

# Long Term Care Application for Professional Liability and General Liability Insurance

Each question must be fully answered. If not applicable, please state "N/A"

(Complete a separate application for each location)

Requested effective date: \_\_\_\_\_

## PART I - GENERAL INFORMATION

1 a. **Name of Applicant** \_\_\_\_\_  
 (Include full legal entity and all trade names. Attach a separate sheet if necessary)

Street address \_\_\_\_\_ City, State, Zip \_\_\_\_\_

b. **Name of facility** \_\_\_\_\_

Physical address of facility \_\_\_\_\_ City, State, Zip \_\_\_\_\_

Telephone No: \_\_\_\_\_ Fax Number \_\_\_\_\_

Web Site: www. \_\_\_\_\_ Email address \_\_\_\_\_

2 a. Number of years this facility has been:  
 Operating \_\_\_\_\_ Owned by present owners \_\_\_\_\_ Managed by present management company \_\_\_\_\_

b. Current Administration:

Position	Name	Years in this position at Facility	Years of Experience in position	Full Time	Part Time
Administrator					
Risk Manager					
DON/DNS					
Medical Director					

3 a. Organizational Structure (check all that apply):  
 Individual  Corporation  Partnership  Joint Venture  LLC  Governmental  Other \_\_\_\_\_

For Profit  Not for Profit  Medicare certified  Medicaid certified  Accredited by JCAHO

b. Applicant's interest in facility is:  Owner  Lessor  Management Company  Tenant.  Other \_\_\_\_\_

c. If management company, provide name and corporate address

\_\_\_\_\_  
 \_\_\_\_\_

d. Name and address of all similar facilities managed by this management company (if not included in submission for coverage):

\_\_\_\_\_  
 \_\_\_\_\_

4. Is the applicant engaged in, owned by or associated with or involved in any other enterprise?  
 Yes  No If yes, please describe \_\_\_\_\_
5. Is the facility licensed by the state that they operate in?  Yes  No
- a. Has license ever been revoked or suspended?  Yes  No  
 If so, please provide full details \_\_\_\_\_
- b. Has there been a disruption in Medicare or Medicaid certification?  Yes  No  
 If so, please provide full details \_\_\_\_\_
6. Surveys and Inspections:
- a. Date of last Dept of Health survey: \_\_\_\_\_ b. Date of last HCFA Life Safety Inspection: \_\_\_\_\_
- c. Date of last Fire Marshall Inspection: \_\_\_\_\_
- d. Date of any complaints or sentinel event investigation(s) within prior 18 months? \_\_\_\_\_ ATTACH COPY

**PART 11 - DESCRIPTION OF SERVICES**

1.a. Beds:	Number of Licensed Beds	Number Occupied
<b>SUBACUTE/REHAB CARE -</b> Provides comprehensive inpatient care designed for someone who had an acute illness, injury, or exacerbation of disease process. It is a goal-orientated treatment requiring the coordinated services of an interdisciplinary team and rendered immediately after, or instead of, acute hospitalization to treat one or more complex medical conditions. Subacute is generally more intensive than traditional nursing facility care and less intensive than acute inpatient care.	_____	_____
<b>SKILLED NURSING CARE -</b> Inpatient nursing services to residents requiring 24-hour medical and nursing care. Skilled care services usually include some or all of the following: I.V., medical administration, suctioning, tube feeding, catheterization, other procedures ordered by physicians.	_____	_____
<b>INTERMEDIATE CARE -</b> Inpatient nursing services to residents, but not a continuous basis. Residents may require some minor nursing care or help in daily activities such as taking of medications, bathing, dressing, and walking.	_____	_____
<b>ASSISTED/RESIDENTIAL CARE -</b> Provides minimal nursing services to residents with possible minor medical disorders, but only as an adjunct to its primary residential or sheltered care function. May assist individuals with their everyday essential activities.	_____	_____
<b>INDEPENDENT LIVING -</b> Retirement communities where residents live in apartments, and nursing care or personal care services are available on an incidental or emergency basis.	_____	_____
OTHER (please describe): _____		

b. Other Professional Liability Exposures:

- Adult Day Care  #of Licensed beds \_\_\_\_\_  # of client days per year \_\_\_\_\_  
 Hospice Care  # of residents \_\_\_\_\_  
 Home Health Care  # of visits per year \_\_\_\_\_  
 Respite Care  # of client days per year \_\_\_\_\_  
 Child Day Care  **NOTE: We are unable to provide coverage for this service.**  
 Other \_\_\_\_\_

c. Provide percentage of payment/reimbursement in each category:

Medicaid: \_\_\_\_\_ Medicare: \_\_\_\_\_ Private Pay: \_\_\_\_\_ Other: \_\_\_\_\_

2. Patient Census - Residents receiving services relating to:

Service	# Ambulatory	# Non-Ambulatory
Skilled Nursing Care		
Intermediate Nursing Care		
Alzheimer/Dementia		
Rehabilitation (PT, OT, ST)		
Drug or Alcohol Rehabilitation		
Psychiatric Care		
Mental Retardation		
Subacute/Rehabilitation		
Other (specify):		

3. Patient Ages:

Age Group	# of Designated/Licensed Beds	# of occupied beds
Less than 25		
25-54		
55-64		
Over 65		

Youngest: \_\_\_\_\_ Oldest: \_\_\_\_\_ Average Age: \_\_\_\_\_

For residents aged 0 - 25, please provide primary diagnosis: \_\_\_\_\_

**PART III - ADMISSION POLICIES**

1. a. Is a nursing assessment conducted for all new residents, including readmissions?  Yes  No  
 If yes, does this assessment include the evaluation of:
- |  |   |  |                          |
|--|---|--|--------------------------|
| <input type="checkbox"/> Yes <input type="checkbox"/> No | Mobility limitations                              | <input type="checkbox"/> Yes <input type="checkbox"/> No | History of skin problems |
| <input type="checkbox"/> Yes <input type="checkbox"/> No | History of prior injuries                         | <input type="checkbox"/> Yes <input type="checkbox"/> No | History of falls         |
| <input type="checkbox"/> Yes <input type="checkbox"/> No | Required assistance                               | <input type="checkbox"/> Yes <input type="checkbox"/> No | Psychiatric history      |
| <input type="checkbox"/> Yes <input type="checkbox"/> No | Disorientation, history of wandering or elopement | <input type="checkbox"/> Yes <input type="checkbox"/> No | Cognition limitations    |
- b. Are attending physician written orders required for admission?  Yes  No  
 c. Do you accept residents who are a threat to themselves or others?  Yes  No  
 d. Is a current (within last 60 days) physical required before admission?  Yes  No  
 e. How often is the care plan updated? \_\_\_\_\_
2. Do residents have their own attending physician?  Yes  No  
 If no, who performs the role of the attending physician? \_\_\_\_\_  
 How many residents utilize the Medical Director as their attending physician? \_\_\_\_\_

**PART IV - RISK MANAGEMENT**

- 1. Is there a corporate Risk Management Program?  Yes  No
  
- 2. Risk manager responsibilities:
  - a. Loss control:  Yes  No
  - b. Identification and investigation of potential claims:  Yes  No
  - c. Safety/Security:  Yes  No
  
- 3. Does the risk management program include the following:
  - a. Incident Reporting/Critical Indicator Screening:  Yes  No
  - b. Claims Management:  Yes  No
  - c. Patient complaint/grievance procedures:  Yes  No
  - d. Contract review and evaluation:  Yes  No
  
- 4. Is there a written emergency plan?  Yes  No
  - a. Does the plan include advance arrangements for transportation/shelter?  Yes  No
  - b. Are evacuation directions posted on all parts of your facility?  Yes  No
  
- 5. Does your staff orientation plan include a review and walk thru disaster plan?  Yes  No

**PART V - MONITORING & CONTROLS**

- 1. Are residents allowed to leave the premises unattended?  Yes  No  
 If yes, what procedures have been implemented to monitor their whereabouts? \_\_\_\_\_

**2. Fall prevention:**

- a. Do you have a fall prevention program?  Yes  No
- b. Does it include an assessment tool for identifying patients at risk for falls?  Yes  No
- c. Are fall precautions implemented based on level of risk determined by assessment?  Yes  No
- d. Are falls monitored and tracked to identify patterns or problems?  Yes  No
- e. Are handrails provided in halls and bathrooms?  Yes  No
- f. Are the bathtub and shower flooring nonskid?  Yes  No
- g. Are call buttons operational in each room?  Yes  No If yes, who responds? \_\_\_\_\_
- h. Are all residents accounted for at least once every 24 hours?  Yes  No
- i. Is there a 24-hour "Awake Staff" on premises?  Yes  No

**3. Alzheimer's/Dementia or Mentally Impaired Residents:**

- a. Please check the most appropriate
  - The entire facility is designed for Specialized Alzheimer's or Related Disorders
  - There is a Specialized Alzheimer's Unit within the facility
  - There is no special Alzheimer's or Related Disorders Unit. Residents are integrated into the overall population.
  
