

FACILITY NAME:

FACILITY-WIDE SELF ASSESSMENT

FACILITY PROFILE

483.70(E)

COMPLETION DATE:

To ensure the required thoroughness, individuals involved in the facility assessment should, at a minimum, include the administrator, a representative of the governing body, the medical director, and the director of nursing. The environmental operations manager, and other department heads (for example, the dietary manager, director of rehabilitation services, or other individuals including direct care staff should be involved as needed.

Facility Contact Information	
Assessment Date	
Campus Name	
Address	
Phone	
Email	
Healthcare Administrative (License Holder)	
Medical Director	
Director of Nursing	
Governing Body Representative/Corporate Rep.	
Social Services Director	
Food Services Director	
Plant/Environmental Operations Director	
Therapy Director	

Facility Licensing and Census Information			
	Current	12 month Average	
Total residents			
Total capacity (licensed beds)			
Short term rehabilitation Medicare beds			
Long term beds			
Long Term Private beds			
Dually Cert Beds			
Long Term Medicaid beds			

§483.70(e)(1) The facility's resident population, including, but not limited to,

(i) Both the number of residents and the facility's resident capacity;

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RESIDENT POPULATION

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Current Census 0

ADL	INDEPENDENT	ASSIST of 1 or 2 STAFF	DEPENDENT
Bathing			
Dressing			
Transferring			
Toilet Use			
Eating			
Other: Describe			

A. BOWEL/BLADDER STATUS	B. MOBILITY
-------------------------	-------------

indicate the number (or previous 12 month average) of residents with:

_____ With indwelling or external catheter
Of the total number of residents with catheters,
how many were present on admission?

_____ Occasionally or frequently incontinent
of bladder.

_____ Occasionally or frequently incontinent
of bowel.

_____ On urinary toileting program

_____ On bowel toileting program

NOTES: _____

_____ Bedfast all or most of time

_____ In a chair all or most of time

_____ Independently ambulatory

_____ Ambulation with assistance or
assistive device

_____ Physically restrained
manyOf the total number of residents with restraints, how
were admitted or readmitted with orders for restraints?

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

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C. MENTAL STATUS	D. SKIN INTEGRITY
<p>indicate the number (or previous 12 month average) of residents with:</p> <p>_____ Intellectual and/or developmental disability</p> <p>_____ Documented signs and symptoms of depression</p> <p>_____ Documented psychiatric diagnosis (exclude dementias and depression)</p> <p>_____ 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</p> <p>_____ Behavioral healthcare needs(Including Trauma/ PTSD)</p> <p>Of the total number of residents with behavioral healthcare needs how many have an individualized care plan to support them?</p> <p>_____</p> <p>_____ Receiving health rehabilitative services for MI and/or ID/DD</p>	<p>_____ Pressure ulcers (exclude Stage 1)</p> <p>Of the total number of residents with pressure ulcers (excluding Stage 1), how many residents had pressure ulcers on admission?</p> <p>_____</p> <p>_____ Receiving preventive skin care</p> <p>NOTES: _____</p> <p>_____</p> <p>_____</p> <p>_____</p> <p>_____</p>

COMMENTS: _____

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E. SPECIAL CARE

indicate the number (or previous 12 month average) of residents with:

