NEW YORK STATE DEPARTMENT OF HEALTH
BUREAU OF LONG TERM CARE SERVICES

Facility Survey Report

General Instructions

All facilities are required to submit the attached Facility Survey Report (FSR) to the New York State Department of Health in accordance with Article 28 of the Public Health Law and Part 412 of the Medical Facilities Code of Department regulations (10 NYCRR 412).

This form will be used as a data source document for certification of compliance with Article 28 of the Public Health Law and/or Title(s) XVIII and XIX of the Social Security Act.

The report period covered by this form shall be for the period from the first day of the certification survey to the last day prior to a current survey.

Please note that the Facility Survey Report is a single omnibus form which applies to all government, voluntary, and proprietary nursing homes.

The following specific instructions are to be followed

KEEP A BLANK MASTER FSR AND MAKE COPIES AS NEEDED.

1. Complete the facility name and permanent facility identifier (PFI) on page 3 and the facility name on each subsequent page. By the end of the first day of the survey be prepared to give the Team Leader a copy of your current FSR.

2. Providers of Title XVIII and/or XIX services are to complete the enclosed federal forms requested on page three of the report. These forms will be given to you by the Team Leader during the Entrance Conference. The completed forms are to be given to the Team Leader at the end of the survey.

3. Answer ALL questions.

4. Where regulation mandates specific committee composition, the required representation has been indicated in the questions on committee structure. Please supply the name of the committee member for each mandated position. Additional members (if any) are to be included by name and position.

5. In questions 6 through 27, the expiration date requested is the expiration date of the certification, licensure or registration of the licensee, whichever is applicable.

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FACILITY NAME:

FACILITY SURVEY REPORT

CERTIFICATION SHEET

THE FOLLOWING STATEMENTS MUST BE READ AND A CERTIFICATION OF SUCH BE SIGNED BY THE OPERATOR OR ADMINISTRATOR FOR THE APPROPRIATE OWNERSHIP CATEGORY. PLEASE ENTER ONLY ONE SIGNATURE. CARE SHOULD BE EXERCISED SO THAT THE DATE, SIGNATURE, AND TITLE OF THE RESPONSIBLE INDIVIDUAL APPEARS UNDER THE CORRECT SPONSORSHIP (OWNERSHIP) CATEGORY.

CERTIFICATION STATEMENT

MISREPRESENTATION OR FALSIFICATION OF ANY INFORMATION CONTAINED IN THIS FORM MAY BE PUNISHABLE BY FINE AND/OR IMPRISONMENT UNDER NEW YEAR STATE LAW.

CERTIFICATION OF OPERATOR

PROPRIETARY FACILITIES
I HEREBY CERTIFY THAT I HAVE READ THE ABOVE STATEMENT AND THAT THE INFORMATION FURNISHED IN THIS DOCUMENT IS TRUE AND CORRECT TO THE BEST OF MY KNOWLEDGE.

DATE   SIGNATURE OF OPERATOR (PRINCIPAL PARTNER OR PRINCIPAL OFFICER OF CORPORATION) OR ADMINISTRATOR

VOLUNTARY FACILITIES
I HEREBY CERTIFY THAT I HAVE READ THE ABOVE STATEMENT AND THAT THE INFORMATION FURNISHED IN THIS DOCUMENT IS TRUE AND CORRECT TO THE BEST OF MY KNOWLEDGE.

DATE   SIGNATURE OF PRINCIPAL OFFICER OR ADMINISTRATOR

TITLE

GOVERNMENTAL FACILITIES
I HEREBY CERTIFY THAT I HAVE READ THE ABOVE STATEMENT AND THAT THE INFORMATION FURNISHED IN THIS DOCUMENT IS TRUE AND CORRECT TO THE BEST OF MY KNOWLEDGE.

