JANSEN & HASTINGS APPLICATION FOR NURSING HOME PROFESSIONAL & COMMERCIAL GENERAL LIABILITY

INSTRUCTIONS:
Please complete a separate application for each nursing home location if multiple locations exist. Please type or print clearly Answer ALL questions completely leaving no blanks. If any questions, or part thereof, do not apply, print N/A in the space. If additional space is needed to answer any questions, use the comment section or attach a separate page. This application must be completed, dated and signed by a principal of the business.

Program Manager	City	State	Principal

PART 1 - GENERAL INFORMATION

Name	Web Site Address

Street Address	PO Box	County

City	State	Zip

Telephone Number

Coverage Effective Dates

From:	To:

List below all subsidiaries, date acquired, description of operations and ownership in percentage

Subsidiaries	**Date Acquired**	% **Ownership**	**Description of Operations**

__ Individual
__ Governmental
__ Charitable
__ Partnership
__ Operated for Profit
__ Religious Affiliation
__ Corporation
__ Not for Profit
__ Medicare Certified*
__ Medicaid Certified*
__ Accredited by JCAH0
__ Licensed /Approved by State Board of Health

If not, please explain in the Comment Section (Part IIX)

Location of Nursing Home To Which This Application Refers:

Name:
Address:

Number of years this facility has been:

Operating:

Owned by Present Owners:	Managed by present management:

List all licenses held by your facility and their expiration dates: _______________
____

List all association memberships held by your facility: _______________
____

Annual Gross Receipts: Estimated next twelve months: $______________

Annual Payroll: Estimated next twelve months: $______________

Applicant/Facility is licensed for how many beds? ________ **(Attach a copy of current license)**

Please state percentage of payment/reimbursement in each category:

Medicaid: ________ Medicare: ________ Private Pay: ________ VA: ________

Other: ________ If other, advise source______________________________________

PRIMARY LIABILITY LIMITS

Professional and General Liability limits must be the same.

Professional Liability

☐ $ 1,000,000 any one occurrence and $3,000,000 in the aggregate annually.

☐ $ ___________ each wrongful act/ $ ____________ Aggregate

Commercial General Liability (Bodily Injury, Personal Injury, Property Damage & Advertising Injury)

☐ $ 1,000,000 any one occurrence and $3,000,000 in the aggregate annually.

☐ $ __________each occurrence/ $ _____________ Aggregate

DEDUCTIBLE:

__ $5,000 __ $25,000 Other: $ ____________

__ $10,000 __ $50,000

PART II - PROFESSIONAL LIABILITY/DESCRIPTION OF SERVICES

1. Facility Classification and Bed Census

	Total # of Lic. Beds	Average # Occupied
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 procedure ordered by physicians; 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 (i.e. walking, bathing, dressing, eating) some assistance with administering medications.		
Residential Care Services/assisted living 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, but do have access to skilled or intermediate nursing care within the same facility complex.		

2. Indicate all outpatient services provided by your facility with the number of such visits per year *(If none please state None)*

Services	**Visits**
Home Health Care, Personal Care, Chore or Companion Services	____________
infusion Therapy	____________
Rehabilitation Therapy	____________
Physical Therapy	____________
Adult Day Care	____________
Occupation Rehabilitation	____________
Respiratory Therapy	____________

3. **Resident Conditions**: Indicate the number of residents in each category. *Attach a copy of HCFA 672*

_________ Ambulatory (Including walkers)
_________ Semi/Non-Ambulatory
_________ Bedfast
_________ Total Occupied
(NOTE: Total Occupied should equal the total of above three categories)

_________ Residents with HIV or aids
_________ Tube Fed Residents
_________ Dependent on Eating
_________ Urinary Incontinence
_________ Behavioural Symptoms
_________ Restricted Joint Motion
_________ Unplanned Weight Loss / Gain

_________ Decubitus - Number that developed in-house _________ Stages of each _________
Number admitted with decubitus _________ Stages of each _________

Please attach a copy of Wound Care Program

_________ Restraints - Number and type of restraints used: _______________________________
Are doctors orders verified for all restraints **Yes** **No**

_________ Alzheimer Residents. Number of Alzheimer Residents including any resident assessed to be at risk for wandering or elopements.

