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# STAFFING DOMAIN

## Description of Staffing Data File

The accompanying, comma delimited data file can be read by a number of computer programs, including standard spreadsheet programs. It contains one record for every nursing home currently shown on Nursing Home Compare. Each of these records contains the CMS Certification Number (CCN) for the provider, the name of the provider, the city and state in which the provider is located, and 15 staffing values, calculated as hours per resident per day. The 15 staffing variables are divided into 3 groups of 5 values each. The first group of values include values derived from those reported by the nursing home on the CMS 671 and 672 reporting forms. The second group of values represents CMS's calculation of expected staffing time based on the RUGS 53 staff time values for residents in the nursing home at the time of the survey. The third group of values represents the adjusted time, which is calculated by this formula:

$$\text{Hours Adjusted} = (\text{Hours Reported} / \text{Hours Expected}) * \text{Hours National Average}$$

For a much more extensive discussion on the calculation of staffing values and ratings, please see the *Five Star Nursing Home Quality Rating System Technical Users Guide* found at:

<http://www.cms.hhs.gov/CertificationandCompliance/Downloads/usersguide.pdf>

CMS will update this spreadsheet on a monthly basis, coinciding with website updates.

Note: If a provider has no staffing data, then it may have a new participation date or it may have invalid staffing data.

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

## 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 <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> MM DD YY	
Street Address		City		County	State
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

- 01 Individual
- 02 Partnership
- 03 Corporation

#### NonProfit

- 04 Church Related
- 05 Nonprofit Corporation
- 06 Other Nonprofit

#### Government

- 07 State
- 08 County
- 09 City
- 10 City/County
- 11 Hospital District
- 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 <input type="text"/> <input type="text"/> <input type="text"/> AIDS                             | F16 <input type="text"/> <input type="text"/> <input type="text"/> Alzheimer's Disease            |
| F17 <input type="text"/> <input type="text"/> <input type="text"/> Dialysis                         | F18 <input type="text"/> <input type="text"/> <input type="text"/> Disabled Children/Young Adults |
| F19 <input type="text"/> <input type="text"/> <input type="text"/> Head Trauma                      | F20 <input type="text"/> <input type="text"/> <input type="text"/> Hospice                        |
| F21 <input type="text"/> <input type="text"/> <input type="text"/> Huntington's Disease             | F22 <input type="text"/> <input type="text"/> <input type="text"/> Ventilator/Respiratory Care    |
| F23 <input type="text"/> <input type="text"/> <input type="text"/> Other Specialized Rehabilitation |   |

Does the facility currently have an organized residents group?	F24	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Does the facility currently have an organized group of family members of residents?	F25	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Does the facility conduct experimental research?	F26	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Is the facility part of a continuing care retirement community (CCRC)?	F27	Yes <input type="checkbox"/>	No <input type="checkbox"/>

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 <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>	Hours waived per week: F29 _____
Waiver of 24 hr licensed nursing requirement.	Date: F30 <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>	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

	Tag Number	A			B					C					D				
		Services Provided			Full-Time Staff (hours)					Part-Time Staff (hours)					Contract (hours)				
		1	2	3															
<b>Administration</b>	F33																		
<b>Physician Services</b>	F34																		
Medical Director	F35																		
Other Physician	F36																		
Physician Extender	F37																		
<b>Nursing Services</b>	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																		
<b>Pharmacists</b>	F46																		
<b>Dietary Services</b>	F47																		
Dietitian	F48																		
Food Service Workers	F49																		
<b>Therapeutic Services</b>	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																		
<b>Dentists</b>	F63																		
<b>Podiatrists</b>	F64																		
<b>Mental Health Services</b>	F65																		
<b>Vocational Services</b>	F66																		
<b>Clinical Laboratory Services</b>	F67																		
<b>Diagnostic X-ray Services</b>	F68																		
<b>Administration &amp; Storage of Blood</b>	F69																		
<b>Housekeeping Services</b>	F70																		
<b>Other</b>	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."

**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.

### 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.

#### 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).



## 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:**

**F119** \_\_\_\_ 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

**F130** \_\_\_\_ 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 \_\_\_\_\_%

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## RESIDENT CENSUS AND CONDITIONS OF RESIDENTS

### (use with Form CMS-672)

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#### 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.

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## RESIDENT CENSUS AND CONDITIONS OF RESIDENTS

### (use with Form CMS-672)

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#### 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).

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## RESIDENT CENSUS AND CONDITIONS OF RESIDENTS

### (use with Form CMS-672)

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#### 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 = 1 OR 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, M0300F1 and/or M0300G1 > 0.

**F116: Of the total number of residents with pressure ulcers (excluding Stage I), 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.

**F118: 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:** Receiving 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.



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## RESIDENT CENSUS AND CONDITIONS OF RESIDENTS

### (use with Form CMS-672)

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**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, uretostomy, 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
- Haloperidol 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
- Amitriptyline
- Lithium
- Maprotiline
- Isocarboxazid
- Phenelzine
- Serzone
- Desipramine
- Tranlycypromine Paroxetine
- Fluoxetine
- Sertraline
- Doxepin
- Imipramine
- Protriptyline

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## RESIDENT CENSUS AND CONDITIONS OF RESIDENTS

### (use with Form CMS-672)

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**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.

