# Greene Arc, Inc.

Policy and Procedure Manual

## 882 Adult Protective Services Policy

**December 17, 2015**

Washington County follows the Adult Protective Service (APS) Law to ensure our consumers' health, safety and wellbeing.

Any mandated reporter witnessing the Abuse, Neglect, Exploitation or Abandonment of an adult in our program must take the following steps:

- Make an oral report to the Statewide Protective Services Hotline by calling 1-800-490-8505.
- Within 48 Hours of making the oral report, the reporter must make a written report using the "Mandatory Abuse Report" form PDA/DHSMAR (04/15), available on the DHS website at http://www.dhs.state.pa.us under the "Report Abuse" link on the left side of the page.
- The report must be emailed to RA-PWAPSMandatoryRon@pa.gov or faxed to 484-434-1590.
- The reporter must follow all required Incident Management regulations, policies and procedures that are applicable.
- **Note:** If the case involves sexual abuse, serious injury, serious bodily injury or is a suspicious death, the reporter must, in addition to the previous steps,:

    1. Make an immediate oral report to local law enforcement.
    2. Make an immediate oral report to the DHS staff responsible for the APS Program at 717-265-7887.
    3. Within 48 hours of making the oral reports, submit a written report to law enforcement. The forms currently used by the facility, a HCSIS report or an EIM report form are all acceptable.

In addition to the above mandatory steps, any and all of the following offices may be contacted if the alleged victim is receiving services from their programs:

**OFFICE OF DEVELOPMENTAL PROGRAMS**

If the person has an intellectual disability or autism, the allegation will be referred to the ODP Regional Office where the person resides. The Office of Developmental Programs' Customer Service Line is 1-888-565-9435 and can direct the caller to the appropriate Agency.

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**OFFICE OF MENTAL HEALTH AND SUBSTANCE ABUSE SERVICES**
If the person has mental illness or substance abuse issues, the allegation can be referred to the Office of Mental Health and Substance Abuse Consumer Information Line at 1-877-356-5355. Information can then be referred to the appropriate County Mental Health Agency or the Office of Mental Health and Substance Abuse Community Program Manager.

**OFFICE OF LONG-TERM LIVING**
If the allegation involves an individual with a physical disability, brain injury or other disability served by the Office of Long Term Living or a person living in an assisted living facility, it can be referred to the Office of Long-Term Living Participant Help Line by calling 1-800-757-5042.

**PERSONAL CARE HOME**
If the allegation involves a person in a Personal Care Home, the case can be referred to the field Office of Administration of DPW, which oversees these programs, by calling at 1-877-401-8835.

**NURSING HOME**
If the allegation involves a person in a nursing home, contact the Department of Health at 1-800-254-5164 or 717-787-1816 to file a complaint.

# 882 Adult Protective Services Policy

**Background**:
The Adult Protective Services Act (Act 70 of 2010) created a Protective Services program for adults with disabilities between the ages of 18 and 59. Under the Act, the Department of Public Welfare (DPW) is the designated agency to administer the program. The Act requires the Department to, through a competitive bidding process, contract with agencies to investigate allegations of abuse, neglect, exploitation or abandonment and provide Protective Services to adults found to be in need. The services provided by the contract agencies are only short term in nature and are to detect, prevent, reduce and eliminate abuse, neglect, exploitation and abandonment.

The Act defines an adult as "A resident of this Commonwealth between 18 and 59 years of age who has a physical or mental impairment that substantially limits one or more major life activities."

## INVESTIGATION OF CASES

**Investigations for Adults Who Are Not Current DPW Consumers or Not Residing in a DPW-Licensed Facility**:

For allegations of abuse, neglect, exploitation or abandonment of adults who are not currently a consumer of a DPW service or a resident of a DPW licensed facility, the report will be investigated by the participating Older Adult Protective Services Agency.

As not all OAPSA agencies are participating, investigations will also be conducted by staff and contractors of DPW and PDA. Please see the attached map for how coverage will occur. The APS Investigating Entity will implement the following procedures:

- Assure investigations deemed "priority" begin immediately and, to the extent feasible, the Agency shall conduct a face-to-face interview with the adult no later than 24 hours from the referral.
- If the adult is in need of immediate medical or local law enforcement intervention, call 911. The Agency will also contact law enforcement when there is cause to suspect sexual abuse, serious injury, serious bodily injury or a death that is suspicious.
- Assure investigations deemed "non-priority" begin within 72 hours from the referral of the report.

## 882 Adult Protective Services Policy

- Enter the relevant demographic and case-specific information into the Social Assistance Management System (SAMS) database for each case in a timely manner. In addition, enter all Protective Services purchased and provided into SAMS, similar to the process for OAPSA cases.

