SENIOR LIVING PROFESSIONAL LIABILITY RENEWAL QUESTIONNAIRE

MMIC Risk Retention Group, Inc.

curi.com

Required Documents

In addition to this questionnaire, the following information is required:

1. Prior carrier loss runs covering the past ten (10) years if the Applicant has been insured with us for less than ten (10) years (dated within 90 days of the renewal date).
2. If excess liability coverage is provided, updated loss runs covering the past ten (10) years for all underlying coverages not insured by us (dated within 90 days of the renewal date).
3. Listing of locations or Statement of Values with a description of occupancy for each location.
4. Latest annual financial statements.
5. Corporate organizational chart.
6. Quality Improvement or Risk Management Plan.
7. Most recent state survey reports, licensure reports, and accreditation survey reports as applicable.
8. Current CMS forms: 671 Facility Staffing, 672 Resident Census, CMS 2567, and Quality Indicator Report for the past two (2) six-month periods.
9. Copy of facility license for each location.

Please explain all "yes" answers in the Comments section at the end of the questionnaire. Include section and question number for each response.

A. APPLICANT INFORMATION

The term "Applicant" used throughout this questionnaire shall mean all entities proposed for coverage.

Name of Applicant:			
Mailing Address:			
Physical Address:			
Tax ID:	County:	Website:	
Main Contact Name:		Phone:	Email:
Administrator Name:		Phone:	Email:
Risk Manager Name:		Phone:	Email:
Director of Nursing Name:		Phone:	Email:

Legal Structure (check all that apply):

☐ Sole Proprietorship ☐ Corporation ☐ Partnership ☐ Joint Venture ☐ Government

☐ Not For Profit ☐ For Profit ☐ Other (specify): _____

Describe services provided: _____

_____

_____

Accreditations/Certifications (check all that apply):

☐ JCAHO Accredited ☐ CCAC Accredited ☐ CCRC Accredited

☐ Medicare/Medicaid Certified ☐ Other (specify): _____

Is the Applicant currently enrolled in a Patients' Compensation Fund or other state insurance fund? ☐ Yes ☐ No

If yes, please specify fund name: _____

B. OPERATIONAL CHANGES

1. Indicate yes/no for operational changes that took place during the **past** twelve (12) months *and* any anticipated changes within the **next** twelve (12) months:

a. Obtain another operation/legal entity? ☐ Yes ☐ No

b. Add or reduce the number of employees by more than 10%? ☐ Yes ☐ No

c. Add or reduce the number of locations? ☐ Yes ☐ No

d. Add or reduce current services? ☐ Yes ☐ No

e. Operate in additional states? ☐ Yes ☐ No

f. Participate in or form joint venture(s) or limited partnerships? ☐ Yes ☐ No

g. Complete construction or renovation projects? ☐ Yes ☐ No

If yes to any questions above, please explain in the Comments section at the end of the questionnaire.

2. Within the past five (5) years, has the Applicant acquired, sold, or discontinued any operations? ☐ Yes ☐ No

If yes, please explain in the Comments section at the end of the questionnaire.

C. EXPOSURE INFORMATION

Please specify exposure information based upon the following:

Exposure Types
Total number of employees: _____
Vacant land: ☐ Yes ☐ No *If yes, how many total acres:* _____
Pay parking area(s): ☐ Yes ☐ No *If yes, what is the total revenue:* _____
Fitness center(s) open to the public: ☐ Yes ☐ No *If yes, what is the total revenue:* _____
Total annual revenue (most current twelve (12) months): _____
Total annual revenue (projected twelve (12) months): _____
Indicate the percentage of residents by age range: < 30: _____ 30-64: _____ 65-74: _____ 75-84: _____ 85-94: _____ > 94: _____ *If any residents are younger than 64, please explain in the Comments section at the end of the questionnaire.*

D. STAFFING

1. Specify the number of personnel in each applicable category:

Provider Type	**Employees**		**Contractors**		**Volunteers**	
	Full-Time	**Part-Time**	**Full-Time**	**Part-Time**	**Full-Time**	**Part-Time**
Physicians						
Dentists						
Chiropractors						
Podiatrists						
Oral Surgeons						
Nurse Practitioners						
Phys Assist/Surgical First						
EMTs/Paramedics						
Occupation Therapists						
Therapists						

RNs/LPNs/LVNs						
Social Workers						
Psychologists						
Lab Technicians						
Optometrists						
Pharmacists						
Estheticians						

Please list and describe any additional personnel in the Comments section at the end of the questionnaire.

2. Specify staffing by shift:

Category	1st shift	2nd shift	3rd shift	Annual Turnover %
Registered Nurse (RN)				
LPN / LVN				
CNA / Personal Caregiver				
Staffing Agency				

3. Are nursing agencies/registries utilized? ☐ Yes ☐ No *If yes, how many?* _____

4. Is there a complete shift staffed exclusively by temporary staff? ☐ Yes ☐ No

E. PROFESSIONAL SERVICES

Indicate applicable professional services below. Complete any corresponding questions with information for the most recent twelve (12) months.

