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.

FACILITY NAME: ______________________________

FACILITY SURVEY REPORT

CERTIFICATION SHEET

THE FOLLOWING STATEMENTS MUST BE 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

MISREPRESENTATXON OR FALSIFICATION OF ANY INFORMATION CONTAINED IN THIS FORM MAY BE PUNISHABLE BY FINE AND/OR IMPRISONMENT UNDER NEW YORK 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

____

TITLE

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

PFI ____________

Facility Address ______________________

____

Date of First Day of Last Certification Survey ____/____/____ month day year

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

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

	Medicare only	Medicare-Medicaid	Medicaid only
Ownership and Control Interest Disclosure Statement - Form HCFA-1513 - one set	☐	☐	☐
Long Term Care Facility Request to Establish Eligibility in the Medicare and/or Medicaid Programs Form - HCFA-671 - one set	☐	☐	☐
New York State Department of Social services Agreement - three copies 1	☐	☐	☐

FACILITY NAME: ______________________________

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

____________ ____/____/____
month day year

Alternate Administrator

Name ______________________________

Nursing Home Administrator License -
Number and Expiration date

____________ ____/____/____
month day year

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

____________ ____/____/____
month day year

Hours per week ____________ hours

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

Name ______________________________

License Number / Expiration date

____________ ____/____/____
month day year

(10) Does the Director of Nursing Services have other responsibilities within your facility?
If yes, specify:

YES ☐ NO ☐

____

____

FACIALITY NAME: ______________________________

FACILITY NAME: ______________________________

(13)

Occupational Therapist and Certified Occupational Therapy Assistants (please indicate if OT or OTA)	License Number Certification Number	Expiration Date
Name	#	/ /
Name	#	/ /
Name	#	/ /
Name	#	/ /
Name	#	/ /

(14)

Speech Language Pathologist	License Number	Expiration Date
Name	#	/ /

(15)

Audiologist	License Number	Expiration Date
Name	#	/ /

FACILITY NAME: ______________________________

(16)

Social Worker 42 CFR 483.15; 10 NYCRR 415.5

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 ______________________________

____

____

FACILITY NAME: ______________________________

(17)

Activities Director 42 CFR 483.15; 10 NYCRR 415.5

Name ______________________

Qualified professional credentials and experience:

	YES	NO
• Therapeutic Recreation Specialist	☐	☐

Certification Number # ____________ Expiration Date ____/____/____ (month day year)

• Is eligible for certification as a therapeutic recreation specialist or as an activities professiona1,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 # ______________ Expiration Date ___ / ___ /_____ (month day year)

OR

• Certified Occupational Therapist Assistant	☐	☐

Certification Number # ______________ Expiration Date ___ / ___ /_____ (month day year)

FACILITY NAME: ______________________________

(18) Pharmacist 42 CFR 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: ______________________

____

____

FACILITY NAME: ______________________________

OUTSIDE RESOURCES

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

(22) If your facility does not employ a qualified person to render a specific service needed by your facility: Have you made arrangements to have the service 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)?

*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:

	YES	NO
(a) defined in writing?	☐	☐
(b) signed by an authorized representative of your facility?	☐	☐
(c) signed by the person or agency providing the service?	☐	☐
(d) written in such a manner that your facility retains ultimate responsibility for service rendered to residents?	☐	☐

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

____

____

____

____

____

____

____

____

FACILITY NAME: ________________________________

(24) Does your facility assist residents in securing transportation to and from the source of services when services are provided off-site? YES ☐ NO ☐

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

Name ________________________________

Address ________________________________

____

Permit # ____________

Medicare provider # ____________ Medicaid Provider # ____________

Under supervision of a certified Director:

Name ________________________________

MD License and Expiration date # ____________ ___ / ___ / ___
month day year

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 Number # ____________ Expiration Date ___ / ___ / ___
month day year

Medicare provider # ____________ Medicaid Provider # ____________

Under direction of Qualified Roentgenologist:

Name ________________________________

MD License and Expiration date # ____________ ___ / ___ / ___
month day year

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 # ______________________

(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 ______________________________

FACILITY NAME: ____

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.ll

(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.

Type of facility	Name	Year Entered
Hospital:	____________________	__________
Other Nursing Home:	____________________	__________
Agencies and Other Health Facilities:	____________________	__________

(B) List the HMQs 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 ent.er into transfer agreement? YES ☐ NO ☐

(35) Have the terms of any of the transfer agreements you entered into changed since the last OHSM 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 designated 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? ☐ ☐

FACILITY NAME: ______________________________

DIETARY SERVICES

42 CFR 483.15; 483.10; 10 NYCRR 415.14

(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 if 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 OHSM 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

FACILITY NAME: ______________________________

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

Breakfast ____________________

Midday ____________________

Evening Meal ____________________

Other (Specify) ____________________

	YES	NO
(42) Do any residents in your facility use assistive devices for eating?	☐	☐
(43) Has your facility established a procedure whereby the dietetic service 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:

Location (floor)	Seating Capacity	Average Number of Residents using the Dining Rooms for Each Meal		
		Breakfast	Noon	Evening

	YES	NO
(45) Are the dining rooms in your facility used for any purpose other than meal services?	☐	☐

Personnel, Infection Control

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

FACILITY NAME: ______________________________

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? YES ☐ NO ☐

MEALS PREPARED FOR CONSUMPTION OFF-SITE

(48) There are nursing homes that prepare meals for delivery offsite, 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 which 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 ______________________

FACILITY NAME: ______________________________

MEDICAL SERVICE

Medical Director 42 CFR 483.75; 10 NYCRR 415.15

	YES	NO
(49) Has your Medicaid 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

