RESIDENTIAL CARE FACILITY SURVEY PROCEDURE GUIDE

OBJECTIVE:

- To determine the facility's compliance with the State Residential Licensure Rules.

- To provide guidelines for surveyors to assess the facility's compliance.

PROCEDURE:

1. OFFSITE SURVEY PREPARATION: Team Coordinator

- Residential Care Offsite Survey Preparation Worksheet (SF53722) is completed by the Team Coordinator.

- Review pre-survey report.

- Identify areas of concerns and/or potential areas of concerns.

- Review for any open complaints and ensure they are investigated also.

- Team Coordinator makes surveyor assignments

2. ENTRANCE CONFERENCE/ONSITE PREPARATORY ACTIVITIES: Team Coordinator

- Informs the facility's administrator/designee of the purpose of the survey and introduces the team.

- Reviews and explains the information needed from the Residential Entrance Conference Checklist (SF53725) with the administrator/designee. A copy of this can be provided to the facility for their reference.

- Provides the facility with the survey sign for posting at all entrance doors and locations accessible to all residents at wheelchair level. The facility should be informed that the signs should be posted immediately after the entrance conference and remain posted throughout the survey.

- Will notify the area ombudsman of the entrance into the facility and inquire of the ombudsman regarding any additional concerns.

- Informs the facility at entrance, the survey team will be communicating with the staff throughout the survey and will ask for facility assistance when needed.

Inform the facility they can provide the team with information to clarify issues or concerns at anytime throughout the survey.

3. INITIAL TOUR: All Team Members

- As the Team Coordinator conducts the entrance conference. The other team members should start the initial tour of the facility.

- Team members should tour the facility as assigned by the Team Coordinator.

- The initial tour should begin as soon as possible after entrance to the facility. Tour should occur with a staff member knowledgeable of the resident care if possible.

- Meet and greet all available residents and staff.

- Document residents' appearance, comments, and other information that will be helpful in sample selection. Use the Residential Care Surveyor Notes Worksheet (SF53716)

4. SAMPLE SELECTION: All team members, after initial tour

- Sample selection should relate to the areas of concerns and/or potential areas of concern that were identified during the offsite preparation/complaint investigations.

- Sample selection should also include residents identified with concerns during the initial tour.

- Sample selection should include (3) residents for Residential Care Infection Control Review. (SF57102)

- Sample selection should be five (5%) percent of the total resident population with a minimum of five (5) residents and maximum of twenty (20) residents.

- Complete 2 closed record reviews (SF53715)

- Residents selected for sample should be listed on a Residential Care Resident Roster/Sample Matrix (SF53718)

- Interview 3 residents using Residential Care Resident Interview (SF53717)

5. INFORMATION GATHERING: All Required

Observation is key during the survey. Follow the guidance on the State Forms for observation, interviews, and follow-up.

- Residential Care Clinical Record Review (SF53715): 5% of census, minimum of 5, maximum of 20

- Residential Care Resident Interview (SF53717): Must complete 3 interviews if possible

- Residential Care Kitchen/Food Service Observation (SF53723)

- Residential Care General Observations of the Facility (SF53721)

- Residential Care Medication Pass (SF53724): Must observe 5 residents, multiple Routes

- Residential Care Residential Infection Control (SF57102): Must sample 3 residents

- Residential Employee Records (SF53877): Must review 5 employee files

6. INFORMATION ANALYSIS FOR COMPLIANCE DETERMINATION

- Team meeting will be conducted to determine facility compliance.

- Review information from each surveyor and additional information obtained during the survey process.

- Team Coordinator will document state finding(s) determination summary on the Residential Surveyor Notes Worksheet.

- Review Residential State Licensure rules to determine compliance.

- If the facility is determined to be out of compliance with Residential State Licensure regulation(s) a finding should be written in ASE-Q.

- Follow the Principles of Documentation (POD) manual for documentation of findings.

7. EXIT CONFERENCE

- Team Coordinator invites the facility staff to the exit conference. Residents and Ombudsman may come if they would like.

- Team Coordinator leads the exit conference and completes the Exit Conference Checklist and Attendance Record (SF53739).

- The facility should be informed of all areas of concerns and those areas documented on Exit Conference Checklist and Attendance Record.

- The facility can submit additional information at anytime.

SURVEY REPORT:

- Team documents Residential State finding(s) in ASE-Q.

- Report is reviewed by all team members for errors in POD.

- Team Coordinator then submits report (include 2567L and 670) to QR within 24 hours of exit.

- QR is either completed, returned to team for corrections, which need to be completed asap and send back to supervisor for submission to ACO.

PACKET SUBMISSION:

- Each team member reviews documentation then provides all survey documentation to the Team Coordinator for Packet Submission.
- Team Coordinator completes Survey Packet Cover Sheet and Surveyor Packet Checklist and submits all information to the office no later than 5 days after the survey has been submitted to ACO.

ANY PROBLEMS/CONCERNS RELATED TO SURVEY PROCESS WILL BE DISCUSSED WITH AREA SUPERVISOR IMMEDIATELY.

