For example, the purpose of QAPI in our organization is to take a proactive approach to continually improving the way we care for and engage with our residents, caregivers and other partners so that we may realize our vision to [reference aspects of vision statement here]. To do this, all employees will participate in ongoing QAPI efforts which support our mission by [reference aspects of mission statement here].

STEP 4. ESTABLISH GUIDING PRINCIPLES

Guiding Principles describe the organization's beliefs and philosophy pertaining to quality assurance and performance improvement. The principles should guide what the organization does, why it does it and how.

For example:

- Guiding Principle #1: QAPI has a prominent role in our management and Board functions, on par with monitoring reimbursement and maximizing revenue.
- Guiding Principle #2: Our organization uses quality assurance and performance improvement to make decisions and guide our day-to-day operations.
- Guiding Principle #3: The outcome of QAPI in our organization is the quality of care and the quality of life of our residents.
- Guiding Principle #4: In our organization, QAPI includes all employees, all departments and all services provided.
- Guiding Principle #5: QAPI focuses on systems and processes, rather than individuals. The emphasis is on identifying system gaps rather than on blaming individuals.
- Guiding Principle #6: Our organization makes decisions based on data, which includes the input and experience of caregivers, residents, health care practitioners, families, and other stakeholders.
- Guiding Principle #7: Our organization sets goals for performance and measures progress toward those goals.
- Guiding Principle #8: Our organization supports performance improvement by encouraging our employees to support each other as well as be accountable for their own professional performance and practice.
- Guiding Principle #9: Our organization has a culture that encourages, rather than punishes, employees who identify errors or system breakdowns.

Add any additional Guiding Principles that may be important to your nursing home. Review the five QAPI elements to ensure you identify and capture guiding principles for your organization.

STEP 5. DEFINE THE SCOPE OF QAPI IN YOUR ORGANIZATION

The **Scope** outlines what types of care and services are provided by the organization that impact clinical care, quality of life, resident choice, and care transitions. Be sure to incorporate the care and services delivered by all departments.

For example:

Post-acute care
Dementia care and services
Dietary
Dining

Once the list of care and service area has been identified, you can determine how each will use QAPI to assess, monitor and improve performance on an ongoing basis.

STEP 6. ASSEMBLE DOCUMENT

Once you've completed steps 1-5, assemble the vision and mission statements, guiding principles, and scope of QAPI into a separate document that may be used as a preamble to your QAPI plan. This document will help you articulate the goals and objectives of your organization; QAPI will help you get there. Consider posting for all to see.

The next step is to develop a written QAPI plan that will meet your purpose, guiding principles and comprehensive scope described above. See *"Guide for Developing a QAPI Plan."*

Disclaimer: Use of this tool is not mandated by CMS for regulatory compliance nor does its completion ensure regulatory compliance.

Guide for Developing a QAPI Plan

DIRECTIONS:

The QAPI plan will guide your organization's performance improvement efforts. Prior to developing your plan, complete the *Guide to Develop Purpose, Guiding Principles, and Scope for QAPI.* Your QAPI plan is intended to assist you in achieving what you have identified as the purpose, guiding principles and scope for QAPI, therefore this information is needed before you begin working on your plan. This is a living document that you will continue to refine and revisit. Use these step-by-step instructions to create your QAPI plan. This plan should reflect input from caregivers representing all roles and disciplines within your organization.

I. QAPI Goals

Based on the *Guide to Develop Purpose, Guiding Principles, and Scope for QAPI*, indicate the QAPI goals that your plan will strive to meet. Goals should be specific, measurable, actionable, relevant, and have a time line for completion. (See *Goal Setting Worksheet*).

II. Scope

a. Describe how QAPI is integrated into all care and service areas of your organization.

b. Describe how the QAPI plan will address:

   i. Clinical care

   ii. Quality of life

   iii. Resident choice (i.e., individualized goals for care)

c. Describe how QAPI will aim for safety and high quality with all clinical interventions while emphasizing autonomy and choice in daily life for residents (or resident's agents).

d. Describe how QAPI will utilize the best available evidence (e.g., data, national benchmarks, published best practices, clinical guidelines) to define and measure goals.

III. Guidelines for Governance and Leadership

a. Describe how QAPI is integrated into the responsibilities and accountabilities of top-level management and the Board of Directors (if applicable).

b. Describe how QAPI will be adequately resourced.

   i. Designate one or more persons to be accountable for QAPI leadership and for coordination.

   ii. Indicate the plan for developing leadership and facility-wide training on QAPI.

   iii. Describe the plan to provide caregivers time, equipment, and technical training as needed for QAPI.

   iv. Indicate how you will determine if resources are adequate for QAPI.

   v. Describe how your caregivers will become and remain proficient with process improvement tools and techniques. How will you assess their level of proficiency?

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c. QAPI Leadership

   i. While everyone in the organization is involved in QAPI, you will likely have a small group of individuals who will provide the backbone or structure for QAPI in your organization. Who will be part of this group? Many of these individuals may be on your current QAA committee.

   ii. Describe how this group of people will work together, communicate, and coordinate QAPI activities. This could include but is not limited to:

   - Establishing a format and frequency for meetings
   - Establishing a method for communication between meetings
   - Establishing a designated way to document and track plans and discussions addressing QAPI.

   iii. Describe how the QAPI activities will be reported to the governing body; i.e., Board of Directors, owner.

IV. Feedback, Data Systems, and Monitoring

a. Describe the overall system that will be put in place to monitor care and services, drawing data from multiple sources.

b. Identify the sources of data that you will monitor through QAPI

   i. Input from caregivers, residents, families, and others

   ii. Adverse events

   iii. Performance indicators

   iv. Survey findings

   v. Complaints

c. Describe the process for collecting the above information.

d. Describe the process for analyzing the above information, including how findings will be reviewed against benchmarks and/or targets established by the facility.

e. Describe the process to communicate the above information. What types of reports will be used? One way to accomplish this is to use a dashboard or dashboards for individual performance improvement projects.

f. Identify who will receive this information (i.e., executive leadership, QAPI leadership, resident/family council, and a center's caregivers), in what format, and how frequently information will be disseminated.

V. Guidelines for Performance Improvement Projects (PIPs)

a. Describe the overall plan for conducting PIPs to improve care or services.

   i. Indicate how potential topics for PIPs will be identified.

   ii. Describe criteria for prioritizing and selecting PIPs: areas important and meaningful for the specific type and scope of services unique to the facility, requires a concentrated effort on a particular problem in one area of the facility or facility wide.

   iii. Indicate how and when PIP charters will be developed.

   iv. Describe the process for reporting the results of PIPs. Identify who will receive this information (i.e., quality committee, resident/family council, and a center's caregivers), in what format, and how frequently information will be disseminated.

b. Describe how to designate PIP teams and establish and describe a process for assembling teams to work on specific PIPs.

c. Define the required characteristics for any PIP team. This may include that the team be interdisciplinary (i.e., representing each of the job roles affected by the project), that it include resident representation (as appropriate), and that a qualified team leader is selected (i.e., ability to coordinate, organize and direct all activities of the project team). Describe how PIP teams should document and report their work.

d. Describe your process for documenting PIPs, including highlights, progress, and lessons learned. For example, what project documentation templates will you use consistently and file electronically in a standardized fashion for future reference.

VI. Systematic Analysis and Systemic Action

a. Any change that is made has the potential to have broader impact than intended. If you are trying to make a change to a specific system or process, it is important to recognize any "unintended" consequences of your actions. Describe how your organization will identify these consequences which may be either positive or negative.

b. Describe the process you will use to ensure you are getting at the underlying causes of issues, rather than applying quick fixes that address symptoms only.

c. Describe how you will monitor to ensure that interventions or actions are implemented and effective in making and sustaining improvements.

VII. Communications

Outline the audiences for QAPI communications and the frequency and format of these communications.

VIII. Evaluation

a. Describe the process for assessing QAPI in your organization on an ongoing basis. (See *QAPI Self-Assessment Tool*.)

b. Describe the purpose of this evaluation – to help your organization to expand your skills in QAPI and increase the impact of QAPI in your organization.

IX. Establishment of Plan

a. Date your plan.

b. Determine when you will revisit the plan (i.e., at least annually).

c. Determine how you will track revisions or updates to the plan.

Goal Setting Worksheet

Directions: Goal setting is important for any measurement related to performance improvement. This worksheet is intended to help QAPI teams establish appropriate goals for individual measures and also for performance improvement projects. Goals should be clearly stated and describe what the organization or team intends to accomplish. Use this worksheet to establish a goal by following the SMART formula outlined below. Note that setting a goal does **not** involve describing what steps will be taken to achieve the goal.

Describe the business problem to be solved:

Use the SMART formula to develop a goal:

SPECIFIC

Describe the goal in terms of 3 'W' questions:

What do we want to accomplish?
Who will be involved/affected?
Where will it take place?

MEASURABLE

Describe how you will know if the goal is reached:

What is the measure you will use?
What is the current data figure (i.e., count, percent, rate) for that measure?
What do you want to increase/decrease that number to?

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ATTAINABLE

Defend the rationale for setting the goal measure above:

Did you base the measure or figure you want to attain on a particular best practice/average score/benchmark?
Is the goal measure set too low that it is not challenging enough?
Does the goal measure require a stretch without being too unreasonable?

RELEVANT

Briefly describe how the goal will address the business problem stated above.

TIME-BOUND

Define the timeline for achieving the goal:

What is the target date for achieving this goal?

Write a goal statement, based on the SMART elements above. The goal should be descriptive, yet concise enough that it can be easily communicated and remembered.

[*Example:* Increase the number of long-term residents with a vaccination against both influenza and pneumococcal disease documented in their medical record from 61 percent to 90 percent by December 31, 2011.]

Tip: It's a good idea to post the written goal somewhere visible and regularly communicate the goal during meetings in order to stay focused and remind caregivers that everyone is working toward the same aim.

Appendix B: QAPI Definitions

Performance Improvement (PI)

PI (also called Quality Improvement - QI) is a pro-active and continuous study of processes with the intent to prevent or decrease the likelihood of problems by identifying areas of opportunity and testing new approaches to fix underlying causes of persistent/systemic problems. PI in nursing homes aims to improve processes involved in health care delivery and resident quality of life. PI can make good quality even better.

Performance Improvement Project (PIP)

A PIP project typically is a concentrated effort on a particular problem in one area of the facility or facility wide; it involves gathering information systematically to clarify issues or problems, and intervening for improvements. PIPs are selected in areas important and meaningful for the specific type and scope of services unique to each facility.

Quality Assurance and Performance Improvement (QAPI)

QAPI is a data-driven, proactive approach to improving the quality of life, care, and services in nursing homes. The activities of QAPI involve members at all levels of the organization to: identify opportunities for improvement; address gaps in systems or processes; develop and implement an improvement or corrective plan; and continuously monitor effectiveness of interventions.

Quality Assurance (QA)

QA is a process of meeting quality standards and assuring that care reaches an acceptable level. Nursing homes typically set QA thresholds to comply with regulations. They may also create standards that go beyond regulations. QA is a reactive, retrospective effort to examine why a facility failed to meet certain standards. QA activities do improve quality, but efforts frequently end once the standard is met.

Root Cause Analysis (RCA)

Root cause analysis is a term to describe a systematic process to get to the underlying cause of a problem.

Systems Thinking

Systems thinking is a perspective that considers how things influence one another as a whole, rather than individual elements, or static "snapshots."

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Facility Assessment Worksheet Summary
QAPI

Design & Scope: _____

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Governance & Leadership: _____

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Feedback, Data Systems & Monitoring: _____

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Performance Improvement Projects (PIPs): _____

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Systematic Analysis & Systematic Action: _____

_____

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Training Plan-
Facility Assessment Overview

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Training Plan: Facility Assessment Overview

Training Name: Facility Assessment Overview		
	❑ Training ❑ Simulation ❑ Workshop ☑ Presentation	
Training Objectives	1. Obtain a basic understanding of the new changes to the RoP – The New Facility Assessment. 2. Understand the roles and responsibilities of the facility team as it relates to the facility assessment and its intent.	
Connection to Overall Project Goals	The training is part of the overall project to educate and support nursing facility operators and staff regarding the requirements of participation for nursing homes as it relates to the facility assessment requirements – preparation, understanding, process, completion and utilization of the findings.	
Participants: Who should attend?	• Governing Body • Administrator • Director of Nursing • Medical Director • IDT members	
	What training should they attend before this one?	• No pre-requisite
	What training should they attend after this?	• Annually and as needed
Facilitators: (How many trainers should participate and whom?)	One presenter will be needed to facilitate the presentation, discussion and post-test	
Logistics Requirements	**What is needed?**	
	• Room for training • Projector • Screen or other blank light colored surface	

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Training References

CMS: State Operations Manual, Appendix PP, Guidance to Surveyors for Long Term Care Facilities:

- https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/GuidanceforLawsAndRegulations/Downloads/Advance-Appendix-PP-Including-Phase-2-.pdf

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Data Collection Tools and/or Resources

The following Tools and Resources are included in this Section of **The RoP Facility Assessment Toolkit ©**

Item	Description	Source *(If Applicable)*
Facility Assessment Overview - Training Plan	This template will assist the facility determining the training objectives and outline for the Facility Assessment overview. Target Audience is facility management team.	Pathway Health
Facility Assessment Training and Speakers Notes	The power point presentation with speaker notes to be used by the facility as it trains individuals on the overview of the facility assessment, role and intent	Pathway Health
Post Test for Facility Assessment Training	Competency post test	Pathway Health
Post Test with Answer Key for Facility Assessment Training	Answer key	Pathway Health

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Facility Wide Resource Assessment

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Objectives

- Understand the intent of the regulation for facility wide resource assessment
- Learn the elements of a compliant facility wide resource assessment
- Describe the method to complete a hazard vulnerability assessment
- Participate in the development of our facility specific resource assessment materials and plans

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Purpose of Assessment

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

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Intent of FWRA

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

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Regulation

- **The facility assessment must address or include the resident population:**
  - Number of residents and capacity
  - Care required by resident population considering
    - Diseases and conditions
    - Physical and cognitive disabilities
    - Overall acuity
    - Other pertinent facts of your population

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Regulation

The facility assessment must address or include:

- Staff competencies necessary to provide level and types of care needed for your resident population
- Physical environment, equipment, services and other physical plant considerations necessary to care for population
- Any ethnic, cultural, or religious factors that may potentially affect the care provided by the facility including activities and nutrition services

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Regulation

The facility assessment must address or include the facility's resources:

- All buildings and/or other physical structures and vehicles
- Equipment (medical and non-medical)
- Services provided such as therapy and pharmacy
- All personnel including managers, staff (both employees and those providing services under contract), volunteers, as well as their education, training, and competencies related to resident care

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Regulation

The facility assessment must address or include the facility's resources:

- Contracts, memorandums of understanding, or other agreements with third parties to provide services or equipment to the facility during normal operations and in emergencies
- Health Information Technology resources such as systems for electronically managing patient records and electronically sharing information with other organizations

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Regulatory Guidance

- May be similar to common business practices for strategic and capital budget planning
- An organization's process of defining its strategy or direction and making decisions on allocating resources to pursue its strategy
- Must be conducted at the facility level, may include input from corporate organization

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Regulatory Guidance

- Will enable each nursing home to thoroughly assess the needs of its resident population and the required resources to provide care and services
- A record for staff and management to understand the rationale for decisions made regarding staffing and other resources
- May include the operating budget necessary to carry out facility functions

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Recommended Participants

- Participants should include at a minimum:
  - Administrator
  - Member of governing body
  - Medical Director
  - Director of Nursing
- Others who should be involved as needed
  - Environmental Services / Plant Operations
  - Dietary Manager
  - Director of Therapy Services
  - Direct Care Staff

- Providers are strongly encouraged to seek input from residents and representatives (could include resident or family council)

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Individualized Approach

- Foundation to determine staffing levels and competencies
- Evaluation of overall number of facility staff needed to ensure sufficient numbers of qualified staff are available to meet resident needs
- Competency based approach to determine knowledge and skills required among staff to ensure residents are able to maintain or attain the highest practicable physical, functional, mental, and psychosocial well-being

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Individualized Approach

- Meet current professional standards of practice
- Ethnic, cultural, or religious factors
- Review of individual staff assignments and systems for coordination and continuity of care

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Updates to the FWRA

- If a change in service provision occurs
  - Example: A facility begins to admit residents who have new tracheostomy or ventilator
- Evaluate the training program to ensure staff have the required skills and competencies to care for these residents
- Review policies and procedures that may be required in the provision of this care
- A minimum of annually

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FWRA Policy

- The facility will conduct a facility wide resource assessment will be completed and updated at least annually and with any major modification to facility resident population, staff or other resources, program additions or changes, or major physical plant changes

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FWRA Procedure

- The facility designated participants will participate in evaluating the following to ensure adequate resources are in place for both day to day operations and in emergencies:
  - Facility/community demographics
  - Types of diagnoses & conditions
  - Types of care provided
  - Facility personnel
  - Facility training program

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FWRA Procedure

- Evaluating the following (cont.)
  - Hazard vulnerability risk and emergency plan
  - Physical plant/environment
  - Nursing services
  - Staff competencies
  - Nutrition services staffing plan
  - Cultural competencies
  - Health information technology
  - Third party agreements

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FWRA Template

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: Our Resident Profile

Numbers

1.1. 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).