DATE   SIGNATURE OF COMMISSIONER OR ADMINISTRATIVE OFFICER
FACILITY NAME:

NEW YORK STATE DEPARTMENT OF HEALTH
BUREAU OF LONG TERM CARE SERVICES

RHCF Title XVIII, XIX, and/or Article 28 Survey
Facility Survey Report

USE INK OR TYPE. THIS REPORT WILL BE PHOTOCOPIED

PFI

Facility Address

Date of First Day of Last Certification Survey:

(1) Is your facility applying for participation in the Medicare Program? YES NO

(2) Is your facility applying for participation in the Medicaid Program? YES NO

If your answer to questions 1 and/or 2 was yes, please complete and return the enclosed form(s) as follows:

<table>
<thead>
<tr>
<th>Ownership and Control Interest Disclosure Statement – Form</th>
<th>Medicare Only</th>
<th>Medicare-Medicaid</th>
<th>Medicaid Only</th>
</tr>
</thead>
<tbody>
<tr>
<td>HCFA-1513 – one set</td>
<td>( )</td>
<td>( )</td>
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</tbody>
</table>

<table>
<thead>
<tr>
<th>Long Term Care Facility Request to Establish Eligibility in the Medicare and/or Medicaid Programs</th>
<th>Medicare Only</th>
<th>Medicare-Medicaid</th>
<th>Medicaid Only</th>
</tr>
</thead>
<tbody>
<tr>
<td>HCFA - 671 – one set</td>
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</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>New York State Department of Social Services Agreement – three copies</th>
<th>Medicare Only</th>
<th>Medicare-Medicaid</th>
<th>Medicaid Only</th>
</tr>
</thead>
<tbody>
<tr>
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</tbody>
</table>
Conformity with Federal, State and Local Laws 42 CFR 483.75; 10 NYCRR 415.1 and 415.26

(3) (a) Since the last OHSM inspection, have you been inspected by any governmental agency (other than OHSM) in regard to fire and safety, sanitation, communicable and reportable diseases, postmortem procedures, water supply or other relevant health and safety requirements?  YES NO (   ) (   )

(b) If so, were you officially notified that you were in violation of any laws or regulations in regard to such inspection?  YES NO (   ) (   )

Administration 42 CFR 483.75; 10 NYCRR 415.26

(4) Has the nursing home developed and implemented procedures to carry out the policies of the governing body regarding management and operation?  YES NO (   ) (   )

Licensure or Registration of Personnel

(5) Has your facility ensured that employees and other persons providing resident services in your facility are licensed, registered or certified in accordance with applicable laws?  YES NO (   ) (   )

Fill in the names and qualifications of key facility staff listed on the following pages and answer the remaining questions as indicated.
FACILITY NAME:

(6) Facility Administrator
42 CFR 483.75; 10 NYCRR 415.26

Name______________________________

Nursing Home Administrator License #:___________ __________ / __________ / __________
Number and Expiration Date: __________ / __________ / __________

Alternate Administrator
Name:______________________________

Nursing Home Administrator License #:___________ __________ / __________ / __________
Number and Expiration Date: __________ / __________ / __________
(if applicable)

Not a licensed nursing home administrator ( )

(7) Does the administrator have other institutional responsibilities? If yes, specify:
YES NO ( ) ( )

________________________________________

(8) Medical Director
42 CFR 483.75; 10 NYCRR 415.15

Name______________________________

License Number/Expiration date: #:___________ __________ / __________ / __________

Hours per week: __________ hours

(9) Director of Nursing Services
42 CFR 483.30; 10 NYCRR 415.13

Name______________________________

RN Registration Number/Expiration Date: #:___________ __________ / __________ / __________

(10) Does the Director of Nursing Services have other responsibilities within your facility?
YES NO ( ) ( )

If yes, specify:______________________________________________________________
(11) Dietary Supervisor
42 CFR 483.35; 10 NYCRR 415.14

Name: ___________________________

ADA Number and expiration date: #:___________ __________/________/________

If not ADA registered, provide qualifications: ______________________________________

