

NAME \_\_\_\_\_ DATE \_\_\_\_\_

LP103

**NURSE FINDERS**

1. I understand that I must administer and document administration of all medications in accordance with the MEDICATION OMISSION PROCESS of Susquehanna Nursing and Rehabilitation Center.
2. I understand that I must complete and document administration of all treatments in accordance with the TREATMENT OMISSION PROCESS of Susquehanna Nursing and Rehabilitation Center.
3. I understand that I must document in the progress notes in accordance with the MEDICARE PART A documentation guidelines of Susquehanna Nursing and Rehabilitation Center, that I must document on each resident as designated by the bolded areas on 24 report.
4. I have read the BLOOD BORNE PATHOGENS TRAINING provided by Susquehanna Nursing and Rehabilitation Center.
5. I have read and understand, the INFECTION CONTROL ORIENTATION PACKET Susquehanna Nursing and Rehabilitation Center.
6. I understand that I am a mandatory reporter of abuse and that I must stop any kind of abuse when I see it and report it immediately to the nursing supervisor at 725-7098.
7. I understand that if I have any questions about my responsibilities when I am working at Susquehanna Nursing and Rehabilitation Center, I can call the supervisor at 725-7098 and if she is unable to answer the questions I have, I can ask her to call the Inservice Coordinator.
8. I understand that all Parkinson's medications must be given with the 15 minute window of the time ordered, including (but not limited to) Sinemet, Stalevo, parlodel, requip, amantadine, Mirapex, neupro, artane, Cogentin, syymetrell, and Exelon. PARKINSON's residents are identified with a GOLD STAR in Sigmacare. The medications for these residents should be prioritized so that these medication are given on time.

Signature \_\_\_\_\_ Date \_\_\_\_\_



Please fill out the information below in order to be set up on our computer system and Electronic Medical Record.

**Print Name:** \_\_\_\_\_

**Title:** \_\_\_\_\_

**Emergency Contact Phone #:** \_\_\_\_\_

**Have you ever been employed by Susquehanna Nursing & Rehabilitation Center?** Yes/No

**If you answered "yes" above, did you have access to SigmaCare?** Yes/No

Please contact Medical Records Director or Administrator for SigmaCare issues and/or questions.

Please contact Administrative Assistant or Administrator for Windows issues and/or questions.

Process:

1. Form provided/completed at General Orientation by In-Service Coordinator.
2. Provide form to Medical Records Director or Administrator to receive SigmaCare access.
3. Provide to Administrative Assistant or Administrator to receive Windows access.
4. When SigmaCare and Windows access is complete, the form will be provided to the HR Director to file.

SigmaCare username and password created on \_\_\_\_\_ by \_\_\_\_\_

Windows username and password created on \_\_\_\_\_ by \_\_\_\_\_

(Please tear along dotted line)

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Microsoft Windows Access:

**Username** \_\_\_\_\_ (first initial, last name)

**Generic Password** SNRC12345! (Minimum of 8, Upper and lower case, numbers and symbol)

**\*You will be prompted to change your password upon login.**

SigmaCare Access:

**Username** \_\_\_\_\_ (first initial, last name)

**Generic Password** Sigmacare01 (Minimum of 6 characters with at least one number)

**\*You will be prompted to change your password upon login.**

Updated/Reviewed 04/2014

R Drive > P&P > Medical Records > Security > Policy 1304 Computer Use

## SNRC Policy 1304 **Computer Use, Including the Internet**

This policy is adopted to protect both SNRC and its employees.

1. SNRC computers are SNRC property, the same as any other tool, machinery, office equipment or other equipment. Unauthorized use or use for other than SNRC business is considered misconduct, and contrary to the principles of good and sensible behavior.
2. Any SNRC information system communications such as transmission, downloading, or any use of e-mail, or other communication method containing sexually-explicit images, messages or cartoons, ethnic slurs, racial epithets, or anything that may be construed as harassment or offensive to others based on actual or perceived race, national origin, sex, sexual orientation, age, disability, religious or political beliefs, or the like is strictly prohibited and against SNRC policy.
3. All employees must understand that there is no such thing as privacy or absolute security when it comes to e-mail or other internet communications. It must be assumed that any information or data entered into these systems are accessible by or may be seen by anyone.
4. Access to the Internet from within SNRC's facilities or from SNRC owned computer requires specific approval. This approval will be by computer location and individual employee.
5. Accessing the Internet for personal purposes from SNRC's facilities or from a SNRC owned computer is strictly prohibited.
6. The right to access all computer and related files at any time is retained by SNRC.
7. Violations of this policy will result in disciplinary action ranging from a written reprimand to termination of employment.

