Prairie Home Health
Living your best life at Home

EMPLOYEE ONBOARDING CHECKLIST

Employee Name: _____

Application Date: _____

Date of Hire: _____

New Employee Checklist	Date Completed	Supervisor Initials
1. Application Forms		
2. Identification Documents		
3. Background Check		
4. Orientation: • Review Company Policies • Job descriptions and Responsibilities • Scheduling • Confidentiality and HIPAA • Dress Code • Pay schedule and Time Off • Mileage Reimbursement • Client Financial Transaction		
5. 3 Hours in Office Training Video		
6. Caregiver University Training		
7. Employee AxisCare Training and Account Set up		
8. Employment Verification and Reference check		
9. Medical Document		
10. Employee Availability		

TEL: 872-208-5609 | Fax:773-409-5047

Prairie Home Health
Living your best life at Home

PHYSICIAN STATEMENT

Employee Name: _____ D.O.B: _____
This portion must be completed by a physician or health examiner.

	Required by	Date of Testing	Findings
A.	**Pre-employment Physical Exam**		**[ ] Fit to work** **[ ] Unfit to work**
B.	**PPD/ Mantoux Testing** **(if Positive, a chest X-ray is required)**		**Millimeter Duration** **Read by**
	Complete only if mandated by the state	**Date Given**	
C.	**Rubella/ Titer Vaccine**		
D.	**Diphtheria/ Tetanus Booster**		

PHYSICAL EXAM	NORMAL	ABNORMAL	H&P FINDINGS	COMMENTS
SKIN				
ENT				
RESPIRATORY				
GU				
GI				
URINARY				
MUSCULOSKELETAL				
LIFTING (MINIMUM 50LBS.)				

I have examined the individual named above and to the best of my knowledge they are in good physical and mental health, free of any communicable diseases, and able to function in their profession at full capacity. By signing below, I certify that the above information is true.

_____
Physician's / Health Examiner's Printed Name

_____
Physician's/ Health Examiner's Signature

Office Address_____
City State

Phone: _____

Office stamp

Title (Must Circle One): MD DO NP PA APN APRN RPh Others :

Date of Exam: _____

A more human resource.℠

ADP-SBS-EI002

Employee Information Form

* Denotes required field

First Name * **MI**

Last Name *

Address 1 * **Gender ***

Male Female

Address 2

City * **State *** **Zip ***

Social Security Number * **Date of Birth *** **Date of Hire ***

- - / / / /

Email Address

Pay Rate (check one) * **Amount *** **Tax Status (check one) ***

Hourly Salary $. W-2 1099

Pay Frequency (check one) *

Weekly Bi-weekly Semi-monthly Monthly Quarterly

Federal Filing Status (check one) *

Single Married Married - at Higher Single Rate Allowances

Additional Federal Withholdings (check one) *

Additional Amount Withheld Flat $ Amount .

Additional % Withheld Flat % Amount .

State Filing Status (check one) *

Same as Federal Single Married Married - at Higher Single Rate Allowances

Additional State Withholdings (check one) *

Additional Amount Withheld Flat $ Amount .

Additional % Withheld Flat % Amount .

Prairie Home Health
Living your best life at Home

APPLICATION FOR EMPLOYMENT

It is our policy to comply with all applicable state and federal laws prohibiting discrimination in employment based on race, age, color, sex, religion, national origin, disability or other protected classifications.

Please carefully read and answer all questions. You will not be considered for employment if you fail to completely answer all the questions on this application. You may attach a résumé, but all questions must be answered.

"Employer"	Position applying for

Email Address:

PERSONAL DATA

Name (last, first, middle)

Street Address and/or Mailing Address	City	State	Zip

Home Telephone Number	Business Telephone Number	Cellular Telephone Number

Date you can start work	Salary Desired	Do you have a High School Diploma or GED?
		Yes ☐ No ☐

POSITION INFORMATION

Check all that you are willing to work

Hours:				Status:	
Full Time	☐	Days	☐	Swing	☐	Regular	☐
Part Time	☐	Evenings	☐	Graveyard	☐	Temporary	☐
				Weekends	☐		

Are you authorized to work in the U.S. on an unrestricted basis? Yes ☐ No ☐

Have you ever been convicted of a felony? (Convictions will not necessarily disqualify an applicant for employment.) Yes ☐ No ☐

If yes, explain:

Have you been told the essential functions of the job or have you been viewed a copy of the job description listing the essential functions of the job?
Yes ☐ No ☐

Can you perform these essential functions of the job with or without reasonable accommodation? Yes ☐ No ☐

QUALIFICATIONS

Please list any education or training you feel relates to the position applied for that would help you perform the work, such as schools, colleges, degrees, vocational or technical programs, and military training.

	School Name	Degree	Address/City/State
School			
School			
Other			

SPECIAL SKILLS

List any special skills or experience that you feel would help you in the position that you are applying for (leadership, organizations/teams, etc.

REFERENCES

Please list three professional references not related to you, with full name, address, phone number, and relationship. If you don't have three professional references, then list personal, unrelated references.

Name	Address/City/State	Phone	Relationship

WORK HISTORY Start with your present or most recent employment and work back. Use separate sheet if necessary. (INCLUDE PAID AND UNPAID POSITIONS)		
Job Title #1	Start Date (mo/day/yr)	End Date (mo/day/yr)
Company Name	Supervisor's Name	Phone Number
City	State	Zip
Duties:		
Reason for Leaving	Starting Salary	Ending Salary

May we contact your present employer? **Yes** ☐ **No** ☐ **N/A** ☐

Job Title #2	Start Date (mo/day/yr)	End Date (mo/day/yr)
Company Name	Supervisor's Name	Phone Number
City	State	Zip
Duties:		
Reason for Leaving	Starting Salary	Ending Salary

Job Title #3	Start Date (mo/day/yr)	End Date (mo/day/yr)
Company Name	Supervisor's Name	Phone Number
City	State	Zip
Duties:		
Reason for Leaving	Starting Salary	Ending Salary

Job Title #4	Start Date (mo/day/yr)	End Date (mo/day/yr)
Company Name	Supervisor's Name	Phone Number
City	State	Zip
Duties:		
Reason for Leaving	Starting Salary	Ending Salary

I certify that the facts set forth in this Application for Employment are true and complete to the best of my knowledge. I understand that if I am employed, false statements, omissions or misrepresentations may result in my dismissal. I authorize the Employer to make an investigation of any of the facts set forth in this application and release the Employer from any liability. The employer may contact any listed references on this application.

I acknowledge and understand that the company is an "at will" employer. Therefore, any employee (regular, temporary, or other type of category employee) may resign at any time, just as the employer may terminate the employment relationship with any employee at any time, with or without cause, with or without notice to the other party.

_____ _____

Applicant Signature Date

PRE-EMPLOYMENT INTERVIEW QUESTION:

Name: _____ Date: _____

1. Tell me about a time where you had to work towards a deadline. Did you meet it? If not, what would you do differently next time?

2. Why do you want to work with us?

3. What do you know about our Company/ Practice/ Business?

4. What are your short term and long-term goals?

5. Where do you see yourself in five years?

6. Can you give me an example of working as part of a team? What was your contribution to the team and what was the outcome of this exercise?

