SUPPLEMENTAL INSURANCE APPLICATION

Please complete a separate application for each facility if multiple locations exist. If additional space is needed to answer any questions, use the comment section or a separate page.

Submission Requirements: Please check all that have been included:
___ Completed ACORD application;
___Five years currently valued loss runs and loss summary showing premium and losses by line of business and by policy period;
___Brochures, if available;
___State Inspection Report with the Plan of Correction.

PART I – APPLICANT

A. **Named Insured**		
Street Address	**P.O. Box**	**County**
City, State, Zip Code	**Coverage effective dates:** **From: To:**	
Location Name and Address:	**Additional subsidiaries and descriptions:**	
Number of years this facility has been: **Operating_____Owned by Present Owners_____Managed by Present Management_____**		

B. BED CENSUS

	Independent	Assisted	Skilled
Total Number of Licensed Beds			
Average Number Occupied			
Age Range of Residents			

- **If any residents age 59 or below, please provide the number and a description:**

C. What percentage of residents are non-ambulatory? _____
D. Are any non-ambulatory residents above the second floor? □ YES □ NO

E. Do you accept residents who are chemically dependent, physically impaired or mentally/emotionally disturbed? □ YES □ NO

F. If yes, describe the number of each as follows:

- **Bi-Polar Disorder_____#_____ Age Ranges_____**
- **Schizophrenia_____#_____ Age Ranges_____**
- **Significant Dementia___#_____ Age Ranges_____**
- **Alzheimers_____#_____ Age Ranges_____**

G. Do any of the residents have a history of violent behavior? _____

H. Are procedures in place to ensure MI / DD residents are on the proper medication? _____

I. Are adult or child care services provided? □ YES □ NO

J. Are any home health care services provided? □ YES □ NO

PART II - ADMINISTRATION AND STAFF—Required information for each building

A. Administration:

Administrator's name: _____Years in Position:_____
Director of Nursing's name: _____Years in Position:_____
Medical Director's name: _____Years in Position:_____

B. Describe the background checks done for the Administrator, DON, and Medical Director: ____

_____

C. Total Number of volunteers_____ Primary Source(s): _____

D. Is there a formal screening process for volunteers? Explain: _____

E. Is there a formal, documented competency process for all staff? _____

F. Do you conduct an orientation for new hires and new volunteers? _____

G. How are workers recruited? _____

H. Describe background verification checks on new employees;

- **Work History _____**
- **Education _____**
- **Criminal Record _____**
- **Driving Record (When appropriate) _____**
- **Drug Testing _____**
- **Does your facility keep proof of licensure or certification of employees? □ YES □ NO**

I. R. Does your facility require staff to have basic training in CPR? □ YES □ NO

J. Does your facility keep records of employee references? □ YES □ NO

K. How many workers compensation claims have been filed within the last 12 months and what were the types of claims? _____

L. Do nurses carry their own separate limits of liability? □ YES □ NO

- **What are the limits of liability? _____**

M. Inservice Records

- **Does your facility have a designated staff educator? □ YES □ NO**
- **How does your facility determine the yearly educational plan or inservices for the staff? _____**
- **What were the inservice topics for the last 6 months? _____**

- **Are patients' charts reviewed for quality & consistency? □ yes □ no**
- **Have all nursing personnel received in service instruction advising them that:**
  - **all patients' charts must be updated at each shift change? □ yes □ no**
  - **charting discrepancies must be brought to the attention of the charge nurse? □ yes □ no**
  - **as patient advocates, they are required to notify the charge nurse anytime they become aware of any practices which appear to be harmful to a patient? □ yes □ no**
  - **as patient advocates, they are required to notify the charge nurse anytime they become aware of a physician's actions or failure to act that appears to be harmful to a patient? □ yes □ no**

N. RISK MANAGER:

Name:_____ Phone Number: _____

O. For each classification below, show the number of employees (complete for each location):

	1st Shift	2nd Shift	3rd Shift
Registered Nurses			
Licensed Practical Nurses			
Certified Nursing Assistants			
Dieticians			
Beauticians/Barbers			
Administrative personnel			
Maintenance/Security personnel			
Others - Describe:			
TOTAL NUMBER OF EMPLOYEES			

PART III - RULES AND PROCEDURES

A. What security measures are used to control unauthorized entrance to your facility?_____

B. ASSESSMENTS

- **Who completes your admission assessments (RN or LVN)? _____**
- **Is the assessment nurse full time, part time, or contract? _____**
- **Have you denied any possible admissions due to high acuity?_____**
- **If so, what were the conditions that led you to deny them? _____**
- **Do you conduct pre-admission assessments in person?_____**

