APPLICATION FOR LONG-TERM CARE FACILITIES

(Nursing Homes, Assisted Living, Residential Facilities)

PROFESSIONAL & GENERAL LIABILITY INSURANCE

A. INSTRUCTIONS

1. Please type or print clearly.
2. Answer ALL questions completely leaving no blanks. If any questions do not apply, print N/A in the space.
3. If additional space is needed to answer any questions fully, attach a separate page.
4. This application must be completed, dated and signed by a principal or officer of the business.

B. ATTACHMENTS

Please include the following attachments with this application:

1. Attachment #1 – Schedule of Locations to be covered.
2. Attachment #2 – Risk Management Addendum.
3. Organizational Chart.
4. Historical Bed Count by State for the past 10 years.
5. 10 Years of Company Produced Loss Information.
6. Most Recent CPA Prepared Financial Statements.
7. Resident Admission Agreement.
8. Advertisements and Marketing Material.
9. For Assisted Living Facilities – Description of levels of service with number of Residents at each level.

C. GENERAL INFORMATION

1. New Application ☐ **If Renewal, please give policy #** ☐

2. Applicant Name: ☐

3. Street Address: ☐

4. Telephone: ☐

5. Contact Person for Risk Management Survey: ☐

6. Title: ☐

7. Type of Operation: ☐

8. Total Number of Locations: ☐

***** Attachment #1 must also be completed. *****

9. Number of Years Applicant has been:

- **a. Operating** ☐
- **b. Owned by Present Owners** ☐
- **c. Managed by Present Management** ☐

D. Current Coverage

1. **Insurance Carrier:**
2. **Professional Liability Per Claim Limit**
3. **General Liability Limit Per Claim Limit**
4. **Policy Aggregate:**
5. **Per Claim Deductible / SIR :**
6. **Annual Premium:**
7. **Coverage Form (Check One):** **Occurrence** ☐ **Claims Made** ☐
8. **Retroactive Date (For CM Coverage Only):**
9. **Policy Expiration Date:**
10. **Has coverage ever been cancelled or non-renewed?**

If yes, when and state reason:

10. **Total Excess Professional / GL Limits Purchased:**
11. **Insurance Carrier:**
12. **Annual Premium:**

E. CORPORATE STRUCTURE / OPERATIONS ***Please Attach Organizational Chart***

1. **Is the Applicant:**

	YES	NO
a. Part of a chain?		
If yes, total number of locations in chain?		
	YES	**NO**
b. Located within a Hospital System?		
c. For-Profit?		
d. Not-for-Profit?		
e. Corporation?		
f. Partnership?		
g. Joint Venture?		
h. Medicaid Certified?		
i. Medicare Certified?		

2. Are any locations operated by an outside Management Company?	**YES**	**NO**

If yes, please explain:

3. Have any locations been acquired in the past three years?	**YES**	**NO**

If yes, please explain:

4. Have any locations been closed, sold or otherwise divested in the past three years?	**YES**	**NO**

If yes, please list facility name, state, # licensed beds:

5. Are you planning to acquire or open any new locations in the next year?

YES	NO

If yes, please list facility location, # licensed beds and beds classification:

6. Do you operate or manage any locations for which you are NOT applying for coverage?

YES	NO

If yes, please describe:

F. SCHEDULE OF LOCATIONS TO BE COVERED

*** ATTACHMENT #1 Must be Completed ***

G. LICENSING / CERTIFICATION

1. Has your state license for any location been limited, suspended or revoked within the last three years?

YES	NO

If yes, please describe:

2. Has your Medicare or Medicaid certification for any location been limited, suspended, or revoked within the last three years?

YES	NO

If yes, please describe:

3. Have any of your locations been placed under Immediate Jeopardy during the past three years?

YES	NO

4. Are there any current investigations, aside from routine surveys, into the applicant's operation by any other government agency/body?

YES	NO

If yes, please describe:

H. ADDITIONAL SERVICES

1. Please indicate if any of the following services are provided at your facility. For any service offered marked "Yes", on a separate sheet provide a detailed description of the services being provided.

