

Christian Brothers

RISK MANAGEMENT SERVICES

a division of Christian Brothers Services

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Open to the Public Care Facility Application

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

REQUIRED INFORMATION:

1. Current audited Financial Statements with Management Notes and Current Annual Report
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. Nursing Home Compare Report: www.medicare.gov
8. 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:

Has the facility ever been cited for any of the following?

- Health code violations? Yes No
- Restrictions or probation on license? Yes No
- License Suspension or revocation? Yes No
- Medicare Fraud? Yes No
- Ever been on National Watch List Yes No

Has the facility had any of the following activities?

- Filed for Bankruptcy? Yes No
- Facility Expansion? Yes No
- Merger Acquisition? Yes No

Please explain any **YES** answers. (please attached separate explanation)

11. Does the Facility have a Risk Manager? Yes No Full-Time Part-Time **If yes, attached latest reports.**

- Full name of Person(s): _____
- Qualifications: _____
- Address: _____ Phone: _____ Email: _____

12. Does the Facility have an Outside Risk Manager? Yes No Full-Time Part-Time **If yes, attached latest reports.**

- Full name of Person(s): _____
- Qualifications: _____
- Address: _____ Phone: _____ Email: _____

13. Practices / Protocols:

- a) Does applicant have a written safety program. Yes No
- b) Does the above program include an emergency evacuation plan. Yes No
How often are emergency evacuation drills conducted? _____
- c) Does applicant have a written "do not resuscitate" policy in place? Yes No
- d) Does applicant obtain advanced written consent from the resident or guardian allowing the facility to provide necessary emergency medical care? Yes No
- e) Does applicant have a policy regarding the use of physical and chemical restraints? Yes No
- f) Does applicant transfer patients with Stage III or IV Decubitus ulcers to another facility providing a higher level of care for treatment? Yes No
- g) Does applicant perform total body skin assessments? Yes No How often? _____
- h) Does applicant have a written policy / procedure to investigate the following:
 - a. Alleged resident abuse and neglect? Yes No
 - b. All other incidents? 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?

Occupancy Information:

Please read facility definitions carefully:

Skilled Nursing Care [Include Sub Acute]

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
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.

Skilled Nursing Care	Number of Licensed Beds	Average Occupancy %	Occupied Beds

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

Intermediate Care	Number of Licensed Beds	Average Occupancy %	Occupied Beds

Residential Care [Including the following: a) Assisted Living, b) Personal Care]

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

Residential Care	Number of Licensed Beds	Average Occupancy %	Occupied Beds

f. Number of Physicians (other than Medical Director): Employed _____ Contracted _____

8. Does facility provide home care? Yes No If yes, annual number of calls made by visiting nurse(s): _____
a. Describe the services provided by the visiting nurse(s) _____

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

- | | |
|--|--|
| Complete job application | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Police / Criminal background check | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Previous employer check | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| National Registry of Nurse Assistants check | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Personal references (non-family members) | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Drug testing | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Physical examination | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Probationary employment period | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Are drivers licenses checked for anyone who transports residents? | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Does Applicant provide monetary incentives for continuing education? | <input type="checkbox"/> Yes <input type="checkbox"/> No |

Please include a copy of all policy and procedures involved with hiring, probationary periods and dismissal.

10. What types of training programs are in place? Is training done by an outside source or in house. How often is training done? _____ (Please attach program information)
11. Indicate whether any of the following services are provided by an independent contractor:
 Food Laundry Housekeeping Other
a. If so, are certificates of insurance obtained from the contractor and the facility held harmless? Yes No
12. Average number of volunteers working at facility: _____
13. Is there a formal screening/selection process? Yes No Police / Criminal background check? 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 No 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 _____
2. Have all known claims as well as incidents, which may give rise to future claims, been reported to past or current insurers? Yes No
3. Has applicant conducted a recent review of such incidents and other potential claims and have all been forwarded to the applicants insurer Yes No If yes, by whom? _____
4. Person handling claims for facility:
 - Name: _____ Title: _____
 - Address: _____
 - Phone: _____ Email: _____

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