FISCAL 2021-2022

NOT FORGOTTEN
Home & Community Services
Uniqueness | Inclusion |Opportunity

POLICY & PROCEDURES MANUAL

STAFF VERSION

Revised September 2021

ABOUT THIS MANUAL/DISCLAIMER

This Policy & Procedure Manual is designed to inform you about the history, the policies, the activities, and the services of Not Forgotten Home & Community Services and its departments. We prepared this manual to help employees find the answers to many questions that they may have regarding their employment with Not Forgotten Home & Community Services. Please take the necessary time to read it.

We do not expect this manual to answer all questions. However, Supervisors and Human Resources also serve as a major source of information.

Neither this manual nor any other verbal or written communication by a management representative is, nor should it be considered to be, an agreement, contract of employment, express or implied, or a promise of treatment in any particular manner in any given situation, nor does it confer any contractual rights whatsoever. Not Forgotten Home & Community Services adheres to the policy of employment at will, which permits the Not Forgotten Home & Community Services or the employee to end the employment relationship at any time, for any reason, with or without cause or notice.

This manual provides both the agency and governmental regulatory guidelines. Not Forgotten Home & Community Services adheres to these strict guidelines, by updating the manual with new/updated information. Not Forgotten Home & Community Services may, at any time, in its sole discretion, modify or vary from anything stated in this manual, with or without notice, except for the rights of the parties to end employment at will, which may only be modified by an express written agreement signed by the employee and the Executive Director and Director of Administration.

This manual supersedes all prior manuals.

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Section 1 – Governance

1.1 Welcome from the Executive Director

Welcome to Not Forgotten Home & Community Services! We are happy to have you as a new member of our family!

This document has been developed in order to familiarize Staff with Not Forgotten Home & Community Services (NFHCS) and provide information about working conditions, key policies, and procedures, affecting employment at NFHCS.

We are confident that you will find Not Forgotten Home & Community Services to be a dynamic and rewarding place to work and we look forward to a productive and successful association. We consider the employees of Not Forgotten Home & Community Services to be its most valuable resource. Our manual has been written to serve as a guide for both our employer/employee relationship and comply with all regulations.

There are several things to keep in mind about this manual. First, it contains regulatory information and guidelines. Our manual is comprehensive to address all the possible applications of, or exceptions to, the general policies and procedures described. For that reason, if you have any questions concerning applicability of a policy or practice to you, please address your specific questions to your supervisor who will direct you to our Human Resource support team.

Again, welcome to Not Forgotten Home & Community Services, we are very pleased that you are joining us.

Sonja Garnett-Williams

Sonja Garnett-Williams, Executive Director

1.2 Non-Discrimination

Implemented: December 2015 **Revised:** October 2018

References/Source: Department of Health & Human Services, Civil Rights Compliance for Providers.

Persons Affected: Individuals, Families, Board members, Staffs, Contractors, and un-paid volunteers of Not Forgotten Home & Community Services.

Our Purpose: Our purpose is to inform the affected of Not Forgotten Home & Community Services, of our non-discrimination policy.

Definitions:

- **NFHCS**: Not Forgotten Home & Community Services
- **DHS**: The Department of Human Services of the Commonwealth.

Policy Objectives:

- Ensuring employment in a nondiscrimination manner
- Policy statements & EEO
- Board Members
- Reporting Guidance

Statement of Policy: NHFCS is required to ensure our employment practices are conducted in a nondiscriminatory manner, without regard to an individual's race, color, sex, age, religious creed, national origin, disability, ancestry, sexual orientation, or gender identity.

In addition, NFHCS is required to maintain non-discrimination in our services without regard to an individual's race, color, sex, age, religious creed, national origin (including limited English proficiency), ancestry, disability, sexual orientation, or gender identity.

To ensure that NFHCS and other facilities licensed by the Department of Human Services (DHS) operate in compliance with state and federal civil rights laws and regulations, all licensed providers (NFHCS) must complete an annual Civil Rights Compliance Questionnaire as part of our licensing and our renewal process.

NFHCS must have and maintain a current Equal Employment Opportunity and Nondiscrimination in Services policy statements. Please see appendix 1 of this Policy

Procedures:

- NFHCS is required to develop a nondiscrimination in service policy statement and a nondiscrimination in employment policy statement, signed by the responsible official, (Our Executive Director), which advises Our Individual's / Parents/Guardians, the public and our Staff that services and employment are provided in a nondiscriminatory manner, without regard to race, sex, color, national origin (address issue of Limited English Proficiency, in the service policy only), ancestry, religious creed, disability, and age.
- Our policies must be distributed to our Individuals /Parents/Guardians, the General Public, and our Staff via publications and/or internal Meetings:
    - Staff/Individual Orientation
    - Staff Meetings/Conferences
    - Language Card
    - Written Announcements
    - Interpreter Services
    - Postings (housed in specific locations)
    - Sign Language
- If NFHCS serves non-English speaking Individual(s) we must have a method to communicate with them. (Translator)
- When NFHCS advertises our services and employment opportunities to the public, we must include a nondiscrimination clause in our brochures, media notices and/or posters, and websites.
- Individual's/ Parents/Guardians must be informed that complaints of discrimination may be filed with the U.S. Department of Health and Human Services' Office of Civil Rights, (OCR) the DHS Bureau of Equal Opportunity (BEO) and/or the Pennsylvania Human Relations Commission (PHRC).
- NFHCS must provide information to all staff regarding their rights to file complaints of employment discrimination based on Title VII of the Civil Rights Act of 1964, Section 504 of the Rehabilitation Act of 1973, and the Age Discrimination Act of 1975, and/or the Pennsylvania Human Relations Act of 1955, as amended with the PHRC or Equal Employment Opportunity Commission (EEOC).
- NFHCS restrooms, and access to our kitchen facilities (located at the home office location) (e.g., human needs facilities) are accessible to our Individuals/Parents/Guardians and our Staff.
- NFHCS must ensure all minorities, persons with disabilities or with Limited English Proficiency are properly integrated into our programs and activities.

- NFHCS must have methods employed to make services accessible to those who may have mobility or sensory impairments.
- NFHCS nondiscrimination policy states that a reasonable accommodation will be provided for our Staff/and Individual's with a disability (e.g., hearing, speech, vision, mobility impairments)?

Governing Board:

- NFHCS must have a policy and/ or criterion used to select our board members.
- Each Board Member must review and sign our Non-Discrimination statement (informs the board of our Civil Rights compliance requirements).

Appendix 1: **NFHCS NON- Discrimination Statement for Staff & Board Members**

Staff Name: _____

Date: _____

Board Member Name: _____

From: Executive Director: Sonja Garnett- Williams
Executive Directors Signature: _____

Subject: Nondiscrimination Policy Statement

Equal Employment Opportunity: NFHCS has an equitable personnel system, which has been established and maintained. Personnel policies, procedures and practices has been designed to prohibit discrimination on the basis of race, color, sex, age, religious creed, national origin, disability, ancestry, sexual orientation, or gender identity.

Employment opportunities will be provided for applicants with disabilities and reasonable accommodation(s) will be made to meet the physical and/or mental limitations of qualified applicants and / or Staff.

Any Staff of NFHCS who believes they have been discriminated against may file a complaint of discrimination with any of the following.

Our Office: Not Forgotten Home & Community Services, 101 West Main Street, Carnegie, PA 15106

Phone: 412/279-5000 Email: sgwilliams@nfhcs.org

Commonwealth of Pennsylvania
Department of Human Services
Bureau of Equal Opportunity
Room 225, Health & Welfare Building
P.O. Box 2675
Harrisburg, PA 17110

PA Human Relation Commission
Pittsburgh Regional Office
301 Fifth Avenue
Suite 390, Piatt Place
Pittsburgh, PA 15222

Commonwealth of Pennsylvania
Department of Human Services
Bureau of Equal Opportunity
Western Regional Office
301 Fifth Avenue
Suite 410, Piatt Place
Pittsburgh, PA 15222

US Department of Health and Human Services
Office for Civil Rights
Suite 372, Public Ledger Building
150 South Independence Mall West
Philadelphia, PA 19106-1911

Appendix 2 **NFHCS NON- Discrimination Statement for Individuals/Families/ Guardians**

To: _____ Date: _____

From: Executive Director: Sonja Garnett- Williams

Executive Directors Signature: _____

Subject: **Nondiscrimination in Service Policy Statement**

Admissions, the provisions of services and referrals of Individuals shall be made without regards race, color, sex, age, religious creed, national origin, disability, ancestry, sexual orientation, or gender identity.

NFHCS program services are made accessible to eligible persons with disabilities through the most practical & economically feasible methods available. These methods include, **but not limited to:**

- Equipment redesign
- The provision of aids and the use of alternative service delivery location.
- Structural modifications will be considered only as a last resort among methods.

Any Individual/ Family or Guardian who believes they have been discriminated against, may file a complaint with:

Staff Resources:
Western Region:
Dr. Teresa R. Randleman, Regional Manager
Commonwealth of Pennsylvania
DHS - BEO Western Regional Office
301 Fifth Avenue
Suite 410, Piatt Place
Pittsburgh, PA 15222-1210
Phone: 412-565-7607
trandleman@pa.gov

Our Office: Not Forgotten Home & Community Services, 101 West Main Street, Carnegie, PA 15106 Phone: 412/279/5000 Email: sgwilliams@nfhcs.org

Commonwealth of Pennsylvania
Department of Human Services
Bureau of Equal Opportunity
Room 225, Health & Welfare Building
P.O. Box 2675
Harrisburg, PA 17110

PA Human Relation Commission
Pittsburgh Regional Office
301 Fifth Avenue
Suite 390, Piatt Place
Pittsburgh, PA 15222

Commonwealth of Pennsylvania
Department of Human Services
Bureau of Equal Opportunity
Western Regional Office
301 Fifth Avenue
Suite 410, Piatt Place
Pittsburgh, PA 15222

US Department of Health and Human Services
Office for Civil Rights
Suite 372, Public Ledger Building
150 South Independence Mall West
Philadelphia, PA 19106-1911

1.3 ODP Mission & Vision

Implemented: December 2015 **Revised:**

ODP Mission: The mission of the Office of Developmental Programs (ODP) is to support Pennsylvanians with developmental disabilities to achieve greater independence, choice, and opportunity in their lives.

ODP Vision: The vision of the Office of Developmental Program (ODP) is to continuously improve an effective system of accessible services and supports that are flexible, innovative, and person-centered.

1.4 Records Management

Implemented: December 2015 **Revised:** August 2019

Reference/Source: Pa Code Chapter 51.15 Provider Records

Persons Affected: Individuals and Staff of Not Forgotten Home & Community Services.

Our Purpose: Our purpose is to inform the affected of Not Forgotten Home & Community Services, of our written policy for retention and access to records in compliance with 55 Pa. Code Chapter 51 regulations.

Definitions:

- **NFHCS**- Not Forgotten Home & Community Services
- **Department**: The Department of Health & Human Services of the Commonwealth
- **ED**- Executive Director
- **AE**- Administrative Entity
- **SC**- Support Coordinator
- **ODP**- Office of Developmental Programs
- **DHS**- Department of Health and Human Service (including the US Department of Health & Human Service).
- **ISP**- Individual Support Plan
- **HCBS** – Home and Community Based Service

Policy/ Procedures Objectives:

- Establish NFHCS policy and procedures regarding records management, to ensure all the requirements are met pursuit to Chapter 51.15 Records Management.
- Record Keeping: Responsible party, oversight, inactivation of accounts.

Our Policy Requirements: NFHCS will document that the HCBS for which we claim payment. Were provided to the individual and that information submitted in support of the payment will be:

- Complete
- Accurate
- True

NFHCS will preserve all records verifying our compliance with Chapter 51 for a minimum of 5 years. After the waiver service is provided, unless otherwise specified.

NFHCS will keep all individual records confidential and secure. In addition to the restriction of use or disclosure of information for the purposes directly related to the information of the ISP.

Availability & Accessibility of Records: NFHCS will not make individual's records accessible to anyone without the written consent of the individual, the person holding the individual's power of attorney for healthcare or healthcare proxy, or if a court orders disclosure other than the following:

- The individual
- NFHCS staff for the purpose of providing HCBS to the individual
- The Department or the Department's designee
- An entity that is permitted to access records under law
- Support Coordinator, AE, and ODP

NFHCS will provide all records, as requested, to the Department regarding HCBS delivered, and payments received for HCBS.

NFHCS may use electronic record documentation under the following conditions. Parameters:

- The electronic record must be readable
- The electronic format conforms to the requirements of Federal and State laws
- The medium used to produce the electronic record accurately reproduces the paper(s) original records
- The medium used is not subject to subsequent deletion, change or manipulation
- The electronic record constitutes a duplicate or substitute copy of the original paper record and has not been altered. Or, if altered, shows the original and altered versions, dates of creation and creator.
- The electronic record can be converted back into legible paper copies and assessed by an auditing agency.

NFHCS MUST have a back-up system for electronic records:

- NFHCS has placed this records management policy in accordance with Chapter 51.
- NFHCS is required to document in the individual's record when the individual voluntarily chooses to use the individual's personal funds to purchase items and a description of the item purchased in accordance with the ISP.

- NFHCS may use technology that allows our staff to submit progress notes as required throughout a work shift.

Updated: Record Keeping Responsibilities

- The Executive Director has full access and overall decision-making oversight regarding third party systems. These including but not limited to; (Paycor, Quick Mar, IT Systems, Relias, HCSIS).
- The primary responsibility to ensure overall compliance with authorization of the aforementioned systems will be the ED. No staff will have exclusive oversight into these systems.
- Designees can be assigned as a "Back- Up." This will consist of appointed Executive Level Management Personnel. The "Back-Up" staff will not have full access to the system. However, will be able to utilize the system to conduct their job responsibilities.
- Terminated Staff who have access to the NFHCS systems. HR or Supervisor will immediately notify ED as well departments heads. ED and department heads will immediately make the moves to remove the former Staff from all systems. The former Staff will be shut out from any system immediately upon notifications of termination to insure NFHCS records are not jeopardized.

All Staff files, training binders and any information requested must be reviewed at 101 W Main Street, Carnegie Pa 15106 and a sign in/sign out sheet will be completed.

- Please request file to be reviewed with Human Resources.
- Please use the sign in and sign out sheet when reviewing the information. This will be found at the front desk at 39 W. Main Street Carnegie, PA 15106.
- Staff files, binders and training information will not be permitted to leave 39 W Main Street, Carnegie PA 15106.
- When requesting copies of information from a Staff record or a training binder, please request that with Human Resources.

Chapter 51.15 Provider Records:
https://www.pacode.com/secure/data/055/chapter51/chap51toc.html#51.15.

1.5 Grievance Procedures to Document, Respond and Resolve Grievances

Implemented: December 2015 **Revised:**

Background: The grievance policy is established to define: 55 Pa. Code § 51.26.

Not Forgotten Home & Community Services (NFHCS) will have written grievance procedures for individuals, individual's families, advocates, and staff persons that assure investigation and resolution of complaints.

Complaints: Dissatisfaction with any aspect of program operations, activities, or services received or not received involving Home and Community-Based Services are considered complaints. All complaints should be directed to an individual's Service Coordinator, caregiver and/or the supervisor of this Staff. When issues are not able be resolved or an individual is not comfortable discussing with their Service Coordinator, caregiver, or supervisor, the OLTL Quality Assurance Helpline is available at (800) 757-5042. Concerns or complaints about services should not be reported as incidents.

Incidents: In the course of provision of home and community-based services, an incident is related to the following and is considered reportable:

- **Death, Injury, or Hospitalization** – any incident that occurred as a result of the provision of Home and Community Based Services or lack of provision of documented services.
- **Provider and Staff Misconduct** – deliberate, willful unlawful or dishonest activities related to the provision of Home and Community- Based Services.
- **Abuse** – the infliction of injury, unreasonable confinement, intimidation, punishment, mental anguish, sexual abuse, or exploitation on an individual.

Types of Abuse include (but are not necessarily limited to):

- **Physical abuse** (a physical act by an individual that may cause physical injury to an individual).
- **Psychological abuse** (an act, other than verbal, that may inflict emotional harm, invoke fear and/or humiliate, intimidate, degrade, or demean an individual).
- **Sexual abuse** (an act or attempted act such as rape, incest, sexual molestation, sexual exploitation, or sexual harassment and/or inappropriate or unwanted touching on an individual); and,

Verbal Abuse (using words to threaten, coerce, intimidate, degrade, demean, harass, or humiliate an individual):

- **Exploitation** - an act of depriving, defrauding or otherwise obtaining the personal property of an individual in an unjust or cruel manner, against one's will, or without one's consent or knowledge for the benefit of self or others.
- **Neglect** - The failure to provide goods or services essential to avoid a clear and serious threat to the physical or mental health of an individual.
- **Service interruption** - Any event that results in temporary or permanent service interruption or termination by the provider NFHCS or staff that may place the home and community-based service individual at risk. In the event of temporary or permanent service interruption or termination, the provider NFHCS must have a plan for temporary stabilization.

Mandatory Reporting: It is mandatory that administrators and Staff of direct care agencies and facilities report incidents related to individuals who receive home and community-based services and supports in, or from the NFHCS or facility.

Individual Autonomy: In order to protect an individual's autonomy and possible safety from an alleged perpetrator, reports of alleged incidents under the individual-employer model should only be made with the consent of the individual. Individuals in any service model have the right to report alleged incidents at any time. Individuals are encouraged to report incidents because failure to do so may put them at risk. However, Individuals are not compelled to report, and no adverse consequences from OLTL, will result from an individual's decision not to report. Individuals shall not be terminated or threatened with the loss of services because they file complaints or incident reports of any kind. Further guidance is provided below on the documentation and reporting of incidents to OLTL. Failure to comply with this directive will result in remediation activities by OLTL.

As indicated in the Title 55 – Department of Public Welfare [55PA.Code Ch. 51] Office of Developmental Programs Home and Community-Based Services, section 51.26 it states: (a) a provider shall develop grievance procedures to document, respond and resolve grievances; (b) a provider shall provide a copy of its grievance procedures to the Department or the Department's designee upon request; (c) a provider shall review and document all grievance information; (d) a

provider shall review its grievance procedures at least annually to determine the number of grievances and their disposition.

In an ongoing effort to ensure quality of service and safeguard individual's rights, the IDD Department at NFHCS, shall maintain a Grievance Procedure whereby an individual/family can seek and secure a remedy when he or she believes that a circumstance or action has adversely affected them.

This grievance procedure is neither a pre-requisite, nor a substitute for a fair hearing through the Bureau of Hearings and Appeals (BHA) for waiver recipients or someone denied the right to apply for a waiver. For non-waiver recipients, disputes can be heard in accordance with local agency (County/Administrative Entity) policy following 55 PA. Code Chapter 4300 regulations. Reviewers will review the provider's grievance procedures. The procedures should include the following:

- Processes to resolve a grievance within 21 days.
- Instructions for individuals and their families regarding grievance procedures, including how to seek help in filing a grievance.
- Process to review, document and resolve each grievance including name, nature, date, actions to resolve resolution and date resolved.
- Process to review procedures annually to determine number of grievances and their disposition.

Compliance is indicated when a provider has grievance procedures that meet **all** criteria above.

Procedure

Administrative Responsibility: The overall responsibility of the grievance process shall be vested by the Incident Manager at 412.956.9633.

General Provisions: The following guidelines shall apply in all grievances:

- An aggrieved individual/family may be accompanied and assisted by a representative of his or her choice at any step in the formal grievance procedure.
- All documents, communications, memoranda, and other pertinent information related to each grievance shall be maintained in a separate file developed for that purpose; such file to be maintained with the IDD Director.

- A formal review of all grievances will be completed annually by the IDD Program Director as part of the SCO Quality Management Strategy. A report will be generated and maintained to include the number of grievances and their disposition.
- All meetings or conferences pertaining to the formal grievance shall be conducted in private and shall include only those persons involved; their designated representative; and as appropriate, witnesses and other parties who can assist in constructing a factual framework relative to the grievance.
- All received formal grievances will have a goal set to resolve within 21 calendar days.
- The Grievance procedure and form will become a part of the ID SCO Handbook and all ID staff will be trained initially on 3/01/2015 and annually thereafter. New ID Staff will be trained on the Grievance procedure during their new Staff training and annually thereafter.
- The Grievance procedure and form will become part of the SCO Annual Information Packet given to all Individuals at the time of intake and thereafter at the Annual ISP Review.

Steps in Grievance Process: Confidentiality and privacy of the individual will always be taken into consideration. Concerns or disagreements held by the individual or family will be handled through the following problem resolution process:

An Individual/family will present their concerns with their respective Supports Coordinator. The SC will attempt to resolve the issue at that time. If the individual/family is still dissatisfied, the SC will (a) explain the formal grievance procedure, (b) initiate a grievance form (within 24 hours from when individual/family indicates they want to speak to supervisor) to alert their supervisor and start the formal grievance process.

First Level Appeal: The initiated grievance form is given to the Supervisor by the SC within 24 hours from when the individual/family indicates they want to speak to the supervisor. If the individual/family directly contacts the supervisor in writing or by phone their desire to file a grievance, then the supervisor will initiate the grievance form. The supervisor will communicate with the individual/family and address the concern(s) identified in the grievance form, written letter, or phone call. The set goal will be a mutually acceptable resolution of the problem. The

supervisor will complete the grievance form within five (5) working days from date of filing and will send to the IDD Director if a resolution was agreed upon.

If the individual/family is not satisfied with the resolution or a resolution cannot be agreed upon then the individual will be referred to the IDD Program Manager/Director, and Supervisor will notify IDD Program/Director immediately (within 24 hours) and forward the grievance form.

Second Level Appeal: The IDD Program Manager/Director will communicate with the individual/family and address the concern(s) identified in the grievance form, along with unsuccessful resolutions. The set goal will be a mutually acceptable resolution of the problem. The IDD Program Manager/Director will complete the grievance form within ten (10) working days from the date of filing the grievance and will send to the IDD Director if a resolution was agreed upon. All staff involved will be notified of the resolution.

If the individual/family is not satisfied with the resolution or a resolution cannot be agreed upon then the individual will be referred to the Executive Director of NFHCS and the IDD Program Manager/Director will notify the Executive Director immediately (within 24 hours) and forward the grievance form.

Third Level Appeal: The NFHCS Executive Director will communicate with the individual/family and address the concern(s) identified in the grievance form, along with unsuccessful resolutions. The set goal will be a mutually acceptable resolution of the problem. The Executive Director will complete the grievance form within twenty-one (21) working days from initiation of process, send to be filed in the NFHCS Administrative office, directed to the Executive Assistant. All staff involved will be notified of the disposition.

If the individual/family does not feel that his/her grievance has been resolved at this point, he/she may refer the grievance to the following:

- Office of Developmental Programs
  Western Region
  Piatt Place, Room 490
  301 Fifth Avenue
  Pittsburgh, PA 15222

- ODP Customer Service Line 1-888-565-9435
  Laurel Legal Services

Westmoreland County
306 South Pennsylvania Avenue
Greensburg, PA 15601
724-836-3680

- Bureau of Civil Rights Compliance
  Dept. of Public Welfare
  Western Field Office
  301 Fifth Avenue
  Pittsburgh, PA 15222

- Pennsylvania Human Relations Committee
  101 South Section Street
  Suite 300 Harrisburg, PA 17105

1.6 Organizational Structure

Implemented: December 2015

Revised: October 2016; September 2017; September 2018; August 2019; September 2020; September 2021

ORGANIZATIONAL HEIARCHERY:

Board of Directors: Provide direction for the organization. The board has a strategic function in providing the vision, mission, and goals of the organization. These are often determined in combination with the Executive Director and Director of Administration.

- President, Mattie Woods
- Vice President, Caroletta Richards
- Member, Sonja Garnett-Williams
- Member, Dr. Meghan Blaskowitz

Executive Team (Reports directly to the Executive Director):

- Executive Director, Sonja Garnett-Williams:
  - Directly responsible for overseeing the administration, programs, and strategic plan of the NFHCS. Other key duties include fundraising, marketing, and community outreach. The position reports directly to the Board of Directors.
- Director of Administration, Jonathan Williams:
  - Directly responsible for the overall administration, operations, coordination, and evaluation of the human resource function. Reports to Executive Director and works with the Board and other members of the leadership team to set the organization's strategic goals.
- Director of Creative of Services, Laura Stuart:
  - Directly responsible for recreation activities with groups in public, private, or volunteer agencies or recreation facilities. Organize and promote activities, such as arts and crafts, sports, games, music, dramatics, social recreation, camping, and hobbies, taking into account the needs and interests of individual members.
- Chief Financial Officer, Cheryl Allen:
  - Supervise, control, interpret and communicate the fiscal operations of the company to provide information and guidance to the company's Executive Director.

Risk Management Team (Reports directly to the Executive Director):

- Compliance Officer, Josie Wiley

- HR Consultant, Wes Garnett
- Director for Biling & Utilization, Kathy Bell
- Director of Services, Daria Jack
- Compliance Officer, Josie Wiley
- Director of Programs, Taylor Kasavage
- Incident Manager, Angelique King
- Director of Administration, Jonathan Williams

Quality Management Team (Reports directly to the Director of Administration):

- Compliance Officer, Josie Wiley
- Director for Biling & Utilization, Kathy Bell
- Director of Services, Daria Jack
- Executive Director: Sonja Garnett-Williams
- Director of Programs, Taylor Kasavage
- Incident Manager, Angelique King
- Director of Administration, Jonathan Williams

Health & Safety Team (Reports directly to the Director of Services):

- Administrative Assistant, Magnolia White-Horton
- Director of Programs, Taylor Kasavage
- Nurse Coordinator, Charlene Stiffey
- HR Specialist, Vicki Karabasz

Administrative Team (Reports to Director of Administration):

- Director for Biling & Utilization, Kathy Bell:
  - Approvers
  - Direct Support Specialist (Habilitation)
- Director of Services, Daria Jack:
  - IT Specialist, Samuel Ward
  - Administrative Assistants
  - Maintenance
- CFO, Cheryl Allen:
  - Administrative Assistant, Jeanine Graham
- HR Consultant, Wes Garnett
- Compliance Officer, Josie Wiley
- HR Specialist, Vicki Karabasz:
  - Training Coordinator, Brandon McDowell
  - Administrative Assistant, Magnolia Horton-White

Residential Services (Reports to Executive Director)

- Program Specialist, Michelle Putt
- Nurse Coordinator, Charlene Stiffey

- Program Leads
- Direct Support Specialist

Activities Services (Reports to Director of Creative of Services):

- Creative Service Manager
- Art Facilitators

Habilitation Services (Reports directly to the Director for Biling & Utilization):

- Direct Support Specialist

SECTION 1 - GOVERNANCE ACKNOWLEDGMENT

Section 1 of this Policy and Procedure Manual is an important document intended to help you become acquainted with the Not Forgotten Home & Community Services, as it relates to governing. This document is intended to provide guidelines and detail descriptions, according to both strict governmental and agency wide regulations.

The regulations provided in this section is regulatory in manner to maintain employment and for Not Forgotten to maintain compliance as a provider. The section covers all policies related to governing, including both state and federal regulations listed below:

- Non-Discrimination
- ODP Mission & Vision
- Records Management
- Grievance Procedure
- Organizational Structure

This section will count **1 HOUR** towards training.

Because Not Forgotten Home & Community Services operations may change, the contents of this manual may be changed at any time, with or without notice, in an individual case or generally, at the sole discretion of management.

Please read the following statements and sign below to indicate your receipt and acknowledgment of Section 1 of the Policy and Procedure Manual.

I have received and read a copy of Not Forgotten Home & Community Services Policy and Procedure Manual. I understand that the policies, rules, and benefits described in it are subject to change at the sole discretion of the Not Forgotten Home & Community Services at any time.

I understand that my signature below indicates that I have read and understand the above statements and that I have received a copy of the Not Forgotten Home & Community Services Policy and Procedure Manual.

Employee's Printed Name: _____

Employee's Signature: _____

Position: _____

Date: _____

The signed original copy of this acknowledgment should be given to management - it will be filed in your personnel file.

Section 2 - Finance

2.1 Billing & Payroll Documentation Requirements

Implemented: December 2015

Revised: September 2017; October 2018; September 2019; September 2020; September 2021

Billing: NFHCS's billing policies and procedures serve as a resource to ensure that services are billed according to the requirements set forth by federal, state and county guidelines and meet the minimum standards for Generally Accepted Accounting Principles.

Fiscal Department Policies and Procedures: The Fiscal Department Procedures have been revised to ensure that the new procedures reflect:

- Adherence to all policies and procedures of funding entities inclusive of Promise.
- Timely billing practices.
- Resolution of overpayments/underpayments.
- Internal monitoring of revenues and detailed receivables.
- Audit requirements.

Internal Service Monitor Reviews: There are several current and proposed monitoring efforts to assist with the accuracy of information being billed for and reported through the Fiscal Department. These include, a) billing safeguards that are built into the THERAP billing software, b) remittance advices saved on-line and self-review audit.

Reporting Results of Internal Service Monitoring Reviews: Results from the audit are shared with the Board of Directors and the Administrative Executive Team members. Strengths and areas of recommended improvements, along with the fiscal health of the organization are presented.

DATA DOCUMENTATION:

Habilitation Staff: All Staff working Habilitation must complete Electronic Visit Verification (EVV) through our new THERAP Billing system. The EVV is a real-time system showing date, check-in and check-out times, tasks, written documentation as to what was achieve towards the individual's goal(s), along with the individual's

signature, (or the signature of an authorized representative). All EVV steps must be completed to bill the state. **If Staff does not check into THERAP there is no proof of services rendered, and no way to re-create a prior real-time service, therefore staff will not be paid for the day.**

All habilitation staff will submit (if applicable) a non-Billable time and mileage sheet due by noon **EVERY** Monday. Non-billable hours consist of: Orientation, PTO, Training, Administration work, etc.

Residential Staff: All Staff working Residential will complete T-Notes in THERAP to document the events of the day with their individuals. All Residential staff will submit timesheets, due by noon **EVERY** Monday.

Payroll: NFHCS's work week is Sunday through Saturday. Payroll is prepared weekly and paid out bi-weekly. All Staff are responsible for submitting their own documentation. All documentation must be scanned to info@nfhcs.org every Monday by noon or dropped off at the main office at 101 W Main Street, Carnegie, PA 15106. If not received by noon your hours/mileage WILL BE delayed until the next payroll period.

Payroll Activity Expense Reimbursement: NFHCS is committed to providing excellent service to our Individuals. Many ISPs include socialization and interacting in the community. This can sometimes be costly for the staff to participate with the individuals.

In these cases, where a staff must pay an entrance fee, ticket, or other payment to gain access to an area in which the individual wishes to go, or participate in, NFHCS will reimburse the following:

- $10.00 per individual, per day for an activity will be reimbursed
- Anything over $10.00 must be approved prior to reimbursement
- The individual is responsible for paying his or her own way. NFHCS is not responsible for paying any costs or fees for the individual
- Staff is not permitted to use individual's money for costs
- NFHCS **DOES NOT REIMBURSE** for food purchases

Reimbursement Travel for Individuals: NFHCS will reimburse staff .58 cents per mile up to 20 miles within the individual's community. Exceptions for this rule are NFHCS events, Doctor's appointment, or prior approval by your manager. All payroll expenses and mileage must be recorded on the timesheet for payment.

Respite Billing. Respite Process - Internal

You must have the Individual receiving the service admitted and respite code setup in Therap.

Create ISP, Individual Tab, ISP Program, New:

- ISP must be set up for individual with respite services
  - Select Program Name/service location
  - Select Individual that has respite service
  - A blank ISP Program will pop up
  - Enter ISP Program Name (Wxxxx (MMM, YYYY)
  - Enter Start Date that HCSIS gives you – Do not enter End Date
  - Enter from the ISP, Long Term Objective (Outcome Action Plan-What are current needs), Goal (Outcome Action Plan-How will you know progress is being made, Reason for ISP (Individual Outcome Summary-Reason for Outcome) and under Criteria for Completion and Materials Required enter. Pick Key points you only have 3000 characters under each category.
    - Like and Admire
    - Key Points in Know and Do
    - Desired Activities
    - Medications/Supplements
    - Allergies/Current Health Status
    - General Health/Safety Risks
    - Meals/Eating
    - Supervision Care Needs
    - Physical Development (i.e., Ambulation)
    - Adaptive/Self Help (i.e., Adaptive Equipment)
    - Communication
  - Schedule and Frequency: Units, Hours annually or specific according to ISP
  - Scoring method is the same for all codes (Measurable Goals 2)
  - Task Scoring Comments – Required for all score
- Tasks
  - Goal - Has staff provided the service (goal) as stated in the ISP? Then add the goal.
  - Services - Were the needs and preferences met from the individual's perspective?
  - Health Have the services impacted the Individual's health, safety, well-being, preferences, and routine? Please explain.
  - Progress Has the individual progressed or regressed? Please explain.
- External Module Connection

  - Some Wcodes are EVV some are not (attached is the listing) C:\Users\kbell\Not Forgotten Home & Community Services\NFHCS Office Files - FISCAL\Billing\EVV\Respite codes through EVV only.xlsx
  - If the code is not EVV, under External Module Connect select "No" for EVV supporting Document, if it is EVV required select "Yes"
- Other Details
  - If EVV all sections will populate, exception Are other Comments required for data collection? "YES"
- **After review, go to the bottom click "APPROVE"**

Service Authorization - Billing, Service Authorization, **New:**

- The Service Authorization must be completed to bill
  - Select Program Name from list
  - Select Individual for Service Authorization from list
- The Service Authorization will come up
  - Select Funding Source
  - Begin and End date of Fiscal Year
  - Under "Service" Click Add new service
- A new screen will pop up
  - Add Service Description/Code (WCode) from drop down. When you add the Service code the unit of measure and Default Unit Rate will populate.
  - Add Total Billable Units, Total Authorized Amount (click on calendar), ICD-10 Primary Diagnosis Code
- Under Data Collection Information
  - Method of Data Collection "EVV"
  - Unit Calculation Rule = Daily
  - Duration Calculation Rule = Overnight Billing
  - Link Current ISP Program
- Under EVV
  - if respite code is not EVV required do NOT check if it is EVV required check EVV Service.
- Under Automatic Unit Calculation from Time in/Out
  - Respite = 15 minutes
  - Rounding Algorithm for Respite = None
  - Smallest Allowed Increment for Respite will adjust to null.
- Validation
  - Ignore (Create Billing Data with calculated units ignoring Authorized Units per period rule)
  - Click Save
  - This will take you back to Service Authorization, click approve.
  - Add New Service if there is another Service, if not, scroll to bottom and click
  - **APPROVE**

Create a new Claim Template:

- Billing Tab: Claim Template, Search, then click on Search at the bottom of the screen
- Select any individual
- Go to the bottom and click "Copy for Another Individual"
- A new template will pop up, change only the individual Name, go to the bottom and under Service Link click the services you will be billing.
- Then Submit

Respite Process – External:

- A training process is provided for all new staff or staff that have left and come back to NF. C:\Users\kbell\Not Forgotten Home & Community Services\NFHCS Office Files - BILLING SUPPORTS & HABILITATION\NF SERVICES\THERAP Nov 2019\Therap Training\Andriod Device Update 3-29-21.docx.
- Trainer will contact staff to setup a time and place for the training prior to start date.
- Trainer will go to the home, meet in the community, or work over the phone until the staff fully understands the process and how to complete documentation on their individual.
- All respite staff must enter check-in and check-out times in therap.
- Respite must be 16-24 hours to be billed as a 1 daily unit in Therap according to PA rules.
- Adjusted Unit Calculation rule so that multiple staff can check-in and check-out as long as the daily service duration is greater than 16 hours to generate billing through Therap.
- First time checking-in and prior to checking-out, staff must read and acknowledge the ISP Program.
- Each time ISP is updated staff must read and acknowledge.
- The acknowledgement will pop up on the phone prior to being able to complete documentation.
- All task documentation must be completed and must be specific to their individual's goal.
- The State/County requires Not Forgotten staff to get an individual's signature. There is a 15-minute window from the time you check-out to the time you get a signature.
- If you are distracted by the individual and cannot sign within the 15-minute window you must complete a manual signature. This is a last resort. C:\Users\kbell\Not Forgotten Home & Community Services\NFHCS Office Files - FISCAL\Billing\Signature Sheet Template.xlsx.

- The signature sheet must be mailed into the office as soon as possible to be attached to the ISP Data.
- If you do not check-in or check-out at the proper times, please contact your approver immediately with an explain why, the explanation is required to be entered into the system before the change can be made.

2.2 Program Procedures for Individual's Funds (Room & Board)

Implemented: August 2018 **Revised:**

Funds. NFHCS recognizes the basic right of all staff to receive, manage and utilize financial resources in their best interest to the maximum extent possible. We further recognize an individual's right to own and maintain personal property of their choice. Realizing that sound financial management is strongly correlated to the health and welfare of all people, NFHCS is committed to provide financial counseling and training in money management to the extent that a person's ability and circumstance warrants.

Property:

- NFHCS will ensure proper care and accountability to the individuals we serve. Staffs or volunteers shall be responsible for the safekeeping, serviceable condition, and proper care of every individual's property.
- Damaged property shall not be thrown away, sold, traded, donated, destroyed, or otherwise disposed of without proper consent from NFHCs supervisory staff. If property become damaged or lost, no staff shall attempt to repair or lie about the individual's property.
- A staff's intentional or negligent abuse or misuse of individual's belongings will lead to appropriate disciplinary action which may include, but may not be limited to, a verbal counseling, verbal reprimand, written reprimand, suspension, demotion, or termination of employment.

Reference/Source: Chapter 51.121-122 Room and Board,51.123 Actual Room and Board Costs,51.124 Modification to The Room and Board Contract,51.125 Completing and Signing the Room & Board Contract,51.126 Copy of The Room & Board Contract

Persons Affected: Individuals, Rep. Payees, Families (if applicable), Surrogates, and Staff of NFHCS

Our Purpose: To inform the affected of NFHCS, of Our Room & Board policy, and to ensure compliance with the Chapter 51 regulations.

Policy Objectives:

- Ensure Residential Habilitation Individuals has a current signed department - approved Room & Board contract on file.
- Description of requirements
- **Completing and signing Room & Board contracts**
- Actual Room & Board Costs

- Retaining Copies of the Room & Board Contracts

Room and Board Requirements:

- NFHCS will cooperate with monitoring of room and board charges and collections conducted by the Department or the Department's designee.
- If our individual is not currently receiving SSI benefits, assistance will be provided to the individual to contact the appropriate county assistance office so that the individual can obtain SSI benefits.
- If an individual is denied benefits, NFHCS will assist our individual(s) in filing an appeal if desired.
- If actual room and board costs are 72% or more of the SSI maximum rate, the Department will use the following criteria to establish room and board rates:
    - An individual's share of room and board shall not exceed 72% of the SSI maximum rate.
    - The proration of board costs is to occur for every day the individual is on leave from the residence.
- This proration can occur monthly, quarterly, or semiannually as long as there is a record that the board costs were returned to the individual for every day of leave.
- If our individual has earned wages, personal income from inheritance, Social Security, or other types of income, NFHCS may not assess the room and board cost for the individual in excess of 72% of the SSI maximum rate.
- If available income for an individual is less than the SSI maximum rate, NFHCS can charge 72% of the individual's available monthly income as the individual's monthly obligation for room and board.
- Our individual(s) must receive at least the monthly amount as established by the Commonwealth and the Social Security Administration for the individual's personal needs allowance.
- If actual room and board charges to an individual are less than 72% of the SSI maximum rate, NFHCS must retain the following documentation:
    - The actual value of the room and board is less than 72% of the current maximum SSI monthly benefit.
    - The Social Security Administration's denial of the individual's initial application for SSI benefits, but also the upholding of the initial denial because of at least one appeal.
- NFHCS must assist our individual to secure information regarding the continued eligibility benefits of the individual.

- There may not be a charge for room and board to the individual for respite care if respite care is provided for 30 or fewer days in a State fiscal year.
- There may not be a charge for room and board to the individual from the waiver after 30 consecutive days of being in a hospital or rehabilitation facility and the individual is placed in reserved capacity.
- NFHCS must collect the room and board from the individual or representative payee directly and will not delegate this responsibility.
- NFCHS will not charge for board to the individual if the individual is tube-fed and takes nothing by mouth.

Room and Board Contract:

- NFHCS will utilize the document – Approved room and board contract. For our Individuals receiving Residential Habilitation Service.
- NFCHS must ensure that a standard contract is signed and completed for an individual on an annual basis.

Actual Room and Board Costs:

- NFHCS must ensure the total amount charged for room and board to our individual(s) does not exceed the actual documented value of the room and board provided to our individual(s)
- NFHCS will compute and document actual room and board costs each time an individual signs a new standard room and board contract.
- All documentation of actual room and board costs must be kept and on file.

Modifications Made to the Room & Board Contract:

- If an individual(s) pays rent directly to a landlord, but food is supplied through NFHCS, ‘‘room’’ must be deleted from the room and board contract and the following shall apply:
    - The individual must only pay 32% of the SSI maximum rate for board.
    - If an individual’s income is less than the SSI maximum rate, 32% of the available income must be charged to fulfill the individual’s monthly obligations for board.
- If an individual(s) pays rent to NFHCS, but the individual(s) purchases their individual’s own food, ‘‘board’’ must be deleted from the room and board contract and the following must apply:
    - The individual must only pay 40% of the SSI maximum rate for room.

- If an individual's income is less than the SSI maximum rate, 40% of the available income must be charged to fulfill the individual's monthly obligations for room.

Completing & signing Individual's Room and Board Contract

- If an individual(s) is adjudicated incompetent to handle their finances, the individual's surrogate must sign the room and board contract.
- If an individual is 18 years of age or older and is not the representative payee for the individual's benefits, the representative payee and the individual must sign the room and board contract.
- The written room and board contract MUST be completed and signed in accordance with one of the following:
  - **Prior** to an individual's admission to a residential habilitation service location.
  - **Prior** to an individual's transfer from one residential habilitation service location **or** provider **to another** residential habilitation service location **or** provider.
- Within 15 days after an emergency residential habilitation service location placement.

Copy of the Individual's Room & Board Contract:

- A copy of the completed and signed room and board contract will be given to the individual **or** individual's surrogate.
- A copy of the completed and signed room and board contract must be retained in the individual's record at the NFHCS Office.

SECTION 2 - FINANCE ACKNOWLEDGMENT

Section 2 of this Policy and Procedure Manual is an important document intended to help you become acquainted with the Not Forgotten Home & Community Services, as it relates to finances. This document is intended to provide guidelines and detail descriptions, according to both strict governmental and agency wide regulations.

The regulations are provided in this section is regulatory in manner to maintain employment and for Not Forgotten to maintain compliance as a provider. The section covers all policies related to financing, including both state and federal regulations listed below:

- Program Procedures for Individuals Funds (Room and Board)
- Billing & Payroll Documentation Requirements

This section will count **.75 HOURS** towards training.

Because Not Forgotten Home & Community Services operations may change, the contents of this manual may be changed at any time, with or without notice, in an individual case or generally, at the sole discretion of management.

Please read the following statements and sign below to indicate your receipt and acknowledgment of Section 2 of the Policy and Procedure Manual.

I have received and read a copy of Not Forgotten Home & Community Services Policy and Procedure Manual. I understand that the policies, rules, and benefits described in it are subject to change at the sole discretion of the Not Forgotten Home & Community Services at any time.

I understand that my signature below indicates that I have read and understand the above statements and that I have received a copy of the Not Forgotten Home & Community Services Policy and Procedure Manual.

Employee's Printed Name: _____

Employee's Signature: _____

Position: _____

Date: _____

The signed original copy of this acknowledgment should be given to management - it will be filed in your personnel file.

SECTION 3 - Information Technology (IT)/Media

3.1 IT Management Agreement

Implemented: December 2015 **Revised:**

Purpose. This policy is established to provide Authorized Users with guidelines for, restrictions upon and standards for acceptable use of Commonwealth IT resources. All Authorized Users must be familiar with this policy and adhere to it.

Background. The Commonwealth of Pennsylvania has established a complex enterprise network of IT resources that connects NFHCS networks with the Internet and other business partner networks for the purpose of sharing and accessing information in accordance with the mission of the Commonwealth. Commonwealth workforce members, including staff, contractors, consultants, volunteers, and other Authorized Users, are expected to use this network and its connected IT resources in accordance with authorized job functions and in accordance with the acceptable use guidelines documented in this directive.

It is the policy of the Commonwealth to ensure that all Authorized Users that have access to Commonwealth IT resources are made aware of and comply with the standards set forth in this directive and in Enclosure 1. These standards encourage effective use of IT resources and provide a framework to prevent misuse or illegal use of these resources. This directive does not prohibit staff from performing authorized job duties.

Scope: This directive applies to all Authorized Users in all agencies under the Governor's jurisdiction who have access to Commonwealth IT resources.

Policy: These standards are designed to prevent use that may be illegal, abusive, or which may have an adverse impact on the Commonwealth or its IT resources and to identify permissible and effective uses. Authorized Users are encouraged to assist in the enforcement of these standards by promptly reporting any observed violations to their supervisor, the human resources office, NFHCS contact or contracting officer.

The improper use of Commonwealth IT resources by staffs or volunteers may result in disciplinary action, up to and including termination, depending on the circumstances of the incident. The improper use of Commonwealth IT resources by contractors or consultants may result in disciplinary action that may include formal action under the terms of the applicable contract or debarment under the

Contractor Responsibility program. When warranted, the Commonwealth or its agencies may pursue or refer matters to other authorities for criminal prosecution against persons who violate local, state, or federal laws using Commonwealth IT resources.

Authorized Users of Commonwealth IT resources should be aware that all records of computer use, Internet use and/or E-mail communication (sent, received, or stored) conducted on Commonwealth IT resources are the property of the Commonwealth. Individual Authorized Users do not control access to such records. At its discretion, executive level or Human Resources staff or their authorized designees may access and review any computer files or data, Internet records or E-mail communications for compliance with the provisions of this directive. NFHCS heads may determine who may access these records, including, but not limited to, executive level staff, legal staff, human resource management staff, network system administrators, individuals in the Authorized User's chain of command or others, including law enforcement. Files and records of IT resource use may be reviewed at any time and are routinely backed up and stored without the user's knowledge. All physical equipment, intellectual property, information, software, data, files, or programs that are provided, stored, or otherwise utilized by or on any Commonwealth-provided IT resource is the property of the Commonwealth.

All Authorized Users should understand that all electronic communication and access may be traced and/or monitored. Agencies and their designees may use tracking, blocking, and monitoring software to restrict certain access and/or alert information technology staff to certain inappropriate uses. Authorized Users must use passwords and/or encryption in a manner that is consistent with Commonwealth and NFHCS policy. Utilization of special passwords or encryption does not necessarily guarantee the confidentiality of any electronic communication. Authorized Users must keep passwords secure and must not share them with others.

The Internet and E-mail are information tools that the Commonwealth has made available on Commonwealth computer resources for Commonwealth business purposes. Where personal use of these resources does not interfere with the efficiency of operations and is not otherwise in conflict with the interests of the Commonwealth, reasonable use of the Internet and/or E-mail for personal purposes will be permitted in accordance with standards established for business use. Such personal use shall be limited, occasional, and incidental. Any personal use which is inconsistent with Commonwealth policy regarding availability or

capability of computer equipment, or inappropriate content of communications as defined by this policy, is prohibited.

All existing staffs must be provided a copy of this policy. All new staffs must review this policy during new staff orientation. All non-staff Authorized Users must review this policy prior to their use of Commonwealth IT resources.

As acknowledgement of receipt and understanding of this policy, agencies must obtain a signed user agreement in the form of Enclosure 2, from each Authorized User who has been granted access to Commonwealth IT resources. Agencies must obtain a signed user agreement from each new staff prior to granting such staff access to Commonwealth IT resources. Agencies may continue to use existing user agreements for ninety (90) days after the issue date of this Directive, but thereafter agencies may only grant access to Commonwealth IT Resources to Authorized Users who had signed a user agreement in the form of Enclosure 2, unless a waiver of this requirement has been granted by the Office of Administration.

Each NFHCS must maintain copies of the agreement signed by each user authorized by the NFHCS. Completed user agreements shall be maintained as part of the staff's Official Personnel Folder. Alternately, users may sign, and agencies may store these agreements in an electronic format consistent with Management Directive 210.12, Electronic Commerce Initiatives and Security, and ITB-- SEC006, Commonwealth of Pennsylvania Electronic Signature Policy. Signed agreements must be accessible to individuals who are authorized to view or use the documents.

Technical standards for use of the Commonwealth IT resources will be published in Office of Administration/Office for Information Technology (OA/OIT) "IT Bulletins" that will be available on the OA/OIT Internet site at <http://www.oit.state.pa.us>.

Requests for records pertaining to Commonwealth IT resources must be addressed consistent with all laws, directives or policies that would apply to the same information if maintained in a non-electronic format. These requests should be referred to NFHCS legal counsel.

This policy supplements and where conflicting, supersedes Management Directive 205.29, Commonwealth Internet Access.

This policy supersedes any existing IT, Internet and/or E-mail use policy issued by agencies under the Governor's jurisdiction that is inconsistent with this directive, unless specific exemptions are granted by the Secretary of Administration or

designee. Approved labor agreements or "side letters" should be read in a manner to effectuate both this policy and any such agreement or letter. In cases where a provision of an approved labor agreement or "side letter" cannot be reconciled with this policy, the labor agreement or side letter will control. Agencies may develop supplemental IT, Internet and/or E-mail policies only with the approval of the Secretary of Administration or designee. Agencies must ensure that Authorized Users with access to Commonwealth IT resources have access to this directive and Enclosures 1 and either Enclosure 2 or Enclosure 3, as appropriate, either electronically or in hard copy. All use of Commonwealth IT resources must conform with Executive Order 1980-18, Code of Conduct, Management Directive 505.7, Personnel Rules, and Commonwealth policies on nondiscrimination and sexual harassment.

Enclosure 1

COMMONWEALTH ACCEPTABLE USE STANDARDS FOR INFORMATION TECHNOLOGY (IT) RESOURCES: Each Authorized User must comply with these standards when using the Internet or Commonwealth IT resources.

AUDITING AND REPORTING: The Commonwealth reserves the right to monitor and/or log, with or without notice, all Internet activity, all Internet web site access, all E-Mail and any other communications or data accessed, stored, or otherwise used by or on Commonwealth IT resources. Therefore, Authorized Users should have no expectation of privacy in the use of the Commonwealth's IT resources. Authorized Users are encouraged to assist in the enforcement of these standards by promptly reporting any observed violations to their supervisor, the human resources office, NFHCS contact or contracting officer. All physical equipment, intellectual property, information, software, data, files, or programs that are provided, stored, or otherwise utilized by or on any Commonwealth IT resource is the property of the Commonwealth.

DISCIPLINE: Misuse of Commonwealth IT resources by staffs or volunteers may result in disciplinary action, up to and including termination, depending on the circumstances of the incident. The improper use of Commonwealth IT resources by contractors or consultants may result in disciplinary action that may include formal action under the terms of the applicable contract or debarment under the Contractor Responsibility program. When warranted, the Commonwealth or its agencies may pursue or refer matters to other authorities for criminal prosecution against persons who violate local, state, or federal laws using Commonwealth IT resources.

GENERAL IT RESOURCE USE:

- As part of the privilege of being an Authorized User, Authorized Users may not attempt to access any data or programs contained on Commonwealth systems for which they do not have authorization or explicit consent.
- Authorized Users may not share their Commonwealth or NFHCS account(s), passwords, Personal Identification Numbers (PIN), Security Tokens (i.e., Smartcard), or similar information or devices used for identification and authorization purposes with any other person or Authorized User. Authorized Users are strictly responsible for maintaining the confidentiality of their Commonwealth or NFHCS account(s), passwords, PIN, Security Tokens or similar information or device.
- Authorized Users may not make unauthorized copies of copyrighted software.
- Authorized Users may not use non-standard shareware or freeware software without NFHCS IT management approval unless it is on the NFHCS's standard software list.
- Authorized Users may not purposely engage in activity that may: harass, threaten, or abuse others; degrade the performance of IT Resources; deprive an Authorized User of access to an IT resource; obtain extra IT Resources beyond those allocated; or circumvent computer security measures.
- Authorized Users may not use Commonwealth IT resources for personal gain.

INTERNET USE. All security policies of the Commonwealth and its agencies, as well as policies of Internet sites being accessed, must be strictly adhered to by Authorized Users.

Software. In connection with Authorized Users' use of and access to Commonwealth IT Recourses:

- All software used to access the Internet must be part of the NFHCS's standard software suite or approved by the NFHCS IT department. This software must incorporate all vendor provided security patches.
- All files downloaded from the Internet must be scanned for viruses using the approved Commonwealth distributed software suite and current virus detection software.

- All software used to access the Internet shall be configured to use an instance of the Commonwealth's standard Internet Access Control & Content Filtering solution.

Expectation of Privacy. Authorized Users may not rely on any communications via the Internet
using Commonwealth IT Resources being secure, private, or inaccessible, except where appropriate security applications are used, e.g., data encryption.

All activity on Commonwealth IT resources is subject to logging and review.

Access Control and Authorization. Agencies should authorize access to the Internet using Commonwealth computer resources through the utilization of a user ID/password system. Security violations can occur through unauthorized access and all possible precautions should be taken to protect passwords. Authorized Users are responsible for activity and communications transmitted under their account.

Incidental Use

- Use of Commonwealth IT resources is only authorized for personal use on a limited, occasional, and incidental basis and in a manner consistent with this policy.
- Incidental personal use of Internet access is restricted to Authorized Users; it does not extend to family members or other acquaintances.
- Access to the Internet from a NFHCS owned, home based computer must adhere to all the same policies that apply to use from within NFHCS facilities. Staff may not allow family members or other non-staff to access NFHCS computer systems.
- Incidental use must not result in direct costs to the Commonwealth.
- Incidental use must not interfere with the normal performance of an Authorized User's work duties.
- No user may send or solicit files, documents or data that may risk legal liability for, or embarrassment to, the Commonwealth.
- All files and documents located on Commonwealth IT resources, including personal files and documents, are owned by the Commonwealth, and may be accessed in accordance with this policy. In addition, such documents may be subject to the Right to Know Law 65 P.S. § 66.1, et seq. and other laws that may require the Commonwealth to disclose the content of its IT resources.

Acceptable Use of the Internet. Accepted and encouraged use of the Internet for Authorized Users on Commonwealth IT Resources includes, but is not limited to, the following:

- Access, research, exchange, or posting of information that relates to the assigned job duties of an Authorized User for carrying out Commonwealth business.
- Promotion of public awareness regarding Commonwealth law, NFHCS services, and public policies.
- Posting of NFHCS information that has been authorized by appropriate management.

EMAIL USE

Expectation of Privacy:

- When sensitive material is sent electronically via E-mail, it is important to verify that all recipients are authorized to receive such information and to understand that E-mail is not fully secure and/or private, except where appropriate security applications are used, e.g., data encryption.
- Users should understand that messages can be quickly and easily copied and may be forwarded inappropriately.
- Where it is necessary to transmit Commonwealth proprietary or restricted information beyond the Commonwealth Connect E-mail network, the messages should be protected by encryption. Authorized Users should contact their NFHCS network coordinator or Information Technology Coordinator for assistance if encryption is needed.
- E-mail messages to be transmitted outside of the United States should comply with local laws governing international transmission of data as well as United States export control regulations. For assistance, Authorized Users should contact their network coordinator or Information Technology Coordinator, who may receive technical assistance from the Office of Administration, Office for Information Technology.
- The NFHCS head or designee should determine specific NFHCS policy regarding business information which is determined to be too confidential or sensitive to be transmitted via E-mail.
- All user activity on Commonwealth IT resources is subject to logging and review.

Access Control and Authorization:

- Only Authorized Users may use Commonwealth IT resources to send or view E-mail or access the Commonwealth's E-mail systems.

- Unauthorized persons may not use the network or Commonwealth equipment to originate E-mail messages or read E-mail messages directed to others.
- Access Commonwealth E-mail will only be granted to Commonwealth workforce members, including staff, contractors, consultants, volunteers, and other authorized users if they agree to abide by all applicable rules of the system, including this policy and its related standards.
- Unauthorized access of an Authorized User's E-mail files is a breach of security and ethics and is prohibited. An Authorized User may not access the E-mail or account of another Authorized User unless granted permission to do so by the Authorized User. This restriction does not apply to system administrators and management staff in the Authorized User's chain of command who are authorized to access E-mail for legitimate business purposes.
- In accordance with NFHCS policy, Authorized Users should use password protection to limit access to E-mail files. Authorized Users must safeguard their passwords so that unauthorized users do not have access to their E-mail. Authorized Users are responsible for messages transmitted under their account.

Message Retention. E-mail messages may be subject to Commonwealth and/or NFHCS document retention standards.

See Management Directive 210.5 Records Management for additional guidelines.

E-mail Security Issues - Worms & Viruses. E-mail and attachments to E-mail increasingly are reported to be sources of computer viruses. All Authorized Users should act in accordance with the latest Information Technology Bulletins regarding containment methods for computer viruses.

Maintaining Professionalism. Every Authorized User who uses Commonwealth computer resources is responsible for ensuring posted messages are professional and businesslike. To impose personal restraint and professionalism, all staff should assume that whatever they write may at some time be made public. Authorized Users should follow the following guidelines:

- Be courteous and remember that you are representing the Commonwealth with each E-mail message sent.
- Review each E-mail message before it is sent and make certain that addresses are correct and appropriate.

- Consider that each E-mail message sent, received, deleted, or stored has the potential to be retrieved, seen, and reviewed by audiences, including the public, who were not the intended recipient of the message.
- Ensure that content is appropriate and consistent with business communication; avoid sarcasm, exaggeration, and speculation which could be misconstrued.
- Be as clear and concise as possible; be sure to clearly fill in the subject field so that recipients of E- mail can easily identify different E-mail messages. Avoid subject fields that are vague and general, e.g., "question," "comment," etc.