_____ Hospice care

_____ Radiation therapy

_____ Chemotherapy

_____ Dialysis

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

_____ Respiratory treatment

_____ Tracheostomy care

_____ Ostomy care

_____ Suctioning

_____ Injections
(exclude vitamin B12 injections)

_____ Tube feedings

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

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

_____ Assistive devices with eating

COMMENTS: _____

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F. MEDICATIONS	G. Other
<p>indicate the number (or previous 12 month average) of residents with:</p> <p>_____ Any psychoactive medication</p> <p>_____ Antipsychotic medications</p> <p>_____ Antianxiety medications</p> <p>_____ Antidepressant medications</p> <p>_____ Hypnotic medications</p> <p>_____ Antibiotics</p> <p>_____ On pain management program</p> <p>_____ Opioids</p>	<p>_____ With unplanned significant weight loss/gain (Bariatric Resident)</p> <p>_____ Who do not communicate in the dominant language of the facility (include those who use American sign language)</p> <p>_____ Who use non-oral communication devices</p> <p>_____ With advance directives</p> <p>_____ Received influenza immunization</p> <p>_____ Received pneumococcal vaccine</p> <p>_____ Tobacco use (include smokeless and E-cigs)</p>
H. ALARMS	<p><i>(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.</i></p>
<p>indicate the number (or previous 12 month average) of residents with:</p> <p>_____ Bed/Chair Alarms</p> <p>_____ Personal Alarms (Include clip-on, laser, and wander guard types)</p>	

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CARE & COMPETENCY REQUIREMENTS

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ADL	INDEPENDENT	ASSIST of 1 or 2 STAFF	DEPENDENT
Bathing	0	0	0
Dressing	0	0	0
Transferring	0	0	0
Toilet Use	0	0	0
Eating	0	0	0

*Staff competency and care area requirements as identified in the Resident Population Assessment:

	Catheter Care		Intravenous therapy, IV nutrition, medication administration and/or blood transfusion
	Incontinence/Toileting Program		Respiratory treatment
	End of Life Care		Tracheostomy care
	Dementia Care		Behavioral Healthcare (Including PTSD and Trauma History)
	Ostomy care		Gastronomy Tube Care/Use
	**Restorative Nursing: Dressing, Grooming, and Bathing		Pain Management
	Pressure ulcer prevention and treatment		Infection Control
	Fall Risk Identification		Communication and interpersonal needs
	Technical Skills		Safety and emergency procedures

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CARE & COMPETENCY REQUIREMENTS

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*Staff competency and care area requirements as identified in the Resident Population Assessment:

Assessing Nutritional Needs

Meeting the needs of individuals with MI/ID/DD

The regulation outlines that the individualized approach of the facility assessment is the foundation to determine staffing levels and competencies. Therefore, the facility assessment must include an evaluation of the overall number of facility staff needed to ensure sufficient number of qualified staff are available to meet each resident's needs. Furthermore, the assessment must include a competency-based approach to determine the knowledge and skills required among staff to ensure residents are able to maintain or attain their highest practicable physical, functional, mental, and psychosocial well-being and meet current professional standards of practice.

Staff competencies and annual training requirements per regulatory authority and/or facility policy:

- Abuse, Neglect, Exploitation, and Misappropriation
- Advance Directives
- Behavioral Health
- Communication
- Compliance and Ethics
- CPR
- Dementia Care Management
- Equipment and assistive device training
- Infection Control
- Other areas identified as areas of weakness during annual performance review/competency evaluation
- Promoting resident's independence
- Quality Assurance and Performance Improvement
- Resident Rights including confidentiality of resident information, right to dignity, privacy, and property.
- Safety and emergency procedures, including the Heimlich Maneuver
- Job responsibilities and lines of authority
- Emergency Preparedness
- Facility policies and procedures

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*The staff competencies required will auto-fill based on the diagnosis and conditions identified on the resident population sheet. If a care area/staff competency area is identified "required" will be displayed in the highlighted box.

**Per Missouri Regulation 19 CSR 30-85.042 (23): Restorative nursing training shall be conducted by a registered nurse or qualified therapist. The training must include the following elements: Turning and positioning for the bedridden resident, range of motion (ROM) exercises, ambulation assistance, transfer procedures, bowel and bladder retraining and self-care activities of daily living.

Newly identified care areas/competencies needed based on this assessment:

Notes:

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CARE & COMPETENCY REQUIREMENTS

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RESIDENT ACUITY

There are many ways to determine resident acuity. Below is a table with one way to determine resident acuity based on RUG Level. Once this table is complete, it will give you an estimate of the total number of nursing hours needed based on your resident population's acuity levels. This is only one of many ways to determine your residents acuity. This page can be formatted to fit whatever approach you want to use to determine acuity, feel free to modify as needed.

