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Position Titles defined as they relate to Policies and Procedures

Designated Manager:

- HMC – Program Director
- LivingLinks – Program Director

Designated Coordinator:

- HMC – Program Managers
- LivingLinks – Program Coordinator

Title Changes:

- Director of Program Services -> Program Director for the respective program.
- Employee Relations Director -> HR Business Partner and/or HR Assistant.
- Finance Director -> Operations Director

Section: Services	Review Date: 01/2014, 08/2016
Topic: Admission Policy	Revision:

PURPOSE

The purpose of this policy is to establish procedures that ensure continuity of care during admission or service initiation including the Harry Meyering Center's (HMC) admission criteria and processes.

POLICY

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

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

Section: Services	Review Date: 01/2014
Topic: Admission Procedure	Revision: 08/2016, 6/2017

ADMISSION CRITERIA

- A. Criteria will be used to determine whether the Harry Meyering Center (HMC) is able to develop services to meet the needs of the person as specified in their Coordinated Service and Support Plan. In addition to registration and licensed ability, the criteria include:
 - Harry Meyering Center does not base admission decisions on race, color, creed, spirituality, ancestry, national origin, gender, sexual orientation, disability, age, marital status, or status in regard to public assistance.
 - Admission is based on the individual's functioning as determined by the referral material, a determination of appropriateness of the service for the individual's current needs and the predicted compatibility with the individuals currently living in that setting.
 - A preadmission evaluation will be completed involving the individual, the legal representative if applicable, a representative of the funding source and an agency representative who is a Program Manager/Program Director. The purpose of the pre-evaluation will be to determine the needs of the person seeking service and the capability of the service to create and implement the type and amount of service the person needs and wants as well as funding level required.
 - Each HMC service has criterion for admission specific to the service: Intermediate Care Facility (ICF), Waivered Services (SLS) and Semi-Independent Living Services/InHome (SILS/InHome).
 - When the service to be provided includes a residential setting provided by HMC, efforts will be made to select an opening that is most agreeable to the person and to individuals already living in the setting. Preparation will be made with roommates to welcome the individual and ease the transition. Staff will be trained on the skills needed to support the individual.
- B. HMC will notify all residents when a registered predatory offender is admitted into the program or to a potential admission when the facility is already serving a registered predatory offender. This notification will be done according to the requirements in MN Statutes, section [243.166](#).
- C. Prior to admitting a person, HMC will provide the following information on the limits to services available from the program, including the knowledge and skill of the program staff and the program's ability to meet the person's service and support, to the person or the person's legal representative.
- D. When the person to be served is to receive foster care or supported living services in a residential site controlled by HMC, the person and/or legal representative and the license holder must sign and date the residency agreement. The residency agreement must include service termination requirements. It must be reviewed annually, dated, and signed by the person and/or legal representative and license holder.
- E. When a person and/or legal representative requests services from HMC, a refusal to admit the person must be based upon an evaluation of the person's assessed needs and HMC's lack of capacity to meet the needs of the person.
- F. HMC will not refuse to admit a person solely upon the basis of:
 - Severity of disability.
 - Orthopedic or neurological handicaps.
 - Sight or hearing impairments.
 - Lack of communication skills.
 - Physical disabilities.

- Toilet habits.
 - Behavioral disorders.
 - Past failures to make progress.
- G. Documentation regarding the basis for the refusal will be completed using the Admission Refusal Notice and must be provided to the person and/or legal representative and case manager upon request. This documentation will be completed and maintained by the Program Director or designee.

ADMISSION PROCESS AND REQUIREMENTS

- A. In the event of an emergency service initiation, HMC must ensure that staff training on individual service recipient needs occurs within 72 hours of the direct support staff first having unsupervised contact with the person served. HMC must document the reason for the unplanned or emergency service initiation and maintain the documentation in the person's service recipient record.
- B. Prior to or upon the initiation of services, the Program Manager and/or Program Director will develop, document, and implement the Individual Abuse Prevention Plan according to MN Statutes, [section 245A.65, subdivision 2](#).
- C. The Program Manager and/or Program Director will ensure that during the admission process the following will occur:
- Each person to be served and/or legal representative is provided with the written list of the Rights of Persons Served or ICF Bill of Rights that identifies the service recipient's rights according to MN Statutes, [section 245D.04, subdivisions 2 and 3](#).
 - An explanation will be provided on the day of service initiation or within five (5) working days of service initiation and annually thereafter.
 - Reasonable accommodations will be made, when necessary, to provide this information in other formats or languages to facilitate understanding of the rights by the person and/or legal representative.
 - Orientation to HMC's Program Abuse Prevention Plan will occur within 24 hours of service admission, or for those persons who would benefit more from a later orientation, the orientation may take place within 72 hours.
 - An explanation and provision of copies (may be provided within five [5] working days of service initiation) of the following policies and procedures to the person and/or legal representative:
 - Policy and Procedure on Grievances
 - Policy and Procedure on Temporary Service Suspension and Termination
 - Policy and Procedure on Data Privacy
 - Policy and Procedure on Emergency Use of Manual Restraint
 - Policy and Procedure on Reporting and Reviewing of Maltreatment of Vulnerable Adults
 - Policy and Procedure on Reporting and Reviewing of Maltreatment of Minors
 - Written authorization is obtained (and annually thereafter) by the person and/or legal representative for the following:
 - Authorization for Medication and Treatment Administration and Assistance and Authorization to Act in an Emergency
 - Release of Information
 - Financial Authorization
 - ❖ This authorization may be obtained within five (5) working days of the service

- initiation meeting and annually thereafter.
- The individual facesheet is signed by the person and/or legal representative and includes the date of admission or readmission, identifying information, and contact information for members of the support team or expanded support team and others as identified by the person or case manager.
- D. Also during the admission meeting, the support team or expanded support team will discuss:
 - HMC's responsibilities regarding health service needs and the procedures related to meeting those needs as assigned in the Coordinated Service and Support Plan and/or Addendum.
 - The desired frequency of progress reports and progress review meetings, at a minimum of annually.
 - The initial financial authorization. The Program Manager and/or Program Director will survey, document, and implement the preferences of the person served and/or legal representative and case manager for the frequency of receiving statements that itemizes receipt and disbursements of funds or other property. Changes will be documented and implemented when requested.
- E. If a person's licensed health care professional or mental health professional has determined that a manual restraint would be medically or psychologically contraindicated, HMC will not use a manual restraint to eliminate the immediate risk of harm and effectively achieve safety. This statement of whether or not a manual restraint would be medically or psychologically contraindicated will be completed as part of service initiation planning.

ADMISSION PROCESS FOLLOW UP AND TIMELINES

- A. The Program Manager and/or Program Director or designee will ensure that the person's other providers, medical and mental health care professionals, and vendors are notified of the change in address and phone number.
- B. The Program Manager and/or Program Director or designee will ensure that the person's service recipient record is assembled according to HMC standards.
- C. Within 15 calendar days of service initiation, the Program Manager and/or Program Director will complete a preliminary Coordinated Service and Support Plan Addendum that is based upon Coordinated Service and Support Plan. At this time, the person's name and date of admission will be added to the Admission and Discharge Register maintained by the Program Director or designee.
- D. When a person served requires a Positive Support Transition Plan for the emergency use or planned use of restrictive interventions prohibited under MN Statutes, chapter [245D](#), and is admitted after January 1, 2014:
 - The Positive Support Transition Plan must be developed and implemented within 30 calendar days of service initiation.
 - No later than 11 months after the implementation date, the plan must be phased out.
- E. Before the 45-day meeting for SLS and SILS/InHome or the 30-day meeting for ICF, the Program Manager and/or Program Director will complete the Self-Management Assessment regarding the person's ability to self-manage in health and medical needs, personal safety and symptoms or behavior. This assessment will be based on the person's status within the last 12 months at the time of service initiation.
- F. Within 45 calendar days of service initiation for SLS and SILS/InHome or 30 calendar days of service initiation for ICF, the Support Team or Expanded Support Team must meet to assess

and determine the following based on information obtained from the assessment, Coordinated Service and Support Plan and person centered planning:

- The scope of services to be provided to support the person's daily needs and activities including how the provider will support the individual to have control of their schedule.
- Outcomes and necessary supports to accomplish the outcomes.
- The person's preference for how services and supports are provided.
- Whether the current service setting is the most integrated setting available and appropriate for the person.
- How services for this person will be coordinated across 245D licensed providers and members of the support team or expanded support team to ensure continuity of care and coordination of services for the person.
- A discussion of how technology might be used to meet the individual's desired services and supports will be included. The Coordinated Service and Support Plan and/or Coordinated Service and Support Plan Addendum will include any discussion points regarding the use of technology.
- Within 10 working days of the 45-day SLS or SILS/InHome meeting or 30-day ICF meeting, the Program Manager and/or Program Director will develop a service plan that documents outcomes and supports for the person based upon the assessments completed at the 45-day SLS or SILS/InHome meeting or 30-day ICF meeting.
- Within 20 working days of 45-day meeting SLS or SILS/InHome meeting or 30-day ICF meeting, the Program Manager and/or Program Director will submit to and obtain dated signatures from the person and/or legal representative and case manager to document completion and approval of the assessment and Coordinated Service and Support Plan Addendum.
 - If, within 10 working days of this submission, the legal representative or case manager has not signed and returned the assessments or has not proposed written modifications, the submission is deemed approved and the documents become effective and remain in effect until the legal representative or case manager submits a written request to revise the documents.

BEDROOM SHARING (SLS SPECIFIC)

- A. Each person receiving services that will share a bedroom in a foster care or supported living services in a residential site controlled by HMC, must have a choice of roommate. Both persons must mutually consent, in writing, to sharing a bedroom with one another. Persons served also retain the right to request a change in roommate and may notify the Program Director/Program Manager in these instances.
- B. The Program Director/Program Manager will ensure that there is a bedroom sharing consent form that has been completed prior to sharing of the bedroom. The consent will be reviewed, signed, and dated by the person and/or legal representative. A copy of the consent will be maintained in each person's perm file,
- C. No more than two people receiving services may share one bedroom.

Section: Operations	Review Date: 1/2014
Topic: Blood-borne Pathogens Policy	Revision:

Blood-borne pathogens are pathogenic microorganisms that are present in human blood and can cause disease in humans. These pathogens include, but are not limited to, hepatitis B virus (HBV) and human immunodeficiency virus (HIV).

All employees will follow [universal precautions](#) in situations where contact with blood could occur in order to prevent the spread of disease.

Section: Services	Review Date: 1/2014, 12/2016
Topic: Cleanliness Policy	Revision:

Individuals served will be responsible for cleaning and upkeep of their homes and individual rooms to the extent their current level of functioning will allow. Individual programs will address this issue if the team feels that it is appropriate for the individual served.

It is the responsibility of the Harry Meyering Center (HMC) employees to ensure a reasonable level of cleanliness and safety. State and federal guidelines will be followed in all HMC settings. Employees are expected to include the individual served in the maintenance and upkeep of the house or apartment with or without a formal program as appropriate for each individual, to the extent of their ability. Employees are expected to help in training these skills, with or without a formal program goal.

SLS, Homestead and Prairie's Edge: If an individual served is unable to do all or part of the necessary tasks, staff will perform those functions that an individual served cannot, to ensure that an individual's room receives a thorough cleaning weekly. This includes, but is not limited to, vacuuming, dusting, cleaning linens, straightening drawers and general tasks necessary for the neat and clean appearance of the room.

Section: Services	Review Date: 1/2014, 8/2016
Topic: Commissioner's Right to Access Procedure	Revision:

Per Minnesota Statutes [245A.04, subdivision 5](#):

- A. When the commissioner is exercising the powers conferred by this chapter and sections [245.69](#), [626.556](#), and [626.557](#), the commissioner must be given access to:
 - the physical plant and grounds where the program is provided;
 - documents and records, including records maintained in electronic format;
 - persons served by the program; and
 - Staff and personnel records of current and former staff whenever the program is in operation and the information is relevant to inspections or investigations conducted by the commissioner.
- B. The commissioner must be given access without prior notice and as often as the commissioner considers necessary if the commissioner is investigating alleged maltreatment, conducting a licensing inspection, or investigating an alleged violation of applicable laws or rules. In conducting inspections, the commissioner may request and shall receive assistance from other state, county, and municipal governmental agencies and departments. The applicant or license holder shall allow the commissioner to photocopy, photograph, and make audio and video tape recordings during the inspection of the program at the commissioner's expense. The commissioner shall obtain a court order or the consent of the subject of the records or the parent(s) or legal guardian(s) of the subject before photocopying hospital medical records.
- C. Persons served by the program have the right to refuse to consent to be interviewed, photographed, or audio or videotaped. Failure or refusal of an applicant or license holder to fully comply with this subdivision is reasonable cause for the commissioner to deny the application or immediately suspend or revoke the license.

Section: Operations	Review Date: 1/2014
Topic: Communicable Disease Policy	Revision:

Communicable disease is defined as illnesses caused by microorganisms and transmitted from an infected person or animal to another person or animal. Some diseases are passed on by direct or indirect contact with infected persons or with their excretions. Most diseases are spread through contact or close proximity because the causative bacteria or viruses are [airborne](#); i.e., they can be expelled from the nose and mouth of the infected person and inhaled by anyone in the vicinity. Some infectious diseases can be spread only indirectly, usually through contaminated food or water. Still other infections are introduced into the body by animal or insect carriers. The human disease carriers, i.e., the healthy persons who may be immune to the organisms they harbor are also a source of transmission.

Section: Operations	Review Date: 1/2014
Topic: Communicable Disease Procedure	Revision:

To prevent the spread of communicable disease within the Harry Meyering Center (HMC), the following steps will be taken:

- Employees with any signs and/or symptoms of communicable disease will refrain from working directly with individuals served or food preparation until they are no longer infectious.
- Staff diagnosed with a communicable disease may return to work with a written return to work statement by a health care professional.
- Employees will report any signs of possible infections or symptoms of communicable diseases that an individual served is experiencing to nursing, if applicable.
- When an individual served has been exposed to a diagnosed communicable disease, staff will promptly report to other licensed providers and residential settings.

Section: Services	Review Date:01/2014, 7/2016
Topic: Data Privacy Policy	Revision:

PURPOSE

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

POLICY

According to MN Statutes, section [245D.04, subdivision 3](#), persons served by HMC have protection-related rights that include the rights to:

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

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

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

Section: Services	Review Date: 1/2014, 8/2016
Topic: Data Privacy and Accessibility to Records Procedure	Revision:

ACCESS TO RECORDS AND RECORDED INFORMATION AND AUTHORIZATIONS

- A. The person served and/or legal representative have full access to their records and recorded information that is maintained, collected, stored, or disseminated by the company. Private data are records or recorded information that includes personal, financial, service, health, and medical information.
- B. Access to private data in written or oral format is limited to authorized persons. The following HMC personnel may have immediate access to persons' private data only for the relevant and necessary purposes to carry out their duties as directed by the Coordinated Service and Support Plan and/or Coordinated Service and Support Plan Addendum:
 - Executive staff.
 - Administrative staff.
 - Financial staff.
 - Nursing staff including assigned or consulting nurses.
 - Management staff including the Program Manager and/or Program Director.
 - Direct support staff.
- C. The following entities also have access to persons' private data as authorized by applicable state or federal laws, regulations, or rules:
 - Case manager.
 - Child or adult foster care licensor, when services are also licensed as child or adult foster care.
 - Minnesota Department of Human Services and/or Minnesota Department of Health.
 - County of Financial Responsibility or the County of Residence's Social Services.
 - The Ombudsman for Mental Health or Developmental Disabilities.
 - US Department of Health and Human Services.
 - Social Security Administration.
 - State departments including Department of Employment and Economic Development (DEED), Department of Education, and Department of Revenue.
 - County, state, or federal auditors.
 - Adult or Child Protection units and investigators.
 - Law enforcement personnel or attorneys related to an investigation.
 - Various county or state agencies related to funding, support, or protection of the person.
 - Other entities or individuals authorized by law.
- D. HMC will obtain authorization to release information of persons served when consultants, sub-contractors, or volunteers are working with the company to the extent necessary to carry out the necessary duties.

- E. Other entities or individuals not previously listed who have obtained written authorization from the person served and/or legal representative have access to written and oral information as detailed within that authorization. This includes other licensed caregivers or health care providers as directed by the release of information.
- F. Information will be disclosed to appropriate parties in connection with an emergency if knowledge of the information is necessary to protect the health or safety of the person served or other individuals or persons. The Program Manager and/or Program Director will ensure the documentation of the following:
 - The nature of the emergency.
 - The type of information disclosed.
 - To whom the information was disclosed.
 - How the information was used to respond to the emergency.
 - When and how the person served and/or legal representative was informed of the disclosed information.
- G. All authorizations or written releases of information will be maintained in the person's service recipient record. In addition, all requests made to review data, have copies, or make alterations, as stated below, will be recorded in the person's record including:
 - Date and time of the activity.
 - Who accessed or reviewed the records.
 - If any copies were requested and provided.

REQUEST FOR RECORDS OR RECORDED INFORMATION TO BE ALTERED OR COPIED

- A. The person served and/or legal representative has the right to request that their records or recorded information and documentation be altered and/or to request copies.
- B. If the person served and/or legal representative objects to the accuracy of any information, staff will ask that they put their objections in writing with an explanation as to why the information is incorrect or incomplete.
 - The Program Manager and/or Program Director will submit the written objections to the Executive Director, Lori Weinberg, who will make a decision in regards to any possible changes.
 - A copy of the written objection will be retained in the person's service recipient record.
 - If the objection is determined to be valid and approval for correction is obtained, the Program Manager and/or Program Director will correct the information and notify the person served and/or legal representative and provide a copy of the correction.
 - If no changes are made and distribution of the disputed information is required, the Program Manager and/or Program Director will ensure that the objection accompanies the information as distributed, either orally or in writing.
- C. If the person served and/or legal representative disagrees with the resolution of the issue, they will be encouraged to follow the procedures outlined in the Policy and Procedure on Grievances.

SECURITY OF INFORMATION

- A. A record of current services provided to each person served will be maintained on the premises of where the services are provided or coordinated. When the services are provided in a licensed facility, the records will be maintained at the facility; otherwise, records will be maintained at HMC's program office. Files will not be removed from the program site without valid reasons and security of those files will be maintained at all times.
- B. The Program Manager and/or Program Director will ensure that all information for persons served is secure and protected from loss, tampering, or unauthorized disclosures. This includes information stored by computer for which a unique password and user identification is required.
- C. No person served and/or legal representative, staff, or anyone else may permanently remove or destroy any portion of the person's record.
- D. HMC and its staff will not disclose personally identifiable information about any other person when making a report to each person and case manager unless HMC has the consent of the person. This also includes the use of other person's information in another person's record.
- E. Written and verbal exchanges of information regarding persons served are considered to be private and will be done in a manner that preserves confidentiality, protects their data privacy, and respects their dignity.
- F. Data created prior to the death of a person retains the same legal classification (public, private, confidential) after the person's death that it had before the death.
- G. Data is to be kept in the individual's records for three years and summary data is to be kept for five years.
- H. All staff will receive training at orientation and annually thereafter on this policy and their responsibilities related to complying with data privacy practices.
- I. Breaches of confidentiality are to be brought to the attention of the supervisor so that appropriate corrective or disciplinary action might be taken.

Section: Services	Review Date: 1/2014, 11/2016
Topic: Drinking and Smoking Policy	Revision:

SMOKING

(Does not apply to SILS/InHome)

The Harry Meyering Center (HMC) must comply with the requirements of the [Minnesota Clean Indoor Air Act](#) (sections 144.411 to 144.417), when smoking is permitted in the residences.

Individuals served and guests will limit their smoking to the designated areas of the house or facility.

Prairie's Edge is a completely smoke-free environment. Smoking will not be allowed in the home or on the property.

DRINKING

INDIVIDUALS:

Drinking habits of the individuals receiving services are his/her own choice, unless it is contraindicated for medical and/or health reasons. Responsible drinking behavior is reviewed with individuals served as necessary.

Individuals served may have the right to consume beverages that contain alcohol. Persons served may store alcoholic beverages at a program site; however, based on a person's vulnerabilities or other related concerns, alcoholic beverages may be prohibited at any or all times from a program site.

EMPLOYEES:

Employees will intervene if an individual is deemed to be under the influence of alcohol and is a danger to themselves or others.

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

A pattern of smoking and/or drinking which threatens the comfort of roommates or the safety of the individual served shall be cause for discussion with roommates, employees and professionals as deemed relevant.

Section: Services	Review Date: 10/2015, 8/2016
Topic: Emergency Use of Manual Restraint Policy	Revision:

PURPOSE

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

POLICY

It is the policy of the Harry Meyering Center (HMC) to ensure the correct use of EUMR, to provide training and monitoring of direct support staff, and to ensure regulations regarding the EUMR are followed. According to MN Statutes section [245D.02](#) (subdivision 8a), EUMR is defined as “using a manual restraint when a person poses an imminent risk of physical harm to self or others and is the least restrictive intervention that would achieve safety. Property damage, verbal aggression, or a person’s refusal to receive or participate in treatment or programming does not constitute an emergency.

Section: Services	Review Date: 10/2015
Topic: Emergency Use of Manual Restraint Procedure	Revision: 8/2016

POSITIVE SUPPORT STRATEGIES

- A. The Harry Meyering Center (HMC) will attempt to de-escalate a person's behavior before it poses an imminent risk of physical harm to self or others. Some of the following procedures could be used to de-escalate the situation and are options that could be implemented by staff. This is not a fully inclusive list of options that could include:
- Techniques taught in Therapeutic Relationships. These techniques include, but are not limited to:
 - i. A calm discussion between the individual served and direct support staff regarding the situation, the individual's feelings, their responses, and alternative methods to handling the situation, etc.
 - ii. A staff suggesting or recommending that the individual participate in an activity they enjoy as a means to self-calm.
 - iii. A staff suggesting or reminding that the individual served has options that they may choose to spend time alone, when safety permits, as a means to self-calm.
 - iv. The individualized strategies that have been written into the individual's Coordinated Service and Support Plan (CSSP) and/or CSSP Addendum, or Positive Support Transition Plan.
 - v. The implementation of instructional techniques and intervention procedures that are listed as **"Permitted actions and procedures"** in the next section.
 - vi. A combination of any of the above.
- B. **Permitted actions and procedures** include the use of instructional techniques and intervention procedures used on an intermittent or continuous basis. If used on a continuous basis, it must be addressed in the individual's CSSP Addendum. These actions include:
- Physical contact or instructional techniques that are the least restrictive alternative possible to meet the needs of the individual and may be used to:
 - i. Calm or comfort an individual by holding that individual with no resistance from that individual.
 - ii. Protect an individual known to be at risk or injury due to frequent falls as a result of a medical condition.
- C. Facilitate the individual's completion of a task or response when the individual does not resist or the individual's resistance is minimal in intensity or duration.
- D. Block or redirect an individual's limbs or body without holding the individual or limiting the individual's movement to interrupt the individual's behavior that may result in injury to self or others with less than 60 seconds of physical contact by staff.
- E. Redirect an individual's behavior when the behavior does not pose a serious threat to the individual or others and the behavior is effectively redirected with less than 60 seconds of physical contact by staff.

- F. Restraint may be used as an intervention procedure to:
- Allow a licensed health care professional to safely conduct a medical examination or to provide medical treatment ordered by a licensed health care professional.
 - Assist in the safe evacuation or redirection of an individual in the event of an emergency and the individual is at imminent risk of harm.
 - Position a person with physical disabilities in a manner specified in their CSSP Addendum.
 - Use of adaptive aids or equipment, orthotic devices, or other medical equipment ordered by a licensed health professional to treat a diagnosed medical condition do not in and of themselves constitute the use of mechanical restraint.
 - Positive verbal correction that is specifically focused on the behavior being addressed.
 - Temporary withholding or removal of objects being used to hurt self or others.

PROHIBITED PROCEDURES

HMC and its staff are prohibited from using the following:

- Chemical restraints
- Mechanical restraints
- Manual restraints
- Time outs
- Seclusion
- Any other aversive or deprivation procedures
 - As a substitute for adequate staffing
 - For a behavioral or therapeutic program to reduce or eliminate behavior
- Punishment
- For staff convenience
- Prone restraint, metal handcuffs, or leg hobbles
- Faradic shock
- Speaking to a person in a manner that ridicules, demeans, threatens, or is abusive
- Physical intimidation or a show of force
- Containing, restricting, isolating, secluding, or otherwise removing a person from normal activities when it is medically contraindicated or without monitoring the individual served
- Denying or restricting an individual's access to equipment and devices such as walkers, wheelchairs, hearing aids, and communication boards that facilitate the individual's functioning. When the temporary removal of the equipment or device is necessary to prevent injury to the individual or others or serious damage to the equipment or device, the equipment or device must be returned to the individual as soon as imminent risk of injury or serious damage has passed.
- Painful techniques, including intentional infliction of pain or injury, intentional infliction of fear of pain or injury, dehumanization, and degradation
- Hyper extending or twisting an individual's body parts
- Tripping or pushing an individual
- Requiring a person to assume and maintain a specified physical position or posture
- Forced exercise

- Totally or partially restricting an individual's senses
- Presenting intense sounds, lights, or other sensory stimuli
- Noxious smell, taste, substance, or spray, including water mist
- Depriving a person of or restricting access to normal goods and services, or requiring a person to earn normal goods and services
- Token reinforcement programs or level programs that include a response cost or negative punishment component
- Using individual receiving services to discipline another individual receiving service.
- Using an action or procedure which is medically or psychologically contraindicated
- Using an action or procedure that might restrict or obstruct an individual's airway or impair breathing, including techniques whereby individuals use their hands or body to place pressure on an individual's head, neck, back, chest, abdomen, or joints
- Interfering with an individual's legal rights, except as allowed by Minnesota statutes [245D.04, subdivision 3c.](#)

RESTRICTIVE INTERVENTION:

A restricted procedure must not:

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

POSITIVE SUPPORT TRANSITION PLAN

HMC must and will develop a Positive Support Transition Plan on forms provided by the Department of Human Services and in the manner directed for an individual served who requires intervention in order to maintain safety when it is known that the individual's behavior poses an

immediate risk of physical harm to self or others. A Positive Support Transition Plan must be developed in accordance with [MN Statutes, section 245D.06, subdivision 8](#) and [MN Rules, part 9544.00700](#) for a person who has been subjected to three (3) incidences of EUMR within 90 days or four (4) incidents of EUMR within 180 days. This Positive Support Transition Plan will phase out any existing plans for the emergency use or programmatic use of restrictive interventions procedures prohibited under [MN Statutes, Chapter 245D](#) and [MN Rules, Chapter 9544](#).