Electronic Message Distribution, Size and Technical Standards:

- Authorized Users should receive authorization from their chain supervisor before wide scale "broadcasting" an E-mail bulletin to groups of staff.
- The use of "reply to all" should be avoided unless it is appropriate to respond to all addressees.
- Authorized Users wishing to send E-mail bulletins to all Commonwealth or NFHCS staff must first obtain authorization from NFHCS management.
- E-mail messages should be brief, and attachments to E-mail messages should not be overly large. NFHCS IT staff will inform Authorized Users of limitations on the size of E-mail messages and attachments. The Office for Information Technology periodically will provide technical standards and guidance to agencies through IT Bulletins on the technical capacities of the Commonwealth Connect system and limitations on E- mail message size. Technical standards will be provided in areas such as file size and backup procedures, and will be available on the OA/OIT Internet site at <http://www.oit.state.pa.us>.

UNACCEPTABLE USES OF IT RESOURCES. The following are examples of impermissible uses of Commonwealth IT resources. This list is by way of example and is not intended to be exhaustive or exclusive. Authorized Users are prohibited from:

- Viewing, accessing, posting, or transmitting any material that is generally considered to be personally offensive or inappropriate, including sexually suggestive, pornographic, or obscene materials.
- Viewing, accessing, posting, or transmitting material that expresses or promotes discriminatory attitudes toward race, gender, age, nationality, religion, or other groups including, but not limited to, protected groups identified in Executive Order 1996-9, Equal Employment Opportunity.

- Conducting personal, for-profit transactions or business or conducting any fundraising activity not specifically sponsored, endorsed, or approved by the Commonwealth.
- Participating in Internet activities that inhibit a staff job performance or present a negative image to the public, such as auctions, games, accessing pornographic or offensive material, or any other activity that is prohibited by directive, policy, or law.

Attempting to test or bypass the security ("hacking" or "cracking") of computing resources or to alter internal or external computer security systems:

- Participating in or promoting computer sabotage through the intentional introduction of computer viruses, worms, or other forms of malware, i.e., malicious software.
- Promoting, soliciting, or participating in any activities that are prohibited by local, state, or federal law or the Commonwealth rules of conduct.
- Violating or infringing the rights of any other person.
- Using any other Authorized User's password and/or equipment to conduct unacceptable activities on Commonwealth IT Resources.
- Harassing or threatening activities including, but not limited to, the distribution or solicitation of defamatory, fraudulent, intimidating, abusive, or offensive material.
- Transmitting or soliciting any proprietary material, such as copyrighted software, publications, audio, or video files, as well as trademarks or service marks without the owner's permission.
- Promoting or participating in any unethical behavior or activities that would bring discredit on the Commonwealth or its agencies.
- Downloading and/or installing any unapproved software.
- Transmitting or posting any messages that intentionally misrepresent the identity of the sender, hide the identity of the sender, or alter a sender's message.
- Sending or forwarding confidential or sensitive Commonwealth information through non-Commonwealth email accounts. Examples of non-Commonwealth email accounts include, but are not limited to, Hotmail, Yahoo mail, AOL mail, and email provided by other Internet Service Providers.
- Sending, forwarding, or storing confidential or sensitive Commonwealth information utilizing non-- Commonwealth accredited mobile devices.

Examples of mobile devices include, but are not limited to, Personal Data Assistants, two-way pagers, and cellular telephones.

- Participating in any other Internet or E-mail use that is deemed inappropriate by the Commonwealth and/or its agencies and is communicated as such to Authorized Users.

SECTION 3 - INFORMATION TECHNOLOGY (IT)/MEDIA ACKNOWLEDGMENT

Section 3 of this Policy and Procedure Manual is an important document intended to help you become acquainted with the Not Forgotten Home & Community Services, as it relates to IT. This document is intended to provide guidelines and detail descriptions, according to both strict governmental and agency wide regulations.

The regulations are provided in this section is regulatory in manner to maintain employment and for Not Forgotten to maintain compliance as a provider. The section covers all policies related to IT, including both state and federal regulations listed below:

- IT Management Agreement

This section will count **.5 HOURS** towards training.

Because the Not Forgotten Home & Community Services operations may change, the contents of this manual may be changed at any time, with or without notice, in an individual case or generally, at the sole discretion of management.

Please read the following statements and sign below to indicate your receipt and acknowledgment of Section 3 of the Policy and Procedure Manual.

I have received and read a copy of Not Forgotten Home & Community Services Policy and Procedure Manual. I understand that the policies, rules, and benefits described in it are subject to change at the sole discretion of the Not Forgotten Home & Community Services at any time.

I understand that my signature below indicates that I have read and understand the above statements and that I have received a copy of the Not Forgotten Home & Community Services Policy and Procedure Manual.

Employee's Printed Name: _____

Employee's Signature: _____

Position: _____

Date: _____

The signed original copy of this acknowledgment should be given to management - it will be filed in your personnel file.

Section 5 - Individual Services

4.1 Individual Grievance

Implemented: December 2015 **Revised:**

Background: Any NFHCS or family representative (parent or legal guardian on behalf of a minor age individual or court-appointed guardian of an incapacitated adult individual) **may voice a concern or lodge a complaint or grievance with any staff of the NFHCS.**

Complaints regarding alleged discrimination in admission to, or treatment in a NFHCS services being provided, or related service activity receiving Federal financial assistance or which allegedly any action prohibited by Section 504 of the Rehabilitation Act of 1973 (29 U.S.C. 794) or the U.S. Department of Health and Human Services regulations implementing the Act can be communicated directly to the Compliance Manager, at NFHCS, 101 West Main Street, Carnegie, Pennsylvania, 15106.

Staff who have been informed of a concern or complaint will immediately document the issue and offer an appropriate resolution or notify their immediate supervisor who shall begin an immediate review to confirm that a satisfactory resolution has occurred or has been offered.

If the Individual or Family representative is not satisfied with the resolution and wishes further review, then the immediate supervisor or delegate will provide appropriate assistance to the Individual to file a formal Grievance.

Complaints and Grievances will be filed at the NFHCS's Administrative office and collectively reviewed and analyzed on an annual basis.

NFHCS is committed to ensuring that individual rights are protected and that services are provided in a professionally responsive manner. NFHCS has established a complaint and grievance process, which permits individuals, guardians, and family representatives to express any dissatisfaction. Through this process the NFHCS hopes to resolve concerns as quickly as possible through discussion with staff at the service location. More significant concerns will be addressed and resolved by leadership staff. Significant complaints that are not resolved to the satisfaction of the individual, guardian or family representative may be submitted as a grievance for ISC coordination and Executive Staff review.

NFHCS staff will assist individuals with alternate forms of communicating grievances including transcriptions of verbal complaints. and alternate language translation service as needed.

4.2 Individual Rights

Implemented: December 2015 **Revised:** September 2020

Background: Each individual (or legal guardian) shall be informed verbally and in writing of these rights as follows:

General "Services" Rights:

- The right to be **treated professionally** and with consideration and respect for human dignity and autonomy.
- The right to **receive any NFHCS service** regardless of one's race, color, religious creed, disability, ancestry, national origin, age, sex, actual or perceived sexual orientation, actual or perceived gender identity or actual or perceived gender expression.
- The right to **receive an explanation of the reasons for the denial of a NFHCS service**. The right to **exercise and enjoy all civil rights** including but not limited to the right to register to vote, practice a religion or faith of choice, and associate and communicate freely and privately with others.
- The right to **be free from neglect, punishment, and mistreatment or physical or verbal abuse** by staff, contract personnel or by other individuals of NFHCS services.
- The right **to be free from the use of any form of seclusion and freedom from physical restrain** except in emergency situations as noted in the NFHCS's Restrictive Procedures Policy. The policy will present a clear, present, and unavoidable danger for bodily injury to self or others may be physically restrained.
- The right to **a current, written individualized service/rehabilitation plan** that is consistent with the identified services of choice and addresses the c1ient's mental health, physical health, vocational, educational, social, and economic needs.
- The right to **active participation in the establishment, periodic review, and reassessment of the individual service/rehabilitation plan**.
- The right **to service in a community setting**, which is the most independent setting feasible, as defined in the individual's service/treatment plan.
- The right **to be informed of and consent or refuse any service, rehabilitation goal, or treatment upon** full explanation of the expected consequences of such consent or refusal. This right is extended to a parent or legal guardian on behalf of a minor or incapacitated individual.

- The rights to have **the opportunity to consult with independent service providers**, treatment specialists, legal counsel, or advocates at one's own expense and assistance in contacting such entities.
- The right **to not be required to participate** in any research projects.
- The right **to be advised of and consent or refuse observation** by such techniques such as one-way mirrors, tape recorders, video cameras or photographs.
- The right to confidentiality of information regarding participation in any service and of all personal identifying information.

No confidential information will be disclosed unless the individual (parent or legal guardian of a minor individual or court-appointed guardian of the person of an adult individual) specifically authorizes a written release of information. This right is limited by the NFHCS's Policy on Confidentiality requirements for nonconsensual disclosure:

- to professionals actively engaged in treating the individual
- to third party insurance payers
- by Federal or State laws
- by order of a court
- In response to an emergency medical situation to prevent serious risk of bodily harm or death

The right **to have access to and control the release of your own service/rehabilitation record** upon request to and approval by the Executive Director (ED) of NFHCS, who reserves the right to limit access to specific NFHCS records/documents in the following situations:

- If your interdisciplinary or clinical team document that disclosure of specific information will constitute a substantial detriment to you, or that disclosure of specific information will reveal another individual's identity or breach the trust or confidentiality of persons who have provided information upon an agreement to maintain confidentiality, under those limited circumstances such information may be withheld from you.
- Should a request to have access to your service/rehabilitation record be denied then the ED shall record, date, and sign the justification for denial in the individual's record.
- The right **to be informed in advance of the reason(s) for discontinuance of service provision**, and to receive and be involved in post discharge planning for the consequences of that event.

- The right **to know the cost of NFHCS services**.
- The right **to exercise all rights without reprisal** in any form including continued access to service.
- The right **to file a grievance, and the right to have oral and written instructions for filing a complaint**. NFHCS staff have been instructed to assist any individual of service in communicating a complaint to appropriate supervisory staff.

Additional "Residential Services" Rights:

- The right **to privacy of self during treatment**, in bathrooms, bedrooms and during personal care and privacy of personal possessions. The NFHCS will provide for appropriate limited storage for personal possessions in "Residential" services (NFHCS, reserves the right to forbid possession of weapons, illegal items or items reasonably judged to be dangerous or hazardous to others in NFHCS owned/leased property).
- The right **to be free to choose and wear your own clothing**.
- The right **to be free from excessive medication**.
- The right **to receive scheduled and unscheduled visitors**, communicate, associate, and meet privately with family and persons of the individual's own choice. NFHCS., reserves the right to establish reasonable guidelines to assure that the rights of other individuals to a quiet and peaceful environment are protected by requesting that visits occur at reasonable times of the day and night.
- The right **to receive, purchase, have and use personal property**. This right is contingent upon possessing and using personal property which does not violate the rights of other individual's reasonable expectations to a reasonably peaceful and quiet residence. NFHCS reserves the right to forbid possession of weapons, illegal items or items reasonably judged to be dangerous or hazardous to others in NFHCS owned/leased property.
- Individuals will not be required to work at the home, except for the upkeep of the individual's personal living areas and the upkeep of common living areas and grounds.
- The right **to participate in any appropriate and available NFHCS service**, regardless of refusal of one or more other services, programs, or activities and regardless of relapse while in that earlier service, unless there is a valid and specific necessity which precludes and/or requires the individual's participation in other services. This necessity shall be explained

to the individual and written in the individual's current individualized service plan.

- The right **to unrestricted mailing privileges**, access to United States Mail and the opportunity to send and receive uncensored and unopened mail.
- The right **of reasonable access to a telephone** and the opportunity to make and receive confidential calls, with assistance, when necessary. Individuals living in a NFHCS owned, or leased residences have the right to install a telephone in the apartment/bedroom in which they reside.
- The right **to manage personal financial affairs**. Individuals who have been legally declared incapacitated to manage their financial affairs will have an authorized guardian, trustee or designee assigned the responsibility of managing their funds.
- Individuals shall be informed of their rights through this Individual Rights Policy prior to or at the beginning of service delivery and annually thereafter.

ACKNOMLEDGEM£NT OF INDIVIDUALS RIGHTS POLICY

I, [name of Individual], acknowledge and agree that I have received an explanation and copy of NFHCS Individual Rights Policy

Individuals Signature Date:	Individual's Legal Representative/Guardian (if applicable) Date
Individuals Signature Date:	Individual's Legal Representative/Guardian (if applicable) Date
Individuals Signature Date:	Individual's Legal Representative/Guardian (if applicable) Date
Individuals Signature Date:	Individual's Legal Representative/Guardian (if applicable) Date
Individuals Signature Date:	Individual's Legal Representative/Guardian (if applicable) Date

4.3 Successful Implementation of Each Individual's Back-Up Plan

Implemented: December 2015 **Revised:** August 2021

Reference/Source: ODP quality assessment and information (QA& I) updated 06/22/18, 55 Pa. Code Chapter 51 Section 51.32 (b) ODP Bulletin 00-15-01, Individual Support Plans (ISPs); Page 15 (3.8) of Attachment # 1, Informational Memo 069-13 "Office of Developmental Programs Home and Community-Based Services Regulation Questions and Answers"

Persons Affected: Individuals, Families (if applicable), Guardians/and Staffs of NFHCS.

Our Purpose: Our purpose is to inform the affected of Not Forgotten Home & Community Services, of the written protocol in accordance with the Chapter 51 regulations, to ensure the successful implementation to each of our Individual's Back- up Plan

Definitions:

- **NFHCS**- Not Forgotten Home & Community Services
- **Department**: The Department of Health & Human Services of the Commonwealth
- **BUP**- Back-up Plan
- **ISP**- Individual Support Plan
- **ED**- Executive Director
- **DBHS**-Director of Billing and Habilitation Supports
- **DP**- Director of Programs
- **DSP**-Direct Support Specialist
- **PL**- Program Leads

Policy/Procedures Objectives:

- NFHCS assurance and verification that the service(s) we provide are being provided at the frequency and duration established in the Individual's ISP.
- Verification that the service is provided during a change in staff, such as shift changes or changes in our staffing patterns.

NFHCS Policy: NFHCS is obligated and committed to rendering services according to the approved and authorized ISP.

Definition: A back-up plan is the strategy developed by a provider (NFHCS) to ensure the HCBS the provider is authorized to provide is delivered in the type, amount, frequency, and duration as referenced in the individual's ISP.

These back-up plans are developed with the unique needs and risk factors of the Individual in mind and discussed and shared with the Individual and the team. NFHCS must develop and provide detailed information in the back-up plan in accordance with 55 Pa. Code 51.32, when our Individuals are supported in their own private residence or other settings where staff might not be continuously available**.**

Implementation: The ISP should include a backup plan to address contingencies such as emergencies, including the failure of a support worker to appear when scheduled to provide necessary services. When the absence of the service presents a risk to the Individual's health and welfare.

SC Responsibilities: SCs should monitor that the individual is receiving the appropriate type, amount, duration, and frequency of services to address the individual's assessed needs and support desired, Outcome Statements as documented in the approved and authorized ISP.

SC Notification: If services are not rendered per the ISP due to the Individual not being available because they are in hospital/rehabilitation care for an extended period, NFHCS *MUST* notify the SC and AE immediately.

NFHCS BACK- UP Plan Development: NFHCS must develop and provide detailed information on the back-up plan for each HCBS; NFHCS renders for an Individual to the Individual and the SC for inclusion in the ISP.

This policy is a written protocol to ensure the successful implementation of each Individual's back-up plan contains information that:

- Assures and verifies the HCBS is being provided at the frequency, duration and amount established in the Individual's ISP. This will be verified be utilizing our In-service Verification form.
- The below graph is a sample of the form's contents:

Individuals Name	Date of Service	Present	Absent (Hospital, Therapeutic leave)	Amount of in-service days	Amount of absent days

- Verifies that the HCBS is provided during a change in staff, such as shift changes or changes in staffing patterns.

Procedure: Failure of Support Staff worker not appearing or changes in the staffing pattern:

- In the event, of one of our staff workers not appearing for a scheduled shift. (e.g., a Residential Direct Support) The Support Staff on duty will remain with our Individuals until properly relieved. (Mandated stay up to 16 hours). (If staff has been there for the allotted time and/ or can't stay, the Program Leads/ Supervisor must work that shift.
- If a staff member fails to show up at an Individuals Home the Assigned Supervisor, will ensure continuum of care and work the scheduled shift. Please see call tree below.
- In the event of a shift change or a change the staffing pattern. The DSP on duty (if applicable) will remain with our Individuals until properly relieved. (Mandated stay up to 16 hours.) If a staff person fails to show for his/her shift. The immediate Supervisor will need to be notified. If a replacement staff could not be obtained, the staff's immediate supervisor (will be required to work that shift) Please see call tree below.
- Should a DSP have to leave a change in the staffing pattern: The staff is required to call his/her immediate supervisor. And wait to be properly relieved. Staff must never leave our Individuals alone. (Unless indicated in the ISP)
- Should the Supervisor, be unavailable, The ED/DP will need to find a replacement DSP to relieve the DSP or (the Assistant/ Executive Director) will have to work the shift.
- Should the Supervisor, DP, or a replacement DSP be available, The ED will fill in to replace the DSP worker.

	Habilitation	**Residential**	**Activities**	**Administration**
1st Contact	Director of Billing and Habilitation Supports	Program Lead	Director of Creative Services/Activities	Director of Administration

2nd Contact	Executive Director	Executive Director/Director of Programs	Executive Director	Executive Director
3rd Contact	Director of Services	Program Specialist	Director of Administration	Director of Services
HR Related	HR Specialist	HR Specialist	HR Specialist	HR Specialist
Medical	911	Nurse Coordinator/911	911	911
Training	Training Coordinator	Training Coordinator	Training Coordinator	Training Coordinator
Services/Utilization	Director of Services	Director of Services	Director of Services	Director of Services
Therap	Assigned Approver	Program Leads	Director of Services	Director of Services
Billing/Payroll	Chief Financial Officer	Chief Financial Officer	Chief Financial Officer	Chief Financial Officer

- NFHCS will implement the Individual's back-up plan when an individual is available for the authorized HCBS to be delivered. And if an event occurs which requires NFHCS to implement the back-up plan, so the HCBS continues to be rendered as specified in the approved ISP.
- Any deviation in frequency, duration, or amount of HCBS as specified in the ISP due to our failure to implement a back-up plan when an Individual is available to receive the HCBS will result in an incident report of neglect. Which is specified in chapter 51.17 (relating to incident management).

Staff Resources:

- 55 Pa. Code Chapter 51 Section 51.32 (b)
- ODP Bulletin 00-15-01, *Individual Support Plans (ISPs)* Page 15 (§ 3.8) of Attachment # 1
- Informational Memo 069-13 "Office of Developmental Programs Home and Community-Based Services Regulation Questions and Answers"

4.4 Accessibility of Intellectual Disability Services for Individuals who are Deaf

Implemented: December 2015 **Revised:** October 2018

Reference/Source: ODP Bulletin 00-14-04, Accessibility of Intellectual Disability Services for Individuals Who Are Deaf, ODP Bulletin 00-08-18 Communication Supports & Services, ODP Quality Assessment & Improvement 06/22/18

Persons affected: Individuals, Family/ Guardians, Friends of the Individuals, Support Coordinator, Staffs, including Contractors and unpaid volunteers of Not Forgotten home & community services

Our Purpose: Our purpose is to inform the affected of Not Forgotten Home & Community Services, of our written protocols in place that address accessibility for individuals who are deaf as specified in ODP Bulletin 00-14-04, Accessibility of Intellectual Disability Services for Individuals Who Are Deaf.

Definitions:

- **NFHCS**- Not Forgotten Home & Community Services
- **Department**: The Department of Health & Human Services of the Commonwealth
- **ODP**- Office of Developmental Program
- **AAC**- Augmentative and Alternative and Alternative Communication
- **ADA**- Americans with Disability Act
- **ASL**- American Sign Language. Include: Sign language from other countries, such as Spanish sign language: signed exact language: a mixture of ASL and signed English: textile sign: and visual gestural communication.
- **HOH**- Hard of Hearing.
- **ISP** - Individual Support Plan
- **IEP** - Individualized Education Plan

Certified Deaf Interpreters (CDI) - An interpreter certified by the Registry of Interpreters for the Deaf who is deaf or hard of hearing. A CDI is required to register with the Office for the Deaf and Hard of Hearing per the Sign Language Interpreter and Transliterator State Registration Act. In addition to proficient communication skills and general interpreter training, the CDI has specialized

training and/or experience in the use of gesture, mime, props, drawings, and other tools to enhance communication.

The CDI has knowledge and understanding of deafness, the Deaf community, and Deaf culture. The CDI possesses native or near-native fluency in American Sign Language. Often a CDI works in conjunction with a Pennsylvania registered interpreter when a person who is deaf has a unique mode of communication that is not readily understood by the interpreter who can hear for various reasons.

4.5 Visitation

Implemented: November 2017 **Revised:** September 2018; September 2020

Background: Guidance for Not Forgotten Home and Community Services (NFHCS), Visitation in Residential Settings, Licensed by the Office of Developmental Programs (ODP) in the Green Phase.

Audience: Individuals, families, and designated persons, Staffs of Not Forgotten Home and Community Services and all interested parties.

Purpose: To provide guidance on NFHCS updated visitation policy in our residential settings. Code Chapter 6500).

Discussion: Governor Wolf's Process to Reopen Pennsylvania includes a strategic three-phase, color coded matrix to determine when counties are ready to begin easing some restrictions on work, congregate settings, and social interactions.

On May 13, 2020, ODP released ODP Announcement 20-052 Update, which provided updated guidance for rendering services in "Yellow Phase" counties and included information about visitor restrictions in residential settings.

Per the Governor's Process to Reopen Pennsylvania, homes located in counties in the "Green Phase" may lift visitation restrictions in certain congregate care settings using the guidance provided in this document.

ODP and NFHCS recognizes that many families and persons designated by our individuals who live within our residential settings are eager to resume in-person visits with their friends and loved ones.

Decision: NFHCS has taken the position to continue our Non visitation policy **within** our Residential Settings until June 26, 2020. Enclosed are additional options that have been approved and considered.

Outside Visitation: NFHCS encourages all individuals and visitors to:

- Be aware of and comply with Governor Wolf's Green Phase social restrictions

- Wear cloth or surgical masks when within six feet of others. (***Individuals within NFHCS will be supplied masks)***
- Continue to practice social distancing
- Select outdoor activities that will minimize exposure to other people such as visiting a park or other open areas.
- Continue hand washing practices when practicable **or** use hand sanitizer.

NFHCS discourages community outings in counties that <u>have not</u> transitioned to the Green Phase. For the most up to date in formation on the phased reopening plan, please click here: <u>https://www.pa.gov/guides/responding-to-covid-19/#PhasedReopening</u> or visit PA Department of Health.

Our commitment to Facilitating Personal Relationships: When in-person visitation continues to be restricted to contain the spread of the COVID-19 virus, NFHCS is responsible to facilitate ongoing communication between individuals, family members, friends, and anyone else the individual chooses to communicate with during the COVID-19 pandemic.

Unless otherwise indicated by the individual: The expectation is that communication with family and friends continue to be fully supported on a regular and routine basis for everyone.

NFHCS will aid our individual(s) to communicate with friends and family, when needed. We are committed to assist the individual(s) with learning new ways to communicate with people he or she has a relationship with.

This includes but not limited to: creative ways that assist the individual to remain in contact with family and friends and feel comfortable with the method of communication.
Examples:

- Arranging a meeting that occurs between an individual or family/friends viewing each other through a window or glass door, so that social distancing guidelines can be followed
- Using technology such as FaceTime, Skype, Zoom meetings, Facebook, Messenger, etc. Promoting communication through telephone calls, email, writing letters, texting, sending photographs or videos, or the use of virtual assistant technology (ex. Amazon's Alexa or Google Home)

Internet Access: NFHCS Residential Homes have access to the internet. * Per ODP's regulations, the provision of internet services **is included** as part of room and board for Residential Habilitation services. In homes that provide services to more than one individual, access to items such as (Amazon Fire tablets) may be scheduled to allow everyone access to their preferred method of contact.

Our Staff, including Program Specialists, Program Leads, and/or Direct Support Professionals, must collaborate with our individuals and family/friends to plan available time to communicate.

Next Phase: The ODP has offered the following guidance to assist NFHCS in developing procedures that will allow for in-person visits in a safe and judicious manner.

Visits That Occur Inside the Home: NFHCS will continue to update written "Visitation Policy" for in person visits.

This policy will be disseminated to all individuals and persons designated by the individual.

Our Updated Visitation Policy will include, at a minimum:

- Scheduling in-person visits in advance of the visit
- Establishing "visiting hours" for in-person visits
- Limiting the number of visitors who may enter the home per individual, (e.g., no more than two visitors at any time).
- Requiring social distancing
- Staggering visitation times such that only one individual receives in-person visits at any given time.
- Restricting visits that take place in the home to areas that reduce contact with other individuals, e.g., the individual's bedroom or an outdoor area on the premises.
- Requiring visitors to wear cloth or surgical masks when present in the home and continue hand washing practices when practicable or use hand sanitizer
- **Strictly Prohibiting** visitors from entering any of our home(s) where individuals who are at higher risk for serious illness from COVID-19 reside.
- **Prohibiting** any visits from people **<u>who are</u>**:
  - Currently diagnosed with COVID-19
  - Have been exposed to someone with COVID-19 in the 14 days prior to the visit.

- Are demonstrating symptoms of COVID-19 or any other illness.

Information about people who are at higher risk for severe illness is available at https://www.cdc.gov/coronavirus/2019-ncov/need-extra-precautions/people-athigher-risk.html

A plan for implementing screening procedures for visitors, such as taking each visitor's temperature using a no-touch thermometer **and** asking the visitor(s) are they experiencing shortness of breath or has a cough.

Statement: Our Visitation Policy may be modified based on future changes to visitation guidance issued by the Pennsylvania Department of Health or ODP.

Person-Centered Planning and Support: NFHCS has a responsibility to identify any skills the individuals need to acquire **or** practice to participate in desired in-person visits and assist individuals in learning skills. This includes learning how to practice social distancing, wear masks, and hand washing protocols.

Should you have any questions, regarding this policy update, please contact the following.
Persons responsible: Incident Manager & Contracted Compliance Officer

_____ _____
Individuals Signature Date

_____ _____
NFHCS Program Specialist Date

4.6 Policy on Confidentiality of Individual Records/Information

Implemented: December 2015 **Revised:**

Background: One of the primary responsibilities of all Not Forgotten Home & Community Services, Inc. staff members is to safeguard all individual information. All staff, including volunteers and students, are bound by the law of the Commonwealth of Pennsylvania and by NFHCS (NFHCS) policy not to reveal the identity or condition of any individual to unauthorized persons, and are further expected to follow conscientiously all sections of the NFHCS (NFHCS) Policy on Confidentially.

Release of Information: No information about an individual will be communicated to any other person, NFHCS, or facility unless the following conditions have been met:

- An individual or his or her authorized representative may consent to the release of information provided that written consent is given on a form containing the following information:
    - The name of the person, NFHCS, or organization to which the information is to be disclosed
    - The specific information to be disclosed
    - The purpose for the disclosure
    - The date the consent was signed and the signature of the individual witnessing the consent
    - A notice that the consent is valid only for a specified period
    - Actual date information is released
    - The signature of the staff releasing the information

- The written consent of an individual or his/her legally appointed guardian/advocate, for the disclosure information shall be considered valid only if the following conditions have been met:
    - The individual or the representative shall be informed, in a manner calculated to assure his or her understanding, of the specific type of information that has been requested and, if known, the benefits and disadvantages of releasing the information.
    - The individual or the representative shall give consent voluntarily.
    - The individual or the representative shall be informed that the provision of services is not contingent upon his/her decision concerning the release of information

- The individual's consent shall be acquired in accordance with all applicable federal, state, local laws and NFHCS rules and regulations.

In general, upon receipt of assigned release of information (written consent) from the individual or authorized representative, the primary staff person will prepare a summary of pertinent and essential information or will copy the information, and only that information, which has been requested. A signed release from the individual must be secured each time information is requested. This provision applies to requests from all agencies. At no time may an individual be asked to sign a blank release of information form.

- All individual information so released must be stamped or otherwise labeled: "Confidential". It is the responsibility of the Service Director to see to it that this stamp/label is affixed to all information to be released, whether it be a form, a summary, a letter, or photocopies.
- Copies of all requests for information, all signed release of information forms, copies of the summaries forwarded or a list detailing the information released must be added to the individual's chart.

Confidentiality Policy: Since it is generally recognized that program records are the property of the NFHCS, under the direct control of the Executive Director, and that program records do not fall under the provisions of freedom of information laws, the Executive Director may reserve to herself the decision to release, or not release, information when it is in the individual's best interest.

Program Records: In order to further ensure confidentiality, the following steps must always be taken:

- Only the **name** of the individual involved should be listed in program notes, records, incident reports, etc. No other individual should be listed by name in records pertaining to other individuals.
- At no time may a program record owned by *NFHCS, Inc.,* be physically removed from the premises controlled by NFHCS. Individual records may be **transported** in the case of need by a designated NFHCS staff. When individual records are being so transported, they must remain at all times in the possession of the transporting staff person.
- At the end of each business day, all program records are to be **secured** and **locked**, inside NFHCS file.

- Discretion must always be exercised in the use of individual information from program records for **clinical discussion** or **educational efforts** and the identity of the individual must be totally disguised.

Permitted Violation of Confidentiality: Confidentiality may be violated only when a clear and present danger exists to the individual and/or others, as defined by the Mental Health Procedure Act of 1966 of the Commonwealth of Pennsylvania. Such information may then be released only to the appropriate professional and civil authorities.

"Clear and present danger" is defined as follows:

- The person has acted in such a manner as evidenced that he/she would be unable, without care, supervision, and continued assistance of others, to satisfy his/her need for nourishment, personal or medical care, shelter or self-protection and safety, and that there is reasonable probability that death, serious bodily injury, or serious physical debilitation would ensue within 30 days unless adequate treatment were afforded.
- The person has attempted suicide and there is reasonable probability of suicide unless adequate treatment is afforded.
- The person has severely mutilated himself or attempted to mutilate himself severely.

4.7 Planning Standards Procedures

Implemented: December 2015 **Revised:**

Support/Service Planning Guidelines: Service planning is done in accordance with NFHCS mission, professional standards and within planning guidelines.

Respect: ISP meetings will be done in an atmosphere of respect and dignity for the person supported and all involved, adhering to the highest standard of privacy and confidentiality. Each person will be present, listened to, encouraged, and valued.

Individual Choice*:* In all support planning, the person and/or family will exercise their right to express their choice in choosing outcomes, methods, and resources to the extent possible.

Each person and/or family will be assisted in the planning process to the maximum extent possible to aid them in expressing their needs, wants and desires in whatever form possible including the use of assistive technology. All communication will be documented in clear everyday language; all planning will be conducted face to face with the person being supported.

Each person and/or family will be assisted through the planning process to become active Individuals in their community to the best of their ability and interest.

Team Support: Each person and/or family will be assisted in gathering an effective team of supporters, based on personal preference.

Each personal support planning will encourage the furtherance of the person's independence to live, work, volunteer, learn, worship, recreate and develop as they wish.

Each personal support plan will have objectives and outcomes that are thoughtful, meaningful measurable and obtainable.

Each person, family, and the Individual support planning team will promote activities that recognize, acknowledge, and embrace the strengths of individual uniqueness related to ability, age, culture, ethnicity, gender, interests, perspective, race, religion, sexual orientation social economic status, and talent.

4.8 Transition of Individuals

Implemented: December 2015 **Revised:** September 2018; September 2020; August 2021

Reference/Source: Pa code Chapter 51.31, ODP question, answers, and information (QA& I) updated 06/22/18

Persons Affected: Individuals, Families, (if applicable), Guardians/ the department or the department designee, support coordinator, support coordinator organization and staffs of Not Forgotten Home & Community services.

Our Purpose: Our purpose is to inform the affected of Not Forgotten Home & Community services, of our Transition of Individual's Policy in accordance with PA. Code Chapter 51.

Definitions:

- **NFHCS**- Not Forgotten Home & Community Services
- **DHS**: The Department of Health & Human Services of the Commonwealth
- **HCBS**- Home & Community Base Service
- **SC**- Support Coordinator
- **SCO**- Support Coordinator Organization
- **AE**- Administrative Entity

Policy/ Procedures Objectives: Written notice to the following in accordance with Chapter 51:

- Our Individual
- The Department/or Department Designee
- The SC and the SCO/SCA

Written notice includes:

- The HCBS NFHCS is unwilling or unable to provide
- The location where the HCBS is currently provided
- The reason(s) NFHCS is no longer willing to provide the HCBS to the Individual
- A detailed description of the efforts made to address or resolve the issues that has led NFHCS becoming unwilling or unable to deliver the HCBS to the Individual
- Suggested times frames for transitioning the delivery of the HCBS to a selected willing & Qualified Provider

- NFHCS Name & MPI Number

NFHCS Requirements: When an Individual select's another willing and qualified provider to replace NFHCS both providers must cooperate with:

- The Department or the Department's designee
- The Individual
- The Individual's SCO or SCA during the transition between providers
- NFHCS will continue to provide the authorized HCBS during the transition period to ensure continuity of care until a willing and qualified provider is selected and/or unless otherwise directed by the Department or the Department's designee
- NFHCS will provide written notification to the Department or the Department's designee if NFHCS cannot continue to provide the HCBS until another willing provider is selected due to emergency circumstances.
- If NFHCS is the (selected willing provider**)** We must fully cooperate with transition planning activities including participation in transition planning meetings

Our Process: When NFHCS becomes a provider, we must ensure the following:

- Participation in transition planning meetings to aid in the successful transition from the previous provider.
- Full cooperation with visitation schedules identified during the transition meeting.
- Arrangements for the transportation of the on-boarding Individual that supports the visitation schedule.
- Ensure previous Provider has closed all open incidents in EIM (get assistance if need) Previous Provider must provide documentation of closed incidents.
- Ensure no undue influence has been exerted to the incoming Individual in making the choice to come to NFHCS.

Our Process if an Individual is transitioning from NFHCS to another willing provider.

NFHCS must ensure the following:

- Participation in transition planning meetings to aid in the successful transition to the new willing provider.
- Full cooperation with visitation schedules identified during the transition meeting.

- Arrangement for the transportation of our Individual to support the visitation schedule.
- Close all open incidents in EIM.
- Ensure no undue influence is exerted when our Individual is making the choice to a new willing and qualified provider.

Procedure: If NFHCS**,** exhausted all measures to provide and HCBS to an individual, NFHCS will provide written notice at least 45 days prior to the date of discharge to:

- Our Individual
- Individuals Family / Guardian (If applicable)
- The Department or the Department's designee
- The SC / SCO

NFHCS will provide written notification that includes the following:

- The HCBS NFHCS is unwilling or unable to provide services
- The HCBS location where the HCBS is currently provided
- The reason why NFHCS is no longer willing to provide the HCBS to the Individual
- A description of our efforts made to address or resolve the issue that has led to NFHCS becoming unwilling or unable to deliver the HCBS to our Individual
- Suggested time frames for transitioning the delivery of the HCBS to another selected willing and qualified provider
- Our provider's name: Not Forgotten Home & Community Services
- Our Master Provider Index Number
- NFHCS will provide available records to the selected willing provider within 7 days of the date of transfer.
- NFHCS will cooperate with any transition planning activities of any new Individual to whom we may intend to provide service.

NFHCS will also need to assist the individual's ISP Team with filling out **The New Home Transition Checklist** written notification that includes the following:

- The checklist needs to be sent to AE, within 14 days prior to the move date
- AE is going to be using the checklist for ISP approval and authorization of the move

Staff Resources: PA Code Chapter 51.
https://www.pacode.com/secure/data/055/chapter51/chap51toc.html#51.31.

Individual Transitional Guide due to COVD-19: COVID-19 Individual Transition Guide the Individual Transition Guide (ITG) was designed to assist individuals, families, Supports Coordinators (SCs) and the rest of their team with identifying supports and services needed for individuals to reengage in activities outside of their home, if and when they choose to do so, when stay-at-home orders imposed as a result of the COVID-19 pandemic are lifted. This guide should be used to evaluate an individual's circumstances as conditions change and teams reconvene and reevaluate if revisions or modifications to an individual's supports and services are necessary. SCs should begin collecting information during their weekly well-being check ins and facilitating team discussions.

The ITG should be used to identify any changes in support needs, services, risk mitigation strategies and plan outcomes as outlined in the individual's ISP. SCs should use the Annotated ISP in conjunction with this transition tool with an emphasis on the health and safety focus areas.

The ITG includes six core areas to consider when an individual is transitioning to more activities outside of the individual's home: Desire to Return to Community Activities and Settings, Physical Health Status, Infection Control Measures, Mental Health and Behavioral Health Needs, Changes in Routine, Conditions of Supports and Services. Each section includes questions for consideration, guidance that is based on where the individual may be in each of the six core areas, and resources that may be helpful. The questions are framed for the individual but can also be asked to family/caregivers.

It is critical for teams to consider provider impacts and if they are able to resume services at the same level as before the stay-at-home orders were put in place as a result of the COVID-19 pandemic. For some providers, it will only be possible to render services when their location is in the green phase. For example, some facility-based day CPS may be unable to serve the same number of people due to social distancing guidance. Teams need to consider what additional or alternative services would need to be put in place to support the individual to engage in community activities.

This document is intended to be used as a guide for conversations the SC is having with the individual and their family and the results of the ongoing discussions and next steps should be documented in service notes.

Desire to return to community activities and settings questions to consider:

- Are you able to do the things you liked doing before the stay-at-home order went into effect?
- Are the preferred activities currently closed or have limited access? (Some examples might be shopping, movies, bowling, volunteering.)
- What do you like to do/what are your preferred activities? • How do you feel about going out into the community to participate in activities you enjoyed before the stay-at-home order?
- How would you like to spend your day?
- Are there any concerns/anxiety about community activities and transportation to/from community activities?
- Have you noticed new strengths/resiliencies that have come out during this time for you and your family? (For example, did you spend time doing something new or find a new hobby that you didn't do before, like cooking?)

Guidance: If the individual is demonstrating a desire to return to community settings and/or activities then:

- The SC should facilitate a conversation with the individual, their family/caregivers and team to assess if the individual needs support with reintegrating back into the community. This should be very individualized and highly dependent on the unique needs of the individual and potential challenges.
- Plan for supporting the individual in returning to those activities, if they are available and in accordance with ODP guidelines (for example, transportation trip should limit the number of passengers).
- If it is an activity that cannot be done while complying with current precautions, identify and offer alternative activities that the individual might enjoy instead.
- The team should discuss how the individual typically engages with others, both people they know and people they do not know to identify risks and mitigation strategies.
- If the individual is unsure or is expressing some anxiety about returning to community settings and/or activities, then:
- The SC should facilitate a conversation with the individual, their family/caregivers and team to assess if the individual needs support with reintegrating back into the community. This should be very individualized and highly dependent on the unique needs of the individual and potential challenges.
- Consider continuing to support the individual remotely and engage the providers to help them identify solutions to ease anxieties.
- Consider ways to systematically expose an individual to the community in hopes of assuaging the individual's concerns or anxiety.

- If the individual appears unwilling to return to community settings and/or activities or is expressing significant anxiety about returning to community settings and/or activities, then:
- Continue to support the p individual in their current environment and then reengage in conversations over time in an effort to build up to increasing their comfort levels.
- The SC should facilitate a conversation with the individual, their family/caregivers and team to assess if the individual needs support with reintegrating back into the community. This should be very individualized and highly dependent on the unique needs of the individual and potential challenges.

Resources:

- https://aidinpa.org/back-into-the-community-who-to-listen-to-and-what-to-trust/
- https://paautism.org/resource/vision-boards-community-supports/
- https://asdnext.org/resource/activities-community-social-recreation/
- https://paautism.org/resource/social-distancing-social-story/
- https://paautism.org/resource/wearing-mask-social-story/
- https://aidinpa.org/safety-while-completing-errands/

Physical Health Status

Questions to consider:

- How do you feel physically?
- Have there been any changes in your health status since the initiation of restrictions as a result of the COVID-19 pandemic?
- Do you have any signs or symptoms of COVID-19?
- Have you or anyone in your household been tested for COVID-19? If so, what were the results of the test?
- Prior to the COVID-19 pandemic, did you have any medical conditions that required support?
- Do you have any identified health risks? (Diabetes, lung disease, high blood pressure, age (65+), other risks identified through the health risk screening tool for people in residential services)
- Are you taking all prescribed medicine, if applicable?
- Are you on a special diet? Have there been any changes to special dietary precautions?
- Are any members of your household sick or have a positive COVID-19 diagnosis?

Note: In addition to the typical symptoms of COVID-19 that are identified by the CDC, ODP providers have noted that for individuals with ID/A, COVID-19 infection has presented as weakness or a change in baseline behavior without or prior to

respiratory symptoms emerging. Providers should take this into consideration during service provision and screenings prior to service provision and closely observe individuals for weakness or changes in behavior that may be indicative of illness.

Guidance: If the individual has recovered fully from COVID-19, or has no signs/symptoms of COVID-19, or is able to report on potential emergence of COVID-19 symptoms or has reliable family/caregiver to do so, and has no other physical health issues then:

- Consider how to support the individual returning to increased community activities, if they are available, while continuing to monitor and check in on current health status.

If the individual has any signs/symptoms of COVID-19 other than a fever (cough, shortness of breath/difficulty breathing) or is not able to report on potential emergence of COVID-19 symptoms and/or does not have reliable family/caregiver to do so, or is having some other physical health issues, then:

- Put strategies in place to ensure that health issues are being addressed and followed up on by the appropriate medical experts and COVID-19 testing is considered; 5
- Services should be provided remotely, if applicable.
- Consider how tele-health options can support the individual.

If the individual has active, confirmed COVID-19 symptoms/illness, or awaiting results of COVID-19 screening, or has current signs/symptoms consistent with COVID-19, or has any high-risk health conditions, then:

- The individual should seek medical attention and team transition discussions should be on hold until the health issues are resolved.
- Consider how tele-health options can support the individual.

Resources:

- https://www.health.pa.gov/topics/disease/coronavirus/Pages/Coronavirus.aspx
- https://paautism.org/health
- https://paautism.org/resource/telehealth-covid19/
- https://aidinpa.org/telehealth/

Infection Control Measures

Questions to consider:

- Are you washing your hands frequently?
- Do you need support with washing your hands?
- Are you able to practice social distancing when you are interacting with others? Do you understand why that is important? (For example, if you saw

your friend today, what would you do? Give her a hug, stand back and wave?)
- Are there challenges in maintaining social distancing? If so, what are they?
- Do you have a mask and are you able to wear it to go out for activities?
- How long can you wear a mask?
- If you live at home with your family, does everyone in your family have masks?
- Can you and do you cough or sneeze into your elbow?
- Will you agree to participate in screening precautions when engaging in community activities (temperature checks, etc.)?
- Do you have allergies or sensitivities to cleaning products or hand sanitizer/soap?
- Will your communication be hampered using masks, either receptively (read lips) or expressively?
- Are you working?
- Are you able to follow all the new safety measures at work?

Guidance: Teams must plan based on the individual's ability to engage in social distancing, use of masks, and regular handwashing and sanitizing safety precautions. If the individual is able to independently or with supports practice good hand washing/hygiene, social distancing, wear a mask for the amount of time needed for a given activity, cough, or sneeze into elbow, then:
- Support the individual in returning to community activities if they are available

If the individual inconsistently practices good hand washing/hygiene, social distancing, wearing a mask for the amount of time needed for a given activity, coughing, or sneezing into elbow, then:
- Support the individual in improving their skills related to following the proper safety precautions to avoid contracting or spreading COVID-19. 7 If the individual is not able or is unwilling to (with or without supports) practice good hand washing/hygiene, social distancing, wear a mask for the amount of time needed for a given activity, cough, or sneeze into elbow, then:
- If there is a medical reason preventing an individual from being able to wear a mask, continue providing supports the individual is currently receiving until the requirement to wear masks is lifted.
- Continue supporting the individual in their current environment and then reengage in conversations over time and build up to increasing their ability and/or willingness to practice necessary safety precautions to avoid contracting or spreading COVID-19.

Resources:
- https://www.google.com/search?q=face+mask+with+clear+window&sxsrf=ALeKk03tvkkCI6rNxlZZ4ALwsmitUTLnvA:1588692738156&source=lnms&tb

m=isch&sa=X&ved=2ahUKEwjFp8LShZ3pAhXngnIEHa1iBG8Q_AUoAnoECAwQBA&biw=1458&bih=720
- https://www.governor.pa.gov/wp-content/uploads/2020/04/20200415-SOH-worker-safety-order.pdf
- https://paautism.org/resource/coronavirus-resources/
- https://paautism.org/resource/coronavirus-social-story/
- https://paautism.org/resource/hand-washing-social-story/
- https://paautism.org/resource/testing-covid-social-story/
- https://paautism.org/resource/wearing-gloves-social-story/
- https://paautism.org/resource/wearing-mask-social-story/
- https://aidinpa.org/handwashing-for-self-advocates/

Mental Health & Behavioral Health

Needs questions to consider:
- Have you acquired any new skills (like coping skills) to help you deal with the COVID-19 crisis?
- Have you noticed any new or worsening symptoms that you think might be related to your mental health?
- Do you have any concerns for your safety (self-harm or aggression)?
- Have you had any problems come up at home that you did not know how to deal with? Do you feel prepared for a problem that might come up?
- Was behavioral support and/or mental health treatment (counseling/therapy) being provided prior to the restrictions as a result of the COVID-19 pandemic? If so, is it still being provided? Is the plan still effective/working?
- Have you experienced any of the following while at home?
    - Stress
    - Isolation
    - Death of a family member, caregiver, friend
    - Someone in your household has/had COVID-19 (individual had to move out of their home for quarantine, change of staff, change of routine)
    - Other traumatic events you may have experienced
- If any of the above were experienced, does behavioral support and/or mental health support (counseling/therapy/grief counseling) and/or other supports need to be provided?

Guidance: If the individual is feeling safe and has the necessary supports and skills to deal with any current mental or behavioral concerns then:
- Support the individual in returning to community activities if they are available. If the individual is feeling unsafe and does not have enough support or skills to deal with any current mental or behavioral challenges, then:

- Ensure that appropriate supports are in place or access to services is available and can help the individual with their mental health/behavioral health needs. If the individual is experiencing a mental health crisis due to their recent experience, then:
- Ensure that appropriate supports are in place or access to services is available and can help the individual with their mental health/behavioral health needs.

Resources:

- https://www.dhs.pa.gov/Services/Mental-Health-In-PA/Pages/default.aspx
- ODP Announcement 20-035: Preventing and Responding to Behavioral Crises.
- https://paautism.org/resource/mindful-about-meltdowns/
- https://paautism.org/resource/coping-covid/
- https://paautism.org/resource/be-well-mental-health/
- https://paautism.org/resource/get-safe-and-be-sound/
- https://paautism.org/resource/how-to-create-a-coping-zone/
- https://paautism.org/resource/mental-health-stressors-coping/
- https://paautism.org/resource/coping-covid/
- https://aidinpa.org/anxiety-what-you-need-to-know/
- https://aidinpa.org/dealing-with-negative-thoughts-and-maintaining-a-sense-of-control/
- https://paautism.org/resource/mental-health-crisis-intervention/
- https://paautism.org/resource/trauma-and-coping/

Conditions of Supports & Services

Questions to consider:

- What services are you currently receiving every week?
- How have you been receiving supports during the stay-at-home order?
- How satisfied were you with those supports?
- How do you want to receive supports moving forward?
- Do you have the assistive technology you need to receive services remotely? (Smart phone, tablets, etc.)
- Have you had the same staff during the stay-at-home order?
- Is there a certain staff person that you would like to continue to support you?
- Do you have access to the necessary technology to be successful with remote supports?
- Do you have what you need to be able to communicate your wants and needs? (e.g., interpreter)
- Do you have a job that you will be returning to?
- Will you need support in order to be able to return to work?

- Are there family supports currently in place that will need to be replaced due to their return to work?
- If you self-direct your services, is there staff (SSPs) available as the 40/60 rule is reinstituted?

Guidance: If the individual does not want any changes to their current supports and services after the stay-at-home order is lifted then:

- Continue to provide the current supports and services as allowed under Appendix K, as long as health and safety of the individual can be assured (for example, continue providing remote services).
- Assess whether the individual has what they need to receive remote supports and/or telehealth (assistive technology) and if not, support them in getting what they need.
- Assess if the individual has lost any skills since the stay-at-home order or gained new skills or competencies. If the individual needs some changes to their current supports and services after the stay-at-home order is lifted, then:
- The team should discuss available options to provide needed supports to the individual (for example, the individual is going back to work and needs support on the job) and adjust accordingly.
- Assess if the individual has lost any skills since the stay-at-home order or gained new skills or competencies. 13 If the individual needs significant changes to their supports and services after the stay-at-home order is lifted then:
- The team should discuss available options to provide needed supports to the individual (for example, the individual's provider had stopped providing services that the individual benefited from) and adjust accordingly.
- Assess if the individual has lost any skills since the stay-at-home order or gained new skills or competencies.

Resources:

- https://aidinpa.org/caring-for-someone-with-covid-19-at-home/
- https://aidinpa.org/staying-connected-while-socially-distancing/

4.9 Individuals Lost & Damage Property

Implemented: October 2018 **Revised:**

Reference/Source: Pa code Chapter 51.27 Misuse and abuse of funds & Damage of Individuals Property, Chapter 51.153, PA Code Chapter 1101, QA & I Quality Assessment Improvement 06/22/18

Persons Affected: Individuals, Families (if applicable), Guardians/ the department or the department designee, and staffs of Not Forgotten Home & Community Services.

Our Purpose: Our purpose is to inform the affected of Not Forgotten Home & Community Services, of our Lost & Damage Property Policy in accordance with PA. Code Chapter 51 and Chapter 6400 Regulations. Our procedures will ensure the replacement of an Individual's lost or damaged property.

Definitions:

- **NFHCS:** Not Forgotten Home & Community Services
- **Department:** The Department of Health & Human Services of the Commonwealth

Policy/ Procedures Objectives: NFHCS commitment to replace the property that was lost or damaged or pay the Individual the replacement value for the lost or damaged item.

Policy: NFHCS Responsibilities: In the event of an Individual's property becoming lost or damage. NFHCS will either replace or pay the Individual the replacement value for the lost or damaged item. If confirmed by NFHCS, Department or the Department's designee. Through a review of the circumstances that an Individual's personal property was lost or damaged by NFHCS while providing an HCBS to our Individual.

Audit and Review Compliance:

- NFHCS records and invoices may be reviewed. And NFHCS may be required to provide a written explanation of billing practices during an audit, fiscal review, or provider monitoring.

- If the Department's audit, fiscal review, or provider monitoring (QA& I) indicates that NFHCS has been billing for HCBS that are inconsistent with Chapter 51 regulations, unnecessary or inappropriate to an Individual's needs or contrary to the Individual's ISP, the Department will suspend payment for not more than 120 days pending the Department's review of billing and HCBS.
- In the event of a suspension of payments, the department will notify NFHCS in writing.

Sanctions: In addition to sanctions provided in chapter 51, 51.153. (Sanctions). NFHCS must also adhere to PA Code Chapter 1101 General Provisions Section 1101.74. **Provider fraud.** 1101.75. **Provider prohibited acts.** 1101.76. **Criminal penalties.** 1101.77. **Enforcement actions by the Department.**

Staff Resources:

- 55 Pa. Code Chapter 51 Section 51.27(e)
- 51.153.
- Provider fraud.
- Provider prohibited acts.
- Criminal penalties.
- Enforcement actions by the Department.

4.10 Sexual Health, Personal Relationships, & Sexuality

Implemented: December 2015 **Revised:** October 2018; August 2021

Policy Source:

- DHS Bulletin 00-18-01
- Everyday lives and values 2016
- ODP News November 2018

Scope:

- Individuals and Families
- Administrative Entity Administrators or Directors
- County Mental Health/Intellectual Disability Program Administrators or Directors
- Supports Coordination Organization Administrators or Directors
- Providers of Targeted Support Management
- Providers of Consolidated, Person/Family Directed Support, Community Living, and Adult
- Autism Waiver Services
- Providers of Adult Community Autism Program Services

DHS Bulletin 00-18-01

Purpose: The purpose of this bulletin is to distribute "Sexual Health, Personal Relationships, and Sexuality Guidelines" and encourage provider agencies to develop policies consistent with the Guidelines.

Background: In 2016, the Office of Developmental Programs contracted with the Institute on Disabilities at Temple University to form a cross-system, statewide committee of individuals with disabilities, professionals, family members, provider organizations, educators, medical professionals, and direct care staff to review and update the Department's Guidelines Concerning Sexuality, which were distributed in 1996. The committee has developed "Sexual Health, Personal Relationships and Sexuality Guidelines" to support the sexual health and relationships of individuals with disabilities.

Discussion: Sexuality at its core is a natural and integral part of who we are. It begins at birth and extends over our life span. It influences how we feel about ourselves and our relationships. The Guidelines are being issued to:

- Promote an environment where individuals with disabilities can pursue personal relationships and their sexuality.
- Promote an environment where individuals with disabilities can receive objective, non-judgmental, comprehensive information regarding sexual health and relationships.
- Establish an expectation that provider agencies develop policies on sexual health, personal relationships, and sexuality consistent with the Guidelines

The Objectives of These Guidelines Are to:

- Promote an environment where individuals with disabilities have the right to pursue personal relationships and their sexuality and experience a life that is no different than that of individuals without disabilities, without being neglected, exploited, or abused.
- Ensure that individuals with disabilities have the same opportunity to receive accurate sexual health and relationship information as individuals without disabilities.
- Establish an expectation that provider agencies develop or review their policies on sexual health, personal relationships, and sexuality. The policies should support the concept of Everyday Lives and be consistent with the below considerations.

Everyday Lives Values as They Apply to Sexual Health, Personal Relationships, and Sexuality:

- Not Forgotten Home and Community Services (NFHCS) will provide an environment where individuals with disabilities can live like individuals without disabilities and not be neglected, exploited, and abused.
- NFHCS will allow individuals to access supports in a manner that ensures their privacy. Privacy covers all forms of communication. Information regarding an individuals' sexual health, personal relationships, and sexuality is private and must be treated with respect and dignity and handled in a professional manner.
- NFHCS organizational and managerial resources are available to staff to support individuals that have issues related to sexual health, personal relationships, and sexuality needs.
- NFHCS must provide resources and training for all staff on understanding, supporting, and responding to sexual health, personal relationships, and sexual issues.
- Individuals are sexual human beings with their own cultural, religious/faith, ethnic and family values.

- An individual may not be discriminated against because of ethnicity, religious affiliation, disability, ancestry, national origin, age, gender, or sexual orientation nor be deprived of civil or legal rights.
- An individual has the right to be free from abuse, neglect and exploitation and has the right to report abuse, neglect, or exploitation.
- An individual has the right to voice complaints or concerns about treatment or services.
- Individuals who are of voting age must be informed of their right to register and vote in all elections. Individuals must also be informed of voting procedures.
- Individuals have the right to refuse administration of prescribed and non-prescribed medications.
- Individuals have the right to enjoy a personal relationship and sexuality in a safe, consensual, and legal manner, while respecting the rights of others.
- Individuals have the same basic rights as Individuals without disabilities to self-identify their gender, sexual orientation, and sexual preferences.
- Individuals have the right to accessible & appropriate education, information, and resources that addresses their individuals' personal relationships, sexual health, and sexual needs.
- Individuals have the right to privacy when accessing supports and have the right to have information about their personal relationships remain private unless they consent to a disclosure. Privacy covers all forms of communication. Information regarding an individual's personal relationship, sexual health, and sexuality must be considered private and be treated with respect and dignity.
- Individuals have the right to enjoy relationships & express their sexuality in a safe manner.
- Individuals have their sexual health & personal relationship supported by NFHCS staff & ISP Plan Team.

Recommendations for NFHCS that are Consistent with Everyday Lives:

- Provide an environment where individuals with disabilities can live like individuals without disabilities and not be neglected, exploited, or abused.
- Allow individuals with disabilities to access supports in a manner that ensures their privacy. Privacy covers all forms of communication. Information regarding an individuals' sexual health, personal relationships, and sexuality is private and must be treated with respect and dignity and handled in a professional manner.

- Have a positive policy on sexuality that is consistent with the values of Everyday Lives. A positive policy is one that acknowledges and supports a person's right to have a healthy, consensual sexual life, such as hand holding, going on dates, etc., opposed to a negative policy that focuses on "no and can't" in terms of personal relationships. The policy should be reviewed annually by a cross-disciplinary team that includes administrators, direct support professionals, individuals with disabilities, and family members.
- Provide accessible and appropriate education, information, and resources that address sexual health, personal relationships, and sexuality needs.
- Ensure that organizational and managerial resources are available to staff to support individuals with disabilities that have issues related to sexual health, personal relationships, or sexuality.
- Provide resources and training for all staff on understanding, supporting, and responding to sexual health, personal relationships, and sexual issues.

SECTION 4 – INDIVIDUAL SERVICES ACKNOWLEDGMENT

Section 4 of this Policy and Procedure Manual is an important document intended to help you become acquainted with the Not Forgotten Home & Community Services, as it relates to Individual services. This document is intended to provide guidelines and detail descriptions, according to both strict governmental and agency wide regulations.

The regulations are provided in this section is regulatory in manner to maintain employment and for Not Forgotten to maintain compliance as a provider. The section covers all policies related to Individual Services, including both state and federal regulations listed below:

- Individual Grievance
- Individual Rights
- Successful Implementation of Each Individual's Back-Up Plan
- Accessibility of Intellectual Disability Services for Individuals Who Are Deaf
- Sexual Health, Personal Relationship and Sexuality
- Visitation Policy
- Confidentiality of Individual Records/Information
- Planning Standards Procedures
- Transition Of Individuals

This section will count for **2 HOURS** towards training.

Because the Not Forgotten Home & Community Services operations may change, the contents of this manual may be changed at any time, with or without notice, in an individual case or generally, at the sole discretion of management.

Please read the following statements and sign below to indicate your receipt and acknowledgment of Section IV of the Policy and Procedure Manual.

I have received and read a copy of Not Forgotten Home & Community Services Policy and Procedure Manual. I understand that the policies, rules, and benefits described in it are subject to change at the sole discretion of the Not Forgotten Home & Community Services at any time.

