Quality Care Nursing
A Vital Force in Nursing

P.O. Box 490 | Leland, MS 38756 | 662-378-2009

www.qcnstaffing.com

Thank you for requesting information regarding our agency. We are a nurse owned agency that is proud to offer excellent hourly rates and expert nursing resources. Please review the information and if you have any questions, call our office at 662-378-2009 or 888-378-2009. The application packet must be returned to our mailing address listed above.

## CAN I FAX MY APPLICATION?

Sure! If you choose to fax your application packet, call prior to faxing to let us know. Afterwards, we will call to verify that it printed out on our end. Fax # 662-378-2090.

## WHAT HAPPENS AFTER APPLICATION IS RECEIVED?

A recruiter will call you as soon as we receive your application. Please list all valid phone numbers where you can be reached. Normally we can process your application the day it is received so you may begin accepting shifts

## WE LOOK FORWARD TO HAVING YOU ON OUR TEAM!

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# APPLICATION DOCUMENTS

_____ APPLICATION

_____ COPY OF SOCIAL SECURITY CARD

_____ COPY OF DRIVER'S LICENSE

_____ COPY OF NURSING LICENSE

_____ COPY OF CPR AND/OR ACLS

_____ SKILLS CHECKLIST

_____ PHYSICIAN'S STATEMENT/HEALTH CERTIFICATE

_____ CURRENT TB SKIN TEST OR CXR

_____ HEPATITIS WAIVER OR RECORD

_____ MMR/VARICELLA FORM

_____ 2 REFERENCES (FORMS PROVIDED)

_____ COPY OF MALPRACTICE (NOT REQUIRED BUT RECOMMENDED)

_____ I-9 EMPLOYEE ELIGIBILITY VERIFCATION FORM

_____ SIGNED CONTRACT

_____ COMPLETED JCAHO/OSHA QUIZ

_____ BACKGROUND CHECK FINGERPRINT VERIFICATION

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# NURSING EMPLOYMENT APPLICATION

Date Available to Work_____ Today's Date_____

---

## Personal Information

Name _____

Permanent Address _____ City _____ State/Zip_____

Phone (____) _____-_____ Best time to call _____ Cell (____)-_____

Email address_____

Current Address_____ City _____ State/Zip_____

Social Security Number_____

---

## Employment Status

Are you a U.S. Citizen (yes)_____ (no)_____ If not a U.S. citizen, please indicate your immigration status

(HI-B Visa)_____ (TN Visa)_____ (Resident Alien)_____ (Other) _____

---

## Additional Information

How did you hear about us? _____

If referral, please indicate whom _____ Have you ever applied with us before? _____

If so, when?_____

Emergency Contact (Name)_____(phone number)_____

---

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## Medical Experience

Healthcare Discipline

Advanced Practice RN _____ RN _____

LPN II _____ LPN _____

Other _____

Total Years of Experience: _____

Date Passed Boards: _____

---

## Education ( please fill out at least one of the following Education rows completely)

Graduate School _____City_____State_____Year Graduated_____Degree Type_____

Nursing School_____City_____State_____Year Graduated_____Degree Type _____

College/University _____City _____State _____Year Graduated _____Degree Type_____

Vocational/Technical _____ City _____State_____Year Graduated _____ Degree Type _____

---

## Clinical Experience

Please identify the amount of experience you have in each unit listed below. Greater flexibility with float experience translates into more opportunity for assignments.

| | | | |
|---|---|---|---|
| Critical Care | _____ | Medical Surgical | _____ |
| Cardiac Cath Lab | _____ | Neonatal ICU | _____ |
| Emergency Room | _____ | Labor & Delivery | _____ |
| Telemetry | _____ | Post Partum | _____ |
| Stepdown/ICU | _____ | Operating Room | _____ |
| Psychiatric Nursing | _____ | Geri-Psych | _____ |
| Inpatient Rehab | _____ | Orthopedics | _____ |
| Neurology | _____ | Dialysis | _____ |

