245D RESIDENTIAL INTENSIVE SUPPORT SERVICES POLICIES AND PROCEDURES

June 2017

245D RESIDENTIAL INTENSIVE SUPPORT SERVICES POLICIES AND PROCEDURES

Policy and Procedure Number	Policy and Procedure Title	Date
D-RISS-01	Admission	Rev. 6/17
D-RISS-02	Temporary Service Suspension	Rev. 8/15
D-RISS-03	Grievances	Rev. 7/15
D-RISS-04	Data Privacy	New 7/13
D-RISS-05	Emergency Use of Manual Restraint	Rev. 8/15
D-RISS-06	Responding to and Reporting Incidents	Rev. 6/17
D-RISS-07	Emergencies	Rev. 8/15
D-RISS-08	Reviewing Incidents and Emergencies	Rev. 7/14
D-RISS-09	Reporting and Review of Maltreatment of Vulnerable Adults	Rev. 6/17
D-RISS-10	Reporting and Review of Maltreatment of Minors	Rev. 8/15
D-RISS-11	Safe Transportation	New 7/13
D-RISS-12	Anti-Fraud	New 7/13
D-RISS-13	Alcohol and Drug Use	New 7/13
D-RISS-14	Death of a Person Served	New 7/13
D-RISS-15	Universal Precautions and Sanitary Practices	New 7/13
D-RISS-16	Health Service Coordination	Rev. 7/15
D-RISS-17	Safe Medication Assistance and Administration	Rev. 7/15
D-RISS-18	Service Termination	New 8/15
D-RISS-19	Person-Centered Planning and Service Delivery	New 8/15

Synstelien Community Services

POLICY AND PROCEDURE ON ADMISSION

I. PURPOSE

The purpose of this policy is to establish procedures that ensure continuity of care during admission or service initiation including the company's admission criteria and processes.

II. POLICY

Services may be provided by the company as registered and licensed according to MN Statutes, chapter 245D and MN Statutes, chapter 245A. All services will be consistent with the person's service-related and protection-related rights identified in MN Statutes, section 245D.04. The company may provide services to persons with disabilities, including, but not limited to, developmental or intellectual disabilities, brain injury, mental illness, age-related impairments, or physical and medical conditions when the company is able to meet the person's needs.

Documentation from the admission/service initiation, assessments, and service planning processes related to the company's service provision for each person served and as stated within this policy will be maintained in the person's service recipient record.

III. PROCEDURE

Admission criteria

A. Certain criteria will be used by this company to determine whether the company is able to develop services to meet the needs of the person as specified in their *Coordinated Service and Support Plan.* In addition to registration and licensed ability, the criteria includes:
   1. For programs that are licensed as Community Residential Settings, persons served are 18 years of age or older.

B. The company, when defined as a health care facility according to MN Statutes, chapter 245A, will notify all residents when a registered predatory offender is admitted into the program or to a potential admission when the facility is already serving a registered predatory offender. This notification will be done according to the requirements in MN Statutes, section 243.166.

C. When a person and/or legal representative requests services from the company, a refusal to admit the person must be based upon an evaluation of the person's assessed needs and the company's lack of capacity to meet the needs of the person.

D. The company must not refuse to admit a person based solely on the type of residential services the person is receiving or solely on the person's:
   1. Severity of disability.
   2. Orthopedic or neurological handicaps.
   3. Sight or hearing impairments.
   4. Lack of communication skills.
   5. Physical disabilities.
   6. Toilet habits.
   7. Behavioral disorders.
   8. Past failures to make progress.

E. Documentation regarding the basis for the refusal will be completed using the *Admission Refusal Notice* and must be provided to the person and/or legal representative and case manager upon request. This documentation will be completed and maintained by the Designated Coordinator and/or Designated Manager or designee.

Admission process and requirements

A. In the event of an emergency service initiation, the company must ensure that staff training on individual

service recipient needs occurs within 72 hours of the direct support staff first having unsupervised contact with the person served. The company must document the reason for the unplanned or emergency service initiation and maintain the documentation in the person's service recipient record.

B. Prior to or upon the initiation of services, the Designated Coordinator and/or Designated Manager will develop, document, and implement the *Individual Abuse Prevention Plan* according to MN Statutes, section 245A.65, subdivision 2.

C. When the person to be served is to receive foster care or supported living services in a residential site controlled by the license holder, the person and/or legal representative and the license holder must sign and date the residency agreement. The residency agreement must include service termination requirements. It must be reviewed annually, dated, and signed by the person and/or legal representative and license holder.

D. The Designated Coordinator and/or Designated Manager will ensure that during the admission process the following will occur:
   1. Each person to be served and/or legal representative is provided with the written list of the *Rights of Persons Served* that identifies the service recipient's rights according to MN Statutes, section 245D.04, subdivisions 2 and 3.
      a. An explanation will be provided on the day of service initiation or within five (5) working days of service initiation and annually thereafter.
      b. Reasonable accommodations will be made, when necessary, to provide this information in other formats or languages to facilitate understanding of the rights by the person and/or legal representative.
   2. Orientation to the company's *Program Abuse Prevention Plan* will occur within 24 hours of service admission, or for those persons who would benefit more from a later orientation, the orientation may take place within 72 hours.
   3. An explanation and provision of copies (may be provided within five [5] working days of service initiation) of the following policies and procedures to the person and/or legal representative:
      1. *Policy and Procedure on Grievances*
      2. *Policy and Procedure on Temporary Service Suspension*
      3. *Policy and Procedure on Service Termination*
      4. *Policy and Procedure on Data Privacy*
      5. *Policy and Procedure on Emergency Use of Manual Restraint*
      6. *Policy and Procedure on Reporting and Reviewing of Maltreatment of Vulnerable Adults*
      7. *Policy and Procedure on Reporting and Reviewing of Maltreatment of Minors*
   4. Written authorization is obtained (and annually thereafter) by the person and/or legal representative for the following:
      a. *Authorization for Medication and Treatment Administration*
      b. *Agreement and Authorization for Injectable Medications*
      c. *Authorization to Act in an Emergency*
      d. *Standard Release of Information*
      e. *Specific Release of Information*
      f. *Financial Authorization*
         i. This authorization may be obtained within five (5) working days of the service initiation meeting and annual thereafter.
      g. The *Admission Form and Data Sheet* is signed by the person and/or legal representative and includes the date of admission or readmission, identifying information, and contact information for members of the support team or expanded support team and others as identified by the person or case manager.

E. Also during the admission meeting, the support team or expanded support team will discuss:
   1. The company's responsibilities regarding health service needs and the procedures related to meeting those needs as assigned in the *Coordinated Service and Support Plan* and/or *Coordinated Service and Support Plan Addendum.*
   2. The desired frequency of progress reports and progress review meetings, at a minimum of annually.

3. The initial financial authorization and the Designated Coordinator and/or Designated Manager will survey, document, and implement the preferences of the person served and/or legal representative and case manager for the frequency of receiving statements that itemizes receipt and disbursements of funds or other property. Changes will be documented and implemented when requested.

F. If a person's licensed health care professional or mental health professional has determined that a manual restraint would be medically or psychologically contraindicated, the company will not use a manual restraint to eliminate the immediate risk of harm and effectively achieve safety. This statement of whether or not a manual restraint would be medically or psychologically contraindicated will be completed as part of service initiation planning.

Admission process follow up and timelines

A. The Designated Coordinator and/or Designated Manager or designee will ensure that the person's other providers, medical and mental health care professionals, and vendors are notified of the change in address and phone number.

B. The Designated Coordinator and/or Designated Manager or designee will ensure that the person's service recipient record is assembled according to company standards.

C. Within 15 calendar days of service initiation, the Designated Coordinator and/or Designated Manager will complete a preliminary *Coordinated Service and Support Plan Addendum* that is based upon *Coordinated Service and Support Plan*. At this time, the person's name and date of admission will be added to the *Admission and Discharge Register* maintained by the Designated Coordinator and/or Designated Manager.

D. When a person served requires a *Positive Support Transition Plan* for the emergency use or planned use of restrictive interventions prohibited under MN Statutes, chapter 245D, and is admitted after January 1, 2014:
   1. The *Positive Support Transition Plan* must be developed and implemented within 30 calendar days of service initiation.
   2. No later than 11 months after the implementation date, the plan must be phased out.

E. Before the 45-day meeting, the Designated Coordinator and/or Designated Manager will complete the *Self-Management Assessment* regarding the person's ability to self-manage in health and medical needs, personal safety, and symptoms or behavior. This assessment will be based on the person's status within the last 12 months at the time of service initiation.

F. Within 45 calendar days of service initiation, the support team or expanded support team must meet to assess and determine the following based on information obtained from the assessment, *Coordinated Service and Support Plan,* and person centered planning:
   1. The scope of services to be provided to support the person's daily needs and activities.
   2. Outcomes and necessary supports to accomplish the outcomes.
   3. The person's preferences for how services and supports are provided including how the provider will support the person to have control of the person's schedule.
   4. Whether the current service setting is the most integrated setting available and appropriate for the person.
   5. How services for this person will be coordinated across 245D licensed providers and members of the support team or expanded support team to ensure continuity of care and coordination of services for the person.

G. Also, at the 45-day meeting, a discussion of how technology might be used to meet the person's desired outcomes will be included. The *Coordinated Service and Support Plan* and/or *Coordinated Service and Support Plan Addendum* will include a summary of this discussion. The summary will include a statement regarding any decision that is made regarding the use of technology and a description of any further research that needs to be completed before a decision regarding the use of technology can be made.

H. Within 10 working days of the 45-day meeting, the Designated Coordinator and/or Designated Manager will develop a service plan that documents outcomes and supports for the person based upon the assessments completed at the 45-day meeting.

I. Within 20 working days of 45-day meeting, the Designated Coordinator and/or Designated Manager will submit to and obtain dated signatures from the person and/or legal representative and case manager to document completion and approval of the assessment and *Coordinated Service and Support Plan Addendum.*
   1. If, within 10 working days of this submission, the legal representative or case manager has not signed and returned the assessments or has not proposed written modifications, the submission is deemed approved and the documents become effective and remain in effect until the legal representative or case manager submits a written request to revise the documents.

Bedroom sharing

A. Each person receiving services that will share a bedroom in a foster care or supported living services in a residential site controlled by the license holder, must have a choice of roommate. Both persons must mutually consent, in writing, to sharing a bedroom with one another. Persons served also retain the right to request a change in roommate and may notify the Designated Coordinator/Designated Manager in these instances.

B. The Designated Coordinator/Designated Manager will ensure that the *Bedroom Sharing Consent* form has been completed prior to sharing of the bedroom. The consent will be reviewed, signed, and dated by the person and/or legal representative. A copy of the consent will be maintained in each person's file,

C. No more than two people receiving services may share one bedroom.

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POLICY AND PROCEDURE ON TEMPORARY SERVICE SUSPENSION

I. PURPOSE

The purpose of this policy is to establish determination guidelines and notification procedures for service suspension.

II. POLICY

It is the intent of the company to ensure continuity of care and service coordination between members of the support team including, but not limited to the person served, the legal representative and/or designated emergency contact, case manager, and other licensed caregivers during situations that may require or result in temporary service suspension. The company restricts temporary service suspension to specific situations according to MN Statutes, section 245D.10, subdivision 3.

III. PROCEDURE

The company recognizes that *temporary service suspension* and *service termination* are two separate procedures. The company must limit temporary service suspension to specific situations that are listed below. A temporary service suspension may lead to or include service termination or the company may do a temporary service suspension by itself. The company must limit service termination to specific situations that are listed in *Policy and Procedure on Service Termination*. A service termination may include a temporary service suspension or the company can do a service termination by itself.

A. The company must limit temporary service suspension to situations in which:
   1. The person's conduct poses an imminent risk of physical harm to self or others and either positive support strategies have been implemented to resolve the issues leading to the temporary service suspension, but have not been effective and additional positive support strategies would not achieve and maintain safety, or less restrictive measures would not resolve the issues leading to the suspension;
   2. The person has emergent medical issues that exceed the company's ability to meet the person's needs; or
   3. The program has not been paid for services.

B. Prior to giving notice of temporary services suspension, the company must document actions taken to minimize or eliminate the need for service suspension. Action taken by the company must include, at a minimum:
   1. Consultation with the person's expanded/support team to identify and resolve issues leading to issuance of the suspension notice; and
   2. A request to the person's case manager for intervention services identified in section 245D.03, subdivision 1, paragraph (c), clause (1), or other professional consultation or intervention services to support the person in the program. This requirement does not apply to temporary suspensions issued due to non-payment of services.
   3. If, based on the best interests of the person, the circumstances at the time of the notice were such that the company was unable to take the actions listed above, the company must document the specific circumstances and the reason for being unable to do so.

C. The notice of temporary service suspension must meet the following requirements:
   1. This company must notify the person or the person's legal representative and case manager in writing of the intended temporary services suspension. If the temporary services suspension is from residential supports and services, as defined in section 245D.03, subdivision 1, paragraph (c), clause (3), the company must also notify MN Department of Human Service's Commissioner in writing;
   2. The notice of temporary services suspension must be given on the first day of the services suspension;
   3. The notice must include the reason for the action; a summary of actions taken to minimize or eliminate the need for temporary services suspension as required under MN Statutes, section 245D.10, subdivision 3, paragraph (d); and why these measures failed to prevent the suspension.

D. During the temporary suspension period, the company must:
   1. Provide information requested by the person or case manager;
   2. Work with the expanded/support team to develop reasonable alternatives to protect the person and others and to support continuity of care; and
   3. Maintain information about the temporary service suspension, including the written notice of temporary services suspension, in the service recipient record.

E. If, based on a review by the person's expanded/support team, the team determines the person no longer poses an imminent risk of physical harm to self or others, the person has a right to return to receiving services. If at the time of the temporary service suspension or at any time during the suspension, the person is receiving treatment related to the conduct that resulted in the service suspension, the expanded/support team must consider the recommendation of the licensed health professional, mental health professional, or other licensed professional involved in the person's care or treatment when determining whether the person no longer poses an imminent risk of physical harm to self or others and can return to the program. If the expanded/support team makes a determination that is contrary to the recommendation of a licensed professional treating the person, the company must document the specific reasons why a contrary decision was made.

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POLICY AND PROCEDURE ON GRIEVANCES

I. PURPOSE

The purpose of this policy is to promote service recipient right by providing persons served and/or legal representatives with a simple process to address complaints or grievances.

II. POLICY

Each person served and/or legal representative will be encouraged and assisted in continuously sharing ideas and expressing concerns in informal discussions with management staff and in support team meetings. Each concern or grievance will be addressed and attempts will be made to reach a fair resolution in a reasonable manner. Should a person and/or legal representative feel an issue or complaint has not or cannot be resolved through informal discussion, they should file a formal grievance. Staff and persons served and/or legal representatives will receive training regarding the informal and formal grievance procedure. This policy will be provided, orally and in writing, to all persons served and/or legal representatives. If a person served and/or legal representative feel that their formal complaint has not or cannot be resolved by other staff, they may bring their complaint to the highest level of authority in the program, the Chief Executive Officer, who may be reached at the following:

Name: Daryl Synstelien, Chief Executive Officer (CEO)
Address: 128 E. Meadowlark Lane, Fergus Falls MN 56537
Telephone Number: 218-736-7322

The company will ensure that during the service initiation process that there is orientation for the person served and/or legal representative to the company's policy on addressing grievances. Throughout the grievance procedure, interpretation in languages other than English and/or with alternative communication modes may be necessary and will be provided upon request. If desired, assistance from an outside agency (i.e. ARC, MN Office of the Ombudsman, local county social service agency) may be sought to assist with the grievance.

Persons served and/or legal representatives may file a grievance without threat or fear of reprisals, discharge, or the loss of future provision of appropriate services and supports.

III. PROCEDURE

A. All complaints affecting a person's health and safety will be responded to immediately by the manager.

B. Direct support staff will immediately inform the manager of any grievances and will follow this policy and procedure. If at any time, staff assistance is requested in the complaint process, it will be provided. Additional information on outside agencies that also can provide assistance to the person served and/or legal representative are listed at the end of this procedure.

C. If for any reason a person served and/or legal representative chooses to use the formal grievance process, they will then notify in writing or discuss the formal grievance with the manager will initially respond in writing within 14 calendar days of receipt of the complaint.

D. If the person served and/or legal representative is not satisfied with the manager response, they will then notify in writing or discuss the formal grievance with the Chief Executive Officer, who will then respond within 14 calendar days.

E. All complaints must and will be resolved within 30 calendar days of receipt of the complaint. If this is not possible, the Chief Executive Officer will document the reason for the delay and the plan for resolution.

F. If the person served and/or legal representative believe their rights have been violated, they retain the option of contacting the county's Adult or Child Protection Services or the Department of Human Services. In

addition, persons may contact advocacy agencies (listed at the end of this policy) and state they would like to file a formal grievance regarding their services, provider company, etc.

G. As part of the complaint review and resolution process, a complaint review will be completed by the Social Services Manager or the Designated Coordinator and documented by using the *Internal Review* form regarding the complaint. The complaint review will include an evaluation of whether:
   1. Related policies and procedures were followed.
   2. The policies and procedures were adequate.
   3. There is a need for additional staff training.
   4. The complaint is similar to past complaints with the persons, staff, or services involved.
   5. There is a need for corrective action by the company to protect the health and safety of persons served.

H. Based upon the results of the complaint review, the company will develop, document, and implement a corrective action plan designed to correct current lapses and prevent future lapses in performance by staff or the company, if any.

I. A written summary of the complaint and a notice of the complaint resolution to the person served and/or legal representative and case manager will be provided by using the *Complaint Summary and Resolution Notice* form. This summary will:
   1. Identify the nature of the complaint and the date it was received.
   2. Include the results of the complaint review.
   3. Identify the complaint resolution, including any corrective action.

J. The *Complaint Summary and Resolution Notice* will be maintained in the service recipient record.

Outside Agency Name	Telephone Number	Address and Email Address
ARC MN	(651) 523-0823 (800) 582-5256	770 Transfer Road, Suite 26, St. Paul, MN 55114 www.thearcofminnesota.org mail@arcmn.org
ARC Greater Twin Cities	(952) 920-0855	2446 University Ave W, Suite 110, St. Paul, MN 55114 www.arcgreatertwincities.org info@arcgreatertwincities.org
ARC Northland	(218) 726-4725	424 W Superior St, Suite 201, Duluth, MN 55802 www.arcnorthland.org cbourdage@arcnorthland.org
Disability Law Center/Legal Aid Society	(612) 332-1441	430 1st Ave North, Minneapolis, MN 55401 www.mndlc.org website@mylegalaid.org
MN DHS-Licensing	(651) 431-6500	444 Lafayette Road, St. Paul, MN 55115 www.mn.gov/dhs/general-public/licensing/ dhs.info@state.mn.us
MN Office of the Ombudsman for Families (and Children)	(651) 603-0058 (651) 643-2539 Fax 1-888-234-4939	1450 Energy Drive, Suite 106 St. Paul, Minnesota 55108 http://mn.gov/ombudfam/
MN Office of the Ombudsman for MH/DD	(651) 757-1800 (800) 657-3506	121 7th Place East, Suite 420, Metro Square Building, St. Paul, MN 55101 www.ombudmhdd.state.mn.us ombudsman.mhdd@state.mn.us
MN Office of the	(651) 431-2555	P.O. Box 64971, St. Paul, MN 55164

Ombudsman for Long-Term Care	(800) 657-3591	www.dhs.state.mn.us/main dhs.info@state.mn.us
Otter Tail County Social Service Agency: ask for either child protection or adult protection dependent upon the age of the person	218-998-8150	Government Services Center 530 W. Fir Ave. Fergus Falls, MN 56537

MN Area on Aging:
Please select the specific row (below) for applicable telephone number or address based upon your location

	MN Area on Aging	Telephone Numbers	Address and Email Address: http://mn4a.org/aaas/
1.	Arrowhead Area Agency on Aging	Main: 218-722-5545 Toll Free: 1-800-232-0707 Fax: 218-529-7592	221 West 1st Street Duluth, Minnesota 55802 Serves: Aitkin, Carlton, Cook, Itasca, Koochiching, Lake & St. Louis counties.
2.	Central MN Council on Aging	Main: 320-253-9349 Fax: 320-253-9576	1301 W St. Germain Street, SE St. Cloud, Minnesota 56301-3456 Serves: Benton, Cass, Chisago, Crow Wing, Isanti, Kanabec, Mille Lacs, Morrison, Pine, Sherburne, Stearns, Todd, Wadena, & Wright counties.
3.	Land of the Dancing Sky Area Agency on Aging	Main: 218-745-6733	109 South Minnesota Street Warren, Minnesota 56762 Serves: Becker, Beltrami, Clay, Clearwater, Douglas, Grant, Hubbard, Kittson, Lake of the Woods, Mahnomen, Marshall, Norman, Otter Tail, Pennington, Polk, Pope, Red Lake, Roseau, Stevens, Traverse & Wilkin.
4.	Metropolitan Area Agency on Aging	Main: 651-641-8612 Fax: 651-641-8618	2365 N McKnight Road, Suite 3 North St. Paul, Minnesota 55109 Serves: Anoka, Carver, Dakota, Hennepin, Ramsey, Scott, & Washington counties
5.	MN Chippewa Tribe Area Agency on Aging	Main: 218-335-8586 Toll Free: 1-888-231-7886 Fax: 218-335-8080	PO Box 27 Cass Lake, Minnesota 56633 Serves: Bois Forte, Grand Portage, Leech Lake, & White Earth reservations
6.	MN River Area Agency on Aging	Mankato Office: Main: 507-389-8879 Fax: 507-387-7105 Slayton Office: Main: 507-836-8547 Fax: 507-836-8866	***Mankato Office*** 10 Civic Center Plaza, Suite 3 PO Box 3323 Mankato MN 56002-3323 ***Slayton Office*** 2401 Broadway Avenue, Suite 2 Slayton, MN 56172-114 Serves: Big Stone, Blue Earth, Brown, Chippewa, Cottonwood, Faribault, Jackson, Kandiyohi, Lac Qui Parle, Le Sueur, Lincoln, Lyon, Martin, McLeod, Meeker, Murray, Nicollet, Nobles, Pipestone, Redwood, Renville, Rock, Sibley, Swift, Waseca, Watonwan, & Yellow Medicine counties.
7.	Southeastern MN Area Agency on Aging	Main: 507-288-6944 Fax: 507-288-4823	421 SW First Avenue, Room 201 Rochester, Minnesota 55902 Serves: Dodge, Fillmore, Freeborn, Goodhue, Houston, Mower,

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	MN Area on Aging	Telephone Numbers	Address and Email Address: http://mn4a.org/aaas/
			Olmsted, Rice, Steele, Wabasha, & Winona counties

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POLICY AND PROCEDURE ON DATA PRIVACY

I. PURPOSE

The purpose of this policy is to establish guidelines that promote service recipient rights ensuring data privacy and record confidentiality of persons served.