If the findings of the investigation support that Protective Services are required, the APS Investigative Entity will arrange for the immediate provision of interim services to meet the victim's needs (e.g., home health services, emergency shelter, personal assistance services, etc.). The APS Investigative Entity will seek the least-restrictive possible means of providing Protective Services to the victim.

The APS Investigating Agency will follow the existing protocols for OAPSA for investigation and the provision of services, except where differences exist between the OAPSA protocols and the APS Act. The differences between the two were noted during the training provided to the participating OAPSA agencies. If the APS Investigative Entity has questions during the investigation that require further guidance, it should contact the APS Division within DPW or the OAPSA Division within PDA. The APS Investigative Entity will contact the DPW APS Division if any of the following situations arise:

- The alleged victim is at imminent risk of death, sexual abuse, serious bodily injury or serious injury, but refuses Protective Services.
- Interim services are required for more than 30 days.
- The APS Investigative Entity requires assistance in securing the cooperation of a service provider to provide interim services.
- A recommendation is made to move the victim to a more restrictive setting.

**Investigations Involving Current DPW Consumers or Adults Residing in Licensed DPW Facilities:**

For adults receiving services from a DPW program or residing in a licensed DPW facility, the responsible program offices will investigate the cases. These cases will be investigated using the existing protocols for the Incident Management process used by the responsible program office. The program office may contact the APS Division for complex cases that require assistance. The DPW program office will track APS-related reports and investigations.

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**Investigations Involving Residents of DPW-Operated Facilities (State Centers, State Hospitals and Youth Development Centers):**

For alleged victims who reside in a DPW-operated facility, the facility should investigate the allegation(s) consistent with its established policy for such cases. Upon completion of the investigation, it will forward its findings to the APS Division within three (3) business days of completion of the report. The APS Division will review the investigative findings and determine if any further investigation or information is necessary.

**Mandatory Reporting of Suspected Abuse:**
*(See Act 70, specifically Section 501 and the definitions of employee and facility)*

The Act requires that an employee or administrator (of a facility) who has reason to suspect that a recipient is a victim of abuse or neglect shall make a report. The Act requires employees, including contractors, to report suspected abuse or neglect if they work for any of the following facilities:

- Assisted Living Facility
- Domiciliary Care Home
- Home Health Care Agency
- Home Care Agency
- Intermediate Care Facility for Individuals with Intellectual Disabilities
- Nursing Home
- Older Adult Daily Living Center
- Personal Care Home
- Residential Treatment Facility
- An organization or group of people that use public funds and is paid, in part, to provide care and support to adults in a licensed or unlicensed setting

During the transition phase, APS reporting requirements will be met if providers submit allegations according to their Department's established Incident Management protocols. If the incident is not covered by a current Incident Management protocol, then a call must be made to the Bureau of Human Services Licensing Hotline at 1-877-401-8835. This is the interim hotline for these calls and it is anticipated that, in the near future, a statewide hotline for this program will be established.

# 882 Adult Protective Services Policy

**Procedure for Handling Employees Accused of Abuse and Neglect:**
*(See Act 70, specifically Section 501 and the definitions of employee and facility)*

The Act requires, "On notification that an employee is alleged to have committed abuse or neglect, the facility shall immediately suspend the employee or, where appropriate and subject to approval by the Agency and by the appropriate state licensing department with regulatory authority over the facility, shall implement a plan of supervision." During the transition phase, plans of supervision are to be submitted to the participating OAPSA agency and licensing agency. For those counties without a participating OAPSA agency, plans of supervision are to be submitted to the APS Division and licensing agency. Based upon the definition of Facility in Act 70, this applies to employees of the following:

- Assisted Living Facility
- Domiciliary Care Home
- Home Health Care Agency
- Home Care Agency
- intermediate Care Facility for Individuals with Intellectual Disabilities
- Nursing Home
- Older Adult Daily Living Center
- Personal Care Home
- Residential Treatment Facility
- An organization or group of people that use public funds and is paid, in part, to provide care and support to adults in a licensed or unlicensed setting

**Notification Process When the Abuse or Neglect is Criminal in Nature:**

Employees and/or administrators who have reasonable cause to suspect that a recipient is a victim of abuse involving sexual abuse, serious injury, serious bodily injury or if a death is suspicious, shall immediately make an oral report to the APS Investigative Entity. In addition to reporting to the APS Investigative Entity, oral reports must be made to the PDA and local law enforcement. Within 48 hours of making all oral reports, the employee or administrator shall make a written report to the Agency.

Additionally, within 48 hours of making an oral report, the employee and the administrator shall make a joint written report to appropriate law enforcement officials for abuse involving sexual abuse, serious physical injury, serious bodily injury or if a death is suspicious.