Other _____

---

## Preferences

Shift Preference _____ Days _____ Evenings _____ Nights

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---

## Employment History

Employment Dates
From (month/year) _____/_____ To (month/year) _____/_____

Hospital/Facility _____

Street Address _____

City _____ State _____

Agency (if a travel or per diem assignment) _____

Position _____ Charge Experience _____

Phone (____)-_____-_____

Supervisor Name and Title _____

Reason for Leaving _____

May we contact this employer? _____yes _____no

---

From (month/year) _____/_____ To (month/year) _____/_____

Hospital/Facility _____

Street Address _____

City _____ State _____

Agency (if a travel or per diem assignment) _____

Position _____ Charge Experience _____

Phone (____)-_____-_____

Supervisor Name and Title _____

Reason for Leaving _____

May we contact this employer? _____yes _____no

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Employment History

---

From (month/year) _____/_____ To (month/year) _____/_____

Hospital/Facility _____

Street Address _____

City _____ State _____

Agency (if a travel or per diem assignment) _____

Position _____ Charge Experience _____

Phone (____)-_____-_____

Supervisor Name and Title _____

Reason for Leaving _____

May we contact this employer? _____yes _____no

---

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APPLICATION ACKNOWLEDGEMENT
AUTHORIZATION AND RELEASE

Name _____
Last First Middle Name

I certify that the information in this application and any supporting documentation is true, accurate, current and complete. I understand that any misstatement, misrepresentation, omission or falsification of facts on this application or supporting documentation may result in disqualification from further consideration or termination of contractual agreement.

I authorize Quality Care Nursing Inc. to investigate my employment history, professional licensure and credentials and to obtain any relevant information (including criminal background check) needed to make a decision regarding utilizing my services. I authorize Quality Care Nursing Inc. to contact any current or former employer, staffing companies through whom I have worked, state licensing boards, professional organizations, references, medical malpractice insurance carriers, educational institutions and any other sources of information about me to inquire about my background, education, work history, character, experience and clinical skills. I authorize Quality Care Nursing Inc. to disclose this application along with any information about me obtained through reference checks or during the course of the interview process for state, federal, contractual or accreditation audit purposes. I also authorize Quality Care Nursing Inc. to disclose any of my performance appraisals, disciplinary records or skills assessments for the same purposes as above. I release Quality Care Nursing Inc. and any individual or entity providing information to Quality Care Nursing Inc. from all liability for any damages resulting from disclosure of this information.

I also understand and agree that passing a medical examination and/ or participating in a post – conditional offer medical screening may be required. If medical restrictions cannot be reasonably accommodated, my services may not be utilized as an independent contract nurse.

I consent that, subject to applicable state laws, Quality Care Nursing Inc. reserves the right to conduct drug screening and testing for reasonable suspicion at any time during our contractual agreement. Any violation of this policy shall result in termination of my services with Quality Care Nursing Inc.

I understand and agree that nothing contained in this employment application or in granting of an interview creates an employment between Quality Care Nursing Inc. and myself. No promises regarding employment have been made to me. If any employment relationship is established, I understand that my employment will be terminable “at will”, that I will have the right to terminate my employment at any time, and that Quality Care Nursing Inc. will retain a similar right to terminate my services at any time.

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APPLICATION ACKNOWLEDGEMENT
AUTHORIZATION AND RELEASE

---

Applicant Name (print): _____

Signature of Applicant: _____

Date: _____

Social Security #: _____ Date of Birth: _____

Driver's License #: _____ State: _____

Quality Care Nursing is an Equal Opportunity Employer

Pursuant to Title VII of the Civil Rights Act of 1964 (42 U.S. C s200d et seq.) and 45 C.F.R. Part 80, Section 504 of the Rehabilitation Act of 1973, as amended (29 U. S. C s794) and 45 C. F. R Part 84, and the Age discrimination Act of 1975 (42 U. S. C s6101 et seq.) and 45 C. F. R. Part 91, the agency adheres to an equal opportunity policy for all persons seeking contractual employment, and for all persons employed by the agency. Quality Care Nursing Inc. does not discriminate on the basis of age, race, color, religion, military status, marital status, gender, gender preference, national origin, or disability.

