MCH

SECTION 1: GENERAL POLICIES, PROCEDURES & OPERATIONS

September 2022

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MISSION STATEMENT

Macon Citizens Habilities, Inc. advocates for and protects the rights of individuals with intellectual and developmental differences. MCH provides comprehensive residential and community-based services. Our focus is to provide services that allow individuals to define and reach their personal life goals.

Revised: 8/17
Reviewed: 7/18; 8/19; 7/20; 5/22

INTRODUCTION

MACON CITIZENS HABILITIES, INC. (MCH) provides services through 4 Intermediate Care Facilities for Individuals with Intellectual Differences (ICF-IID) group homes, 2 Developmentally Disabled Adult (DDA) group homes and community-based programs including a licensed day program, periodic Medicaid waiver services (NC Innovations), licensed and unlicensed alternative family living arrangements (AFL) and Supported Employment. An annual financial audit is conducted by an independent firm. Audit results are provided to the board of directors and to funding sources as required by contract(s). Financial consultation and direction are obtained from certified public accountants with experience in the business practices of private, non-profit organizations with a wide array of funding sources. MCH welcomes and solicits evaluations from regulatory and related parties and has an internal quality assurance program. MCH is accredited by CARF, the Commission on Accreditation of Rehabilitation Facilities.

MCH promotes social and economic opportunities for people with intellectual and developmental differences both in the community and within the organization and encourages and trains staff and persons served to access opportunities. Persons served are recruited to employment positions whenever possible.

MCH does not discriminate on the basis of sex, age, race, religion, national origin, or disability with regard to employment *or* services and makes every effort to make reasonable accommodations for both persons served and employees.

MCH maintains an open-door policy between persons served and employees and encourages input from both. Input is solicited during routine staff meetings, clinical supervisions, anonymous surveys, interviews with persons served, networking with other community agencies and integrating persons served on various MCH committees.

MCH has methodology in place to measure and manage outcomes. Such mechanisms include, but are not limited to satisfaction surveys, quality assurance, program evaluation, and measurement and documentation of progress toward goals. Outcome measurement is documented and disseminated through an annual report, newsletters, board minutes, goal plans, news releases, etc. Annual results are provided in an annual report to the board, employees, and to stakeholders.

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GOVERNANCE

MCH is a private, non-profit corporation [501(c)3] with a board of directors. The executive director is directly responsible to the MCH Board and is charged with the supervision or delegation of supervision of all personnel. The MCH Board strives to assure that its members and employees are qualified to carry out their assigned duties responsibly.

New MCH Board members are oriented by the board president or a delegated board representative to their responsibilities and the history of the organization. The function of the board is described in a separate board manual.

See Attachment—Organizational Chart

Revised: 8/17; 6/19; 9/22
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OPERATIONAL COMPLIANCE

Each program operated by MCH complies with the respective federal and state standards and requirements of that program or funding source. When applicable, specific laws, policies and/or rules are referenced within this manual. It is the intention of each policy and practice to meet all applicable standards as referenced by the following governing sources:

- Department of Labor (DOL)
- General Accepted Accounting Principles
- Occupational Health Safety Administration (OSHA)
- Americans with Disabilities Act (ADA)
- North Carolina Division of Health Service Regulation (DHSR)
- North Carolina Administrative Code (NCAC)
- NC Division of Medical Assistance Health Choice Clinical Coverage Policies
- Department of Health and Human Services (DHHS)
- ICF-IID Guidelines
- MCO Contract Performance
- Employment and Community Standards through CARF

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CULTURAL COMPETENCY AND DIVERSITY PLAN

MCH is based in western North Carolina and makes every effort to serve persons within this area. Within that scope, MCH recognizes not only the culture of indigenous persons but also Appalachian traditions when applicable. MCH is committed to providing effective, equitable, quality, respectful, and understandable services and supports for individuals with intellectual/developmental differences and their families. Our Cultural Competency and Diversity Plan which is designed to:

1. Emphasize our awareness of, respect for and attention to the diversity of persons served, employees, families/caregivers and other stakeholders. This is awareness, respect and attention to diversity are reflected in the attitudes, organizational structure, policies and services of MCH.
2. Address how MCH will respond to this diversity
3. Address how the knowledge, skills and behaviors will enable personnel to work cross-culturally by understanding, appreciating, and respecting differences and similarities in beliefs, values and practices within and between cultures.

Cultural Competency is defined as an MCH's ability to recognize, respect and address the unique needs, worth, thoughts, communications, actions, customs, beliefs and values that reflect an individual's racial, ethnic, religious, and/or social groups or sexual orientation.

Diversity is defined as differences due to cognitive or physical ability, age, culture, economic/socioeconomic status, ethnicity, gender identity and expression, religion, sexual orientation, or spiritual beliefs$_2$. Diversity also includes education, experiences, job level, language, listening ability, perspectives, physical appearance, skills, and thinking styles

MCH policies make clear that no person shall be excluded from services, or be subjected to any form of discrimination, including disparate treatment, based on age, culture, disability, gender, economic status, ethnicity, language, national origin, race, religion/spiritual beliefs, sexual orientation or veteran status. We have a clear and consistent strategy that all personnel practices, including recruitment, hiring, training, promotion, compensation, benefits, transfers and layoffs are administered without regard to age, color, gender, national origin, race, religion, sexual orientation, veteran status, physical or mental disability.

This Cultural Competency and Diversity Plan expands those policies to address our proactive efforts toward awareness of and respect for the diversity of the people with whom we interact including, but not limited to, persons served, families, employees, professional associates and other stakeholders. This is accomplished through assessing the diversity of our community, making note of what applies within our own organization and then training staff accordingly. Diversity is addressed in terms of age, culture, gender, language, sexual orientation, socioeconomic status and spiritual beliefs.

Purpose

The purpose of this Cultural Competency and Diversity Plan is to recognize, respect and address the needs, worth, customs, beliefs, and values of our stakeholders. Our goal is to increase awareness of cultural diversity within our organization and promote practices that lead MCH in the direction of equality, accessibility and understanding. This plan addresses cultural competency by using the following guiding elements:

- Valuing diversity by accepting individual preferences and respecting individual differences
- Cultural Self-Assessment: the ability to look at our own cultural behaviors to learn to modify them when they don't honor diversity.
- Recognizing the importance of individuality
- Incorporating awareness of diversity into MCH practices
- Awareness of and adaptation to the culture and diversity within our local community

Procedures

Although it is not expected that MCH employees know everything about all cultures, it is necessary to develop some understanding of the major values and beliefs of those served by our organization. Knowledge of and response to aspects of diversity is a critical component in providing respectful and individualized services and supports for persons served. Cultural competency is an ongoing learning process that fosters inclusion, tolerance, and respect for diversity in all forms.

1. MCH will ensure that employees receive adequate training about cultural competence and diversity in an effort to enhance awareness and sensitivity. Individualized service plan development should include consideration of the person's cultural, spiritual and socioeconomic background.
2. MCH will periodically provide training for management staff on the prevention of harassment and discrimination in the workplace. The treatment of employees with respect to differences will be emphasized.
3. All service plans for persons supported by MCH will include information about cultural beliefs and personal preferences. MCH will assist persons served to participate in cultural experiences that are valued including holiday celebrations (or lack thereof), spiritual beliefs and the preparation of culturally favored foods.
4. MCH recognizes its obligation to increase access in the community for people with differences and will continue its involvement in community groups, organizations and local government. MCH maintains an accessibility plan that is reviewed at least annually as one component of our Cultural Competency and Diversity Plan.
5. For individuals needing interpretation/translation service to support adequate communication, MCH will arrange for a translator to be available through local resources if a MCH staff is unavailable to translate.
6. MCH's Cultural Competency and Diversity Plan will be reviewed at least annually and updated as needed.

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CORPORATE COMPLIANCE

MCH is committed to conducting all activities in compliance with the rules, regulations and laws governing its services in a manner that prevents healthcare fraud, waste, and abuse (per Sentencing Reform Act of 1984 (Title II of the Comprehensive Crime Control Act, 28 USC, 994). The purpose of the MCH Compliance Program is to ensure that all employees do the *right thing* in every aspect which includes:

- complying with federal, state, and insurance regulations
- completing all work according to written policy
- creating an environment where personal behavior reflects commitment to persons served
- applying only the highest moral and ethical standards in all our interactions with others
- immediate reporting and investigation of questionable activities and practices without consequences to the reporting party
- timely correction of any situation which puts the organization, its leadership, staff, funding sources, or persons served at risk

MCH staff are trained to report any acts of wrongdoing or suspicions of wrongdoing to the compliance officer with no retaliation or reprisal for making such reports. Reasonable efforts to protect the confidentiality of the reporting employee will be made, but MCH makes no claim that such confidentiality will be possible in all situations. All MCH employees are expected to exemplify the integrity and ethics of this organization and make a commitment to ethical and legal standards for:

- care of persons served
- confidentiality
- billing practices
- conflicts of interest
- use of corporate property
- vendor relationships

Organizational Code of Ethics: Since MCH employs staff and contractors from a variety of disciplines, it is MCH's expectation that every staff person will act and operate in a manner consistent with the code of ethics of his/her respective discipline. Additionally, MCH expects that contractors sign and adhere to the practices outlined in the Business Associates Agreement.

No-Reprisal Reporting System: An integral part of MCH's Corporate Compliance Program is a non-retaliatory system that employees can use to report suspected abuse, fraud, waste and other questionable activities and practices. Reports can be submitted to the Executive Director in the following ways: (1) by mail, (2) by telephone, (3) by fax, (4) by e-mail, or (5) by requesting a meeting in person. Each employee receives training about MCH's expectations for compliance and how to report suspicious activities.

Procedures

1. The executive director is responsible for the corporate compliance program and serves as the corporate compliance officer.
2. The compliance officer makes regular reports to the MCH Board of Directors on matters pertaining to corporate compliance.
3. The corporate compliance team includes the business director and QPs.
4. The compliance officer monitors the corporate compliance plan via internal and external monitoring, auditing, investigating, and reporting processes and procedures.
5. The compliance officer monitors MCH policies, procedures, and standard operating practices for compliance with all regulatory requirements.
6. The compliance officer should monitor all Medicaid-funded services for validity of original signatures, dates, and billed service hours. Any discrepancies should be reported immediately.
7. The compliance officer develops a report from each internal audit and makes the findings available to the board.
8. No employee shall be punished solely on the basis that he or she reported what was reasonably believed to be an act of wrongdoing or a violation of this program or the MCH code of ethics. However, an employee will be subject to disciplinary action if MCH reasonably concludes that the report of wrongdoing was knowingly fabricated by the employee or was knowingly distorted, exaggerated, or minimized either to injure someone else or to protect the reporting party or others.
9. An employee whose report of misconduct contains admissions of personal wrongdoing will not, however, be guaranteed protection from disciplinary action. In determining what, if any, disciplinary action may be taken against an employee, MCH will take into account an employee's own admission of wrongdoing, providing the employee's wrongdoing was not previously known or its discovery was not imminent, and that the admission was complete and truthful.
10. If an allegation of illegal or unethical practice is reported or discovered, an investigation by the program compliance team must be conducted and documented. The results of the investigation will determine the next course of action as to employee discipline, termination, or prosecution. In all cases, the board of directors must be notified.
11. If wrongdoing is substantiated which results in misuse of Medicaid monies, MCH will be responsible for reporting the wrongdoing to the appropriate entity.

Violations Procedure: Substantiated violations of the Corporate Compliance Program and/or any policies therein are serious matters and have potential legal ramifications for both MCH and its employees. Violators will be subject to disciplinary action up to and including termination. Additionally, violations can subject employees to both civil and criminal sanctions at no expense to MCH.

Search Warrants, Subpoenas, Investigations and Other Legal Actions: MCH has very specific instructions in place to guide personnel in responding to search warrants, subpoenas, investigations, inquiries or other legal actions involving this organization. The instructions for staff are to immediately refer the authority presenting the search warrant, subpoena, investigation, inquiry or other legal action to the executive director and/or business director. MCH staff are instructed to not respond to the presenting authority in any manner, other than to refer the authority to Executive Director. The Executive Director will handle the matter according to legal counsel. Copies of any legal documents served against MCH and/or its employees will be immediately copied and emailed or faxed to the MCH Board President. Under no circumstances will any records, files, receipts, or other forms of documentation be released without specific authorization from the Executive Director and/or MCH Board President. This policy recognizes that employees might well find themselves in a situation in which they could potentially be threatened or coerced into releasing documentation without following this policy. All employees must fully recognize and understand that (1) "due process" includes the opportunity to follow the established procedures of MCH regarding search warrants, subpoenas, investigations and other legal actions, and (2) these procedures include immediate notification to the Executive Director in all cases and without delay.

Legal Conformance: MCH's Corporate Compliance Program includes, as required by various legal mandates, periodic inspections and audits from State regulatory bodies, such as EDS, MCO post-payment reviews, annual external CPA audit and surveys from CARF International. As part of this policy, the Executive Director must be immediately informed of any regulatory inspection and/or upcoming surveys. If formal correspondence is received, the original must be immediately provided to the MCH Board President.

Responsibility for Conformance: All MCH employees are responsible for strict conformance with this policy. This is reviewed with all new employees at the time of orientation and at least annually thereafter. If a person served or other stakeholder requests a copy of MCH's Business Ethics and Personal Conduct policy, the Executive Director will immediately give it to them.

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RISK MANAGEMENT

MCH is committed to long range planning to ensure service continuity and, therefore, to a formal and periodic risk management process. Specifically, MCH is committed to risk management as a way to (1) identify any loss exposures, (2) analyze and evaluate any loss exposures, (3) identify a strategy (including techniques and/or actions) to be taken to counter any potential losses or identified exposures, (4) implement the most effective strategy/plan to reduce risk for this organization, (5) provide on-going monitoring of any actions taken to reduce risk, (6) report results of action taken to reduce risks, and (7) include the results of risk reduction activities in performance improvement activities.

Procedures

The Executive Director is responsible for ensuring that an annual risk management plan assessment is conducted and for reporting the findings of that assessment to management staff and the Board of Directors. Results of this annual assessment will be presented to MCH Board of Directors and incorporated into the outcomes management report as well as incorporated into performance improvement activities, strategic planning, community advocacy efforts, and financial decisions.

See Attachment—Risk Management Plan Assessment

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Reviewed: 7/18, 8/19; 5/22

QUALITY MANAGEMENT

Quality Management includes both Quality Assurance and Quality Improvement. The foundation of both is measurable data and how that data is used to measure system performance. This data is compiled into an annual report referred to as the **MCH Information Management and Performance Improvement Report.**

Quality Improvement is a continual, cyclical process in which MCH identifies and studies a systematic problem, plans and tests a systematic change to address the problem, and adopts the change to be successful. QI is an internal function of continuously self-monitoring and carrying out improvement projects. MCH believes there is no limit for improving quality of services delivered. The upper management team serves as the Quality Improvement Committee and discusses quality goals, measurements and plans of action.

The MCH Quality Assurance Plan includes:

- a quality assurance committee
- reports documenting outcomes of quality assurance reviews
- methods for monitoring and evaluating the quality and appropriateness of services, including individual outcomes and utilization of services
- professional or clinical supervision of staff
- strategies for improving service delivery to the persons supported by MCH
- routine review of staff qualifications and habilitation privileges
- review of all incidents that occur during a time a person is receiving services by MCH
- adoption of policies and procedures that assure operational and programmatic performance meeting applicable standards of practice. For this purpose, "applicable standards of practice" means a level of competence established with reference to the prevailing and accepted methods, and the degree of knowledge, skill and care exercised by other practitioners in the same field.

Procedures for Service Records

1. The Quality Assurance Committee (QAC) consists of, but is not limited to the Executive Director, MCE manager, QP(s), DDA Coordinator and/or program assistants.
2. The Service Record Review tool is service-specific and lists all record components to be reviewed in both paper records and the electronic health record (Therap).
3. Corrective actions for each service record reviewed are reported to the appropriate QP or manager at the time of finding and should be corrected within 10 working days.

4. A report is compiled of all QAC findings and presented to the Board of Directors. An annual report is compiled at the end of each fiscal year and included in the Information Management report.

See Attachment—Service Record Review Tool

Procedures for Personnel Records

1. Staff qualifications are verified at time of hire and with evidence filed within the personnel record.
2. Training and monitoring of paraprofessionals is completed by the supervising QP and documented on the individualized supervision plan.
3. All training employees receive is documented in their personnel file. Transcripts for completion of online training modules are printed upon request.
4. Training as required by the employee's position is monitored to ensure it is completed, that the employee demonstrated competency on all outcome-based assessments and remains current as required.

- All open personnel files are reviewed at least annually for content and accuracy in the following areas:
    - evidence that training is current
    - competency demonstrated on outcome-based assessments
    - required documentation is current and accurate
    - all required releases and documentation of training are signed and dated
    - status changes are current
    - all Records of Supervision/Warnings are current and signed

5. The Personnel File Review is maintained in the last section of the personnel file.
6. Corrective actions are provided to the supervisor for follow up and documented on the review form.

See Attachment—Personnel File Review

Revised: 8/17; 7/20
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PERFORMANCE & OUTCOME MEASUREMENT

Providers such as MCH need to show evidence that supports offered produce benefits to the persons receiving services. MCH measures outcomes to determine if our programs really make a difference in the lives of the people we serve. Outcome measurement can lead to a more focused and productive delivery of services.

MCH uses information gathered to improve outcomes in the following areas:

- recruitment and retention of staff
- providing services to new persons
- expanding services provided to offer increase in choice
- high quality of services as measured through surveys by oversight agencies
- increasing and retaining funding
- gaining public recognition
- procurement and use of grants

Board and upper management may use outcome data to:

- strengthen and improve existing services
- identify services for expansion
- identify staff training needs
- develop and justify budgets
- make long-range plans

MCH uses a variety of documents to gather information to ensure it is in conformance with various standards. MCH takes steps to ensure the data collected is done so in a consistent manner by utilizing the same process each year so that the data collected is reliable. MCH chooses a variety of indicators, measures and data points to ensure the data being collected is valid. Efforts are made to ensure all factors are measured thoroughly. Data is reviewed by the MCH management team prior to publishing the findings to ensure feedback/data/responses are accurate.

The executive director compiles an annual report summarizing findings from surveys, review of strategic plan, data from incident reports, data from quality assurance, corporate compliance, personnel record reviews, budgets, financial audits, cost reports, complaints, grievances, staff incidents and demographics of persons served. The Information Management Report is used by both the MCH Board of Directors and MCH Management team to evaluate services, make

changes, provide stakeholders with information about MCH, and make long and short-range plans.