Is there a separate Alzheimer Unit? **Yes** **No**
If yes, describe the facility: __________________________________
____

Is a Wander Guard System in place **Yes** **No**

Please attach a copy of Elopement Policies and Procedures

4. Do you accept patients who are either chemically dependent, physically impaired or mentally 1 emotionally disturbed? ☐ Yes ☐ No

5. Resident Age Groups

Age Group	No. of Patients/ Residents	% Non-Ambulatory
Under 22		
22-54		
55-64		
Over 65		

III ADMINISTRATION AND STAFF

1. **Administrator (Attach Brief Resume)**

Name: ____

Brief Summary of Administrative Experience: ____

Years of Experience: _________ Length of Employment at facility: ____________________________

2. **Director Nurses (Attach Brief Resume)**

Name: ____

Brief Summary of Experience: ____

Years of Experience: ________ Length of Employment at facility: ____________________

3. **Medical Director**

Do you employ a full-time medical director? **Yes** **No**

Name: ______________________ Years of Experience: ________________________

Brief Summary of qualifications: ____

Average number of hours, per month, spent at the facility by the Medical Director:

For administrative duties: ________ Seeing patients as a physician: ________

What percentage of the residents are private patients of the Medical Director: ________

4. For each classification listed below, show the number of employees (F/T =1, P/T = 0.5)

	1st Shift	**2nd Shift**	**3rd Shift**
Physicians			
Dentists			
Registered Nurses			
Licensed Practical Nurses			
Nurse's Aides			
Physical Therapists			
Social Workers			
Speech Pathologists			
Audiologists			
Beauticians / Barbers			
Recreation Therapist			
Activities Director			
Administrative Personnel			
Maintenance/Security Personnel			
Others - Describe			
Total Number of Employees			

4B. Total number of nurse staff hours per resident per day: ________ hours

5. Name of individual that our Risk Management Services representative may contact for an on-site inspection of your facility.

Name:	Title:
Phone Number:	

6. Please indicate all of the procedures you use when hiring professionals and para-professionals:

- ☐ Check of educational background or residency program, when applicable
- ☐ Check of previous employers: ☐ in writing ☐ by telephone
- ☐ Criminal background checks
- ☐ Check on hospital privileges for privileges for physicians, oral surgeons and dentists. How often do you update your list of specific privileges? ________________________
- ☐ Verify any pending license suspensions or revocations, or any pending disciplinary actions by others.
- ☐ Require information on any professional liability or work-related claim that has previously been made against the individual.

7. Does your facility have written job descriptions? Yes / No

8. Do you perform background checks on all potential hires? Yes / No

IV - RISK MANAGEMENT LOSS CONTROL

1. Do you require evidence of acceptable health (physical examination) of all new patients admitted to your facility? ☐ Yes ☐ No

2 What security measures are used to control unauthorised entrance to your facility?

[ ]

3. Evacuation Procedures:

Are any Non-Ambulatory patients above the ground floor?	**Yes**	**No**
Do you have a written emergency evacuation plan?	**Yes**	**No**
Does your plan include advance arrangements for transportation and temporary shelter?	**Yes**	**No**
Are evacuation directions posted in all parts of your facility?	**Yes**	**No**
Does your staff orientation plan include a review and "walk through" of any disaster plan?	**Yes**	**No**

How often are evacuations / fire drills conducted each year for each shift?

[ ]

4. Do all patients have their own attending physicians? .	**Yes**	**No**

If no, who performs the role of attending physician?

____

If employed or contract physicians, what medical malpractice limits do these individuals carry? $___________________________

5. Are attending physician written orders required for:

All drugs or medicines?	**Yes**	**No**
Special dietary requirements?	**Yes**	**No**
Any other specific therapy 1 treatment?	**Yes**	**No**
6. All medications kept under locked conditions?	**Yes**	**No**

7. How often are attending physicians required to update their patient charts? (number of days) __________

8. Is a nursing assessment conducted for new patients?	**Yes**	**No**
If Yes, does this assessment include evaluation of:		
Mobility limitations	**Yes**	**No**
History of prior injuries	**Yes**	**No**

Required assistance **Yes** **No**
Disorientation **Yes** **No**

9. Do you obtain advance (patient or guardian) written consent that allows your facility to provide non-emergency medical care when it is needed? **Yes** **No**

10. Please attach details of Restraint Polices and Procedures.

11. Do you retain (on-site or on-call) a physician on a 24-hour basis? **Yes** **No**
12. Who determines if a patient must be transferred to another facility for further medical diagnosis or treatment? ____

13. Is smoking permitted in patient rooms? **Yes** **No**

Describe any other rules applicable to smoking: ______________________________________

14. Are there alarms on exit doors to prevent patients from leaving the premises without proper authorisation?
Yes **No**
If No, how is this otherwise controlled? ____

V. CONTRACTUAL AGREEMENTS

1. Identify all contracted professional services performed for you and the minimum professional liability limits required of such contracted providers.