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PROFESSIONAL CREDENTIALS

AND CERTIFICATIONS

---

Name: _____

(Last) (First) (Middle Name)

Please list all credentials ( CPR, ACLS, TNCC, CNOR, BLS, etc.) along with expiration dates

| Credential/ Certification | Expiration Date |
|---|---|
| _____ | _____ |
| _____ | _____ |
| _____ | _____ |
| _____ | _____ |
| _____ | _____ |
| _____ | _____ |

---

Professional Licensure

License #: _____ State _____

Have you ever held a nursing license under a different name? if yes, please list name and location_____

_____

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PROFESSIONAL CREDENTIALS

AND CERTIFICATIONS

---

If you answer yes to any of the questions below, please attach a separate sheet with circumstances, dates and final outcome:

Have you ever been convicted of a crime other than a minor traffic violation _____ yes _____no

Has your license or certification ever been investigated or suspended _____ yes _____no

Have you ever been named as a defendant in a malpractice claim _____yes _____no

---

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REFERENCE

INFORMATION

Print Name _____ Signature _____

Notice to Employer

The applicant named above has applied to Quality Care Nursing for contractual employment and has given us your name as a professional reference. We would greatly appreciate it if you would verify employment dates as well as provide an evaluation of this applicant's past performance using the criteria outlined below. Please make any additional comments you feel would assist us in making our decision in hiring this applicant. Your comments will be kept in the strictest confidence Thank you.

Employment Dates: From (month/year) _____/_____ To (month/year)_____/_____

Hospital/ Facility _____ Number of Beds_____

Specialty/Units Worked _____ Average Patient Ratio _____

Position _____

Applicant Role in Unit _____Advanced Practice RN _____RN _____ LPN _____Other (Explain)_____

Charge Experience _____yes _____no Is this applicant eligible for rehire _____yes _____no (explain)
_____

---

Clinical Performance/ Attributes

| | Exceeds Standards | Meets Standards | Does not Meet Standards* |
|---|---|---|---|
| Clinical Competence | _____ | _____ | _____ |
| Critical Thinking Skills | _____ | _____ | _____ |
| Quality of Work | _____ | _____ | _____ |
| Quantity of Work | _____ | _____ | _____ |
| Ability to Follow Directions | _____ | _____ | _____ |
| Accepts Feedback | _____ | _____ | _____ |
| Dependability | _____ | _____ | _____ |
| Attitude | _____ | _____ | _____ |
| Initiative | _____ | _____ | _____ |
| Interpersonal Skills | _____ | _____ | _____ |

Signature _____ Title _____

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REFERENCE

INFORMATION

Print Name _____ Signature _____

Notice to Employer

The applicant named above has applied to Quality Care Nursing for contractual employment and has given us your name as a professional reference. We would greatly appreciate it if you would verify employment dates as well as provide an evaluation of this applicant's past performance using the criteria outlined below. Please make any additional comments you feel would assist us in making our decision in hiring this applicant. Your comments will be kept in the strictest confidence Thank you.

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Hospital/ Facility _____ Number of Beds_____

Specialty/Units Worked _____ Average Patient Ratio _____

Position _____

Applicant Role in Unit _____Advanced Practice RN _____RN _____ LPN _____Other (Explain)_____

Charge Experience _____yes _____no Is this applicant eligible for rehire _____yes _____no (explain)
_____

---

Clinical Performance/ Attributes

| | Exceeds Standards | Meets Standards | Does not Meet Standards* |
|---|---|---|---|
| Clinical Competence | _____ | _____ | _____ |
| Critical Thinking Skills | _____ | _____ | _____ |
| Quality of Work | _____ | _____ | _____ |
| Quantity of Work | _____ | _____ | _____ |
| Ability to Follow Directions | _____ | _____ | _____ |
| Accepts Feedback | _____ | _____ | _____ |
| Dependability | _____ | _____ | _____ |
| Attitude | _____ | _____ | _____ |
| Initiative | _____ | _____ | _____ |
| Interpersonal Skills | _____ | _____ | _____ |

Signature _____ Title _____

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HIPAA Participation Training Guide

On completion of the HIPAA Training Module, the employee will

- Have knowledge of the origins and intent of HIPAA
- Have understanding of the Security Rule and the Privacy Rule
- Have knowledge of the definitions and regulations pertaining to Protected Health Information (PHI)
- Have knowledge of enforcement and criminal penalties associated with HIPAA

What is HIPAA?