(  ) Full-time  (  ) Part-time  (  ) Consultant

If Dietician is not the full-time dietetic service supervisor, provide the name and qualifications of the full-time dietetic service supervisor:

Name_____________________________

Qualifications:_____________________

(12) Specialized Rehabilitative Services Personnel
42 CFR 483.45 and 483.75; NYCRR 415.16

Physical Therapist and Physical Therapist Assistant (please indicate if RPT or PTA)

<table>
<thead>
<tr>
<th>NAME</th>
<th>LICENSE NUMBER</th>
<th>EXPIRATION DATE</th>
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<tbody>
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<tr>
<td>(13)</td>
<td>Occupational Therapist and Certified Occupational Therapy Assistants (please indicate if OT or OTA)</td>
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<td>------</td>
<td>---------------------------------------------------------------------------------------------</td>
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<td></td>
<td>Name: _______________________________  License Number  Expiration Date</td>
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<tr>
<td>(14)</td>
<td>Speech Language Pathologist</td>
<td></td>
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<td></td>
<td>Name: _______________________________  License Number  Expiration Date</td>
<td></td>
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<tr>
<td>(15)</td>
<td>Audiologist</td>
<td></td>
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<tr>
<td></td>
<td>Name: _______________________________  License Number  Expiration Date</td>
<td></td>
</tr>
</tbody>
</table>
Name: ______________________________

Social Worker: Full-time ( ) Part-Time ( ) Consultant ( )

CSW # ______________________

Expiration Date: _____ / _____ / _____
month  day  year

Qualifications:
Master’s degree in Social Work ( )
Bachelor’s degree in Social Work ( )
YES  NO
Two years of supervised social work experience in a health care setting working directly with individuals. ( ) ( )
Similar professional qualifications pertinent to a health care setting. ( ) ( )
Do you obtain services of a qualified Social Work consultant through a contract? ( ) ( )
If yes, specify the date of the most recent contract renewal.
_____ / _____ / _____
month  day  year
Have any of the provisions of the contract been changed since the last OHSM annual survey? ( ) ( )

Name of Consultant: ______________________________

Qualifications: __________________________________________

______________________________________________________

______________________________________________________
Name: ________________________________

Qualified professional credentials and experience:

* Therapeutic Recreation Specialist

Certification Number and Expiration Date:

# __________________

/ / /
month day year

* Is eligible for certification as a therapeutic recreation specialist or as an activities professional by a recognized accrediting body on or after October 1, 1990.

OR

* Two years of age-appropriate experience within the last five years, one of which was full-time in a patient activities program in a health care setting?

OR

* Occupational therapist Registered

Certification Number and Expiration Date:

# __________________

/ / /
month day year

OR

* Certified Occupational Therapist Assistant

Certification Number and Expiration Date:

# __________________

/ / /
month day year
(18) Pharmacist 483.60; 10 NYCRR 415.18
Name:______________________________
License Number and Expiration Date: #__________ ______/____/____
month day year

(19) Dentist 42 CFR 483.55; 10 NYCRR 415.17
Name:______________________________
License Number and Expiration Date: #__________ ______/____/____
month day year

(20) Volunteers 10 NYCRR 415.26
Does your facility have a volunteer program? YES NO ( ) ( )
If yes, answer (a):
(a) Person responsible for volunteers
Name:______________________________
Position:______________________________
Department:______________________________

(21) Person(s) responsible for supervision of housekeeping services and maintenance 10 NYCRR 415.29
Name(s):__________________________________________
__________________________________________
Qualifications:____________________________________

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OUTSIDE RESOURCES

Use of Outside Resources; Institutional Services: 42 CFR 483.75; 10 NYCRR 415.26

<table>
<thead>
<tr>
<th></th>
<th>YES</th>
<th>NO</th>
</tr>
</thead>
<tbody>
<tr>
<td>(22)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>If your facility does not employ a qualified person to render a specific service needed by your facility: Have you made arrangement to have the services provided by an outside resource – a person or agency that will render direct service to residents or act as a consultant to your facility (e.g., laboratory, radiology, dental, audiology, pharmacy services)?</td>
<td>YES</td>
<td>NO</td>
</tr>
</tbody>
</table>