Procedures

1. The MCH Management team, composed of the executive director, business director, professional staff, facility managers and administration office personnel, meet at least annually to develop agency goals and objectives and to review and evaluate current goals and objectives. All pertinent statistics, outcomes, and reports are made available to be used in developing new strategies and evaluating current status.
2. Long and short-range goals and objectives developed by the management team are presented to the board of directors for their review and endorsement at the next regularly scheduled board meeting.
3. Personnel statistics are calculated and presented to the board annually for review.
4. The business director provides fiscal reports or income statements for each facility as well as a consolidated income statement both quarterly and annually.
5. The executive director compiles an annual report of the overall status of the organization to the board of directors. This report is made available to stakeholders and employees.
6. A demographics data base of all persons served by MCH is maintained for comparative reports as needed.
7. Each person served has a person-centered plan with measurable outcomes with documentation of their and/or their guardian's input in each plan.
8. MCH polls vendors, stakeholders, persons served, families, etc. regarding satisfaction with services and areas for improvement. MCH Board members, employees, persons served and stakeholders are provided results of these surveys and outcomes.
9. The progress of persons receiving services from MCH services may be measured by guardian/family opinion, outcome-based test results, goal progress, etc.
10. All reports and statistics are made available to the board of directors through reports or discussion at board meetings. The executive director and business director provide information to the board as requested. The board shall use the information as it deems necessary to make recommendations or make changes in policy or service delivery.
11. Information about outcomes will be provided as appropriate through staff meetings, facility meetings, board meetings, social media platforms, memorandums, reports, etc.
12. Information will be compiled into an outcomes management report to be used to plan and make improvements to service delivery.

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ACCESSIBILITY

MCH acknowledges that there have always been barriers to services and accessibility for persons with intellectual and developmental differences and physical differences and strives to remove these barriers. MCH makes every effort to provide facilities and premises accessible to persons with differences and meet the intent of the Americans with Disabilities Act. Barriers may be identified in buildings, attitudes, environment, finances, employment, communication, transportation, community integration, or any other obstacle which creates a hardship or hinders providing services. MCH tries to improve the architectural accessibility of its facilities, accessibility in the community and encourages employees and persons served to participate in such efforts. MCH makes every effort to make reasonable accommodations and to employ as well as serve persons with differences.

Procedures

1. All staff and persons served are encouraged to be involved in community efforts which promote social and economic opportunities for persons with intellectual and developmental differences.
2. Employees are trained to serve as advocates for persons served at all times.
3. Routine documented inspections of policies, facilities, and practices must be conducted in respect to the ADA at least annually.
4. Barriers, when identified, are eliminated as quickly as possible. If needed, a plan of correction will be developed to eliminate all identified barriers as affordable or otherwise feasible.
5. Accessibility is monitored by the health and safety committee and upper management. Any identified barriers are reported to the executive director.
6. An ongoing list of identified barriers which cannot be corrected is maintained with explanation as to why the barrier cannot be corrected or eliminated and any future plans to correct the barrier.
7. The MCH Board of Directors reviews, monitors, and visits facilities to ensure accessibility. Board participation and awareness is reflected in meeting minutes.
8. While MCH cannot correct all community barriers, MCH employees and board members assume responsibility for educating the community to the needs of persons served.

See Attachment—Checklist to Identify Barriers to Accessibility
See Attachment—ADA Compliance Checklist

Revised: 8/17; 7/20
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HIPAA

The Health Information Portability and Accountability Act is a federal law that outlines how MCH is to protect the personal health information of the persons we support. HIPAA is very comprehensive in terms of laying down guidelines governing the sharing or disclosure of Patient Health Information. MCH is subject to the HIPAA regulations as a covered entity since it bills Medicaid directly.

It is MCH's policy to comply fully with HIPAA requirements. All staff members who have access to PHI must comply with this HIPAA Privacy and Security Plan. The following protocols should be followed by MCH staff regarding the uses and disclosures of Protected Health Information (PHI) of the persons we serve. This policy also provides MCH staff with a standard procedure for keeping health information on a need-to-know basis and maintaining the confidentiality of each person's served or employee's medical history. This is in addition to and does not replace confidentiality or rights policy contained in other MCH Policies, Procedures, and Operations.

General Practices

MCH staff may use and disclose Protected Health Information for treatment, payment and Health Care Operations without written authorization from employees, persons served and/or legally responsible persons.

It is permissible to disclose PHI to business associates where MCH has obtained signed business associate contracts that require the business associate to safeguard the Protected Health Information.

For uses and disclosures that are not for treatment, payment, or healthcare operations, a signed authorization to disclose PHI must be on file.

MCH staff are granted access to Protected Health Information (PHI) whether written, electronic or verbal in nature in accordance with HIPAA (Health Insurance Portability and Accountability Act) and other state and federal laws. Such access shall be limited to the minimum necessary amount of PHI MCH employees need to know in order to accomplish their job. Communications between staff which involve PHI shall also be considered confidential and should not take place in public areas. If it is necessary to conduct such conversations in public areas, reasonable steps shall be taken to assure the confidentiality of the PHI.

When using or disclosing Protected Health Information, MCH makes reasonable efforts to limit what is shared to the minimum necessary to accomplish the intended purpose of the use, disclosure, or request.

Persons served or employee PHI should never be removed from MCH's facility without specific authorization or following the procedures for checking out records found in the general policies and procedures.

If PHI in any form is lost or stolen, the executive director or designee should be notified immediately but no later than 24 hours after the loss is discovered in order to initiate the mitigation process.

See Attachment—Consent to Release Information
See Attachment—Confidentiality Agreement

Privacy Officer

The executive director serves as the privacy officer for MCH. The privacy officer will be responsible for the development and implementation of policies and procedures relating to privacy, including but not limited to this policy and MCH's use and disclosure procedures. The privacy officer will also serve as the contact person for persons served who have questions, concerns, or complaints about the privacy of their PHI. The privacy officer can be reached at (828) 524-5888.

Employee Training

At the time of hire and at least annually thereafter, MCH employees receive HIPAA training. If a privacy incident occurs, the Privacy Officer in collaboration with management will evaluate the incident to determine whether additional staff training is in order. Depending upon the situation, the Privacy Officer may determine that all staff should receive training that is specific to the incident. The Privacy Officer will review any privacy training developed as part of a privacy incident resolution to ensure the materials adequately address the circumstances regarding the privacy incident and reinforce MCH's privacy policies and procedures.

Safeguards

MCH has established technical and physical safeguards to prevent PHI from intentionally or unintentionally being used or disclosed in violation of HIPAA's requirements. Technical safeguards include limiting access to information by creating computer firewalls. Physical safeguards include locking doors or filing cabinets and periodically changing door access codes. Additionally, all staff members can only access PHI by using their own login information. Firewalls ensure that only authorized employees will have access to PHI, that they will have access to only the minimum amount of PHI necessary for their job functions, and that they will not further use or disclose PHI in violation of HIPAA's privacy rules. Currently all data on stored MCH computers is backed up using industry standards with off-site storage of media. Personal computers and laptops are not loaned to others. Any MCH computers which have internet access must have active anti-virus protection which is regularly updated. Anti-virus server software should be configured to check for virus signature updates automatically.

Passwords for all electronic systems are subject to the following rules:

- Passwords are not to be spoken, written, e-mailed, hinted at, shared, or in any way known to anyone other than the user involved. This includes supervisors and assistants.
- Passwords are not to be shared in order to cover for someone out of the office.
- Passwords should not involve any term or number which could easily be guessed or decoded by someone who is familiar with you.
- Passwords are not to be displayed or concealed in the workspace.

The privacy officer must have a copy of each password.

Privacy Notice

The Privacy Officer is responsible for developing and maintaining a notice of MCH's privacy practices that describes the uses and disclosures of PHI that may be made by MCH, the rights of the persons served and MCH's legal duties with respect to the PHI. The privacy notice provides a description of MCH's complaint procedures, the name and telephone number of the contact person for further information, and the date of the notice. All employees, persons served and/or legally responsible persons should receive a Notice of Privacy Practices that explains the individual's rights and MCH's legal duties regarding Protected Health Information. This notice provides the individual with a clear definition of disclosures made by MCH. It is provided at the time of starting with MCH and at least every three years thereafter.

Consent to Release PHI

Personal health information may be disclosed when authorized by the employee, person served or legal guardian. Authorization of release is documented on the Consent to Release Information form. Consents must contain who is receiving the information, the purpose of the release, exact documents or information that is being shared and be signed. Consents are time-limited and must be updated at least annually. Any time an individual no longer wants their information shared, they may revoke a consent. All consents must be signed and dated to be valid. In an emergent situation, verbal consent may be obtained but must be documented in the person's record as well as followed up with a written consent within 30 days.

Complying with the "Minimum-Necessary"

HIPAA requires that when PHI is used or disclosed, the amount disclosed generally must be limited to the "minimum necessary" to accomplish the purpose of the use or disclosure. The "minimum-necessary" standard does not apply to any of the following:

- uses or disclosures made to the individual
- uses or disclosures made pursuant to a valid authorization
- disclosures made to the Department of Labor
- uses or disclosures required by law
- uses or disclosures required to comply with HIPAA.

For making disclosures of PHI to any providers or internal/external auditing purposes, only the minimum necessary amount of information will be disclosed. MCH may use professional judgment and experience with common practice to make reasonable inferences for the person's served best interest in allowing employees to act on behalf of the person served to pick up filled prescriptions, medical supplies, X rays, or other similar forms of PHI. MCH staff

are expected to carry out these activities in providing supports to persons receiving residential services, as indicated in their job descriptions.

All visitors to MCH facilities and all MCH employees are required to sign a confidentiality agreement. A copy of the signed confidentiality agreement shall be maintained in the personnel file.

Disclosures of De-Identified Information

MCH may freely use and disclose de-identified information. De-identified information is health information that does not identify an individual and with respect to which there is no reasonable basis to believe that the information can be used to identify an individual. There are two ways a covered entity can determine that information is de-identified: either by professional statistical analysis, or by removing 18 specific identifiers listed below:

1. Name
2. Geographic subdivisions smaller than a state
3. All elements of dates (except year) related to an individual - including dates of admission, discharge, birth, death - and for persons >89 y.o., the year of birth cannot be used.
4. Telephone numbers
5. FAX numbers
6. Electronic mail addresses
7. Social Security Number
8. Medical Record numbers
9. Health plan beneficiary numbers
10. Account numbers
11. Certificate/license numbers
12. Vehicle identifiers and serial numbers including license plates
13. Device identifiers and serial numbers
14. Web URLs
15. Internet protocol addresses
16. Biometric identifiers, including finger and voice prints
17. Full face photos, and comparable images
18. Any unique identifying number, characteristic or code

Rights to Health Information

Per the HIPAA privacy rule, persons served by MCH, their legally responsible person(s) and employees have the following rights regarding their health information:

- accessing and copying their health information, consistent with certain limitations;
- receive an accounting of disclosures MCH has made of their PHI for up to six years prior to the date of requesting such accounting. Certain limitations do apply as outlined in the policy for Accounting of Disclosures
- may submit complaints if they believe or suspect that information about them has been improperly used or disclosed;
- request MCH to amend health information in their record if the person believes information is inaccurate

- ask MCH to take specific actions regarding the use and disclosure of their information. MCH may either approve or deny the request. Specifically, persons have the right to request that MCH restrict use and disclosures of their individual information while carrying out treatment, payment activities, or health care operations and to receive information from MCH by alternative means, such as mail, e-mail, fax or telephone, or at alternative locations.
- request to receive confidential communications about their health information.

Verifying Identity of Individuals Requesting PHI

MCH staff must verify the identity of persons requesting Protected Health Information and ensure the individual has the proper authority to request such information. A valid authorization for the disclosure of PHI must be obtained before the health information can be released to any third party requesting the information. The person making the request must present identification prior to receipt of any records.

MCH staff may rely on the following information to demonstrate identity:

- written request on agency letterhead or an oral statement if a written statement would not be possible (a natural disaster, other emergency situations, etc.);
- a written statement on government letterhead that the person is acting under the government's authority, or a contract or purchase order evidencing the same;
- a court order

MCH staff should verify identity of any phone requests from all individuals, including law enforcement officers and others who have an official need for PHI by using a callback phone number before releasing information.

MCH staff should verify facsimile number of any faxed requests. The main number of the sending agency should be called, and the fax number verified. Fax machines shall be set to imprint the origin. All incoming faxes shall be reviewed for imprint origin.

MCH staff shall verify e-mail address by calling the person making the request. The general number for the sending agency shall be called and then a request shall be made to be transferred to the specific individual who made the contact.

MCH staff may disclose information to the person making the request if all requirements for use and disclosure are met and if all requirements within this policy are met. If identify is not verified, staff may deny access to health information.

The MCH Executive Director shall assure that a mechanism is in place which tracks disclosure of both written and verbal Protected Health Information. The same format shall be utilized for all facilities.

Accessing and Inspecting PHI

It is the policy of MCH to protect the privacy of individually identifiable health information. In cases where a person has been civilly adjudicated, is incapacitated, or is a minor, the parent or the legal guardian or personal representative may request access. There may be exceptions as allowed by law.

Procedures:

1. A person who has or is receiving services from MCH, or a parent of a minor, or a personal representative or a legal guardian must request in writing for access to inspect, or receive copies of Protected Health Information.

2. The Access to Individual Record form shall be provided to facilitate the request. MCH personnel may assist in initiating the process requesting inspection of Protected Health Information.
3. All requests by employees, persons served and their legal representatives for PHI must be forwarded to the executive director for approval.
4. This request shall be processed within 30 days after receipt of the request. If the record cannot be accessed within the 30 days, the timeframe may be extended once for an additional 30 days with notification in writing to the individual outlining reasons for the delay and the date the request will be concluded.

See Attachment—Access to Individual Record

Denial of Access to Individual Record

There are situations where a request to access an individual's record may be denied. Those situations include the following:

- information compiled for use in a civil, criminal or administrative action or proceeding; or information that would be prohibited from use or disclosure under the Certified Laboratory Information Act (CLIA) laws and regulations;
- if access is precluded by law;
- if the information was obtained from someone other than a health care provider under a promise of confidentiality and the access requested would be reasonably likely to reveal the source of the information; or
- if MCH has been provided a copy of a court order from a court of competent jurisdiction which limits the release or use of PHI
- a licensed health care professional based on an assessment of the particular circumstances, determines that the access requested is reasonably likely to endanger the life or physical safety of the client or another person.
- there is a reasonable belief that the person served has been or may be subjected to domestic violence, abuse, or neglect by the individual; or treating such individual as the personal representative could endanger the person served; and MCH, exercising professional judgment, decides that it is not in the best interest of the person served to treat that individual as the personal representative of the person served.

Upon denial of any request for access to PHI, in whole or in part, a written letter shall be sent to the client, or other valid representative making the request for access stating in plain language the basis for the denial.

If the individual has a right to a review of the denial, the letter shall contain a statement of how to make an appeal of the denial including the name, title, address, and telephone number of the board of directors to whom an appeal should be addressed.

This letter shall also address the steps to file a complaint with the secretary of DHHS. If the information requested is not maintained by MCH, but it is known where the client may obtain access, MCH must inform the individual where to direct the request for access.

Appealing Decisions to Deny Access to PHI

A person served, parent of a minor, or legal guardian has the right to appeal MCH's decision to withhold portions or all of the record for safety or confidentiality reasons. The request for appeal should be submitted in writing to MCH's Board of Directors.

During the review, the Board must determine if access meets an exception as described above. If the board determines that the initial denial was appropriate, the individual will be notified in writing, using plain language, that the review resulted in another denial of access. The notice must include the reasons for denial and must describe the process to make a complaint to the Secretary of DHHS.

If the denial was not appropriate, the board will refer the request to MCH's Privacy Officer for action. If access is denied to any portion of the PHI, access must still be granted to those portions of the PHI that are not restricted. MCH is bound by the decision of the board.

Record Amendment

Employees, person's served and/or legally responsible persons who believe information in the medical records is incomplete or incorrect may request an amendment or correction to the information. Amendments will be made by following these procedures:

1. The person requesting the amendment will complete a Record Correction/Amendment Form. If a person served is making the request and needs assistance, their QP may assist them in completing the form.
2. The entry author can correct the entry or add a progress note to clarify content according to standard documentation procedures allowable under state statute.
3. Whenever the corrected/amended entry is disclosed, a copy of the correction/amendment form will accompany the disclosed entry.

See Attachment—Record Correction/Amendment Form

Requests for Restrictions of PHI

If an employee, person served or legally responsible person wishes to request a restriction on the use or disclosure of Health Information, a Request for Restrictions of PHI form should be completed. Each request is handled and reviewed on a case-by-case basis; however, it is the standard practice of MCH to deny requests that interfere with treatment, payment, or operations.

Before approving this request appropriate considerations will be given to the need to access PHI for treatment purposes. If the restriction may interfere with treatment it is MCH's policy to discuss this with the person and only agree to restrictions that will not interfere with treatment the person is receiving. Any agreed upon restrictions will be documented in the individual's goal plan or some other conspicuous place in the record. Information use and disclosure must remain consistent with any agreed-upon restrictions. A restriction set by an individual can only be terminated with a written agreement.

See Attachment—Request for Restrictions of PHI

Business Associates

It is the practice of MCH to utilize third parties to perform activities and provide services that involve the use and/or disclosure of Protected Health Information. Consultants who perform activities involving Protected Health Information are referred to as business associates. A business associate is not an employee of MCH.

It is the policy of MCH to obtain a business associate agreement that the business associate will maintain the confidentiality and security of MCH Protected Health Information. MCH is required to act if it becomes aware of a practice or pattern that constitutes a material breach of this policy.

MCH staff must strictly observe the following standards relating to business associates per contract:

- not use or further disclose the information other than as permitted or required by the contract or as required by law;
- employ appropriate safeguards to prevent use or disclosure of the information other than as provided for by contract;
- report to MCH any use or disclosure of the information not provided for by contract;
- ensure that any agents, including any subcontractors, to whom it provides PHI received from, or created by, or on behalf of MCH, agree to the same restrictions and conditions that apply to the business associate with respect to such information;
- make available the information required to provide an accounting of disclosures in accordance with the MCH policy;
- make internal practices, books, and records relating to the use and disclosure of PHI received from, or created by or on behalf of MCH, available to NC DHHS for purposes of determining MCH compliance; and

- at termination of the contract, if feasible, return or destroy all PHI received from, or created by or on behalf of, MCH that the business associate still maintains in any form and retain no copies of such information. If such return or destruction is not feasible, extend the protections of the contract to the information and limit further uses and disclosures to those purposes that make the return or destruction of the information infeasible.

In the event MCH becomes aware of a pattern or practice of the business associate that constitutes a material breach or violation of the business associate's obligations under its contract, MCH must take reasonable steps to cure the breach or to end the violation, as applicable. In the event that the business associate cannot or will not remedy the practice or pattern, MCH must terminate the contract if feasible. Where termination is not feasible, the executive director must report the breach to DHHS, as required.

Breach Notification

A breach is an unauthorized use or disclosure of protected health information (PHI) and is presumed to be a breach unless MCH demonstrates through a risk assessment that there is a low probability that the protected health information has been compromised.

In conducting the risk assessment, MCH will consider: (1) the nature and extent of the PHI involved; (2) the person who used the PHI or to whom the disclosure was made; (3) whether the PHI was actually acquired or used; and (4) the extent to which any risk to the PHI has been mitigated.