## Appendix

Table A1 RUG Based Case-Mix Adjusted Nurse and Aide Staffing Minute Estimates					
1995-1997 Time Study Average Times (Minutes)					
RUG-53	Resident Specific Time + Non-Resident Specific Time Minutes				
Group	STAFF TYPE				Total Minutes
	RN	LPN	Nurse Total	AIDE	All Staff Types
<b>REHAB &amp; EXTENSIVE</b>					
RUX	160.67	84.89	245.56	200.67	446.22
RUL	127.90	59.19	187.10	134.57	321.67
RVX	137.28	58.33	195.61	167.54	363.15
RVL	128.93	47.75	176.67	124.30	300.97
RHX	130.42	48.69	179.12	155.39	334.50
RHL	117.25	69.00	186.25	127.00	313.25
RMX	163.88	91.36	255.24	195.76	450.99
RML	166.61	62.68	229.29	147.07	376.36
RLX	116.87	55.13	172.00	132.63	304.63
<b>REHABILITATION</b>					
<b>REHAB ULTRA HIGH</b>					
RUC	100.75	46.03	146.78	174.86	321.64
RUB	84.12	34.94	119.06	123.13	242.19
RUA	64.98	39.49	104.47	97.91	202.38
<b>REHAB VERY HIGH</b>					
RVC	93.31	50.21	143.52	163.59	307.10
RVB	85.90	42.54	128.44	138.37	266.81
RVA	72.04	26.53	98.56	103.49	202.05
<b>REHAB HIGH</b>					
RHC	94.85	45.04	139.89	166.48	306.37
RHB	100.85	34.80	135.65	130.40	266.05
RHA	89.76	27.51	117.27	102.59	219.85
<b>REHAB MEDIUM</b>					
RMC	78.01	49.35	127.37	172.16	299.53
RMB	88.69	38.05	126.73	140.23	266.96
RMA	94.15	34.41	128.55	116.54	245.10
<b>REHAB LOW</b>					
RLB	69.38	46.52	115.91	196.33	312.24
RLA	60.88	33.02	93.89	124.29	218.18



**Table A1  
RUG Based Case-Mix Adjusted Nurse and Aide Staffing Minute Estimates**

<b>1995-1997 Time Study Average Times (Minutes)</b>					
<b>RUG-53</b>	<b>Resident Specific Time + Non-Resident Specific Time Minutes</b>				
<b>Group</b>	<b>STAFF TYPE</b>				<b>Total Minutes</b>
	<b>RN</b>	<b>LPN</b>	<b>Nurse Total</b>	<b>AIDE</b>	<b>All Staff Types</b>
<b>EXTENSIVE</b>					
SE3	143.56	101.33	244.89	193.50	438.39
SE2	108.52	86.06	194.58	163.54	358.12
SE1	80.79	57.68	138.47	191.79	330.26
<b>SPECIAL</b>					
SSC	72.9	64.3	137.20	184.1	321.30
SSB	70.9	55.0	125.90	172.4	298.30
SSA	91.7	41.7	133.40	130.4	263.80
<b>CLINICALLY COMPLEX</b>					
CC2	85.2	42.50	127.70	191.1	318.80
CC1	55.7	57.70	113.40	176.9	290.30
CB2	61.5	41.80	103.30	159.0	262.30
CB1	59.0	36.20	95.20	147.3	242.50
CA2	58.8	43.30	102.10	130.3	232.40
CA1	59.7	37.60	97.30	103.3	200.60
<b>IMPAIRED COGNITION</b>					
IB2	40.0	32.0	72.00	137.2	209.20
IB1	39.0	32.0	71.00	130.0	201.00
IA2	38.0	27.0	65.00	100.0	165.00
IA1	33.0	26.0	59.00	96.0	155.00
<b>BEHAVIOR</b>					
BB2	40.0	30.0	70.00	136.0	206.00
BB1	38.0	28.0	66.00	130.0	196.00
BA2	38.0	30.0	68.00	90.0	158.00
BA1	34.0	25.0	59.00	73.5	132.50

Table A1 RUG Based Case-Mix Adjusted Nurse and Aide Staffing Minute Estimates					
1995-1997 Time Study Average Times (Minutes)					
RUG-53	Resident Specific Time + Non-Resident Specific Time Minutes				
Group	STAFF TYPE				Total Minutes
	RN	LPN	Nurse Total	AIDE	All Staff Types
PHYSICAL FUNCTION					
PE2	37.0	32.0	69.00	184.8	253.80
PE1	37.0	29.4	66.40	181.6	248.00
PD2	36.0	25.0	61.00	170.0	231.00
PD1	36.0	27.6	63.60	160.0	223.60
PC2	25.6	32.8	58.40	154.4	212.80
PC1	45.1	20.6	65.70	124.2	189.90
PB2	28.0	36.8	64.80	80.6	145.40
PB1	27.5	27.7	55.20	93.9	149.10
PA2	31.9	30.6	62.50	72.9	135.40
PA1	28.2	29.8	58.00	72.8	130.80

**Table A2**  
**Coefficients for Risk-Adjustment Model**

Quality Measure/Covariate	Constant (Intercept)	Coefficient
<b>Percent of long-stay residents who had a catheter inserted and left in their bladder</b>	-3.645993	
1. Indicator of frequent bowel incontinence on prior assessment		0.545108
2. Indicator of pressure sores at stages II, III, or IV on prior assessment		1.967017
<b>Percent of long-stay residents who self-report moderate to severe pain</b>	-2.428281	
1. Indicator of independence or modified independence in daily decision making on the prior assessment		1.044019
<b>Percent of short-stay residents with pressure ulcers that are new or worsened</b>	-5.204646	
1. Indicator of requiring limited or more assistance in bed mobility on the initial assessment		1.013114
2. Indicator of bowel incontinence at least occasionally on initial assessment		0.835473
3. Indicator of diabetes or peripheral vascular disease on the initial assessment		0.412676
4. Indicator of low body mass index on the initial assessment		0.373643

Source: <http://www.cms.hhs.gov/NursingHomeQualityInits/Downloads/NHQIQMUsersManual.pdf>