II. POLICY

According to MN Statutes, section 245D.04, subdivision 3, persons served by the program have protection-related rights that include the rights to:

- Have personal, financial, service, health, and medical information kept private, and be advised of disclosure of this information by the company.
- Access records and recorded information about the person in accordance with applicable state and federal law, regulation, or rule.

Orientation to the person served and/or legal representative will be completed at service initiation and as needed thereafter. This orientation will include an explanation of this policy and their rights regarding data privacy. Upon explanation, the Designated Manager and/or Designated Coordinator will document that this notification occurred and that a copy of this policy was provided.

This company encourages data privacy in all areas of practice and will implement measures to ensure that data privacy is upheld according to MN Government Data Practices Act, section 13.46. The company will also follow guidelines for data privacy as set forth in the Health Insurance Portability and Accountability Act (HIPAA) to the extent the company performs a function or activity involving the use of protected health information and HIPAA's implementing regulations, Code of Federal Regulations, title 45, parts 160-164, and all applicable requirements. The Chief Executive Officer will exercise the responsibility and duties of the "responsible authority" for all program data, as defined in the Minnesota Data Practices, MN Statutes, chapter 13. Data privacy will hold to the standard of "minimum necessary" which entails limiting protected health information to the minimum necessary to accomplish the intended purpose of the use, disclosure, or request.

III. PROCEDURE

Access to records and recorded information and authorizations

A. The person served and/or legal representative have full access to their records and recorded information that is maintained, collected, stored, or disseminated by the company. Private data are records or recorded information that includes personal, financial, service, health, and medical information.

B. Access to private data in written or oral format is limited to authorized persons. The following company personnel may have immediate access to persons' private data only for the relevant and necessary purposes to carry out their duties as directed by the *Coordinated Service and Support Plan* and/or *Coordinated Service and Support Plan Addendum*:
   1. Executive staff.
   2. Administrative staff.
   3. Financial staff.
   4. Nursing staff including assigned or consulting nurses.
   5. Management staff including the Designated Coordinator and/or Designated Manager.
   6. Direct support staff.

C. The following entities also have access to persons' private data as authorized by applicable state or federal laws, regulations, or rules:
   1. Case manager.
   2. Child or adult foster care licensor, when services are also licensed as child or adult foster care.
   3. Minnesota Department of Human Services and/or Minnesota Department of Health.

4. County of Financial Responsibility or the County of Residence's Social Services.
5. The Ombudsman for Mental Health or Developmental Disabilities.
6. US Department of Health and Human Services.
7. Social Security Administration.
8. State departments including Department of Employment and Economic Development (DEED), Department of Education, and Department of Revenue.
9. County, state, or federal auditors.
10. Adult or Child Protection units and investigators.
11. Law enforcement personnel or attorneys related to an investigation.
12. Various county or state agencies related to funding, support, or protection of the person.
13. Other entities or individuals authorized by law.

D. The company will obtain authorization to release information of persons served when consultants, sub-contractors, or volunteers are working with the company to the extent necessary to carry out the necessary duties.

E. Other entities or individuals not previously listed who have obtained written authorization from the person served and/or legal representative have access to written and oral information as detailed within that authorization. This includes other licensed caregivers or health care providers as directed by the release of information.

F. Information will be disclosed to appropriate parties in connection with an emergency if knowledge of the information is necessary to protect the health or safety of the person served or other individuals or persons. The Designated Coordinator and/or Designated Manager will ensure the documentation of the following:
   1. The nature of the emergency.
   2. The type of information disclosed.
   3. To whom the information was disclosed.
   4. How the information was used to respond to the emergency.
   5. When and how the person served and/or legal representative was informed of the disclosed information.

G. All authorizations or written releases of information will be maintained in the person's service recipient record. In addition, all requests made to review data, have copies, or make alterations, as stated below, will be recorded in the person's record including:
   1. Date and time of the activity.
   2. Who accessed or reviewed the records.
   3. If any copies were requested and provided.

Request for records or recorded information to be altered or copies

A. The person served and/or legal representative has the right to request that their records or recorded information and documentation be altered and/or to request copies.

B. If the person served and/or legal representative objects to the accuracy of any information, staff will ask that they put their objections in writing with an explanation as to why the information is incorrect or incomplete.
   1. The Designated Coordinator and/or Designated Manager will submit the written objections to the Chief Executive Officer who will make a decision in regards to any possible changes.
   2. A copy of the written objection will be retained in the person's service recipient record.
   3. If the objection is determined to be valid and approval for correction is obtained, the Designated Coordinator and/or Designated Manager will correct the information and notify the person served and/or legal representative and provide a copy of the correction.
   4. If no changes are made and distribution of the disputed information is required, the Designated Coordinator and/or Designated Manager will ensure that the objection accompanies the information as distributed, either orally or in writing.

C. If the person served and/or legal representative disagrees with the resolution of the issue, they will be encouraged to follow the procedures outlined in the *Policy and Procedure on Grievances.*

Security of information

A. A record of current services provided to each person served will be maintained on the premises of where the services are provided or coordinated. When the services are provided in a licensed facility, the records will be maintained at the facility; otherwise, records will be maintained at the company's program office. Files will not be removed from the program site without valid reasons and security of those files will be maintained at all times.

B. The Designated Coordinator and/or Designated Manager will ensure that all information for persons served are secure and protected from loss, tampering, or unauthorized disclosures. This includes information stored by computer for which a unique password and user identification is required.

C. No person served and/or legal representative, staff, or anyone else may permanently remove or destroy any portion of the person's record.

D. The company and its staff will not disclose personally identifiable information about any other person when making a report to each person and case manager unless the company has the consent of the person. This also includes the use of other person's information in another person's record.

E. Written and verbal exchanges of information regarding persons served are considered to be private and will be done in a manner that preserves confidentiality, protects their data privacy, and respects their dignity.

F. All staff will receive training at orientation and annually thereafter on this policy and their responsibilities related to complying with data privacy practices.

Synstelien Community Services

POLICY AND PROCEDURE ON EMERGENCY USE OF MANUAL RESTRAINT

I. PURPOSE

The purpose of this policy is to promote service recipient rights and protect the health and safety of persons served during the emergency use of manual restraint (EUMR). This policy will also promote appropriate and safe interventions needed when addressing behavioral situations.

II. POLICY

It is the policy of this company to ensure the correct use of emergency use of manual restraint, to provide intense training and monitoring of direct support staff, and to ensure regulations regarding the emergency use of manual restraint are followed. According to MN Statutes, section 245D.02, subdivision 8a, emergency use of manual restraint is defined as "using a manual restraint when a person poses an imminent risk of physical harm to self or others and is the least restrictive intervention that would achieve safety. Property damage, verbal aggression, or a person's refusal to receive or participate in treatment or programming on their own do not constitute an emergency."

III. PROCEDURE

Positive support strategies

A. The company will attempt to de-escalate a person's behavior before it poses an imminent risk of physical harm to self or others. Some of the following procedures could be used to de-escalate the situation and are options that could be implemented by staff. This is not a fully inclusive list of options that could include:
   1. A calm discussion between the person served and direct support staff regarding the situation, the person's feelings, their responses, and alternative methods to handling the situation, etc.
   2. A staff suggesting or recommending that the person participate in an activity they enjoy as a means to self-calm.
   3. A staff to suggest or remind that the person served has options that they may choose to spend time alone, when safety permits, as a means to self-calm.
   4. The individualized strategies that have been written into the person's *Coordinated Service and Support Plan (CSSP)* and/or *CSSP Addendum*, or *Positive Support Transition Plan*.
   5. The implementation of instructional techniques and intervention procedures that are listed as **"Permitted actions and procedures"** as defined in Letter B of this **Positive support strategies** section.
   6. A combination of any of the above.

B. **Permitted actions and procedures** include the use of instructional techniques and intervention procedures used on an intermittent or continuous basis. If used on a continuous basis, it must be addressed in the person's *CSSP Addendum*. These actions include:
   1. Physical contact or instructional techniques that are the least restrictive alternative possible to meet the needs of the person and may be used to:
      a. Calm or comfort a person by holding that person with no resistance from that person.
      b. Protect a person known to be at risk or injury due to frequent falls as a result of a medical condition.
      c. Facilitate the person's completion of a task or response when the person does not resist or the person's resistance is minimal in intensity or duration.
      d. Block or redirect a person's limbs or body without holding the person or limiting the person's movement to interrupt the person's behavior that may result in injury to self or others with less than 60 seconds of physical contact by staff.
      e. Redirect a person's behavior when the behavior does not pose a serious threat to the person or others and the behavior is effectively redirected with less than 60 seconds of physical contact by staff.
   2. Restraint may be used as an intervention procedure to:
      a. Allow a licensed health care professional to safely conduct a medical examination or to provide medical treatment ordered by a licensed health care professional.
      b. Assist in the safe evacuation or redirection of a person in the event of an emergency and the person is

at imminent risk of harm.

c. Position a person with physical disabilities in a manner specified in their *CSSP Addendum.* Any use of manual restraint allowed in this paragraph must comply with the restrictions stated in the section of this policy **Restrictive Intervention.**

3. Use of adaptive aids or equipment, orthotic devices, or other medical equipment ordered by a licensed health professional to treat a diagnosed medical condition do not in and of themselves constitute the use of mechanical restraint.
4. Positive verbal correction that is specifically focused on the behavior being addressed.
5. Temporary withholding or removal of objects being used to hurt self or others.

Prohibited Procedures

The company and its staff are prohibited from using the following:

A. Chemical restraints
B. Mechanical restraints
C. Manual restraint
D. Time out
E. Seclusion
F. Any other aversive or deprivation procedures
G. As a substitute for adequate staffing
H. For a behavioral or therapeutic program to reduce or eliminate behavior
I. Punishment
J. For staff convenience
K. Prone restraint, metal handcuffs, or leg hobbles
L. Faradic shock
M. Speaking to a person in a manner that ridicules, demeans, threatens, or is abusive
N. Physical intimidation or a show of force
O. Containing, restricting, isolating, secluding, or otherwise removing a person from normal activities when it is medically contraindicated or without monitoring the person served
P. Denying or restricting a person's access to equipment and devices such as walkers, wheelchairs, hearing aids, and communication boards that facilitate the person's functioning. When the temporary removal of the equipment or device is necessary to prevent injury to the person or others or serious damage to the equipment or device, the equipment or device must be returned to the person as soon as imminent risk of injury or serious damage has passed.
Q. Painful techniques, including intentional infliction of pain or injury, intentional infliction of fear of pain or injury, dehumanization, and degradation
R. Hyperextending or twisting a person's body parts
S. Tripping or pushing a person
T. Requiring a person to assume and maintain a specified physical position or posture
U. Forced exercise
V. Totally or partially restricting a person's senses
W. Presenting intense sounds, lights, or other sensory stimuli
X. Noxious smell, taste, substance, or spray, including water mist
Y. Depriving a person of or restricting access to normal goods and services, or requiring a person to earn normal goods and services
Z. Token reinforcement programs or level programs that include a response cost or negative punishment component
AA. Using a person receiving services to discipline another person receiving services
BB. Using an action or procedure which is medically or psychologically contraindicated
CC. Using an action or procedure that might restrict or obstruct a person's airway or impair breathing, including techniques whereby individuals use their hands or body to place pressure on a person's head, neck, back, chest, abdomen, or joints
DD. Interfering with a person's legal rights, except as allowed by MN Statutes, section 245D.04, subdivision 3, paragraph (c).

Restrictive Intervention:
A restrictive intervention means prohibited procedures identified in MN Statutes, section 245D.06, subdivision 5; prohibited procedures identified in MN Rules, part 9544.006; and the emergency use of manual restraint.
A restricted procedure must not:

A. Be implemented with a child in a manner that constitutes sexual abuse, neglect, physical abuse, or mental injury as defined in MN Statutes, section 626.556, subdivision 2.
B. Be implemented with an adult in a manner that constitutes abuse or neglect as defined in MN Statutes, section 626.5572, subdivisions 2 or 17.
C. Be implemented in a manner that violates a person's rights identified in MN Statutes, section 245D.04.
D. Restrict a person's normal access to a nutritious diet, drinking water, adequate ventilation, necessary medical care, ordinary hygiene facilities, normal sleeping conditions, or necessary clothing, or to any protection required by state licensing standards and federal regulations governing the program.
E. Deny the person visitation or ordinary contact with legal counsel, a legal representative, or next of kin.
F. Be used as a substitute for adequate staffing, for the convenience of staff, as punishment, or as a consequence if the person refuses to participate in the treatment of services provided by the company.
G. Use prone restraint (that places a person in a face-down position).
H. Apply back or chest pressure while a person is in the prone or supine (face-up) position.
I. Be implemented in a manner that is contraindicated for any of the person's known medical or psychological limitations.

Positive Support Transition Plans **(PSTP)**
The company must and will develop a *Positive Support Transition Plan* on forms provided by the Department of Human Services and in the manner directed for a person served who requires intervention in order to maintain safety when it is known that the person's behavior poses an immediate risk of physical harm to self or others. A PSTP must be developed in accordance with MN Statutes, section 245D.06, subdivision 8 and MN Rules, part 9544.0070 for a person who has been subjected to three (3) incidents of EUMR within 90 days or four (4) incidents of EUMR within 180 days. This *Positive Support Transition Plan* will phase out any existing plans for the emergency use or programmatic use of restrictive interventions prohibited under MN Statutes, Chapter 245D and MN Rules, Chapter 9544.

Emergency use of manual restraint (EUMR)

A. If the positive support strategies were not effective in de-escalating or eliminating the person's behavior, emergency use of manual restraint may be necessary. To use emergency use of manual restraint, the following conditions must be met:
    1. Immediate intervention must be needed to protect the person or others from imminent risk of physical harm.
    2. The type of manual restraint used must be the least restrictive intervention to eliminate the immediate risk of harm and effectively achieve safety.
    3. The manual restraint must end when the threat of harm ends.

B. The following conditions, on their own, are not conditions for emergency use of manual restraint:
    1. The person is engaging in property destruction that does not cause imminent risk of physical harm.
    2. The person is engaging in verbal aggression with staff or others.
    3. A person's refusal to receive or participate in treatment of programming.

C. **The company allows certain types of manual restraints which may be used by staff on an emergency basis**. **Detailed instructions on the safe and correct implementation of these allowed manual restraint procedures are included at the end of this policy**. Use of these allowed manual restraints may be preceded by use of a Prompted Escort (1.i.) Gestural Prompt or (1.ii.) Physical Prompt) and include items (2), (3), and (4):
    1. Prompted Escort/Walking
        i. Gestural Prompt

ii. Physical Prompt
2. Arm Control Restraint
3. Arm Wrap Restraint
4. Body Wrap Restrain

D. If a person's licensed health care professional or mental health professional has determined that a manual restraint would be medically or psychologically contraindicated, the company will not use a manual restraint to eliminate the immediate risk of harm and effectively achieve safety. This statement of whether or not a manual restraint would be medically or psychologically contraindicated will be completed as part of service initiation planning.

Monitoring of emergency use of manual restraint

A. Each single incident of emergency use of manual restraint must be monitored and reported separately. For this understanding, an incident of emergency use of manual restraint is a single incident when the following conditions have been met:
   1. After implementing the manual restraint, staff attempt to release the person at the moment staff believe the person's conduct no longer poses an imminent risk of physical harm to self or others and less restrictive strategies can be implemented to maintain safety.
   2. Upon the attempt to release the restraint, the person's behavior immediately re-escalates and staff must immediately re-implement the restraint in order to maintain safety.

B. During an emergency use of manual restraint, the company will monitor a person's health and safety. Staff monitoring the manual restraint procedure will not be the staff implementing the procedure, when possible. A monitoring form will be completed by the staff person for each incident of emergency use of manual restraint to ensure:
   1. Only manual restraints allowed according to this policy are implemented.
   2. Manual restraints that have been determined to be contraindicated for a person are not implemented with that person.
   3. Allowed manual restraints are implemented only by staff trained in their use.
   4. The restraint is being implemented properly as required.
   5. The mental, physical, and emotional condition of the person who is being manually restrained is being assessed and intervention is provided when necessary to maintain the person's health and safety and prevent injury to the person, staff involved, or others involved.

Reporting of emergency use of manual restraint

A. Reporting of the incident of emergency use of manual restraint will be completed according to the following process and will contain all required information per MN Statutes, sections 245D.06, subdivision 1 and 245D.061, subdivision 5.

B. Within 24 hours of the emergency use of manual restraint, the company will make a verbal report regarding the incident to the legal representative or designated emergency contact and case manager. If other persons served were involved in the incident, the company will not disclose any personally identifiable information about any other person when making the report unless the company has the consent of the person.

C. Within three (3) calendar days of the emergency use of manual restraint, the staff who implemented the emergency use of manual restraint will report, in writing, to the Designated Coordinator and/or Designated Manager the following information:
   1. The staff and person(s) served who were involved in the incident leading up to the emergency use of manual restraint.
   2. A description of the physical and social environment, including who was present before and during the incident leading up to the emergency use of manual restraint.
   3. A description of what less restrictive alternative measures were attempted to de-escalate the incident and maintain safety before the manual restraint was implemented. This description must identify the when,

how, and how long the alternative measures were attempted before the manual restraint was implemented.
4. A description of the mental, physical, and emotional condition of the person who was restrained, and other persons involved in the incident leading up to, during, and following the manual restraint.
5. Whether there was any injury to the person who was restrained or other persons involved, including staff, before or as a result of the manual restraint use.
6. Whether there was a debriefing with the staff, and, if not contraindicated, with the person who was restrained and other persons who were involved in or who witnessed the restraint, following the incident. The outcome of the debriefing will be clearly documented and if the debriefing could not occur at the time of the incident, the report will identify whether a debriefing is planned in the future.

D. Within five (5) working days of the emergency use of manual restraint, the Designated Manager will complete and document an internal review of each report of emergency use of manual restraint. The internal review will include an evaluation of whether:
1. The person's served service and support strategies developed according to MN Statutes, sections 245D.07 and 245D.071 need to be revised.
2. Related policies and procedures were followed.
3. The policies and procedures were adequate.
4. There is a need for additional staff training.
5. The reported event is similar to past events with the persons, staff, or the services involved.
6. There is a need for corrective action by the company to protect the health and safety of the person(s) served.

