MCH

SECTION 5: ICF-IID POLICIES, PROCEDURES & OPERATIONS

September 2022

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INTRODUCTION

Persons with developmental disabilities have the inherent right to fulfill their potential as human beings and can be helped to lead dignified lives regardless of their level of functioning. Intermediate Care Facilities for Individuals with Intellectual Disabilities (ICF-IID) were established in 1971 under Section 1905 (d) of the Social Security Act. This benefit funds 4 or more bed homes in community settings to provide active treatment to persons with intellectual and/or developmental disabilities.

Active treatment is a continuous, aggressive and consistent implementation of a program of specialized and generic training, treatment, and health or related services, directed toward helping a resident function with as much self-determination and independence as possible. ICF-IID is the most comprehensive benefit in Medicaid (42 CFR 483.440).

Federal rules provide for a wide scope of required services and facility requirements for administering services. All services including health care services and nutrition are part of active treatment and based on an evaluation and individualized program plan (IPP) by an interdisciplinary team. Facility requirements include staffing, governing body and management, protections of the persons served, behavior management and physical environment, which are specified in the survey and certification process. Each ICF-IID home receives an unannounced site visit by surveyors with the Department of Health Service Regulation as a part of the annual recertification process. Any practices MCH is engaging in that are found to not meet the regulatory tags outlined in the ICF guidelines will result in cited deficiencies against MCH. All deficiencies require a plan of correction to bring the practice back in line with the ICF standard within a specified time.

MCH operates 4 ICF-IID group homes within Macon and Jackson counties of North Carolina. Macon Group Home, Iotla Street Group Home, Smoky Group Home and Webster Group Homes are the individual home names. These homes, for the remainder of this section, shall be referred to as “the group home”.

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GENERAL PRACTICES

1. First priority for admission is given to citizens of Macon, Jackson, Swain, Clay, Cherokee, Graham, and Haywood Counties.
2. The group home provides services according to the principles of normalization and person-centered planning with a positive, person-centered approach to habilitation.
3. The group home is licensed to serve 6 adults (adult, as defined by licensing, is 18 years of age or older).
4. The group home promotes a family-like atmosphere and provides the training necessary to help each resident become as independent as possible. Each resident is assisted to develop skills which allow for self-sufficiency, independence, and social acceptance in the community.
5. The group home is located in the community to assist eligible persons in realizing their full potential, as an alternative to institutionalization and to provide the necessary level of care for eligible persons to live in and/or near their home communities.
6. As with any group of persons living together, MCH has established house rules to govern individual behavior within a group setting. The House Rules are posted within each home, reviewed routinely at monthly house meetings, and provided within the ICF Handbook.
7. At least annually, provider choice will be reviewed with residents and guardians. If a change is desired, MCH will help find another provider.
8. At least annually and any time there are updates, each resident and their guardian receives an updated ICF Handbook which describes the services, policies and procedures of the home as well as several consents for services.

See Attachment–Handbook for ICF

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ADMISSIONS

Prior to admission, all applicants must complete and submit an MCH application with required attachments, be approved by the MCH Admissions Committee and have ICF services approved and authorized by the MCO.

Criteria

1. The applicant must be at least 18 years of age or older unless there are special circumstances that meet the intent of the Certificate of Need.
2. The applicant must be eligible for Medicaid or be able to pay the current Medicaid per diem rate.
3. The applicant must be able to have his or her health and safety needs met by the group home.
4. The applicant must be able to benefit from programs and participate in the activities of the group home without limiting the delivery of services to other residents.
5. In order to be Medicaid-certified at an ICF/IID level of care, an applicant must meet the following criteria as established in DMA Clinical Coverage Policy 8E:
   - require active treatment necessitating the ICF/IID level of care; and
   - have a diagnosis of Intellectual Disability per the Diagnostic and Statistical Manual on Mental Disorders, fifth edition, text (DSM-5), or a condition that is closely related.
6. An intellectual disability is a disability characterized by significant limitations both in general intellectual function resulting in, or associated with, deficits or impairments in adaptive behavior. The disability manifests before age 18.
7. Persons with closely related conditions refers to individuals who have a severe, chronic disability that meets **ALL** of the following conditions:
   A. is attributable to:
      - Cerebral palsy, epilepsy; **or**
      - Any other condition, other than mental illness, found to be closely related to mental retardation because this condition results in impairment of general intellectual functioning or adaptive behavior similar to that of Intellectually Disabled persons, and requires treatment or services similar to those required for these persons;

