Department of Health, Nursing Care Facilities

TEAM COORDINATOR ENTRANCE CONFERENCE CHECKLIST

Other information may be required depending on the type of survey performed

FACILITY: _____ **DATE**: _____

OBTAIN THE FOLLOWING BY THE END OF THE ENTRANCE CONFERENCE		Received
	1. Actual working schedule for RNs and LPNs for all shifts for the survey period.	

OBTAIN THE FOLLOWING BY THE END OF THE ORIENTATION TOUR		Received
	1. Completed **CMS 802 (Resident Roster/Sample Matrix)** – Including all bed holds. *The facility has 24 hours to correct this form.*	
	2. List of all residents who are receiving or have received antipsychotic medications over the past 30 days.	
	3. Name of contact person for the survey.	

OBTAIN THE FOLLOWING WITHIN ONE HOUR OF THE ENTRANCE CONFERENCE		Received
	1. List of key personnel and their locations, including those responsible for infection control and quality assurance.	
	2. Written information provided to residents regarding their rights.	
	3. Copy of admission packet/contract for all residents including payment sources.	
	4. Medication pass start times by unit.	
	5. Copies of menus, including therapeutic menus, which will be used for the duration of the survey.	
	6. Meal Serving Schedule, including tray arrival times by unit and dining room service.	
	7. List of admissions during the past month.	
	8. List of residents transferred/discharged during the past three months with dates of admission and discharge, destinations, and payor sources.	
	9. Copy of the facility's layout indicating the name of the facility, the location of nurses' stations, individual resident rooms with room numbers and number of beds in each room, and common areas.	
	10. List of hospice residents and a copy of the contract/agreement.	
	11. List of dialysis residents and dialysis contract.	
	12. List of residents age 55 and under.	
	13. The names and room numbers of any residents who communicate with non-oral communication devices, sign language, or who speak a language other than the dominant language of the facility.	
	14. Evidence of routine monitoring of accidents and incidents, clinical record documentation, and the system to prevent and/or minimize accidents and incidents.	
	15. Facility policies and procedures to prohibit and investigate allegations of abuse and the name of a person the administrator designates to answer questions about what the facility does to prevent abuse.	

	16. Copy of two or three most recent Nurse Aide PB22 Investigative Reports.	
	17. Name and room number of president of the Resident Council.	
	18. If the survey occurs April 1 through September 30 -- List of current residents who were in the facility during the previous influenza season (October 1 through March 31). Name of the person responsible to coordinate the immunization program.	
	19. List of residents with current infections, including bacteria and site.	
	20. If facility utilizes Feeding Assistants, list at bottom of **CMS-671**, provide a list of all staff that completed the training for feeding assistants and are currently assisting residents with eating meals and/or snacks. The name of the person who could answer questions about feeding assistants.	
	21. Copy of facility's policy/procedure and training for Reporting Suspicion of a Crime in Long Term Care Facilities. (Section 1150B of the Social Security Act, as established by section 6703(b)(3) of the Patient Protection and Affordable Care Act of 2010)	

OBTAIN THE FOLLOWING WITHIN 24 HOURS OF THE ENTRANCE CONFERENCE Received

	1. List of residents with payment source.	
	2. Completed **CMS 671** (Application for MC/MA).	
	3. Completed **CMS 672** (Resident Census and Condition).	
	4. List of Medicare residents who requested demand billing in the last six months.	
	5. Completed influenza and pneumonia vaccine questionnaire.	
	6. List of personnel hired and/or agency and contracted personnel utilized since the last standard survey. A sample of personnel files will be requested with their professional licenses available for review, date of hire, State Police background checks (or FBI background check if personnel lived out of state within last two years), and reference checks.	
	7. A copy of the disaster plan, policy and procedure for emergency transport and contracts, if applicable, including emergency water supply.	
	8. Is the facility's emergency management/disaster preparedness plan current and address all related contingencies?	
	9. Copy of job descriptions and licenses of the NHA and DON. The medical director's name and address.	
	10. Existing and pending exceptions and waivers	
	11. Evidence of the facility's primary insurance liability and professional liability insurance coverage (MCare Insurance Information).	
	12. Copy of the contract for hazardous waste removal.	

Does the facility use physician extenders? _____ PAs _____ CRNPs

OBTAIN THE FOLLOWING AS DESIGNATED Received

	1. Nursing time schedules for the weeks of _____ _____ _____: Three-week nursing schedule with census (separated by unit and shift – observed posted daily for each shift).	
	2. Time schedules for all other personnel for the week of: _____	
	3. Pre-Survey Civil Rights Questionnaire.	
	4. Fire drill records for the past 12 months.	
	5. Surety Bond.	

PLEASE NOTE: Page 3 is for surveyor's reference only.

Areas requiring Federal waiver(s):

1. Rooms with less square footage than required
2. Rooms occupied by more than four residents
3. At least one window to the outside
4. Any bedrooms not at or above ground level
5. Any bedrooms that do not have access to an exit corridor

Are there variances for any of these rooms and will you continue to request them?

Areas to Discuss with Administrator at Entrance:

___ 1. Provide copy of QM reports and Casper 3 and 4 reports and explain the reports and how they were used by the survey team. If any discrepancies, ask the administrator to explain the discrepancies.

___ 2. Explain the survey process. Inform the administrator that the team will be communicating with the staff throughout the survey and will ask for assistance when needed.

___ 3. Advise the administrator that they will have the opportunity to provide the team with any information that will clarify an issue brought to their attention.

___ 4. Is there a functioning Quality Assurance and Assessment Committee and:

- Who participates on the committee_____
- Who leads the committee_____
- How often does the committee meet_____
- With who should the survey team discuss QA&A concerns_____

___ 5. Survey signs.

___ 6. Who can a team member speak with to discuss special features of the facility's care and treatment programs and resident case mix?

- Does the facility have special care units for residents with heavy clinical needs, people with dementia or those receiving specialized rehabilitation services? _____ _____
- What individualized care and services are provided for residents with dementia?_____ _____
- How are staff educated and trained to care for people with dementia, including how to prevent or address the behavioral and psychological symptoms of dementia (BPSD)?_____ _____
- How does the facility monitor the use of psychopharmacological medications, specifically antipsychotic medications?_____ _____
- Improvement of Dementia Care and Reduction of unnecessary antipsychotic medication use. (CMS initiative 2012) - you may use talking points list to help with the discussion. The website for educational information is: http://www.portal.state.pa.us/portal/server.pt?open=514&objID=1328934&mode=2

___ 7. List the names and room numbers of any resident on experimental drugs or experimental treatment.

___ 8. Contract for management.

___ 9. Any contracted services, i.e. housekeeping, therapies, etc.

___ 10. Does the facility allow LPNs to take verbal or telephone orders?

___ 11. Does the facility have any bariatric/morbidly obese residents?

___ 12. Does the facility use Electronic Medical Records?
If yes, provide instructions for surveyors to have unrestricted access.

___ 13. Does the facility have CLIA certification/waiver and State Lab permit?

___ 14. Procedure to gain entrance to the building after regular hours.

___ 15. Verification of e-mail address through Password Agreement.

___ 16. Any problems with the Message Board access/Password Agreement?

___ 17. Any problems with Nurse Aide Registry website information?

___ 18. HIPAA

___ 19. Does the facility have a beauty shop and is it licensed? If they have a beauty shop, but it is not licensed, inform them that beauty shops are required to be licensed in Pennsylvania.