E. Based upon the results of the internal review, the company will develop, document, and implement a corrective action plan for the program designed to correct current lapses and prevent future lapses in performance by the individuals or the company, if any. The Designated Manager will ensure that the corrective action plan, if any, must be implemented within 30 days of the internal review being completed.

F. Within five (5) working days after the completion of the internal review, the Designated Coordinator and/or Designated Manager will consult with the person's expanded support team following the emergency use of manual restraint. The purpose of this consultation is to:
1. Discuss the incident and to define the antecedent or event that gave rise to the behavior resulting in the manual restraint and identify the perceived function the behavior served.
2. Determine whether the person's served *CSSP Addendum* needs to be revised to positively and effectively help the person maintain stability and to reduce or eliminate future occurrences requiring emergency use of manual restraint.

G. Within five (5) working dates of the expanded support team review, the Designated Coordinator and/or Designated Manager will submit, using the DHS online *Behavioral Intervention Reporting Form* (DHS-5148-ENG-1), the following information to the Department of Human Services and the Office of the Ombudsman for Mental Health and Developmental Disabilities:
1. The report of the emergency use of manual restraint.
2. The internal review and corrective action plan, if any.
3. The written summary of the expanded support team's discussion and decision.

H. The following written information will be maintained in the person's service recipient record:
1. The report of an emergency use of manual restraint incident that includes:
   a. Reporting requirements by the staff who implemented the restraint
   b. The internal review of emergency use of manual restraint and the corrective action plan, with information about implementation of correction within 30 days, if any
   c. The written summary of the expanded support team's discussion and decision
   d. The notifications to the expanded support team, the Department of Human Services, and the MN Office of the Ombudsman for Mental Health and Developmental Disabilities
2. The PDF version of the completed and submitted DHS online *Behavioral Intervention Reporting Form*

(DHS-5148-ENG-1). An email of this PDF version of the *Behavioral Intervention Reporting Form* will be sent to the MN-ITS mailbox assigned to the license holder.

Staff training requirements

A. The company recognizes the importance of having qualified and knowledgeable staff that are competently trained to uphold the rights of persons served and to protect persons' health and safety. All staff will receive orientation and annual training according to MN Statutes, section 245D.09, subdivisions 4, 4a, and 5. Orientation training will occur within the first 60 days of hire and annual training will occur within a period of 12 months.

B. Within 60 calendar days of hire, the company provides orientation on:
   1. The safe and correct use of manual restraint on an emergency basis according to the requirements in section 245D.061 or successor provisions, and what constitutes the use of restraints, time out, and seclusion, including chemical restraint; and
   2. Staff responsibilities related to prohibited procedures under section 245D.06, subdivision 5, MN Rules, part 9544.0060, or successor provisions, why such procedures are not effective for reducing or eliminating symptoms or undesired behavior, and why such procedures are not safe.

C. Before staff may implement an emergency use of manual restraint, and in addition to the training on this policy and procedure and the orientation and annual training requirements, staff must receive training on emergency use of manual restraints that incorporates the following topics:
   1. Alternatives to manual restraint procedures including techniques to identify events and environmental factors that may escalate conduct that poses an imminent risk of physical harm to self or others.
   2. De-escalation methods, positive support strategies, and how to avoid power struggles
   3. Simulated experiences of administering and receiving manual restraint procedures allowed by the company on an emergency basis
   4. How to properly identify thresholds for implementing and ceasing restrictive procedures
   5. How to recognize, monitor, and respond to the person's physical signs of distress including positional asphyxia
   6. The physiological and psychological impact on the person and the staff when restrictive procedures are used
   7. The communicative intent of behaviors
   8. Relationship building.

D. For staff that are responsible to develop, implement, monitor, supervise, or evaluate positive support strategies, *Positive Support Transition Plans*, or *Emergency Use of Manual Restraint*, the staff must complete a minimum of eight (8) hours of core training from qualified individuals prior to assuming these responsibilities. Core training must include the following:
   1. De-escalation techniques and their value
   2. Principles of person-centered service planning and delivery and how they apply to direct support services provided by staff
   3. Principles of positive support strategies such as positive behavior supports, the relationship between staff interactions with the person and the person's behavior, and the relationship between the person's environment and the person's behavior
   4. What constitutes the use of restraint, including chemical restraint, time out, and seclusion
   5. The safe and correct use of manual restraint on an emergency basis, according to MN Statutes, section 245D.061
   6. Staff responsibilities related to prohibited procedures under MN Statutes, section 245D.06, subdivision 5; why the procedures are not effective for reducing or eliminating symptoms or interfering behavior; and why the procedures are not safe
   7. Staff responsibilities related to restricted and permitted actions and procedure according to MN Statutes, section 245D.06, subdivisions 6 and 7
   8. Situations in which staff must contact 911 services in response to an imminent risk of harm to the person

or others

9. Procedures and forms staff must use to monitor and report use of restrictive interventions that are part of a *Positive Support Transition Plan*
10. Procedures and requirements for notifying members of the person's expanded support team after the use of a restrictive intervention with the person
11. Understanding of the person as a unique individual and how to implement treatment plans and responsibilities assigned to the license holder
12. Cultural competence
13. Personal staff accountability and staff self-care after emergencies.

E. Staff who develop positive support strategies, license holders, executives, managers, and owners in non-clinical roles, must complete a minimum of four (4) hours of additional training. Function-specific training must be completed on the following:
   1. Functional behavior assessment
   2. How to apply person-centered planning
   3. How to design and use data systems to measure effectiveness of care
   4. Supervision, including how to train, coach, and evaluate staff and encourage effective communication with the person and the person's support team.

F. License holders, executives, managers, and owners in non-clinical roles must complete a minimum of two (2) hours of additional training. Function-specific training must be completed on the following:
   1. How to include staff in organizational decisions
   2. Management of the organization based upon person-centered thinking and practices and how to address person-centered thinking and practices in the organization
   3. Evaluation of organizational training as it applies to the measurement of behavior change and improved outcomes for persons receiving services.

G. Annually, staff must complete four (4) hours of refresher training covering each of the training topics listed in items D, E, and F listed above.

H. For each staff, the license holder must document, in the personnel record, completion of core training, function-specific training, and competency testing or assessment. Documentation must include the following:
   1. Date of training
   2. Testing or assessment completion
   3. Number of training hours per subject area
   4. Name and qualifications of the trainer or instructor.

I. The license holder must verify and maintain evidence of staff qualifications in the personnel record. The documentation must include the following:
   1. Education and experience qualifications relevant to the staff's scope of practice, responsibilities assigned to the staff, and the needs of the general population of persons served by the program; and
   2. Professional licensure, registration, or certification, when applicable.

IV. DETAILED INSTRUCTIONS ON ALLOWED MANUAL RESTRAINT PROCEDURES

If an emergency use of manual restraint is needed, staff will attempt to verbally calm the person down throughout the implemented procedure(s), unless to do so would escalate the person's behavior. The least restrictive manual restraint will be used to effectively handle the situation.

Prompted Escort Techniques

Gestural Prompt Escort: Staff stands on either the left or right side of the individual and extends their outside arm with hand flat, palm up, fingers together, and pointing in the direction the individual is to walk. Staff directs independent walking with verbal interactions only, "Walk with me."

Physical Prompt Escort: Staff extends their outside arm with hand flat, palm up, fingers together, and pointing in the direction the individual is to walk. The inside hand is flat, in a palm-up position with finger pads (not finger tips) gently touching the individual's back.

Allowed Manual Restraints

Arm Control Restraint: Standing next to the individual, staff grasps the fleshy part of the triceps with the hand closest to the individual. The thumb is positioned on the outside of the arm. With the other hand, staff grasps the individual's wrist with the thumb on top. The individual's arm should remain in an "L" shape, with the upper arm parallel to the body and the forearm parallel to the floor. Staff walks in the desired direction, gently leading the individual.

Arm Wrap Restraint: Standing next to the individual, staff loops their arm closest to the individual under his arm as if walking arm in arm. The hold is deep enough to allow the staff's elbow to point slightly forward. The individual's elbow is then pulled into the staff's chest. With the other hand, staff grasps the individual's wrist, with thumb on top. If taller than the individual, staff slightly bends at the knees so the individual's shoulders are neither lower nor higher than they would be during escort. Staff walks in the desired direction, gently leading the individual.

Body Wrap Restraint: With the hand grasping the individual's wrist in either the Arm restraint or the Body Wrap restraint, staff moves the individual's arm across the front of the individual's body and places it against the opposite arm. With the other hand, staff releases their hold on the upper arm, repositions their arm around the back of the individual's body, and grasps the wrist against the individual's arm. Staff then slides their front hand back to just above the elbow of the arm that is across the individual, making sure to position the thumb on the inside of the arm. Staff then pulls the individual into their own body. Staff bends forward on the side of the bent elbow to place the side of their head against the individual's side. Staff walks in the desired direction, gently leading the individual. Optionally, staff plants their feet in a wide stance and lowers their center of gravity to immobilize.

Synstelien Community Services

POLICY AND PROCEDURE ON RESPONDING TO AND REPORTING INCIDENTS

I. PURPOSE

The purpose of this policy is to provide instructions to staff for responding to and reporting incidents.

II. POLICY

The company will respond to incidents as defined in MN Statutes, section 245D.02, subdivision 11, that occur while providing services to protect the health and safety of and minimize risk of harm to the person(s) served. Staff will address all incidents according to the specific procedure outlined in this policy and act immediately to ensure the safety of persons served. After the situation has been resolved and/or the person(s) involved are no longer in immediate danger, staff will complete the necessary documentation in order to comply with licensing requirements on reporting and to assist in developing preventative measures. For emergency response procedures, staff will refer to the *Policy and Procedure on Emergencies*.

All staff will be trained on this policy and the safe and appropriate response and reporting of incidents. In addition, program sites will have contact information of a source of emergency medical care and transportation readily accessible. In addition, a list of emergency phone numbers will be posted in a prominent location and emergency contact information for persons served at the facility including each person's representative, physician, and dentist is readily available.

III. PROCEDURE

Defining incidents

A. An incident is defined as an occurrence which involves a person and requires the program to make a response that is not a part of the program's ordinary provision of services to that person, and includes:
   1. Serious injury of a person as determined by MN Statutes, section 245.91, subdivision 6:
      a. Fractures
      b. Dislocations
      c. Evidence of internal injuries
      d. Head injuries with loss of consciousness or potential for a closed head injury or concussion without loss of consciousness requiring a medical assessment by a health care professional, whether or not further medical attention was sought
      e. Lacerations involving injuries to tendons or organs and those for which complications are present
      f. Extensive second degree or third degree burns and other burns for which complications are present
      g. Extensive second degree or third degree frostbite and others for which complications are present
      h. Irreversible mobility or avulsion of teeth
      i. Injuries to the eyeball
      j. Ingestion of foreign substances and objects that are harmful
      k. Near drowning
      l. Heat exhaustion or sunstroke
      m. Attempted suicide
      n. All other injuries considered serious after an assessment by a health care professional including, but not limited to, self-injurious behavior, a medication error requiring medical treatment, a suspected delay of medical treatment, a complication of a previous injury, or a complication of medical treatment for an injury
   2. Death of a person served.
   3. Any medical emergency, unexpected serious illness, or significant unexpected changes in an illness or medical condition of a person that requires the program to call "911," physician treatment, or hospitalization.
   4. Any mental health crisis that requires the program to call "911," a mental health crisis intervention team, or a similar mental health response team or service when available and appropriate.
   5. An act or situation involving a person that requires the program to call "911," law enforcement, or the fire department.

6. A person's unauthorized or unexplained absence from a program.
7. Conduct by a person served against another person served that:
   a. Is so severe, pervasive, or objectively offensive that it substantially interferes with a person's opportunities to participate in or receive service or support
   b. Places the person in actual and reasonable fear of harm
   c. Places the person in actual and reasonable fear of damage to property of the person
   d. Substantially disrupts the orderly operation of the program
8. Any sexual activity between persons served involving force or coercion as defined under MN Statutes, section 609.341, subdivisions 3 and 14.
9. Any emergency use of manual restraint as identified in MN Statutes, section 245D.061.
10. A report of alleged or suspected maltreatment of a minor or vulnerable adult under MN Statutes, sections 626.556 or 626.557.

Responding to incidents

A. Staff will respond to incidents according to the following plans. For incidents including death of a person served, maltreatment, and emergency use of manual restraints, staff will follow the applicable policy and procedure:
   1. **Death of a person served**: *Policy and Procedure on the Death of a Person Served*
   2. **Maltreatment**: *Policy and Procedure on Reporting and Review of Maltreatment of Vulnerable Adults* or *Policy and Procedure on Reporting and Review of Maltreatment of Minors*
   3. **Emergency use of manual restraint**: *Policy and Procedure on Emergency Use of Manual Restraint*

B. **Any medical emergency (including serious injury), unexpected serious illness, or significant unexpected changes in an illness or medical condition of a person that requires the program to call "911," physician treatment, or hospitalization**
   1. Staff will first call "911" if they believe that a person is experiencing a medical emergency (including serious injury), unexpected serious illness, or significant unexpected change in illness or medical condition that may be life threatening and provide any relevant facts and medical history.
   2. Staff will give first aid and/or CPR to the extent they are qualified, when it is indicated by their best judgment or the "911" operator, unless the person served has an advanced directive. Staff will refer to the *Policy and Procedure on the Death of a Person Served* for more information.
   3. Staff will notify the Designated Coordinator and/or Designated Manager or designee who will assist in securing any staffing coverage that is necessary.
   4. If the person is transported to a hospital, staff will either accompany the person or go to the hospital as soon as possible. Staff will not leave other persons served alone or unattended.
   5. Staff will ensure that a completed *Medical Referral* form and all insurance information including current medical insurance card(s) accompany the person.
   6. Staff will remain at the hospital and coordinate an admission to the hospital. If the person served is not to be admitted to the hospital, staff will arrange for transportation home.
   7. Upon discharge from the hospital or emergency room, staff transporting to the program site will coordinate with the assigned nurse or nurse consultant, Designated Coordinator and/or Designated Manager or designee and ensure that:
      a. All new medications/treatments and cares have been documented on the *Medical Referral* form
      b. All medications or supplies have been obtained from the pharmacy
      c. All new orders have been recorded on the monthly medication sheet
      d. All steps and findings are documented in the program and health documentation, as applicable
   8. If the person's condition does not require a call to "911," but prompt medical attention is necessary, staff will consider the situation as health threatening and will call the person's physician, licensed health care professional, or urgent care to obtain treatment.
   9. Staff will contact the assigned nurse or nurse consultant or Designated Coordinator and/or Designated Manager or designee and will follow any instructions provided including obtaining necessary staffing coverage.
   10. Staff will transport the person to the medical clinic or urgent care and will remain with the person. A

Medical Referral form will be completed at the time of the visit.

11. Upon return from the medical clinic or urgent care, staff will coordinate with the assigned nurse or nurse consultant, Designated Coordinator and/or Designated Manager or designee and ensure that:
    a. All new medications/treatments and cares have been documented on the *Medical Referral* form
    b. All medications or supplies have been obtained from the pharmacy
    c. All new orders have been recorded on the monthly medication sheet
    d. All steps and findings are documented in the program and health documentation, as applicable

C. **Any mental health crisis that requires the program to call "911." a mental health crisis intervention team, or a similar mental health response team or service when available and appropriate.**

1. Staff will implement any crisis prevention plans specific to the person served as a means to de-escalate, minimize, or prevent a crisis from occurring.
2. If a mental health crisis were to occur, staff will ensure the person's safety, and will not leave the person alone if possible.
3. Staff will contact "911," a mental health crisis intervention team, or a similar mental health response team or service when available and appropriate, and explain the situation and that the person is having a mental health crisis.
4. Staff will follow any instructions provided by the "911" operator or the mental health crisis intervention team contact person.
5. Staff will notify the Designated Coordinator and/or Designated Manager or designee who will assist in securing any staffing coverage that is necessary.
6. If the person is transported to a hospital, staff will either accompany the person or go to the hospital as soon as possible. Staff will not leave other persons served alone or unattended.
7. Staff will ensure that a completed *Medical Referral* form and all current insurance information including current medical insurance card(s) accompany the person.
8. Staff will remain at the hospital and coordinate an admission to the hospital. If the person served is not to be admitted to the hospital, staff will arrange for transportation home.
9. Upon discharge from the hospital or emergency room, staff transporting to the program site will coordinate with the assigned nurse or nurse consultant, Designated Coordinator and/or Designated Manager or designee and ensure that:
    a. All new medications/treatments have been documented on the *Medical Referral* form
    b. All medications or supplies have been obtained from the pharmacy
    c. All new orders have been recorded on the monthly medication sheet
    d. All steps and findings are documented in the program and health documentation, as applicable

D. **An act or situation involving a person that requires the program to call "911," law enforcement, or the fire department**

1. Staff will contact "911" immediately if there is a situation or act that puts the person at imminent risk of harm.
2. Staff will immediately notify the Designated Coordinator and/or Designated Manager or designee of any "911," law enforcement, or fire department involvement or intervention.
3. If a person served has been the victim of a crime, staff will follow applicable policies and procedures for reporting and reviewing maltreatment of vulnerable adults or minors.
4. If a person has been sexually assaulted, staff will discourage the person from bathing, washing, or changing clothing. Staff will leave the area where the assault took place untouched, if it is under the company's control.
5. If a person served is suspected of committing a crime or participating in unlawful activities, staff will follow the person's *Coordinated Service and Support Plan Addendum* when possible criminal behavior has been addressed by the support team.
6. If a person served is suspected of committing a crime and the possibility has not been addressed by the support team, the Designated Coordinator and/or Designated Manager will determine immediate actions and contact support team members to arrange a planning meeting.

7. If a person served is incarcerated, the Designated Coordinator and/or Designated Manager or designee will provide the police with information regarding vulnerability, challenging behaviors, and medical needs.

E. **Unauthorized or unexplained absence of a person served from a program**

1. Based on the person's supervision level, staff will determine when the person is missing from the program site or from supervision in the community.
2. Staff will immediately call "911" if the person is determined to be missing. Staff will provide the police with information about the person's appearance, last known location, disabilities, and other information as requested.
3. Staff will immediately notify the Designated Coordinator and/or Designated Manager or designee. Together a more extensive search will be organized, if feasible, by checking locations where the person may have gone.
4. The Designated Coordinator and/or Designated Manager or designee will continue to monitor the situation until the individual is located.
5. If there is reasonable suspicion that abuse and/or neglect led to or resulted from the unauthorized or unexplained absence, staff will report immediately in accordance with applicable policies and procedures for reporting and reviewing maltreatment of vulnerable adults or minors.

F. **Conduct by a person served against another person served**

1. Staff will immediately enlist the help of additional staff if they are available and intervene to protect the health and safety of persons involved.
2. Staff will redirect persons to discontinue the behavior and/or physically place themselves between the aggressor(s) using the least intrusive methods possible in order to de-escalate the situation.
3. If the aggressor has a behavior plan in place, staff will follow the plan as written in addition to the methodologies that may be provided in the *Coordinated Service and Support Plan Addendum.*
4. Staff will remove the person being aggressed towards to an area of safety.
5. If other least restrictive alternatives were ineffective in de-escalating the aggressors' conduct and immediate intervention is needed to protect the person or others from imminent risk of physical harm, staff will follow the *Policy and Procedure on Emergency Use of Manual Restraint* and/or staff will call "911."
6. If the ordinary operation of the program is disrupted, staff will manage the situation and will return to the normal routine as soon as possible.
7. To the extent possible, staff will visually examine persons served for signs of physical injury and document any findings.
8. If the conduct results in injury, staff will provide necessary treatment according to their training.

G. **Sexual activity between persons served involving force or coercion**

1. Staff will follow any procedures as directed by the *Individual Abuse Prevention Plans* and/or *Coordinated Service and Support Plan Addendums*, as applicable.
2. Staff will immediately intervene in an approved therapeutic manner to protect the health and safety of the persons involved if there is obvious coercion or force involved, or based on the knowledge of the persons involved, that one of the persons may have sexually exploited the other.
3. If the persons served are unclothed, staff will provide them with a robe or other appropriate garment and will discourage the person from bathing, washing, changing clothing or redressing in clothing that they were wearing.
4. Staff will leave the area where the sexual activity took place untouched if it is under the company's control.
5. Staff will call "911" in order to seek medical attention if necessary and inform law enforcement.
6. To the extent possible, staff will visually examine persons served for signs of physical injury and document any findings.
7. If the incident resulted in injury, staff will provide necessary treatment according to their training.