   B. The related condition manifested before age 22;
   C. Is likely to continue indefinitely; and
   D. Have Intellectual Disability or a related condition resulting in substantial functional limitations in three or more of the following major life activity areas:
      - Self-Care (ability to take care of basic life needs for food, hygiene, and appearance)
      - Understanding and use of language (ability to both understand others and to express ideas or information to others either verbally or non-verbally)

- Learning (ability to acquire new behaviors, perceptions and information, and to apply experiences to new situations)
- Mobility (ambulatory, semi-ambulatory, non-ambulatory)
- Self-direction (managing one's social and personal life and ability to make decisions necessary to protect one's life)
- Capacity for independent living (age-appropriate ability to live without extraordinary assistance)

Procedures

1. An application for admission must be completed and returned to the executive director or designee.
2. Current required evaluations (physical, psychological and applicable specialists) *must* be submitted with the application.
3. Any progress notes, treatment plans or special reports from the current residential or day activity provider, if applicable, should be provided for review.
4. MCH staff will meet and interview the applicant and/or legal guardians, social workers, care coordinators and staff or personnel who have worked with the applicant in the past to determine appropriateness for placement and ability to integrate with other residents in the facility.
5. Applicants who are screened and found appropriate will be presented to the Admissions Committee for consideration for placement when openings occur.
6. The Admissions Committee will make the final decision regarding acceptance for admission to the group home.
7. Applicants who are selected for admission will be notified by the executive director or designee, and an admission date will be determined.
8. All applicants who are not selected for admission will also be notified in writing by the executive director or designee.
9. All applications will remain active unless a request is made to terminate active status or the applicant becomes ineligible. Applications will remain on file at the administrative office.
10. Applicants are not prioritized until time of opening because factors such as facility opening, mix of residents, specific health/safety needs, age, etc. are considered for appropriate placement.
11. If a vacancy occurs at the group home, the executive director or designee will contact all active applicants to determine if they wish to be considered for placement. MCO staff will be notified of openings as well.
12. Applicants who have been previously determined ineligible may reapply at any time and be considered again with other applicants.
13. If a vacancy occurs, all current applicants are given equal consideration.
14. Upon acceptance to the group home, a medical, social, and psychological evaluation all dated within 30 days of admission to the group home will be completed.
15. An agreement in writing between the resident, his/her guardian and/or family and the group home that will define the:
    - responsibilities of the group home and
    - responsibilities of the resident

16. The applicant and/or guardian must review the group home Admissions and Discharge policy, the Resident's Rights Policy, and indicate by signature that they have been advised of and understand these policies.
17. The applicant, family and/or guardian must sign other consent documents, releases of information, and emergency service permission forms upon the date of actual admission.
18. If the group home is a managed property, all appropriate HUD housing forms must be completed, submitted and approved by The Arc of NC, the property management agency, prior to the applicant moving into the group home.
19. If the applicant is accepted, MCH staff will provide instruction to the person and/or their legal guardian, on steps to be taken prior to admission including, but not limited to notifying insurance(s) of benefit redirection and having a TB test completed prior to moving into the group home.
20. Any applicant and/or guardian of an applicant who is denied admission to the group home has the right to appeal the decision of the Admissions Committee by notifying the executive director in writing within 15 business days of the date of notice of rejection.
21. The Admissions Committee will meet within 15 business days of receipt of notice of the appeal and review the appeal.
22. The applicant may bring to the Admissions Committee a representative of his/her choice to present an appeal.
23. All decisions made by the Admissions Committee are final.
24. If an applicant is selected, the director or QP will review the admissions and discharge policies with the applicant and, if applicable, their guardian to ensure they understand the process and expectations of both.

See Attachment—Application for Services
See Attachment—Level of Care (LOC)
See Attachment—Admissions/Discharge Committee Review
See Attachment—Admissions and Discharge Acknowledgement

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DISCHARGE

While MCH strives to serve residents as long as possible, sometimes it becomes necessary to discharge to more appropriate services or because the person and/or their family needs to make a change.