Rug IV Classification	*RUG Based Case Mix Minutes Estimates (Strive Time Study)			*Current Number of Residents	Staff Type (Results converted to hours)				Total NHPD
	RN	LPN	AIDE		RN	LPN	Nurse Total	Aide	
REHAB PLUS EXTENSIVE									
RUX	68.37	111.44	131.11						
RUL	109.06	63.87	199.94						
RVX	29.24	95.88	145.94						
RVL	67.74	97.39	139.99						
RHX	128.79	51.92	155.24						
RHL	67.28	48.41	135.32						
RMX	97.54	74.61	148.44						
RML	133.82	84.04	153.24						
RLX	133.82	84.01	153.24						
REHABILITATION									
RUC	27.80	66.41	148.95						
RUB	45.01	71.09	141.03						
RUA	35.18	54.55	101.01						
RVC	34.22	68.45	156.53						
RVB	28.86	56.56	119.90						
RVA	31.30	59.35	113.73						
RHC	36.62	54.88	156.14						
RHB	36.42	47.88	119.48						
RHA	27.09	51.76	99.82						
RMC	32.58	56.05	148.87						
RMB	32.10	55.47	134.74						
RMA	25.99	48.79	98.81						
RLB	33.86	44.58	185.83						
RLA	15.46	43.58	118.93						

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RESIDENT ACUITY

EXTENSIVE SERVICES									
ES3	130.49	58.49	152.12						
ES2	65.19	75.23	146.55						
ES1	72.81	49.49	127.62						
SPECIAL CARE HIGH									
HE2	21.25	67.93	190.47						
HD2	41.89	70.63	153.76						
HC2	35.13	53.63	154.72						
HB2	60.64	67.91	133.86						
HE1	19.20	67.73	149.47						
HD1	16.89	54.54	141.80						
HC1	22.43	54.17	135.33						
HB1	21.65	50.50	106.77						
SPECIAL CARE LOW									
LE2	22.16	58.83	176.15						
LD2	19.59	58.10	153.29						
LC2	27.44	47.80	116.12						
LB2	29.52	50.73	128.44						
LE1	22.11	52.25	143.41						
LD1	11.78	43.94	130.80						
LC1	15.72	46.56	124.77						
LB1	18.99	48.66	106.16						
CLINICALLY COMPLEX									
CE2	21.05	44.13	162.70						
CD2	20.01	45.17	175.51						
CC2	19.77	36.95	132.92						
CB2	23.50	36.46	114.97						
CA2	20.69	44.63	80.92						
CE1	21.26	33.75	159.10						
CD1	15.31	41.90	151.40						
CC1	16.00	35.10	126.91						
CB1	16.17	34.99	118.45						
CA1	22.39	40.22	72.76						

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RESIDENT ACUITY

BEHAVIORAL SYMPTOMS AND COGNITIVE PERFORMANCE									
BB2	11.30	33.26	117.96						
BA2	18.34	41.18	101.56						
BB1	14.93	32.83	114.30						
BA1	13.60	31.57	86.06						
REDUCED PHYSICAL FUNCTIONING									
PE2	15.11	39.76	163.58						
PD2	12.09	38.01	163.38						
PC2	8.14	33.51	124.90						
PB2	15.49	38.95	118.83						
PA2	5.50	35.91	73.16						
PE1	19.91	36.07	161.23						
PD1	16.18	33.58	147.31						
PC1	14.07	36.94	123.74						
PB1	12.49	31.80	95.60						
PA1	14.32	32.42	70.77						
*Minutes based on RUG III to RUG IV Conversion				0.00	0.00	0.00	0.00	0.00	0.00

(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;

*Based on Table A1 RUG-IV Based Case Mix Adjusted Nurse and Aide Staffing Minutes Estimates, Five Star Technical User's Guide July 2018

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WORKFORCE

COMPLETION DATE:

Workforce Profile						
Administrative Staffing Information						
Position/Workforce	Employee (E) or Contractor (C)	Desired Number Y/N	Education Level	Professional Requirement	Y/N	Gaps in Training
Executive Director						
Associate Executive Director						
Director of Nursing						
Assistant Director of Nursing						
Staff Development Coordinator						
MDS Coordinator						
Admission Director						
Social Services						
Activity Coordinator						
Director of Therapy						
Dietitian						
Business Office						
Human Resources						
Facilities - Maintenance						
Dining Director						

