

LONG TERM SOLUTIONS FOR LONG TERM CARE

FACILITY APPLICATION FOR PROFESSIONAL AND COMMERCIAL GENERAL LIABILITY INSURANCE

A. Name Insured:

Named Insured Address:

City, State, Zip:

B. Is facility accredited by JCAHO: Yes No

C. Number of years this facility has been:

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

D. Number of visits per year for all outpatient services provided:

Services	Visits	Services	Visits
Adult Day Care		Physical Therapy	
Home Health Care		Rehab Therapy	
Infusion Therapy		Respiratory Therapy	
Occupational Therapy		Other	

E. 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.

	1 ST SHIFT	2 ND SHIFT	3 RD SHIFT
Administrative Personnel			
Dieticians			
Licensed Practical Nurses			
Maintenance/Security Personnel			
Nurse's Aides			
Physical Therapists			
Physicians			
Recreation Therapists			

Registered Nurses			
Social Workers			
Others – Describe:			

F. Is there a full time employed medical director? Yes No

G. What percentage of your residents are physically restrained?

H How often are your residents monitored for weight loss?

I. Does your facility employ a Registered Dietician to evaluate each resident’s needs? Yes No

J. How many residents in the past year experienced a significant weight loss? (5% or > in the past 30 days; or 10% or > in the past 180 days.)

K. How many complaints were investigated by the State in the past year?

- How many were substantiated?

Please provide details of each substantiated complaint

L. What is your facility’s quality improvement team doing to improve quality (i.e.: pressure ulcers, fall prevention, B&B retraining, sentinel events [fecal impaction, dehydration, and pressure ulcers in low risk residents])?

M. Has your facility ever had an immediate jeopardy determination? Yes No

If yes, please provide details

N. Have you ever been de-licensed, de-certified, issued a restricted license, had reimbursement denied, or had new admissions restricted or denied? Yes No

If yes, please provide details

GENERAL LIABILITY/BUILDING INFORMATION (Complete for Each Facility.)

A. Construction/Protection

- Year built - Construction type - Number of stories

1. Sprinkler System

- Is building completely sprinklered? Yes No

- If partially sprinklered, what areas are sprinklered? (Check all that apply)

None Soiled Linen Chutes/Rooms Hallways Trash Collection Areas

Resident Rooms Common Areas Rest Rooms Kitchens

Other

2. Smoke Detectors – Locations (check all that apply)

None Soiled Linen Chutes/Rooms Hallways Trash Collection Areas