- **How often do you reassess your residents? _____**
- **Does the reassessment use the same tool as the admission assessment? _____**
- **What system do you have in place for assuring reassessments are on time?**

  _____
- **What is the system for identifying when a resident needs to be transferred to another level of care (i.e. nursing home)?_____**
- **Does assessment of new residents include evaluation of:**

Mobility limitations	**□ YES**	**□ NO**
History of prior injuries	**□ YES**	**□ NO**
Required assistance	**□ YES**	**□ NO**
Disorientation	**□ YES**	**□ NO**

C. Fall Prevention

- **Does your facility assess each resident for fall risk upon admission?_____**
- **Once a resident is assessed to be at risk for falls, what is the facility protocol for interventions?**

  _____
- **Does your facility have a written Fall Program? _____**
- **What is the system for educating the staff on the Fall Program? _____**
- **Does your facility have a Fall Committee? _____**
- **If so, who is on the committee and what is the frequency of the meetings? _____**
- **Have you had any residents fall within the last month and receive a fracture or been hospitalized as a result of the fall? _____**
- **Does your facility have a "call alert" system? □ YES □ NO**
- **Where is the call alert sent and who is responsible for responding to the call alert system?**

  _____
- **What other interventions are used for residents who have fallen, and when are they used?**

  _____

D. Elopement

- **Are alarms on exit doors to prevent residents from wandering or leaving the premises without proper authorization? □ YES □ NO**
- **If no, how is this controlled?_____**
- **Do you conduct wandering risk assessments on all residents upon admission, and does this include a cognitive assessment? □ YES □ NO**
- **Do you have a WanderGuard or similar system to prevent elopements? _□ YES □ NO**
- **Identify brand if other than WanderGuard?_____**
- **Does your facility have a policy to clearly identify the types of dementia residents that your staff are capable of providing care to? □ YES □ NO**
- **Does your facility have a locked unit(s) for residents prone to wandering? □ YES □ NO**
- **If so, what system secures the unit? _____**
- **What is the protocol or criteria for placing an alarm bracelet on a resident, and do you notify the family? _____**
- **Has your facility had any residents elope from the facility? □ YES □ NO**
- **Are residents allowed to sit or wander unsupervised in unsecured areas such as on the facility grounds? □ YES □ NO**

E. EVACUATION PROCEDURES

- **Do you have a written emergency evacuation plan?** □ YES □ NO
- **Are evacuation directions posted in all parts of your facility?** □ YES □ NO
- **Does your staff orientation plan include a review and "walk through" of any disaster plan?** □ YES □ NO
- **How often are evacuation/fire drills conducted each year for each shift?** _____
- **Are they fire department supervised?** □ YES □ NO

F. Are written orders from an attending physician required for:
All drugs or medicines or special dietary requirements? □ YES □ NO

G. Are Physician orders recorded, maintained , and up-to-date? □ YES □ NO

H. Is there a written resident agreement in place? □ YES □ NO
Is your most recent copy attached? (Required) □ YES □ NO

I. Is smoking permitted in resident rooms? □ YES □ NO

J. MEDICATION ADMINISTRATION

- **Is the unitdose medication system used by the facility?** □ YES □ NO
- **If not, what system is used?**_____
- **Who is responsible for administering medications to the residents in the facility: licensed staff or medication aide?**_____
- **If your facility uses the medication aide to administer medication, what system do you have in place to ensure medications are administered according to manufactures recommendations and industry standards?** _____

K. WOUND CARE

- **Is a skin assessment done upon admission?** ☐ **Yes** ☐ **No**
- **Do you complete regular skin assessments?** ☐ **Yes** ☐ **No**
- **How often?** _____
- **Who reviews them?**_____
- **Identify wound care specialist/team members**_____
- **Identify wounds:**

	Inherited	Acquired
Stage I	_____	_____
Stage II	_____	_____
Stage III	_____	_____
Stage IV	_____	_____

- **Provide specifics for the causation of each patient's wound(s).**
  _____
  _____
- **Are all ulcers healing? If not, explain**_____
  _____

- **Do you photograph all ulcers and include the photos in the residents medical records? ☐ Yes ☐ No**
- **Provide copy of wound care protocol.**

L. CARE PLAN COMPLIANCE

Is discharge of the patient /resident required if he or his legal guardian does not comply with the patient's/resident's care plan? Examples of non-compliance include but are not limited to bedfast patients/residents with bedsores who are unable or unwilling to comply with rotation schedules; patients/residents who require assistance with ambulating but try to ambulate without it: patients/residents placed in approved restraint devices who try to disconnect themselves from the restraints; guardians who violate the patient's/resident's dietary restrictions. If discharge is not required, describe the alternate actions undertaken_____

PART IV CONTRACTUAL AGREEMENTS

Are Certificates of Insurance attached for all contracted professional services? ☐ YES ☐ NO
If not, please explain_____

PART V- BUILDING AND EQUIPMENT FEATURES –Required for each building.

