New Jersey Department of Health
Medical Day Care Assessment and Survey
EXIT CONFERENCE GUIDE

CONFIDENTIAL

Facility Name		Facility ID
Medicaid Provider Number	Date	Time

Facility Staff Attended?

☐ Yes ☐ No

If Yes, List: _____

_____

_____

Facility provided additional information upon request?

☐ Yes ☐ No

If Yes, List: _____

_____

_____

☐ Facility was provided with a list of sample residents (names and identifiers only).

☐ Summarize survey protocols and decision making and purpose of the Exit Conference (5 minutes).

☐ Systematically describe specific deficiencies, one regulatory area at a time with substantiating evidence.

Comments/ Def.	Tag No.	Issues
C / D		
C / D		
C / D		
C / D		
C / D		
C / D		
C / D		
C / D		
C / D		
C / D		

Medical Day Care Assessment and Survey
EXIT CONFERENCE GUIDE
(Continued)

Comments/ Def.	Tag No.	Issues
C / D		
C / D		
C / D		
C / D		
C / D		

☐ Maintain resident confidentiality.

☐ Use understandable language that avoids medical terminology and regulatory jargon (okay to use tag numbers but describe deficiency also).

☐ Notify the facility formally if there is an Immediate Jeopardy, Curtailment of Admissions or other special situations (if applicable).

☐ Inform the facility that they will receive the Statement of Deficiencies (SOD) via email within ten days and they will have ten days in which to respond (via email) with an acceptable Plan of Correction (POC).

☐ Describe the elements of an acceptable POC. Explain to the facility the importance of accurate completion dates.

Facility questions/concerns:

_____

_____

_____

_____

Signature of Team Leader below indicates that the above steps were completed as described.

Name of Team Leader (Print)	Signature of Team Leader

Signature of Administrator (or alternate) below indicates that the above items were completed as described. It does not indicate agreement with any deficiencies identified.

Name of Administrator (Print)	Signature of Administrator