



# **MASSACHUSETTS REHABILITATION COMMISSION**

## **COMMUNITY LIVING DIVISION PROVIDER MANUAL**

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**Section I:**

**MRC Principles and Practices for All Providers**

## DEFINITION of TERMS

The following is provided to facilitate common language and understanding of terms used throughout this manual.

**BI&SSCS** – stands for the Brain Injury and Statewide Specialized Community Services department within the Community Living Division of the Massachusetts Rehabilitation Commission, and includes the Statewide Head Injury Program (SHIP), the Nursing Facility Transition Team (Rolland) and the School Transition Team.

**Caregivers** – person trained and approved to provide daily care,, supervision and oversight of an individual served in Shared Living and Shared Home Support models.

**Case Managers** -- MRC, ABI and MFP Waiver staff who arrange for the provision of services and monitor that services are provided as authorized. Includes Program Coordinators of BI&SSCS of the MRC.

**Community Living Division** – represents a division of the Massachusetts Rehabilitation Commission which includes Protective Services, Consumer Involvement, Homecare Assistance, Independent Living, BI&SSCS, ABI and MFP Waivers.

**Guardian** – a person who has been appointed by a court to make decisions for a person who has been adjudicated incompetent, with respect to making certain decisions (e.g., consent to surgery).

**Individual** – someone who receives funded services dependent upon eligibility criteria and requirements. Inclusive of the term participant, consumer, resident and includes Rolland Class Members, Waiver participants and consumers of the MRC funded services.

**Office of Medicaid** – manages the MassHealth program which includes the administration of Waiver programs.

**Providers** – independent contractors or agencies/organizations qualified to provide a funded service.

**Rehabilitative Specialists** -- refers to independent contractors or organizational/agency licensed staff who specialize in therapy services to improve functioning, increase and maintain skills, or prevent the regression of skills (e.g. physical therapy, occupational therapy)

**Residential** – refers to 24/7 group living or shared living.

**Site-based programs** – refers to all structured day programs, 24/7 group living residences and shared living.

**Shared Living** – refers to a 24/7 residential model of support provided in an identified caregiver home

**Shared Home Supports** – residential model of supports for individuals needing less than 16 hours per day of care.

**Staff** – refers to employees paid by a provider organization

**Waiver Programs** – applies to Acquired Brain Injury waiver (ABI), Money Follows the Person waiver (MFP), and Traumatic Brain Injury waiver (TBI) which are all administered by the Office of Medicaid

## A. STATEMENT OF HUMAN RIGHTS

### 1. Values and Principles

It is the policy of the Massachusetts Rehabilitation Commission (MRC) to seek to affirm, promote, and protect the rights of all people participating in the programs of the Commission, including the ABI and MFP Waiver programs. The denial of any individual's rights, whether it occurs because of ignorance, misinformation, or malice, is unacceptable.

This policy establishes MRC's basic framework for promoting, protecting and ensuring understanding of the rights of MRC Community Living consumers and Waiver participants by those who provide services to them.

Three key principles guide and inform the Human Rights policy of the Commission.

- a. Respect for every individual.
- b. Information and support for every individual and those that support them to enable them to understand their rights and that exercising their rights involves the responsibility to consider the rights of other persons.
- c. Freedom and the power for individuals to express their wishes and to exercise their rights, including those individuals for whom a guardian has been appointed.

### 2. Purpose and Scope

The Massachusetts Rehabilitation Commission is committed to the affirmation, promotion, and protection of the rights of all individuals. This policy is a statement of the human rights of these individuals.

This policy is intended to assure respect for the human rights and dignity of all individuals by the providers. Every person who is engaged in the provision of services is individually responsible for affirming, promoting, and protecting human rights of individuals in a manner consistent with this policy.

### 3. Statement of Human Rights

The Massachusetts Rehabilitation Commission expressly adopts each of the following statements in furtherance of the goal of respecting the human rights and dignity of the people it serves.

- a. **Dignity.** Individuals have the right to be treated with respect, including respect for ethnic and cultural diversity.
- b. **Self-determination.** Individuals must have the opportunity to make meaningful choices and to make informed decisions about their lives. Informed decision-making includes the right to decide to take reasonable risks. It also requires adequate support to help the individual understand and weigh the risks and benefits of their decisions, as needed.

- c. **Communication.** Individuals have the right to communicate with others and to fully express themselves. Individuals shall have access to the assistance necessary to communicate, including access to adaptive equipment, to alternative hearing and communication devices.
- d. **Relationships.** Individuals have the right to visit others and to receive visitors, including the right to have friendships and relationships with mutually consenting adults.
- e. **Privacy.** Individuals have the right to privacy. This includes privacy during care of personal needs, privacy in communication, privacy in visits, privacy in one's home and personal space, and confidentiality of personal information.
- f. **Personal Safety.** Individuals have the right to be safe and the right to be free from harm or abuse.
- g. **Personal Property.** Individuals have the right to obtain, keep, use, and dispose of personal possessions.
- h. **Education, Employment, and Compensation.** Individuals have the right to equal access to opportunities for education and for employment. Individuals who are employed have the right to be fairly compensated for the work that they do.
- i. **Community Membership.** Individuals have the right to expect services and supports will be provided in a manner that promotes their ability to live in the least restrictive, and most typical, settings appropriate to them. Supports and services shall encourage and maintain meaningful community membership. As members of a community, all individuals have a responsibility to respect other people and to exercise their rights with due regard for the rights of other members of the community.

## **B. PERSON CENTERED PLANNING PRINCIPLES**

All MRC Community Living Division providers are expected to deliver services consistent with the principles of Person-Centered Planning.

Person-Centered Planning (PCP) identifies the strengths, preferences, needs, and desired outcomes of the individual related to the service being provided. The individual may choose to include other persons in the service planning process. PCP incorporates these elements:

1. **Accessibility.** Communication and services must be provided in a manner that is accessible to individuals (cognitively, visually, linguistically) and reasonable accommodations must be made for translation of documents, interpretation into other languages, or production of documents in alternate formats as appropriate.
2. **Personal Preferences.** Understanding of the individual's personal preferences: those preferences that "work" and "do not work."  
**Works:** What situations or factors create happiness, motivation or well-being, or encourage learning, communication or relationship building?

**Does Not Work:** What situations or factors cause discomfort, reduce motivation, or discourage learning, communication or maintaining relationships? What situations or factors are likely to place the individual, or his/her community, at risk?

3. **Quality of Life & Values.** The individual is encouraged to clarify the traditions and values that must be honored; what must continue in his/her life; and what is personally important.
4. **Future Goals.** Help the individual to identify the goals they wish to accomplish, both short-term and longer term. These goals may be articulated by the individual and/or guardian, or may be suggested by others based on knowledge of or more formal assessment of the individual.
5. **Action Plan.** Assist the individual to identify the steps needed to achieve the goals identified. This will include the actions required, the individual responsible, and the anticipated timeline.

### **C. PERFORMANCE MANAGEMENT OUTCOMES**

The goal and purpose of each service provided by a provider is directed toward the following:

1. The individual maintains or improves functional independence.
2. The individual experiences an improved quality of life.
3. Individual and/or family expresses satisfaction with the services they receive.
4. Improvement in the overall quality of life and functioning of each individual as documented by measurable progress made by each person toward their goals.

Each provider will acknowledge and work toward these basic goals with the individuals they serve. Other performance outcomes may be developed by MRC.

### **D. SUPERVISION**

Supervision is a key component to providing quality community-based services to individuals. It is an opportunity for a professional to receive consultation, guidance and support in thinking through interventions, handling difficult situations and learning new skills to meet challenges. There is an expectation that all staff employed by a provider organization receive appropriate and on-going supervision on a regular basis to include performance evaluations.

## **E. ACCOUNTABILITY**

Provider organizations and self-employed providers must comply with these MRC Provider Standards. Failure to do so, particularly in relation to the following violations, may result in disqualification as Provider:

1. Interactions with individuals that are deemed to be inappropriate or harmful to the individuals
2. Verbalizing or exhibiting prejudice toward any person or group of people
3. Illegal activities and/or any conviction for a crime
4. Noncompliance with mandated reporting of suspected abuse
5. Lack of appropriate supervision and oversight by an organization's supervisory staff
6. Non-responsiveness to established expectations under overall performance measures and targets
7. Breach of confidentiality
8. Failure to comply with the MRC Incident Reporting policy
9. Failure to maintain a complaint resolution policy and to address complaints in an effective and timely manner
10. Failure to comply with contractual obligations

## **F. REQUIRED PROVIDER PRACTICES**

Providers of goods (i.e., Specialized Medical Equipment) are excluded from these practices.

1. Providers must have a plan in place for dealing with emergencies in the person's home or other place of service delivery including accessing emergency medical services and contacting provider supervisors (if applicable).
2. Provider organizations must have job descriptions and salary scales.
3. All job applicants being considered for employment in MRC or Waiver programs shall, prior to their being hired, sign a release authorizing the provider organization to access his/her Criminal Offender Record Information (CORI). Under no circumstances shall a provider organization hire an individual who exhibits a history of felonious criminal behavior, or any criminal charges which may potentially place individuals at risk. Further, no provider staff member, who has pending charges or who exhibits a history of conviction during the past five years for DUI/OUI, vehicular homicide, or other similar motor-vehicle related offenses, shall be

responsible for transporting individuals. Providers of residential group living and shared living services as well as shared home supports will be expected to send an annual letter of assurance that they are complying with this policy to the appropriate MRC administrative staff for the contract file.

4. Provider organizations must maintain files with documentation including:
  - a. Results of CORI checks
  - b. Results of reference checks
  - c. Resumes
  - d. Training/in-service certificates
  - e. Copy of license(s), if applicable
  - f. Performance evaluations
5. Applicable Center for Disease Control/OSHA guidelines must be followed.
5. Providers must have policies to ensure annual tuberculosis screening and have documentation that testing has been performed for all provider staff who come into direct contact with individuals served. For independent contractors, documentation of annual testing must be also maintained and provided upon request.
7. Whenever applicable, providers must have an infection control plan to prevent occupational exposure to blood-borne illnesses including AIDS/HIV and hepatitis.
8. Providers must have policies for handling allegations of loss, theft, and/or damage of individual's property.
9. The number of qualified staff must be available to meet the needs of individuals accepted for service and reflected in the contract.
10. Providers must ensure that all workers are able to perform assigned duties and responsibilities.
11. All provider staff are expected to consistently conduct themselves in an informed and professional manner, with respect to the performance of their assigned responsibilities.
12. In cases where an individual is moving into a residence including group and shared living or a shared home support setting, special attention should be given to transition-related issues that can help to insure a successful move into someone's new home. The transition planning process should address the following:
  - a. Updated information regarding residential site and home modifications, when indicated. Confirmation of date when residence would be ready for occupancy.
  - b. Emergency Evacuation Safety Plan: Status regarding content and completion.

- c. Fire drills to ensure the evacuation of individuals within 2 ½ minutes during both awake and asleep drills.
- d. Status regarding equipment and assistive technology needs (when applicable), as well as personal needs (e.g., clothing, furnishings).
- e. Staff or caregiver hiring and training: Confirmation of date when residential staff/caregivers will have been hired. Schedule of required trainings, in accordance with the Manual of Policies and Procedures, as well as training of direct care staff/caregivers with respect to the personal care of the individual.
- f. Specific plan for addressing medical transition needs, to include: scheduling of appointments with a primary care physician and other clinical specialists, when indicated (e.g., psychiatry for medication management; speech and language pathologist for dysphagia protocol, etc.); transfer of prescriptions for medication; visiting nurses, etc.
- g. Specific plan regarding day services and other community-based programs/services, and status of referrals to these programs.
- h. Review of financial status and needs (e.g., application for SSI/SSDI benefits, transfer of bank accounts, funds, etc).
- i. Plan for transitioning and orienting an individual into their new home. This should include provisions for:
  - i. Site visits by the individual, guardian, and/or designated family/significant other(s).
  - ii. Graduated plan for visitation, to include an overnight stay, when indicated.
  - iii. Plan for introducing individual to roommate(s), when applicable.
  - iv. Status regarding review of required program documents with individual, guardian, and/or designated family/significant others, including Program Participant Expectations, Confidentiality Policy, Program Fees Policy, etc., as well as a Behavioral Management plan (when applicable).
  - v. Plan for decorating, purchasing and moving personal items.
  - vi. Designated date for consumer to move into their home/ program.

## **G. EXPECTATIONS REGARDING PROFESSIONAL BEHAVIOR**

### **1. Dress Code**

Staff working in programs may dress in relatively casual attire. However, provider staff shall not wear the following clothing items:

- Shirts (e.g., T-shirts, sweatshirts) or other clothing with obscene, violent, vulgar, racist, sexist, or sexually-provocative images or text.

- Shirts (e.g., T-shirts, sweatshirts) or other clothing with text or images advocating illegal, personal or political causes; alcohol or cigarette advertisements; or any other pictorial or written information which may potentially offend or provoke individuals.
- Ripped jeans or other ripped/torn clothing.
- High heels, flip flops, or other footwear which may place an employee at risk for injury or impede their ability to support/care for individuals.
- Tight-fitting or revealing clothing, including but not limited to, sheer blouses/shirts, short shorts, mini-skirts, halter tops, “muscle” shirts, clothing revealing the midriff, breasts, or other private body areas.

Staff serving individuals who exhibit a known history of aggressive, problematic sexual behavior, or other high risk behaviors which may potentially place staff at risk, may be required to comply with additional restrictions, with respect to their work attire or accessories. Restricted items may include, but not be limited to, the following:

- Certain jewelry items (e.g., hoop earrings, nose rings, etc.)
- Neckties and neck chains
- Open toed shoes/sandals
- Other accessories or clothing items which are judged to constitute a potential risk to the employee

## 2. Professional Boundaries

Each staff person is expected:

- To exhibit a thorough knowledge and understanding of the personal history; clinical and other service needs; service plans; and all specialized care and behavioral management protocols developed for all individuals for whom they are responsible.
- To provide services to individuals without any evidence of prejudice, bias, or discrimination on the basis of the participant’s religion; race or ethnicity; age; gender or sexual preference; cause or manifestation of the person’s disability.
- To interface and communicate with all individuals, as well as their legal guardians (when applicable), family members, significant others, and friends, in a respectful, empathic, and courteous manner.
- To cooperate and collaborate with all MRC and Waiver case management staff.
- To understand and comply with all administrative, clinical, and other policies and procedures established by the provider organization and the Massachusetts Rehabilitation Commission.

In addition, and in consideration of the need to establish clear professional boundaries, avoid dual relationships, and/or prevent inequitable treatment or victimization, provider staff are **strictly prohibited** from:

- Engaging in any sexual or otherwise intimate, or personal relationship with individuals.
- Engaging in clandestine exchanges, or withholding information from other provider staff that has been communicated to them by individuals or their guardians, family members, significant others or friends.
- Accepting or giving money or other gifts from/to individuals, and their legal guardians (if applicable), family members, significant others, or friends.

- Taking or inviting individuals to their homes or other places unrelated to the provision of services (e.g., other work sites, church, extended family homes etc.).
- Disclosing information of a personal nature about themselves, their family members, significant others or friends. This shall include, but not be limited to, disclosure of a staff member's medical status, mental health status, religious and/or political beliefs, substance abuse history, interpersonal relationships/ conflicts, financial status/ difficulties and/or conflicts/difficulties with administrative, other program, and/or Waiver or MRC staff.
- Touching individuals in an intimate (e.g., hugging, kissing, etc.) or aggressive (e.g., pushing, pulling, striking, etc.) manner.
- Violating a person's personal space, or inappropriately examining, using, or touching an individual's personal belongings, except in the implementation of a Room Search (see Room Search Policy).
- Sitting/lying on or sleeping in a person's bed.
- Taking or utilizing a person's checkbook, credit card(s), or monies (see Money Management Policy).

## **H. COMPLAINT RESOLUTION**

All providers, including independent contractors, shall have a written complaint reporting and resolution policy. Provider organizations shall provide training to all provider staff, regarding the Complaint Resolution Process ("CRP").

1. Each provider shall make available to the individuals they serve, and other interested parties, their complaint resolution policy. Such policy shall be subject to inspection by the Waiver staff and MRC, as appropriate.
2. The CRP shall clearly describe how to file a complaint and the provider's protocol for addressing the issue and working toward an appropriate resolution, whenever possible. The CRP shall also include the provider's timelines for responding to a complaint in a timely manner and notification that the Individual will receive a written response within 30 days.
3. The provider shall attempt to resolve complaints, whenever possible, quickly and informally and shall include the individual, the case manager and the person's legally authorized representative, as appropriate, in the complaint resolution process.

## **SECTION II**

### **POLICIES for ALL PROVIDERS**

# ASSISTIVE TECHNOLOGY and ADAPTIVE EQUIPMENT

## POLICY

Individuals may require assistive technology devices or have been prescribed adaptive equipment to enhance functional capacity. Specialized equipment may include, but not be limited to, augmentative communication devices/systems; mechanical or electronic lifts; manual or motorized wheelchairs; electronic devices which may be utilized to compensate for cognitive deficits; and low tech apparatus (e.g., shower chairs, grab bars, walkers, etc.).

It is expected that all qualified providers understand the importance and implications for use of adaptive equipment. All providers should continuously be aware and responsive to risks identified when equipment is not functional and assist in the acquisition of needed repairs or modifications (i.e., encourage individual to pursue or coordinate repairs, notify case manager or residential provider of identified concerns). It is, however, the expectation that residential provider organizations will ensure that all adaptive equipment and assistive technology devices utilized by individuals are well maintained and operational. Additional implementation requirements are reviewed below.

## IMPLEMENTATION

1. **Residential** providers shall assume **primary** responsibility for ensuring that all assistive technology devices and adaptive equipment utilized by participants are well maintained, operational, or repaired/replaced, when necessary.
2. **Non-residential** providers are responsible for identifying assistive technology repair needs when it becomes evident and making the case management or residential provider (if applicable) aware.
3. All provider staff charged with the responsibility for caring for individuals who utilize adaptive equipment and/or assistive technology devices will be thoroughly trained in the use of such equipment/devices. In site-based programs, the Program Manager/Director shall be primarily responsible for ensuring that all program staff have been trained (see Provider Training Policy).
4. All providers, in collaboration with case management staff, shall identify individuals who may benefit from an assistive technology or adaptive equipment assessment, as part of the service planning process, and as needed.

**POLICIES REGARDING BEHAVIORAL ASSESSMENT,  
MANAGEMENT and MODIFICATION in SITE-BASED PROGRAMS**

## **A. GENERAL BEHAVIOR MANAGEMENT GUIDELINES**

### **POLICY**

The primary goals of all behavior management/modification interventions shall be to facilitate independence, to improve functional capacity, to promote social integration, and to enhance the quality of life of individuals.