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WORKFORCE

COMPLETION DATE:

Direct Care Staffing Information						
Position/Workforce	Employee (E) or Contractor (C)	Desired Number FTE	Education Level	Professional Requirement	Y/N	Training Needs
Registered Nurses						
Licensed Practical/Vocational Nurses						
Certified Nursing Assistant						
Physical Therapist						
Physical Therapist Assistant						
Occupational Therapist						
Certified Occupational Therapist Assistant						
Speech Therapist						
Receptionist						
Activity Aids						
Cooks						
Dietary Aids						
Housekeepers						
Volunteer Staffing Information						
Position/Workforce	Employee (E) or Contractor (C)	Desired Number Y/N	Education Level	Professional Requirement	Y/N	Training Needs

(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;

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TRAINING EVALUATION

COMPLETION DATE:

The assessment must include or address an evaluation of the facility's training program to ensure any training needs are met for all new and existing staff, individuals providing services under a contractual arrangement, and volunteers, consistent with their expected roles. The assessment should also include an evaluation of what policies and procedures may be required in the provision of care and that these meet current professional standards of practice.

There are many methods you can choose to use to evaluate the effectiveness of your employee training program. Examples include skills assessment which include return demonstration, follow up-quizzes for the training topic, and employee surveys. If you use a computer based training program, use the available reports to determine competency and completion rates

When assessing your training needs and your current program, ask the following questions:

1. What training needs to be done? This may be determined by the results of the skills assessments, quizzes or employee surveys completed.

2. Which employee groups should receive the training? Keep in mind, staff members of the different departments will not always need the same type of training.

3. What skills, knowledge, and abilities are needed by each departments staff?

The questions above are only three examples of many to utilize to assess your training program. Modify this sheet to best fit the needs of your home.

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PHYSICAL PLANT

COMPLETION DATE:

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Building and Physical Environment

Buildings (Resident occupied structures only)

Attach a facility layout to your assessment (if multiple buildings, number each layout and attach a layout for each building).

What is the construction type of each building? (For resident occupied structures only)		
1	I (442), I (332), II (222)	Any number of stories non-sprinklered or sprinklered
2	II (111)	One-story non-sprinklered Maximum 3 stories sprinklered
3	II (000)	Not allowed non-sprinklered
4	III (211)	Not allowed non-sprinklered Maximum 2 Stories Sprinklered
5	IV (2HH)	
6	V (111)	Not allowed non-sprinklered Maximum 1 Story Sprinklered
7	III (200)	
8	V (000)	

Other Structures: Garages, sheds, laundry facilities, etc. (include any rented/leased space also)

Structure/Description	Structure/Description

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PHYSICAL PLANT

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COMPLETION DATE:

Building and Physical Environment			
Building Elements	Count		
Number of Private Rooms			
Number of Shared Rooms			
Number of Offices			
Condition			
Building Elements	Y/N	Condition	Notes - Additional Explanation
Dining Room(s)			
Kitchen			
Laundry Room			
Med Room			
Nourishment Room			
Nurse Station			
Medical Record Room			
Beauty Shop			
Server Room(s)			
Shower Room(s)			
Common Restroom(s)			
Designated Activity Room			
Supply Storage Room(s)			
Oxygen Tank Storage Room			
Rehabilitation/PT Area			
Clean Utility Room(s)			
Soiled Utility Room(s)			
Mechanical Room(s)			
Staff Breakroom(s)			

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SERVICES

COMPLETION DATE:

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Evaluate the services provided by your home. Use the following services listed or add/delete services as needed.