I have read and accept the conditions outlined in the SNRC computer policy.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

NAME \_\_\_\_\_ DATE \_\_\_\_\_

Parkinson's Medication Management POST TEST

1. What are the medications used for Parkinson's Disease?
2. What are the consequences of not giving Parkinson's Medications on time?
3. What ICON do you look for in Sigmacare on the administration record to identify residents with Parkinson's disease?
4. What is the process for administering medications to ensure that resident's get their Parkinson's medication on time?
5. What are the symptoms of Parkinson's disease
6. When you have administered a medication, what must you do immediately after?

NAME \_\_\_\_\_

DATE \_\_\_\_\_

### **BloodBorne Pathogens / SNRC Exposure Control POST TEST**

1. What employees are at risk of being exposed to bloodborne pathogens?
2. What is the efficacy of the hepatitis B vaccine?
3. What is the cost of the hepatitis B vaccine to employees?
4. Who do you report it to if you have an exposure to blood or body fluids?
5. How often are staff required to get bloodborne pathogen training?
6. Who can you request a copy of the SNRC Exposure Control plan from? How many days does SNRC have to give it to you?
7. Are you allowed to eat or drink in areas where contamination with blood or body fluids could occur
8. How long can hepatitis B live on dried blood?
9. Where are the blood spill kits located?
10. What PPE is required when cleaning up a blood spill?
11. If you use a blood spill kit, who do you call for a replacement?
12. What is the procedure for an exposure to bloodborne pathogens in the eyes?
13. Where are the emergency eye wash locations in the facility?
14. How long is does your employer have to keep your records if you a blood/body fluid exposure?
15. What are the limitations of using PPE?

NAME \_\_\_\_\_ DEPT \_\_\_\_\_ DATE \_\_\_\_\_

### 2015 Plan of Correction Post Test

1. New equipment and devices can be added to the resident plan of care without a restraint evaluation/assessment?
  - a. True
  - b. False
  
2. Circle all of the incidents that need to be reported to the nurse and nursing supervisor if they are witnessed by staff members or reported by visitors to the staff and have an investigation statement completed by the staff/visitor witnessing
  - a. Resident fell at a family outing
  - b. Resident observed bumping into another resident in their wheelchair and it struck the resident resulting in possible bruising/injury
  - c. Resident observed propelling themselves and bumped their arm on the table
  - d. Resident observed falling
  - e. Resident found on the floor
  - f. Resident observe having a significant coughing/possible choking episode while eating
  - g. A resident hitting another resident
  - h. A staff member verbally, physically, mentally abusing or mistreating a resident
  
3. When must any of the items in question 2 be reported to the nurse & nursing supervisor if observed or reported to staff by a visitor?
  - a. At the end of your shift
  - b. As soon as you are done charting
  - c. Immediately after being observed or reported to you by a visitor
  
4. When an incident occurs, statements need to be obtained from all staff involved, the resident, and any visitors that were involved or witnessed the incident.
  - a. True
  - b. False
  
5. If a resident reports that a cream is causing burning when applied to the skin or a medication is causing negative side effects, you must hold the medication at that time and call the physician for further direction
  - a. True
  - b. False

NAME \_\_\_\_\_ DEPT \_\_\_\_\_ DATE \_\_\_\_\_

### 2015 Plan of Correction Post Test

6. Circle all of the steps that should be performed to ensure that a resident is receiving the correct food items and food consistencies?
  - a. Verify it is the correct resident
  - b. Verify that each food item and consistencies you are giving to the resident match the meal ticket prior to placing the food in front of the resident
  - c. (dietary staff) Verify you the food items and consistencies match the meal ticket that you are placing the tray
  - d. When asking for additional food items, you must give dietary the resident's name and diet when requesting an alternate choice or additional food
  - e. If there is a question of an incorrect food item or consistency, remove food from in front of the resident while you are clarifying the food items match the meal ticket
  
7. All medications errors must be reported to the nursing supervisor and have a medication error form filled out. The nurse(s) responsible for the medication error must be educated and the error must be reported to the DOH if it meets reporting requirements
  - a. True
  - b. False
  