Revised 4/2021

RESIDENTIAL CARE CLINICAL RECORD REVIEW

State Form 53715 (R / 4-21)
INDIANA STATE DEPARTMENT OF HEALTH / DIVISION OF LONG-TERM CARE

Name of facility		Facility number
Name of resident		Resident identifier
Date of birth *(month, day, year)*	Room number	Date of admission *(month, day, year)*
Name of surveyor	Identification number of surveyor	Date of review *(month, day, year)*
Primary diagnosis		

Interviewable:	☐ Yes ☐ No	
Service Plan for services provided, revised as needed and signed and dated by the resident:	☐ Yes ☐ No	**R 0217**
Pre-Admission Evaluation:	☐ Yes ☐ No	**R0214 / R0215 / R0216**
Semi-Annual Evaluation:	☐ Yes ☐ No	**R0216**
Weight Recorded on Admission and Semi-Annually:	☐ Yes ☐ No	**R0216**
Does Resident Self-Administer Medications?	☐ Yes ☐ No	
If Yes, Self-Administration Evaluation:	☐ Yes ☐ No	**R0216**
Are medications secured in the resident's room?	☐ Yes ☐ No	**R0295**
Physician Orders for Medications:	☐ Yes ☐ No	**R0241 / R0242**
PRN Medications Administered by QMA Authorized Before Given:	☐ Yes ☐ No	**R0246**
Pharmacist Drug Regimen Review at least every sixty (60) days *(if facility controls, handles, and administers resident's medications)*:	☐ Yes ☐ No	**R0298**
Diet Orders Reviewed and Revised by the Physician as Resident's Condition Requires:	☐ Yes ☐ No	**R0275**
Chest X-Ray Within six (6) Months of Admission:	☐ Yes ☐ No	**R0408**
Tuberculin Test on, or Prior to, Admission:	☐ Yes ☐ No	**R0410**
Second Step:	☐ Yes ☐ No	**R0410**
Tuberculin Test Annually:	☐ Yes ☐ No	**R0412**
If applicable, Risk Assessment:	☐ Yes ☐ No	**R0412**
Annual Health Statement:	☐ Yes ☐ No	**R0409**
Mental Health Screening for individuals who are recipients of Medicaid or Federal SSI:	☐ Yes ☐ No	
If Major Mental Illness, is there a Comprehensive Care Plan Addressing Those Needs?	☐ Yes ☐ No	**R0379**
Care Plan Developed in Cooperation with Mental Health Provider:	☐ Yes ☐ No	**R0383**
Resident Rights Acknowledgement Signed:	☐ Yes ☐ No	**R0026**
Current Emergency Information File:	☐ Yes ☐ No	**R0356**

RESIDENTIAL CARE SURVEYOR NOTES

State Form 53716 (R / 4-21)
INDIANA STATE DEPARTMENT OF HEALTH / DIVISION OF LONG-TERM CARE

Name of facility		Facility number
Name of surveyor	Identification number of surveyor	Date(s) of survey *(month, day, year)*
Primary diagnosis		

STATE RULES	DOCUMENTATION

STATE RULES	DOCUMENTATION

RESIDENTIAL CARE RESIDENT INTERVIEW

State Form 53717 (R / 4-21)
INDIANA STATE DEPARTMENT OF HEALTH / DIVISION OF LONG-TERM CARE

Name of facility		Facility number
Name of resident		Resident identifier
Name of surveyor	Identification number of surveyor	Date *(month, day, year)* and time of interview

RIGHTS		
Are you aware of the rights you have as a resident?	☐ Yes ☐ No	**R0026**
Has anyone ever physically harmed you? If so, describe what happened.	☐ Yes ☐ No	**R0052 (offense)**
Did you report it? How did staff respond?	☐ Yes ☐ No	
Has anyone ever yelled or sworn at you? If so, please describe what happened.	☐ Yes ☐ No	**R0053**
Did you report it? How did staff respond?	☐ Yes ☐ No	
Does staff treat you with respect?	☐ Yes ☐ No	**R0029**
Has anyone ever taken anything belonging to you without your permission?	☐ Yes ☐ No	**R0064**
Are you able to have privacy when you want it?	☐ Yes ☐ No	**R0055**
Do staff and other residents respect your privacy?	☐ Yes ☐ No	**R0055**
Do you have a private place to meet with visitors?	☐ Yes ☐ No	**R0059 / R0060**
Do you have privacy when you are on the telephone?	☐ Yes ☐ No	**R0049**
Do you receive your mail unopened?	☐ Yes ☐ No	**R0057**
Does staff try to resolve your problems?	☐ Yes ☐ No	**R0039**
Comments		

FOOD		
Tell me about the food served.		
Are your hot and cold foods served at a temperature that you like and are your personal preferences honored (i.e. substitutions provided)?	☐ Yes ☐ No	**R0272 / R0270**
Comments		