EMERGENCY USE OF MANUAL RESTRAINT

- A. If the positive support strategies were not effective in de-escalating or eliminating the individual's behavior, emergency use of manual restraint (EUMR) may be necessary. To use EUMR, the following conditions must be met:
 - o Immediate intervention must be needed to protect the individual or others from imminent risk of physical harm.
 - o The type of manual restraint used must be the least restrictive intervention to eliminate the immediate risk of harm and effectively achieve safety.
 - o The manual restraint must end when the threat of harm ends.
- B. The following conditions, on their own, are not conditions for Emergency Use of Manual Restraint (EUMR):
 - o The individual is engaging in property destruction that does not cause imminent risk of physical harm.
 - o The individual is engaging in verbal aggression with staff or others.
 - o An individual's refusal to receive or participate in treatment of programming.
- C. **HMC allows certain types of manual restraints which may be used by staff on an emergency basis. Detailed instructions on the safe and correct implementation of these allowed manual restraint procedures are included at the end of this policy.** These allowed manual restraints include the following:
 - o Physical escort/walking: Level 3 – 1 person
 - o Physical escort/walking: Level 3 – 2 person
 - o Level 4 Hold – 1 person
 - o Level 4 Hold – 2 person
- D. If an individual's licensed health care professional or mental health professional has determined that a manual restraint would be medically or psychologically contraindicated, HMC will not use a manual restraint to eliminate the immediate risk of harm and effectively achieve safety. This statement of whether or not a manual restraint would be medically or psychologically contraindicated will be completed as part of service initiation planning.

MONITORING OF EMERGENCY USE OF MANUAL RESTRAINT

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

- Upon the attempt to release the restraint, the individual's behavior immediately re-escalates and staff must immediately re-implement the restraint in order to maintain safety.
- B. During an emergency use of manual restraint, HMC will monitor an individual's health and safety. Staff monitoring the manual restraint procedure will not be the staff implementing the procedure, when possible. An Emergency Use of Manual Restraint Incident Report will be completed by the staff person for each incident of emergency use of manual restraint to ensure:
 - Only manual restraints allowed according to this policy are implemented.
 - Manual restraints that have been determined to be contraindicated for an individual are not implemented with that individual.
 - Allowed manual restraints are implemented only by staff trained in their use.
 - The restraint is being implemented properly as required.
 - The mental, physical, and emotional condition of the individual who is being manually restrained is being assessed and intervention is provided when necessary to maintain the individual's health and safety and prevent injury to the individual, staff involved, or others involved.

REPORTING OF EMERGENCY USE OF MANUAL RESTRAINT

- A. Reporting of the incident of emergency use of manual restraint (EUMR) will be completed according to the following process and will contain all required information per MN Statutes, sections [245D.06](#), subdivision 1 and [245D.061](#), subdivision 5.
- B. Within 24 hours of the EUMR, Harry Meyering Center (HMC) will make a verbal report regarding the incident to the legal representative or designated emergency contact and case manager. If other individuals served were involved in the incident, HMC will not disclose any personally identifiable information about any other individual when making the report unless HMC has the consent of the individual.
- C. Within three (3) calendar days of the EUMR, the staff who implemented the EUMR will complete an Emergency Use of Manual Restraint Incident Report Form and submit it to the Program Director and/or Program Manager with the following information:
 - The staff and individual(s) served who were involved in the incident leading up to the EUMR.
 - A description of the physical and social environment, including who was present before and during the incident leading up to the EUMR.
 - Descriptions of what less restrictive alternative measures were attempted to de-escalate the incident and maintain safety before the manual restraint was implemented. This description must identify the when, how, and how long the alternative measures were attempted before the manual restraint was implemented.
 - A description of the mental, physical, and emotional condition of the individual who was restrained, and other persons involved in the incident leading up to, during, and following the manual restraint.
 - Whether there was any injury to the individual who was restrained or other persons involved, including staff, before or as a result of the manual restraint use.

- Whether there was a debriefing with the staff, and, if not contraindicated, with the individual who was restrained and other persons who were involved in or who witnessed the restraint, following the incident. The outcome of the debriefing will be clearly documented and if the debriefing could not occur at the time of the incident, the report will identify whether a debriefing is planned in the future.
- D. Within five (5) working days of the EUMR, the Program Director will complete and document an Internal Review of each report of EUMR. The internal review will include an evaluation of whether:
 - The individual's served service and support strategies developed according to MN Statutes, sections [245D.07](#) and [245D.071](#) need to be revised.
 - Related policies and procedures were followed.
 - The policies and procedures were adequate.
 - There is a need for additional staff training.
 - The reported event is similar to past events with the individuals, staff, or the services involved.
 - There is a need for corrective action by HMC to protect the health and safety of the individual(s) served.
- E. Based upon the results of the internal review, HMC will develop, document, and implement a corrective action plan for the program designed to correct current lapses and prevent future lapses in performance by the individuals or HMC, if any. The Program Director will ensure that the corrective action plan, if any, must be implemented within 30 days of the internal review being completed.
- F. Within five (5) working days after the completion of the internal review, the Program Director and/or Program Manager will consult with the individual's expanded support team following the emergency use of manual restraint. The purpose of this consultation is to:
 - Discuss the incident and to define the antecedent or event that gave rise to the behavior resulting in the manual restraint and identify the perceived function the behavior served.
 - Determine whether the Coordinate Service and Support Plan (CSSP) Addendum of the individual served needs to be revised to positively and effectively help the individual maintain stability and to reduce or eliminate future occurrences requiring emergency use of manual restraint.
- G. Within five (5) working dates of the expanded support team review, the Program Director and/or Program Manager will submit, using the Minnesota Department of Human Services' (DHS) online Behavioral Intervention Reporting Form, the following information to the DHS and the Office of the Ombudsman for Mental Health and Developmental Disabilities:
 - The EUMR Report.
 - The Internal Review and corrective action plan, if any.
 - The written summary of the expanded support team's discussion and decision.
- H. The following written information will be maintained in the individual's permanent file:
 - The report of an EUMR incident that includes:
 - Reporting requirements by the staff who implemented the restraint.
 - The Internal Review of emergency use of manual restraint and the corrective action plan, with information about implementation of correction within 30 days, if any

- The written summary of the expanded support team's discussion and decision
- The notifications to the expanded support team, the DHS and the MN Office of the Ombudsman for Mental Health and Developmental Disabilities
- The PDF version of the completed and submitted DHS online Behavior Intervention Reporting Form (DHS-5148-ENG). An email of this PDF version of the Behavior Intervention Reporting Form will be sent to the Minnesota Department of Human Services electronic mailbox assigned to the license holder.

STAFF TRAINING REQUIREMENTS

- A. All staff will receive orientation and annual training according to MN Statutes, section [245D.09](#) subdivisions 4 and 5. Orientation training will occur within the first 60 days of hire and annual training will occur within a period of 12 months.
- B. Within 60 calendar days of hire, HMC provides orientation on:
 - The safe and correct use of manual restraint on an emergency basis according to the requirements in section [245D.061](#) or successor provisions, and what constitutes the use of restraints, time out, and seclusion, including chemical restraint; and
 - Staff responsibilities related to prohibited procedures under section [245D.06, subdivision 5, MN Rules, part 9544.0060](#), or successor provisions, why such procedures are not effective for reducing or eliminating symptoms or undesired behavior, and why such procedures are not safe.
- C. Before staff may implement an emergency use of manual restraint (EUMR), and in addition to the training on this policy and procedure and the orientation and annual training requirements, staff must receive training on EUMR that incorporates the following topics:
 - Alternatives to manual restraint procedures including techniques to identify events and environmental factors that may escalate conduct that poses an imminent risk of physical harm to self or others.
 - De-escalation methods, positive support strategies, and how to avoid power struggles.
 - Simulated experiences of administering and receiving manual restraint procedures allowed by HMC on an emergency basis.
 - How to properly identify thresholds for implementing and ceasing restrictive procedures.
 - How to recognize, monitor, and respond to the individual's physical signs of distress including positional asphyxia.
 - The physiological and psychological impact on the individual and the staff when restrictive procedures are used.
 - The communicative intent of behaviors.
 - Relationship building.
- D. For staff that is responsible to develop, implement, monitor, supervise, or evaluate positive support strategies, Positive Support Transition Plans, or Emergency Use of Manual Restraint, the staff must complete a minimum of eight (8) hours of core training from qualified individuals prior to assuming these responsibilities. Core training must include the following:

- De-escalation techniques and their value
 - Principles of person-centered service planning and delivery and how they apply to direct support services provided by staff
 - Principles of positive support strategies such as positive behavior supports, the relationship between staff interactions with the individual and the individual's behavior, and the relationship between the individual's environment and the individual's behavior
 - What constitutes the use of restraint, including chemical restraint, time out, and seclusion
 - The safe and correct use of manual restraint on an emergency basis, according to [MN Statutes, section 245D.061](#)
 - Staff responsibilities related to prohibited procedures under MN Statutes, section [245D.06, subdivision 5](#); why the procedures are not effective for reducing or eliminating symptoms or interfering behavior; and why the procedures are not safe
 - Staff responsibilities related to restricted and permitted actions and procedure according to MN Statutes, section [245D.06, subdivisions 6 and 7](#)
 - Situations in which staff must contact 911 services in response to an imminent risk of harm to the individual or others
 - Procedures and forms staff must use to monitor and report use of restrictive interventions that are part of a Positive Support Transition Plan
 - Procedures and requirements for notifying members of the individual's expanded support team after the use of a restrictive intervention with the individual
 - Understanding of the individual as a unique individual and how to implement treatment plans and responsibilities assigned to the license holder
 - Cultural competence
 - Personal staff accountability and staff self-care after emergencies
- E. Staffs that develop positive support strategies, license holders, executives, managers, and owners in non-clinical roles, must complete a minimum of four (4) hours of additional training. Function-specific training must be completed on the following:
- Functional behavior assessment
 - How to apply person-centered planning
 - How to design and use data systems to measure effectiveness of care
 - Supervision, including how to train, coach, and evaluate staff and encourage effective communication with the individual and the individual's support team.
- F. License holders, executives, managers, and owners in non-clinical roles must complete a minimum of two (2) hours of additional training. Function-specific training must be completed on the following:
- How to include staff in organizational decisions
 - Management of the organization based upon person-centered thinking and practices and how to address person-centered thinking and practices in the organization
 - Evaluation of organizational training as it applies to the measurement of behavior change and improved outcomes for individuals receiving services
- G. Annually, staff must complete four (4) hours of refresher training covering each of the training topics listed above.

H. For each staff, the license holder must document, in the personnel record, completion of the core training, function-specific training, and competency testing or assessment.

Documentation must include:

- Date of training
- Testing or assessment completion
- Number of training hours per subject area
- Name and qualifications of the trainer or instructor

I. The license holder must verify and maintain evidence of staff qualifications in the personnel record. The documentation must include the following:

- Education and experience qualifications relevant to the staff's scope of practice, responsibilities assigned to the staff, and the needs of the general population of individuals served by the program; and
- Professional licensure, registration, or certification, when applicable.

DETAILED INSTRUCTIONS ON ALLOWED MANUAL RESTRAINT PROCEDURES

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

Physical Escort/Walking:

If an individual served has escalating behaviors and it is necessary to move the individual, staff may follow level 1 and 2 of physical escort/walking.

Level 1: Staff will gently touch the person above the elbow while walking with and to the side and slightly behind as they begin to move forward. Remove hand once person begins to move on their own.

Level 2: If Level 1 is not effective, from the level 1 escort, staff will replace grasp above elbow with the opposite hand and place dominant hand to small of back while stepping behind and continue moving forward. If there is resistance, staff will move to a Level 3 escort.

Level 3 Escort – 1 person: From Level 2 escort, push arm across the chest and grasp wrist with opposite hand. Smoothly slide your free hand under the arm of the person that is crossed in front and grasp the person's forearm. Release the wrist and place your hand on the small of the back of the person as you move forward.

Level 3 Escort – 2 people: This level of physical assistance provides two-staff restraint/guidance; two staff will use both hands to redirect the person. Each staff will place one hand on the person's wrist and the other hand on the person's elbow to block any attempts of aggression or self-harm. The two staff will position themselves to either side of the person and each staff would use one hand on the person's hand/arm and walk forward with the person.

Level 4 Hold – 1 person: From Level 3 escort, re-grasp the wrist of the arm crossed in front of the body. Place your dominant foot between their feet leaning the person into your hip. If the person begins to strike out with their free arm, release the wrist and circle your arm around their arm and bring it in toward the person's body and then re-grasp the wrist. Keep your head low and directed into

the person's back to eliminate being hit in the head. If the person tries to drop to the floor, allow this to happen by having the person slide down your leg to the floor as you maintain the hold. Do not attempt to keep the person up as this can cause severe injury.

Level 4 Hold – 2 people: Two staff will physically hold the person, by each placing two hands on the person's arm; staff will position themselves on either side of the person to keep themselves safe during this restraint. Two staff will hold the person's hands either to his side or to the chair as long as the person is showing resistance and is continuing to attempt to engage in aggression and/or self-harm.

Section: Services	Review Date: 1/2014
Topic: Alarm Systems Procedure	Revision: 11/2016

For PRAIRIE'S EDGE:

A. Fire Alarm:

- When the fire alarm sounds follow Fire Procedure.

B. Door Alarm:

- Every door leading to the outside of the house has the capability to be alarmed, including the doors from the staff office and the main entry hallway that lead into the garage. When a door alarm sounds, employees will check the alarm panel to identify which door has been opened and then go to that door to see what happened. When the alarm sounds, employees need to ensure that all of the individuals served are present and accounted for. The patio door and the side garage door will have key pads to turn the alarm off before entering. The front door and side door need to be turned on and off at the central alarm panel.

C. Panic Pendants:

- When the pendant is activated an alarm sounds throughout the house. Employees will need to check the alarm panel to know which pendant has been activated. Other employees will respond to the employees activating the pendant and offer assistance as the situation warrants.

D. Motion Detectors:

- Some bedrooms are equipped with motion detectors so employees can be alerted to situations as stated in individuals' Coordinated Service and Support Plans (CSSP) and Addendums.

For HOMESTEAD:

A. Fire Alarm:

- When the fire alarm sounds, follow Fire Procedure.

B. Door Alarm:

- Every door leading to the outside at Homestead has the capability to be alarmed. When a door alarm sounds Building Charge will investigate the source of the alarm, taking action as necessary.

C. Panic Pendants:

- When a panic pendant is activated an alarm sounds at the alarm panel and on employee pagers. Employees with pagers, or their designees, will respond to the listed site and offer assistance as the situation warrants.

D. Motion Detectors: Some bedrooms are equipped with motion detectors so employees can be alerted to situations which require assistance or attention as stated in individuals' Coordinated Service and Support Plans (CSSP) and Addendums.

Section: Services	Review Date:01/2014
Topic: Autopsy Procedure	Revision:

An autopsy shall be performed upon death unless permission is refused by legal representative, parents or the Minnesota Department of Human Services Licensing Division (if individual is under public guardianship.)

Permission obtained by phone must be witnessed and signed by two people and will be obtained by the Program Director or their designate. The autopsy finding will be reported to the family, legal representative, the Commission of Human Services and a copy placed in the permanent file.

Section: Services	Review Date: 1/2014, 11/2016
Topic: Bomb Threat Procedure	Revision:

FOR HOMESTEAD, PRAIRIE’S EDGE, AND SLS:

- A. In the event that a property owned or managed by the Harry Meyering Center becomes aware of the threat of a bomb, the house staff (SLS or Prairie’s Edge) or Building Charge (Homestead) will:
 - Dial *57 to trace call.
 - Phone 911 to report the circumstances.
 - Evacuate the house/building to a nearby secure area (the vehicle(s), a neighbor).
 - Work with the Law Enforcement personnel until the area is declared safe.
 - Notify On-Call as soon as circumstances allow.
- B. Document incident on an Incident and Emergency Report.

FOR SILS/IN-HOME:

- A. Employees review quarterly with each individual served what to do if a bomb threat is made to their home or apartment and document on the Quarterly Emergency Review form.

Section: Services	Review Date: 1/2014, 11/2016
Topic: Cold Weather Procedure	Revision:

Cold weather is defined as temperature or wind-chill of zero (0) degrees Fahrenheit or a combination of temperature and wind chill of 0 degrees Fahrenheit or below.

FOR SILS/ IN-HOME

Quarterly, employees review with individuals served in this program the effects of severe cold weather, precautions individuals should take in dressing appropriately and advisable method of traveling when the weather is potentially dangerous due to temperatures, winds and visibility. Individuals served are encouraged to listen to the weather forecast and dress appropriately.

Individuals served are advised to limit their outdoor activities when severe cold weather conditions exist. If travel is necessary, individuals served are advised to notify someone of where they are going and when they are expected to return. Individuals served are also instructed what to do if stranded in a vehicle during a winter storm.

FOR SLS

Quarterly, employees review threats of cold weather with individuals served according to the CSSP and Addendum.

During severe cold weather, individuals who typically walk more than one block to/from bus stops, work, etc. will be given rides. Individuals served will be encouraged to dress appropriately for the weather. If an individual decides to not dress appropriately, employees may delay any outing until everyone is dressed safely. Decisions may be made by employees regarding the rides and the dress using criteria based on individual vulnerabilities and medical concerns and as assessed in the Coordinated Service and Support Plan (CSSP) and Addendum.

If the weather forecast is for snow storms, blizzards, white out conditions or wind chill of -15 F or below, SLS cars will not leave the city limits. Generally, unnecessary outings should be canceled. Employees should use their best judgment about transporting individuals served within the city limits based on the weather and road conditions.

All SLS vehicles are equipped with winter survival kits (blankets, first aid kit, flashlights).

FOR HOMESTEAD AND PRAIRIE'S EDGE:

When there is cold weather, out-of-the-facility activities are to be reviewed by the ICF Homestead nurse on duty and/or Homestead Building Charge, taking into account the purpose of the activity, individual(s) involved, vehicles and destination. If the nurse on duty and/or Building Charge feels that the outing is contraindicated for the individual(s) that decision will be final. The decision is based on weather conditions; it also takes into account individual medical concerns and vulnerabilities as assessed in the CSSP and Addendum.

If no travel is advised or if the weather forecast is for snow storms, blizzards, white out conditions or wind chill of -15 F or below, activities will not take place. Generally, unnecessary outings should

be canceled. Employees should use their best judgment about transporting individuals served within the city limits based on the weather and road conditions.

All Homestead and Prairie's Edge vehicles are equipped with winter survival kits (blankets, first aid kit, flashlights.)

Section: Services	Review Date: 1/2014, 10/2016
Topic: Death of an Individual Served Procedure	Revision:

- A. Employees trained in CPR will be available on all shifts.
- When an individual served is found and is not breathing and/or has no pulse, follow recommended techniques of CPR and First Aid (an exception to this would be if there is a DNR/DNI order for that individual).
 - When the ambulance crew arrives, the crew will make a determination as to the level of medical attention warranted.
- B. If the individual is to be transported to the hospital and two employees are present, one will accompany the individual. If only one employee is present, the employee will arrange for the individual to be met at the hospital. If the ambulance crew decides hospitalization is not appropriate, a call to the coroner will be made by the ambulance personnel to obtain a release to remove the body. The body shall be released to the coroner by On-Call or their designee. On-Call is to be summoned to the site as quickly as circumstances allow.
- C. The following persons will be notified within 24 hours:
- the Program Director
 - the Director of Program Services
 - the family, if appropriate. (If appropriate, a copy of the letter from the Office of the Ombudsman for Mental Health and Mental Retardation will be sent to the family within 24 hours.)
 - the individual's legal representative or designated emergency contact
 - the Health Services Manager (ICF) or primary nurse (SLS)
 - the Primary Care Physician
 - the Executive Director
 - the Chair of the Board (to be notified by the Executive Director)
 - the case manager and the rest of the individual's team, including, but not limited to, other licensed services, and/or day services
 - **for SLS:** the Office of Ombudsman for Mental Health and Developmental Disabilities and the Minnesota Department of Human Services (DHS) Licensing Division, within 24 hours
 - **for ICF (Prairie's Edge and Homestead):** the Office of Ombudsman for Mental Health and Developmental Disabilities and the Minnesota Department of Human Services (DHS) Licensing Division and the Minnesota Department of Health, Office of Health Facilities Complaints, within 24 hours.
 - the funeral home
- D. Personal belongings shall be left as they are and the room closed until employees can comply with the wishes of the family. If there is no family, the individual's legal representative (case manager if there is no legal representative) will be contacted to direct the facility regarding what should be done with the personal belongings. Anything that is of value that employees feel may

be removed or lost shall be inventoried, taken from the room and placed in a locked storage area.

- E. The entire procedure regarding notification, family wishes, inventory of personal belongings, employees involved, and any other relevant information shall be documented in the individual's permanent file.
- F. Staff will complete a written Incident and Emergency Report. A Vulnerable Adults Maltreatment Report will also be completed if the death was the result of suspected maltreatment.

Section: Services	Review Date: 1/2014
Topic: Do Not Resuscitate / Do Not Intubate Procedure	Revision:

Do Not Resuscitate (DNR) orders refer to a request by an individual served or the individual's legal representative that no lifesaving measures be administered if the individual served is found to be in respiratory arrest (breathing has ceased) or full cardiopulmonary arrest (no pulse and is not breathing.) Do Not Intubate (DNI) orders refer to a request by an individual served or the individual's legal representative that in the event that breathing has ceased, an artificial breathing machine will not be placed. If *only* a DNI order is in place and not a DNR order, chest compressions/rescue breathing will be performed at the Harry Meyering Center. In the case of public guardianship, Minnesota statute dictates that DNR orders require judicial consent.

When the Harry Meyering Center (HMC) receives a DNR order, the individual served or the individual's legal representative will be notified that should the individual experience a respiratory arrest or a full cardiopulmonary arrest, NO resuscitation measures will be initiated. 911 will be called and the DNR order will be presented to the emergency responders.

If present at the time of the emergency, HMC employees are responsible for notifying emergency medical personnel that a DNR order exists and providing them with the DNR/DNI orders. DNR/DNI orders will accompany an individual served each time they go to the hospital or emergency room. HMC is NOT responsible for actions taken or not taken by emergency medical personnel or other licensed providers.

In the event of a DNR/DNI order for an individual served by HMC, employees will provide active and appropriate first aid treatment.

DNR orders cannot be honored by medical personnel without being signed and dated by legal representative and health care professional.

OBSTRUCTED AIRWAY

The individual served or the individual's legal representative will also be notified that, should the individual experience an obstructed airway, emergency measures, which include abdominal thrusts and back blows, will be taken to prevent or reverse acute airway obstruction while the person is conscious. If the individual becomes unconscious, 911 will be called and chest compressions and rescue breathing will be provided until the arrival of emergency medical responders. The DNR order will be presented to the emergency responders upon arrival. If the legal representative does not want the above mentioned first aid performed in the event of a choking incident, specifics will be indicated in writing on the DNR/DNI order.

LOCATION OF DNR ORDERS

Copies of DNR orders (including a copy of the court order for individuals under public guardianship) are readily accessible to employees (see below for specific locations for these documents). Program Managers, in conjunction with nursing, will ensure that copies of DNR orders

are given to the office of the primary physician, the legal guardian, other licensed providers, and the county case manager.

For SLS:

In the SLS Program sites, copies of DNR/DNI orders are kept:

- in the individual's program books
- in the house and vehicle First Aid Kit
- in the On-Call reference book
- copy to Activities Coordinator and Director of Program Services

The ORIGINAL will be kept in the individual's permanent file.

DNR/DNI orders are explained in the individual's Coordinated Service and Support Plan (CSSP) and/or Addendum which is part of orientation for all new employees. Any DNR/DNI orders are noted on the front page of the individual's medical face sheet.

For SILS/In-Home:

In the SILS/In-Home Program, copies of DNR/DNI orders are kept:

- in the individual's program book(s)
- in a drawer nearest to the phone in the individual's home (exact location will be posted on the front page of the face sheet)
- in the On-Call reference book
- copy to Activities Coordinator and Director of Program Services

The ORIGINAL will be kept in the individual's permanent file.

DNR/DNI orders are explained in the individual's Coordinated Service and Support Plan (CSSP) and/or Addendum which is part of orientation for all new employees. Any DNR/DNI orders are noted on the front page of the individual's medical face sheet.

For HOMESTEAD:

At Homestead, copies of DNR/DNI orders are kept:

- in the individual's program book (under a separate tab)
- in each vehicle with the First Aid Kit
- copy to Activities Coordinator and Director of Program Services

The ORIGINAL will be kept in the individual's medical file.

DNR/DNI orders are explained in the individual's Coordinated Service and Support Plan (CSSP) and/or Addendum which is part of orientation for all new employees. Any DNR/DNI orders are noted on the front page of the individual's medical face sheet and are reviewed by all staff with Quarterly Emergency Procedures.

For PRAIRIE'S EDGE:

At Prairie's Edge, copies of DNR/DNI orders are kept:

- in the individual's program book (under a separate tab)
- in each vehicle with the First Aid Kit
- copy to Activities Coordinator and Director of Program Services

The ORIGINAL will be kept in the individual's medical file.

DNR/DNI orders are explained in the individual's Coordinated Service and Support Plan (CSSP) and/or Addendum which is part of orientation for all new employees. Any DNR/DNI orders are noted on the front page of the individual's medical face sheet and are reviewed by all staff with Quarterly Emergency Procedures.

Section: Services	Review Date: 10/2015, 11/2016
Topic: Fire Procedure	Revision:

In the case of an actual fire, staff will follow the Incident and Emergency Report Procedure to ensure that appropriate notifications occur within designated timelines.

