**Kaigler & Company 7028 Church St. East Brentwood, TN 37027**
**Phone: 615-376-0798 Fax: 615-376-0799 www.kaigler.com**

# NURSING HOME APPLICATION

INSURED:

MAILING ADDRESS:

LOCATION:

(Attach a sheet for additional locations)

Proposed effective date: From to
12:01 A. M. Standard Time at the address of the Applicant

Applicant is: Individual Corporation Partnership Joint Venture Other (specify)

Is the business currently in or currently considering bankruptcy? Yes No

1. Full Named Insured:

Note: If more than one Named Insured, explain the ownership/operational interest of each.

2. Is the above Named Insured the parent company and sole owner of each location listed above, if not provide the details:

3. Operating as: For Profit Non Profit Number of licensed beds:
How long under present management?

4. Named Insured is: Building Owner Tenant General Lessee

5. Building owner (if other than Named Insured):

6. Are there any other occupants of the premises? Yes No If yes, identify:

7. Officers and general partners Titles

8. How many years has the facility been in business under the current ownership?

9. How many years experience does the current ownership have in health facilities?

   How many years experience does the current management have in health facilities?

10. What professional or industry association(s) is the facility a member in good standing?

11. Name of Administrator:
    (a) How long at this facility?
    (b) Experience as Administrator or Assistant Administrator: years

12. Who is in charge when Administrator is absent? (name and title)

13. Number of Administrators at the facility during the prior 10 years?

14. Does the facility have a Medical Director? Yes No
    Number of years with the Facility?
    Does the Medical Director have his/her own professional liability insurance? Yes No

15. Name of Director of Nursing:
    (a) How long at this facility?
    (b) Experience as Director of Nursing? years

16. Is the facility certified for: Medicare? Yes No
    Medicaid? Yes No
    Other? Yes No Explain:

17. Number of patients in each category? Private Pay: Medicare:
    Medicaid: Other: Explain:

18. Gross annual receipts of the facility (including Medicare and Medicaid): $

19. Please attach the most recent copies of state and county inspections. Are there any deficiencies uncorrected? Yes No

20. License information:
    (a) Please attach licenses required for this facility's operation.
    (b) Is licensing conditional, provisional, probationary or temporary? Yes No If yes, explain:

    (c) Has license ever been revoked? Yes No If yes, explain:

21. Type of Home: Convalescent or Nursing Home for Aged Residential Care
    Other (describe)

22. Facility Classification and Bed Census

| | Total # of Licensed Beds | # Currently Occupied |
|---|---|---|
| **Skilled Care Services**<br>Professional nursing care – 24 hours by licensed nurses. Registered Nurse coverage during the day shift. LPN coverage required during other shifts. Skilled care services usually include some or all of the following: medication administration, other procedure ordered by physicians, injections, tube feeding, catheterizations. | | |
| **Intermediate Care Services**<br>Nursing care during the day shift 7 days per week, by either RN's or LPN's. No complex nursing care (IV's, tube feeding, etc.) Assistance with activities of daily living (i.e. walking, bathing, dressing, eating) some assistance with administering Medications. | | |
| **Residential Care Services**<br>Residents are ambulatory with possible minor disorders and are provided protective environments (meals and planned programs for social and/or spiritual needs.) Residents are eligible for incidental health care services, including assistance with medications. | | |
| **Independent Living**<br>Residents at retirement age and in general good health, occupy apartment, condominium, or dwelling unit that normally include cooking facilities. Residents do not receive any health care services or assistance with medications, but may have access to skilled or intermediate nursing care within the same facility complex. | | |

23. Patient/Resident Age Groups

| Age Group | Number of Patients/Residents | % Non-Ambulatory |
|---|---|---|
| Under 50 | | |
| 50-65 | | |
| Over 65 | | |

24. State approximate division of patients (MUST equal 100%):

| | | |
|---|---|---|
| % Surgical | % Mentally ill/mentally disabled | % Developmentally disabled |
| % Senile or Aged | % Drug addicts | % Alcoholics |
| % Alzheimer | %AIDS/HIV* | % Any other classes |
| | *Complete Question 50. | Explain: |

