Purpose

The purpose of the assessment is to comply with CMS Survey and Certification requirements found at F838 to demonstrate that Demo SNF Home has reviewed our resident / patient population served, identified their care orders, assessment determined needs and clarified what we do, what we learn, what resources we have to meet needs and care plans and what we do not have to meet those needs, orders and care plans. In this way, needs are examined so that the resources necessary to care for residents competently are available during both day-to-day operations and emergencies.

Additionally this assessment is used to review direct care staffing needs to meet resident care so that the staffing decisions are reviewed and subject to continuous improvement. In addition to monitoring staff sufficiency, this assessment reviews direct care staff needs for obtaining, maintaining and improving capabilities to provide services to residents.

Using a competency-based approach derived from the CMS recommended QIO Facility Assessment Tool, the findings from the assessment assist Demo SNF Home to continuously assure that each resident is provided care that allows that person 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 Demo SNF Facility-Wide Assessment

This assessment has three parts as required by F838:

1. **Resident profile** presenting summary numbers of the population, admissions, diseases/conditions, physical and cognitive disabilities, CMS Case Mix acuity, and ethnic/cultural/religious factors present among the persons served. These summary numbers may or may not impact care, however they do reflect our efforts to support resident rights for choice, freedom and respect as individuals receiving our care.

2. **Services and care offered** based on resident needs defined by the Resident Assessment Instrument that includes the types of care our historic population of individuals have required; our focus is to include in aggregate the care resulting from individual level care plans so that in the whole the estimated resources needed to support assessment and care typically offered is reviewed. Note – when asked to accept patients and residents whose needs cannot be met by our resources, our choice is to refuse to accept the resident or make such acceptances conditional on the referring organization or individuals to supply the resources necessary. In this way, CMS Requirements of Participation are honored at all times.

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 has collected and used information from a variety of sources including but not limited to MDS data, 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.

Facility Name	Demo SNF Home
Persons (names/ titles) involved in completing assessment	Administrator: Director of Nursing: Governing Body Rep: Medical Director: Other:
Date(s) of assessment or update	September 9, 2017
Date(s) assessment reviewed with QAA/QAPI committee	

Part 1: Our Resident Profile

Numbers

1.1. The number of residents Demo SNF Home is licensed to provide care for is XXX.

The population care for represents short and long stay persons as follows:

All Patients & Residents during by Gender and Age Group				
Age Group	**Men**	**Women**	**Total**	**%**
< 65				
65 - 70				
71 - 75				
76 - 80				
81 - 85				
86 - 90				
91 - 95				
96 - 100				
Greater than 100				
Total				100%
Percent	xx%	xx%		

All Long Term Care Residents during by Gender and Age Group				
Age Group	**Men**	**Women**	**Total**	**%**
< 65				
65 - 70				
71 - 75				
76 - 80				
81 - 85				
86 - 90				
91 - 95				
96 - 100				
Greater than 100				
Total	xx	xxx		100%
Percent	xx%	xx%		

All Short Term Care Residents during by Gender and Age Group				
Age Group	**Men**	**Women**	**Total**	**%**
< 65				
65 - 70				
71 - 75				
76 - 80				
81 - 85				
86 - 90				
91 - 95				
96 - 100				
Greater than 100				
Total				100%
Percent	40%	60%		

1.2 Demo SNF Home average daily census:

Short Stay is
XX-XX

Long Stay persons is
XX-XX

1.2a. While some consider it helpful to describe the number of persons admitted and discharged within the SNF, an "admission" is measured as an entry by the MDS and as such it is facility entries and reentries that helps us to evaluate need for initial assessments, baseline care plans and facility and resource need as applied to changing population.

Demo SNF Home* **Measured from Readmissions Watch for Entries*	**Total Number of persons with entry or reentry**	**Total Number of facility entries and reentries**
July 1, 2016 to June 30, 2017	XX	XXXX

Demo SNF Home July 1, 2016 to June 30, 2017	**Number (enter average or range) of persons admitted or discharged**
Weekday	2.3
Weekend	0.7

Diseases/conditions, physical and cognitive disabilities

1.2. Demo SNF Home accept residents with a variety of diseases, conditions, physical and cognitive disabilities, or combinations of conditions that require complex medical care and management. As an example of the persons accepted who require complex medical care and management is the list of persons with multiple active diagnoses. In addition in the table below is summary information on the counts of resident with each type of condition.