Reporting incidents

A. Staff will first call "911" if they believe that a person is experiencing a medical emergency that may be life threatening. In addition, staff will first call "911," a mental health crisis intervention team, or a similar mental health response team or service when available and appropriate for a person experiencing a mental health crisis.

B. Staff will immediately notify the Designated Coordinator and/or Designated Manager that an incident or emergency has occurred and follow direction issued to them and will document the incident or emergency on an *Incident and Emergency Report* and any related program or health documentation. Each *Incident and Emergency Report* will contain the required information as stated in the *Policy and Procedure on Reviewing Incidents and Emergencies.*

C. When the incident or emergency involves more than person served, the company and staff will not disclose personally identifiable information about any other person served when making the report to each person and/or legal representative and case manager unless the company has the consent of the person and/or legal representative.

D. The Designated Coordinator and/or Designated Manager will maintain information about and report incidents to the legal representative or designated emergency contact and case manager within 24 hours of an incident occurring while services are being provided, within 24 hours of discovery or receipt of information that an incident occurred, unless the company has reason to know that the incident has already been reported, or as otherwise directed in the person's *Coordinated Service and Support Plan* and/or *Coordinated Service and Support Plan Addendum.*

E. A report will be made to the MN Office of the Ombudsman for Mental Health and Developmental Disabilities and the Department of Human Services Licensing Division within 24 hours of the incident, or receipt of the information that the incident occurred, unless the company has reason to know that the incident has already been reported, by using the required reporting forms. These forms include *Death Reporting Form, Serious Injury Form,* and *Death or Serious Injury Report FAX Transmission Cover Sheet.* Incidents to be reported include:
   1. Serious injury as determined by MN Statutes, section 245.91, subdivision 6.
   2. Death of a person served.

F. Verbal reporting of an emergency use of manual restraint will occur within 24 hours of the occurrence. Further reporting procedures will be completed according to the *Policy and Procedure on Emergency Use of Manual Restraint* which includes the requirements of reporting incidents according to MN Statutes, sections 245D.06, subdivision 1 and 245D.061.

G. Within 24 hours of reporting maltreatment, the company will inform the case manager of the nature of the activity or occurrence reported and the agency that received the report. The company and staff will follow the applicable policy and procedure on reporting maltreatment for vulnerable adults or minors, as applicable.

H. For residential programs, licensed under the Adult Foster Care rule and not as a MN Statutes, chapter 245D-CRS Satellite license, the Designated Coordinator and/or Designated Manager will ensure that a report is made to the county licensing authority for the following incidents within 24 hours of:
   1. The occurrence of a fire that causes damage to the residence or requires the services of a fire department or the onset of any changes or repairs to the residence that require a building permit.
   2. The occurrence of any injuries of a person served that require treatment by a physician.
   3. The occurrence of a death of a person served.
   4. Suspected or alleged maltreatment.
   5. Notification to a person's physician because medication has not been taken as prescribed and the physician has determined that the refusal or failure to take the medication as prescribed created an immediate threat to the person's health or safety or the health or safety of other persons served.

I. For residential programs licensed as a MN Statutes, chapter 245D-CRS Satellite site, the company will notify the local agency within 24 hours of the onset of changes in a residence resulting from construction, remodeling, or damages requiring repairs that require a building permit or may affect a licensing requirement of MN Statutes, chapter 245D.

Synstelien Community Services

POLICY AND PROCEDURE ON EMERGENCIES

I. PURPOSE

The purpose of this policy is to provide guidelines on preparing for, reporting, and responding to emergencies to ensure the safety and well-being of persons served.

II. POLICY

The company will be prepared to respond to emergencies as defined in MN Statutes, section 245D.02, subdivision 8, that occur while providing services, to protect the health and safety of and minimize risk of harm to the person(s) served. Staff will address all emergencies according to the specific procedure outlined in this policy and act immediately to ensure the safety of persons served. After the situation has been resolved and/or the person(s) involved are no longer in immediate danger, staff will complete the necessary documentation in order to comply with licensing requirements on reporting and to assist in developing preventative measures, if applicable. For incident response procedures, staff will refer to the *Policy and Procedure on Responding to and Reporting Incidents*.

All staff will be trained on this policy and the safe and appropriate response to and reporting of emergencies. Program sites will have contact information of a source of emergency medical care and transportation readily available for quick and easy access. In addition, a list of emergency phone numbers will be posted in a prominent location and emergency contact information for persons served at the facility including each person's representative, physician, and dentist.

III. PROCEDURE

Defining emergencies

A. Emergency is defined as any event that affects the ordinary daily operation of the program including, but not limited to:
   1. Fires.
   2. Severe weather.
   3. Natural disasters.
   4. Power failures.
   5. Emergency evacuation or moving to an emergency shelter.
   6. Temporary closure or relocation of the program to another facility or service site for more than 24 hours.
   7. Other events that threaten the immediate health and safety of persons served and that require calling "911."

Preparing for emergencies

A. To be prepared for emergencies, a staff person trained in first aid will be available on site in a community residential setting, and when required in a person's *Coordinated Service and Support Plan* (*CSSP*) and/or *CSSP Addendum*, be able to provide cardiopulmonary resuscitation (CPR), whenever persons are present and staff are required to be at the site to provide direct services.

B. Each community residential setting will have a first aid kit readily available for use by, and that meet the needs, of persons served and staff. The first aid kit will contain, at a minimum, bandages, sterile compresses, scissors, and ice bag or cold pack, an oral or surface thermometer, mild liquid soap, adhesive tape, and a first aid manual.

C. Community residential setting facilities will have:
   1. A floor plan available that identifies the locations of:
      a. Fire extinguishers and audible or visual alarm systems
      b. Exits, primary and secondary evacuation routes, and accessible egress routes, if any
      c. An emergency shelter within the facility

2. A site plan that identifies:
   a. Designated assembly points outside the facility
   b. Locations of fire hydrants
   c. Routes of fire department access
3. An emergency escape plan for each resident.
4. A floor plan that identifies the location of enclosed exit stairs for facilities that have three (3) or more dwelling units.

D. Quarterly fire and severe weather drills will be conducted throughout the year on various days of the week and times of the day or night. Staff and persons served in the facility will not be notified prior to the drill, if possible, to ensure correct implementation of staff responsibilities for response. The manager or designee will be responsible for the initiation of the emergency drill and will record the date, day, and time of the drill in the emergency plan files.

E. As part of the emergency plan file kept at the facility site, the following information will be maintained:
1. The log of quarterly fire and severe weather drills.
2. The readily available emergency response plan.
3. Emergency contact information for persons served at the facility including each person's representative, physician, and dentist.
4. Information on the emergency shelter within the facility and the designated assembly points outside the facility.
5. Emergency phone numbers that are posted in a prominent location.

F. If persons served require the use of adaptive procedures or equipment to assist them with safe evacuation, staff will receive specific instruction on these procedures and equipment.

Responding to emergencies

A. Staff will call "911" based upon the emergency situation as provided in each individual response procedure as stated below.

B. **Fire**
1. Staff will respond immediately to all fire and smoke detector alarms or signs of fire by activating the alarms system.
2. All persons will be evacuated from the building by staff and assembled at the established designated assembly point outside the facility.
3. "911" will be immediately called from a neighbor's telephone or a cell phone in order to report the fire.
4. Staff will contain the area of the fire, if feasible, by closing doors. If it is possible to put out the fire with a fire extinguisher, staff will attempt to do so.
5. Staff will notify the manager or designee.
6. Persons served and individuals will not reenter the program site until the police or fire department issue instructions that the area is safe.
7. If the program site is not habitable and relocation to a designated safe area such as an emergency shelter is necessary, staff will follow the procedures in Letter E of this **Responding to emergencies** section.

C. **Severe weather conditions and natural disasters**
1. At the first sign of severe weather, including but not limited to high winds, heavy snow or rain, or extreme temperatures, staff will confirm the location and safety of all persons served.
2. Staff will listen to the radio or watch television for current weather conditions.
3. Upon hearing sirens or a take cover warning, staff will notify all persons that they need to seek shelter and will guide all persons to the designated safe area in the facility and will also bring a battery operated radio or television set, first aid kit, and flashlight.
4. If feasible, persons served but not scheduled for supervision will be called and warned.
5. Staff will assist all persons in staying in the safe area until an all clear is issued through the radio or by

other means.

6. If injury or damage occurs, staff will notify the manager or designee and follow directions given.
7. If relocation to a designated safe area such as an emergency shelter is necessary, staff will follow the procedures in Letter E of this **Responding to emergencies** section.

D. **Power failure (electricity outage or gas leak**)

1. During a power failure, all staff will remain with persons served. If persons are not in the immediate area at the program, staff will locate them and bring them to the central program area.
2. The power company will be contacted by cell phone to determine estimated length of the power outage. If estimated to last less than two hours, the manager or designee will be contacted to determine what actions will be taken. If the power outage is to last more than two hours, staff will transport the persons to a safe area or location as previously established by the manager.
3. If gas is smelled or a gas leak is suspected, staff will evacuate persons to the established designated assembly point outside the facility.
4. The gas company will be immediately notified and instructions followed.
5. No one will be permitted to use lighters, matches, or any open flame during this time. All electrical and battery-operated appliances and machinery will be turned off until the all clear has been provided.
6. The manager or designee will be notified of the gas leak. This call will be made by staff from the safe area using a cell phone or from a neighbor's phone.
7. If relocation to a designated safe area such as an emergency shelter is necessary, staff will follow the procedures in Letter E of this **Responding to emergencies** section.

E. **Emergency evacuation, moving to an emergency shelter, and temporary closure or relocation of the program to another facility or service site for more than 24 hours**

1. Staff will ensure that everyone leaves the building and will assist all persons in gathering at the designated assembly point outside the facility.
2. Staff will immediately notify the manager or designee of the conditions that may require emergency evacuation, moving to an emergency shelter, temporary closure, or the relocation of program to another site.
3. The manager or designee will coordinate relocation of services in a way that promotes continuity of care of persons served.
4. The manager or designee will coordinate and assist staff as necessary in transporting persons to the designated location.
5. If access to the program site is permitted, staff will transfer persons' program files, clothing, necessary personal belongings, current medications, and medication administration records to the designated location.
6. The manager will notify the legal representative or designated emergency contact, and case manager, and other licensed caregiver (if applicable) of the new location of the program if necessary.

F. **Other events that threaten the immediate health and safety of persons served and that require calling "911"**

1. Pandemic event: Upon request, staff will cooperate with state and local government disaster planning agencies working to prepare for or react to emergencies presented by a pandemic outbreak.
2. Bomb threat
   a. Upon receiving a bomb threat, staff at the program site should pull the fire alarm, if available.
   b. Staff will ensure that everyone leaves the building and assembles at the designated assembly point outside the facility.
   c. Staff will immediately call "911" from a neighbor's telephone or a cell phone.
   d. Staff and persons will remain outside the building until further instructions are received from the police or fire department.
   e. If unable to re-occupy the building, staff will staff will follow the procedures in Letter E of this **Responding to emergencies** section.
3. Repeated and unwanted or threatening phone calls

a. Upon receiving repeated and unwanted or threatening phone calls, staff will hang up the phone immediately or encourage the person served to hang up the phone.
b. Staff will lock all doors and windows.
c. Staff will monitor the frequency of disruptive phone calls, informing the manager when the calls continue to a point where the safety of persons served is in question or when the calls are personally threatening or environmentally threatening to a program site or property.
d. Staff will call "911" if at any point they feel threatened.
e. The manager will determine when and if the telephone number will be changed due to the harassing or threatening telephone calls.

Reporting emergencies

A. Staff will immediately notify the manager that an incident or emergency has occurred and follow direction issued to them and will document the incident or emergency on an *Incident and Emergency Report* any related program or health documentation. Each *Incident and Emergency Report* will contain the required information as stated in the *Policy and Procedure on Reviewing Incidents and Emergencies.*

B. If an incident resulted from the emergency situation, the manager will maintain information about and report incidents to the legal representative or designated emergency contact and case manager within 24 hours of an incident occurring while services are being provided, within 24 hours of discovery or receipt of information that an incident occurred, unless the company has reason to know that the incident has already been reported, or as otherwise directed in the person's *CSSP* and/or *CSSP Addendum.*

C. When the incident or emergency involves more than person served, the company and staff will not disclose personally identifiable information about any other person served when making the report to each person and/or legal representative and case manager unless the company has the consent of the person and/or legal representative.

D. If a serious injury or death were to occur as a result of the emergency situation, staff will follow the response and reporting procedures as stated in the *Policy and Procedures on Responding to and Reporting Incidents* and, if needed, the *Policy and Procedure on Death of a Person Served.*

Synstelien Community Services

POLICY AND PROCEDURE ON REVIEWING INCIDENTS AND EMERGENCIES

I. PURPOSE

The purpose of this policy is to establish guidelines for the internal review of incidents and emergencies.

II. POLICY

This company is committed to the prevention of and safe and timely response to incidents and emergencies. Staff will act immediately to respond to incidents and emergencies as directed in the *Policy and Procedure on Responding to and Reporting Incidents* and the *Policy and Procedure on Emergencies.* After the health and safety of person(s) served are ensured, staff will complete all required documentation that will be compiled and used as part of the internal review process.

The company will ensure timely completion of the internal review procedure of incident and emergencies to identify trends or patterns and corrective action, if needed.

III. PROCEDURE

A. The Designated Manager will conduct a review of all reports of incidents and emergencies for identification of patterns and implementation of corrective action as necessary to reduce occurrences. This review will include:
   1. Accurate and complete documentation standards that include the use of objective language, a thorough narrative of events, appropriate response, etc.
   2. Identification of patterns which may be based upon the person served, staff involved, location of incident, etc. or a combination.
   3. Corrective action that will be determined by the results of the review and may include, but is not limited to, retraining of staff, changes in the physical plant of the program site, and/or changes in the *Coordinated Service and Support Plan Addendum.*

B. Each *Incident and Emergency Report* will contain the following information:
   1. The name of the person or persons involved in the incident. It is not necessary for staff to identify all persons affected by or involved in an emergency unless the emergency resulted in an incident.
   2. The date, time, and location of the incident or emergency.
   3. A description of the incident or emergency.
   4. A description of the response to the incident or emergency and whether a person's *Coordinated Service and Support Plan Addendum* or program policies and procedures were implemented as applicable.
   5. The name of the staff person or persons who responded to the incident or emergency.
   6. The determination of whether corrective action is necessary based on the results of the review that will be completed by the Designated Manager.

C. In addition to the review for the identification of patterns and implementation of corrective action, the company will consider the following situations reportable as incidents or emergencies which will require the completion of an internal review:
   1. Emergency use of manual restraint as defined in MN Statutes, sections 245D.02, subdivision 8a and 245D.061. MN Statutes, section 245D.061, subdivision 6, has an internal review report requiring the answering of six questions.
   2. Death and serious injuries not reported as maltreatment according to MN Statutes, section 245D.06, subdivision 1, paragraph g.
   3. Reports of maltreatment of vulnerable adults or minors according to MN Statutes, sections 626.557 and 626.556.
   4. Complaints or grievances as defined in MN Statutes, section 245D.10, subdivision 2.

D. When the company has knowledge that a situation has occurred that requires an internal review, the Designated Manager will ensure that an *Incident and Emergency Report* or *Emergency Use of Manual Restraint Incident*

Report has been completed.

1. In addition to the *Incident and Emergency Report*, if there was a death or serious injury, the Designated Manager will also ensure that the applicable documents have also been completed for the MN Office of the Ombudsman for Mental Health and Developmental Disabilities and the Department of Human Services Licensing Division.
2. For internal reports of suspected or alleged maltreatment of a vulnerable adult, a copy of the *Notification to an Internal Reporter* will also be submitted for the internal review.
3. The internal review and reporting of emergency use of manual restraints will be completed according to the *Policy and Procedure on Emergency Use of Manual Restraint.*

E. Documentation to be submitted to the designated person responsible for completing internal reviews will include, as applicable:
   1. *Incident and Emergency Report*.
   2. *Notification to an Internal Reporter.*
   3. *Emergency Use of Manual Restraint Incident Report.*
   4. *Death Reporting Form.*
   5. *Serious Injury Form.*
   6. *Death or Serious Injury Report FAX Transmission Cover Sheet.*
   7. *Complaint Summary and Resolution Notice.*

F. The Designated Coordinator is the primary individual responsible for ensuring that internal reviews are completed for reports. If there are reasons to believe that the Designated Coordinator is involved in the alleged or suspected maltreatment or is unable to complete the internal review, the Designated Manager is the secondary individual responsible for ensuring that internal reviews are completed.

G. The internal review will be completed (within 30 calendar days for maltreatment reports) using the *Internal Review* form and will include an evaluation of whether:
   1. Related policies and procedures were followed.
   2. The policies and procedures were adequate.
   3. There is a need for additional staff training.
   4. The reported event is similar to past events with the persons or the services involved.
   5. There is a need for corrective action by the license holder to protect the health and safety of persons served.

H. Based upon the results of the review, the license holder will develop, document, and implement a corrective action plan designed to correct current lapses and prevent future lapses in performance by staff or the license holder, if any.

I. The following information will be maintained in the service recipient record, as applicable:
   1. *Incident and Emergency Report* including the written summary and the Designated Manager's review.
   2. *Emergency Use of Manual Restraint Incident Report* and applicable reporting and reviewing documentation requirements.
   3. *Death Reporting Form.*
   4. *Serious Injury Form.*
   5. *Death or Serious Injury Report FAX Transmission Cover Sheet.*
   6. *Complaint Summary and Resolution Notice*.

J. Completed *Internal Reviews* and documentation regarding suspected or alleged maltreatment will be maintained separately by the internal reviewer in a designated file that is kept locked and only accessible to authorized

individuals.

K. Internal reviews must be made accessible to the commissioner immediately upon the commissioner's request for internal reviews regarding maltreatment.

Synstelien Community Services

POLICY AND PROCEDURE ON REPORTING AND REVIEW OF MALTREATMENT OF VULNERABLE ADULTS

I. PURPOSE

The purpose of this policy is to establish guidelines for the internal and external reporting and the internal review of maltreatment of vulnerable adults.

II. POLICY

Staff who are mandated reporters must report all of the information they know regarding an incident of known or suspected maltreatment, either internally or externally, in order to meet their reporting requirements under law. All staff of the company who encounter maltreatment of a vulnerable adult will take immediate action to ensure the safety of the person(s) served. Staff will define maltreatment of vulnerable adults as abuse, neglect, or financial exploitation and will refer to the definitions from Minnesota Statutes, section 626.5572 at the end of this policy. Staff are to conduct themselves in a supportive and respectful manner which does not maltreat Vulnerable Adults.

Staff will refer to the *Policy and Procedure on Reporting and Review of Maltreatment of Minors* regarding suspected or alleged maltreatment of persons 17 years of age or younger.

III. PROCEDURE

A. Staff of the company who encounter maltreatment of a vulnerable adult, age 18 or older, will take immediate action to ensure the safety of the person or persons as well as the safekeeping of their funds and property. If a staff knows or suspects that a vulnerable adult is in immediate danger, they will call "911."

B. If a staff knows or suspects that maltreatment of a vulnerable adult has occurred, they must make a report immediately (within 24 hours) internally to the company or externally to the Minnesota Adult Abuse Reporting Center. Should the staff choose to make a report directly to an external agency, they must make the report by notifying the Minnesota Adult Abuse Reporting Center.

C. To make a report internally to the company, staff must make a verbal report to their supervisor or Designated Coordinator. The Designated Coordinator is the primary individual responsible for receiving internal reports of maltreatment and for forwarding internal reports to the Minnesota Adult Abuse Reporting Center. If there are reasons to believe that the Designated Coordinator is involved in the alleged or suspected maltreatment, the Social Services Manager (Designated Manager) is the secondary individual responsible for receiving internal reports of maltreatment and for forwarding internal reports to the Minnesota Adult Abuse Reporting Center.

D. To make a report externally to the Minnesota Adult Abuse Reporting Center staff can call **844-880-1574** or report at **mn.gov/dhs/reportadultabuse/**.

E. When reporting the alleged or suspected maltreatment, either internally or externally, staff will include as much information as known and will cooperate with any subsequent investigation.