Services Provided	Yes/No
ADL Assistance	
Art Therapy	
Barber/Beauty	
Bariatric Care	
Cable/Satellite TV	
Dementia Care	
Diabetes Management	
Dialysis	
Internet/Wi-Fi	
Music Therapy	
Occupational Therapy	
Palliative/Hospice Care	
Pet Therapy	
Pharmacy/Medication Management	
Physical Therapy	
Post-acute care	
Religious Programs	
Restorative Nursing Program	
Specific Rehabilitation Services	
Speech Therapy	
Telephone	
Trach Care	
Transportation	
Wound Care	

§483.70(e)(2) (iii)

The facility's resources, including but not limited to, services provided, such as physical therapy, pharmacy, and specific rehabilitation therapies;

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ETHNIC, CULTURAL, RELIGIOUS NEEDS

COMPLETION DATE:

Male	Female		
Indicate the number of residents who identify as:			
A. Race and Ethnicity indicate the number of residents who identify as:		B. Religion	
_____ American Indian or Alaska Native		_____ Catholic	
_____ Male	_____ Female	_____ Jewish	
_____ Asian		_____ Protestant	
_____ Male	_____ Female	_____ Baptist	
_____ Black or African American		_____ Other [type in]	
_____ Male	_____ Female	_____ Other [type in]	
_____ Hispanic or Latino		_____ Other [type in]	
_____ Male	_____ Female	_____ Other [type in]	
_____ Native Hawaiian or Other Pacific Islander (NHOPI)		_____ Other [type in]	
_____ Male	_____ Female	_____ Other [type in]	
_____ White		_____ Other [type in]	
_____ Male	_____ Female	_____ Other [type in]	
		_____ Other [type in]	
		_____ Other [type in]	

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ETHNIC, CULTURAL, RELIGIOUS NEEDS

COMPLETION DATE:

The regulation outlines that the individualized approach of the facility assessment is the foundation, therefore, the facility assessment must include an evaluation of any ethnic, cultural, or religious factors that may need to be considered to meet resident needs, such as activities, food preferences, and any other aspects of care identified.

Ethnic, cultural, or religious needs identified based on resident population:

*Any **ethnic, cultural, or religious factors** that may potentially affect the care provided by the facility, including, but not limited to, activities and food and nutrition services.*

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CONTRACTS

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COMPLETION DATE:

(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;

Healthcare Related Contracts, Memorandums of Understanding, or Other Agreements						
Main Agreements	Contract=C MOU=M Agreement=A	Vendor/Supplier/Agency	Expiration Date	Current Copy Available Y/N	Contract Has Expired Y/N	Available During an Emergency Y/N
Lab Services						
Therapy						
Respiratory Therapy						
X-Ray						
Dialysis						
Nursing Agency Services						
DMS						
Pharmacy						
Security						
Food Services						
DME Equipment						
Lawn Care						
Kitchen Equipment Maintenance						
Ambulance						
Emergency Transportation						
Food and Water						
Managed Care Contracts						
Surety Bond						
Medical Director						
Podiatry						
Dental						
Medical Supply Company						
CLIA						
Other						
Other						

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RESOURCES

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The assessment must include or address the facility’s resources which include but are not limited to a facility’s operating budget, supplies, equipment or other services necessary to provide for the needs of residents. Review and attach a copy of the facility operating budget.

Systems					
Systems	Required Y/N	Condition	Quantity	Available Inspection Records	Notes - Additional Explanation
Wander Management					
Call System					
Phones					
Printers and Fax Machines					
Fire Alarm					
Fire Protection and Sprinkler System					
Paging /Intercom Systems					
Other					
Medical Equipment					
Medical Equipment	Required Y/N	Condition	Quantity	Available Inspection Records	Notes - Additional Explanation
BiPap/Cpap					
Bladder Scanner					
CPM					
Defibrillator					
DVT Pump					
E Stem Machine					
ECG Machine					
EKG Machine					
Electric Bed					
Manual Wheel Chair					
Electric Wheel Chair w/charger					
Wheel Chair Battery Charger					
IV Pump					
Lift Chair					