# 882 Adult Protective Services Policy

**Coordination of Investigations:**

To the fullest extent possible, law enforcement officials, facilities and agencies shall coordinate their respective investigations, advise each other and provide any applicable additional information on an ongoing basis. Cases involving law enforcement may, at the written request of the law enforcement agency, require law enforcement to take the lead.

**Confidentiality of Information:**

Information contained in reports, records of investigation, assessment and service plans shall be considered confidential. Except as provided in Section 306 of the Act, confidential information shall not be disclosed to anyone outside the Agency other than to a court of competent jurisdiction, pursuant to a court order. An agency's access to confidential records held by other entities or individuals, or an adult reported to be in need of Protective Services, shall require the consent of the adult or a court-appointed guardian, except as provided under Section 307 of the Act.

**Assuring the Provision of Necessary Long-Term Supports:**

Protective Services are intended to be short-term, not to exceed 30 days. As such, it is imperative that adults who need long-term supports promptly receive an assessment, eligibility determination and enrollment into the least-restrictive, most-integrated service setting.

When an APS Investigative Entity identifies that an adult may need long-term supports, it shall notify the appropriate local entity responsible for the assessment/case management (i.e., MH/ID). If the case is not progressing in a timely fashion, or there are differences of opinions on how the long-terms supports need to be handled, the APS Investigative Entity will contact the APS Division at 717-783-3670.

If the APS Investigative Entity is unsure about which agency is appropriate to serve the individual, or there does not appear to be a program for the person, the APS Investigative Entity will contact the APS Division. The APS Division will work with the single points of contact within DPW to identify a service solution and assure that a decision is made.

# 883 Request for Service Change

**December 17, 2015**

**POLICY:** This policy will address the methods, procedures and rational for changing services for a single individual, an entire service location (house), obtaining a change in Providers or termination of an individual from a program or service due to a **"Health or Safety"** need that has been identified for an individual through any team member (Individual, Supports Coordinator, Program Specialist, Guardian or Family Member).

**PURPOSE:** To outline the steps and usage of the **"Provider Request for Service Change Form" will additionally require a DP 1022** (and possibly House Budget or Cost Report) that must be completed in their entirety in order to modify or discontinue services for an individual.

**GUIDELINES:** The Washington County Administrative Entity (AE) and Supports Coordination Organizations (SCOs) that support the County must be made aware of and be given the appropriate information in order to assist our individuals in modifying, discontinuing services or obtaining Provider changes.

## Request for Service Change: Single Individual Process

1. A **"Health or Safety"** need has been identified for an individual (through any team member).

2. The Supports Coordinator (SC) is notified of the requested **"Health or Safety"** need. The SC will schedule a team meeting to discuss the requested need to determine if a service change is needed. *(The SCs will inform the team members of the agreed upon date, time and place of the meeting via email or letter.)*
    a. The SC ensures that all pertinent information is gathered at this step (via email).
    b. If this change is to obtain a new Provider, the Provider Selection Process begins and, once a new Provider has been identified through this process, the SC will schedule a team meeting with the new Provider. In this meeting, the team must discuss the change and the expectations of the individual, family/guardian and the new Provider.
        i. *The new Provider's fiscal department will complete the "request for service" form. The information (service type, service level, rate per unit, number of units and total dollar amount of requested change) needs to be accurate and the form must be totally completed. It is the new Providers' responsibility to have the **"Provider Request for Service Form"** available*

*for the Supports Coordinator at the meeting. Failure to have this completed at the time of the meeting will cause a delay in the process, as the Supports Coordinator cannot move forward on the request until the Provider submits all requested information.*

3. Prior to this scheduled meeting, the Program Specialist (PS) will contact their fiscal department. The Provider's fiscal department will request and complete a **"Provider Request for Service Change Form."**
    a. The information entered on this form needs to be accurate and complete. It is the *Providers' responsibility* to obtain the **"Provider Request for Service Change Form"** and have it available for the SC at the afore mentioned meeting. Failure to have the form completed at the time of the meeting will cause a delay in the request.

4. At the team meeting, the Provider will present the **"Provider Request for Service Change Form"** to the SC for discussion by the team. At the meeting, the SC will obtain all present team members' signatures upon a signature sheet.
    a. All amounts, W-Codes, units, budgets need to be examined for appropriateness of the request.
    b. The SC will complete the Office of Developmental Program's (ODP's) form **DP1022** at this meeting and have the involved individual sign it.
        i. All necessary steps required in the DP1022 instructions shall be adhered to, including any time frames involved.
    c. If the identified need is accepted as a "Health or Safety" need by the team, the SC will bring the completed **"Provider Request for Service Change Form"** back to Washington County Behavioral Health and Developmental Services (BHDS) for continuation in the service change process.
        i. The process time frames start at this meeting.
        ii. The SC has two (2) days to send the form to the SCO.