Criteria

1. The Discharge Committee is made up of the same representatives as the Admissions Committee and must be consulted before a resident is discharged from the group home.
2. No resident shall be discharged without a recommendation from the interdisciplinary team.
3. A resident may be discharged if they or their family request or otherwise indicate a need for discharge.
4. A resident may be discharged if their medical needs change including a need for a different level of care.
5. A resident may be discharged if after a 90-day probationary period the resident's adjustment to the group home is unsuccessful.
6. A resident may be discharged if his/her behavior endangers himself and/or others.
7. A resident may be discharged for non-payment of fees except as prohibited by Medicaid.
8. A resident may be discharged if the group home is no longer the most appropriate environment for meeting the resident's needs.

Procedures

1. A parent/resident may request discharge and/or transfer. Guardians intending to make other living arrangements for a resident should give 2-week notice of intent to do so. Notice should be given to the executive director or assistant director in writing. Failure to provide 2-week advance written notice may result in an additional cost to the parent/guardian. This billing will reflect the actual daily cost of care for all days up to 2-weeks notification period or until such time that the bed is filled by another individual.
2. The interdisciplinary team will determine if a resident should be discharged from the group home. Documentation supporting reasons for discharge and the recommendation should be presented to the Admissions/Discharge Committee, resident, and/or legal guardian.
3. The interdisciplinary team will facilitate the location of an appropriate placement and will discuss with the resident and/or guardian to determine the most appropriate placement such as institution, rest home, home, or other group home.
4. Notice of discharge and/or transfer will be made to the resident, parent/guardian, and Admissions/Discharge Committee at least 30 days prior to discharge date. The Department

of Social Services in the appropriate county will also be notified of the discharge. The QIDP will be responsible for writing a detailed discharge summary and providing it to the facility, resident, and/or legal guardian. The QIDP will assist resident and/or family during the discharge process. There will be a follow-up consultation within 90 days after discharge to assure that an appropriate transition occurs.

See Attachment—Admissions/Discharge Committee Review
See Attachment—Discharge Summary

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PROTECTION OF RESIDENT RIGHTS

Every person, regardless of disability, has rights. MCH employee are trained on how to advocate and protect the rights of the persons we serve. At the time of orientation and at least annually thereafter, each resident receives a copy and is explained the contents of the MCH Rights Brochure. The intent of all governing policies is to adhere to the Client Rights in Community Mental Health, Developmental Disabilities, and Substance Abuse Services 10A NORTH CAROLINA ADMINISTRATIVE CODE 27C, 27D, 27E, 27F (APSM 45-2) which comply with G.S. 122C, article 3, Client's Rights. In summary, each person served shall always have the right to:

1. Exercise civil rights.
2. Receive written notice and rationale for transfer to another treatment or within the facility five days prior to the treatment.
3. Contact and consult with legal counsel and private physicians of their choice at their expense.
4. Communicate and meet under appropriate supervision with persons of their own choice, upon consent of such persons.
5. Receive visitors or refuse to receive visitors.
6. Make visits outside the facility.
7. Obtain and/or retain a vehicle driver's license.
8. Live in an unlocked environment.
9. Be out of doors daily and have access to recreational facilities and equipment for physical exercise several times per week.
10. Be free from seclusion.
11. Be free from mistreatment.
12. Be free from exclusion from ongoing programming because of inappropriate behavior.
13. Be free from physical and personal restraint and time out.
14. Be free from treatment given without informed consent involving aversive stimulation, the use of experimental drugs or procedures, or surgery other than emergency surgery.
15. Be free from unnecessary or excessive medication and not receive medication as punishment or discipline.
16. Send and promptly receive sealed, uncensored mail.
17. Have access to a schedule for collecting and distributing mail and packages.
18. Have access to writing material, postage, and staff assistance when necessary.
19. Make and receive confidential telephone calls.

20. Participate in religious worship by choice.
21. Keep and use their own clothing and personal possessions, *i.e.*, individual toothbrush, comb, deodorant, etc.