Behavioral assessment and the development of a behavior intervention plan or behavior modification strategies may be indicated for some, but not all individuals. Most often, such interventions are necessitated to address the neurobehavioral/neuropsychiatric consequences of acquired brain injury (ABI), which are related to the etiology, localization and severity of the injury. Behavioral intervention strategies may also be implemented with individuals who exhibit behavioral and psychiatric symptoms which arise from other etiologies (e.g., psychiatric symptoms related to Lyme's Disease). The need for a Behavioral Intervention Plan should be identified during the initial assessment and addressed through the service planning process. For certain individuals, behavioral symptoms may be complicated by a history of substance abuse, premorbid psychiatric disorder, seizure disorder, and/or post-traumatic stress disorder (PTSD). All Behavioral Intervention/Modification Plans must be developed by a licensed mental health clinician with training in development and monitoring of behavioral interventions. Treatment plans, which are based upon principles of learning theory, must also reflect and integrate an understanding of the specific cognitive deficits identified through comprehensive psychological or neuropsychological evaluation. In addition, and not uncommonly, behavioral management/modification plans must be developed in concert with community-based psychiatrists and/or neurologists, who may simultaneously prescribe pharmacological agents to treat the individual. Staff also play an integral role, with respect to gathering baseline data, implementing the behavioral strategies designed to address pre-defined target behaviors, monitoring and recording the qualitative and quantitative effects of both behavioral and psychopharmacologic interventions.

### **IMPLEMENTATION**

1. Behavior intervention/management plans, shall always be cognitively and visually accessible and must be reviewed with and signed by the individual and his/her legal guardian (when applicable) indicating their willingness and consent to participate in these plans. Should an individual exhibit difficulty in reading, visually accessing (e.g., secondary to visual impairments), or understanding (e.g., secondary to aphasia, cognitive compromise, etc.) the behavior management plan, alternative methods for ensuring the individual's comprehension and retention of the information should be utilized (e.g., audio taping, large print format, re-wording for cognitive accessibility). If the primary language of the individual, or his/her legal guardian, is not English, behavior management/modification plans must be translated into his/her primary language and explained with the assistance of an interpreter.
2. Consent to any and all behavior plans can be withdrawn at any time by the individual or their legal guardian (when applicable). The individual/guardian may also request a meeting at any time to discuss modifications to the plan.

3. The provider staff, in collaboration with the individual's case manager and/or licensed clinicians and/or behavioral therapists, shall be primarily responsible for identifying the possible need for behavioral assessment and/or development of a behavior intervention/ modification treatment plan.
4. It is expected that behavioral assessment and treatment plans shall be developed in accordance with the accepted professional standards.
5. Behavior intervention/management plans may include, but not be limited to the following interventions:
  - Positive Reinforcement
  - Extinction
  - Restitution
  - Time-Out
  - Token Economy
  - Levels System
  - Plan Regarding Unsupervised Time in Residence/Community

However, certain behavioral interventions may be limited (e.g., time-out) or strictly forbidden from use (see Prohibited Behavioral Interventions Policy).

6. The implementation of behavior intervention/management plans, and the status of individuals in response to such plans, shall be closely and systematically monitored via data collection procedures. Staff shall be trained and primarily responsible for data collection and implementation activities. The Program Director/Manager or On-Call personnel, as well as any supervising clinician, should be notified immediately in the event an individual exhibits any significant adverse response to a behavior intervention/modification plan, or in the event of a behavioral decompensation.
7. General (i.e., not individual-specific) behavioral strategies, or standardized response protocols (e.g., Elopement Policy) shall consistently be implemented by staff, and do not require the authorization or approval of the individual or his/her legal guardian.
8. Behavior intervention/management protocols shall be systematically and regularly reviewed, and on a PRN basis, revised by the licensed clinician who developed the treatment plan.
9. All behavioral intervention/management plans developed for MRC/BI&SSCS-funded program participants will be reviewed and approved by the MRC/BI&SSCS Behavior Intervention Plan Review Committee using the BIP Review Form (see Appendix A). Revised plans shall be re-submitted to the Behavior Intervention Plan Committee for review and approval.

## B. PROHIBITED BEHAVIORAL INTERVENTIONS

Behavioral interventions which employ excessively restrictive/intrusive strategies, or which potentially pose significant psychological or physical risk/harm to individuals are strictly prohibited from use. Specifically, the following intervention strategies shall **not** be employed in any behavior management/modification plan:

- Mechanical (e.g., bedside rails) or physical restraint, including forced escort or other hands-on interventions which limit the individual's freedom of movement
- Chemical restraint
- Any kind of involuntary seclusion, including locked or closed door seclusion
- Unsupervised/unmonitored (i.e., by program staff) or prolonged time-out (i.e., exceeding 15 minutes)
- Use of cigarettes, tobacco, or other carcinogens as positive reinforcers/rewards or the withholding of tobacco products as part of a behavior intervention strategy
- Deprivation of essential foods/liquids, sleep, clothing, bed/bedding, or bathroom use
- Physical punishment
- Verbal abuse, humiliation, or other degrading responses
- Any other contingent response which may potentially pose the risk or harm (psychological or physical), injury, and/or significant adverse consequences, with respect to individuals

## C. RISK ASSESSMENT

This policy applies only to individuals who exhibit a history of victimization secondary to cognitive deficit, or behavioral/psychiatric disorder evidenced in significant disinhibition; fire setting; unacceptable levels of aggressive behavior or violent behavior; recurrent suicidal behavior; sex offender or problematic sexual behavior (PSB). These individuals may also exhibit a history of incarceration or criminal charges, or may exhibit a history of substance abuse, including intravenous drug abuse (IVDA). Some individuals themselves present significant risk of being victimized by others, secondary to their psychiatric symptoms (e.g., depression) or neurocognitive compromise. Staff responsible for providing services to these individuals are expected to exhibit a high degree of vigilance and to fully comply with all behavioral management protocols developed to ensure the safety of the individual, staff, and in residential programs, the individual's housemates and those who share the community in which the program may be sited. With respect to residential programs, decisions regarding the ability of individuals to independently engage in activities both within and outside the residential program necessitates informed and careful consideration, not only by residential staff, but by clinicians who are trained and experienced in risk assessment and management.

A risk assessment may be recommended by the individual's case manager or provider staff and should be collaboratively considered with respect to making the following determinations regarding the individual's ability to:

- Spend time in his/her home unsupervised, or engage in unsupervised, community-based activities
- Participate in specific vocational training programs, to be independently employed, and/or to be responsible for certain job-related activities
- To engage in unsupervised recreational or social activities
- To travel on public transportation to a site-based program (e.g., day program)
- To engage in any activity which may serve to potentiate the behavioral vulnerabilities of the individual or victimization of others

When a risk assessment has been completed, the findings of such assessment shall be utilized to inform the service planning processes, and when applicable, a behavior intervention plans.

# CONFIDENTIALITY and RELEASE of INFORMATION

## POLICY

It is the expectation that all providers will maintain a policy of strict confidentiality, with respect to all individuals' clinical and program records, as well as personal and family-related information.

## IMPLEMENTATION

### A. Record Storage

1. All historical and current records related to an individual shall be maintained in a locked filing cabinet, or other secure location (e.g., locked storage room). Providers shall also maintain the security of all individual data contained within computerized files consistent with the provision of the providers' contract for services with the Commonwealth.
2. An individual's record should be readily accessible to the case manager, as well as supervisory staff.
3. An individual's records should never be left in common areas, or other places within site-based programs, where these documents could be easily accessed by visitors and other unauthorized individuals.

### B. Release of Information

1. The release or disclosure of **all or any** information, including written, typed, e-mailed, faxed documents, or verbally-communicated information regarding individuals **requires** written authorization (i.e., signed release form) of the individual, his/her legal guardian (when applicable) or by a lawfully designated representative (e.g., attorney, healthcare proxy).
2. The release form should be explicit with respect to the information to be shared (e.g., as in "collateral consultation" or "exchange of information for the purpose of clinical planning"), or specific records to be released.
3. Release forms should be signed by the individual or his/her legal guardian (when applicable) or by a lawfully designated representative (e.g., attorney, health care proxy).
4. If the individual cannot read, the content of the release form should be read to him/her, and this should be noted on the release form.
5. If the individual or his/her legal guardian (if applicable) is unable to read or comprehend English, release forms must be translated into his/her primary language.
6. Release forms should be dated and time-limited (one year), and the expiration date noted. Releases should be updated on an annual basis.

7. The provider is responsible for knowledge of all applicable state and federal laws governing the storage, use and release of personal data and shall comply with their obligations under those laws.
8. Release of any information regarding HIV status or AIDS requires a separate and explicit release form. It is also advisable to obtain specific consent to release information of a highly sensitive nature.
9. Authorization of release of information may be withdrawn at any time by an individual or his/her legal guardian or by a lawfully designated representative (e.g., attorney, healthcare proxy), and this information should be typed on the release form.

### **C. Other Issues Related to Confidential/Privileged Information**

1. If a guardian has been appointed by the court, a copy of the guardianship decree should be obtained and the authority it conveys should be thoroughly understood by the provider.
2. The type of information to be released to family members/significant others should be specified (i.e., if family member/significant other is not the legal guardian), and the individual also has the right/authority to forbid a provider from sharing particular events and/or information with a family member/significant other.
3. All service providers are advised to seek legal consultation with respect to any issues related to confidentiality; the development of release forms; the scope of the guardianship; and in cases where the ability to consent has been questioned in an individual who has not been adjudicated incompetent (or presumed competent).
4. Authorization to release or receive information ceases at the point a provider organization and its employees ceases to provide services, or the authorization for release of information expires.
5. Providers have **no authority** to **re-release** records from other programs, facilities, or providers of service, without specific written authorization from the individual or his/her guardian (when applicable) or by a lawfully designated representative (e.g., attorney, healthcare proxy).
6. While individuals may sign release forms which authorize the release or receipt of information to/from an organization, hospital, or facility, within that facility or program, the provision and access of information should be on a "need-to-know" basis (i.e., those directly responsible to providing services to the individual).
7. For all organizations, programs, and facilities, an individual should be designated as the Keeper of the Records and all requests for information reviewed by him/her. Independent sole providers assume this role and responsibility (e.g., independent case managers, community habilitation).
8. Providers who work independently and/or are not affiliated with an agency or organization, should **not** use their home phone for receiving voice mail messages or faxes from other professionals, consumers, families, or guardians, if other unauthorized

individuals will have access to this information (e.g., access to answering machine) as this constitutes a violation of confidentiality.

9. Providers shall not ask individuals to sign releases to obtain his/her criminal records (i.e., CORI) except when provider staff have been engaged to facilitate HUD applications. In these instances, the information would be forwarded to the housing authority.

#### **D. Review/Access of Confidential/Privileged Information by Individuals**

1. Individuals, or their legal guardians (when applicable), are entitled to know the content and receive copies of their records (e.g., assessments, individualized service plans, etc.). It is expected that the provider staff will assume responsibility for reviewing and explaining the content of these records with both the individual and his/her legal guardian (when applicable), and when requested or clinically appropriate.
2. Should an individual exhibit difficulty in reading, visually accessing (e.g., secondary to visual impairments), or understanding (e.g., secondary to aphasia, neurocognitive compromise, etc.) the content of his/her records, alternative methods for ensuring the individual's comprehension of the information included in the records should be employed (e.g., audio taping, large print format, re-wording for cognitive accessibility). For individuals or guardians whose primary language is not English, the records should be translated into his/her primary language.
3. Individuals or legal guardians (when applicable), or lawfully designated representatives who request copies of records from other sources, including but not limited to, physicians, mental health professionals, substance abuse programs, primary care physicians, shall be directed to these other providers of service to obtain copies of their records, and to schedule an opportunity to discuss/review the content of such records.
4. Information contained within, or copies of written documents, which have been primarily developed or are utilized to facilitate communication among provider staff working in site-based programs shall not be provided to individuals, legal guardians, family members, significant others/friends. Such documents include, but are not limited to, program staff meeting notes/minutes, log books, shift notes, and staff memos. The information discussed within these documents or staff meetings shall also not be verbally disclosed to individuals, family members, legal guardians, or significant others/friends.

#### **E. Limits of Confidentiality**

1. All individuals shall be apprised by the provider of the limits of confidentiality, with respect to the following:

- a. Suicidal Behavior/Threat
  - b. Homicidal Behavior/Threat
  - c. Obligatory Reporting Laws
  - d. Court-ordered Mandate
2. The circumstances which may lead to the need to disclose confidential information are reviewed in the Confidentiality Policy Form, which all individuals and his/her legal guardians are asked to sign (see Appendix B).
  3. A copy of the signed Confidentiality Policy Form (see form) shall be provided to the individual and his/her legal guardian (when applicable). The original shall be retained by the provider and placed in the individual's record file.
  4. Should an individual exhibit difficulty in reading, visually accessing (e.g., secondary to visual impairments), or understanding (e.g., secondary to aphasia, neurocognitive compromise, etc.) the content of the Confidentiality Policy Form, alternative methods for ensuring the individual's comprehension and retention of the information included in the Confidentiality Policy should be employed (e.g., audio taping, large print format, rewording for cognitive accessibility). For individuals or guardians whose primary language is not English, the Confidentiality Policy Form should be translated into his/her primary language.

# **ELOPEMENT POLICY for SITE-BASED PROGRAMS**

## **POLICY**

In situations where an individual exhibits a history of intentional, and most often impulsive, elopement from a site-based program, which for the purposes of this policy shall include shared living and shared home supports, it is expected that the provider develop specific anticipatory strategies to address and prevent either intentional elopement or an individual's wandering away from either the program or off-site activities. The need for such a policy and approach should be identified during the initial assessment and addressed through the service planning process. This may also apply to other individuals who, secondary to cognitive impairment, may unintentionally wander or become lost while in off-site locations (e.g., shopping mall) or during unsupervised, independent excursions into the community. When applicable, the anticipatory/prevention strategies shall be developed in collaboration with other community-based programs in which the individual may participate, and when indicated, local police authorities, to facilitate coordinated, consistent management, and/or response, in the event of elopement. In residential programs developed for individuals who exhibit high risk for elopement, an alarm system shall be installed on both windows and doors to alert residential staff in the event a resident attempts to elope from the program.

## **IMPLEMENTATION**

In the event an individual is determined to have eloped, or is found to be missing, the following procedures shall be followed:

1. The Program Director/Manager or On-call personnel shall be notified immediately.
2. If the individual is visible to program or caregiver staff, every effort should be made to facilitate their return to the program or scheduled activity. However, a provider staff person who is solely responsible for individuals other than the individual who has eloped shall never leave other individuals unattended to locate the individual who has eloped or is missing.
3. If an individual is located by staff but refuses to return to the program or other scheduled activity, a range of responses should be considered, depending upon the risk associated with such a refusal or indications specified (when applicable) in the context of a behavior intervention plan. These responses may include offering accommodations or alternatives based on the individual's needs, requesting assistance from the individual's guardian, family or significant others, or contacting the local mobile crisis team, if appropriate. If initial interventions are unsuccessful or if the individual cannot be located within a reasonable period of time, as defined in the individual's service plan, a 911 call shall be placed to local police by the Program Director/Manager or On-call personnel. Police authorities shall be provided with pertinent information regarding the individual, including, but not limited to, the following details:
  - Name of Individual
  - Time and location where individual was last seen
  - Age, attire, appearance, including identifying characteristics (e.g., hair color, eye color, etc.)
  - Precipitating/antecedent events

- Possible destinations
- Information regarding any immediate medical concerns
- Contact information for the program, Program Director/Manager, and On-call personnel
- Name and phone number of legal guardian (if applicable) or other designated emergency contact person

The police shall also be faxed or otherwise provided with a copy of the individual's Emergency Fact Sheet.

4. The individual's legal guardian or designated emergency contact person shall be immediately contacted by the Program Director/Manager or On-call personnel and informed that the individual has eloped or is missing.
5. The Incident Reporting procedures shall be completed for all elopements (See Incident Reporting Policy).
6. When the individual is located, the Program Director/Manager or On-call personnel shall be primarily responsible for conferring with the individual, staff or caregiver and determining the need for additional clinical assessment by a physician or mental health professional. Should an individual exhibit obvious injury or psychiatric decompensation, or if the individual has been the victim of a sexual and/or physical assault, the individual, without exception, shall be taken to the nearest emergency room for evaluation, and the individual's PCP shall be contacted. In any situation where an individual in a site-based residential program, which shall include shared living or shared home supports, is transported to a hospital setting, provider staff or caregiver shall accompany and remain with the individual in the Emergency Department until he/she has been medically and/or psychiatrically evaluated and a clinical disposition determined.
7. The individual's PCP shall be contacted to address any other injuries, medical complaints, missed medication questions, as well as any other issues of a medical nature. Any individual who engaged in unprotected or coerced sexual activity shall be evaluated by his/her PCP and/or OB-GYN specialist, and screened for sexually-transmitted diseases and any other consequences related to these sexual encounters.
8. The police authorities shall also be notified of any assault, rape, or other alleged crimes perpetrated against the individual.

Last Revised: March 30, 2012

## **INCIDENT REPORTING**

### **POLICY**

An Incident Report must be filed in response to any significant injury, medical, behavioral/psychiatric or other events involving an individual. In addition to ensuring a reliable record of all significant events, the Incident Reporting Policy is designed to provide consistent mechanisms for:

- a. The provider and case management staff to review the precipitants to, and nature of, significant incidents/events, with respect to the individual and program, when applicable.
- b. The provider to systematically investigate significant incidents/events, and to establish a basis for developing anticipatory, preventative and corrective interventions.
- c. The provider to identify individual needs, as well as, staff training and supervision needs.

## **IMPLEMENTATION**

1. The Incident Report form (see Appendix E) should be completed by provider staff who witness an incident. However, in residential programs, an Incident Report Form shall also be completed for unwitnessed events which constitute incidents that might have occurred off-site (e.g., during independent time in the community). All other providers (e.g., day program staff, community support worker, individual aid, etc) who become aware of significant unwitnessed events (e.g., hospitalizations, serious injury, an event which occurs off site while attending a day program), shall inform the case manager of such occurrences, either verbally or in a contact/progress note. Separate Incident Report forms should be completed for each person, when more than one individual is involved.
2. The completed Incident Report form shall be preferably e-mailed (i.e., electronic form), or faxed, to the individual's case manager within **24** hours, including weekends and holidays. Electronic submissions of incident reports shall be password protected. The categories and definitions of incidents are contained within Appendix F.
3. In residential programs, the provider's designated person On-Call should be immediately contacted via pager or cell phone, and notified of all incidents. Incident Reports should be reviewed by the designated On-Call person, or Program Director/Manager (site-based provider organizations), who may submit, in a separate document, additional or clarifying information, when indicated.
4. In completing Incident Reports related to non-compliance with medications or medication errors, the name of the medication(s), dose and scheduled time of administration should be specified in the Incident Report. A Medication Occurrence Form should also be completed and attached to the Incident Report.
5. The individual's case manager, shall be immediately contacted by cell phone in the event of the following:
  - a. Elopement from a residential or day program

- b. Events which result in the necessity to report alleged abuse/neglect of a disabled individual or others (e.g., child under age 18)
- c. Event involving law enforcement
- d. Hospitalization (psychiatric or medical) of an individual
- e. Death of an individual
- f. Relocation or evacuation of residential program participants

Should these events occur on weekends, or outside of business hours, a voicemail message shall be left for the designated case manager. In addition, the typed Incident Report must be submitted within 24 hours.

6. Guardians, family members, or designated significant others should be contacted by the designated On-Call person (residential program), or Program Director/Manager (provider organization), for all events of a serious nature.
7. For all instances of suspected or substantiated abuse or neglect of a disabled individual, the provider shall file a report immediately with the Disabled Persons Protection Commission (DPPC).
8. Should an incident result in, or involve, the suspected or documented abuse of a child under 18 years of age, the provider shall file a report immediately with the Department of Children and Family Services (DCFS).
9. Should an incident result in, or involve, the suspected or documented abuse, including financial exploitation, of an adult 60 years or older, the provider shall file a report immediately with the Executive Office of Elder Affairs.
10. Local police authorities shall be contacted by the provider for assistance for the following events:
  - a) An individual's elopement from a residential or day program (see Elopement Policy) in situations where the staff are unable to maintain the individual's safety while negotiating a return home, or the person is considered missing for a defined period of time as determined in the service planning process. In these situations, police are advised of the voluntary nature of the residential or day program and any safety plan which should be employed when approaching the individual.
  - b) Episodes of threatened or actual significant aggression directed at staff or other individuals, or serious threats of aggression which exceed staff capacity to manage.