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Conduct the Assessment

1. Assign a FWRA Leader to lead process
2. FWRA Leader:
   a) Reviews regulation and interpretive guidance
   b) Review optional tool from CMS
3. Identifies and invites team members
   a) Consider and plan how to get input from residents, families, and CNAs
   b) Consider and plan how to engage the medical director and other practitioners in the process

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Conduct the Assessment

4. FWRA Leader convenes a team
   a) Review and discuss requirements
   b) Review process, discuss, and clarify steps needed
   c) Establish timeline for process
      a) Consider budgeting process with timeline
   d) Decide how assessment will be completed
      a) One person takes the lead on draft
      b) Assign different people to complete different sections

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Complete the Assessment

5. FWRA Leader and others evaluate and discuss different sections
6. Check in meeting to discuss questions or barriers
7. Review findings and discuss to make decisions about needed resources, staffing, capabilities, and competencies
8. Address day to day and emergencies

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Incorporate QAPI

- What opportunities exist for quality initiatives as a result of what we learned from the FWRA to improve our facility's services and resources?
- What findings in the FWRA indicate a need for us to collect and use additional data to inform decision making for future care and improvement?

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Incorporate QAPI

- Are there any OTHER resources that we need to care for residents competently during day to day operations or in emergencies based on the FWRA?
- Has our budget been evaluated with relation to anticipated needs in the coming year, are adjustments needed in our budget to address gaps in resource needs?

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Incorporate Infection Control

- Address the Infection Control program used in the facility
- Discuss the Antibiotic Stewardship component of Infection Control

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Surveyor Questions on FWRA

- How did the facility assess the resident population?
- How did facility assess acuity?
- How did facility determine staffing levels?
- How did facility determine skill and competency requirements?
- Who was involved in conducting the assessment?
- How did facility determine equipment, supplies, and physical environment

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Summary

- The FWRA will need to be ready for the survey team by November 28, 2017
- An investigator may request the FWRA plan so being ready with the assessment on November 28, 2017 is imperative

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Questions?

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THANK YOU FOR PARTICIPATING IN THIS EDUCATION SESSION!

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REFERENCES

CMS: State Operations Manual Appendix PP – Guidance to Surveyors for Long-Term Care Facilities:

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Post Test – FWRA

Question: True or False?	Answer
1. The facility can wait to prepare the facility wide resource assessment until their next annual survey.	
2. The facility does not have to assess the acuity of the resident population for the FWRA.	
3. The purpose of the FWRA is to determine resources needed to care for residents during day to day operations and in emergencies.	
4. The cultural, religious, and ethnic factors of the residents must be considered in the FWRA.	
5. Only resident care areas need to be addressed or included in the FWRA.	
6. Contracts and memos of understanding must be addressed or included in the FWRA.	
7. Budgetary guidance cannot be used in determining sufficient staffing.	
8. The recommended participants on the FWRA team include the Medical Director.	

Employee Printed Name_____ Date: _____

Employee Signature: _____

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Post Test Answer Key – FWRA

Question: True or False?	Answer
1. The facility can wait to prepare the facility wide resource assessment until their next annual survey.	False – Even if the facility annual survey is later in the year, the survey team or investigator can ask any time 11/28/17 or afte.r
2. The facility does not have to assess the acuity of the resident population for the FWRA.	False – the facility must assess the acuity of the resident population.
3. The purpose of the FWRA is to determine resources needed to care for residents during day to day operations and in emergencies.	True
4. The cultural, religious, and ethnic factors of the residents must be considered in the FWRA.	True
5. Only resident care areas need to be addressed or included in the FWRA.	False – All areas of the physical plant including non-resident areas must be addressed or included.
6. Contracts and memos of understanding must be addressed or included in the FWRA.	True
7. Budgetary guidance cannot be used in determining sufficient staffing.	False – budgetary guidelines are an important part of assessing resources.
8. The recommended participants on the FWRA team include the Medical Director.	True

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Acronyms

Because of the many terms to which we refer by acronym in this final rule, we are listing the acronyms used and their corresponding meanings in alphabetical order below:

AAA Area Agencies on Aging

ACL Administration for Community Living

ADL Activities of Daily Living

AHCA American Health Care Association

AHLA American Health Lawyers Association

ANSI American National Standards Institute

ASPE Assistant Secretary for Planning and Evaluation

BPSD Behavioral and Psychological Symptoms of Dementia

CASPER Certification and Survey Provider Enhanced Reports

CIL Centers for Independent Living

CLIA Clinical Laboratory Improvement Amendment

CMS Centers for Medicare & Medicaid Services

CNS Clinical Nurse Specialist

CPR Cardiopulmonary Resuscitation

DoN Director of Nursing

EHR Electronic Health Records

FDA Food and Drug Administration

GAO Government Accountability Office

HACCP Hazard Analysis and Critical Control Point

HAI Healthcare-Associated Infection

HHS U.S. Department of Health and Human Services

HIPAA Health Insurance Portability and Accountability Act of 1996

ICN International Council of Nurses

IDT Interdisciplinary Team

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IG Interpretive Guidance

IP Infection Preventionist

IPCP Infection Prevention and Control Program

LSC Life Safety Code

LTC Long-Term Care

NATCEP Nurse Aide Training Competency Evaluation Program

MAR Medication Administration Record

MDS Minimum Data Set

NA Nurse Aide

NF Nursing Facility

NP Nurse Practitioner

OIG Office of the Inspector General

OMB Office of Management and Budget

ONC Office of the National Coordinator

PA Physician Assistant

PASARR Preadmission Screening and Resident Review

PIPs Performance Improvement Projects

PEU Protein-Energy under Nutrition

QA Quality Assurance

QAA Quality Assessment and Assurance

QAPI Quality Assurance and Performance Improvement

QIO Quality Improvement Organization

RFA Regulatory Flexibility Act

RN Registered Nurse

SNF Skilled Nursing Facility

WHO World Health Organization

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Antibiotic Stewardship
Policy and Procedure Checklist

Purpose and Intent of 483.80(a)(3)

The purpose of the facility Antibiotic Stewardship Policy and Procedure is to develop guidelines about facility staff expectations in the nursing home to develop and implement a solid system to ensure residents receive the appropriate antibiotic, reduce the risk of adverse events and monitor the use of antibiotics for quality outcomes. The facility will put into place a quality improvement system based on clinical standards of practice and evidence-based guidelines, as well as regulatory compliance.

To assure that the individual facility has followed all the required steps for the development and implementation of a comprehensive Antibiotic Stewardship policy in accordance with the new Requirements of Participation (RoP), the following checklist captures specific action items for successful completion. The left column represents the actual Requirements of Participation (RoP) language and the right column indicates specific strategies for successful completion and implementation of the revised RoP. When preparing updated policies and procedures, it is recommended to include actual RoP language as applicable.

Suggested Checklist
Program and Policy and Procedure

Regulation	Recommended Actions
F881 §483.80(a) 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: **§483.80(a)(3)** **An antibiotic stewardship program** that includes antibiotic use protocols and a system to monitor antibiotic use. **INTENT**: The intent of this regulation is to ensure that the facility: • Develops and implements protocols to optimize the treatment of infections by ensuring that residents who require an antibiotic, are prescribed the appropriate antibiotic;	❒ Review, revise and institute an Antibiotic Stewardship Program Policy and Procedure with elements for compliance with F881 ❒ Update staff education materials for orientation, annual education, and agency staff orientation, as needed. ❒ Educate the interdisciplinary team about the Antibiotic

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• Reduces the risk of adverse events, including the development of antibiotic-resistant organisms, from unnecessary or inappropriate antibiotic use; and • Develops, promotes, and implements a facility-wide system to monitor the use of antibiotics.	Stewardship Policy and Procedure that includes the facility's antibiotic use protocols and system to monitor antibiotic use.
GUIDANCE: As part of their IPCP programs, facilities must develop an antibiotic stewardship program that promotes the appropriate use of antibiotics and includes a system of monitoring to improve resident outcomes and reduce antibiotic resistance.[1][2][3] This means that the antibiotic is prescribed for the correct indication, dose, and duration to appropriately treat the resident while also attempting to reduce the development of antibiotic-resistant organisms. Nursing home residents are at risk for adverse outcomes associated with the inappropriate use of antibiotics that may include but are not limited to the following: • Increased adverse drug events and drug interactions (e.g., allergic rash, anaphylaxis or death); • Serious diarrheal infections from C. difficile; • Disruption of normal flora (e.g., this can result in overgrowth of Candida such as oral thrush); and/or • Colonization and/or infection with antibiotic-resistant organisms such as MRSA, VRE, and multidrug-resistant GNB. NOTE: The Centers for Disease Control and Prevention (CDC) has identified core actions to prevent antibiotic resistance within the control of the nursing home. For more information, refer to CDC NH Core Elements at: http://www.cdc.gov/longtermcare/pdfs/core-elements-antibiotic-stewardship-appendix-a.pdf	❒ Educate residents and resident representatives about the Antibiotic Stewardship Policy and Procedure ❒ Conduct updated training for infection preventionist, nursing leaders, and other clinical department leaders about supervising and monitoring for compliance with the Antibiotic Stewardship Policy and Procedure ❒ Provide a written education program for prescribing practitioners on the facility's antibiotic stewardship policy and procedure ❒ Review the Antibiotic Stewardship Policy and Procedure with the Medical Director and Pharmacy

[1] Centers for Disease Control and Prevention. (2013). Antibiotic resistance threats in the United States, 2013. Accessed on June 9, 2017 from http://www.cdc.gov/drugresistance/threat-report-2013/pdf/ar-threats-2013 508.pdf

[2] Spellberg, B., Bartlett, J.G., & Gilbert, D. N. (January 24, 2013). The future of antibiotics and resistance. The New England Journal of Medicine, 368, 299-302.

[3] The White House. (2014). National Strategy for Combating Antibiotic Resistant Bacteria. Accessed on June 9, 2017 from https://obamawhitehouse.archives.gov/sites/default/files/docs/carb_national_strategy.pdf

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NOTE: For examples of antibiotic use protocols, policies and practices developed by the Agency for Healthcare Research and Quality, see: http://www.ahrq.gov/nhguide/index.html Antibiotic Stewardship Program As summarized by the CDC[4], the core elements for antibiotic stewardship in nursing homes include: • Facility leadership commitment to safe and appropriate antibiotic use; • Appropriate facility staff accountable for promoting and overseeing antibiotic stewardship; • Accessing pharmacists and others with experience or training in antibiotic stewardship; • Implement policy(ies) or practice to improve antibiotic use; • Track measures of antibiotic use in the facility (i.e., one process and one outcome measure); • Regular reporting on antibiotic use and resistance to relevant staff such as prescribing clinicians and nursing staff; and • Educate staff and residents about antibiotic stewardship. The facility must develop an antibiotic stewardship program which includes the development of protocols and a system to monitor antibiotic use. This development should include leadership support and accountability via the participation of the medical director, consulting pharmacist, nursing and administrative leadership, and individual with designated responsibility for the infection control program if different.[54] The antibiotic stewardship program protocols shall describe how the program will be implemented and antibiotic use will be monitored, consequently protocols must: • Be incorporated in the overall IPCP	Consultant and pharmacy provider in conjunction with the Quarterly Quality Assurance Committee meeting

[4] Centers for Disease Control and Prevention. (2015). The core elements of antibiotic stewardship for nursing homes. Accessed on June 9, 2017 from https://www.cdc.gov/longtermcare/prevention/antibioticstewardship.html
[4] Centers for Disease Control and Prevention. (2015). The core elements of antibiotic stewardship for nursing homes. Accessed on June 9, 2017 from https://www.cdc.gov/longtermcare/prevention/antibioticstewardship.html

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• Reviewed on an annual basis and as needed
• Contain a system of reports related to monitoring antibiotic usage and resistance data
• Incorporate monitoring of antibiotic use, including the frequency of monitoring/review.
  o New resident review/monitoring
  o When a resident is transferred, or returns
  o During the MMR when a resident receives an antibiotic
  o When requested by the QAA committee
  o Establishment of frequency, mode and mechanism of feedback to prescribing practitioners on antibiotic resistance data, antibiotic use and compliance with facility protocols
  o Medical record reviews for new antibiotics and determination of resident signs/symptoms of infection
  o Laboratory tests ordered and results
  o Prescription documentation to include indication for use
  o Dose and duration
  o Clinical justification for use beyond the initial duration ordered
• Assess residents for any infections using standardized tools and criteria
• Include the mode and frequency of education for prescribing practitioners and nursing staff on antibiotic stewardship and the facility's protocols	

§483.45(c), F756, Drug Regimen Review The Antibiotic Stewardship Program in Relation to Pharmacy Services The assessment, monitoring, and communication of antibiotic use shall occur by a licensed pharmacist in accordance with §483.45(c), F756, Drug Regimen Review. A pharmacist must perform a medication regimen review (MRR) at least monthly, including review of the medical record and identify any irregularities, including unnecessary drugs.	❒ Collaborate with Pharmacy Consultant in review of antibiotic use with the monthly medication regimen review and as needed

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The below areas serve as a cross reference for facility leaders to conduct addition policy and procedure review across departments to incorporate the changes set forth in **§483.80(a)(3) Antibiotic Stewardship Program**

This listing is not all encompassing however should serve as a resource for leaders as they update their internal policies, procedures and operational processes.

Cross Reference: (additional areas for review)

CMS Regulations
State and Local Regulations
Employee Orientation
Annual Training Requirements
Medical Director
Practitioner Training
Pharmacy Consultant Training and Monthly Medication Regimen Review
Quality Assurance and Performance Improvement
Staff Training and Education

References

CMS State Operations Manual, Appendix PP – Guidance to Surveyors for Long Term Care Facilities, Accessed on August 28, 2017:

- https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/GuidanceforLawsAndRegulations/Downloads/Advance-Appendix-PP-Including-Phase-2-.pdf
- Centers for Disease Control and Prevention. (2015). The core elements of antibiotic stewardship for nursing homes. Accessed on August 28, 2017 from: https://www.cdc.gov/longtermcare/prevention/antibiotic-stewardship.html
- Agency for Healthcare Research and Quality (2016): Nursing Home Antimicrobial Stewardship Guide. Accessed on August 28, 2017 from: https://www.ahrq.gov/nhguide/index.html
- Centers for Disease Control and Prevention. (2013). Antibiotic resistance threats in the United States, 2013. Accessed on August 28, 2017 from https://www.cdc.gov/drugresistance/pdf/ar-threats-2013-508.pdf
- Spellberg, B., Bartlett, J.G., & Gilbert, D. N. (January 24, 2013). The future of antibiotics and resistance. The New England Journal of Medicine, 368, 299-302.
- The White House. (2014). National Strategy for Combating Antibiotic Resistant Bacteria. Accessed on August 28, 2017 from https://obamawhitehouse.archives.gov/sites/default/files/docs/carb_national_strategy.pdf

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DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
7500 Security Boulevard, Mail Stop C2-21-16
Baltimore, Maryland 21244-1850

Center for Clinical Standards and Quality/Survey & Certification Group

Ref: S&C: 17-36-NH

DATE: **June 30, 2017**

TO: State Survey Agency Directors

FROM: Director
Survey and Certification Group

SUBJECT: Revision to State Operations Manual (SOM) Appendix PP for Phase 2, F-Tag Revisions, and Related Issues

Memorandum Summary

- **Revised Interpretive Guidance:** In September 2016, the Centers for Medicare & Medicaid Services (CMS) released revised Requirements for Participation under the Medicare and Medicaid Programs; Reform of Requirements for Long-Term Care Facilities rule. CMS is releasing revised Interpretive Guidance to be effective November 28, 2017.
- **Revised F Tags**: The revisions to the regulations caused many of the prior regulatory citations to be re-designated. As such, CMS was required to re-number the F-Tags used to identify each regulatory part. Those new F-Tags are described here.
- **Training Resources:** CMS is providing several training resources on our website and on an MLN Connect call on July 25, 2017 from 1:30 to 3:00pm EST.
- **Enforcement and Nursing Home Compare Considerations:** To address concerns related to the scope and timing of the changes, CMS will be providing limited enforcement remedies for certain Phase 2 provisions and will be holding constant the Nursing Home Compare health inspection rating for one year.