*YES NO

*A yes response indicates that one or more services are provided by an outside resource*

(23) Are the responsibilities, functions, objectives and terms of agreements, including financial arrangements and charges of each outside resource:

<table>
<thead>
<tr>
<th></th>
<th>YES</th>
<th>NO*</th>
</tr>
</thead>
<tbody>
<tr>
<td>Are the responsibilities, functions, objectives and terms of agreements, including financial arrangements and charges of each outside resource:</td>
<td>YES</td>
<td>NO*</td>
</tr>
</tbody>
</table>

(a) defined in writing:|YES | NO* |

(b) signed by an authorized representative of your facility?|YES | NO* |

(c) signed by the person or agency providing the service?|YES | NO* |

(d) written in such a manner that your facility retains ultimate responsibility for service rendered to residents?|YES | NO* |

*For each “NO” response, specify the outside resource(s) to which the “NO” applies:

________________________________________________________________________

________________________________________________________________________

________________________________________________________________________

________________________________________________________________________

*For each “NO” response, specify the outside resource(s) to which the “NO” applies:
(24) Does your facility assist residents in securing transportation to and from the source of services when services are provided off-site?

(25) Laboratory Services
42 CFR 483.75;
10 NYCRR 415.20

Name: ____________________________
Address: ____________________________

Permit #: ____________________________

Medicare Provider #:__________________
Medicaid Provider #:__________________

Under the supervision of a Certified Director:

Name: ____________________________
MD License and Expiration date: #______________ / / / ______

If arranged for by contract, is there a contract in effect?

YES ( ) NO ( )

Contract expiration date:____________

(26) Radiology Service:
42 CFR 483.75;
10 NYCRR 415.21

Name: ____________________________
Address: ____________________________

Registration #:____________________
Expiration Date:______ / / / ______

Medicare Provider #:______________
Medicaid Provider #:______________

Under direction of Qualified Roentgenologist:

Name: ____________________________
MD License and Expiration date #:______________ / / / ______

If arranged for by contract, is there a contract in effect?

YES ( ) NO ( )

Contract expiration date:____________

(27) Does your facility provide blood transfusion services?

YES ( ) NO ( )
Resident Rights 42 CFR 483.15; 483.10; 10 NYCRR 415.5

(28) Has your governing body established written policies regarding all mandated resident rights and specifying resident responsibilities? YES NO

(29) Has your governing body, working through the administrator, developed policies and procedures regarding use of restraints, abuse, and staff treatment of residents? YES NO

RESIDENT OR FAMILY GROUPS

(30) (a) Give the name and room number of the officers. (Please obtain their permission to provide this information.)

Officer: __________________________ Room #________
Officer: __________________________ Room #________
Officer: __________________________ Room #________
Officer: __________________________ Room #________
Officer: __________________________ Room #________

(b) Give the name of the designated staff person responsible for providing assistance to the group or groups:

Name: __________________________
Title: __________________________

VISITING HOURS

(31) Visiting hours:

From: ________________ To: ________________

Place where visiting hours are posted: ________________
ADMISSION, TRANSFER, DISCHARGE

Resident Transfer/Transfer Agreement
42 CFR 483.75; 483.12 and 10 NYCRR
415.30; 415.26; 400.9; 400.11; 400.12;
400.13 and 415.11

(32) Are residents screened for mental illness or mental retardation prior to admission using the PASAAR procedure?

YES ( ) NO ( )

(33) (a) Name the facilities with which your facility has transfer or affiliation agreements and state the year this agreement was first entered into. If any type of facility is left blank, answer question 34.

