

Long-Term Care Staffing Ratios A Toolkit for Public Policy Staff

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1. Introduction

During the COVID-19 pandemic, regular news articles and constituent concerns exposed significant gaps in the provision of care across the country, especially for the individuals and families living with Alzheimer's. People living with Alzheimer's and other dementia compose a significant portion of all long-term care recipients, comprising 48% of residents in nursing homes and 42% of all residents in assisted living communities and other residential care settings.¹

Staffing requirements in long-term care settings providing dementia care vary by the setting and state. Federal mandatory staffing requirements exist for registered nurses and licensed practical nurses in nursing homes, yet there is no minimum requirement for certified nursing assistants, though many states have established additional staffing requirements for these facilities.² Residential care, including assisted living communities, are licensed by the respective state agencies, though most states do not specify minimum staffing levels or ratios in dementia care.³

With significant licensure and oversight authorities around nursing homes and assisted living, state governments are in a prime position to rethink the provision of long-term care and what is necessary for high quality care. State policymakers have taken acute interest in determining the adequacy of current staffing policies toward ensuring high quality care for all residents, including those living with dementia. With a wide body of scholarly literature affirming a significant relationship between staffing levels and quality of care, numerous policy options are being considered.

Public policy can support states toward implementing acuity-based staffing models to ensure staffing levels consistently meet the needs of the residents. Adopting person-centered assessment and care planning in line with the Alzheimer's Association's evidence-based Dementia Care Practice Recommendations can further improve the provision of care by focusing on the individual needs of the resident and care partner to customize and personalize care for the individual. The strategies in this toolkit provide a guide to identifying current staffing levels and needs and considering solutions to further improve high quality dementia care.

2. Issue Background

The Landscape of Long-Term Care Staffing Ratios

As part of their long-term care licensing and oversight responsibilities, states are often at the center of discussions around staffing requirements for long-term care. According to an internal staff survey (see [Appendix B](#)) and external analyses, multiple states have existing policies

¹ Alzheimer's Association, 2021, (Pg. 58), <https://www.alz.org/media/Documents/alzheimers-facts-and-figures.pdf>

² Harrington, 2010

³ Carder, 2017

dictating staffing levels in long-term care settings.^{4,5} These requirements often build off of the federal regulations for nursing homes as outlined in 42 C.F.R. § 483.35 of the Code of Federal Regulations (CFR), which states:

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...⁶

The regulations further specify that nursing homes must have a charge nurse for every shift, a registered nurse for at least eight consecutive hours every day, and a full-time registered nurse to serve as director of nursing. However, while the regulations specify the “competencies and skill sets” necessary of nursing staff, the “sufficient” level of nursing staff is not further defined (where nursing staff includes registered nurses, licensed practical nurses and certified nurse aides). **This provides an opportunity for state policymakers to specify what “sufficient” nurse staffing means for nursing homes in their state.**

Other settings not regulated by the federal government, such as assisted living and memory care communities, also have staffing level requirements in certain states. These requirements generally follow two models - specifying the ratio of staff to residents (e.g. at least 1 staff member for 7 residents) or specifying the hours of care each resident shall receive daily (e.g. at least 3.85 hours of care per resident per day).

⁴ Harrington, 2008.

https://www.justice.gov/sites/default/files/nursing_home_staffing_standards_in_state_statutes_and_regulations.pdf

⁵ [Direct Care Staffing Levels Survey - State Affairs Analysis](#) - See additional information in [Appendix B](#).

⁶ Code of Federal Regulations, https://www.ecfr.gov/cgi-bin/text-idx?node=pt42.1.483#se42.5.483_135

Impact of COVID-19

During the COVID-19 pandemic, long-term care communities across the country were severely impacted, accounting for a significant share of all deaths. An existing direct care worker shortage was magnified by the pandemic and is now visible to policymakers across the country. As families raised concerns of their loved ones' health and wellbeing amid the pandemic and inadequate staffing, policymakers took great interest in considering statutory and regulatory measures to improve the quality of care to people receiving long-term care. Multiple states issued legislation regarding the staffing levels with no consistent approach - some increased the required staff present while others proposed relaxing existing requirements. However, among the multiple strategies offered, policy proposals generally lacked clarity and failed to consider dementia care best practices in the effort to update staffing standards.