The following information is needed for each building used for patient or resident occupancy. If you have more than one such building, you should either complete a copy of this section for each additional building or provide the information in the comments section.

A. Building Identification: _____ Year Built : _____
Number of Stories:____
Building Construction:_____
☐ ***Frame*** ☐ ***Joisted Masonry*** ☐ ***Masonry Non-Combustible*** ☐ ***Fire Resistive***

B. Was this building originally designed and constructed as a Nursing Home? ☐ *Yes* ☐ *No*
If no, what was the original building occupancy?_____
If applicable, what year was the building retrofitted for use as an assisted living facility?_____

C. When was this building's electric, heating or plumbing system last inspected or updated?

	Electric	Heating	Plumbing
Qualified Inspection			
Replaced or Updated			

D. When was this building last inspected by the:
Local Fire Authorities_____State Department of Heath_____

E. Are there at least two exits, located remotely from each other, on each floor and fire area? ☐ *Yes* ☐ *No*

F. 1. Are fire doors kept closed routinely or arranged to automatically close in the event of a fire alarm? ☐ *Yes* ☐ *No* Explain:_____
2. Are doors to residents rooms equipped with self-closing devices? ☐ *Yes* ☐ *No*

G. Is there an Automatic Fire Sprinkler System installed in all buildings? ☐ *Yes* ☐ *No*
If yes, please check areas that are protected:

□ *Resident Rooms* □ *All common areas (corridors, lobbies, dining room, etc.)*
□ *Rest Rooms* □ *Closets* □ *Attic Areas* □ *Concealed Spaces above Ceilings*
□ *Basements, if any* □ *Enclosed Stairways* □ *Exterior Porches*

Is the sprinkler system NFPA 13_____ or NFPA13 R_____?
Who was the sprinkler system contractor that installed system?
Name _____ City_____ Phone ( ) _____
How often is the sprinkler system tested?_____Date of last test? _____

H. Is there a Smoke or Heat Detection System installed in all buildings? □ ***Yes*** □ ***No***
If yes, please check areas that are protected:
□ *All Common Areas* □ *Resident Rooms* □ *Attic Areas*
□ *Concealed Areas above Ceilings* □ *Elevator Lobbies only*
Is the system: □ *Hard wired to building electric service*
□ *Battery units only*
□ *Combination (Explain:_____)*

What happens upon activation of system? Check all that apply:
□ *Alarm sent to off site central station. Name:_____*
□ *Alarm sent automatically to Fire Department.*
□ *Local signal at front desk/ nurses station.*
□ *Local alarm sounded throughout facility.*

How often is Smoke/Heat Detection System tested?_____
Date of last Test: _____
Who Tested: _____

I. 1. Do you have an auxiliary electrical supply system? □ ***Yes*** □ ***No***
2. Is there an emergency lighting system? □ ***Yes*** □ ***No***
3. Are all exit signs arranged to be illuminated in the event of power failure? □ ***Yes*** □ ***No***

J. Are handrails provided in hallways and bathrooms? □ ***Yes*** □ ***No***

K. Are bathtubs/showers equipped with non-slip surfaces? □ ***Yes*** □ ***No***

L. Are you planning any new construction for the next twelve months? □ ***Yes*** □ ***No***

If yes, use the comment section to describe the purpose, estimated cost and estimated completion date for such construction.

M. Does facility have a formal safety program in place? □ **YES** □ **NO**

N. If No, Please describe: _____

O. RECREATIONAL FACILITIES

Swimming Pool □ YES □ NO
Heath Club, Gym, or Other (Please Describe, Controls and Monitoring):

_____

P. Describe management's commitment to resident and employee safety. Attach copies of any safety policies. _____

_____

PART VI- CURRENT COVERAGE

A. Current professional/general liability coverage:

Present Insurance Company:	**Policy Period:**
	From: **To:**
Limits: **Deductible(s)** **CGL** **Prof**	**Is present coverage:** □ ***Occurrence*** □ ***Claims-made*** _____ **Retro-Active Date**

Expiring Premium: $ _____

COMMENTS: _____

_____

_____

_____

Insured Signature _____ **Date** _____

(Printed Name) _____