



Facility Name, Legal Entity: \_\_\_\_\_

Requested Effective Date: \_\_\_\_\_

Professional and General Liability Survey Form. Circle whether: New/Renewal.  
Circle whether: Independent Living/Assisted Living/ Skilled care/ Other: \_\_\_\_\_

Include current payroll information if requesting WC, and Acord Property forms if requiring Property Coverage.

- \_\_\_\_\_ Most Current HCFA 672 (Resident Census & Conditions) "2-Pages" "If Medicare Certified" (If Applicable)
- \_\_\_\_\_ Most Current HCFA 671 (Staffing) Report
- \_\_\_\_\_ Most Current Quality Indicator Profile "2-Pages" "If Medicare Certified" (If Applicable)
- \_\_\_\_\_ Most Recent Annual Survey, including original cover letter showing highest tag, facility Plan of Correction  
**(Life Safety Survey - K-tag survey- Not needed)**
- \_\_\_\_\_ Financial Statement (Balance Sheet & Statement of Income)
- \_\_\_\_\_ Copy of Facility License
- \_\_\_\_\_ Estimated Annual Payroll (Current Work Comp Estimated Payroll is \$ \_\_\_\_\_) % Clerical \_\_\_\_\_
- \_\_\_\_\_ Confirm Limit to be used on Resident Fund Surety Bond renewal (Currently \$ \_\_\_\_\_ limit)

**Resident Census Information**

- # of Available Beds: \_\_\_\_\_ Current Average Census/Occupied Beds \_\_\_\_\_
- # of Medicare Beds: \_\_\_\_\_ # of **Primary** Alzheimer/Dementia Residents: \_\_\_\_\_
- # of **Primary** Psychiatric Care Residents: \_\_\_\_\_ # of Non-Ambulatory Residents: \_\_\_\_\_ (Use of wheelchair or cane does not constitute non-ambulatory)
- Is Facility Accredited? (Y/N) If yes, with whom? \_\_\_\_\_
- Any Outpatient Services Provided? (Y/N) If yes, explain: \_\_\_\_\_

<b><u>Resident Ages</u></b>		<b><u>Level of Care</u></b>	<b>Available</b>	<b>06-07 Average Occupied</b>	<b>07-08 Average Occupied</b>
# of Residents Under 20 _____	# of Residents 20 – 49 _____	Skilled	_____	_____	_____
# of Residents 50 – 64 _____	# of Residents 65 – 74 _____	Intermediate	_____	_____	_____
# of Residents 75 – 84 _____	# of Residents 85 & Up _____	Residential	_____	_____	_____
		Assisted Living	_____	_____	_____
		Independent Living	_____	_____	_____
		Total:	_____	_____	_____

Please indicate if any licensed beds are unavailable for use.  
(While the facility may have a 100% skilled license, we need the actual occupied bed breakdown)

# of Residents assessed as potential elopers: \_\_\_\_\_

**Check techniques in place to control identified potential elopers:**

- Exit doors equipped with eloper alarms: \_\_\_\_\_ Exit doors leading to fenced areas: \_\_\_\_\_
- Electronic wrist bracelets: \_\_\_\_\_ Secure units/wings: \_\_\_\_\_
- Photos of residents at exits: \_\_\_\_\_

Name of Administrator: \_\_\_\_\_  
Years at Facility: \_\_\_\_\_ Years Experience in Position: \_\_\_\_\_ Years Experience in Long Term Care \_\_\_\_\_

Name of Director of Nursing: \_\_\_\_\_  
Years at Facility: \_\_\_\_\_ Years Experience in Position: \_\_\_\_\_ Years Experience in Long Term Care: \_\_\_\_\_

Name of Risk Manager: \_\_\_\_\_  
Years at Facility: \_\_\_\_\_ Years Experience in Position: \_\_\_\_\_

**Facility Name:** \_\_\_\_\_

Name of Medical Director: \_\_\_\_\_ Years with facility: \_\_\_\_\_  
 Average Number of Hours at facility per week: \_\_\_\_\_ # of Residents MD is attending physician for: \_\_\_\_\_

Has facility had an immediate jeopardy in the past 12 months? \_\_\_\_\_ If yes, please explain on a separate sheet of paper.

Have there been any substantiated complaints in the past 12 months? \_\_\_\_\_ If yes, please explain:

Any recreational facilities? \_\_\_\_\_ Swimming pool? \_\_\_\_\_ Sauna/Hot Tub? \_\_\_\_\_ Weight Room? \_\_\_\_\_ Other: \_\_\_\_\_

**Staffing**      1<sup>st</sup> Shift   2<sup>nd</sup> Shift   3<sup>rd</sup> Shift

# of RN            \_\_\_\_\_    \_\_\_\_\_    \_\_\_\_\_  
 # of LPN/LVN    \_\_\_\_\_    \_\_\_\_\_    \_\_\_\_\_  
 # of CNA          \_\_\_\_\_    \_\_\_\_\_    \_\_\_\_\_

Average # of daily Volunteers: \_\_\_\_\_

Total # of Nursing Staff: \_\_\_\_\_

Total # of Staff Employed by facility: \_\_\_\_\_

What is your annual turn-over ratio for the past year:  
 CNA's \_\_\_\_\_ Professionals \_\_\_\_\_

**Employment Procedures**

Check each procedure used when hiring staff:

- \_\_\_ Criminal Background Check on ALL employees, prior to hiring
- \_\_\_ Pre-employment drug screening on ALL employees
- \_\_\_ Nurses Aid registry check for ALL new hires prior to first assignment
- \_\_\_ Professional nurse licensure board checked for all licensed staff prior to first assignment
- \_\_\_ Annual checks of the licensing agencies on licensed and certified staff
- \_\_\_ Copy of current license for all licensed staff
- \_\_\_ Check personal and professional references    \_\_\_ **In Writing**    \_\_\_ **By Phone**
- \_\_\_ Reference check documented and completed prior to first assignment
- \_\_\_ General orientation program for all new employees    \_\_\_ **Number of hours**
- \_\_\_ Job specific orientation program for new employees    \_\_\_ **Number of hours**

When was the building last inspected by the :  
 Local fire authorities \_\_\_\_\_ State Department of Health \_\_\_\_\_  
 (\*If the inspection was completed in the last three years please submit a copy.)

Describe rules applicable to smoking: \_\_\_\_\_  
 \_\_\_\_\_

Is there a deep fat fryer in the facility kitchen? \_\_\_\_\_

# of Exits: \_\_\_\_\_ # of beds per floor: \_\_\_\_\_

Any major renovations scheduled for the next 12 months: \_\_\_\_\_

Is the facility providing/offering any new services since last year? \_\_\_\_\_ If yes, Please explain: \_\_\_\_\_  
 \_\_\_\_\_

**We request quote information remitted to my office by \_\_\_\_\_.**

Please contact our office immediately, should you have any questions. Remit this material over your contact/letterhead information to:

**Deidra A. Penney**  
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