8. Nectar consistency liquids include tomato juice, egg nog, and cream soups.
  - a. True
  - b. False
  
9. If you find areas in the facility in need of cleaning, you need to notify housekeeping as soon as possible to address it
  - a. True
  - b. False
  
10. The facility has a responsibility to the residents to provide housekeeping/maintenance services necessary to maintain a sanitary, orderly, and comfortable environment.
  - a. True
  - b. False
  
11. If a new device is added to a resident's plan of care, a therapy screen must be performed along with a restraint assessment by nursing.
  - a. True
  - b. False
  
12. If a new device is determined to be a restraint, an order must be obtained from the physician/NP.
  - a. True
  - b. False

NAME \_\_\_\_\_ DEPT \_\_\_\_\_ DATE \_\_\_\_\_

2015 Plan of Correction Post Test

I have received education on the 2015 Plan of Correction For  
Susquehanna Nursing and Rehabilitation.

Signature \_\_\_\_\_ Date \_\_\_\_\_



Dietary Consistency In-service

Name: \_\_\_\_\_

Date: \_\_\_\_\_

Situational questions:

What would you do if...

1. Someone on a mechanical soft solids diet asks for a piece of whole bacon?
2. Someone on nectar thick liquids asks for an ice cream after dinner?
3. A resident is asking you for the alternate choice meal after being served their tray
4. You notice a regular dessert was placed on a person's tray who has a pureed diet order
5. What is one of the leading causes of infection, potentially resulting in death in some cases, for residents of long term care?
6. What is one reason the elderly are susceptible to dysphagia?

## 4/2015 MEDICATION OMISSIONS/MEDS NOT ADMINISTERED

### Medication Administration Process for MEDICATIONS NOT AVAILABLE

1. It is the responsibility of the full time nurse to monitor the supply of medications and re-order when there is a 3-4 day supply remaining. Use the refill icon in sigmacare.
2. If the supply is less than 3 days, a phone call MUST be made to pharmscript for the refill. Do not use refill icon in sigmacare at this time because it will take 48-72 hours to fill and the meds will not arrive before supply depleted.

In the event the medication is NOT available, the following steps should occur

1. Double check the medication cart
2. If medication is not found, CALL PHARMSCRIPT
3. If PHARMSCRIPT has sent the medication, re-check all carts on the unit
4. If still unable to locate, notify SUPERVISOR to call PHARMSCRIPT to give verbal permission to send medication at our cost
5. Ask for drug to be delivered stat from pharmacy
6. If unable to get the medication STAT, notify MD for further orders
7. DOCUMENT in nurses note- update and new orders received

Failure to follow this protocol resulting in medication not being administered is an OMISSION and a MEDICATION ERROR.

Any OMISSION that has the possibility of causing harm to a resident can result in an **IMMEDIATE JEOPARDY** from the state and professional liability may also result.

**NARCOTIC ADMINISTRATION**- REQUIRES that you initial and date next to the dose you removed to administer to the resident.

**HOLDING MEDICATIONS DUE TO PARAMETERS**- REQUIRES MD notification and documentation for EVERY DOSE NOT ADMINISTERED.

**REFUSALS**- 3 consecutive dose refusals of the same medication require the MD to be called and updated. Documentation stating you offered it 3 times and documentation that you notified the MD must be put in the progress note. Call another nurse/supervisor to offer the medication and have them document if refused in progress note. Update family as well.

\*\*\*\*\*REFUSAL of ANTICOAGULANTS, ANTIBIOTICS, INSULIN, CARDIAC, OR ANTICONVULSANTS SHOULD BE DISCUSSED WITH MD IMMEDIATELY\*\*\*\*\*

NURSE SIGNATURE \_\_\_\_\_ DATE \_\_\_\_\_

11/2014

# Treatment Omissions

All treatments in Sigmacare are to be completed and signed off prior to the end of your shift.

***Documentation of a treatment that has been done when the treatment was not performed is falsification of the medical record and is a criminal offense.***

When performing a treatment, make sure to read the entire order. Orders may change since you last cared for the resident. It is your responsibility to completely read the order and carry out the treatment. Do not rely on memory. This leads to errors.

***Documentation of a treatment as NOT DONE (red dotted) requires a valid reason to be documented for the reason it was not done. Residents may refuse treatments. However, if a resident refuses the treatment, you need to ask your unit manager to offer the resident to do the dressing change. If the resident still refuses (you should offer on 3 separate occasions), you must document this in a progress note and the other nurse that offered should also document the refusal. IF A TREATMENT IS OMITTED FOR ANY REASON, THE PROVIDER MUST BE CALLED AND THIS MUST BE DOCUMENTED IN THE PROGRESS NOTE.***

OOB, OFF THE UNIT, OTHER, and CLINICAL MONITORING are not acceptable reasons to document a treatment as not done.