11. All suicidal threats, gestures, and/or attempts exhibited by individuals shall be immediately evaluated by a licensed mental health professional affiliated with the program, a hospital-based emergency room, mental health facility, or regional mental health screening team. Provider staff are expected to facilitate this process and to provide assistance to the individual in accessing appropriate mental health services.
12. All medical illnesses, injuries, or events (e.g., exacerbation of seizures, decubiti) shall be immediately evaluated by the individual's primary care physician or medical specialist (e.g., neurologist). When indicated emergency service providers shall be accessed (i.e., ambulance, hospital emergency room), and all discharge paperwork, including the results of diagnostic testing when performed, shall be forwarded with the incident report. Should an individual be admitted to a hospital, the medical documentation should be sent to the individual's case manager upon discharge. Nursing staff, employed by residential or day programs shall also be contacted by the On-Call staff person or Program Director/Manager, in response to medical events.
13. When requested, a Supplemental Incident Report shall be completed or additional information submitted by the provider.

## LEGAL GUARDIANS and OTHER SUBSTITUTE DECISION MAKERS

Individuals are presumed competent to make all legal decisions, absent a court decision that identifies the specific areas in which a person lacks capacity. However, some individuals have been adjudicated incompetent and have required the appointment of a legal guardian or a conservator secondary to documented cognitive compromise and/or the presence of a behavioral/psychiatric disorder. Other competent individuals have appointed agents to serve as substitute decision makers in certain situations. In such cases, providers are expected to be thoroughly knowledgeable, with respect to the powers, duties, and scope of responsibilities of such substitute decision-makers. Copies of all legal documents pertaining to individuals for whom a substitute decision maker has been appointed shall be included in the individual's file, and copies should also be provided to all other relevant community-based clinicians (e.g., primary care physician, medical specialists, etc.) or agencies (e.g., banking institution). Types of substituted decision-makers may include:

**Legal Guardian (Full and Limited)** may be responsible for making decisions regarding the individual's medical care, treatment program, and/or other matters, as determined by a Massachusetts probate court. Most guardians have limited authority. A guardian must have specific authority from the probate court to consent to certain kinds of medical treatment, including antipsychotic medication.

Individuals who are the subject of a guardianship petition, or who are currently under guardianship, have a right to request legal counsel. A concerned party may also submit a request for counsel on the individual's behalf. Appointment of counsel forms can be found on the Probate and Family Court website:

<http://www.mass.gov/courts/courtsandjudges/courts/probateandfamilycourt/upc.html>.

**Roger's Monitor** is appointed to monitor an antipsychotic medication treatment regimen, developed by a treating physician and authorized by a court. A Roger's monitor has no authority over the person, unless the monitor is also the guardian.

**Conservator** is appointed by a probate court to make financial and property decisions for a ward.

**Health Care Agent** may be chosen by a competent individual to make or communicate decisions regarding medical treatment in the event that he or she becomes incapacitated. Incapacity must be determined by a physician. The document appointing the agent is called a Health Care Proxy or an Advanced Directive.

**Power of Attorney** is an agent, called an attorney in fact, who may be authorized by a competent individual to perform tasks related to the person's property (e.g., writing checks, selling property, etc.).

**Representative Payee** refers to an agency or person who is appointed by the Social Security Administration to accept payment from an entitlement program (e.g., SSI/SSDI) on behalf of the individual beneficiary. Representative Payees must use these benefits to pay for the current and foreseeable needs of the individual, and must observe various

record keeping and reporting requirements for Social Security. An individual need not be adjudicated incompetent or have a court-appointed guardian in order to have a representative payee.

With the exception of assuming the responsibilities associated with representative payee status, no employee of a residential provider organization shall be appointed as a substitute decision maker for a residential program participant.

Last Revised: March 30, 2012

# OBLIGATORY REPORTING of ABUSE and NEGLECT

## POLICY

All qualified providers are required to comply with all state laws and statutes regarding abuse, mistreatment and neglect. These include the following Massachusetts General Laws:

**CHAPTER 19A:** which concerns any abusive acts, or omissions, causing physical or emotional injury to an elderly person (age 60 or older), or financial exploitation of an elderly person. A report must be filed with the Department of Elder Affairs.

**CHAPTER 19C:** which established the **Disabled Persons Protection Commission** and concerns the abuse, neglect, and mistreatment of disabled adults (ages 18 – 59). A report must be filed with the Disabled Persons Protection Commission (DPPC).

**CHAPTER 119 (51A):** which concerns the reporting and investigation of incidents of abuse, neglect, or mistreatment of children (under 18 years of age). A report must be filed with the Department of Children and Family Services (DCFS).

**CHAPTER 111:** which concerns the reporting and investigation of incidents of abuse, neglect, and mistreatment of patients/residents of nursing homes, rest homes, convalescent homes, charitable homes for the aged, and community-based intermediate care facilities for the mentally retarded. A report must be filed with the Department of Public Health (DPH), Division of Health Care Quality.

## IMPLEMENTATION

1. The provider shall be held responsible for ensuring that all staff are trained, with respect to all obligatory reporting laws and requirements, as part of the orientation and training of newly-hired staff. In addition to providing an understanding of each law regarding abuse, neglect, mistreatment and financial exploitation, the provider organization shall emphasize the following training points:
  - a. That the primary responsibility of staff is to file a **verbal report immediately** for any instances of suspected abuse, neglect, mistreatment, or financial exploitation - **not** to investigate or substantiate such incidents which is the responsibility of the designated State agency.
  - b. That within 48 hours of filing the verbal report to the responsible agency, the provider must provide that agency (when applicable) with a written report, in accordance with the responsible agency's required report format.
  - c. That all staff are expected to comply fully with the investigator, as well as any request for additional information by the Waiver case manager or MRC staff.
  - d. That staff cannot be held liable, and are protected against retaliation, discharge, or any other forms of discipline or discrimination by their employer, for reporting any suspected or documented instances of abuse, neglect, mistreatment or financial exploitation.

- e. That certain cases of reported abuse, neglect, mistreatment, or financial exploitation may be referred by the responsible State agency for possible criminal investigation and prosecution (e.g., assault and battery, larceny, etc.).
  - f. That provider organizations may choose to conduct their own review of incidents which would necessitate the filing of a report of abuse, neglect, mistreatment or financial exploitation. **However, such a review undertaken by a provider does not eliminate the need to file a report with the appropriate and responsible State agency immediately.**
  - g. That an Incident Report should be simultaneously completed for all instances when a report of abuse, neglect, mistreatment, or financial exploitation has been filed.
  - h. That a DPPC report must be filed in all cases when an individual has died, regardless of cause.
- 2. All individuals shall be informed of the provider's obligations, with respect to obligatory reporting. In addition, all individuals and their legal guardians (when applicable), shall be requested to sign the Limits of Confidentiality policy statement, with respect to obligatory reporting (see Confidentiality Policy section).
  - 3. All individuals and their legal guardians (when applicable) shall be provided with an informational brochure/flyer, and the phone number to access the Disabled Persons Protection Commission. Should an individual exhibit difficulty in reading, visually accessing (secondary to visual impairments), or understanding (e.g., secondary to aphasia, cognitive compromise, etc.) the information regarding the DPPC, alternative methods for ensuring the individual's comprehension and retention of the information provided regarding the DPPC should be employed (e.g., audiotaping, large print format, re-wording for cognitive accessibility). For individuals or legal guardians whose primary language is not English, the DPPC information shall be translated into his/her primary language.
  - 4. The Hotline phone numbers for reporting all instances of suspected abuse, neglect, mistreatment, and financial exploitation shall be posted in the staff office and in the common area of each site-based program.

# PROVIDER TRAINING

## POLICY

Providers are expected to be thoroughly knowledgeable of the “Policies for All Providers” within the MRC Community Living Division Provider Manual. In site-based provider organizations, the Program Manager/Director shall be primarily responsible for ensuring that all staff have received a copy of the provider policies, principles and practices and that required trainings have been completed by individual staff. In addition, the training requirements delineated below must be completed by provider staff and independent contractors.

### Training Requirements for all Provider Organizations

- Accessing and utilization of On-Call Personnel
- Emergency Protocols developed by the provider organization, to include, but not be limited to:
  - Evacuation procedures in the event of a fire
  - Emergency protocols related to the physical plant
  - Medical Emergencies
  - Psychiatric/Behavioral Emergencies
- CPR\*
- Infection Control including proper disposal of medical waste products (e.g., syringes)
- Filing reports related to abuse/neglect
- Fire Drills
- Fire Safety\*
- First Aid to include intervention for choking\*
- Procedures for transporting individuals and use of program vehicle(s), if applicable
- Seizure Management
- Universal Precautions
- Non-Violence Crisis Intervention/Restraint Training

### Training Requirements for Independent Contractors

- CPR\*
- First Aid to include intervention for choking and seizure management\*
- Filing reports related to abuse/neglect
- Procedures for transporting individuals and use of program vehicle(s), if applicable

*\*Training, with respect to these topics, shall be provided by a Program Director/Manager or a certified, licensed or otherwise qualified trainer (when applicable).*

## **Individual-Specific Training Requirements for All Providers**

Providers are expected to have received and reviewed all individual-related documents, to include, but not be limited to the following:

- The individual's Service Plan and related assessments
  - Clinical history
  - Specialized Medical/Rehabilitation Protocols, when applicable
  - Assistive Technology/Adaptive Equipment utilization/operation
  - Behavioral Management Plan (if applicable)
- Any other individual-specific training and/or documents

### **Documentation**

In site-based programs, the provider organization and Program Director/Manager shall be primarily responsible for ensuring and documenting staff attendance and participation in all staff training activities/requirements. Documentation records shall be made available and provided, upon request, to MRC or Waiver administrative/supervisory staff, who are responsible for oversight and ensuring contract compliance.

### **Non-Compliance**

Failure on the part of a provider organization to ensure compliance with employee training requirements is regarded as a very serious breach of the signed contractual agreement between the provider organization, MassHealth and/or the Massachusetts Rehabilitation Commission. Most importantly, providers who have not been adequately and appropriately trained, place individuals at risk and compromise their quality of life. It should, therefore, be recognized that provider organizations and all employees hired by that organization, as well as independent contractors, shall be held strictly accountable, with respect to their compliance with required staff training. Providers shall also be reported to the Disabled Persons Protection Commission (DPPC) in response to any and all incidents involving an individual(s) who has been the documented, or suspected, victim of neglect, abuse, or other significant adverse effects arising wholly, or in part, from a provider's failure to fulfill training requirements.

# **SPECIALIZED MEDICAL and REHABILITATION PROTOCOLS**

## **POLICY**

Many individuals require specialized medical protocols and equipment to address the neurological, physical and other consequences of their disabling condition(s). These protocols are developed/prescribed by the individual's primary care physician or medical specialists (e.g., neurology, physiatry, etc.), or may be prescribed by a licensed rehabilitation professional (e.g., speech pathologist). Specialized protocols utilized with participants include, but are not limited to, prescribed procedures to address:

- Dysphagia (swallowing disorder), which may include G-tube feedings
- Seizures - e.g., Vagal Stimulator
- Diabetes
- Spasticity and other Neuromuscular Disorders - e.g., Baclofen pump
- Sleep Apnea
- Mobility and Transfers – e.g., Hoyer Lifts
- Dysarthria (articulation disorder) - e.g., palatal lift
- Aphasia (Language disorder) – e.g., augmentative communication system
- Excessive Secretions
- Prevention of Anaphylactic Reactions (severe allergic reaction)
- Incontinence
- Recurrent Decubitus Ulcers
- Respiratory Compromise - e.g., mechanical ventilation

It is expected that all providers responsible for serving individuals who exhibit these conditions/disorders and their associated specialized care needs will be comprehensively trained in the implementation of such protocols and the use of specialized equipment, prescribed for the individual. Additional implementation requirements are delineated below.

## **IMPLEMENTATION**

1. All providers shall be trained with respect to all specialized protocols which shall be typed, placed in the individual's record, and kept current.
2. No newly-hired, or otherwise untrained provider staff, in site-based programs, shall be requested or expected to be independently responsible for the care of an individual until they have received training on specialized protocols and equipment.
3. When indicated and prescribed by treating clinicians, licensed nursing (e.g., VNA) and rehabilitation professionals shall provide clinical services to individuals and/or ongoing consultation to providers.
4. Copies of all specialized protocols, which should be typed, shall be provided to the individual's case manager.

Last Revised: March 30, 2012

## **TRANSPORTATION**

## **POLICY**

Qualified providers may own, or lease, automobiles or vans to transport individuals, who may also be taught to access and use public transportation when available. All staff will be trained in the proper use of vehicle restraints. With respect to these varied modes of transportation, provider organizations are expected to adhere to the implementation guidelines delineated below.

## **IMPLEMENTATION**

1. The Program Director/Manager, and/or the provider organization's Executive Director shall be primarily responsible for ensuring that all vehicles owned, leased or used by the organization, its staff, agents or contractors, for the purpose of transporting individuals are insured, well maintained, accessible and modified when necessary, to accommodate the physical needs and to ensure the safety of individuals.
2. All staff operating a vehicle utilized to transport individuals shall possess a valid driver's license and shall be specifically covered under the provider's insurance policy. As reviewed in the Required Provider Practices section of this manual, any staff person who has pending charges, or during the past five (5) years has been convicted of Driving Under the Influence (DUI), Operating to Endanger, or other equally concerning motor vehicle-related crimes such as vehicular homicide, shall not be responsible for transporting individuals. Staff who have had two or more convictions for motor vehicle-related crimes shall never be responsible for transporting individuals.
3. The use of staff vehicles will only be acceptable if there is documentation of insurance coverage for the transport of individuals. This coverage must be included in either the independent contractor or staff person's insurance policy, or under the provider organization's. With respect to provider organizations, the agency is responsible for keeping copies of all insurance policies held by the staff who use their personal vehicles to transport individuals. If the provider agency holds that insurance coverage, a copy must be kept in the provider agency's administrative file.
4. Documentation regarding insurance coverage and maintenance for vehicles owned or used by the provider organization, including staff policies, shall be made available to MRC staff during oversight monitoring reviews.
5. In the event a vehicle utilized by the provider organization, but owned by MRC becomes inoperable or in need of repair, MRC supervisory staff shall be informed immediately.
6. All transportation accidents, including those which occur on public or private (e.g., taxi) transportation, shall be reported to the Waiver or MRC case manager and an Incident Report completed (see Incident Reporting Policy).
7. When applicable, all individuals shall be assessed with respect to their interest and ability to learn to access and utilize public transportation options, when available, as part of the service planning process. Should an individual articulate a goal of utilizing public transportation, methods for developing these skills should be incorporated as specific behavioral objectives in the individual's service plan. Any plans for

unsupervised use of public transportation will be determined pending completion of a community safety assessment (see policy regarding Unsupervised Time in the Residence/Community).

8. Vehicles that are leased or owned by the provider organization or the MRC shall not be operated by, or used to transport, family members, legal guardians, significant others, or friends of the individual. Vehicles owned or leased by the provider organization or the MRC shall not be driven by individuals.
9. Staff shall not access vehicles owned or leased by the provider organization or the MRC for their personal use.

Last Revised: March 30, 2012

**SECTION III**

**SUPPLEMENTAL POLICIES  
for  
GROUP LIVING RESIDENTIAL PROGRAM PROVIDERS**

# **ALCOHOL and DRUG ABSTINENCE**

## **POLICY**

Clinical research and experience have substantiated that alcohol and drug use contributes significantly to the occurrence of brain injury and secondary disabling conditions. Further, use of alcohol and drugs serves to compromise recovery, functional capacity and outcome. Therefore, all residential programs must maintain a policy of abstinence with respect to alcohol and drug use, excluding medications which are taken as prescribed.

## **IMPLEMENTATION**

1. Prior to admission to a residential program, the Program Director/Manager shall review the Alcohol and Drug Abstinence Policy, which is incorporated within the Program Participant Expectations document and signed by the residential program candidate and his/her legal guardian (when applicable).
2. In addition to exhibiting a willingness to adhere to the Alcohol and Drug Abstinence Policy and other Program Participant Expectations, residential program candidates who exhibit a recent or active history of alcohol and/or other substance abuse may be required to participate in substance abuse treatment prior to their acceptance into a residential program.
3. The Alcohol and Drug Abstinence Policy shall also be reviewed by the Program Director/Manager, as part of the Residential Policies regarding Family Members, Significant Others, and Legal Guardians (see policy rationale and implementation guidelines). While encouraged to support the goals of this policy, Family Members, Significant Others, and legal Guardians will not be required to enforce abstinence from otherwise legal activities in the community. Nor will their access to the individual be conditioned upon agreeing to such reinforcement.
4. Individuals who also exhibit a past history of alcohol and/or other drug use shall be provided with substance abuse education, and in particular, the potential consequences of continued substance abuse. Referral to appropriate support (e.g., AA) and therapeutic services should be facilitated by residential program staff, when indicated.
5. Use of drugs or alcohol by an individual in a residential program requires the completion of an Incident Report. Further, any illegal drugs discovered in a residence require the notification of the local police department by the Program Director/Manager for the purposes of confiscation.

Last Revised: March 30, 2012

## **POLICY REGARDING EMERGENCY RESPONSE MANAGEMENT and**

# EMERGENCY EVACUATION SAFETY PLANS

## POLICY

It is expected that qualified residential provider organizations will develop emergency response/management protocols and will comply with the Emergency Evacuation Safety Guidelines specific to Residential Supports as established by the Department of Developmental Services (DDS) (see Appendix C). In addition, provider organizations shall comply with 115 CMR 7.00 et seq, an in sections 7.02, 7.06 and 7.08 (2 and 3). The implementation guidelines delineated below shall also be completed. **Any and all references to the DDS in the above referenced policies and regulations should be read as references to the MRC.**

## IMPLEMENTATION

1. The Residential Program Director/Manager will develop emergency response/management protocols through the identification of, collaboration with, and establishment of linkages with community-based service providers and resources, including the local police authorities; fire department; ambulance/rescue squad; hospitals; psychiatric treatment programs and screening teams; and substance abuse treatment programs. These protocols will address: a) repairs or other problems of an emergency nature within the residence; b) psychiatric/behavioral emergencies; c) medical emergencies; d) relocation plans.
2. Each emergency response/management protocol shall specify the following:
  - a. Names, rotation schedule (if applicable), and mechanisms for accessing designated provider organization staff who are primarily responsible for responding to emergencies
  - b. Detailed actions to be taken by residential program staff in response to emergencies
  - c. Contact information for all community-based resources
3. Copies of all Emergency Response and Management Protocols shall be provided to the staff of each residential program, who shall also be trained, on these protocols/procedures.
4. On-Call personnel who are responsible for responding to emergencies shall be available 24 hours/day, seven days/week (see On-Call Policy).
5. In addition to these protocols, the Residential Program Director/Manager will also develop emergency evacuation safety plans.
6. **For MRC/BI&SSCS funded individuals only**, emergency response/management protocols and emergency evacuation safety plans will be submitted to the Director of Residential Services for approval, as part of the proposed Plan of Care for a new

residential program or when an individual transitions into an established residential program.