MDS Counts of Residents with Diseases and Conditions	**Number of Conditions**	**Conditions per Resident**		**Active Diagnoses**	**Resident Count**	**Percent**
Cancer				>5 Diseases		
Heart / Circulation				3-5 Diseases		
Gastrointestinal				2 Diseases		
Genitourinary				1 Disease or Condition		
Infections				**Total**		**100%**
Metabolic				**Average per Resident**		
Musculoskeletal						
Neurological						
Nutritional						
Psychiatric/Mood Disorder						
Pulmonary						
Vision						
Total						

Decisions regarding caring for residents with conditions not typically presented by persons accepted for admission at Demo SNF occur as follows:

1.3. The process to make admission or continuing care decisions for persons that have diagnoses or conditions that are typically not presented or that we have previously not supported is as follows:

A. If a person requires strict isolation care and our rooms and resources are not available then the person cannot be admitted
B. Individuals who are experiencing acute care episodes or exacerbations of diseases are immediately referred to the Hospitals for care
C. Individuals with a diagnosis not seen or experienced by our facility are evaluated at the time of admission by our clinical leadership to determine if we have the staff capacity to render the needed care.
D. Other comments:
    a. Demo SNF when asked by any official agency or organization for example a local area agency on aging or a locally assigned QIO, or our Local Hospitals to accept a person for admission where the resources needed to meet care needs are not available are asked, should our clinical team be willing to take on the request to render such care, to provide Demo SNF with additional resources for the period of time required to provide care and support for the person.
    b. xxxx – insert other comments here.

Acuity

1.4. Demo SNF Home RUG 48 acuity levels for all persons served by month for the facility-wide assessment 12 month period is as follows. The source of the data in the table below is the MDS RUG 48 CMI and category for all the residents served during each month and for the year. Slight differences in counts between this report and others exist because of MDS assessment timing in collecting the data.

July 1, 2016 to June 30, 2017 Haymarket RUG 48 Category Days of Care, Average Census for All Persons Served													
RUG 48	**Jul 2016**	**Aug 2016**	**Sep 2016**	**Oct 2016**	**Nov 2016**	**Dec 2016**	**Jan 2017**	**Feb 2017**	**Mar 2017**	**Apr 2017**	**May 2017**	**Jun 2017**	**Total**
Extensive													
Rehabilitation													
Special Care													
Clinically Complex													
Impaired Cognition													
Behavior Problems													
Physical Function													
Default MDS													
Total Residents													
Days of Care													
Average Per Day													
RUG 48 Acuity													

It is important that all persons served are included because as one facility Demo SNF staff work as a team, caring for each person based on their needs and assessment requirements. The measure of acuity in Case Mix is based on the Project Strive from CMS and is directly associated with predicted need for staffing at a certain level to provide care. CMS invested heavily in collecting the data on the staffing time required for nursing facilities' activities in resident care. This measure of acuity was then applied by CMS as statistics to support the staff needed in a case mix level.

As a unified care team, Demo SNF determines staffing based on resident acuity, the burden of care presented by each person and as such the staffing by acuity is determined as follows in the table below:

This Table presents the Haymarket Staff Stars, Expected time per Resident based on CMS RUG Minutes for Acuity and the Form 671 Reported to CMS												
	16-Jul	**16-Aug**	**16-Sep**	**16-Oct**	**16-Nov**	**16-Dec**	**17-Jan**	**17-Feb**	**17-Mar**	**17-Apr**	**17-May**	**17-Jun**
Staffing Star												
RN Star												
RN Points												
All Staff Star												
All Staff Points												
Expected RN per Resident Day												
Reported RN per Resident Day												
Expected All Staff per Resident Day												
Reported All Staff per Resident Day												

Using the CMS 5-star methodology, Demo SNF Home has below average staffing for resident acuity throughout the 12 months. In a few months based on acuity, staffing was above average or average, then due to turnover in the RN positions and the difficulty in finding RNs who want to work in nursing facilities, we suffered below average staffing for 5 months. Beginning June, staffing positions are filled and returned to the average level.

