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|  | | RESIDENTIAL CARE ENTRANCE CONFERENCE CHECKLIST State Form 53725 (R2 / 4-21)  INDIANA STATE DEPARTMENT OF HEALTH / DIVISION OF LONG-TERM CARE | | | |
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| Name of facility | | | | Facility number | |
| Date(s) of survey *(month, day, year)* | | | | | |
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| **ITEMS NEEDED WITHIN ONE (1) HOUR OF CONCLUSION OF ENTRANCE CONFERENCE** | | | | | |
|  | 1. List of all residents | | | | |
|  | 1. List of residents admitted within the past thirty (30) days | | | | |
|  | 1. List of residents transferred or discharged during the last ninety (90) days *(Please specify destinations.)* | | | | |
|  | 1. List of residents fifty-five (55) years old or younger | | | | |
|  | 1. List of residents with Major Mental Illness diagnosis | | | | |
|  | 1. Schedule of mealtimes, menus, including modified diets | | | | |
|  | 1. List of residents who self-administer medications | | | | |
|  | 1. Schedule of medication pass times, by unit and their locations | | | | |
|  | 1. List of key personnel by name, title, and their locations:   Administrator  Licensed Nurse to supervise medication and residential nursing care  Medical Records designee  Activity Director  Food Service Supervisor  Dietitian *(if Food Service Supervisor is not a dietitian)*  Pharmacy Consultant *(if medications are administered)* | | | | |
|  | 1. Infection Control Program: to include items specified at **R0406-R0407** | | | | |
|  | 1. List of all residents who are confirmed or suspected COVID-19 positive currently in building. | | | | |
|  | 1. List of residents with special care needs and type (skin care, treatments, oxygen, catheters, ostomies, blood glucose testing, injections, nebulizer / aerosol treatments) | | | | |
|  | 1. List of residents receiving contracted services and type | | | | |
|  | 1. Waivers (CLIA) | | | | |
|  | 1. Policy on residential admittance and continued stay at residential level: **R0001 / R0002 / R0030** | | | | |
|  | 1. Fire Drills: **R0092** | | | | |
|  | 1. Admission Agreement: **R0030** | | | | |
|  | 1. Activity calendar, if used in program: **R0326-R0329** | | | | |
|  | 1. Current Facility Floor Plan | | | | |
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| **ITEMS NEEDED WITHIN TWENTY-FOUR (24) HOURS OF ENTRANCE** | | | | | |
|  | 1. Employee Records form (State Form 53877) | | | | |
|  | 1. Staffing for one (1) week | | | | |
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| **ITEMS TO BE PROVIDED TO SURVEYORS IF REQUESTED** | | | | | |
|  | 1. In-services: **R0120** | | | | |
|  | 1. Pet Policy:  **R0035 / R0150** | | | | |
|  | 1. Resident Funds: **R0050** | | | | |
|  | 1. Residents Rights Documentation: **R0026** | | | | |
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| **QUESTIONS TO BE ASKED OF ADMINISTRATOR AT ENTRANCE** | | | | | |
|  | 1. Room size waivers? | | Yes  No | | **R0183** |
|  | 1. Resident rooms below ground level? | | Yes  No | | **R0185** |
|  | 1. Special Care Units (i.e., Alzheimer’s)? | | Yes  No | | **R0095 / R0120 / R0030** |
|  | 1. Name of director of Alzheimer’s and dementia special care unit: | | | | |