	LONG TERM CARE ORGANIZATIONS - FACILITY SUPPLEMENT

THIS SUPPLEMENT IS PART OF THE APPLICATION, INCLUDING A RENEWAL APPLICATION, SUBMITTED BY OR ON BEHALF OF THE APPLICANT FOR THE PROPOSED INSURANCE. THE NOTICES, CONDITIONS AND REPRESENTATIONS CONTAINED IN SUCH APPLICATION ARE INCORPORATED INTO AND APPLY TO THIS SUPPLEMENT.

Instructions:

1. A separate Long Term Care Organizations Facility Supplement must be completed for each facility seeking coverage.
2. Please attach copies of the following documents to this Supplement. These documents shall be considered part of the application for the proposed insurance submitted by or on behalf of the Applicant identified in question 1 below.

   · Most recent state survey with plan of correction

   · Current quality indicator profile

   · CMS Form 672 — Resident census and conditions of residents

A. ACCOUNT INFORMATION

1. Applicant Name (as identified in the application submitted for the proposed insurance):	

B. FACILITY INFORMATION

2. Legal Name of Facility			
3. Physical Address	Street:		
	City:	State:	Zip:
	County:		
	Telephone Number:		
	Website:	Email Address:	
4. How many years has the Facility been in operation?			
5. How many years has the Facility been under current ownership/management?			

C. EXPOSURE DETAILS

6. Please provide the following information:

   a. Total number of beds: _____ b. Total number of Medicare beds: _____ c. Total number of Medicaid beds: _____

Bed Census	Licensed Beds	Occupied Beds
Long Term Acute Care (LTAC)		
Ventilator		
Subacute		
Skilled Nursing		

Bed Census	Licensed Beds	Occupied Beds
Hospice		
Intermediate Care		
Alzheimer's		
Residential Care/Assisted Living		

	Number of Units	Current Number of Occupants	Total Number of Occupants at Full Occupancy
Independent Living (No medical professional services provided)			

If independent living services are provided:

a. Is there a common dining area? ☐ Yes ☐ No

b. Do individual units have cooking appliances? ☐ Yes ☐ No

c. Is there a daily resident check-in program? ☐ Yes ☐ No

If "Yes," please explain:

Ancillary Services	Annual Visits	
Home Health Care		☐ Facility residents ☐ General public
	Daily Census	
Adult Day Care (Social)		
Adult Day Care (Enhanced/Medical)		
Child Day Care		☐ Open to the public ☐ Restricted to facility staff/visitors

7. Does the Facility employ any physicians, nurse practitioners or physician assistants who provide direct patient care? ☐ Yes ☐ No

If "Yes," please indicate full time equivalents of each:
Physicians: _____ Nurse practitioners: _____ Physician assistants: _____

8. Indicate which of the following services are provided at the Facility: (check all that apply)

☐ Physical therapy ☐ Respiratory therapy ☐ Developmentally disabled care
☐ Speech therapy ☐ Occupational therapy ☐ Drug and alcohol rehab
☐ Rehabilitation care ☐ Psychiatric care ☐ Ventilator management
☐ IV therapy ☐ Transfusion therapy ☐ Total parental nutrition
☐ Resident rooms equipped with in-wall suction ☐ Resident Rooms equipped with in-wall oxygen

9. Please identify all contracted professional services performed for the Facility and indicate the required professional liability insurance limits each contractor is required to maintain.

Type of Service	Required Limits	Type of Service	Required Limits
☐ Beautician/Barber		☐ Physical Therapy	
☐ Dental		☐ Physician	
☐ Dietary		☐ Radiology	
☐ Laboratory		☐ Respiratory Therapy	
☐ Occupational Therapy		☐ Speech Therapy	
☐ Podiatrist		☐ Pharmaceutical	
☐ Patient Transportation		☐ Other: _____	
If "None," please check here ☐			

