



CHELSEA RETIREMENT COMMUNITY

A UMRC SENIOR LIVING COMMUNITY

Volunteer Checklist

Volunteer Name: _____

Start Date: _____

Volunteer Organization: _____

End Date: _____

Department: _____

FORMS

Volunteer must provide all required documentation to the facility prior to working in the facility. The five documents below must be returned to Chelsea Retirement Community

Volunteer Checklist

Authorization for Criminal History File Search

Confidentiality Agreement

Notice of Reportable Conditions

TB Questionnaire *(subject to TB skin test if indicated)*

If under the age of 18, Parent or Legal Guardian Authorization

EDUCATION

Volunteer must complete training on the following topics prior to placement in the facility. Volunteer is to check off below that provided information was reviewed with them.

Resident Rights and Abuse

Bloodborne Pathogen and Infection Control

Emergency and Disaster Plans

I certify that the above volunteer has provided all required documentation and has received training in all topics listed above prior to placement at Chelsea Retirement Community.

Volunteer Signature

Date

Volunteer Coordinator / Supervisor Signature

Date



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AUTHORIZATION FOR CRIMINAL HISTORY FILE SEARCH

In compliance with the licensing requirements all volunteers and individuals with clinical privileges at Chelsea Retirement Community will be subject to a criminal history file search following an offer of approval to be a volunteer on Chelsea Retirement Community premises or acceptance of contractual service.

Please check one of the following boxes:

I have been a resident of Michigan for at least three (3) years immediately preceding the offer to be a volunteer or contractual services by Chelsea Retirement Community and authorize United Methodist Retirement Communities (UMRC) to conduct a name-only Michigan criminal conviction search through the Michigan State Police.

- ☐ I have not been a resident of Michigan for at least three (3) years immediately preceding the offer to be a volunteer or contractual services by Chelsea Retirement Community and authorize UMRC to conduct a name-only Michigan criminal background conviction search and national FBI criminal history fingerprint check through the Michigan State Police.

Please complete the following information necessary to conduct a Michigan Criminal Conviction search:

Name: _____
Last First Middle

Please list any previous names used (maiden, alias): _____

Date of Birth: _____

Race: ☐ White ☐ Black ☐ Asian / Pacific Islander ☐ American Indian / Alaskan Native ☐ Unknown / Other

Sex: ☐ Male ☐ Female

I understand and agree that I must notify Chelsea Retirement Community immediately upon being arrested for or convicted of one or more of the following:

1. Any felony, or attempt or conspiracy to commit a felony.
2. A misdemeanor that involved abuse, neglect, assault, battery, or criminal sexual conduct against anyone or fraud or theft against a vulnerable adult (as defined under the Michigan Penal Code), a state or federal crime that is substantially similar to such a misdemeanor.

Name of Applicant: _____

Signature of Applicant: _____

Date: _____

CONFIDENTIALITY OF PERSONAL HEALTH INFORMATION

- 1.0 In accordance with applicable federal and state laws, personal health information must be protected during its collection, use, disclosure, storage, and destruction by all UMRC employees and associates, including independent contractors, volunteers, interns, researchers, and members of the Board of Directors.
- 2.0 Personal health information shall be defined as all information, recorded or exchanged verbally about an identifiable individual that relates to the following:
 - a.) The individual's health, or health care history, including genetic information about the individual or the individual's family;
 - b.) Observations, including conduct or behavior that may be a result of illness or the effect of treatment;
 - c.) The provision of health care to the individual resident;
 - d.) Payment for health care provided to the individual including any personal health identification assigned to a resident and any identifying information about the individual that is collected in the course of, and is incidental to, the provision of health care or payment for health care;
 - e.) The individual's personal information, including financial position, home conditions, domestic difficulties or any other private matters relating to the patient which have been disclosed to staff or associates of UMRC.
- 3.0 Use or disclosure of personal health information is acceptable on in the discharge of one's responsibilities and duties (including reporting duties imposed by legislation) and based on the need to know. Discussions regarding personal health information shall not take place in the presence of persons not entitled to such information or in public places.
- 4.0 Unauthorized use or disclosure of confidential information shall result in disciplinary action, up to and including discharge. A confirmed breach of confidentiality may be reported to the individual's professional regulatory body and may result in monetary fines.
- 5.0 Any individual who becomes aware of a possible breach of confidential information shall immediately notify the facility Privacy Officer or the Corporate Compliance Officer. The Corporate Compliance Officer or their designee shall work with the Director of Human Resources to conduct an investigation and take appropriate disciplinary action if necessary.
- 6.0 The Corporation shall designate a Corporate Compliance Officer whose responsibilities including dealing with requests from individuals who wish to examine and copy or to correct personal health information collected and maintained by UMRC.
- 7.0 As a condition of employment/contract/association with UMRC, each individual must confirm in writing their review and agreement to abide by this procedure. Additionally, each employee of UMRC will receive training regarding the protection of personal health information.