***You must offer to perform dressing changes when the resident is still present on the unit and plan your schedule accordingly.***

Dressings must be dated and have the nurse's initials on them.

***If a CNA reports a dressing as missing after you have already performed the dressing change, you must reapply the dressing.***

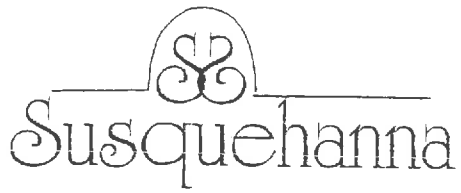
A weekly report is pulled from SIGMA on Thursdays indicating treatment omissions. All staff documenting treatment omissions with unacceptable reasons will be re-educated and disciplinary action may follow.

***Dressing changes that were not done properly may require the staff member to attend SWAT rounds as part of re-education.***

When a dressing change is performed, the nurse changing the dressing should document their findings (appearance, drainage, odor, tolerance of the treatment, size, wound edge, and if resident was premedicated for pain prior to the treatment) in the progress notes.

Signature \_\_\_\_\_ Date \_\_\_\_\_

Printed Name \_\_\_\_\_



NURSING & REHABILITATION CENTER  
282 Riverside Drive, Johnson City, NY 13790

## *Job Description*

Employee Name (Print) \_\_\_\_\_

\*I acknowledge receipt of my job description dated \_\_\_\_\_

Employee Signature \_\_\_\_\_

Date \_\_\_\_\_

Job Title: \_\_\_\_\_



NURSING & REHABILITATION CENTER  
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## Nutritional Needs & Safety of the Elderly

Employee Name (Print) \_\_\_\_\_

- I have been provided with information regarding SNRC's resident dining experience.
- I have received information regarding my responsibilities to ensure proper nutritional intake and documentation requirements for the facility residents.
- I acknowledge receipt of the training regarding the facility Aspiration Risk Prevention Program and identifying residents at risk for aspiration.
- I acknowledge receipt of the training identification of a potential Chocking event for a resident and the Removal of a Foreign Airway Body Obstruction.
- SNRC's Cardiopulmonary Resuscitation P & P's (CPR/AED Response Responsibilities) – **CODE BLUE**.
- I have had the opportunity to ask questions regarding this topic.

Employee's Signature \_\_\_\_\_ Date \_\_\_\_\_

# Certification of Personal Protective Equipment Training

Employee Name: \_\_\_\_\_ Department: \_\_\_\_\_ Dates of Training: \_\_\_\_\_

Inservice Training Covered for All Employees:

- When Personal Protective Equipment is necessary.
- What Personal Protective Equipment is necessary.
- How to properly don, doff, adjust, and wear the applicable Personal Protective Equipment.
- The limitations of the Personal Protective Equipment.
- The proper care, maintenance, cleaning, useful life and disposal of the applicable Personal Protective Equipment.
- Requirements of the Personal Protective Equipment Standard – OSHA 29 CFR 1910.132 (f).

All Employees:

I certify that I have received and understand the above training and have reviewed the Personal Protective Equipment Hazard Assessment for the Department in which I will be working. I understand that I am to always use the required Personal Protective Equipment, and that I may be subjected to disciplinary action, up to and including termination, should I fail to wear Personal Protective Equipment while performing a task that could cause injury.

Employee's Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Inservice Training Covered for Departmental Employees required to use respiratory protection:

- Why respiratory protection is necessary (the type of hazard and potential health effects of exposure as a result of non-use or improper use).
- Engineering and Administrative controls being used in addition to the use of the respiratory protection.
- How to store, apply, remove and properly dispose of respiratory protection.
- How improper use, application and removal can compromise the protective effect of the respiratory protection.
- Limitations and capabilities of the respiratory protection, as well as selecting the appropriate type of respiratory protection.
- How to effectively use the respiratory protection in emergency situations, and procedures to follow if the respiratory protection malfunctions.
- Recognition of medical signs and symptoms that may limit or prevent effective use of the respiratory protection.
- How to properly inspect, apply and remove a respirator, use and check the seals and wear of the respirator (should a respirator be required).
- Procedures for proper care, maintenance, cleaning, useful life and disposal of the respirator (should a respirator be required).
- The purpose of fit testing (should a respirator be required).
- General requirements of the Respiratory Protection Standard – OSHA 29 CFR 1910.134.

