

**Please read the application in its  
entirety**

**Each section must be addressed**

**Missing items will cause a delay in the  
approval/re-approval/relocation  
process**

**Applications submitted for Approval  
must be complete for consideration.**

**APPLICATION FOR APPROVAL  
NURSE AIDE TRAINING AND COMPETENCY  
EVALUATION PROGRAM**

**Please submit original application and retain a copy for your records. Do not fax. Make sure that the individual completing the application signs and dates the appropriate page. If the application is incomplete it will not be considered for approval.**

**Please complete all 7 pages of the application for approval/re-approval of the nurse aide training program (NATP). Attach all requested information as outlined on the application. Review the enclosed Federal and State Core Curriculum and Skills Checklist. The enclosed skills checklist is MANDATORY. Skills may be added to the checklist but not deleted. All skills must be listed on the lesson plan the day of demonstration and return demonstration. The information MUST be enclosed with the application and mailed to Alliant Health Solutions.**

**All State of Georgia approved NATPs are required a minimum of 85 hours. The hours are divided between Classroom/Lab/Clinical. A minimum of 24 hours is required clinical rotation. Clinical rotation must be in a nursing home. The minimum 85 hours must cover the required NATP Federal and State Core Curriculum (CFR, Title 42, 483.150-483.158) and state requirements for clinical rotation.**

- NO CERTIFIED NURSE AIDE CLASSES CAN START UNTIL THE APPROVAL IS GIVEN BY THE STATE CONTRACTOR.**
- Funds cannot be accepted from potential nurse aide students until the approval letter from the State Contractor is received.**
- Pending programs cannot advertise for Certified Nurse Aide courses until the approval letter from the State Contractor is received.**

**Private NATPs are required to have an on-site visit to the classroom prior to approval. All equipment listed on the equipment form for classroom/lab should be present prior to the visit. Failure to have the required equipment will postpone the approval of the program. Any NATP is subject to unannounced on-site visit at the discretion of the Alliant Health Solutions.**

**Programs are allowed to submit an application 3 times in 1 year. If the initial application is incomplete, denied because of insufficient material and/or there are needed corrections, there are 2 remaining opportunities to re-submit the requested information. The program contact person will receive an e-mail and/or letter from the reviewer outlining missing components and/or the need to edit elements of the application. If the third application is denied there is a wait period of 1 year from the date of the review letter.**

**Applications for approval for a new program have a 90 day time frame for approval. Re-approvals are required every 2 years and have a 45 day time frame for re-approval**

**Effective July 1, 2007, the written/oral and skills competency exam will be administered by Credentia and information regarding standardized testing can be viewed and/or downloaded from <https://credentia.com/test-takers/ga>. Search Nurse Aide Registry link.**

**Alliant Health Solutions  
Nurse Aide Training Program**

**Policy: Submission of Application  
(Approval, Re-Approval & Relocation)**

**Please read carefully, sign and date at the bottom of the page.**

**In a minority of cases applications may not be approved or re-approved. In these instances the Alliant Health Solutions Nurse Aide Program Reviewers spend an extended amount of time providing one-to-one feedback with applicants giving advice on how and what to include in an application.**

**The Alliant Health Solutions allows up to three (3) submissions of an application either for approval or re-approval of a Nurse Aide Training and Competency Evaluation Program.**

**Once an application is denied for the third time, the applicant will be able to submit another application at one year from the date of the last submission and after attendance at another Train-the-Trainer Workshop.**

**I, the undersigned, attest that I have read the above policy and understand that I have three attempts to submit an application for approval or re-approval. I also understand that within one year from the time of my last application submittal I can again apply for approval or re-approval once I have attended a Train-the-Trainer Workshop.**

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**SIGNATURE**

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**DATE**

**ALLIANT HEALTH SOLUTIONS  
NURSE AIDE TRAINING PROGRAM**

**Program Coordinators:**

**By signing, you are acknowledging the fact that when a change to the nurse aide training program is made Alliant Health Solutions must be notified in writing of the change. This includes any subject from pages one (1) – seven (7) of the approval/re-approval packet application.**

**Information must be submitted within ten (10) business days of the change. All changes must be approved prior to implementation.**

**Send information to: (UPS or FedEx will not deliver to a P O Box)**

**Alliant Health Solutions  
Nurse Aide Training Program  
P. O. Box 105753  
Atlanta, GA 30348  
[www.mmis.georgia.gov](http://www.mmis.georgia.gov)**

**Failure to submit the information will result in disciplinary action and/or withdrawal of the nurse aide training program.**

**Signature: \_\_\_\_\_**

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

# Alliant Health Solutions Nurse Aide Training Program (NATP) Application

(Please print or type)

## Program Offering Information

**(Complete a separate application for each training program location):**

Legal Business Name of Organization/School/Agency/Nursing Facility

\_\_\_\_\_

List all Affiliated Business Names, including Doing Business As (DBA)

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Business Address:

Street \_\_\_\_\_

City \_\_\_\_\_ Zip Code \_\_\_\_\_

County \_\_\_\_\_

Phone ( ) \_\_\_\_\_ Fax ( ) \_\_\_\_\_

## Program's E-mail Address

**(required)** \_\_\_\_\_

Program's Contact

Person \_\_\_\_\_

Name

Title

Name of Administrator of facility (if applicable) \_\_\_\_\_

E-mail Address \_\_\_\_\_

Program: APPROVAL

RE-APPROVAL

RELOCATION

Title, Author and Edition of textbook \_\_\_\_\_

*(All textbooks must be within 5 years of the copyright date. Do not mail the textbook with submitted paperwork)*

Title of nurse aide  
course \_\_\_\_\_

**Classroom/lab/clinical hours must correspond with total number of hours documented on the lesson plans/hourly breakdown form.**

**Day class- Use whole numbers only**

Classroom hours \_\_\_\_\_ Lab hours \_\_\_\_\_ Clinical hours \_\_\_\_\_

**Evening Class- Use whole numbers only**

Classroom hours \_\_\_\_\_ Lab hours \_\_\_\_\_ Clinical hours \_\_\_\_\_

**Weekend class- Use whole numbers only**

Classroom hours \_\_\_\_\_ Lab hours \_\_\_\_\_ Clinical hours \_\_\_\_\_

**Each time frame requires lesson plans and an hourly breakdown form for each class.**

**A minimum of twenty-four (24) hours of clinical is required in a nursing home.**

**Location of Classroom/Lab Training Site:** New programs and relocation sites must have an onsite visit. The location can be pending upon application submission prior to scheduled on-site visit. See Page 6 of this application for additional information.

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Provide a description of the classroom/lab to include seating capacity, writing space and describe method of lighting/temperature control: **This section must be provided to the State Contractor once the training site is obtained by the applicant**

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Location(s) of Clinical Training Site(s) - The signed clinical contract must be obtained and submitted with the Nurse Aide Training Application. All applications submitted without the clinical contract **will not** be reviewed until the signed clinical contract is submitted. Failure to submit the signed clinical contract will delay the 90 day process.

| Agency | Address | Type of patient care unit |
|--------|---------|---------------------------|
|--------|---------|---------------------------|

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**Faculty- For this location only.**

Program Coordinator - must be a RN with two (2) years of nursing experience and one (1) year employment in a nursing home as a Registered Nurse.

Please review the enclosed Program Coordinator's Guide for position guidelines.

| <u>Name</u> | <u>Title</u> | <u>GA License Number</u> |
|-------------|--------------|--------------------------|
|-------------|--------------|--------------------------|

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Primary Instructors (RN or LPN) - **Must have one (1) year of nursing experience For this location only:**

| <u>Name</u> | <u>Title</u> | <u>GA License Number</u> |
|-------------|--------------|--------------------------|
|-------------|--------------|--------------------------|

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If more space is needed for clinical sites and/or instructors, please enclose a typed form with the additional clinical sites and instructors.

Recommended student/instructor ratio is 14:1 in classroom/lab and clinical setting. Recommended student/instructor ratio may change based on the state contractor's on-site visit. Additional students require an additional instructor.

Expert Supplemental speaker (attached additional pages if necessary)

List the name, profession and work experience of each healthcare professional utilized to **assist** in the instruction of the nurse aide course. Examples of supplemental instructors are as follows: CPR certified instructor, Alzheimer’s guest speaker, guest speaker on Ombudsman duties, etc... Refer to the Federal Guidelines (42CFR483.152) for Nurse Aide Training Programs for a complete listing of supplemental instructors. Supplemental instructors are required to have one (1) year of experience in their field.

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|      |           |
|------|-----------|
| Name | Job Title |
|------|-----------|

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|      |           |
|------|-----------|
| Name | Job Title |
|------|-----------|

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|                 |           |
|-----------------|-----------|
| Name            | Job Title |
| Work Experience |           |

\*\*\* Credentia Nurse Aide Evaluator must administer the written/oral and skills competency exam to candidates for all programs including candidates testing for re-certification. Information provided at <https://credentia.com/test-takers/ga>.

**First time applicants must submit all items listed below.**

**Please note any changes to the program during the two (2) year time period between re-approval should be submitted for approval within ten (10) days. The change cannot be implemented until approval is granted.**

**Place preparer’s initials in front of each item submitted and reviewed.**

\_\_\_ Program coordinator/instructor (s) – copy of current GA nursing license.