<table>
<thead>
<tr>
<th>Type of Facility</th>
<th>Name</th>
<th>Year Entered</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hospital:</td>
<td></td>
<td></td>
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<tr>
<td>Other Nursing Home:</td>
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<td></td>
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<tr>
<td>Agencies and Other Health Facilities:</td>
<td></td>
<td></td>
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</tbody>
</table>

(b) List the HMO’s with which this facility has a network agreement:

(34) If your facility has been unable to enter a transfer agreement with any of the types of facilities listed above, can you document that your facility has made reasonable efforts to enter into transfer agreement?

YES ( ) NO ( )

(35) Have the terms of any of the transfer agreements you entered into changed since the last OHSMS annual survey?

( ) ( )

(36) Does the facility provide security and account for resident’s personal effects upon transfer?

( ) ( )

(37) Does the facility routinely provide for notification of the resident and/or his or her designed representative prior to a transfer or discharge and include reason, effective date, location, appeal rights, and name, address and telephone number of the State’s long-term care ombudsmen?

( ) ( )
(38) Does your facility secure food management services from an outside resource? YES NO*  
*If “no”, go directly to next question. If yes, Name of food Service Contractor: _______________________________

(a) Specify the qualifications of the qualified dietitian if not directly employed by your facility.

Name: ______________________

ADA Number and Expiration Date: #_________ / / 

month day year

If not ADA registered, provide qualifications:

________________________________________________________________________

________________________________________________________________________

If the dietitian is not the dietetic service supervisor, provide the name and qualifications of the full-time dietetic service supervisor.

Name__________________________ Qualifications____________________

________________________________________________________________________

(b) Have any of the provisions of the contract for food service management been changed since the last OHSQM annual survey? YES NO

Specify the date of the most recent contract renewal. / /

month day year

(39) Does the dietary department maintain and have available records of weekly menus of all diets served to residents? YES NO

(40) Title of the diet manual used in your facility and the latest revision/publication date:

Title: ________________________________ / /

month day year
(41) List the times meals are served in your facility:

Breakfast

Midday

Evening Meal

Other (specify)

(42) Do any residents in your facility use assistive devices for eating?  

YES  NO

(43) Has your facility established a procedure whereby the dietetic services is informed of physician diet orders and of resident dietetic problems?

(44) Indicate below the seating capacity of your dining room(s) and the number of residents routinely eating in the room(s) for each meal:

<table>
<thead>
<tr>
<th>Location</th>
<th>Seating</th>
<th>Average Number of Residents Using the Dining Rooms for Each Meal</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>Breakfast</td>
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</table>

(45) Are the dining rooms in your facility used for any purpose other than meal services?  

YES  NO

(46) (a) Does your facility have any food service employees assigned to any duties outside the dietary department?

(b) Does your facility have any non-dietary employees assigned to duties within the dietary department?
Kosher Food

(47) Does your facility have a procedure for obtaining, preparing, and serving kosher foods?

YES NO

( ) ( )

Have employees been trained in the procedures:

( ) ( )

MEALS PREPARED FOR CONSUMPTION OFF-SITE

(48) There are nursing homes that prepare meals for delivery off-site, e.g., Meals on Wheels. The office of Public Health (OPH) and the Office of Health Systems Management (OHSM) have agreed that OHSM will conduct the OPH required inspection of these food preparation sites. To assist us, please provide the following information.

Does your facility prepare meals that are delivered off-site?

Yes________ No________

If yes, please check the meal(s) provided:

Breakfast______ Lunch______ Hot noon meal______ Dinner______

On what day(s) of the week are the meals prepared?

______________________________

On the average, how many meals are prepared each day?______________________________

During what hours are these meals prepared? From______ To______

What is the name and address of the organization that sponsors/pays for this program?

Name:________________________________

Address:________________________________

_________________________________________________________________________

When did the facility begin preparing meals for off-site delivery?