- b. What is the screening process for residents at risk for wandering? Check all that apply.
  - Preadmission assessment
  - Elopement Risk Assessment completed on admission
  - Assessment completed  quarterly  annually  other \_\_\_\_\_
  - Staff reports wandering behavior to DON or Social Worker for follow up
  - None of the above

c. How are resident at risk for wandering protected by your staff? Check all that apply:

Doors accessible to wandering residents are secured with a coded keypad for entry and exit

All  Some  None

Exits are equipped with "WanderGuard" or a similar wander alert system

All  Some  None

Windows only open to a secure courtyard or other fenced area

All  Some  None

Unsecured doors open to a secure courtyard or other fenced area

All  Some  None

Unsecured windows open to a secure courtyard or other fenced area

All  Some  None

Unattended doors have exit alarms that must be turned off

at the door  from the nurses station or another remote location

d. If "WanderGuard" or similar alert system is used?  Yes  No If yes, check all that apply:

The system is checked for defaults on what basis?  daily  weekly  monthly

A "dummy" bracelet is used by staff to check the system on what basis?  daily  weekly  monthly

A system is in place to report malfunctioning bracelets and alarm defects  Yes  No

Alternate methods are in place in the event of system failures  Yes  No

Arm or ankle bands are checked for accurate activation, damage and proper fit on what basis?  daily  weekly  monthly

Door alarms are checked for proper operation on what basis?  daily  weekly  monthly

e. Does the behavior management program include:

Behavior Management Programs are in place for individualized behavior?  Yes  No

Activities Programs are individualized per resident?  Yes  No

Group activities are conducted \_\_\_\_\_ times per week

Structured Activities are planned and conducted by a registered or certified staff member specifically trained for the residents?  Yes  No

f. Elopement Management

Number of elopements in past 12 months \_\_\_\_\_

Number of elopements in past 12 months that resulted in injury to resident \_\_\_\_\_

Number of elopements in past 12 months that resulted in death of resident \_\_\_\_\_

*Attach a copy of your incident reports for each of the missing resident/elopement incident(s)*

**4. Physical and chemical restraints:**

a. Is there a program in place to reduce the use of restraints?  Yes  No

b. Are restraints used only as a last resort after less restrictive alternatives have been tried?  Yes  No

c. Is the use of restraints continuously evaluated and monitored?  Yes  No

d. Is physician evaluation and written notice from the physician (except in the case of emergency) required for the use of chemical or physical restraints?  Yes  No

e. Is patient or patient's legal representative/guardian required to approve the use of chemical or physical restraints in writing?  Yes  No

f. Chemical restraints are currently in place for (enter number) \_\_\_\_\_ of residents

g. Physical restraints are currently in place for (enter number) \_\_\_\_\_ of residents

h. What type of physical restraints are used?

Lap buddies  Waist belts  Chest or vest restraints

Geri chairs  Side rails  Lap trays

Other \_\_\_\_\_

i. Are any restraints applied while the resident is in bed?  Yes  No

**5. Skin Care**

- a. Are there written policies and procedures for the prevention and treatment of skin breakdown?  Yes  No
- b. Are all patients evaluated for skin breakdown and risk of breakdown at the time of admission?  Yes  No
- c. Are there policies and procedures for skin care and treatment based on the resident's condition?  Yes  No
- d. How often do nurses perform total body skin assessments? \_\_\_\_\_
- e. Is there a wound care nurse on staff?  Yes  No

Current resident population with Decubitus Ulcers:

Stage	# of Acquired Ulcers	# of Inherited Ulcers	Reporting Period (month/year)
I			
II			
III			
IV			

**6. Medications:**

- a. Are medications self-administered?  Yes  No
- b. If yes, what percentage of residents self-administer? \_\_\_\_\_% Does this include injections?  Yes  No
- c. Who dispenses medications to the residents?  RN  LVN  Medication Aide  Other \_\_\_\_\_
- d. Where are medications stored? \_\_\_\_\_
- e. Are medications kept under locked conditions?  Yes  No
- f. Do only authorized personal have keys?  Yes  No
- g. How are medications packaged when received from the vendor? (ie. bubble pack, etc.) \_\_\_\_\_
- h. Is there a system in place to track medication errors?  Yes  No
- i. What is your medication error rate for the last month? \_\_\_\_\_ as of \_\_\_\_\_
- j. Are physician orders required for all medications including over the counter medications?  Yes  No

**7. Smoking policies and procedures:**

- a. Are any residents allowed to smoke unattended?  Yes  No  
If yes, under what circumstances? \_\_\_\_\_
- b. Are residents allowed to possess their own matches or lighters?  Yes  No  
If yes, under what circumstances? \_\_\_\_\_
- c. Is smoking allowed in the residents' room?  Yes  No
- d. Where are the designated smoking areas? \_\_\_\_\_ Inside  Outside
- e. Are smoking areas directly supervised by a member of the staff?  Yes  No
- f. Are fire alarms in place and fully functional in all smoking areas?  Yes  No