RELATED PROCEDURES

POP #365 – Formal Grievance Procedures for Non Union Employees

POP #740 – Rules of Conduct

Conflict of Interest

Violations of the Conflict of Interest policy are serious disciplinary matters.

9. See full Conflict of Interest policy for complete information. However, points to note are:

- Employees may not engage in private business dealings with a resident or family member. (Ex: Private caregiver, housekeeper, personal assistant, etc). All such potential arrangements must be disclosed to your department manager.
- Employees may not purchase, or solicit for purchase, a resident's private property without prior approval of the facility Executive Director.
- Money, gift certificates, merchandise or their equivalent may never be accepted from a vendor, resident, family member, etc. with the following exception:

Nominal and *unsolicited* gifts having apparent retail value under \$50.00 per year, may be accepted *from a vendor* at the recipient's discretion, after approval from the campus Executive Director, COO or CEO.

Money, gift certificates, merchandise or their equivalent, given from a *resident or family member*- even if less than \$50 value- must be discussed with department manager *prior to accepting*. Personal gifts of any kind must never be suggested or encouraged.

- At a vendor's invitation, an employee or trustee may accept meals, refreshments or tickets to a theater, sporting event or similar form of entertainment at the vendor's expense, provided that a regular business representative of the vendor is also in attendance, and that no more than one such event is held in each six month period.
- Personal loans may never be accepted from a vendor, or obtained or guaranteed for any purpose by a vendor. This does not apply to loans obtained independently and in the ordinary course of business from a bank or other public lending institution.
- Travel or lodging for an employee may not be accepted from or reimbursed by a vendor, unless such travel or lodging is for educational or consultative purposes, and approved by the President and CEO.
- No employee may participate in or receive personal benefit from any vendor-sponsored contest or promotional effort.
- Any employee who is uncertain about whether a relationship does or might constitute a conflict of interest should consult the Executive Director or Corporate Compliance Officer of UMRC.

References	
Related Full Policies Available for Review	<ul style="list-style-type: none"> • Corporate Compliance • Code of Conduct • Conflict of Interest
Survey Tag Numbers	F490; F492
Policy Reviewed/Revised	<p>Date: October 2013 By: M. Latter, Director of Quality</p> <p>R. Martonchik, HR Director</p> <p>Date: _____ By: _____</p>



Employee Confidentiality Agreement

I, the undersigned, have reviewed United Methodist Retirement Community's (UMRC/CRC) confidentiality agreement. I have been given instruction on the Privacy Standards of the Health Insurance Portability and Accountability Act of 1996 (HIPAA) and how they affect my work as an employee at Chelsea Retirement Community.

I understand UMRC/CRC procedures of how to protect written or verbal resident information that I may be exposed to, including proper storage of and/or disposal of written resident information. I understand use of UMRC's electronic medical record is also protected by HIPAA laws. I agree to access the EMR only under my assigned private password and that passwords are **not** to be shared, under any circumstances, at any time during the course of my employment.

I hereby agree that I will not, at any time during or after my association with UMRC/CRC, access or use personal health information or reveal/disclose to any persons within or outside of UMRC, any personal health information except as may be required in the course of my duties and responsibilities and in accordance with applicable law.

I further acknowledge that unauthorized use or disclosure of such information may result in disciplinary action, up to and including termination of employment/contract/association with UMRC. Violations may also result in being reported to my professional regulatory body and possible monetary fines.

Signed: _____ Date: _____

Printed Name: _____

Notice of Reportable Conditions

Name: _____ Date: _____

Position: _____ Department: _____

In compliance with our established policies governing employee health, you must immediately report illnesses to your supervisor or to the Infection Control Coordinator. While this list is not all inclusive, any potential/known contagious illness must be reported.