\_\_\_ Program coordinator/instructor (s) – copy of the Train-the-Trainer certificate and resume if not on file.

\_\_\_ Copy of business license, fire code inspection report and fire evacuation procedure must be submitted prior to scheduled on-site visit. **(Pending for new programs is acceptable prior to paperwork approval). Submit a current business license every two (2) years for re-approval.**

\_\_\_ Contract/Agreement for all clinical site experiences **must have a valid 2 year expiration date.** Clinical contracts without an expiration dates will not be accepted. **See page 3 of the application regarding clinical contract submission.**

\_\_\_ Criteria for passing the course and a student evaluation form with a provision for progress notes.

\_\_\_ Classroom/clinical attendance policies with make-up policy. All nurse aide students must complete the number of hours the program was approved for in order for the student to receive a Certificate of Completion.



\_\_\_ Program office and clinical rotation policies **must** include a detailed refund policy. Office policy must include an itemized list for total cost of the program and breakdown of refund policy.

\_\_\_ Equipment list with lab equipment- **(Pending is acceptable prior to scheduled on-site visit).**

\_\_\_ Instructor evaluation form

\_\_\_ Student evaluation form

\_\_\_ Program Acknowledgement form:

The enclosed form is to be given to the student upon the completion of the nurse aide training program. All programs must keep a program acknowledgement form in each student's file acknowledging receipt of program evaluation. The student is responsible for mailing or faxing the form to Alliant Health Solutions.

\_\_\_ Skills performance checklist must follow the Federal/State Core Curriculum Skills Checklist (enclosed with approval/re-approval packet). Additional skills can be added but none can be deleted. All skills on the skills checklist must appear on lesson plans on the appropriate day the skill will be demonstrated. Skills must either be taken from the textbook rubric or created by the program. The competency skills are not to be used for teaching purposes until the completion of the nurse aide training program.

\_\_\_ Federal/State Core Curriculum with page numbers listed from textbook next to each subject & hours for first six (6) subjects. The first six (6) subjects require sixteen (16) hours prior to "hands on" care during skill performance. Observation of the first six (6) subjects is to be included in all student skill performance. All page numbers should be on the lesson plans to ensure Federal/State Guideline compliance. If the book does not meet the criteria, the program must use supplemental material, which must be enclosed with the application.

\_\_\_ Hourly breakdown form with breaks and meals deleted. The hourly breakdown form must match time allotments on lesson plans. All time allotments for classroom/lab must be documented on each of the lesson plans. **Total number of hours from this form must match the number of hours on page one (1) of this approval application.**

\_\_\_ Lesson plans, must coincide with skills checklist and hourly breakdown form. Lesson plans must contain all material on the Federal/State Core Curriculum, skills demonstrations, and time allotments for classroom and lab. Lesson plans must be individualized. Lesson plans are not to be shared with other programs.

\_\_\_ Copies of all quizzes/exams must be attached to the appropriate lesson plan day - A **FINAL** exam is required for each student

\_\_\_ Handouts, pamphlets, role-plays, and/or games must be attached to the appropriate lesson plan day so the instructor will have all the necessary material for a specific day.

\_\_\_ **Print and review** the Nurse Aide Training Program Manual **quarterly**- (keep on file in office) [www.mmis.georgia.gov](http://www.mmis.georgia.gov), click on the provider information tab, click on view full list under the Medicaid Manuals section. This manual is updated quarterly. **DO NOT SUBMIT A COPY WITH APPLICATION.**

\_\_\_ **Review** the enclosed copy of the training program completion certificate. All information on the enclosed certificate must be on the certificate issued to the candidate at the **completion** of the nurse aide training program course. The date documented on the completion certificate should be the date of the completion of the program.

\_\_\_ The state contractor is **not** responsible for lease agreements, purchase of equipment and/or building prior to the approval of the submitted paperwork for the nurse aide training program. The program location and equipment can be obtained, once the approval is given by the state contractor regarding the required submitted paperwork. The program location, business license and equipment list on the application can be left blank until notified by the state contractor. The state contractor will notify the applicant via e-mail, when submitted paperwork is approved.

**THE PROGRAM MUST HAVE A VALID E-MAIL ADDRESS.**

- **Certified Nurse Aide Courses cannot start without the approval letter from the State Contractor;**
- **Funds cannot be accepted from potential nurse aide students until the approval letter from the State Contractor is received;**
- **Pending programs cannot advertise for Certified Nurse Aide Courses until the approval letter from the State Contractor is received;**
- **Do not submit text books with submitted paperwork;**
- **State Contractor Reviewer allowed ninety (90) business days for review of new programs;**
- **State Contractor Reviewer allowed forty-five (45) business days for review of re-approvals/relocation; and**
- **The State Contractor will advise the new program when the submitted paperwork is approved and schedule an on-site visit.**

**RE-APPROVALS ONLY**

**The following documents must be submitted: Place preparer's initials in front of each item submitted.**

\_\_\_ Nurse Aide Training Program Application (Pages 1-7)

\_\_\_ Current updated signed Clinical contract(s) - clinical contracts without expiration dates will not be accepted (Nursing Home Programs are exempt)

\_\_\_ Updated copies of current nursing licenses for all approved instructors

\_\_\_ Current business license (Nursing Home Programs are exempt)

\_\_\_ Enclosed **Mandatory** skills checklist with page/rubric information - additional skills may be added to the skills checklist

\_\_\_ Updated Lesson plans/hourly breakdown form with additional changes listed on the enclosed Federal & State Core Curriculum

**Relocation Only**

- \_\_\_ Cover letter with detailed information regarding relocation
- \_\_\_ Nurse Aide Training Program Application (Pages 1-3 & 7)
- \_\_\_ Copy of business license
- \_\_\_ Fire code inspection report
- \_\_\_ Fire evacuation procedure
- \_\_\_ Equipment List

The application may not include complete requirements for the Georgia Nurse Aide Training Program. The applicant **must** read the Nurse Aide Training Program Manual located at [www.mmis.georgia.gov](http://www.mmis.georgia.gov) (click on Nurse Aide/Medication Aide tab) for all requirements.

I certify that all the information on all pages of the application form is true and complete. False information will delay and/or withdraw the Georgia Nurse Aide Training Program approval/re-approval from the State Contractor.

\_\_\_\_\_  
**Preparer's Signature**

\_\_\_\_\_  
**Date**

**Mailing address: (UPS or FedEx will not deliver to a P O Box)**

**Alliant Health Solutions  
Attn: Nurse Aide Training Program  
P. O. Box 105753  
Atlanta, GA 30348  
[www.mmis.georgia.gov](http://www.mmis.georgia.gov)**

|  |  |
|--|--|
| <b>Alliant Health Solutions Use Only</b> |  |
| <input type="checkbox"/> Approved        | By: _____<br>Reviewer _____ Date _____ |
| <input type="checkbox"/> Denied          |  |
| <b>Program#</b> _____                    | <b>Program Type</b> _____              |

## NURSE AIDE TRAINING PROGRAM

*All supplies must be stocked in adequate supply at all times*  
**SUPPLIES MUST BE ADEQUATE FOR THE NUMBER OF STUDENTS ATTENDING**

### **ENVIRONMENTAL CLEANLINESS MANDATORY**

| <b>Rationale for equipment - to recreate a resident's room in the nursing home &amp; for proper skills training.</b> | <b>DATE</b> | <b>COMMENT</b> |
|--|-------------|----------------|
| Table/desk/chairs (desk must be arranged 3ft apart)  |             |                |
| Whiteboard - large   |             |                |
| TV/DVD (projector-optional)  |             |                |
| Videos (optional)  |             |                |
| Reference Books  |             |                |
| Disposable gloves - varied sizes (small, medium, large)  |             |                |
| Hospital Bed with side rails- must raise to working height (telescoping side rails <b>NOT</b> allowed)               |             |                |
| Full Body Manikin<br>(complete with interchangeable M/F parts that fit properly)                                     |             |                |
| Wall Clock with second hand in lab area near sink  |             |                |
| Call Light   |             |                |
| Overbed Table  |             |                |
| Bedside Table with drawers for equipment placement   |             |                |
| Wheelchair with footrest and brakes  |             |                |
| Geri chair (optional for private programs and schools)   |             |                |
| Lift (optional for private programs and schools)   |             |                |
| Restraints for slip knot   |             |                |
| Heel/Elbow Protectors- several   |             |                |
| Walker with wheels   |             |                |
| Quad Cane  |             |                |
| Gait Belt - several  |             |                |
| Ambulatory scale/height measuring device   |             |                |
| Non-electronic/non-digital standing or bathroom scale  |             |                |
| Waste basket with plastic liners   |             |                |
| Tongues blades for stool specimen – several boxes  |             |                |
| Measuring tape for the height of bedridden   |             |                |
| Graduated cylinder - CLEAR PLASTIC (2) ( <b>No Beakers</b> )   |             |                |
| Bedpan (standard and fracture)   |             |                |
| Urinal - MALE  |             |                |
| Bedside Commode  |             |                |
| Speci Pan  |             |                |
| Chux - package   |             |                |
| Incontinent Briefs - package   |             |                |
| Specimen cups with small clear biohazard bags  |             |                |
| Foley Catheter with closed drainage system   |             |                |
| Alcohol Wipes – several boxes  |             |                |
| Sphygmomanometer – Manual (Regular, Large, Extra Large)  |             |                |
| Thermometer Covers - Disposable – several boxes  |             |                |
| Thermometer – Digital or Electronic - several  |             |                |
| Thermometer - mercury-free oral/rectal - several oral  |             |                |

