Christian Brothers

RISK POOLING TRUST

Administered by the Risk Management Services Division of Christian Brothers Services

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Open to the Public Care Facility

This application must be completed and signed by the applicant for each facility. In addition, the following must be attached to this application.

1. Current audited Financial Statements with Management Notes,
2. Marketing Materials and Brochures
3. Most recent 5 years loss exhibits from previous / present carrier,
4. Current Accreditation Report (JCAHO, Commission on Accreditation of Rehabilitation Facility, etc)
5. State Inspection Reports with statement of Deficiencies (and plan of corrections),
6. Copy of Quality Indicator Profile (or Reports)
7. Annual Report
8. Two latest State surveys
9. If a larger risk and where reinsurance of captive is being considered: Attach previous insurance policies, Captive financials, Trust agreement, claims handling procedures, risk management protocols and Latest Actuarial Report
10. Nursing Home Compare Report: www.medicare.gov
11. Copy of State License

GENERAL INFORMATION

1. Legal name of facility: ____________________
2. Corporate Address: ____________________
3. Owner of Facility is: ☐ Individual, ☐ Partnership, ☐ Corporation,
4. Entity is: ☐Non Profit, ☐For Profit, ☐Government, ☐ Hospital Affiliated
5. Who manages the facility if not Owner? ____________________
6. How long has the applicant been in operation as long term care business? ____________________
7. Please list licenses:

Type of Facility	License Number	States Licensed	Expiration Date
Skilled Nursing [Include Sub Acute]			
Intermediate Care			
Residential Care			
Assisted Living			
Personal Care			
Independent Care			

8. To what associations does the applicant belong? ____________________

9. Accreditation:
   a) Is this facility accredited? ☐Yes ☐ No
   b) If yes, by whom? ____________________
   c) Accreditation Score? ____________________
   d) Date of Last accreditation visit: ____________________
   e) If applicant has a personal care unit, is it accredited? ☐ Yes, ☐ No

10. Facility Operational Issues:

<u>Has the facility ever been cited for any of the following?</u>
Health code violations? ☐ Yes, ☐ No,
Restrictions or probation on license? ☐ Yes, ☐ No,
License Suspension or revocation? ☐ Yes, ☐ No,
Medicare Fraud? ☐ Yes, ☐ No,

<u>Has the facility had any of the following activities?</u>
Filed for Bankruptcy? ☐ Yes, ☐ No,
Facility Expansion? ☐ Yes, ☐ No,
Merger Acquisition? ☐ Yes, ☐ No,

If yes, please explain? ____________________

11. Indicate, which programs are in place; (please attach copy with the application)
  a) Written Safety Program including emergency evacuation plan ☐ Yes, ☐ No,
  b) Skin / Wound Protocols ☐Yes, ☐ No,
  c) Employee Selection And Training Guidelines ☐ Yes, ☐ No
  d) Fall Assessment Program ☐Yes, ☐ No
  e) Incident Reporting ☐ Yes, ☐ No

12. Does the Facility have a Risk Manager? (Yes, (No, if yes, list person(s) and qualifications. If yes, attached latest reports.

13. Does the Facility have an Outside Risk Manager? (Yes, (No, if yes, list person(s) and qualifications. If yes, attached latest reports

14. Other practices / protocols:
  a) Does the client have new employee staff orientation plan include a review and "walk through" of any disaster plan? (Yes, (No
  b) A "do not resusitate"policy in place? (Yes, (No
  c) Applicant obtains written consent from the resident or guardian that allows the facility to provide emergency medical care when it is needed? (Yes, (No
  d) Does applicant have a policy regarding the use of physical and chemical restraints? (Yes, (No
  e) Does applicant transfer patients with Stage III or IV Decubitius ulcers to another facility providing a higher level of care for treatment, or does Applicant provide treatment? (Yes, (No
  f) Does the applicant nurses perform total body skin assessments? (Yes, (No, How often _________
  g) Does the Applicant have a written policy / procedure to investigate alleged resident abuse and neglect? (Yes, (No
  h) Does the Applicant obtain advance written consent from the resident or guardian that allows the facility to provide emergency medical care when it is needed? (Yes, (No
  i) How often are attending physicians required to update their patient charts? _______________
  j) Who determines if a resident must be transferred to another facility for further medical diagnosis or treatment? ____