Understanding Staffing Levels by Care Setting

Nursing Homes: Nursing home staffing has long been connected to the quality of care provided, however the federal government does not currently set clear, quantifiable staffing minimums.⁷ While most states have set their own minimum staffing requirements for nursing homes, these staffing ratios are generally well below the 4.1 total hours of care per resident per day (hprd) recommended by researchers.⁸ A recent report using 2019 hprd data submitted to the Centers for Medicare & Medicaid Services (CMS) indicated nursing homes reported 3.89 hprd.⁹ However, such staffing ratios are expected to have declined amid the pandemic.

Assisted Living Facilities: Assisted living facilities (ALFs) assist older adults with activities of daily living (ADL) but provide less intensive supervision that nursing homes would normally provide. Seventy-two percent of ALFs provide dementia care services¹⁰ and 22% have their own dementia care unit.¹¹ Appropriate staff ratio practices affect the quality of life for those in ALFs, especially those living with dementia. According to one study, residents showed lower verbal aggression scores when there was a higher staff-to-resident ratio.¹² Another study on 41% of

⁷ Schnelle, J. F., Simmons, S. F., Harrington, C., Cadogan, M., Garcia, E., & M Bates-Jensen, B. (2004). Relationship of nursing home staffing to quality of care. *Health services research*, 39(2), 225–250. <https://doi.org/10.1111/j.1475-6773.2004.00225.x>

⁸ Harrington, C., Dellefield, M. E., Halifax, E., Fleming, M. L., & Bakerjian, D. (2020). Appropriate Nurse Staffing Levels for U.S. Nursing Homes. *Health services insights*, 13, 1178632920934785. <https://doi.org/10.1177/1178632920934785>

⁹ *ibid*

¹⁰ Harris-Kojetin L, Sengupta M, Park-Lee E, et al. Long-Term Care Providers and services users in the United States: data from the National Study of Long-Term Care Providers, 2013-2014. *Vital & Health statistics. Series 3, Analytical and Epidemiological Studies*. 2016 Feb(38):x-xii; 1-105. PMID: 27023287.

¹¹ Paula C. Carder, PhD, State Regulatory Approaches for Dementia Care in Residential Care and Assisted Living, *The Gerontologist*, Volume 57, Issue 4, August 2017, Pages 776–786, <https://doi.org/10.1093/geront/gnw197>

¹² John Zeisel, PhD, Nina M. Silverstein, PhD, Joan Hyde, PhD, Sue Levkoff, ScD, M. Powell Lawton, PhD, William Holmes, PhD, Environmental Correlates to Behavioral Health Outcomes in Alzheimer's Special Care Units, *The Gerontologist*, Volume 43, Issue 5, October 2003, Pages 697–711, <https://doi.org/10.1093/geront/43.5.697>

the ALFs nationwide found that the median staffing level of direct care staff to residents was 1:14. These staff were also responsible for other duties as assigned, such as laundry, housekeeping, and meal service, instead of focusing on direct resident care.¹³ Most states, however, have no regulations related to staff-to-resident ratios.

Day Centers/Adult Day Services: Adult day services (ADS) are non-residential services outside of an individual's home that provide direct care to older adults and younger adults with disabilities for less than a full day. ADS often provide respite to caregivers who care for family members with dementia who are in need of constant supervision by allowing the caregiver to engage in other activities and recover from their caregiving responsibilities. Across the country, 44 states require minimum direct staff-to-participant ratios ranging between 1:4 and 1:10.¹⁴ Those without minimum ratios allow providers to determine how many staff members will be employed. Recognizing the higher level of care needed for people with dementia, some states have also established higher minimum staffing ratios for participants with dementia. Michigan, for example, requires Dementia Adult Day Care Programs (ADC) to ensure a minimum staff-to-participant ratio of 1:3.¹⁵

