

Nursing Home Questionnaire

Supplemental to
Fully Completed ACORD 130 Workers' Compensation Application

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| Applicant Name | Effective Date |
| FEIN | Website |

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| Description of Operations |
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| COVID-19 | |
| <input type="checkbox"/> Yes <input type="checkbox"/> No | Screen workers and residents regularly for signs and symptoms |
| <input type="checkbox"/> Yes <input type="checkbox"/> No | Quarantine workers and residents if they have been exposed to COVID |
| <input type="checkbox"/> Yes <input type="checkbox"/> No | Regularly clean and disinfect surfaces, rooms and workstations |
| <input type="checkbox"/> Yes <input type="checkbox"/> No | Ensure all workers have proper personal protective equipment (PPE) |
| <input type="checkbox"/> Yes <input type="checkbox"/> No | Instruct sick workers to stay at home |

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| Hiring Practices | |
| <input type="checkbox"/> Yes <input type="checkbox"/> No | Written Application |
| <input type="checkbox"/> Yes <input type="checkbox"/> No | Written Job Description |
| <input type="checkbox"/> Yes <input type="checkbox"/> No | Background / Reference Check |
| <input type="checkbox"/> Yes <input type="checkbox"/> No | Pre-Hire Drug Testing |
| <input type="checkbox"/> Yes <input type="checkbox"/> No | Pre-Hire Physical Fitness Test |

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| Safety Practices | |
| <input type="checkbox"/> Yes <input type="checkbox"/> No | Formal Injury & Illness prevention program |
| <input type="checkbox"/> Yes <input type="checkbox"/> No | Formal Return to Work program |
| <input type="checkbox"/> Yes <input type="checkbox"/> No | Quarterly (or more) safety meetings |
| <input type="checkbox"/> Yes <input type="checkbox"/> No | Quarterly (or more) safety training |
| <input type="checkbox"/> Yes <input type="checkbox"/> No | Safety Incentive Plan |

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| Management | |
| # | Number of years this facility has been operating? |
| # | Number of years owned by present owner? |
| # | Number of years owned by present management? |
| <input type="checkbox"/> Yes <input type="checkbox"/> No | Is this facility owned by an outside management company? |

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| <input type="checkbox"/> Yes <input type="checkbox"/> No | Is this facility owned or leased by a multi-facility operator? |
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| Management Practices, Operations, Loss Control, Claims Handling & Benefits | |
|---|---|
| <input type="checkbox"/> Yes <input type="checkbox"/> No | Is there a FT risk/safety mgr. employed whose job is 50%+ safety related? |
| <input type="checkbox"/> Yes <input type="checkbox"/> No | Is there a post-accident drug testing program for all workplace injuries? |
| <input type="checkbox"/> Yes <input type="checkbox"/> No | Is there a formal accident investigation and claims reporting process? |
| <input type="checkbox"/> Yes <input type="checkbox"/> No | Do more than 50% of employees receive group health that is 50% employer paid? |
| <input type="checkbox"/> Yes <input type="checkbox"/> No | Do you provide vacation and sick time to all employees? |
| <input type="checkbox"/> Yes <input type="checkbox"/> No | Are certifications/ licenses verified? |
| <input type="checkbox"/> Yes <input type="checkbox"/> No | Are employees required to wear non-slip shoes? |
| <input type="checkbox"/> Yes <input type="checkbox"/> No | Are employees encouraged to stretch prior to their workday? |

| Patient Profile | |
|------------------------|----------------------------|
| % Non-Ambulatory | % Physically Disabled |
| % Alzheimer/ Dementia | % Developmentally Disabled |
| % Hospice Patients | % Short Term Care |

| Operations | |
|--|---|
| <input type="checkbox"/> Yes <input type="checkbox"/> No | Is this a Non-Profit organization? |
| <input type="checkbox"/> Yes <input type="checkbox"/> No | Do employees work consecutive 24-hour shifts? |
| | How many independent contractors / 1099 employees used? |
| <input type="checkbox"/> Yes <input type="checkbox"/> No | Do you verify workers comp coverage for independent contractors? |
| <input type="checkbox"/> Yes <input type="checkbox"/> No | Do you lease out employees or provide temp staffing to outside clients? |
| % | If yes, what is the % of payroll leased or temp staffing to others? |

| Patient Safety/ Mobility | |
|----------------------------------|----------------------|
| | Check all that apply |
| Powered Sit to Stand | |
| Standing Assist Devices | |
| Lateral Transfer / Repositioning | |
| Trapeze Bars / Hand Blocks | |
| Bathtub, Shower, Toilet Devices | |
| Portable Lift Devices | |
| Ambulation Assist Devices | |
| Electric Adjustable Beds | |
| Pelvic Lift Devices | |

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| Push up Bars | |
| Ceiling Mounted Lifting Devices | |
| Wheel Chairs | |

| Safety Program – Check any that apply | | |
|---|--|---|
| <input type="checkbox"/> Personal Protective Gear | <input type="checkbox"/> Combative Patient Training | <input type="checkbox"/> Safety Committee |
| <input type="checkbox"/> Lifting Procedures & training | <input type="checkbox"/> Blood Borne Pathogen Training | <input type="checkbox"/> New Employee Orientation |
| <input type="checkbox"/> Needle disposal (OSHA compliant) | <input type="checkbox"/> Contaminated Waste/Hazardous products disposal (OSHA compliant) | <input type="checkbox"/> Other (please describe) |