Month/Year________________________________
MEDICAL SERVICE

(49) Has your Medical Director developed written medical by-laws, rules, and regulations which have been approved by the governing body? ( ) ( )

(50) Do the medical by-laws include the granting or renewing of professional privileges as required by PHL Section 2805-1? ( ) ( )

NURSING SERVICES

(51) Has your facility specified in writing that the Director of Nursing Services:

(a) Has administrative authority, responsibility, and accountability for the functions, activities, and training for nursing services? ( ) ( )

(b) Serves only your facility and on a full-time basis in the capacity of Director of Nursing Services? ( ) ( )
SPECIALIZED REHABILITATIVE SERVICES

Specialized Rehabilitative Services: Physical Therapy, Occupational Therapy, speech-Language Pathology, Audiology
42 CFR 483.45; 10 NYCRR 415.16

(52) Mark the appropriate space to describe services provided:

<table>
<thead>
<tr>
<th>Type of Service</th>
<th>Facility Employees Provide On-site</th>
<th>Outside Resource Provides On-site</th>
<th>Outside Resource Provides Off-site</th>
<th>Non-resident Receives Services On-site</th>
<th>Service Not Provided</th>
</tr>
</thead>
<tbody>
<tr>
<td>Physical Therapy</td>
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<tr>
<td>Occupational Therapy</td>
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<tr>
<td>Speech/Language</td>
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<tr>
<td>Audiology</td>
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DENTAL SERVICES

Provisions of routine and emergency dental services 42 CFR 483.55; 10 NYCRR 414.17

(53) Are routine dental services provided within your facility? ( ) ( )

(54) Does your facility have a cooperative agreement with an outside dental service? ( ) ( )

Have any of the provisions of the agreement been changed since the last OHSM annual survey? ( ) ( )

(55) Does your facility obtain emergency dental services from an outside resource? ( ) ( )

If yes, specify provider: Name: ________________________________

License and Expiration Date: #______________ ___/___/___

month day year

PHARMACY SERVICES

42 CFR 483.60; 483.10; 483.15; 10 NYCRR 415.18

(56) Does your pharmacy service have procedures for the control of and accountability for all drugs and biologicals throughout your facility? ( ) ( )

(57) Is an account of all controlled drugs maintained and reconciled? ( ) ( )

(58) Complete applicable statement below:

The facility has a Class 3 license #______________ OR

The facility has a Class 3A license#______________ and

obtains drugs from: ________________________________

Name of Pharmacy

(59) Do any residents in your facility self-administer medications? ( ) ( )

(59) Title of drug information source used and publication date:

Title: ____________________ Year: _______

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(61) Indicate room(s) designated for strict isolation:

<table>
<thead>
<tr>
<th></th>
<th>YES</th>
<th>NO</th>
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<tbody>
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<td>This room(s)</td>
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<td>is single</td>
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<td>toilet and</td>
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<td>hand-washing</td>
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<td>facilities.</td>
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<tr>
<td>If none,</td>
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<td>explain below:</td>
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CLINICAL RECORDS

42 CFR 483.75; 10 NYCRR 415.22

(62) Does your facility have written policies and procedures
which ensure confidentiality of resident information and
safeguard medical records against loss, destruction and
unauthorized use?

<table>
<thead>
<tr>
<th></th>
<th>YES</th>
<th>NO</th>
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</table>

(63) Indicate the number of years your facility retains medical
records after a resident is discharged.

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</table>

(64) Are the resident’s records available to professional and other
staff directly involved with residents?

<table>
<thead>
<tr>
<th></th>
<th>YES</th>
<th>NO</th>
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<tbody>
<tr>
<td></td>
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</tbody>
</table>

(65) Is each resident permitted to inspect his/her records on
request?

