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.)

	1ST SHIFT	2ND SHIFT	3RD SHIFT
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.) or N/A

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	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.