Congress passed a federal law, the Health Insurance Portablility and Accountability Act of 1996 (HIPAA) to improve efficiency and effectiveness of the health care system. The law included:

| | |
|---|---|
| 1 | A Series of " administrative simplification" provisions that required the Department of Health and Human Services (HHS) to adopt national standards for electronic health care transactions; and |
| 2 | The adoption of security and privacy standards in order to secure protected health information( PHI) |

The origins of HIPAA

The act is comprised of two major legislative actions:

| | |
|---|---|
| 1 | Health insurance reform that included a wide array of provisions designed to make health insurance more affordable and accessible |
| 2 | Administrative simplification of creation, retention, and transmission of electronic health information |

Who is covered by HIPAA?

Almost every organization that provides or pays for health services, or exchanges health care data of any kind is subject to HIPAA. All health care providers (MDs, nurses, etc) all health plans (HMOs, insurers) and all health information clearing houses are "covered entities"

HIPAA extends protection to every patient whose information is collected, used or disclosed by such covered entities. It imposes responsibilities on the entire workforce of a covered entity to secure those rights. A covered entity's work force includes all employees, volunteers and "business associates" i.e. all companies that handle health information on a covered entity's behalf.

As a provider of health care staffing, Quality Care Nursing Inc. is a "business associate" of "covered entities" (hospitals, clinics, doctor's offices, etc)

HIPAA is abot the

- Protection of health information (security)
- Proper use of health information (privacy)
- Promotion of electronic data interchange

| |
|---|
| Security Standards Security Standards are defined as controls to protect confidential information from unauthorized access, modification or destruction. The goals of these standards are to ensure confidentiality, integrity and availability. These goals are based on good business practices. These standards include the Privacy Rule. – Effective date April 14, 2003 |

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# HIPAA TRAINING MODULE TEST

T F 1. HIPAA stands for Health Insurance Portability Accountability Act.

T F 2. The date for compliance with HIPAA privacy standards is April 14, 2003

T F 3. The HIPAA regulation affects only electronic transmission of health information

T F 4. PHI stands for Protected Health Information

T F 5. Quality Care Nursing is a "business associate" of hospitals, clinics, and other health care providers subject to HIPAA.

T F 6. You must know and comply with the privacy policies and procedures of any organization where you work.

T F 7. The HIPAA regulation affects me and my responsibilities to the patients that I provide services for.

T F 8. You are allowed to repeat protected information only when it is necessary to do your job.

T F 9. Only information that would virtually be impossible to identify the person is not subject to the privacy rules.

T F 10. No one will ever know that I don't follow the law about privacy. So, I can ignore the part about criminal penalties.

I certify that I have completed the HIPAA privacy training. I understand and will honor all of the organization's privacy policies and procedures. I am aware that violations of the privacy policies and procedures may result in disciplinary action including termination.

_____ _____

Signature Date

_____

Printed Name Score_____%

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# INFECTIOUS WASTE AND FIRE SAFETY QUIZ

Name: _____Date:_____

1. ABC fire extinguishers can be used on any fire. _____ True _____ False
2. Smoking in the presence of oxygen is dangerous because it can accelerate fire. _____ True _____ False
3. Handwashing should be done before and after contact with a patient, but not after removing gloves _____ True _____False
4. Fire exits should be located before fire occurs. _____ True _____ False
5. If you are asked to operate equipment which is unfamiliar to you, you should:
   a. Do the best you can to figure it out
   b. Ask the patient
   c. Call the charge nurse or supervisor for instructions
6. Universal precautions must be followed for all patient contact. _____ True _____ False
7. Equipment that has a strange noise, vibration or frayed wires should not be used _____ True _____ False
8. All used needles should be recapped, bent or broken to dispose of _____ True _____ False
9. Any dressing and/or disposable supplies should be:
   a. Placed in the regular trash
   b. Separated from regular trash and placed in impervious plastic bags
   c. Be labeled according to local and state ordinances
   d. Both B and C
10. Signs and symptoms of infection should be reported to the charge nurse or the nursing supervisor _____ True _____False

