

**BUREAU OF SURVEY AND CERTIFICATION  
RESIDENTIAL CARE FACILITY (RCF)  
ENTRANCE AND MANAGEMENT AUDIT CHECKLIST**

Facility Name:		Licensure Number:	
Survey Entrance Date:		Survey Exit Date:	
Surveyor(s):			

<input type="checkbox"/>	Census with room numbers. <b>(R034)</b>	
<input type="checkbox"/>	Floor plan with room numbers.	<input type="checkbox"/> Any physical changes since last survey? <b>(R030)</b>

**Identification of Services:**

<input type="checkbox"/>	Medication administration <b>(R335, R336, R337)</b>	Med pass times: _____
<input type="checkbox"/>	Supervision of therapeutic diets <b>(R550, R562, R566)</b>	
<input type="checkbox"/>	Dressings <b>(R350)</b>	
<input type="checkbox"/>	Tube feedings <b>(R508)</b>	
<input type="checkbox"/>	Skilled care beyond exempted skilled cares <b>(R502-R507)</b>	
<input type="checkbox"/>	Special Care Unit 3701-17-50 (II) <b>(R305, R315)</b>	
<input type="checkbox"/>	Animals/pets <b>(R369)</b>	
<input type="checkbox"/>	Resident rooms locks/keys <b>(R678)</b>	
<input type="checkbox"/>	Adult day care on-site <b>(R124)</b>	
<input type="checkbox"/>	Any volunteers > 10 hrs. per month	
<input type="checkbox"/>	Admits residents with late stage cognitive impairment (w/ADL, emotional, or behavior issues) or serious mental illness	<input type="checkbox"/> Needs met by private physician or psychologist (or experienced physician on staff or consultant basis <b>(R105)</b> )

**Required Information:**

<input type="checkbox"/>	Admission packet, including resident agreement <b>(R302, R303, R304)</b>
<input type="checkbox"/>	List of residents with risk agreements <b>(R306, R307)</b>
<input type="checkbox"/>	List of residents who were given discharge notices <b>(R770, R771, R772)</b>
<input type="checkbox"/>	Activity calendar <b>(R360)</b> <input type="checkbox"/> Local newspaper <b>(R360)</b> <input type="checkbox"/> Transportation information <b>(R360)</b>
<input type="checkbox"/>	Resident funds (i.e., surety bond, written authorizations, five (5) accounts since last survey).
<input type="checkbox"/>	Meal times. _____
<input type="checkbox"/>	Copies of the current week's menus and spreadsheet for day of survey <b>(R561, R566)</b>
<input type="checkbox"/>	Incident log since last annual inspection <b>(R391, R802)</b>
<input type="checkbox"/>	Monthly self inspection for fire safety <b>(R624)</b>
<input type="checkbox"/>	Fire and disaster drill reports for past twelve (12) months <b>(R614-R618)</b>
<input type="checkbox"/>	State Fire Marshal's most recent report <b>(R803)</b>
<input type="checkbox"/>	Transfer agreement <b>(R630)</b>
<input type="checkbox"/>	Inspection report of the central heating system <b>(R660)</b>
<input type="checkbox"/>	Staffing schedules for previous week <b>(R102-R113)</b>
<input type="checkbox"/>	Employee personnel files (i.e., administrator, four (4) new employees, two (2) long term employees).
<input type="checkbox"/>	Criminal background check log <b>(R098)</b>
<input type="checkbox"/>	Grievance Committee Information <b>(R701)</b>
<input type="checkbox"/>	Evidence that facility checked new admissions since September 2014 in the sex offender and child-victim offender database <b>(R301)</b>
<input type="checkbox"/>	TB control plan and facility's TB risk assessment <b>(R400)</b>
<input type="checkbox"/>	Infection Control Designee <b>(R399)</b>

Comments/Remarks/Observations:

BUREAU OF SURVEY AND CERTIFICATION  
 RESIDENTIAL CARE FACILITY (RCF)  
 RESIDENT ACCOUNT CHECKLIST

Facility Name: <input style="width: 95%;" type="text"/>	Licensure Number: <input style="width: 95%;" type="text"/>
Survey Entrance Date: <input style="width: 95%;" type="text"/>	Survey Exit Date: <input style="width: 95%;" type="text"/>
Surveyor(s): <input style="width: 95%;" type="text"/>	

Resident Identifier	Witnessed Authorization <b>(R362)</b>	Deposited in Interest Bearing Account <b>(R363)</b>	Accounting of Receipts and Expenditures <b>(R362)</b>	Final Disbursal <b>(R365)</b>

<input style="width: 95%;" type="text"/>	Surety Bond <b>(R364)</b>
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Comments/Remarks/Observations:

**BUREAU OF SURVEY AND CERTIFICATION  
RESIDENTIAL CARE FACILITY (RCF)  
ENVIRONMENT WORKSHEET**

Facility Name:		Licensure Number:	
Survey Entrance Date:		Survey Exit Date:	
Surveyor(s):			

**General Environment:**

		Buildings and grounds in good condition <b>(R661, R680)</b>
		Clean and safe; floors and rugs in good condition <b>(R661, R674, R710)</b>
		Safe and comfortable temperature/humidity levels <b>(R690, 691)</b>
		Safe storage of poisons and hazardous materials <b>(R677)</b>
		Effective pest control <b>(R661)</b>
		Accessible first aid kit <b>(R679)</b>
		Required posted information:
		RCF License <b>(R032)</b>
		Floor plans on each section with evacuation/fire safety features <b>(R619)</b>
		Resident rights <b>(R704)</b>
		Availability of rules/regulations <b>(R704)</b>
		Notice of availability or actual results of licensure survey results <b>(R704)</b>
		List of resident rights advocates <b>(R704)</b>
		Corridors, exits and pathways free of obstacles <b>(R675)</b>
		Common areas and exits well lighted <b>(R676)</b>
		Dining room availability <b>(R650)</b>
		Smoking and "No Smoking" signs <b>(R627)</b>
		Nonflammable waste baskets in common areas <b>(R672)</b>
		Ashtrays in smoking areas <b>(R627)</b>
		Non-pay telephone for private, local calls <b>(R673)</b>
		Emergency telephone numbers available for phones provided by the facility <b>(R681)</b>
		Carbon monoxide detectors or alarms <b>(R625, R626)</b>
		Laundry:
		Separation of clean and soiled laundry <b>(R393)</b>
		Linens handled to maintain infection control <b>(R393)</b>
		Dryer free of lint build up <b>(R370)</b>

Comments/Remarks/Observations:

**Bathroom**

	Clean and sanitary facility and equipment <b>(R651)</b>
	Call system <b>(R645)</b>
	Equipped with soap and toilet paper <b>(R654, R658)</b>
	Accommodation for privacy in multiple use bathrooms <b>(R652)</b>
	Safety features non-skid surfaces, grab bars <b>(R656)</b>
	Hot water temperature (105 - 120 degrees) <b>(R657)</b>
	Plumbing fixtures free of leakage and odors <b>(R602)</b>

Comments/Remarks/Observations:

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**Resident Rooms:**

	Clean and safe <b>(R661)</b>
	Adequate furnishings and resident care equipment <b>(R648)</b>
	Call system in resident room and toilet room <b>(R645)</b>
	Clean bed linens <b>(R663)</b>
	Hot water temperature (105-120 degrees) <b>(R657)</b>

Comments/Remarks/Observations:

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BUREAU OF SURVEY AND CERTIFICATION  
 RESIDENTIAL CARE FACILITY (RCF)  
 MEDICATION PASS WORKSHEET

Facility Name: <input style="width: 95%;" type="text"/>	Licensure Number: <input style="width: 95%;" type="text"/>
Survey Entrance Date: <input style="width: 95%;" type="text"/>	Survey Exit Date: <input style="width: 95%;" type="text"/>
Surveyor(s): <input style="width: 95%;" type="text"/>	

MEDICATION PASS

RCF Residents ID	Room No.	Medications	Observation	Order verified
		Document in field below		
		Document in field below		
		Document in field below		
		Document in field below		

Add Resident

<input type="checkbox"/>	Privacy/confidentiality maintained. <b>(R719, R720)</b>
<input type="checkbox"/>	Medications given as ordered. <b>(R339)</b>
<input type="checkbox"/>	Medications properly stored. <b>(R344)</b>
<input type="checkbox"/>	Prescription medications properly labeled. <b>(R345)</b>
<input type="checkbox"/>	Over-the-counter medications properly labeled. <b>(R345)</b>

Comments/Remarks/Observations:

BUREAU OF SURVEY AND CERTIFICATION  
RESIDENTIAL CARE FACILITY (RCF)  
DIETARY SERVICES WORKSHEET

Facility Name: <input style="width: 95%;" type="text"/>	Licensure Number: <input style="width: 95%;" type="text"/>
Survey Entrance Date: <input style="width: 95%;" type="text"/>	Survey Exit Date: <input style="width: 95%;" type="text"/>
Surveyor(s): <input style="width: 95%;" type="text"/>	