10. Does the Facility obtain certificates of insurance for the contracted professional individuals? ☐ Yes ☐ No

If "Yes," how often are the certificates updated? _____

11. Percentage of payment/reimbursement in each category:

Medicare: _____ % Medicaid: _____ % Private pay: _____ %

Other (describe): _____

12. On average, how many residents are restrained during a 24 hour time period? _____

Type of restraints used: ☐ Physical ☐ Chemical

13. Are there any non-ambulatory residents above the first floor? ☐ Yes ☐ No

14. Please indicate the number of residents and percentage of which are non-ambulatory for the following age groups:

Age Groups	Number of Residents	Percentage of Non-Ambulatory
Age 55 and Under		
56 to 64 Years of Age		
Age 65 and Over		

15. What services are provided to non-geriatric residents?

16. Please indicate the number of residents in each category:

	Number of Residents		Number of Residents
Confined to Bed		Receiving IV Therapy	
Receiving Tube Feedings		Receiving Respiratory Treatment	
Receiving Daily Dialysis Care		Receiving Dementia Care	
In Need of Assistive Devices While Eating		Receiving Specialized Rehabilitation Care	
Receiving Chemotherapy/Radiation Therapy		Receiving Hospice Care	
Traumatic Brain Injured Patients		Receiving Suctioning	

17. Please indicate the number of assisted living residents receiving assistance with the following Activities of Daily Living:

	Bathing	Dressing	Transferring	Toilet Use	Eating
Needing Assistance					
Totally Dependent					

18. For each classification below, indicate the total number of employees and the turnover percentage:
(Use full time equivalents. Only include direct care providers.)

	1st Shift	2nd Shift	3rd Shift	Turnover %
Registered Nurses				
Licensed Practical Nurses				
Certified Nursing Assistants				
Medication Aides				
Physical Therapists				
Social Workers				
Allied Health Care Professionals				
Volunteers				
Dieticians				
Beauticians/Barbers				
Maintenance/Security Personnel				

19. Do members of the Facility's nursing staff belong to any union? ☐ Yes ☐ No

20. What is the primary source for volunteers? _____

21. Is there a formal screening and orientation process for volunteers? ☐ Yes ☐ No

22. Does the Facility provide staff monetary incentives for continuing education? ☐ Yes ☐ No

23. Does the Facility conduct formal, ongoing skill assessments and training of all staff providing resident care? ☐ Yes ☐ No

If "Yes," how often is this done? _____

How is this documented? _____

24. Do the Facility's physical premises include recreation facilities? ☐ Yes ☐ No

If "Yes," indicate which of the following:

☐ Exercise/weight room
☐ Sauna/hot tub
☐ Swimming pool
☐ Tennis or racquetball court
☐ Other (describe): _____

25. Please provide the following information for the Facility:

a. Year built: _____

b. Number of floors: _____

c. Total square feet: _____

d. Construction type: ☐ Frame ☐ Brick ☐ Non-combustible
☐ Masonry non-combustible ☐ Fire resistive

e. Location of smoke detectors:

☐ None ☐ Entire facility ☐ Hallways ☐ Common areas
☐ Resident rooms ☐ Other: _____

f. Areas protected by approved automatic sprinkler system:

☐ None ☐ Entire facility ☐ Hallways ☐ Common areas
☐ Resident rooms ☐ Soiled linen chutes and rooms ☐ Trash collection area

g. When was the electric, heating or plumbing last inspected or updated?

Electric: Inspected: _____ Updated: _____

Heating: Inspected: _____ Updated: _____

Plumbing: Inspected: _____ Updated: _____

h. Was the building originally designed and constructed for nursing home occupancy? ☐ Yes ☐ No

i. Does the building meet applicable current NFPA life safety codes? ☐ Yes ☐ No

j. Is smoking permitted: ☐ In resident rooms ☐ In common areas

Describe rules applicable to smoking: _____

k. What security measures are used to control unauthorized entrance to the facility?