	Employed		Contracted		Insurance Limit Required
	YES	NO	YES	NO	
a. Physicians					
b. Dentists					
c. Podiatrists					
d. Chiropractors					
e. Psychologists/Psychiatrists					

	Service Offered		Contracted		Insurance Limit Required
	YES	NO	YES	NO	
f. Occupational Rehabilitation					
g. Respiratory Therapy					
h. Physical Therapy					
i. Speech Therapy					
j. Alzheimer's Special Unit					
k. Alcohol or Drug Treatment					

2. **Are Certificates of Insurance obtained and updated annually for all professional services that are contracted?**

YES	NO

3. **Additional Services:**

YES	NO

a. Do you have an in-house pharmacy?
   i.) If yes, number of employed pharmacists:
   ii.) If yes, report total annual sales:

YES	NO

b. Do you offer Home Health?

If yes, give the number of visits per year, by location:

YES	NO

c. Do you offer Adult Day Care?
   i.) If yes, do you administer medication?
   ii) If yes, do you provide transportation?
   iii.) If yes, do you have Alzheimer patients?

YES	NO

iv.) If yes, average daily attendance, by location:

d. Do you have any non-geriatric chronic care / rehab beds?
   If yes, describe the amount and type of services provided:

YES	NO

e. Do you offer on site Day Care for Children?

YES	NO

If yes, average daily attendance, by location:

f. Are any other Social Services provided?
   If yes, provide detailed description with exposure amount:

YES	NO

g. Are there any other Services and/or Products offered that are NOT documented above?

YES	NO

If yes, describe:

I. ADMINISTRATION AND STAFFING

1. For EACH facility for which you are applying for coverage, do you:

	YES	NO	
a. Employ a full-time Medical Director?			
b. Employ a full-time Director of Nursing?			
c. Employ a full-time Risk Manager?			Number
d. Do you have any leased Employees?			
e. Do you have any temporary Employees?			

2. Describe how Risk Management is structured within your facility?

3. For all employees, prior to hiring, do you check:

	YES	NO
a. Educational background and training?		
b. Work background with at least two previous employers?		
c. Criminal records?		
i.) Local?		
ii.) State?		
iii.) National?		
d. Driving Record?		
e. Credit Reports?		
f. Drug Tests?		

4. Is any part of your workforce unionized?

YES	NO

If yes, please describe:

5. In the past five years have there been any actual, or threatened work stoppages/strikes? If yes, please explain:

YES	NO

6. Do you have written policies that address each of the following:

	YES	NO
a. Workplace rules?		
b. Expected Standards of Patient Care?		
c. Charting Requirements for Staff Members?		
d. Grievance Procedures for Employees?		
e. Competency based written performance evaluations?		
i.) Are these given to all employees at least annually?		
f. Progressive discipline program for under-performing employees?		
g. Are exit interviews conducted following all employee terminations?		
i.) Are results of these interviews documented in writing?		

	YES	NO
h. Do you have an on-going training program?		
i.) Are all employees required to attend?		

ii.) Who is responsible in your organization for training of employees (title)? _____

iii.) How often are training sessions held? _____

Describe training sessions held over the past 12 months?

J. PATIENT INFORMATION

1. Patient Information

	YES	NO
a. Do you require a full physical examination of every patient prior to admittance?		
b. Is a nursing assessment conducted for every new patient?		
c. Does every resident sign a Resident Agreement upon entering your facility?		
d. Does this agreement contain a mandatory arbitration clause where allowed?		
e. Does this agreement contain a limitation of liability clause where allowed?		
f. Do you have a written grievance procedure for Residents (attach copy)?		
g. Do you have a written grievance procedure for family members (attach copy)?		
h. Do all patients have their own attending physician ?		

i.) If no, who performs the role of attending physician?

i. Who determines if a patient must be transferred to another facility for further medical diagnosis or treatment?

