

**ENTRANCE CONFERENCE WORKSHEET
(QIS Facility Copy)**

INFORMATION TO PROVIDE IMMEDIATELY UPON ENTRANCE	
<input type="checkbox"/>	1. An <i>alphabetical resident census</i> , with room numbers/units. Note census residents who are not in the facility (e.g., in the hospital, home visit, etc.).
<input type="checkbox"/>	2. The <i>completed New Admission Information</i> form. List all new admissions after the date listed (the 30 day period before the survey) on the form. Include only residents <u>still residing in the facility</u> . Include Admission Date, Date of Birth, and Room Number/Unit for each resident.
<input type="checkbox"/>	3. Post survey announcement signs in high-visibility areas.
<input type="checkbox"/>	4. A copy of the facility floor plan.
<input type="checkbox"/>	5. A copy of the staffing schedules for licensed and registered nursing staff for the survey time period.
INFORMATION TO PROVIDE WITHIN ONE (1) HOUR OF ENTRANCE CONFERENCE	
<input type="checkbox"/>	6. List of key personnel and their locations.
<input type="checkbox"/>	7. Name of resident council president or an officer/active council member.
<input type="checkbox"/>	8. Schedule of meal times and location of dining room(s).
<input type="checkbox"/>	9. Schedule of Medication Administration times.
<input type="checkbox"/>	10. All closed records from the list of Admission Sample residents provided to the facility after the Entrance Conference. Bring these records to the survey team work area. Make arrangements for overnight storage of the records in a secure location; the survey team will need to access them throughout the survey.
<input type="checkbox"/>	11. If the facility employs paid feeding assistants, provide the following information: a) Whether the paid feeding assistant training was provided through a State-approved training program by qualified professionals as defined by State law, with a minimum of 8 hours of training; b) The names of staff (including agency staff) who have successfully completed training for paid feeding assistants, and who are currently assisting selected residents with eating meals and/or snacks; c) A list of residents who are eligible for assistance and who are currently receiving assistance from paid feeding assistants.

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INFORMATION TO PROVIDE WITHIN FOUR (4) HOURS OF ENTRANCE CONFERENCE
<input type="checkbox"/> 12. Complete pages 3 and 4 of this worksheet and return the information to the survey team. The form requests a list of residents who receive Preadmission Screening and Resident Review (PASRR) Level II services, ventilator, dialysis (whether in or out of the facility), end of life services (including residents receiving comfort care), or certified Medicare hospice. a) Provide the location of PASRR information. b) For dialysis care residents, provide access to the written contract, agreement, arrangement, policies/procedures, and/or plan of care, specifying how dialysis care is coordinated, to assist with the evaluation of care. i) Mark the appropriate columns to indicate the type of dialysis (certified ESRD unit, peritoneal, or home (in-facility)). ii) If there are residents receiving home dialysis services, provide the following information on page 4 of this worksheet: a. Residents' names, room numbers, name of ESRD assigned caregiver/technician (and indication whether this caregiver is provided by the ESRD facility, the DME supplier, or the LTC facility); b. Days and times each resident will receive his/her dialysis treatment.
<input type="checkbox"/> 13. Influenza / Pneumococcal Immunization – Policy & Procedures.
<input type="checkbox"/> 14. List of rooms meeting any one of the following conditions that require a variance: <ul style="list-style-type: none">• Less than the required square footage• More than four residents• Below ground level• No window to the outside• No direct access to an exit corridor
<input type="checkbox"/> 15. Quality Assessment and Assurance (QAA) committee information (name of contact, names of members and frequency of meetings).
<input type="checkbox"/> 16. Description of any experimental research occurring in the facility.
<input type="checkbox"/> 17. Name of contact person for Abuse Prohibition Policies and Procedures/Complaints/Grievance information.
INFORMATION TO PROVIDE WITHIN 24 HOURS OF ENTRANCE CONFERENCE
<input type="checkbox"/> 18. Medicare/Medicaid Application (CMS-671), and Resident Census and Conditions (CMS-672).
<input type="checkbox"/> 19. List of Medicare beneficiaries who requested a demand bill in the past six months.
<input type="checkbox"/> The survey team will be requesting information about the facility's emergency water source and DON coverage (verbal confirmation is acceptable).

COMMUNICATION THROUGHOUT THE SURVEY

Ongoing communication occurs throughout the nursing home survey between the survey team and the facility staff. During the first couple of days of the survey (Stage 1), the team will not have completed full investigations and cannot yet discuss findings. The survey team will be communicating with staff throughout the survey, and staff will have opportunities to clarify issues when brought to their attention. However, surveyors are not to release information about ongoing concerns until their investigation is completed.

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**Preadmission Screening and Resident Review (PASRR), Ventilator, Dialysis,
Certified Medicare Hospice and/or End of Life Services Residents**

Please complete and return this worksheet to the survey team within four hours of entrance.

Resident	Room #	PASRR Level II Services		Ventilator	Dialysis Complete page 4 for any residents receiving home dialysis services			Certified Medicare Hospice	Comfort Care/End of Life Care
		MI	MR		Certified ESRD Unit	Peritoneal	Home		
1.									
2.									
3.									
4.									
5.									
6.									
7.									
8.									
9.									
10.									
11.									
12.									

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Caregiver/Treatment Information for Residents Receiving Home (in-facility) Dialysis

Please complete and return pages 3 and 4 of this worksheet to the survey team within four hours of entrance.

If there are residents receiving home dialysis, provide the following information:				
Resident Receiving Home Dialysis	Room #	ESRD Assigned Caregiver/Technician	Caregiver/Technician Provider:	Dialysis Treatment Days and Times
1.			<input type="checkbox"/> ESRD Facility <input type="checkbox"/> DME Supplier <input type="checkbox"/> LTC Facility	
2.			<input type="checkbox"/> ESRD Facility <input type="checkbox"/> DME Supplier <input type="checkbox"/> LTC Facility	
3.			<input type="checkbox"/> ESRD Facility <input type="checkbox"/> DME Supplier <input type="checkbox"/> LTC Facility	
4.			<input type="checkbox"/> ESRD Facility <input type="checkbox"/> DME Supplier <input type="checkbox"/> LTC Facility	
5.			<input type="checkbox"/> ESRD Facility <input type="checkbox"/> DME Supplier <input type="checkbox"/> LTC Facility	
6.			<input type="checkbox"/> ESRD Facility <input type="checkbox"/> DME Supplier <input type="checkbox"/> LTC Facility	
7.			<input type="checkbox"/> ESRD Facility <input type="checkbox"/> DME Supplier <input type="checkbox"/> LTC Facility	