Hospitals: While outside of the Alzheimer's Association's public policy scope, the hospital setting provides a helpful model to highlight states' progress in codifying staffing ratios to ensure a high quality of care. Currently 14 states have some type of safe staffing laws for hospitals, but with the exception of California, they are not regulated. Lower staff ratios in hospitals have been linked to several positive outcomes, one of them being higher job satisfaction.¹⁶ Others include lower nurse burnout and fatigue, improved safety outcomes, and reductions in medication errors. Lower ratios have also been linked to shortened hospital stays and lower costs,¹⁷ and better quality of care.^{18,19} National Nurses United, the largest union and professional association of registered nurses, has proposed their own staffing ratio recommendations, in which they emphasize that having an appropriate staff-to-patient ratio can be cost-effective for hospitals, improve patient safety and care quality.²⁰

Acuity-Based Staffing

In residential long-term care settings, staffing is a key driver of quality care. A review of scholarly literature on this subject verifies that there is a clear association between higher levels

¹³ Hawes, C., & Phillips, C. D. (2000). *High Service or High Privacy Assisted Living Facilities, Their Residents and Staff: Results from a National Survey*. <https://aspe.hhs.gov/reports/high-service-or-high-privacy-assisted-living-facilities-their-residents-staff-results-national-1>

¹⁴ *Regulatory Review of Adult Day Services: Final Report - Section 1*. (2005). <https://aspe.hhs.gov/reports/regulatory-review-adult-day-services-final-report-section-1-0#main-content>

¹⁵ O'Keefe, J., O'Keefe, C., & Shrestha, M. (2014). *Regulatory Review of Adult Day Services: Final Report, 2014 Edition*. <https://aspe.hhs.gov/reports/regulatory-review-adult-day-services-final-report-2014-edition-0>

¹⁶ AFL-CIO: Department of Professional Employees, 2011.

¹⁷ Dall et al., 2009.

¹⁸ Needleman et al., 2011; mortality.

¹⁹ Aiken et al., 2019; patient care satisfaction.

²⁰ National Nurses United, <https://www.nationalnursesunited.org/ratios>

of licensed staff and higher quality of care.²¹ A resident's individual outcomes (including the presence of weight loss, bed sores and general functional ability), is regularly linked to staffing and there is an association between higher turnover rates and lower quality of care.²² However, there is limited research identifying an optimal ratio of staffing.

Beyond meeting any mandatory staffing numbers required in organizations serving persons with dementia, there is a growing awareness of the need to deploy staff in a manner that aligns with resident routines and needs.²³ **A simple staffing ratio, while clear, may not be sufficient to consistently deliver high quality care.** The makeup of the resident population including, for example, the number of people with dementia, should impact the numbers of nursing staff present at any given time.

States should look toward implementing acuity-based staffing models. Acuity-based staffing refers to “the allocation of clinical expertise and caregiver resources necessary to ensure a resident’s quality of care/life, based on their medical complexity, ADL dependency, and behavior challenges, as defined by a formal assessment process.”²⁴

For long-term care communities, developing the appropriate acuity-based nurse staffing levels can be challenging but existing research has provided guidance to inform facilities and policymakers. According to Harrington et. al. (2020), there are five steps to determine sufficient nurse staffing levels²⁵:

1. Determine the Collective Resident Acuity and Care Needs
2. Determine the Facility’s Actual Per Resident Per Day Staffing Levels
3. Determine Appropriate Nurse Staffing Levels Based on Resident Acuity
4. Identify Evidence Regarding the Adequacy of Staffing
5. Analyze the Adequacy of Facility Staffing

Dementia Care Practice Recommendations

The Alzheimer’s Association’s Dementia Care Practice Recommendations (DCPRs) outline recommendations for quality care practices based on a comprehensive review of current evidence, best practice, and expert opinion. The DCPRs were developed to better define quality care across all care settings and throughout the disease course. The DCPRs are fundamentally based on a person-centered focus and acknowledge that this focus is the core of quality care.

