**XS BROKERS**

Fiercely Committed.
Proudly Independent.

TEL 617 471 7171 / TF 800 972 5381
FAX 617 471 7180 / TF 888 628 1906
EMAIL info@xsbrokers.com

WEB
xsbrokers.com

# Health Care Facility Inspection Supplemental Questionnaire

(Information should be obtained from the facility Administrator)

Name of Agent: _____

1. Who is the inspection contact and what is his or her title? _____

   A. How long has the administrator been at this facility? _____

   B. Experience as administrator or assistant administrator: _____ years

   C. Number of administrators at the facility during the prior 10 years? _____

2. Please include copies of the most recent state and county inspections, including all violations, with your report. If the inspection is a revisit report, please include the prior inspection.

3. Please include a copy of the facility's license with your report.

4. Please describe the facility's medical recordkeeping system and charting procedures.

   A. How often is charting done? _____

   B. Does the insured have sufficient staff and equipment to ensure that complete medical records are kept? ........ ❑ Yes   ❑ No

   C. Does the insured employ (or use as a consultant) a medical records practitioner? ............................................ ❑ Yes   ❑ No

5. It is essential that we have a patient breakdown by Scottsdale Insurance Company definitions. Please provide a breakdown of the number of patients by the degree of care given determined by the following definitions:

   A. **Skilled Nursing Services:** _____
      **The residents' conditions, needs, and/or services are of such complexity and sophistication so as to require the frequent or continuous observation and intervention of a registered nurse, and the supervision of a licensed physician (not on staff). Skilled nursing care includes some or all of the following: medication administration, injections, tube feedings, catheterizations, or other procedures ordered by a physician.**

   B. **Intermediate Nursing Services:** _____
      **The residents' physiological and psychological functions are stable, but require individually planned treatment and services under the direction of a licensed nurse and supervision of a licensed physician (not on staff). Emphasis is on maintenance of maximum independence and return to the community as soon as possible. Some assistance in medication administration.**

   C. **Residential or Personal Care:** _____
      **Facility provides personal care, residential and social care with some routine health care, but not continuous skilled nursing care. Residents of homes for the aged must be ambulatory, group homes are for trainable developmentally disabled. (There is no daily medical attention.) Patients are responsible for their own medication.**

      **Aged:** **Senior citizens 55 and up. Acceptable at any age as long as they are ambulatory and able to care for themselves. No medical care is provided. Supervision of daily medication is provided. Medical assistance, if any, must be provided by guest's own physician.**

      **Developmentally Disabled:** **Adults or children able to care for themselves despite their disability or retardation.**

   D. **Mentally Disabled:** _____
      **Adults or children able to care for themselves (substantial number hold jobs). Behavior is controlled primarily through medi- cation and monitored by their personal physician. This category would include individuals whose primary diagnosis is an emotional or mental illness including but not limited to schizophrenic, psychopathic, and sociopathic diagnosis.**

6. Using the following definition, advise number of ambulatory and non-ambulatory patients. **Ambulatory—**A person who is physically and mentally capable of walking a normal path to safety, including the ascent and descent of stairs.

   Ambulatory: _____   Non-ambulatory: _____

7.  How many patients were observed? _____

    A.   Was the clothing of those patients clean and dry? ............................................................................ ❑ Yes  ❑ No

    B.   Did those patients have a clean and well groomed appearance? .................................................... ❑ Yes  ❑ No

    C.   Were those patients dressed appropriately for the time of day? ................................................... ❑ Yes  ❑ No
       (For example, were any of those patients in pajamas at noon?)

8. How many patient rooms were observed? _____ Were those rooms clean and orderly? ........ ❑ Yes ❑ No

9. Was the odor of urine noticeable at any time during the inspection? ....................................................... ❑ Yes ❑ No

   If yes, please describe the circumstances: _____

   _____

   _____

10. Were employees viewed interacting with patients? ............................................................................... ❑ Yes ❑ No

    Did the patients appear to be treated in a respectful manner by the employees? ..................................... ❑ Yes ❑ No

    Did the observed patients have adequate privacy? ................................................................................ ❑ Yes ❑ No

11. Was any evidence of rodents or insects observed? .............................................................................. ❑ Yes ❑ No

12. Are there any underground fuel storage tanks? .................................................................................... ❑ Yes ❑ No