7. **For Waiver funded programs**, emergency response/management protocols and emergency evacuation safety plans will be reviewed by the case manager during initial home visits.
8. An Individual Assessment shall be completed for each individual annually in conjunction with the service planning process to ensure that the emergency evacuation safety plan meets each individuals needs.

Last Revised: March 30, 2012

# **RELATIONSHIPS WITH FAMILY MEMBERS, SIGNIFICANT OTHERS, FRIENDS, and LEGAL GUARDIANS**

## **POLICY**

Individuals have a right to maintain personal contacts and relationships with family members and friends. Residential staff are expected to encourage and assist individuals to communicate regularly with family members, significant others, friends and legal guardians. In doing this, however, individuals have the right to determine who, when, and how frequently these contacts occur. In addition, as most residential programs have been developed for a group of individuals, guidelines have been established to accommodate each person's needs and to ensure the personal safety, privacy, and participation in scheduled activities of all who reside in a program.

## **IMPLEMENTATION**

1. The Residential Program Director/Manager shall review the guidelines (see Appendix D) regarding family members, significant others, friends, and legal guardians prior to moving in to a community program, with both the individual and his/her designated contacts. After transition, any additional visitors/contacts specified by the individual shall likewise meet with the Residential Program Director/Manager to review the guidelines regarding family members and significant others on an as needed basis.
2. Each of the individual's designated contacts should be provided with a copy of the guidelines.
3. At the time of transition to a residential program, the Residential Program Director/Manager shall specify a staff member who will serve as the primary contact for family members, significant others/friends, and/or the individual's legal guardian. These designated contact persons shall be informed regarding mechanisms for contacting the provider's designated residential staff member. The residential staff person who serves as the primary contact should preferably be a Program Director/Manager, Site Supervisor, or other staff member with administrative/supervisory responsibilities.
4. For any incident in which a guardian, family member or significant other/friend in any way jeopardizes the safety of an individual, or in which a guardian, family member, significant other/friend is suspected of abuse or neglect, a report shall be filed to the responsible agency (see Obligatory Reporting Policy) immediately by the residential provider staff, who must also complete and submit an Incident Report (see Incident Reporting Policy).

# LEAVES of ABSENCE

## POLICY

Individuals in group living residential programs have agreed, and have made a commitment, to participate in these programs, which have been specifically designed, developed and staffed to accommodate their care/supervision needs and to ensure the delivery of the services stipulated in each person's individualized service plan. It is recognized, however, that individuals may be absent from a residential program for several reasons, including but not limited to the following: short-term hospitalization (medical or psychiatric admission); admission to a subacute or rehabilitation program; social/recreation events; and scheduled vacations.

MRC and Waiver case managers shall be informed of all LOAs.

## IMPLEMENTATION

### MRC/BI&SSCS funded Residential Programs:

All BI&SSCS contracts for residential services are unit rate based on an 85% utilization factor. Therefore providers are reimbursed for the full year's costs in a 310 day payment system. This allows for absences of up to 55 days without a provider experiencing any revenue shortfall. This approach is premised on the concept that the majority of residential costs associated with operating a 24/7 home are fixed regardless of the number of individual's residing there any given night.

1. It is expected that individuals served in residential programs will not exceed a total of 21 planned days/year out of the program (excluding time out of program for medical or other clinical reasons (e.g., psychiatric hospitalization). Requests for a LOA which exceeds the planned absences per calendar year (including vacations) require approval from MRC. A scheduled LOA shall require submission of a written request and the approval from MRC, if the period of time exceeds 21 days, either cumulatively within a calendar year, or continuously. When indicated, the approval process may include a clinical review. The written request shall also be accompanied by a plan, when indicated, regarding any modification in the established residential staffing pattern.
2. In the event a person is absent from a residential program, secondary to hospitalization (psychiatric or medical admission) or admission to a subacute or rehabilitation program, the case manager shall be informed immediately, via the filing of an Incident Report. During absences from the residential program secondary to such events, the Residential Program Director/Manager shall assume primary responsibility for monitoring the person's status; maintaining communication with key staff at the facility (e.g., attending physician) to which the person was admitted; maintaining communication with the individual's case manager; and developing a transition plan prior to the person's discharge.

In the event, an individual or his/her legal guardian (when applicable) refuses to return, or is determined to be inappropriate for return to a residential program, the Program Director/Manager shall be primarily responsible for developing an alternative disposition plan, in collaboration with key staff associated with the facility to which the person was admitted, as well as MRC supervisory and case management staff.

3. Under no circumstances shall a residential service provider organization abandon, or otherwise relinquish responsibility for, an individual who has been admitted to a hospital (including urgent care or the emergency room) or other short-term program/facility.
4. If an individual is absent from a residential program for any other reason, including reasons not necessitating an Incident Report, the designated case manager shall be notified immediately.

### **MRC/BI&SSCS funded Residential Programs – Extended Illnesses**

This policy is intended to address extended absences beyond 55 days that result in a bed vacancy totaling 69 days or more and not those situations where an individual may be absent from the home only a few additional days beyond that 55 day period of time that is already being reimbursed.

Residential providers delivering services to consumers of the BI&SSCS may request approval of payment for individuals whose absenteeism due to medical issues exceeds 69 days per fiscal year. Therefore the first 14 sick days beyond the 55 days being reimbursed through the established unit rate will not be billable. Requests may be submitted for day 70 forward but not to exceed an additional 60 days.

Each request must be accompanied by a description of the individual's medical situation, the total number of days out of service to date, anticipated return to program (if known) and the number of days for which the provider is seeking reimbursement. This request will be sent directly to the BI&SSCS Residential Supervisor and Director for review. Approval will be based on clear documentation and justification of an extended illness as defined above. The provider will be notified in writing of the agency's approval or denial of the request. If denied, an explanation will be included.

### **Waiver/Medicaid funded Residential Programs (includes TBI, ABI and MFP)**

Planned or unplanned LOAs **cannot** be billed for under the contract.

1. It is expected that individuals served in group living residential programs will not exceed a total of 21 days/year out of the program, excluding time out of program for medical or other clinical reasons (e.g., psychiatric hospitalization). Requests for a LOA which exceeds the planned absences per calendar year must be reviewed and approved by the case manager.
2. In the event an individual is absent from a residential program, secondary to hospitalization (psychiatric or medical admission) or admission to a subacute or rehabilitation program, the case manager shall be informed immediately, via the filing of an Incident Report. During absences from the residential program secondary to such events, the Residential Program Director/Manager shall assume primary responsibility for monitoring the individual's status; maintaining communication with key staff at the facility (e.g. attending physician) to which the individual was admitted; maintaining communication with the individual's case manager; and developing a transition plan, prior to the individual's discharge.

In the event, an individual or his/her legal guardian (when applicable) refuses to return, or is determined to be inappropriate for return to a residential program, the Program Director/Manager shall be primarily responsible for developing an alternative disposition plan, in collaboration with key staff associated with the facility to which the individual was admitted, as well as MRC and Waiver supervisory and case management staff.

3. Under no circumstances shall a residential service provider organization abandon, or otherwise relinquish responsibility for, an individual who has been admitted to a hospital (including urgent care or the emergency room) or other short-term program/facility.
4. If an individual is absent from a residential program for any other reason, including reasons not necessitating an Incident Report, the designated case manager shall be notified immediately.

## **MEDICAL MANAGEMENT POLICIES**

## **A. GENERAL HEALTH REQUIREMENTS**

### **POLICY**

All individuals shall be supported by residential program staff with respect to maintenance of their general health, prevention/progression of disease, and addressing, diagnosing, and treating any identified physical problem or disorder. Individuals shall also be assisted in complying with all medically prescribed treatments and directives recommended by their primary care physicians, medical specialists, rehabilitative or other clinicians. These efforts shall be evidenced in documentation of the supports delineated below, which shall be incorporated as specific objectives in each individual's service plan.

### **IMPLEMENTATION**

1. A primary care physician (PCP) shall be identified for each individual, prior to transition to a residential program. The PCP shall preferably be located in close proximity to the residential program; have admitting privileges at a local hospital in the event of a medical emergency; and be experienced in addressing the medical needs of persons with disabilities.
2. All individuals shall be scheduled for an annual physical and routine, age-appropriate laboratory, screening and diagnostic testing. Screening tests should, at a minimum, include Pap smears and mammography for women; colonoscopy (age 50 or older); prostate evaluation for men, and other tests specified in practice guidelines, established by the American Medical Association.
3. All individuals shall be provided with ongoing, health education to be provided by licensed or otherwise certified professionals. Should an individual exhibit difficulty in reading, visually accessing (secondary to visual impairments), or understanding (e.g., secondary to aphasia, cognitive compromise, etc.) the information regarding the health education, alternative methods for ensuring the individual's comprehension and retention of the information should be employed (e.g., audiotaping, large print format, re-wording for cognitive accessibility). Educational training sessions shall, at a minimum, focus upon the potentially serious medical consequences of illegal drug use, alcohol and smoking. When applicable, individual health educational sessions shall be provided on the nature and management of other medical conditions, such as seizures, diabetes, dysphagia, sexually-transmitted diseases, psychotropic medication, hepatitis and other medical conditions.
4. Supports provided around health education and health maintenance efforts shall be documented in progress reports.
5. All individuals shall be expeditiously referred to an appropriate clinician to assess, diagnose and treat all physical and mental health concerns, identified or reported by the individual, his/her legal guardian (when applicable), or residential staff. Documentation regarding clinical assessments, diagnostic procedures, and clinical recommendations shall be made available to individuals or their legal guardians (when applicable), as well as their case manager. With written permission from the individual or guardian, this

information can be shared with significant others, designated representative and relevant providers.

Last Revised: March 30, 2012

## **B. MEDICATION MANAGEMENT**

### **POLICY**

Qualified residential provider organizations shall be responsible for ensuring that residential staff have been certified under the Medication Administration Program (MAP) curriculum (see Supplemental Training for Residential Providers Policy), and that MAP guidelines regarding the administration of prescribed medications are utilized. In addition, all residential programs shall ensure that all prescribed and over-the-counter (OTC) medications, as well as administration equipment (e.g., syringes) shall be stored in a locked cabinet or room within the residential program. Medications prescribed, or taken, by individuals should be clearly labeled and separated within the locked storage cabinet or room. The provider organization shall also ensure that medications are accurately dispensed and that all medication administration be appropriately documented.

### **IMPLEMENTATION**

1. A typed Current Medication Regimen record shall be placed in each individual's file, as well as a medication log notebook. This Medication Regimen document shall always be current and include the following information:
  - a. Names (both generic and brand) of each prescribed medication and specific indications
  - b. Dosage and schedule of administration for each medication
  - c. Information regarding possible side effects which should be monitored by residential staff
  - d. Name and phone number of the prescribing physician
  - e. Information regarding allergies to medication
  - f. Names of OTC medications and administration guidelines
2. A copy of the Current Medication Regimen record shall accompany all individuals to scheduled medical appointments or any other medical encounters (e.g., emergency room).
3. For any errors made in the administration of medication, the prescribing physician or pharmacist, or when available, the residential program nurse shall be immediately contacted. In addition, an Incident Report shall be completed (see Incident Reporting Policy) and the Program Director/Manager, or on-call personnel, contacted. If qualified medical staff are not immediately available to evaluate the individual's condition and potential risks associated with the medication error, emergency medical care should be secured.

4. For individuals who exhibit a history of allergic reaction to medication, the Program Director/Manager shall ensure that these individual's wear a Medic Alert bracelet or necklace and/or carry a Medic Alert card.
5. If an individual declines medication, residential staff should seek to understand the nature of the individual's concern and reason for refusal. If appropriate, staff will assist the individual in communicating their concerns or questions to the prescribing medical professional. When this is not successful and the lack of compliance with taking prescribed medication places the individual at risk, the Residential Program Director/Manager shall refer the individual for clinical assessment with the prescribing physician (e.g., psychiatrist). If the individual's non-compliance with prescribed medication places him/her at risk for immediate and/or serious medical/health consequences (e.g., refusal of insulin injection), such situations necessitate emergency intervention to include hospitalization.

## **C. ASSESSMENT of CAPACITY to SELF-MANAGE MEDICATIONS**

When indicated, individuals who have not been adjudicated incompetent with respect to making medical decisions, and who have not been determined to require a Rogers monitor, should be evaluated to assess their capacity to manage prescribed medications.\* Such evaluations shall be performed by a qualified, licensed clinician (e.g., Program Nurse, Primary Care Physician), who is thoroughly familiar with the individual's clinical history, cognitive capacity and functional skills, as evidenced and documented by program staff. The use of a standardized assessment tool should also be included in the assessment process (e.g., MacArthur Competence Assessment Tool for Treatment).

Massachusetts law and ethical practice guidelines require that individuals shall be competent, with respect to making treatment decisions (e.g., informed consent to medication), and that individuals exhibit the requisite competence to participate in treatment or follow treatment directives, which includes prescribed medications. When an individual's competence is obviously impaired or judged to be potentially compromised, a clinical evaluation of competence is indicated and necessary. With respect to medication management and the ability to self-medicate, the following competencies shall be assessed:

- Mental Status
- Willingness, desire, and capacity to learn to self-medicate
- Physical capacity to self medicate (e.g., load and inject a syringe; remove medications from blister pack, etc.)
- Knowledge of prescribed medications and their indications
- Knowledge of, and ability to remember and adhere to, prescribed dose and schedule of administration
- Knowledge of contraindications and side effects of prescribed medications, as well actions to be taken should these occur
- Ability to follow universal precautions when indicated (e.g., syringe preparation, suppository insertion)
- Risk Level – e.g., history of suicide attempt by overdosing; past abuse of prescribed medications; past history of trafficking prescribed medications, etc.

Based upon the data derived from an assessment of these domains, informed decisions may be made regarding the capacity of an individual to self-medicate. While an individual may be judged to be incapable of self-managing his/her medications at the time he/she is assessed, a re-evaluation should be completed in response to documented improvement in the individual's cognitive/behavioral capacity. Should someone who is initially judged to be capable of self-managing his/her medication exhibit cognitive/psychiatric decompensation (e.g., onset of a dementing disorder), a re-evaluation would likewise be indicated. The need for re-evaluation should be addressed at least annually as part of the service planning process, as well as on a prn basis, when indicated. The need for re-evaluation should include the following indicators:

- Change in mental status
- Improvement/decline in cognitive status
- Change in the complexity of a prescribed medication protocol which calls into question the capacity of the individual to self-medicate
- Change in risk level or occurrence of significant incident related to medication administration

**\*NB:** Prescribed and OTC medications shall, however, be stored in a locked cabinet/room within the residential program (see Policy Re: Medication Management).

# **MONEY MANAGEMENT and STORAGE of VALUABLES**

## **POLICY**

Goals and objectives regarding the development of money management skills, to the extent possible, shall be incorporated into each individual's service plan. In addition, residential provider organizations shall provide, within the residence, secure place(s) for individuals to safely store spending money, ATM cards, checkbooks, credit cards and other financially-related materials/information (e.g., bank statements), as well as valuables (e.g., jewelry, watches, etc.). In general, it is assumed that the individual has a right to control his/her money unless they have a guardian or other legal representative designated to manage their funds.

## **IMPLEMENTATION**

1. The Residential Program Director/Manager shall assume primary responsibility for ensuring the safe storage of individuals' monies, valuables, and other financially-related material in either a secure, central area within the residence (e.g., staff office), or for encouraging individuals to store these items in a personal lock box, locker or other secure location within their room. If staff have stored money or valuables in a central area within the residence, the individual should be given a receipt for these possessions.
2. Residential staff shall not take or utilize any individual's ATM/credit card(s) or checkbook, but may accompany or supervise individuals during money management tasks, as stipulated in the individual's service plan.
3. Individuals shall be encouraged and assisted, when indicated, with respect to opening a bank account. Individuals should be discouraged from carrying substantial sums of money on their person or keeping these funds within their home.
4. When applicable, residential provider staff are expected to cooperate with an individual's legal guardian, power of attorney, representative payee, or conservator, in managing an individual's finances and expenditures.
5. In certain programs who serve individuals who exhibit a history of behavioral or psychiatric disorders, access to monies and ATM/credit card(s) may be restricted in order to address high risk behaviors (e.g., accessing illegal drugs, elopement, etc.), as part of a behavioral management plan that is discussed with and agreed to by the individual or substituted decision maker (if applicable) prior to implementation.
6. When the provider is assigned as the representative payee for an individual or manages the individual's funds, the provider will have a system in place for tracking all expenses and income. This information is available to the individual and/or the guardian at any time.

Last Revised: March 30, 2012

## **ON-CALL POLICY**

## **POLICY**

All qualified residential service provider organizations shall train and designate On-Call personnel to be available to residential programs, 24 hours/day, 365 days/year. Personnel chosen and designated for On-Call duty shall hold positions within the provider organization at a supervisory and/or administrative level, or may be licensed nurses, or mental health clinicians, who are employed by the provider organization. While larger scale provider organizations may designate more than one person to assume specific on-call responsibilities, there shall be a person, or persons, who are always available to residential staff and able to address and respond to the following:

- Emergencies related to the residence itself, to include, but not be limited to the following situations: loss of electrical power; flooding; fire; loss of heat or cooling systems; loss of water supply; need for repair of fixtures, appliances or other relevant household items.
- Need to relocate or evacuate individuals, in response to eviction, natural disasters (e.g., hurricanes, blizzards, etc.) or in the event the residence becomes uninhabitable.
- Incidents involving individuals and which necessitate filing of an Incident Report (see Incident Reporting Policy).

## **IMPLEMENTATION**

1. The provider organization's executive director, or designated administrative staff, shall be primarily responsible for ensuring that all staff assuming On-Call responsibilities are prepared and trained, with respect to all emergency response protocols developed by the provider organization. In addition, persons who are assigned responsibility for responding to incidents, as defined in the Incident Reporting Policy, shall participate in mandatory trainings developed and periodically provided by MRC.
2. A list of On-Call personnel and their access phone numbers shall be kept current, be posted within the residential program's staff office and be provided to the supervisory staff of MRC and the Waiver Units. In addition, this designated list of on-call staff will be provided to the individual's legal guardian or other designated family members.
3. All repair and other identified needs related to the residential property shall be addressed immediately.
4. In the event that individuals in a residential program need to be relocated or evacuated secondary to natural disaster, weather conditions, or the compromised operation or status of the residence, the supervisory staff of MRC and the Waiver case managers, shall be notified immediately and provided with detailed information and a proposed plan of action.
5. Relocation of individuals necessitates both a verbal and written incident report, which must be completed for each individual who is relocated.

# **PET POLICY**

## **POLICY**

Pets are permitted in residential programs contingent upon the individual(s)' ability and agreement to (a) assume primary, or share (e.g., among housemates), responsibility for caring for the pet; and (b) financially support the pet (e.g., veterinary care, food, etc.). In addition, there must be physical space within the residence to accommodate the pet, and the pet must not pose any potential risk to the individual or other individuals served by the program. Potential risks include, but are not limited to, dangerous breeds of dogs; venomous snakes, fish, or other animals; animals to which other individuals exhibit allergic reactions; or any animals which provoke an adverse psychological response (e.g., significant fear/phobic reaction) among individuals within a program.