FOR SILS/IN-HOME

- A. Individuals served in the SILS/In-Home Program will be trained in calling the fire department and/or seeking assistance in the case of fire. Evacuation of the apartment will be stressed in the case of fire. The individual will be instructed not to re-enter the apartment until the fire department indicates that it is advisable.
- B. Quarterly, employees will review fire evacuation routes, teach kitchen safety techniques incorporating putting out small fires (such as stove top, oven and waste basket), and observe the individual checking the smoke detector to assure that it is working properly.
- C. If the building is deemed uninhabitable, On-Call will contact and work with the Red Cross to find suitable accommodation(s) and to ensure the health and safety of individuals affected.

FOR SLS

Individuals in the SLS Program are instructed in the calling of the fire department and/or seeking assistance in the case of a fire. Each individual is instructed not to re-enter the house/apartment until the fire department indicates that this is advisable. Each house will have a fire exit plan. On this plan a designated meeting place is to be indicated.

FIRE DRILL:

- A. Quarterly fire drills and evacuations will be reviewed with all individuals in the house. The Supportive Living Coordinator (SLC) will see that drills occur within 90 days of previous drill and are documented.
- B. During the quarterly fire drills, the following procedure will be used:
 - No notice will be given.
 - Set off the alarm.
 - Follow evacuation procedure.
 - Employees to exit the building and account for all individuals served.
 - Document the drill on the Fire Drill Report Form.

ACTUAL FIRE:

- A. In the case of an actual fire, the most important task of the employees is to evacuate all individuals in the house as quickly as possible. Employees will assist in removal of anyone who is in an area of immediate danger and close doors to rooms. Employees are not to take time to turn off lights or close windows; the immediate concern is for the individuals in the house.

- B. In the case of an actual fire, an Incident and Emergency Report will be filled out and subsequent notifications will be made
- C. If the building is deemed uninhabitable, On-Call will contact and work with the Red Cross to find suitable accommodation(s) and to ensure the health and safety of individuals affected.

FOR HOMESTEAD

FIRE DRILL:

- A. Fire drills are conducted monthly and on each shift quarterly. Six times a year the entire building must be completely evacuated, two times on each shift. Building Charge will be notified when this is to occur. The ICF Program Director is responsible for making sure that the fire drills do occur and the results are documented. The Safety Committee reviews all fire drill reports to ensure that safety procedures are being met.
- B. The alarm system is checked monthly by the Physical Plant Manager and a record of those checks is maintained in the Harry Meyering Center (HMC) Fire Book.
- C. Homestead is electronically alarmed by Hawk Alarm Systems. Since Homestead is electronically alarmed, prior to any fire drills the designated employee (generally the Building Charge) will:
 - 1. Call Hawk (account number and password are located on the fire system panel). State that you are calling from the Harry Meyering Center (not “HMC”), that it is only a drill (there is no need to respond), and the anticipated length of time for the drill.
 - 2. After the drill, call back to confirm that Hawk Alarm Systems received the DACT signal.
- D. All employees present in the building at the time of the fire drill will assist in the fire evacuation process.
 - a. Those employees not responsible for a specific apartment should meet outside the nurse’s office for instructions from the designated employee (generally the Building Charge.)
 - b. Building Charge is responsible for the safety of the individuals served and evacuation during fire emergencies. If the Building Charge is on break when the alarm sounds, they are to return to work immediately.

ACTUAL FIRE:

- A. In the event of an actual fire, the Building Charge must call 911 to confirm that trucks are responding and to relay any pertinent information.
- B. All employees present in the building at the time of the fire alarm sounding will assist in the fire evacuation process.
 - Those employees not responsible for a specific apartment should meet outside the nurse’s office for instructions from the designated employee (generally the Building Charge.)

- Building Charge is responsible for the safety of the individuals served and evacuation during fire emergencies. If the Building Charge is on break when the alarm sounds, they are to return to work immediately.

FOR PRAIRIE'S EDGE

FIRE DRILL:

- A. Fire drills are conducted monthly and on each shift quarterly. The Home Coordinator is responsible for making sure that the fire drills do occur and the results are documented. The Safety Committee reviews all fire drill reports to ensure that safety procedures are being met.
- B. The alarm system is checked monthly by the Home Coordinator and a record of those checks is maintained. Prairie's Edge is electronically alarmed through Hawk Alarm Systems.
- C. Since Prairie's Edge is electronically alarmed, prior to any fire drills the designated employees will:
 1. Call Hawk Alarm Systems and tell them that it is only a drill and there is no need to respond.
 - a. When calling Hawk Alarm Systems, staff will need to provide the account number and password (these are located on the fire panel as well as by the phone in the office) and tell them an anticipated length of time for the drill.
 2. After the drill, call Hawk Alarm Systems to confirm that they received the DACT signal.

ACTUAL FIRE:

- A. In the event of an actual fire, employees will call 911 to confirm that trucks are responding and to relay any pertinent information. Employees will also contact On-Call as soon as possible.

PRAIRIE'S EDGE AND HOMESTEAD

Discovery of Actual Fire or Fire Drill Sign in Your Work Area:

- Evacuate individuals served who are in the immediate area of danger.
- Pull alarm.
- Notify other employees.
- Continue with evacuation efforts to designated areas as directed by Building Charge (Homestead).
- If possible, extinguish fire once individuals are safe and if the fire is small enough to contain.
- Return only when the all clear is given by the Building Charge or the fire department in the event of an actual fire.
- Document on Fire Drill Report Form and turn in to the Program Director.

Fire Alarm Sounds (Drill or Actual):

- Check apartment (Homestead)/house (Prairie's Edge) for fire.
- Meet with Building Charge to determine if the fire is anywhere on the unit (Homestead).
- Evacuate the unit to the designated area if the fire is on the unit. If the fire is not on the unit return to the apartment and get into a state of readiness, preparing to evacuate should the need arise.

- Return only when the all clear is given by the Building Charge or the Fire Department in the event of an actual fire.
- Document on Fire Drill Report Form and turn in to the Program Director.

In the case of an actual fire, notify the legal representative or designated emergency contact, case manager and other licensed providers, Program Director and Executive Director within 24 hours.

Section: Services	Review Date: 1/2014, 11/2016
Topic: Hot Weather Procedure	Revision:

Hot weather is defined as a heat index of 101 or above.

HEAT INDEX CHARTS

- A. To use the heat index charts, find the appropriate temperature at the top of the chart. Read down until you are opposite the humidity/dew point. The number which appears at the intersection of the temperature and humidity/dew point is the heat index.

Heat Index Chart (Temperature & Dew Point)

Dew Point (° F)	Temperature (° F)															
	90	91	92	93	94	95	96	97	98	99	100	101	102	103	104	105
65	94	95	96	97	98	100	101	102	103	104	106	107	108	109	110	112
66	94	95	97	98	99	100	101	103	104	105	106	108	109	110	111	112
67	95	96	97	98	100	101	102	103	105	106	107	108	110	111	112	113
68	95	97	98	99	100	102	103	104	105	107	108	109	110	112	113	114
69	96	97	99	100	101	103	104	105	106	108	109	110	111	113	114	115
70	97	98	99	101	102	103	105	106	107	109	110	111	112	114	115	116
71	98	99	100	102	103	104	106	107	108	109	111	112	113	115	116	117
72	98	100	101	103	104	105	107	108	109	111	112	113	114	116	117	118
73	99	101	102	103	105	106	108	109	110	112	113	114	116	117	118	119
74	100	102	103	104	106	107	109	110	111	113	114	115	117	118	119	121
75	101	103	104	106	107	108	110	111	113	114	115	117	118	119	121	122
76	102	104	105	107	108	110	111	112	114	115	117	118	119	121	122	123
77	103	105	106	108	109	111	112	114	115	117	118	119	121	122	124	125
78	105	106	108	109	111	112	114	115	117	118	119	121	122	124	125	126
79	106	107	109	111	112	114	115	117	118	120	121	122	124	125	127	128
80	107	109	110	112	114	115	117	118	120	121	123	124	126	127	128	130
81	109	110	112	114	115	117	118	120	121	123	124	126	127	129	130	132
82	110	112	114	115	117	118	120	122	123	125	126	128	129	131	132	133

Note: Exposure to full sunshine can increase HEAT INDEX values by up to 15° F

<http://www.weatherimages.org/data/heatindex.html>

For HOMESTEAD AND PRAIRIE'S EDGE:

When there is hot weather, out-of-the-facility activities are to be reviewed by the nurse on duty and/or Building Charge, taking into account the purpose of the activity, individual involved, vehicles and destination. If the nurse feels that the outing is contraindicated for the individual(s) that decision will be final. The decision will be based on weather conditions and individual medical concerns and vulnerabilities. The Building Charge will notify all employees of restriction of activities outside of the facility.

FOR SLS:

Decisions regarding out-of-the-facility activities will be made by employees taking into account purpose, individual(s), vehicles, destination as well as vulnerabilities and medical concerns as assessed in the Coordinated Service and Support Plan (CSSP) and Addendum (Example: IAPP/SMA).

FOR SILS/IN-HOME:

Quarterly, employees review threats of heat and humidity with individuals served according to the CSSP and Addendum. SILS/InHome staff encourages an intake of adequate fluid and monitor appropriate thermostat settings during regularly scheduled visits.

Section: Services	Review Date: 1/2014, 11/2016
Topic: Medical Emergency Procedure	Revision:

- A. If an individual served becomes ill or injured, the following steps should be taken:
- Provide necessary First Aid and treatment.
 - Gather as much information as possible and as training allows:
 - current temperature
 - pulse
 - blood pressure
 - blood sugar (if applicable)
 - facts about the symptoms or injury
 - Contact designated individuals (listed below).
 - Homestead and Prairie's Edge ICF – Notify the nurse, Program Manager, or Program Director. In absence of these individuals, contact on-call.
 - SLS – Notify the nurse, Program Manager, or Program Director. In absence of these individuals, call on-call.
 - SILS – if person responding is not designated on-call person, contact on-call, Program Manager, or Program Director.
 - If the individual's condition is assessed to be serious, transport them to the nearest clinic or Emergency Room for medical intervention or, if deemed to be necessary, call 911 for an ambulance.
 - When a medical emergency or a serious situation is suspected, staff is authorized to call 911 without approval from a management staff person or a facility health professional.
 - If individual is being transported by ambulance, employees should either accompany the individual or meet the individual at the Emergency Room.
 - When accompanying an individual to the clinic or Emergency Room, take along the individual's medical file, medical assistance card and Medicare Card (if applicable).

DOCUMENTATION

- A. Document the nature of the illness or injury and action taken on an Incident and Emergency Report.
- B. An Internal Review will be completed by the Program Director, Program Manager, or on-call.

NOTIFICATION

- A. The Program Director, Executive Director, Program Manager, and Director of Program Services will be notified within 24 hours of the medical emergency or HMC knowledge of a medical emergency occurring.
- B. The Program Director or their designee will be responsible for notifying the legal representative, case manager and other licensed providers within 24 hours of the medical emergency or known HMC knowledge of a medical emergency occurring.

Section: Services	Review Date: 1/2014, 11/2016
Topic: Mental Health Crisis Procedure	Revision:

- A. A mental health crisis could include, but is not limited to:
 - the immediate need for a check of medications or side effects
 - an emergency that has significant risk to health or safety including suicide or homicide (where calling 911 is not imminent)
 - an acute psychotic illness in which an individual may need to be observed in an inpatient/hospital setting, or as the Program Director, on-call, or nursing deem necessary.
- B. If a mental health crisis were to occur, staff will ensure the person's safety, and will not leave the person alone if possible. Staff will implement any crisis prevention plans specific to the person served as a means to deescalate, minimize or prevent a crisis from occurring.
 - During regular business hours: a call should be made to the clinic where the individual's primary psychiatrist is on duty. If that psychiatrist is unavailable, a request to speak to the psychiatrist On-Call should be made. Full explanation of the events at hand and medical information should be available for that conversation.
 - During non-business hours: an assessment should be made as to the need for police or a mental health crisis intervention team or similar mental health response team or service when available and appropriate in order to protect the health and safety of the individual and others.
- C. If risk is imminent contact 911, a mental health crisis intervention team or a similar mental health response team or service when available and appropriate.
- D. If imminent risk to self or others is not present, a call should be placed to the clinic that serves the individual; request to speak to the On-Call clinician, having a full explanation of the current concern(s). The On-Call clinician will make a determination as to whether the individual would need to be seen in the Emergency Room. If, for some reason, the behavioral health unit at the hospital is not available, the individual may require transport to another hospital. Only as a last resort, Harry Meyering Center (HMC) personnel should assist in this transport (by HMC vehicle).

NOTIFICATION

- A. For any mental health crisis, notify the On-Call designate in the program in which the individual is served.
- B. The Program Director, Executive Director, Program Manager, and Director of Program Services will be notified within 24 hours of a mental health crisis or HMC knowledge of a mental health crisis occurring.
- C. The Program Director or their designee will be responsible for notifying the legal representative, case manager and other licensed providers within 24 hours of the mental health crisis or known HMC knowledge of a mental health crisis occurring.

DOCUMENTATION

- A. Document the nature of the illness or injury and action taken on an Incident and Emergency Report.

- B. An Internal Review will be completed by the Program Director, Program Manager, or on-call.
- C. If an Emergency Use of Manual Restraint is needed in the midst of a mental health crisis, staff will follow the EUMR policy regarding required notification and documentation.

Section: Services	Review Date: 1/2014, 11/2016
Topic: Natural Disaster Procedure	Revision:

A natural disaster is an unexpected happening in nature that has the potential to cause great harm or damage to people or property.

A. Evacuation

- In the event that disaster conditions force evacuation, the staff person/On-Call will remain tuned to the radio and follow evacuation procedures outlined there.
- The staff person/On-Call will ensure all individuals served are safely removed from the affected area.
- Once everyone is safely removed the staff person/On-Call will notify the Program Director(s) and/or their designees.

B. Temporary Shelter

- In the event of any disaster that results in a residential site being uninhabitable, supervisor/designee will direct staff and individuals served to a pre-designated temporary shelter. The temporary shelter is located at:
 - SILS/ In-Home, SLS, Prairie's Edge: Harry Meyering Center, 109 Homestead Rd, Mankato, MN
 - Homestead: Red Cross, 105 Homestead Rd, Mankato, MN

C. Documentation and Notification

- After appropriate arrangements have been made to meet everyone's immediate needs, the person who was in charge at the time of the emergency will fill out an Incident and Emergency Report and complete subsequent notifications according to the Incident and Emergency Report Procedure.

Section: Services	Review Date: 1/2014, 10/2016
Topic: Need for Detoxification Services Procedure	Revision:

- A. The Program Director and On-Call should be notified prior to admission to a detoxification facility if at all possible. The need for detoxification services would be appropriate if any of the following conditions are present:
 - When an individual consumes mood altering chemicals that detrimentally influence their physical condition (i.e. blood pressure, pulse, breathing) and it is determined that their safety is at risk.
 - If alcohol or other mood altering chemicals are contraindicated in the individual's medication regime or compromises other physical treatments.
 - If an individual behaves in a manner that poses risk to their own safety, the safety of others or property, and it is determined that the behavior is secondary to chemicals.
- B. If any of these criteria are met, a call should be made to the Emergency Room at the hospital with a request to have the individual seen immediately. If the individual will go voluntarily, transport them with a minimum of 2 employees to the Emergency Room. If the individual refuses to go and the emergency cannot be handled by an employee, a call to 911 should be made with a request that the police assist in the transportation to the Emergency Room.
- C. If, for some reason, the hospital in Mankato does not serve severely intoxicated persons, the individual may require transport to another hospital. Harry Meyering Center (HMC) personnel should assist in this transport (by HMC vehicle) only as a last resort.
- D. Document the circumstances and the outcome of such an occurrence on an Incident Report. Notify legal representative, case manager and other licensed providers, Program Director and Executive Director within 24 hours.

Section: Services	Review Date: 1/2014, 1/2016
Topic: Pandemic Planning Procedure	Revision:

Upon request, the Harry Meyering Center shall cooperate with state and local government disaster planning agencies working to prepare for or react to emergencies presented by a pandemic outbreak.

Section: Services	Review Date: 1/2014
Topic: Power Failures and Gas Leaks Procedure	Revision: 11/2016

Quarterly, review the threat of power failures with staff and/or individuals served according to Coordinated Service and Support Plans (CSSP) and Addendums (ex: Self Management Assessments, Individual Abuse Prevention Plan). Individuals are encouraged to use emergency supplies such as flashlights and/or battery operated radios until power is restored.

POWER FAILURE:

- During a power failure, staff will remain with individuals served. If individuals are not in the immediate area, staff will locate them and bring them to the central program area.
- The power company will be contacted by cell phone to determine the estimated length of the power outage. If estimated to last more than two hours, on-call will be contacted to determine what actions will be taken.

GAS LEAK:

- If gas is smelled or a gas leak is suspected, staff will evacuate the individuals to the established designated assembly point outside the facility.
- The gas company will be immediately notified and instructions followed.
- No one will be permitted to use lighters, matches, or any open flame during this time. All electrical and battery-operated appliances and machinery will be turned off until the all clear has been provided.
- On-Call will be notified of the gas leak. This call will be made by staff from the safe area using a cell phone or from a neighbor's phone.

FOR HOMESTEAD:

Homestead has a generator to provide back-up power. In the event of a power outage, the generator will automatically turn on. (There should be a less than 10 second delay before the generator turns on.) When power is restored, the generator may still cycle on and off for up to an hour to ensure that the power is going to stay on.

In the event the generator does not start in a power outage call:

- Maintenance (Monday through Friday, 7 a.m. to 3:30 p.m.
- Katolight Corporation: 800-325-5450 or 507-625-7973 during business hours or 888-218-0298 after hours

DOCUMENTATION AND NOTIFICATION:

Incident and Emergency Report and subsequent notifications will be completed for Power Failures and Gas Leaks according to the Incident and Emergency Report Procedure.

Section: Services	Review Date: 1/2014, 10/2016
Topic: Preparing for Emergencies Procedure	Revision:

- A. All staff will be trained in first aid and will be available on-site in a residential setting and when required in a person's CSSP and/or CSSP Addendum, be able to provide CPR whenever persons are present and staff are required to be at the site to provide direct services.
- B. Each SLS, Homestead, and Prairie's Edge site will have a first aid kit readily available for use by, and that meets the needs of, individuals served and staff. The first aid kit will contain, at a minimum, bandages, sterile compresses, scissors, and ice bag or cold pack, an oral or surface thermometer, mild liquid soap, adhesive tape, and a first aid manual.
- C. Each SLS, Homestead, and Prairie's Edge site will have a flashlight and a portable radio or television set that do not require electricity and can be used if a power failure occurs.
- D. Each SLS, Homestead, and Prairie's Edge site will have a non-coin-operated telephone that is readily accessible. A list of emergency numbers must be posted in a prominent location. Emergency numbers will include 911; a mental health crisis intervention team number, if applicable; and names and numbers of each person's legal representative, physician, and dentist.
- E. Each SLS, Homestead, and Prairie's Edge site will have:
 - A floor plan available that identifies the locations of:
 - i. Fire extinguishers and audible or visual alarm systems
 - ii. Exits, primary and secondary evacuation routes, and accessible egress routes, if any
 - iii. An emergency shelter within the facility
 - A site plan that identifies:
 - i. Designated assembly points outside the facility
 - ii. Locations of fire hydrants
 - iii. Routes of fire department access
 - An emergency escape plan for each resident
 - A floor plan that identifies the location of enclosed exit stairs for facilities that have three (3) or more dwelling units.
- F. Quarterly drills will be conducted at SLS, Homestead, and Prairie's Edge sites throughout the year on various days of the week and times of the day or night. Staff and individuals served will not be notified prior to the drill, if possible, to ensure correct implementation of staff responsibilities for response. Supportive Living Coordinators (in SLS), Building Charge (at Homestead), and Home Coordinator (at Prairie's Edge), will be responsible for the initiation of the emergency drill and will record the date and time of the drill.
- G. As part of the emergency plan file kept at the site, the following will be maintained:
 - Log of quarterly fire and severe weather drills
 - Readily available emergency response plan
 - Emergency contact information for individuals served at the site including each person's legal representative, physician, and dentist

- Information on the emergency shelter within the facility and the designated assembly points outside the facility
 - Emergency phone numbers that are posted in a prominent location
- H. If individuals served require the use of adaptive procedures or equipment to assist them with safe evacuation, staff will receive specific instruction on these procedures and equipment.

Section: Services	Review Date: 1/2014, 11/2016
Topic: Sexual Assault Procedure	Revision:

- A. Sexual assault is an involuntary sexual act where a victim is forced or coerced to do a sexual act against their will. Refer to Minnesota statute [609.341](#) for more information on what can be defined as sexual assault.

- B. If an individual served is the victim or perpetrator, the following steps will be taken:
 - Instruct those involved in a calm, non-judgmental manner to discontinue the activity.
 - Direct the people involved to separate areas.
 - If an individual served does not respond to verbal redirection, intervene to protect others involved by following the Emergency Use of Manual Restraint policy as needed.
 - Summon additional staff if necessary and feasible.
 - Contact law enforcement (911) as soon as possible and follow all instructions.
 - If the persons are unclothed, provide them with appropriate clothing. Do not have them redress in the clothing that they were wearing.
 - Do not allow the persons involved to bathe or shower until law enforcement has responded and cleared this action.
 - Notify the designated program On-Call and nursing, if appropriate.
 - If the person(s) express physical discomfort and/or emotional distress, or for other reasons you may feel it necessary, contact medical personnel and follow all instructions.
 - Transport individual(s) to the Emergency Room; On-Call will either accompany or meet the individual(s) there.
 - At the Emergency Room, give information as requested to the physician and law enforcement.
 - Emergency Room personnel can treat victims of sexual assault under the implied consent law and do not need guardian consent.
 - The following persons will be notified within 24 hours:
 - Program Director
 - Case Manager and other licensed providers
 - Executive Director
 - Program Manager
 - Director of Program Services
 - Legal representative/emergency contact
 - Complete an Incident and Emergency Report.

Section: Services	Review Date: 1/2014, 11/2016
Topic: Thunderstorm and Tornado Procedures	Revision:

Severe Thunderstorm Warning occurs when the National Weather Service expects thunderstorms with large hail and/or damaging winds in excess of 57 miles per hour. (Be ready!)

Tornado Watch is when the current weather conditions could produce a tornado. (Plan!)

Tornado Warning is when a tornado or funnel cloud has been sighted or detected on radar. (Act NOW!)

FOR ICF, PRAIRIE'S EDGE AND SLS:

- Employees will be aware of weather conditions and be prepared to act if necessary. Employees should listen to the weather alert radio, television, or radio.
- Each house or apartment will be equipped with a flashlight and battery operated radio. These items will be checked frequently to ensure working order by designated employees.
- In the event of a tornado watch, employees will be prepared to act and have flashlights, blankets, pillows, etc. ready.
- Employees need to also know the whereabouts of all individuals served that they are assigned to.
- Discretion must be used in regards to community activities.
- During a tornado warning, individuals served and employees will seek shelter in the designated area of the house or apartment. Employees will reassure individuals served and attempt to make them as comfortable as possible. Keep doors shut and stay away from glass.
- No community activities during a tornado warning. If out in the community during a tornado warning, seek shelter in the designated place or if in the car go to the side of the road and get into the ditch, avoiding electrical lines. If at all possible, try to notify HMC Building Charge (ICF Homestead) or On-Call (Prairie's Edge and SLS) of your whereabouts.
- Staff working will assist all individuals in seeking and staying in the safe shelter when sirens are heard or a tornado warning is issued. Individuals and employees will remain in the shelter area until an all clear is issued through the radio or by other means.
- If Injury or damage occurs, staff will notify On-Call and follow instructions given.

FOR SILS/IN-HOME:

- All individuals served by this program will be instructed using the Quarterly Emergency Procedures on information regarding thunderstorms, tornadoes, power outages and natural disasters. Training includes:
 - Use TV or battery-operated radio for updates on weather conditions.
 - If outside seek shelter for protection.
 - Organize storm materials such as flashlights, transistor radio, blankets, and pillows.

Section: Services	Review Date: 1/2014, 11/2016
Topic: Unexplained Absence Procedure	Revision:

FOR PRAIRIE'S EDGE:

In those instances where employees have reason to believe an individual served is absent for a period of time that is cause for concern, the employee will contact on-call for advice as to necessary action. In general the procedure will be as follows:

- Employees will search the house including storage closets, offices, etc. as well as the yard and the neighborhood.
- If unable to locate after the search, file a missing person report with local authorities - an explanation of the individual's vulnerabilities, physical description, etc. will be given to the authorities to assist them in the search.
- Notify legal representative or designated emergency contact, case manager and other licensed providers, Program Director and Executive Director within 24 hours if the individual is not immediately found.
- When individual is found and circumstances are confirmed, notify relevant people.

If individual is lost in the community:

- Use resources on hand to assist in the search (PA system, security, etc.)
- If there are two employees, one will search and the other will take other individuals served and go get help.
- On-call should be notified as soon as possible.
- If deemed to be necessary, contact law enforcement for assistance - an explanation of the individual's vulnerabilities, physical description, etc. will be given to the authorities to assist them in the search.
- Notify legal representative or designated emergency contact, case manager and other licensed providers, Program Director and Executive Director within 24 hours if the individual is not immediately found.
- When individual is found and circumstances are confirmed, notify relevant people.

Document incident on an Incident and Emergency Report.

FOR HOMESTEAD:

Whenever the whereabouts of an individual served is not known, employees will follow these steps:

- Notify the Building Charge immediately.
- Building Charge will assign employees to search the apartments, storage closets, offices, etc. in the building, starting with the area in which the individual lives. If the individual is not located, the grounds, parking lot and vehicles will be searched.
- If the individual is not found, call 911 and notify Law Enforcement and request assistance – an explanation of the individual's vulnerabilities, physical description, etc. will be given to the authorities to assist them in the search.
- Building Charge will notify the Program Manager or their designee.

- Notify On-Call.
- Notify the legal representative or designated emergency contact, case manager, other licensed providers, Program Director and Executive Director within 24 hours if individual is not found.
- When the individual is found and circumstances are confirmed, notify relevant people.