Each resident receives individualized care. In addition to individualized Care Plans, many aspects of a Care Plan are social and are discussed in the section of this Facility-Wide Assessment addressing preferences. Each resident receives multiple assessments and has each assessment used in the creation of their care plans. As required by the resident assessments, care plans are written, reviewed, revised and updated as often as needed. The care plan updates typically occur with a quarterly review. If a resident condition changes, it is often necessary to perform additional assessments which also will cause care plan changes. In this way, the care each resident receives is subject to continuous review and improvement. Below are the aggregated results for MDS assessments where care plans decisions are included as being part of the formal assessment process. The table shares where symptoms trigger the need for specific types of care plans and shows those counts of instances where a triggered symptom or condition was not included in a resident's care plan. The numbers represent the number of MDS assessments where care plan decisions were part of the process.

Ideally care plans support the individual resident expectations and wishes so as to fulfill the mandate to attain or maintain residents by application of skilled nursing and therapy at their highest level of function. The resident assessment process suggests based on clinical information collected those areas needing a possible care plan to address resident need.

Care Area Assessments Mandated by MDS Care Area Assessment Triggers	Care Symptom Triggered	Care Plan Created		Care Symptom Not Triggered	Symptom and No Care Plan
Delirium					
Cognitive Loss/Dementia					
Visual Function					
Communication					
ADL Potential					
Urinary					
Psychosocial Well-Being					
Mood State					
Behavioral Symptoms					
Activities					
Falls					
Nutritional Status					
Feeding Tube					
Dehydration					
Dental Care					
Pressure Ulcer					
Psychotropic Drug Use					
Physical Restraints					
Pain					
Return to Community Referral					

In cases ere the symptom or condition was not addressed in a formal care plan, the reasons vary by the individual trigger for the care plan. For example, delirium can be a temporary condition that will disappear when a resident recovers from use of a drug in the acute care setting which includes as a side effect the symptoms of delirium. Because no action can be taken except to allow the patients individual metabolism to eliminate the drug from their system, a care plan to treat delirium is not appropriate. Other examples include.

XXXXXXXXXXX

Special Treatments are often needed by residents and are part of the measure for patient acuity. The Special Treatments are included in the Project Strive nursing hours and so are included by CMS in the measure for acuity of staffing. Just because a resident did not receive Chemotherapy during the 12 months of this assessment does not mean our center needs to change our approach to nursing and care to accommodate a resident receiving Chemotherapy. Chemotherapy as a condition demanding nursing care calls on the basic nursing skills to monitor hydration, nausea,

fever, respiration, mood and pain. Complications from Chemo when detected by a nurse are immediately reported to the patients' physician or advance practitioner for examination and consultation. Our center does not accept ventilator patients and did not have need for isolation or respite care during the 12 month period.

Haymarket Demo Special Treatments for Persons 7/1/2016 to 6/30/2017		
Treatment	**Persons**	**Percent of Persons**
Chemotherapy		
Radiation		
Oxygen Therapy		
Suctioning		
Tracheostomy Care		
Ventilator or Respirator		
BiPAP/CPAP		
IV Medications		
Transfusions		
Dialysis		
Hospice Care		
Respite Care		
Isolation or Quarantine		

Assistance with Activities of Daily Living – are recorded in a number of ways in the MDS data. The table below shares our 12 month resident population and views the levels of assistance they required to be self-performing key ADL services.