## **IMPLEMENTATION**

1. The Residential Program Director/Manager shall assume primary responsibility for processing a request made by one or more individuals to own and care for a pet within a residential program. This process shall include the obtaining of approval from all the individuals within the program and the Program Director/Manager's confirming that no individual or staff within the program exhibits a history of allergic, or other adverse response to the chosen pet.
2. Owning and caring for a pet potentially provides an opportunity for individuals to develop and/or apply budgeting, planning, organizational, and leisure skills. However, the individual(s) shall, prior to purchasing or obtaining a pet (e.g., from a shelter program), be educated and made aware of all aspects of the pet's care and expectations, with respect to his/her responsibilities, which shall be delineated in writing accompanied by a daily pet care checklist.
3. An area within the residence must be designated for the pet and storage of pet supplies. This designated area should not interfere with the operation of the residential program or compromise access/use of common areas by other individuals within the program.
4. Should the individual(s) demonstrate that he/she is unable to care for a chosen pet, the Residential Program Director/Manager shall assume responsibility for developing an intervention plan, and if this should fail, for seeking alternative options for the pet.
5. Written permission must be obtained from the Program Director/Manager regarding the bringing of any pets onto the premises of any residential program by staff or visitors.

# PROGRAM FEES

## POLICY

All individuals in a residential program, their legal guardian or other substitute decision makers (when applicable) are required to contribute to the costs associated with their residential program-specifically room and board. Individuals shall contribute 75% of their income or less if required in order to allow an individual to retain \$200 per month for personal needs.\*

## IMPLEMENTATION

1. Program fees shall be collected by, and paid directly to, the provider organization, which in certain instances, also serves as the individual's representative payee.
2. Program fees shall be paid on a monthly basis, and designated residential program staff shall be responsible for ensuring that individuals are aware of, and have managed their available monies appropriately, to meet this program expectation.
3. For individuals and/or legal guardians who are non-compliant with this policy, the case manager should be notified.

***\*For TBI waiver and SHIP residential programs, this policy will go into effect beginning July 1, 2013.***

# **PROGRAM PARTICIPANT EXPECTATIONS**

## **POLICY**

All individuals in residential programs are expected to comply with basic Program Participant Expectations established for all residential programs. These guidelines were developed and designed to ensure the safety, health, wellbeing, and program participation for individuals, as well as to facilitate cooperation and mutual respect among individuals. Under no circumstances will this policy be used to evict an individual from their home. Non-compliance with these expectations should be addressed through the service planning process and may also require a Behavioral Management Plan.

## **IMPLEMENTATION**

- 1) The Residential Program Director/Manager shall assume primary responsibility for reviewing the Program Participant Expectations (see Appendix G) with a residential candidate and his/her legal guardian (when applicable), prior to transition to a residential program.
- 2) A copy of the Program Participant Expectations shall be provided to each individual and his/her legal guardian (when applicable). Should an individual exhibit difficulty in reading, visually accessing (e.g., secondary to visual impairments), or understanding (e.g., secondary to aphasia, cognitive compromise, etc.) the Program Participant Expectations, alternative methods for ensuring the individual's comprehension and retention of the information included in the Program Participant Expectations should be employed (e.g., audio taping, large print format, re-wording for cognitive accessibility). For individuals or guardians whose primary language is not English, the Program Participant Expectations should be translated into his/her primary language.
- 3) Residential staff or PCA staff (when applicable) shall provide assistance to individuals who exhibit physical challenges, with respect to the completion of personal care and hygiene tasks, delineated in the Program Participant Expectations.
- 4) Program Participant Expectations may need to be re-reviewed periodically, secondary to psychiatric or cognitive impairment (e.g., memory disorder) and when non-compliance with these guidelines has occurred.
- 5) When indicated (e.g., in behavioral residential programs), the Program Participant Expectations may need to be supplemented by an Individualized Behavior Management Plan, designed to address behavioral/psychiatric symptoms or problematic behaviors not specified in the basic Program Participant Expectations, or to promote compliance with the behavioral expectations delineated in the Program Participant Expectations.

# RECORD KEEPING

## POLICY

A file shall be developed for each individual residing in a residential program. Each individual's program file shall be kept electronically or in a loose leaf binder and stored in a locked file cabinet or room within the residential program, where they are accessible to residential program staff, the Waiver case manager and MRC staff during annual review. The individual's record must be available to the individual, legal guardian or lawfully authorized representative, and case manager upon request:

The individual's file shall contain the following documents in divided subsections of the binder:

- Emergency Fact Sheet which should be copied to accompany an individual in the event of an emergency room visit or hospitalization
- Copy of a guardianship decree or other documentation related to substitute decision-makers
- Copies of current release forms
- Typed list of current medications and their indications for use; schedule of administration; dosages; prescribing physician contact information; list of possible side effects
- Service Plan
- Specialized Medical or Other Protocols (e.g., dysphagia protocol)
- Behavior Management/Modification Plan (if applicable)
- Copies of Incident Reports for the current fiscal year
- Copies of records related to medical or other clinical consultations
- VNA records (when applicable)
- PCA records (when applicable)
- Miscellaneous (e.g., pertinent historical records)

As part of each individual's annual review, the individual's file shall be updated and records pertaining to the previous year, shall be archived in a secure (i.e., locked) storage area.

In addition, residential staff shall maintain a shift log and communication book to facilitate communication between shifts of residential staff. This document shall also be kept in a locked file cabinet or room within the residence, and log/communication notes shall be archived periodically.

# ROOM/PERSONAL POSSESSIONS SEARCH

## POLICY

All individuals in a residential program and their legal guardians (when applicable) shall be provided, at the time an individual is being considered for a residential placement, with a copy of the Program Participant Expectations (see Appendix G), which shall be reviewed prior to transition. Individuals must agree to refrain from bringing certain items into the residence which may potentially pose a risk to themselves, other individuals or staff. In certain residential programs which serve individuals who exhibit a history of high risk and/or dangerous behavior, additional items may be designated as contraband (see Sharps Policy).

The following search policy will be followed when residential staff have reason to believe that these prohibited items have been brought into, or are hidden within, the residential program or among an individual's personal possessions and present a danger to the individual and/or other individuals and staff in that home. In these instances, a room and/or possession search may be indicated and conducted, in accordance with the implementation guidelines delineated below.

## IMPLEMENTATION

1. Residential staff will inform the Residential Program Director/Manager or On-Call personnel in the event that a room and/or personal possessions search would appear to be indicated. The contraband items believed to have been brought into, or hidden within, the residence should be specified to the extent possible and the basis for their belief that such items are present in the home described.
2. A room and/or personal possessions search may also be warranted in the event an individual threatens to harm him/herself, other individuals, or staff. Residential staff should be particularly vigilant about such threats in residences where access to certain items (e.g., matches, knives, etc.) has not been restricted previously.
3. The Residential Director/Manager or On-Call personnel shall be primarily responsible for determining the need to conduct a room and/or personal possessions search and for documenting why the decision to conduct a search or not was reached.
4. Residential staff shall ask to speak with the individual privately and preferably within the staff office. The individual, and when applicable, his/her legal guardian, should be apprised of the perceived need to conduct a room and/or personal possessions search.
5. Residential staff should discuss with the individual, in a calm and non-provocative manner, the reasons for conducting a room and/or personal possessions search. If not significantly agitated, the individual will be allowed to be present for this search.

It is preferable and advised that at least two residential staff be responsible for completing a room and/or personal possessions search, so that one staff person may devote his/her attention to the search process, while the other staff person can be available to address the individual's response, questions, and concerns. In programs that serve individuals who exhibit a history of aggressive behavior, or in circumstances where the individual's mental status appears to be acutely compromised or deteriorated,

which at times may be secondary to drug or alcohol use, two staff persons may be needed to address the individual's response to the room and/or personal possessions search. In the event the individual's psychiatric presentation or behavior causes serious concerns regarding the safety of the individual or others, 911 shall be called immediately, and if determined necessary, the emergency services crisis program, and the room and/or personal possessions search process shall not be initiated in these circumstances.

6. While staff may need to examine the content of the individual's clothing (e.g., pockets, socks, shoes, etc.) during a search, residential staff shall request the individual's compliance and voluntary participation in this process. An examination of clothing, as well as other personal possessions (e.g., back pack, pocket book, etc.) shall preferably be conducted in the staff office. Two staff should be available for this.
7. Under no circumstances shall a residential staff person ask an individual to expose any body area/part, or touch/examine an individual's person during a personal possessions search.
8. Should staff have reason to believe that an individual has hidden contraband items in another individual's room, or other locations within the residence, these areas shall also be searched. The same steps described above shall be followed, with respect to the need to search the room and/or personal possessions of another individual. Such additional searches shall be conducted consecutively, and not at the same time.
9. An Incident Report shall be filed whenever a room and/or personal possessions search has been completed (see Incident Reporting Policy). A plan for addressing the individual's non-compliance with the Program Participant Expectations and/or other policies (e.g., Sharps Policy) shall subsequently be generated by the Residential Program Director/Manager.
10. An individual's room and personal possessions will not be routinely searched except in the following circumstances utilizing this procedure: certain individuals, who exhibit a history of high risk and/or dangerous behaviors, or who repetitively access/bring contraband items into the residence, may require a search of his/her personal possessions, whenever he/she has participated in off-site activities within the community. In such instances, the need to conduct routine searches of his/her personal possessions after community excursions may be indicated. These interventions shall be incorporated into an Individualized Behavioral Management Plan, the provisions of which are reviewed and agreed to by the individual and his/her legal representative, if applicable, and which can be reviewed and amended at anytime at the request of the individual. Incident reports need not be completed for each routine search, unless the outcome of these searches is positive (e.g., finding a weapon, drugs, etc.), or the circumstances of the search would necessitate the completion of an Incident Report (e.g., involvement of law enforcement, altercation between individuals, etc.).

# SHARPS

## POLICY

This policy only applies to individuals who exhibit behavioral or psychiatric disorders. In some instances, their clinical presentation has been complicated by a premorbid history of mental illness and/or post-traumatic stress disorder (PTSD). Behavioral symptoms may be evidenced in episodic aggression, self-injurious, suicidal, sexually-disinhibited and other behaviors which may place the individual, staff, or others at risk. For these reasons, programs who serve these individuals shall restrict and control access to sharp items, tools or instruments defined below, as part of the programmatic design and behavioral management plan regarding these residences. This risk factor should be identified during the initial assessment and addressed during the service planning process. Initiation and enforcement of a Sharps Policy may also occur in response to the unanticipated development of high risk behaviors by an individual.

However, all residential programs shall ensure that any tools, utensils or other devices which may pose potential risk for program participants due to unsupervised or improper use, be securely stored.

## IMPLEMENTATION

1. The Residential Program Director/Manager shall be primarily responsible for ensuring that the Sharps Policy is enforced in all residential programs **which have been determined to require the implementation of this policy.**
2. Access to the following items shall be limited and utilization (when applicable) shall be under the direct supervision of staff (e.g., razor for shaving):
  - All carving or serrated knives, metal knives, forks, and sharp/pointed serving/cooking utensils (e.g., barbecue forks)
  - Scissors
  - Needles (e.g., sewing, knitting, etc.)
  - Pocket/tool knives
  - Metal hair pins
  - Metal nail clippers
  - Razors, including disposable and electric razors
  - Metal tools
  - Metal wire
  - Metal lids from cans
  - Any other items known to constitute a "sharp" (e.g., glass in photo frames).
3. All sharps shall be stored in a locked storage cabinet or room.
4. A typed inventory list of all sharps which may be utilized by staff (e.g., cooking utensils) or an individual under direct supervision (e.g., razor) shall be generated by the Residential Program Director/Manager. Following any activity necessitating use of these items, designated residential staff shall be responsible for ensuring that these items have been collected and returned to locked storage. In addition, the entire inventory of sharps should be reviewed at least weekly, or more often if necessary.

5. Sharps utilized for cooking and food preparation shall never be left in a dishwasher, sink, or kitchen area.
6. The Residential Program Director/Manager, or On-call personnel, shall be contacted immediately should any sharps be determined to be missing.
7. A room or personal possession search shall be instituted to recover missing sharps, or in the event that an individual is suspected of being in possession of undocumented sharps (see Room/Personal Possession Search Policy).
8. In residential programs in which access to sharps has not been limited, the Program Director/Manager shall nonetheless ensure that any tool, utensil, or other device that could potentially cause unintentional harm to an individual, secondary to improper or unsupervised use, be securely stored and utilized by individuals only under the direct supervision of program staff.

Last Revised: March 30, 2012

# SMOKING

## POLICY

Smoking of legal substances by individuals is permitted, between 8am and 10pm, in designated areas, located away from entrances and outside residential programs. A smoke-free environment, within the residence, shall be maintained and enforced by residential program staff. Additional implementation guidelines are delineated below.

## IMPLEMENTATION

1. All individuals who wish to smoke in a designated area outside a residential program shall be assessed, upon admission, with respect to his/her capacity to safely engage in this behavior. In the event that an individual cannot demonstrate that he/she can engage in this activity safely, he/she shall not be permitted to smoke, or to do so under the close, direct supervision of staff.
2. While smoking is permitted, between the hours of 8am and 10pm, in designated areas outside residential programs, all individuals shall be educated, at least twice annually, regarding the addictive, carcinogenic, and other physically deleterious consequences associated with smoking cigarettes and cigars, as well as the use of other tobacco products (e.g., chewing tobacco). Individual education shall be provided by a qualified, trained educator, and training materials shall be accessible (i.e., cognitively, linguistically and visually).
3. All individuals who smoke shall be actively encouraged, with respect to participating in a smoking cessation program. For these individuals, educational goals regarding the serious consequences of smoking shall be incorporated, as specific behavioral objectives, in his/her service plan, with the individual's agreement, or the agreement of a guardian (when applicable).
4. Under no circumstances shall cigarettes, cigars, or tobacco products be used as reinforcers in the context of a behavior modification program (see Policy regarding Prohibited Behavioral Interventions). However, smoking cessation strategies may be implemented with the consent of the individual or his/her legal guardian.
5. In residential programs which serve individuals who exhibit certain high risk behaviors or a history of arson, all smoking-related igniting devices shall be stored in a locked area. Items to be locked include lighters, lighter fluid, matches, and other incendiary devices.
6. Staff employed by residential provider organizations shall not smoke within residential programs (i.e., within the house/apartment) and shall in no way promote smoking by individuals. Related to the latter, staff breaks, during which time they may choose to smoke, shall be scheduled not to coincide with smoking breaks scheduled by individuals. Further, in residential programs which provide for only one (1) overnight staff member to supervise and be responsible for individuals, this sole staff person shall not leave the residence for the purpose of smoking.

# SUPPLEMENTAL TRAINING for RESIDENTIAL STAFF

## POLICY

In addition to the policies for all qualified providers, residential provider organizations are additionally responsible for ensuring that all residential staff are oriented and trained in the following categories and topic areas:

### General Training Requirements

- Medication Administration Program (MAP) training and certification, developed in collaboration with the Massachusetts Department of Public Health
- Content of the MRC Practices, Policies and Procedures and Supplemental Policies for Group Living Residential Program Providers

### Individual-Specific Training Requirements

During the first month of their employment, the Program Director/Manager shall also ensure that all residential staff are held responsible for reading and comprehending the following:

- All individual-related documents, to include, but not be limited to the following:
  - Clinical History
  - The individual's Service Plan and related assessments
  - Specialized Protocols regarding the management of seizures, dysphagia, utilization of assistive technology devices, transfer/transport of individuals, ADL assistance, and any other individual-specific care protocols
  - Behavioral Management Plan (if applicable)
- Any other individual-specific training and/or documents

**Residential provider organizations shall not expect, or require, any newly-hired staff working in group living programs, who have yet to complete the required trainings for all providers and those specific for residential providers, to be independently responsible for the care, or sole management, of individual(s).** Newly-hired staff, who have not yet completed these training requirements may, however, care for or provide services to individuals, under the direct supervision of a staff member who is on-site and who has completed all required trainings.

## **MRC-Sponsored Training on Acquired Brain Injury**

All newly hired Program Directors/Managers working in group living programs who serve individuals with brain injury are also required to attend the Core Training developed, sponsored and provided by the BI&SSCS of the MRC. This training program is held in a central location within Massachusetts, and topic areas reviewed include:

- Orientation to the Brain Injury and Statewide Specialized Community Services Department of the Massachusetts Rehabilitation Commission and the Waiver Programs
- Overview of Acquired Brain Injury and associated disabling conditions
- Review of the neurobehavioral/neuropsychiatric disorders associated with Acquired Brain Injury
- Family Response to Acquired Brain Injury

Residential Directors and House/Site Managers are also mandated, on a periodic basis, to attend and participate in trainings pertaining to MRC administrative policies, procedures, and protocols. In addition, and in order to enhance the skills and expertise of Program Directors/Managers, seminars are offered, and at times mandated, regarding clinical and programmatic topics. Affiliated community-based provider organizations (e.g., day habilitation) and other professional staff working within a residential program (e.g., program nurse) are also welcome to participate in these training programs, developed and provided by the MRC.

It is anticipated and expected that Program Directors/Managers, who have participated in the trainings described above, will be instrumental in sharing the information provided in these training programs with the staff whom they supervise, either directly, when applicable, or through their informed and educated management of staff and through their enhanced understanding of, or provision of services to, individuals served in residential programs.

### **Documentation**

The provider organization and Program Director/Manager shall be primarily responsible for ensuring and documenting staff attendance and participation in all staff training activities/requirements. Documentation records shall be made available and provided, upon request, to MRC administrative/supervisory staff, who are responsible for oversight and ensuring contract compliance, with respect to all residential programs.

### **Non-Compliance**

Failure on the part of a provider organization to ensure compliance with employee training requirements is regarded as a very serious breach of the signed contractual agreement between the provider organization and the Massachusetts Rehabilitation Commission. Most importantly, staff who have not been adequately and appropriately trained and supervised, place individuals at risk and compromise their quality of life. It should, therefore, be recognized that provider organizations and all employees hired by that organization shall be held strictly accountable, with respect to their compliance with required staff training. The provider organization and its employees shall also be reported to the Disabled Persons Protection Commission (DPPC) in response to any and all incidents involving an individual(s)

who has been the documented, or suspected, victim of neglect, abuse, or other significant adverse effects arising wholly, or in part, from a staff person's failure to be provided with or to fulfill training requirements.

Last Revised: March 30, 2012

# TELEPHONE, CABLE and INTERNET USAGE

## POLICY

Each residential program shall install and maintain phone service for use by individuals in residential programs, and these phones shall be available to individuals to receive and make calls and must offer individuals a reasonable level of privacy in making and receiving calls. The cost of this phone service, which should include a long-distance flat rate provision, is absorbed by the program. However, the phone line (i.e., phone and jack) utilized by individuals should be separated from any answering or fax machines utilized by program staff.

Some residential programs also make available to individuals the use of a computer, within common area space, and access to the Internet. However, no confidential information or program-related data should be entered or stored on computers designated for use by individuals, who should also be provided with, and taught to utilize, passwords for personal e-mail. Computers installed for use by individuals are not to be utilized by residential program staff, and the cost of the computer and Internet service is absorbed by the provider.