If individual is lost in the community:

- Use resources on hand to assist in the search (PA system, security, etc.)
- If there are two employees, one will search and the other will take other individuals served and go get help.
- Homestead Building Charge should be notified as soon as possible.
- If deemed to be necessary, contact Law Enforcement for assistance -- an explanation of the individual's vulnerabilities, physical description, etc. will be given to the authorities to assist them in the search.
- Building Charge will notify on-call.
- Notify the legal representative or designated emergency contact, case manager and other licensed providers, Program Director and Executive Director within 24 hours if the individual is not found.
- When the individual is found and the circumstances are confirmed, notify relevant people.

Document incident on an Incident and Emergency Report.

FOR SILS/IN-HOME AND SLS

In those instances where employees have reason to believe an individual served is absent for a period of time that is cause for concern, the employees will contact the SILS Program Director, Program Manager, or On-Call for advice as to necessary action. In general, the procedure will be as follows:

- Contact roommates for information.
- Contact work counselor, friends, parents/family, legal representative or designated emergency contact or other people as to possible whereabouts or for possible information.
- If no information, file a missing person report with local authorities - an explanation of the individual's vulnerabilities, physical description, etc. will be given to the authorities to assist them in the search.
- Notify legal representative or designated emergency contact, case manager and other licensed providers, Program Director and Executive Director within 24 hours if the individual is not found.
- When individual is found and circumstances are confirmed, notify relevant people.

Document incident on an Incident and Emergency Report.

Section: Operational	Review Date: 1/2014
Subject: Expense Reimbursements Procedure	Revision: 3/2017

When an employee is designated to conduct work or represent the agency away from the Harry Meyering Center (HMC), the agency will pay a portion of the expenses incurred by the employee. Employees have a responsibility to use HMC resources wisely.

The guidelines for what the agency will pay are as follows:

- All employees must complete an expense sheet when requesting reimbursement for expenses accrued as part of their position.
- Receipts are required for reimbursement, with the exception to mileage.
- Expense sheets shall be completed and receipts for any claimed expense attached along with the reason for the expense (examples: meal with individual served, medical appointment with individual served, in-service).
- Expense sheets shall be signed by the employee.

Expense sheets are turned in to the employee's supervisor for their signature, which indicates approval. The supervisor will be responsible for turning expense sheets in to the Finance Department.

HMC will reimburse expenses for the prior month by the 15th of the next month, if received in a timely manner.

Current guidelines for reimbursement when program employees use their personal money for activities in the community (including snacks/meals if part of the activity) with individual(s) served:

- Snacks and beverages – Up to \$2.00
- ICF – Up to \$4.00
- SLS – Up to \$4.00 (\$7.00 at the supervisor's discretion)
- SILS – Up to \$7.00 (this is a one-time per year expense for one staff to celebrate a birthday or other approved occasion)

Meals while at in-services or other work activities such as a medical appointment or vacation with an individual served will be reimbursed at the following rates:

- Breakfast – Up to \$ 8.00
- Lunch – Up to \$10.00
- Supper – Up to \$12.00

When designated, by HMC, to drive their own vehicle, employee reimbursement will be \$0.50 per mile. When using parking ramps/lots, employees will be reimbursed for the amount on the receipt. When overnight accommodations are necessary, HMC makes reservations for designated employees at mid-range hotels in economical rooms. When out of state travel of an employee is necessary, HMC pays for the most economical mode of transportation.

Costs incurred as part of a team-approved consumer goal, other than food, beverage or mileage, will also be reimbursed for the employee and individual served. This would include costs for materials needed to carry out the goal of the individual served, with a receipt.

For SLS, Homestead and Prairie's Edge:

Program money is available at each location. The account will be balanced monthly and reimbursed as needed. These funds are monitored by:

- SLS – Supportive Living Coordinator (SLC)
- Prairie's Edge – House Coordinator
- Homestead – Apartment Coordinator

Employees may utilize this money for those expenditures, which are immediately necessary to maintain the functioning of the house/apartment, for employee expenses while working or for any cost incurred by the employee or individual served for running a team-approved consumer's goal using the approved reimbursement rates and with receipts. Any time an amount is taken, the original receipt must be placed in the designated spot. If the vendor does not supply receipts a Missing Receipt Documentation form must be filled out. Employees will not be reimbursed without an appropriate receipt. Employees will not be reimbursed for drinks or snacks purchased and brought back to the house.

Section: Services	Review Date: 1/2014, 12/2016
Subject: Management of Personal Funds Policy	Revision:

The Harry Meyering Center (HMC) will not tolerate any misuse or theft of funds from any individual served. Tampering with these funds is a violation of the [Vulnerable Adults Act](#) and may also violate state criminal laws and/or federal Social Security laws. HMC will aid in the civil and criminal prosecution of any employee who tampers with the funds of an individual served. HMC will also seek full restitution.

Section: Services	Review Date: 1/2014, 12/2016
Subject: Management of Personal Funds Procedure	Revision:

- A. The Harry Meyering Center (HMC) will ensure:
- Individuals served will retain the use and availability of personal funds or property unless other restrictions are justified in the individual's plan
 - Separation of funds by individuals served from HMC's funds, the program, or staff
 - Adhering to the following when assisting an individual served:
 - Immediate documentation of receipt and disbursement of the person's fund or other property including signature of the individual served, conservator, or payee
 - Return of funds and property in HMC's possession subject to restrictions in the person's treatment plan with three working days of the request.
- B. HMC and staff will not:
- Borrow money to or from an individual served
 - Purchase personal items from an individual served
 - Sell merchandise or personal services to an individual served
 - Require an individual served to purchase items for which the license holder is eligible for reimbursement
 - Use funds to purchase items for which public or private payments are already received
- C. Funds or property that have been requested and documented in the Coordinated Service and Support Plan or Addendum (CSSP/A) will be reviewed annually or when requested by the individual served and/or their legal representative.
- D. The following are standards for the protection of money owned by the individuals served in all programs of HMC:
- Individuals served will be encouraged to control their personal funds whenever possible and to the maximum extent of their capabilities as determined by the Support Team. A restriction to access of any personal funds is explained in the Individual Abuse Prevention Plan as well as a rights restriction, if deemed necessary.
 - Written authorization from the case manager and legal representative is obtained to assist the individual served with safe keeping of funds and property.
 - If HMC assists a person with safekeeping of funds or other property, written authorization to do so from the individual served or legal representative and the case manager must be obtained within five working days of service initiation and renewed annually. When initial authorization is obtained, HMC must document and implement the preferences of the individual served or legal representative and the case manager for frequency of receiving a statement that itemizes receipts and disbursement of funds or other property. HMC must document changes to these preferences when they are requested.
 - Dual signature will be used if needed for protection of the individual's financial interests, recommended by the support team, and approved by the case manager and legal representative. In this event, written permission from the individual served or legal representative and the case manager will be obtained annually. The written permission

will include reasons for the necessity of the dual signature method, and will be justified in the CSSP/A.

- Dual signature account in no way implies ownership of the account. Dual signature accounts are established by the facility with agreement by the individual served and the legal representative to provide a staff signature indicating approval that funds are being utilized in a planned and responsible manner.
- Receipts are to be saved for all purchases, with the receipt being stapled to the duplicate check when possible. If no receipt can be attained, a makeshift receipt is to be completed.
- Upon the transfer or death of an individual served, any funds or property of the person must be surrendered to the person or their legal representative, or given to the executor or administrator of the estate and documented on the Discharge Inventory Form.

HOMESTEAD AND PRAIRIE'S EDGE:

- A. The use of automatic teller machines is discouraged.
- B. All checks and money received must be directly deposited into the checking account in full without cash deductions unless approved by the Support Team. A complete record of money use will be kept in the form of the account checkbook register held by the individual served.
- C. The Program Manager or their designate is responsible for tracking all incoming checks and seeing that deposits are made in a timely manner.
- D. Checks are written for the amount of the purchase only unless pre-approved by the Program Manager or designate. The check ledger will indicate what was purchased, the amount of cash received, and the reason for getting the cash.
- E. Personal spending money checks will be written out to the individual served. The individual served has total control over how their personal spending money is spent and is not required to keep receipts unless the individual's Support Team requests receipts.
- F. Bank statements and petty cash ledgers are reconciled monthly and are overseen by the Program Manager or their designate.
- G. Purchases are identified by store, description of the purchase, amount, and date in the checkbook. Check numbers should be written on receipts.
- H. Reporting of receipts and disbursements will be available to individual team members as determined and documented by the team as requested on the Financial Authorization Form.
- I. The responsibility of overseeing individual finances, checkbook balancing is that of the Program Manager or their designate.
- J. Purchases over \$10.00 need to be approved by the Apartment Coordinator or Home Coordinator, with purchases over \$50.00 requiring the approval of the Program Manager or designate, unless otherwise identified by the individual's Support Team.

SILS/IN-HOME:

Since the area of financial responsibility is not always assigned to HMC for those individuals receiving services in the SILS/InHome Program, assistance with financial matters is directed by the Support Team on the Financial Authorization Form.

Accounts are reviewed by the Program Director if requested by the Support Team and/or because the account is a dual signature.

SLS:

- A. The use of automatic teller machines is discouraged.

- B. All checks and money received must be directly deposited into the checking account in full without cash deductions unless approved by the Support Team. A complete record of money use will be kept in the form of the account checkbook register..
- C. The Supportive Living Coordinator is responsible for monitoring that all incoming checks come in and seeing that deposits are made in a timely manner.
- D. Checks are written for the amount of the purchase only. The “memo” line of the check is used to indicate what was purchased. Purchased made with the debit card should be for the amount of the purchase only and no cash back should be received.
- E. Personal spending money checks will be written out to the individual served. The individual served determines how their personal spending money is spent with assistance and input as needed from staff. Purchases from petty cash accounts require a receipt unless the individual’s Support Team specifies otherwise.
- F. Individual petty cash pouches are kept separate from all other money and are in the individual’s possession, office, or in a secure location if needed by the individual.
- G. Receipts are to be saved on all purchases made with check or debit card. The receipts are filed with finances and if a check is used the receipts are stapled to duplicate checks before filing.
- H. Receipts are identified by store, purchase, amount, date. Check numbers or DC (for debit card purchases) should be written on the receipts. Bank statements are reconciled month. Petty cash ledgers are balanced as needed and are reviewed at a minimum of annually unless otherwise specified by the Support Team.
- I. All accounts (checking and savings) are audited monthly by the Program Director and Program Manager.
- J. Copies of itemized statements of receipts and disbursements are given to the legal representative and case manager per their request as indicated on the Financial Authorization Form.
- K. The responsibility of overseeing individual finances, checkbook balancing, and helping individuals served purchase wisely is that of the SLC.

Section: Services	Review Date: 1/2014, 12/2016
Topic: Food Safety Procedure	Revision:

All food will be obtained, handled and properly stored to prevent contamination, spoilage or a threat to individuals served. Food and drink will not be stored in areas where bodily fluids, hazardous materials and harmful substances may be present.

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

Food served must meet any special dietary needs of a person as prescribed by the person's physician and/or dietician. Three nutritionally balanced meals a day must be served, or made available to individuals served, and nutritious snacks must be available between meals.

Section: Services	Review Date: 1/2014
Subject: Fraud Policy	Revision: 10/2016

PURPOSE

This policy is established to protect the assets and interests of the Harry Meyering Center (HMC), to increase overall fraud awareness and to ensure a coordinated approach toward resolution of financial fraud. It is the intent of HMC to promote consistent organizational behavior by providing guidelines and assigning responsibility for the development of controls and conduct of investigations.

POLICY

Fraud in any form will not be tolerated by HMC. It is the policy of HMC to identify and promptly investigate any possibility of fraudulent or related dishonest activities against HMC and, when appropriate, to pursue legal remedies available under the law.

HMC will take appropriate disciplinary and legal actions against employees and/or entities to include the possibility of termination of employment, restitution, and forwarding information to the appropriate authorities for criminal prosecution.

DEFINITIONS

Fraud generally involves a willful or deliberate act with the intention of obtaining an unauthorized benefit, such as money or property, by deception or other unethical means. All fraudulent acts and other fiscal irregularities are included under this policy and include but are not limited to such things as:

- Any dishonest or fraudulent act.
- Misappropriation of funds, securities, supplies, or other assets.
 - As a license holder, HMC receives public funding reimbursement for services and is required to comply with enrollment requirements as a licensing standard (MN Statutes [sections 245A.167](#) and [256B](#) (subdivision 21)). Funds from state or federal government include, but are not limited to:
 - Minnesota's Medical Assistance, Medicaid or Medicare
 - Brain Injury Waiver
 - Community Alternative to Care Waiver
 - Community Alternatives for Disabled Individuals Waiver (CADI)
 - Developmental Disability Waiver
 - Elderly Waiver
 - Minnesota's Alternative Care Program
- Impropriety in the handling or reporting of money or financial transactions.
- Profiteering as a result of insider knowledge of company activities.
- Disclosing confidential and proprietary information to outside parties.
- Authorizing or receiving payments for goods not received or services not performed.
- Authorizing or receiving payment for hours not worked.

- Any apparent violation of Federal, State, or local laws related to dishonest activities or fraud.
- Accepting or seeking anything of material value from contractors, vendors, or persons providing services/materials to Harry Meyering Center.
 - Exception: Gifts less than \$50.00 in value.
- Destruction, removal, or inappropriate use of records, furniture, fixtures, and equipment: and/or
- Any similar or related irregularity.

Section: Services	Review Date: 1/2014, 10/2016
Subject: Fraud Procedure	Revision:

This procedure applies to any irregularity, or suspected irregularity, involving employees as well as board members, consultants, vendors, contractors, outside agencies doing business with employees of such agencies, and/or any other parties with a business relationship with the Harry Meyering Center (HMC).

This procedure addresses the responsibility of employees for detecting and reporting fraud or suspected fraud. It is also established to facilitate the development of controls that will aid in the detection and prevention of fraud.

This procedure applies to all employees and any investigative activity required will be conducted without regard to the suspected wrongdoer's past performance, length of service, position/title, or relationship to the company.

Implementation

Fraud is defined as the intentional, false representation, or concealment of a material fact for the purpose of inducing another to act upon it to his or her injury.

HMC believes that it is everyone's responsibility to report any possible fraudulent activity. Each member of the management team will be familiar with the types of improprieties that might occur within his or her area of responsibility, and be alert for any indication of irregularity.

The Finance Director or their designee shall review routine financial reports for accuracy and compliance.

Any irregularity that is detected or suspected must be reported immediately to the Executive Director and Finance Director/Public Funds Compliance Officer (PFCO). The Finance Director/PFCO coordinates all investigations with corporate counsel and other affected areas, both internal and external. If the Finance Director/PFCO is suspected of Fraud, the report shall be made to the Executive Director and the Board of Directors Treasurer. If the Executive Director is suspected of fraud, the report shall be made to the Finance Director/PFCO and the Board of Directors Treasurer

If there are any questions as to whether an action constitutes fraud, contact the Finance Director/PFCO for guidance.

Other Irregularities

Irregularities concerning an employee's moral, ethical, or behavioral conduct should be resolved by departmental management and the Human Resources Department per applicable policies and procedures.

Investigation Responsibilities

The Finance Director/PFCO with assistance from corporate counsel has the primary responsibility for the investigation of all suspected fraudulent acts as defined in the policy. If the investigation substantiates that fraudulent activities have occurred, the Finance Director/PFCO will issue reports to the Executive Director, appropriate designated personnel and, if appropriate, to the Board of Directors through the Finance Committee.

Members of the investigative team will have:

- Free and unrestricted access to all HMC records and premises, whether owned or rented, and
- The authority to examine, copy, and/or remove all or any portion of the contents of files, desks, cabinets, and other storage facilities on the premises without prior knowledge or consent of any individual who might use or have custody of any such items or facilities when it is within the scope of their investigation.

Decisions to prosecute or refer the examination results to the appropriate law enforcement and/or regulatory agencies for independent investigation will be made in conjunction with legal counsel and senior management, as will final decisions on deposition of the case.

The Finance Director/PFCO shall promptly report to MN DHS any identified violations of Medical Assistance laws or regulations.

If a Medical Assistance reimbursement overpayment occurs, HMC has sixty days to report the discovery to MN DHS. A report of the overpayment shall be completed and arrangements made with DHS to recover the overpayment.

Confidentiality and Integrity

HMC and the Finance Director/PFCO treats all information received confidentially. Any employee who suspects dishonest or fraudulent activity will notify the Finance Director/PFCO immediately, and should not attempt to personally conduct investigations or interviews/interrogations related to any suspect fraudulent act.

Great care shall be taken in the investigation of suspected improprieties or irregularities so as to avoid mistaken accusations or alerting suspected individuals that an investigation is under way.

Investigation results will not be disclosed or discussed with anyone other than those who have a legitimate need to know. This is important in order to avoid damaging the reputations of persons suspected but subsequently found innocent of wrongful conduct and to protect HMC from potential civil liability.

No staff/board member who, in good faith, reports a violation of this policy shall suffer harassment, retaliation or adverse employment consequences.

Administration

The Finance Director/PFCO is responsible for the administration, revision, interpretation, and application of this policy. The policy will be reviewed regularly and revised as needed.

Section: Services	Review Date: 1/2014, 10/2015, 8/2016
Topic: Grievance Policy	Revision:

PURPOSE

The purpose of this policy is to promote service recipient right by providing person(s) served and/or legal representative(s) with a simple process to address complaints or grievances.

POLICY

Each person served and/or legal representative will be encouraged and assisted in continuously sharing ideas and expressing concerns in informal discussions with management staff and in support team meetings. Each concern or grievance will be addressed and attempts will be made to reach a fair resolution in a reasonable manner.

Should a person and/or legal representative feel an issue or complaint has not or cannot be resolved through informal discussion, they should file a formal grievance. Staff and person(s) served and/or legal representative(s) will receive training regarding the informal and formal grievance procedure. This policy will be provided, orally and in writing, to all persons served and/or legal representatives. If a person served and/or legal representative feel that their formal complaint has not or cannot be resolved by other staff, they may bring their complaint to the highest level of authority in the program, the Executive Director, Lori Weinberg, who may be reached at the following:

Harry Meyering
Center 109
Homestead Road
Mankato, MN 56001
507-387-8281

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

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

Section: Services	Review Date: 1/2014, 8/2016
Topic: Grievance Procedure	Revision:

- A. All complaints affecting a person's health and safety will be responded to promptly by the Program Manager and/or Program Director
- B. Direct support staff will immediately inform the manager of any grievances and will follow this policy and procedure. If at any time, staff assistance is requested in the complaint process, it will be provided. Additional information on outside agencies that also can provide assistance to the person served and/or legal representative are listed at the end of this procedure.
- C. If for any reason a person served and/or legal representative chooses to use the formal grievance process, they will then notify in writing or discuss the formal grievance with the Program Manager and/or Program Director
- D. When a formal grievance is made, the Program Manager and/or Program Director will initially respond in writing within 14 calendar days of receipt of the complaint.
- E. If the person served and/or legal representative is not satisfied with the Program Manager and/or Program Director's response, they will then notify in writing or discuss the formal grievance with the Executive Director, who will then respond within 14 calendar days.
- F. All complaints must and will be resolved within 30 calendar days of receipt of the complaint. If this is not possible, the Executive Director, will document the reason for the delay and the plan for resolution.
- G. If the person served and/or legal representative believe their rights have been violated, they retain the option of contacting the county's Adult or Child Protection Services or the Department of Human Services. In addition, persons may contact advocacy agencies (listed at the end of this policy) and state they would like to file a formal grievance regarding their services, provider company, etc.
- H. As part of the complaint review and resolution process, a complaint review will be completed by the Program Director or the Director of Program Services and documented by using the Internal Review form regarding the complaint. The complaint review will include an evaluation of whether:
 - o Related policies and procedures were followed.
 - o The policies and procedures were adequate.
 - o There is a need for additional staff training.
 - o The complaint is similar to past complaints with the persons, staff, or services involved.
 - o There is a need for corrective action by the company to protect the health and safety of persons served.
- I. Based upon the results of the complaint review, HMC will develop, document, and implement a corrective action plan designed to correct current lapses and prevent future lapses in performance by staff or the company, if any.

- J. A written summary of the complaint and a notice of the complaint resolution to the person served and/or legal representative and case manager will be provided by using the Complaint Summary and Resolution Notice form. This summary will:
- Identify the nature of the complaint and the date it was received.
 - Include the results of the complaint review.
 - Identify the complaint resolution, including any corrective action.
- K. The Complaint Summary and Resolution Notice will be maintained in the individual's permanent file.

Organizations that may be contacted Regarding to Resolve Grievances:

Outside Agency Name	Telephone Number	Address and Email Address
Blue Earth County Human Services	(507)304-4319	410 South Fifth Street Mankato, MN 56001 www.blueearthcountymn.gov hsdirector@blueearthcountymn.gov
Southern Minnesota Regional Legal Services	(507)387-5588	12 Civic Center Plaza Mankato, MN 56001 www.smrls.org mankato@smrls.org
Minnesota Office of the Ombudsman for MH/DD	(651)431-2555 (800)657-3506	121 7 Place East Metro Square Building, Suite 420 St. Paul, MN 55101 www.ombudmhdd.state.mn.us ombudsman.mhdd@state.mn.us
Minnesota Department of Human Services - Licensing	(651)431-6500	444 Lafayette Road St. Paul, MN 55115 www.mn.gov/dhs/general- public/licensing/ dhs.info@state.mn.us
MDH Department of Health Facilities Complaints	(651)201-4201 (800)369-7994	85 East 7 th Place St. Paul, MN 55101 www.health.state.mn.us health.ohfc- complaints@state.mn.us
Disability Law Center/Legal Aid Society	(612)332-1441	430 1 st Avenue North Minneapolis, MN 55401 www.mndlc.org website@mylegalaid.org

ARC Minnesota	(651)523-0823 (800)582-5256	770 Transfer Road Suite 26 St. Paul, MN 55114 www.thearcofminnesota.org mail@arcmn.org
ARC Greater Twin Cities	(952)920-0855	2446 University Avenue West Suite 110 St. Paul, MN 55114 www.arcgreatertwincities.org info@arcgreatertwincities.org
ARC Northland	(218)726-4725	424 West Superior Street Suite 201 Duluth, MN 55802 www.arcnorthland.org cbourday@arcnorthland.org

Section: Operations	Review Date: 1/2014
Topic: Hazards and Toxic Substances Procedure	Revision:

The Harry Meyering Center (HMC) must ensure that service sites owned or leased by the license holder are free from hazards that would threaten the health or safety of individuals served by ensuring the following requirements are met:

- Chemicals, detergents and other hazardous or toxic substances are not stored with food products in any way that poses a hazard to individuals served.
- HMC must install handrails and nonslip surfaces on interior and exterior runways, stairways and ramps according to the applicable building code.
- If there are elevators in the facility, the license holder must have elevators inspected each year. The date of the inspection, any repairs needed and the date the necessary repairs were made must be documented.
- HMC must keep stairways, ramps and corridors free of obstructions.
- Outside property must be free from debris and safety hazards. Exterior stairs and walkways must be kept free of ice and snow.
- Heating, ventilation, air conditioning units and other hot surfaces and moving parts of machinery must be shielded or enclosed.
- Use of dangerous items or equipment by individuals served by the program must be allowed in accordance with the Individual Abuse Prevention Plan or Coordinated Service and Support Plan (if not addressed in the Coordinated Service and Support Plan Addendum).

Section: Operations	Review Date: 1/2014
Topic: Health and Safety Policy	Revision:

Policy Statement

The Harry Meyering Center (HMC) values the best health possible for the individuals served and employees. HMC is committed to providing a safe and healthful workplace through routine care and sanitation of the program sites. Employees will follow training on [universal precautions](#) to minimize the transmission of illness and communicable disease within the workplace.

Scope

A safe and healthy workplace is maintained through knowledge, mutual responsibility and compliance. All employees will be trained and educated on the following components of infection control to maintain a safe and healthy workplace:

- [Universal precautions](#)
- Hand washing
- Sanitation
- Disposal of contaminated items
- [Personal protective equipment \(PPE\)](#)

Section: Services	Review Date: 10/2015, 9/2016
Topic: Health Service Coordination Policy	Revision:

PURPOSE

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

POLICY

The Harry Meyering Center (HMC) is designated as a residential program and will implement procedures to ensure the continuity of care regarding health-related service needs as assigned in the Coordinated Service and Support Plan (CSSP) and/or CSSP Addendum. These procedures will be implemented in a way that is consistent with the specific health needs of the individual served and which follows the procedures stated in the Medication Assistance and Administration Policy. Decision making regarding the health services needs of the individual served will be guided by person-centered philosophy and medical practice.

Section: Services	Review Date: 10/2015, 9/2016
Topic: Health Service Coordination Procedure	Revision:

- A. If responsibility for meeting the individual's health service needs has been assigned to the Harry Meyering Center (HMC) in the Coordinated Service and Support Plan (CSSP) and/or CSSP Addendum, HMC must maintain documentation on how the individual's health needs will be met, including a description of the procedures HMC will follow in order to:
 - Provide medication set up assistance or medication administration according to MN Statutes, [chapter 245D](#).
 - Monitor health conditions according to written instructions from a licensed health care professional.
 - Assist with or coordinate medical, dental, and other health service appointments.
 - Use medical equipment, devices, or adaptive aides or technology safely and correctly according to written instructions from a licensed health care professional.
- B. Unless directed otherwise in the CSSP or the CSSP Addendum, HMC will ensure the prompt notification to the legal representative, if any, and the case manager of any changes to the individual's mental and physical health needs that may affect the health service needs assigned to HMC in the Coordinated Service and Support Plan and/or CSSP Addendum. This notice will be made, and the date documented, when the change in mental and physical health needs of the individual has been discovered by HMC, unless HMC has reason to know that the change has already been reported.
- C. When an individual served requires the use of medical equipment, devices, or adaptive aides or technology, HMC will ensure the safe and correct use of the item and that staff is trained accordingly on its use and assistance to the individual. These items will only be used according to the written instructions from a licensed health care professional.
- D. When an individual served requires the use of medical equipment to sustain life or to monitor a medical condition that could become life-threatening without proper use of medical equipment, staff will be specifically trained by a licensed health care professional or a manufacturer's representative including an observed skill assessment to demonstrate staff's ability to safely and correctly operate the equipment according to the treatment orders and manufacturer's instructions. Equipment includes, but is not limited to ventilators, feeding tubes, and endotracheal tubes

Section: Operations	Review Date: 1/2014
Topic: Hepatitis B Policy	Revision:

Hepatitis B is an inflammation of the liver caused by the Hepatitis B virus (HBV). Infectious Hepatitis B may be present as a silent infection in people, known as Hepatitis B carriers. It can be transmitted in the following ways:

- [Direct contact](#) with infected blood, blood products, saliva and semen
- [Indirect contact](#) through breaks in the skin or contact with contaminated environmental surfaces
 - Tables
 - Counters
 - Razors
 - Toothbrushes
- Absorption through mucous membranes
 - Eyes
 - Mouth

Training is provided to employees regarding the safety, benefits, efficacy, availability and methods of administration of Hepatitis B vaccinations. The Hepatitis B vaccination series is available at no cost to employees identified in the exposure determination section of the Health and Safety plan. It is available following training and within ten days of initial contact with individuals served.