Score _____%

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# HEPATITIS B VACCINATION STATUS

Name _____ Classification: _____

The hepatitis B Vaccination will be made available to all healthcare personnel after personnel have received the required training, within 10 working days of initial assignment and to all who have occupational exposure , unless the healthcare personnel are exempted from having the Hepatitis B Vaccination series for any of the following reasons:

(check one)

_____ antibody testing indicates me to be immune

_____ the vaccine cannot be given for medical reasons

_____ I have received the complete Hepatitis B Vaccination series previously

_____ I would like the Hepatitis B Vaccination

_____ I am currently receiving the Hepatitis Vaccination

_____ _____

Signature Date

---

Declination Statement

I decline the Hepatitis B Vaccination at this time. I understand that my declining this vaccine, I continue to be at risk of acquiring Hepatitis B, a serious disease. I understand that due to my occupational exposure to blood and other potentially infectious materials, I may be at a higher risk of acquiring Hepatitis B. However, if in the future I continue to have occupational exposure to blood and other potentially infectious materials and want to be vaccinated with the Hepatitis B Vaccine, I will receive the Vaccination series at that time

_____ _____

Signature Date

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# PHYSICIAN'S STATEMENT OF HEALTH

This nurse, _____, is free from infectious or contagious disease, and there is no cause to prevent the nurse from performing the tasks required by his/her profession.

Date: _____

Physician's Signature: _____

Physician's Printed Name: _____

Return this completed statement to Quality Care Nursing Inc. for submission with your application packet

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# TUBERCULIN SKIN TEST REPORTING FORM

Name _____

Please print

Date of Test: _____

Date Read: _____

( have test read 48 to 72 hours after it is administered)

Read By: _____

Results _____ 0mm/negative

_____ mm/positive

- If redness or swelling occur, your test must be read by employee health nurse or nurse certified in reading test

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NON-DISCLOSURE STATEMENT

I understand I may come in contact with confidential information, both clinical and personnel related, through written records, documents, ledgers, and internal verbal correspondence and communication.

I agree not to divulge or disclose to anyone directly or indirectly, either during or after my work with Quality Care Nursing any confidential information acquired during the course of my work with this organization

I understand and acknowledge that in the event I breach any provision of this agreement, Quality Care Nursing in addition to any other legal remedies available to them, has the right to reprimand, suspend and/or terminate my working relationship with or without notice at their discretion.

I also agree not to serve as an expert witness in any case on behalf of any plaintiff wherein medical care was given by me, at any time during or after working with Quality Care Nursing.

_____

Name (please print)

_____ _____

Signature Date

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CONTRACTOR'S STATEMENT OF UNDERSTANDING

1. I understand that RNs will be paid $36-$37.50/hr and LPNs $23-$24.50/hr. for subcontracting to client facilities.
2. I understand that I may be pulled to other areas in the facility, at the client facilities discretion, if I refuse I agree to contact the office first at 888-378-2009
3. I understand that I can contact the on-call person after hours at 662-378-2009 or 888-378-2009
4. I understand that I am not an employee of the hospital. Any changes to my schedule or cancellations must be handled by Quality Care Nursing
5. I understand that I must sign in and out in order to receive payment for any given shift during that pay period. If I fail to sign in or out I must wait until a hospital representative is able to confirm that I actually worked that particular shift
6. I understand that if I need to cancel, I must contact Quality Care Nursing (not the client facility) within 4 hours prior to the start of my scheduled shift
7. I understand that if I am a no call/no show, I may be made a DNR (Do Not Return) to that client facility
8. I understand that falsifying work sign in sheets is considered Forgery and may be viewed as a criminal act
9. I understand that excessive/consistent cancellations or failure to provide current licensure and certifications my render my work status "inactive"
10. I understand Quality Care Nursing is not responsible for providing Worker's Compensation or Professional Liability Insurance for me because of my independent contractor status and that I am responsible for providing my own Professional Liability Insurance
11. I understand that I am not an employee of Quality Care Nursing and as an independent contractor I will receive a 1099 from Quality Care Nursing, and at the end of the tax year, I am responsible for my own tax reporting
12. I authorize and understand that my application packet (to include Social Security number and Health Status Information) may be released to client facilities