Should an individual wish to purchase/install a cell phone, landline phone service, subscribe to a cable/Internet service, or purchase his/her own computer, the costs associated with these products/services shall be entirely assumed by the individual, or his/her legal guardian or representative payee (when applicable). However, for certain individuals who exhibit a history of high risk behavior, or victimization, secondary to Internet or phone contacts, access to private phones and/or computers may be denied or limited, as part of a behavioral management plan and the service planning process. Limitations on an individual's communication access shall be discussed with and explained to the individual, and their legally authorized representatives (if applicable), and in all instances be the least restrictive limitation that is clinically appropriate and effective. Limitations on communications access must be regularly reviewed.

Dated: March 30, 2012

# **UNSUPERVISED TIME IN RESIDENCE/COMMUNITY**

## **POLICY**

To the extent possible, individuals should be supported in attaining and exercising independence, and in participating in meaningful activities within the community, including employment opportunities, in the absence of supervision. However, some individuals may need assistance or direct supervision secondary to their behavior management needs, cognitive impairment, physical challenges, and/or medical status. Plans for increasing independence as well as unsupervised time should be incorporated into the service planning process.

## **IMPLEMENTATION**

With respect to considering the ability of an individual to independently engage in activities within the community without supervision and/or be at home without supervision, the following steps shall be completed:

1. Completion of a home safety/risk assessment or community safety/risk by a licensed clinician, in collaboration with program staff.
2. Depending upon the findings generated by the home and community safety assessment, a plan shall be developed in conjunction with the individual designed to facilitate the individual's goals for independence. This plan shall be developed by a licensed clinician and include graduated steps, as well as both a definition of the circumstances under which an individual may be left alone/unsupervised within the residence and a definition of the circumstances and specific activities in which the individual may participate within the community and in the absence of supervision.
3. A behavioral contract, which includes the stipulated plan, shall be developed with the individual and his/her legal guardian (when applicable).
4. Plans developed to promote independence within the community shall also incorporate training, when applicable, regarding utilization of public transportation (see Transportation Policy).
5. All staff who work directly with the individual shall be trained, with respect to the implementation of the plan; methods for monitoring the individual's behavior/response; and other responsibilities (e.g., securing the residence, mechanisms for accessing staff, etc.).
6. Should an individual not follow the agreed upon plan and behavioral contract designed to facilitate unsupervised time within the residence or community, or should any unanticipated events or behaviors of clinical concern occur, the Residential Program Director/Manager shall be responsible for immediately contacting the clinician who developed the plan. The individual's participation in unsupervised activities shall be suspended at that point, until the individual's status and ability to successfully participate in the plan has been thoroughly re-assessed.



# VACATION POLICY

## POLICY

It is the expectation that qualified residential provider organizations will support and facilitate the development of the recreational/social skills of all individuals. These efforts shall be documented and evidenced in each individual's service plan as specific behavioral objectives, which may include vacation planning. Vacation planning shall always include the individual and his/her legal guardian, as well as family members and significant others, when applicable. Additional implementation guidelines are reviewed below.

## IMPLEMENTATION

1. The Residential Program Director/Manager shall be responsible for ensuring that vacation planning skills and related activities are incorporated in the service planning process.
2. Vacation planning shall reflect an understanding and accommodation of the individual's abilities, challenges, financial resources, and specific needs, to include personal care, medication administration, behavioral management and implementation of specialized care protocols.
3. As a planned vacation represents a type of leave of absence (LOA) (see Leaves of Absence Policy), the Waiver or MRC case manager shall be informed of any planned vacations which are not expected to exceed more than 21 days per year. Any absences which exceed the maximum number of days require the approval of the MRC or Waiver case manager.
4. For BI&SSCS funded programs, staff and other associated travel costs related to a recreational group experience shall be assumed within the existing contract obligations. However, individuals are expected to financially contribute to the costs of such events.
5. Individuals may chose to plan vacations, which require the assistance/supervision of a residential staff member of the provider organization. In these instances, the individual, or his/her legal guardian, shall assume all costs related to travel, accommodations, and salary for the staff member who accompanies him/her on vacation. The provider organization shall develop a method for selecting and training residential staff who accompany individuals on vacations. In addition, staff shall comply with all established policies and procedures established for residential programs, and in particular, policies related to staff expectations and requirements, when accompanying individuals on vacations.
6. Any vacation which entails travel outside of the Commonwealth of Massachusetts, regardless of the duration, requires the approval of the Waiver or MRC case manager. A detailed plan, which shall include the complete itinerary (e.g., travel methods, accommodations, etc.) shall be submitted with the request for approval.

## **APPENDIX A**

**Brain Injury & Statewide Specialized Community Services Department  
Massachusetts Rehabilitation Commission**

**BEHAVIOR INTERVENTION PLAN (BIP) REVIEW FORM**

<b>A. Identifying Information</b>	
<b>Name:</b>	<b>DOB (Age):</b>
<b>Legal Status:</b>	<b>Roger's Monitor:    Yes        No</b>
<b>Resident's Primary Language:</b>	<b>BIP Author:</b>
<b>Guardians' Primary Language:</b>	<b>BIP Author Role:</b>
<b>Residential Program:</b>	<b>BIP Date:</b>
<b>Service Coordinator:</b>	<b>BIP Review Date:</b>

<b>B. BIP Required Elements</b>	<b>Present</b>	<b>Not Present</b>	<b>Comments</b>
1. Client information (name, DOB, age, legal status, primary language)			
2. Consent/assent by individual and guardian, if applicable			
3. BIP author and role/position			
4. BIP implementation date			
5. Behavioral profile or summary (clinical, functional analytic, and/or target behavior history; must include behavioral data to support BIP)			
6. Evidence of coordination with an outside provider, if applicable (e.g., medication treatment)?			
7. Target behaviors identified and defined			
8. Behavior interventions or procedures are clearly identified			
9. Crisis and/or adverse response plan			
10. Data collection methods identified (e.g., dimensions of behavior, context, interval)?			
11. BIP review interval/date specified			
12. Specify additional considerations for this resident or plan:			

<b>C. BIP Quality Review</b>	<b>Yes</b>	<b>No</b>	<b>Comments/Recommendations</b>
1. Is the BIP author a licensed clinician?			
2. Is the BIP written in plain language with non-technical terms (easily understood by resident given their level of cognition and staff)?			
3. Are BIP target behaviors identified in clearly observable and measurable terms?			
4. Desired alternate or replacement behaviors are identified?			
5. Are methods for teaching alternate/replacement behaviors identified?			
6. Methods of staff response to the target behavior(s) are clearly identified?			
7. Does the BIP specify who/which staff will respond to the target behavior(s)?			
8. Does the BIP include interventions to increase adaptive behavior? If so, are reinforcement procedures clearly identified (who will provide reinforcement, when it is available, and how much is available)?			
9. Does the BIP include interventions to decrease maladaptive behavior (time-out, response cost, loss of privileges)? If so, is the criterion for fading reduction techniques identified?			
10. Does the BIP include any BI&SSCSS prohibited behavioral interventions (e.g., excessively restrictive or intrusive procedures, restraint, denial of access to food)?			
11. Does the BIP include a backpack and/or room search procedure for contraband? If so, was an assessment conducted and documented to support the procedure?			
12. Does the BIP target (a) home alone time and/or (b) independence in the community? If so, was a safety risk assessment conducted and adequately documented?			
13. Does the BIP include a "level system"? If so, is there an assessment and rationale supporting its development (e.g., safety risk assessment) and is it appropriate for the risk determination?			

14. Is a crisis and/or adverse response plan adequately specified and clinically appropriate?			
15. Are safety concerns adequately addressed and clinically appropriate?			
16. Is the schedule of when, how and by whom the BIP will be reviewed clearly specified and reasonable (e.g., new plans should be reviewed within 30 days)?			
17. Other considerations (note below and comment):			

***D. BIP Review Committee Determination***

Determinations must specify (please check):

Approved without revision

Approved with Required Modifications

Disapproved with Required Modifications

Requires Immediate Cessation Due to Violations of BI&SSCSS Policies and Procedures and/or Ethics Determinations

Additional Comments:

Deadline for Resubmission of Behavior Intervention Plan:

***E. BIP Review Committee Participant List and Signature of BIP Review Chair***


Chair:

Date:

## **APPENDIX B**

## CONFIDENTIALITY TEMPLATE FORM

All provider staff shall maintain a policy of strict confidentiality regarding information pertaining to an individual.

However, Massachusetts State Laws specify certain circumstances when professionals may be required to disclose confidential information. These include the following circumstances:

- a. An individual is judged to pose a danger to self.
- b. An individual communicates his/her intent to harm another identified individual. The law requires that the identified victim(s) be warned and/or that information be released (e.g., to police authorities) to protect the potential victim(s).
- c. If a provider knows or suspects that a child under the age of 18 is being sexually, physically, or emotionally abused, or neglected, he/she is mandated by state law to file a report (51A) with the Department of Children and Family Services (DCFS).
- d. If a provider knows or suspects that a physically or mentally disabled person between the ages of 18 and 59 is being sexually, physically, or emotionally abused, financially exploited, or has died, he/she is mandated by state law to file a report (19C) with the Disabled Persons Protection Commission.
- e. If a provider knows or suspects that an elderly person (i.e., age 60 and older) is being physically or emotionally abused, financially exploited, or has died as a result of abuse, he/she is mandated by state law to file a report with the Executive Office of Elder Affairs.
- f. A judge orders a provider to disclose confidential information. In such instances, provider's legal counsel, the individual's legally authorized representative, and the MRC legal office should be notified of this request, prior to the release of confidential or protected health information.

I have read, understand and have received a copy of the Confidentiality Policies.

\_\_\_\_\_  
Signature of Individual

\_\_\_\_\_  
Date

\_\_\_\_\_  
Signature of Legal Guardian (if applicable)

\_\_\_\_\_  
Date

\_\_\_\_\_  
Provider Staff Member

\_\_\_\_\_  
Date

## **APPENDIX C**

# **EMERGENCY EVACUATION SAFETY PLAN MANUAL**

***Any and all references to the DDS in the referenced policies and regulations below should be read as references to the MRC and any references to area office should be read as references to MRC or Waiver case management staff.***

## **I. Introduction**

Since 1995, the Department of Developmental Services has required provider agencies of day, residential, and site based respite supports to develop a safety plan for each service site. The purpose of the safety plan is to demonstrate how all individuals supported at a specific site would be supported to evacuate safely in an emergency.

The safety plan process outlines the procedure for compliance with the safety section of the DDS regulations, 115 CMR 7.08. It recognizes that individual safety should be viewed in a holistic manner, as safety is composed of a number of inter-related factors including individual capabilities and needs, staff support and training, environmental modifications and adaptive technology. Although guidelines were developed that outlined 10 required components for all safety plans, there was no mandated format for plan development.

While the safety plan process has been an important and valuable tool in ensuring individual safety, the lack of a standard format for the development of safety plans led to variability in expected plan format and requirements between DMR Area Offices. Additionally, the narrative format of the safety plan was time consuming and was not found to be the most effective teaching tool for staff.

In response to these issues, a number of changes have been developed that streamline and standardize the process while maintaining the original intent of safe evacuation in an emergency. Input was gathered from both the DDS and provider agency community and proposed changes were piloted in all areas of the state.

Based on all of the input received, the safety plan process has been revised with the key elements as follows:

- While recognizing the importance of ensuring individual safety in a variety of areas, it is important to maintain the limits of the safety plan process to the original intent of safe evacuation in an emergency. Other areas of safety should be addressed through other identified processes.
- The name “Safety Plan” in many ways became a misnomer, in that safety plans often took on a broader meaning than the original intent. This further contributed to the wide variation in requirements for acceptable safety plans. In an effort to focus the safety plan process on safe evacuation only, the Safety Plan is being renamed the Emergency Evacuation Safety Plan.
- The Emergency Evacuation Safety Plan continues to cover the essential elements as required in the original safety plan process.
- Provider agencies will now complete Emergency Evacuation Safety Plans using a standardized format. There are separate forms for work/day supports and for residential supports (which includes site based respite supports).

- Individuals who receive less than 15 hours a week of provider agency support will not utilize the Emergency Evacuation Safety Plan format to address evacuation safety. The involved DDS Area Office and provider agency should address the safety needs of these individuals through other processes.
- Individual assessments will continue to be completed at the time of each individual ISP. Office to address these concerns.

## **IV. Individual Assessments**

### **A. Introduction**

The cornerstone of the Emergency Evacuation Safety Plan is an assessment of the unique capabilities and needs of each individual. It is from this assessment that a determination is made concerning the adaptations an individual may require in order to be safe in their residential or work/day support. The assessment of each individual's capabilities and needs is combined with the assessment of other individuals being supported at the same residential or work/day location to form the basis for the location specific Emergency Evacuation Safety Plan.

The Individual Service Plan (ISP) is the most appropriate context for this assessment to be completed. DDS regulations specifically require an assessment of the safety and ability of the individual to evacuate (with or without assistance) their home within 2 ½ minutes or their work/day support in a timely manner. The assessment should describe the supports needed (i.e., skill teaching, staffing assistance, environmental modifications) to assist the individual to be as independent and safe as possible.

As with any assessment conducted as part of the ISP process, the individual safety assessment should be guided by the following principles:

1. It should focus on strengths and abilities rather than weaknesses. Therefore, it should focus on providing "safe roads to independence" rather than an exclusive focus on risk prevention.
2. It should result in a determination of which supports are the least restrictive and most appropriate for the individual.

### **B. When Assessments Should Be Done**

The individual safety assessment should be completed at the time of the Individual Service Plan development, with follow-up assessments as determined necessary by the Individual Service Plan team. The assessment and safety strategies associated with it should be reviewed by the team when the individual's health, mobility or other capabilities affecting safety and evacuation change.

### **C. Guidelines**

In order to assess an individual's skills and abilities to evacuate the home or work/day support in the event of an emergency, the Individual Service Plan team must ask the following key questions:

1. ***Can the individual recognize danger or an alarm that signals danger?***
2. ***Can the individual respond appropriately to danger or an alarm that signals danger?***

**3. Can the individual evacuate in 2 ½ minutes from a residential support or in a timely manner from a day/work support with or without assistance? If the answer to this question is “yes,” are any supports being provided?**

**Guidelines**

Members of the ISP team need to come to the ISP meeting prepared to answer the above questions. There are a number of effective formats that can be used to arrive at these answers. Provider agency staff, service coordinators and others should use tools that have been effective in the past, that include both individual responses to specific questions, knowledge of staff or family familiar with the individual, and actual observations of behavior in emergency situations or drills. Regardless of what format is utilized, the Individual Service Plan team must be able to determine the following:

- Can the individual recognize a fire or other emergency that would require evacuation?
- Can the individual call 911 or staff for help?
- Can the individual leave their home or workplace through the appropriate main exit or through an alternative exit if the main exit is blocked?
- Can the individual respond when they are asleep as well as when they are awake?
- Can the individual respond independently, or do they need verbal and/or physical prompts or hands-on physical assistance?

**4. If the individual is not able to evacuate independently, what are the individual characteristics that affect his or her ability in these areas; e.g. health, mobility cognitive level, behavior?**

**Guidelines**

If an individual cannot recognize danger or respond appropriately, it is important for the ISP team to understand why this is so. The primary rationale for assessing these areas is so that the team may more appropriately determine what types of supports an individual needs.

The ISP team should review the following domains:

**a. Health**

- What conditions exist that might impede an individual’s response time, or which may be exacerbated under the stress of an emergency? This would include conditions such as heart disease, stroke, seizure disorder, Alzheimer’s disease, mental illness, cerebral palsy, and respiratory illness such as asthma.
- Is the person ambulatory, non-ambulatory, or in need of assistance to walk? Can the person transfer independently?
  - Is the person hearing impaired or visually impaired?
  - Is the person taking any medications that might impede response time?

## **b. Cognitive Level**

- Is the person able to understand and follow directions?
  - Can the person communicate his or her needs?
    - Can the person be educated to understand and respond to emergency situations?

## **c. Social and Behavior Needs**

- Will the person cooperate when necessary?
- Does the person become anxious easily?
- Is the person afraid of unfamiliar people, such as a new or relief staff person?

## **5. What supports are necessary to assist the individual to evacuate safely within 2 ½ minutes from a residential support or in a timely manner from a work/day support?**

## **Guidelines**

The final and most important question that must be answered for the individual safety assessment relates to what supports need to be provided in order to assist an individual to safely evacuate a home in 2 ½ minutes or a work/day support in a timely manner. In all likelihood, there will be a variety of supports that will be used in combination. It is incumbent upon the ISP team to consider those supports that are the least intrusive measures available to support an individual. They should be respectful of an individual's dignity, privacy and need for as much independence as possible. The ISP team should look at the following:

- What supports are currently in place? Are they sufficient?
- What are the most effective methods to help the individual become familiar with and responsive to an Emergency Evacuation Safety Plan?
- What adaptive devices (e.g., bed shakers, visual alarms, enhanced 911 systems, walkers, wheelchairs) can be provided to assist an individual in an emergency?
- What environmental modifications (e.g., first floor bedroom, proximity to exit) should be considered?
- What staffing supports and what staff training are required?

## **D. Summary**

When completed, the individual assessment should provide the individual, family, Area Director, service coordinator and provider agency with a thorough analysis of the person's support needs. The next step, which is outlined in Section V, details the components of the Emergency Evacuation Safety Plan.

## **V. Emergency Evacuation Safety Plan Guidelines**

### **A. Introduction**

Emergency Evacuation Safety Plans must be completed on the forms located in the appendix of this manual. There is a separate Emergency Evacuation Safety Plan form for work/day supports and for residential supports (which includes site based respite supports).

It is planned for the EESP forms to also be available on the DDS Website so that providers can choose to download the forms and complete them electronically. However, the forms cannot be submitted electronically, in compliance with HIPPA requirements.

Although each plan will be developed in a specified format, each Emergency Evacuation Safety Plan will be unique to each residential, respite or work/day location. Individuals, staff (if present), and the residential, respite or work/day location itself will vary; therefore each location's approach to safety will be different. There will be different ways to achieve safety in different settings and with different individuals.

Three key building blocks are examined through the Emergency Evacuation Safety Plan: individual needs, the physical environment and staff. A careful analysis of these three factors will determine the character and emphasis of each plan.

The Emergency Evacuation Safety Plan formats contain 10 key areas and are intended to be a reflection of the capacities of the individuals being supported. The plan should assure safety, but it should not restrict or overprotect people or interfere with their activities. Individuals should not be considered passive "benefactors" but should be integral contributors to their safe evacuation from their residential or work/day location.

The 10 elements that are addressed in the Emergency Evacuation Safety Plan are:

1. Environmental standards
2. Individual abilities and safety strategies
3. Adaptive technology
4. Group interactions/dynamics
5. Staff
6. Evacuation
7. Fire Drills
8. Methods to notify police, fire, emergency personnel, provider on-call staff, families and DDS
9. Transportation and immediate temporary resettlement
10. Continuity of services and supports

In each location, the interplay of these ten factors will vary and this will be reflected in the Emergency Evacuation Safety Plan. For example, one scenario could be four individuals with a long history of

successful evacuations during fire drills living in a single story ranch house. The house design is basic. There is nothing unusual about the house or the home environment that would cause excess risk. The individuals do not have any special mobility or health concerns. Based on an assessment of all these factors, the Emergency Evacuation Safety Plan would be very straightforward in addressing the required elements.

On the other hand, should these variables change in any way, the provider may need to change the emphasis of the plan. Should the design of the home be such that it poses additional risk, then adaptations such as a fire suppression system may be considered. Should the individuals have hearing deficits, then adaptive equipment such as flashing strobe lights and bed shakers could be tied into a fire alarm system.