5. SC gives to SC Supervisor (SCS), who in turn reviews the request before submission to the AE.

6. AE approval or denial.

7. Returned to SCO.

## 883 Request for Service Change

8. SCO Returns to SC, who enters the approved services into the plan.
9. SC Returns to SCS for verification.
10. Services Authorized by AE after plan entry.
11. Provider is notified by mail via the **"Revised ISP Distribution Letter."**

- **Special Note:** if the service change is due to a "new house/location," the rate, location and status of the site license must be reported to the Washington County BHDS before any changes can move forward. *Absolutely no service change will be approved without this information.*

# Greene Arc, Inc.

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## 884 Transitions Policy

**December 17, 2015**

It is the expectation of the Washington County BHDS that our Providers follow the guidelines established in PA Code Chapter 51.31 regarding the "Transition of Participants" when discharging one of our consumers from any program or service.

Specifically, Providers cannot discharge a consumer without at least thirty (30) days written notice to the County or Washington Communities SCO and County AE in addition to attending transition meetings with the consumer's entire team.

Please refer to Ch. 51.31 on the reverse of the Transitions Policy.

# 884 Transitions Policy



**§ 51.31. Transition of participants.**

a) When a participant selects another willing and qualified Provider to replace the current Provider, both Providers shall cooperate with the Department or the Department's designee, the participant and the participant's SCO or SCA during the transition between Providers.

b) The current Provider shall ensure the following:
   1) Participation in transition planning meetings to aid in the successful transition to the new, willing Provider.
   2) Cooperation with visitation schedules identified during the transition meeting.
   3) Arrangement for transportation of the participant to support the visitation schedule.
   4) Closing of open incidents in HCSIS.
   5) Undue influence is not exerted when the participant is making the choice to a new, willing and qualified Provider.

c) A Provider that is no longer willing to provide an HCBS to a participant shall provide written notice at least 30 days prior to the date of discharge to the participant, the Department, the Department's designee and the *SC* when the Provider is not the SCO or SCA.

d) The Provider shall provide written notification that includes the following:
   1) The HCBS the Provider is unwilling or unable to provide.
   2) The HCBS location where the HCBS is currently provided.
   3) The reason the Provider is no longer willing to provide the HCBS to the participant.
   4) A description of the efforts made to address or resolve the issue that has led to the Provider becoming unwilling or unable to deliver the HCBS to the participant.
   5) Suggested time frames for transitioning the delivery of the HCBS to a selected willing and qualified Provider.
   6) The current Provider name and Master Provider Index number.

e) Provider shall continue to provide the authorized HCBS during the transition period to ensure continuity of care until a willing and qualified Provider is selected, unless otherwise directed by the Department or the Department's designee.

f) A Provider shall provide written notification to the Department or the Department's designee if the Provider cannot continue to provide the HCBS until another willing Provider is selected due to emergency circumstances.

g) A selected willing Provider shall cooperate with transition planning activities including participation in transition planning meetings.

h) A current SCO Provider shall cooperate with transition planning activities, including utilization of HCSIS transfer functionality and participation in all transition planning meetings that occur during the transition period.

i) A Provider shall provide available records to the selected willing Provider within 7 days of the date of transfer.

j) This section does not apply to an SSW Provider and an AWC/FMS Provider.

# 885 Infestation/Epidemic Emergency/Crisis Policy

**Introduction:** Unforeseen incidents may occur at short notice that must be dealt with urgently outside the standard policy framework. While precise procedures cannot be laid down, there is a need for general policy to guide the organizational response to crisis.

**Purpose:** The Infestation/Epidemic Emergency/Crisis Response Policy is intended to facilitate the management of a crisis within Greene Arc, Inc. and to minimize risks to the individuals ("consumers") who receive our services as well as personnel. This policy is intended to protect Greene Arc and to implement urgent recovery procedures.

**Policy:**

1. Reported Infestations/Epidemics which pose a potential threat to Greene Arc consumers and personnel will be investigated and dealt with on a case-by-case basis.

2. Should potential threats be found, Greene Arc reserves the right to protect its consumers and personnel until the potential threats are neutralized or contained.

3. Technical assistance is requested to provide support and specific directions to staff in order to aide in the reduction and elimination of potential threats.

4. Outside resources are utilized to assist with concerns (exterminators, CDC, code enforcement officers, Adult Protective Services, etc.).

5. County Human Services are contacted for assistance.

# Greene Arc, Inc.

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## 886 Grievance Procedure

Greene Arc will resolve a grievance within twenty-one (21) days.

A. If you have a problem that cannot be resolved with your immediate Supervisor, you may talk to their Supervisor.

B. The grievance is to be written. If you need assistance completing grievance form, you may request a designated person to assist you.