I. Background

Revised Medicare and Medicaid requirements for participation for Long Term Care (LTC) facilities (42 CFR part 483, subpart B) were released on September 28, 2016 and became effective as of November 28, 2016, with a three-part phase-in of implementation dates over the next three years. These requirements include the minimum health and safety standards that long-term care facilities must meet to participate in Medicaid and Medicare. **The implementation date for Phase 2 of the revisions is November 28, 2017**. CMS is releasing this revised version of Appendix PP in advance of that implementation date so that State Survey Agencies (SAs), long term care facilities and the public have sufficient time to become aware of the sub-regulatory guidance for the regulations and how they will be surveyed.

We recognize that CMS has asked for comment on the underlying regulations to reduce burden and simplify rules and policies for Medicare beneficiaries, clinicians, providers and supplier through the proposed rule (CMS-1679-P) released in April 2017. We are reviewing these comments and sincerely appreciate all of the stakeholder input provided to date.

II. Appendix PP

CMS provides surveyor guidance through Interpretive Guidelines in the SOM. The Interpretive Guidelines for Long-Term Care include guidance primarily for the surveyors, however these guidelines are frequently used by facilities to ensure they understand the health and safety expectations that will be evaluated through the survey process. Many standards have remained unchanged since the early 1990's. For these areas, CMS reviewed the existing Interpretive Guidelines and updated where necessary to ensure that the standards and examples were clear. We also added a section in some areas to the Interpretive Guidance titled "Key Elements of Noncompliance." This is intended to guide surveyors and nursing facilities about the key behaviors and practices identified in the regulation.

This Interpretive Guidance is effective November 28, 2017. The Interpretive Guidance includes clarifications to existing requirements, guidance for new Phase 2 requirements, and references to the revised survey process and protocols.

III. F-Tags

As described above, CMS is revising the nursing facility F-Tags to correspond with the new regulatory sections. We are enclosing two documents for your use:

1) A revised list of the F-Tags under each regulatory group; and,
2) A crosswalk of old tags to new tags.

Given the re-structuring of the regulation, some tags were combined, and some tags were split into multiple subparts as described in these Attachments. These new F-Tags will be used after November 28, 2017.

IV. Survey Process

In addition, implementation of Phase 2 is scheduled to occur simultaneously with a new, computer-based Long Term Care survey system. CMS is incorporating the new regulatory requirements while combining the Traditional and Quality Indicator Survey processes. Within the Interpretive Guidance, there is information about the survey process. Information about the survey process is also available on our website described below, where CMS will be making additional materials available in the coming months

V. Training Resources

Between July and October 2017, CMS will provide a number of trainings for SAs, nursing facilities and the public to understand and meet the new requirements of the survey process and regulations. States may offer additional training. Publicly-available training will include:

- A Medicare Learning Network (MLN) Call on July 25th from 1:30 to 3:00pm to discuss the Interpretive Guidance and Survey Process. Questions can be submitted in advance to NHSurveyDevelopment@cms.hhs.gov.

- Information about the call can be found at https://www.cms.gov/Outreach-and-Education/Outreach/NPC/National-Provider-Calls-and-Events.html when it is posted in the coming weeks. The call information will also be posted on our registration website at https://blh.ier.intercall.com/ when registration opens.

- CMS' website at https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/GuidanceforLawsAndRegulations/Nursing-Homes.html which includes a slide deck outlining the survey process. We will also be posting a Frequently Asked Questions document and links to other training resources in the future.
- The Integrated Surveyor Training Website (https://surveyortraining.cms.hhs.gov/index.aspx) will also host the following in the coming months:
  - Training videos by CMS staff that review highlights of 11 key topics for the Interpretive Guidance including for example, person-centered care, sufficient and competent staff, pharmacy services and infection control. These videos will review key components of the requirements;
  - Self-paced, online training describing the survey process changes to the Regional Office and State staff (which will also be made available publicly); and
  - Provider-specific training that will focus on those elements needed for the LTC survey process (e.g., materials to be requested during the entrance conference, etc.).

VI. Enforcement and Nursing Home Compare Considerations

Enforcement

CMS has heard concerns regarding the scope and timing of the new requirements for Phase 2. We believe that these standards (for example, development of an antibiotic stewardship program to combat multi-drug resistant organisms) represent important national health and safety standards. However, to address these concerns, CMS will provide a one- year restriction of enforcement remedies for specific Phase 2 requirements. Specifically, we will not utilize civil money penalties, denial of payment, and/or termination. Should a facility be found to be out of compliance with these new requirements beginning in November of 2017, CMS would use this year-long period to educate facilities about certain new Phase 2 quality standards by requiring a directed plan of correction or additional directed in-service training. Enforcement for other existing standards (including Phase 1 requirements) would follow the standard process. Please note, this one-year period is not a change in the required implementation date for Phase 2 provisions.

The listing of specific Phase 2 requirements associated with enforcement delays will be shared at a later date. In general, CMS will identify those requirements that are associated with a unique and separate tag and where specialized efforts and technical assistance may be needed (e.g., antibiotic stewardship, facility assessment, Quality Assurance and Performance Improvement (QAPI) plan).

Nursing Home Compare
Currently, the *Nursing Home Five Star Quality Rating System* calculates a rating based on each facility's survey performance as compared to others' in the same State. Most facilities will be surveyed for compliance with Phase 2 requirements using the revised survey process within a year of the November 28, 2017 effective date. However, due to the differing standards being phased in over the year, CMS will be holding constant for one year the Nursing Home Compare health inspection rating for any surveys conducted after November 28, 2017. CMS has done this previously where the star ratings are maintained for a period of time as new requirements are phased-in. To address the concern that serious quality concerns will not be known, CMS will separately flag those nursing facilities to ensure public transparency. CMS will provide more detailed methodology information at a later date.

Contact: For any questions, please contact CMS at NHSurveyDevelopment@cms.hhs.gov.

Effective Date: November 28, 2017. This information should be communicated with all survey and certification staff, their managers and the State/Regional Office training coordinators immediately.

/s/
David R. Wright

Attachments:
Attachment 1: F-Tag Crosswalk
Attachment 2: Advanced Copy-Revised Interpretive Guidance, Appendix PP SOM

cc: Survey and Certification Regional Office Management

The contents of this letter support activities or actions to improve patient or resident safety and increase quality and reliability of care for better outcomes.

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The *"CMS S&C Memo 17-36-NH"* document can be found at:

https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/GuidanceforLawsAndRegulations/Downloads/Survey-and-Cert-Memo-Revision-SOM-Appendix-PP-Phase-2.pdf

Reference:

CMS. (2017). CMS S&C Memo 17-36-NH. Retrieved August, 2017, from https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/GuidanceforLawsAndRegulations/Downloads/Survey-and-Cert-Memo-Revision-SOM-Appendix-PP-Phase-2.pdf

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Federal Regulatory Groups for Long Term Care Facilities

* Substandard quality of care = one or more deficiencies with s/s levels of F, H, I, J, K, or L in Red

F540 Definitions

483.10 Resident Rights

F550 *Resident Rights/Exercise of Rights
F551 Rights Exercised by Representative
F552 Right to be Informed/Make Treatment Decisions
F553 Right to Participate in Planning Care
F554 Resident Self-Admin Meds-Clinically Appropriate
F555 Right to Choose/Be Informed of Attending Physician
F557 Respect, Dignity/Right to have Personal Property
F558 *Reasonable Accommodations of Needs/Preferences
F559 *Choose/Be Notified of Room/Roommate Change
F560 Right to Refuse Certain Transfers
F561 *Self Determination
F562 Immediate Access to Resident
F563 Right to Receive/Deny Visitors
F564 Inform of Visitation Rights/Equal Visitation Privileges
F565 *Resident/Family Group and Response
F566 Right to Perform Facility Services or Refuse
F567 Protection/Management of Personal Funds
F568 Accounting and Records of Personal Funds
F569 Notice and Conveyance of Personal Funds
F570 Surety Bond - Security of Personal Funds
F571 Limitations on Charges to Personal Funds
F572 Notice of Rights and Rules
F573 Right to Access/Purchase Copies of Records
F574 Required Notices and Contact Information
F575 Required Postings
F576 Right to Forms of Communication with Privacy
F577 Right to Survey Results/Advocate Agency Info
F578 Request/Refuse/Discontinue Treatment;Formulate Adv Di
F579 Posting/Notice of Medicare/Medicaid on Admission
F580 Notify of Changes (Injury/Decline/Room, Etc.)
F582 Medicaid/Medicare Coverage/Liability Notice
F583 Personal Privacy/Confidentiality of Records
F584 *Safe/Clean/Comfortable/Homelike Environment
F585 Grievances
F586 Resident Contact with External Entities

483.12 Freedom from Abuse, Neglect, and Exploitation

F600 *Free from Abuse and Neglect
F602 *Free from Misappropriation/Exploitation
F603 *Free from Involuntary Seclusion
F604 *Right to be Free from Physical Restraints
F605 *Right to be Free from Chemical Restraints
F606 *Not Employ/Engage Staff with Adverse Actions
F607 *Develop/Implement Abuse/Neglect, etc. Policies
F608 *Reporting of Reasonable Suspicion of a Crime
F609 *Reporting of Alleged Violations
F610 *Investigate/Prevent/Correct Alleged Violation

483.15 Admission, Transfer, and Discharge

F620 Admissions Policy
F621 Equal Practices Regardless of Payment Source
F622 Transfer and Discharge Requirements
F623 Notice Requirements Before Transfer/Discharge
F624 Preparation for Safe/Orderly Transfer/Discharge
F625 Notice of Bed Hold Policy Before/Upon Transfer
F626 Permitting Residents to Return to Facility

483.20 Resident Assessments

F635 Admission Physician Orders for Immediate Care
F636 Comprehensive Assessments & Timing
F637 Comprehensive Assmt After Significant Change
F638 Quarterly Assessment At Least Every 3 Months
F639 Maintain 15 Months of Resident Assessments
F640 Encoding/Transmitting Resident Assessment
F641 Accuracy of Assessments
F642 Coordination/Certification of Assessment
F644 Coordination of PASARR and Assessments
F645 PASARR Screening for MD & ID
F646 MD/ID Significant Change Notification

483.21 Comprehensive Resident Centered Care Plans

F655 Baseline Care Plan
F656 Develop/Implement Comprehensive Care Plan
F657 Care Plan Timing and Revision
F658 Services Provided Meet Professional Standards
F659 Qualified Persons
F660 Discharge Planning Process
F661 Discharge Summary

483.24 Quality of Life

F675 *Quality of Life
F676 *Activities of Daily Living (ADLs)/ Maintain Abilities
F677 *ADL Care Provided for Dependent Residents
F678 *Cardio-Pulmonary Resuscitation (CPR)
F679 *Activities Meet Interest/Needs of Each Resident
F680 *Qualifications of Activity Professional

483.25 Quality of Care

F684 *Quality of Care
F685 *Treatment/Devices to Maintain Hearing/Vision
F686 *Treatment/Svcs to Prevent/Heal Pressure Ulcers
F687 *Foot Care
F688 *Increase/Prevent Decrease in ROM/Mobility
F689 *Free of Accident Hazards/Supervision/Devices
F690 *Bowel/Bladder Incontinence, Catheter, UTI
F691 *Colostomy, Urostomy, or Ileostomy Care
F692 *Nutrition/Hydration Status Maintenance
F693 *Tube Feeding Management/Restore Eating Skills
F694 *Parenteral/IV Fluids
F695 *Respiratory/Tracheostomy care and Suctioning
F696 *Prostheses
F697 *Pain Management
F698 *Dialysis
F699 *{PHASE-3} Trauma Informed Care
F700 *Bedrails

483.30 Physician Services

F710 Resident's Care Supervised by a Physician
F711 Physician Visits- Review Care/Notes/Order
F712 Physician Visits-Frequency/Timeliness/Alternate NPPs
F713 Physician for Emergency Care, Available 24 Hours
F714 Physician Delegation of Tasks to NPP
F715 Physician Delegation to Dietitian/Therapist

483.35 Nursing Services

F725 Sufficient Nursing Staff
F726 Competent Nursing Staff
F727 RN 8 Hrs/7 days/Wk, Full Time DON
F728 Facility Hiring and Use of Nurse
F729 Nurse Aide Registry Verification, Retraining

Federal Regulatory Groups for Long Term Care Facilities

*** Substandard quality of care = one or more deficiencies with s/s levels of F, H, I, J, K, or L in Red**

F730 Nurse Aide Perform Review – 12Hr/Year In- service
F731 Waiver-Licensed Nurses 24Hr/Day and RN Coverage
F732 Posted Nurse Staffing Information

483.40 Behavioral Health Services

F740 Behavioral Health Services
F741 Sufficient/Competent Staff-Behav Health Needs
F742 *Treatment/Svc for Mental/Psychosocial Concerns
F743 *No Pattern of Behavioral Difficulties Unless Unavoidable
F744 *Treatment /Service for Dementia
F745 *Provision of Medically Related Social Services

483.45 Pharmacy Services

F755 Pharmacy Svcs/Procedures/Pharmacist/Records
F756 Drug Regimen Review, Report Irregular, Act On
F757 *Drug Regimen is Free From Unnecessary Drugs
F758 *Free from Unnec Psychotropic Meds/PRN Use
F759 *Free of Medication Error Ratesof 5% or More
F760 *Residents Are Free of Significant Med Errors
F761 Label/Store Drugs & Biologicals

483.50 Laboratory, Radiology, and Other Diagnostic Se

F770 Laboratory Services
F771 Blood Blank and Transfusion Services
F772 Lab Services Not Provided On-Site
F773 Lab Svs Physician Order/Notify of Results
F774 Assist with Transport Arrangements to Lab Svcs
F775 Lab Reports in Record-LabName/Address
F776 Radiology/Other Diagnostic Services
F777 Radiology/Diag. Svcs Ordered/Notify Results
F778 Assist with Transport Arrangements to Radiology
F779 X-Ray/Diagnostic Report in Record-Sign/Dated

483.55 Dental Services

F790 Routine/Emergency Dental Services in SNFs
F791 Routine/Emergency Dental Services in NFs

483.60 Food and Nutrition Services

F800 Provided Diet Meets Needs of Each Resident
F801 Qualified Dietary Staff
F802 Sufficient Dietary Support Personnel
F803 Menus Meet Res Needs/Prep in Advance/Followed
F804 Nutritive Value/Appear ,Palatable/Prefer Temp
F805 Food in Form to Meet Individual Needs
F806 Resident Allergies, Preferences and Substitutes
F807 Drinks Avail to Meet Needs/Preferences/ Hydration
F808 Therapeutic Diet Prescribed by Physician
F809 Frequency of Meals/Snacks at Bedtime
F810 Assistive Devices - Eating Equipment/Utensils
F811 Feeding Asst -Training/Supervision/Resident
F812 Food Procurement, Store/Prepare/Serve - Sanitary
F813 Personal Food Policy
F814 Dispose Garbage & Refuse Properly

483.65 Specialized Rehabilitative Services

F825 Provide/Obtain Specialized Rehab Services
F826 Rehab Services- Physician Order/Qualified Person

483.70 Administration

F835 Administration
F836 License/Comply w/Fed/State/Local Law/Prof Std
F837 Governing Body
F838 Facility Assessment
F839 Staff Qualifications
F840 Use of Outside Resources
F841 Responsibilities of Medical Director
F842 Resident Records - Identifiable Information
F843 Transfer Agreement
F844 Disclosure of Ownership Requirements
F845 Facility closure-Administrator
F846 Facility closure
F849 Hospice Services
F850 *Qualifications of Social Worker >120 Beds
F851 Payroll Based Journal

483.75 Quality Assurance and Performance Improvem

F865 QAPI Program/Plan, Disclosure/Good Faith Attempt
F866 {PHASE-3} QAPI/QAA Data Collection and Monitoring
F867 QAPI/QAA Improvement Activities
F868 QAA Committee

483.80 Infection Control

F880 Infection Prevention & Control
F881 Antibiotic Stewardship Program
F882 {PHASE-3} Infection Preventionist Qualifications/Role
F883 *Influenza and Pneumococcal Immunizations

483.85 {PHASE-3} Compliance and Ethics Program

F895 {PHASE-3} Compliance and Ethics Program

483.90 Physical Environment

F906 Emergency Electrical Power System
F907 Space and Equipment
F908 Essential Equipment, Safe Operating Condition
F909 Resident Bed
F910 Resident Room
F911 Bedroom Number of Residents
F912 Bedrooms Measure at Least 80 Square Ft/Resident
F913 Bedrooms Have Direct Access to Exit Corridor
F914 Bedrooms Assure Full Visual Privacy
F915 Resident Room Window
F916 Resident Room Floor Above Grade
F917 Resident Room Bed/Furniture/Closet
F918 Bedrooms Equipped/Near Lavatory/Toilet
F919 Resident Call System
F920 Requirements for Dining and Activity Rooms
F921 Safe/Functional/Sanitary/Comfortable Environment
F922 Procedures to Ensure Water Availability
F923 Ventilation
F924 Corridors Have Firmly Secured Handrails
F925 Maintains Effective Pest Control Program
F926 Smoking Policies

