



# INITIAL SURVEY PROTOCOL

State Form 55350 (R / 7-21)  
INDIANA DEPARTMENT OF HEALTH

Facility number

## PROVIDE TO FACILITY UPON ENTRANCE

Check when facility returns.

- |  |   |
|--|---|
| <input type="checkbox"/> Application for Medicaid / Medicare (CMS 671)       | <input type="checkbox"/> Employee Listing                   |
| <input type="checkbox"/> Roster Sample Matrix                                | <input type="checkbox"/> Bed Inventory (State Form 4332)    |
| <input type="checkbox"/> Resident Census and Condition of Resident (CMS 672) | <input type="checkbox"/> Facility Census (State Form 51296) |

## REQUEST FROM FACILITY UPON ENTRANCE

Check when received from facility.

- |   |   |  |
|---|---|--|
| <input type="checkbox"/> Facility Floor Plan              | <input type="checkbox"/> Admissions Packet                              | <input type="checkbox"/> Medication Pass Times |
| <input type="checkbox"/> List of Residents by Room Number | <input type="checkbox"/> Nurse Staffing for Current Two Week Pay Period | <input type="checkbox"/> Meal Times            |
| <input type="checkbox"/> Policy and Procedure Manual      |   |  |

Name of resident council president

Name of person with whom to discuss abuse and reporting reasonable suspicion of a crime

Name of person with whom to discuss quality assessment and assurance

Name of person with whom to discuss infection control, including influenza / pneumococcal immunizations

- |  |                              |                             |
|--|------------------------------|-----------------------------|
| Are there any special units?   | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Is there any experimental research?  | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Are there any variances for more than four (4) residents per room?         | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Are there any variances for less than the required square footage?         | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Are there any rooms below ground level?                                    | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Is there at least one outside window in each resident room?                | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Is there a nurse aide and/or a qualified medication aide training program? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |

## SURVEY TASKS

- Tour the facility.
- Meet the residents.
- Observe a medication pass.
- Assess the environment.
- Assess dietary sanitation.
- Observe a meal service.
- Review the facility's program for reporting a reasonable suspicion of a crime as part of the Abuse Prohibition Protocol.
- Review employee files; check license and certifications on all applicable staff.
- Review quality assessment and assurance
- Follow Table 1 in the SOM (Survey Procedures for Long Term Care facilities – Resident Sample Selection) to determine comprehensive / focus reviews / closed records and interviews
- Attempt a group interview if the census is over four (4) residents.
- Review the infection control protocol.
- Complete the contract and service agreement checklist.  
Review the contracts to ensure the facility has informed the business of their abuse policy and the requirements for reporting a reasonable suspicion of a crime. Ensure there is a contract for each service they provide. If they have no resident receiving dialysis, they would not need to have a contract.