Vaccination is encouraged unless:

- Documentation exists that the employee has previously received the series
- Antibody testing reveals the employee is immune
- Medical evaluation shows the vaccination is contraindicated

If an employee chooses to decline vaccination, a declination form must be signed and will be kept in the Human Resources office. Employees who decline may request and obtain the vaccination at a later date at no cost.

Section: Operations	Review Date: 1/2014
Topic: Human Immunodeficiency Virus Policy	Revision:

The Human Immunodeficiency Virus (HIV) causes acquired immune deficiency syndrome (AIDS). HIV infects certain cells in the immune system and destroys them. There is no vaccine for HIV, and once infected, it is for life. HIV is spread through the following ways:

- Close sexual contact in which blood, semen, or vaginal secretions are exchanged
- Shared use of needles
- During pregnancy or birth process to infant

HIV is not spread by casual contact including:

- Kissing
- Hugging
- Sharing food
- Touching

Section: Operations	Review Date: 1/2014
Topic: Human Immunodeficiency Virus Procedure	Revision:

Consent for Acquired Immune Deficiency Syndrome (AIDS) Testing:

AIDS testing will only be done with the consent of the legal representative. If the individual served is his/her own legal representative, the nearest relative and/or case manager will be informed and enlisted to act as the individual's advocate. Prior to consent being requested or given, the employee or involved individual served must be considered high risk for becoming infected with AIDS. High risk is determined by the existence of a preponderance of evidence of at least one of the following behaviors or conditions:

- Sharing or history of sharing intravenous (IV) drug needles
- Use or history of sharing IV drugs
- Use or history of use of IV blood products for the treatment of hemophilia
- Multiple sexual contacts with known persons with AIDS or high risk individuals
- Sexual contact with sexual partners of persons in the above group
- People who received infected blood or blood factors prior to HIV screening of blood donors (April 1985)
- Victims of sexual abuse, rape and perpetrator engaged in high risk activities

The program staff will obtain a written request to test based on the blood-borne pathogen exposure incident, medical symptoms or indications of high risk behavior. The legal representative, relative and/or case manager can request a second opinion. If the individual served can demonstrate understanding of the reasons for testing following an explanation in language he/she understands, written consent or denial will also be obtained. In cases where the individual is under guardianship with controversy surrounding, an appeal will be made to the State guardianship office and recommendations will be issued. All AIDS testing will be kept strictly confidential.

Section: Services	Review Date: 1/2014, 8/2016
Topic: Bed Rest Procedure – ICF	Revision:

Orders prescribing bed rest for residents are self-terminating in three (3) days unless renewed by a physician. The order and resulting renewal orders, if needed, will be filed in the person's medical record.

Section: Services	Review Date: 1/2014, 9/2016
Topic: Diet Plan Changes Procedures – ICF	Revision:

Recommendations for dietary changes can be initiated by any member of the individual's support team. All dietary changes must be approved by the individual's physician with recommendations of a qualified dietitian before implementation can take place.

All changes will be documented and brought to the attention of appropriate staff (nurses, Program Manager, dietary department, and direct support staff) and documentation will be maintained in the individual's medical file and in the dietary department. This documentation will include a written justification and rationale for the diet change.

Section: Services	Review Date: 1/2014
Topic: Medical and Dental Examination Procedures – ICF	Revision: 8/2016

MEDICAL EXAMINATIONS

Annually, each individual will receive a medical examination by a physician, to include an evaluation of hearing and vision capabilities. Should a medical problem requiring intervention by a medical specialist be identified an appropriate referral will be made. If a person served's vision and/or hearing only is assessed through examinations by a specialist, these tests need not be conducted yearly, but rather at the recommendation of the specialist.

DENTAL PROCEDURES

Dental exams for each individual served will occur at least annually. Dental exams are conducted by a licensed dentist and coordinated by the nurse to ensure that appropriate prophylactic and remedial care is delivered on a timely basis. If a person served is edentulous they will have an oral exam completed by a primary care provider no less than on an annual basis.

Upon admission to HMC, a person served will receive a complete extraoral and intraoral examination, using all diagnostic aids necessary to properly evaluate the person's condition not later than one month after admission to the facility (unless the examination was completed within twelve months before admission).

The nurse and/or designated employee will accompany an individual served to medical and dental exams, unless they are able to attend the appointment independently. Whenever possible, the individual served will be encouraged and allowed to participate in the exam/appointment process. In all situations, the nurse is responsible to ensure that necessary documentation of the exam and appointment is processed appropriately and that all medical orders are carried out.

At Homestead and Prairie's Edge, assessment of the health status of the individuals served by a licensed nurse is an on-going process. The goal of nursing is to identify any real or potential health problems and implement the appropriate nursing action to help ensure or restore wellness. Each individual served will be observed for any clues (including visual, tactile, non-verbal gestures, grimaces, etc.) to detect if there is a potential need to follow-up and monitoring. The intent of the quarterly physical assessment is to identify health problems or potential health problems as soon as possible. Some physical findings by the nurse during the physical assessment will not necessarily result in the referral to a physician. The findings from these assessments, along with date of assessment, will be documented in the individual's file.

This practice is acceptable if the nurse is acting within the scope of the [Minnesota Nurse Practice Act](#).

Section: Services	Review Date: 1/2014,
Topic: Nursing Care Service Procedures – ICF	Revision: 9/2016

A quarterly review of the individual's medication administration will be completed by the pharmacist and referred to the physician by the Harry Meyering Center (HMC) nursing staff if the pharmacist makes recommendation for change.

Tardive Dyskinesia monitoring is completed by a staff trained under the DHS guidelines.

Nursing staff participates in reporting of communicable diseases per CDC guidelines. Nursing staff provides ongoing infection control monitoring as appropriate.

Employees are to report to nurses any observable signs or symptoms of illness. It is the responsibility of the nurse to assess the individual further and implement any corrective medical intervention deemed necessary. In the absence of the nurse, the Building Charge will initiate the appropriate medical response with input from on-call as deemed necessary and will notify the nurse as soon as possible.

Maintenance of documentation for the on-going health status and any medical intervention for an individual served is primarily the responsibility of the nurse. Such documentation will be kept in the individual's medical file.

Nurses will ensure that all federal and state guidelines governing health care in the ICF are followed.

Section: Services	Review Date: 10/2015, 10/2016
Topic: Incidents and Emergencies Policy	Revision: 6/2017

PURPOSE:

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

POLICY:

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

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

Definitions:

Incident: an occurrence which involves an individual served that requires the program to make a response that is not part of the ordinary provision of services provided to that individual and includes:

- Serious injury of a person as determined by MN Statutes, section [245.91](#), (subdivision 6):
 - Fractures
 - Dislocations
 - Evidence of internal injuries
 - Head injuries with loss of consciousness or potential for a closed head injury or concussion without loss of consciousness requiring a medical assessment by a health care professional, whether or not further medical attention was sought.
 - Lacerations involving injuries to tendons or organs and those for which complications are present
 - Extensive second degree or third degree burns and other burns for which complications are present
 - Irreversible mobility or avulsion of teeth
 - Injuries to the eyeball
 - Ingestion of foreign substances and objects that are harmful
 - Near drowning

- Heat exhaustion or sunstroke
- Attempted suicide
- All other injuries considered serious after an assessment by a health care professional including, but not limited to self-injurious behavior, a medication error requiring medical treatment, a suspected delay of medical treatment, a complication of a previous injury, or a complication of a medical treatment for an injury
- A person's death
- Any medical emergency, unexpected serious illness, or significant unexpected change in an illness or medical condition of a person that requires the program to call 911, physician treatment, or hospitalization
- Any mental health crisis that requires the program to call 911 or a mental health crisis intervention team
- An act or situation involving a person that requires the program to call 911, law enforcement, or the fire department
- A person's unauthorized or unexplained absence from a program
- Conduct by an individual served against another individual served that:
 - Is so severe, pervasive or objectively offensive that it substantially interferes with a person's opportunities to participate in or receive service or support
 - Places the person in actual and reasonable fear of harm
 - Places the person in actual and reasonable fear of damage to property of the person
 - Substantially disrupts the orderly operation of the program
- Any sexual activity between individuals served involving force or coercion as defined under MN Statutes, section [609.341](#), (subdivisions 3 and 14).
- Any emergency use of manual restraint
- A report of alleged or suspected maltreatment of a minor or vulnerable adult under MN Statutes, sections [626.556](#) or [626.557](#).

Emergency: an event that affects the ordinary daily operation of the program including, but not limited to:

- Fires
- Severe weather
- Natural disasters
- Power failures
- Emergency evacuation or moving to an emergency shelter
- Temporary closure or relocation of the program to another facility or service site for more than 24 hours
- Other events that threaten the immediate health and safety of an individual served and that requires calling "911."

Section: Services	Review Date: 10/2015, 11/2016
Topic: Incident and Emergency Procedure	Revision:

Incident and Emergency Reports are to be completed in the following circumstances:

- *Death or serious injury as determined by section [245.91](#), subdivision 6
- *Medical emergency, unexpected serious illness or significant unexpected changes in an illness or medical condition of an individual that requires the program to call 911, physician treatment or hospitalization.
- *Mental health crisis that requires the program to call 911 or a mental health crisis intervention team
- *An act or situation involving an individual that requires the program to call 911, law enforcement, or the fire department (related to the health, safety or supervision of a individual served)
- *An individual's unauthorized or unexplained absence from a program
- *Emergency evacuation, moving to an emergency shelter, and temporary closure or relocation of the program to another facility or service site for more than 24 hours,
- *Conduct by a person receiving services against another person receiving services (see [245D.02 subdivision 11](#) for severity)
- *Any sexual activity between individuals served involving force and coercion.
- *Emergency use of manual restraint (EUMR) (requires a verbal report within 24 hours)
 - If EUMR is used, an EUMR Report would need to be filed instead of an Incident and Emergency Report.
- *Unexplained injuries.
- *Alleged or suspected child or vulnerable adult maltreatment
- Un-witnessed injuries.
- Injury to client, staff or visitor.
- Incident without apparent injury (which is not covered by other programming).
- Damage to vehicles, property/possessions of individuals served, employees or HMC.
- Other
- Emergency (fire, severe weather, natural disasters, power failures, other events that threaten health and safety of a person receiving services and that require calling 911, and emergency evacuation or moving to an emergency shelter)

The employee handling the incident is to complete the Incident and Emergency Report and/or required documentation and forward the report(s) to the following person(s) as soon as possible, but no later than the end of the shift:

- Homestead = Building Charge
- Prairie's Edge = On-Call
- SLS = Program Director, Program Manager, or On-Call
- SILS/ In-Home = Program Director, Program Manager or On-Call as available

COMPLETION AND ROUTING OF INCIDENT AND EMERGENCY REPORTS

A. FOR HOMESTEAD

- Incident and Emergency Reports are to be completed and given to the Building Charge. The Building Charge will ensure that the Incident and Emergency Report is filled out completely.
- Building Charge will contact On-Call to notify them of any incident report and Building Charge will follow instructions given by On-Call. If any instructions are given, the Building Charge will ensure that the information is passed along to needed individuals.
- On-Call is responsible for immediately initiating the internal investigation as well as making required internal and external notifications.
- The Incident and Emergency Report is then processed by On-Call.
- The Program Director or designate will investigate and/or review the documentation and coordinate any follow-through necessary. The investigation and documentation must be completed within 5 working days. If the investigation and documentation cannot be completed in 5 working days, an explanation must be provided.
- The original Incident and Emergency Report is filed in the Incident and Emergency Report Book by the Program Director after completion of the review. Notation of the Incident and Emergency Report will be documented in the individual's CSSP Addendum.

B. FOR PRAIRIE'S EDGE

- Incident and Emergency Reports are to be completed and notification made to On-Call. On-Call will ensure that the Incident and Emergency Report is filled out completely.
- Prairie's Edge staff will follow instructions given by On-Call. If any instructions are given, Prairie's Edge staff will pass along to needed individuals.
- On-Call is responsible for immediately initiating the internal investigation as well as making required internal and external notifications.
- The Incident and Emergency Report is then processed by On-Call.
- The Program Director or designate will investigate and/or review the documentation and coordinate any follow-through necessary. The investigation and documentation must be completed within 5 working days. If the investigation and documentation cannot be completed in 5 working days, an explanation must be provided.
- The original Incident and Emergency Report is filed in the Incident and Emergency Report Book by the House Coordinator after completion of the review. Notation of the Incident and Emergency Report will be documented in the individual's CSSP Addendum.

C. FOR SLS AND SILS/ IN-HOME

- Completed reports are to be turned into the Program Director, Program Manager, or On-Call within 24 hours of the incident.
- Program Director, Program Manager, or On-Call will ensure that required notification happens within 24 hours. CLC for SILS InHome or SLC for SLS may also complete 24 hour notification to legal representative or designated emergency contact, case manager and licensed provider.
- The Program Director or Program Manager will investigate and/or review the incident and documentation and coordinate necessary follow-through. The investigation and documentation must be completed within 5 working days. If investigation and

documentation cannot be completed in 5 working days, an explanation must be provided.

- The Program Director or Designate will follow up with the necessary person(s) to determine any action(s) that may need to be taken in the future to reduce the likelihood of future incidents.
- The Program Director or Designate will ensure that employees are informed of any action that needs to be taken.
- The original Incident and Emergency Report is placed in the file of the individual served. Notation of the Incident and Emergency Report will be documented in the individual's CSSP Addendum.

D. NOTIFICATION

- All Incident and Emergency Reports are to be treated in a confidential manner. Only persons who need to be made aware of the incident will be notified.
- Incidents indicated above with a (*) are to be reported to the Executive Director, Director of Program Services, Program Director, Program Manager, legal representative or designated emergency contact, case manager and, if necessary, other licensed providers within 24 hours of an incident occurring while services are being provided, within 24 hours of discovery or receipt of information that an incident occurred, unless staff have reason to know that the incident has already been reported, or as otherwise directed in a person's Coordinated Service and Support Plan (CSSP) or Addendum. The fact that this notification occurred will be documented. When the incident involves more than one individual, personally identifying information about any other individual must not be disclosed, when making the report to each individual's legal representative or designated emergency contact, other licensed caregiver, if any, and case manager, unless consent has been given by the individual or the individual's legal representative.
- Other incidents, not indicated above with a (*) will be reported to the Executive Director and other internal and external parties at the discretion of the Program Director and/or Director of Program Services. At the discretion of the Executive Director, the Board President and other board members will be notified.

REVIEWING INCIDENTS AND EMERGENCIES:

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

- B. Each Incident and Emergency Report will contain the following information:
- The name of the individual(s) involved in the incident. It is not necessary for staff to identify all persons affected by or involved in an emergency unless the emergency resulted in an incident.
 - The date, time, and location of the incident or emergency.
 - A description of the incident or emergency.
 - A description of the response to the incident or emergency and whether a person's Coordinated Service and Support Plan Addendum or program policies and procedures were implemented as applicable.
 - The name of the staff person or persons who responded to the incident or emergency.
 - The determination of whether corrective action is necessary based on the results of the review that will be completed by the Program Director and/or Program Manager.
- C. In addition to the review for the identification of patterns and implementation of corrective action, the Harry Meyering Center (HMC) will consider complaints or grievances, as defined in MN Statutes, section [245D.10](#), subdivision 2, reportable as an incident which will require the completion of an Internal Review.
- D. In addition to the Incident and Emergency Report, if there was a death or serious injury, the Program Director or their designate will also ensure that the applicable documents have also been completed for the MN Office of the Ombudsman for Mental Health and Developmental Disabilities, the Department of Human Services Licensing Division, and/or the MN Department of Health, Office of Health Facilities Complaints, as appropriate.
- E. For internal reports of suspected or alleged maltreatment of a vulnerable adult, a copy of the Notification to an Internal Reporter will also be submitted for the Internal Review.
- F. The internal review and reporting of emergency use of manual restraints will be completed according to the Policy and Procedure on Emergency Use of Manual Restraint.
- G. Documentation to be submitted to the designated person responsible for completing internal reviews will include, as applicable:
- Incident and Emergency Report
 - Notification to an Internal Reporter
 - Emergency Use of Manual Restraint Report
 - Death Reporting Form
 - Serious Injury Form
 - Death or Serious Injury Report FAX Transmission Cover Sheet
 - Complaint Summary and Resolution Notice
- H. The internal review will be completed using the Internal Review Form and will include an evaluation of whether:
- Related policies and procedures were followed
 - The policies and procedures were adequate
 - There is a need for additional staff training
 - The reported event is similar to past events with the persons or the services involved
 - There is a need for corrective action by the license holder to protect the health and safety of persons served
- I. Based upon the results of the review, the license holder will develop, document, and implement a corrective action plan designed to correct current lapses and prevent future lapses in performance by staff or the license holder, if any.

- J. The following information will be maintained in the individual's permanent file:
- Incident and Emergency Report
 - Behavior Intervention Reporting Form and applicable reporting and reviewing documentation requirements
 - Death Reporting Form
 - Serious Injury Form
 - Death or Serious Injury Report FAX Transmission Cover Sheet
 - Complaint Summary and Resolution Notice
- K. Completed Internal Reviews and documentation regarding suspected or alleged maltreatment will be maintained separately by the internal reviewer in a designated file that is kept locked in the Program Director's office and only accessible to authorized individuals. Internal reviews must be made accessible to the commissioner immediately upon the commissioner's request for internal reviews regarding maltreatment.

Section: Services	Review Date: 1/2014, 12/2016
Topic: Personal Care Items Procedure	Revision:

HOMESTEAD, PRAIRIE'S EDGE, SLS:

Each individual served will have the following personal care items available to them for their own use if needed and/or desired:

- Hair comb/brush and hair accessories
- Toothbrush, toothpaste, and floss
- Cosmetics
- Deodorants
- Razors/shavers
- Bath soap/body wash
- Shampoo/conditioner

The items will be stored in a safe and sanitary manner to prevent contamination.

Some goods will be provided by the Harry Meyering Center (HMC). These items will include individual clean bed linens appropriate for the season and the person's comfort, towels and washcloths. Usual or customary goods for the operation of a residence which are communally used by all individuals served living in the residence must be provided by HMC. This includes household items for meal preparation, cleaning supplies to maintain the cleanliness of the residence, window coverings on windows for privacy, toilet paper and hand soap.

If purchased by the program, furnishings become the property of the program. An individual served may choose to purchase the above furnishings, in which case, these items are owned by the individual. Employees should be responsible for noting which items are owned by the individual served.

HMC must also provide a separate bed of proper size and height for the convenience of each individual served, with a clean mattress in good repair. An individual cabinet or dresser, shelves, closet for storage of personal possessions and clothing and a mirror for grooming must also be provided.

When possible, an individual served must be allowed to have items of furniture that they personally own in the bedroom, unless doing so would interfere with safety precautions, violate a building or fire code, or interfere with another individual's use of the bedroom. An individual served may choose not to have a cabinet, dresser, shelves, or a mirror in the bedroom as otherwise required. An individual served may choose a mattress other than an innerspring mattress and choose not to have the mattress on a frame or support. If a person chooses to use a mattress other than an innerspring mattress, or chooses not to have a mattress frame or support, HMC must document this choice and allow the alternative desired by the individual served.

Individuals served must be allowed to bring personal possessions into the bedroom and other designated storage space, if such space is available, in the residence. The individual served must be allowed to accumulate possessions to the extent the residence is able to accommodate them, unless

doing so is contraindicated for the person's physical or mental health, would interfere with safety precautions or the use of the bedroom by another individual served or violates a building or fire code. HMC must allow for locked storage of personal items, including requiring a person to use a lock provided by HMC. This must comply with section [245D.24](#) (subdivision 3) and allow the person to be present if and when HMC opens the lock.

Section: Services	Review Date: 1/2014, 9/2016
Topic: Levels of Supervision Procedure	Revision:

The Harry Meyering Center will provide the level of direct service support staff supervision, assistance, and training necessary to

- Ensure the health and safety and protection of rights of each person:
- Be able to implement the responsibilities assigned in the individual's Coordinated Service and Support Plan/Addendum

ICF LEVELS OF SUPERVISION

- The Harry Meyering Center (HMC) will make all reasonable efforts to ensure that employees are present in sufficient number to respond to the developmental, behavioral and health needs of the individuals served. HMC is also committed to the importance of staff trained to effectively implement active treatment for each individual served. Regulations state that the ICF must be adequately staffed 24 hours each day.
- HMC shall meet, or exceed minimum staff ratios specified in the [CMS State Operations Manual W187](#). Staff shall be of sufficient numbers, as necessary, to implement active treatment as indicated by active treatment needs of person served.
- Volunteers serve a valuable role in the provision of supplementary services, but volunteers will not be relied upon to fill required staff positions.

HOMESTEAD - ICF STAFFING RATIO

- During the time period that is deemed day/night shift, the building will meet the ratio of 1:3.200, as defined by the Centers for Medicare and Medicaid Services. Program staff is defined as all DSPs, Program Manager, nurses (LPN, RN, Health Services Manager), Program Director, Day/Night Services Supervisor, On-Call, Medical Support Staff (CMA, TMA, MSA), Apartment Coordinators, Apartment Leads.
- During the time period that is deemed evening shift or as early as 9 p.m., the number of program staff may reduce at the discretion of the Building Charge. The agency must have staff on in adequate numbers to meet the needs of the individuals who live at Homestead. The Building Charge is expected to use good judgment when making decisions related to reducing the number of staff available.
- During the night shift (11:00pm to 7:00am), the number of staff awake and available will be at least four (4) program staff.

PRAIRIE'S EDGE – ICF STAFFING RATIO

- When the individuals who live at the Prairie's Edge site are awake the building will have at least 2 program staff. This is a direct staff ratio of 1:3.200.
- During the night shift (11:00pm to 7:00am), the number of staff awake and available will be 1 program staff.

Section: Services	Review Date: 1/2014, 11/2016
Topic: Locked Area Policy	Revision:

Under no circumstance is an individual served to be locked in any area under confinement. It is permissible for an individual served to lock the door of their apartment or house.

FOR HOMESTEAD, PRAIRIE'S EDGE, AND SLS:

Those areas that provide a probable degree of danger, or those that would normally be locked in a family environment, may be locked.

Examples may include:

- Dangerous: sharps or weapons
 - Weapons and ammunition must be stored separately in locked areas inaccessible to individuals served.
- Toxic: chemicals or medications
- Financial: justification, access, and approval will be documented on rights restriction
- Other: items justified by Coordinated Service and Support Plan and Addendum

Areas that need to be locked due to programmatic reasons will be cleared with the Human Rights Committee. HMC staff must justify and document how the determination to lock items away was made in consultation with the individual served or the individual's support team. This is not to be a substitute for staff supervision or interactions. There must be a procedure in place that outlines how access, to the locked areas, will be provided to the individual. Any decision to lock any door will rest with the Program Director.

Section: Services	Review Date: 9/2015, 8/2016, 10/2017, 10/2018
Topic: Maltreatment of Minors Policy	Revision:

PURPOSE


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

POLICY

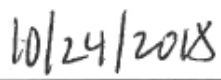
Staff who are mandated reporters must report externally all of the information they know regarding an incident of known or suspected maltreatment of a child, in order to meet their reporting requirements under law. All staff of the Harry Meyering Center (HMC) who encounter maltreatment of a minor will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

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

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



 President, Board of Directors



 Date

Section: Services	Review Date: 9/2015, 8/2016, 10/2017, 10/2018
Topic: Maltreatment of Minors Procedure	Revision:

- A. Staff of the Harry Meyering Center (HMC) who encounter maltreatment of a child, age 17 or younger, will take immediate action to ensure the safety of the child or children. If a staff knows or suspects that a child is in immediate danger, they will call “911.”
- B. An individual mandated to report physical or sexual child abuse or neglect within a licensed facility will report the information to the agency responsible for licensing the facility. If the mandated reporter is unsure of what agency to contact, they will contact the county agency and follow their direction. The applicable agencies include:
 - The Department of Human Services (DHS) is the agency responsible for assessing or investigating allegations of maltreatment in facilities licensed under chapters [245A](#) and [245D](#), except for child foster care and family child care.
 - DHS Licensing Division’s Maltreatment Intake telephone number is 651-431-6600.
 - The Minnesota Department of Health is the agency responsible for assessing or investigating allegations of child maltreatment in facilities licensed under sections [144.50](#) to [144.58](#) and [144A.46](#).
 - The local county welfare agency is the agency responsible for assessing or investigating allegations of maltreatment in child foster care, family child care, legally unlicensed child care, juvenile correctional facilities licensed under section [241.021](#) located in the local welfare agency's county, and reports involving children served by an unlicensed personal care provider organization under section [256B.0659](#).
- C. Reports regarding incidents of suspected abuse or neglect of children occurring within a family or in the community should be made to the local county social services agency or local law enforcement referencing the phone numbers contained within this policy.
- D. When verbally reporting the alleged maltreatment to the external agency, the mandated reporter will include as much information as known to identify the child involved, any persons responsible for the abuse or neglect (if known), and the nature and extent of the maltreatment.
- E. If the report of suspected abuse or neglect occurred within HMC, the report should also include any actions taken by HMC in response to the incident. If a staff attempts to report the suspected maltreatment internally, the person receiving the report will remind the staff of the requirement to report externally.
- F. A verbal report of suspected abuse or neglect that is made to one of the listed agencies by a mandated reporter must be followed by a written report to the same agency within 72 hours, exclusive of weekends and holidays, unless the appropriate agency has informed the mandated reporter that the oral information does not constitute a report.
- G. When HMC has knowledge that an external report of alleged or suspected maltreatment has been made, an internal review will be completed. The Program Director is the primary individual responsible for ensuring that internal reviews are completed for reports of maltreatment. If there are reasons to believe that the Program Director is involved in the alleged or suspected maltreatment, the Executive Director is the secondary individual responsible for ensuring that internal reviews are completed.
- H. The Internal Review Form will be completed within 30 calendar days. The person completing it

will:

- Ensure an Incident and Emergency Report has been completed.
 - Contact the lead investigative agency if additional information has been gathered.
 - Coordinate any investigative efforts with the lead investigative agency by serving as the company contact, ensuring that staff cooperates and that all records are available.
- I. The Internal Review will include the following evaluations of whether:
- Related policies and procedures were followed
 - The policies and procedures were adequate
 - There is a need for additional staff training
 - The reported event is similar to past events with the children or the services involved
 - There is a need for corrective action by the license holder to protect the health and safety of the children in care
- J. Based upon the results of the internal review, HMC will develop, document, and implement a corrective action plan designed to correct current lapses and prevent future lapses in performance by individuals or the company, if any.
- K. Internal reviews must be made accessible to the commissioner immediately upon the commissioner's request for internal reviews regarding maltreatment.
- L. Staff will receive training on this policy, MN Statutes, section [245A.66](#) and section [626.556](#), and their responsibilities related to protecting children in care from maltreatment and reporting maltreatment. This training must be provided within 72 hours of first providing direct contact services and annually thereafter.