F. For internal reports of suspected or alleged maltreatment, the person who received the report will:
   1. Contact the Minnesota Adult Abuse Reporting Center if the report is determined to be suspected or alleged maltreatment.
   2. Ensure an *Incident and Emergency Report* has been completed.
   3. Inform the case manager within 24 hours of reporting maltreatment, unless there is reason to believe that the case manager is involved in the suspected maltreatment. The person who received the report will disclose to the case manager the:
      a. Nature of the activity or occurrence reported

   b. The agency that received the report
4. Complete and mail the *Notification to an Internal Reporter* to the home address of the staff who reported the maltreatment within two working days in a manner that protects the reporter's confidentiality. The notification must indicate whether or not the company reported externally Minnesota Adult Abuse Reporting Center. The notice must also inform the staff that if the company did not report externally and they are not satisfied with that decision, they may still make the external report to the Minnesota Adult Abuse Reporting Center themselves. It will also inform the staff that they are protected against any retaliation if they decide to make a good faith report to the Minnesota Adult Abuse Reporting Center on their own.

G. When the company has knowledge that an internal or external report of alleged or suspected maltreatment has been made, an internal review will be completed. The Designated Coordinator is the primary individual responsible for ensuring that internal reviews are completed for reports of maltreatment. If there are reasons to believe that the Designated Coordinator is involved in the alleged or suspected maltreatment, the Social Services Manager (Designated Manager) is the secondary individual responsible for ensuring that internal reviews are completed.

H. The *Internal Review* will be completed within 30 calendar days. The person completing it will:
   1. Ensure an *Incident and Emergency Report* has been completed.
   2. Contact the lead investigative agency if additional information has been gathered.
   3. Coordinate any investigative efforts with the lead investigative agency by serving as the company contact, ensuring that staff cooperate, and that all records are available.
   4. Complete an *Internal Review* which will include the following evaluations of whether:
      a. Related policies and procedures were followed
      b. The policies and procedures were adequate
      c. There is a need for additional staff training
      d. The reported event is similar to past events with the vulnerable adults or the services involved
      e. There is a need for corrective action by the license holder to protect the health and safety of the vulnerable adult(s)
   5. Complete the *Alleged Maltreatment Review Checklist* and compile together all documents regarding the report of maltreatment.

I. Based upon the results of the internal review, the company will develop, document, and implement a corrective action plan designed to correct current lapses and prevent future lapses in performance by staff or the company, if any.

J. Internal reviews must be made accessible to the commissioner immediately upon the commissioner's request for internal reviews regarding maltreatment.

K. The company will provide an orientation to the internal and external reporting procedures to all persons served and/or legal representatives. This orientation will include the telephone number and website for the Minnesota Adult Abuse Reporting Center. This orientation for each new person to be served will occur within 24 hours of admission, or for persons who would benefit more from a later orientation, the orientation may take place within 72 hours.

L. Staff will receive training on this policy, MN Statutes, section 245A.65 and sections 626.557 and 626.5572 and their responsibilities related to protecting persons served from maltreatment and reporting maltreatment.

This training must be provided within 72 hours of first providing direct contact services and annually thereafter.

MINNESOTA STATUTES, SECTION 626.5572 DEFINITIONS

Subdivision 1. **Scope.**
For the purpose of section 626.557, the following terms have the meanings given them, unless otherwise specified.

Subd. 15. **Maltreatment.**
"Maltreatment" means abuse as defined in subdivision 2, neglect as defined in subdivision 17, or financial exploitation as defined in subdivision 9.

Subd. 2. **Abuse.**
"Abuse" means:
(a) An act against a vulnerable adult that constitutes a violation of, an attempt to violate, or aiding and abetting a violation of:

(1) assault in the first through fifth degrees as defined in sections 609.221 to 609.224;
(2) the use of drugs to injure or facilitate crime as defined in section 609.235;
(3) the solicitation, inducement, and promotion of prostitution as defined in section 609.322; and
(4) criminal sexual conduct in the first through fifth degrees as defined in sections 609.342 to 609.3451.

A violation includes any action that meets the elements of the crime, regardless of whether there is a criminal proceeding or conviction.

(b) Conduct which is not an accident or therapeutic conduct as defined in this section, which produces or could reasonably be expected to produce physical pain or injury or emotional distress including, but not limited to, the following:

(1) hitting, slapping, kicking, pinching, biting, or corporal punishment of a vulnerable adult;
(2) use of repeated or malicious oral, written, or gestured language toward a vulnerable adult or the treatment of a vulnerable adult which would be considered by a reasonable person to be disparaging, derogatory, humiliating, harassing, or threatening;
(3) use of any aversive or deprivation procedure, unreasonable confinement, or involuntary seclusion, including the forced separation of the vulnerable adult from other persons against the will of the vulnerable adult or the legal representative of the vulnerable adult; and
(4) use of any aversive or deprivation procedures for persons with developmental disabilities or related conditions not authorized under section 245.825.

(c) Any sexual contact or penetration as defined in section 609.341, between a facility staff person or a person providing services in the facility and a resident, patient, or client of that facility.

(d) The act of forcing, compelling, coercing, or enticing a vulnerable adult against the vulnerable adult's will to perform services for the advantage of another.

(e) For purposes of this section, a vulnerable adult is not abused for the sole reason that the vulnerable adult or a person with authority to make health care decisions for the vulnerable adult under sections 144.651, 144A.44, chapter 145B, 145C or 252A, or section 253B.03 or 524.5-313, refuses consent or withdraws consent, consistent with that authority and within the boundary of reasonable medical practice, to any therapeutic conduct, including any care, service, or procedure to diagnose, maintain, or treat the physical or mental condition of the vulnerable adult or, where permitted under law, to provide nutrition and hydration parenterally or through intubation. This paragraph does not enlarge or diminish rights otherwise held under law by:

(1) a vulnerable adult or a person acting on behalf of a vulnerable adult, including an involved family member, to consent to or refuse consent for therapeutic conduct; or

(2) a caregiver to offer or provide or refuse to offer or provide therapeutic conduct.

(f) For purposes of this section, a vulnerable adult is not abused for the sole reason that the vulnerable adult, a person with authority to make health care decisions for the vulnerable adult, or a caregiver in good faith selects and depends upon spiritual means or prayer for treatment or care of disease or remedial care of the vulnerable adult in lieu of medical care, provided that this is consistent with the prior practice or belief of the vulnerable adult or with the expressed intentions of the vulnerable adult.

(g) For purposes of this section, a vulnerable adult is not abused for the sole reason that the vulnerable adult, who is not impaired in judgment or capacity by mental or emotional dysfunction or undue influence, engages in consensual sexual contact with:

(1) a person, including a facility staff person, when a consensual sexual personal relationship existed prior to the caregiving relationship; or

(2) a personal care attendant, regardless of whether the consensual sexual personal relationship existed prior to the caregiving relationship.

Subd. 9. **Financial exploitation.**

"Financial exploitation" means:

(a) In breach of a fiduciary obligation recognized elsewhere in law, including pertinent regulations, contractual obligations, documented consent by a competent person, or the obligations of a responsible party under section 144.6501, a person:

(1) engages in unauthorized expenditure of funds entrusted to the actor by the vulnerable adult which results or is likely to result in detriment to the vulnerable adult; or

(2) fails to use the financial resources of the vulnerable adult to provide food, clothing, shelter, health care, therapeutic conduct or supervision for the vulnerable adult, and the failure results or is likely to result in detriment to the vulnerable adult.

(b) In the absence of legal authority a person:

(1) willfully uses, withholds, or disposes of funds or property of a vulnerable adult;

(2) obtains for the actor or another the performance of services by a third person for the wrongful profit or advantage of the actor or another to the detriment of the vulnerable adult;

(3) acquires possession or control of, or an interest in, funds or property of a vulnerable adult through the use of undue influence, harassment, duress, deception, or fraud; or

(4) forces, compels, coerces, or entices a vulnerable adult against the vulnerable adult's will to perform services for the profit or advantage of another.

(c) Nothing in this definition requires a facility or caregiver to provide financial management or supervise financial management for a vulnerable adult except as otherwise required by law.

Subd. 17. **Neglect.**

"Neglect" means:

(a) The failure or omission by a caregiver to supply a vulnerable adult with care or services, including but not limited to, food, clothing, shelter, health care, or supervision which is:

(1) reasonable and necessary to obtain or maintain the vulnerable adult's physical or mental health or safety, considering the physical and mental capacity or dysfunction of the vulnerable adult; and

(2) which is not the result of an accident or therapeutic conduct.

(b) The absence or likelihood of absence of care or services, including but not limited to, food, clothing, shelter, health

care, or supervision necessary to maintain the physical and mental health of the vulnerable adult which a reasonable person would deem essential to obtain or maintain the vulnerable adult's health, safety, or comfort considering the physical or mental capacity or dysfunction of the vulnerable adult.

(c) For purposes of this section, a vulnerable adult is not neglected for the sole reason that:

(1) the vulnerable adult or a person with authority to make health care decisions for the vulnerable adult under sections 144.651, 144A.44, chapter 145B, 145C, or 252A, or sections 253B.03 or 524.5-101 to 524.5-502, refuses consent or withdraws consent, consistent with that authority and within the boundary of reasonable medical practice, to any therapeutic conduct, including any care, service, or procedure to diagnose, maintain, or treat the physical or mental condition of the vulnerable adult, or, where permitted under law, to provide nutrition and hydration parenterally or through intubation; this paragraph does not enlarge or diminish rights otherwise held under law by:

(i) a vulnerable adult or a person acting on behalf of a vulnerable adult, including an involved family member, to consent to or refuse consent for therapeutic conduct; or

(ii) a caregiver to offer or provide or refuse to offer or provide therapeutic conduct; or

(2) the vulnerable adult, a person with authority to make health care decisions for the vulnerable adult, or a caregiver in good faith selects and depends upon spiritual means or prayer for treatment or care of disease or remedial care of the vulnerable adult in lieu of medical care, provided that this is consistent with the prior practice or belief of the vulnerable adult or with the expressed intentions of the vulnerable adult;

(3) the vulnerable adult, who is not impaired in judgment or capacity by mental or emotional dysfunction or undue influence, engages in consensual sexual contact with:

(i) a person including a facility staff person when a consensual sexual personal relationship existed prior to the caregiving relationship; or

(ii) a personal care attendant, regardless of whether the consensual sexual personal relationship existed prior to the caregiving relationship; or

(4) an individual makes an error in the provision of therapeutic conduct to a vulnerable adult which does not result in injury or harm which reasonably requires medical or mental health care; or

(5) an individual makes an error in the provision of therapeutic conduct to a vulnerable adult that results in injury or harm, which reasonably requires the care of a physician, and:

(i) the necessary care is provided in a timely fashion as dictated by the condition of the vulnerable adult;

(ii) if after receiving care, the health status of the vulnerable adult can be reasonably expected, as determined by the attending physician, to be restored to the vulnerable adult's preexisting condition;

(iii) the error is not part of a pattern of errors by the individual;

(iv) if in a facility, the error is immediately reported as required under section 626.557, and recorded internally in the facility;

(v) if in a facility, the facility identifies and takes corrective action and implements measures designed to reduce the risk of further occurrence of this error and similar errors; and

(vi) if in a facility, the actions required under items (iv) and (v) are sufficiently documented for review and evaluation by the facility and any applicable licensing, certification, and ombudsman agency.

(d) Nothing in this definition requires a caregiver, if regulated, to provide services in excess of those required by the caregiver's license, certification, registration, or other regulation.

(e) If the findings of an investigation by a lead agency result in a determination of substantiated maltreatment for the sole reason that the actions required of a facility under paragraph (c), clause (5), item (iv), (v), or (vi), were not taken, then the facility is subject to a correction order. An individual will not be found to have neglected or maltreated the vulnerable adult based solely on the facility's not having taken the actions required under paragraph (c), clause (5), item (iv), (v), or (vi). This must not alter the lead agency's determination of mitigating factors under section 626.557, subdivision 9c, paragraph (c).

POLICY AND PROCEDURE ON REPORTING AND REVIEW OF MALTREATMENT OF MINORS

I. PURPOSE

The purpose of this policy is to establish guidelines for the reporting and internal review of maltreatment of minors (children) in care.

II. POLICY

Staff who are mandated reporters must report externally all of the information they know regarding an incident of known or suspected maltreatment of a child, in order to meet their reporting requirements under law. All staff of the company who encounter maltreatment of a minor will take immediate action to ensure the safety of the child. Staff will define maltreatment as sexual abuse, physical abuse, or neglect and will refer to the definitions from MN Statutes, section 626.556 at the end of this policy.

Any person may voluntarily report to the local welfare agency, agency responsible for assessing or investigating the report, police department, or the county sheriff if the person knows, has reason to believe, or suspects a child is being neglected or subjected to physical or sexual abuse. Staff of the company cannot shift the responsibility of reporting maltreatment to an internal staff person or position. In addition, if a staff knows or has reason to believe a child is being or has been neglected or physically or sexually abused within the preceding three years, the staff must immediately (within 24 hours) make a report to the local welfare agency, agency responsible for assessing or investigating the report, police department, or the county sheriff.

Staff will refer to the *Policy and Procedure on Reporting and Review of Maltreatment of Vulnerable Adults* regarding suspected or alleged maltreatment of individuals 18 years of age or older.

III. PROCEDURE

A. Staff of the company who encounter maltreatment of a child, age 17 or younger, will take immediate action to ensure the safety of the child or children. If a staff knows or suspects that a child is in immediate danger, they will call “911.”

B. An individual mandated to report physical or sexual child abuse or neglect within a licensed facility will report the information to the agency responsible for licensing the facility. If the mandated reporter is unsure of what agency to contact, they will contact the county agency and follow their direction. The applicable agencies include:
   1. The Department of Human Services is the agency responsible for assessing or investigating allegations of maltreatment in facilities licensed under chapters 245A and 245D, except for child foster care and family child care. DHS Licensing Division’s Maltreatment Intake telephone number is 651-431-6600.
   2. The Department of Health is the agency responsible for assessing or investigating allegations of child maltreatment in facilities licensed under sections 144.50 to 144.58 and 144A.46.
   3. The county local welfare agency is the agency responsible for assessing or investigating allegations of maltreatment in child foster care, family child care, legally unlicensed child care, juvenile correctional facilities licensed under section 241.021 located in the local welfare agency's county, and reports involving children served by an unlicensed personal care provider organization under section 256B.0659.

C. Reports regarding incidents of suspected abuse or neglect of children occurring within a family or in the community should be made to the local county social services agency or local law enforcement referencing the phone numbers contained within this policy.

D. When verbally reporting the alleged maltreatment to the external agency, the mandated reporter will include as much information as known to identify the child involved, any persons responsible for the abuse or neglect (if known), and the nature and extent of the maltreatment.

E. If the report of suspected abuse or neglect occurred within the company, the report should also include any actions taken by the company in response to the incident. If a staff attempts to report the suspected maltreatment internally, the person receiving the report will remind the staff of the requirement to report externally.

F. A verbal report of suspected abuse or neglect that is made to one of the listed agencies by a mandated reporter must be followed by a written report to the same agency within 72 hours, exclusive of weekends and holidays, unless the appropriate agency has informed the mandated reporter that the oral information does not constitute a report.

G. When the company has knowledge that an external report of alleged or suspected maltreatment has been made, an internal review will be completed. The Designated Coordinator is the primary individual responsible for ensuring that internal reviews are completed for reports of maltreatment. If there are reasons to believe that the Designated Coordinator is involved in the alleged or suspected maltreatment, the Designated Manager is the secondary individual responsible for ensuring that internal reviews are completed.

H. The *Internal Review* will be completed within 30 calendar days. The person completing it will:
   1. Ensure an *Incident and Emergency Report* has been completed.
   2. Contact the lead investigative agency if additional information has been gathered.
   3. Coordinate any investigative efforts with the lead investigative agency by serving as the company contact, ensuring that staff cooperate, and that all records are available.
   4. Complete an *Internal Review* which will include the following evaluations of whether:
      a. Related policies and procedures were followed
      b. The policies and procedures were adequate
      c. There is a need for additional staff training
      d. The reported event is similar to past events with the children or the services involved
      e. There is a need for corrective action by the license holder to protect the health and safety of the children in care
   5. Complete the *Alleged Maltreatment Review Checklist* and compile together all documents regarding the report of maltreatment.

I. Based upon the results of the internal review, the company will develop, document, and implement a corrective action plan designed to correct current lapses and prevent future lapses in performance by individuals or the company, if any.

J. Internal reviews must be made accessible to the commissioner immediately upon the commissioner's request for internal reviews regarding maltreatment.

K. Staff will receive training on this policy, MN Statutes, section 245A.66 and section 626.556 and their responsibilities related to protecting children in care from maltreatment and reporting maltreatment. This training must be provided within 72 hours of first providing direct contact services and annually thereafter.

EXTERNAL AGENCIES

COUNTY	DAY	EVENING/WEEKEND
AITKIN	(218) 927-7200 or (800) 328-3744	(218) 927-7400
ANOKA	(763) 422-7215	(651) 291-4680
BECKER	(218) 847-5628	(218) 847-2661
BELTRAMI	(218) 333-4223	(218) 751-9111
BENTON	(320) 968-5087	(320) 968-7201

Synstelien Community Services

BIG STONE	(320) 839-2555	(320) 815-0215
BLUE EARTH	(507) 304-4111	(507) 625-9034
BROWN	(507) 354-8246	(507) 233-6720
CARLTON	(218) 879-4583	(218) 384-3236
CARVER	(952) 361-1600	(952) 442-7601
CASS	(218) 547-1340	(218) 547-1424
CHIPPEWA	(320) 269-6401	(320) 269-2121
CHISAGO	(651) 213-5600	(651) 257-4100
CLAY	(218) 299-5200	(218) 299-5151
CLEARWATER	(218) 694-6164	(218) 694-6226
COOK	(218) 387-3620	(218) 387-3030
COTTONWOOD	(507) 831-1891	(507) 831-1375
CROW WING	(218) 824-1140	(218) 829-4740
DAKOTA	(952) 891-7459	(952) 891-7171
DODGE	(507) 635-6170	(507) 635-6200
DOUGLAS	(320) 762-2302	(320) 762-8151
FARIBAULT	(507) 526-3265	(507 526-5148
FILLMORE	(507) 765-2175	(507) 765-3874
FREEBORN	(507) 377-5400	(507) 377-5205
GOODHUE	(651) 385-3232	(651) 385-3155
GRANT	(218) 685-4417	(800) 797-6190
HENNEPIN	(612) 348-3552	(612) 348-8526
HOUSTON	(507) 725-5811	(507) 725-3379
HUBBARD	(218) 732-1451	(218) 732-3331
ISANTI	(763) 689-1711	(763) 689-2141
ITASCA	(218) 327-2941	(218) 326-8565
JACKSON	(507) 847-4000	(507) 847-4420
KANABEC	(320) 679-6350	(320) 679-8400
KANDIYOHI	(320) 231-7800	(320) 235-1260
KITTSON	(218) 843-2689	(218) 843-3535
KOOCHICHING	(218) 283-7000	(218) 283-4416
LAC QUI PARLE	(320) 598-7594	(320) 598-3720
LAKE	(218) 834-8400	(218) 834-8385
LAKE OF THE WOODS	(218) 634-2642	(218) 634-1143
LE SUEUR	(507) 357-8288	(507) 357-8545
LINCOLN	(800) 810-8816	(507) 694-1664

LYON	(800) 657-3760	(507) 537-7666
MAHNOMEN	(218) 935-2568	(218) 935-2255
MARSHALL	(218) 745-5124	(218) 745-5411
MARTIN	(507) 238-4757	(507) 238-4481
MC LEOD	(320) 864-3144	(320) 864-3134
MEEKER	(320) 693-5300	(320) 693-5400
MILLE LACS	(320) 983-8208	(320) 983-8250
MORRISON	(320) 632-2951	(320) 632-9233
MOWER	(507) 437-9700	(507) 437-9400
MURRAY	(800) 657-3811	(507) 836-6168
NICOLLET	(507) 386-4528	(507) 931-1570
NOBLES	(507) 295-5213	(507) 372-2136
NORMAN	(218) 784-5400	(218) 784-7114
OLMSTED	(507) 328-6400	(507) 328-6583
OTTER TAIL	(218) 998-8150	(218) 998-8555
PENNINGTON	(218) 681-2880	(218) 681-6161
PINE	(320) 591-1570	(320) 629-8380
PIPESTONE	(507) 825-6720	(507) 825-6792
POLK	(218) 281-8483	(218) 281-0431
POPE	(320) 634-5750	(320) 634-5411
RAMSEY	(651) 266-4500	(651) 291-6795
RED LAKE	(218) 253-4131	(218) 253-2996
REDWOOD	(507) 637-4050	(507) 637-4036
RENVILLE	(320) 523-2202	(320) 523-1161
RICE	(507) 332-6115	(507) 210-8524
ROCK	(507) 283-5070	(507) 283-5000
ROSEAU	(218) 463-2411	(218) 463-1421
SCOTT	(952) 445-7751	(952) 496-8484
SHERBURNE	(763) 241-2600	(763) 241-2500
SIBLEY	(507) 237-4000	(507) 237-4330
ST. LOUIS	N. (218) 749-7128 or S. (218) 726-2012	N. (218) 749-6010 or S. (218) 727-8770
STEARNS	(320) 656-6225	(320) 251-4240
STEELE	(507) 444-7500	(507) 444-3800
STEVENS	(320) 589-7400	(320) 589-2141
SWIFT	(320) 843-3160	(320) 843-3133
TODD	(320) 732-4500	(320) 732-2157

TRAVERSE	(320) 563-8255	(320) 563-4244
WABASHA	(651) 565-3351	(651) 565-3361
WADENA	(218) 631-7605	(218) 631-7600
WASECA	(507) 835-0560	(507) 835-0500
WASHINGTON	(651) 430-6457	(651) 291-6795
WATONWAN	(507) 375-3294	(507) 507-3121
WILKIN	(218) 643-8013	(218) 643-8544
WINONA	(507) 457-6200	(507) 457-6368
WRIGHT	(763) 682-7449	(763) 682-1162
YELLOW MEDICINE	(320) 564-2211	(320) 564-2130

DEPARTMENT OF HUMAN SERVICES LICENSING DIVISION MALTREATMENT INTAKE: 651-431-6600

MINNESOTA STATUTES, SECTION 626.556 DEFINITIONS

Subdivision. 2. **Definitions.**
As used in this section, the following terms have the meanings given them unless the specific content indicates otherwise:

(c) "Substantial child endangerment" means a person responsible for a child's care, by act or omission commits or attempts to commit an act against a child under their care that constitutes any of the following:

(1) egregious harm as defined in section 260C.007, subdivision 14;
(2) abandonment under section 260C.301, subdivision 2;
(3) neglect as defined in paragraph (f), clause (2), that substantially endangers the child's physical or mental health, including a growth delay, which may be referred to as failure to thrive, that has been diagnosed by a physician and is due to parental neglect;
(4) murder in the first, second, or third degree under section 609.185, 609.19, or 609.195;
(5) manslaughter in the first or second degree under section 609.20 or 609.205;
(6) assault in the first, second, or third degree under section 609.221, 609.222, or 609.223;
(7) solicitation, inducement, and promotion of prostitution under section 609.322;
(8) criminal sexual conduct under sections 609.342 to 609.3451;
(9) solicitation of children to engage in sexual conduct under section 609.352;
(10) malicious punishment or neglect or endangerment of a child under section 609.377 or 609.378;
(11) use of a minor in sexual performance under section 617.246; or
(12) parental behavior, status, or condition which mandates that the county attorney file a termination of parental rights petition under section 260C.301, subdivision 3, paragraph (a).