ACTIVITIES		
How do you find out about the activities that are going on?		**R0326**
What kinds of activities do you participate in?		**R0326**
Do you like these activities?	☐ Yes ☐ No	**R0326**
Are there activities that you like that are not offered?	☐ Yes ☐ No	**R0326**
Have you talked to anyone about this? If so, what was the response?	☐ Yes ☐ No	
Do you ever leave the facility to attend activities?	☐ Yes ☐ No	**R0327**
Do you have a resident council?	☐ Yes ☐ No	**R0040**
If so, do you participate?	☐ Yes ☐ No	

Comments

ENVIRONMENT		
Is the facility usually clean and free of bad smells?	☐ Yes ☐ No	**R0144**
Is the room temperature comfortable?	☐ Yes ☐ No	**R0178**
Is there enough light for you?	☐ Yes ☐ No	**R0184**
Are you able to have ice when you want it?	☐ Yes ☐ No	**R0189**
Is there anything that would make the facility more comfortable for you?	☐ Yes ☐ No	

Comments

ACTIVITIES OF DAILY LIVING		
Do you get help when you need it and are your preferences met?	☐ Yes ☐ No	**R0239 / R0240**

Comments

MEDICAL SERVICES			
Did you choose your physician?	☐ Yes ☐ No		**R0035 / R0237**
Can you see your doctor if you need to?	☐ Yes ☐ No		**R0058 / R0090**
Do you have privacy when you are examined by your physician?	☐ Yes ☐ No		**R0055**
Does facility staff help make doctor's appointments?	☐ Yes ☐ No		**R0035 / R0090**
Can you see a dentist, podiatrist, or other specialist if you need to?	☐ Yes ☐ No		**R0090**
Did you participate in the development of your service plan?	☐ Yes ☐ No		**R0035**

Comments

DECISIONS			
Are you involved in making decisions/choices about your care at this facility?	☐ Yes ☐ No		**R0035**
Are you able to participate or request a review or change in your service plan or plan of care?	☐ Yes ☐ No		**R0217**
If you are unhappy with something, or if you want to change something about your daily schedule, how do you let the facility know?			**R0039**
Can you choose how you spend your day?	☐ Yes ☐ No		**R0027**
Have you ever refused care or treatment? If so, what happened?	☐ Yes ☐ No		**R0035**
Do you manage your personal affairs and funds?	☐ Yes ☐ No		**R0050**

Comments

RESIDENTIAL CARE ROSTER / SAMPLE MATRIX

State Form 53718 (R / 4-21)
INDIANA STATE DEPARTMENT OF HEALTH / DIVISION OF LONG-TERM CARE

| Name of facility | | | | | | | | Facility number |

Resident Number	Resident Room	Surveyor Assigned	Name of Resident	Observation	Record Review	Interview	Closed Record	Infection Control
				☐	☐	☐	☐	☐
				☐	☐	☐	☐	☐
				☐	☐	☐	☐	☐
				☐	☐	☐	☐	☐
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				☐	☐	☐	☐	☐

RESIDENTIAL CARE GENERAL OBSERVATIONS OF THE FACILITY

State Form 53721 (R / 4-21)
INDIANA STATE DEPARTMENT OF HEALTH / DIVISION OF LONG-TERM CARE

Name of facility		Facility number
Name of surveyor	Identification number of surveyor	Date of observation (month, day, year)
Potential concerns from offsite preparations		

1.	CLEANLINESS: How clean is the environment (walls, floors, drapes, furniture)?	☐ Yes ☐ No	**R0144**
2.	FURNISHINGS: Are dining, activity, and lounge areas adequately furnished?	☐ Yes ☐ No	**R0190**
3.	ODORS: Is the facility free of objectionable odors? Are resident areas well ventilated?	☐ Yes ☐ No	**R0178 / R0148**
4.	SPACE: Sufficient space to accommodate dining, activity, and lounge needs of residents without interference?	☐ Yes ☐ No	**R0190**
5.	HAZARDS: Is the facility as free of accident hazards as possible? Are water temperatures safe and comfortable? Oxygen, if available, stored safely?	☐ Yes ☐ No	**R0148 / R0153 / R0144 / R0145**
6.	CALL SYSTEM: Is there a method by which each resident may summons a staff person at any time?	☐ Yes ☐ No	**R0185**
7.	LINEN: Is clean and soiled line handled, stored, processed, and transported in a safe and sanitary manner that will prevent the spread of infection?	☐ Yes ☐ No	**R0152**
8.	EQUIPMENT (Excluding kitchen): Equipment and supplies in safe and operational condition and in sufficient quantity to meet the needs of the residents? (e.g., boiler room equipment, unit refrigerators, laundry equipment)	☐ Yes ☐ No	**R0145**
	Has the heating and ventilating system been inspected at least yearly?	☐ Yes ☐ No	**R0148**
9.	SURVEY REPORT: Is the most recent annual survey and any POC readily accessible and posted? Any subsequent surveys posted? Notice of availability posted?	☐ Yes ☐ No	**R0042**
10.	INFORMATION POSTED: Information for contacting advocacy agencies posted in an area accessible to residents and kept updated.	☐ Yes ☐ No	**R0033**
	Copy of residents' rights available in a publicly accessible area in 12-point font.	☐ Yes ☐ No	**R0026**
11.	EMERGENCY: Review the facility written fire and disaster preparedness Plan. Interview two (2) staff related to fire and disaster preparedness. Names of staff		
	Are fire drills conducted quarterly on each shift (12 drills per year)? Has the facility attempted to conduct a fire and disaster drill at least every six (6) months in conjunction with the local fire department**?**	☐ Yes ☐ No	**R0092**
12.	PESTS: Is the facility pest free?	☐ Yes ☐ No	**R0149**
13.	WASTE: Is waste contained in cans, dumpster, or compactors including contaminated waste?	☐ Yes ☐ No	**R0155**