MDS Captured Haymarket Demo Resident Self Performance on Activities of Daily Living July 2016 to June 2017						
Activity of Daily Living	**Indep-endent**	**Super-vision**	**Limited Assist**	**Extensive Assist**	**Totally Dependent**	**Total**
Bed Mobility						
Transfer						
Toilet Use						
Walk in Room						
Walk in Corridor						
Locomotion on Unit						
Locomotion Off Unit						
Dressing						
Eating						
Personal Hygiene						
Bathing						

The total ADL Score is representative of the resident to be independent, the higher the score the less independent and more dependent the resident is for Bed Mobility, Transfer, Toileting and Eating. These measure are used in calculating resident acuity in the Case Mix and in Medicare payment for the RUG Levels.
The three individuals who are totally dependent (ADL = 16) require more STNA care than those 115 individuals whose ADL = 3. It is important that as CMS changes methods of measuring resident functional status that our care team remains current. CMS has proposed changing from use of the Late Lost ADL scoring seen at right to the Resident Classification Instrument RCS-1 method of measuring functional status.

The measure of functional status is seen below for the same population as noted in the late loss ADL measurement. For the functional status, CMS is using the sum of the self-performance for resident transfer, toilet use and eating from the ADL Scoring. This measure of function when combined with resident cognition yields those individuals needing a much higher level of care from our staff.

Haymarket Late Loss ADL Score July 2016 to June 2017		
ADL Scores	**Residents**	**Percent**
0		
1		
2		
3		
4		
5		
6		
7		
8		
9		
10		
11		
12		
13		
14		
15		
16		
Total		

Haymarket RCS-I Functional Score Levels July 2016 to June 2017		
Functional Score	**Residents**	**Percent**
0		
1		
2		
3		
4		
5		
6		
7		
8		
9		
10		
11		
12		
13		
14		
15		
16		
17		
18		
Total		

In the future CMS will support providers with refinement of cognition and function assessments and data. This new information and analysis from CMS will help Demo SNF to better estimate of needs by residents for greater staff support. The variation of resident function during a 24 hour period for both ADL and cognitive support is challenging to capture with current technology and necessity for cost efficient documentation. Many clinical diagnoses, conditions and treatments have differing expressions in residents minute by minute, specific examples of causes include resident fatigue, pain, and sundowner syndrome. Nevertheless, minute by minute our staff look to learn from this annual facility-

wide assessment to better prepare care plans, treatments, monitoring and care evaluation and outcomes so that our person centered care is measured and continuously improves.

Cognition is a product of resident to use their higher executive functions and is influenced by resident hearing, vision, speech and understanding as limited thru these senses.

Haymarket Resident Cognitive Function Scale Score July 2016 to June 2017			
Cognitive Function Scale	**Res. Count**	**% of All Residents**	**CFS Score**
Cognitively Intact			
Mildly Impaired			
Moderately Impaired			
Severely Impaired			
All MDS Assessed Residents			

As can be seen in the table above, less than half of the persons receiving care in 12 months had full use of their higher executive functions.

It is notable that 95% of the persons served had hearing that functioned will and 80% had adequate vision. Staff are alert to individual resident hearing and vision limitations and work as best as humanly possible to support residents understanding

Haymarket Demo Resident Hearing and Vision for the period July 1 2016 to June 30, 2017									
Hearing Status		**Hearing Aid by status**	**Percent of Residents**		**Vision**		**Vision with Lenses**	**Total Residents Vision**	**Percent of Residents**
Hearing Aid									
Comatose									
Hearing									
Minimal Difficulty									
Adequate									
Moderate									
Highly Impaired									
Total									

As staff work to support resident use of the higher executive functions, influencing these factors are resident to communicate and to hear and understand communication.

As seen in the tabulation of our data over 12 months, about 2% of our residents rarely or never are able to express themselves or understand others.

Speech	Residents	Percent of Residents
Clear speech-distinct intelligible words		
No speech-absence of spoken words		
Unclear speech-slurred or mumbled words		
Total		
Can Resident express self and be understood		
Understood		
Sometimes understood- is limited to making concrete requests		
Usually understood-difficulty communicating some words or finishing thoughts but is able if prompted or given time		
Rarely/never understood		
Can Resident understand others		
Understands-clear comprehension		
Sometimes understands-responds adequately to simple, direct communication only		
Usually understands-misses some part/intent of message but comprehends most conversation		
Rarely/never understands		

Staff work to support resident expression. Staff education supports care methods to facilitate resident expression. Further, individual care plans and care delivery respects the need for residents to know and follow the process by which they receive care.