I understand that my signature below indicates that I have read and understand the above statements and that I have received a copy of the Not Forgotten Home & Community Services Policy and Procedure Manual.

Employee's Printed Name: _____

Employee's Signature: _____

Position: _____

Date: _____

The signed original copy of this acknowledgment should be given to management - it will be filed in your personnel file.

Section 5 - Risk Management

5.1 Behavior, Health, Emergency Crisis Plan

Implemented: September 2016 **Revised:** October 4, 2018

Reference/Source: Informational Memo 080-12 – Reporting Unauthorized Restrictive INTERVENTIONS (QA& I) updated 06/22/18, Dr. Gregory Cherpes (ODP Medical Director) Health Alert: Choking: A Medical Emergency 08/14/18 Health Alert, 01/04/2015 Dr. Greg Cherpes ODP Medical Director (Call 911 in a medical Emergency)

Persons Affected: Individual, Families (if APPLICABLE), and Guardians/ AND staff OF Not Forgotten Home & Community services.

Our Purpose: Our purpose is to inform the affected of Not Forgotten Home & Community services, on the procedures on how to respond to cases of Individual Health, Behavioral Emergencies and Crisis.

Definitions:

- **NFHCS:** Not Forgotten Home & Community Services
- **Department:** The Department of Health & Human Services of the Commonwealth
- **ED:** Executive Director

Policy/Procedures Objectives:

- How our staff are to respond to an actual Behavior, Health and Crisis Emergency
- Guidance on when to call 911 when it's appropriate
- Staff notification requirements
- Staff training
- Restraints
- Composing of an incident report
- Only supervisor can notify the families in the case of an emergency

Guidance: Upon ODP Guidance, per Dr. Cherpes (ODP Medical Director) there have been reports of injuries and deaths, where there was an apparent delay in seeking emergency medical care.

There are two key issues in reducing this risk for delay:

- Recognize a medical emergency - because correctly interpreting and acting on these signs could potentially save a life.
- Seek immediate attention for the emergency. With medical emergencies, time is of the essence, and delays in treatment can often lead to more serious consequences, or even death. Policies that require staff to contact supervisors before calling 911 jeopardize the health and welfare of the Individual. (Our Policy, when in doubt, call 911).

What is a Medical (Health) Emergency? Any event that threatens someone's life or limb in such a way that immediate medical care is needed to prevent death or serious impairment of health, such as severe pain, bad injury, serious illness, or a medical condition that is quickly getting worse.

Unsure whether it's a medical emergency? Ask these questions:

- Is the condition life or limb threatening?
- Could the condition worsen quickly on the way to the hospital?
- If you move the victim, will it cause further injury?
- Does the person need skills or equipment that paramedics or EMT's carry right away?

  If you answer YES or "I Don't Know" Call 911 right away

The list of signs and symptoms below is not intended to represent every kind of medical emergency or substitute for a physician's medical advice, but rather to provide examples of common issues:

WARNING SIGNS AND SYMPTOMS CALL 911 WHEN:

- A fast heartbeat (more than 120-150) at rest especially if associated with shortness of breath or feeling faint
- Allergic reaction, especially if there is any difficulty breathing (anaphylactic shock)
- Bleeding from any wound that won't stop
- Bleeding from the mouth, nose, vagina, or rectum that won't stop
- Broken bones visible through an open wound, or a broken leg
- Chest or upper abdominal pain or pressure lasting two minutes or more
- Choking
- Confusion or changes in mental status, unusual behavior, difficulty waking
- Coughing or vomiting blood
- Difficulty breathing, shortness of breath

- Drowning
- Drug overdose or poisoning
- Extremely hot or cold skin/body temperature
- Fainting, sudden dizziness, weakness
- Fall with suspected injury
- Motor vehicle accident injury
- Neck or back injury
- New severe headache
- Numbness, or weakness of any part of the body
- Seizures that are new or uncontrolled
- Severe burns
- Severe or persistent vomiting or diarrhea
- Severe or sudden pain
- Someone is unresponsive or unconscious
- Speech changes including slurred speech or difficulty speaking
- Sudden blindness or vision changes
- Suicidal or homicidal feelings or statements
- Unusual abdominal pain

Prohibited: NFHCS must not require our staff to contact supervisors or other persons prior to calling 911 in a medical emergency.

Choking: A Medical Emergency Health Alert 08/14/18

Important: A Health Alert was reissued to clarify the section: Action to Take for an Individual Choking.

All NFHCS caregivers should follow First Aid/CPR training instructions for an Individual who is choking.

ODP guidance was intended to emphasize the importance to call **911** at the appropriate time and not delay the call by seeking supervisory approval.

This Health Alert is intended to make NFHCS, staff and other caregivers aware of this serious issue of choking. All should become familiar with resources to aid in the identification of Individuals at risk for choking, the training of our staff and the appropriate documentation of special dietary needs and choking precautions.

Two key issues to promote safety for Individuals:

- The information contained in the individuals' care plans, including medical evaluations/recommendations, assessments, ISPs, and any treatment plans used by NFHCS (hereafter "care plans") must be accurate, consistent, and followed precisely for feeding plans, supervision of the Individual while eating to maintain safety, proper positioning, and the use of specialized equipment.
- All staff providing service to an Individual must be trained on the Individual's dietary needs, including awareness of proper foods and food textures; supervision needs during meals; proper positioning during meals; and the use of specialized equipment related to the risk of aspiration and choking.

Action to Take for an Individual Choking:

- Immediately begin First Aid for an Individual who is conscious and choking, meaning the Individual is alert and unable to cough, speak or breathe. If possible, have someone else call 911 at the same time.
- If the Individual is unconscious, call 911 if this has not already been done, and begin First Aid/CPR care for an unconscious choking Individual.
- When calling 911, do not delay by seeking supervisory approval prior to calling 911.
- Contact the health care practitioner after any episode of choking. A single choking event may be a warning sign for future choking events.

Signs of an Individual Choking: (Fatal Four)

- This is an Emergency
- Anxious or agitated state
- Reddened face
- Difficulty breathing
- Noisy breathing
- Severe coughing or gagging
- Hands at throat
- Not able to talk
- Not able to breath
- Skin turning gray or blue
- Loss of consciousness

Dysphagia: Defining Dysphagia, Aspiration, and Choking: Dysphagia, which is the term for difficulty in swallowing, is a frequent cause of choking. Dysphagia

can develop at any time and is usually related to underlying medical or physical conditions. It can cause both choking and aspiration, either of which can lead to injury, illness, and death. The closeness between the esophagus, which is the channel that carries food from the mouth to the stomach, and the trachea or windpipe leading to the lungs. The closeness of the esophagus and the trachea helps to explain why swallowing and choking issues are so serious.

Aspiration: Aspiration is when fluid, food or saliva enters the lungs. A person may choke, cough or gag when this happens but it may occur without any signs. This is called silent aspiration. Aspiration can lead to wheezing, difficulty breathing and/or pneumonia, which can cause death. Choking is when food or other items become lodged in the back of the Individual's throat causing a blockage of the person's airway. This blockage prevents air from entering the lungs. This deprives the body of the necessary oxygen it needs. This can quickly lead to irreversible brain damage and death.

Who is at risk for Choking and Aspiration? Individuals:

- With swallowing disorders
- With problems affecting the muscles used to swallow. For example, the decompensated elderly, those with seizures, cerebral palsy, ALS, Parkinson's disease, multiple sclerosis, muscular dystrophy, myasthenia gravis or dementia
- Who have had strokes, traumatic brain injuries, spinal cord injuries and problems affecting the head and neck?
- With decayed or missing teeth or improperly fitted dentures
- Who are taking certain medications?
- With Gastroesophageal Reflux Disease (GERD)
- With feeding tubes
- With tracheostomies

What are the Signs of an Individuals Risk for Choking?

- Coughing or excessive drooling while eating
- Difficulty breathing or shortness of breath while or after eating
- Making statements such as "food is getting stuck" or "going down the wrong pipe."
- Frequent throat clearing while eating
- Eating too fast or packing one's mouth

Ways of Preventing Choking and Aspiration

- Identify the symptoms of dysphagia.
- Consider getting a dysphagia assessment for the Individual.
- Support for identifying dysphagia is available through the health care practitioner as well as from the Health Care Quality Units.
- Notify the Individual's physician or speech therapist of any concerns so the appropriate testing can be completed to identify the issue.
- A swallowing study may be recommended by the health care practitioner.
- Review and follow the care plans.
- Provide appropriate supervision of the Individual and assistance with eating.
- Prepare food as instructed on the care plans.
- Avoid food identified on the care plans that will increase risk.
- Utilize identified adaptive equipment (specialized cups, utensils, plates etc.) with every meal and with snacks.
- Check that dentures are in place and properly secured and oral hygiene is completed as per the care plans
- Utilize identified adaptive equipment (specialized cups, utensils, plates etc.) with every meal and with snacks.
- Check that dentures are in place and properly secured and oral hygiene is completed as per the care plans

What Training and Resources are available to Decrease the Risk of Choking?

- All NFHCS staff should be currently certified in CPR and First Aid
- Staff should be trained and oriented in all aspects of the care plans for the Individuals for whom staff are providing service
- Policy and Procedure for calling 911 should address events that occur both in and outside of the Individual's residence (Enclosed in this policy are scenarios)

Policy: Below are factious scenarios, Staff is required to only contact 911 in the event of an actual Behavior or Health Threating Emergency. In the event of an emergency (Health) the following will be adhered to:

Scenario: One of our Individuals "Johnny" is physically exhibiting and verbally stating "My chest hurts" Staff will immediately:

Address the health & safety of the Individual:

- Immediately, Staff will assist our Individual and advise him to lie down.

Communication – When to call 911

- Staff will IMMEDIATELY call 911. (See the above chart) And observe the individual until help arrives. (Remember, this can be life threating.)
- Once the ambulance has arrived, assist them in any way (e.g., Giving them a copy of the current medication record (if you have access to this information, answering questions).
- When it's safe to do so, Contact your immediate supervisor. And the Supervisor will call the Individuals family.

Operations Policy:

- Remain with the individual. Until relieved by your immediate Supervisor. See below.
    - **5.1 Explanation:** If you're in a 1:1 ratio. Remain with our Individual. Until relieved by your immediate supervisor.
    - **5.2 Explanation:** If you're in ratio with additional individuals (Example 1:3) "Johnny" can be transported via hospital alone with medical professionals. STAY behind with our other Individuals.
- Compose an Incident report. And submit to your supervisor.

In the event of an emergency (Behavior and Crisis emergency) the following will be adhered to:

- **Scenario:** One of our individuals "Lucy" is out with a DSP on a community outing to Walmart. Suddenly, Lucy becomes enraged due to her not being able to ride the bike in the store.

Address the health & safety of the Individual:

- Should staff not be able to de-escalate 'Lucy" per their training. Staff should remain calm and utilize re- direction techniques.
- Should re-direction and de-escalation techniques fail Staff should re-direct Lucy out of the store to prevent "Lucy" from hurting herself or others. Remember it's not a restraint to re-direct.

Communication: when to call 911:

- Should Lucy be in a full Behavior Crisis

- **Explanation: of a full Behavior Crisis: But not limited to:** A behavioral emergency, also called a behavioral crisis or psychiatric emergency, occurs when someone's behavior is so out of control that the person becomes a danger to everyone. The situation is so extreme that the person must be treated promptly to avoid injury to themselves or others. Time is of the essence in a behavioral emergency, so it is important to recognize the symptoms of this type of emergency and to realize the degree to which the situation can escalate if immediate steps are not taken to diffuse the situation.
- **The symptoms of a behavioral emergency include** extreme agitation, threatening to harm him/her or others, yelling or screaming, lashing out, irrational thoughts, throwing objects and other volatile behavior. "Lucy "seems angry, irrational, out of control and unpredictable. The unpredictable nature of this type of emergency can lead to injuries to bystanders if "Lucy" displays violent behavior during the episode.

- Staff should **IMMEDIATELY call 911**. If Lucy is exhibiting the aforementioned behavior. And remain calm." if Lucy sees you getting upset. Her behavior may escalate. In a calm voice continue to reassure "Lucy" praise and de-escalation trained techniques are very helpful.
- When assistance arrive, Staff should give the emergency Personnel, Pertinent information about our Individual (e.g., Medications, Diagnosis,) When it's safe to do so, Staff should call their immediate supervisor. And the Supervisor will contact the Individuals family.

Operations Policy:

- Remain with the individual until relieved by your immediate Supervisor.
  - Explanation: If you're in a 1:1 ratio. Remain with our Individual. Until relieved by your immediate supervisor.
  - Explanation: If you're in ratio with additional individuals (Example 1:3) "Lucy" can be transported via hospital alone with medical professionals. STAY WITH OUR PARTICPANTS.
- Compose of an Incident report. And submit to your supervisor.

Training: All NFHCS staff will be trained in various areas, including but not limited to: Individuals ISP, Restraint procedures, Restrictive procedures, Emergency Preparedness, and this crisis policy. Should staff encounter a situation not described in these scenarios they must always remember the steps:

- **Step 1**- Address the health & safety of the Individual. Rely on your training, If the situation is outside of your training (like an individual requiring assistance beyond first aid) "Get Help Immediately"
- **Step 2** – Communicate- when to call 911 Communicate with your immediate supervisors, Emergency personnel (Call 911) and the families. Trust your instincts! Our Individuals and staff are our highest priority.
- **Step 3**- Follow Operations policy and stay with our individual. At conclusion, compose an incident report and submit it to your immediate supervisors.

Staff of NFHCS are prohibited from performing the following activities:
Seclusion -is placing our Individual in a locked room.

- Locked room includes a room with any type of engaged locking device. (Such as a key lock, spring lock, bolt lock, foot pressure lock or physically holding the door shut).

Chemical Restraint - is a drug used to control acute, episodic behavior that restricts the movement or function of an Individual and is not a standard treatment for the Individual's medical or psychiatric diagnosis.

- When a physician orders a medication that is part of the ongoing Individual Individualized plan and has documented as such for treating the symptoms of mental illness, the medication is not considered a chemical restraint.

Mechanical Restraint - is a device used to control acute, episodic behavior that restricts the movement or function of an Individual or portion of an Individual's body.

Examples of mechanical restraints include:

- Anklets
- Wristlets
- Camisole
- Helmets with fasteners
- Muffs and mitts with fasteners
- Posey's
- Waist straps
- Head straps
- Restraining sheets and similar devices.

Please Note: When a physician orders a mechanical device to protect the Individual from possible harm following surgery or an injury, it is not a mechanical restraint.

Examples of mechanical devices that are not restraints include:

- Device used to provide support for functional body position or proper balance.
- Device(s) used for medical treatment such as sandbags to limit movement after medical treatment.
- A wheelchair belt that is used for body positioning and support.
- A helmet for prevention of an injury during seizure activity IS NOT considered mechanical restraints.

Manual Restraints- also commonly referred to as physical restraints - are used only as a last resort safety measure. When the Individual is in imminent danger of harming oneself and/or others and other measures are ineffective.

Manual Restraint: is a" hands-on technique" that lasts more than 30 seconds.

When a hands-on technique occurring for less than 30 seconds and is used to guide or redirect the Individual away from potential harm/injury, it is not a physical restraint.

- The following techniques are considered especially problematic and known to increase the risk of injury and death. These techniques are also strictly Prohibited by NFHCS.
  - Prone (face down) manual (physical) restraint.
  - Manual restraints that inhibit the respiratory and/or digestive system of use.
  - Manual restraints that involve his infliction of pain, hyperextension of joints, and pressure on the chest or joints.
  - 'Takedown' techniques in which the Individual is not supported and/or that allows for a free fall as the Individuals goes to the floor.

Below are the actives which are permitted by our trained staff:

- Positive approached
- De-escalation techniques
- Behavior Plan guidance
- Behavior and environmental support

Training will be ongoing for all NFHCS staff and will focus on the overall supports improving our Individual's quality of life, while maintaining his or her health and welfare.

NFHCS is committed to serving and supporting our Individuals. Remember, restraints by NFHCS will only be applied in Emergency situations only. NFHCS will provide our staff with extensive training. Below are the guidelines to be followed and implemented.

All NFHCS staff will be trained in procedures that address how people are supported in emergency situations (as noted above) where an Individual's health, safety and welfare may be at risk.

All NFHCS staff will have initial training within 30 calendar days after their first day of employment and prior to working directly with an Individual. Or have documented training that has occurred within the past 12 months. Ongoing training is expected to occur within every calendar year. Training in the application of restraints is needed only for selective Provider agencies (NFHCS) who utilize restraint as part of our operating procedures. Staff will be trained in the following curriculum but not limited to:

- Environmental design and social, physiological, and cultural motivators for behavior, including information on Individuals who have experienced trauma such as abuse. This includes understanding the impact of environmental factors and triggers.
- Positive practices and behavioral support methods that include:
- Techniques to de-escalate behavior; listening and communication skills; awareness of environmental factors that can cause disruptive behaviors; violence prevention and conflict resolution; and how to complete a functional analysis.
- Information on "best practice" methods for interacting with Individuals who have a dual diagnosis of mental retardation (Intellectual's with disabilities) and a mental illness. This includes the effects of medications, how medication changes can impact behavior, and teaching alternative strategies and other coping mechanisms.
- Person-centered alternatives to the use of restraint, including:
    - An understanding of which positive practices are most effective with Individuals and teaching strategies that emphasize prevention of future negative incidents. This also will include the integration of effective behavioral supports.
    - Basic training in body mechanics that illustrates how to avoid hyperextensions and other positions that may endanger Individual safety.

- Awareness of an Individuals health history to assess increased risk that may occur during the application of a restraint.
- The use of physical restraints, including the proper application of restraints appropriate to the age, weight, and diagnosis of the Individual. Also, possible negative psychological effects of restraint and monitoring an Individual's physical condition for signs of distress or trauma.
- Definitions of restraint; policies on the use of restraints; the risks associated with the use of restraints; and staff experience the use of physical restraint applies to themselves. This includes debriefing techniques with the Individuals they support as well as staff members.

Overview of our commitment procedures: Recap of commitment procedures: NFHCS Staff must follow, but are not limited to:

- Call 911 in the event of an actual Health or Life threating emergency
- Call ambulance
- Mobile crisis intervention
- Notify His/ her immediate supervisor with any questions requiring the Individual.
- Notify individual's family/ advocates (Supervisors will notify)
- Seek immediate help from the aforementioned if assistance is out of the scope of your training
- Document encounters on Service notes
- NFHCS will remain with the Individual in the event of a Health, Behavior or Crisis Emergency, unless you're in ration with more than one Individual
- Compose of an Incident report and submit to your immediate supervisor.
- Meet with Support Coordinators regarding issues of the Individual
- Attend all trainings
- When in doubt "ask"

Staff Resources:

- MR Bulletin 6000-04-01, Incident Management
- MR Bulletin 00-06-09, Elimination of Restraints through Positive Practices
- 55 Pa. Code Chapter 51 Section 51.4
- Waiver Assurances Appendix G-3, (relating to Individual Safeguards)
- American Heart Association: Heart Saver CPR, AED, and First Aid Training Course- information available online or by calling 1-877-AHA-4CPR or 1-877-242-4277
- American Red Cross First Aid Certification information available online
- Health Care Quality Units (HCQUs) online
- NIDCD Fact Sheet│ Voice, Speech, and Language: Dysphagia, NIH Publication No. 13-4307, October 2010, reprinted February 2014.

- American Speech-Language-Hearing Association (ASHA), Adult Dysphagia

5.2 Bloodborne Pathogens Exposure Control Plan

Implemented: September 2020 **Revised:**

Osha Bloodborne Pathogen Standard Guidelines -Exposure Control Plan

Introduction: In 1992 the Occupational Safety and Health Administration (OSHA) passed regulations amended to eliminate or minimize work related exposure to communicable diseases. The OSHA regulations apply to employers whose workers may reasonably be anticipated to have "occupational exposure" (come in contact with blood or other potentially infectious material such as saliva, semen, or any other body fluid/solid which may contain blood).

One of the major responsibilities of NFHCS workers is to provide assistance to individuals with disabilities in tasks they are unable to do independently. At times, this may involve assistance in completing personal hygiene tasks or assistance in dealing with a medical emergency. Under certain circumstances assisting an individual in these activities may place a staff at risk of an infectious disease through blood, blood products or bodily fluids or tissues which may contain blood.

OSHA: Regulations require that employers develop an "Exposure Control Plan" and to adopt certain safety procedures and standards which would minimize work related exposure. The OSHA regulations also require employers to maintain records concerning the staff's training in these safety procedures, their immunization or vaccination for certain communicable diseases and any exposure incident that may occur while at work.

NFHCS: Complies with these OSHA regulations and has developed this Exposure Control plan.

Exposure Determination of Current Staff: The following is a list of job classifications that are associated with tasks that may have the potential to occupational exposure to blood and other potentiality infectious materials.

- Direct Support Specialist (Residential)
- Nurse Coordinator
- Program Specialist
- Director of Programs
- Compliance Contractor
- Direct Support Specialist (Habilitation)
- Executive Director
- Director of Biling & Habilitation Support
- Approvers
- Director of Administration

- Program Leads
- Administrative Assistant
- Incident Manager
- IT Specialist
- Activities Coordinator
- Director of Activities
- Training Coordinator
- HR Specialist
- Maintenance Contractor
- Employment Specialist

Universal Precaution: When applying the concept of universal precautions to infection control, all blood and body fluids are treated as if they contain bloodborne pathogens, such as human immunodeficiency virus (HIV) and hepatitis B virus (HBV). HIV and HBV can be found in.

- Anal, oral, or vaginal sex
- Needles, syringes, or other injection equipment
- Sharing items such as toothbrushes, razors, or medical equipment (like a glucose monitor) with an infected
- Exposure to an infected person's blood through needle sticks or other sharp
- Pregnancy, childbirth, or breastfeeding
- Small amounts of blood spread during deep kissing or oral sex—extremely
- Direct contact with the blood or open sores of an infected person

HBV may also be found in saliva and other body fluids such as urine, vomitus, nasal secretions, sputum, and feces. It is not possible to know whether these fluids contain bloodborne pathogens therefore, all body fluids should be considered potentially infections. Universal precautions should therefore be observed when handling or coming in contact with any blood or body fluids.

The following work practice controls are followed, and all staff were trained and know that:

- Handwashing is required at all NFHCS facilities. Proper handwashing is the backbone of infection control and should be done diligently.

Hands should be washed:

- Before and after physical contact with an individual.
- Immediately after contact with blood or body fluids or clothing or objects soiled with body fluids or blood.
- Also, for contact with equipment used during a procedure or to clean a contaminated area.
- After removing personal protective equipment (PPE) such as gloves.
- Always before handling food and after food preparation.

Proper Handwashing

- Eating. drinking, smoking, applying cosmetics or lip balm, and handling contact lenses are prohibited in work areas where there is a reasonable likelihood of exposure to blood or other potentially infections materials. (Example fusions to this control are homes where the laundry equipment is located in the kitchen. Such homes will follow procedures which prohibit simultaneous food preparation and cooking while doing laundry and will further prohibit simultaneous use of fables or counters for sorting laundry and preparing or serving food.)
- Food and drink shall be kept in refrigerators, freezers, shelves, cabinets or on countertops where there is the potential for exposure to blood and other infectious material. A bathroom which contains the laundry equipment shall not be used as a bathroom while being used for laundry. (Exclusions to this control are homes where the food storage areas are co- located with the laundry equipment. In these homes' storage of food items, cooking equipment, utensils, or serving items are prohibited in the immediate area used for sorting or laundering. Such storage must be maintained separately and protected from contamination by means of a closed door, closed cabinets, or drawers.)
- Leak proof containers with red "bio—hazard" bag will be provided to collect all items that may become contaminated, such as clothing, bedding, or towels. Larger items, such as furniture or equipment, will be inspected after an exposure incident for blood or other potentially infectious material and decontaminated is possible. If not possible to decontaminate, professional services to do so may be needed. If this fails, disposal of the items will be necessary in accordance with local regulations.
- Leak-proof, puncture-resistant sharps containers are provided and are stored as close as feasible to the immediate area where sharps are used. These containers must be closable and maintained upright throughout use. Contaminated disposable sharps shall be discarded immediately after use in the sharp's container. Sharps containers should be replaced when full to prevent accidental needle sticks. All disposable equipment used in diabetic blood sugar testing will be collected in the sharp's container.
- Re-capping, bending, or breaking of needles is prohibited by staff. Sharps containers are removed from the site with other medical waste by a medical waste pick-up service as often as needed and in accordance to state and local regulations.

Facility Engineering Controls
Handwashing facilities are available in the following locations:

- Administration Offices Restrooms Site bathrooms
- Site kitchen
- Site laundry room

Liquid hand soap and clean towels/toiletries are available at the locations listed above.

Leak-proof, puncture resistant containers are provided and are stored in the site office area in a locked cabinet.

Regulated waste is not usually generated on a daily basis in the day-to-day operations of most sites. In some sites regulated waste can occur daily and therefore medical waste pickup will be arranged according to state and local requirements. This waste will be separate from normal daily waste and garbage. It may include wound dressings, clothing, bedding, or towels contaminated by blood or potentially infectious material that cannot be safely laundered and decontaminated, and furnishings and equipment substantially contaminated with blood/ infectious material that cannot be properly cleaned and decontaminated.

Regulated waste includes:

- Liquid or semi-liquid blood or other potentially infectious materials.
- Contaminated items that would release blood or other potentially infectious materials in a liquid or semi-liquid state if compressed.
- items that are caked with dried blood or other potentially infectious materials and are capable of releasing these materials during handling.
- Contaminated sharps objects such us those supplies used by a diabetic to test blood sugar and inject insulin.
- Staff have been advised that in a serious medical emergency, arrangements will be made for proper pick up and disposal of regulated medical waste.

The following controls are inspected and maintained regularly accordingly:

- Restrooms are cleaned each day and decontaminated after any exposure incident.
- Laundry areas and equipment are cleaned weekly, decontaminated after use in laundering any clothing which may have been contaminated by blood or other potentially infectious material, and disinfected after each individual use. Staff who handle contaminated laundry are to wear protective gloves and other personal protective equipment as needed. Laundry should never come in contact with the staff's body/clothing and should be handled as little

as possible before placing in washing machine. Wet, contaminated items will be transported to the laundry facilities in leak—proof bags and the bags will be disposed of properly.

Personal Protective Equipment: All personal protective equipment (PPE) needed to protect staff when doing procedures in which exposure to the skin, eyes, mouth, or other mucous membranes is anticipated is provided. The PPE to be worn will depend on the expected exposure. Available for use are gloves, goggles, CPR face shields and shoe protection. All staff know gloves are worn whenever there may be contact with body fluids. These items will be kept together at an identified location in order to be accessed during a potential exposure incident. Gloves will be kept available throughout each location, including bathrooms, laundry rooms, and vehicle first aid kits.

Staff know that after each use, gloves should be removed without touching the outside of the glove with an exposed hand and properly disposed of. Do not reuse gloves. After removing gloves, the hands should be washed according to the handwashing procedure.

Staff know that gloves are located in the site staff office. all bathrooms, laundry rooms, and first aid kits, including vehicle first aid kits.

Staff know that all garments that have been soiled by blood or body fluids will be removed and laundered at the site or placed in a leak proof plastic bag for disposal or cleaning al another location, such as a professional cleaner or commercial laundry facility. Each location will have available clothing for I his purpose, such as sweatshirts and sweatpants in several sizes.

Clean-Up: Spills of blood and body fluids containing visible blood should be cleaned up immediately with an approved disinfectant cleaner. All materials used for clean-up of these body fluids must be collected and red- bagged for medical waste pick-up.

- Wear gloves
- Mop up spill with absorbent paper products
- Spray area well with disinfectant, allowing solution to remain on area for several minutes
- Wipe area with clean paper towels and repeat as needed
- Continue this process until the area is cleaned and free from soil. The last application of disinfectant will be rinsed with clean water
- Remove and dispose of gloves and paper products in red bag container

WASH YOUR HANDS!

Housekeeping: The following schedule will be followed for routine cleaning: The following are standard housekeeping procedures used in group homes:

- Cleaning/decontaminating furnishings, counters, floors, and wall surfaces with an approved disinfectant will be done immediately after as incident involving blood or any other potentially infectious material.
- Trash receptacles that may have been contaminated with infectious material or common household trash are cleaned and disinfected on a weekly basis, or as often as necessary, to provide a safe, clean environment.
- Broken glass should not be picked up directly with the hands. The broken glass may be contaminated and will be picked up using mechanical means such as a brush and dustpan or tongs. The broken glass will be placed in a sturdy cardboard closable box and when full, taped, marked "broken glass" and placed curbside for garbage pick-up.
- Sharps containers used will be closable, puncture resistant, and leak proof. The container will be replaced when full and the top secured to prevent spillage of contents. Sharps containers are then placed in the red bag hamper for medical waste pick—up.

Laundry: Contaminated laundry is laundry soiled with blood, semen, and body fluids containing blood or feces. All staff have been trained in the following procedure for contaminated laundry.

On-site laundry facilities are located in each site.

- Staff have been instructed to wear protective gloves when handling contaminated laundry.
- Staff have been instructed to dispose of any fecal contaminate material by flushing the material in a bathroom toilet.
- Staff have been instructed to disinfect the laundry equipment before and after each use of the equipment.
- Staff know that contaminated clothing must be laundered separate from other laundry using the hottest water temperature, a commercial detergent, and commercial disinfectant.
- Staff know laundry machines, counters, worktables or sorting tables should be disinfected after use whenever used for the laundering of contaminated materials.

Vaccinations: OSHA regulations require that all staff determined to be at substantial risk of exposure to body fluids be offered Hepatitis B vaccinations (as prescribed by standard practices) free of charge by NFHCS. Workers are not required to accept the offer of vaccination and may choose to reject the offer. If the staff chooses at a later date to accept the vaccination, NFHCS is required to furnish the vaccination free of charge at that time.

Individuals who are hypersensitive to yeast or any other components of the vaccine are advised to check with their personal physician before accepting the Hepatitis B vaccinations.

When a worker chooses to accept the vaccination, the agency will assist in making arrangements to schedule the staff to be seen by medical personnel trained in vaccination. The injections will be given according to medical standards established for Hepatitis B vaccination by the U.S. Public Health Service. Presently, the vaccine is given in a series of three (3) injections. The second injection is given one (1) month from the initial injection. The final dose is given six (6) months from the initial dose. Pre- and post-vaccination blood tests to determine immunity as demonstrated through antibody testing ore not provided by the agency.

As of May 1999, the Advisory Committee on Immunization Principles (ACIP). a Federally chartered advisory committee with the goals of providing immunization recommendations to the Director of CDC. and the Secretary Department of Health and Human Services (DHS) has indicated that Hepatitis B vaccination immunity is "long—term and may be lifelong". As such, the Agency does not offer or recommend booster vaccinations. If at some time in the future the ACIP would determine a booster is necessary. the agency would comply with their recommendations.

Hepatitis B Vaccine: All staff designated as being at risk of "occupational exposure" and will be offered the Hepatitis B vaccine, free of discharge:

- All staff understand they must sign an acceptance form if they agree to be vaccinated. A copy of the Hepatitis B Vaccine Acceptance form is included in their confidential medical record.
- All staff understand they must sign a waiver if they decline to be vaccinated. A copy of the Hepatitis B Vaccine Declination Waiver Form is included in their confidential medical record.
- All staff understand they must sign a Post Exposure Incident Medical Evaluation Declination Form if they decline to receive follow—up medical

treatment subsequent to an exposure incident. A copy of this declination waiver is included in their confidential medical record.

Exposure: Any staff who in the course of fulfilling their job duties has "specific eye, mouth, other mucous membrane, or parenteral contact with blood, semen, vaginal secretions, or body fluid that is visibly contaminated with blood" has had an "Exposure Incident".

In the event of an exposure incident, the following procedures are to be followed:

- Staff are instructed to report any exposure incident to their supervisor, the Nurse Coordinator the, or the Executive Director On-Call staff.
- Within 24 hours or the next working day, the staff must meet with the Nurse Coordinator (or in their absence, Executive Director.
    - A Staff Incident Report and a Staff Exposure Incident Report must be completed by the staff in the presence of the Nurse Coordinator (or in their absence, a member of the executive team).
    - The Executive Director will confirm than an "exposure incident" has occurred and will assure that the appropriate follow-up procedures are followed.

In the event of an exposure incident, the following procedures are followed: If the staff grants permission, they should be tested for HIV/HBV as soon as possible. Facts preventing the testing of source individual (i.e., source unknown, source refuses, prohibited by state or local law) are carefully documented. If it is known that the source individual is infected with HIV or HBV, testing of the staff need will be repeated.

The results from the staff are made available to the staff if the source individual or them guardian grants permission. The staff is informed of Pennsylvania's Act #148. See section XID.

The exposed staff is offered the option of HIV/HBV testing. If the staff wishes, a blood sample is drawn as soon as possible after the exposure incident. The blood is either tested immediately or at the discretion of the exposed staff, preserved for 90 days. This protocol allows the staff time to decide whether or not he/she wants or needs the sample to be tested. This decision may be based on the results of the source individual's lest if permission for such testing was granted.

A licensed health care professional performs an evaluation, post—exposure prophylaxis, including immune globulin for Hepatitis B when medically indicated, counseling, and medical follow-up. In the event of an HIV exposure, recommendations of an evaluating health care provider who is familiar with current CDC guidelines on post—exposure prophylaxis treatment for HIV will be

provided. These medical services are provided for the staff at no charge to the staff.

Employer provides the evaluating health care professional with a copy of the OSHA Blood borne Pathogens Standard, a copy of the Exposure Incident Record, and a copy of all relevant medical records which the employer must maintain.

A written opinion by the evaluating health care professional is made available to the staff within 15 days of the completion of the evaluation. The written report is limited to the fact that the staff has been told about...1.) the results of the evaluation, and 2.) also talked about possible medical conditions resulting from exposure which may require further medical attention. This report is included in the staff's confidential medical record.

All laboratory tests are done by an accredited laboratory at no cost to the staff.

Pennsylvania's Act #148: Because state lawmakers believe that HIV/AIDS testing and counseling are promoted by requiring confidentiality, Pennsylvania Act #148 was passed and signed into law in December 1990. Act #148 establishes a protocol for confidential testing in order to encourage those most in need to obtain testing and appropriate counseling. Additionally, the Act places certain restrictions on the dissemination of information about a person's HIV/A IDS status, which have been accumulated by health care providers or institutions.

Staff Medical Records: Confidential staff medical records are limited to the (I) Staff Medical Record, (2) the Staff Exposure Incident Report. Staff medical records are not disclosed or reported without the staffs' express written consent to any person as required by law.

Training: Training for all staff is conducted before they are assigned to tasks which may expose them to hazards. The following is included in staff training:

- OSHA Blood borne Pathogen Standard
- Hepatitis B Vaccination program

Discussion of blood borne pathogens including but not limited to:

- Hepatitis B
- Human immunodeficiency virus (AIDS)

This Exposure Control Plan

- Recognition of tasks and acclivities which may pre-dispose to exposure.
- Methods to reduce exposure.
- Personal Protective Equipment (PPE) to avoid contact with body fluids, including.

- Proper use, removal, and handling techniques

5.3 Compliance Plan

Implemented: October 2018 **Revised:**

Background: NFHCS has developed and is committed to maintaining a Compliance Program. The purpose of this program is to ensure that the Agency's Mission, values, and principles are met, and that the Agency remains in full compliance with all federal, state, and local requirements, as well as those applicable requirements with contracted Managed Care Organizations. In addition, the Corporate Compliance Program will assist the Agency in maintaining the highest ethical standards in all aspects of service provision and business decisions.

Objective & Compliance Plan: The purpose of the Corporate Compliance Plan is to assist the Agency in maintaining full compliance with all Agency policies, applicable laws, regulations, and statutes, with respect to federal, state, and local requirements. As a part of the Compliance Plan, NFHCS has identified a Compliance Officer who will oversee all compliance efforts.

NFHCS compliance efforts will consist of:

- Enforcing the Fraud and Abuse Policy, Professional Standards, and other Agency related policies.
- Training to enhance staff understanding of the applicable responsibilities and related to their positions and the Compliance Plan.
- Routine monitoring practices that will assist the Agency to identify and correct non- compliance.
- Establish multiple contacts, reporting points and processes for staff that may have compliance questions, complaints, or issues of suspected violations.
- Establishing a Compliance Committee to assist the Compliance Officer in reviewing and overseeing issues related organizational adherence to the Compliance Plan.
- Maintaining a documentation process which demonstrates NFHCS adherence to compliance requirements.

Elements of a Complex Program: As an Agency receiving Federal and State funding, NFHCS is encouraged to combat fraud and abuse. In support of these efforts, NFHCS. has elected to base our compliance program on seven fundamental elements. These elements include:

- Establishing written Fraud and Abuse policies and procedures that encourage staff to perform in professionalism

- Designating a Compliance Officer and Compliance Committee
- Conducting training and education on the Agency's Compliance Plan, including face-to-face trainings, handouts, web postings, and other internal compliance plan informational efforts
- Developing open lines of communication with staff through the use of organizational reporting systems, the use of an anonymous complaint process and the understanding of protection from retaliation through the use of whistleblower protections
- Conducting internal compliance reviews and monitoring
- Enforcing adherence to compliance standards through the use of appropriate disciplinary mechanisms for those staff or contractors who have violated corporate compliance policies and procedures
- Responding promptly to detected offenses and developing appropriate corrective action and preventive measures

Compliance Standard: NFHCS encourages all Board members, staff, and contractors to actively participate in the compliance efforts and activities. NFHCS further encourages everyone to always act in a legal and ethical manner.

As a part of NFHCS Compliance Plan and in addition to the Agency's Professional Standards, a Code of Conduct for all organizational staff and contract parties will be maintained.

The purpose of this Code of Conduct is to assist staff in maintaining high ethical standards in aspects of their work. The Code of Conduct will help guide staff in making decisions that conform to the ethical and legal standards expected. It will also help to ensure that NFHCS remains in compliance with the applicable laws and regulations.

Staff and contract staff working with NFHCS are responsible to abide by the following standards:

- **Business Records**: All business records must be accurate. Each staff is expected to record and report information accurately and honestly. If any staff has a question with regards to the appropriateness of a data, census, or billing entry, that staff should discuss the situation with their supervisor.
- **Billing and Claim Submission**: NFHCS staff shall professionally, accurately, and completely provide and document service. and submit claims for reimbursement in a manner conforming to all applicable laws, regulations, and statutes. Staff who know of or suspect that a billing or claim for reimbursement is incorrect or non-compliant must report their concerns immediately to their supervisor or the Compliance Officer. No services will

be billed unless fully justified and reflected in the individual records. Clinical team members are responsible to inform Fiscal team members of consumer changes related to frequency of service duration of service or billing changes.

- **Independent Contractors and Vendors**: Contractors and vendors shall conform to the highest professional standards of work and business ethics. As such. contractors and vendors must comply with all NFHCS Fraud and Abuse Policy, as well as all applicable laws, regulations, and statutes. A contractor or vendor is required to report false or fraudulent claims attempted by others or the use of false information to defraud NFHCS to their immediate supervisory or management staff.
- **Conflict of Interest:** NFHCS will enforce its Conflict-of-Interest Policy. NFHCS Officers, Directors. Agents or Staff should not receive any financial gain by virtue of their relationship with NFHCS or persons served, beyond direct compensation. Additionally, individuals must avoid any potential or perceived conflict of interest. Any concerns about what constitutes a conflict of interest should be discussed with supervisory staff or the Compliance Officer.
- **Market:** NFHCS will comply will all applicable laws and regulations pertaining to "antitrust" issues. This includes the prohibition of sharing certain information with other health care providers, including information about our charges, staff salaries, or other internal business practices.
- **NFHCS Property:** No NFHCS property may be used for personal purposes. Use of Agency property outside of NFHCS locations must receive prior approval from supervisor's staff.
- **Kickbacks & Purchasing**: NFHCS shall abide by all applicable federal and state laws related to kickbacks. No staff or Board Member shall accept a payment or gift in exchange for business priority or participation. Any offer of a gift or payment to a staff or Board member in exchange for business priority or participation must be immediately reported to the Compliance Officer.
- **Document and Record Maintenance**: All documents and records should be maintained in a manner consistent with Agency policy. As well as applicable state and federal guidelines in addition, consumer records must be maintained in accordance with NFHCS's Policy and Procedures on Single Case Records. Document and record destruction will be in accordance with the Agency's Policy and procedures for Document Retention and Destruction.
- **Confidentiality**: NFHCS shall comply with all applicable federal and state laws related to maintaining the confidentiality of Protected Health Care Information. Board Members, staff and contractors must comply with NFHCS's Policies and Procedures on the Confidentiality of Individual Records Policy and the Notice of Privacy Information (HIPAA). No individual should access information they do no1 need in order to perform their job.

- **Criminal Investigations**: NFHCS shall cooperate with all criminal investigations, subpoenas, search warrants and other similar documents and actions to the full extent of the law. If contacted by a criminal investigator regarding compliance issues, staff must immediately notify supervisory staff or the Compliance Officer.
- **Non-Retribution and Non-Retaliation**: Any action which is intended to intimidate, threaten, coerce, discriminate against, or take any other retaliatory action against any individual for exercising his or her right(s), in good faith to report non- compliance, shall be immediately reported to the Compliance Officer. All reports shall be investigated and documented. Disciplinary action will be undertaken, accordingly (see NFHCS's Whistleblower Policy and Procedures).
- **Fraud and Abuse Policy**: NFHCS is required to abide by Section 6032 of the Federal Deficit Reduction Act of 2005. This act pertains to organizations assisting the federal and state government compel financial fraud, waste and abuse and educates staff about false claims recovery (reference Fraud and Abuse Policy).

Each staff or contract party who has information pertaining in actual compliance violations or suspects compliance violations must report their suspicions to their immediate supervisor, management, or administrative staff or to the Quality Resource and Compliance Department.

Compliance Officer & Compliance Committee

The Compliance Officer: The Compliance Officer will serve as the Manager for all Agency related compliance activities, compliance investigations and compliance follow-up. The Compliance Officers responsibilities will consist of:

- Ensuring that there are sufficient policies and procedures to meet federal and state regulatory requirements.
- Developing, establishing, and maintaining an effective and broad-based compliance program designed to prevent, monitor, and detect areas of non-compliance.
- Conducting periodic and random compliance reviews throughout the Agency.
- Investigating (or delegate investigative responsibility) any issues that arise through the use either the dedicated reporting system or the use of an anonymous complaint process.
- Recommending corrective actions when necessary to fully meet compliance requirements.
- Working with the Executive Staff. Board of Directors or Legal Counsel in dealing with the appropriate reporting of self-discovered violations of program requirements.

- Maintaining open lines of communication with all staff in the Agency through the use of dedicated reporting systems and the use of an anonymous complaint process.

The Compliance Officer will have access to review all documents and other relevant information, including billing. service documentation and consumer documentation, as a means of establishing organizational compliance.

The Compliance Committee: The Compliance Committee will consist of representatives from the Executive Management team. Managers or Directors within the Agency. The Compliance Committee will be chaired by the Compliance Officer. The Compliance Committee will meet on an as needed basis to review appropriate strategies and approaches to promote the Compliance Plan within NFHCS and when appropriate, make recommendations to the Executive Team for modifications to the plan.

The Compliance Committee should meet at least twice in a calendar year. Meetings will be called with the concurrence of the COO.

Reporting Compliance Issues: The Agency will maintain an open door and non-retaliatory policy towards staff and contract personnel who report any area of concern related to the Fraud and Abuse policy, this Compliance Plan and related compliance policies and procedures.

As noted in the Fraud and Abuse Policy, staff may choose to confidentially share information pertaining to suspected or actual compliance violations with the Corporate Compliance Officer by:

- in forwarding a written statement to the Compliance Officer
- leaving a phone message with the Compliance Officer
- emailing the Compliance Officer at jriley@nfhcs.org

A staff's failure to follow the notification process set forth in this Compliance Plan may result loss of employment or other disciplinary action. Independent contractors may have their contracts terminated. Claims of ignorance or good intentions will not excuse an individual from the obligations under this Compliance Plan.

Compliance Officer: NFHCS believes that a successful compliance program requires an effective process for evaluating the implementation of a compliance plan. This is completed using a compliance monitoring process.

Compliance monitoring will be completed by the Quality Resource and Compliance Department. The Quality Resource and Compliance Department will document all monitoring activities, including reports of suspected non-compliance and share these findings with the Executive Management Team.

Compliance monitoring will include a sampling of internal program and administrative protocols. This permits the Compliance Office or designee(s) to review information related to established rules and regulations of the Federal Government, State Government, and Local Government, Managed Care Organizations and Agency policy and procedure.

Findings, which demonstrate non-compliance with the accepted standards, will be reviewed with the appropriate Regional Management Team representatives and result in corrective recommendations and/or suggestions by that service.

Compliance monitoring may consist of:

- On-site announced/unannounced reviews
- Review of Staff and Contractor Qualifications Trend Analysis
- Billing and Claims Verification
- Service or Program Licensing Follow-Up
- Look-behind interviews with consumer, family, and staff

In order to assess service progress and compliance, monitoring will occur every 3 months. Special attention will be given to previous corrective recommendations and suggestions.

Additional detail on the Compliance Monitoring process can be found in the Compliance Review Protocol, maintained in the Quality Resource & Compliance Department.

Assessing Compliance Effectiveness: Evaluating the effectiveness of a Compliance Plan is a necessary phase to ensure that outcomes within the Compliance Plan have been successfully achieved. The effectiveness of a Compliance Plan is not demonstrated or strengthened by the number of non-compliant activities discovered, rather it is an assurance that all Compliance Plan activities have been successfully implemented and an assurance that follow-through on non-compliance response has occurred.

Compliance Effectiveness will be measured in the success or failure of the following:

- Appropriate Policies, Procedures and Compliance Plan are in place
- Staff are framed in applicable policies
- Staff are aware of the reporting process
- Compliance Plan information has been shared with all management/administrative and contract parties
- Staff have received training in the Compliance Plan protocol: Self-assessment reporting has occurred as required
- On-site monitoring for all service components has occurred; Billing verification/billing review has been completed
- The Compliance Committee has reviewed all monitoring efforts; Recommendations based on monitoring findings have been implemented
- The Compliance & Quality Department has met the goals of the Executive Team and Board of Directors
- The Compliance and Quality Department has completed a trend analysis profile

Compliance Policy & Procedure: NFHCS policy and procedures; plans and professional activities and other organizational requirements collectively represent elements of NFHCS's compliance efforts:

- Adherence to NFHCS Professional Standards
- Adherence to BIPAA requirements
- Adherence to NFHCS Policy of Records Retention (pending)
- Adherence to NFHCS Policy on Confidentiality Adherence to Agency Policy on Consumer Funds Adherence to NFHCS Policy on Fraud and Abuse
- Adherence to NFHCS Whistleblower Policy and Procedure Adherence to Agency Policy on Incident Reporting Adherence to NFHCS Policy on Conflict of Interest
- Adherence to NFHCS Policy on Document Retention and Destruction
- Awareness of NFHCS disciplinary guidelines Awareness of Agency Risk Management Plan Awareness of emergency procedures
- Awareness of fiscal claims and billing protocol (Fiscal Dept.)
- Awareness of staff training requirements
- Corporate Compliance Plan

Meeting NFHCS requirements for Credentialing, Certification and/or Licensing.

Staff Management/Contractor Responsibility: The effectiveness of NFHCS's Compliance Plan depends on the efforts of staff in all phases of service and business performance.

It will be the staff's responsibilities to:

- Participate in Professional Standards and Fraud and Abuse training at hire and annually thereafter.
- Maintain knowledge of the Fraud and Abuse Policy and understand what obligations are expected of them. If a staff is unsure of his/her obligation, then they should seek clarification from their supervisor or the Compliance Officer.
- Report all actual or suspected compliance issues to their supervisor or the Compliance Officer as
- Identified.
- Implement the Individual plan as identified in their ISP or other planning/ program document.
- Maintain appropriate licensing and/or certification in order to meet the needs or expectations of their position responsibilities.
- Accurately complete the documentation requirements for program operation.

It will be management's responsibilities to:

- Familiarize themselves with the Fraud and Abuse Policy and this Compliance Plan and understand their obligations.
- Ensure that supervisory staff communicate the importance of compliance to all staff and contract personnel.
- Prepare management staff to respond to and explain the organizational Compliance Plan.
- Ensure participation in compliance training during hire and annually, thereafter.
- Report all actual or suspected compliance issues to their supervisor or the Compliance Officer or as identified in the Reporting Compliance Issues section of this document.
- Appropriately respond to staff reports of compliance issues and communicate these issues to their supervisory staff and the Compliance Officer.
- To maintain appropriate credentialing, licensing and/or certification in order to meet the needs or expectations of your position responsibilities.
- Accurately complete the documentation requirements for all program and administrative services.

It will be staff's responsibilities to:

- Maintain accurate and understandable billing information.
- Report all actual or suspected compliance issues the Compliance Officer.
- To maintain appropriate credentialing, licensing and/or certification in order to meet the needs or expectations of their profession.
- Accurately complete the documentation requirements for services provided.

Staff's Printed Name Date:

Staff's Signature

5.4 Disaster Drills

Implemented: September 2017 **Revised:** September 2020

Background: In the event that NFHCS's facilities, individuals or staff are required to evacuate their respective locations as a result of unexpected disasters, preparation and planning for these unexpected events will aid in the successful evacuation and limit the disruption of individual care.

NFHCS's Quarterly Disaster drill will incorporate planning for the following concerns: floods, weather related disasters, earthquakes, intruders, bomb threats, utility failure, nuclear disaster, other (unspecified).

Procedure: Every 3 months, NFHCS should complete a Quarterly Disaster Drill Form. Report as follows:

- Indicate the name of the facility where the drill is being held.
- Indicate the date, day, and time of the drill.
- Check which kind of drill is being conducted (for other, please write-in what type of event the drill is preparing.
- For evacuations requiring relocation to an alternate location, please indicate that location under Evacuation Destination.
- Please identify the escape route used in the evacuation of the home/apartment.
- Please identify all individuals and staff involved. List each staff by name and by their regular shift assignment; all shifts need to be represented at and aware of Disaster Drills and procedures, as we will never know when a disaster may occur.
- Please indicate if there were any individual or staff issues that arose during the drill and indicate the results of the drill.
- For individual and staff educational purposes, please discuss issues related to that specific drill and evacuation. Also, indicate if the educational discussion was prior.
- The person conducting the drill should sign and date the drill form. The drill should then be reviewed and signed by the appropriate supervisory staff.
- The Quarterly Disaster Drill must be maintained on site.
- Drills must be rotated, so that the same drill is not reviewed every quarter.
- Fire Drills may be incorporated into the Quarterly Disaster Drill routine during I of 4 quarterly reviews, annually. Please keep in mind that you must continue to complete all normal fire drill routines as outlined in the current protocol.

- Prior to conducting a drill, please make the individuals aware in the next several hours or days, that a drill will be conducted to deal with a specific emergency.
- Educational discussions surrounding the drill are important to give individuals and all staff regardless of their regular shift assignment better awareness and allow for a safer reaction in the event of an evacuation.
- In conducting drills that require you to leave the area in a vehicle, it is not necessary to actually enter and drive away in the vehicle. The drill can be conducted as you are exiting the home or planning to enter the vehicle.
- Please use common sense judgment when conducting a drill during inclement weather.
- Please refer to your specific evacuation plans and temporary relocation plans, within your facility/service manual (if applicable), to assist you with relocation needs and appropriate communication needs.
- Prepare a "Take with Me" list of items, in event you have some time within the evacuation constraints. This list may include medications, money, changes of clothing, emergency, and family phone numbers, etc.

5.5 Dog Bites

Implemented: September 2020 **Revised:**

Background: Each year, more than 4.5 million people in the U.S. are bitten by dogs. Almost one in five of those who are bitten, about 885,000, require medical attention for dog bite-related injuries. 10 to 20 people a year die as a result of dog bites.

What can you do to prevent being bitten?

- Never approach a strange dog
- Don't pet a dog without letting him/her see and sniff your first
- Never turn your back to a dog and run away – natural instinct is to chase and catch you
- Do not disturb a dog while they are sleeping, eating, chewing on a toy, or caring for puppies
- Always assume a dog who does not know you might perceive you as an intruder or a threat
- Try to look less threatening
- Turn sideways to the dog
- Don't reach out or lean over the dog
- Don't make direct eye contact
- If the dog loses interest, back away slowly until you are at a safe distance – Never put yourself between the dog and its escape route.

If the dog attacks:

- Try feeding it anything you have handy, jacket, clipboard, purse, or anything you can put between yourself and the dog
- Don't yell and don't run
- Stay on your feet
    - Try not to struggle
    - Back away and look for a safe place to retreat
- If you do get knocked to the ground.
    - Try to remain as motionless as possible until the dog loses interest
    - Protect your face, chest, and throat, keep your hands in fists to protect your fingers
- If you are bitten, report this to your supervisor and complete an Accident Report. Seek medical treatment as needed.

5.6 Emergency Disaster Response Plan

Implemented: September 2016 **Revised:** October 2018

Reference/Source: ODP Bulletin 00-10-02, Quality Management Strategy of the Office of Developmental Programs, Focus Area II: Individual-Centered Service Planning and Delivery, Focus Area IV: Individual Safeguards (Appendices D and G of waiver) 55 Pa. Code Chapter 51 Section 51.4

Persons Affected: Individuals, Families (if applicable), Guardians and staff of Not Forgotten Home & Community services.

Our Purpose: Our purpose is to inform the affected of Not Forgotten Home & Community Services, of our Emergency Disaster Plan for Natural Disasters. Which includes but not limited to: Our response plan that addresses our Individual's Safety, Protection, and the Communication to be utilized (Including Calling 911) and our operation policies.

Definitions:

- **NFHCS**: Not Forgotten Home & Community Services
- **Department**: The Department of Health & Human Services of the Commonwealth
- **ED**: Executive Director
- **Staff**: Staff of Not Forgotten Home & Community Services (including unpaid volunteers)
- **ODP**: Office of Developmental Program
- **EDRP**: Emergency Disaster Response Plan

Policy/ Procedures Objectives:

- Our policy will address the Protections of our Individuals.
- Communications and Operational Procedures.

Staff Training: Staff will be trained upon hiring and annually thereafter. (Including updates to the EDRP) This training curriculum includes but not limited to:

- **Fire Safety**
- **Fire Drills**
- **Emergency Disaster Response Plan**
- **Incident Management**
- **Quality Management Plan**
- **Emergency Contact Phone numbers and Emergency Location sites**

- **Emergency Evacuation Procedures**

Ensuring the safety & protections of our Individuals and staff is our highest priority. Below are "some" emergency situations which would require an immediate response. "Remember" this list is not limited to only these situations.

"Any situation which impedes on the Health, Safety and Protection of our Individuals must be implemented immediately.''

Individuals Safety & Protections from:

- Fire
- Flood
- Gas Leak
- Terrorist Attack
- No heat in the winter/ Extreme heat in the summer.

Communication- When to call 911
Policy & Operations Procedures

In the event of a Fire inside of an establishment while providing services to our Individual{s) "Walmart" **Scenario**:

- Individual Health & Safety: Staff will assist our Individual(s) in evacuating "Walmart" immediately. Utilizing the emergency exits.
- Staff and Individuals are to remain in a safe area outside of the establishment. If staff is providing services to more than one Individual, Staff will conduct an immediate head count to ensure all Individual(s) are out of "Walmart". Assess and ensure our Individuals hasn't experience any injury's while exiting "Walmart"
- Communication (When to call 911) – Immediately, Staff will place a call to 911. "Don't assume others have placed a call, you make the call also! And contact your immediate supervisor.
- Supervisors will contact our individual's families & assist in transporting our Individuals (if applicable).
- Operation Policy and Procedures. NFHCS staff are required to compose an internal Incident Report with the aforementioned information.

In the event of a "Flash" Flooding situation outside of our Individuals home while providing a service: (e.g., Street flooding occurring at the residence of an Individual receiving Residential Habilitation) **Scenario**:

- Individual safety and Protections: Staff will assist our Individual's to retreat to the highest level of the Individuals home. Staff & Individuals will remain at that location. Until further directed by Emergency Personnel.
- Communication (Including calling 911): Staff will immediately contact 911. Provide the 911 operator with pertinent information. (Exact address, where you are located inside of the Individuals home) "Remain calm" And wait for further instruction.
- Staff will contact their immediate Supervisor.
- Supervisors will contact the Individuals families, Program Coordinator & Executive Director.
- Policy and Operation Procedures: Our staff must wait for instructions from Emergency Personnel regarding transporting our Individuals. (Remember you must never drive through standing water)
- If Staff and our Individuals must relocate, (Emergency evacuation) to an emergency shelter. Via Fire Department, Staff will assist our Individual in (gathering any clothing, medication, medical cards etc.) Only if it's safe to do so. Once safely at the Emergency Location, Staff will notify their immediate supervisor with this updated information. STAFF MUST REMAIN WITH OUR PARTICPANT. To ensure the health and safety of our Individual.
- Supervisors will notify the Individuals family / guardian (If applicable) and compose of an Incident Report regarding the situation.

Scenario: Staff and Individual return to the individual's home. And discover there is a Gas Leak at the Residence while returning from a community outing with the Individual:

- Individual safety and Protections: Staff will assist our Individual in IMMEDIATELY evacuating the residence. (Don't turn on any lights or any electronics). Retreat to a safe location away from the residence. (Don't stand in front of the residence, retreat at least a block away). Immediately, after evacuating the residence, assess our Individual to ensure no injuries has occurred during the evacuation. Call 911 and utilize the Individuals Back-Up plan. This could consist of driving our Individual to another safe location outlined in the Individual's ISP. (Parents/ sibling's residence) Staff must remain with our Individual until the Individual is safely with Family or designated person listed in the Back-Up plan of the ISP.
- Communication (Including calling 911) **-**Staff will <u>immediately</u> contact 911.
- Staff will contact their immediate Supervisor.
- Supervisors will contact the Individuals families, Program Coordinator and Executive Director

- Policy and Operation Procedures: Our staff must accompany our Individual to the Individuals designated Back-Up Plan location. And leave only when it's safe to do so.
- Supervisors must compose of an internal Incident Report regarding the situation.