RESIDENTIAL CARE OFFSITE SURVEY PREPARATION

State Form 53722 (R / 4-21)

INDIANA STATE DEPARTMENT OF HEALTH / DIVISION OF LONG-TERM CARE

Name of facility	Facility number

Address of facility *(number and street, city, state, and ZIP code)*

Name of ombudsman	Identification number of ombudsman	Date of ombudsman contact *(month, day, year)*

Total number of beds	Date of offsite review *(month, day, year)*	Beginning date of survey *(month, day, year)*

SURVEYOR NOTES

List potential facility areas of concern and any potential residents to be reviewed during the survey. List any current complaints to be investigated onsite.

SURVEYORS / DISCIPLINE

RESIDENTIAL CARE KITCHEN / FOOD SERVICE OBSERVATION

State Form 53723 (R / 4-21)
INDIANA STATE DEPARTMENT OF HEALTH / DIVISION OF LONG-TERM CARE

Regulatory reference: Retail Food Establishment Sanitation Requirements – 410 IAC 7-24 (* for rule number)
Health Facilities / Licensing and Operational Standards – 410 IAC 16.2-5-5.1

Surveyor must:
1. *Wear hair covering when entering kitchen.*
2. *Wash hands when first entering the kitchen. If hand washing area is blocked, observe and document.*
3. *Ask where staff washes hands when entering kitchen.*
4. *Observe one meal service. If concerns arise, observe additional meal service.*

NOTE: *An asterisk (*) denotes items of critical importance.*

Name of facility	Facility number

Name of surveyor	Identification number of surveyor	Date of observation *(month, day, year)*

Presurvey concerns

GENERAL KITCHEN (R0273 / R0191 / R0154)		
Who is in charge?		Section 94*, 96 / **R0274**
Staff is knowledgeable?	☐ Yes ☐ No	Section 96
Employee Health		Section 97*, 98*, 100*
Covered hair?	☐ Yes ☐ No	Section 115
Clean outer clothing?	☐ Yes ☐ No	Section 112
Staff appropriately groomed?	☐ Yes ☐ No	Section 105*
Hygienic Practices?	☐ Yes ☐ No	Section 113*, 114*
Hand washing?	☐ Yes ☐ No	Section 106*, 107*, 108
Kitchen equipment and structure in good repair?	☐ Yes ☐ No	Section 244-263, 362-383
Garbage cans used for food waste covered, unless in use.	☐ Yes ☐ No	Section 355
Surfaces of food prep counters, walls, floors, and ceilings clean and in good repair? Ventilation hoods?	☐ Yes ☐ No	Section 198*, 205, 362, 398
Ceiling fixtures clean and intact?	☐ Yes ☐ No	Section 370
No moisture present between stacked plates, pots, pans, or utensils?	☐ Yes ☐ No	Section 282
Cleanability of food contact surfaces?	☐ Yes ☐ No	Section 198*
Clean equipment and utensils?	☐ Yes ☐ No	Section 264*-274*
If fan used, is it free of dust build-up and is it pointed away from food prep areas?	☐ Yes ☐ No	Section 155, 370
If windows open, are screens intact?	☐ Yes ☐ No	Section 376
Cleanliness of food delivery carts? (Separation of clean / soiled trays)	☐ Yes ☐ No	Section 264
Observe how disposable/single use gloves are used.		Section 149
Trash disposal?	☐ Yes ☐ No	Section 342-361 / **R0155**
Pests?	☐ Yes ☐ No	Section 402*, 403 / **R0149**

Comments

REFRIGERATORS AND FREEZERS (R0273)			
Appropriate temperatures? Food under refrigeration 41º - 45º F, frozen food solid and free of evidence of thawing and refreezing? *Do not rely on the ambient temperatures of the refrigeration and freezers. Once the door is open and you enter the unit the temperature will rise. The temperature of the food is the important factor.*	☐ Yes	☐ No	Section 173*
Freezer temperature 0º F or below?	☐ Yes	☐ No	Section 168
Check temperature of a random sample of foods for proper holding temperatures (unless food is in cool down period).			Section 173*
Are rubber gaskets clean and intact?	☐ Yes	☐ No	Section 244
Food protected from contaminates.	☐ Yes	☐ No	Section 136-160*
Proper thawing of hazardous foods?	☐ Yes	☐ No	Section 152, 170
Egg use?	☐ Yes	☐ No	Section 127*, 128*, 140*, 161*, 181*
Check expiration dates on a sample of items (milk, yogurt, leftovers, etc.).			
What is the facility leftover food policy?			Section 138*, 174*
Comments			