Description of service	Limit
	$
	$
	$
	$

2. Are there other service contracts in effect? **Yes** **No**
   Describe services:____

   Do you indemnify (hold harmless) the owner for liability? **Yes** **No**
   If yes, submit a copy of the contract.

3. Do you lease or rent any equipment from others? **Yes** **No**
   If yes, submit a copy of agreement

VI - COMMERCIAL GENERAL LIABILITY

The following information is needed for each building used for patient or resident occupancy. If you have more than one such building you should either complete a copy of this section for each additional building or provide the information in the comments section.

1. Building Identification
   Year Built ___________ No. of Stories __________ Construction __________

   Total Square Footage ______________________________

2. Was this building originally designed and constructed for nursing home occupancy? **Yes** **No**

If No, what was the original building occupancy?____

3. Smoke detectors and automatic sprinkler system: **Yes** **No**

Is the building completely sprinklered?

If partially sprinklered, identify the areas that are sprinklered _________________________________
____

Location of smoke detectors.

☐ None
☐ Hallways
☐ Commons area
☐ Patient or res. rooms
☐ Trash collection area
☐ Soiled linen areas
☐ Other – Locations ________________________

4. When was this building's electric, heating or plumbing system last inspected or updated?

	ELECTRIC	HEATING	PLUMBING
Qualified Inspection			
Replaced or Updated			

Advise age and type of heating and wiring systems. ____
____

5. When was this building last inspected by the:

Local fire authorities: __________ Month/ Year

State Dept. of Health: __________ Month/ Year

6. Are there at least two exits located remotely from each other, on each floor and fire section? **Yes** **No**

7. Do you have an auxiliary electrical system? **Yes** **No**

If no, describe the type and location of any other emergency lighting system in this building.

8. Are handrails provided in hallways and bathrooms? **Yes** **No**

9. Are bathtubs 1 showers equipped with nonslip surfaces? **Yes** **No**

10. Are all skilled or intermediate care patient beds equipped with side-rails? **Yes** **No**

11. All exit doors are equipped with alarms? **Yes** **No**

12. Are you planning any new construction for the next twelve months? **Yes** **No**

If yes, use the comment section to describe the purpose, estimated cost and estimated completion date for the construction.

13. Recreation Facilities: If none state None

	Number		Number
Swimming Pool		Exercise/Weight room	
Sauna/Hot tub		Other:	
Tennis or Racquet ball		Other:	

VII - POLICY AND LOSS INFORMATION

1. Current professional 1 general liability coverage:

Present insurance Company:	Policy Period:
Limit(s) $	Is present coverage:
Deductible(s) $	(a) 'occurrence'
Current Premium $	(b) 'Claims made' (Retro Date)

2. Losses - describe each professional or general liability claim or circumstances made or brought against your facility during the last five years. Do not include losses insured by us.

i) If a current loss summary is available (from a present or previous carrier), please attach a copy.
ii) If a summary is not available, attach a separate page showing, for each claim:
a. Date of the event and the date the claim was reported to the Insurance company.
b. Brief description of the cause of the loss or claim.
c. Current status of the claim (open or closed).
d. The paid amount and current outstanding reserve amount.

VIII – FINANCIALS

Attach a copy of the facility's latest Financial Report.

PART IX – COMMENT SECTION

THE UNDERSIGNED DECLARE 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, HEISHE (UNDERSIGNED) WILL

IMMEDIATELY NOTIFY THE UNDERWRITERS OF SUCH CHANGES, AND THE UNDERWRITERS MAY WITHDRAW OR MODIFY ANY OUTSTANDING QUOTATIONS, AUTHORIZATION OR AGREEMENT TO AGREEMENT TO BIND THE INSURANCE.

SIGNING OF THIS APPLICATION DOES NOT BIND THE APPLICANT OR THE UNDERWRITERS TO COMPLETE THE INSURANCE, BUT IT IS AGREED THAT THIS APPLICATION SHALL BE THE BASIS OF 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 UNDERWRITERS IN CONJUNCTION WITH THIS APPLICATION ARE HEREBY INCORPORATED BY REFERENCE INTO THE APPLICATION AND MADE A PART HEREOF.