<table>
<thead>
<tr>
<th></th>
<th>YES</th>
<th>NO</th>
</tr>
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<tbody>
<tr>
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</table>

____________________________
PHYSICAL ENVIRONMENT
PHYSICAL PLANT

(66) Waste

Medical Waste Removal Contractor: Name: ______________________________

Emergency Power 42 CFR 483.70; 10 NYCR 415.29; 713.19

(67) Is the emergency generator connected as required to all appropriate equipment and circuits? YES NO

(68) Is the emergency generator exercised under load for at least 30 minutes at intervals of not over 30 days? YES NO

Life Safety Code

(69) Are required automatic sprinkler systems, fire detection and alarm systems, smoke control systems, exit lighting and any other item required for fire protection maintained continuously in proper operating conditions? YES NO

If any fire protection equipment requiring test or periodic operation to assure its maintenance test or operated as specified? YES NO

Date of last automatic sprinkler inspection: _______/_____/_____

By Whom: ________________________________
(70) Record the date and shift (day, evening, night) of all fire drills held in your facility within the past twelve (12) months.

<table>
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<th>DATE</th>
<th>TIME</th>
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(71) Record the dates and types of disaster response (other than fire) rehearsed in your facility within the last twelve-(12) months (10 NYCRR 415.26).

<table>
<thead>
<tr>
<th>Type of Disaster</th>
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<tr>
<td>Power Failure Drill (7-3 shift)</td>
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<td>Power Failure Drill (3-11 shift)</td>
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<tr>
<td>Fire Extinguisher Training</td>
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</table>
(72) List the name and position of the members of the Quality Assessment and Assurance Committee (QA):

__________________________________________  __________________________________________

__________________________________________  __________________________________________

__________________________________________  __________________________________________

__________________________________________  __________________________________________

Three members of facility staff:

__________________________________________  __________________________________________

__________________________________________  __________________________________________

__________________________________________  __________________________________________

(73) Indicate the frequency of the QA meetings and the date of the most recent meeting held:

(a) Weekly ( )    (b) Date: ______/_____/______

   Monthly ( )                      month day year

   Quarterly ( )

(74) Has the QA committee developed a plan to identify issues in which quality assessment and assurance activities are necessary and do the plans include action to correct identified quality deficiencies?

YES ( )   NO ( )
(76) Does your facility have an approved RHCF Nurse Aide training program?  

*If no, go to next question.

If yes, what is your NYS DOH Nurse aide Training Program approval number and date of approval?

#__________________________ /_____ /_____

month day year

Name of Program Coordinator:_____________________________________________________

Name of Primary Instructor: ______________________________________________________

How many nurse aides received training in your program since the last report?________

(a) Do you have a procedure for verifying the state certification of nurse aides working in your facility on a full-time, part-time, and per-diem or private duty basis? 

YES ( )  NO ( )
(77) Have you provided 6 hours of paid inservice training every six months to each nurse aide used in your facility? ( ) ( )

List all inservice topics presented to nurse aides since the last survey (Continue on back if additional space is required)

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Facility Name:

Adult Day Health Care
10 NYCRR 425, 426, 427

(78) Does your facility operate an adult day health care program? YES NO

(79) Program Coordinator:
Name:______________________________________________________

(80) Dietitian responsible for dietetic services of adult day health care program:
Name:______________________________________________________

ADA Number and Expiration Date: ___________ /__ /____

month day year

If not ADA registered, provide qualifications:

________________________________________________________________________

( ) Full-time ( ) Part-time ( ) Consultant

(81) Registered Professional Nurse responsible for nursing services of adult day health care program:
Name:______________________________________________________

RN License Number and Expiration Date: ___________ /__ /____

month day year

(82) Number of registrants enrolled in program: ____________

Scheduled Short-term Care
10 NYCRR 410

(83) Does your facility operate a scheduled short-term care program? YES NO

DOH – 1550(7/95)
(84) Does your facility have a contract with a hospice?  

Yes  No  

Name:____________________________________________________

Demand Billing  
42 CFR 489.21

(85) Number of residents who have requested demand billing since the last certification survey:  

#__________________

Demand Bills Requested

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FACILITY SURVEY REPORT
Civil Rights Addendum

This addendum to the Facility Survey Report will be used in determining compliance with Title VI of the civil Rights Act of 1964 and Article 28 of the Public Health Law.