_____ _____

Independent Contract Signature Date

_____ _____

Management Signature Date

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PAY PERIODS:

QCN pay periods begin Monday and end on Sunday

Sign in/Sign Out Sheets:

Contractors must sign in 15 minutes prior to start of shift and sign out 15 minutes after shift ends. The client facility will be responsible for faxing the sheets to QCN every Monday morning. It is your responsibility to do the following:

1. Make sure every shift you've worked during that pay period is included on that week's sign in sheet
2. If you are first to sign in on Monday morning, please begin another sheet

OVERTIME

All overtime must be pre-approved…..no exceptions!!!!!! Contractor must write OT on their time sheet for that shift. This section must be initialed by a facility representative

LUNCH BREAKS

30 minutes will be automatically deducted from each. It is your duty as a professional to manage your time wisely. All workers are entitled to a 30 minute lunch break…TAKE IT. In the case of a double shift, there will be one 30 minute lunch break deducted from each shift.

What happens if the contractor fails to sign in?

Contractors who fail to sign in or sign out will not be paid for the said shift until it can be validated by the client facility that you actually worked said shift. NOTE: said shift will not be paid until the next pay period or until client facility acknowledges in writing that said shift was worked by contractor.

_____ _____

Independent Contractor Signature Date

_____ _____

Management Signature Date

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# PROBATION POLICY

The following infractions will result in a warning after the first offense. A second offense will result in progressive disciplinary action up to and including termination of services.

- Signing in and out at the same time
- Not signing in or out on 3 or more occasions
- Cancellation with less than 4 hours notice
- Scheduling directly with facility
- Only the nurse contractor may cancel a shift, (not family, friends, etc)
- Arriving more than 15 minutes late without notifying QCN
- More than 3 cancellations within a one month period

NO CALL/NO SHOW OR UNAUTHORIZED OVERTIME WILL RESULT IN IMMEDIATE 30 DAY PROBATION WITH NO WARNING

Misconduct, unprofessional nursing practice and/or failure to adhere to client facility policy and procedure will result in probation and/or suspension

_____ _____

Independent Contractor Signature Date

_____ _____

Management Signature Date

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# STOP!

THE FOLLOWING SECTION IS TO BE REVIEWED AND SIGNED BY ALL NURSES INTERESTED IN WORKING IN THE NURSING HOME SETTING. THE INFORMATION IS VALUABLE TO ALL NURSING STAFF. WE ADVISE THAT ALL APPLICANTS REVIEW THE INFORMATION AND SIGN.

- ABUSE AND NEGLECT PROHIBITION
- THE RESIDENT'S RIGHTS UNDER FEDERAL LAW

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# ABUSE AND NEGLECT PROHIBITION

## Policy

Each patient/resident has the right to be free from mistreatment, neglect, abuse, involuntary seclusion and misappropriation of property

## FUNDAMENTAL INFORMATION

### Definition

Abuse – means the willful infliction of injury, unreasonable confinement, intimidation, or punishment with resulting harm, pain or mental anguish.

Immediate Jeopardy – is a situation in which the provider's noncompliance with one or more requirements of participation has caused, or is likely to cause, serious injury, harm, impairment or death of a resident.

Involuntary seclusion - is defined as the separation of a resident from other residents or from his/her room or confinement to his or her room (with or without roommates) against the resident's will, or the will of the resident's legal representative.

Mental abuse – includes, but is not limited to, humiliation, harassment, and threats of punishment or deprivation

Missappropriation of resident property – means the deliberate misplacement, exploitation, or wrongful, temporary or permanent use of a resident's belongings or money without the resident's consent.

Neglect – means failure to provide goods and services necessary to avoid physical harm, mental anguish, or mental illness.