	YES	NO
j. Do you obtain advance written consent from the patient or guardian that allows your facility to provide non-emergency medical care when it is needed?		

2. What is your policy on the charting requirements of attending physicians?

	YES	NO	Number
a. Do you have any employed physicians on staff?			
b. Do you retain a physician on-site or on-call on a 24 hour basis?			

3. Do you accept any residents under the age of 50?	YES	NO	Number
If yes, please explain:			

4. Do you accept pediatric patients (0-18 Years of Age)?	YES	NO	Number
If yes, please explain:			

5. Do you accept any non-geriatric residents with mental disabilities?	YES	NO	Number
Please explain:			

K. LOSS HISTORY

1. A claim summary showing each professional and commercial general liability claim or suit brought against your company during the last ten years is a mandatory part of this application. If this claims summary is not included with the application, the application may not be processed.

Include the following information for each claim:

a) Date of loss / occurrence / medical incident.
b) Date loss was reported to the insurance company.
c) Name of facility where loss took place.
d) Brief description of the loss.
e) Amount of indemnity, defense and current reserve.
f) Current status of the claim (open or closed).

2. Indicate the source of this loss information.

3. Indicate the valuation date of this loss information

4. Does loss information include ALL historical losses for ALL insured locations?

YES	NO

If no, please explain:

5. Have you EVER been sued by, or have you EVER had a request for records from, the law firm of Wilkes & McHugh?

YES	NO

If yes, please explain:

6. Are you aware of any facts, incidents, or circumstances that may lead to a claim in the next 12 months?

YES	NO

If yes, please explain:

Note: Failure to disclose **KNOWN** facts, incidents, or circumstances that subsequently leads to a claim will void coverage under the policy.

L. EXCESS LIABILITY INFORMATION

1. If you are applying for coverage on an excess basis, list all Primary Liability and Workers Compensation policies.

Type of Insurance	Policy Number	Insurance Company	Policy Period From	Policy Period To	Limits	Premium

YES	NO

2. **Are you applying for excess auto coverage?**

YES	NO

a. Does your automobile liability policy cover hired and non-owned autos?

If yes, indicate the number of:

	Owned	Leased
i.) Cars		
ii.) Ambulances		
iii.) Light Trucks		
iv.) Vans / Buses		
v.) Others, Describe below:		

3. **If applying for excess auto coverage, do you have any vehicles garaged in any of the following states?**

	YES	NO	Number
a. Ohio			
b. Florida			
c. Louisiana			
d. Indiana			
e. Vermont			
f. New Hampshire			

YES	NO

4. **Do you reject uninsured / underinsured motorist coverage in the above states?**

5. **List any auto liability claims or suits made or brought against your facility during the past five years for amounts greater than $25,000? If none, state none.**

Date of Loss	Description of Loss	Status Open/Closed	Paid Amount	Reserve Amount

THIS APPLICATION DOES NOT BIND THE APPLICANT OR THE COMPANY, NOR DOES IT OBLIGATE THE COMPANY TO ISSUE A POLICY OR INSURE ANY SERVICES. HOWEVER, IT IS AGREED THAT SHOULD A POLICY BE ISSUED, THIS APPLICATION WILL BE ATTACHED TO AND MADE A PART OF THE POLICY.

NOTICE:

THE LIMIT OF LIABILITY IN THE POLICY, IF ISSUED, MAY BE REDUCED OR COMPLETELY EXHAUSTED BY CLAIM COSTS AND/OR LEGAL DEFENSE. IN SUCH EVENT, THE COMPANY SHALL NOT BE LIABLE FOR ANY JUDGEMENT, SETTLEMENT OR CLAIM COSTS OR LEGAL DEFENSE COSTS WHICH ARE IN EXCESS OF THE LIMITS OF LIABILITY STATED ON THE DECLARATIONS PAGE OF THE POLICY.