If an evaluation of these factors does not demonstrate a low probability that the PHI has been compromised, then breach notification is required. MCH assumes the burden of proving that all required notifications were made or that the use or disclosure did not constitute a breach. Accordingly, thorough documentation of the risk assessment should be made and kept.

There are three exceptions to the definition of a breach. They include: (1) the unintentional acquisition, access or use of PHI by a MCH employee, if made in good faith and within the scope of authority and no further unauthorized use or disclosure is made; (2) an inadvertent disclosure by a person authorized to access PHI at MCH to another such authorized person at MCH, and no further unauthorized use or disclosure of the information is made; and (3) in the case where MCH has a good faith belief that the unauthorized person to whom the disclosure was made would not reasonably be able to retain such information.

A breach is considered discovered by MCH on the first day that it is known, or by exercising reasonable diligence would have been known, to MCH. Factors to consider in determining whether reasonable diligence was exercised include whether reasonable steps were taken to learn of the breaches and whether there were indications of breaches that a person seeking to satisfy the rule would have investigated under similar circumstances. In addition, MCH is deemed to have knowledge of a breach if, by exercising reasonable diligence, a breach would have been known to an employee who was not the person who committed the breach. Accordingly, if a business associate is acting as an agent of MCH, MCH will be deemed to have knowledge of the breach when the business associate discovers the breach, and the time for

breach notification begins to run when the business associate discovers the breach, not when the business associate actually informs the covered entity of the breach. Individual notifications are to be made without unreasonable delay, but in any event no later than sixty (60) calendar days from when the breach was discovered, unless law enforcement requests a delay.

Mitigation After Breach of PHI

To the extent practicable, MCH will mitigate any harmful effect that becomes known to MCH as a result of a use or disclosure of PHI in violation of HIPAA or other state health privacy laws or MCH policies and procedures.

The executive director shall be responsible for taking corrective measures to remedy violations to the organization's policies and procedures.

If a violation is a result of an employee's negligence or failure to follow MCH's policies or procedures actions to re-train, reprimand, or discipline the staff will be taken immediately as appropriate.

If a violation is a result of negligence by a business associate, the incident should be formally documented and the business associate should provide written assurances to indicate the corrective measures that have been taken to remedy the violations.

In the event of an infraction, breach or violation to a client's Protected Health Information, the person served or legally responsible person should be notified in writing of the violation and the corrective actions taken to further protect the individual's privacy.

Non-Retaliation Against Employees

All MCH staff are allowed to discuss and raise questions to the MCH Privacy Officer or to the appropriate personnel about situations they feel are in violation of HIPAA and other federal and state laws, MCH's policies, and/or accreditation and regulatory requirements.

All MCH employees have a personal obligation to report any activity that appears to violate HIPAA or other applicable laws, regulations, rules, policies, and procedures.

MCH shall not intimidate, threaten, coerce, discriminate against, or take any retaliatory action against any person served, legally authorized representative, employee, staff, volunteer, associate, association, contractor, organization or group that in good faith:

- discloses or threatens to disclose information about a situation they feel is inappropriate, or potentially illegal;
- provides information to or testifies against the alleged offending individual or MCH;
- objects to or refuses to participate in an activity they feel are in violation of HIPAA or any other federal and state law, MCH's policies, or accreditation requirements;
- is involved in any compliance review or peer review process; or
- files a valid or legitimate report or a complaint, or an incident report.

All allegations, complaints, violations and incident reports should be formally documented and provided to the executive director in writing.

The MCH executive director will review any allegation of retaliation and will ensure that a proper investigation is conducted as appropriate. The investigation will be in accordance with the MCH Policy for Unacceptable Job Performance/ disciplinary Action.

Transmitting and Receiving Electronic PHI

It is the policy of MCH to monitor and safeguard all electronic transmissions of PHI. Electronic transmissions include transactions using all media, transmissions over the Internet (including e-mail), and dial-up lines.

Transmitting PHI electronically is a critical part of MCH business operations. Electronic billing is encrypted by the HP Federal software provided for billing. Otherwise, PHI should be encrypted before transmitting.

In the course of business, it may be necessary to send PHI in an e-mail message for the purposes of treatment. Information considered confidential or sensitive must be protected during transmission of the data by adding a statement of confidentiality of information such as the following:

> ***This message (including any attachments) contains confidential information intended for a specific individual and purpose and is protected by law. If you are not the intended recipient, you should delete this message. Any disclosure, copying, or distribution of this message or the taking of any action based on it is strictly prohibited by law.***

In the course of business, it may be necessary to transmit or receive electronic PHI while using a dial-up internet connection or private network. In these instances, MCH staff should implement a personal firewall for data transfers.

Fax Transmittal of PHI

It is the policy of MCH to protect the facsimile transmittal of PHI and hold individuals responsible for following the proper procedure when PHI is sent via facsimile. MCH protects the confidentiality and integrity of confidential medical information as required by law, professional ethics, and accreditation requirements.

Employees must strictly observe the following standards relating to facsimile communications of PHI:

- confidential information may be transmitted by facsimile when urgently needed for care or required by a third-party payer for ongoing certification of payment for a person served
- information transmitted must be limited to the minimum necessary to meet the requester's needs.
- a properly completed and signed authorization must be obtained before releasing PHI for purposes other than treatment, payment, or healthcare operations.

- a facsimile cover letter must be used to send faxes containing PHI. All pages plus the cover page of all confidential documents to be faxed must be stamped Confidential before they are transmitted.
- reasonable efforts must be made to ensure that the facsimile transmission to the correct destination including verifying the fax number by requesting the recipient submit a faxed or email request for PHI which would include the fax number of the recipient if a new recipient,
- periodically remind those who are frequent recipients of PHI to notify MCH if their fax number changes
- maintain a copy of the fax transmittal and fax confirmation sheet for future reference
- confirmation that the facsimile is received
- quick removal of faxes received
- destroy any faxes received in error according to the sender's instructions

The following types of medical information are protected by federal and/or state statute and may NOT be faxed or photocopied without specific written client authorization, unless required by law:

- confidential details of psychotherapy (records of treatment by a psychiatrist, licensed psychologist or psychiatric clinical nurse specialist).
- other professional services of a licensed psychologist
- social work counseling/therapy
- HIV test results

See Attachment—Facsimile Cover Letter

Retention of Documentation

This policy defines the guidelines and procedures that must be followed for the retention of any policy, procedure or documentation developed by MCH while implementing the HIPAA privacy and security standards.

1. As required by the HIPAA privacy and security rules MCH will retain all policies and procedures developed by MCH during its implementation of the HIPAA standards and specifications.
2. MCH will make records and document any activity, action or assessment required by the HIPAA privacy and security rules.
3. MCH will record and retain any communication required by the HIPAA privacy or security rules.
4. MCH will retain the required documentation for six years from the date of its creation or the date when it last was in effect, whichever is later.
5. All documentation and records created for the purpose of compliance with the HIPAA regulations will be stored and recorded in MCH HIPAA compliance manual.

Disposal of PHI

MCH will dispose of PHI by means that assure that it will not be accidentally released to an outside party by using shredders for proper disposal of printouts containing PHI. Shredders may be used for the destruction of copies so long as the destruction is in accordance with this policy. Electronic data will be erased using the appropriate utilities.

Reporting Security Incidents

A security incident is an attempted or successful unauthorized access, use, disclosure, modification, destruction of information, or interference with system operations.

In the event that a member of the MCH staff has knowledge of a security incident that may jeopardize the integrity or confidentiality of MCH information systems, staff are required to immediately notify the privacy officer. The privacy officer will review relevant documentation that may provide additional information regarding the reported incident. If the security incident is a result of inadequate technical safeguards, the privacy officer should take appropriate measures to amend the weakness in MCH's security procedures. The privacy officer will document the security incident and the corrective actions taken to prevent future incidents. The privacy officer will mitigate, to the extent practicable, harmful effects of security incidents that are known to the organization and document security incidents and their outcomes.

Violations of Internal Procedures

All employees of MCH must guard against improper uses and disclosures of Protected Health Information. It is the standard practice of MCH that all employees complete training on MCH's policies and privacy practices. Employees must sign that they understand and agree follow the policies. If there is a question whether a use or disclosure of health information is appropriate, the Privacy Officer should be consulted. The MCH Privacy Officer is responsible for enforcing this policy.

Employees who knowingly and willfully violate state or federal law for improper invasions of personal privacy may be subject to:

- disciplinary action, up to and including termination or dismissal.
- criminal investigation and prosecution, both by the state and by the federal government, depending on the nature of the violation. Federal and state law provides substantial fines and prison sentences upon conviction, depending on the nature and severity of the violation.
- civil monetary penalties that the federal Department of Health and Human Services (DHHS) may impose.

Revised: 8/17
Reviewed: 7/18; 8/19; 7/20; 5/22

HEALTH INFORMATION TECHNOLOGY FOR ECONOMIC AND CLINICAL HEALTH ACT (HITECH)

The HITECH Act, enacted as part of the American Recovery and Reinvestment Act of 2009, imposes notification requirements on covered entities, business associates, vendors of personal health records (PHR) and related entities in the event of certain security breaches relating to protected health information (PHI). In an effort to protect information, MCH utilizes the electronic health record Therap to add an additional layer of protection of the PHI of persons receiving services.

Encryption

All MCH confidential electronic information must be encrypted (a) when transmitted over unsecure networks including the Internet and wireless, and (b) when at rest on portable computing devices and portable/removable electronic media. This policy applies to all MCH electronic information which is considered confidential data.

Monitoring and Enforcement

While the business director is responsible for monitoring and enforcing this policy, all employees are responsible for ensuring compliance with this policy. Policy will be reviewed annually or as needed.

Revised: 8/17; 5/22
Reviewed: 7/18; 8/19; 7/20

TECHNOLOGY

Each year MCH evaluates its existing technology infrastructure and usage in order to make recommendations for future planning and direction. MCH manages technology by providing an inventory of current technology assets, documentation of needs, and a prioritized plan, including a budget, to address these needs. Employees are provided with technology as required by the position and as budgets allow. Inventory is tracked through semi-annual checklists completed by each facility manager which are, in turn, given to the business director

Procedures

1. Each year before the end of the fiscal year, the executive director, business director and QPs review the use of technology and inventory current in use.
2. Staff make requests for new technology on departmental budget requests.
3. Computers, tablets and printers are replaced as needed, and old equipment is offered for sale at reduced prices to employees or donated to a local charity if of little value.
4. Cell phones are replaced as needed.

See Attachment—Technology Tracking

Revised: 8/17; 7/20; 5/22
Reviewed: 7/18; 8/19

ELECTRONIC DATA MANAGEMENT (Therap)

MCH uses an electronic data management system (Therap) for documentation and file management. In order to comply with CMS Electronic Signature Guidance, Health Insurance Portability & Accountability Act of 1996 (HIPAA), Uniform Electronic Transactions Act (UETA) and E-SIGN (The Electronic Signatures in Global and National Commerce Act), compliance guidelines and requirements for the use and storage of electronic data records, MCH's electronic data records will be made available via a special access account for review and will be retrievable for authorized state survey team members, auditors and investigative employees. All modules will be made available for review, including activity tracking, secure communications, archive data, management reports, GER (Incident Reports), behavior data, eMAR, personal finance, IP and ISP Data and health tracking, billing information, staff training records, T-Log notes, and periodic reports, etc.

Staff Training

MCH provides employees training in the use of Therap, methods and requirements for documentation, the use of searches, and summary data and reports for all modules. Online training, "walkabouts", automated training, webinars, a User Guide, online help, feedback, and FAQs are available for all users on: www.TherapServices.net.

MCH employees will receive training in the following procedures:

1. Protected health information (PHI) of persons receiving services should always be communicated securely, e.g., using secure HTTPS, a cryptographically secured protocol and interfaces.
2. Employees will be instructed in the authorized use of PHI for individuals in their care, and to not discuss confidential information outside of their place of employment.
3. Employees will proceed with caution when saving electronic files containing PHI or files exported from THERAP to Excel or PDF.
   Employees should not share their personal login information with others, write down their login information on paper, or save them in electronic file that can be accessed by others.
4. While accessing the system from a shared computer or a public place, employees should not leave the computer screen unattended, delete all information from those computers, including clearing caches cookies and temporary files.
5. MCH employees are advised not to store data on personal computers, laptops, or other storage devices, and any files containing PHI should be deleted after the work has been completed.

6. Management reports, behavior Information, nursing, summary reports and other reports containing PHI may be printed or copied for use as required for MCH business, per MCH policy, or as required by state or federal regulation

Therap Administrators

MCH's Therap Administrators will be trained by Therap employees in the use and management of electronic data within the secure database. These selected Administrators are responsible for proper assignment of access privileges to users, setting up password policies, and activating/deactivating user accounts. Administrators will be required to have a clear understanding and sound knowledge of the various application capabilities and the underlying HIPAA regulations and E-sign policy, including:

Access Control**:** Administrators are responsible for assigning proper roles and privileges to users to grant them access to systems while at the same time restricting access only to authorized information. Administrators are also responsible for updating these user access privileges assigned in accordance with changing job responsibilities and authority.

Implement Password Policy**:** Administrators are able to set up and implement a suitable password policy for MCH by specifying specific properties, including the minimum length, number of letters, digits, special characters required, and the policy regarding the password expiration periods. MCH will not record, or inquire regarding employees' passwords, or assign passwords to employees. MCH may reset a temporary password at the request of employees who have been locked out of the system, however, employees will be asked to reset their temporary Therap System password immediately.

Managing User Accounts**:** Administrators are responsible for creating and activating Therap accounts for employees and providing them with the required login information. Administrators will instruct new account holders to create passwords. If users forget their passwords, login names or provider codes, they will ask their Administrators for this information. (Therap Customer Support will not alter or supply users' login information, except for agency Provider Administrators.). Administrators may also disable employees' user accounts when they terminate employment, are on Administrative Leaves, or extended leaves.

Assignment of Roles and Caseloads**:** Therap implements a multilevel access mechanism based on roles and persons served. MCH specifies the level of access available to particular users of the systems and grant permission accordingly. Administrators will assign users a specific list of roles for access privileges, as well as access to a specific caseload(s) of persons served based upon their need to know, access, and level of responsibility.

Tracking User Activities**:** Administrators are able to track users' activities by using the Therap Activity Tracking module. The module is equipped with the capability to record and report on activities of all user accounts. The Activity Tracker will record all users accessing the system, including, time, date, login name, user name, IP address, and all activities, including viewing of information, creation or modification of any and all data or records. Administrators with this

role or option can detect any attempts to breach the system security (failed login attempts) or other misuse. The Therap system is monitored by security systems and Therap employees for unusual activity. As needed, Therap services will provide training and support materials for Administrators to learn about these and other HIPAA compliant Therap features.

Message Integrity

All communications between end users' browsers and the Therap application are carried over HTTPS, a cryptographically secured protocol. No third parties can modify the data transferred or modify the data stored in Therap without going through the application. The data is stored in multiple secured locations, guaranteeing its safety from natural and manmade disasters.

Secure Sockets Layer (SSL): SSL is the international standard used to ensure protection of data during transmission over the internet. SSL provides endpoint authentication and communications privacy over the Internet using cryptography. The protocols allow client/server applications to communicate in a way which is designed to prevent eavesdropping, tampering and message forgery. Called communications from users to the Therap system use SSL, and thus are secure during transmissions.

Non Repudiation: As data is stored securely no users can access the data without proper privilege and audit trail (activity tracking), and no users can deny the association of their identity with documents stored in Therap.

User Authentication: All users, including Therap employees, must authenticate with a unique login name and a secret password to gain access to the system.

Session Expiration: Therap has a session expiration mechanism such that a session expires when a user has not used the system (i.e., has not hit any key on the keyboard or clicked on a button on the form) for half an hour. The system displays a countdown message for 5 minutes before the session actually expires. If users want to resume work, they can cancel the expiration by simply clicking a button on the countdown message. This is a security feature which prevents unauthorized personnel from using their login in cases where users may have left the program without logging out.

Altering over Non-Secure Media: The Therap system assures that no PHI is transmitted over media, including email, text messaging, paging, while still providing a flexible alerting mechanism. For example, users may configure their notification properties to receive email or text messages that would let them know about critical incident reports being filed without revealing any PHI. When secure media, such as SComm and FirstPage, are used for alerting, the system allows PHI, such as clients' names to be included.

Clear to Zero: All employees are required to clear the FirstPage or Dashboard of all numbers in their Therap accounts at the beginning of their shifts. Employee's' FirstPage or Dashboards can be cleared by opening and reading all information contained in these links. Employees are responsible for all information contained in these communications. The Therap system does record that these items that have been viewed and acknowledged by employees.

Printable Format or Record Access: Information contained in Therap is printable and can be reproduced, upon request, for any quality monitor, licensing employees, survey teams, auditors, or guardians.

Readily Accessible: Therap will be accessible, upon request, to any authorized person including licensing employees, investigators, surveyors, auditors, and monitors, twenty-four hours per day. MCH Administrators can provide immediate and complete access to the electronic records of persons receiving services to authorized personnel through online access and remote approval. The list of MCH Administrators is available under employees' "My Account" section located on their First Page or Dashboard.

Deletion of Information: Therap will maintain all data submitted by users, in the original form, and as approved, updated or modified, all versions of reports, data, and information will be archived and retrievable. Any sensitive or confidential documents, e.g., Abuse, Neglect, Unlawful Acts, etc., will be available upon request by authorized personnel to review, and may be accessed online with restricted access. Records and data will not be deleted from the system, and any such requests for the deletion of any information will be recorded and accessible to auditors, investigators and appropriate authorities. This information will be recorded in Administrators' Secure Communications, and will contain a written explanation of the request, with identification of users making the requests, dates and times, data information, and Form ID numbers.

Implemented: 2/2019
Reviewed: 8/19; 7/20; 5/22

ACCESSING ELECTRONIC HEALTH RECORD (THERAP)

Therap is a web-based electronic health record that serves to provide the documentation and communication needs of MCH. Therap offers an easy and efficient alternative to the immense amount of paper work that hand-documentation requires. The Therap web-based network is the property of Therap Services. The equipment and information is the property of MCH and is to be used for legitimate business purposes. Users are provided access to Therap to assist them in the performance of their jobs. Additionally, certain employees ("Users") may also be provided with access to the Internet through the computer network. All employees have a responsibility to use MCH computer resources, Therap, and the Internet in a professional, lawful and ethical manner. All communication must be complete, professional, factual, and respectful to all parties involved. No derogatory, slanderous, discriminatory, harassing, obscene or otherwise inappropriate documentation or communication will be permitted. Abuse of the computer network, documentation parameters or the Internet, may result in disciplinary action, including possible termination, and civil and/or criminal liability.

The following responsibilities are necessary for all employees that use the Therap system:

1. Electronic signature – Each employee shall choose a password of their choice to enable access to the system and to review activity tracking. The electronic signature tracks time and date stamps all entries within Therap. Employees shall NEVER give this password to any other employee. Violation of this policy shall result in immediate discipline up to and including termination. In addition, violation of this policy puts the employee at risk of document falsification whereby one employee falsely “signs in” as another and implicates an individual in activities not authorized or verified by the employee.
2. Communication through Therap must be professional, accurate, sensitive, and respectful. If communication is not professional, it will be considered an employee performance concern and is subject to disciplinary action.
3. MCH computers, devices and Internet capabilities are not to be used for employee’s personal use, including but not limited to, on-line purchases, accessing personal email accounts, visiting social media sites, etc. and accessing websites of inappropriate content (offensive, violent, sexual content, etc.).
4. Employees are not permitted to install computer applications on program computers without prior authorization from MCH management.