483.95 Training Requirements

F940 {PHASE-3} Training Requirements - General
F941 {PHASE-3} Communication Training
F942 {PHASE-3} Resident's Rights Training
F943 Abuse, Neglect, and Exploitation Training
F944 {PHASE-3} QAPI Training
F945 {PHASE-3} Infection Control Training
F946 {PHASE-3} Compliance and Ethics Training
F947 Required In-Service Training for Nurse Aides
F948 Training for Feeding Assistants
F949 {PHASE-3} Behavioral Health Training

The *"List of Revised F-Tags"* document can be found at:

https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/GuidanceforLawsAndRegulations/Downloads/List-of-Revised-FTags.pdf

Reference:

CMS. (2017). Federal Regulatory Groups for Long Term Care Facilities. Retrieved August, 2017, from https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/GuidanceforLawsAndRegulations/Downloads/List-of-Revised-FTags.pdf

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Phase 2 Tag Crosswalk -

Effective November 28, 2017

Tag # (As of Nov. 28, 2017)	SQC Tag? X = Yes	Tag Title	CFR	Regulatory Groupings	Tags / Subparts Implemented in Phase 3	Old Tag (Taken from App PP 03-08-2017)	RegulationText that was Moved to New Tag
F540		Definitions	483.5			F150	483.5
F550	X	Resident Rights/Exercise of Rights	483.10(a)(1)(2)(b)(1)(2)	483.10 Resident Rights		F151 F240 F241	483.10(b)(1)(2) 483.10(a)(1)(2) 483.10(a)(1)
F551		Rights Exercised by Representative	483.10(b)(3)-(7)(i)-(iii)	483.10 Resident Rights		F152	483.10(b)(3)-(7)
F552		Right to be Informed/Make Treatment Decisions	483.10(c)(1)(4)(5)	483.10 Resident Rights		F154	483.10(c)(1)(4)(5)
F553		Right to Participate in Planning Care	483.10(c)(2)(3)	483.10 Resident Rights		F154 F280	483.10(c)(2)(iii) 483.10(c)(2)(i)(ii)(iv)(v)(3)(i)-(iii)
F554		Resident Self-Admin Meds-Clinically Appropriate	483.10(c)(7)	483.10 Resident Rights		F176	483.10(c)(7)
F555		Right to Choose/Be Informed of Attending Physician	483.10(d)(1)-(5)	483.10 Resident Rights		F163	483.10(d)(1)(2)(4)(5)
F557		Respect, Dignity/Right to have Personal Property	483.10(e)(2)	483.10 Resident Rights		F252	483.10(e)(2)
F558	X	Reasonable Accommodations of Needs/Preferences	483.10(e)(3)	483.10 Resident Rights		F246	483.10(e)(3)
F559	X	Choose/Be Notified of Room/Roommate Change	483.10(e)(4)-(6)	483.10 Resident Rights		F175 F247	483.10(e)(4)(5) 483.10(e)(6)
F560		Right to Refuse Certain Transfers	483.10(e)(7)(i)-(iii)(8)	483.10 Resident Rights		F177	483.10(e)(7)-(8)
F561	X	Self Determination	483.10(f)(1)-(3)(8)	483.10 Resident Rights		F242 F245	483.10(f)(1)-(3) 483.10(f)(8)
F562		Immediate Access to Resident	483.10(f)(4)(i)(A)-(G)	483.10 Resident Rights		F172	483.10(f)(4)(i)
F563		Right to Receive/Deny Visitors	483.10(f)(4)(ii)-(v)	483.10 Resident Rights		F172	483.10(f)(4)(ii)-(v)
F564		Inform of Visitation Rights/Equal Visitation Priviledges	483.10(f)(4)(vi)(A)-(D)	483.10 Resident Rights		F172	483.10(f)(4)(vi)(A)-(D)
F565	X	Resident/Family Group and Response	483.10(f)(5)(i)-(iv)(6)(7)	483.10 Resident Rights		F243 F244	483.10(f)(5)(i)-(iii)(6)(7) 483.10(f)(5)(iv)
F566		Right to Perform Facility Services or Refuse	483.10(f)(9)(i)-(iv)	483.10 Resident Rights		F169	483.10(f)(9)
F567		Protection/Management of Personal Funds	483.10(f)(10)(i)(ii)	483.10 Resident Rights		F158 F159	483.10(f)(10)(i) 483.10(f)(ii)
F568		Accounting and Records of Personal Funds	483.10(f)(10)(iii)	483.10 Resident Rights		F159	483.10(f)(10(iii)
F569		Notice and Conveyance of Personal Funds	483.10(f)(10)(iv)(v)	483.10 Resident Rights		F159	483.10(f)(iv)
F570		Surety Bond - Security of Personal Funds	483.10(f)(10)(vi)	483.10 Resident Rights		F161	483.10(f)(10(vi)

Tag # (As of Nov. 28, 2017)	SQC Tag? X = Yes	Tag Title	CFR	Regulatory Groupings	Tags / Subparts Implemented in Phase 3	Old Tag (Taken from App PP 03-08-2017)	RegulationText that was Moved to New Tag
F571		Limitations on Charges to Personal Funds	483.10(f)(11)(i)-(iii)	483.10 Resident Rights		F162	483.10(f)(11)(i)-(iii)
F572		Notice of Rights and Rules	483.10(g)(1)(16)	483.10 Resident Rights		F156	483.10(g)(1)(16)
F573		Right to Access/Purchase Copies of Records	483.10(g)(2)(i)(ii)(3)	483.10 Resident Rights		F153	483.10(g)(2)(3)
F574		Required Notices and Contact Information	483.10(g)(4)(i)-(vi)	483.10 Resident Rights		F156	483.10(g)(4)
F575		Required Postings	483.10(g)(5)(i)(ii)	483.10 Resident Rights		F156	483.10(g)(5)
F576		Right to Forms of Communication with Privacy	483.10(g)(6)-(9)	483.10 Resident Rights		F170 F171 F174	483.10(g)(8)(i)(9)(i)-(iii) 483.10(g)(7)(ii)(iii) 483.10(g)(6)(7)(i)
F577		Right to Survey Results/Advocate Agency Info	483.10(g)(10)(11)	483.10 Resident Rights		F167 F168	483.10(g)(10)(i)(11) 483.10(g)(10)(ii)
F578		Request/Refuse/Discontinue Treatment;Formulate Adv Directives	483.10(c)(6)(8)(g)(12)(i)-(v)	483.10 Resident Rights		F155	483.10(c)(6)(8)(g)(12)
F579		Posting/Notice of Medicare/Medicaid on Admission	483.10(g)(13)	483.10 Resident Rights		F156	483.10(g)(13)
F580		Notify of Changes (Injury/Decline/Room, Etc.)	483.10(g)(14)(i)-(iv)	483.10 Resident Rights		F157	483.10(g)(14)
F582		Medicaid/Medicare Coverage/Liability Notice	483.10(g)(17)(18)(i)-(v)	483.10 Resident Rights		F156	483.10(g)(17)-(18)
F583		Personal Privacy/Confidentiality of Records	483.10(h)(1)-(3)(i)(ii)	483.10 Resident Rights		F164 F173	483.10(h)(1)(3)(i) 483.10(h)(3)(ii)
F584	X	Safe/Clean/Comfortable/ Homelike Environment	483.10(i)(1)-(7)	483.10 Resident Rights		F252 F253 F254 F256 F257 F258 F461	483.10(i)(1)(i)(ii) 483.10(i)(2) 483.10(i)(3) 483.10(i)(5) 483.10(i)(6) 483.10(i)(7) 483.10(i)(4)
F585		Grievances	483.10(j)(1)-(4)	483.10 Resident Rights		F165 F166	483.10(j)(1) 483.10(j)(2-4)
F586		Resident Contact with External Entities	483.10(k)	483.10 Resident Rights		F168	483.10(k)
F600	X	Free from Abuse and Neglect	483.12(a)(1)	483.12 Freedom from Abuse, Neglect, and Exploitation		F223	483.12(a)(1)
F602	X	Free from Misappropriation/Exploitation	483.12	483.12 Freedom from Abuse, Neglect, and Exploitation		F223/ F224	483.12

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F603	X	Free from Involuntary Seclusion	483.12(a)(1)	483.12 Freedom from Abuse, Neglect, and Exploitation		F223	483.12(a)(1)
F604	X	Right to be Free from Physical Restraints	483.10(e)(1) 483.12(a)(2)	483.10 Resident Rights 483.12 Freedom from Abuse, Neglect, and Exploitation		F221 F222	483.10(e)(1), 483.12(a)(2) 483.10(e)(1), 483.12(a)(2)
F605	X	Right to be Free from Chemical Restraints	483.10(e)(1) 483.12(a)(2)	483.10 Resident Rights 483.12 Freedom from Abuse, Neglect, and Exploitation		F222	483.10(e)(1), 483.12(a)(2)
F606	X	Not Employ/Engage Staff with Adverse Actions	483.12(a)(3)(4)	483.12 Freedom from Abuse, Neglect, and Exploitation		F225	483.12(a)(3)(4)
F607	X	Develop/Implement Abuse/Neglect, etc. Policies	483.12(b)(1)-(4)	483.12 Freedom from Abuse, Neglect, and Exploitation	(b)(4) - Phase 3 Will not be in ASPEN until Phase 3	F226	483.12(b)(1)-(4)
F608	X	Reporting of Reasonable Suspicion of a Crime	483.12(b)(5)(i)-(iii)	483.12 Freedom from Abuse, Neglect, and Exploitation			No Associated Tag
F609	X	Reporting of Alleged Violations	483.12(c)(1)(4)	483.12 Freedom from Abuse, Neglect, and Exploitation		F225	483.12(c)(1)(4)
F610	X	Investigate/Prevent/Correct Alleged Violation	483.12(c)(2)-(4)	483.12 Freedom from Abuse, Neglect, and Exploitation		F225	483.12(c)(2)-(4)
F620		Admissions Policy	483.15(a)(1)-(7)	483.15 Admission, Transfer, and Discharge		F208	483.15(a)(1)-(7)
F621		Equal Practices Regardless of Payment Source	483.15(b)(1)-(3)(c)(9)	483.15 Admission, Transfer, and Discharge		F207	483.15(b)(1)-(3)(c)(9)
F622		Transfer and Discharge Requirements	483.15(c)(1)(i)(ii)(2)(i)-(iii)	483.15 Admission, Transfer, and Discharge		F201 F202	483.15(c)(1)(i)(ii) 483.15(c)(2)(i)-(iii)
F623		Notice Requirements Before Transfer/Discharge	483.15(c)(3)-(6)(8)	483.15 Admission, Transfer, and Discharge		F203	483.15(c)(3)-(6)(8)
F624		Preparation for Safe/Orderly Transfer/Discharge	483.15(c)(7)	483.15 Admission, Transfer, and Discharge		F204	483.15(c)(7)
F625		Notice of Bed Hold Policy Before/Upon Transfer	483.15(d)(1)(2)	483.15 Admission, Transfer, and Discharge		F205	483.15(d)(1)(i)-(iv)(2)
F626		Permitting Residents to Return to Facility	483.15(e)(1)(2)	483.15 Admission, Transfer, and Discharge		F206	483.15(e)(1)(2)
F635		Admission Physician Orders for Immediate Care	483.20(a)	483.20 Resident Assessments		F271	483.20(a)

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F636		Comprehensive Assessments & Timing	483.20(b)(1)(2)(i)(iii)	483.20 Resident Assessments		F272 F273 F275	483.20(b)(1) 483.20(b)(2)(i) 483.20(b)(2)(iii)
F637		Comprehensive Assmt After Significant Change	483.20(b)(2)(ii)	483.20 Resident Assessments		F274	483.20(b)(2)(ii)
F638		Quarterly Assessment At Least Every 3 Months	483.20(c)	483.20 Resident Assessments		F276	483.20(c)
F639		Maintain 15 Months of Resident Assessments	483.20(d)	483.20 Resident Assessments		F279 F286	483.20(d) 483.20(d)
F640		Encoding/Transmitting Resident Assessment	483.20(f)(1)-(4)	483.20 Resident Assessments		F287	483.20(f)(1)-(4)
F641		Accuracy of Assessments	483.20(g)	483.20 Resident Assessments		F278	483.20(g)
F642		Coordination/Certification of Assessment	483.20(h)-(j)	483.20 Resident Assessments		F278	483.20(h)-(j)
F644		Coordination of PASARR and Assessments	483.20(e)(1)(2)	483.20 Resident Assessments		F285	483.20(e)
F645		PASARR Screening for MD & ID	483.20(k)(1)-(3)	483.20 Resident Assessments		F285	483.20(k)(1)-(3)
F646		MD/ID Significant Change Notification	483.20(k)(4)	483.20 Resident Assessments		F285	483.20(k)(4)
F655		Baseline Care Plan	483.21(a)(1)-(3)	483.21 Comprehensive Resident Centered Care Plans			No Associated Tag
F656		Develop/Implement Comprehensive Care Plan	483.21(b)(1)	483.21 Comprehensive Resident Centered Care Plans		F279	483.21(b)(1)
F657		Care Plan Timing and Revision	483.21(b)(2)(i)-(iii)	483.21 Comprehensive Resident Centered Care Plans		F280	483.21(b)(2)(i)-(iii)
F658		Services Provided Meet Professional Standards	483.21(b)(3)(i)	483.21 Comprehensive Resident Centered Care Plans		F281	483.21(b)(3)(i)
F659		Qualified Persons	483.21(b)(3)(ii)(iii)	483.21 Comprehensive Resident Centered Care Plans	(b)(iii) - Phase 3 Will not be in ASPEN until Phase 3	F282	483.21(b)(3)(ii)
F660		Discharge Planning Process	483.21(c)(1)(i)-(ix)	483.21 Comprehensive Resident Centered Care Plans		F284	483.21(c)(1)(i)-(ix)
F661		Discharge Summary	483.21(c)(2)(i)-(iv)	483.21 Comprehensive Resident Centered Care Plans		F283 F284	483.21(c)(2)(i)-(iii) 483.21(c)(2)(iv)

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F675	X	Quality of Life	483.24	483.24 Quality of Life		F309	483.24
F676	X	Activities of Daily Living (ADLs)/ Maintain Abilities	483.24(a)(1)(b)(1)-(5)(i)-(iii)	483.24 Quality of Life		F310 F311	483.24(a)(b)(1)-(5)(i)-(iii) 483.24(a)(1)
F677	X	ADL Care Provided for Dependent Residents	483.24(a)(2)	483.24 Quality of Life		F312	483.24(a)(2)
F678	X	Cardio-Pulmonary Resuscitation (CPR)	483.24(a)(3)	483.24 Quality of Life		F155	483.24(a)(3)
F679	X	Activities Meet Interest/Needs of Each Resident	483.24(c)(1)	483.24 Quality of Life		F248	483.24(c)(1)
F680	X	Qualifications of Activity Professional	483.24(c)(2)(i)(ii)(A)-(D)	483.24 Quality of Life		F249	483.24(c)(2)(i)(ii)(A)-(D)
F684	X	Quality of Care	483.25	483.25 Quality of Care		F309	483.25
F685	X	Treatment/Devices to Maintain Hearing/Vision	483.25(a)(1)(2)	483.25 Quality of Care		F313	483.25(a)(1)-(2)
F686	X	Treatment/Svcs to Prevent/Heal Pressure Ulcers	483.25(b)(1)(i)(ii)	483.25 Quality of Care		F314	483.25(b)(1)(i)(ii)
F687	X	Foot Care	483.25(b)(2)(i)(ii)	483.25 Quality of Care		F328	483.25(b)(2)(i)(ii)
F688	X	Increase/Prevent Decrease in ROM/Mobility	483.25(c)(1)-(3)	483.25 Quality of Care		F317 F318	483.25(c)(1) 483.25(c)(2)(3)
F689	X	Free of Accident Hazards/Supervision/Devices	483.25(d)(1)(2)	483.25 Quality of Care		F323	483.25(d)(1)(2)
F690	X	Bowel/Bladder Incontinence, Catheter, UTI	483.25(e)(1)-(3)	483.25 Quality of Care		F315	483.25(e)(1)-(3)
F691	X	Colostomy, Urostomy, or Ileostomy Care	483.25(f)	483.25 Quality of Care		F328	483.25(f)
F692	X	Nutrition/Hydration Status Maintenance	483.25(g)(1)-(3)	483.25 Quality of Care		F325 F327	483.25(g)(1)(3) 483.25(g)(2)
F693	X	Tube Feeding Management/Restore Eating Skills	483.25(g)(4)(5)	483.25 Quality of Care		F322	483.25(g)(4)(5)
F694	X	Parenteral/IV Fluids	483.25(h)	483.25 Quality of Care		F328	483.25(h)
F695	X	Respiratory/Tracheostomy care and Suctioning	483.25(i)	483.25 Quality of Care		F328	483.25(i)
F696	X	Prostheses	483.25(j)	483.25 Quality of Care		F328	483.25(j)
F697	X	Pain Management	483.25(k)	483.25 Quality of Care		F309	483.25(k)
F698	X	Dialysis	483.25(l)	483.25 Quality of Care		F309	483.25(l)