THE UNDERSIGNED(S) CERTIFIES THAT HE/SHE IS THE DULY AUTHORIZED REPRESENTATIVE(S) OF EACH PROPOSED INSURED WHO SUBMITS THIS APPLICATION TO THE LEXINGTON INSURANCE COMPANY FOR A POLICY OF INSURANCE. THE STATEMENTS AND INFORMATION ABOVE AND ALL SCHEDULES AND DOCUMENTS SUBMITTED THAT THE UNDERWRITER RECEIVES, ARE DEEMED PARTS OF THE APPLICATION (ALL OF WHICH SCHEDULES AND DOCUMENTS SHALL BE DEEMED ATTACHED TO THE POLICY AS IF PHYSICALLY ATTACHED THERETO), AND THE WORD "APPLICATION" REFERS TO ALL OF THE FOREGOING.

EACH PROPOSED INSURED REPRESENTS THAT THE STATEMENTS SET FORTH IN THE APPLICATION ARE TRUE AND CORRECT, AND THAT REASONABLE EFFORTS HAVE BEEN MADE TO OBTAIN INFORMATION SUFFICIENT FOR ACCURATE PROPOSED INSURANCE. IT IS FURTHER AGREED THAT EACH POLICY, OR RENEWAL THEREOF, IF ISSUED, IS ISSUED IN RELIANCE UPON THE TRUTH OF THE REPRESENTATIONS AND INFORMATION IN THE APPLICATION.

EACH PROPOSED INSURED UNDERSTANDS AND AGREES THAT ANY INSURANCE POLICY ISSUED BY THE COMPANY SHALL BE SUBJECT TO RESCISSION IF THIS APPLICATION CONTAINS ONE OR MORE MISREPRESENTATIONS OR OMISSIONS MATERIAL TO THE ACCEPTANCE OF THE RISK BY THE COMPANY.

IF THE INFORMATION SUPPLIED ON THIS APPLICATION OR ATTACHMENTS THERETO CHANGES BETWEEN THE DATE OF THIS APPLICATION AND THE INCEPTION DATE OF THE POLICY, THE APPLICANT WILL IMMEDIATELY NOTIFY THE COMPANY OF SUCH CHANGES.

Applicant Signature	**Title**	**Date**

ATTACHMENT #1
SCHEDULE OF LOCATIONS TO BE COVERED

Please use the following description of services to complete the spreadsheet below:

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 medical administration, tube feeding, order procedure ordered by physicians, injections or catherizations.

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 (I.e. walking, baths, dressing, eating). Some assistance with administering medications.

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

Independent Living
Residents are retirement age and in general good health, occupy apartment, condominium, or dwelling units that normally include cooking facilities.
Residents do not receive any healthcare services or assistance with medications, but do have access or intermediate nursing care within the same facility.

Please complete the following worksheet including each location to be covered, using the above definitions.
Please note that all information must be based on the total number of Licensed beds.

	Facility Name	Full Address	# Licensed Beds	# Occupied Beds	# Skilled	# Intermediate	# Residential	# Indepdent Living	#Alzheimers/ # Dementia	Wandergard Y/N	Year Built	Year Purchased	#Floors	Construction	Fire Protection (Alarms/Sprinklers)
1															
2															
3															
4															
5															
6															
7															
8															
9															
10															

ATTACHMENT # 2

HEALTHCARE RISK MANAGEMENT ASSESSMENT
Addendum to Long Term Care Application

Applicant name _____
Number of LTC facilities _____ Total number of licensed beds _____

READ CAREFULLY TO PREPARE YOUR RESPONSE:
Please provide legible responses; typed responses with attachments are preferred.
For submission of 2 or more facilities:

- **For items I through VII if there is a corporate policy in any area, please attach it. If policies vary among facilities, please attach each facility's policy.**
- **All questions in item VIII ("Additional information") require a response from each individual facility.**

I. Quality and Risk Management

1. Do you have a multi-disciplinary committee to address clinical quality and/or resident risk issues (e.g., falls, elopements, decubitus ulcers)?
   How often do they meet?
   * Attach a list of current committee members (names and titles).