EXTERNAL AGENCIES

COUNTY	DAY	EVENING/WEEKEND
AITKIN	(218) 927-7200 or (800) 328-3744	(218) 927-7400
ANOKA	(763) 422-7215	(651) 291-4680
BECKER	(218) 847-5628	(218) 847-2661
BELTRAMI	(218) 333-4223	(218) 751-9111
BENTON	(320) 968-5087	(320) 968-7201
BIG STONE	(320) 839-2555	(320) 815-0215
BLUE EARTH	(507) 304-4111	(507) 625-9034
BROWN	(507) 354-8246	(507) 233-6720
CARLTON	(218) 879-4583	(218) 384-3236
CARVER	(952) 361-1600	(952) 442-7601
CASS	(218) 547-1340	(218) 547-1424
CHIPPEWA	(320) 269-6401	(320) 269-2121
CHISAGO	(651) 213-5600	(651) 257-4100

CLAY	(218) 299-5200	(218) 299-5151
CLEARWATER	(218) 694-6164	(218) 694-6226
COOK	(218) 387-3620	(218) 387-3030
COTTONWOOD	(507) 831-1891	(507) 831-1375
CROW WING	(218) 824-1140	(218) 829-4740
DAKOTA	(952) 891-7459	(952) 891-7171
DODGE	(507) 635-6170	(507) 635-6200
DOUGLAS	(320) 762-2302	(320) 762-8151
COUNTY	DAY	EVENING/WEEKEND
FARIBAULT	(507) 526-3265	(507) 526-5148
FILLMORE	(507) 765-2175	(507) 765-3874
FREEBORN	(507) 377-5400	(507) 377-5205
GOODHUE	(651) 385-3232	(651) 385-3155
GRANT	(218) 685-4417	(800) 797-6190
HENNEPIN	(612) 348-3552	(612) 348-8526
HOUSTON	(507) 725-5811	(507) 725-3379
HUBBARD	(218) 732-1451	(218) 732-3331
ISANTI	(763) 689-1711	(763) 689-2141
ITASCA	(218) 327-2941	(218) 326-8565
JACKSON	(507) 847-4000	(507) 847-4420
KANABEC	(320) 679-6350	(320) 679-8400
KANDIYOHI	(320) 231-7800	(320) 235-1260
KITTSOON	(218) 843-2689	(218) 843-3535
KOOCHICHING	(218) 283-7000	(218) 283-4416
LAC QUI PARLE	(320) 598-7594	(320) 598-3720
LAKE	(218) 834-8400	(218) 834-8385
LAKE OF THE WOODS	(218) 634-2642	(218) 634-1143
LE SUEUR	(507) 357-8288	(507) 357-8545
LINCOLN	(800) 810-8816	(507) 694-1664
LYON	(800) 657-3760	(507) 537-7666
MAHNOMEN	(218) 935-2568	(218) 935-2255
MARSHALL	(218) 745-5124	(218) 745-5411

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

SWIFT	(320) 843-3160	(320) 843-3133
TODD	(320) 732-4500	(320) 732-2157
TRAVERSE	(320) 563-8255	(320) 563-4244
WABASHA	(651) 565-3351	(651) 565-3361
WADENA	(218) 631-7605	(218) 631-7600
WASECA	(507) 835-0560	(507) 835-0500
WASHINGTON	(651) 430-6457	(651) 291-6795
WATONWAN	(507) 375-3294	(507) 507-3121
WILKIN	(218) 643-8013	(218) 643-8544
WINONA	(507) 457-6200	(507) 457-6368
WRIGHT	(763) 682-7449	(763) 682-1162
YELLOW MEDICINE	(320) 564-2211	(320) 564-2130

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

MINNESOTA STATUTES, SECTION 626.556 DEFINITIONS

Subdivision. 2. **Definitions.**

As used in this section, the following terms have the meanings given them unless the specific content indicates otherwise:

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

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

- (f) "Neglect" means the commission or omission of any of the acts specified under clauses (1) to (9), other than by accidental means:
- (1) failure by a person responsible for a child's care to supply a child with necessary food, clothing, shelter, health, medical, or other care required for the child's physical or mental health when reasonably able to do so;
 - (2) failure to protect a child from conditions or actions that seriously endanger the child's physical or mental health when reasonably able to do so, including a growth delay, which may be referred to as a failure to thrive, that has been diagnosed by a physician and is due to parental neglect;
 - (3) failure to provide for necessary supervision or child care arrangements appropriate for a child after considering factors as the child's age, mental ability, physical condition, length of absence, or environment, when the child is unable to care for the child's own basic needs or safety, or the basic needs or safety of another child in their care;
 - (4) failure to ensure that the child is educated as defined in sections [120A.22](#) and [260C.163](#) (subdivision 11), which does not include a parent's refusal to provide the parent's child with sympathomimetic medications, consistent with section [125A.091](#) (subdivision 5);
 - (5) nothing in this section shall be construed to mean that a child is neglected solely because the child's parent, guardian, or other person responsible for the child's care in good faith selects and depends upon spiritual means or prayer for treatment or care of disease or remedial care of the child in lieu of medical care; except that a parent, guardian, or caretaker, or a person mandated to report pursuant to subdivision 3, has a duty to report if a lack of medical care may cause serious danger to the child's health. This section does not impose upon persons, not otherwise legally responsible for providing a child with necessary food, clothing, shelter, education, or medical care, a duty to provide that care;
 - (6) prenatal exposure to a controlled substance, as defined in section [253B.02](#) (subdivision 2), used by the mother for a nonmedical purpose, as evidenced by withdrawal symptoms in the child at birth, results of a toxicology test performed on the mother at delivery or the child at birth, or medical effects or developmental delays during the child's first year of life that medically indicate prenatal exposure to a controlled substance;
 - (7) "medical neglect" as defined in section [260C.007](#), (subdivision 6), clause (5);
 - (8) chronic and severe use of alcohol or a controlled substance by a parent or person responsible for the care of the child that adversely affects the child's basic needs and safety; or
 - (9) emotional harm from a pattern of behavior which contributes to impaired emotional functioning of the child which may be demonstrated by a substantial and observable effect in the child's behavior, emotional response, or cognition that is not within the normal range for the child's age and stage of development, with due regard to the child's culture.

- (g) "Physical abuse" means any physical injury, mental injury, or threatened injury, inflicted by a person responsible for the child's care on a child other than by accidental means, or any physical or mental injury that cannot reasonably be explained by the child's history of injuries, or any aversive or deprivation procedures, or regulated interventions, that have not been authorized under section [121A.67](#) or [245.825](#).

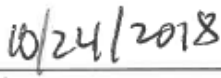
Abuse does not include reasonable and moderate physical discipline of a child administered by a parent or legal guardian which does not result in an injury. Abuse does not include the use of reasonable force by a teacher, principal, or school employee as allowed by section [121A.582](#).

Actions which are not reasonable and moderate include, but are not limited to, any of the following:

- (1) throwing, kicking, burning, biting, or cutting a child;
- (2) striking a child with a closed fist;
- (3) shaking a child under age three;
- (4) striking or other actions which result in any nonaccidental injury to a child under 18 months of age;
- (5) unreasonable interference with a child's breathing;
- (6) threatening a child with a weapon, as defined in section [609.02](#) (subdivision 6);
- (7) striking a child under age one on the face or head;
- (8) striking a child who is at least age one but under age four on the face or head, which results in an injury;
- (9) purposely giving a child poison, alcohol, or dangerous, harmful, or controlled substances which were not prescribed for the child by a practitioner, in order to control or punish the child; or other substances that substantially affect the child's behavior, motor coordination, or judgment or that results in sickness or internal injury, or subjects the child to medical procedures that would be unnecessary if the child were not exposed to the substances;
- (10) reasonable physical confinement or restraint not permitted under section [609.379](#), including but not limited to tying, caging, or chaining; or
- (11) school facility or school zone, an act by a person responsible for the child's care that is a violation under section [121A.58](#).



President, Board of Directors



Date

Section: Services	Review Date: 1/2014, 11/2016
Topic: Mealtime Policy	Revision:

FOR HOMESTEAD, PRAIRIE’S EDGE AND SLS:

Mealtime is intended to be informal and pleasant. A family-style manner encourages the opportunity for individuals to share food, learn correct serving portions, and the politeness that is expected when people eat meals together. It is expected that mealtime will present a low-key and unpressured setting where individuals cannot only enjoy a meal together, but can engage in conversation with their peers and employees.

SLS and Prairie’s Edge employees may eat with the individuals served and will be present when meals are served and being eaten. Homestead employees will be present when meals are served and being eaten. Employees are expected to encourage conversation and coach appropriate behavior. This coaching is to occur with or without a formal program. Individuals will be encouraged to invite friends and/or relatives to eat with them.

If someone chooses not to eat what has been prepared, they may make an alternative meal and employees may assist with the preparation, if needed. An individual may also choose not to eat at all or at a different time.

FOR ICF:

Staff will teach and support the individuals served in an attempt to comply with medically prescribed diets. The consulting dietician and the support team will be responsible for implementing and overseeing the prescribed diets.

FOR SILS/IN-HOME AND SLS:

Employees will educate individuals about nutritionally balanced meal planning and assist in the area of meal management as designated by the teams. If the person has a medically prescribed diet, staff will assist the person in developing a plan to follow the recommended diet.

Section: Services	Review Date: 1/2014
Topic: Media Procedures	Revision: 9/2016

All planned media contacts must be pre-approved by the Executive Director, Director of Program Services or Employee Relations Director.

HMC will review the annual Publicity Release that is obtained for each individual prior to the individual having media contact and follow any special requests as they are outlined.

The following must be identified before proceeding with media contact:

- Name of media – newspaper, television station, etc.
- Reporter name, title, phone, address – request a business card
- Name of reporter’s supervisor, title
- Focus of article – Why are they here?
- Identify who, what, where, when
 - who will be interviewed – has necessary permission received
 - what photos will be taken
 - where – location
 - when – time, date

If a question is asked that employees are unable to answer, it is okay to state “I don’t know, I’ll get back to you.” Employees should relay key messages during contact with media:

- we are highly skilled professionals
- our work enriches our community

Section: Services	Review Date: 1/2014, 8/2016
Topic: Medical Holds Procedure	Revision:

A medical hold can be placed on an individual by the administration of the hospital and will keep the individual hospitalized for 72 hours. A medical hold can be used when the individual presents imminent danger to self or others or is incompetent to handle daily needs. A medical hold can be requested by a health officer, a peace officer or a physician. A health officer is by definition: a doctor, a psychiatric social worker, a public health nurse or a psychiatric nurse or psychologist.

A court hold is different from a medical hold. A court hold requires legal action. The probable cause hearing to decide whether or not an individual is to be kept beyond 72 hours must occur within the 72-hour hold. If the individual is to be considered for a commitment procedure, that hearing must occur 7 to 14 days from the date the individual was originally held. At the probable cause hearing the county attorney usually presents a letter or report to the judge that points out the individual as being dangerous and needs to be held until the hearing.

There are four types of commitment: mental illness, mentally ill and dangerous, mentally deficient or under the influence of drugs and/or alcohol. Two physicians must concur that the individual is one of the above categories. In the categories of mental illness and mental deficiency, one of the physicians must be a psychiatrist.

Section: Services	Review Date: 1/2014, 10/2015, 8/2016
Topic: Medication Assistance and Administration Policy	Revision:

PURPOSE

The purpose of this policy is to establish guidelines to promote the health and safety of individuals served by the Harry Meyering Center (HMC), ensuring the safe assistance and administration of medication and treatments or other necessary procedures.

POLICY

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

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

HMC will obtain written authorization from the person served and/or legal representative to set up, assist, and administer medications or treatments, including psychotropic medications, and will re-obtain this authorization annually. This authorization will remain in effect unless withdrawn in writing and it may be withdrawn at any time. If authorization by the person served and/or legal representative is refused, HMC will not administer the medication or treatment. This refusal will be immediately (within 24 hours) reported to the person's prescriber and staff will follow any directives or orders given by the prescriber.

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

Section: Services	Review Date: 10/2015, 8/2016
Topic: Medication Assistance and Administration Procedure	Revision: 3/2019

STAFF TRAINING

- A. When medication set up and/or administration has been assigned to the Harry Meyering Center (HMC) as stated in the Coordinated Service and Support Plan (CSSP) and/or CSSP Addendum, all staff who will set up or administer medications to individuals served will receive training and demonstrate competency as well as reviewing this policy and procedure.
- B. Unlicensed staff, prior to the set up and/or administration of medication, must successfully complete a medication set up or medication administration training course developed by a registered nurse or appropriate licensed health professional. The training curriculum must incorporate an observed skill assessment conducted by the trainer to ensure staff demonstrates the ability to safely and correctly follow medication procedures. The course must be taught by a registered nurse, clinical nurse specialist, certified nurse practitioner, physician's assistant, or physician, if at the time of service initiation or any time thereafter. This may occur if the individual has or develops a health care condition that affects available service options to the individual because the condition requires:
 - specialized or intensive medical or nursing supervision and
 - non-medical service providers to adapt their services to accommodate the health and safety needs of the person.
 - Employees only responsible for the administration of topical medications/treatments must be tested out by a nurse.
- C. For Homestead, Prairie's Edge, SILS, and SLS the standard procedure for administration of medications is to complete the State of Minnesota course of Medication Administration for Unlicensed Personnel or the Medication Administration curriculum taught by the RN, LPN, or an employee who has passed the Train the Trainer curriculum or is state medication certified.
- D. Upon completion of this course and prior to administering medications, staff will be required to demonstrate medication set up and/or administration established specifically for each individual served at their location, if this has not already been completed.
- E. This training will be completed for each staff person during orientation and annually thereafter and will include a review of this policy and procedure. Staff who demonstrates a pattern of difficulty with accurate medication administration may be required to complete retraining at a greater frequency and/or be denied the responsibility of administering medications.
- F. Documentation for this training and the demonstrated competency will be maintained in each staff person's personnel file.

MEDICATION SET UP

- A. Medication setup means the arranging of medications according to instructions from the pharmacy, the prescriber, or a licensed nurse, for later administration when HMC is assigned responsibility in the CSSP or the CSSP Addendum. A prescription label or the prescriber's written or electronically recorded order for the prescription is sufficient to constitute written instructions from the prescriber. Telephone orders are only taken by a Registered Nurse and followed up with written instructions signed by a health care professional. This documentation is kept in each individual's medical file.
- B. Staff will document the following information in the served individual's medication

administration record:

- Dates of medication set up.
- Name of medication.
- Quantity of dose.
- Times to be administered.
- Route of administration at the time of set up.
- When the person will be away from the service location
- To whom the medication was given.

MEDICATION ASSISTANCE

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

MEDICATION ADMINISTRATION

- A. Medication may be administered within 60 minutes before or after the prescribed time.
- For example, a medication ordered to be given at 7:00 am may be administered between 6:00 am and 8:00 am.
- B. Medications ordered to be given as an “AM medication” and/or “PM medication” may be administered at a routine daily time. The routine time may fluctuate up to two hours in order to accommodate the person's schedule.
- For example, if a person typically receives their medication at 7:00 am, then on the weekends, the medication may be given between 5:00 am and 9:00 am.
- C. Staff administering medication must know or be able to locate medication information on the intended purpose, side effects, dosage, and special instructions.
- D. Medication information, including side effects, can be found in the Drug Reference Book and/or on Therap for all programs. Employees are responsible for knowing the desired effect(s) and possible side effects of the medications for the individuals they serve.
- E. General and specific procedures on administration of medication by routes are included at the end of this policy. Routes included are:
- Oral tablet/capsule/lozenge.
 - Liquid medication
 - Buccal medication
 - Inhaled medication
 - Nasal spray medication
 - Eye medication
 - Ear drop medication
 - Topical medication
 - Subcutaneous Injection

MEDICATION AUTHORIZATION

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

- B. This authorization will remain in effect unless withdrawn in writing and it may be withdrawn at any time.
- C. If authorization by the individual served and/or legal representative is refused, HMC will not administer the medication or treatment. This refusal will be immediately reported the individual's prescriber and staff will follow any directives or orders given by the prescriber.

INJECTABLE MEDICATIONS

- A. Injectable medications may be administered to an individual served according to their prescriber's order and written instructions when one of the following conditions has been met:
 - A supervising registered nurse with a prescriber's order can delegate the administration of an injectable medication to unlicensed staff persons and provide the necessary training.
- B. Only a licensed health care professional is allowed to administer psychotropic medications by injection. This responsibility will not be delegated to unlicensed staff.

PSYCHOTROPIC MEDICATION

- A. When a person served is prescribed a psychotropic medication and HMC is assigned responsibility for the medication administration, the requirements for medication administration will be followed.
- B. HMC will develop, implement, and maintain the following information in the individual's CSSP Addendum according to MN Statutes, sections [245D.07](#) and [245D.071](#). This information includes:
 - A description of the target symptoms that the psychotropic medication is to alleviate.
 - Documentation methods that HMC will use to monitor and measure changes to these target symptoms, if required by the prescriber.
 - Data collection of target symptoms and reporting on the medication and symptom-related data, as instructed by the prescriber, a minimum of quarterly or as requested by the individual and/or legal representative. This reporting will be made to the expanded support team.
- C. If the individual and/or legal representative refuse to authorize the administration of a psychotropic medication as ordered by the prescriber, HMC will not administer the medication and will notify the prescriber as expediently as possible. After reporting the refusal to the prescriber, HMC must follow any directives or orders given by the prescriber. A refusal may not be overridden without a court order. Refusal to authorize administration of a specific psychotropic medication is not grounds for service termination and does not constitute an emergency.

DOCUMENTATION REQUIRMENTS ON THE MEDICATION ADMINISTRATION SHEET (MAS)

- A. The following information will be documented on an individual's medication administration record:
 - Information on the current prescription labels or the prescriber's current written or electronically recorded order or prescription that includes the:
 - Individual's name
 - Description of the medication or treatment to be provided
 - Frequency of administration
 - Other information needed to safely and correctly administer medication or

- treatment to ensure effectiveness
- Easily accessible information on risks and other side effects that are reasonable to expect and any contraindications to the medications use.
- Possible consequences if the medication or treatment is not taken or administered as directed.
- Instruction on when and to whom to report:
 - If a dose of medication is not administered or treatment is not performed as prescribed, whether by staff error, the person's error or by the person's refusal
 - The occurrence of possible adverse reactions to the medication or treatment
- B. Notation of any occurrence of a dose of medication not being administered or treatment not performed as prescribed, whether by staff error, the person's error, or by the person's refusal, or of adverse reactions and when and to whom the report was made.
- C. Notation of when a medication or treatment is started, administered, changed or discontinued.

MEDICATION DOCUMENTATION AND CHARTING

- A. Nursing staff will transcribe a prescriber's new, changed, and/or discontinued medication/treatment orders to the medication administration record by:
 - Comparing the label on the medication with the prescriber's to ensure they match. Any discrepancy must be reported to the pharmacy immediately.
 - Copying any new medication/treatment or change from the original prescriber's orders to the medication administration record.
 - When there is a change in a current medication/treatment, the revision is recorded on the medication administration record to implement the medication change.
 - Entering the medication/treatment name, dose, route, frequency and times to be administered.
 - Ensuring the proper start date
 - Discontinuing a medication/treatment as ordered by entering the appropriate discontinuation date, provider who ordered the discontinuation and the reason on the medication administration record.
 - Completing any applicable health documentation regarding the entry and notifying the necessary personnel.
- B. Staff will document a medication given from the Standing Order Medications List by:
 - Clicking in the correct to populate his or her initials in the box for the date the and time the medication was administered.
 - For PRN medications, documenting what medication/treatment was administered, the dose, the reason it was given and the effect in the "Detail Mode" of the medication administration record one hour after the medication was given.
 - Following any special instructions noted on the Standing Order Medications, notifying the assigned nurse, nurse consultant or prescriber as directed.
- C. Staff will document administration of medications/treatments on the medication administration record by:
 - Ensuring the individual's name, allergies, month and year are correct on the medication administration record
 - Completing documentation on the medication administration record according as per Harry Meyering Center policy

MEDICATION STORAGE AND SECURITY – INCLUDING SCHEDULE II MEDICATION STORAGE – MEDICATION DESTRUCTION

- A. The medication storage area/container will be appropriate for the individual served, which may include being locked by the individual or by HMC, when unattended by staff and will be kept clean, dry and within the appropriate temperature range.
- B. Each individual served will have a separate container for their internal medications and a separate container for their external medications.
- C. Medication will not be kept in the same area as food or chemicals (in the case of refrigerated medications, they will be kept in a locked container and separated from food).
- D. Schedule II controlled substances, names in [MN Statutes, section 152.02 \(subdivision 3\)](#), will be stored in a double locked storage area permitting access to the staff authorized to administer medications.
- E. Medications will be disposed of according to all federal and local laws as well as the Environmental Protection Agency recommendations.

VERIFICATION AND MONITORING OF EFFECTIVENESS OF SYSTEMS TO ENSURE SAFE MEDICATION HANDLING AND ADMINISTRATION (REPORTING AND REVIEW)

- A. The designated person will be responsible for reviewing each individual's medication administration record to ensure information is current and accurate. This will include a monthly review of the medication administration record, referrals, medication orders, etc.
- B. At a minimum, this review will occur quarterly or more frequently if directed by the person and/or legal representative or the CSSP or CSSP Addendum.
- C. Based upon this quarterly or more frequent review, the reviewer will notify the Program Director, as needed, of any issues. Collaboratively, a plan must be developed and implemented to correct patterns of medication administration errors or systemic errors when identified. When needed, staff training will be included as part of this plan to correct identified errors.
- D. The following information will be reported to the, medical provider, legal representative and case manager as they occur or as directed by the CSSP or CSSP Addendum:
 - Concerns about an individual's self-administration of medication or treatment.
 - An individual's refusal or failure to take or receive medication or treatment as prescribed.
 - Any reports as required regarding:
 - If a dose of medication is not administered or treatment is not performed as prescribed, whether by staff error, the individual's error, or by the individual's refusal
 - Occurrence of possible adverse reactions to the medication or treatment

COORDINATION AND COMMUNICATION WITH PRESCRIBER

- A. As part of medication set up and administration, HMC will ensure that clear and accurate documentation of prescription orders has been obtained by the prescriber in written format.
- B. Initiations, dosage changes, or discontinuations of medications will be coordinated with the prescriber and discussed as needed to ensure staff and/or the individual served has a clear understanding of the order. If the order has only been done verbally, staff will request a written or electronically recorded copy from the prescriber. Staff will not make any changes to medications or treatment orders unless there is a written or electronically recorded copy.
- C. All prescriber instructions will be implemented as directed and within required timelines by staff and/or the individual served and documented in related health documentation.
- D. Concerns regarding medication purpose, dosage, potential or present side effects or other medication related issues will be promptly communicated to the prescriber by staff, the manager, assigned nurse or nurse consultant.

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

COORDINATION OF MEDICATION REFILLS AND COMMUNICATING WITH PHARMACY

- A. The nurse or other assigned staff person will be responsible for checking medication supply routinely to ensure adequate amount for administration.
- B. Some pharmacies may automatically refill prescriptions of individuals served. If this is the case, staff will contact the pharmacy if a medication or treatment is discontinued.
- C. HMC will ensure that the pharmacy has the contact information for the service location and the main contact person who can answer questions and be the primary person responsible for coordinating refills.

HANDLING CHANGES TO PRESCRIPTIONS AND IMPLEMENTATION OF THOSE CHANGES

- A. All written instructions regarding changes to medications and treatments are required to be documented through a prescription label or the prescriber's written or electronically recorded order for the prescription.
- B. Changes made to prescriptions will be communicated to the nurse as soon as possible.
- C. Any concerns regarding these changes and the order will be resolved prior to administration of the medication to ensure safety and accuracy.
- D. Staff will implement changes and document appropriately on the medication administration record.
- E. Discontinued medications, expired medications and extra doses of medications will be discarded appropriately.

GENERAL AND SPECIFIC PROCEDURES ON ADMINISTRATION OF MEDICATIONS (BY ROUTE)

- 1. General procedures completed before administering medication by any route:
 - Staff must begin by washing their hands and assembling equipment necessary for administration.
 - The individual's medication administration record is reviewed to determine what medications are to be administered and staff removes the medication from the storage area.
 - Staff will compare the medication administration record with the label of each medication for the following:
 - Right person
 - Right medication
 - Right date
 - Right time
 - Right route
 - Right dose
 - Right documentation
 - If there is a discrepancy, the medication will not be administered. Instructions will be verified by contacting the nurse, pharmacist or prescriber.
 - Staff will compare the label with the medication administration record for the second time.