The certification signed on page two (2) of the Facility Survey Report shall also indicate that the information supplied in this addendum is true and correct to the best of the signer’s knowledge.

1. Has the facility established and implemented written procedures governing the admission process which ensure compliance with State and Federal anti-discrimination laws? [415.26(i)(1)(x)]

   Yes    No

2. Has a legend summarizing applicable Federal and State anti-discrimination laws been prominently included in the facility’s admission policies and documents such as admission applications, admission agreements and transfer agreements? The legend must include race, creed, color, national origin, handicap, sex, age, source of payment, marital status and sexual preference. [415.26(i)(1)(x)(a)]

   Yes    No

3. Does the facility give explicit advice to potential residents of their right to non-discriminatory treatment in admissions? [415.26(i)(1)(x)(c)]

   Yes    No

4. Has the facility developed admission policies which specifically state the criteria used in making admission decisions? [415.26(i)(1)(x)(e)]

   Yes    No

5. Have those admission policies been furnished to all hospitals within the county and to all other regular referral sources? [415.26(i)(1)(x1)]

   Yes    No

6. Date of last amendment to

   Admission Application: ___________
   Admission Agreement: ___________
   Admission Policies ___________

DOH – 1550(7/95)  Page 29 of 31
7. Does the facility use a waiting list in making admission decisions?
   ____Yes  ____No
   a. If the facility uses a waiting list is the list maintained in written form and is the date of each application included?  
      ____Yes  ____No  ____N/A  [415.26(i)(1)(x)(e)]
   b. If the facility uses a waiting list is the operation and utilization of the list described in the written admission policies?  
      ____Yes  ____No  ____N/A  [415.26(i)(1)(x)(e)]

8. Have all personnel involved with resident admission been trained in the requirements of applicable Federal and State anti-discrimination laws? [415.26(i)(1)(x)(d)]
   ____Yes  ____No

9. Does the facility utilize one of the following methods to maintain records for an eighteen (18)-month period of the referral of potential residents to the facility:
   a. A centralized log containing for each referral a patient identifier and indicate the race, sex, color, and national origin of the potential resident, the date of referral, name of referring hospital or agency, and the date and disposition of referral by the facility.
      ____Yes  ____No
   b. Or, a file containing the completed hospital/community patient review instruments. The file must be located in a central place, organized by date of receipt, and marked by date and type of disposition. [415.26(i)(1)(xii)]
      ____Yes  ____No

10. Does the facility give preference in admission to member of any group, organization or municipality?
    ____Yes  ____No
    a. If yes, is membership in the preferred group, organization or municipality restricted to persons of a particular race, creed, color, national origin, handicap, sex, age, marital status or sexual preference?
       ____Yes  ____No  ____N/A
    b. Name of the parent group, organization or municipality:
       
11. Does the facility limit:
    - admission of Medicaid residents?  ____Yes  ____No  ____N/A
    - admission of Medicare residents?  ____Yes  ____No  ____N/A
    - retention of Medicaid residents?  ____Yes  ____No  ____N/A
    - retention of Medicare residents?  ____Yes  ____No  ____N/A
12. Has a legend summarizing applicable Federal anti-discrimination laws been added to the facility’s contracts with vendors and providers of patient services? The legend must include race, creed, color, national origin, handicap, sex and age?
   [45CFR 80.5(a)] [45CFR 90.12]

13. Date public was last notified of the facility’s anti-discrimination policy: __________________________

[45CFR 80.6(d)]

Note: By the authority granted through 45CFR 80.6(d), NYSDOH has adopted a standard policy whereby public notice of non-discrimination must be published at least once every two (2) years.

   a. Name of the newspaper or other media used for this notification:

   ____________________________________________

PRINCIPAL REFERRAL SOURCES: List below the principal referral sources of applicants to your facility:

<table>
<thead>
<tr>
<th>Name of Facility or Organization</th>
<th>Name of Usual Contact Person</th>
<th>Telephone Number</th>
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