2. Do you have a standard form to report resident incidents?
   * Attach resident incident report form.

3. Describe how you track, trend and use incident information for reduction of risk.
   * Attach or describe an example.

II. Staff Education and Training

1. How soon after hire must resident care employees attend/complete an orientation program?
   What topics specific to resident safety and risk management are included?
   *Attach orientation topics and/or checklist, if available.

2. Are skills validated for new employees? ☐ Yes ☐ No
   Are skills validated for current employees? ☐ Yes ☐ No
   If yes, how frequently?
   *Attach competency or skills checklist for resident care providers, if available.

3. Provide a list of all inservices conducted in the past 12 months.
   *Attach list and indicate mandatory and OSHA required inservices

III. Prevention of Elopements

1. How and when are residents assessed and identified as being at risk for wandering?
   * Attach assessment tool, if available.

2. Describe how staff are made aware of residents who are at risk for wandering.

3. Are your entrances/exits secured and alarmed?
   How frequently are security systems tested?

4. Describe other methods you use to prevent resident wandering and elopements.
   * Attach example, if available.

   * Attach your Elopement/Missing Resident Response protocol.

IV. Prevention of Falls

1. How and when are residents assessed for risk of falls?
   * Attach assessment tool, if available.

2. Describe how staff are made aware of residents who are at risk for falls.

3. Describe methods you use to prevent falls.
   * Attach procedures, if available.

V. Skin Care and Decubitus Prevention

1. How and when are residents assessed for skin breakdown and risk of decubitus?
   * Attach assessment tool, if available.

2. Describe your skin care program.
   - Attach policies and procedures, if available.

3. Describe how staff are made aware of residents at risk for skin breakdown.

4. Do you have a wound care team or designated individual responsible for this program?
   ☐ Yes ☐ No
   If yes, describe the additional training or credentials of the team/individual.

5. Describe additional examples of quality improvement efforts to reduce skin breakdown.
   * Attach example, if available (e.g., nutrition programs, weight loss management, special mattresses, etc.).

VI. Prevention of Medication Errors

1. Do you employ or contract with a registered pharmacist to supervise pharmacy services?
   ☐Yes ☐No

2. How often does the pharmacist review every resident record?

3. Describe quality improvement efforts to reduce medication errors.
   - Attach example if available.

VII. Prevention of Abuse

1. * Attach policies and procedures on resident abuse

2. Do you screen potential hires by:
   - Criminal background check ☐ Yes ☐ No
   - Query appropriate state boards and registries ☐ Yes ☐ No
   - Obtain references from past and current employers ☐ Yes ☐ No

ATTACHMENT # 2

VIII. Additional information (A response from each facility is required.)

1. Have you experienced any substantiated incidents of sexual abuse (resident upon resident, staff upon resident, visitor upon resident) in the past 12 months?
   ☐ Yes ☐ No

   If yes, please provide the number of occurrences per location with a brief narrative describing the circumstances of each incident. Number _____

2. Have you experienced other types of abuse were substantiated in the past 12 months? (Other types of abuse include verbal, physical, mental or involuntary seclusion)
   ☐ Yes ☐ No

   If yes, please provide the number of occurrences per location with a brief narrative describing the circumstances of each incident. Number _____

3. Did you experience any elopements during the past 12 months that required initiation of your elopement/missing resident response protocol? ☐ Yes ☐ No

   If yes, please provide the number of occurrences per location with a brief narrative describing the circumstances of each incident. Number _____

4. Is your facility accredited by the JCAHO? ☐Yes ☐No
   If more than one facility, number that are accredited.

5. Provide a HCFA Quality Indicator Profile report for each facility. (2 pages with 24 QI's)

   DO NOT SEND RESIDENT IDENTIFYING INFORMATION. Query the MDS database for a report period reflecting the <u>past 6 months</u> (default settings). This report must have been run within the last 30 days.

Information provided by:

_____
Signature and Title

_____
Date

7/2001