

*Elder*CARE LIGHTHOUSE

Preferred Insurance Partner for Senior Living

APPLICATION

MANAGED BY:

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Lighthouse Underwriters, LLCTM

ACCESS THE EXPERTS



Lighthouse Eldercare, LLC
Supplemental Insurance Application

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

Submission Requirements Please check all that have been included:

- Completed & Signed Acord applications with signed Statement of Values.
- Completed Lighthouse ElderCare supplemental application signed by insured and broker.
- Resident service contract.
- Five years currently valued loss runs by line of business and policy period.
- Five years of premium history by line of business and policy period.
- Most recent financial statements, including balance sheet, income and expense sheets, & notes.
- Copy of current licenses.
- Brochures.
- State Inspection Reports (SNF/ICF) Last two years with any statement of deficiencies and plan of correction.
- Resumes if business is less than 3 years old.
- For facilities that are, less than 3 years old please include a copy of business plan and owners profile Proforma.

PART I- APPLICANT

A.

Named Insured:		
Street Address:	P.O. Box:	County:
City, State, Zip Code	Coverage effctive dates From: To:	Retroactive date
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. Please list the total Annual Gross Sales for each of the last 3 years. However, on the GL Accord application, we must have the projected gross sales broken down per location: _____

C. List all association memberships held by your facility: _____

D. Bed Census

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

• If there are any residents age 59 or below, please provide the number and a description of residents' condition/ diagnosis: _____

E. What is the percentage of residents that are non-ambulatory? _____

F. Are any non-ambulatory residents above the second floor? YES NO

• If yes, please explain: _____

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

H. If yes, describe the percentage of each as follows:

- Bi-Polar Disorder _____ Age Ranges _____
- Schizophrenia _____ Age Ranges _____
- Significant Dementia _____ Age Ranges _____
- Alzheimers _____ Age Ranges _____

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

J. Are procedures in place to ensure MI / DD residents are on the proper medication and seeing their psychiatrist regularly? _____

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

A. Administrators name and brief summary of administrative experience : _____

B. Describe the background checks done for the administrator: _____

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

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 and regularly scheduled in-servicing for all staff? _____

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? _____

I. Does your facility require staff to have basic training in CPR; If so, how are these training requirements maintained?

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. Does your facility have a full time manager and what is the licensure requirement of the manager? _____

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

• What are the limits of liability? _____

N. In-service Records

• Does your facility have a designated staff educator? YES NO

• How does your facility determine the yearly educational plan or in-services for the staff? _____

• List the topics covered in the training program for direct care staff. _____

• What were the in-service topics for the last 6 months? _____

O. Name of individual that our Loss Control Services representative may contact for an on-site survey of your facility:

• Name: _____ Phone Number: _____

P. 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			
Nursing Aides			
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 and exit 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 a fall risk, 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
 - If a resident is found to be at risk for wandering, what is your procedure for prevention? _____
-
- Does your facility have a policy to clearly identify the types of dementia residents to which your staff is capable of providing care? YES NO
 - Does your facility have a locked/secured unit(s) for residents prone to wandering? YES NO
If so, what system secures the unit? _____
 - Do you have a Wander Guard system in place? YES NO
If not, how do you prevent elopements? _____
 - 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
 If Yes, are residents assessed for safe smoking? YES NO

J. Medication Administration

- Is the unit dose 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 manufacture’s recommendations and industry standards? _____

Are Certificates of Insurance attached to this application for all contracted professional services? YES NO
 If not, please explain _____

PART IV- CONTRACTUAL AGREEMENTS

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.

PART V- BUILDING AND EQUIPMENT FEATURES- *Required information for each building*

A. Building Identification: _____ Year Built: _____
 Number of Stories: _____ Basement? YES NO
 Building Construction:
 Frame
 Joisted Masonry
 Masonry Non-Combustible
 Fire Resistive
 Other: _____

B. Was this building originally designed and constructed for Long-term Care facilities? YES NO
 If no, what was the original building occupancy? _____
 If applicable, what year was the building retrofitted for use as a Long-term Care 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 Health _____

E. Are there at least two exits, located remotely from each other, on each floor and fire area? YES NO

F. Fire Doors

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

Is the sprinkler system NFPA 13 _____ or NFPA 13R _____?

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 Lobbies with elevators only
- Concealed Areas above Ceilings Attic Areas

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. Power Supply/ Lighting

- 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): _____

Is there a certified attendant present when in use? YES NO

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

PART VI- CURRENT COVERAGES

A. Current professional/general liability coverage:

Present Insurance Company:		Policy Period:
		From: To:
Limits:	Deductible(s)	Is present coverage:
		<input type="checkbox"/> Occurrence <input type="checkbox"/> Claims-made

COMMENTS: _____

ANY PERSON WHO KNOWINGLY AND WITH INTENT TO DEFRAUD ANY INSURANCE COMPANY OR ANOTHER 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 THE PERSON TO CRIMINAL AND [NY: SUBSTANTIAL] CIVIL PENALTIES. (NOT APPLICABLE IN CO, HI, NE, OH, OK, OR; IN ME AND VA, INSURANCE BENEFITS MAY ALSO BE DENIED.)

Insured Signature: _____ Date: _____

(Printed Name): _____