

## 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.	
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**OBTAIN THE FOLLOWING BY THE END OF THE ORIENTATION TOUR**

Received

1 Completed <b>CMS 802 (Resident Roster/Sample Matrix)</b> – Including all bed holds. <i>The facility has 24 hours to correct this form.</i>	
2 List of all resident who are receiving or have received antipsychotic medications over the past 30 days.	
3 List of all residents who have a DX of dementia & who are receiving, have received, or presently have PRN orders for antipsychotic medications over the past 30 days. Include copy of the policy related to the use of antipsychotic medications in residents with dementia.	
4. 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 payer 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. The names of any 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 2-3 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 resident with current infections, including bacteria and site.	
	20. If facility utilizes Feeding Assistants, list at bottom of <b>CMS-671</b> , 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 <b>CMS 671</b> (Application for MC/MA)	
	3. Completed <b>CMS 672</b> (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 & 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.	
	7. A copy of the disaster plan, policy & 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 DON and NHA and 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)	

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.	