- Immediately prior to the administration of any medication or treatment, staff will identify the individual and will explain to the individual what is to be done.
 - Staff will compare the label with the medication administration record for the third time before administering the medication to the individual. Medication administration will be done according to the procedure below.
 - After administration, staff will document the administration of the medication or treatment or the reason for not administering the medication or treatment.
 - Staff will contact the nurse or prescriber regarding any concerns about the medication or treatment, including side effects, effectiveness, or a pattern of the individual refusing to take the medication or treatment as prescribed.
 - Adverse reactions will be immediately reported to the nurse or prescriber.
2. General procedures completed after administering medication by any route:
 - Staff will throw away all disposable supplies and place all medications in the locked medication storage area/container prior to leaving the area.
 - Staff will wash their hands.

Click on the link below for procedures related to the administration of medications:

- [Oral Tablet/Capsule/Lozenge](#)
- [Liquid](#)
- [Buccal](#)
- [Inhaled](#)
- [Nasal Spray](#)
- [Eye Medications](#)
- [Ear Drops](#)
- [Topical](#)
- [Subcutaneous Injection](#)

PROCEDURES FOR ADMINISTRATION OF ORAL TABLET/CAPSULE/LOZENGE

1. If medications are in a bottle, staff will pour the correct number of tablets or capsules into the lid of the medication container and transfer them to a medication cup.
2. If medications are in bubble packs, staff will push the correct dose into a medication cup.
3. If medication is in lozenge form, staff will unwrap the lozenge and transfer it to a medication cup.
4. Staff will administer the correct dosage by instructing the person to swallow the medication. If the medication is in lozenge form, staff will instruct the person not to chew or swallow the lozenge so it is able to dissolve in their mouth.
5. If the medication is to be swallowed (tablet/capsule), staff will offer a beverage and remain with the person until the medication is swallowed. Some tablet/capsules may be directed to be given in food-substance. Staff will follow any specific instructions according to the medication administration record.

PROCEDURE FOR ADMINISTRATION OF LIQUID MEDICATION

1. Staff will shake the medication if it is a suspension (as per label instructions).
2. Staff will pour the correct amount of medication, at eye level on a level surface, with the label

- facing up, into a plastic medication measuring cup or measuring spoon.
3. Staff will wipe around the neck of the bottle, if sticky, and replace the cap.
 4. Staff will dilute or dissolve the medication if indicated on the label or medication administration record with the correct amount of fluid.
 5. Staff will administer the correct dose according to the directions in an appropriate container.
 6. Staff will remain with the person until the medication is swallowed.

PROCEDURE FOR ADMINISTRATION OF BUCCAL MEDICATION

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

PROCEDURE FOR ADMINISTRATION OF INHALED MEDICATION

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

PROCEDURE FOR ADMINISTRATION OF NASAL SPRAY MEDICATION

1. Staff will ask the person to blow their nose or will gently wipe the nose with gloved hands.
2. Staff will gently shake the spray container.
3. Staff will ask the person to tilt their head slightly forward.
4. Staff will remove the cap from the nozzle and will insert the nozzle into one nostril, aiming away from the septum (middle of the nostril).
5. Holding the other nostril closed, staff will instruct the person to inhale and squeeze once to spray.
6. Staff will repeat steps to deliver the correct dosage to the other nostril.

PROCEDURE FOR ADMINISTRATION OF EYE MEDICATION

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

PROCEDURE FOR ADMINISTRATION OF EAR DROP MEDICATION

1. Staff will have the person sit or lie down with the affected ear up.
2. If sitting, staff will have the person tilt head sideways until the ear is as horizontal as possible.
3. If lying down, staff will have the person turn their head.
4. Staff will observe ears and notify the nurse or prescriber of any unusual condition prior to administration of the medication.
5. Staff will administer the correct number of drops, which are at room temperature, into the correct ear by pulling the ear gently backward and upward.
6. Staff will have the person remain in the required position for one (1) to two (2) minutes.
7. Staff will have the person hold his/her head upright while holding a tissue against the ear to soak up any excess medication that may drain, but this is not necessary.
8. Staff will repeat the procedure for the other ear if necessary.
9. Staff will replace the cap on the container and will avoid touching the tip of the dropper to the person's ear or any other surface.

PROCEDURE FOR ADMINISTRATION OF TOPICAL MEDICATION

1. Staff will position the person as necessary for administration of the medication.
2. Staff will, prior to administering the medication; observe for any unusual conditions of the affected area of the body which should be reported to the nurse or prescriber.
3. Staff will cleanse the affected area unless otherwise indicated.
4. Staff will administer medication to the correct area, according to directions, with the appropriate applicator or with gloved hands.
5. If the topical is in powder form, staff will instruct the person to avoid breathing particles in the air that may result from the application.
6. If the topical is a transdermal patch, staff needs to be aware of the appropriate site location to place the transdermal patch.
7. If the topical is a transdermal patch, staff will remove the old patch and select a new patch site

(new patch should be applied to clean dry skin which is free of hair, cuts, sores, or irritation on upper torso unless otherwise directed).

8. If the topical is a transdermal patch, apply it to the new patch site.
9. Staff will replace the cap on the container, if needed, avoiding contact with any other surfaces.

PROCEDURE FOR ADMINISTRATION OF MEDICATIONS INJECTED SUBCUTANEOUSLY

*Subcutaneous injections can be given straight in at a 90-degree angle or at a 45-degree angle. Staff will give the injection at a 90-degree angle if 2 inches of skin can be grasped between the thumb and first finger. If only 1 inch of skin can be grasped, the injection will be given at a 45-degree angle.

1. Staff will choose an area on the body for the injection, keeping in mind that sites should be rotated.
2. With gloved hands, staff will wipe the area with an alcohol wipe and let the area dry without touching this area until the injection is given.
3. Staff will hold the syringe with the dominant hand and pull the cover off with the other hand. Placing the syringe between the thumb and first finger, letting the barrel of the syringe rest on the second finger.
4. Staff will then grasp the skin with the other hand.
5. Holding the syringe barrel tightly, staff will use the wrist to inject the needle into the skin. Once the needle is all the way in, staff will push the plunger down to inject the medicine.
5. Staff will then remove the needle at the same angle it was put in and place it in the appropriate sharps container.

This policy and procedure was established in consultation with and approved by:

Name: Cindy Winters

Title: Registered Nurse

Company: STAR Services

Date of consultation and final approval: July 31, 2015

Review by Tana Helleksen RN/HSM 3.19

Section: Operations	Last Review Date: 1/2014
Topic: Personal Appearance of Employees Policy	Revision: Draft 8/2014

Every employee of the Harry Meyering Center should dress appropriately to the work setting. Depending on the employee's position, the dress requirements vary.

Section: Operations	Last Review Date: 1/2014
Topic: Personal Appearance of Administrative, Office and SILS Employees Procedure	Revision: Draft 8/2014

Dress requirements for administrative, office, and SILS staff:

Employees in this category have regular contact with the public and are expected to dress in a manner that is normally acceptable in any business establishment. An employee's dress, shoes, and accessories should be appropriate to the days' activities and meet the basic requirements of safety and comfort. The same requirements regarding tattoos, fragrances, and piercings from [above](#) apply.

Section: Operations	Last Review Date: 1/2014
Topic: Personal Appearance of ICF and SLS Employees Procedure	Revision: Draft 8/2014

Dress requirements for all ICF and SLS direct care staff:

Employees of the Harry Meyering Center (HMC) are professionals and representatives of the agency both in consumer's homes and in the community. Personal appearance reflects respect for oneself, the agency, and the individuals served. The dress code is considered casual, but must be appropriate for the activities scheduled for the day. It is important that employees serve as role models for the individuals served who often have trouble deciding what looks good, what might be appropriate for the occasion or season, or how clothing should be maintained.

Direct care staff are required to do bending, stooping, and moving around during the course of a shift. Clothing should not be so tight that it restricts movement, but not so loose that it falls away from the body exposing areas which could cause embarrassment to the employee or those nearby. If an employee chooses not to wear undergarments, clothing should be selected with care so that it does not offend the individuals served. No clothing should be worn that could be considered sexually suggestive.

Shorts and skirts shall be no shorter than fingertip length. Halter tops, spaghetti straps, and jogging bras are not permitted unless a shirt or buttoned jacket are worn over them. Any clothing that reveals midriff, stomach, navel, or backside during any activity are not to be worn at work.

It is expected that direct care staff will not wear clothes that are dirty, wrinkled, exceedingly worn, in need of repair, or have inappropriate images or words displayed. Inappropriate is defined as anything that could be considered offensive, obscene, vulgar or suggestive, including alcohol, drugs, and tobacco. Frayed hems, rips, tears, holes, and stains are unacceptable. Hats, stocking caps, and bandanas are not to be worn indoors. Exercise/athletic wear (including sweatpants) are unacceptable unless exercising with a consumer as part of their programming.

Direct care staff may accompany consumers to church or an appointment, attend a team meeting, or take part in a variety of activities in the community. It is expected that appropriate clothing will be worn. If necessary, staff may bring a change of clothing for the rest of the day.

Due to the large portion of shifts requiring staff to be on their feet, appropriate footwear should be worn. The job may call for quick movements or running, therefore shoes providing a stable stance should be worn. All footwear must be securely fitting, offer foot support, and have a back or back strap. Platform shoes, high-heels, and flip-flops are not allowed for safety concerns. In some work settings, staff and visitors are asked to remove their shoes upon entering the consumer's home.

It is recommended that direct care staff not wear jewelry of value. HMC, nor the agency insurance, will pay for damaged, lost, or stolen jewelry. For safety reasons, employees should not wear any dangling jewelry. Tattoos are acceptable if they are not offensive to other employees or consumers. If tattoos are deemed unacceptable, employees will need to cover them with clothing or a bandage. If consumers object to body piercings or tattoos, they will need to be covered.

Employees are requested to adopt fragrance-free or minimal fragrance in the workplace as a courtesy to coworkers and consumers who may be sensitive to scents. This includes perfumes, colognes, and hand lotions. Consumers who have a chemical sensitivity will require a fragrance-free environment.

The Program Director, or their designate, will make the final determination if there is any question regarding the appropriateness of dress, body piercings, tattoos, or fragrances.

Section: Operations	Last Review Date: 1/2014
Topic: Personal Appearance of Maintenance, Janitorial, Laundry and Dietary Employees Procedure	Revision: Draft 8/2014

Dress requirements for all maintenance, janitorial, laundry, and dietary staff:

Employees in this category must dress in clothing and footwear that meets the basic requirements of safety and comfort. All clothing must be neat, clean, and not restrict movement. The same requirements regarding tattoos, fragrances, and piercings from [above](#) apply to employees in this category.

Section: Operations	Last Review Date: 1/2014
Topic: Personal Appearance of Nursing Employees Procedure	Revision: Draft 8/2014

Dress requirements for nursing staff:

Nurses do not wear uniforms or scrubs. Footwear and accessories should be selected based on comfort and safety. The same requirements regarding tattoos, fragrances, and piercings from [above](#) apply.

Any employee who does not meet the standards will be required to take corrective action, which may include leaving the premises. Non-exempt employees will not be compensated for any work time missed because of failure to comply with this policy. Violation of this policy may result in disciplinary action.

Section: Services	Review Date: 10/2015, 9/2016
Topic: Person-Centered Planning and Service Delivery Policy	Revision:

PURPOSE

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

POLICY

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

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

- Person-centered service planning and delivery which:
 - Identifies and supports what is important to as well as what is important for the person, including preferences for when, how, and by whom direct support services is provided;
 - Uses that information to identify outcomes the person desires; and
 - Respects each person's history, dignity, and cultural background.
- Self-determination which supports and provides:
 - Opportunities for the development and
 - Respects each person's history, dignity, and cultural background.
- Self-determination which supports and provides:
 - Opportunities for the development and exercise of functional and age-appropriate skills, decision making and choice, personal advocacy, and communication; and
 - The affirmation and protection of each person's civil and legal rights.

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

Section: Services	Review Date: 1/2014
Topic: Person-Centered Planning and Service Delivery Procedure	Revision: 9/2016

SUPPORT TEAM

- A. Each individual that receives services from the Harry Meyering Center will have a Support Team to assist the individual with person-centered planning and service delivery. This team may include any or all of the following members as determined by the individual served:
- the individual served
 - the legal representative
 - the case manager
 - family and/or friends
 - work supervisor or counselor
 - advocate
 - employees from other agencies that may also be involved in providing service or supports to the individual served
 - designated employees from HMC.

SERVICE OUTCOME AND SUPPORTS

- A. HMC must develop and document the service outcomes and supports based on the assessments completed and the requirements of person-centered service planning and delivery, self determination, integrated setting, and inclusive service delivery. The outcomes and supports must be included in the Coordinated Service and Support Plan Addendum.
- B. HMC must document the supports and methods to be implemented to support the accomplishment of outcomes related to acquiring, retaining, or improving skills. The documentation must include:
- the methods or actions that will be used to support the person and to accomplish the service outcomes, including information about:
 - any changes or modifications to the physical and social environments necessary when the service supports are provided;
 - any equipment and materials required; and
 - techniques that are consistent with the person's communication mode and learning style;
 - the measurable and observable criteria for identifying when the desired outcome has been achieved and how data will be collected;
 - the projected starting date for implementing the supports and methods and the date by which progress towards accomplishing the outcomes will be reviewed and evaluated; and
 - the names of the staff or position responsible for implementing the supports and methods.
- C. HMC must obtain dated signatures from the person or the person's legal representative and case manager to document completion and approval of the assessment and Coordinated Service and Support Plan Addendum.

PROGRESS REVIEWS

- A. HMC must give the person or the person's legal representative and case manager an opportunity to participate in the ongoing review and development of the methods used to support the person and accomplish outcomes identified. HMC, in coordination with the person's Support Team or Expanded Support Team, must meet with the person, the person's legal representative, and the case manager, and participate in progress review meetings following stated timelines established in the person's Coordinated Service and Support Plan (CSSP) or CSSP Addendum or within 30 days of a written request by the person, the person's legal representative, or the case manager, at a minimum of once per year.
- B. HMC must summarize the person's progress toward achieving the identified outcomes and make recommendations and identify the rationale for changing, continuing, or discontinuing implementation of supports and methods identified in a written report sent to the person or the person's legal representative and case manager at least five (5) working days prior to the review meeting, unless the person, the person's legal representative, or the case manager requests to receive the report at the time of the meeting
- C. Within ten working days of the progress review meeting, the license holder must obtain dated signatures from the person or the person's legal representative and the case manager to document approval of any changes to the Coordinated Service and Support Plan Addendum.
 - If, within ten working days of submitting changes to the coordinated service and support plan and coordinated service and support plan addendum, the person or the person's legal representative or case manager has not signed and returned HMC the coordinated service and support plan or coordinated service and support plan addendum or has not proposed written modifications to HMC's submission, the submission is deemed approved and the coordinated service and support plan addendum becomes effective and remains in effect until the legal representative or case manager submits a written request to revise the coordinated service and support plan addendum

Section: Operations	Last Review Date: 1/2014
Topic: Personnel Record Policy	Revision: Draft 8/2014

The Harry Meyering Center will maintain a personnel record of each employee. The record will include:

- Date of hire, completed application, acknowledgement of reviewing and understanding job duties of the employee, and documentation that the employee meets the requirements of the position.
- Documentation of staff qualifications, orientation, training, and performance evaluations as required by section [245D.09](#) (subdivisions 3-5). This includes the date that training was completed, number of hours per subject area, and the name of the trainer or instructor.
- A completed background study.

Employees that were hired after January 1, 2014 must have documented dates regarding the first time they had direct contact with individuals receiving services. These dates must include their first supervised and unsupervised direct contact, and will be documented in their personnel record.

Section: Services	Review Date: 1/2014, 11/2016
Topic: Pets and Service Animals Procedure	Revision:

OWNED PETS:

When a pet is living at Homestead, Prairie's Edge or SLS, the following criteria will be met:

- The animal will have an up-to-date record of inoculation on file. The animal will be checked annually by a veterinarian.
- The animal chosen will be of mellow mood and temperament and will not be allowed to endanger the safety of the individuals living or working at the site.
- All household members must agree to have a pet and must not be medically contraindicated (i.e. allergy). A new individual or their legal representative will be notified of the presence of pets in the residence before admission.
- The animal will have established directions to ensure appropriate grooming, feeding, watering and provision of regular exercise which is monitored by employees.
- Regardless of ownership of the pet, the Harry Meyering Center is also responsible to take the necessary steps to prevent the pet from jeopardizing the health, safety, comfort, treatment or well-being of individuals at the site. A pregnant employee in contact with a pet cat may request that the cat have a blood test to determine the presence of toxoplasmosis. Employees who are pregnant should not deal with cat litter.
- Individuals are expected to provide for the care and well-being of pets. As much as possible, the owner will be trained to care for the pet. The role of employees will be to supervise and evaluate the care being given.
- In the event of maltreatment of the pet by an individual served, training and counseling will be initiated by an employee. If unsuccessful and maltreatment continues, a new home will be found for the animal as soon as possible. Maltreatment or neglect of the pet by employees will not be tolerated. Employees are to model care of the pet to the individual served.

VISITING PETS:

Homestead, Prairie's Edge and SLS allow pets to visit given the following criteria are met:

- Only cats or dogs are allowed and must be accompanied by a responsible adult.
- The owner must be able to present current certificates that the animal was inoculated as per state regulations, specifically rabies.
- It is expected that the pet will be of mellow mood and temperament so as not to danger the safety of the individuals served or employees.
- The owner shall stay with and be responsible for the animal for the entire visit.
- Employees should examine the visiting pet for any evidence of fleas or other external parasites and, if finding any, shall deny the visit of the pet.

Section: Operations	Review Date: 1/2014
Topic: Physical Plant and Environment Policy	Revision:

The Physical Plant Director, or their designee, will ensure that the program site is maintained in good repair and in a safe and sanitary condition. This includes the physical building, equipment, food safety and storage of personal care items.

Section: Operations	Review Date: 1/2014
Topic: Physical Plant Sanitation and Safety Procedure	Revision:

The following will be maintained by the Physical Plant Director or their designee:

- Interior and exterior of buildings
- Structures
- Enclosures
- Walls
- Floors
- Ceilings
- Registers
- Fixtures
- Equipment
- Furnishings (furniture and carpet) – will be routinely inspected and cleaned as necessary

Any building and/or equipment deterioration, safety hazards, and unsanitary conditions will be corrected. The facility must be clean and free from accumulations of dirt, grease, garbage, peeling paint, mold, vermin and insects. The Physical Plant Director will be the primary individual responsible for this coordination. Cleaning and disinfecting schedules will be developed and implemented by staff.

The Harry Meyering Center (HMC) must:

- ensure the following when listed as the owner, lessor, or tenant of a service site:
 - The service site is a safe and hazard-free environment
 - That toxic substances or dangerous items are inaccessible to individuals served by the program only to protect the safety of the individual served and not as a substitute for staff supervision or interactions. If toxic substances or dangerous items are made inaccessible, the license holder (HMC) must document an assessment of the physical plant, its environment and its population identifying the risk factors which require toxic substances or dangerous items to be inaccessible and a statement of specific measures to be taken to minimize the safety risk to individuals served
 - Doors are locked from the inside to prevent a person from exiting only when necessary to protect the safety of individuals served and not as a substitute for staff supervision or interactions. If doors are locked from the inside, the license holder must document an assessment of the physical plant, the environment and its population identifying the risk factors which require the use of locked doors and a statement of specific measures to be taken to minimize the safety risk to persons receiving services at the service site
 - A staff person is available at the service site who is trained in basic first aid and, when required in the coordinated service and support plan and/or addendum of an individual served, cardiopulmonary resuscitation (CPR) whenever persons are present and staff are required to be at the site to provide direct service
- Maintain equipment, vehicles, supplies and materials owned or leased by the license holder in good condition when used to provide services

- Follow procedures to ensure safe transportation, handling and transfers of the individual served and any of their equipment, when the license holder is responsible for the transportation of the individual served and their equipment
- Be prepared for emergencies and follow emergency response procedures to ensure the safety of the individual served in an emergency
- Follow universal precautions and sanitary practices, including hand washing, for infection prevention and control and to prevent communicable diseases
- Ensure weapons and ammunition are stored in separately locked areas that are inaccessible to individuals served. For purposes of this subdivision, “weapons” refers to firearms and other instruments or devices designed for and capable of producing bodily harm

Inspections and Code Compliance:

- Physical plants must comply with applicable state and local fire, health, building and zoning codes
- Inspections:
 - The facility must be inspected by a fire marshal or their delegate within 12 months before initial licensure to verify that it meets the applicable occupancy requirements, and fire safety standards for that occupancy, as defined in the State Fire Code.
 - The fire marshal inspection of a community residential setting must verify the residence is a dwelling unit within a residential occupancy. A home safety checklist, approved by the commissioner, must be completed for a community residential setting by HMC and the commissioner before the satellite license is reissued.
 - The facility shall be inspected according to the facility capacity specified on the initial application form.
 - If the commissioner has reasonable cause to believe that a potentially hazardous condition may be present, or the licensed capacity is increased, the commissioner shall request a subsequent inspection and written report by a fire marshal to verify the absence of the hazard.
 - Any condition cited by a fire marshal, building official or health authority as hazardous or creating an immediate danger of fire or threat to health and safety must be corrected before a license is issued by the department, and for community residential settings, before a license is reissued.
 - The facility must maintain in a permanent file the reports of health, fire and other safety inspections.
- The facility’s plumbing, ventilation, heating, cooling, lighting and other fixtures and equipment including elevators or food service, if provided, must conform to applicable health, sanitation and safety codes and regulations.
- HMC must notify the local agency within 24 hours of the onset of changes in a residence resulting from construction, remodeling or damages requiring repairs that require a building permit or may affect a licensing requirement.

Section: Services	Review Date: 1/2014, 8/2016
Topic: Program Administration Procedures	Revision:

The Harry Meyering Center shall:

- A. develop, review and update, as needed, the written program policies and procedures necessary to maintain compliance with state and federal licensing requirements.
- B. inform the person or the person's legal representative(s) and case manager of the policies and procedures affecting a person's rights and provide copies of those policies and procedures within five (5) working days of service initiation.
- C. provide a written notice to all persons or their legal representative(s) and case managers at least 30 days before implementing any procedural revisions to policies affecting a person's service-related or protection-related rights and maltreatment reporting policies and procedures. The notice must explain the revision that was made and include a copy of the revised policy and procedure. The license holder must document the reasonable cause for not providing the notice at least 30 days before implementing the revisions.
- D. before implementing revisions to required policies and procedures, HMC must inform all employees of the revisions and provide training on implementation of the revised policies and procedures. HMC will document the provision of training.
- E. annually notify all persons, or their legal representatives, and case managers of any procedural revisions to policies required under [245D.10](#), other than those listed above in paragraph C. Upon request, the license holder must provide the person, or the person's legal representative, and case manager with copies of the revised policies and procedures.
- F. document and maintain relevant information related to the policies and procedures. keep program policies and procedures readily accessible to staff and index the policies

SEPARATE SATELLITE LICENSE REQUIREMENTS FOR SEPARATE SITES:

- A. HMC must obtain a separate satellite license for each community residential setting located at separate addresses when the community residential settings are to be operated by HMC.
- B. Community residential settings are permitted single-family use homes. After a license has been issued, the commissioner shall notify the local municipality where the residence is located of the approved license.

ALTERNATE OVERNIGHT SUPERVISION

- D. A license holder granted an alternate overnight supervision technology adult foster care license according to [section 245A.11, subdivision 7a](#) that converts to a community residential setting satellite license according to this chapter must retain that designation.

POSTING OF LICENSE AND CERTIFICATES

- A. All of the appropriate licenses and certificates required to be posted in the agency shall be posted immediately in an area available to the public and in an attractive manner.

Section: Services	Review Date: 1/2014, 8/2016
Topic: Program Coordination, Evaluation, and Oversight Procedure	Revision:

PROGRAM COORDINATION AND EVALUATION

- E. Harry Meyering Center (HMC) is responsible for:
- coordination of service delivery and evaluation for each person served by HMC
 - program management and oversight that includes evaluation of the program quality and program improvement for services provided by HMC
- F. The same person may perform both of these functions if the work and education qualifications listed are met

COORDINATION AND EVALUATION OF INDIVIDUAL SERVICE DELIVERY

- A. Delivery and evaluation of services provided by HMC must be coordinated by a designated staff person. The Program Manager must provide supervision, support, and evaluation of activities that include:
- oversight of HMC's responsibilities assigned in the person's Coordinated Service and Support Plan and Addendum;
 - taking the action necessary to facilitate the accomplishment of outcomes
 - instruction and assistance to direct support staff implementing the Coordinated Service and Support Plan and the service outcomes, including direct observation of service delivery sufficient to assess staff competency; and
 - evaluation of the effectiveness of service delivery, methodologies, and progress on the person's outcomes based on the measurable and observable criteria for identifying when the desired outcome has been achieved
- B. HMC must ensure that the Program Manager is competent to perform the required duties identified above through education and training in human services and disability-related fields, and work experience in providing direct care services and supports to persons with disabilities. The Program Manager must have the skills and ability necessary to develop effective plans and to design and use data systems to measure effectiveness of services and supports. HMC must verify and document competence. The Program Manager must minimally have:
- a baccalaureate degree in a field related to human services, and one year of full-time work experience providing direct care services to persons with disabilities or persons age 65 and older;
 - an associate degree in a field related to human services, and two years of full-time work experience providing direct care services to persons with disabilities or persons age 65 and older;
 - a diploma in a field related to human services from an accredited postsecondary institution and three years of full-time work experience providing direct care services to persons with disabilities or persons age 65 and older; or
 - a minimum of 50 hours of education and training related to human services and disabilities;
 - four years of full-time work experience providing direct care services to persons with disabilities or persons age 65 and older under the supervision of a staff person who meets the qualifications identified above.