|   |  |  |
|---|--|--|
| Stethoscopes - several  |  |  |
| Teaching Stethoscope  |  |  |
| Hamper with red biohazard bag for gown disposal   |  |  |
| Isolation gowns – several packages  |  |  |
| Masks – several boxes   |  |  |
| Eye Protection - several  |  |  |
| Sharps Container – Puncture Resistant for razors  |  |  |
| Washcloths-2  |  |  |
| Towels-2  |  |  |
| Twin Blanket-2  |  |  |
| Twin Bedspread-2  |  |  |
| Pillowcases–2   |  |  |
| Flat twin sheet-4-can use for draw sheet or bottom sheet  |  |  |
| Fitted twin sheet-2   |  |  |
| Hospital Gown-2   |  |  |
| Orange Sticks/emery boards – several boxes  |  |  |
| Toothbrush (each student must have one)/toothpaste/floss for oral care demonstration  |  |  |
| Denture cup/Dentures/ Denture Brush ( <b>Adult Size Dentures</b> )  |  |  |
| Toothettes – several boxes  |  |  |
| Disposable Razors/Shaving Cream - several razors  |  |  |
| Wash Basin  |  |  |
| Liquid Soap & Body Wash Soap (Several)  |  |  |
| Emesis Basin  |  |  |
| Hair Brush/Comb- several  |  |  |
| Water Pitcher ( <b>bedside pitcher 34 oz</b> )/Cup/ Straws  |  |  |
| Food Tray/Clothing Protector/Plate/Silverware   |  |  |
| Anti-embolic stockings (4)  |  |  |
| Pillows for head of bed and alignment - Six (6)   |  |  |
| Post Mortem Kit   |  |  |
| Sink – H/C water<br>(faucet must extend outward to allow for proper handwashing)  |  |  |
| Privacy curtain or Door   |  |  |
| Nurse Aide Training Manual onsite (most recent)   |  |  |
| File Cabinet with Lock  |  |  |
| Heated/cooled environment/Clean Carpet/No loose wires   |  |  |
| <b>Supplies must be organized in drawers or containers, or on shelves.</b>  |  |  |
| Room accommodation for how many students-class/lab  |  |  |
| <b>SIGNATURE OF PREPARER: _____</b><br><b>REQUIRED: CLASSROOM EQUIPMENT &amp; SUPPLIES MUST BE CLEAN, ORGANIZED, AND IN GOOD WORKING CONDITION AT ALL TIMES FOR NATP APPROVAL</b> |  |  |

**Optional – Private programs, technical colleges and high schools may use “optional” equipment in a nursing facility for training – student must have skill checked off prior to working with residents requiring this equipment.**

**Private programs, technical colleges and high schools - weights must be taught and demonstrated in the nursing home**

**For hair brushing demonstration, have students demonstrate hair brushing on manikin only.**

**REQUIREMENTS  
FOR  
PROGRAM COORDINATOR & INSTRUCTORS**

Approved Nurse Aide Training Programs must designate a Program Coordinator and Primary Instructor(s). Programs cannot commence training until these individuals are approved.

**Program Coordinator (PC):**

Registered Nurse (RN) with two (2) years of nursing experience. One (1) year of nursing experience as an RN must be in a long-term care facility (nursing home). Duties of a Program Coordinator include but are not limited to:

- Overseeing the program in its entirety
- All required documentation for the yearly on-site review
- Assisting instructor in resolving any issues with students
- Making occasional on-site visits to classroom/lab and clinical sites to ensure proper instruction is taking place and documenting progress related to those visits
- Assisting with compilation of material presented for the approval or re-approval prior to submitting to the Georgia Nurse Aide Training Program
- Attending the first clinical rotation with all first time instructors **without** nursing home experience.

Please review the NATP Manual and PC Guide for additional job description

The facility administrator/director must mail a letter requesting approval for the RN to serve as Program Coordinator for the Nurse Aide Training Program. Please include a copy of the current GA nursing license, an updated resume, and a copy of the Train-the-Trainer Workshop certificate. Requirements are as follows:

- Registered Nurse with current **active** Georgia License and in good standing with the GA Board of Nursing- License cannot have the following status codes- probation, suspended, expired, lapsed, inactive, pending, renewal pending, revoked or surrendered
- Two (2) years of nursing experience as an RN, at least one year of experience as an RN must be in a long term care facility (nursing home).
- Train-the-Trainer Workshop attendance certificate from Alliant Health Solutions
- The Director of Nursing may serve as Program Coordinator in a facility based program, but provision for coverage of duties must be assured

**Instructors**

The Program Coordinator must mail a letter requesting approval for the LPN or RN to serve as an instructor in the classroom and/or clinical portion of the Nurse Aide Training Program. Please include a copy of the current GA nursing license, an updated resume and a copy of the Train-the-Trainer Workshop certificate. Requirements are as follows:

- Registered Nurse or License Practical Nurse with current **active** Georgia License and in good standing with the GA Board of Nursing- License cannot have the following status codes- probation, suspended, expired, lapsed, inactive, pending, renewal pending, revoked or surrendered
- Minimum one year of nursing experience
- Train-the-Trainer Workshop attendance certificate from Alliant Health Solutions

## PROGRAM COORDINATOR'S GUIDE

| Program Name & Number _____<br>Program Coordinator (PC) Name: Print _____<br>Signature _____   | DATE | INITIALS |
|--|------|----------|
| FILES IN ORDER FOR ANNUAL AUDIT - ON-SITE REVIEW - PAGE 11 TRAIN THE TRAINER BOOKLET - DATE WHEN FILES CHECKED                           |      |          |
| REVIEWED PROGRAM WITH INSTRUCTOR PRIOR TO TEACHING - MADE EXPECTATIONS KNOWN - DATE  |      |          |
| TEAM MEETINGS HELD TO EVALUATE HOW PROGRAM IS PROGRESSING - DATE & RESULTS OF EVALUATION - DOCUMENT PLAN TO IMPLEMENT CHANGES            |      |          |
| PROBLEMS WITH PROGRAM DOCUMENTED & PROBLEM SOLVING METHODS INITIATED   |      |          |
| REVIEWED INSTRUCTOR EVALUATIONS FOR C/O & IMPROVEMENTS NEEDED - RESULTS DOCUMENTED   |      |          |
| ISSUES NEEDING RESOLUTION - DOCUMENT ISSUES & PLANS FOR RESOLUTION   |      |          |
| INSTRUCTOR(S) ON PROBATION - LIST REASON   |      |          |
| LESSON PLANS BEING FOLLOWED - MONITOR MONTHLY AND DOCUMENT   |      |          |
| SKILL RUBRICS BEING FOLLOWED - MONITOR MONTHLY AND DOCUMENT  |      |          |
| MONITOR EACH INSTRUCTOR IN CLASSROOM, LAB & CLINICAL - DOCUMENT FINDINGS AND FOLLOW-UP DATE  |      |          |
| INSTRUCTOR IMPROVEMENT AND VISITS MADE TO OBSERVE IMPROVEMENT  |      |          |
| MONITOR NEW INSTRUCTOR(S) FOR COMPETENCY OF INSTRUCTION - DOCUMENT FINDINGS & FOLLOW-UP DATE   |      |          |
| PC ATTENDANCE REQUIRED WITH FIRST TIME LTC INSTRUCTORS DURING CLINICAL ROTATION (ADDITIONAL ATTENDANCE MAY BE REQUESTED)                 |      |          |
| ORGANIZE WITH THE INSTRUCTORS THE RE-APPROVAL APPLICATION - DATE   |      |          |
| ASSIST IN CREATING LESSON PLANS BASED ON NURSING HOME EXPERIENCE   |      |          |
| PASSING RATE ON WRITEN/ORAL/SKILLS COMPETENCY EXAM - INVESTIGATED INDIVIDUAL PROBLEMS WITH FAILING THE EXAM WITH INSTRUCTOR - DOCUMENT   |      |          |
| REVIEW STUDENT PROBLEMS WITH INSTRUCTOR AND ASSIST IN PROBLEM SOLVING - DOCUMENT   |      |          |
| ALL REQUIRED LAB EQUIPMENT ALL LOCATIONS PRESENT - DATE ASSESSED - NAME OF LOCATION  |      |          |
| NOTIFIED WITHIN TEN (10) DAYS OF ANY CHANGES TO THE PROGRAM - DATE & DOCUMENT CHANGE   |      |          |
| NOTIFIED OF INSTRUCTOR ADDITION OR DELETION - DATE   |      |          |
| CANDIDATE HANDBOOK FROM CREDITIA REVIEWED WITH INSTRUCTORS & DATE  |      |          |
| <b>WHEN LOW SCORES NOTED ON SKILLS COMPETENCY - OBSERVE STUDENT PERFORMANCE AND/OR REVIEW STUDENT RECORDS</b>                            |      |          |
| ASSISTED IN THE HIRING PROCESS OF INSTRUCTORS - SUBMITTED LETTER OF INTENT, COPY OF NURSING LICENSE, RESUME & COPY OF TTT CERTIFICATE TO |      |          |
| <b>ATTACH DOCUMENTATION IF APPLICABLE</b>  |      |          |