Scenario: In the event of a terrorist attack outside of an establishment where our Individuals is volunteering at a local grocery store.

- Individual safety and Protections: Staff will assist our Individual's to retreat to a safe location inside of the store. Staff & Individuals will remain at that location until further directed by Emergency Personnel. Ensure the Individual and you (you the staff) are ok. Remember: It could be a dangerous situation, so don't venture outside, until you are given a directive from an Emergency Personnel.)
- Communication (Including calling 911) staff will immediately contact 911. Tell the operator exactly where you and the Individual are located inside of the store. Also, inform 911 of any injuries you or the Individual may have incurred. And wait for further instruction. Our Individual as well as you may be terrified. Try to remain calm and reassure our Individual that help is on the way.
- Staff will also contact their immediate Supervisor.
- Supervisors will contact the Individuals families/ guardian (If applicable) and notify the Program Coordinator and Executive Director.
- Policy and Operation Procedures: Our staff must wait for instructions from Emergency Personnel regarding our Individuals. They may need medical attention, so, remain in place until they are medically cleared (If applicable)
- If Staff and our Individual must be transported to the nearest hospital. The staff must inform the emergency personnel about the Individual and their immediate needs. The Program Specialist, Program Coordinator, Director of Administration, Assistant Executive Director, Executive Director or Designee, must be immediately in route to assist our staff and Individual. The designated staff will remain with our individual. To ensure the health and safety of our Individual.
- Supervisors must compose of an internal Incident Report regarding the situation.

Scenario: Staff shows up to work with "Jason". Jason receives Services from NFHCS. Once inside the residence, Staff observe extremely HOT/ COLD conditions inside of the home.

- Individual safety and Protections: Staff will assist "Jason "in evacuating the home. Staff will assess the Individual to ensure he doesn't require any medical attention.
- Communication (Including calling 911): Staff will immediately contact their supervisors and wait for further instructions.
- Supervisors will contact the Individuals families/ guardian (If applicable) and our Program Coordinator and Executive Director.
- Policy and Operation Procedures: Our staff must wait for instructions from their immediate supervisors regarding next steps.
- If our Individuals must relocate, to an emergency shelter. Our staff must accompany our Individual to the designated shelter. Supports could include, driving Jason, to the shelter, collecting personal belongings from "Jason's" residence to ensure a smoother transition, staying with Jason until it's safe to leave under the direction of the Program Coordinator or Assistant or Executive Director.
- Supervisors must compose of an Incident Report regarding the situation.

Emergency Contact Numbers

- Police and Fire 911
- Ambulance 911
- FIRE: 911
- Sonja Garnett – Williams: Executive Director Phone Number: 412-279-5000

Staff Resources:

- NFHCS CALL TREE
- ODP Bulletin 00-10-02, *Quality Management Strategy of the Office of Developmental Programs*,
- Focus Area II: Individual-Centered Service Planning and Delivery
- Focus Area IV: Individual Safeguards (Appendices D and G of waiver)
- 55 Pa. Code Chapter 51 Section 51.4

5.7 Emergency Medical Plan

Implemented: December 2015 **Revised:**

Background: It is the policy of NFHCS to ensure the safety of its constituents in case of a medical emergency, and to this end, specific procedures must be established, and guidelines followed.

This policy applies to all staff whether full-time, part-time, or temporary, visitors and any other persons on the property.

Medical Emergency: In the event of a sudden unexplained or possibly life-threatening medical situation or a severe illness or injury, please dial 911 for Emergency Medical Services (EMS). The individual would need to be transported to St Clair Hospital at 1000 Bower Hill Rd, Pittsburgh, PA 15243. Staff will accompany the transporter to the Hospital. Examples of life-threatening conditions may include, but are not limited to, the following: choking, severe chest pain and/or shortness of breath, loss of consciousness, uncontrolled bleeding, debilitating injuries, and violent behavior. After calling EMS, the following key contacts must be informed by staff:

- Incident Manager: Angie King – 412.956.9633
- The Incident Manager will contact the Executive Director

The above offices must be contacted when staff have work-related illnesses of a minor or major nature. The staff's supervisor is responsible for completing an "Accident Report" form regardless of whether the illness or injury has occurred while working. The Accident Report must be completed within 48 hours of the occurrence; signed by all persons noted on the form; and submitted to the Office of Human Resources.

All accidents which involve persons who are not employed by NFHCS must be reported immediately to the above offices as well as Risk Management.

The cost for EMS services is the responsibility of the staff and non-staff. If the individual refuses transport, or if transport is not recommended by EMS personnel, there is no charge.

Assisting In a Medical Emergency

You can always do something to help in any emergency.

- Take appropriate safety precautions for yourself and the safety of others. Be alert to possible dangers at the scene. Move a victim only if the victim's life is endangered.

- Communicate effectively, giving specifics on what, where, when, and the number of persons involved. Ask a conscious victim for permission before giving care; provide necessary information to EMS personnel upon arrival.
- Organize to the extent possible. Comfort the victim as well as bystanders. Keep the area free of unnecessary traffic and help protect the victim from possible dangers.

5.8 Evacuation Procedure Plan

Implemented: December 2015 **Revised:**

Background: The goals of this evacuation procedure plan are, in order of priority, to protect the lives and health of Not Forgotten Home and Community Service individuals and staff.

All Not Forgotten staff are trained on who to contact in the event of an emergency, (911, Individual contact information, and Not Forgotten designated staff contact information). Not Forgotten maintains all Staff Names and Contact Information. All Staff are provided with the contact information of NFHCS's Executive Management Team, and their immediate supervisor(s). All Staff are provided with the emergency contact information for the individual(s) they provide services to.

All staff are required to carry cell phones on them at all times, in addition to being trained on their individual's health and safety needs to report to the emergency response personnel. All staff of Not Forgotten are trained on NFHCS's Emergency Response Plan and essential preparedness including:

- Fire safety training
- Following the evacuation plan of the facility in the event of a fire
- The staff will maintain a list of emergency numbers, and all individuals phone numbers, medication, and medical history (as per the ISP)
- Establishing a meeting place outside and away from the building
- In the event of an evacuation that you must leave the premises, follow the established guidelines of NFHCS, the City of Pittsburgh and Allegheny County
- Identifying all exits in the building, and making sure that staff is trained

Priorities: The objectives of this plan are, in order of importance:

- To evacuate and account for all staff and visitors
- To contact local emergency service organizations
- To assemble the NFHCS's Emergency Response Team (ERT) for implementation of the response plan
- Contact pertinent regulatory agencies
- Prevent further property damage through protective measures or by removing property
- Conduct post-incident critique and evaluation
- File any applicable reports with regulatory agencies

Training: Not Forgotten will train all individuals and staff, including individuals who are 18 years of age or older, on the procedures contained in this plan. New staff will be trained upon hiring and re-trained any time the staff responsibilities under the plan change or whenever the plan changes.

NFHCS will provide copies of all emergency response plans to be kept in staff handbooks and operation manuals and will post copies on staff bulletin boards.

NFHCS also will designate and train a sufficient number of staff to assist in the safe and orderly evacuation of staff and visitors. **Staff and individuals will be trained and re-trained annually.**

Training will cover:

- Fire Safety Training
- Emergency reporting
- Evacuation routes
- Alarm systems
- Specific assigned duties

Periodic drills will be held to ensure that all staff know the appropriate action to take in case of an emergency. NFHCS will provide additional training and frequent drills for staff with specific emergency-response duties; and invite local emergency service units to participate in training whenever possible.

Evacuation Procedures: After Management Personnel, on the scene determines that evacuation is necessary, instructions will be issued. Specific responsibilities are as follows:

- Lead individuals/staff from work areas when the evacuation alarm sounds
- Assist any individuals/staff with disabilities
- Escort individuals/staff to Designated Assembly Area
- Account for all individuals/staff upon reaching the designated assembly area
- Notify NFHCS Management of any individual/staff not accounted for
- Ensure that individuals/staff stay in the assembly area

Should you have additional questions, please contact Sonja Garnett-Williams, Executive Director.

5.9 Fraud, Abuse, Prevention & Awareness

Implemented: December 2015 **Revised:** September 2020

Background: NFHCS is committed to the delivery of services in an environment that protects against fraudulent claims and abusive actions that can lead to the improper reimbursement of services.

NFHCS, is required to abide by Section 6032 of the Federal Deficit Reduction Act of 2005. This act pertains to organizations assisting the federal and state government in combating financial fraud, waste and abuse and educating staff about false claims recovery.

NFHCS is also required to follow Pennsylvania laws, including the Fraud and Abuse Control Act, 62 P.S. Sec. 1401 et seq., and the Whistleblower Caw, 43 P.S. Section 142 I -1428, in an effort to prevent false and fraudulent claims and protect staff who report misuse of state or federal funds.

NFHCS has developed this procedure as required by its Agency Compliance Plan and the Agency's policy on Fraud and Abuse. The goal of this procedure is to define the legal responsibilities of the Agency and the obligations of its staff in preventing or reporting fraud and abuse.

Section 6032 of the Federal Deficit Reduction Act of 2005 requires providers to inform staff about certain fraud and abuse laws and the whistleblower provisions in those laws. Section 6032 requires the development of policies and procedures for preventing fraud and abuse.

Definition:

- **Fraud:** Fraud is the intentional deception or misrepresentation that an individual knows to be false or does not believe to be true and makes, knowing that the deception could result in an unauthorized benefit to himself/herself or another person. The most frequent kind of fraud arises from a false statement or misrepresentation made or caused to be made, that is material to entitlement or payment under the Medicare program.
- **Abuse:** Federal law defines abuse, as applied to the Medicare program, as incidents or practices by providers, which although not usually considered fraudulent are inconsistent with accepted sound medical, business, or fiscal practices that directly or indirectly create unnecessary costs to the Medicare program. Improper reimbursement or reimbursement for services which fail to meet professionally recognized standards of care, or which are not reasonable and necessary are examples of such practices.

Laws:

- **Deficit Reduction:** Act the Deficit Reduction Act is the United States Governments attempt to bring mandatory spending (entitlements) under control arid ensure the continued stability of entitlement programs over an extended period of time.
- **False Claims Act (as a part o/the Deficit Reduction Act):** Under the False Claim Act, any person who knowingly (knowingly indicates acknowledge, deliberate ignorance or reckless disregard) makes, uses or causes to be made or used, a false record to gel a false or fraudulent claim paid or approved by the Government; who conspires to defraud the Government by getting a false or fraudulent claim paid or approved by the Government; or who knowingly makes, uses, or causes to be made or used, a false record or statement to conceal, avoid, or decrease an obligation to pay or transmit money or property to the Government.....is liable to the United State Government for a civil penalty.
- **Title 43 (Pa. Whistleblower):** The Pennsylvania Whistleblower Law prohibits public employers from retaliating, discriminating, or harassing public staff who report a misuse of state funds or resources or a violation of federal or state laws, rules, or regulations. Even though Pennsylvania law does not contain whistleblower protections for non-governmental staff, NFHCS will comply with the content of federal law and NFHCS policy in this regard.
- **Fraud & Abuse Control Act, 62 P.S.:** The Pennsylvania Fraud & Abuse Control Act imposes liability on persons and companies that make or cause to be made false or fraudulent claims to the government for payment and /or that knowingly make, use, or cause to be made or used, a false record or statement to get a false or fraudulent claim paid by the government. A violation of the Fraud and Abuse Control Act may result in civil or criminal penalties for false claims and statements.
- **Education:** During orientation and annually thereafter, the agency will ensure that staff review the information contained in this policy and procedure and indicate their awareness and understanding by signing an acknowledgment.
- **Staff, Consultants or Contracted:** To further enhance the commitment of the agency to this policy, the agency will through open lines of communication; encourage staff to raise questions or concerns regarding compliance.

Staff, consultants, or contracted agents should feel comfortable reporting any concerns without fear of retaliation.

Staff, consultants, or contracted agents must exercise sound judgment to avoid baseless allegations. A staff who intentionally files a false report of wrongdoing will be subject to disciplinary action up to and including termination.

Additionally, individuals may choose to confidentially share information pertaining to suspected or actual compliance violations with the Compliance Officer, Quality and Compliance Manager by:

- forwarding a written statement to the Compliance Officer 101 W. Main St. Carnegie, Pa 15122
- leaving a phone message with the Compliance Officer by calling 412.758.1819
- entailing the Compliance Officer at compliance@nfhcs.org

Insofar as possible, the confidentiality of the reporting will be maintained. However, identity may have to be disclosed to conduct a thorough investigation. To comply with the law and to provide accused individuals their legal rights of defense.

NFHCS will not retaliate against a whistleblower. This includes. but is not limited to, protection from retaliation in the form of an adverse employment action such as termination, compensation decreases, or poor work assignments and threats of physical harm.

Agency Responsibility:

- **Compliance:** Through the Quality Resource & Compliance Department, periodic and random compliance reviews will be conducted. These reviews will focus on the verification and completeness of documentation, the verification of billing accuracy, the consistency of process and the quality of services provided.
- These compliance reviews will also contain "look-behind" interviews with consumers, family, and staff, in order to ensure that service provision has been provided as prescribed, authorized, and billed.
- Investigative Reviews: All reports of illegal and improper activities will be promptly submitted to the Compliance Officer who is responsible for investigating and coordinating corrective action.

All complaints and investigations will be maintained by the Compliance Officer.

5.10 Hazardous Household Product

Implemented: December 2015 **Revised:** September 2020

Background: NFHCS is committed to providing services, which preserve or develop each individual's abilities necessary to maintain themselves safe in their home and community. With that goal in mind, NFHCS staff are required to follow this Hazardous Household Product Safety Policy, which establishes safety practices for both residential, non-residential services and office taxations.

This policy recognizes the unique abilities of the individuals being served, and as such attempts to provide varying levels of mandatory controls, guidelines, or recommendations with regard to individual access and staff use of hazardous substances. The policy makes every attempt to not restrict individual rights while simultaneously providing necessary safeguards. As such, there are situations where different standards will be applied at different locations and at times differently from one individual to another. Staff should familiarize themselves with the individuals they serve to the requirements of the program or service to which they are assigned, as well as the general requirements applicable to all programs and services.

Categories of Products

Prohibited Products: All commercial and industrial chemicals as well as some household, retail products are extremely dangerous if not carefully and properly used or stored. NFHCS has classified such products as PROHIBITED and has prohibited them from being purchased and used at any home, site, or office owned or leased by NFHCS.

However, there are households or residences where NFHCS cannot restrict the use of these products. Agency staff are required to provide educational guide rice to the members of such households about the dangers associated with PROHIBITED products. Examples of such households exempt from restrictions associated with PROHIBITED products are.

The individual is living **independently** in his or her own, leased, or owned residence.

- Industrial Chemicals
- Commercial Chemicals
- Industrial/Commercial Cleaning Products

- Chemical Drain Cleaners
- Rat Poison, Bait-Type Pest Controls
- Lye
- Kerosene
- All Concentrated/Unmixed or Commercial Fertilizer
- Lighter Bottles
- Solvent (Acetone)
- All Weed Killers or Herbicides

Bait type poisons are prohibited from use/storage at homes, apartments, residences, and offices. Staff should contract for the "professional" services of an exterminator and request (non-poison bait) from of pest control.

Lighter fluid is prohibited from use/storage at homes, apartments, residences, and offices. Staff should use "matchless" charcoal for barbecue grilling. Consumers should be encouraged to use butane lighters (tobacco).

Hazardous Products: Other household products are less hazardous but dangerous if not used carefully and stored properly. NFHCS has identified these products as HAZARDOUS and allows their purchase and use by staff only, provided that the products are stored outside of the living areas, basement, attic or attached garage of any home, site owned or leased by NFHCS.

Staff in a non-residence or field office may also purchase and use this category of products provided that they are appropriately stored in a locked room. Additionally, all staff assigned to regularly work in such offices must be given an orientation to this policy and the requirements associated with the products stored in this locked room.

Once again, there are households or residences where NFHCS cannot restrict the use of these products or wishes to encourage increased independence and self-reliance. Agency staff are required to provide educational guidance to the members of such households about the dangers associated with HAZARDOUS products. Examples of such households exempt from the restrictions associated with HAZARDOUS products:

The individual is living independently in his/her their own leased or owned residence or with family, or friend and these individuals have been given an explanation of this policy and encouraged to carefully follow the manufacturer's directions or use and storage practices for HAZARDOUS category products.

- Ant Poison & Insecticides
- Antifreeze
- Automotive Oil, Oil Additives

- Automotive Power Steering Fluid
- Automotive transmission Fluid
- Fertilizer
- Gasoline, Turpentine
- Paint Lead
- Paint remover & thinner
- Windshield Washer Fluid

Household pesticides must be used as directed. Staff must read and to flow directions of product being used. Proper ventilation must be ensured. Residents, staff, and guests of the home should leave the rooms being treated and not return until the manufactures recommended elapsed time has passed. Food should be stored in closed containers and removed from immediate area.

Paints, paint removers and paint thinners are permitted in sites while the "painting project" is occurring provided that the home, apartment, or site is unoccupied by individual. In the event a residence is being painted while occupied, these products must be under continuous "sight" supervision by the contractor, painter, laborer or NFHCS staff. If the project spans more than 1 day, the products must be removed from the residence and stored off-site. At the conclusion of the painting project, these products must be permanently removed from the residence and stored off-site.

Automotive fluids may be purchased at a service station or automotive supply if used immediately at that location. These products may not be returned to a residence for storage.

Dangerous Products: A third category of products are those generally recognized as being necessary but dangerous items used on an infrequent basis in many households. NFHCS has identified these products as DANGEROUS and requires an evaluation of each individual's awareness of the intended use, proper storage, and directions for use of such products. This documented evaluation shall contain a conclusion stating that the individual is or is not aware of the cautions associated with the proper storage and use of these or similarly described products. Individuals demonstrating such awareness will not be prohibited from purchasing, openly storing, and using these products without staff supervision if the following conditions are met:

- The individual is living independently in his or her own, leased, or owned residence.
- The individual is living in their own residence with family, or friend and these individuals have been given an explanation of this policy and encouraged to

carefully follow the manufacturer's directions of use and storage practices for DANGEROUS category products.
- The individual shares their residence with other individuals all of whom have also been evaluated and documentation concludes that they too are aware of the cautions associated with the storage and use of these products.
- The individual shares their residence with other individuals, however he or she has their own bedroom, which contains a location inaccessible from all other individuals, for the storage of these products.

With such acknowledging documentation, agency staff will demonstrate and encouraged individuals to carefully follow the manufacturer's directions of use and storage practices for DANGEROUS category products.

For all other individuals and all NFHCS offices, this policy requires that DANGEROUS PRODUCTS are stored in a locked container, cabinet, or room.

Cautionary Products: Finally, certain household products used on a given basis and more particularly certain personal hygiene products also used on a frequent basis, are generally recognized as being necessary but if not used cautiously, could be dangerous. Not Forgotten has identified these products as CAUTIONARY PRODUCTS and requires an evaluation of each individual's awareness of the proper storage and use of such products. This documented evaluation shall contain a conclusion stating that the individual is or is not aware of the cautions associated with the proper storage and use of these products. Individuals demonstrating such awareness will not be prohibited from purchasing, openly storing, and using these products without staff supervision if the following conditions are met:
- The individual is living independently in his or her own, leased, or owned residence.
- The individual is living in their own residence with family, or friend and these individuals have been given an explanation of this policy and encouraged to carefully follow the manufacturer's directions of use and storage practices for CAUTIONARY category products.
- The individual shares their residence with other individuals all of whom have onto been evaluated and documentation concludes that they too are aware of the cautions associated with the storage and use of these products.
- The individual shares their residence with other individuals, however he or she has their own bedroom which contains a location, inaccessible to other individuals, for the storage of these products.
- for all other individuals and all NFHCS, this policy requires that these CAUTIONARY PRODUCTS are stored in a locked container, cabinet, or room.

With regard to both Dangerous and Cautionary household products.

- All staff must be aware that Hazardous, Dangerous and Cautionary household products must be used only for their intended purpose described on the products label. Staff must read the product label before use and must follow the directions as written.
- "Dangerous products" are generally items which clearly are not intended for human consumption and usually carry a product label warning such as "Poison", "Human Hazard", "Not for Human Consumption", or "Hazard to Humans and Domestic Animals"
- "Cautionary products" may not carry any warning label but are clearly not intended for human consumption. When staff are unsure about the potential hazard of ingestion or misuse, the identified product should be made inaccessible to individuals who have not demonstrated the awareness of its potential harm.
- All potentially Hazardous, Dangerous, or Cautionary, products must be stored away from food, food preparation or dining surfaces
- All potentially Dangerous, Cautionary and Hazardous household products must be kept in their original container or manufacture's designated "dilution" container ', and labels on containers of Dangerous. Hazardous and Cautionary products must not be removed or defaced, and must be clearly legible as Hazardous, Dangerous and Cautionary household product bottles or containers must be immediately disposed when empty. Unless otherwise directed by warning labels, glass or plastic containers should be thoroughly rinsed with cold water and immediately taken to a garbage container outside the home, apartment, or office. Boxes or containers should be thoroughly emptied and also immediately taken in a garbage container outside the home, apartment, or office.

Only Staff will use permitted to use Hazardous products in a NFHCS owned or leased occupancy.

When using Hazardous household products, staff should never allow themselves to become distracted, or leave the task or chore until it has been completed and the household product secured and locked in the appropriate container or room.

Finally, certain household products used rarely, and more particularly certain personal hygiene products also used on a frequent basis, are generally recognized as being necessary but if not used cautiously, could be dangerous. NFHCS has identified these products as CAUTIONARY PRODUCTS and requires an evaluation of each individual's awareness of the proper storage and use of such products. This

documented evaluation shall contain a conclusion stating that the individual is or is not aware of the cautions associated with the proper storage and use of these products. Individuals demonstrating such awareness will not be prohibited from purchasing, openly storing, and using these products without staff supervision if the following conditions are met.

5.11 Incident Management

Implemented: December 2015 **Revised:** October 2017; September 2018; September 2021

Reference/Source:

- 55. PA code Chapter 51.17,
- Incident Management 51.17 (a) Participants Rights,
- MR Bulletin 6000-04-01 Incident Management,
- 55.Pa Code 6000 Subchapter Q Incident Management,
- MR Bulletin 00-04-11 (Obsolete) Certified Investigations,
- ODP Certified Investigation Peer Review Manuel 2017,
- ODP Bulletin EIM ODP Communication number announcement 110-15,
- Certified Investigation Manual 2017, ODP CIPR Manual 2018,
- Information Packet 031-15, APS Mandatory reporting requirements of adults covered by adult protection service Act of 2018 updated August 2016,
- NFHCS Quality Management Policy #10, Quality Assessment, and Improvement 06/2018,
- APS Updated Addendum to informational Packet 031-15 Mandatory reporting requirements September 10, 2018

Persons Effected: Individuals, Families (if applicable), Guardians, Certified Investigators, Peer Review Committee Members, Support Coordinators, Contractors and unpaid volunteers and Staff of Not Forgotten Home & Community services.

Our Purpose: Our purpose is to inform the affected of Not Forgotten Home & Community Services, of our Incident Management Guide, that meets the requirements of PA Code Chapter 51 Regulations and MR Bulletin 6000-04-01 Incident Management. This guide outlines our requirements and solidifies our commitment to the Health, Safety and Welfare of our Individuals: In this policy guide staff will be able to:

- Identify Incidents
- Inform the affected including but not limited to Law Enforcement
- Reporting Requirements
- Investigate Incidents
- Collect data for analysis
- Corrective Action Measures

Definitions:

- **APS**: Adult Protective Services
- **CI**: Certified Investigators

- **Department**: The Department of Health & Human Services of the Commonwealth
- **DHS**: Department of Health and Human Services
- **EIM**: Enterprise Incident Management
- **HCSIS**: Home and Community Service Information System
- **IM**: Incident Management
- **IMG**: Incident Management Procedure Plan
- **ISP**: Individual Support Plan
- **NFHCS**: Not Forgotten Home & Community Services
- **ODP**: Office of Developmental Program
- **RIQ**: Risk, Incident & Quality Management
- **SC**: Support Coordinator

Policy Objectives: In this guide, you will find:

- A policy to address taking timely & appropriate action in response to incidents
- A written policy (this Guide) to support Incident Management
- NFHCS Staff training requirements
- NFHCS staff responsibility for Preventing, Recognizing, Reporting and Responding to Incidents
- A policy addresses timely reporting & completion of incidents in HCSIS/EIM
- Finalizing incidents within 30 days with exceptions
- A policy that addresses Certified Investigations of incidents, including follow up action
- A policy that addresses taking corrective action in response to incidents
- A policy that addresses our process for Peer Review Investigations
- Quarterly reviews of Data analysis of Incidents

Our Commitment: NFHCS will take prompt and immediate actions to protect our Individuals Health, Safety, Welfare and Rights when an Incident has been discovered or has occurred.

When an incident is recognized or discovered by NFHCS, prompt action will be taken to protect our Individuals.

The responsibility for this protective action is assigned to the initial reporter and point person. These protections may include:

- **Dialing 911**
- **Escorting to medical care**
- **Separating the perpetrator**
- **Calling Child Line**

- **Arranging for counseling and referring to a victim assistance program**

NFHCS's point person or designee will inform the family immediately within 24 hours, or within 72 hours' guidelines for medication error and restraint (unless categorized as abuse), of the occurrence of an incident and will also inform the family of the outcome of any investigation.

After taking all appropriate actions following an incident to protect the Individual, NFHCS must report all categories of incidents and complete an investigation as necessary whenever services or supports are:

- Rendered at NFHCS.
- Provided in a community environment, other than the Individual's home, while the Individual is in the responsibility of our staff's contracted agent(s) or volunteer.
- Provided in our Individual's own home or the home of his family, while our staff, contracted agent or volunteer is providing services in the home.

In situations when multiple providers learn of an incident, the provider responsible for the Individual at the time the incident occurred is to report the incident and conduct any required investigation. If it cannot reasonably be determined which provider had responsibility at the time of the incident, all providers (Including NFHCS) who are aware of the incident are to report the incident and investigate.

If, during an investigation, the certified investigator assigned by NFHCS determines that an alleged perpetrator is not a staff, a volunteer or an individual receiving services from NFHCS, the certified investigator is to complete the investigation summary in the HCSIS/EIM Incident Management Application stating the reason why the investigation could not be concluded. Our certified investigator will review the protective action taken by NFHCS and ensure communication with county staff occurs, outside HCSIS/EIM, to alert the county that appropriate interventions may be needed to protect the Individuals.

In addition, staff, contracted agents, or volunteers of NFHCS are to report deaths, alleged abuse, or neglect when they become aware of such incidents regardless of where or when these incidents occur. If the death, alleged abuse, or neglect occurred beyond NFHCS responsibility, NFHCS is not to report the incident in HCSIS/EIM, but instead should give notice of the incident, outside of HCSIS/ EIM, to the Individual's Supports Coordinator.

Any person, including the victim, must be free from intimidation, discriminatory, retaliatory, or disciplinary actions exclusively for the reporting or cooperating with a Certified Investigation. These Individuals have specific rights including:

- **The Whistleblower Law (43 P.S. 1421—1428)**
- **Older Adults Protective Services Act (35 P.S.10225.101—10225.5102)**
- **Chapter 51.17(a) Participants Rights**

Our Administrative Structure: Purpose: To create an administrative structure that is sufficient to implement the requirements of our IMG.

- We have developed a policy for Incident Management. (This Guide)
- We have assigned an individual (Our Incident Management Representative) with the overall responsibility for IM.
- Ensure our staff, individuals & Individual's families/Guardians are trained on our IMG. (Staff will be trained initially and annually ongoing).
- NFHCS will assign qualified staff within our organization for reporting & investigating incidents.
- Develop and assure corrective action measures to Individual's incidents.
- NFHCS will conduct data analysis on incidents and the quality of our investigations.
- NFHCS will identify and implement systemic & individual changes based on Risk Management Analysis.

The New Incident Management Bulletin (Bulletin 00-21-02): The Department of Human Services, Office of Developmental Programs (ODP) is pleased to announce the release of Bulletin 00-21-02: *Incident Management Bulletin*. This bulletin has been released prior to the effective date for stakeholders to begin to understand the Incident Management (IM) operating procedures and guidelines. This Bulletin will be effective on July 1, 2021. Also released with this bulletin are Attachment 1: *Victim's Assistance Programs*, Attachment 2: *IM Regulation Crosswalk*, and Attachment 3: *DP 1081, Incident Report*, for use when provider is unable to access the EIM system.

Pennsylvania continues to be at the forefront of IM and takes pride with continuing to ensure the IM policies and procedures reflect a new and innovative approach to protect and promote the health, safety, and rights of all individuals. With this said, the *Incident Management Bulletin* was developed to help stakeholders understand how to operationalize the IM policies and procedures as well as to give

interpretation of the IM regulations found in 55 Pa. Code 6100.401-405. The *Incident Management Bulletin* was created with significant stakeholder input ranging from in-person meetings across the state to the public comments received when the Bulletin was released as draft. This bulletin describes:

- Uniform practices for building organizational polices and structures.
- Guidelines about responding to incidents.
- How to report and investigate incidents.
- How to take corrective action in response to those incidents, and how to implement quality management, risk management; and
- IM processes for the analysis of the incident data.

As communicated in ODP Announcement 21-020, there are two webinars that are scheduled for stakeholders to attend. These webinars consist of the Incident Management Introduction Webinar related to the IM process and the Incident Management Overview Webinar that expands on the Introduction webinar. Please reference the communication to register. Questions about the bulletin's implementation or contents may be directed to the appropriate ODP Regional Office or to ODP's Incident Management Unit.

Comments and questions regarding this bulletin should be directed to: The appropriate toll-free number for your provider type Visit the Office of Developmental Programs Web site at http://www.dhs.state.pa.us/dhsorganization/officeofdevelopmentalprograms/index.htm

Scope:

- Individuals and Families
- Administrative Entities (AE)
- Agency with Choice Financial Management Services Organizations
- Base-Funded Service Providers
- County Intellectual Disability (ID) Programs
- Common-Law Employers in the Vendor Fiscal/Employer Agent Model
- Providers licensed pursuant to 55 Pa. Code Chapters 2380, 2390, 6400 and 6500
- Providers of Adult Community Autism Program (ACAP) services
- Providers of Consolidated, Person/Family Directed Support (P/FDS), Community Living, and Adult Autism Waivers services
- Providers of Targeted Support Management (TSM)
- Supports Coordination Organizations (SCO)

Purpose: The purpose of this bulletin is to specify the operating procedures and directions for the incident management process, which is a subset of a larger risk management process, and an essential component of a comprehensive quality management process.

The incident management processes in this bulletin include uniform practices for:

- Building organizational policies and structures to support incident management.
- Taking timely and appropriate action in response to incidents.
- Reporting of incidents.
- Investigation of incidents.
- Taking corrective action in response to incidents that both mitigate risk(s) and decrease the chance of a future occurrence of a similar incident.
- Implementing quality management, risk management, and incident management processes for the analysis and interpretation of individual and aggregate incident data.

Background: The primary goal of the Office of Developmental Programs (ODP) incident management system is to ensure that when an incident occurs or is suspected or alleged to have occurred, the response to the incident protects and promotes the health, safety, and rights of the individual.

In accordance with ODP's guiding principles, *Everyday Lives, Values in Action,* individuals, and their families identified areas of importance to increasing the overall quality of their lives. The guiding principles include self-direction, choice, and control along with promoting health, wellness, and safety. When all stakeholders report incidents, investigate incidents, and take actions based on these reports to prevent recurrence of a similar incident, the guiding principles can be put into practice.

Discussion: Individuals who receive services through programs administered by ODP have the right to be treated with dignity and respect and to receive high quality services in safe environments. High quality services include services where written, oral, and other forms of communication with the individual and persons designated by the individual occur in a language and through a means of communication understood by the individual and any persons designated by the individual (55 Pa. Code § 6100.50).

This bulletin provides instruction on implementing an incident management system that:

- Reflects person-centered practices.
- Begins with recognition, reporting and response.
- Promotes prevention of incident recurrence; and
- Emphasizes agency-wide analysis of incidents to implement processes that promote system-wide changes for quality improvement.

Any person, including the victim, who reports an incident or cooperates with an investigation should be free from intimidation and discriminatory, retaliatory, or

disciplinary actions. Individuals who report an incident or cooperate with an investigation have rights under the Whistleblower Law (43 P.S. §§ 1421–1428) and the Older Adults Protective Services Act (35 P.S. §§ 10225.101–10225.5102).

I. Definitions

Administrative Review – The final step of the investigation process that includes reviewing the competency and quality of an investigation for speed, objectivity, and thoroughness; weighing the evidence and making an investigation determination; determining preventative and additional corrective action plans; and completing the Administrative Review section of the Certified Investigator Report.

Bureau of Support for Autism and Special Populations (BSASP) – A bureau within ODP that administers two programs for adults living with autism spectrum disorders (ASD) – the Adult Autism Waiver and ACAP.

Corrective Action – Action implemented to increase protections to individuals from similar future incidents. Corrective action can be implemented for a single individual or related to an organizational change to prevent similar incidents to all individuals.

Critical Incident – A type of incident that has been determined to be a sufficiently serious indicator of risk that it requires an investigation by a Department Certified Investigator.
Incident – An event with potential to adversely impact an individual's health, safety, or rights.

Incident Management - The response to an event, intended to ensure the adequate, appropriate, and effective protection and promotion of the health, safety, and rights of the individual.

Individual – A person registered with a County Intellectual Disability (ID) Program; enrolled in a Waiver program (Consolidated, Community Living, P/FDS or Adult Autism); enrolled in ACAP; or who receives base-funded services, TSM or services from facilities that must comply with 55 Pa. Code Chapters 2380, 2390, 6400, or 6500.

Individual Incident Report - A type of incident report entered in the electronic incident management system that exists to manage specific incident categories for one individual.

Individual Support Plan (ISP) – A coordinated and integrated description of person-centered activities, including services and supports for an individual.

Initial Management Review – A review to determine if appropriate actions to protect the individual's health, safety, and rights have occurred, which is conducted by County ID Program/AE staff within 24 hours of the submission of the first section of the incident report.

Investigation – The process of identifying, collecting, and assessing evidence from a reportable incident in a systemic manner by a person certified by the Department's approved Certified Investigator Training Program.

Investigation Determination – A finding of confirmed, not confirmed, or inconclusive made during the administrative review stage of an investigation.

Management Review – A review of the entire incident report in the Department's information management system, that results in a status of approved or not approved.

Oversight Entity – An entity with the responsibility and authority to monitor the functions of another entity as they relate to incident management and the health and welfare of individuals. Oversight entities include, but are not limited to: ODP, SCOs, County ID Programs/AEs, and entities that have the authority to license providers.

Provider – The person, entity, or agency that is contracted or authorized to deliver the service to the individual.

Operated Setting - Provider-owned or controlled home and community-based setting.
Risk Mitigation – An approach to minimize the severity of risk and to reduce the likelihood of occurrence or recurrence of an adverse event.

Service (Paid Caregiver or Agency) – An activity, assistance, or product provided to an individual that is paid through a program administered by ODP (Consolidated, Community Living, P/FDS or Adult Autism Waiver programs; State plan; base-funding; or ACAP). The term includes supports coordination, TSM and vendor goods and services, as well as services provided through an organized health care delivery system, agency with choice or vendor fiscal/employer agent financial management services model.

Site Incident Report – A type of incident report in the electronic incident management system that is created when a service location or property is affected by incidents such as emergency closure, vandalism, or fire.

Support (unpaid caregiver) – An unpaid activity or assistance provided to an individual that is not planned or arranged by a provider.

Supports Coordination Organization (SCO) – An entity that delivers Supports Coordination (SC) services through the Consolidated, Community Living, P/FDS, and Adult Autism Waivers; ACAP; TSM; or base-funded SC.

Target – The person or entity who is alleged to have caused the incident to occur.

Victim –The individual to whom the incident occurred or is alleged to have occurred.

Victim's Assistance Programs – Resources available to victims of a crime to assist them medically, physically, emotionally, financially, and legally. There are two main types of victim's assistance programs: system and community-based organizations.

II. Administrative Requirements

Providers, SCOs, and County ID Programs/AEs should create an administrative structure that allows for the implementation of the requirements in this bulletin. If a provider, SCO, or County ID Program/AE delegates or purchases any function(s) of the incident management process, there must be a method to monitor the delegated or purchased function(s). The monitoring must be sufficient to determine if the entity completing the function(s) is compliant with ODP regulations, policies, and procedures as they relate to the delegated or purchased function(s). The monitoring of incident management functions should be completed on at least a quarterly basis and the results of the monitoring should be readily available in a written format. The provider, SCO, or County ID Program/AE must retain all responsibility for the quality, compliance, and completion of all incident management functions, even if the function(s) are delegated or purchased via a contract or agreement.

III. Policy, Procedure and Training Requirements

- **Providers and SCOs shall:**
    - Develop and implement written policies and procedures for incident management that:
        - Meet the requirements of all applicable laws, regulations, policies, and procedures related to incident management.
        - Support the collaboration with appropriate stakeholders to:
            - mitigate individual risk(s).
            - mitigate agency-wide risk(s).

    - promote health, safety, and rights for all individuals.
    - implement incident management, risk management, and quality management activities.
- Require that the security of investigation files and evidence be maintained.
- Ensure that person(s) designated by the individual listed in the ISP are notified about incident management activities as indicated by the individual.
    - The ISP should also contain information about what incidents and circumstances the person(s) designated by the individual should be notified. For example, if the individual only wants the person(s) designated for certain types of incidents.
- Require the release to the individual and persons designated by the individual upon request of the incident report, or a summary of the incident, the findings and the actions taken, redacted to exclude information about another individual and the reporter, unless the reporter is the individual who receives the report (55 Pa. Code §§ 2380.17, 2390.18, 6100.401, 6400.18, 6500.20).
- Assure implementation of appropriate preventative and additional corrective action for incidents.
- Require education of the individual, staff, and others based on the circumstances of incidents (55 Pa. Code §§ 2380.19, 2390.19, 6100.405, 6400.20, 6500.22).
- Mandate that monthly incident data monitoring and three-month trend analysis of incident data be conducted.
- Require that individual and systemic changes based on quality and risk management analysis be identified and implemented (55 Pa. Code §§ 2380.19, 2390.19, 6100.405, 6400.20, 6500.22).
- Explain how documents and complaints about a service that are related to incident management, or the investigation process should be received from the individual and persons designated by the individual and how complaints should be documented and managed (55 Pa. Code § 6100.51).
    - The policy must ensure that there is no retaliation or threat of intimidation relating to the filing of the complaint or during the investigation of a complaint.
- Require the evaluation of the quality of investigations through the Certified Investigator Peer Review (CIPR) process.
- Ensure that individuals, families, and persons designated by the individual are offered education and information about incident management policies and procedures that is presented in a format that meets their communication needs.

- Ensure that staff have, at a minimum, orientation and annual competency-based training on the following topics enumerated in 55 Pa. Code §§ 2380.38-2380.39, 2390.48-2390.49, 6100.142-6100.143, 6400.51-6400.52, 6500.47-6500.48:
  - How to recognize, respond to, report, and prevent incidents.
  - The prevention, detection, and reporting of abuse, suspected abuse, and alleged abuse in accordance with the Older Adults Protective Services Act (35 P.S. §§ 10225.101—10225.5102), the Child Protective Services Law (23 Pa. C.S. §§ 6301—6387), the Adult Protective Services Act (35 P.S. §§ 10210.101—10210.704) and applicable protective services regulations.
  - Individual rights.
  - The safe and appropriate use of behavior supports if the person works directly with an individual.
  - The application of person-centered practices, community integration, individual choice, and assisting individuals to develop and maintain relationships.
  - Job related knowledge, skills, and implementation of the ISP with consideration for topics such as:
    - Trama informed care
    - Risk mitigations

- **County ID Programs/AEs shall:**
  - Develop and implement written policies and procedures for incident management that:
    - Ensure that incidents are reviewed and approved in accordance with the time frames and requirements outlined in this bulletin and the Consolidated, Community Living, P/FDS and Adult Autism Waivers.
    - Meet the requirements of all applicable laws, regulations, policies, and procedures related to incident management.
    - Support the collaboration with appropriate stakeholders to:
      - mitigate individual risk(s).
      - mitigate agency-wide risk(s).
      - promote health, safety, and rights for all individuals.
      - implement incident management, risk management, and quality management activities.
    - Require that the security of investigation files and evidence be maintained.
    - Require the evaluation of the quality of investigations through the CIPR process.
    - Ensure that individuals, families, guardians, advocates, and staff who have a direct role in incident management, are provided at least annually and more often, if necessary, in a

format that meets the communication needs of the audience, education, training and information about:
    - incident management policies and procedures.
    - rights, roles, and responsibilities for health and welfare.
- Ensure that periodic trend analysis is completed by each provider to identify potential systemic issues related to health and welfare.
- Ensure providers and SCOs are provided with ODP's standardized and approved training curriculum on how to identify and report critical incidents and reasonable suspicions of abuse, neglect, and exploitation.
- Ensure ongoing training and technical assistance as needed that relates to the needs of individuals served by the provider. This shall include coordination of training resources to be provided by entities other than the County ID Program/AEs when necessary.
- Explain how documents and complaints about a service that are related to incident management, or the investigation process should be received from the individual and persons designated by the individual and how complaints should be documented and managed.
    - The policy must ensure that there is no retaliation or threat of intimidation relating to the filing of the complaint or during the investigation of a complaint.

IV. Incident Management Process Roles

A person may have more than one role in the incident management process. Providers, SCOs, and County ID Programs/AEs are required to make sure that roles are assigned and managed so that the responsibilities associated with each role are conducted objectively. The nature of each individual incident will dictate what role(s) a person undertakes during the process. While roles can be fluid within the process, providers, SCOs, and County ID Programs/AEs must ensure that their administrative structure supports the ability to adhere to all applicable laws, regulations, and ODP policies and procedures. The roles listed below apply strictly to the incident management process and do not reflect any roles related to technology that may be assigned within the Department's information management system.

A. Initial Reporter (1): An initial reporter is any person who witnesses or experiences the incident, is informed of an allegation of an incident, or is the first to discover or recognize the signs of an incident. Initial reporters may be individuals receiving services, family members, community members or service system staff.

When the initial reporter is a provider's, SCOs, or County ID Program/AE's staff person, contractor, consultant, volunteer, or intern, the initial reporter must take all the following steps:

- Respond to the situation by taking immediate action to protect the individual's health, safety, and rights.
- Notify the appropriate reporting entity's point person of the incident.
- Document observations about the incident in a narrative report.
- Comply with the applicable laws and regulations for incidents of alleged abuse, neglect, or exploitation.

B. Point Person: The point person is a person that receives information from an initial reporter and is responsible to manage the incident from beginning to end. Every provider and SCO must have at least one point person but multiple people within an organization may have this role.
The purpose of this role is to ensure that all incident management activities are completed for each incident. The point person is considered the point of direct contact about an incident and must be available to respond to questions or issues that arise related to an incident.

The point person retains overall responsibility to ensure the activities listed below are completed as required by the provider's, SCOs, or County ID Program's/AE's policy 8

and procedure. However, the point person may delegate any or all the activities listed below. The specific point person assigned to an incident may change at any time. Changes in point persons must be reflected in the incident report in the Department's information management system.

When an incident is reported, the point person must ensure:

- All actions needed to protect the health, safety, rights, and well-being of the individual are taken following the initial knowledge or notice of the incident (55 Pa. Code §§ 2380.17, 2390.18, 6100.402, 6400.18, 6500.20).
- Referral to victim's assistance services is offered and support to access services is provided when an individual expresses an interest in these services. See Attachment 1.
- If the incident involves abuse, suspected abuse, or alleged abuse, the target is separated from the victim (55 Pa. Code § 6100.46).
- If the incident involves abuse, suspected abuse, or alleged abuse, the following are notified about the incident as appropriate:
    - Adult Protective Services
    - Child Protective Services
    - Older Adult Protective Services

  - The individual and persons designated by the individual, unless the person designated by the individual is the target.
  - The Department of Aging and the Department of Human Services
  - The designated managing entity (AE)
  - The county government office responsible for the intellectual disability program (County ID Program) if applicable. (55 Pa. Code § 6100.46)
- The individual is informed of his or her rights and options related to contacting law enforcement.
- The individual, family members or persons designated by the individual are provided with timely response to questions or concerns related to the incident.
- The following incident management activities are completed:
  - The initial incident report is submitted to the Department's information management system within 24 or 72 hours of discovery, depending on the incident category.
  - The incident report is finalized within 30 calendar days of discovery of the incident.
  - If an extension is needed, the need for the extension, including the reason for the extension, is submitted to the Department's information management system.
  - Follow up on all comments received from initial or final management reviews is completed in order to ensure incident closure. (55 Pa. Code §§ 2380.17, 2390.18, 6100.401, 6100.404, 6400.18, 6500.20)
- If the individual is deceased, information is sent to the County ID Program/AE, when applicable, and the appropriate ODP regional office or uploaded to be included as part of the electronic incident report. The final section of the incident report is to be supplemented by a copy of the following:
  - Lifetime medical history
  - Copy of the Death Certificate
  - Autopsy report, as applicable
  - Discharge summary from the final hospitalization if the individual died while hospitalized
  - Results of the most recent physical examination
  - Most recent health and medical assessments
  - A copy of the entire investigation file completed by the provider or SCO

C. Incident Management (IM) Representative: The IM representative is the person designated by a provider or SCO who has overall responsibility for incident management. Each provider and SCO must have an IM representative. As part of his or her job responsibilities, the IM representative must be a certified investigator (CI). The CI certification must be obtained within 12 months of assuming the role of IM representative. The IM representative may delegate the

activities listed below within the organization or to another organization (via a contract, agreement, etc.) but must maintain overall responsibility to ensure completion as required by applicable laws, regulations, policies, and procedures. The IM representative must ensure:

- The point person(s) has completed all required actions and activities.
- Corrective actions are implemented and monitored.
- All quality and risk management activities are completed which include, but are not limited to:
    - Monitoring of incident data.
    - A trend analysis of incident data at least every three months. (55 Pa. Code §§ 2380.19, 2390.19, 6100.405, 6400.20, 6500.22)
- Administrative reviews are conducted for all incidents that were investigated by a CI.
- Investigation files are complete, securely maintained, and readily available for review by oversight entities.
- The quality of investigations is reviewed using the standardized CIPR process and, as a result of the CIPR, the following occur if necessary:
    - Feedback is provided to the CI that conducted the investigation.
    - Corrective actions are implemented.
    - CI retraining, suspension of CI duties, or removal of CI certification.
    - All staff, contractors, consultants, volunteers, and interns are trained on all applicable regulations and laws pertaining to the service provided, and internal incident management policies and procedures.
- Individuals and families or persons designated by the individual are offered education, training, and information about incident management policies and procedures in a format that meets their communication needs.
- Roles (point person, CI, etc.), are managed in the Department's information management system. This includes:
    - Maintaining a list of active CIs including recertification dates.
    - Managing CI roles based on quality management activities and feedback from monitoring completed by oversight entities.
    - Ensuring the previous provider's staff and SCO staff's access to the Department's information management system has been removed when necessary.
    - There is a timely response to complaints about a service that is related to the incident management or investigation processes (55 Pa. Code § 6100.51). The response must be provided in the communication method preferred by the individual.

D. Certified Investigator (CI): A CI is a person who has been trained and certified by the Department to conduct investigations. The CI must:

- Conduct investigations using the process, standards of quality, and template(s) outlined in the most current ODP CI manual.

- Create a CI Report and enter the investigation information in the Department's information management system.
- Ensure the complete original investigation file is given to the entity for whom the investigation is being conducted.
- Participate in the CIPR process.

A person's CI certification can be suspended or removed by the Department at any time for any reason.

E. Administrative Review Committee Member: An administrative review committee member is a person designated by a provider, SCO, or AE to participate in the administrative review process. An administrative review committee member must be familiar with the CI process. An administrative review committee member will:

- Review the CI report, and if necessary, the investigatory file.
- Evaluate the CI's adherence to the principles of speed, objectivity, and thoroughness.
- Develop preventative and additional corrective actions; and
- Conclude the investigation by making a determination of confirmed, not confirmed, or inconclusive.

F. County ID Program/AE Incident Reviewer: An incident reviewer is a person designated by the County ID Program/AE who is responsible for completing all required management reviews of incidents.

G. County ID Program/AE Incident Manager: An incident manager is the person designated by the County ID Program/AE who has overall responsibility for incident management. As part of his or her job responsibilities, the County ID Program/AE Incident Manager must be a CI. The CI certification must be obtained within 12 months of assuming the role of incident manager. The County ID Program/AE Incident Manager may delegate the activities listed below within the organization or to another organization (via a contract, agreement, etc.) but must maintain overall responsibility to ensure their completion as required by applicable laws, regulations, policies, or procedures. The County ID Program/AE Incident Manager must ensure:

- Implementation of policies and procedures that support:
    - The review of incident reports within 24 hours of submission in the Department's information management system.
    - The actions needed to approve or disapprove incident reports submitted by the provider or SCO occurring within 30 calendar days of submission by the provider or SCO.
- Investigations are conducted by the County ID Program/AE as required in this bulletin.

- The individual, and persons designated by the individual, are informed of the investigation determination, unless otherwise indicated in the ISP.
- There is a timely response to complaints that are related to the incident management or investigation processes. The response must be provided in the communication method preferred by the individual.
- An administrative review is conducted for all incidents that required investigation by a CI.
- The quality of investigations conducted by County ID Programs/AEs (including those conducted on behalf of the County ID Program/AE via a contract, agreement, etc.) are reviewed using the standardized CIPR process, and, as a result of the CIPR, the following occurs if needed:
    - Feedback is provided to the CI that conducted the investigation.
    - Corrective actions are implemented.
    - CI retraining, suspension of CI duties, and/or removal of CI certification.
- The quality of provider and SCO conducted investigations.
    - The County ID Program/AE should consider completing the CIPR review process for the service provider and SCO investigations. These CIPR reviews would be on an ad hoc basis as the County ID Program/AE is not required to complete this activity on any scheduled frequency. ODP strongly encourages the County ID Program/AE to use the CIPR process as part of a formal Corrective Action Plan (CAP) or for other quality improvement efforts directed towards service providers and SCOs.
- Periodic training is provided to County ID Program/AE staff that have a direct role in incident management and to individuals and their families, guardians, and advocates, in a format that meets the communication needs of the audience, about:
    - Their rights, roles, and responsibilities for protecting an individual's health and welfare.
    - All applicable incident management policies, procedures, regulations, and laws.
- Ongoing training and technical assistance, as needed, is provided to providers and SCOs that relates to the needs of individuals served by the provider or SCO. This includes coordination of training resources to be provided by entities other than the County ID Program/AE.
- Collaboration with the individual and his or her ISP team, to develop and implement:
    - Mitigation plans to address medical, behavioral, and socio-economic crisis situations in a timely manner as required by the Administrative Entity Operating Agreement.
    - Corrective actions.
- Direct management of individual incidents (including coordination with protective service entities) and crisis situations including the following:

  - Locating resources and opportunities for mitigating the crisis through family or community.
  - Being actively engaged in identifying qualified service providers.
  - Working to divert institutional placement; and
  - If deemed appropriate by the Department, facilitating competency and guardianship appointments.
- All quality and risk management activities are completed related to incident management as outlined in this bulletin.

V. Response Upon Discovery/Recognition of an Incident: The provider and SCO must take immediate action to protect the health, safety, rights, and well-being of the individual following the initial knowledge or notice of an incident, alleged incident, or suspected incident (55 Pa. Code §§ 2380.17, 2390.18, 6100.402, 6400.18, 6500.20).

The actions may include, but are not limited to:

- Dialing 911.
- Quickly reducing or removing any imminent risk to the individual.
- Arranging for emergency or timely medical care.
  - Medical care refers to assessment, examination, or treatment by a qualified medical professional or basic first aid. This includes, but is not limited to:
    - Offering medical assessment, examination, or treatment more than once when an injury or illness may not be immediately recognizable at the time of the incident.
    - Offering and ensuring access to a medical professional, such as a Sexual Assault Nurse Examiner (SANE), that is trained to examine individuals and collect evidence for incidents of sexual abuse.
- The provider's or SCO's point person must ensure separation of the victim from the alleged target(s). This separation shall continue until the investigation is completed.
  - When the alleged target is an employee, staff, volunteer, contractor, consultant, or intern of the provider or SCO, the target shall not be permitted to work directly with the victim or any other individual during the investigation process until the investigation determination is completed and corrective action(s) specific to the target are implemented (55 Pa. Code § 6100.46).
  - When the alleged target is another individual receiving services and presents a reasonable expectation of on-going risk to the victim or other individuals, the provider must collaborate with the SCO and County ID Program/AE to identify ways to protect the health, safety, and rights of the victim (55 Pa. Code § 6100.46). Actions taken should be implemented using a victim centered approach, which includes a

systematic focus on the needs and concerns of a victim to ensure the compassionate and sensitive delivery of services.
    - Examples of actions that may be taken include, but are not limited to, relocation of the target (or victim if requested), increased staffing, and risk mitigation/safety planning
  - When the alleged target is not an employee, staff, volunteer, contractor, consultant, or intern of the provider or SCO (i.e., family member, unpaid caregiver, community member, etc.), the provider or SCO should work with the appropriate County ID Program/AE and/or protective service entity and take all available action to separate the victim from the alleged target(s).
- Notifying the following about the incident as appropriate, in accordance with 55 Pa. Code § 6100.46:
  - Adult Protective Services
  - Child Protective Services
  - Older Adult Protective Services
  - The individual and persons designated by the individual, unless the person designated by the individual is the target.
  - The Department of Aging and the Department of Human Services
  - The designated managing entity (AE)
  - The county government office responsible for the intellectual disability program (County ID Program) if applicable.
- Notifying the person(s) designated by the individual immediately upon recognizing or discovering an incident as stated within the ISP.
- Arranging for counseling by a qualified professional or a victim's assistance program.
- Notifying local law enforcement in accordance with protective service law requirements (23 Pa. C.S. § 6312, 35 P.S. §§ 10210.501(b), 10225.710(b)). Law enforcement notification must occur anytime there is reasonable cause to suspect:
  - The individual is an alleged victim of sexual abuse.
  - The individual is considered a missing person whose health and safety may be compromised.
  - The individual is a victim of serious bodily injury.
  - The individual is deceased, and the circumstances of the death are suspicious.
  - A crime has been committed.
- Informing the individual that he/she can request assistance from their local law enforcement.
- Assisting the individual to notify or access local law enforcement, when requested, regardless of the nature of the incident.

VI. Responsibility for Reporting and Investigating

A. Providers: The provider must take immediate action to protect the health, safety, and well-being of the individual following the initial knowledge or notice of an incident, alleged incident, or suspected incident. (55 Pa. Code §§ 2380.17, 2390.18, 6100.402, 6400.18, 6500.20)

- Providers, including those under the agency with choice model, must report within 24 or 72 hours of discovery or recognition all categories of incidents, alleged incidents, and suspected incidents in the Department's information management system and complete an investigation as necessary when:
    - Services are rendered by the provider.
    - When an incident involves a target, the alleged target is within the scope of the provider to investigate, which includes employees, staff, volunteers, contractors, consultants, interns, and other individuals receiving services from the provider. (55 Pa. Code §§ 2380.17, 2390.18, 6100.401, 6400.18, 6500.20)
- When a provider becomes aware of an incident that is outside of the scope of its responsibility to report, the provider must:
    - Ensure prompt action is taken to protect the individual's health, safety, and rights.
    - Contact the individual's SC to report the incident.
    - Provide the necessary information to the SC to ensure that the incident is able to be reported in the Department's information management system; and
    - Collaborate with the SC to develop and implement corrective actions as a result of the incident and investigation, as it applies to the delivery of service by the provider.
- When multiple providers learn of an incident, the provider rendering services for the individual at the time the incident occurred must report the incident and begin any required investigation within 24 hours. If it cannot reasonably be determined which provider was rendering service at the time of the incident, all providers who are aware of the incident should report the incident and investigate the incident.

B. Individuals and Families: If an individual or family member observes or suspects any health or safety concerns (that may or may not be defined as an incident) or any inappropriate conduct related to a service or support the individual is receiving whether occurring in the home or out of the home, they should contact the provider and/or the individual's SC. In the event of the death of an individual, the family should notify the SC. The individual or family may also contact the ODP Customer Service Line at 1-888-565-9435. After a report is received from an individual or family, the procedures outlined in this bulletin must be implemented by the appropriate entities.

C. Vendor Fiscal/Employer Agent Financial Management Service (VF/EA FMS): In accordance with the VF/EA FMS common law employer agreement, when

an individual or the individual's representative arranges services through a VF/EA FMS, and an incident is discovered or recognized, the Common Law Employer (CLE) must inform the SC that an incident has occurred. The CLE must do the following:

- Work with the SC to ensure prompt action is taken to protect the individual's health, safety, and rights.
- Ensure that the SC has the necessary information to enter the incident report into the Department's information management system.
- Work with the SC to develop and implement preventative and additional corrective actions as a result of the incident and investigation, if needed.

D. County ID Programs/AEs: In some circumstances, County ID Program/AE staff may be notified of an incident and will need to determine the appropriate provider or SCO that will manage the incident.

County ID Program/AE staff are required to:

- Conduct their own investigation if there is a concern that there are circumstances that will compromise the provider's or SCO's objectivity, or if an additional investigation would be valuable to protect the health, safety, and rights of the individual.
    - Conduct investigations for specific incident categories outlined in this document.
    - Conduct an investigation if requested by ODP.

E. Supports Coordination Organizations (SCOs)

SCOs must report and ensure investigation of all categories of incidents when supports coordination is the only service rendered at the time of an incident or if there is no other provider responsible for reporting the incident (55 Pa. Code § 6100.802).

When an SCO is informed of an incident, the SCO will determine if a provider, other than the SCO, is responsible for managing the incident. If there is a provider identified as responsible for reporting the incident, the SCO will notify the provider of the incident and inform the provider of the need to follow the processes outlined in this bulletin.

VII. Reportable Incidents

A. Reporting Guidelines: Specified incidents, alleged incidents, and suspected incidents are to be reported and documented in the Department's information management system (55 Pa. Code §§ 2380.17, 2390.18, 6100.401, 6400.18, 6500.20). A provider, SCO, or County ID Program/AE shall not conduct an "informal review" of an event that may be classified as an incident in lieu of the incident being reported in the Department's information management system.