RECEIVING AREA (R0156)			
Food inspected to ensure quality.	☐ Yes	☐ No	Section 117*, 125*
Food sources?	☐ Yes	☐ No	Section 118*
Comments			

STORAGE (R0154)			
Protected from contamination?	☐ Yes	☐ No	Section 136*, 137*, 140*, 141*, 145*
Food identified, if not easily recognizable.	☐ Yes	☐ No	Section 139
Ready to eat, potentially hazardous food; date and marking?	☐ Yes	☐ No	Section 174*
Check for vermin droppings behind cans and back of shelves.			Section 402*
Check for scoops in bulk storage bins.			Section 146
Are chemicals and foods separated?	☐ Yes	☐ No	Section 425*
Food in storage area clean, dry, and not exposed to splash, dust, or other contaminants.	☐ Yes	☐ No	Section 152
Comments			

DISHWASHING (R0154)

Dish wash staff knowledgeable in function of dishwasher and/or dishwashing procedures?	☐ Yes ☐ No		Section 95, 96
Observe cycle and document temperatures. (If hot water system, follows manufacturer instructions for proper temperature.)			Section 253, 254, 255, 257*, 276*
If chemical system, have staff do chemical test.			Section 257*, 259, 276*
Check for separation of clean / dirty dishes.			Section 289
Is facility following correct manual dishwashing procedures, i.e., three (3) compartment sink, correct water temperature, chemical concentration, and immersion time?	☐ Yes ☐ No		Section 224, 233, 254*, 257*
Cleaning of equipment and utensils.	☐ Yes ☐ No		Section 264*, 265

Comments

FOOD PREPARATION / SERVICE OBSERVATIONS (R0273)

Are hot foods maintained at 130º - 140º F or above and cold foods maintained at 41º - 45º F or below?	☐ Yes ☐ No		Section 173*
Food not held out of safety zone greater than four hours.	☐ Yes ☐ No		Section 175*
Is food protected from contamination? Observe to determine if food handled and processed in a manner to prevent food borne illness. Monitor critical control points through the food production cycle.	☐ Yes ☐ No		Section 136*-160
Are food contact surfaces and utensils cleaned to prevent contamination and food-borne illness?	☐ Yes ☐ No		Section 264*, 265*, 275*, 276*
If potentially hazardous food is cooked and chilled, observe for appropriate time frames and method to monitor.			Section 171 *

Comments

RESIDENTIAL CARE MEDICATION PASS

State Form 53724 (R / 4-21)
INDIANA STATE DEPARTMENT OF HEALTH / DIVISION OF LONG-TERM CARE

Name of facility			Facility number
Name of surveyor		Identification number of surveyor	Date of review *(month, day, year)*

1.	DRUG STORAGE: Are medicine, treatment cabinets or rooms appropriately always locked except when authorized personnel are present? All scheduled II drugs administered by the facility under double lock.	☐ Yes ☐ No	**R0034**
2.	MEDICATION PASS: Observe at least five (5) residents and multiple routes, if possible.		**R0241-R247**

IDENTIFIER	POUR	PASS	RECORD
Full Name of Resident	**Drug Prescription Name, Dose, and Form**	**Observation of Administration**	**Drug Order Written As** *(When different from observation)*

RESIDENTIAL CARE MEDICATION PASS *(continued)*

State Form 53724 (R / 4-21)
INDIANA STATE DEPARTMENT OF HEALTH / DIVISION OF LONG-TERM CARE

IDENTIFIER	POUR	PASS	RECORD
Full Name of Resident	**Drug Prescription Name, Dose, and Form**	**Observation of Administration**	**Drug Order Written As** *(When different from observation)*