C. The Grievance Form is available from the receptionist in the front office. The form includes the following: name, nature, date, actions taken for resolution and date resolved.

D. You may also contact the Pennsylvania Protection and Advocacy, Inc.

E. All grievances will be submitted to the Executive Director for review and resolution. Once the grievance has been received, the Executive Director will contact the person filing the grievance and will notify the appropriate management staff to discuss the resolution. If you are still not satisfied, you may go to the Board of Directors or an advocate of your choice.

The grievance policy for the individuals is included in the Greene Arc. Individual Handbook given to individuals and/or family members/caregivers upon admission.

Greene Arc's Quality Management Committee will review the grievance procedure annually to determine the number of grievances and their disposition. At that time, should any revisions to the policy be required, Greene Arc will distribute the revised policy to staff, individuals and or family members/caregivers.

The grievance policy and form are also located in Greene Arc, Inc.'s Policy & Procedure Manual. All Greene Arc staff are required to review policies annually.

## 886 Grievance Procedure

### GRIEVANCE FORM

**Name of Individual Filing Grievance:** _____

**Nature of Grievance:**

_____

_____

_____

_____

_____

_____

_____

**Date:** _____

**Name of Person Filing on behalf of Participant, if applicable:**

_____

**Date Resolved:** _____

**Provider Signature:** _____

**Participant Signature:** _____

*Revised 11/2/22*

# Greene Arc, Inc.

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## 887 Records Management

**In accordance with Chapter 51 regulation 51.15**

1. In addition to the requirement under § 1101.51 (relating to ongoing responsibilities of Providers), Greene Arc will:
    a) Document that the HCBS for which it claims payment was provided to the participant and that information submitted in support of the payment is true, accurate and complete.

    b) Maintain records verifying compliance with this chapter for a minimum of five (5) years after the waiver service is provided, unless otherwise specified.

2. Adhere to the restriction of use or disclosure of information for purposes directly related to the implementation of the ISP.

3. Greene Arc will keep participant records confidential.

4. Greene Arc will not make participant records accessible to anyone (without the written consent of the participant, the person holding the participant's power of attorney for health care or health care proxy or if a court orders disclosure), other than the following:
    a) The Participant.

    b) Greene Arc's staff (for the purpose of providing HCBS to the participant).

    c) The Department or the Department's designee.

    d) An entity that is permitted to access records under law.

5. Greene Arc will provide records, as requested, to the Department regarding HCBS delivered and payments received for HCBS.

6. Greene Arc may choose to use electronic record documentation under the following conditions:
    a) The electronic record must be readable.

    b) The electronic format conforms to the requirements of Federal and State laws.

c) The medium used to produce the electronic record accurately reproduces the paper original records.

d) The medium used is not subject to subsequent deletion, change or manipulation.

e) The electronic record constitutes a duplicate or substitute copy of the original paper record and has not been altered or, if altered, shows the original and altered versions, dates of creation and creator.

f) The electronic record can be converted back into legible paper copies and assessed by an auditing agency.

g) Greene Arc will have a back-up system for electronic records.

7. Greene Arc will utilize and adhere to the records management policies in place to comply with section 51.15 of the Chapter 51 regulations.

8. Greene Arc shall document in the participant's record when the participant voluntarily chooses to use the participant's personal funds to purchase items and a description of the item purchased in accordance with the ISP.

9. All Greene Arc employees will follow and adhere to all stipulations pertaining to record access as stated in this policy.

# Greene Arc, Inc.

Policy and Procedure Manual

## 888 Restraint & Restrictive Procedure

Greene Arc follows a no restraint/restrictive procedure philosophy and strives to maintain being an agency that remains restraint and restrictive procedure free while ensuring staff are educated in restraint and restrictive procedures definitions and required protocols, as defined in Chapter 51 regulations and MR Bulletin 00-06-09 (Elimination of Restraints through Positive Practices).

Greene Arc staff who provide direct support services are trained annually in Crisis Prevention and Intervention (CPI), which includes staff effectiveness, behavioral guidelines for positive approaches and interaction, preventing crisis with antecedent management, relaxation training and an overview of trauma and trauma informed care.

