Michigan Department of Community Health
Bureau of Health Systems
Division of Nursing Home Monitoring

# QUARTERLY NURSING STAFF REPORT

## 2nd Quarter of Calendar Year 2010

Print

Reset

Facility Name: _____

Address: _____

City & Zip Code: _____

Reporting Period: 5/30/10-6/5/10

Due Date: 8/6/10

State Facility ID: _____

| DAY & DATE | SUNDAY 5/30/10 | MONDAY 5/31/10 | TUESDAY 6/1/10 | WEDNESDAY 6/2/10 | THURSDAY 6/3/10 | FRIDAY 6/4/10 | SATURDAY 6/5/10 |
|---|---|---|---|---|---|---|---|
| CENSUS | | | | | | | |
| DIRECTOR OF NURSING (Hrs.) | | | | | | | |

## TOTAL HOURS WORKED PROVIDING DIRECT RESIDENT CARE

| | MORNING SHIFT | | | | | | AFTERNOON SHIFT | | | | | | NIGHT SHIFT | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | RNs IN HOUSE | RNs POOL STAFF | LPNs IN HOUSE | LPNs POOL STAFF | AIDES/ ORDS IN HOUSE | AIDES/ ORDS POOL STAFF | RNs IN HOUSE | RNs POOL STAFF | LPNs IN HOUSE | LPNs POOL STAFF | AIDES/ ORDS IN HOUSE | AIDES/ ORDS POOL STAFF | RNs IN HOUSE | RNs POOL STAFF | LPNs IN HOUSE | LPNs POOL STAFF | AIDES/ ORDS IN HOUSE | AIDES/ ORDS POOL STAFF |
| **Sunday 5/30/10** | | | | | | | | | | | | | | | | | | |
| **Monday 5/31/10** | | | | | | | | | | | | | | | | | | |
| **Tuesday 6/1/10** | | | | | | | | | | | | | | | | | | |
| **Wednesday 6/2/10** | | | | | | | | | | | | | | | | | | |
| **Thursday 6/3/10** | | | | | | | | | | | | | | | | | | |
| **Friday 6/4/10** | | | | | | | | | | | | | | | | | | |
| **Saturday 6/5/10** | | | | | | | | | | | | | | | | | | |

I hereby certify that I am the administrator of the above facility and that the information provided herein is a correct and accurate record of payroll records of the facility for the period indicated.

Certification of Administrator _____ Printed or Typed Name of Administrator _____ Date _____

Authority: Nursing Homes and County Medical Care Facilities—Section 21720a(2) of P.A. 368 of 1978, as amended, Section 708 of P.A. 246 of 2008 and Rule 325.20704
Hospital Long-Term Care Units—Rule 325.20704

Completion: Mandatory under Rule 325.20705

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**BHS-NHM-145 (7/8/10)**

Return to Data Input Sheet

Print

# DIRECTIONS FOR COMPLETING THE QUARTERLY NURSING STAFF REPORT FORM (BHS-NHM-145) IN ADOBE ACROBAT

This form is to be completed in accordance with the following instructions by the due date given on the form and in the e-mail notification to complete. **THIS FORM MUST BE TYPED.**

**FACILITY INFORMATION:**
Move your cursor to each section and enter the official State licensed name of the facility, address, city, zip code and State Facility ID number. (Hint: this number begins with the two digit county number where the facility is located.)

***CENSUS*:**
Move your cursor to each section and enter the actual **NUMBER** of residents who were residing in the nursing home portion of the facility for each date specified.

***DIRECTOR OF NURSING*:**
Move your cursor to each section and enter the number of **HOURS** the **Director of Nursing** (DON) worked for each date specified. The DON must be a Registered Nurse (RN).

- The hours worked by the DON should also be reported in the *TOTAL HOURS WORKED PROVIDING DIRECT RESIDENT CARE* section **in facilities that have less than 30 beds**.
- The hours worked by the DON must be reported in the Director of Nursing row **but not included** in the *TOTAL HOURS WORKED PROVIDING DIRECT RESIDENT CARE* section **in facilities that have 30 or more beds**.

***TOTAL HOURS WORKED PROVIDING DIRECT RESIDENT CARE*:**
Move your cursor to the first field for ***RNs IN HOUSE*** for Sunday and then tab through the remaining fields to enter:

- ***RNs IN HOUSE, LPNs IN HOUSE, AIDES/ORDS IN HOUSE* columns:** Count hours **only provided by facility-employed nursing staff** who actually provide direct resident care; not volunteers.
- ***RNs POOL STAFF, LPNs POOL STAFF, AIDES/ORDS POOL STAFF* columns:** Count hours **only provided by paid pool staff**. **Do not include pool hours in the "In House" categories.**

***CERTIFICATION OF ADMINISTRATOR*:**
Reports submitted as an e-mail attachment with the typed administrator's name and date are acceptable as certification by the administrator that the report is accurate as submitted. Move your cursor to the ***Typed Administrator's Name*** and ***Date*** to type. The administrator of the home must sign the form as well if mailed instead of e-mailing.

## E-MAIL

Facilities with the professional version may save the completed report with an appropriate name on your hard drive. Otherwise print the completed report, scan, save the scan and follow the same directions for e-mailing. Open the facility e-mail program and enter the "Facility Name" and "Quarterly Staffing" in the subject line. Attach the completed or scanned report to the e-mail and send it to dch-bhs-quarterly-staffing@michigan.gov (preferred method). An e-mail confirming receipt that the document has been received will be sent. The other option is to use U.S. mail sending it to the address shown below.

## CONTACT INFORMATION

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