**DIETARY SERVICES**

<input type="checkbox"/>	Food service operation license. <b>(R558)</b>
<input type="checkbox"/>	Clean and sanitary food storage/preparation/distribution practices. <b>(R559)</b>
<input type="checkbox"/>	Food temperatures - Hot _____ Cold _____
<input type="checkbox"/>	Refrigerator temperatures _____ Freezer Temperatures _____
<input type="checkbox"/>	Dishwasher and 3-sink sanitation. <b>(R563, R559)</b>
<input type="checkbox"/>	Adequate staple and perishable food supplies. <b>(R560)</b>
<input type="checkbox"/>	Menus planned one week in advance. <b>(R561)</b>
<input type="checkbox"/>	A record of meals served, including substitutions, is maintained for three months. <b>(R561)</b>
<input type="checkbox"/>	Special diet menus include specific foods and meal patterns. <b>(R562, R566)</b>
<input type="checkbox"/>	Special diets are prepared and offered as ordered. <b>(R566)</b>
<input type="checkbox"/>	Home style service provided in a manner to prevent contamination. <b>(R559)</b>
<input type="checkbox"/>	Staff hand washing facilities available. <b>(R563)</b>
<input type="checkbox"/>	Garbage/refuse disposal in leak proof containers with lids. <b>(R557, R563)</b>
<input type="checkbox"/>	Correct intervals between meals. <b>(R551)</b>
<input type="checkbox"/>	Accessible, safe drinking water. <b>(R552)</b>

**Dietitian Services:**

<input type="checkbox"/>	Plan, direct, and implement dietary services. <b>(R567)</b>
<input type="checkbox"/>	Provide staff training. <b>(R567, R568)</b>
<input type="checkbox"/>	Therapeutic diets - monitor and evaluate on an ongoing basis. <b>(R567)</b>
<input type="checkbox"/>	Evaluate enteral tube feedings. <b>(R508)</b>
<input type="checkbox"/>	Dietitian required. <b>(R109)</b>

Comments/Remarks/Observations:

**BUREAU OF SURVEY AND CERTIFICATION  
RESIDENTIAL CARE FACILITY (RCF)  
FIRE SAFETY WORKSHEET**

Facility Name:	Licensure Number:
Survey Entrance Date:	Survey Exit Date:
Surveyor(s):	

- |  |                                                                                                                    |
|--|--------------------------------------------------------------------------------------------------------------------|
|  | Review State Fire Marshall's annual inspection report. <b>(R606, R803)</b>                                         |
|  | Review monthly Fire Safety - Self Inspection Form. <b>(R607, R624)</b>                                             |
|  | Identify employee(s) who attended fire prevention training course. <b>(R622)</b>                                   |
|  | Incident of fire reported. <b>(R629)</b>                                                                           |
|  | Alarm transmission/receipt confirmed within 12 hours of coded announcement (9P-6A), where applicable <b>(R614)</b> |

Enter date and type of drill: Fire (F) or Disaster (D) **(R614-R618)**

Shift	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec
<b>Day:</b>												
• alarm activated												
• resident evacuation												
• evaluation of drill												
<b>Evening:</b>												
• alarm activated												
• resident evacuation												
• evaluation of drill												
<b>Night:</b>												
• alarm activated												
• resident evacuation												
• evaluation of drill												

Comments/Remarks/Observations:

BUREAU OF SURVEY AND CERTIFICATION  
RESIDENTIAL CARE FACILITY (RCF)  
Personnel Files

Facility Name:		Licensure Number:	
Survey Entrance Date:		Exit Date:	Surveyor(s):

<b>Employee Name (or ID)</b>						
1st Day Worked						
<b>Physical Examination (R122)</b>						
A) 30 days before 1st day of work.						
B) On 1st day of work.						
<b>Mantoux Testing (R400)</b>						
A) Initial 2-step (2nd step 21 days).						
B) 1 Step Results prior to work.						
C) Annual						
D) Chest film (if applicable).						
<b>Staff Training (R126-R139)</b>						
A) First Aid (w/in 60 days of hire) (R126)						
B) Training/Personal Care (R127)						
Meets one of the following before unsupervised:						
1. Techniques (observational, communication, interpersonal skills) by RN-LPN						
2. State Tested Nurse Aide						
3. Home Health Aide-Meets Medicare Requirements						
C) Specialty Training for... (R128-132)						
1. Cognitive Impairment (R128)						
2. Serious Mental Illness (R129)						
3. CI and SMI (R130)						
4. Other populations						
a. 2 hrs of special training w/in 14 days (R131)						
b. 4 hrs relevant continuing ed annually (R132)						
<b>Written Acknowledgments (R702, R703)</b>						
A) Bill of Rights						
B) Facility Policy/Procedure						
C) Transfer/Discharge Resident Provisions						
D) Address/Phone # of State/ Local Health Board and Dept. of Aging Ombudsman, also State and County Human Services						
<b>Orientation Within 3 days of employment (R137)</b>						
A) Physical Layout						
B) Job Responsibilities						
C) Attaining Emergency Assistance						

