

## NURSING HOME GENERAL LIABILITY AND PROFESSIONAL LIABILITY APPLICATION

Please Note: A separate supplemental application form must be completed for each facility to be included in this proposal.

### FACILITY INFORMATION

Name:

Street Address:

City

State

Zip

Telephone:

A. Number of Years:

In operation:                  Owned by present owner:                  Managed by present management:

B. Does this facility have common ownership/management with other nursing facilities that are not included in this application for insurance?    Yes          No

If yes, please provide names and addresses of these other facilities on page 7 of this application

C. Are all licenses current and in force?    Yes          No                  Expiration date:

D. Has this facility ever been de-licensed, de-certified, issued a restricted license, had reimbursement denied, or had new admissions restricted or denied?    Yes          No  
If yes, attach full details on page 7 of this application and attach all relevant documentation.

E. Provide facility classifications and bed census:

Number of: *(see definitions on page 7)*    # Licensed Beds/Units    # Average Occupied

Sub-Acute:

Skilled Care:

Intermediate Care:

Residential Care:

Independent Living:

Adult Day Care:

Other *(please define)*:

Home Health Services:

Number of Visits per year *(or state "none")* :

Description of home health services provided:

**F. Resident/Patient Profiles:    Age Group (in years)    Number    % Non-Ambulatory**

- <20
- 20-49
- 50-64
- 65-74
- 75-84
- >85

Please explain medical conditions of residents less than 64 years of age:

Number of patients with primary diagnosis of Alzheimers/Dementia:

G. Number of patients with primary diagnosis of Mental Illness:

H. Administrator's Name:

Length of Time as Administrator at: This facility:                      All facilities in career:

I. Is there a full-time employed medical director:    Yes                      No

If part-time, number of hours/week:

J. State number of employees in each classification. If none, state "None".

**Show number of employees in full time equivalents (FTE's) based on 40 hrs. per week. (for example, 4 RN's each working 10 hrs. per week equals 1 FTE.)**

	<b>1<sup>ST</sup> SHIFT</b>	<b>2<sup>ND</sup> SHIFT</b>	<b>3<sup>RD</sup> SHIFT</b>
Administrative Personnel			
Beauticians/Barbers			
Dieticians			
Licensed Practical Nurses			
Maintenance/Security Personnel			
Nurse's Aides			
Physical Therapists			
Physicians			
Recreation Therapists			
Registered Nurses			
Social Workers			
Speech Pathologists			
Others – Describe:			

**HIRING/STAFFING PROCEDURES**

A. Check all procedures you use when hiring professional and para-professional staff:

Check of educational background or residency program, when applicable.

Check of previous employers:                      in writing                      by telephone.

Check on hospital privileges for physicians, oral surgeons and dentists.

Verify any pending license suspensions or revocations, or any pending disciplinary actions by other facilities.

Require information on any professional liability or work-related claim that has previously been made against the individual.

- B. Do you have written job descriptions? Yes No
- C. Are all employees required to attend an orientation program prior to start of employment?  
Yes No
- D. Do you have a new employee preceptor, mentor or "buddy" program? Yes No
- E. Do you have regularly scheduled in-services? Yes No
- F. Is attendance at in-services mandatory? Yes No
- G. Do you perform criminal background investigations on all potential employees? Yes No
- H. Annual staff turnover ratio for:  
RN's % LPN's % CNA's %
- I. Please provide ratios of staff to residents for:  
RN's: LPN's: CNA's:

### RISK MANAGEMENT

- A. Are new residents required to have evidence of acceptable health (physical examination)?  
Yes No
- B. Describe security measures to control unauthorized entrance:
- C. Evacuation Procedures:  
- Is there a written emergency evacuation plan? Yes No  
- Does it include advance arrangements for transport and temporary shelter? Yes No  
- Are evacuation directions posted in all areas? Yes No  
- Is a review and "walk through" of disaster plans a part of staff orientation? Yes No  
- How often are fire/evacuation drills conducted each year?
- D. As respects skilled and intermediate care:  
Do all residents have their own attending physician? Yes No  
If "no", who performs that role?  
Are written orders required from attending physician for:  
- All Drugs/Medicines? Yes No  
- Dietary Special Requirements? Yes No  
- Specific Therapy/Treatment? Yes No
- F. Do you conduct a nursing assessment for new residents? Yes No  
Does it include:  
- History of prior injury? Yes No  
- Disorientation? Yes No  
- Mobility limitations? Yes No  
- Required assistance? Yes No
- G. Is advance written consent obtained from resident or guardian allowing you to provide non-emergency medical care? Yes No

- H. Is smoking permitted in resident rooms? Yes                      No  
Describe other rules applying to smoking:
- I. Is there a physician on site or on call on a 24 hour basis? Yes                      No
- J. Fall Prevention
- 1) How often and when are residents assessed for their risk of falls?
  - 2) What percentage of your residents are physically restrained?
  - 3) How many residents in the past year have had falls from bed or while ambulating, which required transport of the resident to a hospital or other facility for treatment or evaluation?
- K. Elopement/Wandering Prevention
- 1) Number of residents assessed as potential elopers:
  - 2) Which of the following controls are in place:
 