**INSTRUCTOR ORIENTATION**

Instructor printed name: \_\_\_\_\_

Date of hire: \_\_\_\_\_

Instructor status (select all that applies):    **approved**                    **temporary approval**                    **first time instructor**

**Proctor and instructor to initial and date each of the following:**    **Proctor:** program coordinator and/or experience instructor

Orientation to the classroom, lab and equipment placement: \_\_\_\_\_ Date: \_\_\_\_\_ Length of time: \_\_\_\_\_

Orientation to the lesson plans and skills rubrics: \_\_\_\_\_ Date: \_\_\_\_\_ Length of time: \_\_\_\_\_

Instructor observation of proctor teaching & skills check-off methodology: \_\_\_\_\_ Date: \_\_\_\_\_ Length of time: \_\_\_\_\_

PC observation during clinical rotation for first time instructor: \_\_\_\_\_ Date: \_\_\_\_\_ Length of time: \_\_\_\_\_

Proctor observation of instructor teaching methodology: \_\_\_\_\_ Date: \_\_\_\_\_ Length of time: \_\_\_\_\_

Proctor observation of skills check-off methodology: \_\_\_\_\_ Date: \_\_\_\_\_ Length of time: \_\_\_\_\_

State Guidelines for the Nurse Aide Training Program have been reviewed: \_\_\_\_\_ Date: \_\_\_\_\_

Proctor printed name: \_\_\_\_\_ Proctor signature: \_\_\_\_\_ Date: \_\_\_\_\_

Proctor printed name: \_\_\_\_\_ Proctor signature: \_\_\_\_\_ Date: \_\_\_\_\_

Instructor signature: \_\_\_\_\_ Date: \_\_\_\_\_

**When the new instructor and proctor have signed off on each tasks listed above a copy must be remain in the program's file all times for auditing purposes. Methodology includes use of approved lesson plans, skill rubrics, skills checklist and communication skills.**



# Federal and State Guidelines Core Curriculum Required Skills Checklist

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| Required Skills<br>Nurse Aide Training<br>Program  | LAB PRACTICUM<br>Instructor's<br>Initial/Date | CLINICAL<br>PRACTICUM<br>Instructor's<br>Initial/Date | PAGE<br>NUMBER/RUB<br>RIC |
|--|---|---|---------------------------|
| <b>INFECTION<br/>CONTROL</b>   |   |   |                           |
| Handwashing - 20<br>seconds  |   |   |                           |
| Donning and removing<br>gloves   |   |   |                           |
| Donning and removing<br>(PPE) gloves, gown,<br>mask and eye protection<br>~Please use CDC<br>Guidelines~ |   |   |                           |
| <b>SAFETY &amp;<br/>EMERGENCY</b>  |   |   |                           |
| FBAO   |   |   |                           |
| Gait Belt  |   |   |                           |
| Body Mechanics   |   |   |                           |
| <b>POSITIONING,<br/>TURNING, &amp;<br/>TRANSFER</b>  |   |   |                           |
| One/two person assist  |   |   |                           |
| Positioning with draw<br>sheet   |   |   |                           |
| Positioning with resident<br>assist  |   |   |                           |
| Positioning in<br>chair/wheelchair   |   |   |                           |
| Transfer from chair to<br>bed<br>Transfer from bed to<br>chair   |   |   |                           |
| Turn resident away from<br>self  |   |   |                           |
| Logrolling   |   |   |                           |
| Turn resident with<br>resident assist  |   |   |                           |
| Passive range of motion  |   |   |                           |
| Assist resident to stand<br>with/without gait belt   |   |   |                           |

| Required Skills<br>Nurse Aide Training<br>Program  | LAB PRACTICUM<br>Instructor's<br>Initial/Date  | CLINICAL<br>PRACTICUM<br>Instructor's<br>Initial/Date | PAGE<br>NUMBER/RUB<br>RIC |  |  |  |  |  |  |  |  |  |  |
|--|--|---|---------------------------|--|--|--|--|--|--|--|--|--|--|
| Transfer with lift<br>(clinical)   |  |   |                           |  |  |  |  |  |  |  |  |  |  |
| Ambulation with<br>cane/walker   |  |   |                           |  |  |  |  |  |  |  |  |  |  |
| Positioning:<br><ul style="list-style-type: none"> <li>• Lateral</li> <li>• Sims</li> <li>• Fowler's</li> <li>• Supine</li> <li>• Prone</li> </ul> | <table border="1" style="width: 100%; height: 100%;"> <tr><td> </td></tr> <tr><td> </td></tr> <tr><td> </td></tr> <tr><td> </td></tr> <tr><td> </td></tr> </table> |   |                           |  |  |  | <table border="1" style="width: 100%; height: 100%;"> <tr><td> </td></tr> <tr><td> </td></tr> <tr><td> </td></tr> <tr><td> </td></tr> <tr><td> </td></tr> </table> |  |  |  |  |  |  |
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| <b>VITAL SIGNS</b>   |  |   |                           |  |  |  |  |  |  |  |  |  |  |
| Temperature Parameters   |  |   |                           |  |  |  |  |  |  |  |  |  |  |
| Oral/Rectal/Axillary-<br>Digital   |  |   |                           |  |  |  |  |  |  |  |  |  |  |
| Oral/Rectal/Axillary-<br>Glass(mercury free)   |  |   |                           |  |  |  |  |  |  |  |  |  |  |
| Radial pulse –<br>parameters   |  |   |                           |  |  |  |  |  |  |  |  |  |  |
| Radial pulse   |  |   |                           |  |  |  |  |  |  |  |  |  |  |
| Blood pressure -<br>parameters   |  |   |                           |  |  |  |  |  |  |  |  |  |  |
| Blood pressure   |  |   |                           |  |  |  |  |  |  |  |  |  |  |
| Respiration Parameters   |  |   |                           |  |  |  |  |  |  |  |  |  |  |
| Measuring Respiration  |  |   |                           |  |  |  |  |  |  |  |  |  |  |
| Weight (ambulatory and<br>needle indicator scale)  |  |   |                           |  |  |  |  |  |  |  |  |  |  |
| Wheelchair-Chair-Bed<br>Scale<br><b>(clinical only)</b>  |  |   |                           |  |  |  |  |  |  |  |  |  |  |
| Height of the bedridden<br>Resident  |  |   |                           |  |  |  |  |  |  |  |  |  |  |
| Vital Sign Recording -<br>notebook, pen, & watch<br>with second hand   |  |   |                           |  |  |  |  |  |  |  |  |  |  |
| <b>RESIDENT'S<br/>ENVIRONMENT</b>  |  |   |                           |  |  |  |  |  |  |  |  |  |  |
| Admission/Discharge  |  |   |                           |  |  |  |  |  |  |  |  |  |  |
| Care of Resident's<br>belongings   |  |   |                           |  |  |  |  |  |  |  |  |  |  |

| <b>Required Skills<br/>Nurse Aide Training<br/>Program</b>                                     | <b>LAB PRACTICUM<br/>Instructor's<br/>Initial/Date</b> | <b>CLINICAL<br/>PRACTICUM<br/>Instructor's<br/>Initial/Date</b> | <b>PAGE<br/>NUMBER/RUB<br/>RIC</b> |
|--|--|---|------------------------------------|
| Making occupied bed  |  |   |                                    |
| Making unoccupied bed  |  |   |                                    |
| Cleanliness of resident's room   |  |   |                                    |
| <b>ROLE OF THE<br/>NURSE AIDE</b>  |  |   |                                    |
| Communication skills   |  |   |                                    |
| Stress management  |  |   |                                    |
| Interpersonal skills   |  |   |                                    |
| Chain of command   |  |   |                                    |
| Work ethics  |  |   |                                    |
| Care plan  |  |   |                                    |
| Documentation/Shift Report   |  |   |                                    |
| Scope of practice  |  |   |                                    |
| Conflict management  |  |   |                                    |
| Manage cognitively impaired  |  |   |                                    |
| Customer service   |  |   |                                    |
| Aging Process  |  |   |                                    |
| <b>Resident's Grooming<br/>&amp; Personal Care with<br/>observation of<br/>Pressure Ulcers</b> |  |   |                                    |
| Complete and partial bed bath  |  |   |                                    |
| Shower (clinical)  |  |   |                                    |
| Tub bath/Whirlpool (clinical)  |  |   |                                    |
| Perineal care- male/female   |  |   |                                    |
| Skin care  |  |   |                                    |
| Dressing/undressing  |  |   |                                    |
| Dressing with weak side  |  |   |                                    |
| Hair care- shampoo, brushing, combing  |  |   |                                    |
| Nail care  |  |   |                                    |
| Foot care  |  |   |                                    |
| Shaving resident   |  |   |                                    |
| Brushing /flossing teeth & dentures  |  |   |                                    |
| Denture Care   |  |   |                                    |
|  |  |   |                                    |