5. Friends, family, or guardians of the persons served are not permitted to access program computers.
6. The sharing of sensitive information with others through Therap's Secure Communication (S-Comm) is strictly confidential. Any unauthorized sharing of such information may be considered a breach of confidentiality.
7. Staff may use MCH devices to access Therap access to assist them in the performance of their jobs. Users should have no expectation of privacy in anything they create, store, send or receive using MCH computer equipment. The computer network is the property of MCH and may be used only for MCH purposes.
8. MCH has the right to monitor and log any and all aspects of its electronic system including, but not limited to, monitoring Internet sites visited by Users, monitoring Therap access, monitoring chat and newsgroups, monitoring file downloads, and all communications sent and received by users.
9. Non-exempt employees are prohibited from signing onto Therap during their unpaid time unless authorized by their manager. Non-exempt employees are prohibited from signing onto Therap at a location other than one considered MCH property unless authorized by a manager or QP. Violations of the above shall result in immediate discipline up to and including termination.
10. All shift documentation must be completed by the end of each shift, and incident reports must be completed per MCH and state requirements.
11. Use of on-line document should be efficient and should in no way decrease direct interactions with persons who are receiving support.
12. No secure communication or documentation received or sent from any MCH employee can include sexually explicit images or messages, or racial, ethnic or other slurs that may defame, embarrass, threaten, offend or harm another person. MCH retains the right to review, copy, delete and disclose any messages to the appropriate persons.
13. MCH employees who provide periodic, community-based services will be expected to provide their own means of accessing Therap, whether through personal cell phone or computer. This requirement is outlined within the job description and explained at the time of the interview as a condition of employment.
14. All employees will sign a form acknowledging the Therap Access Policy at the time of hire as well as annually thereafter.

See Attachment—Therap Access Policy Acknowledgement

Implemented: 2/2019
Reviewed: 8/19; 7/20; 5/22

PERSONAL DEVICE USE FOR ACCESSING THERAP

While MCH provides computers and tablets to access Therap at group homes and the day program, MCH employees who provide periodic services in the community are required as a condition of employment to access Therap to complete their job duties using their personal device. These employees must adhere to the following requirements:

1. The device will be on and available to use during regularly scheduled work hours and must answer phone calls from MCH.
2. Always be current in payment to prevent disconnection/deactivation.
3. Must have a Phone/Text/Data plan in order to complete job duties.
4. Employees will NOT download any Protected Health Information (PHI) onto their personal device.
5. Use a device lock and encrypt the personal device, so that it is not accessible should it be lost or stolen.
6. Document all logs, program data and MAR within the Therap application (must be downloaded from Google Play/App Store) and not within a mobile browser.
7. Download antivirus software onto phone and run continuously at all times.
8. Wi-Fi access must be a secure and not a public, free hotspot.
9. If no secure Wi-Fi is available, employees must use their device data for work-related use.
10. Employees who are required to utilize their personal device as a condition of employment will review and sign a Personal Device Agreement at the time of hire, which will remain in effect until such time employment with MCH ends.

See Attachment—Personal Device Agreement

Implemented: 2/2019
Reviewed: 8/19; 7/20; 5/22

SECURE COMMUNICATIONS (Therap SComm)

The Therap Secure Communications (SComm) module has been designed to facilitate the exchange of information among co-workers in a secure, HIPAA compliant way. MCH staff can exchange messages on administrative, personal or individual care related issues. Users can also contact and communicate with Therap Customer Support regarding PHI sensitive issues.

Procedure

1. MCH staff are accountable for the information they input into the Therap database
2. Once entered, data never goes away, even when deleted
3. All users are expected and required to document and maintain accurate, appropriate and consistent data in the Therap system in a timely manner.
4. You must complete all required fields marked with a red asterisk (*).
5. If 'Other' is chosen in any of the questions, please specify in 'If Other'
6. Internal reports (e.g., ISP, Individual Data and others within the Therap system) as well as external documents (e.g., Word and Excel among others) can also be attached to a SComm message.
7. SComm messages have attributes such as notification level, purpose, type and topic.
8. SComm has a flexible recipient selection scheme that allows users to select multiple recipients based on user names, or a combination of super roles and programs. You can create custom user groups and send messages to a selected group of users. You can also create and manage personalized folders of your choice.
9. The Secure Communications area can be found on the right panel of the Therap Applications Dashboard.
10. Administrators provide users with SComm Roles. Administrators can restrict SComm access for users by editing users' privileges.
11. All entries in SComms must relate to a program participant or the operation of a program location.

The following describes procedures for specific tasks MCH staff may need to access and/or complete as a part of their daily job duties:

Inbox

1. From the Dashboard, click on the Inbox link under the SComm option under the "To Do" tab
2. Click on the Sender's name as shown below to open the message
3. Click on the 'Mark Read' button to mark the message as read

4. You may click on the 'Mark & Next' button to mark the message as read and to go to the next message
5. You may also click on the 'Mark & Previous' button to mark the message as read and to go to the previous message

Search

- The Search bar can be found at the top of the page while viewing your inbox
- The search feature can be used to search SComm in any of the message folders
- The search function will only search for messages in the folder that users are in
- In the top left column of the page, users will see a bar where the highlighted folder indicates the folder that they are in
- Users can make use of regular and Advanced Search
- You may search using sender's name (for Inbox), recipient's name (for Sent Items) or with the Subject of the message
- Note that the default search will retrieve messages for the date range you selected for your 'My Profile' page. For example, if you select 'Show Inbox/Sent Items: For 1 month', the search will display a list of messages sent/received within a month from the current date. To search using a larger date range, you may use the "Advanced Search" option

Regular Search

The Regular Search found at the top of any of the folders, can be used to search for messages that are maximum 60 days old. Search criteria are limited to sender name, receiver name and message summary.

1. Type desired search criteria in Search bar
2. Click Go
3. By Clicking Show All, all messages will be available to view

Advanced Search

The Advanced Search link is right next to the regular search box. Here users can search using more criteria: message date, sender's name, subject, message type, notification level, message status, and even by using words from the message content. The search function can search for messages maximum one year within the selected date

1. Enter the folder you wish to search in
2. Provide the correct search parameters to find messages that match criteria in the folder

Compose Message

1. From the Dashboard, click on the Compose link under the SComm area
2. Choose the type of SComm message from the following page:
    - Choose General if the message is not specific to any Individual
    - Choose Individual Care if the message is specific to an Individual
    - Choose To Therap Customer Support if you would like to send a message to Therap Customer Support.

General Type SComm Message

1. Choose the recipient(s) of the message from the list under the Select Recipient area.
2. The list is categorized four different tabs:
    - User List - List of all Users (including Administrators) categorized by Staff within the agency
    - User Title - List of all Users categorized by their Titles
    - Programs - List of Users sorted according to their access to different Programs
    - Custom User Group – A group of recipients created by Users
3. You may also select recipients by typing in the first few letters of the recipient name in the text area under the Recipient(s) section.
4. Select the particular recipient from the list.
5. You may also type in User Titles which will display matching recipients.
6. Select your particular recipient(s) from that list
7. Select the Notification Level for the message
8. Enter a Subject for the message before composing the message
9. You may also add attachment(s) to the message
10. Once done, click on the 'Send Message' button in order to send the message
11. You may also save the message as a draft by clicking 'Save As Draft'
12. You will get a confirmation on your screen that message has been sent

Individual Care Type SComm Message

1. You will need to select the particular Individual before composing the message
2. Select the appropriate recipient on the compose page
3. You may attach information related to the Individual with the SComm message
4. In order to attach information within Therap Applications, click on the From Therap link:
    - Clicking on the "From Therap" icon will display a list of Attachable Forms
    - Select the particular form type from the list
    - You will now need to search for it
    - Enter form specific information and click on the 'Search' button
    - Select the particular form from the search result and click on the Add link to attach the form with the message

Therap Customer Support Type SComm

1. Choose the type of message as To Therap Customer Support
2. This will take you to the Feedback to Therap Customer Support page
3. Select a Feedback Category
4. Enter a Summary of your Feedback before writing the Description
5. Once done, click on the 'Submit' button to send the Feedback
6. You will then receive a confirmation message.
7. Responses by Therap Customer Support can be seen from your My Issues section, the link to which can be seen in the top of the right column of your Dashboard.

Add Attachments

This applies to all types of SComm messages

1. Click on the 'Add File' or 'Scan File' buttons.
2. Clicking on 'Add File' will open a pop-up window that lets you choose the file you want to attach from your computer
3. Select the particular file to attach and click on the 'Upload' button to attach the file with the message
4. Clicking on 'Scan File' will open the scanner interface from which you can scan file as attachment.

Implemented: 2/2019
Reviewed: 8/19; 7/20; 5/22

TECHNOLOGY DISASTER PREPAREDNESS AND RECOVERY

Vital functions of MCH depend on the availability of computers. A disaster might prevent the use of our electronic system to process payroll or bill Medicaid. MCH tries to balance the amount of time, effort, and money spent in the planning and preparation of a disaster and the amount of data loss it can sustain but remain operational following a disaster. Although MCH cannot guarantee zero data loss, it has made efforts to be able to access data from on-line storage banks.

All employees who have desktop or laptop computers for work purposes are backed up to Carbonite, software which encrypts files twice before backing them up securely offsite, using the same encryption techniques that banks use. Files remain encrypted at secure data centers and can be accessed or restored if a computer hard drive crashes.

Therap, the electronic health record used by MCH, has a system of firewalls and encryption to protect information. All service records are backed up on three web-based servers maintained by Therap and remain the property of MCH in the event services with Therap are terminated.

Revised: 8/17; 5/22
Reviewed: 7/18; 8/19; 7/20

EMAIL and INTERNET ACCESS

Email and internet usage assigned to an employee's computer or telephone extensions are solely for the purpose of conducting MCH business. Some job responsibilities at MCH require access to the internet and the use of software in addition to the Microsoft Office suite of products. Only people appropriately authorized, for MCH purposes, may use the internet or access additional software.

Internet use is authorized to conduct MCH business only. Internet use brings the possibility of breaches to the security of confidential information. Internet use also creates the possibility of contamination to our system via viruses or spyware. Removing such programs from requires staff to invest time and attention that is better devoted to progress. For this reason, and to assure the use of work time appropriately for work, we ask employees to limit internet use to known and safe sites.

Additionally, under no circumstances may MCH computers or other electronic equipment be used to obtain, view, or reach any pornographic, or otherwise immoral, unethical, or non-business-related internet sites. Doing so can lead to disciplinary action up to and including termination of employment.

Email is to be used for MCH business only. Confidential information must not be shared outside MCH without authorization, at any time.

Any emails that discriminate against employees by virtue of any protected class will be dealt with according to the harassment policy. These emails are prohibited. Sending or forwarding non-business emails will result in disciplinary action that may lead to employment termination.

Email Retention

MCH owns any communication sent via email or that is stored on company equipment. All MCH emails will be stored on the MCH server and can be retrieved for review at any time.

E-mail messages may fall within several broad categories:

1. Transitory and duplicate messages or casual and routine communications: MCH employees sending or receiving such communications may delete them immediately and have no need for retention. Most e-mails are transitory. Transitory documents serve to convey information of temporary importance. The following types of e-mail can be deleted because they are considered transitory:
   - Incoming list server messages

- Personal emails unrelated to MCH business
- Spam, unsolicited advertisements, sales promotions
- Non-policy announcements
- Published reference materials
- Invitations and responses to meetings, etc.
- Thank you's
- Replies to routine questions such as "we're open 8 – 5", "our address is…", "the deadline is…"
- Scheduling meetings
- Out of office auto-replies
- Attachments to e-mail that are identical to records that are stored and managed outside the e-mail system pursuant to approved record retention schedules – that is information which is retained in hard copy or stored as a computer file which is backed up on Carbonite.

2. Records of persons served or other confidential information: if a hard copy is printed and maintained in the service record, there is no retention requirement for the email. However, if there is confidential information which is shared with a person served, guardian or consultant, the email must be deleted after use.
3. MCH business emails: any emails between auditors, MCH Board of Directors concerning MCH business, the LME, or other similar parties should be retained.
4. Carbonite is used to back up saved emails.

Emails will be retained for 3 years then purged unless there is litigation concerning certain emails. Directors and other authorized staff have the right to access any material in employee email or on MCH computers at any time. Employee electronic communication, storage or access is not private if it is created or stored at work.

Media Relations

No one other than one of the directors of MCH may speak to media including newspaper, television, radio on behalf of MCH without the express consent of the executive director.

Social Media

Social networking such as Facebook, Instagram, You Tube, Twitter, etc. presents two concerns for MCH: how employees spend time at work and how employees portray MCH and the persons served online when they are not at work.

MCH employees should understand that what they post online is public, and they have no privacy rights in what they put out for the world to see. Anything in cyberspace can be used as grounds to discipline an employee, whether the employee wrote it from work or outside of work. While MCH does not specifically forbid reference to being employed by MCH in social networking, employees should be made aware that if they post as an MCH employee, MCH will hold them responsible for any negative portrayals, reference to persons served, other MCH employees or other confidential information. No pictures associated with MCH may be posted

on a social network without explicit consent and approval from a director. Any reference to persons served or posting of pictures is a violation of HIPAA. Social networking during work hours is not allowed without approval from a director.

Revised: 8/17; 5/22
Reviewed: 7/18; 8/19; 7/20

PERSONNEL FILES

MCH recognizes that accurate recordkeeping and documentation is essential to a well-organized business and is committed to maintaining accurate records on both employees and persons served according to all federal and state standards. MCH operates with the understanding that information regarding employees must be protected, kept confidential and maintained.

Procedures

1. An annual audit of employee records will be conducted to purge and destroy by shredding any information or record which exceeds the recordkeeping retention time and is not under litigation for any reason. Any record under litigation or sanction by any agency shall not be destroyed.
2. Employee files shall be maintained in a secure, locked environment in the administrative office with access limited to the business director, executive director and/or designee. Confidentiality of the record shall be maintained according to state and federal law. Any exceptions must be approved by the executive director.
3. Employee medical information shall be maintained in a separate file in a locked environment.
4. Employee information maintained on a personal computer shall be protected by password and firewall in order to preserve confidentiality.
5. If an applicant is interviewed and releases MCH to conduct background checks and is not hired based on the results of the background checks, those reports shall be made available to the applicant to the extent allowed by federal and state law.
6. All required signatures must in place before forms are filed in the employee record. If an employee refuses to sign, REFUSED should be noted along with a director's initials and date.
7. All documentation should be typed or written legibly in ink and should be signed, dated and/or initialed as appropriate according to documentation procedures.

Revised: 8/17; 5/22
Reviewed: 7/18; 8/19; 7/20

RECORD RETENTION AND DISPOSAL

MCH follows guidelines for record retention and disposal as outlined by DHHS in APSM 10-5.

RECORD/REPORT	RETENTION	DISPOSAL METHOD
990's and 5500's	6 years	Shredding
Ads	1 year	Trash
Any record under litigation	Until final disposition	Shredding
Applications, resumes, etc.	1 year	Shredding
Audit reports	Permanent	
Bank statements	3 years	Shredding
Cancelled payroll checks	7 years	Shredding
Chart of accounts	Permanent	
Check and Cash Receipt logs	Keep with deposits for that fiscal year	
Contracts and leases (expired)	7 years	Shredding
Correspondence	Permanent	
Criminal History Checks	5 years from date of hire	Shredding
Data sheets	1 year post survey	Shredding
Deeds, property titles, etc.	Permanent or until the property is disposed of	Shredding
Employee benefit plans	Permanent	
Employee file	7 years	Shredding
Employee Outcome-Based Tests:		
• BBP	3 years	Trash
• Hazcom	5 years	Trash
• Medication Administration	As long as employed	Trash
• All other courses	1 year (until next test)	Trash
Exposure incidents	Permanent	
Financial information of persons served	Permanent or until the person is deceased	Shredding
FMLA	3 years	Shredding
Gas and Service Logs	1 year	Trash
General ledgers	Permanent	
Grants	One year after funds are used	Trash
Grievances	4 years after final action	Shredding
Improper Conduct Investigation	3 years after resolution	Shredding
Incident reports	10 years after incident	Shredding
I-9/E-Verify	For duration of employment	Shredding

In-service signup sheets	3 years	Trash
Insurance claims	Permanent	
Insurance policies	4 years after term ends	Shredding
Leave requests	1 year	Trash
Medication return confirmations	1 year	Shredding
Memos	1 year	
Menus	1 year	Shredding
Mileage logs	1 year	Trash
Minutes (board meeting)	Permanent	
Minutes (staff meeting)	3 years	Shredding
Monthly Maintenance Checklist	1 year	Trash
Monthly Vehicle Inspection	1 year	Trash
Narcotic count sheets	1 year	Shredding
OSHA logs	5 years	Shredding
Outing logs	1 year	Shredding
Payroll information, timesheets, wages, FICA, FUTA, W-4, etc.	4 years	Shredding
Payroll journals	4 years	Shredding
Policies and Procedures	1 copy permanent	
QAC	3 years	Shredding
Safety Data Sheets (SDS)	30 years	Trash
Service records	Permanent or until the person served is deceased	Shredding
Staff schedules	2 years	Trash

FISCAL MANAGEMENT

MCH operates in a fiscally sound manner under generally acceptable accounting rules. The Medicare Provider Reimbursement Manual shall provide the general accounting definitions and procedures. Posting to the general ledger shall be done by the business director or his designate, usually the administrative operations manager. Ledger entries are referenced by journal entries and must be approved by the executive director.

Procedures

1. Budgets are prepared by the business director with the assistance of the executive director and approved by the MCH Board. The executive director may make discretionary spending decisions up to $7,500 without specific board approval.
2. Income statements are prepared by the business director and reviewed by the executive director quarterly.
3. Income statements/financial information compiled by the business director is reviewed by the board of directors at least quarterly and is available to the board at any time.
4. Facility manager(s) should submit budget requests to the business director no later than May 15 each year.
5. A detailed chart of accounts is maintained by the business director.
6. Cash and/or checks are deposited promptly and stored in a locked safe until deposited. All cash is receipted. Purchase orders must be approved by a director.
7. All accounts must be reconciled to the general ledger monthly.
8. Resident accounts are reconciled by monthly by the bookkeeper and reviewed by the business director. Reconciliations are given to the QPs to be distributed to guardians as applicable.
9. ICF resident funds are kept in interest-bearing accounts, with interest spread according to individual balance at the end of the month on an excel spread sheet. DDA residents have individual accounts.
10. All resident funds are reconciled monthly and guardians are provided monthly reconciliations. All incoming and outgoing checks are receipted on pre-numbered receipts.
11. The administrative assistant opens mail, removes checks or cash, and distributes mail.
12. Checks and cash are logged in a journal by the administrative assistant.
13. Deposits are made by the business director.
14. Blank checks are stored in a locked environment.
15. All staff who handle funds are bonded.
16. All accounts payable and payroll checks require 2 signatures. The business director and executive director endorse checks.