7. Why do you think you are the best person for the job?

8. What are your strengths and weaknesses?

9. Can you give me five words that best describe you?

10. What skills and qualities can you bring to this position?

11. Do you have any question?

JOB DESCRIPTION / ESSENTIAL FUNCTIONS – HOMEMAKER

Description:

- Homemakers provide service to individuals in their own homes and communities, who need assistance caring for themselves as a result of old age, sickness, disability and/or other inflictions. Home care may include housecleaning, laundry, meal preparation, transportation, companionship and respite.
- Homemakers are responsible for ensuring that service is delivered in a caring and respectful manner, in accordance with relevant Agency policies and industry standards.

Reporting Relationship

- Reports to Supervisor.

Responsibilities/Activities:

- Teach/perform meal planning and preparation, routine housekeeping activities such as making/changing beds, dusting, vacuuming, washing floors, cleaning kitchen and bathroom, and laundry.
- Perform/assist with essential shopping/errands, which may include handling the client's money, in accordance with the care plan and under the observation of the Supervisor.
- Assist with following a written, special diet plan and reinforcement of diet maintenance, which is provided under the direction of a Physician and as identified in the care plan.
- Escort to medical facilities, errands, shopping and outings as specified in the care plan.
- Provide companionship, friendship and emotional support.
- Assist clients with communication by writing or typing correspondence for them or researching information for them.
- Participate on the Care Team by providing input and making suggestions.
- Ensure service is delivered in accordance with all relevant policies, procedures and practices.
- Monitor supplies and resources.
- Evaluate the program and make recommendations to it, as indicated.
- Follow the written care plan.
- Carry out duties as assigned by the Supervisor.
- Observe the client's functioning and report to Supervisor.
- Complete and maintain records of daily activities, observations, and direct hours of service.
- Attend orientation, in-service training sessions and staff meetings.
- Develop and maintain constructive and cooperative working relationships with others.
- Make decisions and solve problems.
- Communicate with Supervisor and co-workers.
- Observe, receive and obtain information from relevant sources.

Required Knowledge

- Knowledge of home management skills.
- Knowledge of principles and processes for providing client and personal services, including needs determinants, meeting quality standards and evaluation of client satisfaction.
- Knowledge of the English language.
- Knowledge of information and techniques needed to diagnose and treat injuries including emergency first aid and CPR.
- Knowledge of clerical procedures such as maintaining records and completing forms.

Required Skills/Abilities

- The ability to be aware of other people's reactions and understand why they react as they do.
- The ability to establish and maintain relationships.
- The ability to teach others.
- The ability to apply reason and logic to identify strengths and weaknesses of possible solutions.
- The ability to identify problems and determine effective solutions.
- The ability to understand written and oral instructions.
- The ability to communicate information orally so others understand.
- The ability to communicate in writing so others understand.
- The ability to listen and understand the spoken word.
- The ability to work independently and in cooperation with others.
- The ability to determine or recognize when something is likely to go wrong.
- The ability to suggest a number of ideas on a subject.
- The ability to perform activities that use the whole body.
- The ability to handle and move objects and people.
- The ability to provide advice and consultation to others.
- The ability to observe and recognize changes in clients.
- The ability to establish and maintain harmonious relations with clients/families/co-workers.

Physical and Mental Demands

- Good physical and mental health.
- Physical ability to stand, walk, use hands and fingers, reach, stoop, kneel, crouch, talk, hear and see.
- Mental fortitude and stability to handle stress.
- Physical and mental ability to drive a vehicle.

Qualifications/Education

- High School Diploma / GED
- Current driver's license.
- Proper Vehicle Insurance Coverage.

Training/Experience:

- May require related experience.

I have read the above job description and fully understand the conditions set forth therein, and if employed as a Homemaker, I will perform these duties to the best of my knowledge and ability.

_____ _____

Employee Signature Date

_____ _____

Supervisor Signature Date

JOB DESCRIPTION / ESSENTIAL FUNCTIONS – HOME HEALTH AIDE (HHA)

NAME _____

JOB SUMMARY:

A paraprofessional person who is specifically trained, competent and performs assigned functions of personal care to the patient in their residence under the direction, instruction and supervision of the registered nurse (RN).

QUALIFICATIONS:

1. Must meet Medicare Conditions of Participation for Home Health Aide training program and competency.
2. Have a sympathetic attitude toward the care of the sick and elderly.
3. Ability to read, write and carry out directions.
4. Maturity and ability to deal effectively with the demands of the job.

RESPONSIBILITIES:

1. Understand and adhere to established Agency policies and procedures.
2. Perform personal care and bath as ordered.
3. Complete appropriate visit records in a timely manner as per Agency policy.
4. Report changes in the patient's condition and needs to the RN.
5. Perform household services essential to health care in the home as assigned.
6. Ambulate and exercise the patient as assigned.
7. Perform simple procedures as an extension of the therapy services for example Range of Motion (ROM) exercises as assigned.
8. Assist with medications that are ordinarily self-administered as assigned.
9. Attend in-service and continuing education programs as scheduled and necessary.
10. Attend patient care conferences as scheduled.

WORKING ENVIRONMENT:

Work indoors in Agency office and patient homes and travel to/from patient homes.

JOB RELATIONSHIPS:

Supervised by: Director of Clinical Services/Nursing Supervisor/RNs, PTs.

RISK EXPOSURE:

High risk

LIFTING REQUIREMENTS:

Ability to perform the following tasks if necessary:

- Ability to participate in physical activity.
- Ability to work for extended period of time while standing and being involved in physical activity.
- Heavy lifting.
- Ability to do extensive bending, lifting and standing on a regular basis.

I have read the above job description and fully understand the conditions set forth therein, and if employed as a Home Health Aide, I will perform these duties to the best of my knowledge and ability.

SIGNATURE: _____ DATE: _____

EMERGENCY CONTACT

Employee Name: _____ Phone Number: _____

Address: _____

Special Instructions:

In the event of a medical emergency, are there any emergency procedures or restrictions on medications of which emergency personnel should be aware? If yes explain,

_____
_____
_____

Emergency Contact:

Primary Contact In case of Emergency:

Name: _____ Relationship: _____

Address: _____

Phone Number: _____ Alternate Phone Number: _____

Secondary Contact In case of Emergency:

Name: _____ Relationship: _____

Address: _____

Phone Number: _____ Alternate Phone Number: _____

EMPLOYEE'S PROFESSIONAL REFERENCE CHECK

TO WHOM IT MAY CONCERN, Mr./Mrs./Miss
_____ IS SEEKING EMPLOYMENT AT PHHC Corp.
as a Home Care Provider.

PLEASE FILL OUT THE FORM TO DETERMINE THE APPLICANT'S ELIGIBILITY AND ABILITY

REFERENCE NAME 1: _____

ADDRESS: _____

TEL. NO: _____

REFERENCE NAME 2: _____

ADDRESS: _____

TEL. NO: _____

FOR OFFICE USE ONLY

HOW LONG HAVE YOU KNOWN THE APPLICANT? _____

MORAL CHARACTER: EXCELLENT _____ GOOD _____ FAIR _____ POOR _____

DEPENDABILITY/RELIABILITY: EXCELLENT _____GOOD_____ FAIR _____ POOR _____

RESPONSIBILTY: EXCELLENT _____GOOD_____ FAIR _____ POOR _____

CONTACTED BY: MAIL _____ PHONE _____ OTHER _____

DATE: _____

SIGNATURE: _____ TITLE _____

COMMENT: _____

_____

BACKGROUND CHECK AUTHORIZATION

I_____ authorize Prairie Home Healthcare Services Corp. to perform a criminal background check on me for employment purposes.