Director of Nursing Services 42 CFR 483.30; 10 NYCRR 415.15

(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?	☐	☐

FACILITY NAME: ______________________________

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:

Type Service	Facility Employees Provide On-site	Outside Resource Provides On-site	Outside Resource Provides Off-site	Non-Resident Receives Services On-Site	Services not Provided
Physical Therapy	☐	☐	☐	☐	☐
Physical Therapy	☐	☐	☐	☐	☐
Speech-language	☐	☐	☐	☐	☐
Audiology	☐	☐	☐	☐	☐
	☐	☐	☐	☐	☐
	☐	☐	☐	☐	☐
	☐	☐	☐	☐	☐

FACILITY NAME: ______________________________

DENTAL SERVICES

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

Question	YES	NO
(53) Are routine dental services provided within your Facility?	☐	☐
(54) Does your facility have a cooperative agreement with an outside dental service?	☐	☐
(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

Question	YES	NO
(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

Question	YES	NO
(59) Do any residents in your facility self-administer medications?	☐	☐

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

Title: ______________________________ Year: ________

FACILITY NAME: ______________________________

Preventing Spread of Infection

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

______________ ______________ ______________ ______________

This room(s) is single bedded, ventilated to the outside, and equipped with private toilet and hand-washing facilities. If none, explain below. YES ☐ NO ☐

____

____

____

CLINICAL RECORDS

42 CFR 483.75; 10 NYCRR 415.22

(62) Does your facility have written policies and procedures which ensure confidentiality of information and safeguard medical records against loss, destruction and unauthorized use? YES ☐ NO ☐

(63) Indicate the number of years your facility discharged. ______________

(64) Are the resident's records available to professional and Other staff directly involved with residents? YES ☐ NO ☐

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

FACILITY NAME: ______________________________

PHYSICAL ENVIRONMENT

PHYSICAL PLANT

(66) **Waste**

Medical Waste Removal Contractor: Name ______________________________

____

Emergency Power 42 CFR 483.70; 10 NYCRR 415.29; 713.19

	YES	NO
(67) Is the emergency generator connected as required to all appropriate equipment and circuits?	☐	☐
(68) Is the emergency generator exercised under load for at least 30 minutes at intervals of not over 30 days?	☐	☐

Life Safety Code

	YES	NO
(69) Are required automatic sprinkler systems, detection and alarm systems, smoke control systems exit lighting and any other item required for fire protection maintained continuously in proper operating conditions?	☐	☐
Is any fire protection equipment requiring test or periodic operation to assure its maintenance tested or operated as specified?	☐	☐

Date of last automatic sprinkler inspection: _____ / _____ / _____
month day year

By whom: ______________________________

FACILITY NAME: ____

Staff Training and Drills, Disaster Preparedness 42 CFR 483.70; 10 NYCRR 415.29; NFPA 101, Section 31 - 4.1.3

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

	DATE	TIME	SHIFT		DATE	TIME	SHIFT
1)	______	______	______	7)	______	______	______
2)	______	______	______	8)	______	______	______
3)	______	______	______	9)	______	______	______
4)	______	______	______	10)	______	______	______
5)	______	______	______	11)	______	______	______
6)	______	______	______	12)	______	______	______
	______	______	______		______	______	______
	______	______	______		______	______	______

(71) Record the dates and types of disaster response (other than fire) rehearsed in your facility within the last 12 months (10 NYCRR 415.26)

Type of Disaster	Date
______________________	____________
______________________	____________
______________________	____________
______________________	____________
______________________	____________

FACILITY NAME: ____

Quality Assessment and Assurance
42 CFR 483.75; 10 NYCRR 415.27

(72) List the name and position of the members of the Quality Assessment and Assurance committee (QA):

Name	Position
______________________	______________________
______________________	Director of Nursing Services
______________________	Physician
______________________	Member of Governing Board

Three members of facility staff:

Name	Position
______________________	______________________
______________________	______________________
______________________	______________________

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

(a) Weekly ☐
Monthly ☐
Quarterly ☐

(b) Date: ___/___/_____

(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 ☐

FACILITY NAME: ______________________________

Nurse Aide Training and Certification 42 CFR 483.75; 10 NYCRR 415.26 and 415.31

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

*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, per diem or private duty basis? YES ☐ NO ☐

FACIFACILITY NAME: ______________________________

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

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

#	Topic	Hours
1		
2		
3		
4		
5		
6		
7		
8		
9		
10		
11		
12		
13		
14		
15		
16		
17		
18		
19		
20		
21		
22		
23		
24		
25		

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 service 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 ☐

FACILITY NAME: ______________________________

Hospice
42 CFR 418.50; 10 NYCRR 86-6

(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:

____

FACILITY NAME: ______________________________

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 Stale 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)(xi)) ☐ Yes ☐ No

6. Date of last amendment to:

   Admission application: ______________

   Admission agreement: ______________

   Admission policies: ______________

7.	Does the facility use a waiting list in making admission decisions?	☐ Yes ☐ No
7a.	If the facility uses a waiting list is the list maintained in written form and is the date of each application included? (415.26(i)(1)(x)(c))	☐ Yes ☐ No ☐ N/A
7b.	If the facility uses a waiting list is the operation and utilization of the list described in the written admission policies? (415.26(i)(1)(x)(c))	☐ Yes ☐ No ☐ N/A
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:	
	1- 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
	2- or, a file containing the completed ho9spital/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 members of any group, organization or municipality?	☐ Yes ☐ No
10a.	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
10b.	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) ☐ Yes ☐ No

13. Date public was last notified of the facility's anti-discrimination policy: (45CFR 80.6(d))

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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.

13a. Name of the newspaper or other media used for this notification

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

Name of facility or Organization	Name of Usual Contact Person	Telephone Number