Type of Facility	Number of Licensed Beds	Average Occupancy %	Occupied Beds
Skilled Nursing Care [Include Sub Acute]			
a) For Profit Beds			
b) Non Profit Beds			
c) Non Profit / Religious Beds			
Intermediate Care			
a) For Profit Beds			
b) Non Profit Beds			
c) Non Profit / Religious Beds			
Residential Care [Including the following: a) Assisted Living, b) Personal Care			
a) For Profit Beds			
b) Non Profit Beds			
c) Non Profit / Religious Beds			
Independent Care			
a) For Profit Beds			
b) Non Profit Beds			
c) Non Profit / Religious Beds			

Patients and Residents

5. Number of residents by age range:
  ☐ Under 20 years ________ ☐ 40-50 __________
  ☐ 20-30 ________ ☐ 50-65 __________
  ☐ 30-40 ________ ☐ Over 65 years __________

6. Average length of stay in the nursing facility: (circle one) days / weeks / months / years ________

7. If the facility's license allows for providing treatment/care in the following areas, indicate the average daily bed occupancy for that type of care:

	Nursing Home/Personal Care		Nursing Home/Personal Care
Adult day care	______	Hospice	______
Alcohol/drug rehabilitation	______	Mentally Disabled Care	______
AIDS / HIV	______	Post operative/sub-acute	______
Alzheimer Residents	______	Psychiatric Care	______
Physical Therapy / Rehab	______	IV Infusion Therapy	______
Ventilation Therapy	______	Injections	______
Dialysis	______	Decubitius	______
Wound Care	______	Confined to Bed	______
Tube Feeding	______		______

8. Number of residents assessed as potential elopers:
   a. in nursing facility _________________
   b. in personal care facility ____________

9. Check techniques in place to control identified potential elopers:
   Exit doors equipped with eloper alarms ☐ Yes, ☐ No
   Exit doors leading to fenced areas ☐Yes, (No Secure units/wings (Yes, (No
   Electronic wrist bracelets (Yes, (No

10. Number of non-ambulatory patients:

11. a. Does facility provide home care? (Yes, (No, if yes, annual number of calls made by visiting nurse(s): _______
    b. Describe the services provided by the visiting nurse(s) ____

12. a. Does facility provide outpatient medical services? (Yes, (No If yes, please describe types of services provided _

    b. Annual number of patients seen: __________ are these services limited to residents of the facility (Yes, (No

13. Staff:

a) Nursing staff on duty

	Employed			Agency/pool service		
	Day Shift	Evening Shift	Night Shift	Day Shift	Evening Shift	Night Shift
RNs						
LPNs / LVNs						
Nurse Practitioners						
Nurses'aides						
Certified Nurse Assistants or NAS in training; medication techs						
Total for Nursing Facility						
Total for Personal Care OnIy						

Please indicate the Applicants most current staff turnover ratio for the following positions:
RPN / LPN's _________% CNAs _________%

b) Other Staff on duty

	Day Shift	Evening Shift
Physical Therapists		
Dieticians		
Beauticians / Barbers		
Administration Personnel		
Social Workers		
Maintenance / Security Personnel		
House Keeping		

14. Physicians and Medical Directors:

a) If any physicians are employed by the facility, please explain their duties: _______________________________________
____

b) Are physicians and medical director required to carry their own medical malpractice coverage? ☐ Yes, ☐ No, if so, are Certificates of insurance obtained and the facility held harmless? ☐ Yes, ☐ No

c) What are the Limits of liability required on each contracted physician $ _____________:

d) Are these limits verified for current coverage via certificates of insurance? ☐ Yes, ☐ No

e) Do you credential the medical staff?

f) Number of Physicians: Employed _________, Contracted _________

15. Please state percentage of payment / reimbursement in each category:

Medicaid %	Medicare %	Private Pay %	Other %

16. Hiring Employees: (Please check the applicable items involved in hiring employees)

Complete job application	☐Yes ☐No
Police / Criminal background check	(Yes (No
Previous employer check	(Yes (No
National Registry of Nurse Assistants check	(Yes (No
Personal references (non-family members)	(Yes (No
Drug testing	(Yes (No
Physical examination	(Yes (No
Probationary employment period	(Yes (No
Do the same procedures apply for Personal Care facility employees?	(Yes (No
Are driver's licenses checked for anyone who transports residents?	(Yes (No
Does Applicant provide monetary incentives for continuing education?	(Yes (No

17. What types of training programs are in place? ____

____

18 . a. Indicate whether any of the following services are provided by an independent contractor:

(Food (Laundry (Housekeeping (Other

b. If so, are certificates of insurance obtained from the contractor and the facility held harmless? (Yes (No Limits:

19. a. Average number of volunteers working at facility: ____

b. Is there a formal screening/selection process? (Yes (No A formal orientation? (Yes (No