1. **Definitions:**
   - A. **Restrictive Procedure:** A Restrictive Procedure is a practice that limits an individual's movement, activity or function, interferes with an individual's ability to acquire positive reinforcement, results in the loss of objects or activities that an individual values, or requires an individual to engage in a behavior that the individual would not engage in given freedom of choice.
   - B. **Seclusion:** Seclusion is defined as placing an individual in a lock room. A locked room includes a room with any type of door locking devices, such as a key lock, spring lock, bolt lock, foot pressure lock or physically holding the door shut.
   - C. **Aversive Conditioning:** Aversive Conditioning is defined as the application, contingent upon the exhibition of maladaptive behavior, of startling, painful or noxious stimuli.
   - D. **Chemical Restraints:** A Chemical Restraint is a drug used to control acute, episodic behavior that restricts the movement or function of an individual.
   - E. **Mechanical Restraints:** A Mechanical Restraint is a device used to control acute, episodic behavior that restricts the movement or function of an individual or portion of an individual's body. Examples of mechanical restraints include: anklets, wristlets, camisoles, helmets with fasteners, muffs and mitts with fasteners, poseys, waist straps, head straps, restraining sheets and similar devices.
   - F. **Physical Restraints:** Physical Restraint is a physical hands-on technique used to control acute, episodic behavior that restricts the movement or function of an individual or portion of an individual's body, such as basket holds and prone or supine containment.
   - G. **Exclusion:** Exclusion is the removal of an individual from the individual's immediate environment and restricting the individual alone to a room or area. If a staff person remains with the individual, it is not exclusion.

## 888 Restraint & Restrictive Procedure

2. The purpose of these sections is to define the prohibition or use of specific types of restrictive procedures, describe the circumstances in which restrictive procedures may be used, the person who may authorize the use of restrictive procedures, a mechanism to monitor and control the use of restrictive procedures and a process for the individual and family to review the use of restrictive procedures. A copy of the Restraint and Restrictive Procedures Policy shall be posted at each program site.

3. **a.** A restrictive procedure may not be used as retribution, for the convenience of staff persons, as a substitute for the program or in a way that interferes with the individual's developmental program.

   **b.** For each incident requiring restrictive procedures:
   (1) Every attempt shall be made to anticipate and de-escalate the behavior using methods of intervention less intrusive than restrictive procedures.
   (2) A restrictive procedure may not be used unless less restrictive techniques and resources appropriate to the behavior have been tried but failed.

4. **a.** For each individual for whom restrictive procedures may be used, a restrictive procedure plan shall be written by the Program Specialist or Behavioral Specialist prior to use of restrictive procedures.

   **b.** The restrictive procedure plan shall be developed and revised with the participation of the Program Specialist and/or Behavioral Specialist, the individual's direct care staff, the interdisciplinary team as appropriate, and other professionals, as appropriate.

   **c.** The restrictive procedure plan shall be reviewed and revised if necessary, according to the time frame established by the Restrictive Procedure Review Committee, not to exceed six (6) months.

   **d.** The restrictive procedure plan shall be reviewed, approved, signed and dated by the chairperson of the Restrictive Procedure Review Committee and the Program Specialist prior to the use of restrictive procedures whenever the restrictive procedure plan is revised and at least every six (6) months.

   **e.** The restrictive procedure plan shall include:
   (1) The specific behavior to be addressed and the suspected antecedent or reason for the behavior.
   (2) The single behavior outcome desired, stated in measurable terms.

(3) Methods for modifying or eliminating the behavior, such as changes in the individual's physical and social environment, changes in the individual's routine, improving communications, teaching skills and reinforcing appropriate behavior.
(4) Types of restrictive procedures that may be used and the circumstances under which the procedures may be used.
(5) A target date for achieving the outcome.
(6) The amount of time the restrictive procedure may be applied, not to exceed the maximum time periods specified in sections 11c and 12c.
(7) Physical problems that require special attention during the use of restrictive procedures.
(8) The name of the staff person responsible for monitoring and documenting progress with the plan.

**f.** The restrictive procedure plan shall be implemented as written.

**g.** Copies of the restrictive procedure plan shall be kept in the individual's record.

5. **a.** If a restrictive procedure is used, there must be a Human Rights Committee.

**b.** The Human Rights Committee shall include a majority of persons who do not provide direct services to the individual. An individual's Supports Coordinator is not included as providing direct services.

**c.** The Human Rights Committee shall establish a time frame for review and revision of the restrictive procedure plan, not to exceed six (6) months between reviews.

**d.** A written record of the meeting and activities of the Human Rights Committee shall be kept.

**e.** Individuals and their families, for whom a restrictive procedure is used, shall be given written invitation to all applicable meetings of the Human Rights Committee. Further, an individual or an individual's family shall have the right to request a meeting of the Human Rights Committee at any time.

6. **a.** If restrictive procedures are used, there shall be at least one (1) staff person available when restrictive procedures are used who has completed training within the past twelve (12) months in the use of and ethics of using restrictive procedures, including the use of alternate positive approaches. If an individual's restrictive procedure

involves the use of restraints, staff implementing those restraints will receive a refresher training every six (6) months.

**b.** A staff person responsible for developing, implementing or managing a restrictive procedure plan shall be trained in the use of the specific techniques or procedures that are used.