This also authorizes Illinois State Police to release any record on me.

Applicant Signature: _____

Date: _____

TB HISTORY

Confidential
TB History & Symptoms
Review Form

Name: _____ Title: _____

1. Have you had a positive TB Screening? Y/N. If yes, indicate what test(s) was/were positive:
   Tuberculin Skin Test (PPD) _____ QuantiFERON_____ T. Spot_____
2. Country of Birth_____ Did you take the BCG Vaccine as a child? Y / N
3. Have you ever been prescribed INH? Y / N
4. Have you ever had an abnormal chest x-ray? Y / N
5. Do you have diabetes, HIV, or another chronic condition that impairs your immune response? Y/N
6. Do you take immunosuppressive medications? Y / N Comments _____

TB EXPOSURE RISK

1. Since your last screening, have any of your roommates, friends, or family member been diagnosed with active tuberculosis? Y / N
2. Since your last screening, have you cared for a TB Patient without wearing an N95 mask? Y / N
3. Since your last screening, have you travelled outside the USA? Y / N

   If yes, where_____

TB SYMPTOM REVIEW

Since your last screening, have you experienced any of the following?

1. Cough or chest pain that lasted longer than 3 weeks? Y / N
2. Fever that lasted longer than 3 weeks? Y / N
3. Coughing blood? Y / N
4. Excessive sweating at night? Y/N
5. Unexplained weight loss? Y / N
6. Unexplained increase in weight/fatigue? Y / N

_____ _____

Signature Date

HEPATITIS B VACCINATION DECLINATION

I hereby decline the Hepatitis B Vaccine injections.

I understand that due to my occupational exposure to blood or other potentially infectious materials I may be at risk of acquiring Hepatitis B virus (HPV) Infection. I have been given the opportunity to be vaccinated with the Hepatitis B vaccine at no charge to me; however, I decline the Hepatitis B vaccination at this time. I understand that by declining this vaccine I continue to be at risk of acquiring Hepatitis B, a serious disease. If, in the future I continue to have occupational exposure to blood or other potentially infectious materials and I want to be vaccinated with the Hepatitis B vaccine, I can receive the vaccination, and be financially responsible for the cost of vaccination.

_____ _____

SIGNATURE DATE

_____ _____

WITNESS DATE

EMPLOYMENT AGREEMENT

This Employment Agreement effective on _____ (date) between PHHS Corp. ("the Employer"), and _____, ("the Employee").

A. Employer is engaged in the business of Home Health Care
B. Employer desires to have the services of Employee/Contractor
C. Employee/Contractor is willing to be employed by Employer

Therefore, the parties agree as follows:

1. EMPLOYEMENT: The Employee shall provide the services described on the attached document **Job Description/Essential Functions** which is made a part of this Agreement by this reference.
2. BEST EFFORTS OF EMPLOYEE: Employee agrees to perform faithfully, industriously and to the best of Employee's ability, experience, and talents all of the duties that may be required by express and implicit terms of this Agreement, to the reasonable satisfaction of Employer. Such duties shall be provided as required by the agency, business, or opportunities the employer may require from time to time.
3. COMPENSATION of EMPLOYEE: As compensation for the services provided by Employee under this Agreement, Employer will pay Employee agreed Hourly Pay wage. This amount shall be paid in accordance with the Employer's usual payroll procedures. Upon termination of this Agreement, payments will be made for periods or partial periods that occurred prior to the date of termination and for which the Employee has not yet been paid.
4. REIMBURSEMENT FOR EXPENSES IN ACCORDANCE WITH EMPLOYER POLICY: The Employer will reimburse Employee for "out-of-pocket" expenses in accordance with Employer policies in effect from time to time.
5. TERMINATION DUE TO DISCONTINUEANCE OF BUSINESS: If the Employer discontinues operating its business at 1117 S. Milwaukee Av. Suite B1, Libertyville, IL 60048, this Agreement shall terminate upon notice of termination as provided in this Agreement.
6. RECOMMENDATIONS FOR IMPROVING OPERATIONS: Employee shall provide Employer all information regarding Employer's business of which Employee has knowledge. Employee shall make all suggestions and recommendations that will be of mutual benefit to Employer and Employee.

7. CONFIDENTIALITY: Employee recognizes that Employer has and will have information regarding the following:

   - Service Rates
   - Processes
   - Trade secrets
   - Protected Health information
   - Business affairs
   - Customer lists

   and other vital information which are valuable, special and unique assets of Employer. Employee agrees that the Employee will not at any time or in any matter, either directly or indirectly, divulge, disclose or communicate any information to any third party without the prior written consent of the Employer. Employee will protect the information and treat it as strictly confidential. A violation by Employee of this paragraph shall be a material violation of this Agreement and will justify legal and/or equitable relief.
8. UNAUTHORIZED DISCLOSURE OF INFORMATION: If It appears that Employee has disclosed (or threatened to disclose) information in violation of this Agreement, Employer shall be entitled to an injunction to restrain Employee from disclosing, in whole or in part such "information" or from providing any services to any party to whom such information has been disclosed or may be disclosed and shall not be prohibited by this provision from pursuing other remedies, including a claim for losses and damages.
9. COMPLIANCE WITH EMPLOYER'S RULES: Employee agrees to submit to all the rules and regulations of the Employer.
10. RETURN OF RECORDS: Upon termination of this Agreement, Employee shall deliver all property (including keys, records, notes, data, memorandum, models and equipment) that are in the Employee's possession or under the Employee's control which is Employer's property or related to the Employer’s business.
11. NOTICES: All notices required or permitted under this Agreement shall be in writing and shall be delivered in person or postage via the United States mail, postage paid, addressed as follows:

Employer:

Prairie Home Healthcare Services Corp.

1117 S. Milwaukee Av. Suite B1
Libertyville, IL 60048

Employer/ Contractor

Such address may be changed from time to time by either party by providing written policies in the manner set forth above.

12. ENTIRE AGREEMENT: This Agreement contains the entire agreement of the parties and there are no other promises or conditions in any other agreement whether oral or written. This Agreement supersedes any prior written or oral agreements between the parties.
13. AMENDMENT: This Agreement may be modified or amended if the amendment is made in writing and is signed by both parties.
14. SEVERABILITY: If any provisions of this Agreement shall be held to be invalid or unenforceable for any reason, the remaining provisions shall continue to be valid and enforceable. If a court finds that any provision of the agreement is invalid or unenforceable, but that by limiting such provisions would become valid or enforceable then such provision shall be deemed to be written, constructed and enforced as so limited.
15. WAIVER OF CONTRACTUAL RIGHT: The failure of either party to enforce any provision of the Agreement shall not be constructed as a waiver or limitation of that party's right to subsequently enforce and complete strict compliance with every provision of the Agreement.
16. APPLICABLE LAW: This Agreement shall be governed by the laws of State of Illinois.