## **B. Emergency Evacuation Safety Plan Documents**

Please note that the actual Emergency Evacuation Safety Plan documents themselves have basic instructions for completing the forms that will make the documents easier to complete and understand. Through this manual more complete guidelines for completing the plans are provided and are divided into five distinct categories: homes providing 24 hour supports, homes providing less than 24 hour a day supports but more than 15 hours per week of support, shared living/home sharing, site based respite supports and work/day supports.

## **C. Revised Emergency Evacuation Safety Plans**

If individuals do not evacuate in 2 ½ minutes from a residential support or in a timely manner from a work/day support, it is the provider's responsibility to notify the appropriate Area Office(s) of the issue and how the evacuation need is being addressed. Depending on the circumstances, the need could be addressed in one of the following ways:

Verbal Plan for Resolution – This action would be appropriate for a situation that has just developed and the provider is determining whether this is an ongoing issue. For example, one individual who has typically exited independently does not exit within 2 ½ minutes during an asleep drill. The provider would inform the Area Office of the difficulty and could state that another drill will be done within a specified period of time to see if this difficulty needs further intervention.

Addendum to Existing EESP – This action would be appropriate for a situation that is considered temporary in nature and requires a short term response. For example, in the illustration outlined above, the provider may determine after doing another drill that this situation requires a more involved intervention, such as a short term teaching program so the individual understands the importance of exiting during practice drills. The provider would inform the Area Office(s) of the ongoing difficulty and submit an addendum to the existing EESP outlining the training program to be implemented and the length of time expected for resolution.

Revised EESP – This action would be appropriate for a situation that requires a permanent revision to the safety plan. In the above example, the provider may find that the teaching program is not successful in ensuring that the individual again exits independently during asleep fire drills. In order to ensure safe evacuation at night, staff need to physically prompt the individual to evacuate. Since this situation now requires a permanent change in the supports provided for safe evacuation, the Area Office(s) should be notified and a revised EESP submitted for approval.



## D. Plans For Homes Providing 24-Hour Supports

COMPONENTS	DDS REGULATORY REQUIREMENTS		
1. Individual Safety Strategies	Derived from Assessments in ISP		
2. Group Interactions	115 CMR 7.08(3)(b)2 Provider Analysis		
3. Environmental Standards	Provider Leased/Owned  115 CMR 7.07(1)-(8) a. two means of egress b. fire extinguisher c. interconnected smoke detectors d. sealed vertical chutes e. no locks on bedrooms with access to egress f. locks on bedroom doors with no access to an egress g. bedroom at grade for people with mobility impairments h. no smoking in bedroom	Individually Leased/Owned  115 CMR 7.07(1)-(2)	<u>PLANS</u>  <u>FOR</u>  <u>HOMES</u>  <u>PROVIDING</u>  <u>24 HOUR</u>
4. Adaptive Technology	115 CMR 7.08(3)(b)4 Derived from Assessments in ISP		<u>SUPPORTS</u>
5. Staff	115 CMR 7.06(3)(a)-(e) a. 3 or more individuals requiring assistance: 2 staff at all times b. 5 or more individuals, 2 or more requiring assistance: 2 staff at all times; c. 1 or more requiring assistance: Required staff must include 1 overnight awake		
6. Evacuation	115 CMR 7.08(3)(b)6 2 ½ minutes with or without assistance		
7. Fire Drills	115 CMR 7.08(3)(b)7 a. Quarterly drills b. Two of which shall be night-time		
8. Notification to Police/Fire	115 CMR 7.08(3)(b)8 Provider knowledge of local resources		
9. Transportation/Resettlement	115 CMR 7.08(3)(b)9 Provider/Area Office Collaboration		
10. Continuity of Services & Supports	115 CMR 7.08(3)(b)10 Provider/Area Office Collaboration		

## **Homes Providing 24 Hour Supports**

### **Introduction**

The guidelines in this section refer to all situations where individuals are receiving 24-hour provider agency staffed supports in homes when those supports are offered and controlled by a public or private provider agency. Provider agencies offering 24-hour supports are required to develop Emergency Evacuation Safety Plans even if the individuals own or lease their own home. In this latter instance all components of the Emergency Evacuation Safety Plan will apply except for the environmental requirements of 115 CMR 7.07 outlined under “General Safety Requirements.”

The guidelines in this section are intended to provide the safeguards necessary for individuals who require the greatest level of support in order to live safely in their homes. As such, the key building blocks of staffing and environmental requirements rely heavily on the regulatory and building code requirements as applicable in 115 CMR Chapter 7.00.

Provider agencies proposing alternatives to any of the requirements in 115 CMR 7.06 (3) (a)-(e) (staffing requirements), 7.07 (environmental standards), or 7.08 (safety), must recognize that there will be a substantial “burden of proof” imposed upon them to demonstrate how alternative approaches safeguard individuals whom they support.

### **Specific Guidelines For The Plan**

#### **GENERAL INFORMATION**

**Date of Completion** – date the plan is developed

**Agency** – provider agency’s full name

**Address of Residential Support** – address of home for which the plan is developed

**Names of Individuals Served At Site** – names of all individuals living in the home

**Home is owned/rented/leased by** – indicate in box provided whether the provider agency or all of the individuals living in the home own/rent/lease the home

**Type of Residential Support** – put an X in the box for “24 Hour Staffed Home.”

**Type of Building** – put an X in the appropriate box that best describes the home. Only one box should be marked. Fill in, as appropriate, the number of floors in the home, including the basement, or the floor(s) the home is located on in a multiple family or apartment building.

When identifying the floors that bedrooms are located on, use the following guide:

Basement – partially below ground floor.

1<sup>st</sup> floor – ground level floor

2<sup>nd</sup> floor – floor one story above ground level

## **ENVIRONMENTAL STANDARDS**

**Fire Safety Equipment** – put an X in as many boxes as apply for this home. Under “other,” list any additional equipment that is not included; e.g. fire extinguishers in other parts of the home beyond the kitchen.

**Floor Plan** – a floor plan should be developed, using page 13 of the EESP form, for each floor of the home used by the individuals living in the home. Add additional pages as needed. Each egress should be clearly marked using the possible egress types provided on the form. These are:

- a. Interior Stairs
- b. Elevator
- c. Door to Exterior Stairs to Grade
- d. Door Directly to Grade
- e. Handicap Accessible Ramp
- f. Basement Interior Stairs
- g. Basement Stairs to Grade
- h. Door to common hallway to egress(s) – this would typically be found in a multiple family or high rise apartment/condominium
- i. Other (describe)

The floor plan provides important information needed for the DDS Area Office to fully evaluate the Emergency Evacuation Safety Plan. This plan will clearly show the layout of the home, the location and type of egress for each floor, proximity of egresses to bedrooms and distance of egresses from each other.

## **GENERAL SAFETY REQUIREMENTS**

This section ensures that regulatory requirements addressing safety in homes and respite facilities providing 24 hour staffed supports are in place. By putting an X in each box, the provider agency is confirming that the site is in compliance with the regulations either because the situation does not exist in the home or respite facility, such as there are no vertical chutes in a home, or that the proper precautions are in place should the situation exist, e.g. all individuals in a home that require physical assistance to evacuate have bedrooms located on a floor at grade level. If there is not an X in each box, there must be a proposed alternative identified as outlined in the following section.

The first question in this section addresses egresses from the home. There need to be two means of egress from floors at grade level. Other floors need to have one means of egress and one proven, usable escape route leading to grade. This means that the escape route has been tested to ensure individuals can safely use the escape route in an emergency with or without staff assistance.

## **PROPOSED ALTERNATIVES**

This section would only be completed if an agency is proposing an alternative to the environmental standards outlined in the regulations under 115 CMR 7.07. Since a provider agency would need to provide compelling evidence, it should be very rare that an alternative would be proposed. The agency would need to provide the following information:

- Identification of the regulation standard for which an alternative is proposed.
- Clear description of the proposed alternative to the standard.

- Explanation of why the standard is not needed.
- How the proposed alternative will assure that a comparable level of safety is achieved.

## **INDIVIDUAL ABILITIES AND SAFETY STRATEGIES**

The first component of this section gives a snapshot of the needs of individuals supported at this location. Answer each of the following questions as they apply:

1. *Does the level of ability (cognitive) of any individual prevent or limit their ability to evacuate independently in 2.5 minutes?*
2. *Does any individual have mobility issues that would prevent or limit their ability to evacuate independently in 2.5 minutes?*
3. *Does any individual have health related issues that would prevent or limit their ability to evacuate independently in 2.5 minutes?*
4. *Does any individual have social or behavioral issues that would prevent or limit their ability to evacuate independently in 2.5 minutes?*
5. *Does any individual need adaptive devices or equipment to ensure safe and timely evacuation?*

If the answer to all of the questions above is no, skip the rest of this section and go to the section on group interactions. If the answer to any of the questions above is yes, the following information on the chart provided in the Emergency Evacuation Safety Plan form needs to be completed for each individual supported in the home.

### **Instructions for completing the individual chart**

If any individual living in the home has needs that affect safe evacuation, the individual chart should be completed for every individual living in the home even if an individual is independent in evacuation. This gives the involved DDS Area Office a comprehensive picture of everyone living in the home. Instructions for the specific elements of the chart are as follows:

**Ability to Evacuate** – this section should include a comprehensive description of each individual’s ability to evacuate and those individual characteristics that could affect timely evacuation.

**Staff Assistance Provided** – this section should include the most extensive staff assistance required to evacuate as outlined in the following list.

- a. Independent – individual requires no assistance to evacuate.
- b. Verbal Prompt – individual requires only verbal direction to evacuate.
- c. Physical Prompt – individual requires only light physical prompt to evacuate, such as a light directional touch on the arm, after which the individual evacuates independently.
- d. Physical Escort – individual requires actual physical assistance to evacuate, such as staff physically guiding the individual out of the home.
- e. Full Physical Assistance – individual is totally dependent on staff for

evacuation, such as physical transfer to a wheelchair needed for evacuation.

**Adaptive Devices/Equipment Needed** – this section should identify any supportive devices needed by an individual including wheelchair, walker, bed shaker, etc.

## **GROUP INTERACTIONS**

This section addresses any interactions between the individuals in the home that could positively or negatively affect any individual's ability to evacuate. For example, one individual could push housemates during evacuation so that others refuse to evacuate. In another example, one individual could verbally encourage others to evacuate, enhancing other housemates' evacuation skills.

## **EVACUATION PLAN**

All of the information previously provided in this document culminates in the actual development of the evacuation plan. Before developing the plan, the following questions need to be answered:

**Minimum ratio of staff to individuals during awake hours** – This should be the lowest ratio that would ever be present in the home during the hours individuals are typically awake. For example, if there are typically 2 staff on in the afternoon but during early evening hours there is one staff present to four individuals, the minimum ratio would be 1:4. The actual evacuation plan needs to describe how one staff person will safely evacuate the four individuals.

**Minimum ratio of staff to individuals during asleep hours** – Again, this should be the lowest ratio that would ever be present in the home during the overnight hours. The agency needs to identify whether staff are asleep or awake staff during the overnight hours. The agency also needs to identify what are considered the asleep or overnight hours. For example, in one home the hours may be from 11 p.m. to 7 a.m. while in another home these hours may be from 10 p.m. to 6 a.m.

The above questions give the reviewing DMR Area Office additional context for the actual evacuation plans that follow.

## **Evacuation Plans**

A separate plan needs to be developed for awake and asleep hours.

Each evacuation plan should be presented in a bullet point format.

Each evacuation plan needs to clearly articulate the sequencing of individual evacuation, using the information provided in the Individual Abilities and Safety Strategies section of the plan. Each evacuation plan needs to clearly describe the staff support provided for safe evacuation, again using the information provided in the Individual Abilities and Safety Strategies section. If the use of any adaptive device or equipment affects safe, timely evacuation, the specific staff assistance needed to address this should be outlined here, e.g., staff needs to lower a bed rail or put on an individual's brace. If more than one staff person is needed for safe evacuation, each staff person's role should be clearly outlined and include how each staff person is trained to understand their specific role. One way to do this could be to label staff as A or B with staff knowing their role based on their specific job position or being informed at the beginning of their work day which person(s) each would support.

### **Amount of time needed for safe evacuation**

This should be the maximum time needed to evacuate all individuals safely. For existing homes, this amount should be based on the results of fire drills during the previous year. For new homes the time should be based on individual assessments. The amount of time should never be more than 2 ½ minutes unless a Fire Safety Equivalency System (FSES) waiver has been processed and approved by the DDS Area Office, Region Office, and Quality Enhancement Office.

### **Primary Escape Route**

This should be the exit(s) that would typically be used during an evacuation unless it is blocked.

### **Secondary Escape Route**

This should be the exit(s) that would typically be used if the primary escape route was blocked.

### **Central Meeting Place**

This should be the place where everyone will meet when all have safely evacuated the home.

### **FIRE DRILLS**

DDS regulations 115 CMR 7.08 require that fire drills be conducted quarterly, with two of those drills being conducted during asleep hours. The provider agency should fill in the requested information to outline how many drills are conducted annually during awake and asleep hours. Additionally, the provider agency needs to identify the range of hours during which asleep fire drills will take place.

Any deviation in the number, schedule and/or format of the fire drills that is different from what is required by regulation must be clearly identified along with the reason for the change and a description of how individual safety will not be compromised.

### **METHODS TO NOTIFY POLICE, FIRE, EMERGENCY PERSONNEL, FAMILIES, DMR**

It is important to have clear procedures for notifying others of an emergency. Provider agencies need to acknowledge in this section that staff understand the procedures for notifying emergency personnel and describe what that procedure is. Additionally there needs to be a description of how other key people would be contacted.

Key people to be contacted should include the Area Offices for each individual supported at the site as well as the Area office in which the site is located even if that Area Office does not support any individuals at the site.

### **TRANSPORTATION AND IMMEDIATE/TEMPORARY RESETTLEMENT**

It is important that provider agencies have a well thought out plan of how to support individuals after an emergency. Therefore, provider agencies need to describe the plans for immediate shelter; temporary resettlement if needed including transportation plans; staff knowledge of these plans; and plans for the continuity of services and supports.

### **PROVIDER ASSURANCE FORM**

This form needs to be completed by the provider and signed by the provider and submitted with the EESP to the appropriate Area Office. This form must be signed by the Area Director or his/her designee, signifying approval of the EESP as submitted.

## **APPENDIX D**

## **Residential Guidelines Regarding Family Members, Significant Others, Friends, and Legal Guardians**

Residential program staff are expected to respect and actively facilitate individuals' efforts to maintain their relationships with designated family members, significant others, and guardians. Given that most individuals served in residential programs live in apartments or houses that are shared with other individuals, the following guidelines have been established to promote personal safety and to accommodate the needs, personal space, and scheduled activities of all who reside in the program. Family members, significant others/friends and legal guardians are, therefore, expected:

- 1) To visit the program between the hours of 9 am and 8 pm, but not during planned program activities or times devoted to personal care/ADLs (e.g., bathing, meal times, etc.). It is requested and advised that visitors contact the residential program staff in advance to ensure that the individual is available and present, and to make prior arrangements with program staff for visits outside these hours, in consideration of the needs of other individuals.
- 2) To place telephone calls to individuals or program staff between the hours of 9 am to 9 pm, unless there is an extraordinary or urgent need to communicate with the individual or staff.
- 3) To visit with individuals in the common areas, or in an individual's space/room, but to not enter the rooms/personal space assigned to other individuals.
- 4) To comply, whether on-site or off-site, with all program policies, procedures and prescribed treatments/interventions developed for an individual and agreed to as part of the individual's service plan. These include, but are not limited to the following:
  - Medication administration
  - Specialized medical directives (e.g., dysphagia protocol, seizure management, etc.)
  - Drug and alcohol abstinence
  - Behavioral Management Plans
  - Use of seatbelts during transport
  - Any other protocols developed to ensure an individual's safety, well-being, and attainment of service plan goals/objectives
- 5) To recognize that the decoration and contents of the common areas are jointly determined by the individuals and facilitated, when necessary by staff.
- 6) To understand that vehicles leased or purchased by the program or MRC are for transport of individuals only.

- 7) To maintain communication with the residential program's designated staff contact person, via scheduled phone conferences or meetings, the frequency of which will be determined and dictated by the individual's needs. In addition, it is expected that family members, significant others, and guardians will inform staff of any significant events/issues that may affect an individual or the residential program.
- 8) To communicate with residential staff and other individuals in a respectful and courteous manner.
- 9) To understand that, except for court-appointed legal guardians, staff will communicate information to family members, significant others/friends only with the written consent of the individual. It should also be understood that an individual may limit the nature/content of information staff are permitted to share and that the individual has the right to withdraw his/her consent at any time.
- 10) To understand that residential staff are expected to maintain strict confidentiality, with respect to information related to other individuals in the program.
- 11) To understand that residential staff are obligated to report any suspected or substantiated, incidents of abuse or neglect involving any participant (ages 18-59) to the Disabled Persons Protection Commission (DPPC). Staff are also obligated to report any suspected, or substantiated, abuse or neglect of a child under 18 years of age to the Department of Children and Family Services (DCFS), and if 60 years or older, to the Executive Office of Elder Affairs.
- 12) To obtain explicit written permission from the Program Director/Manager prior to bringing any pets into the residential program.