Employees required to use or voluntarily wish to use Respiratory Protection:

I certify that I have received and understand the above training and have reviewed the Personal Protective Equipment Hazard Assessment pertaining to the use of respiratory protection. I understand that I may voluntarily use particle dust mask (filtering face-piece) should I desire for protection unless specified as required on my departmental Personal Protective Equipment Hazard Assessment. I understand that N-95 respirators are recommended when caring for residents identified to be positive for the Novel H1N1 influenza. I understand that if required, I am to always use the required respiratory protection when performing functions requiring such protection as indicated on my Departmental Personal Protective Equipment Hazard Assessment. I understand I may be subjected to disciplinary action, up to and including termination, should I fail to wear the required respiratory protection when performing any task causing respiratory illness or injury.

Employee's Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Instructor:

I certify that the above named employee has completed the above training and has demonstrated an understanding and working knowledge of the ability to properly use the required Personal Protective Equipment and respirator as indicated. I understand that retraining is required when there is reason to believe that the affected employee does not have the skill and/or understanding required to properly use the applicable Personal Protective Equipment or respirator, when changes in the workplace render previous training obsolete, or when changes in the types of Personal Protective Equipment or respirator to be used renders previous training obsolete. I understand that this document facilitates compliance with the training requirements as stipulated in the Personal Protective Equipment Standard OSHA 29 CFR 1910.132 (f) and the Respiratory Protection Standard OSHA 29 CFR 1910.134.

Instructor's Signature: \_\_\_\_\_ Date: \_\_\_\_\_



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## **OSHA**

### **(Occupational Safety & Health Administration) The Hazard Communication Standard - HAZCOM**

Employee Name (Print) \_\_\_\_\_

- I have been provided with information pertaining to and under the jurisdiction of the Federal/State Right to Know Law being followed by Susquehanna Nursing & Rehabilitation Center.
- I understand the training & education provided and my responsibility in utilizing safe work practices while performing my job duties.
- I have received a copy of Appendix D of OSHA's Respiratory Protection Standard 29 CFR 1910.134.
- I have had the opportunity to ask questions and discuss the topics of OSHA, The Hazard Communication Standard and "HAZCOM" with regard to:
  1. Categories of Workplace Hazards
  2. Types of Exposure Incidents
  3. Health Effects & degree of effects of Chemical Exposures
  4. Components of the Hazard Communication Standard
  5. SNH's Right to Know Policy
  6. MSDS (Material Safety Data Sheets)
  7. Reading of Labels
  8. Hazardous Chemical use, protection & detection
  9. Proper labeling, storage & usage of chemicals required.
  10. Protecting Myself from Hazards (use of PPE's, including respiratory protection as required).
  11. Location and use of Eyewash Stations

(OSHA regulation 29 CFR 1910.21-32 Subpart D-Walking & Working Surfaces Occupational Safety & Health Act of 1970, Section 5.A.1.)

Employee Signature \_\_\_\_\_ Date \_\_\_\_\_



NURSING & REHABILITATION CENTER  
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## PROACTIVE SAFETY MINDSET TRAINING

Employee Name (Print) \_\_\_\_\_

As part of your training you will receive ongoing orientation on the prevention of accidents. All employees are to reinforce the belief that accidents are

- Preventable
- Unacceptable
- A result of unsafe work practice

Susquehanna Nursing & Rehabilitation Center maintains a commitment to eliminate workplace hazards and unsafe behaviors. Working safely is a condition of employment at this facility. The preservation of each employee's and resident's well being is seen as an obligation by all that work here. All employees are obligated to work safely as well as observe fellow employees work methods. Any unsafe work practice is to be addressed with the employee committing any action putting someone at risk for potential injury. All must be conscious of encouraging safe work practices.

We have a full scale commitment to eliminating injuries caused by unsafe acts and unsafe conditions. Everyone must be committed to 100% safety everyday. By working together, we will prevent accidents. Remember, no job is so important or urgent that we cannot take the time to perform our work safely.