Employer:

PRAIRIE HOME HEALTHCARE SERVICES CORP.

By: _____ Date: _____

Employee/ Contractor:

By: _____ Date: _____

ADDENDUM TO EMPLOYMENT AGREEMENT

As a consideration and as a condition precedent to continued employment with Prairie HOME HEALTHCARE, Corp. (“Prairie”), the undersigned, hereinafter referred to as " Employee " agrees to be bound as follows:

COVENANT OF NONCOMPETITION

At all times during the Employee's employment and for one (1) year after termination of employment with Prairie, Employee agrees not to directly or indirectly, in one or a series of transactions, own, manage, operate, control, invest or acquire an interest in, or otherwise engage or participate in the business of, whether as a proprietor, partner, director, officer, joint, venture, investor, lessor, representative, lender, guarantor, or other participant for, any business, individual or entity engaged in providing of home health care/home care or any other services for which Prairie provides, including any entity employing personnel in any similarity situated position as that held by the Employee with Prairie within fifty (50) miles of any Corporate or Branch Office of Prairie.

COVENANT OF DISCLOSURE

Employee agrees that to the extent that he or she, directly or indirectly, including through any relationship with the employee’s spouse, parent or children, in one or a series of transactions, owns, manages, operates, controls, invests or acquires any interest in, or otherwise engages or participates in the business of, whether as a proprietor, partner, director, officer, employee, joint venture, independent contractor, consultant, investor, lessor, agent , representative, lender, guarantor, or other participant in (collectively referred to as ˝relationship”) any business, individual or entity engaged in the providing of home health care/home care or any other services for which Prairie provides, including any entity employing personnel in any similarly situated position as that held by the Employee with Prairie Home HealthCare Corp., agrees to disclose the relationship, within five (5) business days to the Officers of Prairie. Disclosure of such relationship does not waive any right of Prairie Home HealthCare Corp.

COVENANT OF NONSOLICITATION

At all times during the Employee’s employment and for one (1) year after termination of employment with Prairie, Employees agrees that he or she will not engage in solicitation of Prairie Home's client or patients, whether past or present clientele or patients, and further agrees to not solicit or recruit, directly or indirectly, any employees of Prairie, whichever is closer, nor encourage Employees in the employment of Prairie Home to breach the terms of their agreement with Prairie Home Healthcare Corp.

COVENANT OF NONDISCLOSURE

The term "confidential information" as used in the agreement includes but is not limited to, records, lists and knowledge of Prairie Home's customers, suppliers, methods of operation, processes, trade secrets, methods of determination of prices, business plans, budgets, financial condition, profits, sales, net income, and indebtedness, as the same may exist from time to time in any form, media or format. Employee agrees that they shall not, at any time, form and after the date hereof, in any manner, either directly or indirectly, divulge, disclose, or communicate to any person, firm, corporation, or other entity, or use for their own

benefit or for the benefit of any person, firm, corporation, or other entity and not for the benefit of Prairie, any confidential information of Prairie, without the express prior written consent of an authorized officer of Prairie.
The Employee further agrees to disclose to Prairie HHC within two (2) business days the existence of all data related to Prairie Home HealthCare or its business, in any form, that is stored on his or her personal computer or other equipment including but not limited to cellular phones, personal data assistance, USB drives, CD/DVD or other media. Following disclosure, upon request of Prairie, the employee agrees to immediately irrevocably destroy all such data.

COVENANT OF NONDISPARAGEMENT
At all times during the Employee's employment and after termination of employment with Prairie HHC, Employee further agrees that they shall not, at any time, make, directly or indirectly any oral or written public statements that are disparaging of, or are intended to disparage, discredit or injure Prairie HHC, any products or services Prairie HHC offers, or any of its shareholders, partners, affiliates, successors, assigns, including any of its present or former officers, directors, partners, agents or employees.

The Employee further agrees that they will not make any statements or engage in any conduct, that would in any manner harm Prairie HHC or its shareholders, board of directors, officers, employees or the reputation, relationships and goodwill with its customers, suppliers, employees or others having business dealings with Prairie HHC during Employee's employment and after termination of employment with Prairie HHC.

USE OF Prairie EQUIPMENT/PROPERTY
The Employee agrees to not, directly or indirectly, copy, take, or remove from Prairie HHC premise (s), any of Prairie HHC's books, records, customer lists, or any other documents, data, or materials. The Employee understands that all equipment issued for use by its employees, either directly or indirectly, is and irrevocably remains the sole and exclusive property of Prairie HHC. The Employee agrees to not use personal computer, electronic equipment or media including but not limited to USB drives, CD/DVDs or hard drives in conjunction with Prairie HHC equipment.

Employee agrees not to install any unauthorized computer programs upon Prairie HHC computers and agrees not to use Prairie HHC equipment to surf, download, navigate or peruse the Internet for any personal purpose, without express permission of Prairie HHC. As a condition of employment, upon termination of employment, the Employee agrees to return all equipment and property of Prairie HHC, including but not limited to computer equipment, cellular phones, Global Positioning Systems, books, records, customer lists or any other document or material to Prairie HHC within two (2) business days of termination of employment. The Employee also agrees to be liable to Prairie HHC for any damage to property.

Employee Print Name: _____

Employee Signature: _____ Date: _____

SEXUAL ABUSE AND MOLESTATION POLICY

Prairie Home Healthcare (PHHC) Corp. prohibits and does not tolerate sexual abuse in the workplace or in any organization related activity. PHHC Corp. provides procedures for employees, volunteers, family members, board members, patients, victims of sexual abuse, or others to report sexual abuse and disciplinary penalties for those who commit such acts. No employee, volunteer, patient or third party no matter his or her title or position has the authority to commit or allow sexual abuse.

PHHC Corp. has a Zero-Tolerance policy for any sexual abuse committed by an employee, volunteer, board member or third party. Upon completion of the investigation, disciplinary action up to and including termination of employment and criminal prosecution may ensue.

Sexual abuse is inappropriate sexual contact of criminal nature or interaction for gratification of the adult who is a caregiver and responsible for the patient or child's care. Sexual abuse includes sexual molestation, sexual assault, sexual exploitation, or sexual injury, but does not include sexual harassment. Any incidents of sexual abuse reasonably believed to have occurred will be reportable to appropriate law enforcement agencies and regulatory agencies.

Physical and behavioral evidence or signs that someone is being sexually abused are listed below.

Physical Signs of Sexual Abuse

- Difficulty in walking
- Torn, stained or bloody underwear
- Pain or itching in genital area
- Bruises or bleeding of areas around the external genital area

Behavior signs of sexual abuse

- Reluctance to be left alone with a person
- Wearing lots of clothing especially in bed
- Fear of touch
- Nightmares or fear of night
- Apprehension when sex is brought up

Reporting Procedure

If you are aware of or suspect sexual abuse taking place, you must immediately report it to Victor Olapojoye as the Administrator. PHHC Corp. officer will notify family of suspected abuse victim. If the suspected abuse is to an adult, you should report the abuse to Illinois Department on Aging/ Adult Protective Services for Seniors at 1-800-252-8966. If it is a child who is the victim then you should report the suspected abuse to Illinois Child Abuse Hotline at 1-800-25-ABUSE or 1-217-524-2606. PHHC Corp. will report the alleged sexual abuse incident to appropriate authorities.