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F699	X	Trauma Informed Care	483.25(m)	483.25 Quality of Care	Entire tag - Phase 3 Will not be in ASPEN until Phase 3		No Associated Tag
F700	X	Bedrails	483.25(n)(1)-(4)	483.25 Quality of Care		F323 F461	483.25(n)(1)-(3) 483.25(n)(4)
F710		Resident's Care Supervised by a Physician	483.30(a)(1)(2)	483.30 Physician Services		F385	483.30(a)(1)(2)
F711		Physician Visits- Review Care/Notes/Order	483.30(b)(1)-(3)	483.30 Physician Services		F386	483.30(b)(1)-(3)
F712		Physician Visits- Frequency/Timeliness/Alternate NPPs	483.30(c)(1)-(4)	483.30 Physician Services		F387 F388	483.30(c)(1)(2) 483.30(c)(3)(4)
F713		Physician for Emergency Care, Available 24 Hours	483.30(d)	483.30 Physician Services		F389	483.30(d)
F714		Physician Delegation of Tasks to NPP	483.30(e)(1)(4)(f)	483.30 Physician Services		F390	483.30(e)(1)(4)(f)
F715		Physician Delegation to Dietitian/Therapist	483.30(e)(2)(3)	483.30 Physician Services		F390	483.30(e)(2(3)
F725		Sufficient Nursing Staff	483.35(a)(1)(2)	483.35 Nursing Services		F353	483.35(a)(1)(2)
F726		Competent Nursing Staff	483.35(a)(3)(4)(c)	483.35 Nursing Services		F353 F498	483.35(a)(3)(4) 483.35(c)
F727		RN 8 Hrs/7 days/Wk, Full Time DON	483.35(b)(1)-(3)	483.35 Nursing Services		F354	483.35(b)(1)-(3)
F728		Facility Hiring and Use of Nurse Aide	483.35(d)(1)-(3)	483.35 Nursing Services		F494 F495	483.35(d)(1)(2) 483.35(d)(3)
F729		Nurse Aide Registry Verification, Retraining	483.35(d)(4)-(6)	483.35 Nursing Services		F496	483.35(d)(4)-(6)
F730		Nurse Aide Perform Review – 12 Hr/Year In- service	483.35(d)(7)	483.35 Nursing Services		F497	483.35(d)(7)
F731		Waiver-Licensed Nurses 24 Hr/Day and RN Coverage	483.35(e)(1)-(7)(f)(1)(2)	483.35 Nursing Services		F355	483.35(e)(1)-(7)(f)(1)(2)
F732		Posted Nurse Staffing Information	483.35(g)(1)-(4)	483.35 Nursing Services		F356	483.35(g)(1)-(4)
F740		Behavioral Health Services	483.40	483.40 Behavioral Health Services			No Associated Tag
F741		Sufficient/Competent Staff-Behav Health Needs	483.40(a)(1)(2)	483.40 Behavioral Health Services			No Associated Tag
F742	X	Treatment/Svc for Mental/Psychosocial Concerns	483.40(b)(1)	483.40 Behavioral Health Services		F319	483.40(b)(1)
F743	X	No Pattern of Behavioral Difficulties UnlessUnavoidable	483.40(b)(2)	483.40 Behavioral Health Services		F320	483.40(b)(2)
F744	X	Treatment /Service for Dementia	483.40(b)(3)	483.40 Behavioral Health Services		F309	483.40(b)(3)

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F745	X	Provision of Medically Related Social Services	483.40(d)	483.40 Behavioral Health Services		F250	483.40(d)
F755		Pharmacy Svcs/Procedures/Pharmacist /Records	483.45(a)(b)(1)-(3)	483.45 Pharmacy Services		F425 F431	483.45(a)(b)(1) 483.45(b)(2)(3)
F756		Drug Regimen Review, Report Irregular, Act On	483.45(c)(1)(2)(4)(5)	483.45 Pharmacy Services		F428	483.45(c)(1)(2)(4)(5)
F757	X	Drug Regimen is Free From Unnecessary Drugs	483.45(d)(1)-(6)	483.45 Pharmacy Services		F329	483.45(d)
F758	X	Free from Unnec Psychotropic Meds/PRN Use	483.45(c)(3)(e)(1)-(5)	483.45 Pharmacy Services		F329 F428	483.45(e)(1)-(5) 483.45(c)(3)
F759	X	Free of Medication Error Rates of 5% or More	483.45(f)(1)	483.45 Pharmacy Services		F332	483.45(f)(1)
F760	X	Residents Are Free of Significant Med Errors	483.45(f)(2)	483.45 Pharmacy Services		F333	483.45(f)(2)
F761		Label/Store Drugs & Biologicals	483.45(g)(h)(1)(2)	483.45 Pharmacy Services		F431	483.45(g)-(h)
F770		Laboratory Services	483.50(a)(1)(i)	483.50 Laboratory, Radiology, and Other Diagnostic Services		F502 F503	483.50(a)(1) 483.50(a)(i)
F771		Blood Blank and Transfusion Services	483.50(a)(1)(ii)	483.50 Laboratory, Radiology, and Other Diagnostic Services		F502 F503	483.50(a)(1) 483.50(a)(ii)
F772		Lab Services Not Provided On-Site	483.50(a)(1)(iv)	483.50 Laboratory, Radiology, and Other Diagnostic Services		F503	483.50(a)(iv)
F773		Lab Svs Physician Order/Notify of Results	483.50(a)(2)(i)(ii)	483.50 Laboratory, Radiology, and Other Diagnostic Services		F504 F505	483.50(a)(2)(i) 483.50(a)(2)(ii)
F774		Assist with Transport Arrangements to Lab Svcs	483.50(a)(2)(iii)	483.50 Laboratory, Radiology, and Other Diagnostic Services		F506	483.50(a)(2)(iii)
F775		Lab Reports in Record-Lab Name/Address	483.50(a)(2)(iv)	483.50 Laboratory, Radiology, and Other Diagnostic Services		F507	483.50(a)(2)(iv)
F776		Radiology/Other Diagnostic Services	483.50(b)(1)(i)(ii)	483.50 Laboratory, Radiology, and Other Diagnostic Services		F508 F509	483.50(b)(1) 483.50(b)(i)(ii)
F777		Radiology/Diag. Svcs Ordered/Notify Results	483.50(b)(2)(i)(ii)	483.50 Laboratory, Radiology, and Other Diagnostic Services		F510 F511	483.50(b(2)(i) 483.50(b)(2)(ii)
F778		Assist with Transport Arrangements to Radiology	483.50(b)(2)(iii)	483.50 Laboratory, Radiology, and Other Diagnostic Services		F512	483.50(b)(2)(iii)

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F779		X-Ray/Diagnostic Report in Record-Sign/Dated	483.50(b)(2)(iv)	483.50 Laboratory, Radiology, and Other Diagnostic Services		F513	483.50(b)(2)(iv)
F790		Routine/Emergency Dental Services in SNFs	483.55(a)(1)-(5)	483.55 Dental Services		F411	483.55(a)(1)-(5)
F791		Routine/Emergency Dental Services in NFs	483.55(b)(1)-(5)	483.55 Dental Services		F412	483.55(b)(1)-(5)
F800		Provided Diet Meets Needs of Each Resident	483.60	483.60 Food and Nutrition Services		F360	483.60
F801		Qualified Dietary Staff	483.60(a)(1)(2)	483.60 Food and Nutrition Services		F361	483.60(a)(1)(2)
F802		Sufficient Dietary Support Personnel	483.60(a)(3)(b)	483.60 Food and Nutrition Services		F362	483.60(a)(3)(b)
F803		Menus Meet Res Needs/Prep in Advance/Followed	483.60(c)(1)-(7)	483.60 Food and Nutrition Services		F363	483.60(c)(1)-(7)
F804		Nutritive Value/Appear, Palatable/Prefer Temp	483.60(d)(1)(2)	483.60 Food and Nutrition Services		F364	483.60(d)(1(2)
F805		Food in Form to Meet Individual Needs	483.60(d)(3)	483.60 Food and Nutrition Services		F365	483.60(d)(3)
F806		Resident Allergies, Preferences and Substitutes	483.60(d)(4)(5)	483.60 Food and Nutrition Services		F366	483.60(d)(4)(5)
F807		Drinks Avail to Meet Needs/ Preferences/ Hydration	483.60(d)(6)	483.60 Food and Nutrition Services		F366	483.60(d)(6)
F808		Therapeutic Diet Prescribed by Physician	483.60(e)(1)(2)	483.60 Food and Nutrition Services		F367	483.60(e)(1)(2)
F809		Frequency of Meals/Snacks at Bedtime	483.60(f)(1)-(3)	483.60 Food and Nutrition Services		F368	483.60(f)(1)-(3)
F810		Assistive Devices - Eating Equipment/Utensils	483.60(g)	483.60 Food and Nutrition Services		F369	483.60(g)
F811		Feeding Asst - Training/Supervision/Resident	483.60(h)(1)-(3)	483.60 Food and Nutrition Services		F373	483.60(h)(1)-(3)
F812		Food Procurement, Store/Prepare/Serve - Sanitary	483.60(i)(1)(2)	483.60 Food and Nutrition Services		F371	483.60(i)(1)(2)
F813		Personal Food Policy	483.60(i)(3)	483.60 Food and Nutrition Services		F371	483.60(i)(3)
F814		Dispose Garbage & Refuse Properly	483.60(i)(4)	483.60 Food and Nutrition Services		F372	483.60(i)(4)
F825		Provide/Obtain Specialized Rehab Services	483.65(a)(1)(2)	483.65 Specialized Rehabilitative Services		F406	483.65(a)(1)(2)
F826		Rehab Services- Physician Order/Qualified Person	483.65(b)	483.65 Specialized Rehabilitative Services		F407	483.65(b)
F835		Administration	483.70	483.70 Administration		F490	483.70

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F836		License/Comply w/Fed/State/Local Law/Prof Std	483.70(a)-(c)	483.70 Administration		F491 F492	483.70(a) 483.70(b)(c)
F837		Governing Body	483.70(d)(1)-(3)	483.70 Administration	(d)(3) - Phase 3 Will not be in ASPEN until Phase 3	F493	483.70(d)(1)-(3)
F838		Facility Assessment	483.70(e)(1)-(3)	483.70 Administration			No Associated Tag
F839		Staff Qualifications	483.70(f)(1)(2)	483.70 Administration		F499	483.70(f)(1)(2)
F840		Use of Outside Resources	483.70(g)(1)(2)	483.70 Administration		F500	483.70(g)(1)(2)(i)(ii)
F841		Responsibilities of Medical Director	483.70(h)(1)(2)	483.70 Administration		F501	483.70(h)(1)(2)
F842		Resident Records - Identifiable Information	483.20(f)(5) 483.70(i)(1)-(5)	483.20 Resident Assessments 483.70 Administration		F164 F514 F515 F516	483.70(i)(2) 483.70(i)1)(5) 483.70(i)(4)(i)-(iii) 483.20(f)(5); 483.70(i)(3)
F843		Transfer Agreement	483.70(j)(1)(2)	483.70 Administration		F519	483.70(j)(1)(2)
F844		Disclosure of Ownership Requirements	483.70(k)(1)-(3)	483.70 Administration		F522	483.70(k)(1)-(3)
F845		Facility closure-Administrator	483.70(l)(1)-(3)	483.70 Administration		F523	483.70(l)(1)-(3)
F846		Facility closure	483.70(m)	483.70 Administration		F524	483.70(m)
F849		Hospice Services	483.70(o)(1)-(4)	483.70 Administration		F526	483.70(o)(1)-(4)
F850	X	Qualifications of Social Worker >120 Beds	483.70(p)(1)(2)	483.70 Administration		F251	483.70(p)(1)(2)
F851		Payroll Based Journal	483.70(q)(1)-(5)	483.70 Administration		F527	483.70(q)(1)-(5)
F865		QAPI Program/Plan, Disclosure/Good Faith Attmpt	483.75(a)(b)(f)(h)(i)	483.75 Quality Assurance and Performance Improvement	(a)(1)(3)(4)(b)(f) - Phase 3 Will not be in ASPEN until Phase 3	F520	483.75(a)(2)(h)(i)
F866		QAPI/QAA Data Collection and Monitoring	483.75(c)(1)-(4)	483.75 Quality Assurance and Performance Improvement	Entire tag - Phase 3 Will not be in ASPEN until Phase 3	F520	483.75(c)(1)-(4)
F867		QAPI/QAA Improvement Activities	483.75(d)(1)(2)(e)(1)-(3)(g)(2)	483.75 Quality Assurance and Performance Improvement	(d)(1)(2)(i)-(iii)(e)(1)-(3)(g)(2)(iii) will not be in ASPEN until Phase 3	F520	483.75(g)(2)(ii)

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F868		QAA Committee	483.75(g)(1)(i)-(iv)(2)(i)	483.75 Quality Assurance and Performance Improvement	(g)(1)(iv) - Phase 3 Will not be in ASPEN until Phase 3	F520	483.75(g)(1)(i)-(iii)(2)(i)
F880		Infection Prevention & Control	483.80(a)(1)(2)(4)(e)(f)	483.80 Infection Control		F441	483.80(a)(1)(2)(4)€
F881		Antibiotic Stewardship Program	483.80(a)(3)	483.80 Infection Control			No Associated Tag
F882		Infection Preventionist Qualifications/Role	483.80(b)(1)-(4)(c)	483.80 Infection Control	Entire tag - Phase 3 Will not be in ASPEN until Phase 3		No Associated Tag
F883	X	Influenza and Pneumococcal Immunizations	483.80(d)(1)(2)	483.80 Infection Control		F334	483.80(d)(1)(2)
F895		Compliance andEthics Program	483.85(a)-(e)	483.85 Compliance and Ethics Program	Entire tag - Phase 3 Will not be in ASPEN until Phase 3		No Associated Tag
F906		Emergency Power	483.90(c)(1)(2)	483.90 Physical Environment		F455	483.90(c)(1)(2)
F907		Space and Equipment	483.90(d)(1)	483.90 Physical Environment		F455	483.90(d)(1)
F908		Essential Equipment, Safe Operating Condition	483.90(d)(2)	483.90 Physical Environment		F456	483.90(d)(2)
F909		Resident Bed	483.90(d)(3)	483.90 Physical Environment		F461	483.90(d)(3)
F910		Resident Room	483.90(e)	483.90 Physical Environment		F456	483.90(e)
F911		Bedroom Number of Residents	483.90(e)(1))(i)	483.90 Physical Environment		F457	483.90(e)(1))(i)
F912		Bedrooms Measure at Least 80 Square Ft/Resident	483.90(e)(1)(ii)	483.90 Physical Environment		F458	483.90(e)(1)(ii)
F913		Bedrooms Have Direct Access to Exit Corridor	483.90(e)(1)(iii)	483.90 Physical Environment		F459	483.90(e)(1)(iii)
F914		Bedrooms Assure Full Visual Privacy	483.90(e)(1)(iv)(v)	483.90 Physical Environment		F460	483.90(e)(1)(iv)(v)
F915		Resident Room Window	483.90(a)(7)(e)(1)(vi)	483.90 Physical Environment		F454 F461	483.90(a)(7) 483.90(e)(1)(vi)
F916		Resident Room Floor Above Grade	483.90(e)(1)(vii)	483.90 Physical Environment		F461	483.90(e)(1)(vii)
F917		Resident Room Bed/Furniture/Closet	483.10(i)(4) 483.90(e)(2)(3)	483.10 Resident Rights 483.90 Physical Environment		F461	483.10(i)(4) 483.90(e)(2)(3)
F918		Bedrooms Equipped/Near Lavatory/Toilet	483.90(f)	483.90 Physical Environment		F462	483.90(f)