(d) "Sexual abuse" means the subjection of a child by a person responsible for the child's care, by a person who has a significant relationship to the child, as defined in section 609.341, or by a person in a position of authority, as defined in section 609.341, subdivision 10, to any act which constitutes a violation of section 609.342 (criminal sexual conduct in the first degree), 609.343 (criminal sexual conduct in the second degree), 609.344 (criminal sexual conduct in the third degree), 609.345 (criminal sexual conduct in the fourth degree), or 609.3451 (criminal sexual conduct in the fifth degree). Sexual abuse also includes any act which involves a minor which constitutes a violation of prostitution offenses under sections 609.321 to 609.324 or 617.246. Sexual abuse includes threatened sexual abuse.

(f) "Neglect" means the commission or omission of any of the acts specified under clauses (1) to (9), other than by accidental means:

(1) failure by a person responsible for a child's care to supply a child with necessary food, clothing, shelter, health,

medical, or other care required for the child's physical or mental health when reasonably able to do so;
(2) failure to protect a child from conditions or actions that seriously endanger the child's physical or mental health when reasonably able to do so, including a growth delay, which may be referred to as a failure to thrive, that has been diagnosed by a physician and is due to parental neglect;
(3) failure to provide for necessary supervision or child care arrangements appropriate for a child after considering factors as the child's age, mental ability, physical condition, length of absence, or environment, when the child is unable to care for the child's own basic needs or safety, or the basic needs or safety of another child in their care;
(4) failure to ensure that the child is educated as defined in sections 120A.22 and 260C.163, subdivision 11, which does not include a parent's refusal to provide the parent's child with sympathomimetic medications, consistent with section 125A.091, subdivision 5;
(5) nothing in this section shall be construed to mean that a child is neglected solely because the child's parent, guardian, or other person responsible for the child's care in good faith selects and depends upon spiritual means or prayer for treatment or care of disease or remedial care of the child in lieu of medical care; except that a parent, guardian, or caretaker, or a person mandated to report pursuant to subdivision 3, has a duty to report if a lack of medical care may cause serious danger to the child's health. This section does not impose upon persons, not otherwise legally responsible for providing a child with necessary food, clothing, shelter, education, or medical care, a duty to provide that care;
(6) prenatal exposure to a controlled substance, as defined in section 253B.02, subdivision 2, used by the mother for a nonmedical purpose, as evidenced by withdrawal symptoms in the child at birth, results of a toxicology test performed on the mother at delivery or the child at birth, or medical effects or developmental delays during the child's first year of life that medically indicate prenatal exposure to a controlled substance;
(7) "medical neglect" as defined in section 260C.007, subdivision 6, clause (5);
(8) chronic and severe use of alcohol or a controlled substance by a parent or person responsible for the care of the child that adversely affects the child's basic needs and safety; or
(9) emotional harm from a pattern of behavior which contributes to impaired emotional functioning of the child which may be demonstrated by a substantial and observable effect in the child's behavior, emotional response, or cognition that is not within the normal range for the child's age and stage of development, with due regard to the child's culture.

(g) "Physical abuse" means any physical injury, mental injury, or threatened injury, inflicted by a person responsible for the child's care on a child other than by accidental means, or any physical or mental injury that cannot reasonably be explained by the child's history of injuries, or any aversive or deprivation procedures, or regulated interventions, that have not been authorized under section 121A.67 or 245.825.
Abuse does not include reasonable and moderate physical discipline of a child administered by a parent or legal guardian which does not result in an injury. Abuse does not include the use of reasonable force by a teacher, principal, or school employee as allowed by section 121A.582. Actions which are not reasonable and moderate include, but are not limited to, any of the following:
(1) throwing, kicking, burning, biting, or cutting a child;
(2) striking a child with a closed fist;
(3) shaking a child under age three;
(4) striking or other actions which result in any nonaccidental injury to a child under 18 months of age;
(5) unreasonable interference with a child's breathing;
(6) threatening a child with a weapon, as defined in section 609.02, subdivision 6;
(7) striking a child under age one on the face or head;
(8) striking a child who is at least age one but under age four on the face or head, which results in an injury;
(9) purposely giving a child poison, alcohol, or dangerous, harmful, or controlled substances which were not prescribed for the child by a practitioner, in order to control or punish the child; or other substances that substantially affect the child's behavior, motor coordination, or judgment or that results in sickness or internal injury, or subjects the child to medical procedures that would be unnecessary if the child were not exposed to the substances;
(10) unreasonable physical confinement or restraint not permitted under section 609.379, including but not limited to tying, caging, or chaining; or
(11) in a school facility or school zone, an act by a person responsible for the child's care that is a violation under section 121A.58.

Synstelien Community Services

POLICY AND PROCEDURE ON SAFE TRANSPORTATION

I. PURPOSE

The purpose of this policy is to ensure the safety of persons served as well as staff during transportation and include the provisions for handling emergency situations.

II. POLICY

When transportation is the responsibility of the company, staff will assist in transporting, handling, and transferring persons served in a safe manner and according to their *Community Service and Support Plan* and/or *Community Service and Support Plan Addendum.*

III. PROCEDURE

A. Upon employment, staff are informed of the requirement that they must hold a valid driver's license, appropriate insurance, and maintain a safe driving record. Staff may also be required to complete additional training on safe transportation procedures.

B. The Designated Coordinator and/or Designated Manager will ensure the safety of vehicles, equipment, supplies, and materials owned or leased by the company and will maintain these in good condition. Standard practices for vehicle, equipment, supplies, and materials maintenance and inspection will be followed.

C. Staff will transport persons served with a program's vehicle. If there is no program vehicle, staff will attempt to use public or contracted transportation. If those options are unavailable, staff will use their own vehicle for transportation of persons served.

D. For contracted transportation, the Designated Coordinator and/or Designated Manager will ensure that all required documentation is completed and submitted before the first trip is scheduled. Staff will arrange ongoing use of contracted transportation or will assist persons served, as needed, in arranging transportation for themselves.

E. When dropping off persons served at a site which requires a change in staff, transporting staff will ensure that staff or another responsible party are present before leaving the person served unless otherwise specified in the person's *Community Service and Support Plan* and/or *Community Service and Support Plan Addendum.* Any necessary information will be presented to the staff or other responsible party.

F. In accordance with state laws, anyone riding in a moving vehicle must wear seatbelts and/or child safety restraints.

G. Staff are prohibited by state law (MN Statutes, section 169.475) to compose, send, or receive an electronic message while operating a motor vehicle. This includes a program vehicle or a staff person's own vehicle. An electronic message (as defined by state law) "means a self-contained piece of digital communication that is designed or intended to be transmitted between physical devices. An electronic message includes, but is not limited to, e-mail, a text message, an instant message, a command or request to access a World Wide Web page, or other data that uses a commonly recognized electronic communications protocol. An electronic message does not include voice or other data transmitted as a result of making a phone call, or data transmitted automatically by a wireless communications device without direct initiation by a person."

H. Persons served using wheelchairs will be transported according to manufacturer's safety guidelines. This includes, but is not limited to, safe operation and regular maintenance of lift equipment, checks of straps to secure the wheelchair to the floor of the vehicle, and use of adaptive seating equipment (i.e. headrests, lap trays) when appropriate. Staff who are transporting persons served and who complete "tie-downs" of wheelchairs will receive training on how to do so and will be required to demonstrate competency prior to

transporting persons using wheelchairs.

I. Staff will receive training on each person's transferring or handling requirements for the person and/or equipment prior to transferring or transporting persons. All transfers and handling of persons served will be done in a manner that ensures their dignity and privacy. Any concerns regarding transportation, transfers, and handling will be promptly communicated to the Designated Coordinator and/or Designated Manager who will address these concerns. This will be done immediately if the health and safety of the person(s) served are at risk.

J. When equipment used by a person served is needed, staff will place the equipment in a safe location in the vehicle such as the trunk of a car. If a program vehicle does not have a designated storage space such as a trunk, staff will place the equipment in an area of the vehicle and secure it, when possible, so that there is limited to no shifting during transport.

K. If there is an emergency while driving, staff follow emergency response procedures to ensure the person(s) safety. This will include pulling the vehicle over and stopping in a safe area as quickly and as safely as possible. Staff will use a cell phone or any available community resource to contact "911" for help if needed. If a medical emergency were to occur, staff will call "911" and follow first aid and/or CPR protocols according to their training.

L. While transporting more than one person served and person to person physical aggression occurs, staff will pull over and stop the vehicle in a safe area as quickly and as safely as possible, redirect the persons served, and if necessary, attempt to contact another staff person, the Designated Coordinator and/or Designated Manager, or "911" for assistance.

M. Persons served are prohibited from driving program or staff vehicles at any time.

Synstelien Community Services

POLICY AND PROCEDURE ON ANTI-FRAUD

I. PURPOSE

The purpose of this policy is to provide information regarding the prevention, elimination, monitoring, and reporting of fraud, abuse, and improper activities of government funding in order to obtain and maintain integrity of public funds.

II. POLICY

A holder of a license that is issued by Minnesota Department of Human Services (DHS), pursuant to MN Statutes, chapter 245A [Human Services Licensing Act], and who has enrolled to receive public governmental funding reimbursement for services is required to comply with the enrollment requirements as a licensing standard (MN Statutes, sections 245A.167 and 256B.04, subdivision 21). The company is a provider of services to persons whose services are funded by government/public funds.

Government funds may be from state or federal governments, to include, but not be limited to: Minnesota's Medical Assistance, Medicaid, Medicare, Brian Injury (BI) Waiver, Community Alternative Care (CAC) Waiver, Community Alternatives for Disabled Individuals (CADI) Waiver, Developmental Disability (DD) Waiver, Elderly Waiver (EW), and Minnesota's Alternative Care (AC) program. The company has a longstanding practice of fair and truthful dealing with persons served, families, health professionals, and other businesses. Management, staff, contractors, and other agents of the company shall not engage in any acts of fraud, waste, or abuse in any matter concerning the company's business, mission, or funds.

III. PROCEDURE

A. Definition: Types of fraud, abuse, or improper activities include, but are not limited to, the following:
   1. Billing for services not actually provided.
   2. Documenting clinical care not actually provided.
   3. Paying phantom vendors or phantom staff.
   4. Paying a vendor for services not actually provided.
   5. Paying an invoice known to be false.
   6. Accepting or soliciting kickbacks or illegal inducements from vendors of services, or offering or paying kickbacks or illegal inducements to vendors of services.
   7. Paying or offering gifts, money, remuneration, or free services to entice a Medicaid recipient to use a particular vendor.
   8. Using Medicaid reimbursement to pay a personal expense.
   9. Embezzling from the company.
   10. Ordering and charging over-utilized medical services that are not necessary for the person served.
   11. Corruption.
   12. Conversion (converting property or supplies owned by the company to personal use).
   13. Misappropriation of funds of the company or person served by the company.
   14. Personal loans to executives.
   15. Illegal orders.
   16. Maltreatment or abuse of persons served by the company.

B. Public Funds Compliance Officer: This company has designated the Deputy Executive Officer as their Public Funds Compliance Officer.

C. Reporting responsibility: The company has an open door policy and encourages staff to share their questions, concerns, suggestions, or complaints regarding the company and its operations with someone who can address them properly. In most cases, this will be a staff person's supervisor. However, if the staff person is not comfortable speaking with their supervisor or is not satisfied with the supervisor's response, the staff person is encouraged to speak with the Public Funds Compliance Officer. If the staff is not comfortable speaking

with the Public Funds Compliance Officer, the staff is encouraged to speak with the owner/CEO/Board of Directors. At any time, the staff may speak with an applicable external agency to express their concerns if it is believed that it is not possible to speak with the owner/CEO/Board of Directors. Examples of applicable external agencies are local social service agency's financial manager or law enforcement. This policy is intended to encourage and enable persons to raise serious concerns within the company prior to seeking resolution outside it.

D. Requirement of good faith: Anyone filing a complaint concerning a violation or suspected violation of the law or regulation requirements must be acting in good faith and have reasonable grounds for believing the information disclosed indicates a violation. Any allegations that prove not to be substantiated and which prove to have been made maliciously or knowingly to be false will be viewed as a serious disciplinary offense.

E. Confidentiality: Violations or suspected violations may be submitted on a confidential basis by the complainant or may be submitted anonymously. Reports of violations or suspected violations will be kept confidential to the extent possible, consistent with the need to conduct an adequate investigation.

F. No retaliation: No staff person who in good faith reports a violation of a law or regulation requirements will suffer harassment, retaliation, or adverse employment consequences. A staff who retaliates against someone who has reported a violation in good faith is subject to discipline up to and including termination of employment.

G. Report acknowledgement: The Public Funds Compliance Officer, or designee, will acknowledge receipt of the reported violation or suspected violation by writing a letter (or email) to the complainant within ten (10) business days, noting that the allegations will be investigated.

H. Responding to allegations of improper conduct: The Public Funds Compliance Officer is responsible for responding to allegations of improper conduct related to the provision or billing of Medical Assistance services. This may include, but is not limited to: investigating, interviewing applicable individuals involved, reviewing documents, asking for additional assistance, seeking input on process of the investigation, or seeking input on Medical Assistance laws and regulations interpretations to address all staff complaints and allegations concerning potential violations. The CEO will take on functions of the Public Funds Compliance Officer role if the complaint involves the Deputy Executive Officer. If the complaint involves both the CEO and Deputy Executive Officer, outside legal counsel or an applicable external agency will carry out the functions of the Public Funds Compliance Officer. The Deputy Executive Officer or its designee will implement corrective action to remediate any resulting problems.

I. Evaluation and monitoring for internal compliance: On a regular schedule and as needed, the Deputy Executive Officer, or its designee, will run routine financial reports to review financial information for accuracy and compliance. On a regular schedule and as needed, the Deputy Executive Officer, or its designee, will review standard operations and procedures to ensure that they remain compliant.

J. External auditing for compliance: On a regular schedule, the company will have an external financial audit.

K. Promptly reporting errors: The Public Funds Compliance Officer shall immediately notify appropriate individuals of all reported concerns or complaints regarding corporate accounting practices, internal controls, or auditing. This may include the Chief Financial Officer, the owner/CEO, or the Chairperson of the Board of Directors. The Deputy Executive Officer will promptly report to DHS any identified violations of Medical Assistance laws or regulations.

L. Recovery of overpayment: Within 60 days of discovery by the company of a Medical Assistance reimbursement overpayment, a report of the overpayment to DHS will be completed and arrangements made with DHS for the Department's recovery of the overpayment.

M. Training: Staff are trained on this policy and as needed, they may need to be re-trained. As determined by the company, staff may need to demonstrate an understanding of the implementation of this policy.

Synstelien Community Services

POLICY AND PROCEDURE ON ALCOHOL AND DRUG USE

I. PURPOSE

The purpose of this policy is to establish guidelines regarding the use of alcohol, prescription/legal drugs, chemicals, or illegal drugs while employees (also referred to as staff), subcontractors, and volunteers are on duty, whether they are at the program site, transporting persons served, or with persons in the community.

II. POLICY

It is not permissible for employees, subcontractors, and volunteers to be on duty, transporting a person(s) served, driving on company business, or accompanying a person served into the community when under the influence of alcohol or illegal drugs or impaired by any chemicals or prescription/legal drugs.

The company will give the same consideration to employees, subcontractors, and volunteers with chemical dependency issues as it does to those having other health issues. Voluntarily seeking assistance for such an issue will not jeopardize employment, whereas performance, attendance, or behavioral issues will.

The company will train employees, subcontractors, and volunteers on the company's alcohol and drug policy.

III. PROCEDURE

A. Any employee, subcontractor, or volunteer, while directly responsible for persons served, are prohibited from abusing any prescription/legal drugs, or being in any manner under the influence of a chemical that impairs the individual's ability to provide services or care including alcohol, prescription/legal drugs, or illegal drugs.

B. Any employee, subcontractor, or volunteer reporting or returning to work, whose behavior reflects the consumption of alcoholic beverages or the use of drugs, may be referred for an immediate medical evaluation to determine fitness for work and may be suspended without pay until deemed able to return to work.

C. When prescription or over-the-counter drugs may affect behavior and performance, the employee, subcontractor, and volunteer must inform the Designated Coordinator and/or Designated Manager. Re-assignment, light duty assignment, or temporary relief from duties may be required.

D. At any time, the sale, purchase, transfer, use, or possession of illegal drugs or alcohol, and/or the involvement in these activities of any individual under the legal age of consumption during work hours or at a program site will result in disciplinary action up to and including termination. Law enforcement will be notified as determined by the Designated Coordinator and/or Designated Manager.

E. Employees will immediately take necessary action up to and including contact of medical professionals, "911," and/or contact of law enforcement at any time a person served is believed to be under the influence of illegal drugs, is believed to be under the influence of alcohol under the legal age of consumption, or is believed to be a victim of potential alcohol poisoning.

F. Prescription drugs that belong to an employee, subcontractor, or volunteer are to be stored in a location that is not accessible to any person served.

G. Employees, subcontractors, or volunteers are not allowed to store alcoholic beverages at a program site. Persons served may store alcoholic beverages at a program site; however, based on a person's vulnerabilities or other related concerns, alcoholic beverages may be prohibited at any or all times from a program site.

H. As a condition of continuing employment, under certain circumstances, employees, subcontractors, and volunteers may be required to submit to drug and/or alcohol testing. Drug or alcohol testing may be required when there is a reasonable suspicion that an individual is currently abusing a drug or alcohol, is under the influence of drugs or alcohol while on duty, or has violated any of the procedures in this policy.

I. Failure to complete the testing or upon receiving positive test results are cause for disciplinary action up to and including termination. A positive test result may be explained or a request to pay for a confirmatory result made to the Designated Coordinator and/or Designated Manager.