Anti-retaliation

PHHC Corp. prohibits retaliation made against any employee, volunteer board member or patient who reports a good faith complaint of sexual abuse or who participates in any related investigation. Making false accusations of sexual abuse in bad faith can have serious consequences for those who are wrongly accused. PHHC Corp. prohibits making false and/or malicious sexual abuse allegations as well as deliberately providing false information during an investigation. Anyone who violates this rule is subject to disciplinary action up to and including termination.

Investigation and Follow-up

PHHC Corp. will take all allegations of sexual abuse seriously and will promptly and thoroughly investigate whether sexual abuse has taken place. PHHC Corp. will use a trained internal investigator to investigate the incident. PHHC Corp. will cooperate fully with any investigation conducted by law enforcement or other regulatory agencies. It is the objective of PHHC Corp. to conduct a fair and impartial investigation. PHHC Corp. provides notice that they have the option of placing the accused on a leave of absence or on a reassignment to non-patient contact.

PHHC Corp. will make every reasonable effort to keep the matters involved in the allegation as confidential as possible while still allowing for a prompt and thorough investigation.

Acknowledging Receipt and Understanding of Sexual Abuse Policy

I acknowledge that I have received and read the sexual abuse policy and/or have had it explained to me.

I understand that Prairie Home Healthcare Corp. will not tolerate any employee, volunteer, board member or third party who commits sexual abuse. Disciplinary actions will be taken against those who are found to have committed sexual abuse.

I understand that it is my responsibility to abide by all rules contained in the policy. I also understand how to report incidents of sexual abuse as set forth in the abuse policy, including retaliating against any employee/ volunteer exercising his or her rights under the policy.

_____	_____
Employee / Volunteer	Employee/ Volunteer
Printed Name	Signature

EMPLOYEE STATEMENT OF CONFIDENTIALITY

I _____, the undersigned, understand the importance of observing strict confidentiality policies. Therefore, I agree not to discuss/release any information obtained within the agency regarding any Prairie Home Healthcare (PHHC) Corp. client, their medical record, or any client's condition with any Individual not directly associated with PHHC Corp. nor with PHHC Corp. employees who are not directly associated with that client. I also agree that any information that is released regarding the client or the client's record will only be done with proper authorization and/or in accordance with established agency policy for the release of the information.

My signature on this document indicates that I understand and agree to abide by the policies and that any breach in the aforementioned policies will result in implementation of Disciplinary procedure up to and including possible IMMEDIATE DISMISSAL from employment at PHHC Corp.

_____ _____

Employee Signature Date

_____ _____

Supervisor Signature Date

EMPLOYEE HANDBOOK ACKNOWLEDGEMENT FORM

I _____,

acknowledge that I have received the Employee Handbook of PHHC Corp. It is my responsibility to read the handbook and if I have any questions, I am responsible for clarifying it with my Supervisor at PHHC Corp.

_____ _____

Employee Name Date

Acknowledgement of Limitations on Marketing and Recruiting Activities Under the Community Care Program (Homecare Aides) Training

As a Homecare Aide under the Community Care Program (CCP), you represent the public face of your employer and the Illinois Department on Aging. It is your responsibility to provide approved in-home service in a professional and ethical manner to the older adults who receive services as participants in this program.

I _____, have viewed the Limitations on Marketing and Recruiting Activities Under the Community Care Program (Homecare Aides) and acknowledge my understanding of and responsibility to comply with the following non-exhaustive list of requirements under the CCP as set forth by federal and State laws, the 1915(c) Medicaid Waiver for the Elderly, regulations/rules, policies/procedures, the provider service certification, and the provider service agreement:

- An individual may choose at any time to not receive services for which eligibility has been determined under the CCP.
- An individual has the right to select a provider of his or her choice based on availability in the service area at any time during participation in the CCP.
- All information about an individual's case is to be kept confidential under the CCP. This information may be used ONLY for purposes directly related to the administration of this program. This information cannot and should not be shared between provider agencies.
  - Confidential case information includes, but is not limited to, the following items: Name, SSN, Date of Birth, Address, Medicaid Number and Status, Family/Guardian Name(s) and Contact Information, Phone Numbers, Financial Account Numbers, and Medication(s) or other health information.
  - This information may be maintained in any form or medium (i.e., electronic, oral, or paper).
  - Confidentiality continues beyond the termination of employment.
- The CCP prohibits the use of unsolicited telephone calls (cold-calling) and door-to-door solicitations; sales activities at community meetings, educational events and health care facilities; and cross-selling of non-CCP-related services to current and prospective program clients.
- Failure to comply with program requirements may subject you and/or your employer to sanctions imposed by the Department or other government officials with oversight responsibilities. Possible sanctions include, but are not limited to:
  - Participation in additional mandatory trainings.
  - Imposition of a ban on continued employment in the capacity as a caregiver under the CCP and other publicly funded programs in Illinois.
  - Placement of name on the Adult Protective Service Registry.

- **Original of this acknowledgement should be maintained in each employee's personnel file.**

Agency Name:	
Signature:	Date:

AGREEMENT OF NON- SOLICITATION

Non-solicitation of patient

At all times during the employment and for one (1) year after termination of employment with PHHC Corp., Employee agrees that they will not engage in solicitation of PHHC Corp. patients, whether past or present clientele or patients, and further agrees to not solicit or recruit, directly or indirectly, any employees of PHHC Corp., whichever is closer, nor encourage Employees in the employment of Prairie to breach the terms of their agreement with Prairie HHC Corp.

Non - solicitation of Visit Hours

At all times during the Employee's employment with PHHC Corp., Employee agrees that they will not engage in solicitation of hours from PHHC Corp. client or patients, and/or employees in the employment of PHHC Corp. to breach the terms of their agreement with PHHC Corp.

Non-Solicitation of Referrals

At all times during the Employee's employment and for one (1) year after termination of employment with PHHC Corp., Employee agrees that they will not solicit or attempt to solicit (either directly or by assisting others) any business or referrals from PHHC Corp. referral sources or prospective referral sources
which are actively being sought by PHHC Corp. at the time of Employee's termination for the purpose of providing services that are competitive with the type of services provided by PHHC Corp. at the time of Employee's termination.

Employee Name: _____

Employee Signature: _____

Date: _____

NON-DRIVING AGREEMENT FOR EMPLOYEES

I, _____ declare that I do not possess a valid driver's license or vehicle insurance. I understand that I am not authorized to transport my client in any vehicle, at any time and in any situation.

By signing this contract, I agree that I am liable to the full extent of the law if I breach this agreement in any way.

Employee Name: _____

Employee Signature: _____

Supervisor Signature: _____

Date: _____

☐ Applicant drives

_____

Employer Initials

COVID-19 FIT FOR WORK ACKNOWLEDGEMENT STATEMENT

1. I understand that it is my obligation and responsibility to support Prairie Home Health Care (PHHC) in providing a safe and secure workplace that supports client's well-being, safety, and success by reporting to the workplace "Fit for Work".

2. I shall abide by the agency's policy to wear face masks and PPE in accordance with Centers for Disease Control and Prevention (CDC) guidelines.

3. I further understand that to be considered "Fit for Work", an individual must be able to perform assigned duties and responsibilities safely to an acceptable standard, without limitation caused by the COVID-19 Virus and in the absence of symptoms consistent with COVID-19.