See Attachment—Handbook for ICF

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SUPPORTS PROVIDED

ICF-IID support is designed to provide comprehensive care. The type and level of specific services provided are based on individual need and are identified through evaluations, observations and assessments completed by the interdisciplinary team (IDT). The interdisciplinary team consists of the person served, legal guardian, QIDP, physical therapist, psychologist, nurse, doctor, dietician, day program manager, direct care staff, pharmacist and dentist. Each member of the team provides, at minimum, an initial assessment of the person served within 30 days of admission and at least annually thereafter.

Comprehensive Functional Assessment (CFA)/Habilitation Plan

Within 30 calendar days after a resident moves into the group home, the interdisciplinary team will perform an accurate comprehensive functional assessment or reassessments as needed to supplement the initial evaluation conducted prior to admission. (42 CFR §483.440 (c)(3).

The comprehensive functional assessment of each beneficiary must be reviewed annually by the IDT for relevancy and updated as needed. The habilitation plan is revised as appropriate (42 CFR§ 483.440(f)(2) by the QIDP. Per 42 CFR 483.440 (c)(4), the habilitation plan includes:

- specific objectives necessary to meet the needs as identified by the CFA
- the planned sequence for dealing with these objectives;
- objectives stated separately in terms of a single behavioral outcome:
    - objectives with assigned projected completion dates
    - objectives expressed in behavioral terms that provide measurable indices of performance
    - objectives that are organized to reflect a developmental progression appropriate to the resident
- a description of relevant interventions to support the residence toward independence;
- the location where program strategy information can be found
- for residents who need it, training in personal skills essential for privacy and independence, unless it has been demonstrated that the resident is developmentally incapable of acquiring them
- identification of mechanical supports, if needed, including:
    - reason for each support;
    - situation in which each is to be applied
    - a schedule for the use of each support

See Attachment—CFA/Hab Plan

Physical Therapy

MCH contracts with a licensed physical therapist to evaluate, monitor and address any physical therapy needs of residents. As needed, the PT will provide direct care or train staff on how to properly provide exercises that a resident may need. This includes assessment for use of the MCH Fitness Center.

Dental

MCH ensures each resident has access to quality dental services, preferably in the community if possible. Unless otherwise ordered by the dentist, residents receive prophylaxis treatment at least every 6 months. All dental procedures besides routine cleanings are as recommended by the dentist. If the dentist makes a referral for specialized dental treatment, MCH will assist in coordinating the recommended care. If pre-dental sedation or mechanical restraint is necessary to achieve optimum care, consent and HRC approval must be obtained and desensitization training must occur.

See Attachment—Consent for Dental Sedation and Mechanical Restraints

Recreation

Recreation and leisure services are provided in an organized manner so that each resident's needs may be met with the highest quality of recreational programming available. Individualized programs to improve these skills are developed and implemented as needed based on at least annual assessment.

Occupational Therapy

Residents will receive occupational therapy as need is determined by the interdisciplinary team. Such evaluation targets sensory stimulation, developmental play, perceptual motor skills, occupational skills and small and gross motor skills.

Social Services

MCH completes a social history evaluation at the time of admission. It contains the referral source, reason for admission, services needed and a statement regarding the expected role of the person, their family and MCH in coordination of services. It should summarize the resident's developmental history, precipitating factors for requesting services and describe the resident's level of intellectual, social, and behavioral functioning at the time services with MCH started. The evaluation will cover developmental history, family dynamics and benefit eligibility information.

Social services will include education and assistance, as needed, to either establish or maintain guardianship supports when needed or requested by a resident and/or their family. Monitoring and guidance around benefit eligibility and life-event planning such as pre-needs burial options.