13. Please describe the number of professional staff for each of the three shifts:

| | 1ST SHIFT | 2ND SHIFT | 3RD SHIFT |
|---|---|---|---|
| RN | | | |
| LP/LVN | | | |
| CNA | | | |

14. How many patients are:   Geriatric (elderly) _____

    Mentally Ill/Mentally Disabled _____

    Developmentally Disabled _____

    Non-geriatric (describe disability) _____ _____

15. Ages of patients:   Average: _____   Oldest: _____   Youngest: _____

16. Are there any employed physicians, psychiatrists, dentists or pharmacists? ........................................... ❑ Yes ❑ No

    If yes, are certificates of professional liability insurance kept on file? ..................................................... ❑ Yes ❑ No

17. Are there any contracted physicians, psychiatrists, dentists, pharmacists or other professionals? .......... ❑ Yes ❑ No

    If yes, are certificates of professional liability insurance kept on file? ..................................................... ❑ Yes ❑ No

    Does the insured operate through a written contract with these professionals? ...................................... ❑ Yes ❑ No

18. Does the insured have a quality assurance program in place, such as those designed by the Joint Commission on Accreditation of Hospitals or the American Health Care Association? .................................................. ❑ Yes ❑ No

19. Claims commonly result from negligent dispensing and administration of drugs. The pharmacist (employed, contracted, consultant), the charge nurse and attending physicians should perform a monthly review of all patients' drug regimens. Is this being done and documented? ................................................................ ❑ Yes ❑ No

20. Describe the facility's policy on restraints: _____

    _____

    _____

    Are all incidents involving restraints documented? .............................................................................. ❑ Yes ❑ No

21. What is the experience of the professional staff members? _____

    _____

    What are the insured's criteria for hiring staff, and does the insured provide in-service training? _____

    _____

    Does the insured perform background checks prior to hiring staff?   ❑ Yes   ❑ No   If yes, describe: _____

    _____

    _____

22. Is English the primary language of all professional staff? ...................................................................................... ❑ Yes  ❑ No

    If no, what procedures does the insured have in place to ensure the staff is fluent enough in English to provide adequate care?

    _____

    Does the facility provide in-service training in languages other than English? ........................................ ❑ Yes  ❑ No

23. Describe procedures in place to identify new and existing patients (or residents) as "wanderers": _____

    _____

    Describe procedures in place to control and keep track of wandering patients: _____

    _____

    Describe "Wander Guard" or other electronic system in place: _____

    _____

24. Are there established visiting hours?   ❑ Yes  ❑ No   Please describe: _____

    _____

25. Does the facility have a medical director? ................................................................................................ ❑ Yes  ❑ No

    A.   Does the medical director have his/her own professional liability insurance? ...................................... ❑ Yes  ❑ No

    B.   Are the duties of the medical director administrative only? ................................................................ ❑ Yes  ❑ No

26. Does the facility use any other sub or independent contractors? ............................................................... ❑ Yes  ❑ No

    Are certificates of insurance obtained and kept on file? ............................................................................. ❑ Yes  ❑ No

27. Are there tempering valves that control the temperature of the patients' water? ...................................... ❑ Yes  ❑ No

    A.   At what temperature are they set?_____

    B.   How often are they checked? _____

28. Are there alarms or monitors on exit doors to prevent patients from leaving the premises without authorization? .. ❑ Yes  ❑ No

29. Is there a regular extermination program by an outside firm? .................................................................... ❑ Yes  ❑ No

    A.   If yes, by whom? _____

    B.   How often? _____

    C.   Is a certificate of insurance on file? ............................................................................................... ❑ Yes  ❑ No

30. Does the facility allow smoking? ................................................................................................................ ❑ Yes  ❑ No

    A.   Where is it permitted? _____

    B.   Are the smoking materials controlled by the facility? ....................................................................... ❑ Yes  ❑ No

    C.   If yes, how? _____

    _____

31. Does the facility have a written emergency evacuation plan? ................................................................... ❑ Yes  ❑ No

    A.   Is it posted? ..................................................................................................................................... ❑ Yes  ❑ No

    B.   Is the entire staff familiar with it? .................................................................................................... ❑ Yes  ❑ No

    C.   How often are drills conducted? _____

    D.   Is the plan on file with the local fire department? ............................................................................ ❑ Yes  ❑ No

INSPECTOR'S SIGNATURE _____  Date _____