17. The executive director and the business director do not handle resident funds.
18. An internal control letter is submitted annually to the financial auditors.

See Attachment—Budget Request

Revised: 8/17; 8/19; 5/22
Reviewed: 7/18; 7/20

PURCHASES

1. All purchases require a signed receipt that is to be turned into the bookkeeper or business director within 7 business days of purchase.
2. Purchases over $300.00 that are not related to food, nursing supplies or maintenance expenses must be approved by a director.
3. Purchase orders should be used when a receipt does not clearly define the nature of the money spent and turned in with receipt.
4. Restrictions on purchase of goods which might be construed as conflict of interest shall be determined by the Board of Directors of Macon Citizens Habilities, Inc. Decisions shall be recorded in the board minutes.
5. Employees are prohibited from the following activities:
   - entering into any business transaction of any type with a person served
   - borrowing the assets or properties of a person served
   - requiring that persons served perform tasks or services for employees
   - giving or receiving gifts to or from persons served which are of substantial nature
6. The executive director must have MCH Board approval for purchases over $7500.
7. Procedures to prevent fraudulent purchases are followed. Receipts and goods purchased are witnessed by a second person.
8. The facility manager should submit the gas log from each vehicle to the administrative office on the first working day of each month. The business director or designee will compare to signed receipts and verify with invoices from vendors. Employees should write the vehicle description on the receipt. Receipts should be submitted to the administrative office immediately.
9. Purchases should be verified/witnessed by another staff when taken into the facility, *i.e*. food purchases should be checked in and the witnessing staff should acknowledge by signing and dating the store receipt.
10. Staff should sign and date all delivery tickets.

See Attachment—Purchase Order

Revised: 8/17; 8/20; 5/22
Reviewed: 7/18; 8/19

PETTY CASH

1. Petty cash may be used for purchases under $10.00 when it is not possible to charge or it is inconvenient to use a check.
2. A receipt for the purchase must be attached to the petty cash voucher. The front of the reconciliation form should be completed. The petty cash voucher should be completed and signed ink before being submitted for approval.
3. Facility managers are the designated custodians of their petty cash account. The petty cash check will be made out to the custodian of the fund. The custodian should maintain the petty cash account in a secure place.
4. When the petty cash fund balance is low, the account should be reconciled on a Petty Cash Reconciliation Sheet and along with the vouchers turned in to the business director for reimbursement.
5. The petty cash account is reconciled at least annually by the finance department. Two persons must be present while the petty cash is counted.
6. The custodian of the account is responsible for keeping the account balanced at *all* times.

See Attachment —Petty Cash Reconciliation
See Attachment—Petty Cash Voucher

Revised: 8/17
Reviewed: 7/18; 8/19; 7/20; 5/22

CREDIT CARDS

For convenience, MCH issues key employees credit cards for shopping. Credit cards are issued at the discretion of the business director to staff who have purchasing authority. Purchasing authority is limited to $300 unless there is prior approval from the executive or business director. Credit cards should be treated as cash and requirement for 2 signatures applies to credit card purchases. Misuse of a company credit card could result in termination.

Procedures

1. Facility credit cards should remain in the facility in the cash box when not in use. Employees including managers should check out the cards when it is needed for shopping. The employee should sign and date the Credit Card Checkout form.
2. Credit card receipts should be turned in to the administrative office as soon as possible, preferably by the next working day after purchase. Receipts require 2 signatures to verify the purchase was made on behalf of the facility. A purchase order should be attached if the receipt has limited description.
3. If a card is lost or misplaced, the facility manager should be notified immediately and the manager should contact the business director immediately.

See Attachment—Credit Card Checkout

Revised: 8/17; 5/22
Reviewed: 7/18

CREDIT LINE

MCH maintains a line of credit with a $300,000 limit with Nantahala Bank & Trust Company which is renewed annually. This line of credit has an adjustable interest rate and is only accessible by the executive and business director. The credit line is accessed to meet current obligations or to make purchases deemed necessary by the executive and business director. The credit line is to be used only for short-term financing. Funds received from the credit line are deposited into the MCH operations account the same day received. The credit line balance is paid off as quickly as possible. Any use of the credit line must be approved by the MCH Board of Directors.

Revised: 8/17; 6/20; 5/22
Reviewed: 7/18; 8/19

FEE FOR SERVICE

There are times when persons request services through MCH but are not eligible or approved for Medicaid or state-funded services. In these cases, and when allowed by regulation, MCH will consider receiving private fees for services. MCH uses the state or Medicaid reimbursement rate for the service requests to establish its fees. A schedule of fees is available upon request from the executive director or business director. Payment will be expected within 30 days of services being rendered.

Revised: 8/17; 5/22
Reviewed: 7/18; 8/19; 7/20

PROTECTION OF RIGHTS

MCH is committed to protecting the rights of all persons served. Programs are designed to ensure the people receiving services are assured of the rights to dignity, privacy, and humane care. In keeping with this philosophy, MCH observes the Client Rights in Community Mental Health, Intellectual and developmental differences, and Substance Abuse Services 10A NORTH CAROLINA ADMINISTRATIVE CODE 27C, 27D, 27E, 27F (APSM July 1, 2016) which comply with G.S. 122C, article 3, Client's Rights. MCH employees are trained on protection of rights and the timely reporting of any violation of rights to the appropriate entity at the time of hire and at least annually thereafter. General rights include the right to:

- be fully informed of rights in a manner and language which can be understood
- receive fair remuneration for work done
- be educated about confidentiality
- have input and involvement in individual habilitation/rehabilitation plans
- be given the opportunity to be involved in any program from which the person receiving services can be expected to benefit
- be free from physical, psychological, or sexual abuse, and humiliation
- be free from corporal punishment of any kind
- be given the opportunity for increased independence and growth
- work and reside in a safe environment
- have access to an appeals process
- have a person of choice represent and speak or advocate for them in their dealings with MCH

Procedures

1. Each person served and/or legal guardian shall be provided with a written summary of rights which complies with G.S. 122C, Article 3 as a part of orientation to services with MCH. A rights brochure is available with simplified language and pictures to ensure the information is easy to understand.
2. Each person served shall be informed of their right to contact the Disability Rights North Carolina.
3. Explanation shall be in a manner consistent with the person served or legally responsible person's level of comprehension.
4. In each facility, the information provided to the person served or legally responsible person shall include:
   - rules that the person served is expected to follow and possible penalties for violations of the rules
   - protections regarding disclosure of confidential information

- the procedure for obtaining a copy of the person's served treatment/habilitation plan and governing body
- policy regarding fee assessment and collection practices for treatment/habilitation services, grievance procedures including the individual to contact and a description of the assistance to the person served
- policy regarding suspension and expulsion from service
- policy regarding search and seizure

6. Legal guardians will be informed of any support that includes the use of:
   - purposes, goals and reinforcement structure of any behavior management system that is allowed
   - potential restrictions or the potential use of restrictive interventions
   - provisions regarding emergency use of restrictive intervention procedures
   - any occurrence of the use of restrictive intervention
7. Education of rights will be documented in the service record.
8. The MCH Human Rights Committee (HRC) serves to protect the human, civil, legal and treatment rights of people receiving services through MCH. Persons served have the right to file a grievance or complaint directly to the committee. Any type of restriction implemented must be approved by HRC. All persons served and/or families and guardians will be informed about the committee including the procedure for filing a complaint in a manner they can comprehend.
9. All persons served, guardians, and volunteers will be explained the human rights policy during orientation and admission and refreshed at least annually on their level of understanding.
10. Rights assessments are completed for all MCH residents and persons attending MCE to determine their level of understanding of basic rights. Individualized training may be recommended based on this assessment.

See Attachment—MCH Rights Brochures
See Attachment—Rights Assessment

Revised: 8/17; 5/22
Reviewed: 7/18; 8/19; 7/20

ADMISSIONS/DISCHARGE COMMITTEE

While each service has its own criteria for admissions and discharge of persons served (please see service-specific policies), all utilize the MCH Admissions/Discharge Committee to render final decisions. The committee is made up of the following personnel:

- Executive Director
- QP
- RN
- Group Home Manager (when applicable)
- MCE Manager (when applicable)
- Care Coordinator (when applicable)

The committee uses guidelines established by service definitions, licensing regulations and current make-up of residents to render decisions. All decisions will be documented and kept within the person's service record and on file at the administration office.

Revised: 8/17; 5/22
Reviewed: 7/18; 8/19; 7/20

HUMAN RIGHTS COMMITTEE

MCH has established a Human Rights Committee (HRC) in order to assure that rights of persons receiving services are protected according to the statutes of the State of North Carolina as found in G.S. 221 C, Article 3, 10 NCAC 27GH. 0601-0610, 10A NCAC 27C, 27D, 27E, and 27F. The HRC protects persons served against inhumane, improper, or restrictive treatment. The committee also functions to ensure that appropriate treatment is provided in a timely as well as least-restrictive manner. The MCH Board of Directors delegates responsibility of establishing and monitoring the HRC to the executive director. The committee shall work with any state and local agencies to protect persons' served rights. Nothing within this policy shall override the legal authority of agencies such as DSS or Disability Rights or interfere with their investigations.

At least half of the members serving on the HRC are persons receiving services or family members of persons served. There will also be at least one member who is a professional with training and expertise in the use of the type of interventions being utilized, and who is not directly involved in the treatment or habilitation of the person served. Access to information of persons served by MCH will be limited to what is needed for member of the HRC to perform their duties in accordance with G.S. 122C-52 through 122C-56 and 10 NCAC 26B.

The HRC will meet quarterly at the office to review restrictive practices in place as well as be available for telephone votes when new restrictive interventions are recommended. Any conflict of interest must be revealed and members may choose not to vote concerning their own family members when votes are required for approval. MCH QP's will provide support to the committee as necessary and serve as ex officio members including taking minutes and providing minutes without identifying names to regulating agencies as required.

The Human Rights Committee has the responsibility for the following:

- reviewing and approving each behavior support plan that involves the use of restrictions as well as use of medication to control behavior
- reviewing any alleged instances of abuse and neglect and/or reporting.
- making recommendations about alleged violations of rights of individuals and groups
- assuring that the rights and welfare of research subjects are protected and that consent to participation in research is obtained by adequate and appropriate methods
- visiting all MCH facilities

- hearing grievances which involve rights of the persons served and making recommendation for appropriate reporting or actually reporting as a committee to the appropriate authorities.

An annual report shall be sent to the MCO's with whom there is a service agreement or as required.

See Attachment—Visitation Report

Revised: 8/17
Reviewed: 7/18; 8/19; 7/20; 5/22

INCIDENT REPORTING

An incident is an episode involving persons served and/or employees. It is defined as an event that is unusual, accidental or behavioral. Incidents can occur in a variety of settings and may involve a person served, employee and/or physical property. The following are types of incidents that warrant reporting and documenting:

- injury as a result of a seizure (falling, hitting body part, etc.)
- fall
- any injury as a result of MCH activity or occurs within a MCH facility
- self-injurious behavior
- medication error
- aggression
- PICA
- property destruction
- fire
- injury of unknown origin
- AWOL
- abuse/neglect
- any sentinel event

Reporting an incident is a critical step in helping MCH develop and/or maintain safe environments for the persons we serve and employees. Employees are expected to follow appropriate training protocol to address the particular incident (i.e., access emergency services, contact RN, implement person-specific techniques to address incident etc.). Once the incident is resolved, the following procedures outline when and how to report incidents.

Procedures

1. Incidents should be reported to the appropriate persons as soon as possible.
2. A general event record (GER within Therap) must be filled out completely and submitted ASAP.
3. Incidents must be categorized as Level I, II, or III with Level I being the least severe. Level II and III incidents must be reported to the MCO via the North Carolina Incident Response Improvement System (IRIS) by trained personnel. A printed copy should be maintained for recordkeeping.
4. **Level I** includes any incident, as defined above, which does not meet the definition of a Level II or III incident. Aggregate information on Level I incidents involving restrictive

interventions, medication errors, and searches/seizures must be reported to the host MCO, according to guidelines provided by DHHS.

5. **Level II** includes any incident, as defined in 10A NCAC 27G .0602, which involves a death due to natural causes or terminal illness, or results in a threat to a person's health or safety or a threat to the health or safety of others due to the behavior of a person served. These incidents require communication between the provider and MCO, documentation of the incident, and report to the MCO and other authorities as required by law and completion of an IRIS in addition to the MCH Incident Report.
6. **Level III** includes any incident, as defined in 10A NCAC 27G .0602, that results in (1) a death, sexual assault or permanent physical or psychological impairment to a person served, (2) a substantial risk of death, or permanent physical or psychological impairment to a person served, (3) a death, sexual assault or permanent physical or psychological impairment caused by a person served, (4) a substantial risk of death or permanent physical or psychological impairment caused by a person served or (5) a threat caused by a person served to another person's safety. These incidents require communication among the provider, MCO and DHHS, documentation of the incident, and report to the MCO, DHHS and other authorities as required by law. Level III incidents that occur while the person served was receiving a service or are on MCH premises also require a formal internal team review process to be initiated by MCH within 24 hours of the incident, according to guidelines provided by DHHS. An IRIS must be completed in addition to the MCH Incident Report.
7. A debriefing should occur in a timely manner after investigation or when the incident warrants, such as atypical, aggressive behavior. The QP or nurse will do the debriefing.
8. Documentation of incidents must be kept in a separate file from the service record. The occurrence of an incident shall be recorded in the service notes.
9. The Human Rights Committee and Health and Safety Committee will review all incidents and make recommendations as appropriate.

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Reviewed: 7/18; 7/20

ABUSE, NEGLECT, EXPLOITATION, OR CORPORAL PUNISHMENT

Abuse is the infliction of mental or physical pain or injury by other than accidental means, unreasonable confinement, or the deprivation by an employee of services which are necessary to the mental or physical health of the client. Temporary discomfort that is part of an approved and documented treatment plan or use of a documented emergency procedure shall not be considered abuse.

Neglect is the failure to provide care or services necessary to maintain the mental or physical health and well-being of the person served.

Exploitation is the illegal or unauthorized use of the resources of a person receiving services through MCH for another person's profit, business or advantage. Staff are prohibited from any of the following activities:

- entering into any business transaction of any type with a person served
- borrowing the assets or properties of the person served
- requiring that persons served perform tasks or services for staff or their families.
- giving or receiving gifts to or from persons served which are of substantial nature

Corporal punishment means the use of painful stimulus to the body in an attempt to terminate behavior or as a penalty for behavior.

MCH forbids any form of abuse, neglect, exploitation or corporal punishment. All MCH staff are legally and morally obligated to report immediately any abuse, neglect, exploitation, or use of corporal punishment. It is the responsibility of a MCH staff to prevent actual abuse by any other person. Failure to do so may subject the individual to disciplinary action and/or termination of employment or placement. MCH utilizes from the North Carolina General Statues those laws which pertain to the protection of adults. These laws have been incorporated as part of this policy and supersede this policy.

Procedures

1. Whenever abuse/neglect of a person served is observed or suspected, facts relative to the abuse/neglect or suspected abuse/neglect shall be documented in the service record, including reports made by the person served and actions taken by staff.

2. Per G.S. § 7B-301, every employee of MCH has the duty to report abuse, neglect, exploitation or death due to maltreatment to the Director of the Department of Social Services in the county where the person served lives.
3. Per G.S. § 108A-102, any employee having reasonable cause to believe that a person served by MCH needs protective services should report such information to the Director of the Department of Social Services in the county in which the person served lives.
4. Per 10A NCAC 27G .0604, MCH will submit an NC IRIS to the host MCO, Home MCO, and DMH/DD/SAS [as appropriate for the level of incident] whenever there is an allegation of abuse, neglect, or exploitation of a person receiving services. Per 10A NCAC 27G .0504 (c), the MCO will oversee the implementation of rights protections through a review procedure of cases of alleged abuse, neglect, or exploitation.
5. In every case of suspected abuse, neglect, questionable unknown accident, or the use of corporal punishment, the person served should be checked by a nurse or physician for injury. The findings and treatments shall be documented in the service record. The record entry should include time of examination and any known information about what happened.
6. The physician or nurse checking the injury should be given an estimation of the time the injury occurred. It should be noted if such an opinion cannot be given.
7. In the event the person served makes an allegation, the executive director should be contacted immediately. It is the responsibility of the staff to whom an allegation is made to assist the person served in contacting the director.
8. If a MCH employee witnesses an event that he/she believes to be abuse, neglect, exploitation, or corporal punishment, he/she shall intervene if the incident is such that it places the person served in physical danger. If intervention is necessary, the director or manager must be contacted immediately.
9. In every case of suspected abuse, neglect, exploitation, or use of corporal punishment, the executive director or business director will assume responsibility for notifying the Macon or Jackson County Departments of Social Services and for documenting this notification. The Health Care Registry and MCO must also be notified via IRIS.
10. In all cases of abuse, the Department of Social Services shall be notified by the director within 24 hours regarding the results of the investigation. This notification is in addition to the reporting system already mentioned.
11. All employees suspected of abuse/neglect/exploitation will be immediately removed from their place of employment until such time an internal investigation can be completed. Should the accused staff be found to have committed an act of abuse, neglect or exploitation, they will be involuntarily terminated and placed on the Healthcare Personnel Registry. MCH will pursue or assist families in pursing criminal charges against the former employee if warranted.

See Attachment—Investigation Procedures Checklist

Revised: 8/17
Reviewed: 7/18; 8/19; 7/20; 8/22

DEATH of PERSON RECEIVING SERVICES

The following procedures are to be followed should a person served by MCH die while in our care:

1. If a person served dies while receiving services from MCH, the employee should contact the persons listed below:
   - **911**
   - Management staff (facility manager, QP and nurse)
   - MCH Executive Director
2. Administrative staff will notify the family immediately.
3. An incident report must be completed immediately by the primary staff involved.
3. Employees trained to do so will use the incident report to complete the North Carolina Incident Response Improvement System (IRIS). A printed copy should be maintained for recordkeeping. The IRIS must be completed within 72 hours. Death within 7 days of seclusion or restraint must be reported immediately.
4. In the case of a death which may be the result of abuse, neglect, or exploitation, and where there is reason to believe that other persons served by MCH may be abused, neglected or exploited and in need of protective services, DSS and the police must be notified immediately. Reporting should also be made to the MCO and to the NC Healthcare Personnel Registry if MCH personnel are involved. The NCHPR is included in the IRIS reporting.
5. In the case of a death that occurs as a result of an accident, suicide, or other questionable circumstances the police shall be notified immediately. The MCO will also be notified.
6. Should a resident living in one of MCH's group homes become ill, is taken to the hospital and dies under hospital care, the QP will complete an IRIS and notify all governing bodies as required.