Effective November 28, 2017

Tag # (As of Nov. 28, 2017)	SQC Tag? X = Yes	Tag Title	CFR	Regulatory Groupings	Tags / Subparts Implemented in Phase 3	Old Tag (Taken from App PP 03-08-2017)	RegulationText that was Moved to New Tag
F919		Resident Call System	483.90(g)(1)(2)	483.90 Physical Environment	(g)(1)- Phase 3 Will not be in ASPEN until Phase 3	F463	483.90(g)(1)(2)
F920		Requirements for Dining and Activity Rooms	483.90(h)(1)-(4)	483.90 Physical Environment		F464	483.90(h)(1)-(4)
F921		Safe/Functional/Sanitary/ Comfortable Environment	483.90(i)	483.90 Physical Environment		F465	483.90(i)
F922		Procedures to Ensure Water Availability	483.90(i)(1)	483.90 Physical Environment		F466	483.90(i)(1)
F923		Ventilation	483.90(i)(2)	483.90 Physical Environment		F467	483.90(i)(2)
F924		Corridors Have Firmly Secured Handrails	483.90(i)(3)	483.90 Physical Environment		F468	483.90(i)(3)
F925		Maintains Effective Pest Control Program	483.90(i)(4)	483.90 Physical Environment		F469	483.90(i)(4)
F926		Smoking Policies	483.90(i)(5)	483.90 Physical Environment			No Associated Tag
F940		Training Requirements - General	483.95	483.95 Training Requirements	Entire tag - Phase 3 Will not be in ASPEN until Phase 3		No Associated Tag
F941		Communication Training	483.95(a)	483.95 Training Requirements	Entire tag - Phase 3 Will not be in ASPEN until Phase 3		No Associated Tag
F942		Resident's Rights Training	483.95(b)	483.95 Training Requirements	Entire tag - Phase 3 Will not be in ASPEN until Phase 3		No Associated Tag
F943		Abuse, Neglect, and Exploitation Training	483.95(c)(1)-(3)	483.95 Training Requirements		F226	483.95(c)(1)-(3)
F944		QAPI Training	483.95(d)	483.95 Training Requirements	Entire tag - Phase 3 Will not be in ASPEN until Phase 3		No Associated Tag
F945		Infection Control Training	483.95(e)	483.95 Training Requirements	Entire tag - Phase 3 Will not be in ASPEN until Phase 3		No Associated Tag
F946		Compliance and Ethics Training	483.95(f)(1)(2)	483.95 Training Requirements	Entire tag - Phase 3 Will not be in ASPEN until Phase 3		No Associated Tag
F947		Required In-Service Training for Nurse Aides	483.95(g)(1)-(4)	483.95 Training Requirements		F498	483.95(g)(1)-(4)
F948		Training for Feeding Assistants	483.95(h)	483.95 Training Requirements		F373	483.95(h)

Phase 2 Tag Crosswalk -

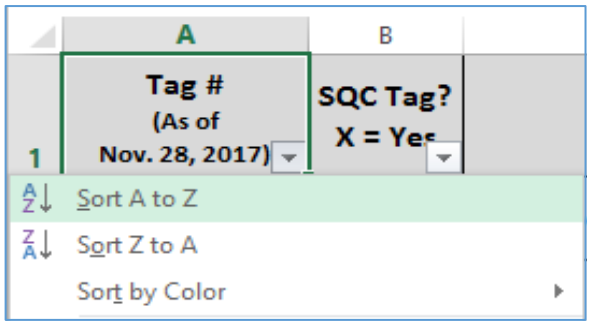
Effective November 28, 2017

Tag # (As of Nov. 28, 2017)	SQC Tag? X = Yes	Tag Title	CFR	Regulatory Groupings	Tags / Subparts Implemented in Phase 3	Old Tag (Taken from App PP 03-08-2017)	RegulationText that was Moved to New Tag
F949		Behavioral Health Training	483.95(i)	483.95 Training Requirements	Entire tag - Phase 3 Will not be in ASPEN until Phase 3		No Associated Tag

Follow the Instructions Below to Sort Tags Located on the "Sortable by Tags" Worksheet.

1. Click the down arrow on either Column A or Column G.

2. Select "Sort A to Z".



Phase 2 Tag Crosswalk -

Effective November 28, 2017

Tag # (As of Nov. 28, 2017)	SQC Tag? X = Yes	Tag Title	CFR
F540		Definitions	483.5
F550	X	Resident Rights/Exercise of Rights	483.10(a)(1)(2)(b)(1)(2)
F551		Rights Exercised by Representative	483.10(b)(3)-(7)(i)-(iii)
F573		Right to Access/Purchase Copies of Records	483.10(g)(2)(i)(ii)(3)
F552		Right to be Informed/Make Treatment Decisions	483.10(c)(1)(4)(5)
F553		Right to Participate in Planning Care	483.10(c)(2)(3)
F578		Request/Refuse/Discontinue Treatment;Formulate Adv Directives	483.10(c)(6)(8)(g)(12)(i)-(v)
F678	X	Cardio-Pulmonary Resuscitation (CPR)	483.24(a)(3)
F572		Notice of Rights and Rules	483.10(g)(1)(16)
F574		Required Notices and Contact Information	483.10(g)(4)(i)-(vi)
F575		Required Postings	483.10(g)(5)(i)(ii)
F579		Posting/Notice of Medicare/Medicaid on Admission	483.10(g)(13)
F582		Medicaid/Medicare Coverage/Liability Notice	483.10(g)(17)(18)(i)-(v)
F580		Notify of Changes (Injury/Decline/Room, Etc.)	483.10(g)(14)(i)-(iv)
F567		Protection/Management of Personal Funds	483.10(f)(10)(i)(ii)
F567		Protection/Management of Personal Funds	483.10(f)(10)(i)(ii)
F568		Accounting and Records of Personal Funds	483.10(f)(10)(iii)
F569		Notice and Conveyance of Personal Funds	483.10(f)(10)(iv)(v)

F570		Surety Bond - Security of Personal Funds	483.10(f)(10)(vi)
F571		Limitations on Charges to Personal Funds	483.10(f)(11)(i)-(iii)
F555		Right to Choose/Be Informed of Attending Physician	483.10(d)(1)-(5)
F583		Personal Privacy/Confidentiality of Records	483.10(h)(1)-(3)(i)(ii)
F842		Resident Records - Identifiable Information	483.20(f)(5) 483.70(i)(1)-(5)
F585		Grievances	483.10(j)(1)-(4)
F585		Grievances	483.10(j)(1)-(4)
F577		Right to Survey Results/Advocate Agency Info	483.10(g)(10)(11)
F577		Right to Survey Results/Advocate Agency Info	483.10(g)(10)(11)
F586		Resident Contact with External Entities	483.10(k)
F566		Right to Perform Facility Services or Refuse	483.10(f)(9)(i)-(iv)
F576		Right to Forms of Communication with Privacy	483.10(g)(6)-(9)
F576		Right to Forms of Communication with Privacy	483.10(g)(6)-(9)
F562		Immediate Access to Resident	483.10(f)(4)(i)(A)-(G)
F563		Right to Receive/Deny Visitors	483.10(f)(4)(ii)-(v)
F564		Inform of Visitation Rights/Equal Visitation Priviledges	483.10(f)(4)(vi)(A)-(D)
F583		Personal Privacy/Confidentiality of Records	483.10(h)(1)-(3)(i)(ii)
F576		Right to Forms of Communication with Privacy	483.10(g)(6)-(9)
F559	X	Choose/Be Notified of Room/Roommate Change	483.10(e)(4)-(6)

F554		Resident Self-Admin Meds-Clinically Appropriate	483.10(c)(7)
F560		Right to Refuse Certain Transfers	483.10(e)(7)(i)-(iii)(8)
F622		Transfer and Discharge Requirements	483.15(c)(1)(i)(ii)(2)(i)-(iii)
F622		Transfer and Discharge Requirements	483.15(c)(1)(i)(ii)(2)(i)-(iii)
F623		Notice Requirements Before Transfer/Discharge	483.15(c)(3)-(6)(8)
F624		Preparation for Safe/Orderly Transfer/Discharge	483.15(c)(7)
F625		Notice of Bed Hold Policy Before/Upon Transfer	483.15(d)(1)(2)
F626		Permitting Residents to Return to Facility	483.15(e)(1)(2)
F621		Equal Practices Regardless of Payment Source	483.15(b)(1)-(3)(c)(9)
F620		Admissions Policy	483.15(a)(1)-(7)
F604	X	Right to be Free from Physical Restraints	483.10(e)(1) 483.12(a)(2)
F604	X	Right to be Free from Physical Restraints	483.10(e)(1) 483.12(a)(2)
F605	X	Right to be Free from Chemical Restraints	483.10(e)(1) 483.12(a)(2)
F600	X	Free from Abuse and Neglect	483.12(a)(1)
F602	X	Free from Misappropriation/Exploitation	483.12
F603	X	Free from Involuntary Seclusion	483.12(a)(1)

F602	X	Free from Misappropriation/Exploitation	483.12
F606	X	Not Employ/Engage Staff with Adverse Actions	483.12(a)(3)(4)
F609	X	Reporting of Alleged Violations	483.12(c)(1)(4)
F610	X	Investigate/Prevent/Correct Alleged Violation	483.12(c)(2)-(4)
F607	X	Develop/Implement Abuse/Neglect, etc. Policies	483.12(b)(1)-(4)
F943		Abuse, Neglect, and Exploitation Training	483.95(c)(1)-(3)
F550	X	Resident Rights/Exercise of Rights	483.10(a)(1)(2)(b)(1)(2)
F550	X	Resident Rights/Exercise of Rights	483.10(a)(1)(2)(b)(1)(2)
F561	X	Self Determination	483.10(f)(1)-(3)(8)
F565	X	Resident/Family Group and Response	483.10(f)(5)(i)-(iv)(6)(7)
F565	X	Resident/Family Group and Response	483.10(f)(5)(i)-(iv)(6)(7)
F561	X	Self Determination	483.10(f)(1)-(3)(8)
F558	X	Reasonable Accommodations of Needs/Preferences	483.10(e)(3)
F559	X	Choose/Be Notified of Room/Roommate Change	483.10(e)(4)-(6)
F679	X	Activities Meet Interest/Needs of Each Resident	483.24(c)(1)

F680	X	Qualifications of Activity Professional	483.24(c)(2)(i)(ii)(A)-(D)
F745	X	Provision of Medically Related Social Services	483.40(d)
F850	X	Qualifications of Social Worker >120 Beds	483.70(p)(1)(2)
F557		Respect, Dignity/Right to have Personal Property	483.10(e)(2)
F584	X	Safe/Clean/Comfortable/ Homelike Environment	483.10(i)(1)-(7)
F584	X	Safe/Clean/Comfortable/ Homelike Environment	483.10(i)(1)-(7)
F584	X	Safe/Clean/Comfortable/ Homelike Environment	483.10(i)(1)-(7)
F584	X	Safe/Clean/Comfortable/ Homelike Environment	483.10(i)(1)-(7)
F584	X	Safe/Clean/Comfortable/ Homelike Environment	483.10(i)(1)-(7)
F584	X	Safe/Clean/Comfortable/ Homelike Environment	483.10(i)(1)-(7)
F635		Admission Physician Orders for Immediate Care	483.20(a)
F636		Comprehensive Assessments & Timing	483.20(b)(1)(2)(i)(iii)
F636		Comprehensive Assessments & Timing	483.20(b)(1)(2)(i)(iii)
F637		Comprehensive Assmt After Significant Change	483.20(b)(2)(ii)
F636		Comprehensive Assessments & Timing	483.20(b)(1)(2)(i)(iii)
F638		Quarterly Assessment At Least Every 3 Months	483.20(c)
F641		Accuracy of Assessments	483.20(g)
F642		Coordination/Certification of Assessment	483.20(h)-(j)
F639		Maintain 15 Months of Resident Assessments	483.20(d)
F656		Develop/Implement Comprehensive Care Plan	483.21(b)(1)

F553		Right to Participate in Planning Care	483.10(c)(2)(3)
F657		Care Plan Timing and Revision	483.21(b)(2)(i)-(iii)
F658		Services Provided Meet Professional Standards	483.21(b)(3)(i)
F659		Qualified Persons	483.21(b)(3)(ii)(iii)
F661		Discharge Summary	483.21(c)(2)(i)-(iv)
F660		Discharge Planning Process	483.21(c)(1)(i)-(ix)
F661		Discharge Summary	483.21(c)(2)(i)-(iv)
F644		Coordination of PASARR and Assessments	483.20(e)(1)(2)
F645		PASARR Screening for MD & ID	483.20(k)(1)-(3)
F646		MD/ID Significant Change Notification	483.20(k)(4)
F639		Maintain 15 Months of Resident Assessments	483.20(d)
F640		Encoding/Transmitting Resident Assessment	483.20(f)(1)-(4)
F675	X	Quality of Life	483.24
F684	X	Quality of Care	483.25
F697	X	Pain Management	483.25(k)
F698	X	Dialysis	483.25(l)
F744	X	Treatment /Service for Dementia	483.40(b)(3)

F676	X	Activities of Daily Living (ADLs)/ Maintain Abilities	483.24(a)(1)(b)(1)-(5)(i)-(iii)
F676	X	Activities of Daily Living (ADLs)/ Maintain Abilities	483.24(a)(1)(b)(1)-(5)(i)-(iii)
F677	X	ADL Care Provided for Dependent Residents	483.24(a)(2)
F685	X	Treatment/Devices to Maintain Hearing/Vision	483.25(a)(1)(2)
F686	X	Treatment/Svcs to Prevent/Heal Pressure Ulcers	483.25(b)(1)(i)(ii)
F690	X	Bowel/Bladder Incontinence, Catheter, UTI	483.25(e)(1)-(3)
F688	X	Increase/Prevent Decrease in ROM/Mobility	483.25(c)(1)-(3)
F688	X	Increase/Prevent Decrease in ROM/Mobility	483.25(c)(1)-(3)
F742	X	Treatment/Svc for Mental/Psychosocial Concerns	483.40(b)(1)
F743	X	No Pattern of Behavioral Difficulties UnlessUnavoidable	483.40(b)(2)
F693	X	Tube Feeding Management/Restore Eating Skills	483.25(g)(4)(5)
F689	X	Free of Accident Hazards/Supervision/Devices	483.25(d)(1)(2)
F700	X	Bedrails	483.25(n)(1)-(4)
F692	X	Nutrition/Hydration Status Maintenance	483.25(g)(1)-(3)
F692	X	Nutrition/Hydration Status Maintenance	483.25(g)(1)-(3)
F687	X	Foot Care	483.25(b)(2)(i)(ii)
F691	X	Colostomy, Urostomy, or Ileostomy Care	483.25(f)
F694	X	Parenteral/IV Fluids	483.25(h)
F695	X	Respiratory/Tracheostomy care and Suctioning	483.25(i)
F696	X	Prostheses	483.25(j)

F757	X	Drug Regimen is Free From Unnecessary Drugs	483.45(d)(1)-(6)
F758	X	Free from Unnec Psychotropic Meds/PRN Use	483.45(c)(3)(e)(1)-(5)
F759	X	Free of Medication Error Rates of 5% or More	483.45(f)(1)
F760	X	Residents Are Free of Significant Med Errors	483.45(f)(2)
F883	X	Influenza and Pneumococcal Immunizations	483.80(d)(1)(2)
F725		Sufficient Nursing Staff	483.35(a)(1)(2)
F726		Competent Nursing Staff	483.35(a)(3)(4)(c)
F727		RN 8 Hrs/7 days/Wk, Full Time DON	483.35(b)(1)-(3)
F731		Waiver-Licensed Nurses 24 Hr/Day and RN Coverage	483.35(e)(1)-(7)(f)(1)(2)
F732		Posted Nurse Staffing Information	483.35(g)(1)-(4)
F800		Provided Diet Meets Needs of Each Resident	483.60
F801		Qualified Dietary Staff	483.60(a)(1)(2)
F802		Sufficient Dietary Support Personnel	483.60(a)(3)(b)
F803		Menus Meet Res Needs/Prep in Advance/Followed	483.60(c)(1)-(7)
F804		Nutritive Value/Appear, Palatable/Prefer Temp	483.60(d)(1)(2)
F805		Food in Form to Meet Individual Needs	483.60(d)(3)
F806		Resident Allergies, Preferences and Substitutes	483.60(d)(4)(5)
F807		Drinks Avail to Meet Needs/ Preferences/ Hydration	483.60(d)(6)
F808		Therapeutic Diet Prescribed by Physician	483.60(e)(1)(2)
F809		Frequency of Meals/Snacks at Bedtime	483.60(f)(1)-(3)
F810		Assistive Devices - Eating Equipment/Utensils	483.60(g)