RESIDENTIAL CARE ENTRANCE CONFERENCE CHECKLIST

State Form 53725 (R2 / 4-21)
INDIANA STATE DEPARTMENT OF HEALTH / DIVISION OF LONG-TERM CARE

Name of facility	Facility number
Date(s) of survey *(month, day, year)*	

ITEMS NEEDED WITHIN ONE (1) HOUR OF CONCLUSION OF ENTRANCE CONFERENCE

- ☐ 1. List of all residents
- ☐ 2. List of residents admitted within the past thirty (30) days
- ☐ 3. List of residents transferred or discharged during the last ninety (90) days *(Please specify destinations.)*
- ☐ 4. List of residents fifty-five (55) years old or younger
- ☐ 5. List of residents with Major Mental Illness diagnosis
- ☐ 6. Schedule of mealtimes, menus, including modified diets
- ☐ 7. List of residents who self-administer medications
- ☐ 8. Schedule of medication pass times, by unit and their locations
- ☐ 9. 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)*
- ☐ 10. Infection Control Program: to include items specified at **R0406-R0407**
- ☐ 11. List of all residents who are confirmed or suspected COVID-19 positive currently in building.
- ☐ 12. List of residents with special care needs and type (skin care, treatments, oxygen, catheters, ostomies, blood glucose testing, injections, nebulizer / aerosol treatments)
- ☐ 13. List of residents receiving contracted services and type
- ☐ 14. Waivers (CLIA)
- ☐ 15. Policy on residential admittance and continued stay at residential level: **R0001 / R0002 / R0030**
- ☐ 16. Fire Drills: **R0092**
- ☐ 17. Admission Agreement: **R0030**
- ☐ 18. Activity calendar, if used in program: **R0326-R0329**
- ☐ 19. Current Facility Floor Plan

ITEMS NEEDED WITHIN TWENTY-FOUR (24) HOURS OF ENTRANCE

- ☐ 1. Employee Records form (State Form 53877)
- ☐ 2. Staffing for one (1) week

ITEMS TO BE PROVIDED TO SURVEYORS IF REQUESTED

- ☐ 1. In-services: **R0120**
- ☐ 2. Pet Policy: **R0035 / R0150**
- ☐ 3. Resident Funds: **R0050**
- ☐ 4. Residents Rights Documentation: **R0026**

QUESTIONS TO BE ASKED OF ADMINISTRATOR AT ENTRANCE

☐	1. Room size waivers?	☐ Yes ☐ No	**R0183**
☐	2. Resident rooms below ground level?	☐ Yes ☐ No	**R0185**
☐	3. Special Care Units (i.e., Alzheimer's)?	☐ Yes ☐ No	**R0095 / R0120 / R0030**
☐	4. Name of director of Alzheimer's and dementia special care unit:		

RESIDENTIAL CARE EXIT CONFERENCE CHECKLIST AND ATTENDANCE RECORD

State Form 53739 (R / 4-21)
INDIANA STATE DEPARTMENT OF HEALTH / DIVISION OF LONG-TERM CARE

Name of facility	Facility number

☐ Reintroduce survey team members.

☐ State that this is an exit conference and identify the type of survey, i.e., annual licensure, complaint, etc. If any complaints were investigated during the survey, give the complaint numbers.

☐ Complete the information at the top of the Residential Exit Conference Record and ask that each person print their name, title, and sign their name. *(The Administrator or person in charge from facility may sign for everyone in attendance.)*

State the Following:

☐ The confidentiality of all resident will be maintained throughout this conference by using Resident identifier numbers. *(You have a copy of the identifier list for your reference.)*

☐ **For complaints only** – The confidentiality of all residents will be maintained throughout this exit conference. Because this is a complaint investigation, you will not be provided a copy of the resident identifier list. We do this inform to comply with state law IC 16-28-4-5, which requires us to protect the identity and privacy of the complainant.

☐ Thank you for your cooperation and assistance.

☐ The purpose of this exit conference is to inform you of the survey team's (my) observations and preliminary findings. If you have any question or additional information you feel is pertinent to the identified findings, please present at the end of the exit conference.

With Findings State:

☐ Review all preliminary licensure findings, by giving enough example for each area to allow the facility the ability to clearly understand the concern. If during the survey, this concern was shared with other staff, please identify who and what was shared, i.e., Food service concerns were shared with the Food Service manager in detail on *(date)*.

☐ Within ten (10) business days, the Division of Long-Term Care will e-mail you a message direction you to the ISDH Survey Report System. The following can be reviewed on the ISDH Gateway.
- The survey report (2567) that contains the written official deficiencies.
- Guidelines for writing an acceptable Plan of Correction; due date of the Plan of Correction, which must be after the survey exit date. The Plan of Correction is the day you expect to have all the deficiencies corrected. Some deficiencies should be corrected immediately or as soon as possible. It is suggested the deficiencies be corrected within thirty (30) days.
- Information regarding the Informal Dispute Resolution (IDR).

☐ Are there any questions or additional information you would like to provide for review?

Without Findings State:

☐ Within ten (10) business days, the Division of Long-Term Care will e-mail you a message direction you to the ISDH Survey Report System. The survey report 2567 and corresponding letter stating you are in substantial compliance can be viewed on the ISDH Gateway.

RESIDENTIAL CARE EXIT CONFERENCE ATTENDANCE RECORD

Part of State Form 53739 (R / 4-21)
INDIANA STATE DEPARTMENT OF HEALTH / DIVISION OF LONG-TERM CARE

Name of facility	Facility number

Address of facility *(number and street, city, state, and ZIP code)*

Date *(month, day, year)* and time of exit conference	Ombudsman present? ☐ Yes ☐ No	Resident(s) present? ☐ Yes ☐ No

PRINTED NAME OF ATTENDEE	TITLE	SIGNATURE

AREAS OF CONCERN COMMUNICATED TO THE FACILTIY

QUESTIONS / CONCERNS

RESIDENTIAL CARE EMPLOYEE RECORDS

State Form 53877 (R3 / 4-21)
INDIANA STATE DEPARTMENT OF HEALTH / DIVISION OF LONG-TERM CARE

Name of facility	
Facility number	Date *(month, day, year)*

FACILITY COMPLETES COLUMNS A, B, AND C. MAKE ADDITIONAL COPIES AS NEEDED. Include all contractual consultants.