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Reviewed: 7/18; 8/19; 5/22

LOST OR MISSING PERSON (AWOL)

It is common for at least some of the persons served to be limited in their mobility. Some may be easily distracted and therefore become easily lost. For these reasons a person going "missing" would be an obvious cause for concern. However, it is accepted that there will be many active persons receiving services who value their mobility and independence and spend time moving around freely without raising concern. Thus, their need for close supervision must always be balanced against their rights to make their own decisions regarding their movements and whereabouts.

Preventing Missing Persons Incidents

Staff must remain vigilant *at all times* and try to be aware of exactly where persons served are at any given time. Persons who are prone to wandering will have this identified in their service plan, with staff trained to maintain the appropriate amount of supervision and monitoring as it relates to the level of risk for elopement.

Action taken to avoid false alarms includes explaining to the persons served and their visitors, to inform staff when they want to go outside or leave MCH property.

Procedure

When staff notice a person served may be missing, they should immediately alert their coworkers and complete a visual sweep of the facility and surrounding outside areas. If the person cannot be located, the following measures should be followed:

1. Notify manager and QP.
2. If there are at least 2 or more staff present, 1 staff may leave the MCH facility and search off property.
3. If there is only 1 staff present, staff should remain with the other persons served and call the executive director or business director to receive instructions.
4. If unable to reach administrative staff, notify police immediately.
5. The QP or executive director will notify the guardian as soon as possible following notification the person is missing.
6. Staff will document all information relating to these events in general progress notes and MCH Incident Report.
7. If the person is missing for more than 3 hours, the QP or executive director will complete an IRIS to notify the person's MCO.

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BEHAVIOR MANAGEMENT

MCH strives to provide supports to persons served in all areas of need, including effective ways to manage behaviors that have a negative impact. All levels and forms of behavior management are delivered in the least restrictive, most appropriate, and most effective treatment manner. Any intervention procedure designed to reduce a behavior shall be accompanied by positive habilitation methods and delivered in a humane, respectful manner and in accordance with NC General Statute 122C, Article 2 and Article 3.

General Practices

1. Prohibited procedures include those interventions which have been prohibited by statute:
    - any intervention which would be considered corporal punishment under G.S. 122C-59; the contingent use of painful body contact
    - substances administered to induce painful bodily reactions, exclusive of Antabuse
    - electric shock (excluding medically administered electroconvulsive therapy); insulin shock
    - unpleasant tasting foodstuffs
    - contingent application of any noxious substances which include but are not limited to noise, bad smells or splashing with water
    - any potentially physically painful procedure, excluding prescribed injections, or stimulus which is administered to the person for the purpose of reducing the frequency or intensity of a behavior
    - use of isolation time out and seclusion
2. The following procedures are allowed only when clinically or medically indicated as a method of therapeutic treatment as referenced in APSM 95-2 (July 1, 2016). Allowable interventions in accordance with these protections include:
    - planned non-attention to specific undesirable behaviors when those behaviors are health threatening; contingent deprivation of any basic necessity
    - other professionally acceptable behavior modification procedures that are not prohibited
3. The use of restrictive interventions shall be limited to:
    - emergency situations, in order to end a behavior or action in which a person served is in imminent danger of abuse or injury to self or other persons or when property damage is occurring that poses imminent risk of danger of injury or harm to self or others

- as a planned measure of therapeutic treatment as specified in the person's served treatment plan

4. Restrictive interventions shall not be employed as a means of coercion, punishment or retaliation by staff or for the convenience of staff or due to inadequacy of staffing. Restrictive interventions shall not be used in a manner that causes harm or abuse.
5. MCH ensures that positive and less restrictive alternatives are considered and attempted whenever possible prior to the use of more restrictive interventions and that consideration is given to the physical and psychological well-being of the person served before, during and after utilization of a restrictive intervention.
6. Preventative techniques may be used only to terminate a behavior or action during which a person served is in imminent danger of abuse or injury to self or others or when substantial property damage is occurring and may only be implemented by employees who have passed the behavior management training curriculum.
7. Protective devices shall be used when the need for the device has been assessed by a privileged professional and when all safeguards and protections are fully implemented.

Physical Restraint

Physical restraint is the application or use of any manual method of restraint that restricts freedom of movement or the application or use of any physical or mechanical device that restricts freedom of movement or normal access to one's body, including material or equipment attached or adjacent to the client's body that he or she cannot easily remove. MCH does not use physical restraint as a protective or behavioral management support. In recognizing that there are times when persons supported by MCH can become aggressive, employees are trained in behavior interventions using a DHHS-approved curriculum. While the training curriculum as certified contains material on use of physical restraint, employees are only trained on preventative, early intervention and protective techniques.

Restrictive Intervention

All persons receiving services through MCH are encouraged to use socially acceptable behaviors. It is the responsibility of MCH staff to model and teach these behaviors. Any method to teach which involves restrictive interventions must be consented by appropriate entities and there must be documentation of such consent in the record of the person served.

The least restrictive method of behavior management should *always* be the first approach. Positive reinforcement should be encouraged before employing restrictive measures. The term restrictive procedure refers to any technique that:

- restricts individual freedom of movement
- causes the loss of objects or privileges the individual normally enjoys
- forces the individual to engage in behavior that may be against his/her will
- causes a reduction in behavior frequency or intensity through use of behavior management drugs

Procedures:

1. Restrictive procedures cannot be used unless documentation indicates that positive approaches have proven ineffective. Restrictive procedures may be used on an emergency basis to prevent harm to self or others or significant property damage.
2. The restrictive intervention shall be considered a planned intervention and shall be included in the person's treatment/habilitation plan whenever it is used:
   - more than 4 times
   - more than 40 hours in a calendar month
3. When a restrictive intervention is used as a planned intervention, the following measures should be taken:
   - prior to the initiation or continued use of any planned intervention, written notifications, consents and approvals shall be obtained and documented in the person's record including approval of the plan by the responsible professional and the habilitation team; consent of the person served or legally responsible person after participation in treatment planning and after the specific intervention and the reason for it have been explained; approval by the Human Rights Committee of the specific intervention that has been planned for the person and the rationale for utilization of the intervention; physician approval, after an initial medical examination, when the plan includes a specific intervention with reasonably foreseeable physical consequences. In such cases, periodic planned monitoring by a physician shall be incorporated into the plan.
   - the requirement that a consent or approval shall be considered valid for no more than 6 months and that the decision to continue the specific intervention shall be based on clear and recent behavioral evidence that the intervention is having a positive impact and continues to be needed
4. Exclusionary time out (ETO) is considered an emergency intervention unless the person has a specific behavior program which prescribes the intervention. ETO usually occurs in the person's bedroom or at the quiet room at MCE. Other areas of the house, such as the living room, may be used so long as it does not interfere with the other residents' need to use the area. A bathroom is never to be used. The person must constantly be monitored while in ETO. No talking or other interaction should occur with the person. Implementation of any of this procedure on an emergency basis requires the notification of the QP and/or executive director. Emergency interventions should be employed only as long as it takes for the person to calm. Generally, calm will be considered met if the person has not engaged in a disruptive behavior for 2-3 minutes. If the person has not calmed within 30 minutes, staff should notify the QP immediately for further instructions. When calm, the person should return to the activity that was in place prior to the intervention.
5. Misuse of planned interventions or prohibited interventions can result in dismissal and/or legal proceedings.

See Attachment—Consent for Behavior Support Plan
See Attachment—Consent for Behavior Management Medication

Search & Seizure

Each person served by MCH shall be free from unwarranted invasion of privacy. Only under certain conditions may search and seizure of private property be permitted. Search or seizure of property belonging to a person served should only occur if there is good cause to suspect possession of stolen property, substances, or items which may be health-threatening, dangerous or illegal. Exceptions to the search and seizure policy may be allowed when specified in a person's behavior plan with proper consents in place. This may be done only if there are substantial reasons for performing the search and seizure such as threats to an individual's health or safety. Persons served may not possess information or items which violate state or federal laws or cause criminal sanctions to MCH. MCH reserves the right to search if such is suspected.

Procedures:

1. Prior to any search, the person will be given the opportunity to consent to the search and/or relinquish the item or substance in question. In addition, it is noted that while incompetent adults or minors cannot legally consent to a search, they should still be informed of the purpose of the search and given the opportunity to agree to the search. If given, any consent must meet the following criteria:
   - the person who has consented must have been advised of the purpose of the search.
   - the person who consents expresses his/her consent clearly.
   - the person who consents does so voluntarily
2. Staff may search the property of a person served only after being authorized to do so by the executive director. To accomplish a search of the person, two staff must be present with one staff of the same sex conducting the search. In the event of imminent danger, a single staff or one of the opposite sex may proceed. Under no circumstances will strip searches be implemented.
2. Documentation of any search and seizure on MCH property must include the scope of search, the reason for search, any procedures followed in the search, a description of any property seized, and an account of the disposition of seized property. The events of the search should be documented carefully in a general progress note and on an incident report.

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Reviewed: 7/18; 8/19; 7/20; 5/22

CONFIDENTIALITY OF INFORMATION FOR PERSONS RECEIVING SERVICES

The service record of persons served is the property of Macon Citizens Habilities, Inc. and will be maintained in accordance with legal requirements. Individuals have the right to have information relating to their care treated as confidential and privileged. MCH will educate all employees, persons served, parents/guardian and any other individuals who have access to information of persons served on confidentiality. Staff should only view information for the persons served for whom they are responsible

Procedures:

1. MCH employees will receive training on current confidentiality regulations and general statutes. These are maintained at the administrative office and are reflected in these policies.
2. All persons associated with MCH will demonstrate understanding of the rules governing confidentiality by signing a statement of compliance.
3. Employees will complete confidentiality training during orientation and at least annually thereafter.
4. A current, signed Confidentiality Agreement shall be maintained in the employee file and updated annually.
5. MCH:
    - provides a secure place with controlled access for the storage of service records, indices and other materials containing confidential information with locked environments in each facility.
    - identifies the persons responsible for overseeing the storage area(s) and maintaining/filing in service records and within the electronic health record
    - identifies which employees are authorized to check service records in and out of the storage area per job description.
    - ensures any employee who checks a service record out of the storage area is responsible for the security of the record until it is returned. Sign out sheets should be maintained in each facility and monitored by the QP
    - ensures that records are transported directly to the administration office in a locked vehicle and are returned in a timely manner. Records should be stored in a locked environment in the administration office when not in use. Only authorized personnel will be able to access the electronic health record, which will require a password to sign in
    - ensures that original service records are not removed from MCH property except when transporting from facility for review, subpoena and specific program needs which

requires the written authorization of the executive director for the purpose of concurrent review or clinical care evaluation studies
- ensures any information released from MCH in response to requests for information is adequate, in acceptable format, and is released in accordance with these policies and procedures
- obtains a completed and signed Consent for Release of Information form

6. Before a person served signs a consent form, he/she must be informed of:
   - the contents of the record to be released
   - a definite need for the information
   - the fact that he/she can give or withhold consent
   - regulations protecting the confidentiality of the information being released
7. All letters, treatment summaries, and other information sent out in response to requests of information should be typed.
8. Information being released must be stamped with the following statement:

Sensitive Information
If individual's request to review contents is granted, such review must be in the presence of qualified clinician. Redisclosure without consent is prohibited by law.

9. The information being released should be sent out under a cover letter and typed on MCH letterhead.
10. Any release of confidential information must be logged on the Record of Information Released form.
11. The following items are maintained in the service record:
    - the signed consent form or a signed progress note documenting the disclosure of information if no signed consent form was obtained
    - a copy of the cover letter
    - a copy of the materials released
12. Releasing information without a signed consent must occur in the following situations:
    - upon request from a treatment facility, defined as a hospital or institution operated by the State of North Carolina for the purpose of treating mental illness, intellectual disability, or substance abuse and any contracted MCO
    - special counsel representing respondents in commitment hearings, special counsel to the court, and counsel representing the interest of the state in commitment hearings
13. Releasing information without a signed consent form can occur only if the person responsible for the individual's care determines that the release of such information is necessary to meet the service needs of the person served or to comply with state or federal statutes or regulations. Such disclosure must be documented in a progress note. Examples of such situations are below:
    - information may be released to a facility or individual that is providing emergency medical services, but only to the extent necessary to meet the emergency
    - information may be released if there is imminent danger of the person inflicting serious bodily injury upon another person
    - there is justified, documented need for a clinical, financial, or administrative audit and each person performing such an audit signs an Assurance of Confidentiality
    - in response to a court order or subpoena

14. Whenever information of a person served is released without a signed consent, the fact of such disclosure must be documented in a progress note in the record and must include:
    - name of the recipient of information
    - extent of information disclosed
    - specific reasons for disclosure
    - date of the disclosure
    - signature of the responsible staff
16. Disclosure of information via telephone must include a call-back to verify the validity of the request and the identity of the requesting party.
17. Any information which is released must be entered on the Information Released/Disclosed Record.

See Attachment—Consent to Release Information
See Attachment—Confidentiality Agreement
See Attachment—Information Released/Disclosed Record

Revised: 8/17; 8/19; 5/22
Reviewed: 7/18; 7/20

RESEARCH

MCH does not engage or participate in research activities. While MCH does not engage in research, there is a process for the review of requests for studies. If requests involve a specific individual served by MCH, the executive director will forward the request to the person and/or their family to make their own decision about participation.

The Human Rights Committee will review all requests for studies within MCH facilities. The Human Rights Committee may invite other persons having expertise in a particular field as needed.

Procedures:

1. Any person wishing to conduct a study activity within a MCH facility must complete the Research Form and submit it to the executive director.
2. When completed, this form must be submitted to the Human Rights Committee for approval.
3. The request will be reviewed by the Human Rights Committee and other appropriate persons as determined by the chairperson. The person wishing to conduct the study may be asked to attend this meeting.
4. The decision will be provided in writing to the requesting party. If the Human Rights Committee does not approve the request for a study within a MCH facility, specific reasons will be stated.
5. All data, information, and formal results of any study within a MCH facility will be submitted to the chairperson of the Human Rights Committee. Confidentiality will be respected at all times.

See Attachment—Research Request

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Reviewed: 7/18; 8/19; 7/20; 5/22

SERVICE RECORDS

A complete MCH service record is a combination of an electronic health record and some paper documents, such as consents, which are maintained in a physical record. For the purposes of this policy, the term "service record" will reflect the combination of these two formats.

Maintaining privacy and security of service records is of utmost importance. MCH adheres to all federal and state laws, rules, regulations, and policies to ensure service records are kept confidential, private, and secure. Service records are maintained in locked (either cyber-locked or physically locked) environment. Employees are expected to follow procedures for authorized use, transporting, and releasing of confidential information. MCH intends to comply fully with all record management requirements outlined in the APSM 45-2.

General Practices

1. The service record, in its entirety, always stays with MCH who created the record, provided the service, and billed for the service. The original service record is not transferable.
2. All records and documents that support service provision are properly safeguarded and maintained for the duration of the retention period. These include service records, billing and reimbursement records, and personnel records.
3. All records subject to audit, state or federal review or litigation shall be made available promptly to the appropriate party upon request. These records must be retained for the specific time period as defined in the retention schedule upon the completion and resolution of the audit, review, or litigation.
4. MCH will make provisions for persons served and legally guardians to access and authorize the release of information contained in their records until the close of the record retention period.
5. Whenever a person served by MCH moves services to another provider agency, MCH will send copies of pertinent information to the new provider in a timely fashion at the request of the person or their guardian. However, MCH will not "transfer" an original service record to another provider.

Contents of Service Record

All information developed or received by MCH about persons served should be included in the service record. The service record shall include the following information or items when applicable, as well as any other relevant information that would contribute to or address the quality of care for the individual:

1. Consents
    - Written consent for the provider to provide treatment
    - Informed written consent or agreement for proposed treatment and plan development – required on the individual's PCP or service plan, or a written statement by the provider stating why such consent could not be obtained [10A NCAC 27G .0205(d)(6)]
    - Informed written consent for planned use of restrictive intervention [10A NCAC 27D .0303(b)]
    - Written consent granting permission to seek emergency care from a hospital or physician
    - Written consent to release information [10A NCAC 26B .0202 and .0203]
2. Demographic Information / In Case of Emergency / Advance Directives
    - Individual's name [must be on all pages in the service record that were generated by MCH]
    - Service record number
    - Face sheet containing basic demographic information
    - Emergency information, which shall include the name, address, and telephone number of the person to be contacted in case of sudden illness or accident; the name, address, and telephone number of the individual's preferred physician; and hospital preference
    - Advance directives
    - Health history, risk factors
    - Documentation of history of mental illness, intellectual or developmental disability, or substance use disorder, according to the DSM-5 or any subsequent edition, and the ICD-10 or any subsequent edition
    - Documentation of medication allergies, other known allergies, and adverse reactions, as well as the absence of known allergies
3. Notification of Rights
    - Evidence of a written summary of the individual's rights given to the individual/legally responsible person, according to 10A NCAC 27D .0201, and as specified in G. S. § 122C, Article 3
    - Documentation that the individual's rights were explained to the individual/legally responsible person
4. Restrictive Interventions
    - Written notifications, consents, approvals, and other documentation requirements per 10A NCAC 27E .0104 (e)(9) whenever a restrictive intervention is used as a planned intervention

- Inclusion of any planned restrictive interventions in the individual's service plan according to 10A NCAC 27E .0104(f), whenever used
- Documentation in the service record that meets the specific requirements of 10A NCAC 27E .0104 (g)(2) and 10A NCAC 27E .0104(g)(6) when a planned restrictive intervention is used, including:
- Documentation of rights restrictions [10A NCAC 27E .0104(e)(15), per G.S. § 122C-62(e)], and
- Documentation of use of protective devices [10A NCAC 27E .0104(G) and 10A NCAC 27E .0105]

5. Screening, Assessments, Eligibility, Admission Assessments, Clinical Evaluations
    - Clinical level of functioning measurement tools
    - Screening, which shall include documentation of an assessment of the individual's presenting problems/needs, and disposition, including recommendations and referrals
    - Documentation of strategies used to address the individual's presenting problem, if a service is provided prior to the establishment of a plan [10A NCAC 27G .0205(b)]
    - Admission/eligibility assessments and other clinical evaluations including reason for admission;
    - Description of the needs, strengths, and preferences of the individual; diagnosis based on current assessment and according to the DSM-5; social, family, medical history; evaluations or assessments, such as psychiatric, medical, vocational, etc., as appropriate to the needs of the individual including recommendations
6. Medications and Lab Documents
    - Documentation of medications, dosages, medication administration, medication errors, and a Medication Administration Record [MAR], per 10A NCAC 27G .0209
    - Medication orders
    - When applicable, orders for, and copies of, lab tests
7. Service Plan
8. North Carolina Support Needs Assessment Profile (NC-SNAP) or Supports Intensity Scale (SIS)
9. Service Authorizations
10. Discharge Information
11. Referral Information, sent or received
12. Service Notes or Grids
13. Release/Disclosure of Information in accordance with G. S. § 122C-52 through 122C-56
14. Legal Information: Copies of any relevant legal papers, such as guardianship/legally responsible person designation
15. Other Correspondence

Record Storage

All service records, current or archived, are kept in secure, locked environments. A log shall be maintained of all active and non-active service record numbers. If a person leaves and re-enters services, their number shall remain the same.