Having a person-centered focus means supporting on-going opportunities for

²¹ Bostick JE, Rantz MJ, Flesner MK, Riggs CJ. Systematic review of studies of staffing and quality in nursing homes. *J Am Med Dir Assoc.* 2006 Jul;7(6):366-76. doi: 10.1016/j.jamda.2006.01.024. Epub 2006 Apr 25. PMID: 16843237.

²² *ibid*

²³ Cohen-Mansfield & Bester, 2006.

²⁴ Youles, L. (2019). *Acuity-based staffing: What does it mean?*

<https://www.mcknights.com/marketplace/marketplace-experts/acuity-based-staffing-what-does-it-mean/>

²⁵ Harrington C, Dellefield ME, Halifax E, Fleming ML, Bakerjian D. [Appropriate Nurse Staffing Levels for U.S. Nursing Homes.](#) *Health Serv Insights.* 2020;13:1178632920934785. Published 2020 Jun 29. doi:10.1177/1178632920934785

meaningful engagement with the individual living with dementia, no matter the care setting. With appropriate staffing ratios in place, staff have more time to comfort individuals and participate in meaningful engagement. This also allows for regular evaluation of care practices and the ability to make appropriate changes for the individual as needed.²⁶ The DCPRs further recommend regular, comprehensive person-centered assessments and timely interim assessments. These assessments should be conducted every six months and prioritize issues that help the individual with dementia to live to their fullest potential. Doing so provides an opportunity to promote mutual understanding of dementia and the specific situation of the individual.

Person-centered assessments should be completed within 14 days of admission and updated at least every 6 months. A comprehensive person-centered assessment should highlight the experience of the person/care partner, the individual’s function and behavior, and the individual’s health status and risk reduction. As appropriate, any previous outcomes of therapeutic interventions should also be considered.

While a care plan is required by federal law for nursing homes, it is important the plan is person-centered. Following the DCPRs, a care plan shall be developed for each resident within 30 days of admission and updated at least every 6 months, or sooner for any significant change, and should be revised regularly as the resident’s goals/outcomes change. The care plan shall be developed in a team approach by appropriately trained and qualified staff in partnership with the resident and resident’s family at the request of the resident. A comprehensive person-centered care plan shall be customized to the needs and preferences of the resident. The resident and the resident’s representative (often family) should also receive a copy of the initial and all subsequent care plans. The care plan shall include the services provided by staff and/or contracted from outside agencies and healthcare providers.

<p>Person-Centered Assessment</p>	<p>Experience of the Person/Care Partner</p> <ul style="list-style-type: none"> ● Strengths/factors that support wellbeing including experiences of at-homeness ● Challenges/unmet needs ● Living situation and care needs ● Advance planning and awareness of resources (including education, support, palliative care) ● Caregiver health, unmet needs, stress (if appropriate) ● Care dyad’s (care partner) knowledge about diagnosis, care options, and community resources (as appropriate) <p>Function and Behavior</p>
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²⁶ Meeks, S., Fazio, S., Pace, D., Kallmyer, B. A., Maslow, K., & Zimmerman, S. (Eds.). (n.d.). Alzheimer’s Association® Dementia Care Practice Recommendations. <https://www.alz.org/media/Documents/alzheimers-dementia-care-practice-recommendations.pdf>

	<ul style="list-style-type: none"> ● Neurocognitive function ● Decisional capacity ● Physical function (including activities of daily living, instrumental activities of daily living) ● Psychosocial, social and spiritual activity and wellbeing ● Everyday routines, activities (including personal care, exercise, recreational activity, sleep) ● Behavior changes, symptoms <p>Health Status and Risk Reduction</p> <ul style="list-style-type: none"> ● Comorbidities (medical/physical) ● Health indicators (e.g. pain, nutritional status, oral health) ● Medications (over-the-counter, prescription, supplements) ● Safety and risk reduction <p>Outcomes of Therapeutic Interventions (as appropriate)</p>
<p>Person-Centered Care Planning</p>	<p>The Care Plan Must Include:</p> <ul style="list-style-type: none"> ● Scope of services ● Frequency of services ● Monitoring of the services be delivered ● Review of the resident’s goals/outcomes ● Who is responsible for the delivery of services