A. FULL NAME	B. JOB TITLE	C. START DATE (mm/dd/yyyy)		D. LICENSE OR CERT.	E. PRE-EMPLOYMENT SCREENING		F. HEALTH SCREEN	G. TB TEST				H. ORIENT.		I. JOB DESC.	J. TRAINING NEW HIRE / ANNUAL	
					Criminal	References		1st Step	2nd Step	Chest X-ray	Annual Risk Assessment	General	Specific		Resident Rights	Dementia
1.	Administrator															
2.	Licensed Nurse															
3.	Beautician															
4.	Pharmacist															
5.	Dementia Care Director															
6.	Registered Dietician															
7.	Activity Director															
8.																
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RESIDENTIAL CARE EMPLOYEE RECORDS *(continued)*
State Form 53877 (R3 / 4-21)
INDIANA STATE DEPARTMENT OF HEALTH / DIVISION OF LONG-TERM CARE

FACILITY COMPLETES COLUMNS A, B, AND C. MAKE ADDITIONAL COPIES AS NEEDED. Include all contractual consultants.

A. FULL NAME	B. JOB TITLE	C. START DATE (mm/dd/yyyy)	D. LICENSE OR CERT.	E. PRE-EMPLOYMENT SCREENING Criminal	References	F. HEALTH SCREEN	G. TB TEST 1st Step	2nd Step	Chest X-ray	Annual Risk Assessment	H. ORIENT. General	Specific	I. JOB DESC.	J. TRAINING NEW HIRE / ANNUAL Resident Rights	Dementia
23.															
24.															
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31.															
32.															
33.															
34.															
35.															

CPR CERTIFIED							
Week of:	Sunday	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday
First Shift							
Second Shift							
Third Shift							

FIRST AID CERTIFIED							
Week of:	Sunday	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday
First Shift							
Second Shift							
Third Shift							

RESIDENTIAL CARE INFECTION CONTROL

State Form 57102 (4-21)
INDIANA STATE DEPARTMENT OF HEALTH / DIVISION OF LONG-TERM CARE

Name of facility		Facility number
Name of surveyor	Identification number of surveyor	Date of observation *(month, day, year)*
Potential concerns from offsite preparations		

Coordination

Each surveyor is responsible for assessing the facility for breaks in infection control.
Sample residents / staff as follows:

- Sample three (3) staff; include at least one (1) staff member who was confirmed COVID-19 positive or had signs or symptoms consistent with COVID-19 (if this has occurred in the facility), for purposes of determining compliance with infection prevention and control national standards such as exclusion from work, as well as screening, and reporting.
- Sample three (3) residents for purposes of determining compliance with infection prevention and control national standards such as transmission-based precautions, as well as resident care, screening, and reporting. Include at least one resident who was confirmed COVID-19 positive or had signs or symptoms consistent with COVID-19 (if any).

Infection Surveillance

The facility must establish and infection control program that includes:

- A system that enables the facility to analyze patterns of known infection symptoms.
- Provides orientation and in-service on infection prevention and control.
- Offers Health information to residents, including, but not limited to, infection transmission and immunizations.
- Reporting communicable disease to public health authorities.
- The plan includes ongoing analysis of surveillance data and review of data and documentation of follow-up activity in response.
- Interview appropriate staff to determine if infection control concerns are identified, reported, and acted upon.

Did the facility establish an infection control program that included, but was not limited to, the above information?	☐ Yes ☐ No	**R0407**

COVID-19 Focus

- The facility has a screening process to ensure all staff must complete prior to or at the beginning of their shift that reviews for signs/symptoms of illness and must include whether fever is present. The facility is documenting staff with signs/symptoms (e.g., fever) of communicable illness including, but not limited to, COVID-19 according to their surveillance plan.
- Interview staff to determine what the screening process is, if they have had signs/symptoms of COVID-19 during the screening process, who they discussed their positive screening with at the facility and what actions were taken (e.g., work exclusion, COVID-19 testing).
- Follows current guidance about returning to work.
- Visitation is conducted according to residents' rights for visitation and in a manner that does not lead to transmission of COVID-19; and has instructs those visiting on Infection Control Practices.
- Signage posted at facility entrances for screening and restrictions as well as a communication plan to alert visitors of new procedures/restrictions.
- Residents on transmission-based precautions are restricted to their rooms except for medically necessary purposes. If these residents must leave their room, they are wearing a facemask or cloth face covering, performing hand hygiene, limiting their movement in the facility, and performing social distancing (efforts are made to keep them at least 6 feet away from others).
- The facility ensures only COVID-19 negative, and those not suspected or under observation for COVID-19, participate in group outings, group activities, and communal dining. The facility is ensuring that residents are maintaining social distancing (e.g., limited number of people in areas and spaced by at least 6 feet), performing hand hygiene, and wearing face coverings.
- The facility has a plan (including appropriate placement and PPE use) to manage residents that are new/readmissions, or are diagnosed with COVID-19, following current CDC guidance and state (e.g., CDC), state and/or local public health authority recommendations.
- For residents who need to leave the facility for care (e.g., hospital transfer, dialysis, etc.), the facility notifies the transportation and receiving health care team of the resident's suspected, observation, or confirmed COVID-19 status.

