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 ORIENTATION TOUR		Received
	1. Completed **CMS 802 (Resident Roster/Sample Matrix)** – Including all bed holds.	
	2. Working schedule for RNs, LPNs, and nurse aides for all days of the survey	
	3. Name of contact person at the facility.	

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. Facility admission contract for MC, MA, private pay, and other payment sources.	
	4. List of any residents adjudicated incompetent through the courts.	
	5. Medication pass start times by unit	
	6. Copies of menus with diet modifications and alternates for the duration of the survey and extensions to be served for the duration of the survey/changes to the one that is posted.	
	7. Meal Serving Schedule, including tray arrival times by unit and dining room service	
	8. List of admissions during the past month	
	9. List of residents transferred/discharged during the past three months with dates of admission and discharge and destinations	
	10. 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	
	11. Hospice residents and a copy of the contract/agreement.	
	12. Dialysis residents and dialysis contract.	
	13. The names of any residents age 55 and under.	
	14. 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.	
	15. Evidence of routine monitoring of accidents and incidents, clinical record documentation, and the system to prevent and/or minimize accidents and incidents.	
	16. 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.	
	17. Copy of most recent Nurse Aide PB22 Investigative Report.	
	18. Name and room number of president of the Resident Council and last three months of Resident Council minutes.	

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. If facility utilizes Feeding Assistants, list at bottom of **CMS-671** and follow guideline for new F373.	
	4. Completed **CMS 672** (Resident Census and Condition)	
	5. List of Medicare residents who requested demand billing in the last six months	
	6. Completed influenza and pneumonia vaccine questionnaire.	
	7. Starting 4/1/07 – List of current residents who were in the facility during the previous influenza season (October 1 through March 31) and the list of current infections.	
	8. List of personnel hired and/or agency & 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 and State Police background checks (or FBI background check if personnel lived out of state within last 2 years) and reference checks.	
	9. A copy of the disaster plan, policy & procedure for emergency transport and contracts, if applicable, including emergency water supply.	
	10. Is the facility's emergency management/disaster preparedness plan current and address all related contingencies?	
	11. Copy of job descriptions and licenses of the DON and NHA and medical director's name and address.	
	12. Existing and pending exceptions and waivers	
	13. Evidence of the facility's primary insurance liability and professional liability insurance coverage (MCare Insurance Information)	

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 twelve months.	
	5. Surety Bond.	

Copy of Survey Results to be sent to:

Governing Body Name ________________________________

Title ________________________________

Address ________________________________

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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

Areas to Discuss with Administrator at Entrance:

___ 1. HIPAA

___ 2. QI Reports

___ 3. Message Board Access/Password Agreement

___ 4. OSCAR 3 & 4 Reports

___ 5. Provide instructions on how to enter the PA UJS website for periodic background checks.

___ 6. As required in Tag F334, starting October 1, 2006, please compile and maintain a list of residents who reside in the facility during the influenza season of October 1 through March 31. This list will be required for every annual survey henceforth.

___ 7. Survey Signs

___ 8. Review the NHA and DON licenses.

___ 9. Contract for Management

___ 10. Special Units

___ 11. Nurse Aide Registry Web Site Information

___ 12. Any contracted services, i.e. Housekeeping, therapies, etc.

___ 13. Procedure to gain entrance to the building after regular hours.

___ 14. Verification of e-mail address through password agreement.

___ 15. List the names and room numbers of any resident on experimental drugs or experimental treatment.

___ 16. Does the facility have CLIA certification/waiver and State Lab permit?

___ 17. Does the facility allow LPNs to take verbal or telephone orders?

___ 18. Does the facility have any bariatric/morbidly obese residents?