3. Policy Solutions

ALZHEIMER’S ASSOCIATION STAFF SHOULD NOT ENGAGE ON THIS ISSUE WITHOUT APPROVAL OF THE STATE AFFAIRS DEPARTMENT

To support staff in the field, the Public Policy and Care and Support Divisions have collaborated to develop an evidence-based model policy that emphasizes the importance of **acuity-based staffing**. The policy language included in this document may enable states to adopt acuity-based staffing by requiring the relevant state agency to ensure long-term care communities have a standardized service plan and for the agency to approve the communities’ acuity staffing model with documentation required.

POLICY RESPONSE: Establish new acuity-based staffing requirements through statutory or regulatory change to ensure adequate staffing based on the needs of the individuals receiving services.

Tactics

- **Understand and join the process if your state is considering staffing ratios through the legislative or regulatory process.** Each state tackles acuity-based staffing requirements/ratios differently. Some states require statutory change while others allow for the implementation of acuity-based staffing requirements/ratios mandates through regulatory change. The pros and cons of legislation vs. regulation depend on the current political climate within a state capital - who is in charge of the executive branch, who has majority rule in the legislature, and how powerful the opposition/industry lobby may be.
- **Engage with professional care providers.** Once you determine what residential or program settings you are focusing on, set up a meeting with the state affiliate or trade association for that group. Regardless of the reaction that you may receive when you speak with provider groups, you are engaging in a good faith effort to hear and address any concerns that they may have, and hopefully they will eventually agree to support acuity-based staffing requirements. In states where lawmakers or other stakeholders are advocating for the extreme in the opposite direction, the industry lobby may see the acuity-based model as a compromise they can get behind.
- **Engage state agency officials.** It is critical to work with the relevant state agency officials from the very beginning. Several meetings and a lengthy education process may be required before you are able to move forward. If you are pursuing policy change through legislation, it is important that agency officials either support or remain neutral on any legislative requests related to acuity-based staffing requirements.
- **Establish a working group of key stakeholders including lobbyists for the care providers, health care experts (including clinicians and industry experts), relevant state agency officials, and other advocacy organizations.** Building a coalition around this effort will demonstrate its broad appeal as well as let potential opponents know that you are not trying to go around them to implement these kinds of policies but rather recognize the importance of them having a seat at the table to induce positive change.

Barriers to Success

- **State reluctance to mandate staffing requirements.** The word “mandate” is often considered to be a “dirty” word in the world of state governments, especially among those that are conservative-leaning. This is especially true when it comes to policies concerning acuity-based staffing requirements or staffing ratios. Use the information in this toolkit to remind policymakers of the evidence-based research that supports acuity-based staffing. Remind policymakers that ensuring the best quality of life possible for individuals and families living with dementia cannot be overlooked. Also consider pointing to other kinds of acuity-based staffing requirements/ratio mandates in the state

and make the case that the needs of people living with dementia should not be seen as less important.

- **Opposition from industry.** The potential cost of staffing ratios, lack of understanding acuity-based models, and enforcement and oversight of ratios are arguments that professional care provider associations often make in opposition to the implementation of acuity-based staffing ratios. This kind of opposition should be expected, but it is not insurmountable and government affairs staff should work to ensure that industry representatives know that we want them at the table as you develop this policy push. It may also be helpful to remind these care providers that also included in the Association's priorities is advocating for increased reimbursement rates.

- **Cost of increased staffing levels.** Each state handles costs differently and oftentimes this depends on the specific care setting that is being addressed. If the cost of the acuity-based staffing model is a major concern for policymakers, consider potential sources of funding that can be used to offset the cost like increased public pay rates (Medicaid or General Funds).