**c.** If physical restraint or exclusion is used, a staff person responsible for developing, implementing or managing a restrictive procedure plan shall have experienced use of the specific techniques or procedures directly on themselves.

**d.** Documentation of the training program provided, including the staff persons trained, dates of training, description of training and training source shall be kept.

**7.** Seclusion, as defined in Section 1, Definitions, is prohibited.

**8.** Aversive Conditioning, as defined in Section 1, Definitions, is prohibited.

**Greene Arc Follows the Protocol Regarding CHEMICAL Restraints as Listed Below:**

**9. a.** Administration of a chemical restraint is prohibited except for the administration of drugs ordered by a licensed physician on an emergency basis.

**b.** If a chemical restraint is administered as specified in subsection (a), the following apply:

(1) Prior to each incidence of administering a drug on an emergency basis, a licensed physician shall have examined the individual and given a written order to administer the drug.

(2) Prior to each re-administration of a drug on an emergency basis, a licensed physician shall have examined the individual and ordered re-administration of the drug.

**c.** If a chemical restraint is administered as specified in subsection (b), the following apply:

(1) The individual's vital signs shall be monitored at least once each hour.

(2) The physical needs of the individual shall be met promptly.

**d.** A Pro Re Nata (PRN) order for controlling acute, episodic behavior is prohibited.

## 888 Restraint & Restrictive Procedure

**e.** A drug ordered by a licensed physician as part of an ongoing program of medication is not a chemical restraint.

**f.** A drug ordered by a licensed physician for a specific, time-limited stressful event or situation, to assist the individual in controlling the individual's own behavior, is not a chemical restraint.

**g.** A drug ordered by a licensed physician as pretreatment prior to medical or dental examination or treatment is not a chemical restraint.

**h.** A drug self-administered by an individual is not a chemical restraint.

**i.** If a drug is administered in accordance with subsection a, e, f or g, there shall be training for the individual aimed at eliminating or reducing the need for the drug in the future.

**j.** Documentation of compliance with subsections a-h shall be kept.

**Greene Arc Follows the Protocol Regarding MECHANICAL Restraints as Listed Below:**

**10. a.** The use of a mechanical restraint is prohibited except for use of helmets, mitts and muffs to prevent self-injury on an interim basis, not to exceed three (3) months after an individual is admitted to the home.

**b.** If a mechanical restraint is used, as specified in subsection (a), the following apply:
(1) The use of a mechanical restraint may not exceed two (2) hours, unless a licensed physician examines the individual and gives written orders to continue use of the restraint. Re-examination and new orders by a licensed physician are required for each two (2) hour period the restrain is continued. If a restraint is removed for any purpose other than for movement and reused within 24 hours after the initial use of the restraint, it is considered continuation of the initial restraint.
(2) A licensed physician shall be notified immediately after a mechanical restraint is used.
(3) The restraint shall be checked for proper fit by a staff person at least every fifteen (15) minutes.
(4) The physical needs of the individual shall be met promptly.
(5) The restraint shall be removed completely for at least ten (10) minutes during every two (2) hours the restraint is used, unless the individual is sleeping.

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(6) There shall be training for the individual, aimed at eliminating or reducing the need for the restraint in the future.
(7) Documentation of compliance with subsection (a) and paragraphs (1-6) shall be kept.

**c.** A device used to provide support for functional body position or proper balance and a device used for medical treatment, such as sand bags, to limit movement after medical treatment, a wheelchair belt that is used for body positioning and support or helmet for prevention of injury during seizure activity, are **not** considered mechanical restraints and therefore, are permitted.

**Greene Arc Follows the Protocol Regarding PHYSICAL Restraints as Listed Below:**

**11. a.** Physical restraint shall be used only when necessary to protect the individual from injuring him/herself or others. **Note:** the following may not be used: prone (face down) position manual restraints, manual restraints that inhibit respiratory/digestive system, inflict pain, causes hyperextension of joints and pressure on chest or joints, techniques in which the individual is not supported and/or would allow for free fall as the individual goes to the floor.

**b.** Physical restraint shall be used only when it has been documented that other less restrictive methods have been unsuccessful in protecting the individual from injuring him/herself or others. An individual is to be immediately released from physical restraint when they no longer present a danger to themselves or others.

**c.** An individual shall be released from the physical restraint within the time specified in the restrictive procedure plan, **not to exceed 30 minutes within a 2-hour period (the 30 minutes is cumulative). There is no limit on the number of times a physical restraint can be applied within a 2-hour period as long as the 30-minute continual time period is compliant.**

**d.** Support staff monitor the individual for signs of distress throughout the restraint process and for a period of time, up to two (2) hours, following the application of a restraint.