25. Physical features of risk:
    (a) Construction of building: Square footage of building:
    (b) Number of floors: Are any non-ambulatory residents above second floor?
    (c) Year built: Age and type of heating system:
    (d) Age and type of wiring: Date if remodeled:
    (e) Purpose for which building was originally constructed:
    (f) Number of fire extinguishers on premises: Tagged/inspected: Number of fire escapes:

    (g) Any swimming pools? Yes No If yes, is it fenced? Yes
    Are patients allowed to use the pool? Yes No If yes, what security measures are taken?

    Is staff trained in CPR and emergency training for water emergencies? Yes No
    What is the ratio of staff to patients while pool is in use?
    (h) Equipped with sprinkler system? Yes No Where?
    (i ) All rooms and halls equipped with smoke detectors? Yes No
    (j ) Equipped with fire alarm? Yes No Central station or Local alarm
    (k) Are there alarms or monitors on exit doors to prevent patients from leaving the premises without authorization? Yes No If no, how is ingress/egress monitored?
    (l) What security measures are used to control unauthorized entrances to the facility?

    (m) Are doors equipped with panic hardware? Yes No
    (n) Distance to nearest fire station? Distance to nearest fire hydrant?
    (o) Are handrails provided in hallways and bathrooms? Yes No
    (p) Are bathtubs and showers equipped with nonskid surfaces? Yes No
    (q) Does facility have tempering valves to control the temperature of the patients' water? Yes No
    If yes, how often are they checked?
    (r) Temperature of hot water F
    (s) Are there separate hot water systems for utility and bath areas? Yes No
    (t) Does the home have emergency lighting? Yes No
    (u) Where are the powered equipment, such as lawn mowers, and fuel stored?
    Are there any underground storage tanks? Yes No
    (v) What is the overall condition of the property including maintenance and housekeeping?
    Excellent Good Average Fair Poor
    (w) Cooking: Gas Electric None
    If none, describe food service:

| | | |
|---|---|---|
| 1. Is stove vented outside with hood and grease filter? | Yes | No |
| 2. Are filters clean? | Yes | No |
| 3. Are hood and cooking services protected with automatic extinguishing system? | Yes | No |
| 4. Are all cooking surfaces directly protected? | Yes | No |
| 5. Is automatic fuel shutdown interlocked to system? | Yes | No |
| 6. Is there any deep fat frying? | Yes | No |

26. Emergency procedures:
    1. Written emergency evacuation plan? Yes No
    2. Does plan include advance arrangement including transportation and emergency shelter? Yes No
    3. Are evacuation procedures posted in all parts of your facility? Yes No
    4. Are drills conducted regularly for each shift? Yes No
    5. Is the entire staff familiar with the emergency evacuation plan? Yes No
    6. Is the plan filed with the local fire department? Yes No

27. Classify number of employees by shift:

| | 1st Shift | 2nd Shift | 3rd Shift |
|---|---|---|---|
| Physicians, interns, residents | | | |
| Graduate nurses/RN | | | |
| Practical nurses/LPN | | | |
| Nurses aides | | | |
| Student nurses | | | |
| Physical therapists | | | |
| Inhalation therapists | | | |
| Dieticians | | | |
| Beauticians/barbers | | | |
| Respiratory therapists | | | |
| Social Worker | | | |
| Speech therapists | | | |
| Recreational therapists | | | |
| Occupational therapists | | | |
| X-ray technicians | | | |
| Lab technicians | | | |
| Maintenance/security | | | |
| Special technicians | | | |
| Dentists | | | |
| Administrative | | | |
| Kitchen | | | |
| Housekeeping | | | |
| Laundry | | | |
| Other | | | |
| Total number of employees | Full-time: | | Part-time: |

Staff turnover % last twelve (12) months

28. Physicians:

(a) Residents are expected required to have their own physician.