☐ **Sub-Acute Care**	Applicable to facilities offering ventilator care, wound management, post-operative care/trauma recovery, intravenous/antibiotic/hydration therapy, spinal cord/head injury care, oncology, total parenteral nutrition (TPN), blood/plasma transfusion, central line care, tracheostomy, and dialysis.
☐ **Skilled Care**	Applicable to facilities administering medications by injection, catheter insertion, sterile irrigation, physical/occupational therapy, administration of oxygen, inhalation therapy and routine changing of dressings.
☐ **Intermediate Care**	Applicable to facilities administering oral medications, assisting with ADLs (activities of daily living - bathing, dressing, walking, eating), preventative turning/repositioning and restorative rehabilitation.
☐ **Assisted Living**	Applicable to facilities offering housing and personalized support services, assistance with ADLs and self- administration and/or assistance with medication.
☐ **Independent Living**	Applicable to facilities offering meals, transportation, recreation and guidance with ADLs and medication.
☐ **Rehabilitation**	Applicable to facilities offering short-term or long-term rehabilitation services to residents.
☐ **Dementia or Alzheimer's Care**	Applicable to facilities offering services to residents with dementia or Alzheimer's.

☐ **Group Home**	Applicable to facilities offering group homes for residents. [illegible]
☐ **Home Health Care**	Applicable to facilities offering home health care services. ☐ [illegible] Number of Visits: ________ ☐ [illegible] Number of Visits: ________ ☐ [illegible] Number of Visits: ________ ☐ [illegible] Number of Visits: ________ ☐ [illegible] Number of Visits: ________
☐ **Miscellaneous Services**	☐ [illegible] Annual Revenue: ______________ Residents Only? ☐ Yes ☐ No ☐ [illegible] Annual Revenue: ______________ Residents Only? ☐ Yes ☐ No ☐ [illegible] Total Licensed: ________ Average Participants: ________ ☐ [illegible] Total Licensed: ________ Average Participants: ________

Please list and describe any additional professional services in the Comments section at the end of the questionnaire.

F. INFECTION CONTROL

1. Have any facilities been cited for any of the following tags: ☐ Yes ☐ No

- F880 Infection Prevention and Control Program
- F881 Antibiotic Stewardship
- F882 Infection Preventionist Role and Qualifications
- F883 Influenza and Pneumococcal Vaccinations
- F945 Infection Control Training

If yes, please attach the Plan of Correction that was sent to CMS at the end of the questionnaire.

2. Has the facility completed the CMS Long Term Care (LTC) Infection Control Worksheet? ☐ Yes ☐ No

a. Are the answers on the CMS Long Term Care (LTC") Infection Control Worksheet still accurate, and correct? ☐ Yes ☐ No

Please attach the most recent completed CMS Infection Control worksheet.

If the response to any question differs, please describe in the Comments section at the end of the questionnaire.

b. Are all answers on the CMS Infection Control Worksheet applicable to all facilities applying for insurance? ☐ Yes ☐ No

If the response for any individual facility differs from the answers on the CMS Long Term Care (LTC) Infection Control Worksheet, please describe in the Comments section at the end of the questionnaire.

Please complete the following questions if CMS infection control worksheet has not been completed within the past three (3) years:

3. Do all facilities follow the CDC recommendations for infection control? ☐ Yes ☐ No

4. Do all facilities have a qualified Infection Preventionist overseeing the facility infection control program? ☐ Yes ☐ No

5. Do all facilities have dedicated trained staff on site to monitor the facility infection control program including conducting surveillance and tracking of infectious organisms? ☐ Yes ☐ No

6. Do all facilities have evidence-based written policies and procedures readily available on the following topics? ☐ Yes ☐ No

a. standard, transmission-based, and enhanced barrier precautions,
b. hand hygiene,
c. cleaning/disinfection policies for resident rooms, common areas, and reuseable medical devices,
d. emergency preparedness,
e. outbreak response, including a list of conditions or potential exposures to infectious agents that should be monitored and/or reported to public health agencies, and
f. Blood Borne Pathogen Exposure plan.

7. Do all facilities have procedures to audit, monitor, and document the following items? ☐ Yes ☐ No

a. staff training and competency,
b. compliance with infection control policies, including the appropriate use of PPE at least every twelve (12) months,
c. injection, and sharps safety,
d. the facility hand hygiene policy, inclusive of monitoring compliance with hand hygiene throughout the facility,
e. the quality of cleaning and disinfection procedures at least every twelve (12) months,
f. infections occurring among residents and implementation of necessary precautions,
g. clusters of illness among staff and implementation of necessary precautions,
h. potentially infectious residents at the time of intake (i.e. history of recent travel/antibiotic use, or colonization with multi-drug resistant organisms), and
i. residents who have temporary medical devices in place (i.e. indwelling catheters, central lines).