Physical abuse – includes hitting, slapping, pinching, and kicking. It also includes controlling behavior through corporal punishment

Sexual abuse – includes, but is not limited to, sexual harassment, sexual coercion, or sexual assault.

Verbal abuse – is defined as the use of oral, written or gestured language that willfully includes disparaging and derogatory terms to residents or their families, or within their hearing distance regardless of their age, ability to comprehend, or disability.

## PROCEDURE

### Screening

1. Quality Care Nursing will screen for contractors with a history of abusive behavior or who may be at risk for being abusive
2. Quality Care Nursing contractual staff may be screened in accordance with policies set forth by contractual facilities

### Training

1. Contractual facilities may provide additional training regarding these policies

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Training (cont'd)

2. Training may be during orientation, annually and more often as determined by the contract facility

Prevention

1. Contractual facility supervisors will immediately correct and intervene in reported or identified situations in which abuse or neglect is at risk of occurring.

2. Instruction on how to report any signs of stress from family and other individuals involved with the resident that may lead to abuse, neglect, or misappropriation resident property, and intervene as appropriate.

3. Residents identified by staff as being self injurious or exhibiting abusive behavior, which require professional services not provided in the facility, will be reviewed by the physician and treatment plans modified as appropriate.

Identification

1. The facility Quality Assessment & Assurance Committee will investigate occurrences, patterns and trends that may indicate the presence of abuse, neglect or misappropriation of resident property and to determine the direction of the investigation/intervention, through analysis of systems, audits and reports.

2. The facility supervisory staff will integrate into the supervisory process monitoring the behavior of staff members and residents, which are indicative of high stress levels that may lead to abuse/neglect or may escalate a continuum of aggression.

3. The facility may accommodate special needs of a resident or staff member who have been affected by past abuse experiences.

Investigation

1. The facility will conduct an investigation of any alleged abuse/neglect or misappropriation of resident property in accordance with state law.

2. The facility will report such allegations to the state, as per state regulation.

3. The facility will report all investigation findings to the state as per state regulations

4. The facility will investigate all patterns, trends or incidents that suggest the possible presence of abuse, neglect or misappropriation or property, identified through analysis conducted by the QA&A Committee, with intervention, reporting or policy/procedure modification conducted as appropriate.

Protection

1. The facility will protect residents from harm during the investigation

2. The facility will make referrals to the appropriate state agencies as necessary, to ensure the protection of the residents or resident's property.

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Reporting and Response

1. The facility will report all allegations and substantiated occurrences of abuse, neglect, and misappropriation of property to the state agency and law enforcement officials as designed by state law.
2. The facility will report to company management and legal departments in accordance with company reporting procedures.
3. The facility will report any occurrences of abuse by registered or certified staff the State Board as required by state law
4. Policies and facility procedures will be analyzed and modified as necessary by the QA&A Committee so as to meet the full intent of the law

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RESIDENT'S RIGHTS UNDER FEDERAL LAW

The resident:

1. Has the right to a dignified existence, self-determination, communication with and access to persons and services inside and outside the facility
2. Has a right to exercise his or her rights as a resident of the facility and as a citizen or resident of the United States
3. Has the right to be fully informed in a language he or she can understand of his or her total health status, including but not limited to, his or her medical condition
4. Has the right to be fully informed in a language he or she can understand of his or her total health status, including but not limited to, his or her medical condition
5. Has the right to refuse treatment and to refuse to participate in experimental research
6. Has the right to exercise his or her legal rights, including filing a grievance with the state survey and certification agency concerning resident abuse, neglect, and misappropriation of resident property in the facility
7. Has the right to manage his or her financial affairs
8. Has a right to choose an attending physician
9. Has a right to be fully informed in advance about care and treatment or changes in care and treatment and any changes in that care or treatment that may affect the resident's well being.
10. Has a right to participate in planning his or her care and treatment or changes in care and treatment unless adjudged incompetent or otherwise found to be incapacitated under the laws of the state
11. Has the right to personal privacy and confidentiality of his or her personal and clinical records
12. Has the right, upon oral or written request, to access all records pertaining to himself or herself, including clinical records, within twenty fours hours. After receipt of his or her records the resident or legal representative has the right to purchase ( at a cost not to exceed the community standard) photocopies of the records or any portions of them upon request and with two days' advance notice to the facility
13. May approve or refuse the release of personal and clinical records to any individual outside the facility except when the resident is transferred to another healthcare institution or record release is required by law or third party payment contract
14. Has a right to voice grievances with respect to treatment or care that is not furnished, without discrimination or reprisal for voicing grievances.
15. Has a right to prompt efforts by the facility to resolve grievances, including those with respect to the behavior of other residents
16. Has a right to examine the results of the most recent survey of the facility conducted by federal or state surveyors and any plan of correction in effect with respect to the facility
17. Has a right to receive information from agencies acting as client advocates and be afforded the opportunity to contact the agencies.