Examples of some primary illnesses/symptoms that must be reported are:

1. Temperature of 100°F or greater;
2. Nausea/Vomiting;
3. Acute diarrheal illness with other symptoms (i.e., fever, abdominal cramps, bleeding, etc.), or diarrhea (with or without other symptoms) lasting longer than twenty-four (24) hours;
4. Orofacial herpes simplex virus (cold sores) or herpetic whitlow;
5. Diagnosed Streptococcal (Group A); sore throat;
6. Head or Body Lice (Pediculosis) or known Bed Bug exposure;
7. Skin lesions which are infected, especially on exposed body parts; Any Staph infection;
8. Any Skin rash; Poison Ivy/Oak, Impetigo; Ring Worm; Pink eye, etc;
9. Acute Upper Respiratory Infection or Flu-like illness defined as respiratory symptoms with:
 - a. Fever 99.6°F or > and at least one of the following:
 - b. Cough, sore throat, nasal congestion, headache, fatigue, myalgia, vomiting, or diarrhea;
10. Active infection with/or exposure to:
 - a. Measles (if the employee is not immune)
 - b. Mumps (if the employee is not immune)
 - c. Rubella (if the employee is not immune)
 - d. Varicella zoster (chickenpox/shingles) virus (if the employee is not immune)
 - e. Influenza (Flu) Virus
 - f. Herpes simplex virus (includes oral, orofacial, herpetic whitlow (herpes of the fingers), an employee is not required to report genital herpes infection)
 - g. Tuberculosis- known or suspected exposure;
 - h. The “Big Five” as relates to foodborne illness: Salmonella, Shigella, Shiga/E. Coli, Hepatitis A, NoroVirus
11. Needle stick/sharps accident, parenteral/mucous membrane or non-intact skin exposure to resident’s blood or body fluids.

My signature on this form certifies that, to the best of my knowledge, I am free from all conditions of infectious disease listed above. I understand that it is my responsibility to notify my supervisor or the facility’s Infection Control Coordinator of any actual or potential infection with a communicable disease that I may have. I understand that this notification is to protect myself, residents, and other staff members.

I understand failure to report known or suspected infection and/or reporting to work ill with any of the above noted S&S/infections may result in disciplinary action and/or termination of privileges of employment with UMRC.. I understand I must be free of the above signs/symptoms for 24hrs before returning to work.

I understand that a return to work note from my doctor may be requested in the event I present with real or potential communicable symptoms, regardless of the number of missed work days.

The employee may be excluded from work assignments for the length of time recommended by their physician and/or the CDC guidelines, depending on the illness and risk for spread of infection to residents or coworkers.

I certify that this document has been explained to me and that I understand its contents. A copy of this document will be provided to me at the New Hire Orientation day, to be scheduled upon completion of all pre-employment requirements.

Signature: _____ Date: _____



TB QUESTIONNAIRE

NAME: _____

DEPARTMENT: _____

This form is to be used for persons who are not required to have a TB screening. Please answer the questions in Part A. If there are any concerns with the answers provided a healthcare professional will evaluate and sign the recommendation section of Part B (only if needed).

PART A *Have you experienced any of the following symptoms in the past year?*

If YES: Circle or Highlight one:

- | | | | | | |
|---|-----|----|--------|-----------|------------|
| a.) A productive cough for more than 3 weeks? | Yes | No | Rarely | Sometimes | Frequently |
| b.) Hemoptysis (coughing up blood)? | Yes | No | Rarely | Sometimes | Frequently |
| c.) Unexplained weight loss in past 6 months? | Yes | No | Rarely | Sometimes | Frequently |
| d.) Fever, Chills, or night sweats for no known reason? | Yes | No | Rarely | Sometimes | Frequently |
| e.) Persistent shortness of breath? | Yes | No | Rarely | Sometimes | Frequently |
| f.) Unexplained fatigue? | Yes | No | Rarely | Sometimes | Frequently |
| g.) Chest Pain? | Yes | No | Rarely | Sometimes | Frequently |
| h.) Loss of Appetite? | Yes | No | Rarely | Sometimes | Frequently |

2. Have you had contact with anyone with active tuberculosis disease in the past year? Yes No

If Yes, Explain: _____

3. Purpose of this TB Test Requirement: Volunteer/Guest Annual

4. Date of Last known TB Test: _____ Results: _____

5. Any history of allergic reaction to TB Test or contraindications to receiving? _____

I declare that my answers and statements are correctly recorded, complete, and true to the best of my knowledge.

Volunteer Signature

Printed Name

Date

PART B *To be completed by a healthcare professional if any of the answers above are of concern.*

I recommend as follows:

- ☐ There is no indication this person has active TB at this time and should complete annual TB screening questionnaire.
- ☐ There is no indication this person has active TB at this time and should have their TB Skin Test deferred until the National PPD shortage has ended.
- ☐ There is reason to be suspicious of TB and further evaluation including a chest x-ray, Interferon Gamma Release Assay or other medical evaluation should be completed prior to work and the Infection Control Nurse has been notified.

Healthcare Professional Signature

Printed Name

Date