Medical

1. Prompt and effective medical treatment is provided as needed.
2. Medical services are arranged as appropriate with informed consent for treatment.
3. If the primary physician is unavailable, the local emergency room or urgent care center may be utilized.
4. A physician performs admission examinations, annual physical examinations, order routine laboratory work, X-rays, *etc*.
5. The diagnosing and treatment of an illness shall be according to written orders which have been prescribed and authenticated by a physician's signature. If the physician uses a stamp, a copy of the original signature and the physician's stamp must be on file in the MCH facility.
6. The physician and MCH nurse will co-sign any orders taken verbally.
7. MCH shall use an approved medical facility for emergency, inpatient, laboratory, x-ray, and special studies, *etc.* or another approved facility if ordered by the physician and with appropriate consents.
8. Emergency Medical Service may be utilized if emergency transportation is needed.
9. MCH is responsible for providing transportation for residents to meet scheduled medical appointments.
10. Appropriate documentation of all medical services rendered are entered into the resident's service record.
11. The physician should provide notes or dictation of each visit. All laboratory/X-ray reports, consultation, medical summaries, etc., are kept in the resident's service record
12. Medications administered in any MCH facility are only those for which there are standing orders or those which have been prescribed by a physician.
13. Legal guardians are informed of needed operative procedures, and consent to treatment according to legal requirements must be obtained.
14. A consent for surgery that is non-emergent, must be signed by the resident or their legal guardian and should include the reason for the surgery, expected results, possible complications, description of the procedure, physician's name and a contact source if there are any questions. Consent forms for the hospital or physician may also be included if required by that facility.
15. In the event of an emergency requiring surgery for a resident when the legal guardian cannot be reached to give consent, after making every effort to do so, the surgical procedure can be authorized by MCH staff as indicated in the Resident/Group Home Agreement or consent to emergency medical services.

See Attachment—Physician's Progress Note
See Attachment--Physician's Orders
See Attachment—Consent to Surgery and Medical Procedures

Nursing

1. MCH employees a RN. The nurse oversee all health care provided to residents and is available to provide residential staff medical guidance.
2. The nurse records observations which pertain to a resident's medical care as needed. This may include but is not limited to:
   - feeding problems
   - changes in appetite
   - changes in appearance
   - changes in behavior
   - elevated temperature
   - any indication of health changes
   - changes in sleeping patterns
   - significant weight changes
   - injuries
   - edema
   - seizures differing from pattern
   - skin changes such as rashes, redness, swelling
   - symptoms of illness or approaching illness
3. During illness or any time there is a problem, progress or lack of progress should be recorded. There should also be documentation as to the resolution of the illness and effectiveness of any medication.
4. Blood pressure will be measured recorded at least monthly.
5. Vital signs should be taken as ordered by the physician and as requested by the nurse.
6. The nurse will complete a physical exam and summary of nursing events at least quarterly. Documentation of the exam and summary are filed in the resident's service record.

See Attachment—Nursing Summary
See Attachment—Nursing Exam

Nutrition

1. MCH ensures that each resident is provided a diet that is appropriate in nutrients, calories and form for their individual needs.
2. All residents will eat in the dining room except where contraindicated for health reasons or by the decision of the team.
3. Individual resident preferences will be considered when developing the menu.
4. Enough time will be offered to promote development of self-feeding skills, encourage socialization, and provide a pleasant mealtime experience.
5. Staff will eat with the residents in a family-style arrangement. Food is prepared according to the menu and placed on the table family style. Residents serve themselves under the supervision of the staff and receive assistance as necessary.
6. Mealtimes should be comparable to those normally observed in the community. There shall be at least 3 meals served daily at regular times with no more than a 14-hour span between a substantial evening meal and breakfast the next morning unless an adequate snack is provided.
7. Food will be served as soon as possible after preparation to conserve nutritive values and palatability and served in an attractive manner, in appropriate quantity and at the consistency recommended by the dietician.
8. Dietary practices related to religious requirements of the resident's faith should be observed.
9. Substitutions will be made for food allergies.
10. Food likes/dislikes will be honored as much as possible.
11. The menus will be approved by a registered dietitian to ensure that they meet the individual nutritional needs of each resident. A 4-week cycle menu is used. When changes are made, substitutions are noted on the backs of the menus. The changes should be of equal nutritional value. Menus and substitutions are kept on file for 3 months. The menu in use is posted in the kitchen. Modified diets must be ordered by a physician. The dietitian will plan the diet according to the objectives of the American Dietetic Association.
12. Special diet patterns must be planned in writing and kept on file.
13. Recipes for regular and therapeutic diets are available in the kitchen and used when preparing food to ensure a standardized product.
14. Standardized portions for each food are specified in the menu. Food is prepared based on serving size and number of portions needed.
15. The group home will maintain a 3-day supply of non-perishable foods to meet the requirements of planned menu.
16. Food storage procedures shall meet state and local regulations. Dry or staple food items are stored at least 12 inches off the floor, in a ventilated room, not subjected to sewage, waste water backflow or contaminated by leakage, rodents, or vermin.
17. Cleaning supplies shall be stored separately from food supplies.
18. Food shall be kept in air-tight containers to prevent spoilage and to keep out bacteria.
19. Perishable food is stored in the refrigerator or freezer. Frozen foods will be kept at a temperature of 0 °F.
20. General storage (dairy, meat, fruits and vegetable) shall be 34 ° - 45 ° F.
21. Food preparers follow training protocol to ensure food handling safety.