4. As a member of the healthcare team, I understand that it is my responsibility to perform self-screening for COVID-19 or for symptoms consistent with COVID-19.

5. I acknowledge that the self-screening will include but will not be limited to: Fever (a body temperature of 100.4 F or >), shortness of breath, fatigue, muscle or body aches, headache, sore throat, nausea or vomiting, cough, new loss of smell, new loss of taste, congestion or runny nose. I consent to providing this information to PHHC as well as any other health information as required pursuant to the COVID-19 administrative policy.

6. I understand that if I have symptoms consistent with COVID-19, it is my responsibility to self-report these symptoms to PHHC at (872) 208-5609, or my health care provider for further guidance.

7. I understand that as a staff of the PHHC team, the agency will maintain the confidentiality of personal information obtained during the process regarding fitness for work and refrain from disclosing personal information. Information will only be disclosed if necessary, for the purpose of investigating concerns, taking corrective action, protecting the health and safety of employees, or as otherwise required by law.

8. I acknowledge that federal, state, county or city agencies having jurisdiction may temporarily implement self-quarantine protocols for individual states that are identified as COVID hot spots and that it is my responsibility to abide by the self-quarantine protocols. I further acknowledge that non-compliance of the mandated self-quarantine protocols could place staff at risk for exposure and may lead to disciplinary action.

9. **I certify that I have read and fully understand the above COVID-19 Fit for Work acknowledgement statement and my responsibility to meet the "Fit for Work" requirements of the Agency.**

   Print Name: _____

   Signature of Employee:_____Date: _____

ANNUAL INFLUENZA TRAINING

Why Get the Influenza (Flu) Vaccine?

- Influenza (flu) can be a serious disease that can lead to hospitalization and sometimes even death. Anyone can get very sick from flu, including people who are otherwise healthy.
- You can get flu from patients and coworkers who are sick with flu.
- If you become sick with flu, you can spread it to others even if you don't feel sick.
- By getting vaccinated, you help protect yourself, your family, and your patients.

Influenza (Flu) Facts

- People with flu can spread it to others. Influenza viruses are spread mainly by droplets made when people with flu cough, sneeze or talk. These droplets can land in the mouths or noses of people who are up to about 6 feet away or possibly be inhaled into the lungs. Less often, a person might get flu by touching a surface or object that has flu virus on it and then touching their own mouth or nose.
- Most healthy adults may be able to infect others beginning 1 day before symptoms develop and up to 5 to 7 days after becoming sick. Children may pass the virus for longer. Symptoms start 1 to 4 days after the virus enters the body. That means that you may be able to pass on the flu to someone else before you know you are sick, as well as while you are sick. Some persons can be infected with the flu virus but have no symptoms. During this time, those persons may still spread the virus to others.
- Some people, such as people 65 years and older, children younger than 5 years, pregnant women, and people with certain chronic health conditions like asthma, diabetes, or heart and lung disease, are at high risk of serious complications from flu.
- Since health care workers may care for or live with people at high risk for influenza-related complications, it is especially important for them to get vaccinated annually.
- Annual vaccination is important because influenza is unpredictable, flu viruses are constantly changing and immunity from vaccination declines over time.
- CDC recommends an annual flu vaccine as the first and best way to protect against influenza. This recommendation is the same even during years when the vaccine composition (the viruses the vaccine protects against) remains unchanged from the previous season.

Flu Vaccine Facts

- The seasonal Flu vaccine protects against the influenza viruses that research indicates will be most common during the upcoming season.
- Flu vaccines CANNOT cause Flu. Flu vaccines are made with either killed or weakened viruses.
- Flu vaccines are safe. Serious problems from a flu vaccine are very rare. The most common side effect that a person is likely to experience is soreness where the injection was given. This is generally mild and usually goes away after a day or two.

Who Is Recommended for Vaccination?

Vaccination to prevent flu is particularly important for people who are at high risk of developing serious flu complications.

Who Shouldn't Be Vaccinated?

Different influenza vaccines are approved for use in different age groups. In addition, some vaccines are not recommended for certain groups of people. Factors that can determine a person's suitability for vaccination, or vaccination with a particular vaccine, include a person's age, health (current and past) and any allergies to influenza vaccine or its components.

I hereby attest that I attended this Influenza training and I [ ] Accept [√]Decline to take the Influenza vaccination.

NAME: _____ SIGNATURE: _____

EMPLOYEE TRAINING COURSES

Employee Name: _____

Application Date: _____

Caregiver University Training (caregiverlist.com)- Pre-Employment Training

Training Title	Training Duration	Completed (Supervisor initials)
Elder Abuse Prevention, Identification and Reporting Description: Intro, Elder Abuse Prevention, Identification and Reporting	2 hours	
IL Sexual Harassment Prevention Training Description: Definition of Harassment Behavior, Positive Behaviors and Responses, Scenarios	2 hours	
Transfer Safety and Proper Body Mechanics, including Hoyer Lifts, Gait Belts and in Autos Description: Intro, Safe Transfers, Gait Belts, Lifts and Fall Prevention, Safe Transportation	2 hours	
Coronavirus COVID-19 Safety and Prevention Description: COVID-19 Hand Washing Tips for Prevention, Basic Hygiene and Infection Control, COVID-19 Virus Explained, Super spreaders, Most Vulnerable	3 hours	

IL Caregiver 8-Hr, Alzheimer's 6-Hr & Sexual Harass. Prevention Description: Intro, Job Description, Care Plan Notes, Communication Skills, Personal Care, Bathing and Toileting, Assistance with Ambulation and Transfers, Basic Hygiene and Infection Control, Maintaining a Clean, Safe and Healthy Environment	16 hours	
IL Medicaid Pre-Service Home Care Aide Training Description: *Caregiver Job Descriptions, Responsibilities, Protocols*	24 hours	

In- Office Videos:

Video Title	Duration	Supervisor Initial
Personal Care	36 min	
Communication skills	14 min	
Fall prevention	18 min	
Medical emergency and emergency prep	7 min	
How to assist with medications	27 min	
HIPPA	24 min	
Infection control and blood pathogen	25 min	
Observation, Reporting and Documentation	12 min	
Proper body mechanics and safety	7 min	

I understand that a certificate will be issued upon completion.

_____
Initials of Acknowledgement

In-Service Training

Employee Name: _____

Introduction to Caregiver Basic Training by CTU
Introduction to your 12-Hour Online Caregiver Training Course

Clients' Rights
Clients' Rights

All Americans maintain certain rights. Being aware of our basic civil and human rights, regardless of race, religion, sex or disability, caregivers may provide care while maintaining both dignity and the legal requirements.

Person Centered Planning means developing a plan of care to include the wants and abilities of the client. Learn how to provide care while taking into consideration the needs and goals for the person you are assisting.

Personal Care, Bathing, and Toileting
Personal Care

Learn personal care tasks skills for senior clients, including bathing, skin care, hair care, nail care, mouth care, dressing, feeding, assistance with ambulation, exercise and transfers, positioning, toileting, and medication reminders.