**PART VI - STAFFING**

1. Staff/Resident ratios over a 2 week time period; Average Census: \_\_\_\_\_

Provide total number of standard daily staff working on each shift below:

Staff member	Day Shift	Evening Shift	Night Shift	Carry their own malpractice insurance?
DON/ADON				<input type="checkbox"/> Yes <input type="checkbox"/> No
RN				<input type="checkbox"/> Yes <input type="checkbox"/> No
LPN				<input type="checkbox"/> Yes <input type="checkbox"/> No
CNAs				<input type="checkbox"/> Yes <input type="checkbox"/> No
Resident Assistants				<input type="checkbox"/> Yes <input type="checkbox"/> No
Medication Aide				<input type="checkbox"/> Yes <input type="checkbox"/> No
Contracted Physicians				<input type="checkbox"/> Yes <input type="checkbox"/> No
Other _____				<input type="checkbox"/> Yes <input type="checkbox"/> No

a. Annual employee turnover rate: RNs: \_\_\_\_\_ LPNs: \_\_\_\_\_ CNAs: \_\_\_\_\_  
 b. Describe procedure for maintaining copies of current licenses for all licensed employees and/or contractors. \_\_\_\_\_

2. a. Is the facility a drug and alcohol free workplace?  Yes  No  
 b. Is 24-hour supervision of all employees provided?  Yes  No

3. Employee Screening:

Does the employee screening/hiring process include the following:

- a. Education  Yes  No  
 b. Licensure/certification  Yes  No  
 c. Employment history  Yes  No  
 d. Criminal background check  Yes  No  
 e. Drug Screening  Yes  No  
 f. Skills assessment and verification  Yes  No  
 g. Abuse registry  Yes  No  
 h. Are pre-employment physicals, including mobility screening required of all employees?  Yes  No

4. Does the applicant utilize temporary nurses/nursing registry?  Yes  No  
 If yes, what is the percentage of temporary nurses/nursing registry? \_\_\_\_\_

5. Are volunteers utilized?  Yes  No

If yes, describe selection process and training provided:

Is there a written screening and selection process?  Yes  No

6. Describe training for all NEW employees for each class of employee:

RN: \_\_\_\_\_  
 LPN: \_\_\_\_\_  
 RESIDENT ASSISTANTS: \_\_\_\_\_  
 DRIVERS: \_\_\_\_\_  
 OTHER (SPECIFY): \_\_\_\_\_

7. Are employees competencies assessed?  Yes  No

If yes, list positions and frequency of testing: \_\_\_\_\_

8. How many in-service hours are required for employees on an annual basis? RNs: \_\_\_\_\_ LPNs: \_\_\_\_\_ CNAs: \_\_\_\_\_

**PART VII - OTHER EXPOSURES**

1. Recreational facilities: Check all that apply

- None  
 Swimming Pool Please provide description including depths, supervision and location

Fenced Yes  No  Fence height: \_\_\_\_\_

Locked Yes  No  Lock type: \_\_\_\_\_

Are residents permitted to use the pool without staff present?  Yes  No

Do any of the units open directly to the pool?  Yes  No

Is the pool  Indoors  Outdoors

- Exercise/Weight room  
 Sauna/Hot Tub area  
 Other recreational facilities \_\_\_\_\_

2. Fully describe all bodies of water on the premises, their use and safeguards currently in place:

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3. Are there any sporting events involving residents Yes  No  If yes, fully describe

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4. a. Is alcohol served or allowed on the premises?  Yes  No

b. If so, fully describe under what circumstances, how often and for what purpose? \_\_\_\_\_

c. Amount of receipts generated from such sales \$ \_\_\_\_\_

5. Are pets allowed on the premises?  Yes  No If yes, under what circumstances? \_\_\_\_\_

Are owners required to provide proof of all necessary vaccinations?  Yes  No

6. a. Fully describe all off premises activities sponsored or conducted by the facility in the past three months. (You may attach your activities calendar.)

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b. As respects all of the above recreational or off site activities:  
are they restricted to resident use only?  Yes  No

may the public use the facilities or be a part of the outings?  Yes  No

If the public is included, please provide full details:

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### PART VIII - TRANSPORTATION

1. Does the facility own or lease vans or other vehicles?  Yes  No

a. If yes, fully describe the use of these vehicles \_\_\_\_\_

b. If the facility does not own any vehicles for the use of transporting residents, is this service contracted to a third party?