Exit doors equipped with eloper alarms:	All	Some	None
Exit doors leading to fenced areas:	All	Some	None
Electronic wrist bracelets:	Yes	No	
Secure units/wings:	Yes	No	
Photos at exits:	Yes	No	
Other (describe):			
  - Is there a system in place to identify residents "at risk" for wandering? Yes                      No
  - 3) How many elopements occurred in your facilities in the past 12 months that required implementation of your elopement procedures?
- L. Pressure Ulcer and Skin Care
- 1) How many residents in the past year developed pressure sores after admission?  
Do you have a wound care team or individual responsible for this program? Yes                      No  
On average, how many residents are receiving weekly special skin care?
- M. Risk Management and Incident Reports
- Does the facility have a designated Risk Manager? Yes                      No
- 1) What criteria do you use for reporting incidents or occurrences?
  - 2) How are substantial complaints addressed?
- N. Physical/Sexual Abuse
- How many reported physical or sexual abuse incidents (upon residents) occurred in your facility in the past 12 months?
- 1) How many involved allegations of resident-to-resident physical or sexual abuse?
  - 2) How many involved allegations of employee-to-resident physical or sexual abuse?
  - 3) How many of the reported physical or sexual abuse allegations were substantiated?  
Provide complete details of substantiated physical abuse allegations:

- O. Weight Loss Monitoring and Prevention Program
- 1) How often are your residents monitored for weight loss?
  - 2) Does your facility employ a Registered Dietician to evaluate each resident's needs?  
Yes    No
  - 3) How many residents in the past year experienced a significant weight loss? (>5% in the past 30 days; or >10% in the past 180 days.)

**CONTRACTUAL AGREEMENTS**

- A. Are physicians and medical director required to carry malpractice coverage? Yes    No
- B. If yes, for what limits?
- C. Are certificates of insurance obtained? Yes    No

**BUILDING INFORMATION**

- A. Construction/Protection
1. Year built:                      Construction type:                      No. of Stories  
Square footage:
  2. Originally designed as long term care facility? Yes    No
  3. Sprinkler System - is building completely sprinklered? Yes    No  
If only partially sprinklered, what areas are sprinklered?
  4. Smoke Detectors: In all common areas? Yes    No  
In all resident rooms? Yes    No
  5. Are there at least two exits, located remotely from each other, on each floor? Yes    No
  6. Are handrails provided in hallways and bathrooms? Yes    No
  7. Are bathtubs/showers equipped with non-slip surfaces? Yes    No
  8. Are you planning any new construction for the next twelve months? Yes    No  
If yes, please describe the purpose, estimated costs and estimated completion date for such construction.
  9. Does the facility have any of the following? (*check all that apply*)  
Swimming Pool                      Exercise/Weight Room  
Sauna/HotTub                      Tennis or Racquetball Court

**CURRENT INSURANCE INFORMATION**

Current Professional/General Liability Insurer:  
 Policy Period:  
 Limits: \$  
 Deductible or Self Insured Retention: \$  
 Claims Made Form?                      or, Occurrence Form?  
 If Claims Made, Retroactive Date:                      Premium: \$  
 Employee Benefits Liability Retroactive Date:

**ATTACHMENTS**

Please attach the following:

- 1. Most recent audited financial statement
- 2. Loss Runs for the last five years with a Loss Summary Sheet outlining the claims
- 3. Copy of all Licenses

THE UNDERSIGNED DECLARES THAT THE STATEMENTS SET FORTH HEREIN ARE TRUE. THE UNDERSIGNED AGREES THAT IF THE INFORMATION SUPPLIED ON THIS APPLICATION CHANGES BETWEEN THE DATE OF THIS APPLICATION AND THE EFFECTIVE DATE OF THE INSURANCE, HE/SHE (UNDERSIGNED) WILL IMMEDIATELY NOTIFY THE COMPANY OF SUCH CHANGES, AND THE COMPANY MAY WITHDRAW OR MODIFY ANY OUTSTANDING QUOTATIONS, AUTHORIZATION OR AGREEMENT TO BIND THE INSURANCE.

SIGNING OF THIS APPLICATION DOES NOT BIND THE APPLICANT OR THE COMPANY TO COMPLETE THE INSURANCE, BUT IT IS AGREED THAT THIS APPLICATION SHALL BE THE BASIS OF THE CONTRACT SHOULD A POLICY BE ISSUED, AND IT WILL BE ATTACHED TO AND BECOME PART OF THE POLICY.

ALL WRITTEN STATEMENTS AND MATERIALS FURNISHED TO THE COMPANY IN CONJUNCTION WITH THIS APPLICATION ARE HEREBY INCORPORATED BY REFERENCE INTO THE APPLICATION AND MADE A PART THEREOF.

Applicant Name:

Applicant Signature:

Printed Name & Title

Date

Please list all other locations with common ownership/management that are not included in this proposal:

Name	Address	Owned or Managed
------	---------	------------------

Please list all details of any de-licensing, de-certification, license restrictions, etc (also attach supporting documentation):

**Patient care definitions:****Sub-Acute:**

Ventilator care, wound management, post-operative/trauma recovery, intravenous antibiotic and/or hydration therapy, spinal cord/head injury, oncology, total parenteral nutrition (TPN), blood plasma transfusion, central line care, tracheostomy, dialysis.

**Skilled Care Services**

Professional nursing care – 24 hours by licensed nurses. Registered nurse coverage during the day shift. LPN coverage required during other shifts. Skilled care services usually include some or all of the following: medical administration, other procedures ordered by physician, injections, tube feeding, catheterizations

**Intermediate Care Services**

Nursing care during the day shift, 7 days, per week, by either RN's or LPN's. No complex nursing care (IV's, tube feeding, etc). Assistance with activities of daily living (e.g., walking, bathing, dressing, eating). Some assistance with administering medications.

**Residential Care Services (includes "Assisted Living" and/or "Personal Care")**

Residents are ambulatory with possible minor disorders, provided protective environments (meals and planned programs for social and/or spiritual needs). Residents are eligible for incidental health care services, including assistance with medications.

**Independent Living**

Residents at retirement age and in general good health, occupy apartment, condominium, or dwelling units that normally include cooking facilities. Residents do not receive any health care services or assistance with medications.