| <b>Required Skills<br/>Nurse Aide Training<br/>Program</b>   | <b>LAB PRACTICUM<br/>Instructor's<br/>Initial/Date</b>   | <b>CLINICAL<br/>PRACTICUM<br/>Instructor's<br/>Initial/Date</b> | <b>PAGE<br/>NUMBER/RUB<br/>RIC</b> |  |  |  |  |  |  |  |  |  |  |  |  |
|--|--|---|------------------------------------|--|--|--|--|--|--|--|--|--|--|--|--|
| Observation & care of skin tears   |  |   |                                    |  |  |  |  |  |  |  |  |  |  |  |  |
| Unconscious mouth care   |  |   |                                    |  |  |  |  |  |  |  |  |  |  |  |  |
| Anti-embolic stocking  |  |   |                                    |  |  |  |  |  |  |  |  |  |  |  |  |
| Resident's rights & personal choice (clothing choice, bathing)   |  |   |                                    |  |  |  |  |  |  |  |  |  |  |  |  |
| <b>Resident's Meal Time &amp; Hydration</b>  |  |   |                                    |  |  |  |  |  |  |  |  |  |  |  |  |
| Diet cards/name card   |  |   |                                    |  |  |  |  |  |  |  |  |  |  |  |  |
| Documenting meal percentage  |  |   |                                    |  |  |  |  |  |  |  |  |  |  |  |  |
| Proper feeding techniques for dependent resident   |  |   |                                    |  |  |  |  |  |  |  |  |  |  |  |  |
| Documenting I&O  |  |   |                                    |  |  |  |  |  |  |  |  |  |  |  |  |
| Assisting visually impaired resident   |  |   |                                    |  |  |  |  |  |  |  |  |  |  |  |  |
| Care of skin with feeding tube   |  |   |                                    |  |  |  |  |  |  |  |  |  |  |  |  |
| <b>Bowel &amp; Bladder Care and Training</b>   |  |   |                                    |  |  |  |  |  |  |  |  |  |  |  |  |
| Incontinent care (observation of pressure ulcers)  |  |   |                                    |  |  |  |  |  |  |  |  |  |  |  |  |
| Bowel & Bladder Training   |  |   |                                    |  |  |  |  |  |  |  |  |  |  |  |  |
| Proper use of bedpan/fracture pan  |  |   |                                    |  |  |  |  |  |  |  |  |  |  |  |  |
| Proper use of urinal   |  |   |                                    |  |  |  |  |  |  |  |  |  |  |  |  |
| Proper technique transferring resident to bedside commode  |  |   |                                    |  |  |  |  |  |  |  |  |  |  |  |  |
| Catheter care male/female  |  |   |                                    |  |  |  |  |  |  |  |  |  |  |  |  |
| Measuring & Recording urine output from: <ul style="list-style-type: none"> <li>• Foley catheter</li> <li>• Bedside commode</li> <li>• Urinal</li> </ul> | <table border="1" style="width: 100%; height: 85px;"> <tr><td style="width: 50%; height: 25px;"></td><td style="width: 50%; height: 25px;"></td></tr> <tr><td style="width: 50%; height: 25px;"></td><td style="width: 50%; height: 25px;"></td></tr> <tr><td style="width: 50%; height: 25px;"></td><td style="width: 50%; height: 25px;"></td></tr> </table> |   |                                    |  |  |  |  | <table border="1" style="width: 100%; height: 85px;"> <tr><td style="width: 50%; height: 25px;"></td><td style="width: 50%; height: 25px;"></td></tr> <tr><td style="width: 50%; height: 25px;"></td><td style="width: 50%; height: 25px;"></td></tr> <tr><td style="width: 50%; height: 25px;"></td><td style="width: 50%; height: 25px;"></td></tr> </table> |  |  |  |  |  |  |  |
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| Collecting a specimen urine-stool-sputum   |  |   |                                    |  |  |  |  |  |  |  |  |  |  |  |  |
| Care of the Ostomy(skin care)  |  |   |                                    |  |  |  |  |  |  |  |  |  |  |  |  |
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| <b>Required Skills<br/>Nurse Aide Training<br/>Program</b>                   | <b>LAB PRACTICUM<br/>Instructor's<br/>Initial/Date</b> | <b>CLINICAL<br/>PRACTICUM<br/>Instructor's<br/>Initial/Date</b> | <b>PAGE<br/>NUMBER/RUB<br/>RIC</b> |
|--|--|---|------------------------------------|
| <b>Care and Use of<br/>Orthotic, Prosthetic, &amp;<br/>Assistive Devices</b> |  |   |                                    |
| Plate guard  |  |   |                                    |
| Clothing reach   |  |   |                                    |
| Denture Care   |  |   |                                    |
| Pressure ulcer<br>prevention devices   |  |   |                                    |
| Eye glasses  |  |   |                                    |
| Observation for pressure<br>sores, redness, &<br>swelling with devices       |  |   |                                    |
| <b>Restraint Use &amp;<br/>Guidelines</b>                                    |  |   |                                    |
| Slip knot technique  |  |   |                                    |
| Geri chair (clinical)  |  |   |                                    |
| Restraint alternatives   |  |   |                                    |
| Residents rights   |  |   |                                    |
| <b>Post Mortem Care</b>  |  |   |                                    |
| Post mortem care &<br>procedure  |  |   |                                    |
| Signs and symptoms of<br>death & grieving process                            |  |   |                                    |
| Cultural & Family<br>Considerations  |  |   |                                    |
| <b>Residents Right's-<br/>Confidentiality &amp;<br/>Privacy</b>              |  |   |                                    |
| HIPAA  |  |   |                                    |
| Ombudsman  |  |   |                                    |
| Providing privacy  |  |   |                                    |
| <b>Observation &amp;<br/>Reporting</b>                                       |  |   |                                    |
| Pain   |  |   |                                    |
| Respiratory changes  |  |   |                                    |
| Bowel/Bladder changes<br>(UTI)   |  |   |                                    |
| Behavioral changes   |  |   |                                    |
| Skin color & condition<br>changes  |  |   |                                    |
| Communication changes  |  |   |                                    |
| Change in eating &<br>drinking habits  |  |   |                                    |
| Changes in weight  |  |   |                                    |
| Nausea & vomiting  |  |   |                                    |

| <p align="center"><b>Required Skills<br/>Nurse Aide Training<br/>Program</b></p>   | <p align="center"><b>LAB PRACTICUM<br/>Instructor's<br/>Initial/Date</b></p> | <p align="center"><b>CLINICAL<br/>PRACTICUM<br/>Instructor's<br/>Initial/Date</b></p> | <p align="center"><b>PAGE<br/>NUMBER/RUB<br/>RIC</b></p> |
|--|--|---|--|
| <p>Change in activity participation</p>  |  |   |  |
| <p>Signs of Hypo/Hyperglycemia</p>   |  |   |  |
| <p><b><u>Beginning Procedure:</u></b><br/>           Check care plan;<br/>           Gather equipment;<br/>           Knock;<br/>           Ask visitors to step out;<br/>           Handwashing prior to contact;<br/>           Gloves if necessary;<br/>           State intent;<br/>           Privacy;<br/>           Adjust bed height, and;<br/>           Keep resident informed throughout care procedure</p>   |  |   |  |
| <p><b><u>Ending Procedure:</u></b><br/>           Remove gloves if necessary;<br/>           Handwashing;<br/>           Gloving, if necessary;<br/>           Replace equipment to proper storage;<br/>           Call light within reach;<br/>           Lower bed;<br/>           Ensures comfort;<br/>           Side rails up if used;<br/>           Open<br/>           Curtain/door/window shade;<br/>           Remove gloves if used at the appropriate time;<br/>           Handwashing; Notify visitors, and;<br/>           Record/report</p> |  |   |  |
| <p>Instructor's initials/<br/>signature: _____</p> <p>Instructor's initials/<br/>signature _____</p> <p>Instructor's initials/<br/>signature _____</p>   |  |   |  |

|  |  |   |                                    |
|--|--|---|------------------------------------|
| Student's signature _____                      |  |   |                                    |
| Comments                                       |  |   |                                    |
| <b>ADDITIONAL SKILLS<br/>MAY BE ADDED HERE</b> | <b>LAB PRACTICUM<br/>Instructor's<br/>Initial/Date</b> | <b>CLINICAL<br/>PRACTICUM<br/>Instructor's<br/>Initial/Date</b> | <b>PAGE<br/>NUMBER/RUB<br/>RIC</b> |
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**EACH SPACE MUST BEAR THE INSTRUCTOR'S INITIALS AND MUST BE DATED WHEN THE STUDENT IS ABLE TO PERFORM THE SKILL AT 100%;**  
**Skills must be checked off in the lab and again in the clinical (if applicable);**  
**Some skills will apply to only one area (clinical or lab); if this is the case, please leave the space blank;**  
**Do not use Candidate Handbook Skills as a substitute;**  
**May use the Candidate Handbook Skills at the completion of the program;**  
**All instructors must teach from the approved skill breakdown/rubric or textbook;**  
**IF THE STUDENT DOES NOT PASS SKILLS AT 100% IN THE LAB, THE STUDENT SHOULD NOT BE ALLOWED TO ATTEND THE CLINICAL ROTATION.**