**I have been provided with the training and expectations regarding Susquehanna Nursing & Rehabilitation Center safe work practice performance. I realize that I must perform my job duties safely and am responsible for addressing any witnessed unsafe work practice performed by another employee.**

Employee Signature: \_\_\_\_\_ Date \_\_\_\_\_

Instructor Signature: \_\_\_\_\_ Date \_\_\_\_\_





NURSING & REHABILITATION CENTER  
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## Resident Rights

Employee Name (Print) \_\_\_\_\_

- I have received a copy of "Resident's Rights". I understand the information received and was given the opportunity to discuss the issue of "Resident's Rights" and my obligations with regard to ensuring that all resident rights are adhered to and respected.
- I was given the opportunity to ask question and discuss situations in which "Resident's Rights could be violated, how to identify such instances and my responsibility in protecting the right of the residents of Susquehanna Nursing & Rehabilitation Center.
- I acknowledge receipt of information pertaining to HIPAA (Health Insurance Portability & Accountability Act) privacy training and SNRC's Restraint Policies & required criteria.
- I understand that it a responsibility of all employees to ensure adherence to the guidelines of this act and the facility privacy policies and procedures with regard to confidentiality of resident medical information. I will follow the guidelines as indicated on Susquehanna Nursing & Rehabilitation Center's Confidentiality Statement.

Employee's Signature \_\_\_\_\_ Date \_\_\_\_\_



URSING & REHABILITATION CENTER  
2 Riverside Drive, Johnson City, NY 13790

## SNRC Code of Conduct

Employee Name (Print) \_\_\_\_\_

All Employees:

- Shall perform their duties in good faith and to the best of their ability;
- Shall refrain from any illegal conduct. When an employee is uncertain of the meaning or application of a statute, regulation, policy or the legality of a certain practice or activity, he or she shall seek guidance from his or her immediate supervisor or the compliance officer;
- Shall not obtain any improper personal benefit by virtue of their employment with SNRC;
- Shall not destroy or alter SNRC information or documents in anticipation of, or in response to, a request for documents by any applicable government agency or from a court of competent jurisdiction;
- Shall not engage in any business practice intended to unlawfully obtain favorable treatment or business from any government entity, physician, resident, vendor, or any other party in a position to provide such treatment or business;
- Shall comply with SNRC's policy regarding the receipt, acceptance, offering, or giving of gifts in connection with an employee's role or status as an employee of SNRC. See SNRC's policy on receiving gifts in the Employee Handbook (section 1110);
- Shall disclose to their immediate supervisor any financial interest, ownership interest, or any other relationship they (or a member of the immediate family) may have with SNRC's residents, customer, vendors, or competitors;
- Shall not participate in any false billing of residents, government entities, or other party;
- Shall not use confidential or proprietary information of SNRC for their own personal benefit or for the benefit of any other person or entity, except SNRC, during or after being employed by SNRC;
- Shall not disclose confidential medical or personal information pertaining to SNRC's residents without the express written consent of the resident or appropriate legal representative and in accordance with applicable law and SNRC's policies and procedures;
- Shall not participate in any agreement or understanding (including agreements based on a course of conduct) with a competitor of SNRC to illegally fix prices, agree to labor costs, allocate markets, or engage in group boycotts. Before considering any agreements or entering into discussions with a competitor concerning any of these issues, all employees shall first speak with their immediate supervisor regarding the matter or obtain the advice of the compliance officer concerning antitrust issues;
- Shall participate in schedule in-service training regarding SNRC's compliance program and applicable state and federal laws standards
- Shall comply with all SNRC policies governing the workplace. These include, among others, SNRC policies governing:  
Sexual harassment, Drug and alcohol use and testing, Confidentiality of medical, personnel, and similar information, Personal use of company equipment, products, and/or services, Compliance with specific federal laws, HIPPA compliance, Resident Rights
- Shall promptly report all violations or suspected violations of this compliance manual or any other part of the compliance program by other employees via the anonymous drop box or to the compliance officer through a written report. The author may report such information anonymously; and
- Shall notify their immediate supervisor, who will in turn notify the compliance officer, immediately upon the receipt (at work or at home) of any inquiry, subpoena (other than for medical records or other routine licensing or tax matters), or other agency or government request for information regarding SNRC.

### ACKNOWLEDGMENT

*I acknowledge that I have received a copy of the above document and was given the opportunity to discuss the code of conduct and my obligations regarding it. I also acknowledge that I have read and understand this information and agree to conduct myself in accordance with and in compliance with the code of conduct as stated above.*

Employee's Signature \_\_\_\_\_ Date \_\_\_\_\_