Psychological

Psychological supports are provided by a licensed psychologist to assess and facilitate as appropriate the maximum intellectual, emotional, and adaptive capacity of each resident. Psychological services are intended solely to maximize the personal freedom and sense of well-being required by each resident.

All residents are examined using standardized psychological tests after admission and are evaluated after that as needs arise. Every effort is made to utilize positive reinforcement and avoid punishment. When addressing difficult behaviors, the least restrictive and most normative measures are employed first. Psychological services will carefully conform to the ethics of the American Psychological Association and the laws and guidelines on human rights as contained in the state statutes and will on all occasions employ the most humanitarian procedures.

MCH encourages the use of individual and group therapy as recommended or requested by the resident, the MCH psychologist, psychiatrist or other members of the interdisciplinary team. MCH will assist residents in locating and accessing an appropriate therapist, including providing transportation as needed to sessions.

Speech/Language and Hearing

Speech/language needs are evaluated annually through the Comprehensive Functional Assessment. If deficits appear, the QIDP will make a referral to a Speech Language Pathologist for further evaluation and recommendations. The evaluation will comprehensive in nature and include assessment of both expressive and receptive languages. MCH will implement any programmatic or service recommendations identified in the evaluation after obtaining support of the interdisciplinary team.

A hearing screening will be completed within 60 days of admission and rescreened according to the recommendation of the audiologist or ENT.

Pharmacy

A registered pharmacist serves on the interdisciplinary team and provides at least a quarterly review of medication and interactions for each resident. This review ensures all aspects of drug utilization are carefully evaluated and monitored to provide safe and beneficial drug therapy.

See Attachment—Quarterly Pharmacy Review

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LIVING ENVIRONMENT

Each resident has their own room and is encouraged to decorate to their own personal tastes. The MCH ICF Handbook outlines rules each resident is asked to follow to allow for respect of each other, especially when sharing spaces like the living and dining rooms. MCH also encourages all residents to be respectful when engaging in activities or hosting visitors so that the sleep time of other residents is not interrupted. MCH adheres to all standards outlined in 10A NCAC 27F .0102.

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RESIDENT FUNDS

MCH strives to strictly follow rules as outlined in the North Carolina Administrative Code when handling or managing the personal funds of its residents (10A NCAC 27F .0105). We encourage residents to handle their own funds whenever possible and offer training in money management to build those skills when needed.

Procedures

1. Resident funds are maintained in an interest-bearing account according to Medicaid requirements. Funds are mingled in one account but tracked separately for each resident, using a spreadsheet to account for each resident's portion. Accumulated interest is spread to each resident equally.
2. Residents endorse checks made out to them unless a legal guardian or personal representative or some other legally constituted authority has been authorized to endorse their checks.
3. Residents are provided the level of support needed to deposit and withdraw money from their banking account.
4. In situations where a resident is unable to manage his/her funds, the legal guardian will provide direction to MCH about the handling of funds. In some cases, the guardian may wish to handle the funds, and in others the guardian may wish the MCH group home manager to handle the funds.
5. Upon the resident's or their legal guardian's signed consent, the group home manager and bookkeeper supervise the personal funds and maintain an accurate accounting of money received and disbursed. The manager can give the balance of available money whenever the resident and/or their guardian requests. A consent allowing this action is signed and maintained in the service record.
6. It is recommended that MCH become the payee for benefit checks.
7. If a resident has a legal guardian, MCH provides to that person the receipts for any money received on behalf of the resident.
8. At least quarterly, reconciliation is done by the facility manager or designee and the bookkeeper. A reconciliation statement of resident funds is provided to each person or their legal guardian. If there is a discrepancy, a report is made to the executive director who will investigate the discrepancy.
9. Receipts from all purchases made by a resident require 2 signatures from staff proving that the resident received the services or goods from the purchase. These signed receipts are attached to the monthly statement which is provided to the resident or their legal guardian.