**THE FEDERAL AND STATE CORE CURRICULUM  
NURSE AIDE TRAINING**

**TITLE & EDITION OF TEXTBOOK:** \_\_\_\_\_

**A minimum of 16 hours of training in the following areas prior to any direct contact with a resident - include how many hours are spent on each one of the first six (6) subjects – include the page numbers next to the subject matter where the material can be located in the book for Parts I-VII**

**PART I.**

A. Communication and interpersonal skills **including stress management and chain of command**

\_\_\_\_\_HOURS; \_\_\_\_\_

B. Infection control \_\_\_\_\_HOURS; \_\_\_\_\_

C. Safety/emergency/FBAO/**Body Mechanics** \_\_\_\_\_HOURS; \_\_\_\_\_

D. Promoting residents' independence \_\_\_\_\_HOURS; \_\_\_\_\_

E. Respecting residents' rights \_\_\_\_\_HOURS; \_\_\_\_\_

F. **Legal/ethical behavior and scope of practice** \_\_\_\_\_HOURS. \_\_\_\_\_

TOTAL: \_\_\_\_\_

**PART II.**

**Basic Nursing Skills:**

A. Taking/recording vital signs **and vital sign parameters;** \_\_\_\_\_

B. Measuring and recording height and weight; \_\_\_\_\_

C. Caring for the residents' environment; \_\_\_\_\_

D. Recognizing abnormal changes in body function and the importance of reporting such changes to a supervisor: \_\_\_\_\_

- Shortness of breath; \_\_\_\_\_

- Rapid respiration; \_\_\_\_\_

- Fever; \_\_\_\_\_

- Coughs; \_\_\_\_\_

- Chills; \_\_\_\_\_

- Pains in chest; \_\_\_\_\_

- Blue color to lips; \_\_\_\_\_

- Pain in abdomen; \_\_\_\_\_

- Nausea; \_\_\_\_\_

- Vomiting; \_\_\_\_\_

- Drowsiness; \_\_\_\_\_

- Excessive thirst; \_\_\_\_\_

- Sweating; \_\_\_\_\_

- Pus; \_\_\_\_\_

- Blood or sediment in urine; \_\_\_\_\_

- Difficulty urinating; \_\_\_\_\_

- Frequent urination in small amounts; \_\_\_\_\_

- Pain or burning on urination; \_\_\_\_\_

- Urine has dark color or strong odor; \_\_\_\_\_

- **Behavioral change;** \_\_\_\_\_

- **Talks or communicates less;** \_\_\_\_\_

- **Physical appearance/mental health changes;** \_\_\_\_\_

- **Participated less in activities or refused to attend;** \_\_\_\_\_

- **Eating less;** \_\_\_\_\_

- **Drinking less;** \_\_\_\_\_



**Observation and Reporting continued:**

- **Weight change;** \_\_\_\_\_
- **Appears more agitated/nervous;** \_\_\_\_\_
- **Appears tired, weak, confused or drowsy;** \_\_\_\_\_
- **Change in skin color or condition;** \_\_\_\_\_
- **Requires more assistance with dressing, toileting, transfers;** \_\_\_\_\_

E. **Recognizing and reporting pain to supervisor; and** \_\_\_\_\_

F. **Caring for a resident when death is imminent and post mortem care.** \_\_\_\_\_

**PART III.**

**Personal Care Skills, including but not limited to:**

- A. **Bathing (to include observation for pressure ulcers);** \_\_\_\_\_
- B. **Grooming, including mouth care;** \_\_\_\_\_
- C. **Dressing;** \_\_\_\_\_
- D. **Toileting;** \_\_\_\_\_
- E. **Assisting with eating and hydration;** \_\_\_\_\_
- F. **Proper feeding techniques;** \_\_\_\_\_
- G. **Skin-care to include observation for pressure ulcers and skin tears;** \_\_\_\_\_
- H. **Transfers, positioning and turning (to include observation for pressure ulcers).** \_\_\_\_\_

**PART IV.**

**Mental Health and Social Service Needs:**

- A. **Modifying aide's behavior in response to resident's behavior including depression;** \_\_\_\_\_
- B. **Awareness of development tasks associated with the aging process;** \_\_\_\_\_
- C. **How to respond to resident behavior;** \_\_\_\_\_
- D. **Allowing residents to make personal choices, providing and reinforcing other behavior consistent with the resident's dignity;** \_\_\_\_\_
- E. **Utilizing resident's family as a source of emotional support;** \_\_\_\_\_
- F. **Emotional and mental health needs of the residents;** \_\_\_\_\_
- G. **Spiritual and cultural needs of the residents.** \_\_\_\_\_

**PART V.**

**Care of Cognitively Impaired Residents:**

- A. **Techniques for addressing the unique needs and behaviors of individuals with dementia (Alzheimer's and others);** \_\_\_\_\_
- A. **Communicating with cognitively impaired residents;** \_\_\_\_\_
- B. **Understanding the behavior of cognitively impaired residents;** \_\_\_\_\_
- C. **Appropriate responses to the behavior of cognitively impaired residents;** \_\_\_\_\_
- D. **Methods of reducing the effects of cognitive impairments** \_\_\_\_\_
- E. **Spiritual and cultural health.** \_\_\_\_\_

## **PART VI.**

**Basic Restorative Services – The nurse aide should be able to demonstrate skills which incorporate principles of restorative nursing, including:**

- A. Training the resident in self-care according to the resident's abilities; \_\_\_\_\_
- B. **Ambulation with/without a gait belt;** \_\_\_\_\_
- C. The use of assistive devices in transferring, ambulation, eating and dressing;  
\_\_\_\_\_
- D. Maintenance of range of motion; \_\_\_\_\_
- E. Proper turning and positioning in bed and chair; \_\_\_\_\_
- F. Bowel and bladder training; \_\_\_\_\_
- G. Care and use of prosthetic/orthotic devices and **eyeglasses.** \_\_\_\_\_

## **PART VII.**

**Residents Rights – The nurse aide should be able to demonstrate behavior which maintains residents' right, including but not limited to:**

- A. Providing privacy and maintenance of confidentiality; \_\_\_\_\_
- B. Promoting the residents' right to make personal choices to accommodate their needs; \_\_\_\_\_
- C. Giving assistance in resolving grievances and disputes (**to include the role of the ombudsman**); \_\_\_\_\_
- D. Providing needed assistance in getting to and participating in resident and family groups and other activities; \_\_\_\_\_
- E. Maintaining care and security of resident's personal possessions; \_\_\_\_\_
- F. Providing care which maintains the resident free from abuse, mistreatment and neglect and reporting any instances of such treatment to appropriate facility staff;  
\_\_\_\_\_
- G. Avoiding the need for restraints in accordance with current professional standard;  
\_\_\_\_\_

**References: Code of Federal Regulations, Title 42, Subpart D, Sec. 483.152  
State of Georgia Nurse Aide Training Program Manual**

# EXAMPLE

## THE FEDERAL AND STATE CORE CURRICULUM NURSE AIDE TRAINING

**TITLE & EDITION OF TEXTBOOK: Nursing Assistant. 4<sup>th</sup> ed.**

**A minimum of 16 hours of training in the following areas prior to any direct contact with a resident - include how many hours are spent on each one of the first six (6) subjects – include the page numbers next to the subject matter where the material can be located in the book for Parts I-VII**

### **PART I.**

A. Communication and interpersonal skills **including stress management and chain of command**

\_20-30, 45-55, 250-256 HOURS; 4

B. Infection control 75-85 HOURS; 10

C. Safety/emergency/FBAO/**Body Mechanics** 90-120 HOURS; 10

D. Promoting residents' independence 30-40 HOURS; 2

E. Respecting residents' rights 2-10 HOURS; 3

F. **Legal/ethical behavior and scope of practice** 12-15 HOURS. 2

TOTAL: 31

### **PART II.**

#### **Basic Nursing Skills:**

E. Taking/recording vital signs **and vital sign parameters;** \_\_\_\_\_

F. Measuring and recording height and weight; \_\_\_\_\_

G. Caring for the residents' environment; \_\_\_\_\_

H. Recognizing abnormal changes in body function and the importance of reporting such changes to a supervisor: \_\_\_\_\_

- Shortness of breath; \_\_\_\_\_
- Rapid respiration; \_\_\_\_\_
- Fever; \_\_\_\_\_
- Coughs; \_\_\_\_\_
- Chills; \_\_\_\_\_
- Pains in chest; \_\_\_\_\_
- Blue color to lips; \_\_\_\_\_
- Pain in abdomen; \_\_\_\_\_
- Nausea; \_\_\_\_\_
- Vomiting; \_\_\_\_\_
- Drowsiness; \_\_\_\_\_
- Excessive thirst; \_\_\_\_\_
- Sweating; \_\_\_\_\_
- Pus; \_\_\_\_\_
- Blood or sediment in urine; \_\_\_\_\_
- Difficulty urinating; \_\_\_\_\_
- Frequent urination in small amounts; \_\_\_\_\_
- Pain or burning on urination; \_\_\_\_\_
- Urine has dark color or strong odor; \_\_\_\_\_
- **Behavioral change;** \_\_\_\_\_
- **Talks or communicates less;** \_\_\_\_\_
- **Physical appearance/mental health changes;** \_\_\_\_\_