Did the facility establish an infection control program that included, but was not limited to, perform appropriate screening of staff and visitors, and follow current standards of Infection control practices for COVID-19?	☐ Yes ☐ No	**R407**

Suspected or Confirmed COVID-19 Reporting to Residents, Representatives, and Families

- Identify the mechanism(s) the facility is using to inform residents, their representatives, and families (e.g., newsletter, e-mail, website, recorded voice message) and ensure the notification follows state guidelines, and ensure notifications are timely.

Did the facility inform residents, their representatives, and families of suspected or confirmed COVID-19 cases in the facility along with mitigating actions in a timely manner?	☐ Yes ☐ No	**R036**

Standard and Transmission-Based Precautions (TBPs)

Surveyors should not cite facilities for not having certain supplies (e.g., Personal Protective Equipment (PPE) such as gowns, N95 respirators, surgical masks) if they are having difficulty obtaining these supplies for reasons outside of their control. However, facilities are expected to take actions to mitigate any resource shortages and show they are taking all appropriate steps to obtain the necessary supplies as soon as possible.

Hand Hygiene

- Appropriate hand hygiene practices (i.e., alcohol-based hand rub (ABHR) or soap and water) are followed.
- Staff wash hands with soap and water when their hands are visibly soiled (e.g., blood, body fluids), or after caring for a resident with known or suspected C. difficile infection (CDI) or norovirus during an outbreak.
- Staff perform hand hygiene (even if gloves are used) in the following situations:
  1. Before and after contact with the resident.
  2. After contact with blood, body fluids, or visibly contaminated surfaces.
  3. After contact with objects and surfaces in the resident's environment.
  4. After removing personal protective equipment (e.g., gloves, gown, eye protection, facemask); and
- When being assisted by staff, resident hand hygiene is performed after toileting and before meals. How are residents reminded to perform hand hygiene?
- Interview appropriate staff to determine if hand hygiene supplies (e.g., ABHR, soap, paper towels) are readily available and who they contact for replacement supplies.

Did the staff wash their hands as indicated by professional standards?	☐ Yes ☐ No	**R0414**

Personal Protective Equipment (PPE) Use for Standard Precautions and Transmission-Based Precautions

Determine if staff appropriately use and discard PPE including, but not limited to, the following:
- All staff are wearing appropriate PPE as indicated by CDC and state guidance.
- Gloves are worn if potential contact with blood or body fluid, mucous membranes, or non-intact skin, and are removed after use and hand hygiene performed.
- An isolation gown is worn for direct resident contact if the resident has uncontained secretions or excretions (e.g., changing a resident and their linens when excretions would contaminate staff clothing).
- Appropriate mouth, nose, and eye protection (e.g., facemasks, goggles, face shield) along with isolation gowns are worn for resident care activities for procedures that are likely to contaminate mucous membranes, or generate splashes or sprays of blood, body fluids, secretions, or excretions.
- PPE is appropriately discarded after resident care, prior to leaving room (except in the case of extended use of PPE per national and/or local recommendations), followed by hand hygiene.
- During the COVID-19 public health emergency, PPE use is extended/reused in accordance with national and/or local guidelines. If reused, PPE is cleaned/decontaminated/maintained after and between uses; and
- Supplies necessary for adherence to proper PPE use (e.g., gloves, gowns, masks) are readily accessible in resident care areas (e.g., nursing units, therapy rooms).
- Interview appropriate staff to determine if PPE supplies are readily available, accessible, and used by staff, and who they contact for replacement supplies.

Did the facility follow infection control practice designed to provide a safe, sanitary, and comfortable environment and help prevent the development and transmission of disease and infection?	☐ Yes ☐ No	**R406 (offense)**

Transmission-Based Precautions (TBP)

Determine if appropriate transmission-based precautions are implemented, including but not limited to:
- Signage on the use of specific PPE (for staff) is posted in appropriate locations in the facility (e.g., outside of a resident's room, wing, or facility-wide).
- Observe staff to determine if they use appropriate infection control precautions when moving between resident rooms, units, and other areas of the facility.
- Interview appropriate staff to determine if they are aware of processes/protocols for transmission-based precautions and how staff are monitored for compliance, including, but not limited to, sanitizing surfaces and reusable equipment.

Did the staff implement appropriate Infection control practices?	☐ Yes ☐ No	**R406 / R0413**