_____

l. Are there any alarms on exit doors to alert the staff that residents may be leaving the building? ☐ Yes ☐ No

If "Yes,":

i. How often are they checked? _____

ii. By whom? _____

iii. How is this documented? _____

m. Are handrails provided in hallways and bathrooms? ☐ Yes ☐ No

n. Are bathtubs/showers equipped with non-slip surfaces? ☐ Yes ☐ No

D. OPERATIONS AND ADMINISTRATION

26. Please indicate accreditation(s)/certification(s) held by the Facility:

- ☐ Joint Commission on Accreditation of Healthcare Organizations (JCAHO)
- ☐ Commission on Accreditation of Rehabilitation Facilities (CARF)
- ☐ Other: _____
- ☐ Medicare certified
- ☐ Medicaid certified

27. Has the Facility had its Medicaid, Medicare or any other federal, state or local government health insurance program certification limited, suspended or revoked within the last five years? ☐ Yes ☐ No

If "Yes," please explain:

28. Has the Facility or any of its owners or operators been accused of any Medicaid, Medicare or any other federal, state or local government health insurance program fraud or abuse violations, or paid any fines or penalties in connection with any such fraud or abuse violations? ☐ Yes ☐ No

If "Yes," please explain:

29. Has the Facility ever had a license suspended, revoked or placed under probation by any licensing agency? ☐ Yes ☐ No

If "Yes," please explain:

30. Facility administrator's name: _____

☐ Full time at the Facility ☐ Part time at the Facility Number of hours per week: _____

a. Number of years experience as an administrator: _____

b. Number of years as administrator at the Facility: _____

c. Does the administrator have a current, unrestricted administrator's license? ☐ Yes ☐ No

d. Is the administrator a member or certified fellow of ACHCA? ☐ Yes ☐ No

31. Does the Facility employ or contract with a medical director? ☐ Employ ☐ Contract

a. Medical director's name: _____

☐ Full time at the Facility ☐ Part time at the Facility Number of hours per week: _____

b. Medical speciality: _____

c. Number of years experience as a medical director: _____

d. Number of years as a medical director at the Facility: _____

e. Does the medical director also act as the attending physician for any residents? ☐ Yes ☐ No

32. If a medical director is not employed or contracted by the Facility, who is responsible for overseeing the delivery and quality of medical services provided? _____

33. Facility risk manager's name: _____

☐ Full time at the Facility ☐ Part time at the Facility Number of hours per week: _____

a. Number of years experience as a risk manager: _____

b. Number of years as a risk manager at the Facility: _____

34. Director of nursing's name: _____

☐ Full time at the Facility? ☐ Part time at the Facility? Number of hours per week: _____

a. Does the director of nursing have a current, unrestricted license? ☐ Yes ☐ No

b. Is the director of nursing a member of NADONNA? ☐ Yes ☐ No

c. Number of years as a registered nurse: _____

d. Number of years experience as a director of nursing: _____

e. Number of years as director of nursing at the Facility: _____

35. Please indicate all of the screening/hiring procedures used for professionals and others who provide patient care services at the Facility:

a. Verification of educational background ☐ Yes ☐ No

b. Verification of previous employers/employment history ☐ Yes ☐ No

c. Verification of personal references ☐ Yes ☐ No

d. Verification of any pending license suspensions or revocations, or any pending disciplinary actions by other facilities ☐ Yes ☐ No

e. Criminal background check: ☐ County ☐ State ☐ Federal ☐ None

f. Drug/alcohol testing ☐ Yes ☐ No

g. MVR check for anyone who transports residents ☐ Yes ☐ No

h. State sexual offender registry check ☐ Yes ☐ No

i. State nurses aides registry check ☐ Yes ☐ No

36. Does the Facility have a written emergency evacuation plan? ☐ Yes ☐ No

a. Are evacuation plans posted in all parts of the Facility? ☐ Yes ☐ No

b. How often are evacuation/fire drills conducted each year for each shift? _____

c. Does the staff orientation plan include a review and "walk through" of any disaster plan? ☐ Yes ☐ No

d. Does the evacuation plan include advanced arrangements for transportation and temporary shelter? ☐ Yes ☐ No

37. Does the Facility have established admission, discharge, and transfer criteria where necessary? ☐ Yes ☐ No

38. Who determines if a resident must be transferred to another facility for further medical diagnosis or treatment? _____

39. Does the Facility require evidence of acceptable health of all new residents admitted to the Facility? ☐ Yes ☐ No

40. Is a comprehensive nursing assessment conducted for new residents? ☐ Yes ☐ No

a. If "Yes," how often is the assessment repeated? _____

b. Does the assessment include:

i. Elopement risk ☐ Yes ☐ No

ii. Falls ☐ Yes ☐ No

iii. Cognitive impairment ☐ Yes ☐ No

iv. Nutritional deficiency ☐ Yes ☐ No

41. How often do nurses perform total body skin assessments? _____

42. Does the Facility transfer patients with Stage III or IV pressure ulcers to another facility providing a higher level of care for treatment, or does the Facility provide treatment?