Safe Transfers (Gait Belts and Lifts), Fall Prevention and Safe Transportation
Assistance with Ambulation

Safe adaptive equipment use for assisting clients with transfers from bed to chair to toilet to showers and in a out of wheelchairs. Learn types of transfers and devices used along with requirements for each device. Consider the Best and Safest Form of Transportation to Destination

Blood Borne Pathogens for Universal Requirements
Bloodborne pathogens are infectious micro-organisms found in the human blood that can cause disease in humans. Because of this, caregivers must be aware of risks for exposure and maintain safe practices to protect themselves and others.

COVID-19 Virus and Symptoms Explained
The coronavirus causes the disease COVID-19

Coronavirus is the name of the virus that causes the disease named COVID-19. Coronavirus a novel virus, meaning it is new to humans. It has spread so quickly and easily between humans that it is a pandemic or a disease that spreads itself to multiple continents or worldwide. HIV is an example of a

pandemic because people in countries around the world have contracted HIV, it is not isolated to one location.

Superspreaders and the Most Vulnerable
Superspreaders are People with Immune Systems that More Easily Spread a Virus

Pandemics sometimes have "superspreaders" and superspreading events. This happens because for reasons that are still not completely understood, some people's genetics enable them to have a very high "viral load" and to shed a lot more virus than other people. They may be spreading the virus before they have full-blown symptoms and are being isolated and careful.

COVID-19 Hand Washing Tips for Prevention
Effective Hand Washing Prevents the Spread of this Virus from your Hands to Face and to Others

Because coronavirus is a new virus that does not have a vaccine, prevention is the best protection and effective hand washing with soap continues to be the best way to prevent spreading the virus. Older people and people with compromised immune systems are at greater risk of getting very sick or dying.

Infection Control, PPE's, Wearing and Caring for your Masks
Hygiene and Infection Control

Learn how to maintain good hygiene for both the senior client and caregiver and safety to protect yourself and control infections. How to wash hands, use gloves properly, protect your face and body, and assist seniors with good daily hygiene.

Chemical Hazards and Safety
Any chemicals used in the workplace should always be reviewed and you should follow the safety precautions as outlined by something OSHA calls the "SDS", meaning: Safety Data Sheet.

Swallowing, Metabolism, and Meal Time
How Eating Changes with Aging

Eating is vital to our overall health. We use all our senses to eat. As people age they often have multiple illnesses, take medication and have decreased senses- all of which can cause a person to eat less.

Nutrition Label
In 1990 Nutrition Labeling and Education Act passed requiring all packaged foods to have nutrition information and be consistent with terms defined by the Secretary of Health and Human Services.

Choking Prevention
It is important to know how to help someone who is choking.

Death and Dying and the Grief Process
Caring for a dying client and post-mortem care.

Hospice and Palliative Care
Hospice and Palliative Care

When involved in end of life care for a client, you will often hear two terms: hospice and palliative care. Learn the difference between hospice and palliative care and how they help serve the client at the end of life.

Fraud and Abuse Protection
Fraud and Abuse Protection

Financial abuse unfortunately continues to be the most common type of abuse of the elderly and disabled.

Learn how to protect yourself and those you care for and how to watch and report any signs financial abuse may be happening.

I understand that the certificate will be issued upon completion.

_____

Initials of Acknowledgement

Prairie Home Health
Living your best life at Home

HOME HEALTH AIDE COMPETENCY EVALUATION

Directions: Read each question carefully and select one answer.

A. OBSERVATION, REPORTING, AND RECORDING

1. Which of the following is true observing and reporting?
    a. You should only report what you see
    b. It is not necessary to report that the patient says she is dizzy if she does not act like she is dizzy.
    c. You should not report something if the patient asks you not to.
    d. You should report changes you observe in the patient.
2. While bathing a client, the home health aide has an opportunity to :
    a. Talk about the aide's personal life.
    b. Visit with the client's family.
    c. Observe the client's eating habit.
    d. Observe the client's skin condition.
3. Which of the following is true about recording something you reported?
    a. You should always include what you observe, when you made the report, and the name of the person you reported to.
    b. It is better to wait a few days to record so you can think about it for a while.
    c. All you need to record is, "Called the office."
    d. You should always include your opinion about the meaning of what you reported.
4. Mr. Jones' pulse rate is usually 60-72 beats per minute. When you take it today, it is 52 beats per minute. You should:
    a. Record the pulse rate on your visit notes and go to next client.
    b. Tell him to go to the doctor's office.
    c. Call your supervisor immediately and report the pulse rate.
    d. Tell Mrs. Jones to check Mr. Jones pulse rate after an hour.
5. Which of the following should you always record on your visit note?
    a. The duties listed on your assignment sheet that were all done.
    b. The patient said she fell last night.
    c. The patient's vital signs, if taken.
    d. All of the above.

B. INFECTION CONTROL PROCEDURES

1. Correct hand washing technique is important because:
    a. It prevents the spread of germs.
    b. It is required by the Health Department.
    c. It makes the patient feel good.
    d. You want to impress the client's family.
2. When performing perineal care, you should wash the perineal area:
    a. from back to front
    b. from front to back
    c. Before washing the client's face.
    d. Only with water.
3. Wearing disposable gloves while performing personal care to your client…
    a. Means your patient has an incurable disease.
    b. Protects you and your client from the spread of germs.
    c. is necessary only when your client has a communicable disease.
    d. Will please your supervisor.
4. When handling dirty linens and clothing, it is best to:
    a. Leave the dirty linens and clothing on the floor.
    b. Place them in the washing machine and wash immediately.
    c. Place them in a clothes hamper or plastic bag until they can be washed.
    d. Shake them before placing in the hamper.
5. Which of the following actions (nurse aide actions) DO NOT help in preventing the spread of germs?
    a. Covering the nose and mouth when sneezing or coughing.
    b. Washing the hands before and after giving personal care to your client.
    c. Covering any cuts or breaks on your skin with band aid or appropriate dressing.
    d. Going to work even if you are ill.

C. BASIC ELEMENTS IN BODY FUNCTIONING AND ABNORMALITIES THAT SHOULD BE REPORTED TO THE AIDE'S SUPERVISOR.

1. Mrs. Smith's catheter bag contains a very large amount of dark red urine. You should:
    a. Encourage her to drink more fluids.
    b. Empty the bag, record the amount on your visit note and go to your next client.
    c. Call your supervisor immediately and her/him about your observation.
    d. Irrigate the catheter.

2. A reddened area over the client's hip should be reported to your supervisor because it:
    a. Could develop into a bedsore.
    b. Is a normal sign of old age.
    c. Should be treated with a heat lamp.
    d. Should be massaged.
3. Which of the following observations about your client's bowel habits should be reported to your supervisor immediately?
    a. Complaints of abdominal pain, swelling or cramps.
    b. Not passing gas.
    c. Bowel movements occur every other day.
    d. Brown- colored stools.
4. Mrs. Whit , who lives alone, is usually talkative during her bath. Today, she says very little, appears anxious, worried, and has difficulty speaking. You should:
    a. Finish visiting all your clients then, call your supervisor to report your observation.
    b. Record your observation on your visit notes then, go to your next patient.
    c. Mrs. Whit was in a bad mood so it is not important to mention your observation to anyone.
    d. Report your observation to your supervisor immediately.
5. When you visited Mrs. Green today, she apologized for taking a long time to open the door. She told you that she had to sit down and rest because she was so tired. When you asked her why she was walking barefoot; she said that her slippers do not fit her anymore. Which of the following actions would you do first?
    a. Check Mrs. Green's vital sign and record on your visit report.
    b. Check Mrs. Green's fluid intake.
    c. Observe Mrs. Mrs. Green's legs for swelling.
    d. Call your supervisor and report your observation of Mrs. Green's tiredness and slippers not fitting.