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Low-air Loss Mattress					
Mechanical Lift					
Oxygen Concentrator					
Oxygen Regulator					
Pulse Oximeter					
Scale					
Suction Equipment					
Tube Feed Pump					
Ultrasound Machine					
Ventilator					
Vision Touch Equipment					
Vital Sign Monitor					
Wound Vac					
Other					
Non-Medical Equipment					
Non-Medical Equipment	Y/N	Condition	Quantity	Available Inspection Records	Notes - Additional Explanation
Emergency Generator					
Cell Phone and Chargers					
Laptops and chargers					
Television					
Food Serving Tables					
Overbed Tables					
Med carts					
Other					

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HIT					
HIT	Y/N	Condition	Quantity	Available Inspection Records	Notes - Additional Explanation
Vision					
Therapy Equipment					
Physical Therapy Equipment	Y/N	Condition	Quantity	Available Inspection Records	Notes - Additional Explanation
Parallel Bars					
Mat table					
Hi-Lo table					
Other treatment table					
Nu-Step or similar					
UBE or similar					
Ultrasound					
Electronic Stimulation or combo with US					
Hydrocollator					
Pulleys					
Balance testing equipment					
Hand testing equipment					
Weight rock/cuff weight					
Wedges/rolls					
Therapy ball					
Kitchen Simulation					
Walkers, canes, and wheelchair					
Slide Band					
Rebounder					
Weight ball					
Mirror					
Hand weight					
Weight bar					

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RESOURCES

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COMPLETION DATE:

Budget Item Review and Operational Indicators Year-to-Date			
Operational Indicators to consider for budget evaluation			Notes:
Occupancy Rate			
Resident days/bed days available*365			
Average Length of Stay			
Inpatient days/discharges			
Wage Expense			
Total salary and wage expense/FTE's			
Budget vs. Actual-Year to Date Analysis			
Budget Items	Budget	Actual	Notes:
Revenue			
Room and Board Income			
Ancillary Income			
Other Income			
Total	0	0	
Expenses-Wages (all positions)			
Nursing Services			
Food Services			
Housekeeping/Laundry Services			
Plant Operations			
Social Services and Activities			
Therapy Services			
Administration			
Total	0	0	

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Other Departmental Expenses			
Nursing Services			
Food Services			
Housekeeping/Laundry Services			
Plant Operations			
Social Services and Activities			
Therapy Services			
Administration			
Total	0	0	
Capital Expenses-Major Items			
Building			
Equipment			
Total	0	0	
Budget Review Notes:			

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NATURAL HAZARDS

COMPLETION DATE:

HAZARD AND VULNERABILITY ASSESSMENT TOOL									
NATURALLY OCCURRING EVENTS									
EVENT	PROBABILITY <i>Likelihood this will occur</i>	SEVERITY = (MAGNITUDE - MITIGATION)						RISK <i>Relative threat*</i>	
		HUMAN IMPACT <i>Possibility of death or injury</i>	PROPERTY IMPACT <i>Physical losses and damages</i>	BUSINESS IMPACT <i>Interruption of services</i>	PREPARED-NESS <i>Preplanning</i>	INTERNAL RESPONSE <i>Time, effectiveness, resources</i>	EXTERNAL RESPONSE <i>Community/Mutual Aid staff and supplies</i>		
SCORE	0 = N/A 1 = Low 2 = Moderate 3 = High	0 = N/A 1 = Low 2 = Moderate 3 = High	0 = N/A 1 = Low 2 = Moderate 3 = High	0 = N/A 1 = Low 2 = Moderate 3 = High	0 = N/A 1 = Low 2 = Moderate 3 = High	0 = N/A 1 = High 2 = Moderate 3 = Low or none	0 = N/A 1 = High 2 = Moderate 3 = Low or none	0 = N/A 1 = High 2 = Moderate 3 = Low or none	0 - 100%
Tornado								0%	
Severe Thunderstorm								0%	
Snow Fall								0%	
Blizzard								0%	
Ice Storm								0%	
Earthquake								0%	
Heat/Humidity								0%	
Drought								0%	
Flood, External								0%	
Wild Fire								0%	
Landslide								0%	
Dam Inundation								0%	
Subsidence								0%	
Epidemic								0%	
AVERAGE SCORE								0%	
<i>*Threat increases with percentage.</i>								0%	
	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0%	