This data does suggest that staff can never assume that all residents understand and understand 100% of the time. As seen at right, 28% of residents treated during the year have some limitations in their understanding others.

Therefore it is important in our person centered care delivery staff continually assess and know if residents can affirm comprehension and understanding.

1.5. E*thnic, cultural, personal resident preferences and other factors:*

Certainly individual culture, ethnic values, preferred language and other factors, for example marital status can influence our residents' to understand, communicate and potentially share information. The measurement of race and ethnicity is influenced by the factor of language.

Haymarket Demo Resident Race / Ethnicity July 2016 to June 2017						
American Indian	**Asian**	**Black or African American**	**Hispanic or Latino**	**Native Hawaiian or Other Pacific Islander**	**White**	**Total**

During the 12 month period for this assessment, 100% of the residents wished to be spoken to and to speak English as their preferred language. Should we need to serve a resident with a non-English language preference, an interpreter will be obtained based on the preference and if not locally available, use of video conferencing if possible can be accessed to accommodate preferred language on a periodic basis determined by resident preference, cost and accept of the language provider to the resident. Learning each individual's life history and appreciating their ethnicity and culture can influence ongoing resident life within our care center. Based on our MDS records, for example resident marital status is as follows:

7/1/16 to 6/30/17		
Marital Status	**Residents**	**Percent**
Widowed		
Married		
Never Married		
Divorced		
Total		

1.5.1. Based on the Admission, Annual or significant change MDS our residents express the following preferences per the MDS questions:

Resident Preferences	Very Important	Somewhat Important	Not Very Important	Not Important at all	Important, but can't do or no choice	No response or non-responsive	Total Inter-viewed	Total Staff Assessed = YES
Choose Clothes								
Personal Belongings								
Bathing Method								
Have Snacks								
Choose Bedtime								
Friends & Family								
Private Phone								
Lock Belongings								
Reading Materials								
Listen to Music								
Animals Around								
Keep up with News								

Disclaimer: This Facility-Wide Assessment used the Facility Assessment Tool provided by and supported by funding from CMS and the QIO Program effective 8/18/2017 for issuance and 9/7/2017 for education and so is used in this assessment. While use of this tool is not mandated by CMS, nor does its completion ensure regulatory compliance, it is what CMS has supported and taught as an example to use.

Do Things with Groups								
Favorite Activities								
Go Outside								
Religious Practices								

Insert text regarding activities, food and nutrition services, access to religious services, or religious-based advanced directives.

Other

1.6. 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.)

A key pertinent fact is the preference of the resident for the outcome of their care during the year. We have learned our residents expect the following results.

Resident's Overall Expectation		
Expectation	**Resident Count**	**Percent**
Discharged to Community		
Expects to remain in this facility		
Unknown or uncertain		
Expects to be discharged to another facility/institution		
Total		

Source of Information		
Resident him or herself		
Family or Significant Other		
Guardian or Legally Authorized Representative		
Unknown or uncertain		
Total		

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 care of individuals with trauma/PTSD Care of individuals with other psychiatric diagnoses Care of individuals with 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 pain management 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 symptoms Assessment, early identification of problems/deterioration, management of psychiatric symptoms Assessment, early identification of problems/deterioration, management of 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 Nutrition 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

1.6 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, The State of Illinois Code has determined by law the mandated approach to staffing to ensure that each Nursing Facility in Illinois has the minimum direct care staff to meet the needs of the residents at any given time.

The Example for Demo SNF is as shown below.