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The resident:

18. Has a right to refuse to perform services for the facility

19. Has right to agree to perform voluntary or paid services for the facility if he or she desires, if there is no medical reason which would contradict the performing of the services, and if compensation for paid services is at or above prevailing rates.

20. Has a right to privacy in written communications, including the right to send and receive mail promptly that is unopened. The resident has a right of access to stationery, postage, and writing implements at the resident's own expense.

21. Has the right to immediate access to any of the following:

- Any representative of the Secretary of the U.S. Department of Health and Human Services
- Any representative of the state
- The resident's individual physician
- The state's long-term care Ombudsman
- The agency responsible for the protection of and advocacy system for mentally ill or developmentally disabled individuals
- Subject to the resident's right to deny or withdraw consent at any time, immediate family or other relatives of the resident or others who are visiting with the consent of the resident.
- Subject to reasonable restrictions and the residents right to deny or withdraw consent at any time, others who are visiting with the consent of the resident

22. The facility must provide reasonable access to any resident by an entity or individual that provides health, social, legal, or other services to the resident, subject to the resident's right to deny or withdraw consent at any time.

23. Has a right to have reasonable access to the private use of a telephone

24. Has a right to retain and use personal possessions, including some furnishings and appropriate clothing, as space permits, unless to do so would infringe on the rights or health and safety of other residents.

25. Has a right to share a room with his or her spouse when married residents live in the same facility and both spouses consent to the arrangement

26. Has a right to self-administer drugs unless the facility interdisciplinary team has determined for a particular resident that this practice is unsafe.

27. Has a right to be free from physical restraint imposed or psychoactive drugs administered for the purpose of discipline or convenience and not required to treat the resident's medical symptoms.

28. Has the right to be free from verbal, sexual, physical or mental abuse, corporal punishment, and involuntary seclusion.

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Resident's Rights (Page 3)

The resident:

29. Has a right to choose activities, schedules, and health care consistent with his or her interest, assessments, and plans of care

30. Has a right to receive advance notice of transfers or discharges of the resident as required by law. The resident has a right to receive notice before the resident's room or roommate is changed. The resident has the right to refuse a room transfer if the purpose of the transfer is to move resident between a Medicare certified bed and a non-Medicare certified bed for purposes of Medicare eligibility.

31. Has a right to organize and participate in resident groups in the facility, and the resident's family has a right to meet with families of other residents.

32. Has a right to participate in social, religious, and community activities that do not interfere with the rights of other residents.

33. Has a right to reasonable accommodation of individual needs and preferences except where the health and safety of the resident or other residents would be endangered.

34. Has a right and the freedom to choose his or her attending physician in accordance with applicable law and subject to the physician's compliance with all applicable laws and reasonable rules and regulations of the facility

35. Facility may not require a third party guarantor of payment ("Agent") to sign the admission agreement as a condition of admission on continued stay. However, facility may require any individual who has legal access to resident's income or resources available to pay for resident's care ("agent") to sign the admission agreement, without incurring personal financial liability, to agree to provide payment to facility from resident's income or resources. Facility will inform resident, verbally and in writing at the time of admission, of the resident's rights during his or her stay in facility, in a language that resident understands, and will notify resident of any changes made to these rights.

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Acknowledgement of Receipt of Abuse & Neglect Prohibition and Resident's Rights

_____ _____

Contractor's Signature Date