D. MAINTENANCE OF A CLEAN, HEALTHY, AND SAFE ENVIRONMENT

1. To protect your client from falling when transferring from bed to the wheelchair, you would:
    a. Put a pillow on the seat.
    b. Put a blanket over the seat and the back of the wheelchair.
    c. Lock the wheelchair and bed brakes.
    d. Lock the wheelchair brakes only.
2. When giving a bath to an elderly client, it is important to check the temperature of the bath water because:

a. You cannot get clean unless the water is hot enough.
b. You have to follow the procedure manual.
c. Elderly skin is more fragile and burns easily.
d. You have to keep the family happy.

3. Wrinkles on your client's bed linens may cause
    a. Bedsore
    b. No problems
    c. Contracture
    d. The linens to wear out
4. Which of the following statements is **FALSE**.
    a. Liquids that spill on the floor should be wiped up immediately to avoid falls.
    b. If your patient uses a cane or a walker, it is a good idea to cushion the floor by using throw rugs.
    c. Always be sure electrical cords are not lying in open walk areas.
    d. Keep cleaning supplies and hazardous materials in a safe and secure cabinet or area.
5. Your nurse tells you that Mr. Peters is on Coumadin. Which of the following precautions should you take?
    a. Check his blood pressure before giving a bath.
    b. Weigh him every time you visit him.
    c. Use an electric razor when shaving him.
    d. Tell him he should eat spinach because vegetables are good for him.

E. PHYSICAL, EMOTIONAL, AND DEVELOPMENTAL NEEDS OF THE ELDERLY AND RESPECT FOR PRIVACY AND PROPERTY

1. In order to communicate clearly with your client who has a hearing loss, you should:
    a. Look directly at the client while speaking.
    b. Speak in a loud voice.
    c. Stand behind the client when speaking.
    d. Communicate only with the family because the client will be frustrated that he/she cannot hear you.
2. Privacy of information means that what you say about a client must not be overheard or read by anyone unless that person has a right to hear or see the information. Which of the following actions maintains the client's right to privacy of information.
    a. Telling the client's neighbor that the client is dying of cancer.
    b. Giving papers that has patient information to your children or grandchildren to use as scratch paper.

c. Placing papers with patient information in an envelope or folder so other people cannot see the information.
d. Talking about your client's personal problems to other aides and nurses who are not assigned to the client.

3. Mr. Roberts is confused. You should:
    a. Ignore him until he starts to make sense.
    b. Help Mr. Roberts recognize familiar things and people.
    c. Tell Mrs. Roberts to keep him in his room at all times.
    d. Tell Mrs. Roberts to pretend that what Mr. Roberts says is accurate.
4. Your client's daughter arrives from out of town. When you arrive at the client's home, she tells you, "I can't seem to get any straight information from my brother. Can you please tell me what is wrong with Dad?" How would you answer her?
    a. Tell the daughter that her father has cancer and you think that her brother should have told her.
    b. Tell the daughter you do not know.
    c. Show the daughter the folder so she can read the information about her dad.
    d. Tell the daughter that you cannot share information about her father and suggest that she should discuss this with her father and brother.
5. Why is it important to identify your own cultural beliefs?
    a. To convert clients to your beliefs.
    b. To find out which cultural beliefs are correct and which are wrong.
    c. So you can understand how your own beliefs might affect the way you approach clients.
    d. So you can change your client's behavior to go along with your cultural beliefs.

F. RECOGNIZING EMERGENCIES AND KNOWLEDGE OF EMERGENCY PROCEDURES

1. Mr. James lives alone and is homebound. When you arrive at his home, the door is locked and you can see the lights on in the living room even though it is noon. When you knock on the door, you can hear a moaning sound coming from inside the house. You would:
    a. Visit your next patient and go back to Mr. James home later.
    b. Call your supervisor.
    c. Break a window and climb in.
    d. Keep knocking until he opens the door.
2. What is the very first action you should take when you find a conscious client lying on the bathroom floor?
    a. Call the office.
    b. Get the client up as quickly as possible.

c. Check for signs of injury.
d. Give the client a glass of water.

3. The Heimlich maneuver (abdominal thrust) is used for a client who has a:
    a. Bloody nose
    b. Blocked airway
    c. Fallen out of bed
    d. Impaired eyesight
4. Your client who is awake and alert complains of heaviness in the chest and nausea. You should:
    a. Call the neighbor for help
    b. Begin CPR
    c. Call supervisor and follow instructions
    d. Give the client the medicine he usually takes for chest pain
5. Upon arriving at the client's home, she tells you that she spilled boiling hot water on her hand while trying to cook. You should:
    a. Cover the area with Vaseline
    b. Apply cold water or ice to the burned area
    c. Tell the client to stay away from the stove
    d. Observe the burned area and call your supervisor immediately

G. ADEQUATE NUTRITION AND FLUID INTAKE

1. Elderly clients may not eat a well balance diet due to
    a. Improperly fitting dentures
    b. Loss of ability to taste food well
    c. Weakness and fatigue
    d. All of the above
2. Fiber or roughage in the diet:
    a. Has no effect on the digestive tract
    b. Helps move food through the digestive tract thus promoting bowel movement
    c. Helps people to chew better
    d. Adds cholesterol to the diet
3. If an elderly client takes a "water pill" (diuretic) every day, you should observe for
    a. Changes in the skin due to incontinence
    b. The floor to be kept dry to prevent falls due to the patient's `urinary accidents"
    c. The need to make more frequent diaper changes
    d. All of the above
4. Your client is on a restricted sodium diet. You should encourage him/her to eat:

a. Foods low in salt
b. Foods seasoned with lemon and vinegar
c. Foods that are grilled and seasoned with herbs and spices
d. All of the above

5. Unless otherwise directed by their doctors, adults need to drink:
    a. Six to eight glasses of water per day
    b. Ten to twelve glasses of water per day
    c. Four glasses of water per day
    d. Whatever the person prefers

H. POSITIONING, AMBULATION, AND RANGE OF MOTION

1. Correct positioning of a client for enema is:
    a. Supine
    b. Prone
    c. Left Simms
    d. Flexion
2. When assisting a client with right-sided weakness to ambulate, you should walk:
    a. to the right of the client
    b. to the left of the client
    c. in front of the client
    d. behind the client
3. Which of the following is true about Range of Motion?
    a. Active range of motion is used for a client who is capable of moving the joint
    b. Passive range of motion is used for a client who cannot move the joint at all
    c. Lack of activity may result in diminished range of motion
    d. All of the above
4. When a client has left-sided weakness, what part of the client's sweater should you put on first?
    a. both sleeves
    b. left sleeve
    c. client's choice
    d. right sleeve
5. When you are transferring a client from bed to chair or chair to bed, most of the client's weight should be supported by your
    a. back
    b. shoulders
    c. legs
    d. wrists