## **APPENDIX E**

# MASSACHUSETTS REHABILITATION COMMISSION INCIDENT REPORT

Name of Program Participant: \_\_\_\_\_

Home/Program Address: \_\_\_\_\_

No.      Street      Apartment      City/Town

Phone Number (Participant): (      ) \_\_\_\_\_

Provider Organization: \_\_\_\_\_

Provider Phone Number : (      ) \_\_\_\_\_

Date of Incident: \_\_\_\_\_

Date IR Sent: \_\_\_\_\_ Method: E-Mail \_\_\_\_\_ Fax \_\_\_\_\_ (check method)

## I. DESCRIPTION OF INCIDENT

### A. Incident Category (check all that apply)

<p>(1) Unexpected/Suspicious Death</p> <ul style="list-style-type: none"> <li><input type="checkbox"/> Accident</li> <li><input type="checkbox"/> Suicide</li> <li><input type="checkbox"/> Unusual Circumstances</li> <li><input type="checkbox"/> Other Unexpected/Sudden Death</li> </ul> <p>(2) Suicidal/Self-Injurious behavior</p> <ul style="list-style-type: none"> <li><input type="checkbox"/> First Known Attempt</li> <li><input type="checkbox"/> Repeat Attempt</li> <li><input type="checkbox"/> Expressed Suicidal Ideation or Intention</li> <li><input type="checkbox"/> Other Self-Injurious Behavior</li> <li><input type="checkbox"/> Other Threat to Harm Self</li> </ul> <p>(3) Unexpected Hospital Visit</p> <ul style="list-style-type: none"> <li><input type="checkbox"/> Medical Hospitalization</li> <li><input type="checkbox"/> Psychiatric Hospitalization</li> <li><input type="checkbox"/> E.R. Visit</li> <li><input type="checkbox"/> Emergency Services Team Evaluation</li> </ul> <p>(4) Near Drowning</p> <ul style="list-style-type: none"> <li><input type="checkbox"/> Bath tub</li> <li><input type="checkbox"/> Swimming Pool</li> <li><input type="checkbox"/> Other Body of Water</li> </ul> <p>(5) Assault or Threatened Assault</p> <ul style="list-style-type: none"> <li><input type="checkbox"/> Sexual Assault – Alleged Victim</li> <li><input type="checkbox"/> Sexual Assault-Alleged Perpetrator</li> <li><input type="checkbox"/> Threat of Sexual Assault – Alleged Victim</li> <li><input type="checkbox"/> Threat of Sexual Assault – Alleged Perpetrator</li> <li><input type="checkbox"/> Physical Assault – Alleged Victim</li> <li><input type="checkbox"/> Physical Assault – Alleged Perpetrator</li> <li><input type="checkbox"/> Threat of Physical Assault – Alleged Victim</li> <li><input type="checkbox"/> Threat of Physical Assault – Alleged Perpetrator</li> </ul> <p>(6) <input type="checkbox"/> Missing Person/Elopement</p> <p>(7) <input type="checkbox"/> Medical Treatment Resulting from Injury</p> <p>(8) Fire</p> <ul style="list-style-type: none"> <li><input type="checkbox"/> Intentional – Started by Individual</li> <li><input type="checkbox"/> Intentional – Not Started by Individual</li> <li><input type="checkbox"/> Accidental – Started by Individual</li> <li><input type="checkbox"/> Accidental – Not started by Individual</li> <li><input type="checkbox"/> Fire of Unknown Origin</li> </ul> <p>(9) Suspected Mistreatment</p> <ul style="list-style-type: none"> <li><input type="checkbox"/> Alleged Victim of Psychological Abuse</li> <li><input type="checkbox"/> Alleged Victim of Verbal Abuse</li> <li><input type="checkbox"/> Alleged Omission – Failure to Provide Needed Supports</li> <li><input type="checkbox"/> Alleged Omission – Failure to Provide Needed Supervision</li> </ul>	<p>(10) Physical Altercation</p> <ul style="list-style-type: none"> <li><input type="checkbox"/> Individual to Individual – Alleged Victim</li> <li><input type="checkbox"/> Individual to Individual – Alleged Perpetrator</li> <li><input type="checkbox"/> Individual to Staff</li> </ul> <p>(11) Property Damage</p> <ul style="list-style-type: none"> <li><input type="checkbox"/> Damage of Agency/Provider Property</li> <li><input type="checkbox"/> Damage of Personal Property</li> <li><input type="checkbox"/> Damage of Public/Community Property</li> <li><input type="checkbox"/> Damage of Another Individual's Property</li> </ul> <p>(12) Theft</p> <ul style="list-style-type: none"> <li><input type="checkbox"/> Alleged Victim</li> <li><input type="checkbox"/> Alleged Perpetrator</li> </ul> <p>(13) Other Criminal Activity</p> <ul style="list-style-type: none"> <li><input type="checkbox"/> Alleged Victim</li> <li><input type="checkbox"/> Alleged Perpetrator</li> </ul> <p>(14) Transportation Accident</p> <ul style="list-style-type: none"> <li><input type="checkbox"/> Agency-Funded Transportation</li> <li><input type="checkbox"/> Provider Transportation</li> <li><input type="checkbox"/> Public Transportation</li> <li><input type="checkbox"/> Private Vehicle</li> <li><input type="checkbox"/> Pedestrian</li> <li><input type="checkbox"/> Recreational Vehicle</li> <li><input type="checkbox"/> Bicycle</li> <li><input type="checkbox"/> Other</li> </ul> <p>(15) <input type="checkbox"/> Emergency Relocation</p> <p>(16) <input type="checkbox"/> Unplanned Transportation Restraint</p> <p>(17) <input type="checkbox"/> Onset of possible Seizure Activity</p> <p>(18) <input type="checkbox"/> Behavioral/Psychiatric Decompensation</p> <p>(19) Medication Administration Error or Non-Compliance</p> <ul style="list-style-type: none"> <li><input type="checkbox"/> Medication Administration Error by Staff</li> <li><input type="checkbox"/> Medication Administration Error by Other Caretaker</li> <li><input type="checkbox"/> Non-compliance with Prescribed Medications or Other Medical Directives-Program Participant</li> <li><input type="checkbox"/> Non-Compliance with Prescribed Medications or Other Medical Directives – Other Caretaker</li> </ul> <p>(20) <input type="checkbox"/> Use of Drugs and/or Alcohol</p> <p>(21) Other</p> <ul style="list-style-type: none"> <li><input type="checkbox"/> Staff Involvement with Law Enforcement</li> <li><input type="checkbox"/> Behavioral Incident in the Community</li> <li><input type="checkbox"/> Behavioral Incident Involving Law Enforcement</li> <li><input type="checkbox"/> Incident Necessitating a Room/Possessions Search</li> <li><input type="checkbox"/> Ongoing or Escalating Series of Minor Events</li> <li><input type="checkbox"/> Community Complaint</li> <li><input type="checkbox"/> Other</li> </ul>
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## **APPENDIX F**

# INCIDENT CATEGORIES and DEFINITIONS

## Modified Version of DDS Home & Community Services Information System Incident Categories

1. **Unexpected/Suspicious Death** – Any death that is sudden, unanticipated or suspicious. This excludes any expected, foreseen or imminent death from natural causes.
  - **Accident** – any death resulting from accidental causes, such as the result of a car accident or choking incident.
  - **Suicide** – any death resulting from a conscious act to take one's own life.
  - **Unusual Circumstances** – any suspicious death, such as one resulting from foul play or a drug overdose.
  - **Other Unexpected/Sudden Death** – any other unexpected or unanticipated death that does not fit into another secondary incident type.
2. **Suicidal/Self-Injurious Behavior**
  - **First Known Attempt**
  - **Repeat Attempt**
  - **Expressed Suicidal Ideation or Intention**
  - **Other Self-Injurious Behavior**
  - **Other Threat to Harm Self**
3. **Unexpected Hospital Visit** – This category is for an unplanned emergency visit to an acute care medical or psychiatric hospital for the purpose of evaluation and treatment of an immediate medical or psychiatric concern. This would not include a hospital visit that is part of routine care, scheduled visit, medical treatment protocol (e.g., a protocol for replacing a feeding tube, even though the timing for this visit may not be planned, but is an expected step in an individual's medical treatment) or planned procedure (e.g., scheduled surgery).
  - **Medical Hospitalization** – This category would be used only when an individual is admitted as an inpatient to the hospital for medical treatment as a result of the unexpected hospital visit. It would not be used if the individual is only seen and treated in the emergency room, even if the time spent in the emergency room is extensive.

- **Psychiatric Hospitalization** – This category would be used only when an individual is admitted as an inpatient to the hospital for psychiatric treatment as a result of the unexpected hospital visit.
  - **E.R. Visit** – This category would be used when any assessment and/or treatment provided is through the emergency room as a result of the unexpected hospital visit, regardless of the amount of time spent in the emergency room.
  - **Emergency Services Team Evaluation** – Emergency psychiatric evaluation.
4. **Near Drowning** – Any water incident that almost results in the individual's drowning and requires emergency response.
- **Bathtub**
  - **Swimming Pool**
  - **Other Body of Water**
5. **Assault or Threatened Assault** – This category includes threatened or intentional physical attacks that cause, or may cause, severe physical or emotional harm to an individual.
- **Sexual Assault – Alleged Victim** – This category is used when an individual is the alleged victim of any unwanted sexual advance, such as exposing oneself in a sexual way, inappropriate sexual touching and up to and including rape.
  - **Sexual Assault – Alleged Perpetrator** – This category is used when an individual is the alleged perpetrator of any unwanted sexual advance, such as exposing oneself in a sexual way, inappropriate sexual touching of another person and up to and including rape.
  - **Threat of Sexual Assault – Alleged Victim**
  - **Threat of Sexual Assault – Alleged Perpetrator**
  - **Physical Assault – Alleged Victim** – This category is used when an individual is the alleged victim of a serious physical attack with such force to cause, or potentially cause, serious injury. An example would be if someone grabs the individual around the throat and is in danger of choking, but for the intervention of staff.
  - **Physical Assault – Alleged Perpetrator** – This category is used for the alleged perpetrator when an individual physically attacks someone with such force as to cause, or potentially cause, serious injury. An example would be an individual grabbing someone around the throat with a danger of choking, but for the intervention of staff. Another example would be an assault on staff that causes injury requiring medical treatment.

- **Threat of Physical Assault – Alleged Victim**
  - **Threat of Physical Assault – Alleged Perpetrator**
6. **Missing Person/Elopement** – This category should be used whenever any individual is missing from, or has intentionally eloped from, a residential or other community-based program.
  7. **Medical Treatment Resulting From Injury** – This category is appropriate when there is medical treatment generally beyond first aid. This would include life saving interventions such as the Heimlich maneuver and CPR. This category also includes wound closure or treatment/evaluation of injury related to seizure activity, by a medical professional or other treatment provided in a health care practitioner’s office or on site by agency medical personnel (RN, LPN, etc.). This would also include evaluation of a possible injury by emergency personnel in response to 911 or consultation with poison control even if the individual were not transported to an emergency room.
  8. **Fire** – Any incident involving a fire in an individual’s environment that requires active involvement of fire personnel or equipment.
    - **Intentional – Started By Individual** – This category would be used when an individual receiving services purposely starts a fire, such as making a conscious decision to burn papers or material in their home or other community-based program.
    - **Intentional – Not Started By Individual** – This category would be used when someone other than an individual receiving service purposely starts a fire in the individual’s environment.
    - **Accidental – Started By Individual** – This category would be used when an individual receiving services starts a fire accidentally, such as causing a grease fire in the kitchen or toast catching on fire that requires intervention by fire personnel.
    - **Accidental – Not Started By Individual** – This category would be used when someone other than an individual receiving service accidentally starts a fire, such as a staff person causing a grease fire in the kitchen or toast catching on fire that requires intervention by fire personnel.
    - **Fire of Unknown Origin**
  9. **Suspected Mistreatment** – This category includes any intentional or negligent action or omission that exposes an individual to a serious risk of physical or emotional harm. This category could be used both if the perpetrator of the suspected mistreatment is a staff person, family member/guardian, person from the general community or another individual receiving services, as long as the suspected mistreatment is determined to expose an individual to a serious risk of physical or emotional harm.

- **Alleged Victim of Psychological Abuse** – This category includes acts other than verbal, which may inflict serious emotional harm, invoke fear or humiliate, intimidate or demean an individual or potentially seriously damage an individual’s self respect. An example would be a housemate regularly not letting an individual into the family room to watch TV with others so that the individual is afraid to come into the room. Another example would be if a staff person hides something of value from the individual as a way of making fun of or intimidating the individual.
  - **Alleged Victim of Verbal Abuse** – This category includes verbalizations that may inflict serious emotional harm, invoke fear or humiliate, intimidate or demean an individual or potentially seriously damage an individual’s self respect. An example would be a staff person or a housemate who always makes fun of an individual, telling him to shut up or calling him names, which makes the individual very nervous and afraid to talk.
  - **Alleged Omission – Failure To Provide Needed Supports** – This category is used for failure to provide services and supports determined to be necessary or otherwise required by law, regulation or contract. Examples would be staff not following nurse’s or doctor’s orders and providing needed treatment to ensure timely resolution of a medical condition; failure to follow specialized medical protocols (e.g., dysphagia protocol); failure to follow other rehabilitation treatment protocols (e.g., range of motion, positioning, etc.).
  - **Alleged Omission – Failure To Provide Needed Supervision** – This category is used for failure to provide supervision determined to be necessary or otherwise required by law, regulation or contract. An example would be a staff person leaving an individual who needs ongoing supervision alone in a van while going into a store.
10. **Physical Altercation** – This category would be used when there is a physical encounter from one individual receiving service to other individual(s) receiving services or to staff that causes some emotional distress or minor physical injury requiring no more than first aid intervention. Examples could include one individual receiving services pushing a peer and grabbing her snack, or punching or slapping a housemate with no observable injury.
- **Individual to Individual – Alleged Victim**
  - **Individual to Individual – Alleged Perpetrator**
  - **Individual to Staff**
11. **Property Damage** – This category includes intentional damage to, or destruction of property, that is typically more than \$200 or of less monetary value, but significant personal value to the owner. For example, a pen would not typically reach the threshold for reporting, but if the pen had been a gift from a favorite relative that had died and the destruction caused significant distress, it would be reportable.

- **Damage of Agency/Provider Property** – This category includes damage to property that is owned by a state agency or the provider.
  - **Damage of Personal Property** – This category includes property that is solely an individual's own property. An example would be damage to a television set that is the property of the individual committing the damage.
  - **Damage of Public/Community Property** – This category includes property in the community at large. Examples would include damage to a neighbor's property or other community sites such as restaurants or stores.
  - **Damage of Another Individual's Property** – This category includes property owned solely or in part by other individual(s). An example would be damage to a television set that is owned solely or in part by a housemate.
12. **Theft** – Unlawful taking of money, other financial assets and/or personal property that is reported to DPPC and/or law enforcement.
- **Alleged Victim**
  - **Alleged Perpetrator**
13. **Other Criminal Activity** – Criminal activity not included under incident type of theft or property damage, such as identity theft or drug possession. This category should be used for new, not remote, events.
- **Alleged Victim**
  - **Alleged Perpetrator**
14. **Transportation Accident** – This category would be used for traffic accidents where there was a potential for serious harm.
- **Agency-Funded Transportation** – This category includes vehicles owned by a state agency.
  - **Provider Transportation** – This category includes transportation by staff of the provider of services using a vehicle owned by the provider.
  - **Public Transportation** – This category includes all forms of public transportation including bus, train, cabs, etc.
  - **Private Vehicle** – This category includes any privately owned vehicle (e.g., taxi, ambulance).

- **Pedestrian** – This category is used if an individual was a pedestrian injured in a traffic accident.
  - **Recreational Vehicle** – This category is used if an individual was a passenger in a recreational vehicle, such as a boat, at the time of the accident.
  - **Bicycle** – This category is used if an individual was riding a bicycle at the time of the accident.
  - **Other**
15. **Emergency Relocation** – Individual(s) relocation on an emergency basis due to fire, local disaster, weather conditions, or as a result of immediate eviction.
  16. **Unplanned Transportation Restraint** – The use of physical holding or a mechanical device to keep an individual safe during transportation that has not been planned for in the individual's ISP.
  17. **Onset of Possible Seizure Activity** -This category is used when an individual exhibits possible seizure activity for the first time and which has not been previously diagnosed.
  18. **Behavioral/Psychiatric Decompensation** – This category is used when an individual's mental status has significantly changed. Examples would include the development of psychotic symptoms, pronounced disinhibition, or other behavioral/psychiatric symptoms that have intensified or have not been observed previously.
  19. **Medication Administration Error or Non-Compliance**
    - **Medication Administration Error by Staff**
    - **Medication Administration Error by Other Caretaker**
    - **Non-Compliance with Prescribed Medications or other Medical Directives-Program Participant**
    - **Non-Compliance with Prescribed Medications or other Medical Directives–Other Caretaker.**
  20. **Use of Drugs and/or Alcohol**
  21. **Other** – This category covers incidents that do not easily fit into one of the other incident types.
    - **Staff Involvement with Law Enforcement** – This category includes situations where a staff person is involved with law enforcement related to an unlawful activity of the staff person and not relating to individuals served. An example would be if the police arrest a staff person for drug possession.

- **Behavioral Incident in the Community** – This category is used for an unusual incident in the community that draws attention to the individual by the community at large. An example would be an individual needing to be restrained while in the community and the incident was observed by members of the community at large.
- **Behavioral Incident Involving Law Enforcement** – This category is used when law enforcement presence is needed because an individual is out of control and cannot be managed by staff. This incident could occur in the community or at the program site.
- **Incident Necessitating Room/Possessions Search** – This category is used when a search is conducted, but is not part of a neurobehavioral treatment plan (i.e., not scheduled as routine).
- **Ongoing or Escalating Series of Events** – This category is used when there are a series of events, each of which do not individually constitute an incident, but when viewed holistically, constitute a pattern that should be reported and addressed. An example would be an individual who is starting to fall frequently. Although there is no injury, staff are feeling these falls may be an indication of something changing for the individual.
- **Community Complaint** – This category is used for a complaint by a community member. An example is a complaint made by a neighbor about noise from individuals in a residential home.
- **Other** – This category is used for incidents that do not fit another incident type. This category should rarely be used because most incidents that are reportable would likely fit into one of the identified categories.



## **APPENDIX G**

# **PROGRAM PARTICIPANT EXPECTATIONS**

## **PROGRAM PARTICIPATION**

- ◆ I understand that I, or my representative payee, will be required to pay room and board on a monthly basis. Information about the exact cost of room and board, the method of calculating that cost, and procedures for making payment will be discussed with me prior to entering the program.
- ◆ I agree that I am responsible for paying for my own personal phone, internet or cable usage.
- ◆ I agree to participate in developing and completing the goals in my service plan.
- ◆ I agree to attend and participate in all medical appointments, take all medications as prescribed, and to follow all of my doctors' orders and instructions.
- ◆ I agree to consider and, to participate in all other needed clinical services, to which I have agreed and consented, which may include substance abuse and/or psychiatric treatment.

## **PERSONAL CARE AND HYGIENE**

- ◆ I agree to keep my room clean on a daily basis.
- ◆ I will clean up the kitchen, bathroom, and toilet areas each time as needed.
- ◆ I agree to bathe and wear clean clothes daily.
- ◆ I agree to keep all personal items in my bedroom or other assigned storage space.
- ◆ I agree to wash clothing and bedding at least weekly.
- ◆ I will help with house chores.
- ◆ I understand that residential staff, or my PCA, will assist me in completing tasks that are physically-challenging.

## **PERSONAL SPACE**

- ◆ I agree not to wear clothes, or post pictures anywhere, with slogans or images of pornography, drugs, alcohol, or any illegal activity.
- ◆ I agree to wear street clothes that cover all private body parts when in common areas.
- ◆ I will not enter rooms of housemates without my housemate's permission.
- ◆ I will not borrow or lend money to staff or my housemates.
- ◆ I agree to always talk to staff and housemates respectfully. I agree not to use loud or abusive language or to make threats to others.
- ◆ I agree never to insult others by making negative comments about their race, ethnic group, age, religion, sex, or sexual preference.
- ◆ I agree to keep the volume of my radio, TV, CD, etc. at a level that cannot be heard outside

my room.

### **SAFETY**

- ◆ I understand that all medication, including prescribed and over-the-counter medication (such as aspirin) will be kept by staff in a locked area. However, if I have been determined able to self administer my medications, I will be given the option of having a locked space in my room where I can keep my medications.
- ◆ I will not bring any object into the house that might cause injury to myself or my housemates, including any object that is or could be used as a weapon.
- ◆ I understand and am aware of the dangers associated with personal or internet contact with strangers.
- ◆ I agree to talk with staff about any situation or person that I feel may harm or threaten me.
- ◆ I understand that a room search and/or personal possession search will be conducted if there is reason to believe that I have items that could be dangerous, or present a risk to myself or others.
- ◆ I understand that individuals may smoke only in designated smoking areas.
- ◆ I will not take part in illegal activities.

### **DRUGS AND ALCOHOL**

- ◆ I will not use, buy, or sell alcohol or illegal drugs.
- ◆ I will not bring any illegal drug-related item into the house (such as syringes, pipes, etc.)
- ◆ I will not have contact with any person who uses drugs.

\_\_\_\_\_  
Signature of Individual

\_\_\_\_\_  
Date

\_\_\_\_\_  
Signature of Legal Guardian (if applicable)

\_\_\_\_\_  
Date

\_\_\_\_\_  
Provider Staff Member

\_\_\_\_\_  
Date