(b) Does facility employ or contract any of the following?

| | **EMPLOYED** | | | **CONTRACTED** | | |
|---|---|---|---|---|---|---|
| Psychologists | Yes | No | If yes, how many? | Yes | No | If yes, how many? |
| Dentists | Yes | No | If yes, how many? | Yes | No | If yes, how many? |
| Psychiatrists | Yes | No | If yes, how many? | Yes | No | If yes, how many? |
| Physicians | Yes | No | If yes, how many? | Yes | No | If yes, how many? |

(c) What are the duties of the contracted physicians?

(d) What are the average hours per week for all contracted physicians?

(e) Does insured obtain and maintain evidence of Professional Liability coverage for contracted professionals?
(f) What minimum limits are required?

29. Are pre-employment physicals required? Yes No

30. Is prior employment history checked? Yes No Attach a copy of facility guidelines.

31. Is English the primary language of all professional staff? Yes No If no, what procedures do the insured have in place to ensure the staff is fluent enough in English to provide adequate care?

Does the facility provide in-service training in languages other than English? Yes No

32. Does applicant have Workers Compensation coverage in force? Yes No

33. Does applicant lease employees? Yes No If yes, explain.

34. Does the facility ever use a nurse's registry or other temporary services to provide any staff? Yes No
(a) If yes, are they covered by their own Workers Compensation? Yes No
(b) If yes, do they have their own Professional Liability Coverage? Yes No
(c) Are certificates of insurance obtained? Yes No
What are the limits?
(d) Is the registry or service licensed? Yes No

35. Do Nurses make outside calls? Yes No If yes, describe:

36. Does applicant provide outpatient hospice care? Yes No If yes, describe:

37. Are physicians or RNs private practitioners (independent contractors) or actual employees of Insured?

38. Does the facility maintain its own: Barber/beauty shop Yes No
Pharmacy Yes No
Gift Shop Yes No
(a) Do the operators have their own professional liability? Yes No
(b) If no, complete and return Professional Application.

39. Are there any volunteer programs? Yes No Type of tasks performed:

Number of volunteers by shift: 1st 2nd 3rd

40. Explain arrangement for medical emergencies (M.D. on call, transfer arrangement with hospital, etc.):

41. Is there a safety committee? Yes No How often does it meet?
Is there a residents' council? Yes No How often does it meet?
Is there a family council? Yes No How often does it meet?

42. Are employees taught to lift using proper techniques? Yes No
(a) Are Hoyer Lifts being used? Yes No
(b) Are Gait Belts being used? Yes No

43. Are all wheelchairs equipped with locks for the wheels? Yes No

44. Is there a regular extermination program by an outside firm? Yes No
(a) If yes, who?
(b) How often?
(c) Is certificate of insurance on file? Yes No

45. Does the facility control the possession of smoking materials? Yes No If yes, how:
Please provide a copy of the facility smoking policy

46. Are there established visiting hours? Yes No If yes, what are they:

47. Are medications kept under locked conditions? Yes No

Do only authorized personnel have keys? Yes No

48. Does the facility have a policy on restraint usage? Yes No If yes, please attach a copy of this policy.

49. Any other premises or operations exposures not stated in this application? Yes No

If yes, attach a compete description and underwriting/rating information

50. Number of AIDS/HIV patients:

(a) Are patients isolated? Yes No If yes, how?

(b) What training is provided to new/existing staff?

(c) Is staff informed of all patients with AIDS/HIV? Yes No How often?

(d) Does insured do any blood testing? Yes No

(e) Attach a copy of the insured's written infection control plan.

(f) How often is infection waste stored and disposed of?

(g) Are employees tested for AIDS/HIV? Yes No How often?

(h)Describe how the laundry from the AIDS/HIV patients is handled:

Previous Insurer: Indicate premium and losses for the past five years. Describe all losses.

| Year | Losses Paid | Losses Reserved | Description |
|---|---|---|---|
| Current | | | |
| 1st Prior | | | |
| 2nd Prior | | | |
| 3rd Prior | | | |
| 4th Prior | | | |
| 5th Prior | | | |

51. Have any claims during the past five years ever been made or suit brought against the applicant because of any alleged malpractice, error, mistake or premises accident arising in any manner out of applicant's operation?