In addition to verbal reports, alleged and suspected incidents may be detected via a variety of methods. These include, but are not limited to:

- Observation of physical, behavioral, or emotional indicators of abuse, neglect, or another incident type.
- Trend analysis that reveals a pattern of injury, illness, or other incidents that could be indicators of abuse, neglect, or another incident type.

When reporting incidents in the Department's information management system, these guidelines must be followed:

- All individual incidents are reported under the name of the alleged victim.
- If the alleged target(s) is an employee of a provider or another individual receiving services, a standard identifier must be used for the alleged target(s) of an incident report. The format for the standard identifier is:
    - The *first and second* initials of the *first* name of the target,
    - The *first and second* initials of the *last* name of the target, and (All initials must capitalize and there can be no spaces, dashes, or other characters between the initials and the number. For example: AOBR1234)
    - The *last* four digits of the target's social security number. If the alleged target is not an employee of a provider or another individual receiving services, the alleged target's full name should be used, if known.
- The Department's information management system has two sections available to document an incident, each with different timelines based on the incident's primary category classification.
    - The initial report, which is the first section, must be reported and submitted in the Department's information management system within 24 or 72 hours of discovery or recognition of the incident, alleged incident, or suspected incident (55 Pa. Code §§ 2380.17, 2390.18, 6100.401, 6400.18, 6500.20).
    - Incidents reported within 24 hours require a final incident report, which is the second section, that must be finalized through the Department's information management system within thirty (30) days of the discovery of the incident, unless the entity entering the incident report notifies ODP in writing that an extension is necessary and includes the reason for the extension (55 Pa. Code §§ 2380.17, 2390.18, 6100.404, 6400.18, 6500.20).
- When multiple individuals are involved in an incident with a primary category listed below, the incident can be reported using a site incident report:
    - Emergency site closure
    - Fire
    - Law enforcement activity

B. Incidents to be reported within 24 hours (2): All incident categories (with the exception of medication errors and physical restraints) shall be reported in the Department's information management system within 24 hours (55 Pa. Code §§ 2380.17, 2390.18, 6100.401, 6400.18, 6500.20).3 Incidents include suspicions, allegations, and actual occurrences of harm. Incidents must be reported regardless of the actual or perceived harm to the individual.2 In this section, primary incident categories are underlined and are broken down into secondary categories that further define the nature of the alleged incident. Secondary categories appear in bold directly below each underlined primary category. 3 See Attachment 2, Incident Management Bulletin Category and 55 Pa. Code §§ 6100.401-6100.402 Crosswalk.

Abuse – Abuse is a deliberate or careless act by a person, including another individual receiving services, which may result in mental or physical harm.

- **Misapplication/Unauthorized Use of Restraint (injury)** – The use of a restraint that does not follow ODP's regulatory requirements, the misapplication of an approved restraint technique, or the use of a restraint that results in an injury requiring treatment beyond first aid. Examples include, but are not limited to, the following, all of which are prohibited:
    - Prone position physical restraints
    - Any physical restraint that inhibits digestion or respiration, inflicts pain, causes embarrassment or humiliation, causes hyperextension of joints, applies pressure on the chest or joints or allows for a free fall to the floor
    - Any physical restraint that is used more than 30 cumulative minutes within a two-hour period
    - Chemical restraints
    - Mechanical restraints
- **Misapplication/Unauthorized Use of Restraint (no injury)** – The use of a restraint that does not follow ODP's regulatory requirements or the misapplication of an approved restraint technique. Examples include, but are not limited to, the following, all of which are prohibited:
    - Prone position physical restraints
    - Any physical restraint that inhibits digestion or respiration, inflicts pain, causes embarrassment or humiliation, causes hyperextension of joints, applies pressure on the chest or joints or allows for a free fall to the floor
    - Any physical restraint that is used more than 30 cumulative minutes within a two-hour period
    - Chemical restraints
    - Mechanical restraints
- **Physical** – An act which causes or may cause physical injury to an individual, such as striking or hitting. Physical injuries may or may not be present with physical abuse. Allegations of physical acts without obvious

signs of injury must be reported. Monitoring or body checks may be necessary to look for signs of injury after initial discovery of the incident. In addition, injuries attributed to a staff person or another individual receiving services that require treatment beyond first aid or an inpatient admission to a hospital are to be reported as abuse.

If the incident involved an injury, common examples of situations that may be present with physical abuse include, but are not limited to:

- A patterned bruise, no matter its size, that is in the shape of an identifiable object such as a belt buckle, shoe, hanger, fingermark, etc.
- Unexplained serious injuries or multiple bruises, cuts, abrasions.
- A spiral fracture.
- Dislocated joints.
- Bilateral bruising, which is bruising on both sides of the body (e.g., the top of both shoulders, both sides of the face or inside of both thighs).
- Bruising to an area of the body which does not typically or easily bruise (e.g., midline stomach, breasts, genitals, inner thighs or middle of the back).
- Injuries that are not consistent with what is reported to have happened.
- Injuries explained as caused by self-injury to parts of the body the individual has not previously injured or cannot access.

- **Psychological –** An act which causes or may cause mental or emotional anguish by threat, intimidation, humiliation, isolation, or other verbal or nonverbal conduct to diminish another. Examples include, but are not limited to:
  - Bullying, rejecting, degrading, and terrorizing acts.
  - Disregard for privacy during personal care.
  - Paid caregiver ignoring an individual, including, but not limited to:
    - Active ignoring (that is not part of an approved plan) such as ignoring a call or request for help/assistance.
    - Passive acts, such as non-essential use of a cellphone (or other electronic device), watching TV, etc.
  - Threats of isolation.
  - Yelling, name-calling, blaming, and shaming.
  - Mimicking or mocking an individual's voice, speech, behaviors, etc.
  - Statements that are intended to humiliate or infantilize, including insults, threats of abandonment or institutionalization and other controlling, dominant or jealous behavior.
  - The act of taking, transmitting, or displaying an electronic image (in any medium including social media, personal computers, cell phones, etc.) of an individual that is intended to shame, degrade, humiliate, or otherwise harm the personal dignity of the individual.

    - When an individual witnesses an incident for which they were not the intended victim, but it causes or has caused mental or emotional anguish.
- **Seclusion** – The involuntary confinement of an individual in an area from which the individual is prevented from leaving. This includes verbal instruction or any explicit or implicit intimidation that indicates to an individual that they may not leave a room, regardless of whether the individual has the ability to physically remove himself or herself from the situation. Examples include, but are not limited to, the following prohibited acts:
    - Placing an individual in a locked room. A locked room includes a room with any type of engaged locking device such as a key lock, spring lock, bolt lock, foot pressure lock, device or object, or a person physically holding the door shut.
    - Placing an individual in a room from which they are unable to exit independently due to the general accessibility of the room (i.e., wheelchair ramps, transitions, etc.), features of the door hardware (i.e., handles that do not meet the accessibility needs of the individual), or any other obstacle that prevents an individual from exiting.

Behavioral Health Crisis Event – An event or situation that exceeds the individual's current resources and coping mechanisms that causes the individual to experience extreme disorganization of thought, hopelessness, sadness, confusion, panic, or other emotional distress. The event includes action(s) by an individual that pose a danger to themselves or others and are unable to be mitigated without the assistance of law enforcement, mental health, or medical services.

- **Community-Based Crisis Response** – An event in which law enforcement or emergency services respond to and resolve without transport to another location for intake, assessment, or treatment.
- **Facility-Based Crisis Response** – An event in which law enforcement or emergency services respond to and an individual is transported to a psychiatric facility, including crisis facility, or the psychiatric department of an acute care hospital for evaluation or treatment that does not result in an admission.
- **Immediate Arrest and Incarceration Crisis Response -** An event in which law enforcement responds to a behavioral health crisis event and arrests, charges and incarcerates an individual without first obtaining a mental health evaluation/admission at a facility designated to provide such services.
- **Psychiatric Hospitalization (involuntary)** – An involuntary inpatient admission to a psychiatric facility, including crisis facility, or the psychiatric department of an acute care hospital for evaluation or treatment.

- **Psychiatric Hospitalization (voluntary)** – A voluntary inpatient admission to a psychiatric facility, including crisis facility, or the psychiatric department of an acute care hospital, for evaluation or treatment.

Death - All deaths are reportable. Deaths attributed to or suspected to have been the result of abuse or neglect require additional reporting in the appropriate corresponding category. In addition, any critical incidents that are discovered during an investigation into a death require additional reporting in the appropriate corresponding category:

- **Natural Causes – Services Provided** – Primarily attributed to a terminal illness or an internal malfunction of the body not directly influenced by external forces. For example, a person who has been diagnosed with cancer and is receiving hospice services or when a do not resuscitate (DNR) order is in place. A death should be reported in this category if it occurs while an individual is enrolled in a Waiver program or ACAP or is receiving services in a provider operated setting.
- **Unexpected – Services Provided** – An unexpected death is primarily attributed to an external unexpected force acting upon the individual. Deaths attributed to events such as car accidents, falls, homicide, choking and suicides would be considered unexpected. A death should be reported in this category if it occurs while an individual is enrolled in a Waiver program or ACAP or is receiving services in a provider operated setting.
- **Natural Causes – Only Supports Provided** – Primarily attributed to a terminal illness or an internal malfunction of the body not directly influenced by external forces. For example, a person who has been diagnosed with cancer and is receiving hospice services or when a DNR order is in place.
- **Unexpected – Only Supports Provided** – An unexpected death is primarily attributed to an external unexpected force acting upon the individual. Deaths attributed to events such as car accidents, falls, homicide, choking and suicides would be considered unexpected.

Exploitation – An act or course of conduct by a person against an individual or an individual's resources without informed consent or with consent obtained through misrepresentation, coercion, or threats of force, which results in monetary, personal, or other benefit, gain, or profit for the target, or monetary or personal loss to the individual. Exploitation should be reported regardless of the actual or perceived value of the loss.

- **Failure to Obtain Informed Consent** – An intentional act or course of conduct by a person which results in the misuse of an individual's consent or failure to obtain consent. Examples include, but are not limited to, signing on behalf of or coercing/deceiving an individual into:
    - Applying for credit cards
    - Signing contracts

  - Signing loan documents, wills and other items that relate to the personal property, money, or identity of an individual.
- **Material Resources** – The illegal or improper act or process of a person using the material resources or possessions of an individual for his or her own personal benefit or gain. This includes, but is not limited to:
  - Misusing or stealing an individual's possessions
  - Soliciting gifts
  - Coercing an individual to spend his or her funds for things he or she may not want or need, things for use by others or for the benefit of the household.
- **Medical Responsibilities/Resources** – An act or course of conduct of a person that results in an individual paying for medical care or items that are normally covered by insurance or other means. This includes, but is not limited to:
  - Requiring an individual to pay for a medical appointment, procedure, or equipment due to failure of the ISP team to provide support or resources to find a medical provider that accepts the individual's insurance or whose services are covered by other means.
  - Requiring an individual to pay for an appointment, procedure, or equipment when there is a failure on the part of the service provider to support an individual to attend or schedule medical appointments or to maintain medical equipment.
- **Missing/Theft of Medications**– Missing medications without explanation or theft of medications.
- **Misuse/Theft of Funds** – The illegal or improper act or process of a person using the funds of an individual for his or her own personal benefit or gain. This includes misuse or mismanagement by a representative payee or other responsible party, theft of money, Supplemental Nutrition Assistance Program (SNAP) benefits, or soliciting monetary gifts from an individual.
- **Room and Board** – Requiring an individual to pay for items that are covered as part of room and board charges, charging more than allowable rates for room and board, or charging for a service or support that is included in a rate for which a provider is or will be reimbursed. This includes any situation in which the individual is required to pay for the same item/service twice. Examples of items that are covered as part of the room and board residency agreement (contract) include, but are not limited to:
  - Standard toiletries (shampoo, deodorant, soap, toothpaste, etc.)
  - Utility costs, including trash removal, lawn care, snow removal
  - Household furniture
  - Basic linens (blankets, towels, washcloths, sheets, pillowcases) Cleaning, laundry, and other household supplies
  - One telephone with local telephone service
  - Internet service

- Food choices of the individual, with consideration of the food cost and nutrition, including the individual's preference, culture, religion and beliefs, and an individual's prescribed diet, if the prescribed diet is not covered by the individual's health care plan or another funding source
  - Prescribed dietary items necessary for individuals' basic health and nutrition include, but are not limited to:
    - Products used to thicken liquids/foods
    - Phenylketonuria (PKU) diet foods
    - Meal replacement shakes and snacks
    - Diabetic diet foods
- Laundry of towels, bedding, and the individual's clothing
- Lawn care, food preparation, maintenance, and housekeeping, including staff wages and benefits to perform these tasks
- Meals provided away from the residential service location that are arranged by a staff person in lieu of meals provided in the residential service location
- Incontinence products, if the incontinence product is not covered by the individual's health care plan or another funding source
- Building and equipment repair, renovation, and depreciation
- Rent, taxes, and property insurance (55 Pa. Code § 6100.684)

Unpaid Labor – The illegal or improper act or process of a person who is using an individual to perform unpaid labor that would otherwise be compensated in a manner consistent with labor laws.

Fire – A situation that requires fire personnel or other safety personnel to extinguish a fire, clear smoke from the premises, etc. While not required, it is strongly recommended that situations in which staff extinguishes small fires without the involvement of fire personnel be reported.

- **Fire with Property Damage** – The fire causes property damage that may or may not make the premises uninhabitable.
- **Fire without Property Damage** – The fire does not cause property damage and may or may not result in the premises being uninhabitable.

Law Enforcement Activity – Law enforcement activity that occurs during the provision of service or for which an individual is the subject of a law enforcement investigation that may lead to criminal charges against the individual. This includes law enforcement responding to a possible crime when an individual is in the community or in a vehicle.

- Individual Charged with a Crime/Under Police Investigation –When an individual is formally charged with a crime by the police or when an individual is informed, he or she is suspected of committing a crime, and charges may be forthcoming. All charges or suspected charges related to a Behavioral Health Crisis Event should be reported as such and not as a law enforcement activity.

Licensed Service Location Crime – A crime such as vandalism, break-ins, threats, or actual occurrences of acts that may result in harm, etc. that occur at the provider's service location.

Missing Individual – An individual is considered missing when they are out of contact for more than 24 hours without prior arrangement or the individual is in immediate jeopardy when missing for any period. Based on an individual's history, safety skills, and familiarity with the area, an individual may be considered in jeopardy before 24 hours elapse. In addition, when police are contacted about a missing individual or the police independently find and return an individual, this is a reportable incident regardless of the amount of time an individual has been missing.

- **In Jeopardy -** The unexpected or risky absence of any duration for an individual whose absence constitutes an immediate danger to the individual or others.

Neglect – The failure to obtain or provide the needed services and supports defined as necessary or otherwise required by law, regulation, policy, or plan (ISP, Behavior Support Plan, safety plan, etc.). This includes acts that are intentional or unintentional regardless of the obvious occurrence of harm.

- **Failure to Provide Medication Management** – An event that may cause harm or lead to inappropriate medication use while the medication is in the control of the person(s) charged with administration. Incidents of this nature include when harm occurs to the individual, the medication error occurs over more than one consecutive administration or an individual receives medication intended for another individual.

  Incidents of this type include, but are not limited to, a failure to:
  - administer medications via the correct route
  - implement medication changes in a timely manner
  - obtain medications from the pharmacy

- **Failure to Provide Needed Care** – The failure to obtain or provide the needed services and supports. This includes, but is not limited to:
    - Failure to implement medical, social, behavioral, and restrictive procedures as outlined in the ISP.
    - Failure to provide needed care such as food, clothing, personal hygiene, prompt and adequate medical care, emergency services, and other basic treatment and necessities needed for development of physical, intellectual, emotional capacity, and well-being.
    - Failure to obtain, keep in working order, or arrange for repair or replacement of equipment such as glasses, dentures, hearing aids, walkers, wheelchairs, etc.
    - Failure to intercede on behalf of the individual with regards to reporting or acting on changes to healthcare needs or failure to ensure medical equipment is repaired or replaced as needed.
- **Failure to Provide Needed Supervision** – The failure to provide attention and supervision, including leaving individuals unattended. This is based upon the supervision care needs in the ISP or recommendations or requirements from a court of law or as a condition of probation or parole.
- **Failure to Provide Protection from Hazards** – The failure to protect an individual from health and safety hazards as part of routine care, service provision or as outlined in the ISP. Examples of failure to provide protection from health and safety hazards include, but are not limited to:
    - Failure to prepare and serve food required by an individual's medical diagnosis.
    - Failure to provide protections from poisonous materials.
    - Failure to provide shelter and basic utilities.
    - Failure to provide basic protections from environmental hazards such as exposure to the sun, extreme elements, and other weather-related conditions.
    - Failure to regulate water temperatures.
    - Failure to provide protection from hazardous activities such as the manufacture, distribution, exposure to and use of illegal drugs.
- **Moving Violation** – Any staff or volunteer receiving a moving violation citation during the provision of services to an individual regardless of if operating an entity's vehicle or personal vehicle.

Passive Neglect – The inability to provide supports due to environmental factors which are beyond the control of an unpaid caregiver because of lack of experience, information, resources, or ability. Passive neglect is reportable if there are no current risk mitigation strategies in the ISP that specifically address the area of passive neglect. Passive neglect is reported by an individual's SCO.

- **Inability to Provide Medical/Personal Care** – The inability of an unpaid caregiver to provide adequate medical or personal care due to lack of education, training, resources, or the physical ability of the caregiver to

perform such tasks. This includes the inability to obtain or maintain communication devices, mobility aides, and other durable medical equipment.
- **Inability to Provide Necessities** – The inability of an unpaid caregiver to provide food, clothing, adequate housing, utilities, or other basic necessities that are essential to maintain the health and safety of an individual.

Rights Violation – An unauthorized act which improperly restricts or denies the human or civil rights of an individual, including those rights which are specifically mandated under applicable law, regulation, policy, or plan. This includes acts that are intentional or unintentional regardless of the obvious occurrence of harm:
- **Civil/Legal** – Any violation of civil or legal rights afforded by law. This includes the right to vote, speak freely, practice religious choice, access law enforcement and legal services, as well as participate in local, state, or national government activities.
- **Communication** – The failure to support an individual to communicate at all times. This includes a failure to obtain needed communication evaluations, assistive devices, or services; provide communication support; or maintain communication devices in working order. Communication includes, but is not limited to:
    - Display of text in fonts and sizes that meet communication needs
    - Access to sign language interpreters
    - Access to translation to preferred languages
    - Access to persons that can facilitate an individual's unique communication style
    - Access to braille materials and other tactile communication assistance
    - Access to plain-language materials
- **Health** – The failure to support choice and opportunity related to health care. This includes failure to inform and educate an individual about physical or behavioral health evaluations and assessments, changes in health status, diagnosis information, test results, medications, treatment options, etc. This also includes the denial of the right of an individual to make informed health care decisions.
- **Privacy** – Any violation of an individual's safely exercised choice to be free from being observed or disturbed by others. This includes an individual's choice to maintain the privacy of his or her physical person, living area, possessions, electronic social media (emails, posts on the internet, accounts, content, or any similar items), communication with others (whether in face-to-face meetings, phone, email, physical mail, or any other correspondence), use of image or likeness without the expressed permission of the individual (including videos or photos taken of the individual for promotional, marketing or any other purpose), or any similar area where a reasonable expectation of privacy exists.

- **Services** – Any violation of an individual's right to control services received. This includes when an individual refuses to participate in, voices a concern about, or wants to make a change to a service, and the ISP team does not address these choices. Individuals have the right to participate in the development and implementation of their ISPs and can choose where, when, and how to receive needed services. This also includes the right to control specific schedules and activities related to services.
- **Unauthorized Restrictive Procedure** – Any restrictive procedure (other than a physical, chemical, or mechanical restraint) that does not follow ODP's guidelines related to restrictive procedures or is prohibited by ODP. Restrictive procedures limit an individual's movement, activity, or function; interfere with the individual's ability to acquire positive reinforcement; result in the loss of objects or activities that an individual values; or require an individual to engage in a behavior in which, given the freedom of choice, the individual would not engage.

Self-Neglect – An action or lack of action by an individual that results in the individual denying himself or herself proper care, supports, and services. Self-neglect is reportable if there are no current risk mitigation strategies in the ISP that specifically address the area of self-neglect. Self-neglect is reported by an individual's SCO.

- **Environmental** – Hazardous or unsafe living conditions (e.g., improper wiring, no indoor plumbing, no heat, no running water, hoarding conditions), unsanitary or unclean living quarters (e.g., animal or insect infestation, no functioning toilet, fecal or urine odor), or grossly inadequate housing or homelessness.
- **Medical** – The refusal by an individual to take medications on a regular basis; ignoring acute or chronic health or medical problems; refusal to obtain, use or maintain prescribed medical devices (e.g., eyeglasses, hearing aids, dentures) needed to maintain health and safety.
- **Personal Care/Nutrition** – Refusal to consistently wear or obtain appropriate or adequate clothing for activities or weather conditions, refusal to maintain proper hygiene that presents a serious risk to health or safety, or refusal to maintain a proper diet which may lead to malnutrition, illness, or dehydration.
- **Other** – Other forms of self-neglect may include refusing to accept services or supports that are essential to maintain health and safety.

Serious Illness – A physical illness, disease, or period of sickness that requires hospitalization. This includes an elective surgery that requires a hospitalization.

- **Chronic/Recurring** – An illness, condition or disease that is persistent or otherwise long-lasting in its effects for which an individual has had previous treatment or diagnosis.

- **New** – An acute illness, condition, or disease for which an individual has not previously received treatment. This includes acute illnesses, conditions or diseases that may become chronic in the future.

Serious Injury – Any injury that requires treatment beyond first aid. This includes injuries that receive an assessment or treatment at an emergency room, urgent care center, primary care physician office, etc., or that require hospitalization. Assessment by emergency medical services that did not require a visit to one of the locations listed above for treatment is not reportable. Serious injuries that are treated by a medical professional (i.e., doctor, nurse, etc. that is used by the organization) on-site are reportable. Examples include, but are not limited to:

- **fractures**
- **dislocations**
- **burns**
- **electric shock**
- **loss or tearing of body parts**
- **eye emergencies**
- **ingestion of toxic substance**
- **head injuries from accidents, falls, or blows to the head**
- **any injury with loss of consciousness**
- **medical equipment malfunction or damage that requires immediate intervention**
- **lacerations requiring stitches, staples, or sutures to close**
- **Choking**– When food or other items become lodged in the back of the throat and the cause is not attributed to neglect. Choking incidents are only reportable when they require interventions, such as back blows, abdominal thrusts, or the Heimlich maneuver.
- **Injury Accidental –** Injury (other than self-inflicted) with a known cause at the time of the report.
- **Injury Self-Inflicted** – Injury with a known cause at the time of the report that can be attributed to an intentional action of an individual to cause harm upon himself or herself.
- **Injury Unexplained** – An injury with no known cause at the time of the report.
- **Medical Equipment Failure/Malfunction** – Any medical equipment failure or malfunction that requires intervention by a medical professional. This does not include routine maintenance or care of medical equipment.
- **Pressure Injury (decubiti, pressure ulcer, pressure sore, bedsore)** – Injuries to skin and underlying tissue resulting from prolonged pressure on the skin, regardless of stage and including an injury that is unstageable. This includes initial diagnoses, newly affected areas of the body, as well as a diagnosis that becomes worse over time.

Sexual Abuse - Any attempted or completed nonconsensual sexual act. The act may be physical or non-physical and achieved by force, threats, bribes, manipulation, pressure, tricks, violence or against an individual who is unable to consent or refuse. Sexual abuse includes any act or attempted act that is sexual in nature between a paid service provider staff and an individual regardless of consent on the part of the individual.

- Examples of methods used to commit sexual abuse include, but are not limited to:
    - Use of intimidation or threat of physical force toward an individual in order to gain compliance with a sexual act (e.g., pinning the victim down, assaulting the victim)
    - Administering alcohol or drugs to an individual in order to gain compliance with a sexual act (e.g., drink spiking)
    - Taking advantage of an individual who is unable to provide consent due to intoxication or incapacitation from voluntary consumption of alcohol, recreational drugs, or medication
    - Exploitation of vulnerability (e.g., immigration status, disability, undisclosed sexual orientation, age)
    - Misuse of authority (e.g., using one's position of power to coerce or force a person to engage in sexual activity)
    - Economic coercion, such as bartering of sex for basic goods, like housing, employment/wages, immigration papers, or childcare
    - Degradation, such as insulting or humiliating an individual
    - Fraud, such as lies or misrepresentation of a target's identity
    - Continual verbal pressure, such as when an individual is being worn down by someone who repeatedly asks for sex or, for example, by someone who complains that the individual does not love them enough
    - False promises by the target (e.g., promising marriage, promising to stay in the relationship, etc.)
    - Grooming and other tactics to gain an individual's trust
    - Control of an individual's sexual behavior/sexuality through threats, reprisals, threats to transmit sexually transmitted infections (STIs), threats to force pregnancy, etc.
- **Rape -** The penetration, no matter how slight, of the vagina or anus with any body part or object, or oral penetration by a sex organ of another person, without the consent of an individual. This includes when an individual was made, or there was an attempt to make the individual, penetrate another person (including the target).
- **Sexual Harassment** - Sexual advances that do not involve physical contact between an individual and a target. This type of sexual abuse can occur in many different venues (e.g., home, school, workplace, in public, or through technology). Examples include, but are not limited to:
    - Sending unwanted sexually explicit photographs
    - Use of inappropriate sexual remarks or language

  - Unwanted exposure to sexual situations - pornography, voyeurism, exhibitionist
  - Threats of sexual abuse to accomplish some other end, such as threatening to rape an individual if he or she does not give the target money
  - Threatening to spread sexual rumors if the individual does not have sex with the target
  - Unwanted filming, taking, or disseminating photographs of a sexual nature of an individual (in any medium to include, but not limited to, social media, personal computers, cell phones, etc.)
  - Exposure to unwanted sexual materials (pornography)
- **Unwanted Sexual Contact** - Intentional touching or molesting, either directly or through the clothing, of the genitalia, anus, groin, breast, inner thigh, buttocks, or any other body part without consent. This includes making an individual touch or molest another person (including the target).
- **Other -** Any sexual abuse of an unknown type at the time of the report or sexual abuse that does not conform to other secondary category options.

Site Closure – The emergency closure of a licensed or provider operated service location for one (1) or more days. This is reported as a site incident report and does not apply to individuals who reside in homes owned, rented, or leased solely by the individual or family member.

- **Infestation** – The closure of a site due to the need to treat for animal, insect, or other pests.
- **Loss of Utilities** – The closure of a site due to loss of utility that was not related to a failure on the part of the operating entity. This includes electrical outages, issues with water or sewer systems and heating or cooling system failures.
- **Natural Disaster/Weather Related** – The closure of a site due to a natural disaster or weather conditions.
- **Structural** – The closure of a site due to structural issues.
- **Other** – The closure of a site due to a reason other than an infestation, loss of utilities, natural disaster or weather related or structural issue.

Suicide Attempt – The intentional and voluntary attempt to take one's own life. A suicide attempt is limited to the actual occurrence of an act and does not include suicidal threats or ideation. If medical treatment was sought after a suicide attempt, it should be reported under suicide attempt as a primary category in all cases, and not as serious injury or illness:

- **Injury/Illness that Requires Medical Intervention** – An individual sustained an injury or became ill due to a suicide attempt and required medical treatment beyond basic first aid.

- **No Injury/Illness that Requires Medical Intervention** – An individual did not sustain an injury or become ill due to a suicide attempt and did not require medical treatment beyond basic first aid.

C. Incidents to be reported within 72 hours

Medication errors and physical restraints are to be reported within 72 hours after the discovery or recognition of the incident.

- **Physical Restraint** – A physical hands-on method that restricts, immobilizes, or reduces an individual's ability to move his or her arms, legs, head, or other body parts freely. A physical restraint may only be used in the case of an emergency to prevent an individual from immediate physical harm to herself or himself or others. Restraints that are permitted by ODP policies and procedures, regulations or laws are to be reported as physical restraints. All other restraints shall be reported as abuse.
- **Human Rights Team Approved Restrictive Intervention** – Any physical restraint that is applied in an emergency situation that is part of an approved ISP that contains a restrictive procedure.
- **Provider Emergency Protocol** – Any physical restraint that is applied in an emergency situation that is part of a provider emergency restraint protocol. This restraint is not part of an individual approved ISP that contains a restrictive procedure.
- **Medication Error** – Any practice that does not comply with the "Rights of Medication Administration" as described in the ODP Medication Administration Training Course. A medication error occurring during a time when an unpaid caregiver is responsible for the administration of medication is not reportable. An individual's refusal to take medication is not reportable as a medication error.
    - **Wrong Medication** – Individual is given a medication that the individual is not prescribed or has been discontinued, or the individual was given medication that was supposed to be given for another reason.
    - **Wrong Dose** – Individual is given too much or too little medication during a scheduled administration.
    - **Wrong Time** – Individual is given medication too early or too late as defined by the range of allowable administration time.
    - **Wrong Route** – Individual is given medication in a different way from the one specified on the label.
    - **Wrong Form** – Individual is given medication in a different type from the one prescribed.
    - **Wrong Position** – Individual is not placed correctly to receive the medication.
    - **Wrong Technique/Method** – Medication is prepared for administration improperly.

- **Omission** – An administration of medication fails to occur.
- **Wrong Person**- An individual is given another individual's medication.

D. Incidents to be reported when directed

ODP will provide specific guidance and direction on what to report, as well as the timelines to report, related to the following emergencies:

Declared Emergency - An event, such as an occurrence of a natural catastrophe, technological accident, or human-caused event that has resulted in, or could potentially cause, severe property damage, deaths, and/or multiple injuries such as, but not limited to, public health emergencies, emergency declarations, major declarations, etc. A Declared Emergency is declared by Federal, State, County, or Municipal officials.

Public Health Emergency - An event such as a disease or natural disaster that causes, or has the potential to cause, harm to a significant number of individuals and is declared as a Public Health Emergency by Federal or State officials. Public Health Emergencies are to be reported within timeframes that are specific to the nature of the event and as directed by ODP.

- **Outbreaks** - The occurrence of disease cases in excess of normal expectancy. The number of cases varies according to the disease-causing agent, and the size and type of previous and existing exposure to the agent.
- **Epidemic** - A disease that affects a large number of people within a community, population, or region.
- **Pandemic** - A disease that affects a large number of people that is spread over multiple countries or continents.
- **Natural Disasters** - An event such as a flood, earthquake, storms, hurricanes, tornados, blizzards, etc.
- **Bio-Terrorist Attacks** - The intentional release or dissemination of biological agents. These agents are bacteria, viruses, insects, fungi, or toxins, and may be in a naturally occurring or a human-modified form.

VIII. Process for Investigation by a Certified Investigator

Incidents that are categorized as critical incidents must be investigated by a certified investigator who has taken and passed the Department's CI course (55 Pa. Code §§ 2380.17, 2390.18, 6100.402, 6400.18, 6500.20). The point person for an incident must review the information given by the initial reporter, determine the appropriate primary and secondary incident category, and determine if an investigation by a CI is required or if not required, desired. If an investigation is required or desired for an incident, each entity investigating must follow the Department's standardized investigation process as outlined in the most current ODP CI manual.

If an investigation is required or desired to be completed by a County ID Program/AE, the County ID Program/AE must fully comply with all applicable procedures related to the investigation of incidents. County ID Program/AE investigators are not permitted to review the investigation of another entity and make an investigation determination based solely on that evidence without conducting their own investigation. In addition, when a County ID Program/AE has a different investigation determination than a provider or SCO, the County ID Program/AE must work with the other investigating entity to reconcile the difference.

A County ID Program/AE is required to complete any investigation requested by ODP.

At no time should the investigating entity covered by the scope of this bulletin (referred to as the ODP investigating entity) delay, halt, or terminate an investigation because of the involvement of an external investigating entity. If an external investigating entity requests that an ODP investigating entity delay, halt, or terminate an investigation, the ODP investigating entity must attempt to obtain this request in writing and discuss the request with the appropriate regional ODP office.

Concurrent investigations by law enforcement and protective service agencies may occur at the discretion of those entities. When there are multiple entities conducting investigations, every effort should be made to coordinate the investigations to avoid continued stress or trauma upon all individuals involved.

The chart below identifies which primary and secondary incident categories require an investigation by a CI. At times, more than one ODP investigating entity will be investigating the same incident.

Incidents to be Investigated by a Certified Investigator: (See Attachment 2, Incident Management Bulletin Category and 55 Pa. Code §§ 6100.401-6100.402 Crosswalk.)

There are circumstances when SCOs will manage incidents in lieu of a provider; therefore, the term "provider" may be replaced with SCO in the chart in certain circumstances (see section, Responsibility for Reporting and Investigating, for further guidance).

Primary Category	**Secondary Category**	**Entity Responsible for Ensuring CI Investigation is Complete**
Abuse	All	Provider
	Misapplication/Unauthorized Use of Restraint (injury)	Provider and County ID Program/AE
Death	Natural Causes – Services Provided	Provider
	Unexpected – Services Provided	Provider
Exploitation	All	Provider
	Medical Responsibilities/Resources	Provider and County ID Program/AE
	Room and Board	Provider and County ID Program/AE
	Unpaid labor	Provider and County ID Program/AE
Neglect	All	Provider
Rights Violation	All	Provider
	Unauthorized Restrictive Procedure	Provider and County ID Program/AE
Serious Injury	Injury Accidental	Provider
	Injury Unexplained	Provider

	Choking	Provider
	Pressure Injury (Decubiti, Pressure Ulcer, Pressure Sore, Bedsore)	Provider
Sexual Abuse	All	Provider
Suicide Attempt	All	Provider

51a. Code §§ 2380.17, 2390.18, 6100.402, 6400.18, 6500.20)

IX. Services for Individuals with an Intellectual Disability or Autism Incident Report Form (This does not include incidents of Passive Neglect and Self-Neglect. Attachment 3, Services for Individuals with an Intellectual Disability or Autism Incident Report.)

In the event that the Department's information management system is unavailable, the submission of incidents is to occur by completing the *Services for Individuals with an Intellectual Disability or Autism Incident Report* form, specifically pages 1 and 2 of Attachment 3 of this Bulletin. The reason why the incident is not entered in the Department's information management system should be included on the form. All incidents submitted using this form must be entered into the Department's information management system as soon as possible after resolution of the issue(s) that prevented entry.

X. Multiple Categories and Sequence of Reporting: A point person must review incident definitions to determine the most appropriate primary and secondary categories for a report. In situations where an incident appears to meet multiple incident definitions, the point person should enter a report based on the information available at the time of entry. Reclassification is an option at any time during the lifecycle of an incident.

The point person must also determine if the information received at the time of the initial report represents a singular incident or if multiple incident reports are needed to adequately capture information about the incident.

Singular reportable incident – When an individual experiences one incident that could have multiple incident categories.

Multiple reportable incidents – More than one incident experienced by one individual, which are not linked to each other and would not be adequately

addressed or resolved through a single incident report or if applicable, an investigation.

To assist the point person in choosing an appropriate classification when singular events represent more than one incident category, the following list of incidents in priority, is suggested as a guide in selecting the most appropriate category and may not be appropriate in all situations:

- Sexual Abuse
- Abuse
- Neglect
- Exploitation
- Rights Violation
- Suicide Attempt
- Serious Injury
- Serious Illness
- Behavioral Health Crisis Event
- Missing Person
- Law Enforcement Activity
- Site Closure
- Fire
- Passive Neglect
- Self-Neglect

If an incident that requires reporting within 24 hours involves or is the result of a medication error, a report must be initiated in the appropriate 24-hour primary category. In addition, an incident report for the medication error must be reported within 72 hours.

Incidents that are reported as a death, are considered singular reportable incidents. A death is considered a separate incident from the events that may have occurred prior. Incidents reported with a primary category other than death should not be reclassified to a death.

XI. Review Process

A. Provider and SCO Review Process: Providers and SCOs are responsible for reviewing incident reports prior to finalizing them for accuracy and to ensure that the final report has all required elements to allow for the closure of the incident. In addition, providers and SCOs must ensure evidence of the implementation of corrective actions is available upon request by oversight entities. This review process applies to providers and SCOs that are fulfilling the roles of point person and IM representative for the incident. Specifically, the review must ensure:

- Documentation that the individual's health, safety, and rights were protected, upon discovery of the incident

- The incident categorization is correct
- The service location, provider type, and service delivery model are correct
- An investigation occurred when required
- The description of the incident is accurate and has enough details to explain the event
- Proper safeguards are in place to reduce the risk of recurrence of an incident
- Target(s) are identified per this bulletin
- No identifying information that pertains to another individual receiving services is included in the incident report
- Discharge and follow-up information related to medical services is included in any incident report involving medical care
- All required notifications of the incident occurred
- An administrative review of the investigation occurred
- Corrective action(s) in response to the incident have, or will, take place, including those that involve actions related to the target(s)
- An analysis to determine the cause of the incident was completed for all confirmed incidents
- All incident management timelines have been met and if they have not, corrective actions related to a failure to meet timelines are included in the incident report
- The investigation information entered by the CI has enough details to explain the process used by the CI, if the CI performed an investigation
- The investigation determination is consistent with the investigation information entered by the CI, if the CI performed an investigation

Upon finalization of the incident report, the incident report is reviewed by the County ID Program/AE or ODP. The incident is considered under review until the County ID Program/AE and ODP approves it. In the event either the County ID Program/AE or 34

ODP disapproves an incident report, the provider or SCO is to respond to the comments from the County ID Program/AE or ODP management review. The provider or SCO has ten days to respond to the disapproval or any issues identified as part of the disapproval and resubmit the final section and investigation documents of the incident report, as appropriate.

B. SCO Incident Review and Monitoring Process: The SCO has a responsibility to respond to and assess emergencies and incidents. This involves a combination of a review of incident reports in the Department's information management system and ongoing monitoring while on-site and via other methods (phone, email, etc.).

Specifically, the SCO must ensure an individual's health, safety, and well-being by:

- Reviewing initial incident reports that are completed in the Department's information management system. This includes confirming the following actions were taken:
    - Individuals were contacted (via the individual's preferred communication method or in person depending on the nature of the incident) to assess their current status and offer assistance to help meet their needs
    - The entity that entered the incident was communicated with and took the following actions, if needed:
        - Additional information (not present in the initial incident report) that was needed to adequately explain an event in order to assess the actions taken to protect the health, safety, and rights of the individuals was requested and obtained
        - Additional information that was needed to address questions and concerns from the initial County ID Programs/AE7 and/or regional management review, if noted during the SCO's review of the initial incident was requested and obtained
    - Recommendations were provided to County ID Programs/AEs or their delegates, in order to improve a situation and increase protections for an individual, when the review of actions taken to protect the health, safety, and rights of an individual reveals inappropriate or potentially ineffective risk mitigation strategies

- A review of final incident reports in the Department's information management system and taking action that may include, but is not limited to:
    - Contacting individuals (via the individual's preferred communication method or in person depending on the nature of the incident) to assess their current status and offer assistance to meet their needs
    - Requesting and obtaining additional information needed to address questions and concerns from the initial County ID Program/AE and/or regional management reviews, if noted during the SCO's review of the initial incident
    - An assessment of preventative and additional corrective actions for appropriateness or effectiveness to mitigate risk
    - Contacting County ID Programs/AEs or their delegates if questions and concerns from the initial AE and/or regional management review are not addressed in the final section of the incident report
    - Providing recommendations to County ID Programs/AEs or their delegates, in order to improve a situation and to increase protections of an individual, when the review reveals inappropriate or potentially ineffective risk mitigation strategies

- Conduct ongoing monitoring of the situation to determine that the needs of the individual are met. Monitoring must be documented per ODP's regulations, policies, and procedures. Ongoing monitoring includes, but is not limited to:
    - Verification of the implementation of preventative and additional corrective actions related to an incident via examination of on-site documentation, discussions with individuals, families, and staff, etc.
    - Communication to providers or other oversight entities about issues identified during monitoring
        - This includes informing the appropriate County ID Program/AE of issues that require additional follow-up action that the SCO is unable to facilitate
    - A determination whether additional monitoring visits are necessary to ensure the protection of health, safety, and rights of individuals and the effective implementation of preventative and corrective actions
    - Based upon review of the final incident report, complete changes to an ISP based upon the incident, if needed

C. County ID Program/AE Review Process: The County ID Program/AE is responsible for reviewing and approving incidents within the timeframes and requirements outlined in this bulletin.

- Within 24 hours of the submission of the first section of the incident report, County ID Program/AE incident reviewers must complete an initial management review of the incident to determine if appropriate actions were taken to protect the individual's health, safety, and rights. This includes, but is not limited to:
    - Communicating with the entity that entered the incident to request and obtain additional information if necessary to adequately explain and assess the actions taken to protect the health, safety, and rights of the individual
        - Additional information must be documented in the management review document in the Department's information management system
    - Contacting the entity that entered the incident to communicate any concerns identified during the management review and to ensure that actions were taken to remediate the identified concern
        - Actions taken must be documented in the management review document in the Department's information management system
- After the provider or SCO submits the final section of the incident report, County ID Program/AE incident reviewers must perform a management review within 30 days. Specifically, County ID Program/AE incident reviewers must ensure:
    - The incident categorization is correct

- The service location, provider type, and service delivery model are correct
- An investigation occurred when required
- Target(s) are identified per this bulletin
- No identifying information that pertains to another individual receiving services is included in the incident report
- All incident management timelines have been met and if they have not, corrective actions related to a failure to meet timelines are in the incident management report
- An administrative review of the investigation occurred
- The investigation determination is consistent with the investigation information entered by the CI
- Proper safeguards are in place to reduce the risk of recurrence of an incident The incident report contains:
    - Documentation of the actions taken to protect the health, safety, and rights of the individual(s), upon discovery of the incident
    - An accurate description of the incident and enough details to explain the event
    - Discharge and follow-up information related to medical services if the incident involved medical care
    - Documentation that all required notifications of the incident occurred
    - Documentation that corrective action(s) in response to the incident has or will take place, including those that involve actions related to the target(s)
    - Investigation information that contains enough details to explain the process used by the investigator
- A review, analysis, and comparison are conducted with the copy information related to death incidents that has been provided by the provider and/or SCO and the incident report information in the Department's information management system
- All issues identified and communicated to the County ID Program/AE by the SCO reviewing/monitoring the incident have been addressed

When the incident report contains all required elements, the County ID Program/AE incident reviewer will give the report the status of *approved*; otherwise, the report will be given a status of *not approved* and sent back to the submitting entity for correction.

D. Administrative Review Process: All entities responsible for incident reports that conducted an investigation must have a written policy and procedure to support administrative reviews of those investigations. Investigations are not finished until the administrative review process has been completed. The administrative review process is completed by a committee of people that must

follow the guidelines established by ODP in the most recent ODP Administrative Review Manual. The committee completing the administrative review process is responsible for the following:

- Reviewing competency and quality of an investigation for speed, objectivity, and thoroughness.
- Weighing the evidence and making the investigation determination: Confirmed, Not Confirmed, or Inconclusive.
- Developing and determining preventative and additional corrective action(s) regardless of investigation determination.
- Completing the Administrative Review section of the Certified Investigator Report.
- Completing the Administrative Review section of the Certified Investigator Report
- Ensuring corrective action(s) were implemented and there is a plan for ongoing monitoring of all corrective action(s).
- Completing the following for each confirmed incident:
    - Conduct analysis to determine the cause of the incident,
    - Corrective action(s), and
    - A strategy to address the potential risks to the individual.

E. ODP Review Process:

- When the incident report contains all required elements, the ODP incident reviewer will give the report the status of *approved*; otherwise, the report will be given a status of *not approved* and sent back to the submitting entity for correction.
- Incident reports are considered closed upon the approval of ODP.

F. Certified Investigator Peer Review Process: All organizations are responsible for the quality of the work performed directly (or via contract, agreement, etc.) related to incident investigations. In order to facilitate consistent quality measures related to investigations conducted by a CI, ODP has created the CIPR process.

The CIPR process helps mitigate risks by monitoring the quality of investigations and monitoring of incident data and trend analysis. If a CI does not conduct investigations following the minimum standards on which the CI is trained, the organization's ability to mitigate and manage risk may be compromised, resulting in individual harm. In the context of continuous quality improvement, the CIPR process is the core for assessing the quality of the investigation process and incident management practices within an entity or system.

The CIPR process assists with:

- Evaluating and improving the quality of investigations
- Providing performance feedback directly to the CI

All entities that complete investigations are required to conduct the CIPR process as outlined in the ODP CIPR manual.

XII. Quality Management

ODP recommends that all providers, SCOs, and County ID Programs/AEs integrate quality management principles, practices and tools in their incident management and risk management policies and activities. Providers, SCOs and County ID Programs/AEs are expected to routinely, and on an ongoing basis, use population-based evidence and individual data to analyze and monitor incident data to identify patterns and trends.

Data-driven decision-making identifies where improvement is needed and suggests where and what type of improvement strategies can be most successful. During the data analysis, root cause should be identified, where possible, so potential points of intervention can guide the development of prevention strategies.

Providers, SCOs, and County ID Programs/AEs are encouraged to incorporate incident management data monitoring and trend analysis activities into their respective quality management plans.

When developing health and safety related quality improvement plans, entities should integrate the principles of *Everyday Lives* to assure that resulting outcomes are person-centered and support choice. When individual plans of any type are developed, they must be person-centered and support the person to express choice in all aspect of his or her life. For example, person-centered risk mitigation plans must address health and safety risk factors identified for the individual, assure the person's health needs are being met and incorporate choice into the plan.

A. Quality, Risk & Incident Management Monitoring, Planning and Trend Analysis: Quality management uses data as a tool to inform decision-making. In risk management, incident data analysis is used to help identify who is at risk for what and why. Incident data also helps to identify emerging trends and patterns or if strategies implemented to prevent recurrence of an incident are successful. Routine and ongoing monitoring of incident data over time is necessary to answer questions at the individual level and the system level.

All entities should work with the individual, the ISP team, and other appropriate stakeholders to mitigate individual medical, behavioral, and socio-economic crises in a timely manner, regardless of if they rise to the level of a reportable incident. Providers, SCOs, and County ID Programs/AEs must create and maintain a method

to communicate quality management, risk management, and incident management activities to appropriate stakeholders to implement risk mitigation, corrective action, training, technical assistance, or education plans.

Quality management practices must be comprised of methods that include individuals in risk mitigation planning and implementation, as appropriate.

Data and analysis should be organized into a written format that supports routine and ongoing monitoring and risk mitigation planning. Based on data analysis results and stakeholder input, strategies are to be developed and implemented to achieve continuous quality improvement.

Quality management plans and data analyses should be made available to oversight entities when requested. ODP may require additional incident management analysis related to monitoring results, corrective action plans, or other oversight activities.

B. Individual Incident Data Monitoring: Providers and SCOs must monitor incident data and take actions to mitigate risk, prevent recurring incidents, and implement corrective action (55 Pa. Code §§ 2380.19, 2390.19, 6100.405, 6400.20 & 6500.22). Providers and SCOs must complete and document the monitoring of each individual's incident data on a monthly basis that at a minimum includes:

- Evaluation of the effectiveness of incident corrective actions for all incident categories
- Evaluation of the circumstances and frequency of restraints
- Evaluation of the circumstances and frequency of medication errors
- Identification and implementation of preventive measures to reduce:
    - The number of incidents
    - The severity of the risks associated with the incident
    - The likelihood of an incident recurring
- Documentation of:
    - The need to revise the ISP with the ISP team to include new and/or revised information, risk mitigation plans, or a change in services or supports
    - The need to consult with a County ID Program/AE for assistance related to monthly data monitoring, if necessary
    - The actions and outcomes of any activities that occurred related to the monthly data monitoring

C. Provider, SCO Three-Month Trend Analysis: Providers and SCOs must review and analyze incidents and conduct and document a trend analysis of all incident categories at least every three months (55 Pa. Code §§ 2380.19, 2390.19, 6100.405, 6400.20, 6500.22). Based on the results of the trend

analysis, the providers and SCOs must develop, implement, and document both individual specific and agency-wide risk mitigation activities.

The three-month analysis shall include, but is not limited to (as applicable):

- An analysis of compliance with regulatory timeframes for reporting, investigation, and finalization of incidents
- Evaluation of effectiveness of corrective actions for all incident categories
- Evaluation of the effectiveness of education to the individual, staff, and others based on the circumstances of an incident
- A review and trend analysis of comments from the County ID Program/AE and ODP initial management review and disapproval reasons from the final management review
- Any measures that have been implemented or will be implemented to reduce:
    - The number of incidents
    - The severity of the risks associated with the incident
    - The likelihood of an incident recurring
- Documentation of the actions and outcomes of any activities that occurred related to the trend analysis

D. County ID Program/AE Trend Analysis: As required by the AE Operating Agreement, County ID Programs/AEs shall conduct a trend analysis by individual and provider entity, as well as specific service locations, to identify risks that require intervention to avoid a crisis. County ID Programs/AEs shall provide assistance to mitigate all situations identified as potential risks to the health and welfare of individuals upon request from providers or SCOs. In addition, the trend analysis must include, but is not limited to:

- An analysis of compliance with timeframes in accordance with this bulletin for reporting, investigation, and finalization of incidents
- Evaluation of the circumstances and frequency of the use of restraints
- Evaluation of the circumstances and frequency of medication errors

To complete the trend analysis, the County ID Program/AE must document the outcomes or findings from the trend analysis, including any actions that need to be taken.

APS Mandatory Reporting Requirements: NFHCS will adhere to the APS reporting requirement process. Below is a description and background information:

Background: The Act 70 of 2010 requires a staff or administrator of a facility (NFHCS) who has reasonable cause to suspect that a recipient is a victim of abuse, neglect, exploitation, or abandonment to make an immediate report.

- Staff and/or administrators who have reasonable cause to suspect that an individual is a victim of abuse, neglect, exploitation, or abandonment, as described above, MUST!!! immediately make an oral report to the statewide Protective Services Hotline by calling 1-800-490-8505.
- In addition to reporting to the Protective Services Hotline, oral reports must be made to the Pennsylvania Department of Human Services/Adult Protective Services Division (by calling the mandatory abuse reporting line at 717-265-7887 and selecting option #3)
- And local law enforcement only for suspected abuse or neglect involving:
    - Sexual abuse
    - Serious injury
    - Serious bodily injury or if a death is suspicious

Within 48 hours of making the oral report to the hotline, the Incident Manager or Designee will fax a written report to 484-434-1590 or email the report to Liberty Healthcare at: mandatoryron@libertyhealth.com.

The written report can be one of the following:

- The mandatory reporting form found on the Department's website at www.dhs.pa.gov under Report Abuse Adult Protective Services.
- An administrator or staff of a facility, licensed by Department of Health, may submit a PB- 22 form; or
- An administrator or staff may submit a Home and Community Services Information System (HCSIS) incident report (Printable Summary) or an Enterprise Incident Management (EIM) report.
- Within 48 hours of making the oral report to law enforcement (only for suspected abuse or neglect involving sexual abuse, serious injury, serious bodily injury or if a death is suspicious), the administrator or staff will send a written report to law enforcement.

The written report can be one of the following:

- The mandatory reporting form can be found on the Department's website at www.dhs.pa.gov under Report Abuse>Adult Protective Services (Enclosed in the guide)
- An administrator or staff of a facility, licensed by Department of Health, may submit a PB- 22 form; or

- An administrator or staff may submit a Home and Community Services Information System (HCSIS) incident report (Printable Summary) or an Enterprise Incident Management (EIM) report.

What to do when an incident occurs

- Take care of your individual – their health and safety are priority.
- Report the incident to your supervisor and Incident Manager as soon as possible!
- Fill out an incident report sheet within 24 hour of the occurrence and e-mail it to the Incident Manager
- Incident report sheets can be found in residential house binders
- They can also be sent to you via e-mail if necessary

Incident Manager: Angie King
Phone: (412)956-9633
E-mail: Aking@nfhcs.org
Incident Report Writing

Write your Incident Report on the same day of the incident in order to keep events fresh in your mind. Reports should be written after the incident has occurred, not during, so that you can help your individual and extinguish the situation.

Please include the following:

- Date/Time/Location
- Names/Identifiers of anyone involved
- List events in sequence, including anything relevant that happened before the incident – be detailed
- Be specific! (List who did/said what and where)
- Document any injuries
- Actions taken by staff to support the individual
- Document who you notified/contacted

Scenario (Hospitalization or ER visit)

- If the incident is a hospitalization or ER visit, please keep any documents or discharge instructions
- These are relevant to the incident and need to be copied to the nurse as well as the incident manager

Scenario (Allegation of abuse and/or neglect)

- Some critical incidents (allegations of abuse/neglect) will require investigation by a CI (Certified Investigator)

- If you are involved in this type of incident, you may be contacted by the CI to give a written statement/interview
- Targets of investigations are suspended from working with individuals during investigation (a target is a person who is accused of abuse/neglect of an individual)
- Investigations can last up to 30 days, but are started within 24 hrs. of an incident

Corrective Action Plan:

- A plan of actions to be taken after an incident to prevent reoccurrence
- Can include changes in protocol, medications, trainings, or re-trainings
- Is NOT meant as a disciplinary action for staff or individual, but as a measure of quality control/performance improvement
- ALL incidents that are filed are followed up with a corrective action plan.
- As staff, you may be asked to sign a Corrective Action plan sign off sheet and to complete actions to fulfill the plan.

How to prevent incidents?

- Not all incidents are avoidable, but there are steps you can take to ensure the health and safety of the individuals we work with – as well as attempt to minimize occurrence of incidents!
- Please be familiar with your Individual's ISP: this includes important information such as:
- Medications/Medical needs and history/allergies
- Preferences of the individual (likes and dislikes) and behaviors/triggers to be aware of
- Safety awareness of the individual/hazards to be aware of (fire/temperature/water/traffic safety needs)

How to prevent incidents?

- Be aware of your surroundings! Some incidents are environmental
- When driving, be aware of traffic laws, stop signs, speed limits, and other vehicles on the road
- When in home, watch for any items in the environment that could cause an injury/fall:
- Wet floors/surfaces
- Electrical cords or other loose objects or debris on the ground
- Any other objects that could cause injury, illness, or be a fire hazard
- Do your best to prevent medication errors!

- Be aware of medications to be given as well as dosage times for each individual you work with
- Utilize the Quick MAR system to prevent errors. Follow all steps as instructed (this includes utilizing the scanner).

REPORTERS - Ensure timely reporting and Completion of Incidents

INTIAL REPORTER
Initial Reporter- is any person who witnesses the incident or is the first to discover or be made aware of the signs of an incident.

Step # 1. The initial reporter first responds to the situation by taking prompt action to protect the Individual's health, safety, welfare, and rights. (This person also ensures that the "target "who is the alleged perpetrator, is completely separated, from the alleged victim)

Step # 2. Protection may include:
- Dialing 911
- Escorting to medical care.
- Or calling Child Line.

Step # 3. As soon as the immediate needs of the individual have been met, the initial reporter notifies the point person of the incident and receives instructions on next steps to take. This will be your immediate supervisor.

Step # 4. The initial reporter documents his/ her observations in a narrative incident reporting form. Which will be submitted via email to your immediate Supervisor. And will housed in the Individual's file. In cases of alleged abuse or neglect, the initial reporter will comply with the applicable laws and regulations. (i.e., Notification to Child line, Law enforcement and APS Hotline.

POINT PERSON

Point Person- A point person is assigned and authorized to perform specific duties as described in this policy. In general, a point person is to receive verbal or other reports or allegations of incidents from Individuals, families, and initial reporters.

The point person responsibilities include, but not limited to:
- Safeguard the individual

- Ensure that HCSIS/EIM Incident Reports are submitted. Calls (if applicable) have been made to APS and written reports have been sent
- Communicate with others involved in investigations
- Follow-up and review of incidents. This role is pivotal in the incident management process. When an incident is reported, the point person, as a representative of NFHCS, is to:
    - First confirm that appropriate actions have been taken **or** order additional actions to secure the safety of the Individual involved in the incident
    - Ensure the safety of the Individual when the Individual's health and safety may be jeopardized
    - Ensure notification requirements (relating to The Older Adults Protective Services Act and Child Protective Services Law) are met
    - Determine whether an investigation or other follow-up is needed
    - Secure the scene of an incident when an investigation may be required
    - Ensure that, when needed, a certified investigator is promptly assigned
    - Notify appropriate (supervisory/management / Executive Director) personnel within 24 hours of the incident, as specified in this policy
    - Initiate a HCSIS/ EIM Incident Report within 24 or 72 hours as described in the Reportable Incident section of this policy guide
    - Notify the family/advocate and SC within 24 hours (72 hours for medication error and restraint) unless otherwise indicated in the individual support plan

INCIDENT MANAGEMENT REPRESENTATIVE

The incident management (IM) representative- is the person designated by NFHCS with overall responsibility for incident management. This person is our Incident Manager.