F812		Food Procurement, Store/Prepare/Serve - Sanitary	483.60(i)(1)(2)
F813		Personal Food Policy	483.60(i)(3)
F814		Dispose Garbage & Refuse Properly	483.60(i)(4)
F811		Feeding Asst - Training/Supervision/Resident	483.60(h)(1)-(3)
F948		Training for Feeding Assistants	483.95(h)
F710		Resident's Care Supervised by a Physician	483.30(a)(1)(2)
F711		Physician Visits- Review Care/Notes/Order	483.30(b)(1)-(3)
F712		Physician Visits- Frequency/Timeliness/Alternate NPPs	483.30(c)(1)-(4)
F712		Physician Visits- Frequency/Timeliness/Alternate NPPs	483.30(c)(1)-(4)
F713		Physician for Emergency Care, Available 24 Hours	483.30(d)
F714		Physician Delegation of Tasks to NPP	483.30(e)(1)(4)(f)
F715		Physician Delegation to Dietitian/Therapist	483.30(e)(2)(3)
F825		Provide/Obtain Specialized Rehab Services	483.65(a)(1)(2)
F826		Rehab Services- Physician Order/Qualified Person	483.65(b)
F790		Routine/Emergency Dental Services in SNFs	483.55(a)(1)-(5)
F791		Routine/Emergency Dental Services in NFs	483.55(b)(1)-(5)

F755		Pharmacy Svcs/Procedures/Pharmacist /Records	483.45(a)(b)(1)-(3)
F756		Drug Regimen Review, Report Irregular, Act On	483.45(c)(1)(2)(4)(5)
F758	X	Free from Unnec Psychotropic Meds/PRN Use	483.45(c)(3)(e)(1)-(5)
F755		Pharmacy Svcs/Procedures/Pharmacist /Records	483.45(a)(b)(1)-(3)
F761		Label/Store Drugs & Biologicals	483.45(g)(h)(1)(2)
F880		Infection Prevention & Control	483.80(a)(1)(2)(4)(e)(f)
F915		Resident Room Window	483.90(a)(7)(e)(1)(vi)
F906		Emergency Power	483.90(c)(1)(2)
F907		Space and Equipment	483.90(d)(1)
F908		Essential Equipment, Safe Operating Condition	483.90(d)(2)
F910		Resident Room	483.90(e)
F911		Bedroom Number of Residents	483.90(e)(1))(i)
F912		Bedrooms Measure at Least 80 Square Ft/Resident	483.90(e)(1)(ii)
F913		Bedrooms Have Direct Access to Exit Corridor	483.90(e)(1)(iii)
F914		Bedrooms Assure Full Visual Privacy	483.90(e)(1)(iv)(v)
F584	X	Safe/Clean/Comfortable/ Homelike Environment	483.10(i)(1)-(7)
F700	X	Bedrails	483.25(n)(1)-(4)

F909		Resident Bed	483.90(d)(3)
F915		Resident Room Window	483.90(a)(7)(e)(1)(vi)
F916		Resident Room Floor Above Grade	483.90(e)(1)(vii)
F917		Resident Room Bed/Furniture/Closet	483.10(i)(4) 483.90(e)(2)(3)
F918		Bedrooms Equipped/Near Lavatory/Toilet	483.90(f)
F919		Resident Call System	483.90(g)(1)(2)
F920		Requirements for Dining and Activity Rooms	483.90(h)(1)-(4)
F921		Safe/Functional/Sanitary/ Comfortable Environment	483.90(i)
F922		Procedures to Ensure Water Availability	483.90(i)(1)
F923		Ventilation	483.90(i)(2)
F924		Corridors Have Firmly Secured Handrails	483.90(i)(3)
F925		Maintains Effective Pest Control Program	483.90(i)(4)
F835		Administration	483.70
F836		License/Comply w/Fed/State/Local Law/Prof Std	483.70(a)-(c)
F836		License/Comply w/Fed/State/Local Law/Prof Std	483.70(a)-(c)
F837		Governing Body	483.70(d)(1)-(3)
F728		Facility Hiring and Use of Nurse Aide	483.35(d)(1)-(3)
F728		Facility Hiring and Use of Nurse Aide	483.35(d)(1)-(3)
F729		Nurse Aide Registry Verification, Retraining	483.35(d)(4)-(6)

F730		Nurse Aide Perform Review – 12 Hr/Year In- service	483.35(d)(7)
F726		Competent Nursing Staff	483.35(a)(3)(4)(c)
F947		Required In-Service Training for Nurse Aides	483.95(g)(1)-(4)
F839		Staff Qualifications	483.70(f)(1)(2)
F840		Use of Outside Resources	483.70(g)(1)(2)
F841		Responsibilities of Medical Director	483.70(h)(1)(2)
F770		Laboratory Services	483.50(a)(1)(i)
F771		Blood Blank and Transfusion Services	483.50(a)(1)(ii)
F770		Laboratory Services	483.50(a)(1)(i)
F771		Blood Blank and Transfusion Services	483.50(a)(1)(ii)
F772		Lab Services Not Provided On-Site	483.50(a)(1)(iv)
F773		Lab Svs Physician Order/Notify of Results	483.50(a)(2)(i)(ii)
F773		Lab Svs Physician Order/Notify of Results	483.50(a)(2)(i)(ii)
F774		Assist with Transport Arrangements to Lab Svcs	483.50(a)(2)(iii)
F775		Lab Reports in Record-Lab Name/Address	483.50(a)(2)(iv)

F776		Radiology/Other Diagnostic Services	483.50(b)(1)(i)(ii)
F776		Radiology/Other Diagnostic Services	483.50(b)(1)(i)(ii)
F777		Radiology/Diag. Svcs Ordered/Notify Results	483.50(b)(2)(i)(ii)
F777		Radiology/Diag. Svcs Ordered/Notify Results	483.50(b)(2)(i)(ii)
F778		Assist with Transport Arrangements to Radiology	483.50(b)(2)(iii)
F779		X-Ray/Diagnostic Report in Record-Sign/Dated	483.50(b)(2)(iv)
F842		Resident Records - Identifiable Information	483.20(f)(5) 483.70(i)(1)-(5)
F842		Resident Records - Identifiable Information	483.20(f)(5) 483.70(i)(1)-(5)
F842		Resident Records - Identifiable Information	483.20(f)(5) 483.70(i)(1)-(5)
F843		Transfer Agreement	483.70(j)(1)(2)
F865		QAPI Program/Plan, Disclosure/Good Faith Attmpt	483.75(a)(b)(f)(h)(i)
F866		QAPI/QAA Data Collection and Monitoring	483.75(c)(1)-(4)
F867		QAPI/QAA Improvement Activities	483.75(d)(1)(2)(e)(1)-(3)(g)(2)
F868		QAA Committee	483.75(g)(1)(i)-(iv)(2)(i)
F844		Disclosure of Ownership Requirements	483.70(k)(1)-(3)
F845		Facility closure-Administrator	483.70(l)(1)-(3)
F846		Facility closure	483.70(m)
F849		Hospice Services	483.70(o)(1)-(4)
F851		Payroll Based Journal	483.70(q)(1)-(5)
F608	X	Reporting of Reasonable Suspicion of a Crime	483.12(b)(5)(i)-(iii)

F655		Baseline Care Plan	483.21(a)(1)-(3)
F699	X	Trauma Informed Care	483.25(m)
F740		Behavioral Health Services	483.40
F741		Sufficient/Competent Staff-Behav Health Needs	483.40(a)(1)(2)
F838		Facility Assessment	483.70(e)(1)-(3)
F881		Antibiotic Stewardship Program	483.80(a)(3)
F882		Infection Preventionist Qualifications/Role	483.80(b)(1)-(4)(c)
F895		Compliance andEthics Program	483.85(a)-(e)
F926		Smoking Policies	483.90(i)(5)
F940		Training Requirements - General	483.95
F941		Communication Training	483.95(a)
F942		Resident's Rights Training	483.95(b)
F944		QAPI Training	483.95(d)
F945		Infection Control Training	483.95(e)
F946		Compliance and Ethics Training	483.95(f)(1)(2)
F949		Behavioral Health Training	483.95(i)

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483.21 Comprehensive Resident Centered Care Plans		
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483.90 Physical Environment		
483.95 Training Requirements	Entire tag - Phase 3 Will not be in ASPEN until Phase 3	
483.95 Training Requirements	Entire tag - Phase 3 Will not be in ASPEN until Phase 3	
483.95 Training Requirements	Entire tag - Phase 3 Will not be in ASPEN until Phase 3	
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483.10(b)(3)-(7)
483.10(g)(2)(3)
483.10(c)(1)(4)(5)
483.10(c)(2)(iii)
483.10(c)(6)(8)(g)(12)
483.24(a)(3)
483.10(g)(1)(16)
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483.10(g)(17)-(18)
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483.10(f)(ii)
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483.10(i)(7)
483.20(a)
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483.35(e)(1)-(7)(f)(1)(2)
483.35(g)(1)-(4)
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483.60(a)(1)(2)
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483.45(c)(1)(2)(4)(5)
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483.90(a)(7)
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483.90(e)
483.90(e)(1))(i)
483.90(e)(1)(ii)
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483.90(e)(1)(iv)(v)
483.10(i)(4)
483.25(n)(4)

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483.70(h)(1)(2)
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483.50(a)(1)
483.50(a)(i)
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483.50(b)(1)
483.50(b)(i)(ii)
483.50(b(2)(i)
483.50(b)(2)(ii)
483.50(b)(2)(iii)
483.50(b)(2)(iv)
483.70(i)1)(5)
483.70(i)(4)(i)-(iii)
483.20(f)(5); 483.70(i)(3)
483.70(j)(1)(2)
483.75(a)(2)(h)(i)
483.75(c)(1)-(4)
483.75(g)(2)(ii)
483.75(g)(1)(i)-(iii)(2)(i)
483.70(k)(1)-(3)
483.70(l)(1)-(3)
483.70(m)
483.70(o)(1)-(4)
483.70(q)(1)-(5)
No Associated Tag

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No Associated Tag
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The *"F-Tag Crosswalk"* document can be found at:

https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/GuidanceforLawsAndRegulations/Nursing-Homes.html

Reference:

CMS. (2017). F-Tag Crosswalk. Retrieved August, 2017, from https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/GuidanceforLawsAndRegulations/Nursing-Homes.html

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Additional Resources

Infection Control

APIC Resources
http://community.apic.org/sierra/resources/overview

CDC: The Core Elements of Antibiotic Stewardship for Nursing Homes:
https://www.cdc.gov/longtermcare/prevention/antibiotic-stewardship.html

AHRQ-Nursing Home Antimicrobial Stewardship Guide:
https://www.ahrq.gov/nhguide/index.html

"Surveillance Definitions of Infections in Long-Term Care Facilities: Revisiting the McGeer Criteria"
https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3538836/

Toolkit to Reduce CAUTI and Other HAIs in Long-Term Care Facilities (AHRQ)
https://www.ahrq.gov/professionals/quality-patient-safety/quality-resources/tools/cauti-ltc/index.html?utm_source=ahrq&utm_medium=en2&utm_term=&utm_content=2&utm_campaign=ahrq_en5_23_2017

Diagnosis, Prevention and Treatment of C. difficile: Current State of the Evidence (AHRQ) May 30, 2017
https://www.effectivehealthcare.ahrq.gov/search-for-guides-reviews-and-reports/?pageaction=displayproduct&productID=2476&utm_source=ahrq&utm_medium=en5&utm_term=&utm_content=5&utm_campaign=ahrq_en5_23_2017

Emergency Preparedness

Health and Human Services – Federal Resources

Emergency Preparedness Interpretive Guidelines
https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/SurveyCertEmergPrep/Downloads/Advanced-Copy-SOM-Appendix-Z-EP-IGs.pdf

CMS S&C memo Emergency Preparedness Interpretive Guidelines
www.cms.gov/Medicare/Provider...and.../Survey-and-Cert-Letter-17-29.pdf

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HSS.gov Emergency Preparedness Resources For Long Term Care – Plans, Tools and Templates
https://asprtracie.hhs.gov/technical-resources/52/long-term-care-facilities/47

Emergency response and Recovery Home Page
https://www.cms.gov/About-CMS/Agency-Information/Emergency/index.html

All hazards FAQ
https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/SurveyCertEmergPrep/Downloads/All-Hazards-FAQs.pdf

CMS Skilled Nursing Resources

Appendix PP – Interpretive Guidance
https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/GuidanceforLawsAndRegulations/Downloads/Advance-Appendix-PP-Including-Phase-2-.pdf

Requirements for Participation – Resource Page
https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/GuidanceforLawsAndRegulations/Nursing-Homes.html

CMS Surveyor Training
https://surveyortraining.cms.hhs.gov/

Reference

CMS. (2017). Federal Regulatory Groups for Long Term Care Facilities. Retrieved August, 2017, from https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/GuidanceforLawsAndRegulations/Downloads/List-of-Revised-FTags.pdf

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Facility Assessment F838 *§483.70(e)*
Corresponding/Referenced F Tags

F Tag	Reference Description
F607	**Abuse** "*Assuring that residents are free from neglect by having the structures and processes to provide needed care and services to all residents, which includes, but is not limited to, the provision of a facility assessment to determine what resources are necessary to care for its residents competently;*
F622	**Transfer and discharge** *"Facilities should not admit residents whose needs they cannot meet based on the Facility Assessment"*
F626	**Permitting Residents to Return to Facility – Readmission** "*Work with the hospital to ensure the resident's condition and needs are within the nursing home's scope of care, based on its facility assessment, prior to hospital discharge. For example, the nursing home could ask the hospital to:* o *Attempt reducing a resident's psychotropic medication prior to discharge and monitor symptoms so that the nursing home can determine whether it will be able to meet the resident's needs upon return;* o *Convert IV medications to oral medications and ensure that the oral medications adequately address the resident's needs.*
F656	**Comprehensive Care Plans** "*If the surveyor identifies concerns about the resident's care plan being individualized and person-centered, the surveyor should also review requirements at:* • *Resident assessment, §483.20* • *Activities, §483.24(c)* • *Nursing services, §483.35* • *Food and nutrition services, §483.60* • *Facility assessment, §483.70(e)*
F689	**Accidents** – resident environment remains free of accident and hazards as is possible and each resident receives adequate supervision and assistance devices to prevent accidents

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F Tag	Reference Description
	Identification of Hazards – *"These sources may include, but are not limited to, Quality Assessment and Assurance (QAA) activities, environmental rounds, MDS/CAAs data, medical history and physical exam, facility assessment"* **Physical Plant Hazards** – *"facility responsibilities regarding the facility's physical environment."*
F695	**Respiratory Care** "*Based upon its facility assessment, the resident population, diagnosis, staffing, resources and staff skills/knowledge, the facility must determine whether it has the capability and capacity to provide the needed respiratory care/services for a resident with a respiratory diagnosis or syndrome that requires specialized respiratory care and/or services. This includes at a minimum, sufficient numbers of qualified professional staff, established resident care policies and staff trained and knowledgeable in respiratory care before admitting a resident that requires those services."*
F715	**Physician delegation of writing order – Dietary and Therapist** *"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 §483.70(e)."* *"noncompliance – will need to refer to facility assessment…"*
F725	**Nursing Services and Sufficient Staff** *"§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*

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F Tag	Reference Description
	considering the number, acuity and diagnoses of the facility's resident population in accordance with the facility assessment required at §483.70(e)." *"Many factors must be considered when determining whether or not a facility has sufficient nursing staff to care for residents' needs, as identified through the facility assessment, resident assessments, and as described in their plan of care. A staffing deficiency under this requirement may or may not be directly related to an adverse outcome to a resident's care or services. It may also include the* ***potential*** *for physical or psychosocial harm."* *"assessment of the resident population is the foundation of the facility assessment and determination of the level of sufficient staff needed. It must include an evaluation of diseases, conditions, physical, functional or cognitive limitations of the resident population's, acuity (the level of severity of residents' illnesses, physical, mental and cognitive limitations and conditions) and any other pertinent information about the residents that may affect the services the facility must provide. The assessment of the resident population should drive staffing decisions and inform the facility about what skills and competencies staff must possess in order to deliver the necessary care required by the residents being served."* *"Does the facility assessment describe the type and level of staff required to meet each resident's needs as required under 483.70(e). Does the type and level of the staff onsite reflect the expectations described in the facility assessment"*
F726	**Competent Nursing Staff** *"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 §483.70(e)."* *"the facility's assessment must address/include an evaluation of staff competencies that are necessary to provide the level and types of care needed for the resident population. Additionally, staff are expected to demonstrate competency with the activities listed in the training requirements per §483.95, such as preventing and reporting abuse, neglect, and exploitation, dementia management, and infection control.*