Privacy and Security of Records

1. MCH employs the following safeguards to ensure the privacy and security of records:
   - only authorized staff may release information and must follow written procedures
   - any release of confidential information must have written authorization and should be recorded on the Record of Information Released/Disclosed form in the record.
   - authorized personnel are identified in the job description
   - all HIPAA regulations (found elsewhere in these policies) are strictly enforced
   - lap top computers which contain information about persons receiving services must have secure passwords and may not be used by unauthorized personnel or persons who are not employees of MCH
   - lap top computers are purged of any confidential information before being assigned to a new individual
   - all desktop computers must be password protected and may not be used by unauthorized personnel or non-employees of the organization
   - names of persons served may not be used in email correspondence which contains confidential information
   - email must be encrypted any time person-specific information is included
   - all email must contain the following statement:

     CONFIDENTIALITY NOTICE: This email message, including any attachments, is for the sole use of the sender and intended recipient(s) and may contain confidential information. Any unauthorized review, use, disclosure or distribution is prohibited. If you are not the intended recipient, please contact the sender by reply email and destroy all copies of the original message.

2. MCH management and professional staff are responsible for overseeing the storage area(s) and maintenance of service records.
3. Employees are authorized to check service records in and out of the storage area per job description.

Transportation out of Facility

Any employee who signs a service record out of the storage area is responsibility for the security of the record until it is returned. Sign out sheets are maintained in each facility and monitored by the compliance officer. MCH ensures that records are transported directly to the designated location, in a locked vehicle and returned in a timely manner. Records are stored in a locked environment when not in use. MCH ensures that original service records are not removed from MCH facilities (other than transporting from facility to administration for review) unless they are under subpoena or clinical care studies.

Review and Quality Improvement

Record storage and security is reviewed at least annually for improvement and conformance to standards.

Security Procedures to Prevent Identity Theft

1. Any information/reports, etc. which contain personal information and are provided to the employee/person served or guardian should be presented in a sealed, secure envelope.
2. Unless required by law, social security numbers should not be displayed on employee reports.
3. Any recordkeeping which includes social security numbers or other identifying information should be maintained in a locked environment.

See Attachment—Information Released/Disclosed Record

Revised: 8/17; 3/19; 5/22
Reviewed: 7/18; 8/19; 7/20

DOCUMENTATION

Documentation gives substances to the services MCH provides, not only in audits or legal matters, but for rules and regulations. MCH strives to provide documentation that meets the standards set by the North Carolina Division of MH/DD/SAS and any other standards and regulations which apply to specific programs. All MCH staff who work directly with persons served are authorized by the executive director to document in the service records, whether via the electronic health record or paper. While most documentation of service provision now occurs electronically, paper formats remain as back up in the event there is an inability to access Therap. Employees are expected to follow all standards regarding documentation.

Procedures

1. All written record entries must be made in black ink or be typewritten. Entries must be legible.
2. All entries in the service record should be signed and contain the appropriate credentials, degree, licensure, and/or title of the person entering the information. The use of initials in lieu of a full signature is only allowed when correcting an error, or when a service is documented on a service grid or checklist. In these cases, the employee's full signature will be included within the document.
3. Whenever an employee is no longer available [extended leave, death, termination from position] to sign a record entry, a notation reflecting this shall be documented in the service record and signed/acknowledged by the employee's supervisor.
4. All record entries should be completed promptly. General service notes must be completed at the end of each shift. Daily notes must be completed within 24 hours of service.
5. If a service is not documented on the day the service was provided, it shall be considered a "late entry." The documentation shall be noted as a "late entry" and shall include at a minimum the date the documentation was made and the date when the documentation should have been entered.
6. Each page must include the name of the person served and Medicaid identification number. The only exception to this rule is correspondence which may contain the person's name but is not required to contain their record number.
7. On forms, each item of information must be filled in. The only exception to this rule is an item entitled "Additional Information." If an employee is unable to obtain certain required information or has no comment to make in a particular section, he/she should

so indicate inserting the word "None" or “N/A” so that any reviewer will know that the information item has not been overlooked.

8. Abbreviations and symbols may be used if they are a part of a diagnosis, medication order or on the MCH Approved Abbreviations List.
9. Whenever corrections are necessary on paper records, employees should draw a single line through the error so that it can still be seen, initial and date.
10. An explanation as to the type of documentation error should be included whenever the reason for the correction is unclear [e.g., “wrong service record”].
11. The word Confidential is to be stamped in red on the front of each paper record.
12. Allergies and hypersensitivities, if any, should be recorded in red ink on the front of the paper record. NKA should appear in red if none.

See Attachment—Approved Abbreviations

Revised: 8/17; 3/19
Reviewed: 7/18; 8/19; 7/20; 7/22

MEDICATIONS

MCH strives to adhere to all requirements outlined in federal and state laws as well as service definition requirements (10A NCAC 27.G .0209; APSM-45; ICF-IID Tags W361-392) when handling and administering medications to the persons we support.

General Practices

1. Medication usage and administration shall be monitored in all MCH facilities by a nurse.
2. No medication, whether prescription or over-the-counter, will be administered without written order of a physician.
3. Verbal orders from a physician will be accepted only by a nurse.
4. The nurse or health care assistant enters all new medication orders into Therap, which provides staff information about the medications effects and possible side effects.
5. The Nurse's Notes must indicate the effectiveness of the medication.
6. Physician's orders must be noted by the nurse or health care assistant.
7. All orders are documented on the Medication Administration Record as dictated by regulations. The MAR is formatted and updated in Therap by the nurse or health care assistant.
8. MCH staff or the nurse must get permission from the physician before discontinuing a drug unless:
   - the order indicates an exact period of time for the drug to be administered
   - specific number of doses was ordered
   - the order has an automatic stop and the medication is no longer needed
9. Prescription medications cannot to be stopped without the approval of the physician.
10. Staff are responsible for informing the nurse or facility manager about orders which will expire in the next 48 hours so that ample time can be allowed to contact the physician to renew the order.
11. It is the responsibility of the manager or designee to pick up medications from the pharmacy and check labels to ensure accuracy.
12. Staff who administer medications are responsible for informing the facility manager when supplies get down to a 3-day supply so that medications can be ordered from the pharmacy.
13. Facility managers are responsible for ensuring that enough medication is available for holidays, weekends, or such times as the pharmacy might be closed. Designated staff should review all medications weekly to prevent weekend or holiday shortages. In the event there is a shortage, immediately call the nurse.
14. It is the responsibility of the nurse and/or MCH staff to relay information to the physician from the interdisciplinary team. Staff should monitor for and report medication reactions and side effects to the nurse. The nurse will monitor medication effectiveness and side

effects and document in nurse's notes. Response to medication, reactions, and side effects will be reported to the MD as necessary.

15. In case of an emergency related to medications, staff should call poison control and report to the staff nurse. The number for poison control is posted on the emergency phone list posted by each telephone.
16. Employees must contact and obtain approval from the MCH nurse or their designee before giving any PRN medication.
17. PRN medications must be documented on the MAR, including the reason they are given.
18. Medications are administered only by employees who passed the Medication Administration Course and is current in recertification, if applicable.
19. Therap generates a medication information form on every medication entered by the nurse or health care assistant. This can be accessed through the T-Log as highlighted.
20. At the beginning of each month or as medications changes are ordered, the nurse prints a paper MAR out of Therap and provides to each facility to ensure consistent delivery of medication in the event this documentation cannot occur in Therap.
21. For any person served who is capable of self-administration their own medications, a written statement must be obtained and kept within the person's service record. Medications must be stored in a secure, locked environment which only the person served and staff can access. All standards which apply to the storage of medications still apply.

Procedures for Administering Medications

Only trained personnel who have successfully completed the Medication Administration Course can administer any medication according to the following procedures:

1. While counting/administering medications, only staff and the person receiving the medication should be at the medication closet.
2. Gather all needed equipment and supplies (MAR, applesauce, juice, cups, *etc*.).
3. Employees administering medications should wear gloves and never touch a medication.
4. Check the label of the medication against the information on the MAR prior to administering. Ensure the information matches. If the label is not legible or does not match, **STOP IMMEDIATELY** and call the manager or QP.
5. Pour medication at the time of administration and never before.
6. Observe and ensure the 6 rights are followed with each medication: right person, right drug, right route, right time, right dose, and right documentation.
7. If there are several medications to be given to a person at the same time, get all the doses from the containers and compare each medication as above.
8. Document all medications given to the person, using the employee's full initials and check again to be sure that all medications for that time period have been given or accounted for.
9. Proceed to the next person served and repeat all steps above for person served receiving medications.
10. Lock medication closet and store key appropriately box.

11. All medications to be administered by MCH staff off site must be kept in a locked box until the administration of the medication. Procedures for administering off-site medication is the same as for on-site.
12. For any medication that was ordered but not administered, employees should select a reason the medication was not given from the options in the drop box.

Procedures for Reporting Medication Errors

1. Any time an error occurs with administering medications, the MCH RN should be contacted immediately, followed by the facility manager and QP.
2. The nurse will investigate the error, contact the person's physician and make the decision as to what action should be taken. If the nurse is unavailable, call the physician or emergency room doctor on duty for advice.
3. The time the error was made should be determined and medications counted to see if the dosage can still be given according to the time limit observed by the facility.
4. The error should be documented as missed. A General Event Report (GER) as well as T Log should be completed in Therap by the employee who committed or found the error.
5. The nurse will complete a Medication Error Form and submit to the MD immediately.
6. If the medication error caused a significant adverse reaction, the RN or QP should also complete an IRIS as required.
7. Medication errors are reviewed by the Health and Safety Committee and the Human Rights Committee quarterly to determine if there are any patterns.

See Attachment—Medication Error Report

Procedures for Disposing Medications

1. Wasted medication should not be destroyed until instruction is given by the nurse and should be placed in a sealed envelope or other container until advised by the nurse. If a medication is dropped and must be wasted, 2 staff must witness the medication being flushed.
2. Any extra medications, regardless of drug class, should be returned the MCH nurse by the next business day.
3. The nurse will keep all returned medications in a locked area until such time the medications can be turned over to the local sheriff department or designated pharmacy per NC requirements.
4. A Returned Medication Confirmation form will be started and filled in by the MCH employee and nurse at the time of return to the nurse.
5. The Returned Medication Confirmation will be completed by the nurse and representative receiving the medications. These forms will be kept on file in the nurse's office.

See Attachment—Returned Medication Confirmation

Procedures for Handling Controlled Medications

1. All controlled medications are stored under double lock.
2. Controlled medications are transported in a locked box.
3. All controlled medications are counted at the change of each shift by 2 persons, 1 staff from the previous shift, and 1 staff coming on. The count must be witnessed by both staff.
4. The count is recorded on a Controlled Substance Count Sheet. There is a separate sheet for each person served and for each controlled medication.
5. New containers are to be opened at the first scheduled count after being received from the pharmacy and included in the total count. If the number contained in the new container or package does not correspond to the number on the label, report to the nurse. The nurse must report the discrepancy to the pharmacy (unless the bottle was sealed from the supplier). If the count in the container is incorrect, staff members counting the contents of a new container should write the correct number on the label and initial. A notation should be made in the block on the count sheet indicating that a new container was received and the number in the container. The total count should include the number in the current container being used and the number in the new container.
6. Any discrepancy in the count is to be reported to the nurse immediately. If a nurse cannot be contacted, the report should be made to the facility manager or to the executive director. The nurse will investigate the discrepancy, report to the executive director, and do a medication error report if needed or write a report and attach to the count sheet.
7. If a dose of a controlled medication is contaminated and must be wasted, 2 staff members must witness the dose being flushed and document in the space provided on the back of the count sheet. If more than 3 tablets or capsules or more than 1 syringe of Diastat must be wasted, they should be returned to the RN by following medication disposal procedures.

See Attachment—Controlled Substance Count Sheet

Procedures for Storing Medications

1. All medications should be stored according to pharmacy recommendations in a clean secure, locked, well-lit area where temperatures are maintained to ensure viability of all stored medications.
2. Medications requiring refrigeration should be stored in a locked container in the refrigerator. Any directions for storing away from light or heat should be followed. Temperature must be between 36 and 48 degrees in the refrigerator, and a thermometer must be present.
3. Each licensed facility has a designated storage area which secured by 2 locks and keys are only available to personnel who have received medication training.
4. Topical medications must be stored separately from other medications such as oral medications.
5. Medications must be in a locked box when being transported.

Medication Review

Medication orders (standing orders) for persons living in a licensed MCH group home are reviewed at least every 6 months by the person prescribing the medication. This may be documented on 180-day physician's orders and the Physician's Annual Summary. These reviews are maintained in the individual's service record. Medication errors are monitored through tracking of incident reports and are reviewed by the safety committee, HRC, and board.

Any medication prescribed to address behavioral concerns is reviewed quarterly by the QP, RN, psychologist, and prescribing physicians or medical professionals to measure effectiveness and determine ongoing need.

Self-Administration of Medication and Risk Reduction

It is the intention of MCH to promote the greatest level of independence possible in all areas. For persons who receive residential supports and wish to administer their own medication, the following procedures will be followed:

1. Prior to services starting, a MCH nurse will assess the ability of the person receiving services to safely store and self-administer their medication utilizing the Self Administration Medication Assessment form.
2. The MCH RN will educate the person served regarding the following:
    a) Indications for use and expected benefits
    b) Method of administration
    c) Side effects and adverse consequences
3. The MCH QP will ensure through inspection that the person receiving services has access to and utilizes proper storage for their medication.
4. Staff will monitor and record indications of therapeutic benefits, side effects and any adverse events in Therap as well as notify the MCH RN of said components. If MCH staff observe practices which could reasonably be attributed to the improper self-administration of medication, staff shall consult with RN and QP.
5. MCH staff or RN will communicate any concerns about potentially detrimental effects regarding ongoing self-administration of medication to the individual's primary health care provider to receive guidance on areas of concern.
6. In order to accommodate the needs and preferences of the person served and to encourage as much independence as possible, the individual may keep their medications, both prescription (Rx) and over-the-counter (OTC), in their possession both on or off the MCH site, or in their own room in a residential setting. Medications must be kept locked. In residential sites, the individual must also document on their Medication Administration Record each time they take a medicine.

See Attachment—Self Administration Medication Assessment

Revised: 8/17; 8/20; 9/20; 7/22
Reviewed: 7/18; 8/19

THERAPEUTIC LEAVE

Therapeutic leave is a termed used to describe when a person receiving residential supports goes out with designated family or friends for a short-period of time and is not accompanied by an MCH employee or contractor. This can be something as simple as going out to eat for lunch with a friend to spending the holidays with their family. MCH encourages the use of therapeutic leave for all residents to foster and maintain relationships outside of those from paid supports.

Procedures

1. Therapeutic leave must be documented in the Person-Centered Plan for residential care and therefore does not require a separate prior authorization.
2. The QP tracks the number of days of service and therapeutic leave days to ensure compliance with service definitions and licensing requirements.
3. Prior to a resident leaving and upon their return, staff will complete an Authorized Leave Form to document length of time the resident was gone, reason for use of therapeutic leave and a statement regarding the individual's condition prior to and after return from the leave.
3. Per regulation, persons living in homes which provide ICF-IID level of care cannot use more than 60 therapeutic leave days per calendar year, and no more than 15 in one quarter, without prior approval of the MCO.
4. Per regulation, persons living in homes which provide DDA level of care cannot use more than 45 therapeutic leave days per calendar year, and no more than 15 in one quarter. While funding sources including NC Innovations Waiver and state-funded residential services do not include therapeutic leave within their service definitions, MCH encourages the use so residents can spend time at home with family and friends.

See Attachment—Authorized Leave

Revised: 8/17; 7/22
Reviewed: 7/18; 8/19; 7/20

HUMAN SEXUALITY

Sexuality and sexual development are important aspects of life in general. In a program where services focus on the development of independent living skills, it is necessary to address the sexual development of persons served. The intent of this policy and these standards is neither to encourage nor restrict sexual behavior. However, this policy does intend to allow appropriate expression or sexual feelings in a manner which is acceptable to persons served, parents or guardians, staff, administration, and MCH Board.

The following should be considered when evaluating the sexuality of a person receiving services:

- the person's values and ability to understand consensual sexual relationships
- the values of the person's family, legal guardian or significant others
- the norms of the community in which the program is based
- legal rights and limitations
- the availability of privacy in a group-living situation

With these considerations in mind, the following standards are intended so that the person served, their parents and/or guardians, the community and staff can integrate efforts to guide individual sexual expression in a way that leads to responsible and acceptable behavior.

Procedures

2. Sexual behavior will be expressed in a manner that is consistent with the training goals of the person receiving services and considered appropriate for the setting. Sexual expression is never appropriate in the vocational setting. This includes kissing and hand holding.
3. Personal or interpersonal sexual behavior will be private and expressed in a manner which respects the privacy of others.
4. There will be regard for the possibility of pregnancy and sexually-transmitted diseases as well as the potential need for birth control.
5. Sexual education should be presented on a level that the person receiving services can understand.
6. If a problem concerning sexual behavior occurs, it will be clearly identified as to why the behavior created a problem and what behavior would be considered appropriate.
7. If the problem is not then resolved, alternate solutions will be discussed, with appropriate professionals consulted as needed.
8. If alternative solutions are not effective in eliminating the problem behavior, restrictions may be taken which affect the individual's right to privacy and sexual expression. If this becomes necessary, policy regarding restriction of rights should be followed.

Revised: 8/17, 7/18
Reviewed: 8/19; 7/20; 7/22

STAFFING AND PERSONNEL REQUIREMENTS FOR LICENSED FACILITIES

It is the intention that MCH provide staffing in accordance with licensure requirements in each of its facilities using the appropriate regulations and standards which apply to the facility as the *minimum* staffing pattern.

General Practices

1. The manager of each facility ensures adequate, trained staff coverage to meet minimum staffing requirements.
2. Only MCH employees who are authorized to do so may provide NC Innovations waiver services.
3. In the event that staffing shortages occur and a temporary agency is used, there will be at least one regular MCH employee working as well. Temporary staff will be expected to follow all facility policies and procedures.
4. There shall be a written job description for the director and each staff position which:
    - specifies the minimum level of education, competency, work experience and other qualifications for the position including credentials if a professional position requiring a degree
    - specifies the duties and responsibilities of the position
    - is signed by the staff and the supervisor and
    - is retained in the staff file
5. MCH shall ensure that the director and each employee who provides care:
    - is at least 18 years of age unless driving MCH vehicles (for insurance requirements)
    - is able to read, write and understand English
    - meets the minimum level of education, competency, work experience, skills and other qualifications for the position
    - has no substantiated findings of abuse or neglect listed on the North Carolina Health Care Personnel Registry or is found on the OIG Exclusions Data Base
6. MCH asks all applicants for employment to disclose any criminal conviction during the interview and notifies applicants that a criminal background check will be completed. The impact of this information on a decision regarding employment shall be based upon the offense in relationship to the job for which the applicant is applying.
7. Employees and contractors will be currently licensed, registered or certified in accordance with applicable state laws for the services provided.