The Incident Manger responsibilities include but not limited to:

- Assurance that the activities of the initial reporter and point person have been completed
- The Incident Manager is responsible for the finalization of the incident report within 30 days of the incident
- Ensure that a completed certified Investigation (if applicable) has been finalized
- The IM representative is responsible to evaluate the quality of incident investigations

CERTIFIED INVESTIGATOR

Certified investigator - is a person who has been trained and received a certificate in investigation from ODP. Requirements - In order to be a Certified Investigator a person must:

- Be a High School Graduate or GED
- Be 21 years of age or older
- Meet the criminal background requirements of the OAPS act. (Older Adult Protective Service) if applicable the Child Protective Service Law
- Complete the Investigative process: Organizational Context & Processes web-based training. Located on the LMS (Learning Management System within 3 months of the course date
- Successfully complete the entire Four-day certification training and pass the exam
    - The Certified Investigator: Investigations needs to be started within 24 Hours. (Meaning, the first interview must be done in 24 hours.) in addition, all interviews should be completed within 10 days, and the final section should be completed by NFHCS, in 30 days. (Unless an extension is requested)
    - Critical incidents require an investigation to occur. An investigation is defined as the process of identifying, collecting, and assessing facts (evidence) in a systematic manner. The purpose of an investigation is to objectively describe and explain what did (or did not) occur at a given place and time. Our Guide in the aforementioned section of this policy outlines the Incidents to be investigated. Our CIs are required to complete these incidents.
    - CI is required to document their findings and complete investigations within 30 days.
    - If an investigator wishes to continue or conduct certified investigations and has done less than three investigations during the certification period. The certification period is 3 years. The investigator must:
        - Actively participate in the quarterly or semi-annual peer review of the quality of investigations by serving as a member of a Peer Review committee member
        - Participation is defined as using the evaluation tools to review at least three investigations and discussing the results with the (RIQ) committee. (Once established, in the process)

- And document the findings

Overview of our incident management components responsibilities

- Promote the health, safety, rights and enhance the dignity of Individual receiving services
- Develop this policy/procedure guide for incident management
- Ensure that our staff and others associated with the Individual have proper orientation and training to respond, report, recognize, and prevent incidents
- Provide ongoing training to our Individual's and (if applicable) families on the recognition of abuse and neglect
- Ensure when incidents occur that affect a person's health, safety, welfare, or rights, that the people who are present take prompt action to protect the person's health, safety, welfare, and rights
- This will include separation of the target when the Individual's health and safety are jeopardized
- This separation will continue until an investigation is completed. In addition, the target will not be permitted to work directly with any other service individual during the investigation process. When the target is another Individual receiving supports or services, and complete separation is not possible, NFHCS will institute additional protections.
- This will include separation of the target when the Individual's health and safety are jeopardized.
- This separation will continue until an investigation is completed. In addition, the target will not be permitted to work directly with any other service individual during the investigation process. When the target is another Individual receiving supports or services, and complete separation is not possible, NFHCS will institute additional protections.
- Notify the responsible person designated in our policy (Incident Manager).
- Assign trained individual(s) (e.g., Point Person) to whom incidents are reported to when they occur and who will make certain that all immediate steps to assure health and safety have been implemented and follow the incident through closure.
- Contact appropriate law enforcement agencies when there is suspicion that a crime has occurred.
- Comply with all applicable laws, regulations, and policies. (e.g., APS, Child Line).
- Conduct certified investigations.

- Analyze the quality of investigations.
- Respond to concerns from individuals/family about the reporting and investigation processes.
- Inform the family of the incident unless otherwise indicated in the individual's support plan.
- Notify the family of the investigation findings unless otherwise indicated in the individual's support plan.
- Maintain an investigation file within our agency.

Create an incident management process which:

- Designate an individual with overall responsibility for incident management. (Incident Manger)
- Consider possible immediate and long-term effects to the individual resulting from an incident or multiple incidents.

Monitors quality and responsiveness of all ancillary services (such as health, therapies, etc.) and acts to change vendors or subcontractors**, or** assists the Individual to file available grievances or appeals procedures to secure appropriate services.

Finalize incident reports in HCSIS/EIM by including additional information about the incident. Results of a required investigation and corrective action within 30 days of discovery or occurrence of the incident unless the deadline is extended in HCSIS/EIM.

Fax or scan an incident report to the Department if HCSIS/EIM is not available within 24 hours or 72 hours depending on the incident type.

Ensure when HCSIS/EIM becomes available, that we will immediately enter the incident into HCSIS/EIM. Ensure NFHCS provide a detailed description in HCSIS/EIM of the actions taken in response to an incident which must include:

- The prompt action to protect the health and welfare of the individual.
- The results of the incident investigation.
- Corrective actions taken.
- The staff that is responsible for implementing the actions.
- The date the actions were implemented or are planned.
- Specific information regarding disciplinary actions taken with staff to assure the health and welfare of our individual.

Review and analyze incidents at least quarterly or more frequently as required by the Department:

- This quarterly review must contain information on the incident target. Submit reports regarding our review and analysis of incidents to the Department or the Department's designee, upon request.
- Identify and implement actions to assure the individual is safeguarded from risk so the number of preventable incidents is reduced.
- Assure our staff receives annual incident management training on preventing, recognizing, reporting, and responding to incidents and assuring an individual is safe.
- Provide additional training to the individual and staff as needed based on the incident circumstances.
- Analyze data on an individual to continuously improve HCBS delivery and to mitigate and manage risk factors.
- Respond to actions promptly designated by the Department or the Department's designee as a result of the management review of an incident.

Individuals & Families

Individuals and families are to notify NFHCS when they feel it is appropriate, or their supports coordinator regarding any health and safety concerns they may have related to a service or support that they are receiving.

If an Individual or family member observes or suspects abuse, neglect, or any inappropriate conduct, whether occurring in the home or out of the home, they should contact NFHCS or their supports coordinator, or both.

They may also contact the ODP directly at 1-888-565-9435.

The supports coordinator will either inform the involved provider (NFHCS or another Provider) of the incident or file an incident report. Once informed by the supports coordinator, the provider(s) is subsequently responsible to take prompt action to protect the Individual, complete an investigation as necessary and file an incident report. In the event of the death of an individual, the family is required to notify the supports coordinator and /or NFHCS.

When an Individual or the Individual's representative arranges his/her own supports through a payment agent or intermediary service organization and an incident occurs, the individual, the individual's family or their representative is to inform the provider, when it is appropriate, or the supports coordinator that an incident has occurred. The provider(s) (NFHCS) or the supports coordinator will take prompt action to protect the Individual, ensure a certified investigator is assigned as necessary and file an incident report in HCSIS/EIM.

Support Coordinator: Support Coordinator-A support coordinator is a person who is responsible for the coordination of services for an individual. And who receives reports from the Individual or family. When an Individual or a family member informs the supports coordinator of an event that can be categorized as abuse or neglect as defined in this policy and there is no relationship relating to providers.

- The supports coordinator functioning in the point person role is to take prompt action to protect the individual. Once the Individual's health and safety are assured, the supports coordinator will ensure a certified investigator is assigned, as necessary, and file a HCSIS/ EIM Incident Report.
- When a family informs their supports coordinator of the death of a relative, the supports coordinator will determine if a report has been filed by a provider (NFHCS). If no provider is required to file the report, the supports coordinator will file a HCSIS/EIM Incident Report.

Support Coordinator Supervisor/ Unit Manager: Supports coordinator supervisor/unit manager- The supports coordinator supervisor and the supports coordinator unit manager are responsible for the finalizing of HCSIS/ EIM Incident Reports filed by the Supports coordinator.

County Incident Manager: County Incident Manager- The county incident manager is the person designated by ODP with overall responsibility for incident management within their county program. This responsibility includes:

- A review to ensure that incidents are managed and reported in accordance with the process described in this policy and to approve or not approve HCSIS/ EIM Incident Reports submitted by NFHCS or supports coordination entity.
- In addition, the county incident manager is responsible for the final submission of HCSIS/EIM Incident Reports filed by the county point person.

Regional Incident Manager: Regional Incident Manager- The regional incident manager is the person designated by ODP with overall responsibility for incident management within their region. This responsibility includes:

- A review to ensure that incidents are managed and reported in accordance with the process described in this policy and to approve or not approve HCSIS/EIM Incident Reports.

Bureau Of State Operated Facilities (BSOF) Incident Manager: BSOF Incident Manager- is the person designated by ODP with overall responsibility for incident management for incidents filed by State-operated facilities.

This responsibility includes:

- A review to ensure that incidents are managed and reported in accordance with the process described in this policy and to approve or not approve HCSIS/EIM Incident Reports.

Incident Reports: EIM- Enterprise Incident Management System: The Office of Developmental Programs (ODP) has begun utilizing the Enterprise Incident Management (EIM) system. Effective: January 4, 2016, for all incident reporting functions. All entities that report incidents in HCSIS will begin to report incidents in the EIM system.

STANDARDIZED INCIDENT REPORT

First Section (completed within 24 hours)

The First Section is to include the following information:

Demographics (pre-populated from HCSIS/ EIM demographics)

- Name of the individual involved/affected by the incident
- Individual's Base Service Unit (BSU) number
- County of Registration
- Gender
- Individual's date of birth
- MR Diagnosis.
- Home address of the individual
- Living Arrangement of the individual
- Name and address of the reporting entity
- Location where the incident occurred
- Name of the point person

Categorization:

- Date and time when the incident was recognized/discovered
- Primary and secondary category of the incident
- Determination if an investigation is required or desired
- Name of the Certified Investigator assigned if the incident requires investigation

Health and safety assurance:

- Description of the immediate and subsequent steps taken by the point person or other representatives of NFHCS to ensure the Individual's health, safety, and response to the incident, including date, time and by whom those steps were taken. If the individual is not registered with a County ODP the report is to list, the county or state where the person is/was a resident.

Incident description

- Narrative description of the incident completed by staff or another person(s) who were present when the incident occurred or who discovered that an incident had occurred.

Final Section (completed within 30 days): The reporting entity will complete the Final Section of the incident report within 30 days from the date of the incident or of the date NFHCS learns of the incident (unless an extension has been made).

The Final Section will retain all of the preceding information from the First Section and will add:

- Name of the initial reporter.
- Name of the individual's supports coordinator (pre-populated).
- Whether CPR was administered.
- Weather the Heimlich was administered.
- If 911 was called, the time, date and person who called.
- If the incident involves an illness or injury, the name of the practitioner/facility by whom the individual was treated initially, the date and time of the initial contact with a healthcare/medical practitioner, the nature/content of the initial treatment/evaluation, and the nature of, date of, time of, and practitioner involved in any subsequent treatments, evaluations.
- In the event of a death, indication if the individual was in hospice care, had a diagnosis of terminal illness, if a "Do Not Resuscitate" order was in effect, if the coroner was contacted, if an autopsy has been or will be performed.
- Identification of all persons to whom the incident notification has been (or will be) submitted (i.e., family, law enforcement agency), the date the notification has been made, and the person who has/will notify the necessary parties.
- Update of incident description, as needed.
- Specific description of any injury received by the individual.

Additional Information Required:

- Present status of the Individual in reference to the incident.
- Identification of other persons who may have witnessed or been directly involved in the incident.
- Specific signs and symptoms of any illness (acute or chronic) which may be contributory to the incident.
- Any relevant background information on the Individual, including medical history and diagnoses.
- Date on which the investigation began, if required.
- Summary of the investigator's findings and conclusions, if required.
- If the incident involves an allegation of abuse or neglect, the conclusion reached on the basis of the investigation (i.e., the allegation is confirmed, not confirmed, inconclusive) and the status of the target.
- NFHCS may summarize the narrative description, but the written statements of the person(s) directly involved are to be available for review, if needed.
- Description of the steps taken by NFHCS in response to the conclusions reached as a result of the investigation.
- If the incident involves an injury of unknown origin, confirmation of the cause (if one has been identified) and steps taken to prevent recurrence.
- Description of any changes in the Individuals plan of support necessitated by or in response to the incident.
- Verification by NFHCS that all necessary corrective actions have been identified.
- If any corrective action cannot/has not been completed by the time the Final Section is submitted, the expected date of completion must be provided along with the identity of the person responsible for carrying the extended action through to completion.
- If the nature of the incident requires contact with local law enforcement, the name and department/office of the person(s) contacted, the date of the contact, the name of the person who initiated the contact, and a description of any steps taken by law enforcement officials.
- If the Individual has been hospitalized, the date of admission, name of the hospital, the admitting diagnosis, indication if the admission was from the emergency room, what occurred during the hospitalization, change involuntary/involuntary status, the date of discharge, the discharge diagnosis, an indication that the Hospital Discharge Instructions were provided, what changed after discharge, current status and any plans for subsequent medical follow-up.

- If the Individual is deceased, the Final Section is to be supplemented by a hard copy of the following:
- Lifetime medical history.
- Copy of the Death Certificate.
- Autopsy Report if one has been completed.
- Discharge Summary from the final hospitalization if the individual died while hospitalized.
- Results of the most recent physical examination.
- Most recent Health and Medical assessments.
- Name of the family member notified of the results of the investigation, if required.
- The incident classification the provider believes is most appropriate.
- The date and time NFHCS believe is most appropriate.
- After final submission the county and ODP will perform a management review and close the incident.
- Documents, which are not immediately available, must be forwarded to the appropriate parties (county and/or ODP Regional Office) as they become available. If, after attempting to acquire the document, it is determined to be unobtainable, the expecting party will be notified.

ABBREVIATED INCIDENT REPORT

Medication Error: Must be reported within 72 Hours
The data entry screen is to include the following information:

Demographics (pre-populated from HCSIS/EIM demographics)

- Name of the individual for whom the Medication Error is being reported.
- Individual's Base Service Unit (BSU) number

Categorization

- Secondary category of Medication Error
- Date and time when the incident was recognized/discovered

Medication Error Incident Information

- Staff position of the person giving medication.
- Name of medication(s).
- Indication if the error occurred over multiple consecutive administrations.

The reason(s) why the Medication Error occurred:

- The response(s) to the Medication Error
- The agency system response to prevent this type of error from occurring in the future
- Any additional comments
- Indication if another Incident Report was filed as a result of the Medication Error. If another Incident Report was filed, the Incident ID number

In addition to the required information, NFHCS may choose to include optional information to further analyze their medication errors.
Optional medication error information

- The name or unique identifier of person making the Medication Error.
- Indication if the person making the Medication Error was working longer than their regular work hours at the time of the Medication Error.
- The length of time the staff person who made the Medication Error has been giving medications.
- The number of medications supposed to be given to this person at the same time as the Medication Error was made including the medication when the Medication Error was made.
- The number of medications this person receives daily.
- The number of people that the staff person who made the Medication Error must give medications to around the same time as the Medication Error occurred.

RESTRAINT The data entry screen is to include the following information:

Demographics (pre-populated from HCSIS/EIM demographics)

- Name of the individual for whom the Restraint was used.
- Individual's Base Service Unit (BSU) number.

Categorization

- Secondary category of Restraint
- Date of the Restraint
- Time in Restraint
- Time out of Restraint

Restraint incident information

- Restraint Agent

- Antecedent to the Restraint
- Reason for the Restraint
- Indication if the Restraint was used on a planned or emergency basis
- Authorizing Staff
- Indication if Prone (face down) Restraint was used
- Indication if another Incident Report was filed as a result of the Restraint
- If another Incident Report was filed, the Incident ID number

Please Note:

- An individual must be treated with dignity and respect.
- An individual may not be discriminated against because of ethnicity, religious affiliation, disability, ancestry, national origin, age, gender, or sexual orientation nor be deprived of civil or legal rights.
- An individual has the right to be free from abuse, neglect and exploitation and has the right to report abuse, neglect, or exploitation.
- An individual has the right to voice complaints or concerns about treatment or services.

INCIDENT MANAGEMENT CONTINGENCY PLAN

If NFHCS is unable to report a 24-hour incident through (HCSIS/EIM), faxed contingency reporting is to be utilized.

Incidents that are reported via fax are to be recorded on a copy of the attached Incident Management Contingency Form. This reporting method will satisfy regulatory requirements to report an incident. In the event of a serious incident (such as abuse with injury, suspicious death), a NFHCS should also call our Regional Office and County ODP Program to alert ODP and the county of the incident.

Once complete, the Incident Management Contingency Form is to be faxed to the appropriate ODP Regional Office and to the County ODP Program.

The form should have a fax cover sheet that identifies the fax as a reportable incident and states the reason that the report needed to be faxed. Faxing the Incident Management Contingency Form is a short-term solution for meeting regulatory requirement for reporting incidents; however, once access to HCSIS/EIM can be established, the incident must be entered into HCSIS/EIM.

CONTACT INFORMATION:
ODP Regional Office Phone Numbers:
ODP Regional Office Fax Numbers: (412)565-5479
Western Region (412) 565-5144

USE OF INCIDENT DATA (QUALITY MANAGEMENT)
(Our Incident Manger**)** responsibility is to:

- Review a representative sample of the Individuals incidents for information about the events.
- The response to the incident including timeliness.
- Thoroughness and the appropriateness of the corrective actions.
- This responsibility also includes analysis of data and information using standardized methodology and processes.

There are a variety of quality management tools for analysis and trending. These tools assist in either defining, analyzing, and preventing incidents or in sustaining improvements already implemented. ODP has begun to conduct training introducing some of these quality management tools and to demonstrate how to use them effectively. The outcome of this assessment and analysis process is to identify strategies for prevention of future incidents. Staff: For additional guidance see NFHCS Quality Management Plan. Which includes but not limited to: Target objectives, Plan of correction methods, and Data collection.

NFHCS Monthly and Quarterly Incident Review Data
Per month and quarterly, all incidents will be reviewed by Incident Manager. During reviews, *the IM will note:*
but not limited to:

- Trends
- Targets
- Root Causes
- Completed Incidents.

All quarterly reviews will be provided to the AE and ODP per request.

Section Overview:

- **Monthly Review of Incidents:** A review of all incidents will be conducted every month. Using the EIM System as our source.
- **Data Collection:** During these reviews, an analysis will be conducted (Information gathered will be composed of in a report). Information include but not limited to:" Target information, Trends, Root Causes, and Closed and open incidents with extensions)
- **Quarterly Reviews:** During our Quarterly QMP Meetings, Our Program Director will submit her findings to the team with a plan to correct areas of non-compliance.
- **Risk Management:** With Monthly and Quarterly reviews being conducted, this will allow NFHCS the Mitigation strategies, to ensure thorough and completed investigations, as well as, most importantly, ensuring the health and safety of our Individuals.

PEER REVIEW

Peer Reviews: The peer review is an ongoing evaluation process that is designed to provide information about the overall quality of incident investigations to an organization as well as the investigator. The primary objective of the peer review is to provide an investigator direct feedback and identify quality improvement recommendations. This policy requires NFHCS, supports coordination entities and AEs to have an administrative structure that supports the analysis of the quality of investigations.

Frequency of CIPRS

- NFHCS will conduct Peer Review investigations quarterly. (Or more frequently if the need arises.) This decision should be based on the scope and the complexity of our incident & risk management.
- Employ standardized approaches to quality management and incident management.
- Use of the peer review mechanism available to aid NFHCS in achieving high level standards.
- In addition, NFHCS will utilize the assigned Team Members to provide quality reviews using the CIPR process for investigations conducted by our Certified Investigators.
- Upon completion of the peer review by the newly formed RIQ Committee. The findings will be shared among the committee with an opportunity to discuss the results and findings.

- NFHCS will provide concluded findings of the Peer reviews to the department for external evaluation upon request.
- Documentation of the Peer Reviews and results will be kept.

Our Guidelines for conducting our CIPR Committee Meetings:

- The committee meeting will consist of a discussion of the CIPR findings for each case sampled. If there is discrepancy or disagreement among members on any item, consensus should be reached.
- Committee members should not evaluate their own cases.
- To expedite the meeting process, committee members must review/evaluate assigned cases prior to the CIPR meeting.
- Documentation of the CIPR process must be kept and results must be shared with appropriate parties to facilitate improvement strategies. Corrective Actions are required within 5 days.

Requirements for choosing a sample to be reviewed: The number of investigations subject to CIPR is flexible based on the needs of NFHCS. The number of investigations selected for CIPR should be proportionate to the number of investigations completed annually and the number of CIs within an NFHCS. The number of investigations selected for CIPR must be no less than ten percent (10%) of the investigations conducted during the review period.

NFHCS will consider these factors when selecting investigations for review:

- NFHCS will select at least one (1) investigation conducted by each of our CI during the review period. This provides an opportunity for each CI to receive constructive, objective feedback on the quality of the investigation process and content of the investigation file. This also provides feedback supporting the CI's focus on his/her own skill/knowledge areas needing improvement. *" Findings" of an CIPR will be shared with the CI who conducted the Investigation.
- NFHCS will include investigations that were problematic, challenging, or complicated to allow the CI(s) and NFHCS the opportunity to learn from those experiences.
- Review our investigations with a variety of final determinations, including inconclusive, to examine what factors contributed to the Administrative Review Committee's determination.
- Investigations from various categories of incidents.

- If there were no investigations conducted during the current review period, then select cases from previous time periods that were not previously reviewed.

Our CIPR members will consist of: NFHCS can structure the process of selecting our members through our newly RIQ committee or by establishing a new CIPR committee.

- Our committee will include a minimum of three (3) members. When possible, membership should be rotated. This allows for the continuing education of our staff through the "hands-on" review process. If NFHCS doesn't have enough staff to have three (3) member CIPR committees, NFHCS will organize membership based on our resources available and consult with an ODP vendor for the Certified Investigator program for additional technical assistance if necessary.
- Members of our CIPR committee should have completed either the Certified Investigators or the Peer Review course offered by ODP, although current certification is not required to participate in the CIPR evaluation process.
- The CIPR process can be approached by using a true peer-review model consisting of only Certified Investigator's in NFHCS reviewing each other's investigations.
- If the CIPR process includes external stakeholders (e.g., service provider organizations, consumers, or other groups within the ODP service delivery system), members will be asked to sign a confidentiality agreement with the understanding that the information contained in the investigative files is to be used only for the CIPR review.

Staff Resources:

- 55. PA code Chapter 51.17, Incident Management 51.17 (a) Participants Rights
- MR Bulletin 6000-04-01 Incident Management,
- 55.Pa Code 6000 Subchapter Q Incident Management,
- MR Bulletin 00-04-11 (Obsolete) Certified Investigations
- ODP Certified Investigation Peer Review Manuel 2017,
- ODP Bulletin EIM ODP Communication number announcement 110-15,
- Certified Investigation Manual 2017,
- ODP CIPR Manual 2018,
- Information Packet 031-15, APS Mandatory reporting requirements of adults covered by adult protection service Act of 2018 updated August 2016,

- NFHCS Quality Management Policy #10,
- APS Update Mandatory Reporting 09/2018
- Quality Assessment and Improvement 06/2018

EMERGENCY & CRITICAL INCIDENT MANAGEMENT: Emergencies and critical incidents in the workplace can affect people physically and psychologically and affect program continuity NFHCS**.** The purpose of this policy is to ensure NFHCS prepares for and effectively responds to emergency situations and critical incidents through the appropriate use of resources. The prevention and effective management of emergency situations and critical incidents can assist to minimize the negative impact of an unexpected event. This policy applies to all staff, consumers, volunteers, Board members and students.

Definitions: An emergency is an unplanned or imminent event that affects or threatens the health, safety or welfare of people, property, and infrastructure, and which requires a significant and coordinated response. The defining characteristic of an emergency event or situation is that usual resources are overwhelmed or have the potential to be overwhelmed. Emergencies may be a specific event with a clear beginning, end and recovery process, or a situation that develops over time and where the implications are gradual rather than immediate.

Emergency management is the coordination of an emergency response and management of recovery. The aim of emergency management is to minimize physical and psychological impacts on all parties and to minimize damage to assets, operations, reputation, and staff productivity. A critical incident is an unexpected traumatic event, involving personal or professional threat, which evokes extreme stress, fear, or injury. Providing appropriate supports following a critical incident is part of emergency arrangement.

A traumatic event is one in which a person experiences, witnesses or is confronted by experiences that involve actual, threatened, or perceived death or serious injury and/ or threat to own or others physical and emotional integrity. The person’s response may then include intense fear, feelings of helplessness and horror, which impact on their sense of ‘self’. Complex trauma refers to a condition resulting from multiple exposures to one or more traumas. When repeatedly exposed to traumatic stress, disruptions can occur in brain structure and function, central and autonomic nervous system arousal, endocrinological and immunological function. These biological disruptions interact with psychological, emotional, cognitive, and spiritual processes.

Critical Incident Debriefing (CID) is a preventative health measure to minimize the impact of traumatic events and the development of major psychological health problems such as Post Traumatic Stress (PTS) Disorder.

Principles: Emergency management planning is being prepared for events or incidents that stretch our ability to cope beyond normal day-to-day capacity. The organization is committed to the protection of consumers, staff, volunteers, Board members, students, and visitors during emergencies. NFHCS swiftly and effectively responds to emergency situations, with the foremost goals of preserving life, protecting the organization's property, and restoring operations as quickly as possible. Critical incidents can be a threatening experience and appropriate supports are required to minimize long term effects arising from exposure to the trauma.

Outcomes: Emergency situations are prevented as far as practical. The negative impacts of emergency situations and critical incidents are minimized through effective management.

FUNCTIONS AND DELEGATIONS

Board of Directors

- Develop and Review Emergency and Critical Incident Policy.
- Compliance with Emergency and Critical Incident Policy.

Management

- Compliance with Emergency and Critical Incident Policy.

CEO/Manager

- Ensures development and implementation of Emergency and Critical Incident Policy.
- Ensures potential disaster and emergency situations are identified, and appropriate emergency management plans are in place.

Director of Administration

- Lead responsibility for implementation of emergency and critical incident procedures, including identification of potential situations, developing, documenting, and communicating response plans, reporting on actual situations, and reviewing policy and procedures following a disaster or emergency situation.

- Coordinate staff training in emergency and critical incident, such as fire response, building evacuation, etc.

Staff

- Compliance with Emergency and Critical Incident Policy.
- Contribute to the development of Emergency and Critical Incident Policy.

Risk Management: Staff and volunteers are trained in disaster and emergency response procedures annually by training coordinator. Emergency evacuation drills are undertaken in all sites annually under the instruction of training coordinator. Disaster and emergency management plans are reviewed annually and/or following the event of a disaster or emergency situation.

As far as possible, traumatic events are prevented, and the impacts of trauma are minimized following traumatic events.

Policy Implementation: All staff have access to and are familiar with policies and procedures relating to disaster emergency management. All staff have information which outlines actions to follow for various disaster and emergency situations and are supported to undertake training for specific roles in emergency and critical incident.

Policy Detail: NFHCS identifies, prevents, and manages disaster and emergency situations within its sphere of responsibility and influence, until the arrival of appropriate emergency services. A range of emergency situations may occur on the premises with the potential to impact on the safety of staff, Board members, volunteers, students, visitors, and consumers, including:

- fire
- gas or water leak
- vehicle and other accidents
- chemical, radiation or biological spill
- bushfire
- storm
- earthquake
- bomb threat
- civil disorder or illegal occupancy
- hostage or terrorist situation
- death
- robbery
- physical (including sexual) assaults.

Risk Assessment: NFHCS uses risk assessment processes to identify and control barriers to effective emergency management. Staff, Board members, students, volunteers, and consumers are expected to behave in a way which minimizes the risk of emergencies occurring.

Preparedness: The organization to prepare for potential disaster and emergency situations and is reviewed on annual basis. Disaster and emergency management plans are reviewed annually basis. All staff, and contractors are provided with training to ensure they are familiar with implementation of disaster and emergency management plans.

All staff, and contractors familiarize themselves with emergency evacuation procedures, including their responsibilities and the emergency evacuation assembly point. All fire safety activities undertaken by the organization are recorded and reviewed to identify gaps in training, knowledge, equipment, or processes. Fire activities include, but are not limited to, fire safety training, drills and exercises, records of maintenance and inventories of equipment kept. Where relevant, all staff, students and volunteers familiarize themselves with techniques to minimize physical and emotional harm from other people.

Response: When a disaster or emergency arises, the primary aim of the response is to ensure the safety of all people on the premises, preserve life and protect property. NFHCS initiates recovery and aims to restore operations as quickly as possible. The availability of critical incident debriefing is an essential component of the organization's approach to emergency management. When required, supportive counselling is provided to consumers, staff, volunteers, students, and board members who are affected by an emergency or critical incident within two hours of the event (for defusing and mobilization) and then within 48 to 72 hours (for critical incident debriefing).

Emergency and Critical Incident Procedures: Staff, contractors and consumers who experience a critical incident related to their involvement with NFHCS should immediately be informed and documented.
A Critical Incident Report:

- is to be completed by the staff member involved in the incident or notification of the incident.
- is to contain as much information as possible and indicate the people directly involved in the incident.

The staff member who receives the report will ensure that the person(s) identified in the critical incident receives all appropriate support. They are to contact emergency services were required and must contact the incident manager immediately. The incident manager in conjunction with the Executive Director will assess the Critical Incident and implement a plan of action to follow up the Critical Incident.

Where required, a meeting will be organized to determine issues and responsibilities
relating to:

- Assessing risks and response actions
- Liaison with emergency and other services
- Contact with the affected person's relatives and other supports
- Liaison with other organizations
- Counselling and supporting staff, board members, volunteers, students, and consumers not directly involved in, but affected by, the incident.
- Media management (if required)

Where appropriate NFHCS may be required to provide support to the family in the form of:

- hiring interpreters
- making arrangements for hospital/funeral/memorial service/repatriation
- obtaining a death certificate
- assisting with personal items and affairs including insurance issues

NFHCS will conduct a review of actions arising from the above meeting to ensure:

- Follow up such as de-briefing, counselling and prevention strategies have been completed.
- Relevant people have been informed of all outcomes from the incident
- A recommendation as to the response to the critical incident is documented and included in the quality improvement cycle
- Further follow up required is documented and responsibilities allocated to appropriate staff.

Critical Incident Debriefing (CID): Critical Incident Debriefing (CID) will occur within 48 - 72 hours after the incident. Debriefing may include individual and group counselling, where the aim is to:

- Decrease feelings of isolation

- Provide people affected by the incident with a facilitated session to assist them to normalize their thoughts and feelings. Groups assist people to explore their differing perspectives of the incident and share their similar thoughts and feelings. There will usually be an initial counselling session, followed up with one or more debriefing sessions. Initial counselling will occur as soon as possible after the incident, preferably immediately or within a few hours. Depending on the type or severity of the critical incident, initial defusing may include:
- A short factual statement about what is known about the incident, the possible effects on those involved, what is being done for them and what is going to happen in the future, e.g., planned debriefing sessions.
- Information on acute stress response (what is happening to people now) and how people can care for themselves.
- See Information Handout – Traumatic Events
- An arrangement for a structured debriefing session within 48-72 hours.

The provision of different levels of service for those differently affected - Referrals to various resources including counsellors NFHCS will maintain confidentiality to ensure that:

- Only a record of when and where a debriefing took place will be kept; and
- No information will be released without the agreement of the individual or group.

Evacuation

- In the event of an alert to evacuate - either verbal, automatic alarm or manual alarm and the threat is not immediate, all consumers, staff, Board members, students, volunteers, and visitors:
- Proceed along designated routes to the designated assembly area(s)
- Ensure assistance is provided to people with disabilities and/or special needs
- Staff to collect visitor sign-in and staff attendance registers and direct people to assembly point
- Check attendance at assembly area against the attendance registers. Mental Health Coordinating Council www.mhcc.org.au Psychological Injury Management Guide 2012
- Remain at the assembly area until advised by the incident manager and/or emergency personnel that it Is safe to return to premises.

In the event of an alert to evacuate - either verbal, automatic alarm or manual alarm and the threat is immediate, all consumers, staff, Board members, students, volunteers, and visitors:

- Proceed along designated routes to the designated assembly area(s)
- Ensure assistance is provided to people with disabilities and/or special needs
- Management team member to collect visitor sign-in and staff attendance registers and direct people to the assembly point.
- Management team member to check attendance at assembly area against the attendance registers.
- Remain at the assembly area until advised by the Staff and/or emergency personnel that it is safe to return to premises.

Additional guidelines for threat of fire: In the event of a fire threat and if it is safe to do so, close all doors and windows and turn off power supply before leaving the premises.

Additional guidelines for bomb threat: In the event of a bomb threat and the threat is not immediate, open all doors and windows before leaving the premises.

Fire: In the event of a fire:

- Trigger the fire alarm
- Contact fire emergency services
- Alert a senior staff member
- Evacuate people from the immediate area of the fire behind a rated fire door or outside the building
- Fight the fire with existing equipment if safe to do so

Bomb Threat: Mental Health Coordinating Council www.mhcc.org.au Psychological Injury Management Guide 2012

In the event of a bomb threat via phone call; Remain calm. Record as much information as possible from the caller using questions and observations including:

- What type of bomb is it?
- How will it go off?
- What does it look like?
- When has it set to go off?
- Where is it?
- When was it put there?
- Who put it there?
- Why was it put there?
- Will it explode or will something be released?

- If a substance is released, what is it? How much is there? How will it be released?
- Observations about the caller: gender, age, accent?
- Any background noises?

Contact police who can assist in determining if evacuation is required.

- If instructed, evacuate consumers, staff, Board members, students, volunteers, and visitors as for the above evacuation procedures
- Notify CEO/Manager and/or other senior staff

In the event of a letter bomb (threat via postal mail):

Do Not disturb, move, or touch the package. If Possible, Contact police who can assist in determining if evacuation is required.

- If instructed, evacuate consumers, staff, contractors, volunteers, and visitors as for as for the above evacuation procedures.
- Notify CEO/Manager and/or Other Senior Staff

In the event of a suspicious item of postal mail arriving to the premises: Do not disturb, move, or touch the package. If possible, contact police who can assist in determining if evacuation is required

- If you have touched the article wash your hands if it is possible, within the work area
- Inform others present of what has occurred and advise them to stay in the Work area
- Prevent others from entering the work area
- Do not attempt to clean up spilt material or brush it off your clothing
- If instructed, evacuate consumers, staff, Board members, students, volunteers, and visitors as for the above evacuation procedures
- Notify CEO/Manager and/or other senior staff

In the event of a hold-up situation:

- Assume the offender is armed and that any firearms are loaded
- Comply with instructions given by the offender, doing no more or less than what you are told to do, and answer all questions asked
- Do not attempt to disarm or apprehend the offender

Mental Health Coordinating Council www.mhcc.org.au Psychological Injury Management Guide 2012.

Take mental notes of details about the offender and any items that are touched by the offender

Immediately after the incident:

- Lock access doors to secure the area and prevent people from approaching
- Notify the police immediately
- Notify CEO/Manager and/or other senior staff
- Attend to the post-incident needs of consumers, staff, Board members, volunteers, contractors, and visitors affected by the incident.

Earthquake: In the event of an earthquake:

If you are indoors:

- Remain indoors and seek shelter under strongly constructed tables, desks, or door frames
- Keep away from windows, fixtures, furniture, and items that may become unstable
- Evacuate the premises if it is safe to do so.

If you are outdoors:

- Move quickly away from buildings, electrical structures, and flammable products
- Proceed to designated assembly area if safe to do so.

After the earthquake:

- Check attendance at assembly area against the attendance registers
- Respond to injured people
- Check for gas leaks, power failure and any other hazard
- Turn off electricity, gas, and water if it is safe to do so
- Prevent entry to premises if unsafe
- Contact and liaise with emergency services if required
- Notify CEO/Manager and/or other senior staff.

In the event of a flood:

- Do not enter the flood waters
- Eliminate potential electrical hazards
- Place high value equipment and records away from impending floodwaters if it is safe to do so
- Stay in a safe location while it continues to offer protection
- Evacuate consumers, staff, Board members, students, volunteers, and visitors as for the above evacuation procedures.
- Contact and liaise with emergency services if required

- Notify CEO/Manager and/or other senior staff.

State Emergency Centre

- Drug Rehabilitation Counselling
- National Association of Loss & Grief
- CenturyLink
- CEO

References + Resources

- Internal
- Critical Incident Report Form
- Emergency Situation Checklist
- Work Health and Safety Policy
- Risk Management Policy

External Legislation

- Work Health and Safety Act 2011 (Commonwealth)
- Model Work Health and Safety Regulations 2011 (Cth)
- Workers Compensation Act 1987 (NSW)
- Workplace Injury Management and Workers Compensation Act 1998 (NSW)
- Workers Compensation Regulation 2010 (NSW)

Resources:

- Workcover NSW 2004, The Community Services Safety Pack: A Guide to
- Occupational Health & Safety. Gosford, NSW.
- Workcover Authority of NSW website:
- www.workcover.nsw.gov.au
- This policy is based on the NADA Disaster and Emergency Management Policy.
- http://www.nada.org.au/index.php?option=com_content&task=view&id=236&Itemid=44

5.12 Reporting of Unusual Incidents Plan

Implemented: October 2016 **Revised:**

Background: In accordance with Chapter 6400 regulations, the primary goal of this emergency response plan (relating to incident management) is to protect the health, safety, and rights of Not Forgotten individuals receiving services when an incident has been discovered or occurred.

An unusual incident is abuse or suspected abuse of an individual; injury, trauma or illness of an individual requiring inpatient hospitalization; suicide attempt by an individual; violation or alleged violation of an individual's rights; an individual who is missing for more than 24 hours or who could be in jeopardy if missing at all; alleged misuse or misuse of individual funds or property; outbreak of a serious communicable disease as defined in 28 Pa. Code § 27.2 (relating to specific identified reportable diseases, infections and conditions); an incident requiring the services of a fire department or law enforcement agency; and any condition that results in closure of the home for more than 1 day.

Unusual Incident Reporting Process: As a caregiver, you are responsible for reporting those situations that meet the criteria of a reportable incident that occur when you are present with an individual.

You must verbally notify not forgotten staff of any reportable incident as soon as possible after its occurrence.

We, in turn, must report the following incidents in HCSIS **within 24 hours** of the discovery or occurrence of the incident:

- Physical Abuse
- Psychological Abuse
- Sexual Abuse
- Verbal Abuse
- Improper or Unauthorized Use of Restraint
- Death
- Disease Reportable to the Department of Health
- Emergency Closure
- Emergency Room Visit
- Fire
- Hospitalization
- Individual-to-Individual Abuse

- Injury Requiring Treatment Beyond First Aid
- Law Enforcement Activity
- Missing Person
- Misuse of Funds
- Neglect
- Psychiatric Hospitalization
- Rights Violation
- Suicide Attempt
- Crisis Event
- Restraint

Incidents to be reported within 72 hours after the discovery or occurrence of an incident:

- Medication Error
- Restraints (UNLESS THE RESTRAINT FALLS INTO THE DEFINITION OF "ABUSE"- 51.3)

Not Forgotten will keep written policies and procedures on the prevention, reporting, investigation, and management of unusual incidents in all NF locations.

The home shall orally notify the county intellectual disability program of the county in which the home is located, the funding agency and the appropriate regional office of the Department, within 24 hours after abuse or suspected abuse of an individual or an incident requiring the services of a fire department or law enforcement agency occurs.

The home shall initiate an investigation of the unusual incident and complete and send copies of an unusual incident report on a form specified by the Department to the county intellectual disability program of the county in which the home is located, the funding agency and the appropriate regional office of the Department, within 72 hours after an unusual incident occurs.

The home shall send a copy of the final unusual incident report to the county intellectual disability program of the county in which the home is located, the funding agency and the appropriate regional office of the Department at the conclusion of the investigation.

A copy of unusual incident reports relating to an individual shall be kept in the individual's record.

A copy of unusual incident reports relating to the home itself, such as those requiring the services of a fire department, shall be kept.

The individual's family or guardian shall be immediately notified in the event of an unusual incident relating to the individual, if appropriate.

Not Forgotten shall electronically notify HCSIS within 24 hours after abuse, or suspected abuse, of an individual or an incident requiring the services of a fire department or law enforcement agency.

Not Forgotten shall initiate an investigation of the unusual incident and complete and send copies of an unusual incident report in HCSIS within 72 hours after an unusual incident occurs.

In the event that HCSIS is unavailable, Not Forgotten will fax or scan the incident report. When HCSIS becomes available, NF staff will immediately enter the incident into HCSIS.

Not Forgotten shall send a copy of the final unusual incident report to the Administrative Entity, Office of Developmental Programs, and the Department of Human Services/ IDD at the conclusion of the investigation.

Not Forgotten will keep a copy of unusual incident reports, relating to an individual, in the individual's record.

Not Forgotten will notify the individual's family or guardian immediately in the event of an unusual incident relating to the individual, if appropriate.

- Not Forgotten shall provide a detailed description in HCSIS of the actions taken in response to an incident to include:
- The prompt action to protect the health and welfare of the individual.
- The results of the incident investigation.
- Corrective actions taken.
- The staff that is responsible for implementing the actions.
- The date the actions were implemented or are planned.
- Specific information regarding disciplinary actions taken with staff to assure the health and welfare of individuals.

Not Forgotten shall review and analyze incidents at least quarterly or more frequently as required by the Department. This quarterly review must contain information on the incident target.

Not Forgotten shall identify and implement actions to assure an individual is safeguarded from risk so the number of preventable incidents is reduced.

Training: Not Forgotten shall assure that its staff receives annual incident management training on preventing, recognizing, reporting, and responding to incidents and assuring an individual is safe as required.

Not Forgotten shall provide additional training to the individual and staff as needed based on the incident circumstances and respond to actions designated by the Department or the Department's designee as a result of the management review of an incident.

Not Forgotten will keep copies of all emergency response plans in staff handbooks and operation manuals, and will post copies on staff bulletin boards

5.13 Infections Control

Implemented: September 2020 **Revised:**

Background: Once an infection has been identified, the Nursing Coordinator must be notified to classify the infection. The nurse will then update the administrative team of the situation, and the following precautions will be implemented:

Droplet precautions/Isolation are most common with the following infections:

- meningitis
- pneumonia
- influenza
- Mumps
- Parvovirus
- Streptococcal
- COVID-19

Instructions:

- Wash hands before and after care of an infected resident
- Wear gloves while rendering care to an infected resident
- Wear a mask while rendering care to an infected resident and while being less than 6 feet away of the resident
- Keep infected resident at least 6 feet of other residents or provide them with masks also
- Wipe down and disinfect all areas occupied, touched, or used by an infected resident. Restrooms, especially must be cleaned and disinfected after each use by an infected person
- If the infection is severe to the point the resident must be isolated, then in addition to the above-mentioned measures, the resident must be quarantined to their bedrooms
- While in quarantine, all meals will be provided in their rooms using disposable dinnerware
- All disposable dinnerware must be deposed of immediately after use
- The resident must remain in quarantine until deemed by a physician the infection is gone, or until the resident is no longer a risk to others
- If it is determined that others are at risk by an infected resident remaining in the dwelling, then we will proceed with evacuation of the infected resident or their roommates, whichever is determined to be most beneficial to all involved (See Evacuation Policy).

Contact Precaution/Isolation are most common with the following infections:

- Vancomycin Resistant Enterococcus (VRE)
- Methicillin-Resistant Staphylococcus Aureus (MRSA)
- C. difficile (Cdiff)
- Open Wounds

Instructions: With these infections, you would take the same measures as you would with the droplet precautions but adding the use of isolation gowns and protective eye wear.

Protective gear must always be worn when coming in contact with an infected resident, or their belongings.

All disposables should be placed in a bag, tied up completely, and removed from the home as soon as possible.

Transportation:

- The following guidelines are to be followed when transporting individuals from settings where exposure to an infectious disease may have occurred
- Staff and individual will wear gloves and facemask during the transport
- The vehicle must be disinfected prior to the next use. This includes wiping down door handles, window controls, seatbelts, headrests, steering wheel, gearshift, and any other potentially contaminated areas

In- house:

- Staff and individual must wash their hands for at least 20 seconds.
- Individual will have their temperature taken upon return to the house.
- Individuals will be encouraged to self-isolate in their room, if individual is unable or unwilling to self- isolate, they must:
- Wear a face mask while in common areas and/or maintain social distancing at a minimum separation of 6 feet.
- Limit interaction with staff, visitors, and roommate.

Signs of illness: If the individual shows sign of illness/fever quarantine precautions will be initiated. These may include but are not limited to:

- Isolation in their room
- Temperature checks on at least each shift and as needed
- Limited interaction with staff
- Meals served in their room utilizing disposable dinnerware
- Staff use of PPE
- Other practices as outlined in the infection control procedure

Lifting of isolation precautions: Individual and staff will maintain isolation protocols until:

- Individual is symptom free for 72 hours.
- Individual is cleared by a physician.
- Specific physician orders will over-ride Not Forgotten policies in regard to infection control/ isolation procedures. Additional precautions may be instituted on a case-to-case basis. Any changed to the above-mentioned guidelines will be at the discretion of the nurse and/or physician.

COVID-19: NFHCS will take proactive steps to protect the workplace in the event of an infectious disease outbreak. It is the goal of NFHCS during any such time period to strive to operate effectively and ensure that all essential services are continuously provided and that employees are safe within the workplace.

NFHCS is committed to providing authoritative information about the nature and spread of infectious diseases, including symptoms and signs to watch for, as well as required steps to be taken in the event of an illness or outbreak.

Preventing the Spread of Infection in the Workplace: NFHCS will ensure a clean workplace, including the regular cleaning of objects and areas that are frequently used, such as bathrooms, breakrooms, conference rooms, door handles and railings. A committee will be designated to monitor and coordinate events around an infectious disease outbreak, as well as to create work rules that could be implemented to promote safety through infection control.

We ask all employees to cooperate in taking steps to reduce the transmission of infectious disease in the workplace. The best strategy remains the most obvious—frequent hand washing with warm, soapy water; covering your mouth whenever you sneeze or cough; and discarding used tissues in wastebaskets. We will also install alcohol-based hand sanitizers throughout the workplace and in common areas.

Unless otherwise notified, our normal attendance and leave policies will remain in place. Individuals who believe they may face particular challenges reporting to work during an infectious disease outbreak should take steps to develop any necessary contingency plans. For example, employees might want to arrange for alternative sources of childcare should schools close and/or speak with supervisors about the potential to work from home temporarily or on an alternative work schedule.

Temperature Screening: All employees will have their temperature taken upon reporting to work. Employees should report to [location] upon arrival at work and prior to entering any other areas of NFHCS property.

Each employee will be screened privately using a touchless forehead/ temporal artery thermometer. The employee's temperature will be documented, and the record will be maintained as a private medical record. An employee who has a fever at or above 100 degrees Fahrenheit will be sent home.

Time spent waiting for the health screening should be recorded as time worked for nonexempt employees.

Limiting Travel: All nonessential travel should be avoided until further notice. Employees who travel as an essential part of their job should consult with management on appropriate actions. Business-related travel outside the United States will not be authorized until further notice.

Employees should avoid crowded public transportation when possible. Alternative scheduling options, ride-share resources and/or parking assistance will be provided on a case-by-case basis. Contact human resources for more information.

Telecommuting: Telework requests will be handled on a case-by-case basis. While not all positions will be eligible, all requests for temporary telecommuting should be submitted to your manager for consideration.

Staying Home: Many times, with the best of intentions, employees report to work even though they feel ill. We provide paid sick time and other benefits to compensate employees who are unable to work due to illness.

During an infectious disease outbreak, it is critical that employees do not report to work while they are ill and/or experiencing the following symptoms: [Enter as warranted. Examples include fever, cough, sore throat, runny or stuffy nose, body aches, headache, chills, and fatigue]. Currently, the Centers for Disease Control and Prevention recommends that people with an infectious illness such as the flu remain at home until at least 24 hours after they are free of fever (100 degrees F or 37.8 degrees C) or signs of a fever without the use of fever-reducing medications. Employees who report to work ill will be sent home in accordance with these health guidelines.

Requests for Medical Information and/or Documentation: If you are out sick or show symptoms of being ill, it may become necessary to request information from you and/or your health care provider. In general, we would request medical information to confirm your need to be absent, to show whether and how an absence relates to the infection, and to know that it is appropriate for you to

return to work. As always, we expect and appreciate your cooperation if and when medical information is sought.

Confidentiality of Medical Information: Our policy is to treat any medical information as a confidential medical record. In furtherance of this policy, any disclosure of medical information is in limited circumstances with supervisors, managers, first aid and safety personnel, and government officials as required by law.

Social Distancing Guidelines for Workplace Infectious Disease Outbreaks:
In the event of an infectious disease outbreak, NFHCS may implement these social distancing guidelines to minimize the spread of the disease among the staff.

During the workday, employees are requested to:

- Avoid meeting people face-to-face. Employees are encouraged to use the telephone, online conferencing, e-mail, or instant messaging to conduct business as much as possible, even when participants are in the same building.
- If a face-to-face meeting is unavoidable, minimize the meeting time, choose a large meeting room, and sit at least one yard from each other if possible; avoid person-to-person contact such as shaking hands.
- Avoid any unnecessary travel and cancel or postpone nonessential meetings, gatherings, workshops, and training sessions.
- Do not congregate in work rooms, pantries, copier rooms or other areas where people socialize.
- Bring lunch and eat at your desk or away from others (avoid lunchrooms and crowded restaurants).
- Encourage members and others to request information and orders via phone and e-mail in order to minimize person-to-person contact. Have the orders, materials, and information ready for fast pick-up or delivery.

Outside activities: Employees might be encouraged to the extent possible to:

- Avoid public transportation (walk, cycle, drive a car) or go early or late to avoid rush-hour crowding on public transportation.
- Avoid recreational or other leisure classes, meetings, activities, etc., where employees might come into contact with contagious people.

5.14 Medication Error

Implemented: October 2017 **Revised:** September 2021

Background: Any practice that does not comply with the "Rights of Medication Administration" as described in the ODP Medication Administration Training Course. A medication error occurring during a time when an unpaid caregiver is responsible for the administration of medication is not reportable. An individual's refusal to take medication is not reportable as a medication error.

- **Wrong Medication** – Individual is given a medication that the individual is not prescribed or has been discontinued, or the individual was given medication that was supposed to be given for another reason.
- **Wrong Dose** – Individual is given too much or too little medication during a scheduled administration.
- **Wrong Time** – Individual is given medication too early or too late as defined by the range of allowable administration time.
- **Wrong Route** – Individual is given medication in a different way from the one specified on the label.
- **Wrong Form** – Individual is given medication in a different type from the one prescribed.
- **Wrong Position** – Individual is not placed correctly to receive the medication.
- **Wrong Technique/Method** – Medication is prepared for administration improperly.
- **Omission** – An administration of medication fails to occur.
- **Wrong Person**- An individual is given another individual's medication.

Prevention: To prevent recurring medication errors and to maintain the safety for the residents:

- When medication errors are made staff are to immediately report the error to their supervisor upon discovery
- The staff who discovers the medication error is to complete the medication error report form
- If the same staff makes a total of 3 medication errors in a 30-day time frame, he or she will not be permitted to administer medications until there are 2 additional medication observations completed, and the practicum observer/ nurse deems it safe for the staff to return to administering medications
- Additional observations may be required, if needed
- If the same staff makes a total of 6 medication errors in a 90-day time frame, he or she will be required to retake the medication administration class before administering medications

5.15 Property Damage

Implemented: October 2018 **Revised:**

Reference/Source: Pa code Chapter 51.27 Misuse and abuse of funds & Damage of Participants Property, Chapter 51.153, PA Code Chapter 1101, QA & I Quality Assessment Improvement 06/22/18

Persons Affected: Individuals, Families (if applicable), Guardians/ the department or the department designee, and staff of Not Forgotten Home & Community Services.

Our Purpose: Our purpose is to inform the affected of Not Forgotten Home & Community Services, of our Lost & Damage Property Policy in accordance with PA. Code Chapter 51 and Chapter 6400 Regulations. Our procedures will ensure the replacement of an Individual's lost or damaged property.

Definitions:

- **NFHCS:** Not Forgotten Home & Community Services
- **Department:** The Department of Health & Human Services of the Commonwealth
- **Policy/Procedures Objectives:** NFHCS commitment to replace the property that was lost or damaged or pay the Individual the replacement value for the lost or damaged item.

Policy/NFHCS Responsibilities:

- In the event of an individual's property becoming lost or damage. NFHCS will either replace or pay the individual the replacement value for the lost or damaged item. If confirmed by NFHCS, Department or the Department's designee. Through a review of the circumstances that an individual's personal property was lost or damaged by NFHCS while providing an HCBS to our individual.
- Audit and Review Compliance
- NFHCS records and invoices may be reviewed, and NFHCS may be required to provide a written explanation of billing practices during an audit, fiscal review, or provider monitoring.
- If the Department's audit, fiscal review, or provider monitoring (QA& I) indicates that NFHCS has been billing for HCBS that are inconsistent with Chapter 51 regulations, unnecessary or inappropriate to an individual's needs or contrary to the individual's ISP, the Department will suspend payment for not more than 120 days pending the Department's review of billing and HCBS.

- In the event of a suspension of payments, the department will notify NFHCS in writing.

Sanctions: In addition to sanctions provided in chapter 51, 51.153. (Sanctions). NFHCS must also adhere to:

- PA Code Chapter 1101 General Provisions Section 1101.74. Provider fraud.
- 1101.75. Provider prohibited acts.
- 1101.76. Criminal penalties.
- 1101.77. Enforcement actions by the Department.

Staff Resources: 55 Pa. Code Chapter 51 Section 51.27(e)

- 51.153.
- Provider fraud.
- Provider prohibited acts.
- Criminal penalties.
- Enforcement actions by the Department.

5.16 Quality Management

Implemented: December 2015 **Revised:** October 2016; September 2018; September 2021

Reference/Source:

- 55 Pa Chapter 51. 51.13(I)(j) ,51.25 (d)(e)(c),
- ODP informational Memo-107-12
- Chapter 51 Regulation implementation instructions for Providers, Including SCO on QM Plans.
- ODP Information Memo 038-15 Implementation Instructions for Providers including SCO on Quality Management Plans, ODP Mission, Vision and Values.
- ODP Quality Management Action Plan.QA& I 06/22/18.
- Chapter 6100.45, ODP Bulletin 00-17-01 Quality management strategy of the ODP, Quality assessment & improvement 2019.
- NFHCS Grievance Policy.

Persons Affected: Individuals, Families, Committee Members, Board Members, Contractors, and unpaid volunteers OF NOT Forgotten Home & Community Services.

Our Purpose: Our purpose is to inform the affected of Not Forgotten Home & Community Services, of our quality management plan, which outlines goals & performance strategies that ensure program compliance, the improvement of quality of care and safeguarding the health and welfare of the individuals we serve.

Definitions:

- **NFHCS**: Not Forgotten Home & Community Services
- **Department**: The Department of Human Services of the Commonwealth.
- **RIQ Committee**: Members of the Risk, Incident, Quality and Safety Management Committee.
- **ODP**: Office of Developmental Programs
- **QMP**: Quality Management Plan
- **ED**: Executive Director
- **DOA**: Director of Administration

Policy Objectives:

- What is a QMP?
- NFHCS is required to develop and implement a quality management plan.
- The quality management plan must include the following:
    - Performance measures
    - Performance improvement targets and strategies

  - Methods to obtain feedback relating to personal experience from individuals, staff persons and other affected parties
  - Data sources used to measure performance
  - Roles and responsibilities of our staff persons related to the practice of Quality Management
- NFHCS compose, analyze, and revise, our Quality Management plan every **3 years**

Description: QMP: A written document describing how NFHCS will measure and remediate our performance to provide quality services and comply with the approved applicable waiver, including approved waiver amendments, and the Chapter 51.

Pursuit to Chapter 51, NFHCS must comply with the development of a QM plan.

- Policy for development and implementation of the QM Plan.
- NFHCS has developed a QMP. Our plan must meet the criteria developed by the department.
- Our QMP must include a continuous process which include but not limited to:
- A cycle of assessment
- Analysis
- Actions for improvement
- Quarterly Performance review data and available reports in HCSIS
- Our compliance with the requirements in 42 CFR 441.302 (relating to state assurances).
- Incident management data, including data on the incident target
- Results of satisfaction surveys and reviews of grievances
- Reflect ODP Mission, Vision & Values
- Our Executive Director is responsible for the overall development, implementation, and remediation of the plan
- Our QM plan must be updated at least every 2-3 years. Or more frequently if the reviews & results from our Provider Monitoring (QA&I) & SCO monitoring indicate noncompliance.
- NFHCS must submit a copy of our QMP and verification that we have reviewed performance data to the Department or the Department's designee upon request.
- QMP must be documented on a QM Action Plan Work Sheet
- NFHCS will maintain our Excel checklist tool and Hard copy tools. With performance data & processes used to select opportunities and improve the quality of our care.

- Staff will receive annual training on our QMP. Including updates, amendments, or revisions.
- Assigned RIQ staff must compile and complete their findings. Failure to comply with the required documentation will result in disciplinary actions.
- Our QM plan will be updated to reflect feedback from submitted satisfaction surveys.
- When submitted surveys have been evaluated. And updated in the QM plan Checklist. Negative feedback will be remediated with a corrective action plan. The Executive Director will resubmit surveys at a later date to
- reflect the corrective action measures.

QM Policy: Pursuit to Chapter 6100.45. NFHCS must develop and implement a Quality Management Plan.

The QMP is required to include the following:

- Our Performance Measures
- Performance improvement targets and strategies
- Methods to obtain feedback relating to personal experience from our individuals, staff persons and other affected parties
- List of data sources used to measure performance
- Roles and responsibilities of our staff persons related to the practice of quality management
- NFHCS must analyze and revise our QMP every 3 years
- Our Executive Director will have the overall responsibility for QMP implementation. Including revisions, documentation and plans to correct non-compliance

Home and Community Based Services Quality Framework: ODP applies the Home and Community Based Services (HCBS) Quality Framework developed by the Centers for Medicare and Medicaid Services (CMS) across its programs. This Quality Framework establishes Focus Areas with outcomes CMS expects states to achieve in order to meet CMS Waiver Assurances.

The HCBS Quality Framework places emphasis on desired outcomes as follows:

Focus	**Desired Outcomes**
Participant Access	Individuals have timely access to needed services and supports.
Participant-Centered Service Planning and Delivery	Services and supports are planned and effectively implemented in accordance with each participant's unique needs, expressed preferences and decisions concerning his/her

life.

Provider Capacity and Capabilities	A network of qualified, competent providers is developed and maintained.
Participant Safeguards	Individuals are safe and secure in their homes and communities, taking into account their informed and expressed choices. Individuals are supported to achieve and maintain optimal health.

Focus	**Desired Outcomes**
Participant Rights and Responsibilities	Individuals are supported to exercise their rights and accept personal responsibilities.
Participant Outcomes and Satisfaction	Individuals are satisfied with services and achieve desired outcomes.
System Performance: Quality Management Human Resources Management Financial Management Information Management	Organizational performance is continuously measured, evaluated, and improved. Individuals and other stakeholders are engaged in designing and improving services. A stable, knowledgeable, and effective workforce is developed and maintained. Fiscal practices are state-of-the-art, accurate, and efficient. Information systems are state-of-the-art, cost-effective, efficient, and support data-based management.

Program design sets the stage for achieving these desired outcomes by establishing standards in areas such as service delivery, provider qualifications, assessment, service planning, safeguards, and monitoring of participant health and welfare. Within the HCBS Framework, **Quality Management** (QM) encompasses three functions:

Discovery	**Remediation**	**Continuous Improvement**
Collecting data and direct participant experiences to assess the ongoing implementation of the program, identifying	Taking action to remedy specific problems or concerns that arise.	Using data and quality information to take actions that lead to continuous improvement.

strengths and opportunities
for improvement.