Synstelien Community Services

POLICY AND PROCEDURE ON THE DEATH OF A PERSON SERVED

I. PURPOSE

The purpose of this policy is to establish guidelines for anticipating the death of a person served. In addition, this policy establishes the response and reporting guidelines for when death occurs of a person served.

II. POLICY

When the death of a person served is anticipated, the priority is to ensure that the person's dignity is preserved and that the wishes of the person and/or legal representative are complied with to the greatest extent possible. In the event that a person dies, staff will ensure proper response and reporting of the death.

III. PROCEDURE

A. If a person served develops a life threatening illness or sustains a life threatening injury from which the attending physician indicates death is anticipated, the Designated Coordinator and/or Designated Manager will ensure that the legal representative, case manager, other service providers, and the company staff are notified immediately (family members and others may be notified by the legal representative).

B. If possible, the Designated Coordinator and/or Designated Manager will ensure that a support team meeting or conference call is scheduled.

C. In coordination with the support team and in anticipation of the person's death, the Designated Coordinator and/or Designated Manager, assigned nurse or nurse consultant, and legal representative will determine whether the person served will reside at a hospital, other facility, or at home.

D. The Designated Coordinator and/or Designated Manager will ensure that the support team makes a decision in regards to an advance directive.
   1. Staff will act as if all persons under state guardianship have "do resuscitate" status unless consent has been given by the Guardianship Unit at the MN Department of Human Services for an advanced directive.
   2. At the request of the support team, the Designated Coordinator and/or Designated Manager will help obtain an advanced directive order by supplying information to the case manager from the physician so that a summary report may be submitted to the Guardianship Unit.
   3. The Designated Coordinator and/or Designated Manager and staff will not take a formal position on whether or not such an advanced directive order should or should not be issued. Staff will work to implement the wishes of the legal representative including helping to arrange and implement all physicians' orders. Staff who cannot in good conscience help obtain or implement particular physicians' orders will report this to the Designated Coordinator and/or Designated Manager.
   4. The Designated Coordinator and/or Designated Manager will review and document the status of all advanced directives regularly with the case manager (consent for advance directive orders for state wards expire annually and must be reauthorized by the Guardianship Unit at the MN Department of Human Services).

E. The Designated Coordinator and/or Designated Manager, in coordination with the support team, will develop a plan describing the protocol to be followed upon death, including notifications.

F. The Designated Coordinator and/or Designated Manager will coordinate with the support team to determine what services the program needs to deliver to meet the needs of the person served, including but not limited to additional supervision, specialized staff training, and implementation and documentation of all physician and nursing orders, including advanced directives.

G. The Designated Coordinator and/or Designated Manager and assigned nurse or nurse consultant, will ensure that staff are trained in, implement, and document all physician and nursing orders related to the person's anticipated death as well as the agreed upon protocol upon witnessing or discovering the death.

H. When discovering a person served who appears to have died, all staff will treat the situation as if it were a medical emergency and will take the following steps:
   1. Staff will call "911" and provide first aid and/or CPR to the extent they are qualified, unless the person served has an advanced directive.
   2. Staff will notify all required persons including the Designated Coordinator and/or Designated Manager and assigned nurse or nurse consultant, if available.
   3. When an authorized person, such as a physician or paramedic, determines that the person served is deceased, the Designated Coordinator and/or Designated Manager will ensure the County Coroner's office is notified and will ensure that the body is not moved until the coroner arrives.
   4. The Designated Coordinator and/or Designated Manager will notify the following individuals or entities within 24 hours of the death, or receipt of information that the death occurred, unless the company has reason to know that the death has already been reported:
      a. Legal representative or designated emergency contact
      b. Case manager
      c. MN Office of the Ombudsman for Mental Health and Developmental Disabilities and the Department of Human Services Licensing Division using the required reporting forms. These forms include the *Death Reporting Form* and *Death or Serious Injury Report Fax Transmission Cover Sheet*.
      d. Adult or Child Foster Care licensing authority, as applicable
   5. The Designated Coordinator and/or Designated Manager will discuss with the legal representative any funeral arrangements and notifications and will offer to assist the family/legal representative as needed.
   6. The Social Services Manager will be responsible for sending the notification letter "Notification Letter to Next-of-Kin" from the MN Office of the Ombudsman for Mental Health and Developmental Disabilities to the next of kin and for offering to arrange grief counseling for staff and other involved persons.

I. Upon the death of the person, any funds or other property of the person will be surrendered to the person's legal representative or given to the executor or administrator of the estate in exchange for an itemized receipt. A written inventory that was completed regarding the person's funds or property will be placed in their file with signatures obtained from the legal representative, executor, or administrator of the estate.

J. The company will conduct an internal review of incident of deaths that occurred while services were being provided and that were not reported by the program as alleged or suspected maltreatment, for identification of incident patterns and implementation of corrective action as necessary to reduce occurrences.

K. The Social Services Manager will complete and document the internal review related to the report of death and will add the person's name to the *Admission and Discharge Register*. The internal review will include an evaluation of whether:
   1. Related policies and procedures were followed.
   2. The policies and procedures were adequate.
   3. There is a need for additional staff training.
   4. The reported event is similar to past events with the persons or the services involved.
   5. There is a need for corrective action by the company to protect the health and safety of person served.

L. Based upon the results of the internal review, the company will develop, document, and implement a corrective action plan for the program designed to correct current lapses and prevent future lapses in performance by the individuals or the company, if any.

Synstelien Community Services

POLICY AND PROCEDURE ON UNIVERSAL PRECAUTIONS AND SANITARY PRACTICES

I. PURPOSE

The purpose of this policy is to establish guidelines to follow regarding universal precautions and sanitary practices, including hand washing, for infection prevention and control, and to prevent communicable diseases.

II. POLICY

It is the policy of the company to minimize the transmission of illness and communicable diseases by practicing and using proper sanitary practices. Staff will be trained on universal precautions to prevent the spread of blood borne pathogens, sanitary practices, and general infection control procedures. This includes active methods to minimize the risk of contracting illness or disease through individual to individual contact or individual to contaminated surface contact.

III. PROCEDURE

Care and sanitation of the general program site

A. The Designated Coordinator and/or Designated Manager will ensure that the program site including the interior and exterior of buildings, structures, or enclosures, walls, floors, ceilings, registers, fixtures, equipment, and furnishings are maintained in good repair and in sanitary and safe condition. Furnishings (such as furniture and carpet), particularly upholstery, will be routinely inspected and cleaned as necessary. The program site will be kept clean and free from accumulations of dirt, grease, garbage, peeling paint, mold, vermin, and insects.

B. Any building and equipment deterioration, safety hazards, and unsanitary conditions will be corrected. The Designated Coordinator and/or Designated Manager will be the primary individual(s) responsible for this coordination. Cleaning and disinfecting schedules will be developed by the Designated Coordinator and/or Designated Manager and implemented by staff.

C. Food will be obtained, handled, and properly stored to prevent contamination, spoilage, or a threat to persons served. Food and drink will not be stored in areas where bodily fluids, hazardous materials, and harmful substances may be present (i.e. bathrooms).

D. Chemicals, detergents, cleaning supplies, and other hazardous or toxic substances will not be stored with food or drink products or in any way that poses a hazard to persons served.

E. Each person served will have the following personal care items for their own use, if needed and/or desired. These items will be stored in a safe and sanitary manner to prevent contamination:
   1. Hair comb/brush and hair accessories.
   2. Toothbrush, toothpaste, and floss.
   3. Cosmetics.
   4. Deodorants.
   5. Razors/shavers.
   6. Bath soap/body wash.
   7. Shampoo/conditioner.

Universal precautions and infection prevention and control

A. Hand washing is the single most important practice for preventing the spread of disease and infection. Proper hand washing will be completed as a part of regular work practice and routine, regardless of the presence or absence of any recognized disease and infection. Staff are also expected to assist persons served to ensure regular hand washing. Hand washing will occur often and will include thorough use of water, soap, rubbing hands vigorously together for 20 seconds, rinsing and drying completely.

B. Staff will ensure that their coughs and sneezes are appropriately covered. Appropriately covered means coughing or sneezing into a tissue or paper towel. When these items are not available, staff will cough or sneeze into their elbows. Staff are also expected to assist persons served to understand and use appropriate means to cover their coughs and sneezes.

C. Gloves will be used as a barrier between hands and any potential source of infection. Gloves must be worn when contact with high risk bodily fluids can be reasonably anticipated. Fresh gloves will be used for each situation and for each person served.

D. Eye protection may be made available whenever splashes or drops of high risk bodily fluids are anticipated. This can include, but is not limited to, oral hygiene procedures and clean up of large amounts of high risk bodily fluids.

E. If necessary, a fluid resistant gown may be provided for staff to wear as a barrier during clean up of high volume fluids.

F. When handling linen and clothing contaminated with high risk bodily fluids, staff will wear gloves at all times. Contaminated laundry will be cleaned in the washing machine and dried in the dryer separate from non-contaminated laundry.

G. Staff are to use extreme, deliberate precaution in handling contaminated needles and sharps. Contaminated needles will not be bent or recapped. All needles and sharps will be disposed of in an appropriate sharps container.

H. Specimens obtained for medical testing or procedures containing high risk bodily fluids or other potentially infectious material must be handled with gloves, placed in a sealed container to prevent leakage, and labeled with the person's name and the type of specimen. If refrigeration is required, the specimen will be placed inside a second sealed container and separated from any refrigerated foods.

Compliance

A. Staff are responsible to adhere to universal precaution procedures. If there are obstacles to the implementation of universal precaution procedures, they will be immediately brought to the attention of the Designated Coordinator and/or Designated Manager. The Designated Coordinator and/or Designated Manager will then develop and implement solutions as necessary.

B. At a minimum, gloves, disinfectant, and appropriate cleaning supplies and materials will be available at the program site. The Designated Coordinator and/or Designated Manager will ensure adequate amounts of the infection control supplies after consideration of the program and staff needs.

C. Staff will receive training at orientation and annually thereafter on universal precaution procedures, infection control, and blood borne pathogens.

Synstelien Community Services

POLICY AND PROCEDURE ON HEALTH SERVICE COORDINATION

I. PURPOSE

The purpose of this policy is to promote the health and safety of persons served through establishing guidelines for the coordination and care of health-related services.

II. POLICY

This company is designated as a residential program and will implement procedures to ensure the continuity of care regarding health-related service needs as assigned in the *Coordinated Service and Support Plan (CSSP)* and/or *CSSP Addendum*. These procedures will be implemented in a way that is consistent with the specific health needs of the person served and which follows the procedures stated in the *Policy and Procedure on Safe Medication Assistance and Administration.*

Decision making regarding the health services needs of the person served will be guided by person-centered philosophy and conservative medical practice. The company will defer to the judgment of the assigned nurse, nurse consultant, or other licensed health care professional regarding medical or health-related concerns. If the company does not have an assigned nurse or nurse consultant, the company will coordinate all health-related services with the licensed health care professionals of the persons served.

III. PROCEDURE

A. If responsibility for meeting the person's health service needs has been assigned to the company in the *Coordinated Service and Support Plan* and/or *CSSP Addendum*, the company must maintain documentation on how the person's health needs will be met, including a description of the procedures the company will follow in order to:
   1. Provide medication setup, assistance, or administration according to MN Statutes, chapter 245D.
   2. Monitor health conditions according to written instructions from a licensed health care professional.
   3. Assist with or coordinate medical, dental, and other health service appointments.
   4. Use medical equipment, devices, or adaptive aides or technology safely and correctly according to written instructions from a licensed health care professional.

B. Unless directed otherwise in the *CSSP* or the *CSSP Addendum*, the company will ensure the prompt notification to the legal representative, if any, and the case manager of any changes to the person's mental and physical health needs that may affect the health service needs assigned to the company in the *Coordinated Service and Support Plan* and/or *CSSP Addendum.* This notice will be made, and the date documented, when the change in mental and physical health needs of the person has been discovered by the company, unless the company has reason to know that the change has already been reported.

C. In coordination with the person's health care providers, the company and person's legal representative will determine how each person's health condition(s) will be monitored.

D. When a person served requires the use of medical equipment, devices, or adaptive aides or technology, the company will ensure the safe and correct use of the item and that staff are trained accordingly on its use and assistance to the person. These items will only be used according to the written instructions from a licensed health care professional.

F. When a person served requires the use of medical equipment to sustain life or to monitor a medical condition that could become life-threatening without proper use of the medical equipment, staff will be specifically trained by a licensed health care professional or a manufacturer's representative including an observed skill assessment to demonstrate staff's ability to safely and correctly operate the equipment according to the treatment orders and manufacturer's instructions. Equipment includes, but is not limited to ventilators, feeding tubes, and endotracheal tubes.

POLICY AND PROCEDURE ON SAFE MEDICATION ASSISTANCE AND ADMINISTRATION

I. PURPOSE

The purpose of this policy is to establish guidelines to promote the health and safety of persons served by ensuring the safe assistance and administration of medication and treatments or other necessary procedures.

II. POLICY

The company is responsible for meeting health service needs including medication-related services of persons as assigned in the *Coordinated Service and Support Plan (CSSP)* and/or *CSSP Addendum.*

Persons served will be encouraged to participate in the process of medication administration to the fullest extent of their abilities, unless otherwise noted in the *Coordinated Service and Support Plan* and/or *CSSP Addendum.* The following procedures contain information on medication-related services for the administration of medication as well as the assistance staff may provide to a person who self-administers their own medication.

All medications and treatments will be administered according to this policy and procedure and the company's medication administration training curriculum.

III. PROCEDURE

Staff training

A. When medication set up and/or or administration has been assigned to the company as stated in the *Coordinated Service and Support Plan* and/or *CSSP Addendum,* staff who will set up or administer medications to persons served will receive training and demonstrate competency as well as reviewing this policy and procedure.

B. Unlicensed staff, prior to the set up and/or administration of medication, must successfully complete a medication set up or medication administration training course developed by a registered nurse or appropriate licensed health professional. The training curriculum must incorporate an observed skill assessment conducted by the trainer to ensure staff demonstrate the ability to safely and correctly follow medication procedures. The course must be taught by a registered nurse, clinical nurse specialist, certified nurse practitioner, physician's assistant, or physician, if at the time of service initiation or any time thereafter the person has or develops a health care condition that affects the service options available to the person because the condition requires specialized or intensive medical or nursing supervision and nonmedical service providers to adapt their services to accommodate the health and safety needs of the person.

C. Upon completion of this course and prior to the setting up and/or administering medications, staff will be required to demonstrate medication set up and/or administration established specifically for each person served at their location, if this has not already been completed.

D. This training will be completed for each staff person during orientation, within the first 60 days of hire. Staff who demonstrate a pattern of difficulty with accurate medication administration may be required to complete retraining at a greater frequency and/or be denied the responsibility of administering medications.

E. Documentation for this training and the demonstrated competency will be maintained in each staff person's personnel file.

Medication set up

A. Medication setup means the arranging of medications according to instructions from the pharmacy, the prescriber, or a licensed nurse, for later administration when the company is assigned responsibility in the *Coordinated Service and Support Plan or the CSSP Addendum.* A prescription label or the prescriber's

written or electronically recorded order for the prescription is sufficient to constitute written instructions from the prescriber.

B. Staff will document the following information in the person's served medication administration record:
   1. Dates of medication set up.
   2. Name of medication.
   3. Quantity of dose.
   4. Times to be administered.
   5. Route of administration at the time of set up.
   6. When the person will be away from the service location,
   7. To whom the medication was given.

Medication assistance

A. There may be occasions when the company is assigned responsibility solely for medication assistance to enable a person served to self-administer medication or treatments when the person is capable of directing their own care or when the person's legal representative is present and able to direct care for the person.

B. If medication assistance is assigned in the *Coordinated Service and Support Plan* and/or *CSSP Addendum*, staff may:
   1. Bring to the person and open a container of previously set up medications, empty the container into the person's hand, or open and give the medication in the original container to the person under the direction of the person.
   2. Bring to the person food or liquids to accompany the medication.
   3. Provide reminders, in person, remotely, or through programming devices such as telephones, alarms, or medication boxes, to take regularly scheduled medication or perform regularly scheduled treatments and exercises.

Medication administration

A. Medication may be administered within 60 minutes before or after the prescribed time. For example, a medication ordered to be given at 7:00 am may be administered between 6:00 am and 8:00 am.

B. Medications ordered to be given as an "AM medication" and/or "PM medication" may be administered at a routine daily time. The routine time may fluctuate up to two hours in order to accommodate the person's schedule. For example, if a person typically receives their medication at 7:00 am, then on the weekends, the medication may be given between 5:00 am and 9:00 am.

C. Staff administering medication must know or be able to locate medication information on the intended purpose, side effects, dosage, and special instructions.

D. General and specific procedures on administration of medication by routes are included at the end of this policy. Routes included are:
   1. Oral tablet/capsule/lozenge.
   2. Liquid medication.
   3. Buccal medication.
   4. Inhaled medication.
   5. Nasal spray medication.
   6. Eye medication.
   7. Ear drop medication.
   8. Topical medication.

Medication Authorization

A. Prior to administering medication for the person served, the company will obtain written authorization from the person served and/or legal representative to administer medications or treatments, including psychotropic

medications.

B. This authorization will remain in effect unless withdrawn in writing and it may be withdrawn at any time.

C. If authorization by the person served and/or legal representative is refused, the company will not administer the medication or treatment. This refusal will be immediately reported to the person's prescriber and staff will follow any directives or orders given by the prescriber.

Injectable medications

A. Injectable medications may be administered to a person served according to their prescriber's order and written instructions when one of the following conditions has been met:
   1. A registered nurse or licensed practical nurse will administer injections.
   2. A supervising registered nurse with a prescriber's order can delegate the administration of an injectable medication to unlicensed staff persons and provide the necessary training.
   3. There is an agreement that must be signed by the company, the prescriber, and the person served and/or legal representative will be maintained in the service recipient record. This agreement will specify:
      a. What injection may be given;
      b. When and how the injection may be given;
      c. That the prescriber retains responsibility for the company to give the injection.

B. Only a licensed health care professional is allowed to administer psychotropic medications by injection. This responsibility will not be delegated to unlicensed staff.

Psychotropic medication

A. When a person served is prescribed a psychotropic medication and the company is assigned responsibility for the medication administration, the requirements for medication administration will be followed.

B. The company will develop, implement, and maintain the following information in the person's *CSSP Addendum* according to MN Statutes, sections 245D.07 and 245D.071. This information includes:
   1. A description of the target symptoms that the psychotropic medication is to alleviate.
   2. Documentation methods that the company will use to monitor and measure changes to these target symptoms, if required by the prescriber.
   3. Data collection of target symptoms and reporting on the medication and symptom-related data, as instructed by the prescriber, a minimum of quarterly or as requested by the person and/or legal representative. This reporting will be made to the expanded support team.

C. If the person and/or legal representative refuse to authorize the administration of a psychotropic medication as ordered by the prescriber, the company will not administer the medication and will notify the prescriber as expediently as possible. After reporting the refusal to the prescriber, the company must follow any directives or orders given by the prescriber. A refusal may not be overridden without a court order. Refusal to authorize administration of a specific psychotropic medication is not grounds for service termination and does not constitute an emergency.

Documentation requirements on the Medication Administration Record (MAR)

The following information will be documented on a person's medication administration record

1. Information on the current prescription labels or the prescriber's current written or electronically recorded order or prescription that includes the:
   a. Person's name
   b. Description of the medication or treatment to be provided
   c. Frequency of administration
   d. Other information needed to safely and correctly administer medication or treatment to ensure effectiveness
2. Easily accessible information on risks and other side effects that are reasonable to expect and any

contraindications to the medications use.
3. Possible consequences if the medication or treatment is not taken or administered as directed.
4. Instruction on when and to whom to report:
   a. If a dose of medication is not administered or treatment is not performed as prescribed, whether by staff error, the person's error, or by the person's refusal
   b. The occurrence of possible adverse reactions to the medication or treatment
5. Notation of any occurrence of a dose of medication not being administered or treatment not performed as prescribed, whether by staff error, the person's error, or by the person's refusal, or of adverse reactions, and when and to whom the report was made.
6. Notation of when a medication or treatment is started, administered, changed, or discontinued.

Medication documentation and charting

A. Staff will transcribe a prescriber's new, changed, and discontinued medication/treatment orders to the monthly Medication Assistance Record (MAR) by:
   1. Comparing the label on the medication with the prescriber's to ensure they match. Any discrepancy must be reported to the pharmacy immediately.
   2. Copying any new medication/treatment or change from the original prescriber's orders to the monthly MAR.
   3. When there is a change in a current medication/treatment, the revision is recorded on the MAR in order to implement the medication change.
   4. Entering the medication/treatment name, dose, route, frequency, and times to be administered.
   5. Recording the date the medication is to start, the name of the prescriber who ordered the medication, and the initials of the person making the entry, on the line just below the arrows or under the order on a separate line.
   6. Discontinuing a medication/treatment as ordered by recording it as "Discontinued," the date, the prescriber's name, and the initials of the person making the entry on the line just below the arrow.
   7. Completing any applicable health documentation regarding the entry and notifying the necessary personnel.

