



SCOTTSDALE INSURANCE COMPANY®

P.O. Box 4110 • Scottsdale, Arizona 85261 • (602) 948-0505 • Fax (602) 483-6752

Health Care Facility Inspection Supplemental Questionnaire

(Information should be obtained from the facility Administrator)

- 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:
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.
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?
C. Does the insured employ (or use as a consultant) a medical records practitioner?
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:
B. Intermediate Nursing Services:
C. Residential or Personal Care:
D. Mentally Disabled:
6. Using the following definition, advise number of ambulatory and non-ambulatory patients.
7. How many patients were observed?
A. Was the clothing of those patients clean and dry?
B. Did those patients have a clean and well groomed appearance?
C. Were those patients dressed appropriately for the time of day?

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 _____