Appendix A: MODEL LEGISLATION

Establishing an Acuity-Based Staffing Model

§ XX.XXX.100 Definitions

"Ambulatory" means the condition of a resident who is physically and mentally capable of self-preservation by evacuating in response to an emergency to a refuge area as defined by the Uniform Statewide Building Code, without the assistance of another person, or from the structure itself without the assistance of another person if there is no such refuge area within the structure, even if such resident may require the assistance of a wheelchair, walker, cane, prosthetic device, or a single verbal command to evacuate.

"Long-Term Care Community" means a skilled nursing facility as defined in [*insert code citation § AAA.AAA*], an assisted living facility as defined in [*insert code citation § BBB.BBB*], a memory care facility as defined in [*insert code citation § CCC.CCC*], or a residential care setting as defined in [*insert code citation § DDD.DDD*].

"Nonambulatory" means the condition of a resident who by reason of physical or mental impairment is not capable of self-preservation without the assistance of another person.

"Person-Centered Assessment and Care Plan" means a form approved by the Department, used by qualified long-term care community staff to determine care needs for an individual. The form shall include the experience of the person and care partner; function and behavior; and health status and risk reduction.

"Physical examination" means a review by a physician to determine general physical condition; any significant medical history; any diagnosis or significant problems that impact neurocognitive function or physical function; any known allergies and description of the person's reactions; any recommendations for care including medication, diet, and therapy.

"Resident interview" means a discussion with a resident or if applicable, their legally authorized representative to collect basic demographic data; personal and social information.

§ XX.XXX.200 Person-Centered Care Plan

A. The comprehensive person-centered care plan shall be completed using a template approved by the Department within 30 days after admission and shall include the following:

1. Description of identified needs and date identified based upon the (i) admission physical examination; (ii) resident interview; (iii) fall risk; (iv) assessment of psychological, behavioral, and emotional functioning, and (v) other sources;
2. A written description of what services will be provided to address identified needs, and if applicable, other services, and who will provide them.

B. The comprehensive person-centered care plan shall be signed and dated by the licensee, administrator, or his designee, (i.e. the person who has developed the plan), and by the resident or his legal representative. The plan shall also indicate any other individuals who contributed to the development of the plan, with a notation of the date of contribution. The title or relationship to the resident of each person who was involved in the development of the plan shall be included. These requirements shall also apply to reviews and updates of the plan.

C. Comprehensive person-centered care plan shall be reviewed and updated at least once every six months and as needed for a significant change of a resident's condition. The review and update shall be performed by a qualified staff person and in conjunction with the resident and, as appropriate, with the resident's family, legal representative, direct care staff, case manager, health care providers, qualified mental health professionals, or other persons.

D. The community shall ensure that the care and services specified in the individualized service plan are provided to each resident, except that:

1. There may be a deviation from the plan when mutually agreed upon between the community and the resident or the resident's legal representative at the time the care or services are scheduled or when there is an emergency that prevents the care or services from being provided.

2. Any deviation from the plan shall:

- a. Be documented in writing or electronically;
- b. Include a description of the circumstances warranting deviation and the date such deviation will occur;
- c. Certify that notice of such deviation was provided to the resident or the resident's legal representative;
- d. Be included in the resident's file; and
- e. Be signed by an authorized representative of the assisted living community and the resident or the resident's legal representative if the deviation is made due to a significant change in the resident's condition.

§ XX.XXX.300 Staffing Requirements

A. Communities must have qualified awake direct care staff, sufficient in number to meet the 24-hour scheduled and unscheduled needs of each resident. Direct care staff provide services for residents that include assistance with activities of daily living, medication administration, resident-focused activities, supervision, and support.

1. If a community employs universal workers whose duties include other tasks (e.g., housekeeping, laundry, food service), in addition to direct resident care, only hours devoted to resident care should be included.