<b>Employee Name (or ID)</b>						
D) Home Policies/Procedures						
E) Resident Rights						
F) Fire Control						
G) Evacuation Procedures						
<b>Criminal Background Log (R090-R098)</b>						
<b>Professional Licenses/Nurse Aide Registry Checks</b>						
Check for Abuse, Neglect, Misappropriation, Exploitation <b>(R140)</b>						
Staff member has current professional license (e.g., RN, LPN, etc.) when functioning in a professional capacity <b>(R138)</b>						

Comments/Remarks/Observations:

BUREAU OF SURVEY AND CERTIFICATION  
RESIDENTIAL CARE FACILITY (RCF)  
RESIDENT RECORD REVIEW WORKSHEET

Facility Name: <input style="width: 95%;" type="text"/>	Licensure Number: <input style="width: 95%;" type="text"/>
Survey Entrance Date: <input style="width: 95%;" type="text"/>	Survey Exit Date: <input style="width: 95%;" type="text"/>
Surveyor(s): <input style="width: 95%;" type="text"/>	
Resident Name: <input style="width: 95%;" type="text"/>	Identifier: <input style="width: 95%;" type="text"/>
	Room No: <input style="width: 95%;" type="text"/>
Date of Admission: <input style="width: 95%;" type="text"/>	Emergency contact noted <b>(R390)</b> : <input type="checkbox"/> Yes <input type="checkbox"/> No

**Health Assessment**

Medical Diagnosis (include date):	<input style="width: 95%;" type="text"/>
Annual - updated medical diagnosis (include date):	<input style="width: 95%;" type="text"/>

*Annual Assessment not applicable - Resident resided in facility less than 1 year* -

	Initial Assessment Date (R311, R312)	Annual Assessment Date (R313)
Psychological history:		N/A
Health history/physical:		N/A
* cognitive functioning		N/A
* sensory/physical impairments		N/A
Developmental diagnosis		N/A
Changes in diagnoses	N/A	
Prescription medications, OTC, dietary suppl.		
Dietary requirements and allergies		
Annual updated dietary requirements		
Height and weight		
Functional assessment		
Type of care or services		
Skilled services/impact on personal care		
Self-administration evaluation		
Falls Assessment		
For medical, psychological, developmental or intellectual impairment, assessment includes a: <ul style="list-style-type: none"> <li>· plan for addressing needs;</li> <li>· physical environment and design features to support needs; and</li> <li>· increased supervision due to decreased safety awareness or other condition</li> </ul>		

Comments/Remarks/Observations:

<b>Medication Documentation</b>	
	List of medications <b>(R348)</b>
	Refusals of medications documented <b>(R338)</b>
	Physician notified of undesirable medication effects <b>(R340)</b>
	Telephone orders <b>(R338)</b>

Comments/Remarks/Observations:

**Skilled Nursing Care (3701-16-09.1[B])**

<input type="checkbox"/> Resident has not received skilled nursing care.	
	Evaluation by nurse and documentation in record every seven (7) days <b>(R504)</b>
	Application of dressings; document all applications and evaluate every 7 days <b>(R350)</b>
	Observation of dressing change
	Notification of dietitian and physician of significant weight change <b>(R566, R567)</b>

**Skilled Nursing Care > 120 Days (3701-16-09.1[D]) - (R333)**

Written agreement between facility and	
	<ul style="list-style-type: none"> <li>• resident and/or sponsor; and</li> <li>• physician (or LHP); and/or</li> <li>• skilled nursing care provider; and/or</li> <li>• hospice care provider</li> </ul>
Signed statement by all parties	
	<ul style="list-style-type: none"> <li>• RCF, physician, and/or skilled care provider determine needs can be met at facility</li> <li>• Individual can be retained, dependent on periodic redeterminations</li> <li>• Redeterminations shall not exceed 30 days or (15 days for Hospice)</li> <li>• Physician determined skilled nursing needs are "routine"</li> <li>• If hospice, individual was given opportunity choose program that best fits their needs</li> </ul>

Comments/Remarks/Observations:

**Special and Supervised Therapeutic Diets**

<input type="checkbox"/> Resident is not on a special or therapeutic diet	
	Dietitian monitors resident nutrition intake and acceptance of diet <b>(R567)</b>
	Adjust nutrition assessment and diet, weight <b>(R566, R567)</b>
	Monitor resident weight and acceptance of diet <b>(R566, R567)</b>

Comments/Remarks/Observations:

**Other Documentation**

	Fire safety assessment and education <b>(R621, R623)</b>
	Notification of sponsor of condition change or change of interventions <b>(R390)</b>
	Incidents presenting risk to resident and/or requiring interventions are documented <b>(R391)</b>
	Risk agreement <b>(R306, R307)</b>

Comments/Remarks/Observations:

Sign & Lock