8. A file shall be maintained for every employee indicating the training, experience and other qualifications for the position, including verification of licensure, registration or certification.
9. Employee training is provided to ensure compliance with federal, state and service-definition requirements. Scores of outcome-based tests are maintained within individual personnel records.
10. Except as permitted under 10a NCAC 27G .5602(b), at least 1 staff shall be available in the facility at all times when a person served is present. That staff member must be trained in First Aid including seizure management and CPR. In any residential facility if only one staff is present, that staff must be certified in medication administration.
11. MCH maintains a pool of trained PRN staff that serve to provide staffing coverage at times when regular employees are scheduled to be off or are not able to work due to an unexpected emergency. Managers and QPs work together to ensure there is staff coverage 24/7. If staff cannot be located to fill in the shift, either the manager or QP will provide coverage.

Revised: 8/17; 7/20
Reviewed: 7/18; 8/19; 7/22Busin

GRIEVANCE and CONFLICT RESOLUTION

It is the intent of MCH that services are provided to all persons served without discrimination on the basis of race, creed, color, age, sex, gender, sexual orientation, religion, disability, ancestry, national origin, or belief. Every person served should expect fair treatment.

Persons served by MCH have the right to file a grievance. Persons served and/or legal guardians are encouraged to register any concerns, complaints, or grievance and pursue an acceptable means to address the grievance. There shall be no retaliation for filing a grievance. Acceptable resolution of any conflict should be expected without retaliation, and persons served/legal guardians should feel free to speak with MCH staff about concerns or problems and expect reasonable explanation or resolution in a timely manner.

Procedures

1. Conflicts or concerns should be taken to the appropriate facility manager for resolution unless the concern is with that person. In that event, the concern should be taken to the qualified professional, business or executive director.
2. Conflicts or informal grievances should be resolved between the person served and/or parent/guardian and management-level personnel or professional personnel, if possible.
3. If the problem cannot be settled with the upper management or professional personnel, the person served/legal guardian should take the issue to the executive director to seek resolution. The executive director should respond to the complaint in writing within 5 working days.
4. If the grievance involves a rights issue, it will be reported to the Human Rights Committee immediately. This committee may make recommendations as to resolution or further reporting to appropriate authorities and the executive or business directors. The HRC has 10 working days to make a recommendation on reporting or resolution of the grievance.
5. Grievances or complaints which cannot be resolved between the executive director and the person served and/or parent/guardian will be heard by the MCH Board. Subsequently, the final resolution may be left to the discretion of the MCH Board. The Board should respond within 10 working days of hearing the grievance. Unless there is immediate jeopardy, the MCH Board will review the complaint at its next regularly scheduled board meeting and shall make written response within 10 working days of that meeting. In the case of immediate jeopardy, the board will call an emergency meeting. Immediate jeopardy would include a health or safety concern which needs immediate remediation.
6. The complaint and action agreed upon by the person served and/or parent/guardian and any others involved will be documented in the client's record.

7. There will be no retaliation or repercussions in service delivery as a result of filing a grievance or making a complaint.
8. All grievances and complaints will be treated in a confidential manner.

Revised: 8/17; 7/22
Reviewed: 7/18; 8/19; 7/20

MAINTENANCE of MCH PROPERTIES

MCH facilities, grounds, and vehicles are to be kept in good repair and working order and should be maintained in clean, neat appearance. Preventive maintenance is an important aspect of keeping MCH safe and barrier free. The maintenance supervisor may expend up to $300 for repairs or supplies at his discretion.

The Health and Safety Committee is responsible for a quarterly inspection of each building to promote safety, prevent maintenance problems which might result from neglect, and to ensure that preventive maintenance occurs. A Quarterly Maintenance Checklist shall be completed by the Safety and Health Committee and kept on file in the facility. Each facility manager is responsible for doing at least a monthly inspection. Any needed maintenance or repair should be completed as soon as possible and documented.

Procedures

1. To report maintenance issues, employees will fill out a work order and send it via internal mail to the administration office.
2. The work order will be given to maintenance staff as received. The business director may help prioritize work orders as needed.
3. When the repair is finished, the work order should be signed by appropriate staff and filed in a notebook maintained in the facility.
4. Completed Work Orders shall be filed in the administrative office on monthly basis.

See Attachment—Work Order
See Attachment—Monthly Maintenance Checklist

Revised: 8/17; 7/20; 7/22
Reviewed: 7/18; 8/19

SECURITY

MCH is concerned for the safety of persons served and staff at all times. We continuously evaluate our security and take measures to make all facilities safer. We strive to prevent unknown hazards or put our persons served and staff at risk.

General Practices

1. All residential exterior doors are to be kept locked at all times. Staff should be aware of anyone who comes in or exits and ask for identification from anyone not known. While residents are encouraged to answer the door in their homes, staff should be vigilant and go to the door with the resident.
2. All doors can be opened from inside without a key in case of emergency evacuation.
3. Door chimes are used on exterior doors of facilities that are located near busy areas. This is done to alert staff when a person served decides to go out. If the location where services are provided has a door chime, consent is obtained from either the person served or their legal guardian as well as the MCH HRC Committee.
4. Third shift staff should carry a portable telephone on his/her person. Third shift staff may not go outside the building during the shift other than in an emergency. No smoke breaks are permissible on third shift, even when 2 staff are present.
5. All doors in the administration building should be locked except the main entrance. Visitors should check in at this entrance and be announced.
6. The door between the reception area and the rest of the administration building is secured by electronic access control.
7. MCE and MCH administration have security systems. All employees who are assigned keys are assigned security codes. Individual security codes are cancelled and keys returned when an employee terminates.
8. MCE has security cameras to alert staff if anyone tries to enter doors other than main door, alert them to unusual persons in the parking areas and monitor of hallways for individual safety.
9. Visitors are requested to check in at MCE to ensure safety and privacy standards are maintained.
10. Employees are trained to scrutinize unknown visitors and request identification if necessary.
11. All MCH persons served are encouraged to have personal possessions and have a designated place to store valuables and personal property.

Revised: 8/17
Reviewed: 7/18; 8/19; 7/20; 7/22

VISITORS

MCH wants an environment open to work and family issues, making accommodations as possible. Because having minor children in work areas during work hours creates a potential liability to MCH, risk of harm to a child and/or decreased employee productivity due to distraction, MCH requests that employees not have their family and friends visit residential facilities unless arrangements have been made with the facility manager or QP for a short visit.

Persons wanting to visit MCE are encouraged to schedule the visit through the MCE manager. It is expected that staff of monitoring agencies as well as MCH professional and management staff who visit MCE protect the confidentiality and rights of all persons served. Business should be conducted as necessary without undue disturbance.

Persons receiving residential services through MCH are encouraged to invite friends and family to their home for visits. MCH provides guidelines for these visits in service-specific handbooks that are provided to residents and their guardians each year. Temporary exceptions to the visitation policy can be made at times when there are general threats to the health and safety of persons served, such as at times of pandemics, local health pandemics or hazardous weather. Any temporary change to the policy will be communicated to the persons served, their families and any potential visitors at the time of the change.

Procedures

1. All first-time visitors must sign a Confidentiality Agreement when they enter a MCH facility other than the administrative office.
2. MCH personnel should not bring minor children to their workplace unless for a brief visit with persons served.
3. Family members and friends of residents can visit in common areas of the home such as the living room or den. If the resident wishes to meet with their visitor privately, they are encouraged to use their bedroom.
4. While residents are encouraged to greet visitors at the door, staff are to monitor and request identification if necessary.
5. Any visitor who refuses to identify him or herself will not be admitted into a MCH building.
6. Visitors to MCE should sign in upon entry.
7. Visitors to the administration building should come in via the main entrance and check in with the administrative staff who will refer the visitor to the appropriate person(s).

Revised: 8/17; 3/20; 7/22
Reviewed: 7/18; 8/19; 7/20

KEY MAINTENANCE

Each MCH facility requires a key to open. Additionally, in order to protect confidential and personal information of employees and persons served, MCH keeps some cabinets, files and closets locked. Keys allowing access to these areas are assigned to authorized personnel. Master and copies of all keys are maintained in a locked cabinet at the administration office.

Procedures

1. Vehicle keys and facility keys are maintained on a common key ring for other personnel to use while on a shift and are to be left in the facility.
2. Keys should not be left or hidden outside of facilities.
3. *Medication closet keys should not leave the facility.*
4. Medication closet keys must be stored in a secure location and persons who are not trained to administer medications should not have access to these keys.
5. Spare keys to confidential information in the administrative office should be housed in a locked cabinet with only authorized personnel having access to the cabinet.
6. Managers should maintain a current list of all persons who have keys to facilities and vehicles.
7. Access to files or closets containing information of persons served will be given to employees whose job description requires such access.
8. All keys should be turned in when employees terminate. The business director maintains a list of who is assigned keys and ensures that keys are obtained when persons terminate.

Revised: 8/17
Reviewed: 7/18; 8/19; 7/20; 7/22

STORAGE AND USAGE OF TOXIC MATERIALS

All cleaning supplies (i.*e.,* bleach, laundry detergents, disinfectants, other caustic materials) are stored in locked areas, that are separate from medications and food items. Staff will return these items to the storage area immediately after their use. Persons served who are involved in cleaning programs are trained on the materials being used and supervised closely by staff. In-service training for staff regarding the proper storage of toxic materials will be provided during orientation and on an on-going basis.

Revised: 8/17
Reviewed: 7/18; 8/19; 7/20; 7/22

PETS

Pets are allowed in MCH residential facilities on a case-by-case basis which takes into account the desires of residents and staff. No pets are allowed in facilities where persons served have documented allergies to pet dander or are afraid of animals. Any facility which houses pets must ensure that all shots are current, the animal is neutered, and provide a clean, odor–free environment. All pets must be approved by the executive director and health and safety committee.

MCE shall have no pets other than fish.

Visiting pets should be accompanied by owner and leashed if appropriate. Any staff who bring pets to work for therapeutic reasons should provide documentation of current shots and have prior approval of the executive director and/or health and safety committee.

All MCH facilities which do allow pets should adhere to the following rules:

1. Each pet must be maintained responsibly and in accordance with all applicable ordinances, state and local public health, animal control, and animal anti-cruelty laws and regulations governing pet ownership. Any waste generated by a pet must be disposed of promptly to avoid any unpleasant and unsanitary odor in the home.
2. Animals that are usually considered vicious and/or intimidating are not allowed. This determination will be made by the director and health and safety committee representatives.
3. Pet(s) shall not disturb, interfere, or diminish the peaceful enjoyment of residents. If so, the home will be given one week to decide for the care of the pet.
4. If the animal should become destructive, create a nuisance, represent a threat to the safety and security of residents, or create a problem in cleanliness and sanitation, the director will notify the home that the animal must be removed immediately.
5. The owner of any pet which is brought to any facility for therapeutic reasons should provide proof of current shots to the executive director and will be responsible for any damages caused by the animal while on MCH property.

Revised: 8/17; 7/22
Reviewed: 7/18; 8/19; 7/20

ADVERSE WEATHER

Some MCH services must continue to be provided during periods of bad weather. All licensed and unlicensed residential sites are considered locations of mandatory operation (24 hours/day, 7 days/week). Employees at these locations are expected to make every effort to report to work. If the employee does not report for work when scheduled during an inclement weather emergency, unless arrangements are made with the supervisor, the employee will be considered absent.

The MCH Administrative office, Macon Citizens Enterprises (MCE) and community-based periodic services are not considered locations of mandatory operation during adverse weather. Operation of both the administrative office and MCE during periods of adverse weather will follow the precedent set by the local school system and close with the approval of the Executive or Business director. Should such decision be rendered, the director making the determination is responsible for notifying affected MCH employees.

Revised: 8/17
Reviewed: 7/18; 8/19; 7/20; 7/22

INFECTIOUS DISEASE MANAGEMENT PLAN

MCH will take proactive steps to protect the workplace in the event of an infectious disease outbreak. It is the goal of MCH during any such period to strive to operate effectively and ensure that all essential services are continuously provided and that employees are safe within the workplace.

MCH is committed to providing authoritative information about the nature and spread of infectious diseases, including symptoms and signs to watch for, as well as required steps to be taken in the event of an illness or outbreak.

For this policy, symptoms of a potential infectious disease are defined as follows:

- Fever greater than 100 degrees F
- Acute intestinal distress (vomiting, diarrhea, heaving)
- Respiratory distress (shortness of breath, labored breathing, tightness of chest)

MCH will adhere to guidelines provided by the Centers for Disease Control and modify potential symptoms as recommended. These modifications will be communicated to employees via interagency email, memos and/or electronic message boards.

Preventing the Spread of Infection in the Workplace

MCH will ensure a clean workplace, including the regular cleaning of objects and areas that are frequently used, such as bathrooms, break rooms, conference rooms, door handles and railings. The MCH Safety Committee and/or RN will monitor the type of cleaning products used in each facility and make recommendations as needed to ensure the products used disinfect effectively.

MCH asks all employees to cooperate in taking steps to reduce the transmission of infectious disease in the workplace. The best strategy remains the most obvious—frequent hand washing with warm, soapy water; covering your mouth whenever you sneeze or cough; and discarding used tissues in wastebaskets. We will also provide alcohol-based hand sanitizer in all facilities.

Unless otherwise notified, our normal attendance and leave policies will remain in place. Individuals who believe they may face challenges reporting to work during an infectious disease outbreak should take steps to develop any necessary contingency plans. For example, employees might want to arrange for alternative sources of childcare should schools close

and/or speak with supervisors about the potential to work from home temporarily or on an alternative work schedule.

Limiting Travel

All nonessential travel should be avoided until further notice. Employees who travel as an essential part of their job should consult with the executive director on appropriate actions.

Work from Home

Requests to work from home will be handled on a case-by-case basis. While not all positions will be eligible, all requests for temporary work-from-home should be submitted to your supervisor for approval.

Staying Home When Ill (Social Distancing)

Many times, with the best of intentions, employees report to work even though they feel ill. MCH provides paid time off to allow employees to stay home when sick without missing pay.

During an infectious disease outbreak, it is critical that employees do not report to work while they are ill and/or experiencing the following symptoms: fever, body aches, chills, shortness of breath/respiratory difficulty or symptoms indicative of a stomach virus. Currently, the Centers for Disease Control and Prevention recommends that people with an infectious illness such as the flu remain at home until at least 24 hours after they are free of fever (100 degrees F or 37.8 degrees C) or signs of a fever without the use of fever-reducing medications. Employees who report to work ill will be sent home in accordance with these health guidelines.

Requests for Medical Information and/or Documentation

If you are out sick or show symptoms of being ill, it may become necessary to request information from you and/or your health care provider. In general, we would request medical information to confirm your need to be absent, to show whether and how an absence relates to the infection, and to know that it is appropriate for you to return to work. As always, we expect and appreciate your cooperation when medical information is sought.

Confidentiality of Medical Information

Our policy is to treat any medical information as a confidential medical record. In furtherance of this policy, any disclosure of medical information is in limited circumstances with supervisors, managers, first aid and safety personnel, and government officials as required by law.

Procedures for Minimizing Impact of Infectious Disease

1. As a part of the initial and ongoing education, MCH employees will receive training on implementing the use of universal precautions to control infection. Employees are expected to follow these guidelines at all times and encourage/instruct persons served to do so as needed.
2. All MCH facilities are equipped with cleaning products that are designed to limit the impact of bacteria and viruses. Cleaning schedules should be adjusted as needed by facility managers at times of the known presence of an infectious disease. MCH will

adhere to recommended cleaning/sanitation processes specific to the disease as recommended by the Centers for Disease Control should it differ from standard cleaning.

3. At times of an infectious disease outbreak, staff and persons served will be encouraged to increase handwashing and/or use of antibacterial sanitizer. PPEs are available in each facility and can be provided to community-based workers as needed.
4. Staff will report any symptoms a person receiving services presents to a MCH nurse immediately. The nurse, QP and/or facility manager will decide as needed for the individual to been assessed by a healthcare professional.
5. Staff who begin to experience symptoms of a suspected infectious disease should notify their manager or QP immediately. If they are at work at the time, the manager or QP will arrange coverage for the employee to leave.

Procedures for Infectious Disease Outbreak

1. Any person receiving supports who presents with symptoms should remain home until such time they are fever-free/symptom-free for a period of 24 hours without the use of fever-reducing medicines.
2. If another individual from the same facility develops similar symptoms within 24 hours, the QP, RN and/or director will issue a directive for all persons in that facility to stay home (mandate a quarantine).
3. Should symptoms appear in 2 or more MCH facilities, MCE will be closed for 48 hours to minimize exposure to persons served as well as employees. This time may be extended depending on the nature of the disease, such as one that has a longer incubation period.

Procedures for Quarantine

1. Monitor residents and employees for fever or respiratory symptoms.
2. Restrict residents with fever or acute respiratory symptoms to their room. If they must leave the room for medically necessary procedures, have them wear a facemask (if tolerated).
3. In general, for care of residents with undiagnosed respiratory infection, use universal precautions.
4. Support hand and respiratory hygiene, as well as cough etiquette by residents, visitors, and employees.
5. Ensure employees clean their hands according to CDC guidelines, including before and after contact with residents, after contact with contaminated surfaces or equipment, and after removing personal protective equipment (PPE).
6. Provide readily accessible alcohol-based hand throughout the group home.
7. Make sure tissues are available and any sink is well-stocked with soap and paper towels for hand washing.
8. Provide the right supplies to ensure easy and correct use of PPE.
9. Post signs in the home that clearly describe the type of precautions needed and required PPE.
10. Make PPE, including facemasks, eye protection, gowns, and gloves, available close to the resident's room.

11. Position a trash can near the exit inside any resident room to make it easy for employees to discard PPE.

Implemented: 3/20
Reviewed: 7/22

PANDEMICS

Pandemics happen when new viruses emerge which can infect people easily and spread from person to person in an efficient and sustained way. Because the virus is new to humans, very few people will have immunity against the pandemic virus, and a vaccine might not be widely available. The new virus will make a lot of people sick. How sick people get will depend on the characteristics of the virus, whether people have any immunity to that virus, and the health and age of the person being infected. With seasonal flu, for example, certain chronic health conditions are known to make those people more susceptible to serious flu infections.

During a pandemic, certain legal authorities, policies, and regulations may apply and serve as the foundation for the US Department of Health and Human Services (HHS) to respond. The HHS Secretary may, under section 319 of the PHS Act, determine that a disease or disorder presents a public health emergency; or that a public health emergency, including significant outbreaks of infectious disease or bioterrorist attacks, otherwise exists.

MCH will adhere to all local, state and federal guidelines issued in regard to the procedures to be followed during a pandemic. Resources will include the local public health department, Centers for Disease Control, the National Health Organization and the World Health Organization. Members of the MCH Management team will be responsible for monitoring and implementing any guidelines as recommended. This information will be provided to staff, persons served, and families of persons served immediately via phone calls, email, internal memos, mailings and/or electronic message boards.

Implemented: 3/20
Reviewed: 7/22