Responsibility: Ultimate responsibility for ODP's QM Strategy rests with the Deputy Secretary. Responsibility is delegated to ODP's Executive Leadership, Program Bureau Oversight Groups, and local oversight groups as appropriate to each Bureau and/or program.

Each layer of ODP's QM Structure-Executive Leadership, each Program Bureau, Regional Offices, Administrative Entities/County MH/ID Programs, and Providers (including Waiver and Non-Waiver Providers, State and Private ICFs/ID) is responsible to carry out the following activities, in consideration of its major functions and contributions to the effectiveness of the service system:

- Establish and/or align with ODP's mission, vision, values, quality framework, and priorities.
- Determine overall QM structure and process.
- Identify persons responsible for overall management of the QM function.
- Oversee and monitor all processes related to the entity's QM Strategy.
- Foster development of a comprehensive inventory of performance measures.
- Evaluate the data sources used to measure system performance and recommend enhancements.
- Approve performance measures that will be assessed.
- Based on review of performance trends, patterns, and outcomes, establish quality improvement priorities.
- Review and approve QM Plans.
- Ensure waiver assurances and requirements are met.
- Ensure remediation activities are completed and evaluate their effectiveness.
- Collaborate with system partners in improving local services and supports.
- Identify practices to be adopted, modified, or eliminated.
- Report progress and recommendations to Executive Leadership and/or the respective quality oversight body.
- Recommend training and technical assistance that will embed desired policies and practices.
- Recommend changes to policies, procedures and practices, waivers, and regulations.
- Review and evaluate the effectiveness of the established QM roles and responsibilities, structure, and process, and implement changes when necessary.
- Ensure QM information is communicated internally and externally.

Quality Improvement (QI) Councils: QI Councils engage stakeholders to review and discuss findings and recommendations for improvement based on the analysis of data. QI Councils then establish QM priorities, identify, and adopt

improvement strategies and choose performance measures to evaluate the results of implemented change.

ODP engages stakeholders through the ISAC. ISAC members include individuals with an intellectual disability and/or autism, families, representatives from each of the state associations committed to supporting individuals with an intellectual disability and/or autism, advocates, county government, providers, supports coordination agencies, the Developmental Disabilities Council, Disability Rights Pennsylvania, and the Temple University Institute on Disabilities. Administrative Entities and providers engage stakeholders in their QM structure and process, including individuals with an intellectual disability and/or autism, families, advocates, county government, providers, supports coordination agencies, local IM4Q teams, and Health Care Quality Units (HCQUs).

Performance Measurement and Improvement: ODP's QM Strategy involves a planned, systematic, and organization-wide approach to data collection and analysis, performance measurement, and continuous improvement. Quality is built into the processes of daily work, and has four interrelated aspects:

- Systemically collecting, analyzing, and using data to make management decisions.
- Complying with regulation and ODP policy.
- Designing and implementing initiatives; and
- Monitoring results for sustainability or need for improvement.

ODP uses the Plan-Do-Check-Act (POCA) Model to implement system improvement.

Plan-Do-Check-Act Model:

- **Plan** how improvement will be accomplished. Write an action/work plan that specifies goals, measurable objectives, action steps, responsible person(s), and evaluation for the targets met.
- **Do** Implement the improvement plan, including education about the process change.
- **Check** the effect of improvement steps by collecting data; analyze data and summarize lessons learned. Determine the success or failure of the plan.
- **Act** to hold the gains or to continue the improvement process. Incorporate the plan and/or solution into practice. Inform and educate all involved. Continue to monitor and evaluate progress.

QM Planning: Using data from Pennsylvania's Independent Monitoring for Quality (IM4Q) along with national data sets, authorization and claims data and other sources, the IM4Q Steering Committee will develop and submit to the ISAC on an annual basis a summary of findings and recommendations for improvement. National data sets include National Core Indicators (NCI), State of the States in

Developmental Disabilities, the Institute for Community Inclusion (ICI) State Data Information on Employment and People with Disabilities, the Residential Information System Project (RISP), and the Supporting Individuals and Families Information System (FISP).

ODP, in conjunction with the ISAC, will review and discuss the summary of findings and recommendations submitted by the IM4Q Steering Committee, determine QM priorities, identify, and adopt improvement strategies, and choose performance measures to evaluate the results of implemented change. ODP will publish QM priorities established in conjunction with the ISAC annually.

Quality Management Certification Curriculum: To build system capacity and ensure success in applying quality management principles and practices across the system, ODP offers a Quality Management Certification Curriculum to ODP staff and stakeholders. The course consists of four prerequisite QM webcast module's introduction to QM, Using Information and Tools for QM, QM Planning, and Quality Improvement (QI) Teams-followed by in-person training. During face-to-face sessions, participants form groups and simulate the activities of QI Teams as they move through the POCA Cycle for improvement with the support of the Office's QM staff.

The curriculum fosters opportunities for stakeholders to join together to improve outcomes for individuals and families through networking and collaboration in areas prioritized for change and improvement by the ISAC. QI Teams consider data gathered through Pennsylvania's IM4Q Program, NCI, and other data sources. Team members identify baselines and targets, and then develop strategies to support priorities including increasing opportunities for integrated employment, promoting self-direction, supporting families, and enhancing participation in the community.

ODP's Quality Management Director and QM staff are also available to provide training and technical assistance upon request.

OBSOLETE DOCUMENTS: Bulletin 00-10-02, Quality Management Strategy of the Office of Developmental Programs

NFCS QM Policy:

Pursuit to Chapter 6100.45. NFHCS has updated the Quality Management Plan.

The QMP is required to include the following:

- Our Performance Measures
- Performance improvement targets and strategies

- Methods to obtain feedback relating to personal experience from our individuals, staff persons and other affected parties
- List of data sources used to measure performance
- Roles and responsibilities of our staff persons related to the practice of quality management
- NFHCS must analyze and revise our QMP every 3 years
- Our Director of Administration will have the overall responsibility for QMP implementation. Including revisions, documentation and plans to correct non-compliance

Prior Quality Management Focus Areas:

- Department Issued Bulletins
- Incident Management
- Grievance/Satisfaction Surveys
- Services Delivered

Current Quality Management Focus Areas:

- Billing & Utilizations
- Residential Process
- Department Issued Bulletins
- Incident Management
- Training Programs

Fiscal 20/21 Planning:

- **Next QMP Meeting:**
  - Mid- September 2020
  - December 2020
  - March 2021
  - June 2021
- **Admin notification:** Email.
- **Location:** Art Studio.
- **Scriber:** To be assigned.

QUALITY MANAGEMENT STRATEGIC PLAN FISCAL 20/21

Discovery

Problem/Weakness:

Supporting data (please attach document as needed):

Data source:

Plan 

Plan-Do-Check-Act (PDCA)

Focus Area:

Responsible person(s):

Team Members

Specific Goals:

1.
2.
3.

Desired Outcome:

Measurable objectives:

Documentation requirements:

Performance Improvement and Strategies: Tools to be used to evaluate performance measures, that target objectives overtime:

Data:

1.
2.
3.
4.
5.

Actions taken to meet the target objective:

1.
2.
3.
4.

Do 

When was the plan in place?

Data supporting the plan (please attach document as needed)

Check 

Data (Performance Measurements per time frame-PM):

Data	QI- PM	QII- PM	QIII- PM	QIV- PM

Data (Summarize lessons learns):

Data	Lessons learn

Action Items (Deadlines)

Action Item	Responsible Person	Target Date	Status	Completion Date

Supporting Document (please attach document as needed)

Act 

Milestones (Improvement Process, plans put in place)

Milestones	Dates

Provide Supporting Document (please attach document as needed)

Monitor and Evaluate the Progress (After implemented):

Data	QI- PM	QII- PM	QIII- PM	QIV- PM

5.17 Restrictive Interventions

Implemented: October 2016 **Revised:** October 2018

Reference/Source:

- ODP Informational Memo 080-12 – Reporting Unauthorized Restrictive INTERVENTIONS, CONSOLIDATED Waiver November 1,2018,
- Quality Assessment & Improvement (QA&I) 06/22/18, NFHCS Incident Management Policy,
- ODP Announcement 111-17 Guidance for Support Coordinator & Administrative Entities for Transition of Behavior Support for people who receive Residential Services in Consolidated Waiver

Persons Affected: Individuals, Individuals Family, Behavior Specialists, Human Rights Committee Members, and staff of Not Forgotten Home & Community services.

Our Purpose: Our purpose is to inform the affected of Not Forgotten Home & Community Services, of our Restrictive Intervention Policy, in accordance with Informational Memo 080-12 – Reporting Unauthorized Restrictive Interventions.

Definitions:

- **NFHCS**: Not Forgotten Home & Community Services
- **Department**: The Department of Health & Human Services of the Commonwealth
- **ED**: Executive Director
- **HCSIS**: Home and Community Service Information System
- **EIM** : Enterprise Incident Management
- **RI** : Restrictive Intervention
- **ODP** : Office of Développemental Programs

Policy/ Procedures Objectives:

- NFHCS policy that addresses Restrictive Interventions:
- The use of allowable restrictive interventions.
- Prohibited restrictive interventions.
- Reporting misuse of restrictive interventions.
- Behavior Specialist Requirements; Behavioral Emergencies and Crisis

Policy: Restrictive Procedure Practices: A restrictive procedure practice is defined as:

- Limiting an Individuals movement, activity, or function
- Interfering with an Individual's ability to acquire positive reinforcement
- Resulting in the loss of objects or activities that an Individual value

- Require an Individual to engage in a behavior in which, given freedom of choice, the Individual would not engage in

Restrictive Interventions: It is ODP's and NFHCS goal to create a healthy and safe environment that enables people to live and participate fully in their communities. ODP uses a person-centered approach to determine the least intrusive supports needed to provide each Individual the greatest quality of life.

Additional Guidance and Information: Restrictive interventions are more intrusive than other supports, so ODP & NFHCS prohibits some forms of restrictive intervention and strongly discourages the use of allowable restrictive interventions unless NFHCS has first tried less restrictive techniques and resources, appropriate to the behavior that has failed.

NFHCS will not use restrictive procedures as retribution, for the convenience of our staff persons, as a substitute for the program, or in a way that interferes with the individual's developmental program.

NFHCS will only employ restrictive interventions as a last resort.

NFHCS use of Restrictive interventions: NFHCS will always use the least intrusive supports prior to implementing restrictive interventions. For each incident requiring a restrictive intervention, NFHCS will make every attempt to anticipate and de-escalate the behavior using less intrusive methods of intervention.

If, after considering the Individual's desires, uniqueness, and strengths, the Individuals and the support team determine those restrictive interventions are necessary to ensure the health and safety of the Individuals, the team must approve a Restrictive Procedure Plan that describes:

- The restrictive intervention and its implementation
- The team must also incorporate the restrictive intervention
- And a description of its implementation into the Individual Support Plan (ISP)

Use of Permitted Restrictive Interventions: NFHCS and the ODP permit the use of the following interventions:

- Intensive supervision such as 1:1 or 2:1 staffing levels or higher, for purposes of behavior monitoring/intervention/redirection (please note that higher staffing due to medical needs or level of medical care is not defined as a restrictive intervention).

- Environmental restrictions appropriate to diagnosis (for example, limiting access to food for Individuals diagnosed with Prater Willi).
- Anything that a person is legally mandated to follow as part of probation or a court restriction that is superseded by regulation or other ODP policy

Exclusions (Within the following parameters only)
What is exclusion? Exclusion is defined as the removal of an individual from the individual's immediate environment and restricting the individual alone to a room or particular area. If, a staff person remains with the individual, it is not exclusion.

- A room or area used for exclusion shall have an open door or a window for staff observation of the individual
- A room or area used for exclusion must be well lighted and ventilated
- A staff person will continually monitor an individual in exclusion
- A room or area used for exclusion must have at least 40 square feet of indoor floor space, with a minimum ceiling height of 7 feet
- An individual must be permitted to return to routine activity within the time specified in the restrictive procedure plan not to exceed 60 minutes within a 2-hour period
- Exclusion may not be used for an individual more than 4 times within a 24-hour period
- Exclusion is only used when necessary to protect the individual from self-injury or injury to others
- Exclusion is only used when it has been documented those other less restrictive methods have been unsuccessful in protecting the Individual from self-injury or injury to others.

Strictly Prohibited Restrictive Interventions: NFHCS and the ODP strictly prohibit the following types of restrictive interventions:

- Exclusion that falls outside the parameters listed in exclusion section of this policy
- Seclusion (defined as placing an individual in a locked room, is prohibited. A locked room includes a room with any type of door locking device, such as a key lock, spring lock, bolt lock, foot pressure lock or physically holding the door shut)
- The use of aversive conditioning (defined as the application, contingent upon the exhibition of maladaptive behavior, of startling, painful or noxious stimuli)

Reporting Misuse of Restrictive Interventions: Description of a Reportable Restrictive intervention - Utilization of restrictive interventions that the team has

not approved and specified in a Restrictive Procedure Plan, violate an Individual's right. NFHCS will report rights violations in the EIM Incident Management system.

Background: HCSIS Release 6.17, effective September 8, 2012, adds a secondary category of Misused Restrictive Intervention to the primary category of Rights Violation. Effective the date of the HCSIS 6.17 release, NFHCS must report use of unauthorized or prohibited restrictive interventions under the category of rights violation, misused restrictive intervention. While many providers already report misused restrictive interventions as a violation of rights, addition of the secondary category allows NFHCS, AEs/counties, and ODP to track and analyze the frequency of these occurrences.

Incident Reporting of unauthorized Restrictive Interventions: Restrictive Interventions that do not follow ODP Guidelines and NFHCS Policy, will be reported in EIM as an Incident. (Rights Violation) and must be investigated.

Rights Violations: Rights violation resulting from unauthorized restrictive interventions occurs when use of a restrictive intervention:

- Does not follow ODP & NFHCS guidelines
- Is prohibited by ODP
- Deviates from NFHCS restrictive procedure policy or from the Individuals restrictive procedure plan

Behavior Specialist Requirements: (Behavioral and Crisis Emergencies): Behavior Specialist(s) within NFHCS is an internal resource. Behavioral Specialists can be available immediately without the need to request a service plan modification, predict the number of units needed and obtain authorization. This allows NFHCS to take a more proactive approach to teach skills and strategies to our staff, Individuals, and groups of individuals (including Families) to address behavioral concerns before they become crises.

Support Plans: Behavior Support Plans with restrictive procedures must be developed and approved by a Human Rights team prior to implementation. The behavior support plan with restrictive procedures must be reviewed, and revised, if necessary, according to the time frame established by the Human Rights team and must not exceed 6 months.

The service plan with restrictive interventions, including physical restraints, must include:

- The specific behavior to be addressed

- An assessment of the behavior including the suspected reason for the behavior.
- The outcome desired
- Methods for facilitating positive behaviors such as changes in the individual's physical and social environment, changes in the individual's routine, improving communications, recognizing, and treating physical and behavior health conditions, voluntary physical exercise, redirection, praise, modeling, conflict resolution, de-escalation, and teaching skills
- Types of restrictive procedures that may be used and the circumstances under which the procedures may be used
- A target date to achieve the outcome
- The amount of time the restrictive procedure may be applied
- The name of the staff person responsible for monitoring and documenting progress with the individual plan

Questions: Any questions regarding ODP Risk Management can be answered by our regional ODP Risk Management Contact Person:

Region: Western Region	Risk Managers Name: Dalila Byrd	Phone: 412-565-5612

Staff Resources:

- ODP Informational Memo 080-12 – Reporting Unauthorized Restrictive Interventions
- ODP Announcement 111-17 – Guidance for Support Coordinator & Administrative Entities for the Transition of behavioral Support.

5.18 Restrictive Procedures

Implemented: October 2016 **Revised:** September 2020

Background: NFHCS recognizes that individuals sometimes present challenging behaviors that potentially present a danger to themselves or others, and that these behaviors represent an attempt to communicate their needs to others in their environment. NFHCS further recognizes that restrictive procedures may need to be implemented at such times to manage such behaviors until such time as the individual's needs can be understood and more adequately met. When restrictive procedures need to be implemented, all staff is required to abide by the following principles:

- NFHCS believes that we must utilize positive treatment approaches first and foremost, when considering the use of more restrictive procedures.
- Only specially trained staff may apply restrictive procedures, using only procedures authorized in the training protocol.
- Staff must constantly monitor and protect individuals' health and safety during the use of any restrictive procedure, with particular attention given to the individuals' safety when a physical restraint is utilized. This focus must continue immediately after the use of any restrictive procedure.
- Respect for the dignity of each individual is of utmost importance.
- Individuals should participate to the fullest extent possible in all decisions affecting them.
- NFHCS believes that we must recognize the uniqueness of each individual and foster such uniqueness when considering the use of restrictive procedures.
- Positive approaches are characterized by an integration of values, philosophies, and technologies. Its purpose is to support people to grow and develop, to make their own decisions, to achieve their personal goals, to develop relationships, and to enjoy life as a full participating member of the community. It requires are examination of all aspects of life including each individual's living environment, relationships, activities, and personal dreams. As such, the focus is on the whole person, not merely on segments of the individual's life. It requires getting to know each individual; their unique qualities as well as their personal history; listening to each person. Positive approaches assume that all behavior has meaning and that an individual's behavior can be a method to communicate needs and wants. It is focused, not on" fixing a person ", but on offering choices that help each individual live a fulfilling life. It measures success by the satisfaction of the

person being supported. It provides viable alternatives and should be implemented to the fullest extent possible.

- The theory of normalization should be operationalized. Normalization means the standards of life for people with disabilities should be the same as the standards applied to people without disabilities. it means a normal routine of life; to experience the year with holidays and days of personal significance; having an opportunity to undergo normal developmental experiences; that an individual's choices, wishes, and desires should be taken into account and respected.

The principles elaborated in Everyday Lives, Psychiatric Rehabilitation, and Community Programs should be implemented as fully as possible.

TYPES OF RESTRICTIVE PROCEDURES

Exclusion — the removal of an individual from his or her immediate environment and restricting him or her alone to a room or area, during which the individual resists or refuses. If an individual willingly goes to another room after a positive suggestion or prompt, this is not exclusion. If a staff person remains with the individual, it is not exclusion; however, this is still a restrictive procedure if the individual resists or refuses. (Children's Behavioral Health Services may use the term 'time-out" when referencing the use of exclusion.)

- Requirements prior to using exclusion:
    - Informed consent of individual, parent, or legally appointed guardian.
    - Other less restrictive methods have been documented as being unsuccessful in protecting the individual from injuring him/herself or others.
    - The written behavior plan is reviewed and approved by a Committee/Team.
    - All staff have been trained in the implementation of the written behavior plan and the use of exclusion.
- Procedural Guidelines for using exclusion
    - Exclusion cannot be used with an individual more than 4 times within any 24-hour period. If exclusion is used within an Adult Training Facility (2380 regulations), it cannot be used more than 2 times in the same day.
    - The individual in exclusion must be continually monitored by a staff person.

- The individual is permitted to return to routine activity within the time specified in the written behavior plan not to exceed 60 minutes within any 2-hour period
- For individuals under the age of 18, the length of time exclusion is use should be appropriate and be consistent with the least restrictive treatment philosophy.
- The room or area for exclusion has a minimum of 40 square feet and a minimum ceiling height of 7 feet.
- The room or area for exclusion is well lit and ventilated
- The room or area for exclusion has an open door or window for staff observation.

Restitution - The act of recovering funds for the NFHCS or another individual for acts of theft or intentional damage.

- Programs supporting individuals with Developmental disabilities - In order to recover funds for the NFHCS or another individual receiving services for acts of theft or intentional damage, the following conditions must be met:
  - The individual or their legal guardian must consent to each incident of restitution.
  - A written record of consent must be kept on record.
- Programs supporting individuals with Mental Illness including Outpatient and Vocational Services — Individuals are informed of the requirement to pay restitution for acts of theft or intentional damage against the NFHCS or another individual receiving service at intake and upon admission.

Restraints - any physical, chemical, or mechanical intervention used to control acute, episodic behavior that restricts the movement or function of the individual or portion of the individual's body.

Types of Restraints

Physical Restraint - a physical, hands-on technique that lasts thirty (30) seconds or more, used to control acute, episodic behavior that restricts the movement or function of an individual or portion of an individual's body. Prompting, escorting, or guiding an individual who does not resist to assist in the activities of daily living is NOT a physical restraint. Basket holds and Primary Restraint Techniques or "PRT's' (Handle with Care) are examples of physical restraints.

Face down or prone restraints are prohibited in programs serving individuals with developmental disabilities in writing by a physician or designated, trained, and competent qualified behavioral health practitioner.

Face down or prone restraints are prohibited in the children's behavioral health program.

- Programmatic/Planned Physical Restraint (Prohibited physical restraints, as a part of a contingent response to a maladaptive behavior, with a desired effect of reducing that Maladaptive behavior.

Emergency Physical Restraint - defined as physical, hands-on techniques that last for more than 30 seconds and are used on an unplanned, emergency basis to control acute, episodic behavior that restricts the movement or function of an individual or portion of the person's body such as basket holds and Primary Restraint Techniques or PRT (Handle with Care).

Requirements prior to using emergency physical restraints:

- Emergency physical restraints should only be used in an emergency as a safety measure, when there is imminent danger of bodily harm to the individual or others, and only after appropriate, less restrictive methods have been tried and proven to be unsuccessful. (Due to the severity and potential risk of a behavior, the progression of using less restrictive methods may be limited.)
- Contributing environmental factors that may promote maladaptive behavior are identified and actions taken to minimize those factors.
- The procedures and possible alternatives for the use of emergency physical restraint are explained and discussed with each individual, parent, or legally appointed guardian as appropriate, prior to the use of the restraint, when possible. A consent form is signed by NFHCS personnel and the individual receiving services, their parent, or legally appointed guardian at the lime of their intake meeting.
- Other less restrictive methods have been documented as being unsuccessful in protecting the individual from injuring him/herself or others.
- The medical history of the individual receiving services is considered when determining whether restraint can be used without risk to health and safety. This information is obtained at Intake and from medical reports/individual's primary care physician. This information must be documented in the individual's record

- Emergency physical restraint is administered by staff who are trained and competent in the proper techniques of applying and monitoring the restraint. Staff administering the restraint must receive annual training in the proper use of and demonstrate competency in restraint techniques. Staff who are trained and competent to administer a restraint must first have the restraint applied to themselves by a trainer prior to using the restraint with an individual receiving services.
- Only restraint training approved by the Director of Administration of NFHCS can be implemented within NFHCS Programs.
- **CURRENTLY APPROVED RESTRAINT TRAINING PROGRAMS:**
    - Handle with Care
    - Personal Emergency Intervention
    - Crisis Prevention Institute
    - Restraint is never used as a form of coercion, discipline, convenience, or retaliation by personnel in lieu of adequate programming

Procedural Guidelines for using emergency physical restraints:

- Cannot be used to prevent property destruction unless the individual's action is likely to result in injury to self or others.
- Administered in a safe manner and consideration is given to the physical, developmental, and when applicable, abuse history of the individual receiving services.
- Staff monitor the condition of the individual being restrained at all times paying particular attention to individual's breathing capacity. Whenever possible a second staff person will assist with the restraint and monitor the physical condition of the individual being restrained. It is not recommended that staff utilize a restraint while working by themselves. However, in some emergency situations, it is necessary to use a restraint while on single coverage.
- Cannot exceed 30 minutes within any 2-hour period. The 30-minute time is a cumulative time within any 2-hour period.
- MH and outpatient programs only, a restraint can extend to 45 minutes only if the policy or emergency personnel have been contacted and have not arrived and the individual continues to present a danger to themselves or others.
- If the restraint is used 2 times within a 6-month period, a written plan addressing the behaviors which warranted the use of the restraint is required.
- In some programs, it is recommended that law-enforcement is notified prior to the use of a physical restraint. In other programs, law enforcement is not

typically contacted prior to the use of a physical restraint. Staff must check with their site or program regarding protocols to follow in contacting law enforcement i.e., 911, silent panic alert, etc.

- NFHCS facilities can safely and humanely accommodate the practice of using emergency physical restraints. Escorts are taught to staff in the event that an individual is in a location that would not be considered safe for a restraint. Staff will not utilize the restraint in an unsafe location.

Requirements following the use of an emergency physical restraint.

- If an individual receiving services comment about physical discomfort after a restraint, or the individual receiving services appears to be in physical discomfort or sustains an obvious injury, the individual will be offered medical attention immediately upon notification of or observation or the discomfort/injury.
- Following the use of a restraint, it is recommended that NFHCS personnel discuss with the individual receiving services the reasons for the use of restraint. This discussion is documented on the Physical Restraint Form and addresses the following issues.
    - The incident
    - The antecedents/environmental factors
    - The reasons for the use of restraint
    - The individual's reaction to intervention
    - Actions that could make future use of restraint unnecessary

Review of Emergency Physical Restraints

- The Director of Operations will review the use of all restraint holds to determine
    - the patterns of use
    - history of use by personnel
    - environmental contributors
    - effectiveness of the technique
    - safety of the technique
- If an injury occurs during a restraint to either staff or the individual receiving services or another individual not involved in the restraint, the incident is reviewed by the Director of Administration.
- If a pattern of increased use of restraint is identified, it is recommended that the Executive Director analyze the pattern of restraint used and takes action to continuously reduce or eliminate the use of restraint.

Training:

- All NFHCS personnel who may be involved in the direct administration of emergency physical restraints must receive initial and ongoing competency-based training in the following areas.
    - Contributing factors or causes of threatening or dangerous behavior
    - Medical conditions which may contribute to aggressive behavior
    - Staff interactions and how they impact upon the behaviors of individuals receiving services
    - The use of alternative interventions/de-escalation techniques as an alternative to restraint holds
    - Recognizing signs of physical distress in the individual who is being
    - Re-establishing communications after the individual has been restrained Preventing threatening or dangerous behavior
    - When and how to restrain safely the letting-go or release process the two-person restraint hold
    - Escape techniques and the one-person restraint hold
- The NFHCS does not recommend using a team intervention (more than two staff) for implementing a restraint other than the two-person restraint and escort because it is rare when there is more than double coverage at a facility. Staff are trained to take both roles in a two-person restraint hold/escort and are trained to communicate which person will take the lead role and which person will take the secondary role. In those cases, where more than two staff are needed to implement a restraint, prior approval by the Director of Administration is required before staff are framed in this restraint procedure.

NFHCS Trainers are certified in a System of Behavior Management as determined by the Executive Director. Only certified trainers can train NFHCS staff.

Mechanical Restraints (Prohibited): A devise used to control acute, episodic behavior that restricts the movement or function of an individual or a portion of an individual's body. Any physical devise used for behavior control or to prevent self-injury is a mechanical restraint unless it is used as a protective devise following surgery or medical treatment for a period of time specified by a physician. A helmet used for prevention of injury during severe seizure activity as recommended by a physician is NOT a mechanical restraint.

Chemical Restraint (Prohibited): A drug used to control acute, episodic behavior that restricts the movement or function of an individual. An order for controlling acute, episodic behavior is prohibited.

What is not a Chemical Restraint?

- A drug order by a licensed physical as part of an on-going program of medication is NOT a chemical restraint.
- A drug ordered by a licensed physician on an emergency basis is not a chemical restraint, provided the following apply: prior to each incidence of administering a drug on an emergency basis, an Incensed physician shall have examined the individual and given a written order to administer the drug.
- Prior to each re-administration of a drug on an emergency basis, a licensed physician shall have examined the individual and ordered re-administration of the drug.
- The individual's vital signs shall be monitored at least once each hour. the physical needs of the individual shall be met properly.
- A drug ordered by a licensed physician for a specific, time-limited, stressful event or situation to assist the individual to control his or her own behavior is not a chemical restraint.
- A drug ordered by a licensed physician as pretreatment prior to medical or dental examinations or treatment is NOT a chemical restrain.
- A drug self-administered by on individual is NOT a chemical restraint.

Training: All NFHCS personnel who may be involved in the direct administration of emergency physical restraints must receive initial ongoing competency- based training in the following areas.

- Contributing factors or causes of threatening or dangerous behavior medical conditions which may contribute to aggressive behavior
- Center for Medicaid and Medicare Services (CMS) Consolidated and Person/Family Directed Support Waivers.

Title 55 of the Pennsylvania Code, Chapters 2380, 6400, and 6500.
Introduces how to report unauthorized restrictive interventions under the primary category, Rights Violation, and secondary category, Misused Restrictive Interventions, effective with the September 8, 2012, 6.17 HCSIS Release.

DISCUSSION

Restrictive Interventions: NFHCS's goal is creating healthy and safe environments that enable people to live and participate fully in their communities. NFHCS uses a person-centered approach to determine the least intrusive supports needed to provide each individual the greatest quality of life.

Restrictive interventions are more intrusive than other supports, so NFHCS prohibits some forms of restrictive intervention and strongly discourages the use of allowable restrictive interventions unless the provider has first tried less restrictive techniques and resources, appropriate to the behavior, that have failed. Entities may not use restrictive procedures as retribution, for the convenience of staff persons, as a substitute for the program, or in a way that interferes with the individual's developmental program. Entities may only employ restrictive interventions as a last resort.

I. Allowable Restrictive Interventions

ODP permits the use of the following restrictive interventions:

- Environmental restrictions appropriate to diagnosis.
- Intensive supervision such as 1:1 or 2:1 staffing levels or higher, for purposes of behavior monitoring/intervention/redirection (please note that higher staffing due to medical needs or level of medical care is not defined as a restrictive intervention). 9/6/2012 ODP Communication Number: Memo 080-12 pages 3 of 5
- Rights violation resulting from unauthorized restrictive interventions occurs when use of a restrictive intervention:
    - Deviates from the provider's restrictive procedure policy or from the individual's restrictive procedure plan.
    - Does not follow NFHCS guidelines.
    - Is prohibited by ODP.
- Exclusion, within the following parameters:
    - Exclusion is defined as the removal of an individual from the individual's immediate environment and restricting the individual alone to a room or particular area. If, a staff person remains with the individual, it is not exclusion.
    - Exclusion is only used when necessary to protect the individual from self-injury or injury to others.
    - Exclusion is only used when it has been documented those other less restrictive methods have been unsuccessful in protecting the individual from self-injury or injury to others.
    - An individual must be permitted to return to routine activity within the time specified in the restrictive procedure plan not to exceed 60 minutes within a 2-hour period.
    - Exclusion may not be used for an individual more than 4 times within a 24-hour period.
    - A staff person will continually monitor an individual in exclusion.
    - A room or area used for exclusion shall have at least 40 square feet of indoor floor space, with a minimum ceiling height of 7 feet.

- A room or area used for exclusion shall have an open door or a window for staff observation of the individual.
- A room or area used for exclusion shall be well lighted and ventilated.

NOTE: If an entity uses exclusion on an unanticipated, emergency basis, then the review by the restrictive procedure review committee and the requirement for a restrictive procedure plan do not apply until after the exclusion is used for the same individual twice in a 6-month period **(55 PA Code §§ 2380.164, 6400.204, and 6500.174).**

Prohibited Restrictive Interventions: ODP prohibits the following types of restrictive interventions:

- The use of aversive conditioning (defined as the application, contingent upon the exhibition of maladaptive behavior, of startling, painful or noxious stimuli). 9/6/2012 ODP Communication Number: Memo 080-12 pages 4 of 5
- Seclusion (defined as placing an individual in a locked room, is prohibited. A locked room includes a room with any type of door locking device, such as a key lock, spring lock, bolt lock, foot pressure lock or physically holding the door shut).
- Exclusion that falls outside the parameters

II. Use of Restrictive Interventions

Providers must try less intrusive supports prior to implementing restrictive interventions. For each incident requiring a restrictive intervention, entities must make every attempt to anticipate and de-escalate the behavior using less intrusive methods of intervention.

If, after considering the individual's desires, uniqueness, and strengths, the individual and the support team determine those restrictive interventions are necessary to ensure the health and safety of the individual, the team must approve a Restrictive Procedure Plan that describes the restrictive intervention and its implementation. The team must also incorporate the restrictive intervention and a description of its implementation into the Individual Support Plan (ISP).

NOTE: In community settings, entities must follow the procedure for developing Restrictive Procedure Plans, including review by the Restrictive Procedure Committee, as required by 55 Pa Code §§ 2380, 6400, and 6500. Public and private ICFs/ID must develop individual program plans, as defined in 42 CFR §483, that state the specific objectives necessary to meet each individual's needs. The individual's plan must specify all facility approved interventions and ensure, prior

to the use of more restrictive techniques, that the facility tried less intrusive or more positive techniques and found them ineffective.

III. Reporting Misuse of Restrictive Interventions

Utilization of restrictive interventions that the team has not approved and specified in a Restrictive Procedure Plan, violate an individual's rights. Providers report rights violations on the HCSIS EIM system.

HCSIS Release 6.17, effective September 8, 2012, adds a secondary category of **Misused Restrictive Intervention** to the primary category of **Rights Violation**. Effective the date of the HCSIS 6.17 release, providers will report use of unauthorized or prohibited restrictive interventions under the category of rights violation, misused restrictive intervention. While many providers already report misused restrictive interventions as a violation of rights, addition of the secondary category allows providers, AEs/counties, and ODP to track and analyze the frequency of these occurrences. 9/6/2012 ODP Communication Number: Memo 080-12 pages 5 of 5

NFHCS staff will need to report **Misuse of Restrictive Interventions immediately** by contacting Incident Manager Angie. Immediately contact NFHCS Executive Director. Angie will later contact local AE liaison Samuel L. Grants, Jr. for further instructions at the address below.

Samuel L. Grantz, Jr.
On – Site Monitoring & Contract Management

Allegheny County Department of Human Services /
Office of Intellectual Disability (ACDHS/OID)
2020 Ardmore Blvd., Suite 380
Forest Hills, PA 15221 – 4652
412.436.2789 (T)
412.271.1392 (F)
412.436.2750 Ext. 4139

Print Name_____

Staff Signature_____
Date_____

5.19 Risk Management Plan

Implemented: October 2016 **Revised:** September 2020

Background: NFHCS has s comprehensive risk management policy. The organization strives to identify, assess, prevent and collectively management all levels of risk while pursuing opportunity for continuous quality in improvement and protecting vital assets and resources, this commitment is evident throughout NFHCS policies, procedures, and operation both at the programming level and administration level. The policy has adopted a risk management structure which draws upon the experience of multiple stake holders: including our contractors, individuals, management, staff, the Board of Directors, and insurance broker, and internal and external resources.

NFHCS maintains systems and protocol Is to ensure consistency and identify areas of risk on a programmatic level. These include the implementation and procedural control Is in the areas of governance, fiscal, operations, human resources, incident management, continuous quality assurance, human rights, health and safety, staff training, individual funds management, outcome management, and licensing processes.

NFHCS adheres to all applicable service regulations established by the respective regulatory, contractual/or funding authorities, where it is applicable, progress are evaluated, revisited, and inspected on a period basis, deficiencies or recommendations are noted during evaluations, NFHCS state prepare a plan of correction with specific timelines for correction. In addition, where applicable, the NFHCS adheres to local municipal in and slate housing as well as fire and safety guidelines.

NFHCS policies and procedures are designed to safeguard the integrity of the NFHCS, its services, individuals, and stakeholders. The policies and procedures manual address the wide spectrum of risk management issues such as individual funds management, medication administration, case record review, outcome management and many others.

NFHCS promotes the rights of persons served by protecting confidentiality information, privacy and random information, abuse, and neglect, financial, exploitation, as well as other areas deemed a health and safety risk. These areas in consistently for review and follow up

NFHCS requires staff to participate in mandatory trainings. That utilizes its training matrix to provide safe work environment through safety and health training for all staff as well as specific Safety Committee, member training and driver training.

5.20 Smoke Detectors & Fire Alarms Plan

Implemented: October 2017 **Revised:** September 2021

Background: A staff who violates any of the fire safety regulations set forth 6400 regulations or the fire emergency procedures below, including those pertaining to the abuse of fire alarm, smoke detector, or fire extinguisher systems, will be subject to disciplinary action, including suspension or termination.

NFHCS **requires electrically powered smoke alarms** outside sleeping area within 15 feet in each sleeping room and should be type approved by the Dept. of Labor or by Underwriters Laboratories. It also requires a smoke alarm on each floor of the structure. There is no requirement for a specific type: ionization, photoelectric or dual. Any of the three will meet the minimum requirements.

Maintenance to ensure fire alarms and smoke detectors operable:

- Test smoke alarms once a month by pushing the "test button."
- Install new batteries at least once a year.
- Clean smoke alarms using a vacuum cleaner without removing the alarms cover.
- Replace smoke alarm every year.
- If a smoke detector or fire alarm is inoperative, notification for repair shall be made within 24 hours and repairs completed within 48 hours of the time the detector or alarm was found to be inoperative.
- Test fire alarms and smoke detectors to ensure all individuals and staff can hear the alarm

Fire Emergency Plan: Any smoke detector in a stairwell or corridor can initiate a general alarm when a predetermined concentration of smoke reaches it. This alarm has the same sound as the alarms initiated manually and is a signal to leave the building. Each room or individual's bedroom are typically equipped with a 110-volt AC smoke detector. If activated, the alarm sounds in that room only. If there is a fire, go to the nearest exit, pull the fire alarm at the pull station, and leave the building.

If you find a fire: Sound the alarm by activating the nearest fire alarm pull station and call the Fire Department at 911 from a safe location. **You can also call**, the Incident Manager, who will notify the Fire Department, the building manager, and other key personnel.

Alert your neighbors only if you can do so without delaying your exit.

Leave the building immediately, close doors behind you as you exit the building and proceed to the designated emergency evacuation meeting location.

If you have information on how the fire started or how the alarm was activated, report it to the Fire Department.

Do not try to put out the fire. Use your common sense. Your safety is more important than property.

If the alarm sounds: Do not delay evacuation or assume that this is a false alarm. Immediately begin to exit the building.
Feel the door. If it is hot, do not open it. Stay in your room. Put a towel or blanket (preferably wet) under the door to keep the smoke out. If your telephone works, call the Fire Department at 911. Attract attention to yourself. Hang a sheet or something out the window.

If the door is not hot, open it slowly. If smoke and heat fill the hall, close the door, stay in your room, and call for help.

If you can safely leave your room, take your key, and close your door behind you. Exit by the nearest clear exit stairway. Do not use the elevators – it may fail in a fire or be automatically recalled to the ground floor. Failure to leave when an alarm sounds, unless there are safety reasons for not doing so, is a punishable offense.

- If you encounter smoke on your way out, stay low and crawl if necessary. You are more apt to find breathable air close to the floor. Cover your nose and mouth with a wet towel or wet handkerchief, if possible.
- So that you may be accounted for, go to the predetermined emergency evacuation meeting location. Do not attempt to reenter the building until the fire department gives permission to do so.
- Do not attempt to reenter the building until the fire department gives permission to do so.

Fire Safety Instructions:

- Do not overload wiring. Appliances should be plugged into wall outlets, never connected to light sockets. Extension cords should be Underwriters Laboratories or National Electric Code approved cords in good condition and of proper rating. Do not splice extension cords; never run them through doorways or partitions or cover them with rugs.

- Use fireproof draperies. Limit the number of flammable decorations and keep your room neat and clean.
- The use of candles and other sources of open flame are prohibited in House may be lit only in common areas and only with the approval of the House supervisor. They must always be attended.
- It is illegal to use fireplaces, as they can present a safety hazard to all occupants.
- Know emergency escape routes: fire doors, window exits, and fire escapes. Never block emergency escape routes or block open or prop open any fire doors. Emergency exit doors within rooms/suites shall not be blocked on either side by furniture or obstructions of any kind.
- Staff and individual's participation in annual fire drills is mandatory.
- If you have information on the cause of a fire alarm activation, report information to tutors, House Masters, or the Fire Department representatives.

Carbon Monoxide: Select rooms may be equipped with carbon monoxide detectors. Carbon monoxide (CO) is an invisible, odorless, tasteless, and non-irritating gas created when fuels (e.g., gasoline, propane, natural gas, oil, and wood) are burned. Improperly vented appliances used for heating and cooking can be sources of carbon monoxide.

Common symptoms of carbon monoxide poisoning are headaches, runny nose, sore eyes, and are often described as "flu-like symptoms." Higher level exposure symptoms may include dizziness, drowsiness, and vomiting. Extreme exposure to carbon monoxide can result in unconsciousness or death.

Carbon Monoxide Alarm Instructions: The carbon monoxide alarm will sound four quick "chirps" every few seconds, indicating that carbon monoxide is present:

- Everyone in the immediate area of the alarm must immediately move to fresh air outdoors. If anyone is experiencing symptoms of carbon monoxide poisoning, call 911.

If there are no symptoms of carbon monoxide poisoning, call the Incident Manager for instructions and assistance. Remain outside until directed by the Police or Fire Department that it is safe to re-enter the building.

5.21 Smoking Plan

Implemented: October 2017 **Revised:** September 2021

Background: Not Forgotten Home & Community Services is committed to providing a safe and healthy workplace and to promoting the health and well-being of its employees. As such, the following policy has been adopted and applies to all employees of NFHCS.

It is the policy of NFHCS to prohibit smoking and vaping on all company premises to provide a safe and healthy work environment for all employees. Smoking is defined as the "act of lighting, smoking or carrying a lighted or smoldering cigar, cigarette or pipe of any kind." Vaping refers to the use of electronic nicotine delivery systems or electronic smoking devices such as e-cigarettes, e-pipes, e-hookahs, and e-cigars.

Scope: This policy applies to:

- All areas of buildings occupied by company employees.
- All company-sponsored offsite conferences and meetings.
- All vehicles owned or leased by the company.
- All company employees.
- All visitors (customers and vendors) to company premises.
- All contractors and consultants and/or their employees working on company premises.
- All temporary employees.
- All student interns.

Smoking and vaping is **permitted *only*** in the following designated outdoor areas:

Procedures: Employees who violate this policy will be subject to disciplinary action up to and including immediate discharge.

A process is in place for resolving complaints about the smoke- and vape-free policy:

- Complaints about the application of this policy should be brought to the attention of the Human Resources Manager or your direct supervisor for resolution.
- The complaint should be submitted in writing and should identify specific objections.
- NFHCS will investigate the complaint and resolve it in accordance with the policy.

No employee shall suffer any form of retaliation for raising a complaint or asking a question about this policy.

This policy is intended to comply with the requirements of § 2800.18 – Applicable Laws; § 2800.144 – Use of Tobacco.

STATEMENT OF UNDERSTANDING

I have read and fully understand the terms of this policy.

I understand that any violation of this policy will result in disciplinary action up to and including immediate discharge.

I understand that Not Forgotten Home & Community Services reserves the right to make changes to this policy as needed.

_____

Employee Name

_____ _____

Employee Signature Date

ENVIRONMENTAL HEALTH HAZARDS POLICIES AND PRACTICES

5.22 Vehicle Plan

Implemented: August 2019 **Revised:** September 2021

Background: Not Forgotten Home & Community Services will make every effort to ensure all vehicles are maintained and operated in a safety manner. Staff who have a driver's license must demonstrate good driving skills, as demonstrated by their driving record. They must also follow all Not Forgotten policies and procedures as well as state laws governing the operation and use of a vehicle. If is the NFHCS' goal to eliminate all vehicle accidents. Safe driving and strict adherence to all traffic laws will protect staff, individuals in service and the Not Forgotten.

Driving records will be verified for prospective staff who have a driver's license, and as such must be deemed insurable by the insurance carrier. This is a condition for both employment and continued employment. All staff must complete NFHCS Driver Information Form and at least meet the following Motor Vehicle Record (MVR) criteria set forth by NFHCS insurance carrier:

- No major or multiple violations within the last 3 years including at-fault accidents
- No suspension status or revocation of their license for any reason within three years.

Prospective staff with a driver's license must complete NFHCS's Driver Information form. This form must be faxed to the Human Resources and will be forwarded to the insurance carrier. The insurance carrier will obtain an MVR report and will determine the insurability of the applicant within 3 days. Results will be forwarded to the appropriate personnel. If a staff is determined to be uninsurable, the staff will be informed in writing by Not Forgotten personnel and receive a notice regarding their rights under applicable state law.

Vehicle Maintenance & Inspection: The vehicle inspection program ensures that each vehicle is in good operating condition. Each staff who drives a NFHCS vehicle must complete the inspection process. This includes a visual inspection of the exterior of each vehicle including condition of tires, lights, and warning lights. No staff may check fluid levels of a Not Forgotten vehicle. These checks must be performed by a professional at a vehicle service center. The Not Forgotten Monthly Vehicle Inspection Form must be completed on a monthly basis. In addition, each program must ensure that timely State Inspections necessary for the operation of the vehicle are completed on a timely basis.

Staff Responsibilities: The purpose of this procedure is to provide clarification regarding use of NFHCS vehicles, and to ensure that all staff understand their responsibilities when operating Not Forgotten vehicles.

In order to comply with insurance requirements, each staff member is to complete the NFHCS employment information form, must also be notified by the staff immediately of any changes in a staff's status as a licensed driver, e.g.,

- NFHCS vehicles are to be used for approved program activities including transportation of individuals in services to and from appointments, shopping, recreational and social activities, and in emergency situations requiring transportation. Vehicles are not to be used by staff for personal transportation needs. Follow-up documentation regarding each use is required utilizing the Time, Gas and Mileage Log.
- All staff are to use NFHCS vehicles, when available, instead of their personal vehicles, for Not Forgotten-related business travel, unless directed otherwise by supervisory personnel.
- All staff are to operate vehicles in a responsible manner and observe all provisions of the PA State Motor Vehicle Code. Supervisory personnel must be notified immediately if there are any tickets or fines (parking, speeding, etc.), so fines can be paid before additional late fees are assigned. If the driver would want to contest the ticket, supervisory personnel should be notified immediately.
- Use of seatbelts in all vehicles is required by all staff and all occupants. Staff who find it necessary to use their personal vehicle for Not Forgotten business are required to use seatbelts, as well as all occupants therein. This requirement is not only State Law, but also has a significant impact reducing injury in the event of an accident. Staff who have documented medical reasons should not wear a seatbelt must not drive Not Forgotten vehicles.
- Program Leads are to assign responsibilities for each vehicle to staff persons in the program to which the vehicle is assigned. All the responsibilities are shared by all staff of the program for the upkeep of the Not Forgotten vehicles. All drivers are to fill out the mileage log, vehicle inspection forms, make sure gas is in the vehicle, follow gas credit card procedures and have oil checked check vehicle for accidents and physical damages. All drivers must follow procedures for reporting accidents involving Not Forgotten vehicles. Supervisors are to ensure that all vehicles are equipped with insurance card, current registration, and Vehicle Evident Report Form, first aid kits and vehicle emergency supply as outlined on the Monthly Vehicle Inspection Form Emergency equipment and supplies need to be secured if stored in the passenger area.

- The Vehicle Documentation Packet must be kept in the glove compartment of every NFHCS vehicle in the event of an accident, Aid the injured, call the Police and follow the instructions on the Vehicle Accident Report Form. The Vehicle Documentation Packet includes copies of the Vehicle Accident Report Form, a copy of these procedures, Current Insurance Card, a Monthly Vehicle Inspection Form, current vehicle registration card, Mileage Log and Cell Phone Videos.
- Smoking, eating, or drinking of beverages is NOT permitted in Not Forgotten vehicles while operating the Not Forgotten vehicle. No bumper stickers, signs, or insignia are to be placed on/in vehicles at any time. Consumers are not to be left unattended by staff in vehicles under any circumstances.
- Staff who use a cell phone, smart phones, tablets, or any other portable device are prohibited from using these devices while operating any Not Forgotten vehicle or any privately-owned vehicle while on any NFHCS business, including boil not limited to, transporting consumers. If receiving or placing a call is necessary, the staff must pull to the side of the road to a safe area and safely stop the vehicle before receiving or placing the call. Only for direction is the cell phone to be used.
- Driver training and all other vehicle related training will be provided to all staff at least annually through Relia's Vehicle Training and by Program Leads. Staff involved in a reportable motor vehicle accident or traffic violation will be retrained by the Program Lead, a Drivers History will be pulled, and Relia's Vehicle Training will be reassigned.
- If the staff is required to use their vehicle for work-related activities the staff will be reimbursed on a per mile basis, with the amount of the reimbursement being determined NF. Such rates are periodically subject to change, with information on the current per mile reimbursement rate available by contacting the Fiscal Department. The per mile reimbursement rate covers all expenses related to the use of the vehicle for employment related reasons including, but not limited to, fuel, maintenance, wear and tear, and insurance.
- The use of motorcycles and similar transportation are not considered safe practices for Not Forgotten business and are not permitted for work related duties, travel, or transportation. When traveling for Not Forgotten business, and always utilize a passenger vehicle/automobile.
- While driving a Not Forgotten vehicle, the lights on the vehicle must be turned on. Day or Night.
- All Staff will be encouraged to equip NF vehicles with standard safety equipment (first Aid Kit, Fire Extinguisher, safety kit, flashlight, blanket, flares etc.….

Violation of Any Part of This Procedure May Result in **Disciplinary Action** Up to and Including Termination from Employment:

- Reporting and Investigating Vehicle Accidents
- Drivers Responsibilities

In all accidents involving staff and/or individuals, the priority, as a driver is to take the necessary precautions to protect the scene so that further damage or injuries do not occur. It is the staff's duty to give aid and assistance to anyone who has been injured or to ensure that someone else gives such aid. The driver must comply with applicable laws by locality in which the accident occurs. Unless your vehicle creates a further hazard, do not reposition it until the police arrive. If the vehicle is unable to be moved, flashers should be turned on until emergency reflective triangles are set in place. No attempt should be made to free the vehicle if entangled with another vehicle or object.

For every accident, the driver must do the following.

- Obtain immediate medical attention if someone is injured
- Using the Vehicle Accident Report Form, obtain names and addresses of all witness, drivers, and passengers
- Obtain names of Insurance Companies and policy numbers for each vehicle involved, along with the driver's license number for each vehicle and license plate number of each vehicle
- Call the local police AND identify the responding officer (Name and Badge#) on the Vehicle Accident Report Form, the police do not come out to the accident Scene, exchange information at the scene with another driver. Physically go to the local police station to fill-out the report. This report must be done the same day or next day. Please bring all information regarding the accident, vehicles and driver involved to the police station
- Supervisory Staff must be notified as soon as possible
- A Vehicle Accident Report Form must be completed as soon as possible but no later than 24 hours after the accident
- The police report (Attempt to ascertain whether citations or arrests were made
- The Program Lead should notify the Program Coordinator of any accident within 24 to 72 hours so that the insurance NFHCS can be notified in a timely manner. Incident Manager will also be notified as it relates to the individuals.
- Staff can cell phone cameras to capture accident pictures.

Guidelines for Vehicle Accident Investigations: The basic objective of a motor vehicle accident investigation is to find out exactly how the accident occurred so that those in charge can:

- Determine whether the accident was preventable, and to prevent future like accidents.
- Assist in liability claims procedures, including court action

Completing the Vehicle Accident Report Form: The **Vehicle Accident Report Form** will assist the claims procedure. it should include as much of the following as possible:

Interviews with drivers involved.

- Statement of witness's and passengers. It is important that these individuals be interviewed before they leave the scene of the accident. Obtain specific facts.
- Names and addresses of all those involved and information on the extent of personal injuries.
- A description of each vehicle. names of vehicle owners and their insurance companies and the extent of damages.
- A diagram of the accident that indicates:
  - the number of traffic lanes, the shoulder of the road,
  - the point of impact,
  - the location and direction of travel of each vehicle prior to impact, at impact and after impact and the distance each traveled after impact.

Safety Committee Responsibility as to Vehicle Accidents: After any accident, the Safety Committee Incident Review Form must be completed by the Safety Committee.

The unsafe acts of drivers and unsafe conditions that because accidents can be corrected only when they are known specifically. It is Program Coordinator's responsibility to define the causes of the accident and make sure it's written on the Report Form. And to submit additional evidence to the incident manager.

The Safety Committee should determine whether the accident was preventable or non-preventable so that appropriate actions can be taken.

A copy of this report must be attached to each Vehicle Accident Report Form.

GUIDELINES FOR USE OF NFHCS VEHICLES

Proper Use of Not Forgotten Vehicle	Improper Use of Not Forgotten Vehicle
Transporting consumers to and from vocational/ day services.	Personal use (shopping for self, checking out new cars, picking up your car from shop).
Transporting consumers on Not Forgotten on their choice of community activities	Going out to lunch for yourself.
Grocery shopping for consumer only	Any shopping for self.
Taking vehicle to dealership for repairs.	Stopping at your house or a friend's house for a moment to change your clothes or get money or whatever.
Transporting consumers to medical appointments.	Stopping at a fast-food restaurant to buy meal for self or going to the bank
Take vehicle to gas station.	Transporting any non-NF staff or consumer personnel.
Running supervisory approved errands (pick up meds at pharmacy, shopping for the program, pick up mail from Not Forgotten Office).	Any other use for personal use.
Transporting consumers in family homes as directed by supervisors.	Transporting of consumer's friends, family, etc.
Transporting consumers from their personal shopping (clothing, personal care items).	
Site to site visit/recreation.	
Driving to a Not Forgotten approved training.	

Improper use of vehicle may result in **DISCIPLINARY ACTION** up to and including termination from employment.

Related Forms: Staff Incident Report Form

- Vehicle Time, Gas and Mileage Log Vehicle

Accident Report Form
- Safety Committee Incident Review Form
- Staff Vehicle Form

Leasing a Temporary Vehicle: When leasing a temporary vehicle, please use the following steps:

- Contact the Director of Services when leasing a temporary vehicle. Program Coordinator from the executive Assistant and Director of Operations
- Try to use Enterprise Rent-A-Car to lease Vehicle. NFHCS has a corporate account with the NFHCS (verify correct Corporate Class Identification Number for Enterprise). Enterprise Rent-a-Car has offices throughout the state of Pennsylvania and other states in the USA.
- Give NFHCS current auto coverage policy number and insurance agents name and number.
- Explain to leasing NFHCS that NFHCS policy covers only Liability for the leased vehicle.
- Ask to include Collision (Physical Damage) coverage in the rental fee

Vehicle Accident Report Form:

- Assist the injured in own vehicle. DO NOT move individuals unless necessary. Warn other drivers.
- People to contact - Immediately call the Police, your supervisor, and Director of Services.

Date of Incident:_____Time of Incident:_____AM____PM

_____

Location of Accident: _____

Police Officer Name:_____Badge #:_____Police Report #: _____

NOT FORGOTTEN NOT FORGOTTEN VEHICLE INFORMATION

NF License Number:_____

VIM#: _____

County:_____ Assigned Program: _____

Driver's Name:_____ Contact Phone: _____

Driver's Address: _____

Other Staff Name:_____Contact Phone: _____

Address:_____

ABOUT OTHER VEHICLE PROPERTY

Owner vehicle/property:_____Contact Phone: _____

Address:_____

Another driver (note if same)._____Contact Phone: _____

Address._____

Property damaged: _____

Vehicle: Year:_____Make_____Model:_____Color: _____

License Number:_____Damage: _____

_____

_____

_____

Insurance Co. Name._____Phone number: _____

Policy_____Number of persons in other vehicle(s): _____

ABOUT PERSON'S INJURED

Injured party's name:_____Contact phone: _____

Address:_____

Passenger in NFHCS vehicle:_Passenger in other vehicle:_Date of birth: _____

Nature of injuries: _____

_____

Injured party's name:_____Contact phone: _____

Address:_____

Passenger in Not Forgotten vehicle:_____Passenger in other vehicle: _____Date of birth: __

Nature of injuries: _____

_____

WITNESSES

Name:_____Contact phone: _____

Address: _____

Name._____Contact phone: _____

Address: _____

VEHICLE MILEAGE LOG

PERIOD START		VEHICLE MAKE:		VIN NO:	
PERIOD END		YEAR:		LICENSE NO:	

Staff Name	To	From	Starting Odometer	Ending Odometer	Purpose for the trip	Condition of Vehicle

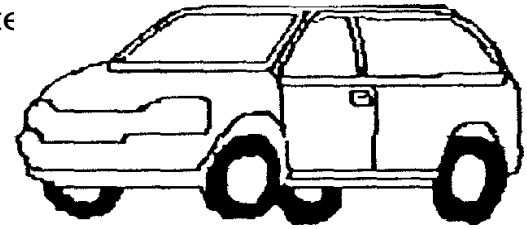
Accident Diagram and Damage Severity

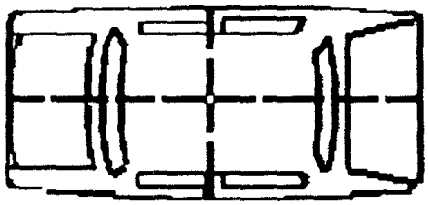
Damage to Vehicle (Circle the Areas)

Light

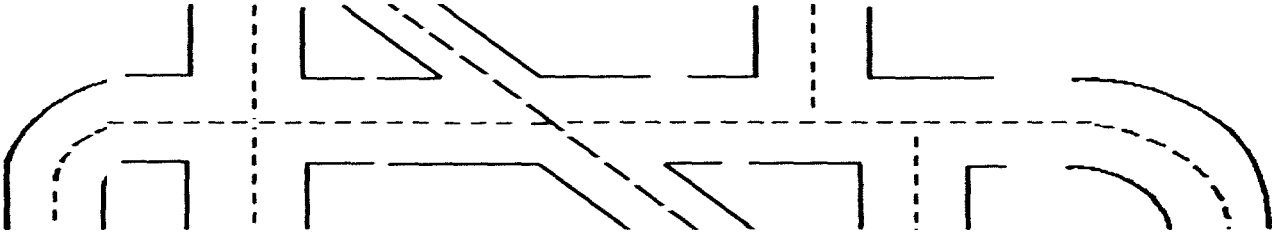
Moderate

Severe





Complete the following diagram showing directions and positions of vehicles or property involved, clearly designating the points of contact. Select the street group that best represents the location of the accident. Please identify all streets by name.



Instructions: GIVE STREET NAMES DIRECTIONS OF TRAVELS, AND LOCATIONS OF ALL OBJECTS/VEHICLES INVOLVED

VEHICLE OPERATER: _____

Signature: _____ Date: _____

SUPERVISOR: _____

Signature: _____

Date: _____

Monthly Vehicle Inspection Form

Does this vehicle have any obvious repair needs?