B. Staff will document administration of medications/treatments on the monthly medication sheet by:
   1. Washing hands.
   2. Sign in to Therap.
   3. Click on the "Health" tab.
   4. Click "Record Data" in Data category at top of page under Medication Administration Record.
   5. Click appropriate residence and then client, or begin with clicking on appropriate client.
   6. Apply "Filter Medications", filtering medication to be given one hour before and one hour after medication is to be administered, and scroll down to medication to be given.
   7. Verify 5 of the "6 Rights" (client, medication, dose, time/date, and route).
   8. Dispense medication from bubble pack and sign bubble pack with initials and correct date. Or draw up liquid medication, granule medication (i.e. Glycolax, Metamucil), medication from a bottle, etc.
   9. Click appropriate box and fill in initials (6th "Right", documentation).
   10. Scroll down to next medication, verifying "rights", until all medications for that medication pass have been drawn up.
   11. Click "save" at bottom of page.
   12. Return to Dashboard, apply "Due Medications" to verify each medication was documented and administered.
   13. Administer medications, making sure client is not pocketing medication under tongue or inside cheek.
   14. Wash hands.

C. Staff will document a medication given from the PRN medication list by:
   1. Washing hands.
   2. Sign in to Therap Medication Assistance Record.
   3. Always verifying when the last dose of PRN medication was given, making sure it is appropriate to

administer.
4. Click "Record Administration in Detail Mode" and fill in all appropriate areas if appropriate to administer.
5. Always record in the comment section how much medication was administered and why it was administered.
6. Documenting the effect in the "follow up" section of the Medication Administration Record one hour after the medication was given.
7. Following any special instructions noted on the PRN Medication Administration Record directions, notifying the Resident Manager (RM), Assistant Resident Manager (ARM), DC and/or DM, assigned nurse, nurse consultant, or prescriber as directed.

D. On the occasion that the Therap computer system is inaccessible, staff will document on a printed paper Medication Administration Record (MAR) kept in the Residential Working File within each residence. Documentation will be completed as follows:
   1. Staff signature will be completed in the appropriate location on the MAR.
   2. Staff will verify client, medication, dosage, route, time/date.
   3. Medication will be dispensed appropriately from container, signing bubble pack with initials and date.
   4. Staff initials (documentation) will then be entered in the appropriate box on the MAR.
   5. Medications will then be administered.
   6. Completing documentation on the monthly medication sheet in black ink, ensuring white-out, erasing, or disfigurement, such as scratching out are not used at any time
E. Each month, staff administering and documenting medication/treatment administration will enter their initials, full name, and title initials in the designated location on the monthly medication sheet.

Medication storage and security, including Schedule II medication storage; Medication Destruction

A. The medication storage area/container will be appropriate for the person served, which may include being locked by the person or by the company, when unattended by staff and will be kept clean, dry, and within the appropriate temperature range.

B. Each person served will have a separate container for their internal medications and a separate container for their external medications. External standing order medications will be in a separate container from internal standing order medications.

C. Medication will not be kept in the same area as food or chemicals (in the case of refrigerated medications, they will be kept in a locked container and separated from food).

D. Schedule II controlled substances, names in MN Statutes, section 152.02, subdivision 3, will be stored in a locked storage area permitting access to the person served and staff authorized to administer medications.
E. Medications will be disposed of according to the Environmental Protection Agency recommendations.

Verification and monitoring of effectiveness of systems to ensure safe medication handling and administration (reporting and reviewing)

A. The designated person will be responsible for reviewing each person's medication administration record to ensure information is current and accurate. This will include a review of the monthly medication sheets, referrals, medication orders, etc.

B. At a minimum, this review will occur quarterly or more frequently if directed by the person and/or legal representative or the *Coordinated Service and Support Plan* or *CSSP Addendum*.

C. Based upon this quarterly or more frequent review, the reviewer will notify the manager, as needed, of any issues. Collaboratively, a plan must be developed and implemented to correct patterns of medication administration errors or systemic errors when identified. When needed, staff training will be included as part

of this plan to correct identified errors.

D. The following information will be reported to the legal representative and case manager as they occur or as directed by the *Coordinated Service and Support Plan* or *CSSP Addendum:*
   1. Concerns about a person's self-administration of medication or treatment.
   2. A person's refusal or failure to take or receive medication or treatment as prescribed.
   3. Any reports as required, regarding:
      a. If a dose of medication is not administered or treatment is not performed as prescribed, whether by staff error, the person's error, or by the person's refusal
      b. Occurrence of possible adverse reactions to the medication or treatment

Coordination and communication with prescriber

A. As part of medication set up and administration, the company will ensure that clear and accurate documentation of prescription orders has been obtained by the prescriber in written format.

B. Initiations, dosage changes, or discontinuations of medications will be coordinated with the prescriber and discussed as needed to ensure staff and/or the person served has a clear understanding of the order. If the order has only been done verbally, staff will request a written or electronically recorded copy from the prescriber. Staff will not make any changes to medications or treatment orders unless there is a written or electronically recorded copy.

C. All prescriber instructions will be implemented as directed and within required timelines by staff and/or the person served and documented in related health documentation.

D. Concerns regarding medication purpose, dosage, potential or present side effects, or other medication-related issues will be promptly communicated to the prescriber by staff, the manager, assigned nurse, or nurse consultant.

E. Any changes to the physical or mental needs of the person as related to medication will be promptly made to the prescriber in addition to the legal representative and case manager.

Coordination of medication refills and communicating with the pharmacy

A. The manager or other assigned staff person will be responsible for checking medication supply routinely to ensure adequate amount for administration.

B. Some pharmacies may automatically refill prescriptions of persons served. If this is the case, staff will contact the pharmacy if a medication or treatment is discontinued.

C. The company will ensure that the pharmacy has the contact information for the service location and the main contact person who can answer questions and be the primary person responsible for coordinating refills.

Handling changes to prescriptions and implementation of those changes

A. All written instructions regarding changes to medications and treatments are required to be documented through a prescription label or the prescriber's written or electronically recorded order for the prescription.

B. Changes made to prescriptions will be immediately communicated to the manager and nurse, as applicable.

C. Any concerns regarding these changes and the order will be resolved prior to administration of the medication to ensure safety and accuracy.

D. Staff will implement changes and document appropriately on the monthly medication sheet.

E. Discontinued medications or medications that the dosage is no longer accurate due to the changes will be

discarded appropriately.

IV. GENERAL AND SPECIFIC PROCEDURES ON ADMINISTRATION OF MEDICATION BY ROUTES

A. General procedures completed before administering medication **by any route**

1. Staff must begin by washing their hands and assembling equipment necessary for administration.
2. The person's monthly medication sheet is reviewed to determine what medications are to be administered and staff remove the medication from the storage area.
3. Staff will compare the medication sheet with the label of each medication for the following:
   a. Right person
   b. Right medication
   c. Right date
   d. Right time
   e. Right route
   f. Right dose
   g. Expiration date
4. If there is a discrepancy, the medication will not be administered. Instructions will be verified by contacting the nurse, pharmacist, or prescriber.
5. Staff will compare the label with the medication sheet for the second time.
6. Immediately prior to the administration of any medication or treatment, staff will identify the person and will explain to the person what is to be done.
7. Staff will compare the label with the medication sheet for the third time before administering it, according to the specific procedures below, to the person.
8. After administration, staff will document the administration of the medication or treatment or the reason for not administering the medication or treatment.
9. Staff will contact the nurse, or prescriber regarding any concerns about the medication or treatment, including side effects, effectiveness, or a pattern of the person refusing to take the medication or treatment as prescribed.
10. Adverse reactions will be immediately reported to the nurse, or prescriber.

B. Additional procedures for administration of **oral tablet/capsule/lozenge**

1. If medications are in a bottle, staff will pour the correct number of tablets or capsules into the lid of the medication container and transfer them to a medication cup.
2. If medications are in bubble packs, staff will, beginning with the highest number, push the correct dose into a medication cup, and write the date and their initials on the card next to the dose popped out.
3. If medication is in lozenge form, staff will unwrap the lozenge and transfer it to a medication cup.
4. Staff will administer the correct dosage by instructing the person to swallow the medication. If the medication is in lozenge form, staff will instruct the person not to chew or swallow the lozenge so it is able to dissolve in their mouth.
5. If the medication is to be swallowed (tablet/capsule), staff will offer at least 4 ounces of a beverage and remain with the person until the medication is swallowed.
6. If the medication is in lozenge form, staff will stay in the vicinity until the lozenge is completely dissolved; checking periodically to ensure the lozenge has not been chewed or swallowed.

C. Additional procedures for the administration of **liquid medications**

1. Staff will shake the medication if it is a suspension (staff will check the label if in doubt).
2. Staff will pour the correct amount of medication, at eye level on a level surface, with the label facing up, into a plastic medication measuring cup or measuring spoon.
3. Staff will wipe around the neck of the bottle with a damp paper towel, if sticky, and replace the cap.
4. Staff will dilute or dissolve the medication if indicated on the label or medication sheet with the correct amount of fluid.
5. Staff will administer the correct dose according to the directions in an appropriate container.

6. Staff will remain with the person until the medication is swallowed.

D. Additional procedures for the administration **of buccal medication**
1. Buccal medications are usually given in a liquid form and administered into the cheek.
2. Staff will open the container and measure the correct dose of liquid medication into a syringe or dropper.
3. Staff will position the person on their side.
4. Staff will administer the medication by squeezing the syringe or dropper into the person's cheek, with gloved hands, avoiding going between the teeth.
5. Staff will remain with the person to ensure that the medication has been absorbed into the cheek and that they have not drank any liquids.

E. Additional procedures for the administration of **inhaled medications**
1. If more than 1 inhaled medication is to be given, staff will state which one is administered first.
2. Staff will position the person sitting, if possible.
3. Staff will gently shake the spray container (Diskus style inhalers do not require shaking).
4. Staff will assemble the inhaler properly, if required, and remove the cover (Diskus style: staff will slide lever to open inhaler, then cock internal lever to insert dose into mouthpiece).
5. Staff will instruct the person to exhale through their mouth completely.
6. Staff will place the mouthpiece into the person's open mouth and instruct the person to close their lips around the mouthpiece.
7. Staff will press down the canister once, while instructing the person to inhale deeply and slowly through the mouth (Diskus style: staff will instruct the person to inhale the powdered medication).
8. Staff will wait 1 minute and repeat steps 5-7, if more than one puff is ordered.
9. Staff will instruct the person to rinse their mouth with water if directed.
10. Staff will return the medication to the locked area.
11. Staff will wash the inhaler mouthpiece daily with soap and warm water and dry it with a clean paper towel (Diskus style: staff will wipe the mouthpiece with a clean dry cloth).

F. Additional procedures for the administration of **nasal spray medications**
1. Staff will ask the person to blow their nose or will gently wipe the nose with gloved hands.
2. Staff will gently shake the spray container.
3. Staff will ask the person to tilt their head slightly forward.
4. Staff will remove the cap from the nozzle and will insert the nozzle into one nostril, aiming away from the septum (middle of the nostril).
5. Holding the other nostril closed, staff will instruct the person to inhale and squeeze once to spray.
6. Staff will repeat steps 4 and 5 to deliver the correct dosage to the other nostril.
7. Staff will rinse the nozzle with warm water, dry it with a clean paper towel, and replace the cap.

G. Additional procedures for the administration of **eye medications**
1. Staff will open the medication container.
2. Staff will position the person in a sitting or lying down position.
3. Staff will observe the eye(s) for any unusual conditions which should be reported to the nurse or prescriber prior to administration.
4. Staff will cleanse the eye (unless otherwise noted) with a clean tissue, gently wiping from the inner corner outward once (if medication is used in both eyes, staff will use a separate tissue for each eye).
5. Staff will assist or ask the person to tilt their head back and look up.
6. With gloved hands, staff will pull correct lower eyelid down to form a 'pocket' or ask the person to pull down their lower eyelid and will administer the correct dose (number of drops/strand for ointments) into the correct eye(s).
7. If different eye medications are prescribed, staff will five (5) minutes before administering the second medication.
8. Staff will avoid touching the tip of the dropper or tube to the person's eyelid or any other object or surface and replace the cap.

9. Staff will offer the person a tissue for each eye or blot the person's eye with separate tissues.

H. Additional procedures for the administration of **ear drop medication**
1. Staff will have the person sit or lie down with the affected ear up.
2. If sitting, staff will have the person tilt head sideways until the ear is as horizontal as possible.
3. If lying down, staff will have the person turn their head.
4. Staff will observe ears and notify the nurse or prescriber of any unusual condition prior to administration of the medication.
5. Staff will administer the correct number of drops, that are at room temperature, into the correct ear by pulling the ear gently backward and upward. For children, under 3 years of age, staff will pull the ear gently back and down.
6. Staff will have the person remain in the required position for one (1) to two (2) minutes.
7. Staff will have the person hold their head upright while holding a tissue against the ear to soak up any excess medication that may drain.
8. Staff will repeat the procedure for the other ear if necessary.
9. Staff will replace the cap on the container and will avoid touching the tip of the dropper to the person's ear or any other surface.

I. Additional procedures for the administration of **topical medications**
1. Staff will position the person as necessary for administration of the medication.
2. Staff will, prior to administering the medication, observe for any unusual conditions of the affected area of the body which should be reported to the nurse or prescriber.
3. Staff will wash and dry the affected area unless otherwise indicated.
4. Staff will administer medication to the correct area, according to directions, with the appropriate applicator or with gloved hands.
5. If the topical is in powder form, staff will instruct the person to avoid breathing particles in the air that may result from the application.
6. If the topical is a transdermal patch, staff needs to be aware of the appropriate site location to place the transdermal patch.
7. If the topical is a transdermal patch, staff will remove the old patch and select a new patch site (new patch should be applied to clean dry skin which is free of hair, cuts, sores, or irritation on upper torso unless otherwise directed).
8. If the topical is a transdermal patch, staff will unwrap the new patch, sign and date the patch, remove the backing, and apply it to the new patch site.
9. Staff will replace the cap on the container, if needed, avoiding contact with any other surfaces.

J. Additional procedures for the administration of **rectal medications**
1. Place client on left side, if possible, with knees drawn toward abdomen.
2. Break suppository seal and lubricate end of suppository.
3. Gently separate buttocks and slowly insert suppository, close to rectal wall.
4. Ask client to retain suppository as suggested by manufacturer, as able.
5. Following the results, use appropriate perineal care.
6. Remove gloves and wash hands.
7. Document results

K. Staff will throw away all disposable supplies and place all medications in the locked medication storage area/container prior to leaving the area.

L. Staff will wash their hands.

This policy and procedure was established in consultation with and approved by:
Name: Cindy Winter
Title: Registered Nurse

Synstelien Community Services

Company: STAR Services
Date of consultation and final approval: July 31, 2015

Synstelien Community Services

POLICY AND PROCEDURE ON SERVICE TERMINATION

I. PURPOSE

The purpose of this policy is to establish determination guidelines and notification procedures for service termination.

II. POLICY

It is the intent of the company to ensure continuity of care and service coordination between members of the support team including, but not limited to the person served, the legal representative and/or designated emergency contact, case manager, and other licensed caregivers during situations that may require or result in service termination. The company restricts service termination to specific situations according to MN Statutes, section 245D.10, subdivision 3a.

III. PROCEDURE

The company recognizes that *temporary service suspension* and *service termination* are two separate procedures. The company must limit temporary service suspension to specific situations that are listed in the *Policy and Procedure on Temporary Service Suspension*. A temporary service suspension may lead to or include service termination or the company may do a temporary service suspension by itself. The company must limit service termination to specific situations that are listed below. A service termination may include a temporary service suspension or the company can do a service termination by itself.

A. The company must permit each person served to remain in the program and must not terminate services unless:
   1. The termination is necessary for the person's welfare and the person's needs cannot be met in the facility;
   2. The safety of the person or others in the program is endangered and positive support strategies were attempted and have not achieved and effectively maintained safety for the person or others;
   3. The health of the person or others in the program would otherwise be endangered;
   4. The program has not been paid for services;
   5. The program ceases to operate; or
   6. The person has been terminated by the lead agency from waiver eligibility.

B. Prior to giving notice of service termination, the company must document actions taken to minimize or eliminate the need for termination. Action taken by the company must include, at a minimum:
   1. Consultation with the person's expanded/support team to identify and resolve issues leading to issuance of the termination notice; and
   2. A request to the case manager for intervention services as identified in section 245D.03, subdivision 1, paragraph (c), clause (1), or other professional consultation or intervention services to support the person in the program. This requirement does not apply to notices of service termination issued due to the program not being paid for services.
   3. If, based on the best interests of the person, the circumstances at the time of the termination notice were such that the company was unable to take the action specified above, the company must document the specific circumstances and the reason for being unable to do so.

C. The notice of service termination must meet the following requirements:
   1. The company must notify the person or the person's legal representative and the case manager in writing of the intended services termination. If the service termination is from residential supports and services, as defined in section 245D.03, subdivision 1, paragraph (c), clause (3), the company must also notify MN Department of Human Service's Commissioner in writing; and
   2. The notice must include:
      a. The reason for the action;
      b. Except for a service termination when the program ceases to operate, a summary of actions taken to minimize or eliminate the need for service termination or temporary service suspension as required

under section 245D.10, subdivision 3a, paragraph (c), and why these measures failed to prevent the termination or suspension;

c. The person's right to appeal the termination of services under MN Statutes, section 256.045, subdivision 3, paragraph (a); and
d. The person's right to seek a temporary order staying the termination of services according to the procedures in MN Statutes, section 256.045, subdivision 4a or 6, paragraph (c).

D. Notice of the proposed termination of service, including those situations that began with a temporary service suspension, must be given:
   1. At least 60 days prior to termination when the company is providing intensive supports and services identified in section 245D.03, subdivision 1, paragraph (c).
   2. At least 30 days prior to termination for all other services licensed under Chapter 245D.
   3. This termination notice may be given in conjunction with a notice of temporary services suspension.

E. During the service termination notice period, the company must:
   1. Work with the expanded/support team to develop reasonable alternative to protect the person and others and to support continuity of care;
   2. Provide information requested by the person or case manager; and
   3. Maintain information about the service termination, including the written notice of intended service termination, in the service recipient record.

Synstelien Community Services

POLICY ON PERSON-CENTERED PLANNING AND SERVICE DELIVERY

I. PURPOSE

The purpose of this policy is to ensure services and supports adhere to the principles covered within the domains of a meaningful life: community membership; health, wellness; safety; one's own place to live; important long term relationships; control over supports; and employment earnings, and stable income. Services and supports address these domains to the extent the person wants and address them in a manner that promotes self-determination, acting on preferences, respecting and understanding cultural background, skill development, and a balance between risk and opportunity.

II. POLICY

This planning process, and the resulting person-centered services, will direct the support team in how to guide the individual in achieving personally defined outcomes in the most integrated community setting, ensure delivery of services in a manner that reflects personal preferences, talents, choices, and contribute to ensuring health and welfare.

Services are provided in a manner that supports the person's preferences, daily needs, and activities and accomplishment of the person's personal goals and services outcomes, consistent with the principles of:

A. Person-centered service planning and delivery which:
   1. Identifies and supports what is important to and the person as well as what is important for the person, including preferences for when, how, and by whom direct support services is provided;
   2. Uses that information to identify outcomes the person desires; and
   3. Respects each person's history, dignity, and cultural background.

B. Self-determination which supports and provides:
   1. Opportunities for the development and exercise of functional and age-appropriate skills, decision making and choice, personal advocacy, and communication; and
   2. The affirmation and protection of each person's civil and legal rights.

C. Providing the most integrated setting and inclusive services delivery which supports, promotes, and allows:
   1. Inclusion and participation in the person's community as desired by the person in a manner that enables the person to interact with nondisabled persons to the fullest extent possible and supports the person in developing and maintain a role as a valued community member;
   2. Opportunities for self-sufficiency as well as developing and maintain social relationships and natural supports; and
   3. A balance between risk and opportunity, meaning the least restrictive supports or interventions necessary are provided in the most integrated settings in the most inclusive manner possible to support the person to engage in activities of the person's own choosing that may otherwise present a risk to the person's health, safety, or rights.