10. If a resident owes MCH money to pay for damages they inflicted upon another resident or MCH property, the resident or their legal guardian must authorize the money to be withdrawn from their personal account before the deduction is made. This authorization is documented within the service record.
11. Any personal funds will be returned to the resident within 30 days of discharge.
12. A $50.00 petty cash account is maintained in a locked, secure place at the group home for each resident who needs assistance handling money. This fund should only be used for the resident to make small purchases (under $15). The group home manager is the custodian of this fund.
13. Vouchers should be completed each time a resident uses their petty cash. A receipt of purchase should be obtained and signed by the staff assisting the resident with the purchased as well as witnessed by another staff. If possible, the resident should also sign or make their mark.
14. The group home manager reconciles the resident's petty cash account and will replenish the fund when it is depleted to $15.00 or less. The fund will be replenished from the resident's checking account by completing a Receipt of Personal Money form, attaching all receipts and vouchers, and turning it into the bookkeeper.
15. No more than $250 will be taken out of a resident's account at one time to make a single purchase without the approval of the legal guardian. Money left over from shopping trips should be returned to the administrative office to be re-deposited into the resident account within 3 working days unless the resident is on extended leave from the group home.

See Attachment—Petty Cash Voucher

See Attachment—Petty Cash Reconciliation

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BEHAVIOR MEDICATION REVIEW

A Behavior Medication Review occurs at least quarterly for all residents who use medications as a part of their behavior management support.

Procedures

1. A behavior medication review is completed by a team composed of the physician, nurse, psychologist, pharmacist and QP. This committee may also consult with the HRC and the results of the review should be provided to the HRC.
2. All data and reports pertaining to problem behaviors for which behavior management drugs are prescribed shall be reviewed.
3. Recommendations for possible action to allow the reduction of behavior management drugs may be made.
4. Medication Review occurs quarterly, with findings being recorded on the Behavior Management Medication Review form and distributed to legal guardian, general practitioner, psychiatrist (when applicable), nurse, QP, pharmacist, psychologist, executive director and HRC.
5. The review team shall only convene when behavior management medications are used in the group home. Otherwise, medication review will be done by the physician, pharmacist, and nurse on at least a quarterly basis.
6. Behavior Management Medication Reviews are signed by the person completing the form. They are filed in the HRC Minutes.

See Attachment—Behavior Management Medication Review for ICF

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UTILIZATION REVIEW

A utilization review is conducted for each ICF resident at least every 180 days for continued authorization of ICF services. The review is documented on a Level of Care (LOC) form and submitted to the respective MCO. The LOC must be signed by the person's physician prior to submission. The LOC is kept in the service record. Failure to complete the utilization review in a timely manner will cause a lapse in payment of services. Both the Business Director and Executive Director track the deadline for submissions of the LOCs to the MCO's to ensure payment for services can be recouped.

Should a MCO reviewer determine the individual no longer needs ICF-IID level of care and denies the LOC, the QP will assist the person and their legal guardian in filing to appeal the MCO decision.

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FIRE AND SANITATION INSPECTIONS

MCH wants to ensure residents live in safe and clean homes. In addition to inspection by the Department of Health Service Regulation, fire and sanitation inspections of each facility are conducted at least annually. Fire inspections are completed by the county fire inspector. Sanitation inspections are completed by the local county health department.

Procedures

1. The group home manager is responsible for scheduling these inspections or ensuring they are done annually.
2. The group home manager is responsible for any plan of correction and for reporting inspections to the executive director and HR manager.
3. Fire extinguishers must also be inspected monthly and by an authorized inspector at least annually.
4. Copies of completed inspections should be maintained on file at both the facility and the administrative office.
5. Copies of inspections are attached to the licensure renewal application annually.

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