8. Does the facility have a written surveillance plan, based on the facility risk assessment, outlining activities for monitoring/tracking infections occurring in new admissions and existing residents of the facility? ☐ Yes ☐ No

9. Does the facility have a system in place for early detection and management of potentially infectious symptomatic residents at the time of admission, including implementation of precautions as appropriate? Examples: Influenza, Norovirus, Legionnaires, MRSA, C difficile or other antibiotic-resistant organisms. ☐ Yes ☐ No

10. Does the facility have a system in place (e.g., notification of Infection Preventionist (IP) by clinical laboratory) for early detection and management of potentially infectious symptomatic residents, including implementation of precautions as appropriate? ☐ Yes ☐ No

11. Do all facilities have a process to review infection control related data and issues inclusive of reporting to a Quality Assurance (QA)/Infection Control Committee to monitor and review the facilities infection control program? ☐ Yes ☐ No

12. Do all facilities have supplies accessible in appropriate locations to implement infection control plan, including but not limited to PPE, EPA-registered products for cleaning/disinfecting, that are effective against C. difficile, and norovirus, appropriate sharps containers, soap, water, and alcohol-base hand rub (ABHR)? ☐ Yes ☐ No

13. Do all facilities have an antibiotic stewardship program that includes the following: ☐ Yes ☐ No

a. a responsible individual to monitor antibiotic use,
b. a system for tracking antibiotic use,
c. monitoring for documentation to support reason for the antibiotic when prescribed,
d. follows treatment recommendations for common infections based on national guidelines to assist in the decision for antimicrobial use,
e. monitoring for appropriate antimicrobial use (e.g. right antibiotic, completion of treatment, improvement of infection),
f. education to facility staff on improving antimicrobial use, and
g. leadership support.

G. EXCESS LIABILITY – UNDERLYING COVERAGE (

Complete the chart below with all liability policies requested as underlying insurance.

Coverage Type	Carrier	Policy Number	Policy Period	Limits of Liability	Annual Premium
Auto Liability					
Employers Liability					
Helipad Liability					
Other:					
Other:					
Other:					

H. EXCESS LIABILITY – AUTO LIABILITY COVERAGE ,

Complete the chart and corresponding auto liability questions below.

Type		# Owned	# Non-Owned	# Leased	Property Hauled	0-50 Miles	50-200 Miles	Over 200 Miles
Private Passenger								
Buses								
Trucks	Light							
	Medium							
	Heavy							
	Ex Heavy							
Trucks/ Tractors	Heavy							
	Ex Heavy							

1. Are passengers carried for a fee? ☐ Yes ☐ No

2. Are vehicles leased or rented to others? ☐ Yes ☐ No

3. Do employees drive their own vehicles on behalf of the Applicant? ☐ Yes ☐ No

If no, proceed to the next section.

If yes, please answer the following questions.

a. How many employees are driving personal vehicles on behalf of Applicant? _____

b. Purpose: _____

c. How often is auto liability coverage verified for each employee? _____

d. What minimum limits of liability are required? _____

e. How often are Motor Vehicle Reports obtained? _____

I. COMMENTS

Please explain all “yes” answers in the Comments section. Please include section and question number.

ææÑα ◊œõ ê ⅄All supplemental information is considered important. Signing this questionnaire does not bind insurance. We must review and formally approve or reject the submission.

b¡ fi A□ ¡ ê œ̂ c □.◊ ◊Ké Kê ◊⅄It is a crime to knowingly provide false, incomplete, or misleading information to an insurance company for the purpose of defrauding the company. Any person who includes any false or misleading information in support of an application for an insurance policy may be guilty of a crime and subject to penalties that include imprisonment, fines, and denial of insurance benefits.

: Ñ œé ..□é AK□ ê A□¡ Kæõ ¡ ◊KA□Aα.: Ñõ ..fi¡ K⅄If any portion of the policy is issued on a claims-made and reported basis, such portions will apply only to claims first made against the Applicant during the policy period arising out of the performance of professional services occurring on or after the prior acts date shown on the policy. Claims must be reported to us during the policy period or under an extended reporting period endorsement.

æ¡ oˆ : ″ □.◊ ◊Ké Kê ◊⅄We will keep your information confidential. We may, however, communicate the results of the questionnaire to the Applicant’s authorized representative, prospective or current employer. To review the newest privacy notice on collection and use of information visit the company’s website at curi.com.

ææÑα ê ◊□ : Çê õ ˜ ÑKAc Ké Kê ◊⅄The applicant certifies this information is complete and accurate. Applicant acknowledges a continuing duty to supplement any information that may materially affect this information.

Applicant Signature	Title	Date