- Participated less in activities or refused to attend; \_\_\_\_\_
- Eating less; \_\_\_\_\_
- Drinking less. \_\_\_\_\_

**Observation and Reporting continued:**

- Weight change; \_\_\_\_\_
- Appears more agitated/nervous; \_\_\_\_\_
- Appears tired, weak, confused or drowsy; \_\_\_\_\_
- Change in skin color or condition; \_\_\_\_\_
- Requires more assistance with dressing, toileting, transfers; \_\_\_\_\_

E. Recognizing and reporting pain to supervisor; and \_\_\_\_\_

F. Caring for a resident when death is imminent and post mortem care. \_\_\_\_\_

**PART III.**

**Personal Care Skills, including but not limited to:**

- I. Bathing (to include observation for pressure ulcers); \_\_\_\_\_
- J. Grooming, including mouth care; \_\_\_\_\_
- K. Dressing; \_\_\_\_\_
- L. Toileting; \_\_\_\_\_
- M. Assisting with eating and hydration; \_\_\_\_\_
- N. Proper feeding techniques; \_\_\_\_\_
- O. Skin-care to include **observation for pressure ulcers and skin tears**; \_\_\_\_\_
- P. Transfers, positioning and turning (to include observation for pressure ulcers). \_\_\_\_\_

**PART IV.**

**Mental Health and Social Service Needs:**

- H. Modifying aide's behavior in response to resident's behavior **including depression**; \_\_\_\_\_
- I. Awareness of development tasks associated with the aging process; \_\_\_\_\_
- J. How to respond to resident behavior; \_\_\_\_\_
- K. Allowing residents to make personal choices, providing and reinforcing other behavior consistent with the resident's dignity; \_\_\_\_\_
- L. Utilizing resident's family as a source of emotional support; \_\_\_\_\_
- M. **Emotional and mental health needs of the residents**; \_\_\_\_\_
- N. **Spiritual and cultural needs of the residents**. \_\_\_\_\_

**PART V.**

**Care of Cognitively Impaired Residents:**

- B. Techniques for addressing the unique needs and behaviors of individuals with dementia (Alzheimer's and others); \_\_\_\_\_
- F. Communicating with cognitively impaired residents; \_\_\_\_\_
- G. Understanding the behavior of cognitively impaired residents; \_\_\_\_\_
- H. Appropriate responses to the behavior of cognitively impaired residents; \_\_\_\_\_
- I. Methods of reducing the effects of cognitive impairments \_\_\_\_\_
- J. **Spiritual and cultural health**. \_\_\_\_\_

**PART VI.**

**Basic Restorative Services – The nurse aide should be able to demonstrate skills which incorporate principles of restorative nursing, including:**

- H. Training the resident in self-care according to the resident's abilities; \_\_\_\_\_
- I. **Ambulation with/without a gait belt**; \_\_\_\_\_

- J. The use of assistive devices in transferring, ambulation, eating and dressing; \_\_\_\_\_
- K. Maintenance of range of motion; \_\_\_\_\_
- L. Proper turning and positioning in bed and chair; \_\_\_\_\_
- M. Bowel and bladder training; \_\_\_\_\_
- N. Care and use of prosthetic/orthotic devices and **eyeglasses**. \_\_\_\_\_

**PART VII.**

**Residents Rights – The nurse aide should be able to demonstrate behavior which maintains residents’ right, including but not limited to:**

- H. Providing privacy and maintenance of confidentiality; \_\_\_\_\_
- I. Promoting the residents’ right to make personal choices to accommodate their needs; \_\_\_\_\_
- J. Giving assistance in resolving grievances and disputes (**to include the role of the ombudsman**); \_\_\_\_\_
- K. Providing needed assistance in getting to and participating in resident and family groups and other activities; \_\_\_\_\_
- L. Maintaining care and security of resident’s personal possessions; \_\_\_\_\_
- M. Providing care which maintains the resident free from abuse, mistreatment and neglect and reporting any instances of such treatment to appropriate facility staff; \_\_\_\_\_
- N. Avoiding the need for restraints in accordance with current professional standard; \_\_\_\_\_

**References: Code of Federal Regulations, Title 42, Subpart D, Sec. 483.152  
State of Georgia Nurse Aide Training Program Manual**



## LESSON PLAN

**TEXTBOOKS:**

| <b>DAILY LESSON<br/>PLAN – DAY</b>               | <b>OBJECTIVES</b> | <b>CONTENT</b> | <b>METHODS<br/>AND<br/>MATERIALS</b> | <b>EVALUATION<br/>METHOD</b> | <b>TEST QUESTION(s)</b> |
|--|-------------------|----------------|--------------------------------------|------------------------------|-------------------------|
| <p>Total Hours:<br/>Class/lab:<br/>Clinical:</p> |                   |                |                                      |                              |                         |

## LESSON PLAN

| <b>DAILY SCHEDULE<br/>– DAY #</b>  | <b>OBJECTIVES</b><br><br><b>Use measurable verbs</b>   | <b>CONTENT</b>   | <b>METHODS AND<br/>MATERIALS</b>  | <b>EVALUATION<br/>METHOD</b>   | <b>TEST<br/>QUESTION</b>   |
|--|--|--|---|--|--|
| <p>Page number(s) in book - author's name if using two books</p> <p>Allotted time for objective</p> <p>Be flexible with allotted time for audience addressing<br/>May need more or less time - this is more for you to figure your total hours in order to meet the mandatory 85 hours</p> <p>Total Hours:<br/>Classroom/lab____<br/>Clinical_____</p> | <p>Cognitive - recall and/or comprehension (define, list, explain, identify and describe)</p> <p>Affective - feeling, emotion and/or value (discuss, observe, participate, identify and relate)</p> <p>Psychomotor - doing such as in return demonstration, group activities, writing personal stories and role play (demonstrate, describe, identify, develop, explain, differentiate, prepare, design, organize and record)</p> <p>Berry, L. 2002. From nurse to educator: creating effective learning experiences for adults. Albuquerque:Hartman</p> | <p>What will be used to support the objective - should be no more than a couple of words</p> | <p>Appeal to Visual, Auditory and Kinesthetic learning abilities</p> <p>Interactive lecture ( includes Qs &amp; As)</p> <p>Role play</p> <p>Case study</p> <p>Group activities such as nail care, pot luck or baby food for feeding</p> <p>Video (with title and publisher)</p> <p>Guest speaker</p> <p>Games such as Jeopardy, Family Feud, Medical terminology bingo with Dollar store rewards</p> <p>Websites</p> <p>Instructor demo</p> <p>Writing personal stories</p> <p>Workbook</p> | <p>Class participation</p> <p>Return demonstration</p> <p>Quiz</p> <p>Test</p> | <p>Cognitive - example of recall or comprehension<br/>what does ___ mean?</p> <p>Affective - <u>Situation</u> that evokes personal feeling, emotion or value</p> |



## LESSON PLAN - EXAMPLE

Textbook: TITLE, EDITION, AUTHOR,

H/O=handout H/W=homework

| DAY 1   | OBJECTIVES  | CONTENT   | METHODS AND MATERIALS   | EVAL        | TEST QUESTION   |
|---|---|---|---|-------------|---|
| pp 3-10, 18-25, 36, 37, 49<br><br>9-10<br>10-10:15 break<br>10:15-10:30<br><br>10:30 - 11:30<br><br>11:30 - 12<br>lunch<br><br>12 - 1:30<br><br>Hours: 3.75 | <p><b>Define the role of a CNA in healthcare</b><br/>           (Rationale: is this position for me (student)? - provides a basic overview of the expectations &amp; career placement opportunities for a CNA)</p> <p><b>Identify opportunities in healthcare</b></p> <p><b>Define the role of the healthcare team</b></p> <p><b>Identify expectations following completion of the NATP</b></p> | <p>Interpersonal skills</p> <p>The art of caring<br/>           Challenges/rewards<br/>           Stress management<br/>           Work ethics in healthcare</p> <p>Scope of practice</p> <p>Career ladder</p> <p>Job opportunities</p> <p>Members of the healthcare team and their role</p> <p>Review competency requirements</p> <p>Nurse aide registry (NAR)</p> | <p>Interactive lecture - 15 minute intervals with class discussion Q &amp; A - Guest speaker - CNA from medical center (<b>30 minutes</b>)<br/>           Q &amp; A - discussion</p> <p>H/O-job description from medical center attached - discuss</p> <p>Overhead - career ladder</p> <p>Overhead - jobs for CNA from a variety of healthcare facilities taken from newspaper - discuss<br/>           H/O discuss - H/W - team members and description - attached - due day 2</p> <p>Q &amp; A - discussion<br/>           H/O - GHP website attached - discuss responsibilities of CNA &amp; the NAR<br/>           H/W: paper due day 2 - "My Goals in Healthcare"<br/>           paper due day 3 - "A Stressful Situation"</p> | <p>quiz</p> | <p>List 4 interpersonal skills a CNA should possess:<br/> <b>1.compassion/empathy</b><br/> <b>2.enjoy people</b><br/> <b>3.art of caring</b><br/> <b>4.good stress mgmt</b></p> <p><u>T/F</u> - the CNA administers medication in the absence of the nurse.</p> <p><u>T/F</u> - all CNAs in the State of Georgia must have current certification to be on the Nurse Aide Registry (NAR) in order to work in a healthcare facility.</p> <p>List the telephone number to the NAR.<br/> <b><u>678-527-3010</u></b><br/> <b><u>option 4</u></b></p> <p>If the CNA does not have a computer where could one go to access the use <b><u>LIBRARY</u></b></p> |