RISK = PROBABILITY * SEVERITY		
0.00	0.00	0.00

FACILITY NAME:

FACILITY-WIDE SELF ASSESSMENT
483.70(E)

HUMAN HAZARDS

COMPLETION DATE:

HAZARD AND VULNERABILITY ASSESSMENT TOOL									
HUMAN-RELATED EVENTS									
EVENT	PROBABILITY	SEVERITY = (MAGNITUDE - MITIGATION)						RISK	
		HUMAN IMPACT	PROPERTY IMPACT	BUSINESS IMPACT	PREPARED-NESS	INTERNAL RESPONSE	EXTERNAL RESPONSE		
	<i>Likelihood this will occur</i>	<i>Possibility of death or injury</i>	<i>Physical losses and damages</i>	<i>Interruption of services</i>	<i>Preplanning</i>	<i>Time, effectiveness, resources</i>	<i>Community/Mutual Aid staff and supplies</i>	<i>Relative threat*</i>	
SCORE	0 = N/A 1 = Low 2 = Moderate 3 = High	0 = N/A 1 = Low 2 = Moderate 3 = High	0 = N/A 1 = Low 2 = Moderate 3 = High	0 = N/A 1 = Low 2 = Moderate 3 = High	0 = N/A 1 = High 2 = Moderate 3 = Low or none	0 = N/A 1 = High 2 = Moderate 3 = Low or none	0 = N/A 1 = High 2 = Moderate 3 = Low or none	0 = N/A 1 = High 2 = Moderate 3 = Low or none	0 - 100%
Mass Casualty Incident (trauma)								0%	
Mass Casualty Incident (medical/infectious)								0%	
Terrorism, Biological								0%	
VIP Situation								0%	
Hostage Situation								0%	
Active Shooter								0%	
Missing Resident								0%	
Bomb Threat								0%	
AVERAGE								0%	
<i>*Threat increases with percentage.</i>								0%	
								0%	
	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0%	

RISK = PROBABILITY * SEVERITY
0.00 0.00 0.00

FACILITY NAME:

FACILITY-WIDE SELF ASSESSMENT
483.70(E)

HAZARDOUS MATERIALS

COMPLETION DATE:

HAZARD AND VULNERABILITY ASSESSMENT TOOL									
EVENTS INVOLVING HAZARDOUS MATERIALS									
EVENT	PROBABILITY	SEVERITY = (MAGNITUDE - MITIGATION)						RISK	
		HUMAN IMPACT	PROPERTY IMPACT	BUSINESS IMPACT	PREPARED-NESS	INTERNAL RESPONSE	EXTERNAL RESPONSE		
	<i>Likelihood this will occur</i>	<i>Possibility of death or injury</i>	<i>Physical losses and damages</i>	<i>Interruption of services</i>	<i>Preplanning</i>	<i>Time, effectiveness, resources</i>	<i>Community/ Mutual Aid staff and supplies</i>	<i>Relative threat*</i>	
SCORE	0 = N/A 1 = Low 2 = Moderate 3 = High	0 = N/A 1 = Low 2 = Moderate 3 = High	0 = N/A 1 = Low 2 = Moderate 3 = High	0 = N/A 1 = Low 2 = Moderate 3 = High	0 = N/A 1 = Low 2 = Moderate 3 = High	0 = N/A 1 = High 2 = Moderate 3 = Low or none	0 = N/A 1 = High 2 = Moderate 3 = Low or none	0 = N/A 1 = High 2 = Moderate 3 = Low or none	0 - 100%
Mass Casualty Hazmat Incident (From historic events at your LTC with >= 5 victims)								0%	
Small Casualty Hazmat Incident (From historic events at your LTC with < 5 victims)								0%	
Chemical Exposure								0%	
Terrorism, Chemical								0%	
Radiologic Exposure, External								0%	
Terrorism, Radiologic								0%	
AVERAGE								0%	
*Threat increases with percentage.								0%	
								0%	
	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0%	

RISK = PROBABILITY * SEVERITY
0.00 0.00 0.00