GENERAL BUILDING CONSTRUCTION

1. Application's interest in building: ☐ Owner ☐ Tenant ☐ General Lessee

2. a. Age of building: ____
   b. Occupancy:____
   c. Has building been reconstructed and/or converted since its original construction ☐ Yes ☐ No If yes, when? ____
   d. Original occupancy/use of building, if not build for current purpose: ______________________________
   e. Dates and types of last renovations: ____

3. Construction: ☐ Fire resistive ☐ Masonry noncombustible ☐ Metal ☐ Masonry or frame ☐ Mixed

4 . Number of: ☐ Floors: ☐ Beds per floor ☐ Elevators, if any ☐ Exits:

5. What measures are taken to provide security for residents and staff? ______________________________
____

6. Are exit doors equipped with panic bars to open them? ☐ Yes ☐ No

7. Distance to nearest fire station: ____
____

8. a. Is entire building equipped with smoke detectors? ☐ Yes ☐ If not, what portions are not? ______________

   b. Is entire building equipped with heat detectors? ☐ Yes ☐ No, if not what portions are not? ______________

   c. Is entire building sprinklered? (Yes (No If not what portions are not? __________________________

9. a. Type of fire alarm system: (Manual pull (Automatic
   b. Alarm sounds: (Locally (At fire station or central alarm station

Automobile Exposures:

1) Do you contract with a transport service (ie. ambulance, buses, and vans) to transport Residents? (Yes (No,
   If Yes, Name: ______________________________Contract: ______________________________
   Telephone #: ____

2) Do employees transport Residents in their own automobiles? (Yes (No
   If Yes; Describe: ________________________Average Frequency: ____________________________

3) Do you require them to carry minimum limits? (Yes (No
If so, what limits are required: ____

4) Do you have any CDL Vehicles? (Yes (No - how many: ______________________________

5) Do Volunteers operate any vehicles? (Yes (No - __________________________________

Products Liability Exposures:

Is the applicant engaged in the manufacture, design or sale of any medical products or devices? (Yes (No If yes, explain
____

Claims and Loss Information – Important, please read carefully

1. Has any company ever cancelled or refused coverage ? (Yes (No, If yes, for what reason ____________
____

1. Have all known claims as well as incidents, which may give rise to future claims, been reported to past or current insurers? (Yes (No

2. Has applicant conducted a recent review of such incidents and other potential claims and have all been forwarded to the applicant's insurer (Yes (No, If yes, by whom? ________________________________

DEFINITIONS OF FACILITIES

Skilled Nursing: administration of medication by injection, catheter insertion and sterile irrigation, physical & occupational therapy, administration of oxygen & inhalation therapy, routine changing of dressings, tube feedings.

Sub-Acute: ventilator care, wound management, post operative/trauma recovery, intravenous antibiotic &/or hydration therapy, spinal cord/head injury, oncology, total parental nutrition (TPN), blood plasma transfusion, central line care, tracheotomy, dialysis

Intermediate Care: administration of oral medications, assistance with ADLs', preventive turning/positioning, **and** restorative rehabilitation

Assisted Living: Combination of housing, personalized supportive services, health care services designed for individual needs for those requiring help with ADL's but not skilled medical care

Personal Care: security, nutritional meals, transportation, recreation, self administration/assistance with medications, guidance with activities of daily living (ADL's - bathing, dressing, eating, walking), Residents normally not safe to stay by themselves

Independent Care: residents are of retirement age, total self care living self sufficiently, occupy apartment/dwelling units including cooking facilities, do not receive health care services, administer own medications without assistance, full time caretaker on premises

SIGNATURE OF APPLICANT – IMPORTANT PLEASE READ CAREFULLY

I HAVE ANSWERED THE QUESTIONS IN THE APPLICATION TO THE BEST OF MY ABILITY AND DECLARE THAT, TO THE BEST OF MY KNOWLEDGE, THE STATEMENTS SET FORTH HEREIN ARE TRUE AND CORRECT. MY SIGNING OF THE APPLICATION DOES NOT BIND THE INSURANCE COMPANY TO COMPLETE THE INSURANCE, BUT IT IS AGREED THAT THIS APPLICATION SHALL BE THE BASIS OF THE CONTRACT SHOULD A POLICY BE ISSUED.

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 SUBJECTS SUCH PERSON TO CRIMINAL AND CIVIL PENALTIES, INCLUDING BUT NOT LIMITED TO FINES, DENIAL OF INSURANCE BENEFITS, CIVIL DAMAGES, CRIMINAL PROSECUTION AND CONFINEMENT IN STATE PRISON.

Applicant Name & Title (Print)	**Authorized Signature of Applicant**	**Date**

RP Long Term Care Facility App (2/2004)