ABC SNF Illinois Revised code (Section 3-202.05(d) of the Act) staffing requirement				
	People	**People w/ Hospice**	**People**	
Extensive	0	0	0	
Rehabilitation	32	0	32	
Special Care High	9	4	13	
Special Care Low	13	3	16	
Clinically Complex	13	2	15	
Behavior or Cognitive	17	0	17	
Physical Function	78	5	83	
Total Residents	**162**	**14**	**176**	

Level of Care	**People**	**IL Required Hours per Day**	**IL Hrs Required per Year**
Skilled Care	93	3.8	1387.0
Intermediate Care	83	2.5	912.5

Total Minimum Staff Hours Needed			**Hrs per Year**
Skilled Care		353.4	128,991
Intermediate Care		207.5	75,738
Total Illinois Required Staffing hours per 24 hours		**560.9**	204,729

Total Minimum Additional Staff Hours needed per 24 hour Day		
Minimum Licensed Nursing Hours per 24 hours	140.225	0.25
Minimum Registered Nursing Hours per 24 hours	56.09	0.1
Additional Direct Care Hours per 24 hours	**420.675**	**0.75**

Minimum Total Direct Care Hours per Shift			
Daily Shift Periods	Min Total Hours per Day	Minimum Percent	Total Minimum Hrs Needed per Shift
7-3	560.9	45%	252.41
3-11	560.9	35%	196.32
11-7	560.9	20%	112.18
Total		100%	560.90

Total Licensed Nursing Time Needed per shift			
Daily Shift Periods	Min Total Hours per Day	Minimum Percent	Total Hrs Needed
7-3	252.41	25%	63.10
3-11	196.32	25%	49.08
11-7	112.18	25%	28.05
Total			140.23

Minimum Total Licensed Nurses Required per shift			
Daily Shift Periods	Min Total Hours per Day	Hours Per Shift	Total Licensed Nurses Needed
7-3	63.10	7.50	8.4
3-11	49.08	7.50	6.5
11-7	28.05	7.50	3.7
Total	140.23		18.7

Total Registered Nursing Time Needed per shift			
Daily Shift Periods	Min Total Hours per Day	Minimum Percent	Total Hrs Needed
7-3	252.41	10%	25.24
3-11	196.32	10%	19.63
11-7	112.18	10%	11.22
Total	**560.90**	**30%**	**56.09**

Minimum Total Registered Nurses Required per shift			
Daily Shift Periods	Min Total Hours per Day	Hours Per Shift	Total Registered Nurses Needed
7-3	25.24	7.50	3.4
3-11	19.63	7.50	2.6
11-7	11.22	7.50	1.5
Total	**56.09**		**7.5**

Minimum Total Additional Direct Care Hours Required per shift			
Daily Shift Periods	Min Total Hours per Day	Minus Licensed Nursing Hrs	Total Additional Direct Care Time Needed
7-3	252.41	63.10	189.3
3-11	196.32	49.08	147.2
11-7	112.18	28.05	84.1
Total			**420.7**

Minimum Total Additional Direct Care Staff Persons Required per shift			
Daily Shift Periods	Min Total Added Direct Care Staff Hours per Day	Minus Licensed Nursing Hours	Total Additional Direct Care Time Needed
7-3	189.30	7.50	25.2
3-11	147.24	7.50	19.6
11-7	84.14	7.50	11.2
Total	**420.68**		**56.1**

Summary Staff Information per Shift per Day				
Daily Shift Periods	Registered Nurses	Other Licensed Nurses	Added Direct Care Staff	Total Staff Per Shift
7-3	3.4	5.0	25.2	33.7
3-11	2.6	3.9	19.6	26.2
11-7	1.5	2.2	11.2	15.0
Total Per Day	**7.5**	**11.2**	**56.1**	**74.8**
Minimum Daily Hours	56.1	84.1	420.7	560.9
Minimum Annual Hours	20472.9	30709.3	153546.4	204728.5
Minimum Annual Employees	9.8	14.8	73.8	98.4

Disclaimer: This Facility-Wide Assessment used the Facility Assessment Tool provided by and supported by funding from CMS and the QIO Program effective 8/18/2017 for issuance and 9/7/2017 for education and so is used in this assessment. While use of this tool is not mandated by CMS, nor does its completion ensure regulatory compliance, it is what CMS has supported and taught as an example to use.

Position	Total Number Needed or Average or Range
Licensed nurses providing direct care	See above table
Nurse aides	See Additional Staff in above table
Other nursing personnel (e.g., those with administrative duties)	See above Table
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	

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 (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 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.