2. The following community employees are ancillary to the caregiver requirements in this section:
 - a. Individuals whose duties are exclusively housekeeping, building maintenance, clerical, administrative, or food preparation.
 - b. Licensed nurses who provide services (Resident Health Services).
 - c. Administrators who do not provide direct care.

3. The Department retains the right to require minimum staffing standards based on acuity, complaint investigation or survey inspection.

4. Based on resident acuity and community structural design there must be adequate direct care staff present at all times, to meet the fire safety evacuation needs of non-ambulatory residents as required by the fire authority or the Department.

5. The licensee is responsible for assuring that staffing is increased to compensate for the evaluated care and service needs of residents at move-in and for the changing physical or mental needs of the residents.

6. A minimum of two direct care staff must be scheduled and available at all times whenever a resident requires the assistance of two direct care staff for scheduled and unscheduled needs in accordance with the resident's Individualized Service Plan.

7. In facilities where residents are housed in two or more detached buildings, or if a building has distinct and segregated areas, at least two direct care staff must be awake and available in each building and each segregated area at all times.

8. Communities employ a system approved by the Department to determine appropriate numbers of direct care staff and general staffing based on resident acuity and service needs in accordance with the resident's Person-centered Care Plan. Such systems may be either manual or electronic.
 - a. Facilities must consider the resident's needs as expressed in the Person-centered Care Plan.
 - b. Guidelines for systems must also consider physical elements of a building, use of technology if applicable and staff experience.
 - c. Facilities must be able to demonstrate how their staffing system works.

OPTION 1

- d. Staffing shall not be less than the following:
 - (i) DAY SHIFT: 1 nursing assistant per 7 residents.
 - (ii) EVENING SHIFT: 1 nursing assistant per 9.5 residents.
 - (iii) NIGHT SHIFT: 1 nursing assistant per 17 residents.

OPTION 2

- d. Each resident will receive a minimum of 4.17 hours of care per resident per day.

9. The community must keep records to document sufficient staffing levels at all times.

Appendix B: ADDITIONAL RESOURCES

[Appropriate Nurse Staffing Levels for U.S. Nursing Homes](#)

Abstract - US nursing homes are required to have sufficient nursing staff with the appropriate competencies to assure resident safety and attain or maintain the highest practicable level of physical, mental, and psychosocial well-being of each resident. Minimum nurse staffing levels have been identified in research studies and recommended by experts. Beyond the minimum levels, nursing homes must take into account the resident acuity to assure they have adequate staffing levels to meet the needs of residents. This paper presents a guide for determining whether a nursing home has adequate and appropriate nurse staffing.

Harrington C, Dellefield ME, Halifax E, Fleming ML, Bakerjian D. Appropriate Nurse Staffing Levels for U.S. Nursing Homes. Health Serv Insights. 2020;13:1178632920934785. Published 2020 Jun 29. doi:10.1177/1178632920934785

[Dementia Care Practice Recommendations](#)

Since its inception, the Alzheimer's Association has been a leader in outlining principles and practices of quality care for individuals living with dementia. Early on, our Guidelines for Dignity described goals for quality care, followed by Key Elements of Dementia Care and the Dementia Care Practice Recommendations, as more evidence became available. In this new iteration, the Alzheimer's Association Dementia Care Practice Recommendations outline recommendations for quality care practices based on a comprehensive review of current evidence, best practice and expert opinion. The Dementia Care Practice Recommendations were developed to better define quality care across all care settings and throughout the disease course. They are intended for professional care providers who work with individuals living with dementia and their families in long-term and community-based care settings. The Practice Recommendations are published as a supplement to *The Gerontologist*.

[Staffing Ratios - Internal Survey and Analysis](#)

In March of 2021, the State Affairs Department released a [survey form](#) for state government affairs staff to complete, identifying the staffing ratios in effect in their state. Forty states completed the form providing their knowledge of the individual staffing ratio requirements in specific residential and HCBS settings along with citations/links for further study as needed. An [analysis of the results](#), as well as the [complete, raw data](#) are available.