Yes No If yes, Date: Brief description:

52. During the past three years has any company ever cancelled, declined, or refused similar insurance to the applicant (Not applicable in Missouri) Yes No

If yes, explain:

REQUIRED ATTACHMENTS

ACORD Application
Most Recent State Inspection
Compliance of deficiencies w/ date of compliance
Resumes of Medical Director, Administrator and Director of Nursing
Copy of current license to operate
Fully Completed Risk Management Addendum
5 years currently valued, hard copy loss runs
12 months audited financials

NOTE: WILL NOT BE ABLE TO CONSIDER FOR QUOTATION WITHOUT THIS APPLICATION FULLY COMPLETED AND THE ABOVE ATTACHMENTS

This application does not bind the applicant nor the company to complete the insurance, but it is agreed that the information contained herein shall be the basis of the contract should a policy be issued.

APPLICABLE IN THE STATE OF NEW YORK:

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 there to commits a fraudulent insurance act, which is a crime and subject to a civil penalty not to exceed five thousand dollars and the stated value of the claim for each such violation.

FRAUD WARNING:

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 there to commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.

APPLICANT'S SIGNATURE Date

NAME AND PHONE NUMBER OF INDIVIDUAL TO CONTACT FOR INSPECTION/AUDIT

Name:

Phone: Fax:

IMPORTANT NOTICE

As part of our underwriting procedure, a routine inquiry may be made to obtain applicable information concerning character, general reputation, personal characteristics and mode of living.
Upon written request, additional information as to the nature and scope of the report, if one is made, will be provided.

# Risk Management Addendum to Nursing Home Application

(Provide brief responses in the space provided and attach any written policies that apply)

I. SAFETY COMMITTEE, RISK MANAGEMENT AND INCIDENT REPORTS

1. Describe the components of your Safety/Risk Management program as it pertains to professional liability issues.

2. What criteria do you use for incident reporting?

3. Explain how you track and trend incident information?

4. How are substantial complaints addressed?

II. STAFFING, EDUCATION AND TRAINING

1. Are all employees required to attend an orientation program prior to beginning their employment? _____ Yes _____ No
   Describe and attach the agenda for your orientation program.

2. Do you have a new employee preceptor program? _____ Yes _____ No
   How does it work? How long do you monitor new caregivers?

3. Do you have regularly scheduled in-services? _____ Yes _____ No
   Describe the type of in-services that have been conducted in the past six months.

4. How do you ensure attendance at your in-services and list what in-services have been held during the last 6 months?

III. ELOPEMENT PREVENTION

1. Is there a system in each facility to identify residents "at risk" for wandering?
   _____ Yes _____ No

2. How and when is your Elopement Prevention program implemented?

3. How are your entrances/exits secured?

4. Describe other methods you have to prevent patient elopements.

IV. FALL PREVENTION

1. Describe your fall prevention program.

2. How and when are residents assessed for their risk of falls?

3. How are patients identified as “at risk” for falls?

4. Describe other methods you have to prevent falls.

V. DECUBITUS PREVENTION AND SKIN CARE

1. Describe your program to prevent decubitus ulcers.

2. How often are resident skin assessments made? Provide the tool used to assess and document resident skin condition.

3. Do you have a wound care team or designated individual responsible for this program? _____ Yes _____ No
   If yes, describe the additional training or credentials of the team/individual.

4. Describe the scale used to determine severity of decubitus ulcers.

5. On an average, how many residents are receiving special skin care weekly?

6. Describe additional quality improvement efforts to reduce decubitus ulcers.

VI. MEDICATION ERRORS

1. Do you employ or contract with a registered pharmacist to supervise pharmacy services? _____ Yes _____ No

2. Describe the method used to monitor medication errors.

3. Describe the quality improvement efforts to reduce medication errors.

VII. ADDITIONAL INFORMATION

1. How many elopements occurred in your facility(s) in the past 12 months?

2. How many sexual assaults (upon residents) occurred in your facility(s) in the past 12 months?