Date \_\_\_\_\_

Name of Long-Term Care Facility \_\_\_\_\_

Long-Term Care Facility Employee Verification Signature \_\_\_\_\_

Name of Nurse Aide Training Program \_\_\_\_\_

**\*Please make sure all instructors and students sign this form upon entering and leaving the facility.\***

| <u>Print Name of Student</u> | <u>Signature of Student</u> | <u>Time of ARRIVAL</u> | <u>Time of DEPARTURE</u> |
|------------------------------|-----------------------------|------------------------|--------------------------|
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| <u>Print Name of Instructor</u> | <u>Signature of Instructor</u> | <u>Time of Arrival</u> | <u>Time of Departure</u> |
|---------------------------------|--------------------------------|------------------------|--------------------------|
|                                 |                                |                        |                          |
|                                 |                                |                        |                          |

# NURSE AIDE TRAINING PROGRAM EVALUATION

Please complete this evaluation after you have completed the Nurse Aide Training Program:

**Return to: ALLIANT HEALTH SOLUTIONS  
NURSE AIDE TRAINING PROGRAM  
P. O. Box 105753  
Atlanta, Georgia 30348**

Name of Nurse Aide Training School/Facility \_\_\_\_\_

Student's Name: \_\_\_\_\_

Student's E-mail Address: \_\_\_\_\_

Student's Phone Number (Optional): \_\_\_\_\_

- How many hours per day did you attend class - did you feel that the amount of hours were adequate for your learning needs? Hours: \_\_\_\_\_ YES  or NO
- What time did the classroom hours begin and end? Begin \_\_\_\_\_ End \_\_\_\_\_
- How many hours did you attend clinical? Hours: \_\_\_\_\_
- Did the instructor portray a professional mannerism? YES  or NO   
Comments \_\_\_\_\_
- Was the instructor knowledgeable on nurse aide training? YES  or NO   
Comments \_\_\_\_\_
- Was the instructor on time for classes and clinical rotation? YES  or NO   
Comments \_\_\_\_\_
- What was the name of your primary nurse aide training instructor?  
\_\_\_\_\_
- Did you have the same instructor throughout the class? If not list each instructor. If not a RN/LPN, what was the instructor's title? YES  or NO   
Comments \_\_\_\_\_
- Are you comfortable taking care of residents of a long-term care facility based on the classroom/lab and clinical training you received? YES  or NO   
Comments \_\_\_\_\_
- Was time allotted for the skills to be checked off with 100% accuracy in the lab portion of your training prior to clinical rotation? YES  or NO   
Comments \_\_\_\_\_
- 
- Was the clinical rotation long enough for you to feel comfortable in caring for residents of a long-term care facility? YES  or NO

Comments \_\_\_\_\_

- Was the instructor with you at all times during your clinical rotation? YES  or NO

Comments \_\_\_\_\_

- Was there time allowed for questions to be answered? YES  or NO

Comments \_\_\_\_\_

- Do you feel you received a quality education? YES  or NO

Comments \_\_\_\_\_

- Would you recommend this Nurse Aide Training Program to a friend? YES  or NO

Comments \_\_\_\_\_

- Did you perform vital signs (temperature, pulse, respiration and blood pressure) in the classroom and during clinical rotation? YES  or NO

Comments \_\_\_\_\_

- Do you feel confident performing vital signs accurately? YES  or NO

Comments \_\_\_\_\_

- If necessary, can your identity be revealed to the program? YES  or NO

Comments \_\_\_\_\_

Additional Comments are welcomed: \_\_\_\_\_

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Please use another sheet of paper if additional space is needed.

## Georgia Nurse Aide Training Program Completion Certificate

- All the information on the attached completion certificate must be present on the program's certificate.
- Each nurse aide candidate must receive a **training program completion certificate after successfully completing all approved curriculum and nurse aide training program hours.**
- The certificate **must** be notarized. The instructor or program coordinator **cannot** notarize the certificate for students taught under their instructional training.
- The notary should use an ink stamp so the certificate can be copied. A copy is required with the testing application for the competency exam.
- The student's name must be printed at the top of the certificate; this is the individual that completed the nurse aide training program course.
- The approved faculty member name must go on the bottom of the certificate, this is the program faculty member validating before the Notary and had the certificates signed. **The student's name cannot be listed in the Notary section.**
- You can put the information on the attached certificate on certificate paper with a program seal, if desired.

# Georgia Nurse Aide Training

*This is to certify that*

\_\_\_\_\_  
(please print)

*has successfully completed* \_\_\_\_\_ *at*

*Number of Hours*

*a Georgia State-approved Nurse Aide Training Program at*

\_\_\_\_\_  
Name of Program (please print)

\_\_\_\_\_  
Program Number

*on the* \_\_\_\_\_ *day of* \_\_\_\_\_, 20\_\_\_\_.

Certified by:

\_\_\_\_\_  
Signature of Approved Faculty

\_\_\_\_\_  
Print Name of Approved Faculty

Notary Public

Georgia

\_\_\_\_\_ County

I, \_\_\_\_\_, a

Notary Public for said County and State, do hereby certify that

\_\_\_\_\_  
personally appeared before me on this day and acknowledged  
the due execution of the foregoing instrument.

Witness my hand and official seal, on the \_\_\_\_ day of \_\_\_\_\_, 20\_\_\_\_.

Notary Public (Signature)

My Commission Expires

. 20 \_\_\_\_ .

NOTE: This certificate does not guarantee that the above mentioned student will be listed by the Georgia Nurse Aide Registry. The student must successfully pass both portions of the National Nurse Aide Assessment Program (NNAAP) examination to be eligible for placement on the Georgia Nurse Aide Registry.

**IMPORTANT INFORMATION**  
**CERTIFIED NURSE AIDE**  
**FINDINGS OF ABUSE, NEGLIGENCE, OR MISAPPROPRIATION OF PROPERTY**

The Nurse Aide Registry (NAR) includes information from Healthcare Facility Regulations regarding allegations of resident abuse, neglect or misappropriation of property made against a Certified Nurse Aide (CNA). Presently all allegations of resident abuse, neglect or misappropriation of property made against a CNA by Healthcare Facility Regulations are attached to the CNA's name on the NAR. A CNA is not allowed to work in a nursing home and/or in other healthcare facilities if the allegation is found to be true. The allegation then becomes a **PERMANENT** restriction against the CNA and imposes a non-active status on the NAR.

Generally, initial complaints are reported to Healthcare Facility Regulations by peers, supervisors, administrators, residents, resident family members or other facility workers. The Nursing Home Administrator and/or the Director of Nursing **MUST** report any allegations of resident abuse, neglect or misappropriation of property to Healthcare Facility Regulations.

**Prior to allegation placement on the NAR:**

- Healthcare Facility Regulations receives all complaints of the occurrence(s) of resident abuse, neglect or misappropriation of property;
- determines if the CNA will receive written Notice of Intent in regards to the allegation of resident abuse, neglect or misappropriation of property; and
- places the attachment of allegation(s) to the CNA's name on the NAR

**Important Information to Remember:**

- CNA will receive written notice from Healthcare Facility Regulations if an allegation is found to be true ;
- the CNA will have thirty (30) days to appeal the Notice of Intent letter by requesting a hearing;
- failure to respond to the Notice will result in placement of the allegation on the NAR ;
- the CNA is responsible to inform state offices of current telephone number, mailing address and/or name change ;
- if Healthcare Facility Regulations sends the Notice of Intent letter to the last known address and the CNA does not receive the letter the allegation will be placed on the NAR;
- a CNA is not allowed to appeal the decision after a period of thirty (30) days;
- a CNA may continue to work pending a decision of the appeal;
- to determine the decision a hearing will be held by an Administrative Law Judge
- if the judge finds that the CNA has indeed committed resident abuse, neglect, or misappropriation of property, the allegation is immediately placed on the NAR on the CNA's record;
- following the confirmation of resident abuse, neglect or misappropriation of property the occurrence becomes public information;
- an allegation remains on the NAR indefinitely and prevents the CNA from further employment in a Medicaid/Medicare nursing home and/or other healthcare facilities; and
- the CNA will be denied certification renewal once an confirmed allegation has been placed on the NAR

Please share this information with CNAs. All questions and/or occurrences to report regarding allegations of resident abuse, neglect or misappropriation of property against a CNA should be directed to Healthcare Facility Regulations at **404-657-5850 or 1-800-878-6442.**