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F Tag	Reference Description
	Also, nurse aides are expected to demonstrate competency with the activities and components that are required to be part of an approved nurse aide training and competency evaluation program, per §483.152." *"Many factors must be considered when determining whether or not facility staff have the specific competencies and skill sets necessary to care for residents' needs, as identified through the facility assessment, resident-specific assessments, and described in their plan of care. A staff competency deficiency under this requirement may or may not be directly related to an adverse outcome to a resident's care or services. It may also include the* ***potential*** *for physical and psychosocial harm."* *"However, through the facility assessment (483.70(e)), facilities are required to address the staff competencies that are necessary to provide the level and types of care needed for the resident population considering the types of diseases, conditions, physical and cognitive disabilities, overall acuity, and other pertinent facts that are present within that population. Furthermore, per §483.95, facilities must determine the amount and types of training based on the facility assessment."* *"Does the facility assessment describe the type of competencies required to meet each resident's needs as required under §483.70(e). Do the competencies of the staff reflect the expectations described in the facility assessment?"*
F741	**Sufficient/Competent Staff-Behav Health Needs** "*§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 §483.70(e),"* *"GUIDANCE §483.40(a), (a)(1) & (a)(2)* *Sufficient Staff to Provide Behavioral Health Care and Services* *The facility must address in its facility assessment under §483.70(e) (F838), the behavioral health needs that can be met and the numbers and types of staff needed to meet these needs."*
F742	***Treatment/Svc for Mental/Psychosocial Concerns (Phase III)** **"***A facility must determine through its facility assessment what types of behavioral health services it may be able to provide."*

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F Tag	Reference Description
F801	**Staffing – Quality Dietary Staff** *"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 §483.70(e)"*
F802	**Sufficient Dietary Support Personnel** "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 §483.70(e)."*
F803	**Menus Meet Res Needs/Prep in Advance/Followed** ***"Periodically"*** *means that a facility should update its menus to accommodate their changing resident population or resident needs as determined by their facility assessment. See F838. This includes 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."*
F837	**Governing Body** **"***How the administrator and the governing body are involved with the facility wide assessment in §483.70(e) Facility assessment at F838."*
F838	**Facility Assessment** **See** https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/GuidanceforLawsAndRegulations/Downloads/Survey-and-Cert-Memo-Revision-SOM-Appendix-PP-Phase-2.pdf
F841	**Medical Director** *"His/her participation or involvement in conducting the Facility Assessment and the Quality Assessment and Assurance (QAA) Committee."*

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F Tag	Reference Description
F865	**QAPI** **"***Each nursing home, including facilities which are a part of a multi-chain organization, should tailor its QAPI plan to reflect the specific units, programs, departments, and unique population it serves, as identified in its facility assessment."*
F866	***QAPI/QAA Data Collection and Monitoring** "*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 §483.70(e) and including how such information will be used to develop and monitor performance indicators."* *"As part of their performance improvement activities, the facility must conduct distinct performance improvement projects. 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 §483.70(e)."*
F880	**Infection Control** *"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 §483.70(e)"* *"The Infection Prevention and Control Program must include the following parts:* *A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases that:* o *Covers all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement;* o *Is based on the individual facility assessment;* o *Follows accepted national standards; "* *"***FACILITY ASSESSMENT** *Pursuant to §483.70(e) (F838), 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 and emergencies. The facility must review and update that assessment, as*

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F Tag	Reference Description
	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. The facility assessment must address or include a facility-based and community-based risk assessment, utilizing an all-hazards approach. See §483.70(e) (F838) for guidance on the facility assessment. The results of the facility assessment must be used, in part, to establish and update the IPCP, its policies and/or protocols to include a system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for residents, staff, and visitors." *"As necessary, and at least annually, review and revision of the IPCP based upon the facility assessment (according to 483.70(e)) which includes any facility and community risk;"* *"Wound care, fecal/urinary incontinence care, and skin care. Since the IPCP must be based on the facility assessment, the presence of certain resident conditions would require that the facility have policies and procedures related to other specific services such as mechanical ventilation, infusion therapy, and/or dialysis either onsite or at an offsite dialysis facility;"* *"The facility must establish a system for surveillance based upon national standards of practice and the facility assessment, including the resident population and the services and care provided."* "*The facility's IPCP and its standards, policies and procedures must be reviewed at least annually to ensure effectiveness and that they are in accordance with current standards of practice for preventing and controlling infections; the IPCP must be updated as necessary. In addition, the facility population and characteristics may change over time, and the facility assessment may identify components of the IPCP that must be changed accordingly."*
F940	**Training Requirements** "*A facility must determine the amount and types of training necessary based on a facility assessment as specified at § 483.70(e)."*
F943	**Abuse, Neglect, and Exploitation Training** "*All facilities must develop, implement and permanently maintain an effective training program for all staff, which includes, at a minimum, training on abuse, neglect, exploitation, misappropriation of resident property, and*

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	dementia management, that is appropriate and effective, as determined by staff need and the facility assessment (as specified at §483.70(e)).” *“Changes to the facility’s resident population, staff turnover, the facility’s physical environment, and modifications to the facility assessment may necessitate ongoing revisions to the facility’s training program.”*
F947	**Required In-Service Training for Nurse Aides** *“Address areas of weakness as determined in nurse aides' performance reviews and facility assessment at § 483.70(e) and may address the special needs of residents as determined by the facility staff”* *“All facilities must develop, implement and permanently maintain an in-service training program for nurse aides that is appropriate and effective, as determined by nurse aide evaluation or the facility assessment as specified at §483.70(e). Changes to the facility’s resident population, the facility’s physical environment, staff turnover, and modifications to the facility assessment may necessitate ongoing revisions to the facility’s training program.”* *“The adequacy of the in-service education program may be measured not only by documentation of hours of completed in-service education, but also by demonstrated competencies of nurse aide staff through written exam and/or in consistently applying the interventions necessary to meet residents’ needs as identified in the facility assessment. Observations of nurse aides that indicate deficiencies in their nurse aide skills may be the result of an inadequate training program and/or inadequate performance review.”*
F949	**Behavioral Health** *“A facility must provide behavioral health training consistent with the requirements at §483.40 and as determined by the facility assessment at §483.70(e).”*

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Facility Assessment Tool

Requirement

Nursing facilities will conduct, document, and annually review a facility-wide assessment, which includes both their resident population and the resources the facility needs to care for their residents (§483.70(e)).

The requirement for the facility assessment may be found in Attachment 1 (page 15 of this document).

Purpose

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

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

Overview of the Assessment Tool

This is an optional template provided for nursing facilities, and if used, it may be modified. 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 and 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, staff training/education and competencies, education and training, 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, 672 (Resident Census and Conditions of Residents) and/or 802 (Roster/Sample Matrix Form) reports, the Payroll-Based Journal, and in-house designed reports.

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, and the director of nursing. 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 are encouraged to 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 there is/the facility plans for any change that would require a modification to any part of this assessment. For example, if the facility decides to admit residents with care needs who were previously not admitted, such as residents on ventilators or dialysis, the facility assessment must be reviewed and updated to address how the facility staff, resources, physical environment, etc., 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 serve as a record for staff and management to understand the reasoning for decisions made regarding staffing and other resources, and may include the operating budget necessary to carry out facility functions.
5. Appendix PP provides 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 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 (page 17 of this document).

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: Our Resident Profile

Numbers

1.1. 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).

1.2. 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).

1.2.a. Consider if it would be helpful to describe the number of persons admitted and discharged, as these processes can impact staffing needs.

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

Diseases/conditions, physical and cognitive disabilities

1.3. 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 in order 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, 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, CVA, 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 Resistant Organisms, Septicemia, Viral Hepatitis, *Clostridium difficile*, Influenza, Scabies, Legionellosis

Decisions regarding caring for residents with conditions not listed above

1.4. 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

1.5. 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 RUGs, MDS data, 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 your organization.* You may elect to use some or all of the tables below or choose your own methodology.

Example 1: Major RUG-IV Categories

Major RUG-IV Categories	**Number/Average or Range of Residents**
Rehabilitation Plus Extensive Services	
Rehabilitation	
Extensive Services	
Special Care High	
Special Care Low	
Clinically Complex	
Behavioral Symptoms and Cognitive Performance	
Reduced Physical Function	

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	

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			
Other care, describe:			
	Independent	**Assistive Device Used to Ambulate**	**In Chair Most of Time**
Mobility			

Ethnic, cultural, or religious factors

1.6. Describe ethnic, cultural, 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, languages, clothing preferences, access to religious services, or religious-based advanced directives.

Other

1.7. 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

2.1 List the types of care that your resident population requires and that you provide for your resident population. 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 in order 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), 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 gastroenteritis, 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
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 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 health care professionals, and medical practitioners that are needed to provide support and care for residents. Potential data sources include staffing records, organization chart, and Payroll-Based Journal reports.

Considering 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, 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, CNA or NAR, medication aide or technician, MDS nurse)
- Food and Nutrition Services (e.g., Director, support staff, registered dietician)
- Therapy Services (e.g., OT, OTA, PT, PTA, 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)

- Pharmacist
- Behavioral and mental health providers
- 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) psychiatric services and mental health providers

Staffing plan

3.2. 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.

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- page 15 of this document). For a discussion on how to determine sufficient staffing, see attachment 2 – page 17 of this document, section 7.b.

Example 1. Evaluation of 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, for example, Nursing (F725), Behavioral Health (F741), Nutrition (F802), and Administration (F839). Enter number of staff needed or an average or range:

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	

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. 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)
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 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 – page 15 of this document).

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

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

- Communication – effective communications for direct care staff
- 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 – 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)

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, MRSA/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
- 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 implementing nonpharmacological interventions

Policies and procedures for provision of care

3.5. 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, 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 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 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 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	
Non-medical supplies (if applicable)	Soaps, body cleansing products, incontinence supplies, waste baskets, bed and bath linens, individual communication devices, computers	

Other

3.9. 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.

3.10. 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.

3.11. 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.

3.12. 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; Reform of Requirements for Long-Term Care Facilities
Federal Register / Vol. 81, No. 192 / Tuesday, October 4, 2016 / Rules and Regulations.

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

§483.70(e): 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 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. The facility assessment must address or include:
(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 considering the types of diseases, conditions, physical and cognitive disabilities, overall acuity, and other pertinent facts that are present within that population;
(iii) The staff competencies 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.
(2) The facility's resources, including but not limited to,
(i) All buildings and/or other physical structures and vehicles;
(ii) Equipment (medical and nonmedical);
(iii) Services provided, such as physical therapy, pharmacy, and specific rehabilitation therapies;
(iv) All personnel, including managers, 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, memorandums 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.
(3) A facility-based and community-based risk assessment, utilizing an all hazards approach.

Additional References to the Facility Assessment:

Nursing Services § 483.35 - 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 §483.70(e).

Behavioral Health Services § 483.40(a) - 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 §483.70(e).
-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 §483.70(e).

Food and Nutrition Services § 483.60(a) - 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 §483.70(e).

§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 §483.70(e) 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 §483.70(e).

Infection Control §483.80(a) - 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 §483.70(e) 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 § 483.70(e).

§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 §483.70(e).

§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 §483.70(e) 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:
    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. Do we need to update job descriptions to coincide with new competencies identified?

iv. 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?

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	

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.

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Facility Wide Resource Assessment Implementation Checklist

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Facility Wide Resource Assessment Implementation Checklist

Purpose: Determine the resources needed to care for residents' competently during both day-to-day operations and emergencies.

Directions: Use the checklist to ensure that you have considered the required areas in your facility assessment.

COMMUNITY DEMOGRAPHICS		FACILITY RESOURCES	
NEED/RISK AREAS	**Notes**	**Description of Facility resources**	**Notes**
Number of Residents ☐ Average daily census ☐ Facility characteristics report		**Operating Budget:**	
Census Capacity ☐ Licensed bed capacity ☐ Capacity with self-imposed restrictions		**Contracts, Memos of Understanding, Other Third Party Agreements for Services or Equipment** **Normal Operations** ☐ Vehicle fuel and maintenance ☐ Medical supplies ☐ Lab ☐ Portable diagnostics ☐ Telephone/communications ☐ Non-medical supplies ☐ Food/nutrition supplies (Identify group purchasing organization if indicated)	

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COMMUNITY DEMOGRAPHICS		FACILITY RESOURCES	
NEED/RISK AREAS	**Notes**	**Description of Facility resources**	**Notes**
Diseases and Conditions ☐ Diagnosis report for 1 year **Physical Disabilities** ☐ CMS 672 **Cognitive Disabilities** ☐ BIMS scores **Overall Acuity** ☐ Average non-Medicare RUG distribution **Specialty care units** ☐ Memory Care ☐ Short stay ☐ Specialty _____ ☐ Specialty _____ **Other Pertinent Facts** ☐ ☐ ☐		**EQUIPMENT** **Medical** ☐ Lifts ☐ Tubs ☐ VS equipment ☐ Bladder scanners ☐ Oxygen concentrators ☐ Wheelchairs ☐ Walkers, canes ☐ Med carts ☐ Therapy equipment ☐ ☐ **Non-Medical** ☐ Room furniture ☐ Common area furniture ☐ Snack areas – refrigerators, microwaves ☐ Kitchen equipment ☐ Steam tables **Physical Environment** PHYSICAL PLANT **Equipment** ☐ Furnace, air conditioning, ☐ Water, emergency generator **Services** ☐ Internal Preventive maintenance	

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COMMUNITY DEMOGRAPHICS		FACILITY RESOURCES	
NEED/RISK AREAS	**Notes**	**Description of Facility resources**	**Notes**
		☐ Contracted Preventive maintenance ☐ **Other Physical Plant Considerations** ☐ **Buildings** ☐ Location, description, and use **Physical Structures** ☐ Location, description, and use **Vehicles** ☐ Description and use **SERVICES PROVIDED BY CONTRACT** ☐ Therapy ☐ Pharmacy ☐ Specific rehab therapies ☐ Mental health services ☐ Hospice ☐ Dietician ☐ Podiatry ☐ Dental ☐ Translation ☐	

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COMMUNITY DEMOGRAPHICS		FACILITY RESOURCES	
NEED/RISK AREAS	**Notes**	**Description of Facility resources**	**Notes**
		HEALTH INFORMATION TECHNOLOGY RESOURCES **Manage Patient Records** ☐ Server location and storage contract ☐ Internet provider ☐ E.H.R. service contract ☐ Offline access to records ☐ Print records **Sharing Info** Electronically share info with other organizations	

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FACILITY PERSONNEL AND NURSING SERVICES		FACILITY RESOURCES	
Areas to consider for competencies		**Description of Facility resources**	
☐ Abuse prevention ☐ Dementia Management ☐ Infection Control ☐ Residents Rights ☐ Person-Centered Care ☐ Communication ☐ Basic Restorative Services ☐ Skin and Wound Care ☐ Pain management ☐ Cultural Competency ☐ Behaviors ☐ ID/MI ☐ Other ☐ Other **Clinical Skills to consider** ☐ Nursing Assessment - VS - Weight - Blood sugar - O2 sat ☐ Suctioning ☐ Dressing Change ☐ Transmission Precautions ☐ IVs ☐ Phlebotomy ☐ Transfers - Mechanical lift - 2 person transfer ☐ Feeding	Competency = measurable pattern of knowledge, skills, abilities, behaviors and characteristics needed to perform the role or occupational function. This is not dependent solely upon qualifications or licensure. Examples include: lecture with return demonstration for physical tasks or activities, the ability to use tools, devices and equipment, an evaluation of adverse events to identify competency gaps and demonstrated ability to perform job functions.	**Staff** ☐ Corporate employees ☐ Department Directors/Managers ☐ Employees – budgeted number, job title, function Contract – budgeted number, job title, function	

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FACILITY PERSONNEL AND NURSING SERVICES		FACILITY RESOURCES	
Areas to consider for competencies		**Description of Facility resources**	
☐ Dressing ☐ Grooming ☐ Restorative - ROM - Mobility ☐ Equipment use - Wound vac - Specialty mattress - Bladder scan ☐ Skills for specialty care unit(s) _____ ☐ Identification of change in resident status ☐ Report change in resident status ☐ Assess resident for change in status ☐ Reference check prior to employment ☐ What is covered in orientation? ☐ Routine skills checks ☐ Staff education for new skills			

Ethnic, Cultural, or Religious Factors Potentially Affecting Care	
Examples: language, dietary restrictions and rules, modesty, eye contact, family involvement, daily routines, religious practices, etc	

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FACILITY PERSONNEL AND NURSING SERVICES	FACILITY RESOURCES	
Areas to consider for competencies	**Description of Facility resources**	
Facility-Based and Community-Based Risk Assessment Utilizing All-Hazards Approach		
☐ Hazard-based Risk Assessment ☐ Emergency Preparedness Plan	**Emergency Operations – refer to Emergency Preparedness Plan** ☐ Emergency water ☐ Emergency food ☐ Transfer agreement	

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