Yes  No If yes, who assists residents into the contracted vehicles? \_\_\_\_\_

2. Does the facility provide transportation to facility sponsored activities?  Yes  No

3. What safety equipment is standard on the facility owned vehicles? \_\_\_\_\_

4. Are employed drivers trained in the proper use of the safety devices?  Yes  No

5. Do employees transport residents in their own automobiles?  Yes  No

6. Are residents allowed to use public transportation unassisted and unattended?  Yes  No

7. Are there written transportation arrangements for residents at time of medical emergencies?  Yes  No

If yes, outline the procedure to be followed:

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**PART IX - CONTRACTUAL AGREEMENTS**

Please indicate which of the following services you utilize on a contracted basis:

Service	Check all that apply	Do you verify on an annual basis?			
		Licenses		Certificates of Insurance	
Physician		<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Nursing		<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Dental		<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Social Services		<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Laboratory		<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Recreation Services		<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Psychiatric		<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Therapy (PT, OT, Speech)		<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Pharmaceutical		<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Dietary		<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Medical Records		<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Barber/Beautician		<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Exterminator		<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Other _____		<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> No

**PART X - DESCRIPTION OF BUILDING**

*If multiple buildings, answer for each on a separate page*

- Is the applicant:  building owner     tenant     general lessee
- Was the building originally designed and constructed for elder care occupancy?  Yes     No  
If no, what was the original building occupancy? \_\_\_\_\_
- Does this location meet all applicable NFPA life safety codes?  Yes     No
- Has your facility ever been inspected or tested for mold, spores, fungus, mildew, yeast and/or other toxins?  Yes     No  
If any of the foregoing were discovered, were proper steps taken to remove, contain, clean up or treat these toxins?  
 Yes     No If no, please explain in detail: \_\_\_\_\_  
Have steps been taken for prevention of future occurrences?  Yes     No Please explain in detail: \_\_\_\_\_

5. Check areas where the following are located:

	Smoke Detectors	Sprinklers
None		
Common areas		
Hallways		
Resident Rooms		
Other		
Other _____		

- Are smoke detectors hard wired to central station?  Yes     No  
Where is the automatic contact?  
 Fire Department     Nurses station     Office  
 Other \_\_\_\_\_

- Construction of building \_\_\_\_\_
  - Year built \_\_\_\_\_    Year Remodeled \_\_\_\_\_    Years of Additions \_\_\_\_\_

c. Type of wiring \_\_\_\_\_ Year wiring was last updated \_\_\_\_\_  
 Does the facility have a back-up power supply?  Yes  No  
 If yes, please describe: \_\_\_\_\_

d. Number of floors \_\_\_\_\_

8. Number of non-ambulatory residents on each floor

1st \_\_\_\_\_ 2nd \_\_\_\_\_ 3rd \_\_\_\_\_ 4th \_\_\_\_\_

9a. Number of fire escapes/exits \_\_\_\_\_ b. Number of fire extinguishers \_\_\_\_\_

10. How often are evacuation and fire drills conducted each year? \_\_\_\_\_ On all shifts?  Yes  No

11. Does the applicant contemplate any new construction for this year?  Yes  No  
 If yes, please provide details: \_\_\_\_\_

**PART XI - CURRENT INSURANCE**

1. Does the facility have Worker's Compensation coverage in force?  Yes  No

2. a. Has facility had previous general liability AND professional liability insurance?  Yes  No  
 If yes, who is the insurance carrier? \_\_\_\_\_

b. What are the current limits of liability? \_\_\_\_\_

c. What is the current policy form?  Occurrence  Claims made  
 If claims made, what is the retroactive date? \_\_\_\_\_

d. What is the expiring:  
 Premium \$ \_\_\_\_\_  
 Deductible \$ \_\_\_\_\_  
 Policy period From: \_\_\_\_\_ To: \_\_\_\_\_

3. a. Does current policy provide coverage for physical/sexual abuse & molestation?  Yes  No  
 If yes, what are the limits of liability? \_\_\_\_\_

b. Was there a separate charge for this enhancement?  Yes  No

4. Does current policy provide coverage for defense in addition to the limit of liability?  Yes  No

5. Does current policy provide coverage for Punitive Damages?  Yes  No  
 If yes, was there a separate charge for this enhancement?  Yes  No

6. Is the current carrier offering renewal?  Yes  No

*If no, please attach a copy of the non-renewal notice.*

7. If carrier is offering renewal, explain reason for submitting account to us

8. Please list the prior 5 years of professional and general liability insurance carriers, effective dates and policy numbers.

Effective Dates	Carrier	Policy Number