**12. a.** Exclusion shall be used only when necessary to protect the individual from self-injury or injury to others.

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**b.** Exclusion shall be used only when it has been documented that other less restrictive methods have been unsuccessful in protecting the individual from self-injury or injury to others.

**c.** An individual shall be permitted to return to routine activity within the time specified in the restrictive procedure plan, **not to exceed 60 minutes within a 2-hour period.**

**d.** Exclusion may **not** be used for an individual **more than 4 times within a 24-hour period.**

**e.** An individual in exclusion shall be monitored continually by a staff person.

**f.** A room or area used for exclusion shall have at least 40 square feet of indoor floor space with a minimum ceiling height of 7 feet.

**g.** A room or area used for exclusion shall have an open door or a window for staff observation of the individual.

**13.** If exclusion or physical restraint is used on an unanticipated, emergency basis, sections 4 and 5 (relating to Restrictive Procedure Review Committee and restrictive procedure plan) do not apply until after the exclusion or physical restraint is used for the same individual twice in a six (6) month period.

**14.** A record of each use of a restrictive procedure, documenting the specific behavior addressed, methods of intervention used to address the behavior, the date and time the restrictive procedure was used, the specific procedures followed, the staff person who used the restrictive procedure, the duration of the restrictive procedure, the staff person who observed the individual if exclusion was used and the individual's condition following the removal of the restrictive procedure, shall be kept in the individual's record.

**Addendum:** Greene Arc, as a Provider, will ensure that all individuals receiving a service have access to food at any time during provision of services consistent with non-medical recipients in the same and/or similar settings.

Revised 7-2-18

# 889 Accessibility of Intellectual Disability Services for Individuals Who Are Deaf

**This policy is meant to clarify the requirement to provide communication assistance to individuals who are:**

- Deaf; AND
- Registered with or seeking registration with a County MH/ID program.
- Enrolled or are enrolling to receive consolidated P/FDS services through the Office of Developmental Programs (ODP).

**The following criteria will be utilized to determine whether an individual is deaf:**

- As a result of a hearing impairment, the person is unable to understand or communicate verbal expressions at a level of his/her intellectual ability, even when wearing hearing aids.
- As a result of a hearing impairment, his/her primary language is sign language.

**The following are examples of communication assistance that may be available based on the individual's needs by the County MH/IDD programs, AE, SC and Provider:**

- Access to video phone equipment
- Assistive technology, such as adapted telephones like video phones, captioned phones and telecommunication devices for deaf persons
- Communication Access Realtime Translation known as (CART)
- Video Remote Interpreting
- Closed caption decoders
- Highly visual communication tools, checklists, schedules and materials
- Open and closed captioning TV
- Staff or interpreters proficient in sign language

# 890 Transportation Policy

**Determining the Need for the Service:**

Providers that transport more than 6 individuals are required to have an aide on the vehicle. The six (6) individuals riding on the vehicle can be supported by different funding streams. This requirement is based solely on the number of individuals in the vehicle. If a provider transports six (6) or fewer, the provider has the discretion to determine if an aide is required. The determination must be based upon the needs of the individuals, the provider's ability to ensure the health and welfare of the individuals and be consistent with ODP requirements for safe transportation. The following is Greene Arc Inc.'s process:

- Vehicles designated for transportation services have an assigned driver and aide.
- Should either driver or aide be unavailable, Greene Arc has established back-up staff for both positions.
- Based on individual's ISPs, transportation schedules are developed, which incorporate days, time of pick-up and drop-off, number of individuals on vehicle and days aides are required on vehicle, adhering to the more than six (6) requirement.
- Designated drivers and aides who are unavailable to fulfill their job duty are required to provide advance notice to the Vocational Director so back-up staff can be assigned to those roles.
- All drivers and aides are required to complete a report should any incident occur. Upon review of report, decisions or determinations will be made to ensure the health and welfare of individuals.

**Greene Arc, Inc.**

# Memo

**To:** Greene Arc Employees

**From:** Cynthia L. Dias, Executive Director

**cc:** Administrative Staff

**Date:** January 24, 2014

**Re:** Revised Vehicle Policy

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Please be advised that it is prohibited to conduct any personal business utilizing a Greene Arc Company vehicle. It has come to my attention, at times, that some staff have been using a Company vehicle for their own personal gain. When transporting a consumer to complete their required activities, such as shopping or banking, staff is not permitted to engage in their own grocery shopping or banking. Staff time and vehicle is dedicated to assist the consumer.

Other areas of concern, which are prohibited, are as follows:

- Utilizing Company vehicle to go to lunch (when not consumer related)
- Utilizing Company vehicle, while on break, to run personal errands
- Permitting and transporting unauthorized persons in Company vehicle

This memo will be included and used as reference to our existing Vehicle Policy (please see attached).

Failure to adhere to this policy could result in disciplinary action.

Thank you.