☐ Transfer to another facility ☐ Treat at the Facility

43. Is an inventory taken of a residents' personal belongings on admittance with a copy maintained in the file? ☐ Yes ☐ No

44. Do all residents have their own attending physician? ☐ Yes ☐ No

If "No," who performs the role of attending physician? _____

45. How often are attending physicians required to update their patients' charts? Number of days: _____

46. Are written orders from an attending physician required for:

All drugs and medications ☐ Yes ☐ No

Any other specific therapy/treatment ☐ Yes ☐ No

Facility or hospital transfers ☐ Yes ☐ No

Restraints ☐ Yes ☐ No

Special dietary requirements ☐ Yes ☐ No

47. Are physicians' orders verified as to restraints? ☐ Yes ☐ No

48. Does the Facility retain a physician on-site or on-call on a 24-hour basis? ☐ Yes ☐ No

49. Who is responsible for administering medications? ☐ Licensed staff ☐ Medication aide ☐ Other

50. How are medications stored? _____

51. Does the Facility obtain advance written consent from the resident or guardian that allows the Facility to provide nonemergency medical care when it is needed? ☐ Yes ☐ No

52. Does the Facility have a "do not resuscitate" policy in place? ☐ Yes ☐ No

53. Does the Facility have a policy regarding the use of physical and chemical restraints? ☐ Yes ☐ No

If "Yes," please attach a copy.

54. Does the Facility have a written policy/procedure to investigate alleged resident abuse and neglect? ☐ Yes ☐ No

If "Yes," please attach a copy.

55. Does the Facility have a dedicated secure alzheimer's unit? ☐ Yes ☐ No

56. Is a wander guard system (or similar system) in place? ☐ Yes ☐ No

57. Number of elopements in the last 3 years:_____

If there have been elopements, please explain the circumstances of each such elopement:

58. Does the Facility conduct elopement drills? ☐ Yes ☐ No

If "Yes," how often? _____

59. Does the Facility have a resident/family council? ☐ Yes ☐ No

E. CLAIMS HISTORY

60. Is the Facility or any individual proposed for coverage under this insurance in connection with such Facility aware of any claim, fact, circumstance, situation, transaction, event, act, error or omission that has not been reported to the Facility's current insurance company? ☐ Yes ☐ No

If "Yes," please attach details to this Supplement.

F. SIGNATURE AND AUTHORIZATION

The undersigned, as the authorized agent of all individuals and entities proposed for this insurance, declares that, to the best of his/her knowledge and belief, after reasonable inquiry, the statements in this Supplement and any attachments or information submitted with this Supplement are true and complete. For Florida Applicants, the preceding sentence is replaced with the following sentence: The undersigned, as the authorized agent of all individuals and entities proposed for this insurance, represents that, to the best of his/her knowledge and belief, after reasonable inquiry, the statements in this Supplement and any attachments or information submitted with this Supplement are true and complete. The undersigned understands that this Supplement and any such attachments of information submitted herein are part of the application submitted by or on behalf of the Applicant for the proposed insurance, and are subject to the representations and conditions set forth therein.

Any person who knowingly and with intent to defraud any insurance company or another person, files an application for insurance containing any materially false information or conceals for the purpose of misleading, information concerning any fact material thereto, may be guilt of committing a fraudulent insurance act, which is a crime and subjects the person to criminal and civil penalties.

NEW YORK APPLICANTS: Any person who knowingly and with intent to defraud any insurance company or other 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 shall also be subject to a civil penalty not to exceed five thousand dollars and the stated value of the claim for each such violation.

Applicant Name	
By (Authorized Signature)	
Name/Title	
Date	