NOTICE TO NEW YORK APPLICANTS: "Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information, or conceals for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act, which is a crime, and shall also be subject to a civil penalty not to exceed five thousand dollars and the stated value of the claim for each such violation"

NOTICE TO OHIO APPLICANTS: "Any person who, with intent to defraud or knowing that he is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement is guilty of insurance fraud.---

Applicant Signature ____________________

Title/Designation _____________________ Date _________________

Please attach the following items to this application.

1. Supplement to Nursing Home Application

2. Form HCFA 672 Resident Census and Condition of Resident

3. Five Years hard copy company loss runs or) If a summary is not available, attach a separate page showing, for each claim:

    a. Date of the event and the date the claim was reported to the Insurance company.
    b. Brief description of the cause of the loss or claim.
    c. Current status of the claim (open or closed).
    d. The paid amount and current outstanding reserve amount.

4. Complete description of any loss in excess of $25,000 incurred

5. Facilities Latest Financial Report.

6. Copy of the most recent annual survey – Health Department (F Tags) and Life Safety (K Tags). Need details of any Level 3 or 4 Deficiency

7. Copy of License for each facility

8. Brief resume of Administrator

9. Brief resume of Director of Nursing

10. Copy of Contract with facility owner – (if contract contains a hold harmless).

11. Copy of a lease agreement for any equipment rented or leased by the Insured.

12. Restraint Policies and Procedures

13. Please attach a copy of Wound Care Program or Procedures

14. Please attach a copy of Elopement Policies and Procedures

15. Please attach a copy of any other Risk Management/Safety documents such as fall prevention programs, training & education, QA plans & programs.

Supplement to Long Term Care Application

(Please provide attachments to answer the questions below)

NAMED INSURED:

____

I. SAFETY COMMITTEE, RISK MANAGEMENT AND INCIDENT REPORTS

1. Describe the components of your Safety/Risk Management program as it pertains to professional liability issues.

____

____

2. What criteria do you use for incident reporting?

____

____

3. Explain how you track and trend incident information?

____

____

4. How are substantial complaints addressed?

____

____

II. STAFFING, EDUCATION AND TRAINING

1. Are all employees required to attend an orientation program prior to beginning their employment?

   ☐ Yes ☐ No

   Describe or attach the agenda for your orientation program.

____

____

2. Do you have a new employee preceptor program? ☐ Yes ☐ No
   How does it work? How long do you monitor new caregivers?

____

____

3. Do you have regularly scheduled inservices? ☐ Yes ☐ No
   Describe the type of inservices that have been conducted in the past six months.

____

____

4. How do you ensure attendance at your inservices and list what inservices have been held during the last 6 months?

ELOPEMENT PREVENTION

1. Is there a system in each facility to identify residents "at risk" for wandering? ☐ Yes ☐ No

2. How and when is your Elopement Prevention program implemented?

3. How are your entrances/exits secured?

4. Describe other methods you have to prevent patient elopements?

III. FALL PREVENTION

1. Describe your fall prevention program?

2. How and when are residents assessed for their risk of falls?

3. How are patients identified as "at risk" for falls?

4. Describe other methods you have to prevent falls?

IV. DECUBITUS PREVENTION AND SKIN CARE

1. Describe your program to prevent decubitus ulcers.

____

____

2. How often are resident skin assessments made? Provide the tool used to assess and document resident skin condition.

____

____

3. 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.

____

____

4. Describe the scale used to determine severity of decubitus ulcers?

____

____

5. On an average, how many residents are receiving special skin care weekly?

____

____

6. Describe additional quality improvement efforts to reduce decubitus ulcers.

____

____

V. MEDICATION ERRORS

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

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

____

____

III. Describe the method used to monitor medication errors.

____

____

IV. Describe the quality improvement efforts to reduce medication errors.

____

____

VI. ADDITIONAL INFORMATION

1. How many elopements occurred in your facility(s) in the past 12 months?

____

____

2. How many sexual assaults (upon residents) occurred in your facility(s) in the past 12 months?

____

____

3. Do you perform background checks on all potential hires? ☐ Yes ☐ No

4. Is your facility(s) accredited by the JCAHO? ☐ Yes ☐No