_____

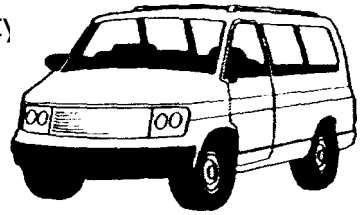
_____

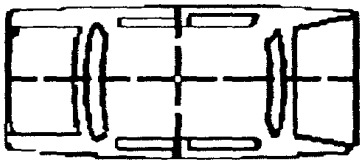
_____

_____

Damage Severity

1. Light
2. Moderate
3. Heavy





(Put severity number on damaged sections)

Vehicle Points of Damage

Comments:

_____

_____

_____

_____

FIRST AID SUPPLY CHECKLIST: Please check the contents of the First Aid Supply Kit in the Vehicle

Please ensure that all the following supplies are contained in the Kit in this vehicle or this date.

- ☐ 4 x 4-inch gauze pads 2
- ☐ 8 x 10-inch gauze pads
- ☐ huger size Band-bids (typical size)
- ☐ 2 x 2 gauze roll
- ☐ tweezers
- ☐ adhesive tape
- ☐ latex gloves
- ☐ pocket mask or similar resuscitation devise

☐ 2 triangular bandages	☐ would cleaning agents
☐ 2 elastic wraps	☐ 1 splint
☐ 1 pair of scissors	☐ emergency first aid instructions
☐ space blanket	☐ Antiseptic (wipes)

***First Aid Kit should not be** accessible to any individuals not capable of understanding hazardous substance issues.

Staff Signature Date Supervisor Signature Date

DRIVER INFORMATION FORM

This form must be completed by all staff who have a driver's license as a condition of employment. and as such be deemed insurable by the insurance carrier This document requests Protected Information and should not be completed until an offer of employment is extended and accepted.

ME: _____

(FIRST) (MIDDLE INITIAL) (LAST)

ADDRESS: _____

(STREET) (CITY) (STATE) (ZIP CODE)

Date of Birth (MM/DO/YY) ____ 2. Driver's License # _____ State_____

Has your driver's license ever been revoked or suspended during the past 3 years? YES

___NO_____

If "yes", please explain. _____

Do you currently have a valid driver's license from your state of residence? _____YES
___NO

If "no". please explain: _____

On what date does your current driver's license expire? (MM/DD/YY) _

Does the address on your driv*er's* license match the address listed above? _____YES
_____ NO_____

Do you currently have a valid driver's license from a state other than your state of residence? _____YES _____NO

If "yes", please provide: State._____
Driver's License #: ___

Insurance NFHCS Name _____ Policy # _____

Effective Date (MM/DD/YY) _____ Expiration Date (MM/DD/YY

Vehicle Identification if (VIN): _____

Registration Expiration Date (MM/DD/YY)): _____

Inspection Due Date (MM/DD/YY) List all motor vehicle accidents in which you have been involved during the past 3 years.

Date	Location (City and State	Brief Description

List all motor vehicle violations for which you've been cited during the past 3 years (excluding parking tickets). List most recent first If none. so, indicate.

Date	Location (City and State	Brief Description

I certify the above information to be correct:

It is NFHCS policy to verify the above information by obtaining motor vehicle reports. Information being obtained will not be used in violation of any federal or state equal opportunity law or regulations. If any adverse action is to be taken based on a motor vehicle report, a copy of the motor vehicle report and -a summary of your rights" will be provided to the staff. If the information on the motor vehicle report obtained by NFHCS is inconsistent with the information provided on the driver information form, the staff may be subject to termination.

BY MY SIGNATURE BELOW, IAM AUTHORIZING NFHCS TO SECURE MY DRIVER'S RECORD SERVICE REPORT AND DRIVING RECORDS HISTORY IN ORDER TO YERIFY MY DRIVING RECORD.

Staff Signature Date

Use of Gasoline Card: NFHCS recognizes the importance of providing transportation for some consumer services. Gas cards are made available exclusively for the use of designated NFHCS vehicles. Any use outside the permitted use of these cards will be considered theft.

All NFHCS owned/leased vehicles will have a gas card assigned to that vehicle. Assigned cards must be used for the assigned vehicle for accurate billing and security purposes.

The gas credit cards in use must be locked in an area designated by the Program Leads.
Gas credit cards must be kept in plastic holders to protect the magnetic strip. The gas card can only be used for purchases of fuel.

Program Leads must provide a running sign-out log for each card. Staff must sign the sign-out log associated with the gas card before each use and sign the return of the gas card when returned to the locked area at the site/home/location.

When making a purchase with the gas credit card, staff are required to supply the vehicle's accurate odometer mileage and pin number. The required information is recorded by using the keypad located on the gasoline pumps or near the register. Simply follow the prompts and enter the information asked for on the screen. The following steps must be followed to fuel the vehicle:

- **Run the card through the card reader**
- **Enter the vehicle odometer by using number key**
- **Enter PIN number (40911)**
- **Quote: Do not keep the PIN# and gas card in the same location while in the community.)**
- **Respond to prompt for receipt — "Yes"**
- **Sign and write the vehicle license plate number on the receipt and forward it to your supervisor**

Failure to accurately follow the above procedure may result in the staff making the transaction paying for the purchase.

A 2nd NFHCS Gasoline credit card when issued will be logged onto a master list maintained at the administrative offices by the Assistant Executive Director. This list will specify the card number, assigned vehicle, assigned site/program/service as well as the person responsible for the card. Any

damaged/cracked/unreadable credit cards are to be returned immediately to the Director of Services issuance of a new card.

Lost or stolen gasoline credit cards are to be reported to the appropriate Director of Services as soon as possible.

Ten (10) days prior to expiration of a current gasoline card, a new gasoline credit card will be issued by the Director of Services, the expired card must be returned to the Director of Services.

5.23 Warm & Cold Weather Precautions Procedures

Implemented: September 2019 **Revised:**

Background: The following guidelines are in place to provide clarification on areas specifically covered by regulations, governing NFHCS programs, or in previously issued NFHCS policies and procedures.

Heat Related Illness: Heat exhaustion happens when your body gets too hot. It can be caused by physical exercise or hot weather. Symptoms include:

- Heavy sweating
- Feeling weak and/or confused
- Dizziness
- Nausea
- Headache
- Fast heartbeat
- Dark-colored urine, which indicates dehydration

An individual experiencing symptoms of heat exhaustion should get out of the heat quickly and rest in a building that has air-conditioning or in a cool, shady place. The individual should drink plenty of water or other fluids. Individuals should not drink alcohol or caffeinated drinks (such as soda). These can make heal exhaustion worse. Advise the individual to take a cool shower or bath or apply cool wafer to the skin. Tight or unnecessary clothing should be removed.

If there is any doubt that a medical Emergency exists, call 911 immediately. You are the first link to o person 's best chance of survival---do not delay----call 911. Remember to provide Care (which includes first aid and CPR for the individual until advanced medical help arrives.)

If heat exhaustion is not treated promptly, if can progress to heat stroke.

Heatstroke occurs when the internal temperature of the body reaches 104°F. It can happen when the body gets too hot during strenuous exercise or when exposed to very hot temperatures, or it can happen after heat exhaustion isn't properly treated. Heatstroke is much more serious than heat exhaustion.

Heatstroke can cause damage to the internal organs and brain. In extreme cases, if can lead to death. Symptoms of heatstroke include:

- High fever (104°F or higher)
- Severe headache

- Dizziness and feeling light-headed
- A flushed or red appearance to the skin
- Lack of sweating
- Muscle weakness or cramps
- Nausea
- Fast heartbeat
- Fast breathing
- Feeling confused, anxious, or disoriented
- Seizures

Get medical help right away if you observe these warning signs:

- Skin that feels hot and dry, but not sweaty
- Confusion or loss of consciousness
- Frequent vomiting
- Shortness of breath or trouble breathing

Sunburn: To the extent possible, the individuals we serve should minimize exposure to the sun from 10am to 3pm, when the sun's rays are most intense. This is especially true for those taking psychotropic medications, which increase photosensitivity thereby increasing risk for sunburn. Other medications, such as Ibuprofen, can have similar effects.

When planning an outdoor activity, the following can be done to prevent sunburn:

- Apply sunscreen with SPF of 30 or greater to exposed areas, including the face, neck, arms,
  shoulders, back and legs.
- Wear a wide-brimmed hat and sunglasses, as well as light weight, long-sleeved shirts, and pants
- Ensure that shaded areas are available so that people can get relief from the sun if needed.

Treatment: Cold water compresses can be applied to sunburn to relieve symptoms. If sunburn is severe, seek medical treatment.

Air Conditioning, Ventilation & Fans: Air conditioners or fans should be installed in each NFHCS operated facility by May 1st to ensure that temperatures remain at or below the maximum allowed by regulation. Additionally, storm windows should be removed, and screens made operational.

Single unit air conditioners must be secured properly to prevent it from falling out of the window. Ideally, such units will be installed by a professional. If a professional is unavailable, a minimum of 2 staff is needed to install or remove units. In programs with central air conditioning, the unit should be serviced annually by a professional and the filter should be changed on a regularly scheduled basis.

Food Safety: When attending or hosting an outdoor barbeque or picnic, ensure that food is maintained at the proper temperature and avoid letting food sit out in the heat for an extended period of time.

Outdoor Grills: To prevent gas grill fires or explosions, please adhere to the following guidelines:

- Follow manufacturer's instructions for lighting and heating the grill
- Do not attempt to repair a faulty gas tank valve or hose
- Check all hoses for wear and tear before each use and keep gas hoses away from hot surfaces
- Do not use a grill indoors. Grills must be used a minimum of 15 feet away from any building and should never be used in garages, breezeways, carports, porches or under any surface that may catch on fire
- Keep propane tanks stored in an upright position and do not store spares beneath or near the grill
- Do not keep full propane tanks in a hot car or car trunk, and secure them in an upright position when transporting

Vehicles: NFHCS owned or operated vehicles should be maintained to ensure appropriate levels of coolant are present. Air conditioning units should be checked to ensure that they are in proper working order.

The individuals we serve should not be unattended in a vehicle even for short periods of time, as temperatures inside the vehicles can rise to dangerous levels very quickly. Prior to departure to or from an activity, staff should conduct a head count to ensure that all individuals are present and accounted for.

Other precautions:

- Advise individuals to avoid alcohol and caffeinated beverages
- Ensure that enough chilled, boiled water is taken and made available for everyone when and outdoor activity is planned

- Close drapes and curtains during the day to keep home temperatures cooled
- Ensure that homes and vehicles have operable flashlights available in case of power outages.
- Plan indoor activities in cool places, such as the movies, shopping at the mall…etc.
- Be sure you have all emergency phone numbers and know the location of the nearest medical facility when you are on an outing with individuals
- If lightning is seen or thunder is heard, get indoors immediately!

5.24 Cold Weather Precipitation

Implemented: October 2017 **Revised:**

Background: As winter approaches and the weather turns colder, it is important to be prepared for circumstances that could pose a risk to the health and safety of individuals and our staff. The following precautions should be taken to mitigate these risks:

Site Supplies: The following items should be kept on hand in case of power failure:

- Extra blankets
- Canned goods and other non-perishable food supplies
- Bottled water
- Manual (non-electric) can opener
- Flashlight w. fresh batteries
- Battery Operated Radio
- Extra batteries for flashlights and radios

Furnaces: Furnaces should be inspected by a professional annually. Additionally, it is important to ensure that furnace fillers are changed on a regularly scheduled basis to optimize performance and prevent maintenance problems.

Snow Removal: All major snow removal is to be completed by subcontractors. Light snowfall that accumulates on walkways and driveways should be swept or shoveled by NFHCS staff. Ice melting products should also be applied to prevent surfaces from re-freezing. Refer to NFHCS Hazardous Products Policy for the proper purchase and storage of ice melting products.

Vehicle Operations: NFHCS operated vehicles should be winterized before cold weather hits and should be serviced by automotive professionals to ensure that tires, fluid levels...etc. meets safety guidelines. Battery jumper cables should not be used by staff on NFHCS vehicles; if the vehicle will not start make arrangements for emergency assistance and have the vehicle towed if necessary. NFHCS individuals should not be left unattended in any NFHCS vehicle at any time.

Fire Safety: Open flames are not permitted in NFHCS operated facilities, including those in fireplaces or from candles, blue-plug adapters are not

permitted, nor are the use of space heaters or air fresheners that plug into electrical outlets. Exterior lights must be plugged directly into a weather safe outlet or socket. Never use stoves or ovens for hearing the facility, even during power outages.

Recreational Activities: Individuals participating in outdoor activities during the winter months should be encouraged to do so in a safe manner. Winter jackets, boots, gloves, and hats must be worn to prevent hypothermia and in extreme cases, frostbite. Ice Skating should occur only in established community ice rinks, not on a frozen body of water. Sledding should occur in areas that are clear and free of obstacles (trees, roadways) that could pose a hazard. Staff should ensure that they have all emergency phone numbers.

5.25 Preventing, Detecting, Recognizing, Responding & Reporting Abuse

Implemented: September 2021 **Revised:**

Reference/Source:

- 55 Pa. Code § 6100.46 Section 6100.46 - Protective services

Abuse- Abuse, suspected abuse, and alleged abuse of an individual, regardless of the alleged location or alleged perpetrator of the abuse, shall be reported and managed in accordance with the following:

- The Adult Protective Services Act (35 P.S. §§ 10210.101-10210.704) and applicable regulations.
- The Child Protective Services Law (23 Pa.C.S. §§ 6301-6386) and applicable regulations.
- The Older Adults Protective Services Act (35 P.S. §§ 10225.101-10225.5102) and applicable regulations.

Incident of Abuse- If there is an incident of abuse, suspected abuse, or alleged abuse of an individual involving a staff person, household member, consultant, intern or volunteer, the involved staff person, household member, consultant, intern, or volunteer may not have direct contact with an individual until the investigation is concluded and the investigating agency has confirmed that no abuse occurred or that the findings are inconclusive.

Reporting Abuse- In addition to the reporting required under subsection (a), the provider shall immediately report the abuse, suspected abuse, or alleged abuse to the following:

- The individual.
- Persons designated by the individual.
- The Department.
- The designated managing entity.
- The county government office responsible for the intellectual disability program, if

applicable. *55 Pa. Code § 6100.46*

Adopted by Pennsylvania Bulletin, Vol 47, No. 33. August 19, 2017, effective 8/19/2017

Amended by Pennsylvania Bulletin, Vol 49, No. 40. October 5, 2019, effective 10/5/2019

SECTION 5 – RISK MANAGEMENT ACKNOWLEDGMENT

Section 5 of this Policy and Procedure Manual is an important document intended to help you become acquainted with the Not Forgotten Home & Community Services, as it relates to Risk Management. This document is intended to provide guidelines and detail descriptions, according to both strict governmental and agency wide regulations.

The regulations are provided in this section is regulatory in manner in order to maintain employment and for Not Forgotten to maintain compliance as a provider. The section covers all policies related to Risk Management, including both state and federal regulations listed below:

- Behavior, Health, Emergency Crisis
- Compliance Plan
- Emergency Disaster Response Plan
- Fraud and Abuse Prevention & Awareness
- Incident Management
- Smoking Plan
- Infections Control
- Medication Error
- Offices Guidelines to Comply with HIPAA
- Property Damage
- Quality Management
- Reporting Suspecting Abuse

This section will count **2.5 HOURS** towards training.

Because the Not Forgotten Home & Community Services operations may change, the contents of this manual may be changed at any time, with or without notice, in an individual case or generally, at the sole discretion of management.

Please read the following statements and sign below to indicate your receipt and acknowledgment of Section 5 of the Policy and Procedure Manual.

I have received and read a copy of Not Forgotten Home & Community Services Policy and Procedure Manual. I understand that the policies, rules, and benefits described in it are subject to change at the sole discretion of the Not Forgotten Home & Community Services at any time.

I understand that my signature below indicates that I have read and understand the above statements and that I have received a copy of the Not Forgotten Home & Community Services Policy and Procedure Manual.

Employee's Printed Name: _____

Employee's Signature: _____

Position: _____

Date: _____

The signed original copy of this acknowledgment should be given to management - it will be filed in your personnel file.

Section 6 – Personnel

6.1 Staff Qualifications

Implemented: January 2016 **Revised:** October 2018

Reference/Source: Pa code Chapter 51.20 Criminal history CHECKS, PA Code Chapter 51.21 Child abuse Clearances, PA CHAPTER 6400.21. Criminal history record CHECK, Quality Assessment & Improvement (QA&I) 06/22/18

Persons Affected: Prospective Applicants, Staff, AND unpaid Volunteers Not Forgotten Home & Community services.

Our Purpose: To inform the affected of Not Forgotten Home & Community Services, of our Staff Qualifications, in accordance with PA. Code Chapter 51 and Chapter 6400 Regulations.

Definitions:

- **NFHCS:** Not Forgotten Home & Community Services
- **Department:** The Department of Health & Human Services of the Commonwealth
- **ISP:** Individual Support Plan
- **Staff:** Staff of Not Forgotten Home & Community Services.

Policy/Procedures Objectives:

- Mechanism in place to ensure staff qualifications requirements remain in compliance throughout the year
- Staff Orientation/ Staff Training
- Background Checks (Criminal History, Child abuse, FBI)
- Staff are 18 or older
- Drivers' information
- Specialized qualification Documentation (Training, Licenses and Certificates: depending on service)

NFHCS Commitment- Not Forgotten Home & Community Services does not discriminate based on:

- Sex
- Age
- Religion

- National Origin
- Race
- Sexual Orientation
- Disability
- Color
- Gender identity

Qualification Requirement Policy: Prospective applicants and current Staff are required to have the following:

- Valid Driver's license, a review of staff's Driving History will be obtained
- All staff must Be at least 18 years of age or older (including Volunteers)
- Have a criminal history clearance per 35 P.S. §10225.101 et seq. and 6 Pa. Code Chapter
- Have a child abuse clearance (when the participant is under age 18) per 23 Pa. C.S. Chapter
- Have documentation that all vehicles used in the provision of service have automobile insurance
- Have documentation that all vehicles used in the provision of the service have current State motor vehicle registration and inspection
- High School Diploma/ GED
- 1 year of experience working in the prospective field in which they are inquiring
- I year of experience working with Individual with disabilities
- Valid social security number
- Current First aid/CPR
- Physical exam with current negative TB

Criminal History Check:

- A prospective applicant must provide a completed criminal background check when applying for any position at NFHCS. And submit the completed record with their application. The record must be within the preceding year. Not to exceed 1 year.
- NFHCS may also conduct an additional criminal history check prior to hire.
- Only reports of criminal history record information from the Pennsylvania State Police or a statement from the Pennsylvania State

Police that the State Police Central Repository does not contain information relating to that person. Information on the prospective applicant must appear on the state central repository if prospective applicant has been a resident of this Commonwealth for at least 2 years.

Central Repository: The central location for the collection, compilation, maintenance, and dissemination of criminal history record information by the Pennsylvania State Police.

Procedure: NFHCS will conduct a Criminal Background Check using the State ePATCH system. The fee for a PSP background check has increase to $22.00.

FBI Clearance: A report of Federal criminal history record information under the Federal Bureau of Investigation (FBI).

Procedure:

- If a prospective applicant has been a resident of this Commonwealth for less than 2 years or is currently a resident of another state an FBI clearance must be obtained.
- FBI Clearance check requirements: The Older Adults Protective Services Act (OAPSA) requires all applicants/staff of specific facilities/agencies (NFHCS) who are not, or have not been, a resident of the Commonwealth of Pennsylvania for the last two years, to obtain criminal history record information reports from both the Pennsylvania State Police (PSP) and the Federal Bureau of Investigation (FBI). The results for applicants/staff who require an FBI check must come from the Pennsylvania Department of Aging.
- Change to Current Process: Effective November 28, 2017, the commonwealth's new supplier of digital fingerprint and electronic federal criminal background check services will be IDEMIA. PA Safe Check is the name of the background check system that will be used by IDEMIA to process applicant digital fingerprinting background checks for the commonwealth. Due to the transition to the new provider, fingerprint services for employment were delayed from November 18-28, 2017. Once the transition is complete, applicants will be able to experience an easier to use, more efficient, process.

- Applicant Registration & Fingerprinting: Monday through Friday, 8:00 AM to 6:00 PM, EST.

Registering: Online, an applicant will be prompted to enter their Service Code, which is: 1KG8RJ. Entering this Service Code ensures that the applicant is processed for the correct NFHCS (Department of Aging) and applicant type. At the end of the registration process, the applicant will be provided with a registration number that they must bring with them when they go to the IdentoGO site for fingerprinting. Applicants must register with IdentoGO prior to arriving at a fingerprinting site. The fee for an FBI background check will decrease to $22.60. Payment can be made during the on-line registration process by using a credit or debit card, or payment can be made in-person at the fingerprint site with a money order or cashier's check made payable to MorphoTrust. No cash transactions or personal checks will be accepted.

Fingerprint requests processed through any other NFHCS, or purpose will not be accepted.

Processing FBI Reports: IdentoGO will forward the applicant's fingerprints electronically to the FBI. The FBI results will be sent to the Department of Aging and official letters will be sent to both the applicant and the facility/NFHCS. (NFHCS) NOTE: Any other source of FBI results is not acceptable under the law.

- The following website will assist in finding an IdentoGO site location: www.identogo.com/locations
- For additional information contact IDEMIA at 844-321-2101 or visit their website www.identogo.com.

NFHCS will conduct our hiring policies in accordance with Department of Aging's Older Adult Protective Services Act Policy Prohibitive Offenses Contained in Act 169 of 1996 as Amended by Act 13 Dept. of Aging Following Offenses as Contained in PA Crimes Code (18 Pa. C.S.)

Update: Peake v. Commonwealth of Pennsylvania, et al., 216 M.D. 2015

The Commonwealth Court held in Peake v. Commonwealth of Pennsylvania that it is unconstitutional for the offenses listed in the Older Protective

Services Act to result in a lifetime employment ban without further evaluation. Although Background Checks are still required, it is recommended that a facility perform an individualized risk assessment on a case-by-case basis and consult with their respective counsel regarding employment.

On December 30, 2015, the Commonwealth Court held in Peake v. Commonwealth of Pennsylvania, et al., 216 M.D. 2015, that the "lifetime employment ban" contained in Section 503(a) of the Older Adults Protective Services Act ("OAPSA"), 35 P.S. §10225.503(a), violates due process guarantees under the Pennsylvania Constitution and is therefore not enforceable. The Court also held that the Department of Aging's ("Department") previously posted "Interim Policy" (pertaining to the employment of individuals with certain criminal convictions caring for older adults) is invalid.

Please note that criminal history background checks are still required for all NFHCS applicants.

The Department recommends (NFHCS) which is subject to OAPSA requirements to consult with an attorney prior to making an employment decision to ensure compliance with the Commonwealth Court's guidance regarding exercising hiring discretion on a case-by-case basis.

This guidance focused on the consideration of factors such as:

- The nature of the crime
- Facts surrounding the conviction
- Time elapsed since the conviction
- The evidence of the individual's rehabilitation
- The nature and requirements of the job and the performance of individualized risk assessments

Child Abuse Clearances: NFHCS will conduct a child abuse clearance for each staff that provides an HCBS to a minor. (If NFHCS serves a participant who is 17 years of age or younger)
A copy of the final child abuses criminal and FBI clearance, (if applicable) will be kept.

Exclusions Checks: Prior to hiring and monthly ongoing NFHCS prospective and current Staff must NOT appear on all 3 exclusions list.

- Medi Check
- SAM
- LEIE

Specialized Training:

- Documentation of Specialized training: Prospective applicants will need to provide a copy of their specialized trainings. (If applicable CNA, LPN, Behavior Specialist,) Licenses/ Certifications must be in good standing.
- Staff who render Community Participation Support: All direct Support Professional, Program Specialists and Supervisors of our Direct Care Professionals, must complete the Department Approved training on Community Participation Support Prior to rending service to our Individual receiving this service.
- Copies of College transcripts, Degrees, Diplomas, and any other specialized training must be provided prior to hiring. All training must be valid, current, and verifiable.
- Should the service require a higher level of training? (CNA, Medication Administration, Diabetes training if applicable) Staff will receive the specialized training prior to rending services. Documentation of all trainings will be kept (Including Sign-in sheets)

Orientation/Staff Training:

- Prospective applicants will receive 5 -7-day new orientation training.
- All staff will receive two days of supervised training in the field.
- In-service and Annual Trainings will be conducted; staff will be notified of trainings via email and/or internal Bulletins.

Trainings include but not limited to:

- ISP – Prior to providing a HCBS to a participant. NFHCS will ensure that all staff has met any additional pre-and in-service training requirements as detailed in a participant's ISP.
- Department policy on intellectual disability principles and values.
- Identification and prevention of abuse, neglect, and exploitation of a participant.
- Training to meet the needs of a participant as identified in the ISP.
- Our QM plans.

- Department-issued policies or procedures, and published announcements
- Recognizing, reporting, and investigating an incident.
- Participant grievance resolution.
- Accurate billing and documentation of HCBS delivery.
- Progress notes.
- Service notes.
- Quality management tracking checklist.
- Conflict of interest policy.
- Backup plan.
- Health, behavior, crisis emergency policy.
- Surveys/participant family feedback.
- Organizational structure.
- Employee Handbook

Mechanisms in place to ensure staff qualification requirements remain in compliance:

- NFHCS will utilize an Excel Spread sheet to maintain clearances, trainings, and expiration of certifications.
- A printed hard copy of the excel spread sheet will be printed quarterly.
- Email alert notifications will be set up as reminders.
- Documentation will be kept.
- Annual Staff training plans will be developed and updated.
- Completed trainings from HCQU and Direct Support and Internal trainings will be kept and reviewed.

Staff Resources:

- PA Code Chapter 6400. https://www.pacode.com/secure/data/055/chapter6400/s6400.21.html Criminal History Checks
- PA Code Chapter 51. https://www.pacode.com/secure/data/055/chapter51/chap51toc.html#51.20
- PA Code Chapter 51. https://www.pacode.com/secure/data/055/chapter51/chap51toc.html#51.21

Provisional Hire Policy: Pursuit to Chapter 51.22: NFHCS may provisionally hire staff pending receipt of a criminal history check and child abuse clearance, as applicable, if the following conditions are met:

- A NFHCS, provisionally hired staff person MUST have applied for a criminal history check and child abuse clearance, as required per this policy. And must have submitted a copy of the completed criminal history request form and child abuse clearance form.
- NFHCS WILL NOT HIRE a person provisionally if NFHCS, has knowledge that the person would be disqualified for employment under 18 Pa. C.S. § 4911
- Provisionally hired staff person MUST swear or affirm in writing that he/she has not been disqualified from employment under chapter 51.
- NFHCS WILL NOT permit the provisionally hired staff person awaiting a criminal history background check or child abuse clearance to work alone with our participant(s).

NFHCS will monitor a provisionally hired staff person awaiting a criminal history check or child abuse clearance through random, direct observation and participant feedback. The results of monitoring will be documented in the provisionally hired staff person's file.

Requirements: The period of provisional hire of a staff person that is and has been for 2 years or more a resident of this Commonwealth may not exceed 30 days. The period of provisional hire of a staff person who has not been a resident of this Commonwealth for 2 years or more may not exceed 90 days.

Staff Resources:

- PA Code Chapter 51 https://www.pacode.com/secure/data/055/chapter51/chap51toc.html#51.20.
- https://www.pacode.com/secure/data/055/chapter51/chap51toc.html#51.21.
- https://www.pacode.com/secure/data/055/chapter51/chap51toc.html#51.22.
- www.dhs.pa.gov

6.2 Limited English Proficiency Policy Statement

Implemented: December 2015 **Revised:**

Background: NFHCS has developed and is committed to maintaining a Limited English Proficiency Policy. The purpose of this program is to ensure that the NFHCS's Mission, Values and Principles are met and that the NFHCS remains in full compliance with all federal, state, and local requirements, as well as those applicable requirements with contracted Managed Care Organizations. In addition, the Corporate Compliance Program will assist the NFHCS in maintaining the highest ethical standards in all aspects of service provision and business decisions.

Procedure: It is the policy of the United States Department of Transportation not to discriminate against any person who is limited English proficient (LEP). In accordance with Title VI of the Civil Rights Act of 1964 and Executive Order 13166, the Department will take reasonable steps to provide LEP persons meaningful access to its programs and activities. This commitment applies to all of the Department's federally conducted programs and activities.

The Department hereby adopts a Language Access Plan (LAP) which articulates the Department's responsibilities, policies, and strategies for providing language assistance services to LEP persons. The LAP applies to all Operating Administrations (OAs), to the Office of the Secretary of Transportation (OST), and to all subdivisions of either. We intend for the LAP to evolve as we learn more about the Department's many interactions with LEP persons and groups, and as we gain experience in providing language assistance services.

Providing appropriate language assistance will require identifying critical points of interaction with the LEP public, assessing LEP communities' particular language assistance needs, and determining, with specificity, how each OA will ensure meaningful access for LEP persons. The Department recognizes that many of these tasks are best addressed by the OAs, which often have more direct contact with the persons and communities requiring language assistance. The LAP is a general framework within which OAs may develop more targeted solutions to the challenge of providing effective

language assistance services. To spur the process, I direct each OA Administrator to issue a memorandum:

- emphasizing the importance of providing appropriate language-based access to the OA's programs and activities.
- setting forth the OA's language access policy; and
- assigning and naming managers and staff responsible for implementation.

6.3 Staff Development, Recognition & Training

Implemented: October 2016 **Revised:** September 2021

Background: NFHCS has developed and is committed to maintaining a Staff Development, Recognition & Training Policy. The purpose of this program is to ensure that the NFHCS's Mission, values and principles are met and that the NFHCS remains in full compliance with all federal, state, and local requirements, as well as those applicable requirements with contracted Managed Care Organizations. In addition, the Corporate Compliance Program will assist the NFHCS in maintaining the highest ethical standards in all aspects of service provision and business decisions.

Procedure: NFHCS recognizes the desirability and necessity to provide opportunities for staff to broaden their knowledge and skills both in the interest of achieving and maintaining a performance-oriented work environment and in accomplishing staff self-development goals. Toward this end, NFHCS has established the Staff Development, Recognition & Training Program, which has the full support and encouragement of the NFHCS administration. The goals and objectives of the program are:

- To assist staff in accomplishing self-development goals.
- To provide an overview of the NFHCS environment and the role of the staff in this setting.
- To develop from current theories of organizational communication an employable model to improve communications at NFHCS.
- To develop a sense of awareness of organizational responsibilities and staff expectations in the day-to-day work environment.
- To develop a modified environment in which morale is uplifted to provide maximum efficiency and effectiveness of services provided.

Trainings: Training Programs: The Staff Development is a priority of the NFHCS and is conducted to the maximum extent possible within resources available both inside and outside the NFHCS. The Program is administered by Director of Operations and includes the following:

- All development/orientation training sessions scheduled by Human Resource Services or Equal Opportunity and Affirmative Action.
- All training sessions given by NFHCS departments at the request of Director of Administration.

- All training made available to staff of the NFHCS from outside sources, such as the Division of Personnel, other state agencies, the federal government, or private industry.
- All training sessions given by administration and outside entity for Staff Development, Recognition and Training.

Any staff of the NFHCS is eligible to attend programs presented by administration. Attendance at programs presented by outside sources may be limited to staff meeting established criteria; however, all staff who meet the criteria may attend.

Attendance at training conducted during a staff's normal working hours will be subject to approval of the supervisor. Programs will generally be offered more than once so staff and supervisors can make necessary work schedule changes.

If a program is mandatory for an identified group of staff, supervisors will permit staff to attend.

Relias: The Relias LMS is a browser-based application designed to help you manage your learning administration needs. If you use a reasonably current operating system and web browser, and you haven't made any unusual modifications to your setup; Relias should work for you and your users. For those users who do encounter problems, or who want to dig under the hood a little more, the following documentation can help you troubleshoot.

What Do I Need to Do to My Computer to Use Relias? Probably nothing. Relias follows W3C standards, which is the norm for most major websites and applications. If you're using a manufacturer supported browser and operating system, W3C standards are supported.

For point of reference, Microsoft is still supporting Internet Explorer 8.0 and above for
browsers, and Windows XP and above for operating systems. Users of similarly current versions of Firefox, Chrome or other browsers obeying W3C standards should also be able to use all major functionality. The system will run on IE 7.0, however there may be cosmetic issues and minor loss of functionality. If possible, please use IE 8.0.

Most browsers now include the settings listed below by default. If you have any concerns that your settings may have been modified, the easiest

solution is to simply reset your browser to defaults. In Internet Explorer 8.0 (IE8), you can find this option by going to Tools, Options and clicking on the Advanced tab. If you do not see the Tools option, press the 'Alt' key on your keyboard and Tools will become available in the top left corner of your screen.

What If I Don't Know What Kind of Browser I'm Using? Relias makes it easy for you to figure out which elements you are using at the time your login. Click on the "View System Requirements" link on the login page and Relias will automatically confirm your browser, operating system, JavaScript status as well as whether you have the ability to view flash and PDF documents (through Adobe Reader).

It is possible for organizations to turn off the system requirements link in environments where users are not permitted to modify their system settings. If you need to check a user's settings in such an environment, you should first go to Settings (after logging on) to turn the check back on (at least temporarily).

Specific browser settings that may cause problems if modified include: Not automatically refreshing from the server. If you click on an area of the application
such as a course and find yourself viewing content you have seen previously rather than
the content you expected, you may not be fully connected to the server. In IE8, you can
modify this by going to Tools, Options, General and clicking on Settings under the
browsing history section.

JavaScript not installed or disabled. JavaScript is now standard on all major operating systems and is required to use many features such as drag-and-drop controls on the hierarchy or to view certain course content. Some earlier versions of Internet Explorer allowed the user to disable JavaScript on the Tools, Options, Advanced tab. If you are unable to use JavaScript on your PC, please contact your organization's IT department.

Popup blocker enabled. Certain areas of the application, such as course activities or certificate printing, require popups. If you use a current browser, it's likely that the first time you try to open a popup you'll be prompted about whether to allow it. The safest approach here is set your

popup blocker to allow popups throughout the http://training.reliaslearning.com domain. If you are unable to do this, or are unsure of how to set your blocker permissions, you should hold down the CTRL key while clicking on the link. The CTRL key universally overrides any popup blocker you have on your computer. If you use any special toolbars (for example, the Google Toolbar), you may need to turn off the toolbar's popup blocker as well.

Adobe Flash plug-in not installed/enabled. When a user accesses course content that uses Flash, the LMS will check to determine whether the plug-in is installed. If it is not, a dialog box should automatically open to allow the user to download the latest version from Adobe. This dialog will not appear if the user's PC does not have security rights to download and install plug-ins.

Studies have shown that online learning is most effective when learners actively engage coursework. As such, many Relias Learning courses contain quizzes, games, and animations that allow learners to interact with courses. Much of this multimedia interactivity leverages Shockwave Flash objects and requires the appropriate plug-in to be used.

Hardware that does not support flash, such as the iPhone, iPad, and most Android devices, cannot be used to access courses utilizing flash. All Relias Learning courses containing flash are indicated with a flash icon () next to the course title.

Administrators who will be uploading course content through the course assembler must have flash installed in order to use the upload controls.

- Adobe Reader plug-in not installed/enabled. While primary content from Relias
  Learning is always delivered through browser-based language, supplemental material
  (e.g., fact sheets associated with content) may be delivered through PDF (portable
  document format). In addition, many organizations upload their own content using
  PDF files.

Most systems of recent vintage come with the free Adobe Reader software preinstalled, but if you have uninstalled the software for any reason or are using a non-Microsoft browser that requires an additional plug-in to view PDF documents, please make sure it has been enabled.

IMPORTANT: Microsoft Silverlight plug-in not installed/enabled: The Training Performance Chart on the Dashboard requires Silverlight. There is an HTML version of the chart; however, it has much less functionality. Upon initial login, you will be requested to download Microsoft Silverlight.

- Training Performance Chart with Silverlight
- Sample HTML version of Training Performance Chart

Note: If you find that you have any configuration issues that weren't covered in this document, please contact Customer Support.

Technical Guidelines for Relias: The following documentation is intended for IT departments that may need to modify settings for their organization. As stated previously, in most cases you won't need to make any modifications to your system to use Relias. However, some organizations do limit internet access on organization terminals and will need to permit Relias to run.

Relias Learning's LMS is a completely web-based application. No application software is installed on the client side. All application activity occurs on a web browser that communicates from the client to our servers using HTTP (or MMS for streaming video content).

Although the system is accessible through HTTPS, course content is not encrypted which can lead to problems with flash and animation. We recommend using the HTTP protocol to access all Relias Learning applications.

System Requirements

- Internet connectivity, broadband recommended
- CPU 1GHz or higher recommended
- 512 MB RAM or higher recommended
- Courses are designed for a screen resolution of at least 1024 x 768. Lower resolutions may be
- used but may require scrolling.
- If using the trusted sites feature in certain browsers, allow reliaslearning.com.
- Client-side JavaScript and VB script must be enabled

- Adobe's Flash plug-in must be installed for most Relias Learning courses, preferably version 8 or higher.
- Client browsers must accept cookies from Relias Learning
- Client browsers must allow pop-ups

Relias Learning IP Addresses
training.reliaslearning.com
…….162.209.16.115
www.reliaslearning.net
…….162.209.16.114
www.reliaslearning.com.....
.162.209.16.114

Security

- No ActiveX components are required to use the Relias LMS or other Relias Learning
  applications.
- Firewalls must allow HTTP traffic on port 80. Some videos require MMS traffic on ports 554 and 1755. By default, these ports are open on most terminals.
- Some functions allow supervisors to send email to students (either in masse or
  individually) directly from the application. This outgoing mail will come from noreply@reliaslearning.com. Please ensure the reliaslearning.com domain is allowed by your mail server and anti-spam software.

Leave with Pay & Expenses: Leave with pay may be authorized for attendance at work-related training or programs when in the judgment of the supervisor the attendance will be of benefit to the state. Payment of tuition/education training expenses of staff may be authorized under two conditions:

- When the training involved is considered as required in order for the staff to perform the duties expected for the position to which he or she is assigned; and
- When the NFHCS or department involved has the funds available.

The following are suggested steps for conducting the Training process for your specific department.

TRAINING SYLLABUS

The following are suggested steps for conducting the Training process for your specific department.

Residential: Residential Staff (e.g., Direct Support Staff, Program Specialist) are required to complete these MANDATORY trainings below:

Required 40 Hours.
Staff Orientation/Annual Training

Hire Date:

Orientation:

- Employment Handbook/Policy & Procedure (Manual's)–
- First Aid, CPR Card (Face to face)–
- Med Training (Face to face)–
- The Safe and Appropriate Use of Behavioral Support
    - Specific Behavioral Plan (ISP)
    - Overview Behavioral Support (Relias)
- Fire Safety Policy (46A) -
    - Fire Safety Certificate (Relias)
    - Fire Drill (16 Hour Orientation)
    - Responsibilities during Fire Drill (16 Hour Orientation)
- Fatal Five Certificate (Relias)
- Everyday Lives (Certificate or Training sheet)-Person Centered Practices
    - Community Integration (Relias)
    - Supporting Individual to develop and maintain relationships (Relias)
        - New Sexuality policy
    - Individual Choice (Relias)
- The Prevention Detection and Reporting of Abuse, Suspected abuse, and Alleged Abuse (Relias)
- Job related and skills. (Face to face)–
    - Job Description
    - 16 House Orientation
- New Incident Management Bulletin (Relias)
- Recognizing, Responding and Reporting Abuse (Relias)-
- Quality Management Certificate (Relias)-
- Individual Rights (Relias)-
- ISP Acknowledgement (Review/Therap)
    - ISP Review and Acknowledgement/Implementation

    of the Individual Support Plan
    - Personal Care ADLS
    - AM/PM Care
    - Dressing
    - Toileting
    - Ambulation/Proper transferring Techniques/ How to apply adaptive equipment.
    - Following prescribed Therapy/Physical-Occupational-Behavioral
    - Medical Conditions/ Caring for Individuals with: Seizures, and diabetes
    - Sensitivity training (History of IDD and the treatment they received)
- Evacuation Procedures (two parts- 16hours/Relias)
- Therap/How to properly document
- Emergency Disaster Response Plan (Relias/16 hours)
- Infectious Control (Relias
    - COVID 19 Questionnaire (DHS)
    - PPE
    - Hand washing
    - Socially distancing
    - Masking
    - COVID Prevention
- Active Shooter (Relias)
- Individual's Communication Method (Relias)
    - Specific to each individual
    - Overview
- Vehicle Policy Certificate *(Policy & Procedure Manual)*
    - Defensive Driver
    - Policy
- Report Child Abuse (Staff working with children)
- 16 Hour Orientation _____, _____, _____, _____
- **Additional Training as needed.**
- **Specialized Training as needed.**

Start Date:

- My ODP Executive Training (Specialty Position)
- HRST Online (Assigned to certain residential staff)
- Contractors Training (Specialty)

Trainings (Every Six Months)

- Medical Related Training CPAP

- Fire Safety Policy (46A)
    - Relias & Video Certificate
    - Fire Drill
    - Responsibilities during Fire Drill
- Individual Rights
- Incident Management
- Medication Error Administration
- **Diabetes Certificate*** (Only Staff in need)**

Annual Trainings:

- Policy and Procedures Certificate
- Employment handbook
- Accurate billing and documentation of HCBS delivery
    - Therap
    - Proper documentation of a service note
- ODP Department issued policy and procedure.
    - Bulletins
    - Information Memo
- First Aide
- The Prevention Detection and reporting of Abuse, suspected abuse, and alleged Abuse
- ISP Acknowledgement-Training to meet the needs of the participate.
- Backup Plan
- Fatal Five Certificate
- Individual Rights (Policy & Procedure Manual)
- Individual Choices (Policy & Procedure Manual)
- Supporting Individual to develop and maintain relationships (Policy & Procedure Manual)
    - New Sexuality policy
- Everyday Lives (Certificate or Training sheet)-Person centered Practices
- Person Centered Practices
    - Community Integration
    - Everyday Lives
- Quality Management Certificate
- Vehicle Policy Certificate (Policy and Procedure)
- Incident Management Certificate
    - Identification, Prevention of Abuse, Neglect and Exploitation
    - Recognizing, reporting, and investigating an incident
- Report Abuse (Certificate or Training Sheet)

- Participant Grievance resolutions
- The Safe and Appropriate Use of Behavioral Support
    - Specific Behavioral Plan
    - Overview Behavioral Support
- Individual's Communication Method
    - Specific to each individual
- **Additional Training as needed.**
- **Specialized Training as needed.**

Administration: Administration Staff (e.g., CFO, Executive Director, Nurse, Supported Employment, Behavioral Specialist) are required to complete these MANDATORY trainings below:

Required 40 Hours Annually

Hire Date:

- Employment handbook
- Policy and Procedures Certificate
- Job Description & Skills
- First Aid, CPR Card
- Fire Safety Certificate
- Everyday Lives (Certificate or Training sheet)
- Quality Management Certificate
- Vehicle Policy Certificate
- Incident Management Certificate
- Report Abuse (Certificate or Training Sheet)
- Active Shooter Certificate
- Defensive Driver Certificate
- Fatal Five Certificate
- **Additional Training as needed. (OSHA, MSDS)**
- **Specialized Training as needed.**

Start Date:
Annual Trainings

- Annual Training on Policy and Procedures
- Employment Handbook
- Fire Safety Certificate
- Fatal Five Certificate
- Everyday Lives (Certificate or Training sheet)
- Quality Management Certificate
- Vehicle Policy Certificate

- Individual Rights (Policy & Procedure Manual)
- Incident Management Certificate
- Report Abuse (Certificate or Training Sheet)
- Defensive Driver Certificate
- Report Child Abuse (Staff working with children)
- First Aid
- **Additional Training as needed. (OSHA, MSDS)**
- **Specialized Training as needed.**

Habilitation: Direct Support Specialists working under Habilitation, are required to complete these trainings below:

Hire Date:

Orientation:

- Employment Handbook/Policy & Procedure –
- First Aid, CPR Card –
- The Safe and Appropriate Use of Behavioral Support
    - Specific Behavioral Plan
    - Overview Behavioral Support
- Fire Safety Certificate
- Fatal Five Certificate
- Everyday Lives (Certificate or Training sheet)-Person Centered Practices
- Person Centered Practices
- Community Integration
- Supporting Individual to develop and maintain relationships (Policy & Procedure Manual)
    - New Sexuality policy
- Individual Choice (Policy & Procedure)
- Individual Rights (Policy & Procedure Manual)
- The Prevention Detection and Reporting of Abuse, Suspected abuse, and Alleged Abuse
- Job related and skills.
    - Job Description
    - Meet & greet with Individual
- Incident Management Certificate (Policy & Procedure Manual)
- Recognizing, Responding and Reporting Abuse (Certificate or Training Sheet) (Policy & Procedure Manual)
- Quality Management Certificate (Policy & Procedure Manual)
- Individual Rights (Policy & Procedure Manual)

- ISP Acknowledgement
    - Cultural Diversity
    - ISP Review and Acknowledgement/Implementation of the Individual Support Plan
    - Personal Care ADLS
    - AM/PM Care
    - Dressing
    - Toileting
    - Ambulation/Proper transferring Techniques/ How to apply adaptive equipment.
    - Following prescribed Therapy/Physical-Occupational-Behavioral
    - Medical Conditions/ Caring for Individuals with: Seizures, and diabetes
    - Therap/How to properly document
- Evacuation Procedures (Policy & Procedure Manual)
- Emergency Disaster Response Plan (Policy & Procedure Manual)
- Infectious Control
    - COVID 19 Questionnaire (DHS)
    - PPE
    - Hand washing
    - Socially distancing
    - Masking
    - COVID Prevention
- Active Shooter
- Individual's Communication Method
    - Specific to each individual
- Vehicle Policy Certificate *(Policy & Procedure Manual)*
    - Defensive Driver
- Crisis Management
- Report Child Abuse (Staff working with children)
- **Additional Training as needed.**
- **Specialized Training as needed.**

Annual Trainings

- Policy and Procedures Certificate
- Employment handbook
- Accurate billing and documentation of HCBS delivery
    - Therap
    - Proper documentation of a service note
- ODP Department issued policy and procedure.
    - Bulletins

    - Information Memo
- First Aide
- The Prevention Detection and reporting of Abuse, suspected abuse, and alleged Abuse
- ISP Acknowledgement-Training to meet the needs of the participate.
- Backup Plan
- Fatal Five Certificate
- Individual Rights (Policy & Procedure Manual)
- Individual Choices (Policy & Procedure Manual)
- Supporting Individual to develop and maintain relationships (Policy & Procedure Manual)
    - New Sexuality policy
- Everyday Lives (Certificate or Training sheet)-Person centered Practices
- Person Centered Practices
    - Community Integration
    - Everyday Lives
- Quality Management Certificate
- Vehicle Policy Certificate (Policy and Procedure)
- Incident Management Certificate
    - Identification, Prevention of Abuse, Neglect and Exploitation
    - Recognizing, reporting, and investigating an incident
- Report Abuse (Certificate or Training Sheet)
- Participant Grievance resolutions
- The Safe and Appropriate Use of Behavioral Support
    - Specific Behavioral Plan
    - Overview Behavioral Support
- Individual's Communication Method
    - Specific to each individual
- **Additional Training as needed.**
- **Specialized Training as needed.**

6.4 American Disability Act (ADA)

Implemented: December 2015 **Revised:** October 2020

Background: The Americans with Disabilities Act (ADA) and the Americans with Disabilities Amendments Act (ADAAA) are federal laws that require employers with 15 or more staff to not discriminate against applicants and individuals with disabilities and, when needed, to provide reasonable accommodations to applicants and staff who are qualified for a job, with or without reasonable accommodations, so that they may perform the essential job duties of the position.

It is the policy of Not Forgotten Home & Community Services (NFHCS) to comply with all federal and state laws concerning the employment of persons with disabilities and to act in accordance with regulations and guidance issued by the Equal Employment Opportunity Commission (EEOC). Furthermore, it is the NFHCS policy not to discriminate against qualified individuals with disabilities regarding application procedures, hiring, advancement, discharge, compensation, training or other terms, conditions, and privileges of employment.

Procedures: When an individual with a disability requests accommodation and can be reasonably accommodated without creating an undue hardship or causing a direct threat to workplace safety, he or she will be given the same consideration for employment as any other applicant. Applicants who pose a direct threat to the health, safety and well-being of themselves or others in the workplace when the threat cannot be eliminated by reasonable accommodation will not be hired.

NFHCS will reasonably accommodate qualified individuals with a disability so that they can perform the essential functions of a job unless doing so causes a direct threat to these individuals or others in the workplace and the threat cannot be eliminated by reasonable accommodation or if the accommodation creates an undue hardship to NFHCS. Contact human resources (HR) with any questions or requests for accommodation.

All staff are required to comply with the NFHCS's safety standards. Current staff who pose a direct threat to the health or safety of themselves or other individuals in the workplace will be placed on leave until an organizational decision has been made regarding the staff's immediate employment situation.

Individuals who are currently using illegal drugs are excluded from coverage under the NFHCS ADA policy.

The HR department is responsible for implementing this policy, including the resolution of reasonable accommodation, safety/direct threat, and undue hardship issues.

Terms Used in This Policy: As used in this ADA policy, the following terms have the indicated meaning:

- **Disability:** A physical or mental impairment that substantially limits one or more major life activities of the individual, a record of such an impairment, or being regarded as having such an impairment.
- **Major life activities:** Term includes caring for oneself, performing manual tasks, seeing, hearing, eating, sleeping, walking, standing, lifting, bending, speaking, breathing, learning, reading, concentrating, thinking, communicating, and working.
- **Major bodily functions**: Term includes physical or mental impairment such as any physiological disorder or condition, cosmetic disfigurement or anatomical loss affecting one or more body systems, such as neurological, musculoskeletal, special sense organs, respiratory (including speech organs), cardiovascular, reproductive, digestive, genitourinary, immune, circulatory, hemic, lymphatic, skin, and endocrine. Also covered are any mental or psychological disorders, such as intellectual disability (formerly termed "mental retardation"), organic brain syndrome, emotional or mental illness and specific learning disabilities.
- **Substantially limiting:** In accordance with the ADAAA final regulations, the determination of whether an impairment substantially limits a major life activity requires an individualized assessment, and an impairment that is episodic or in remission may also meet the definition of disability if it would substantially limit a major life activity when active. Some examples of these types of impairments may include epilepsy, hypertension, asthma, diabetes, major depressive disorder, bipolar disorder, and schizophrenia. An impairment, such as cancer that is in remission but that may possibly return in a substantially limiting form, is also considered a disability under EEOC final ADAAA regulations.
- **Direct threat:** A significant risk to the health, safety, or well-being of individuals with disabilities or others when this risk cannot be eliminated by reasonable accommodation.

- Qualified individual: An individual who, with or without reasonable accommodation, can perform the essential functions of the employment position that such individual holds or desires.
- **Reasonable accommodation:** Includes any changes to the work environment and may include making existing facilities readily accessible to and usable by individuals with disabilities, job restructuring, part-time or modified work schedules, telecommuting, reassignment to a vacant position, acquisition or modification of equipment or devices, appropriate adjustment or modifications of examinations, training materials or policies, the provision of qualified readers or interpreters, and other similar accommodations for individuals with disabilities.

Undue Hardship: An action requiring significant difficulty or expense by the employer. In determining whether an accommodation would impose an undue hardship on a covered entity, factors to be considered include:

- The nature and cost of the accommodation.
  - The overall financial resources of the facility or facilities involved in the provision of the reasonable accommodation, the number of persons employed at such facility, the effect on expenses and resources, or the impact of such accommodation on the operation of the facility.
  - The overall financial resources of the employer; the size, number, type, and location of facilities.
  - The type of operations of the NFHCS, including the composition, structure, and functions of the workforce; administrative or fiscal relationship of the facility involved in making the accommodation to the employer.
- Essential functions of the job: Term refers to those job activities that are determined by the employer to be essential or core to performing the job; these functions cannot be modified.

The examples provided in the above terms are not meant to be all-inclusive and should not be construed as such. They are not the only conditions that are considered to be disabilities, impairments or reasonable accommodations covered by the ADA/ADAAA policy.

6.10 Diversity, Equality, & Inclusion

Implemented: July 2016 **Revised:** July 2019

Persons Affected: Individuals, Families (if APPLICABLE), staff/ Contractors, Vendors, including Sub- Contractors, OF Not Forgotten Home & Community services.

Our Purpose: Our purpose is to inform the affected of Not Forgotten Home & Community Services, of our Policy

Definitions:

- **NFHCS:** Not Forgotten Home & Community Services
- **Department:** The Department of Health & Human Services of the Commonwealth
- **ED:** Executive Director
- **C:** Contractors
- **SC:** Sub- Contractor
- **V:** Vendor

Policy/ Procedures Objectives:

- Background
- Good Faith Efforts.
- NFHCS Procedure on Diversity.
- Contact Information.

Background: It is the policy of Not Forgotten Home and Community Services to support the maximum practical utilization of certificated M/W/DBEs. By promoting diversity throughout our business practice. One of the ways NFHCS accomplishes this, is by making a good faith effort to solicit the services of certified M/W/DBEs, throughout our normal business practices. This will allow the maximum opportunity for M/W/DBEs to participate as contractors, sub-contractors and/or suppliers.

Good Faith Efforts: Good Faith Efforts are made by searching M/W/ DBE database(s), contracting M/W/DBEs for relevant scopes of work, and requesting quotes for services, and/or supplies. With the end goal of utilizing M/W/DBE contractors' services in the amount of 13% MBE and 2% WBE. Databases regularly searched are but not limited to: www.paucp.com and www.dgs.pa.gov

PROCEDURE: NFHCS is committed to fostering, cultivating, and preserving a culture of diversity and inclusion.

Our human capital is the most valuable assets we have. The collective sum of the individual differences, life experiences, knowledge, inventiveness, innovation, self-expression, unique capabilities, and talent that our staff (Contractors and Sub- Contractors) invest in their work, represents a significant part not only of our culture, but our reputation and NFHCS's achievement as well.

We embrace and encourage our staff' (including contractors and sub-contractor) differences in age, color, disability, ethnicity, family or marital status, gender identity or expression, language, national origin, physical and mental ability, political affiliation, race, religion, sexual orientation, socio-economic status, veteran status and other characteristics that make our staff including contractors and sub-contractors unique.

NFHCS diversity initiatives are applicable, but not limited to, our practices and policies on recruitment and selection of all staff (including contractors and sub-contractor).

- Compensation and benefits.
- Professional development and training.
- Promotions.
- Transfers.
- Social and recreational programs.
- Layoffs.
- Terminations
- The ongoing development of a work environment, built on the premise of gender and diversity equality that encourages and enforces.
- Respectful communication and cooperation between all staff, contractors, and sub-contractors.
- Teamwork and staff, contractors, and sub- contractors' participation.
- Permitting the representation of all groups of people.
- Work/life balance through flexible work schedules to accommodate staff varying needs.
- NFHCS staff (including contractors and sub-contractor) contributions to the communities we serve, to promote a greater understanding and respect for diversity.

All staff (including contractors and sub-contractor) of NFHCS, has a responsibility to treat others with dignity and respect. Staff (including contractors and sub-contractor) are expected to exhibit conduct that reflects inclusion during work functions on or off the work site, and at all other NFHCS- sponsored and participative events. All staff are required to attend

and complete Biennial diversity awareness training to enhance their knowledge to fulfill this responsibility. (Updated June17, 2019)

Any staff found to have exhibited any inappropriate conduct or behavior against others may be subject to disciplinary action. Including termination.

Staff who believe they have been subjected to any kind of discrimination that conflicts with our NFHCS's diversity policy and initiatives should seek assistance form their immediate supervisor and/or NFHCS HR representative.

Staff Resources: NFHCS- HR Consultant – Mr. Wes Garnett Phone: (303) 658-9342
Allegheny County M/W/DBE Department Phone: (412) 350-4309 Fax: 412-350-4915
Web site: www.alleghenycounty.us/mwdbe/contact/index.aspx

6.25 A Few Closing Words

This Manual is intended to give employees key regulatory guidelines that govern daily operations, in order to stay in compliance. The information in this manual is comprehensive in nature and, should questions arise, any member of management should be consulted for complete details.

While we intend to continue the policies, rules and benefits described in this manual, NOT FORGOTTEN, in its sole discretion, may always amend, add to, delete from, or modify the provisions of this manual and/or change its interpretation of any provision set forth in this manual.

Employees should not hesitate to speak to management or our HR Specialist vkarabasz@nfhcs.org (412)279-5000 if they have any questions about NOT FORGOTTEN or its personnel policies and practices.

SECTION 6 – PERSONNEL ACKNOWLEDGMENT

Section 6 of this Policy and Procedure Manual is an important document intended to help you become acquainted with the Not Forgotten Home & Community Services, as it relates to Personnel. This document is intended to provide guidelines and detail descriptions, according to both strict governmental and agency wide regulations.

The regulations are provided in this section is regulatory in manner in order to maintain employment and for Not Forgotten to maintain compliance as a provider. The section covers all policies related to Personnel, including both state and federal regulations listed below:

- Staff Qualifications
- Limited English Proficiency Policy Statement
- American Disability Act (Ada)
- Diversity, Equality, And Inclusion
- Staff Development, Recognition & Training

This section will count **1 HOUR** towards training.

Because the Not Forgotten Home & Community Services operations may change, the contents of this manual may be changed at any time, with or without notice, in an individual case or generally, at the sole discretion of management.

Please read the following statements and sign below to indicate your receipt and acknowledgment of Section 6 of the Policy and Procedure Manual.

I have received and read a copy of Not Forgotten Home & Community Services Policy and Procedure Manual. I understand that the policies, rules, and benefits described in it are subject to change at the sole discretion of the Not Forgotten Home & Community Services at any time.

I understand that my signature below indicates that I have read and understand the above statements and that I have received a copy of the Not Forgotten Home & Community Services Policy and Procedure Manual.

Employee's Printed Name: _____

Employee's Signature: _____

Position: _____

Date: _____

The signed original copy of this acknowledgment should be given to management - it will be filed in your personnel file.