Program Management and Oversight:

- A. HMC must designate a managerial staff person or persons to provide program management and oversight of the services provided by the license holder. The Program Director is responsible for the following:
- maintaining a current understanding of the licensing requirements sufficient to ensure compliance throughout the program as identified in section [245A.04, subdivision 1, paragraph \(c\)](#), and when applicable, as identified in section [256B.04, subdivision 21, paragraph \(b\)](#);
 - ensuring the duties of the Program Manager are fulfilled according to the requirements in [245D.081 Subdivision 2](#).
 - ensuring the program implements corrective action identified as necessary by the program following review of incident and emergency reports. An internal review of incident reports of alleged or suspected maltreatment must be conducted according to the requirements in section [245A.65, subdivision 1, paragraph \(b\)](#).
 - evaluation of satisfaction of persons served by the program, the person's legal representative, if any, and the case manager, with the service delivery and progress towards accomplishing outcomes and ensuring and protecting each person's rights
 - ensuring staff competency requirements are met and ensuring staff orientation and training is provided
 - ensuring corrective action is taken when ordered by the commissioner and that the terms and conditions of the license and any variances are met
 - evaluating the information above to develop, document, and implement ongoing program improvements.
- B. The Program Director must be competent to perform the duties as required and must minimally meet the education and training requirements identified above and have a minimum of three years of supervisory level experience in a program providing direct support services to persons with disabilities or persons age 65 and older.

Section: Services	Review Date: 1/2014,
Topic: Program Evaluation Through Satisfaction Surveys Procedure	Revision: 9/2016

Program planning, Support Team process and monitoring of supports and services are valued and important when they contribute to outcomes for individuals served.

In order to determine whether these processes are present and satisfactory to each individual served, a satisfaction survey will be administered on a rotating schedule to the employees, stakeholders and individuals served, with the results made available to all team members.

Section: Services	Review Date: 1/2014, 9/2016
Topic: Electronic Records Procedure	Revision:

- A. HMC’s electronic record keeping or electronic signatures must meet the following requirements:
- use of electronic record keeping or electronic signatures does not alter the license holder's obligations under state or federal law, regulation, or rule;
 - the license holder must ensure that the use of electronic record keeping does not limit the commissioner's access to records as specified under [245A.04, subdivision 5](#)
 - upon request, the license holder must assist the commissioner in accessing and copying all records, including encrypted records and electronic signatures; and
 - the license holder must establish a mechanism or procedure to ensure that:
 - the act of creating the electronic record or signature is attributable to the license holder, according to [section 325L.09](#)
 - the electronic records and signatures are maintained in a form capable of being retained and accurately reproduced
 - the commissioner has access to information that establishes the date and time that data and signatures were entered into the electronic record
 - the license holder's use of electronic record keeping or electronic signatures does not compromise the security of the records.

Section: Services	Review Date: 1/2014, 8/2016
Topic: Record Requirements Procedure	Revision:

ADMISSION AND DISCHARGE REGISTER

A written or electronic register will be kept, listing in chronological order the dates and names of all persons served who have been admitted, discharged, or transferred, including service terminations initiated by Harry Meyering Center (HMC) and deaths.

INDIVIDUAL'S PERMANENT FILE

HMC will maintain a record of current services provided to each person on the premises where the services are provided or coordinated. When the services are provided at Homestead ICF, Prairie's Edge, or SLS houses, the records must be maintained in the facility; otherwise the records must be maintained at the HMC program office. HMC must protect service recipient records against loss, tampering, or unauthorized disclosure.

HMC will maintain the following information in printed or electronic format for each person:

- An admission form signed by the person or the person's legal representative(s) that includes:
 - identifying information, including the person's name, date of birth, address, and telephone number
 - name, address, and telephone number of the person's legal representative(s), if any, and a primary emergency contact, the case manager, and family members or others as identified by the person or case manager
- Service information, including service initiation information, verification of the person's eligibility for services, documentation verifying that services have been provided as identifies in the Coordinated Service and Support Plan or Addendum and date of admission or readmission
- Health information; including medical history, special dietary needs, and allergies, and when HMC is assigned responsibility for meeting the person's health service needs:
 - current orders for medication, treatments, or medical equipment (including a list of side effects) and a signed authorization from the person or the person's legal representative(s) to administer or assist in administering the medication or treatments, if applicable
 - summary of professional service delivery during the past year, including specialized therapy and progress in therapy, if any,
 - signed statement authorizing HMC to act in a medical emergency when the person's legal representative(s), if any, cannot be reached or is delayed in arriving
 - medication administration record documenting the implementation of the medication administration procedures, and the medication administration record review, including any agreements for administration of injectable medication
 - medical appointment schedule when HMC is assigned responsibility for assisting with medical appointments
- The person's current Coordinated Service and Support Plan or that portion of the plan assigned to HMC.

- Copies of the Individual Abuse Prevention Plan and Assessments
- A record of other service providers serving the person when the person's Coordinated Service and Support Plan or Addendum identifies the need for coordination between the service providers, that includes a contact person and telephone numbers, services being provided, and names of staff responsible for coordination
- Documentation of orientation to service recipient rights and maltreatment reporting policies and procedures
- Copies of authorizations to handle a person's funds
- Documentation of complaints received and grievance resolution
- Incident reports involving the person
- Copies of written reports regarding the person's status when requested, progress review reports, progress or daily log notes that are recorded by HMC, and reports received from other agencies involved in providing services or care to the person.
- Discharge summary, including service termination notice and related documentation, when applicable.

Section: Services	Review Date: 1/2014, 8/2016
Topic: Record Retention Procedure	Revision:

- A. HMC will maintain and store records in a manner that will allow for review by the commissioner as identified in section [245A.04, subdivision 5](#). The following records must be maintained as specified and in accordance with applicable state or federal law, regulation, or rule:
 - service recipient records, including verification of service delivery, must be maintained for a minimum of five years following discharge or termination of service;
 - personnel records must be maintained for a minimum of five years following termination of employment; and
 - program administration and financial records must be maintained for a minimum of five years from the date the program closes.
- B. A license holder who ceases to provide services must maintain all records related to the licensed program for five years from the date the program closes. The license holder must notify the commissioner of the location where the licensing records will be stored and the name of the person responsible for maintaining the stored records.
- C. If the ownership of a licensed program or service changes, the transferor, unless otherwise provided by law or written agreement with the transferee, is responsible for maintaining, preserving, and making available to the commissioner on demand the license records generated before the date of the transfer.
- D. In the event of a contested case, the license holder must retain records as required above or until the final agency decision is issued at the conclusion of any related appeal, whichever period is longer.

Section: Operational	Review Date: 1/2014
Subject: Replacement of Destroyed Item(s) Policy	Revision:

Employees should use common sense about clothing and jewelry that they wear while at work. Employees should avoid wearing anything that might allow an individual served to grab at such as necklaces and dangling or hoop earrings. Employees are encouraged to avoid bringing to or wearing costly items.

Section: Operational	Review Date: 1/2014
Subject: Replacement of Destroyed Item(s) Procedure	Revision:

Occasionally, employees may suffer a loss of personal property due to the aggression of an individual served. When such a loss occurs, employees must complete an [Incident and Emergency Report](#) outlining the precipitating event and the action taken. The Harry Meyering Center (HMC) will only reimburse employees for the loss within certain limits. Employees will need to submit a receipt for the replacement of the item for reimbursement. This receipt should be attached to the [Incident and Emergency Report](#) and submitted to the Program Director. The decision regarding the amount to be reimbursed will be made by the Program Director, and will not exceed the outlined limit.

The following outlines reimbursement amounts:

- Repair, replacement or cleaning of an item of clothing – \$25.00
- Replacement of medical equipment – \$400.00
- Replacement of a part or all of an employee's glasses – \$200.00

Section: Services	Review Date:01/2014, 08/2016
Topic: Service Recipient Rights Procedure	Revision:

The Harry Meyering Center (HMC) will ensure that the rights of the individual served are exercised and protected.

HMC must:

- A. Provide the person or the person's legal representative(s) a written notice that identifies the service recipient rights and an explanation of the rights within five working days of service initiation and annually thereafter.
- B. make reasonable accommodations to provide this information in other formats or languages as needed to facilitate understanding of the rights by the person and the person's legal representative(s), if any;
- C. maintain documentation of the person's or the person's legal representative's receipt of a copy and an explanation of the rights; and
- D. ensure the exercise and protection of the person's rights in the services provided by the license holder and as authorized in the Coordinated Service and Support Plan and/or Addendum.

RIGHTS RESTRICTIONS

Restriction of the following person's rights is allowed only if determined necessary to ensure the health, safety, and well-being of the person:

- associate with other persons of the person's choice
- personal privacy
- engage in chosen activities
- have daily, private access to and use of a non-coin-operated telephone for local calls and long-distance calls made collect or paid for by the person
- receive and send, without interference, uncensored, unopened mail or electronic correspondence or communication
- have use of and free access to common areas in the residence
- Privacy for visits with the person's spouse, next of kin, legal counsel, religious advisor, or others, in accordance with [section 363A.09](#) of the Human Rights Act, including privacy in the person's bedroom.

Any restriction of these rights must be documented in the person's Coordinated Service and Support Plan and/or Addendum. The restriction must be implemented in the least restrictive alternative manner necessary to protect the person and provide support to reduce or eliminate the need for the restriction in the most integrated setting and inclusive manner. The Rights Restriction must include the following information:

- the justification for the restriction based on an assessment of the person's vulnerability related to exercising the right without restriction;
- the objective measures set as conditions for ending the restriction;
- a schedule for reviewing the need for the restriction based on the conditions for ending the restriction to occur semiannually from the date of initial approval, at a minimum, or more

frequently if requested by the person, the person's legal representative(s), if any, and case manager; and

- Signed and dated approval for the restriction from the person, or the person's legal representative(s), if any. A restriction may be implemented only when the required approval has been obtained. Approval may be withdrawn at any time. If approval is withdrawn, the right must be immediately and fully restored.

Section: Services	Review Date: 10/2015
Topic: Service Termination Policy	Revision:

PURPOSE

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

POLICY

It is the intent of Harry Meyering Center (HMC) to ensure continuity of care and service coordination between members of the support team including, but not limited to the individual served, the legal representative and/or designated emergency contact, case manager and other licensed caregivers during situations that may require or result in service termination. HMC restricts service termination to specific situations according to Minnesota statutes, section [245D.10, subdivision 3a](#).

Section: Services	Review Date: 10/2015, 7/2016
Topic: Service Termination Procedure	Revision:

A service termination may include a temporary service suspension or HMC can do a service termination by itself.

HMC must permit each individual served to remain in the program and must not terminate services unless:

- The termination is necessary for the individual's welfare and the individual's needs cannot be met in the facility;
- The safety of the individual or others in the program is endangered and positive support strategies were attempted and have not achieved and effectively maintained safety for the individual or others;
- The health of the individual or others in the program would otherwise be endangered;
- The program has not been paid for services;
- The program ceases to operate; or
- The individual has been terminated by the lead agency from waiver eligibility.

Prior to giving notice of service termination, HMC must document actions taken to minimize or eliminate the need for termination. Action taken by HMC must include, at a minimum:

- Consultation with the individual's expanded/support team to identify and resolve issues leading to issuance of the termination notice; and
- A request to the case manager for intervention services as identified in section [245D.03 \(subdivision 1\)](#), or other professional consultation or intervention services to support the individual in the program. This requirement does not apply to notices of service termination issued due to the program not being paid for services.
- If, based on the best interests of the individual, the circumstances at the time of the termination notice were such that HMC was unable to take the action specified above; HMC must document the specific circumstances and the reason for being unable to do so.

The notice of service termination must meet the following requirements:

- HMC must notify the individual or the individual's legal guardian and the case manager in writing of the intended services termination. If the service termination is from residential supports and services, as defined in section [245D.03 \(subdivision 1\)](#), HMC must also notify the Minnesota Department of Human Service's Commissioner in writing; and
- The notice must include:
 - The reason for the action;
 - Except for a service termination when the program ceases to operate, a summary of actions taken to minimize or eliminate the need for service termination or temporary service suspension as required under section [245D.10 \(subdivision 3a\)](#), and why these measures failed to prevent the termination or suspension;

- The individual's right to appeal the termination of services under Minnesota Statutes, section [256.045 \(subdivision 3\)](#); and
- The individual's right to seek a temporary order staying the termination of services according to the procedures in Minnesota statutes, section [256.045 \(subdivision 4a or 6\)](#).

Notice of the proposed termination of service, including those situations that began with a temporary service suspension, must be given:

- At least 60 days prior to termination when HMC is providing intensive supports and services identified in section [245D.03, subdivision 1](#).
- At least 30 days prior to termination for all other services licensed under Chapter 245D. This termination notice may be given in conjunction with a notice of temporary services suspension.

During the service termination notice period, HMC must:

- Work with the expanded/support team to develop reasonable alternative to protect the individual and others and to support continuity of care;
- Provide information requested by the individual or case manager; and
- Maintain information about the service termination, including the written notice of intended service termination, in the service recipient record.

Section: Services	Review Date: 10/2015, 9/2016
Topic: Temporary Service Suspension Policy	Revision:

PURPOSE

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

POLICY

It is the intent of Harry Meyering Center (HMC) to ensure continuity of care and service coordination between members of the support team including, but not limited to the individual served, the legal representative and/or designated emergency contact, case manager and other licensed caregivers during situations that may require or result in temporary service suspension. HMC restricts temporary service suspension to specific situations according to Minnesota Statutes, section [245D.10 subdivision 3](#).

Section: Services	Review Date: 10/2015,
Topic: Temporary Service Suspension Procedure	Revision: 9/2016

A temporary service suspension may lead to or include service termination or HMC may do a temporary service suspension by itself. HMC must limit service termination to specific situations that are listed in the procedure on Service Termination.

- A. HMC must limit temporary service suspension to situations in which:
 - The individual's conduct poses an imminent risk of physical harm to self or others and either positive support strategies have been implemented to resolve the issues leading to the temporary service suspension, but have not been effective and additional positive support strategies would not achieve and maintain safety, or less restrictive measures would not resolve the issues leading to the suspension;
 - The person has emergent medical issues that exceed HMC's ability to meet the individual's needs; or
 - HMC has not been paid for services.
- B. Prior to giving notice of temporary services suspension, HMC must document actions taken to minimize or eliminate the need for service suspension. Action taken by HMC must include, at a minimum:
 - Consultation with the individual's expanded/support team to identify and resolve issues leading to issuance of the suspension notice; and
 - A request to the individual's case manager for intervention services identified in [section 245D.03 subdivision 1 paragraph \(c\), clause \(1\)](#) or other professional consultation or intervention services to support the individual in the program. This requirement does not apply to temporary suspensions issued due to non-payment of services.
 - If, based on the best interests of the individual, the circumstances at the time of the notice were such that HMC was unable to take the actions listed above; HMC must document the specific circumstances and the reason for being unable to do so.
- C. The notice of temporary service suspension must meet the following requirements:
 - HMC must notify the individual or the individual's legal representative and case manager in writing of the intended temporary services suspension. If the temporary services suspension is from residential supports and services, as defined in [section 245D.03 subdivision 1, paragraph \(c\), clause \(3\)](#), HMC must also notify Minnesota Department of Human Service's Commissioner in writing;
 - The notice of temporary services suspension must be given on the first day of the services suspension;
 - The notice must include the reason for the action; a summary of actions taken to minimize or eliminate the need for temporary services suspension as required under Minnesota Statutes, [section 245D.10, subdivision 3, paragraph \(d\)](#); and why these measures failed to prevent the suspension.

- D. During the temporary suspension period, HMC must:
- Provide information requested by the individual or case manager;
 - Work with the expanded/support team to develop reasonable alternatives to protect the individual and to support continuity of care; and
 - Maintain information about the temporary service suspension, including the written notice of temporary services suspension, in the service recipient record.
- E. If, based on a review by the individual's expanded/support team, the team determines the individual no longer poses an imminent risk of physical harm to self or others, the individual has a right to return to receiving services. If at the time of the temporary service suspension or at any time during the suspension, the individual is receiving treatment related to the conduct that resulted in the service suspension, the expanded/support team must consider the recommendation of the licensed health professional, mental health professional, or other licensed professional involved in the individual's care or treatment when determining whether the individual no longer poses an imminent risk of harm to self or others and can return to the program. If the expanded/support team makes a determination that is contrary to the recommendation of a licensed professional treating the individual, HMC must document specific reasons why a contrary decision was made.

Section: Services	Review Date: 1/2014
Topic: Tours Policy	Revision: 10/2016

Tours at any Harry Meyering Center (HMC) site will be approved by the Executive Director and/or Employee Relations Director. They are designed to educate community members about HMC services. All tours will respect the rights and privacy of individuals served as these are their homes. Whenever possible, the individual(s) served will be asked to give their permission for a tour and/or to participate in the tour.

Section: Operational	Review Date: 1/2014
Topic: Training Policy	Revision:

The Harry Meyering Center (HMC) takes great pride in the training it provides to employees. Training provides employees with the opportunity for professional and personal growth.

HMC is committed to providing the level of direct service support, staff supervision, assistance, and training necessary in order to:

- Ensure the health, safety, and protection of rights of each person
- Implement the responsibilities assigned to the license holder in each person's Coordinated Service and Support Plan (CSSP) and Addendum

HMC will ensure that staff providing direct support, or staff with responsibilities for supervising or managing the provision of direct support service, are competent as demonstrated through skills and knowledge training, experience, and education. This is to ensure that all requirements that are written in the CSSP and/or Addendum, or mandated by the case manager or federal waiver plan are met. HMC will verify and maintain evidence of staff competency through documentation of:

- Education and experience qualifications relevant to the job responsibilities and needs of the persons served by the program. Documentation regarding degrees, transcripts, valid license, registration, or certification will be required.
- Demonstrated competency in required orientation and training areas as determined by HMC through knowledge testing and observed skill assessment conducted by the trainer or instructor. When applicable, completion of continuing education required to maintain professional licensure, registration, or certification requirements.
- Periodic performance evaluations completed by HMC of the direct support staff person's ability to perform the job functions based on direct observation.

If a contractor or temporary staff is to perform services, it is HMC's responsibility to ensure that they meet and maintain compliance with all requirements that apply to the services being provided. All training, orientation, and necessary supervision will be provided and background studies will be completed. If applicable, all subcontractors or temporary staff must meet Minnesota licensing requirements and this documentation will be maintained by HMC.

Section: Operations	Last Review Date: 1/2014
Topic: Training Procedure	Revision: Draft 8/2014, 3/2017

Orientation:

New employees to the Harry Meyering Center (HMC) will be required to complete orientation. During orientation, they will be acquainted with HMC's mission and values, policies and procedures, rules and regulations, and job specific requirements.

Within 60 calendar days of hire, unless other stated, HMC will provide and ensure completion of 30 hours of orientation (for intensive services) or 10 hours of orientation (for basic services) for direct support staff which includes supervised on-the-job training. Prior to unsupervised contact with individuals served, or any time the individual's plans or procedures are revised, staff must review and receive instruction on the requirements as they relate to their job functions.

In the event of an emergency service initiation, HMC must ensure training occurs within 72 hours of the staff having their first unsupervised contact with the individuals served. The reason for the unplanned or emergency service initiation must be documented and maintained in the person's service recipient record.

Orientation to Program Requirements:

- Laws governing maltreatment reporting and service planning for children and vulnerable adults, and staff responsibilities related to protecting persons from maltreatment and reporting maltreatment. This training, which must be provided within 72 hours of first providing direct contact services, will include:
 - Vulnerable adults maltreatment reporting, internal review, and staff responsibilities related to protecting persons from maltreatment and reporting maltreatment
 - Maltreatment of minors reporting, internal review, and staff responsibilities related to protecting persons from maltreatment and reporting maltreatment (if applicable)
- Emergency Use of Manual Restraint (EUMR) as outlined in [245D.06](#) (subdivision 5) and [245D.061](#).
- Job description and how to complete specific job functions including responding to and reporting incidents as required under [245D.06](#) (subdivision 1) and following safety practices as required in section [245D.06](#) (subdivision 2).
- Education and related experience specific to job functions as identified in [245D.09](#) (subdivision 3)
 - Copy of valid degree and transcript, or
 - Current professional license, certificate, or registration, or
 - Documentation of continuing education credits completed for professional licensure
- Current policies and procedures including location, access, and staff responsibilities related to their implementation:
 - Universal precautions and sanitary practices
 - Health service coordination
 - Medication assistance and administration
 - Transportation
 - Emergency response, reporting, and review

- Incident response, reporting, and review
- Data privacy
- Admission criteria
- Grievances
- Temporary Service Suspension and Service Termination
- Service recipient rights and staff responsibilities related to ensuring the exercise and protection of those rights according to [245D.04](#).
- Principles of person-centered service planning and delivery as outlined in section [245D.07](#) (subdivision 1a), and how they apply to direct support service provided by the staff person
- Basic First Aid
- Other topics as determined necessary in the person's Coordinated Service and Support Plan (CSSP) and/or Addendum by the case manager or other areas identified by HMC
- Substance abuse
- Program abuse and Prevention Plans

Orientation to Individual Service Recipient Needs:

- Within the scope of service, appropriate and safe techniques related to activities of daily living (ADLs) as defined under section [256B.0659](#) (subdivision 1).
- Within the scope of service, an understanding of what constitutes a healthy diet and the skills necessary to prepare that diet.
- Within the scope of service, skills necessary to provide appropriate support in instrumental activities of daily living (IADLs) as defined under section [256B.0659](#) (subdivision 1).
- A staff person trained in first aid and CPR must be available on site when required in the CSSP and/or Addendum of the individual served. The CPR training must include hands-on practice and an observed skills assessment under the supervision of a CPR instructor.
- The CSSP and/or Addendum of the individual served as it relates to the responsibilities assigned to HMC, and when applicable, the person's individual abuse prevention plan, to achieve and demonstrate an understanding of the person as a unique individual, and how to implement those plans.
- Medication administration, setup, or assistance procedures established for the individual served, as needed for the staff's job description according to section [245D.05](#) (subdivision 1, paragraph b). Unlicensed staff may administer medications only after successful completion of a medication administration or medication setup-training curriculum developed by a registered nurse or appropriate licensed health professional. The curriculum must incorporate an observed skill assessment to ensure staff demonstrate the ability to safely and correctly follow medication procedures.
- Additional medication administration taught by a Registered Nurse (RN), clinical nurse specialist, certified nurse practitioner, physician's assistant, or physician for a person who has, or develops, a medical condition that affects the service options available to the person because the condition requires:
 - Specialized or intensive medical or nursing supervision; and
 - Non-medical service providers to adapt services to accommodate the health and safety of the person.
- A staff person must review and receive instruction on the safe and correct operation of medical equipment used by the person to sustain life or to monitor a medical condition that

could become life threatening without proper use of the equipment, including but not limited to ventilators, feeding tubes, endotracheal tubes.

- The training must be provided by a licensed health care professional or a manufacturer's representative and incorporate an observed skill assessment to ensure staff demonstrate ability to correctly operate the equipment based on orders and instruction.

New Employee Training:

In addition to initial orientation topics above, new employees are also required to complete additional training including, but not limited to:

- Workplace Health and Safety (completed online prior to orientation)
- Policies and Procedures related to (completed during orientation):
 - Harassment Prevention
 - Fraud Prevention
 - Computer Use
 - Phone Use
- Therapeutic Relationships (completed during orientation)
- Physical Intervention Techniques (completed during orientation)
- Fire Safety (within two weeks of hire date)
- Defensive Driving (within one month of hire date)

Staff Meetings:

Employees are required to attend all staff meetings of the site at which they work. Attendance at staff meetings will count toward annual in-service hours. If an employee is unable to attend a staff meeting, they are responsible for being excused by their supervisor in advance. It is then the responsibility of the employee to ensure that they receive any information covered at the meeting. Failure to attend a staff meeting will be treated as a no show.

Annual Training:

All employees will be provided ongoing training to enhance their personal and professional growth and development. In-services will be provided so that all employees can update and improve their skills in the areas related to their position and the needs of the agency.

Completion of in-services is on an annual basis as defined by [245A.02](#) (subdivision 2b). At a minimum, 24 hours of annual training must be completed by direct support staff with fewer than five years documented experience. For direct support with five or more year's experience, the requirement is 12 hours per year ([245D.09](#) subdivision 5). Required hours are indicated on the in-service records and will be updated automatically based on hire date, change to position within the organization, or a change to the employee's regularly scheduled hours.

Employees may be able to receive in-service credit for college classes, training from another provider, reading, research, workshop, or movies. The Employee Relations Director holds the discretion as to whether such credit will be approved, and HMC will maintain the documentation of that training.

HMC will publish a listing of offered in-services. Employees are to sign up for in-services with Human Resources. Staff are expected to attend all in-services they are signed up for, unless they cancel at least 24 hours in advance. If an employee registers and does not attend without cancelling, it will be viewed as a “no show.” No shows for in-services will not be tolerated, will be addressed in a timely fashion by the supervisor, and handled in the same manner as a no show at the work site. All attendance and punctuality issues will be addressed, and could include disciplinary action. If an in-service is cancelled for any reason, HMC will notify all employees signed up.

The following are to be reviewed annually, unless otherwise indicated:

- Laws governing maltreatment reporting and service planning for children and vulnerable adults, and staff responsibilities related to protecting persons from maltreatment and reporting maltreatment. This training, which must be provided within 72 hours of first providing direct contact services, will include:
 - Vulnerable adults maltreatment reporting, internal review, and staff responsibilities related to protecting persons from maltreatment and reporting maltreatment
 - Maltreatment of minors reporting, internal review, and staff responsibilities related to protecting persons from maltreatment and reporting maltreatment (if applicable)
- Infection Control.
- Workplace Health and Safety
- Therapeutic Relationships
- Emergency Use of Manual Restraint
- Physical Intervention Techniques (PIT)
- Values.
- CPR and First Aid Training
- Harassment
 - For supervisors and other designated administrative or programmatic employees.
- Quarterly Emergency Procedures
 - Completed each quarter for all ICF Program staff.
- Defensive Driving
 - Required every third year.
- The person’s CSSP and/or Addendum as it relates to the responsibilities assigned to HMC, and when applicable, the persons Individual Abuse Prevention Plan, and how to implement those care plans.
- Person-Centered Planning.
- Medication Administration (including set-up and assistance)
- Confidentiality and Rights

NOTE:

If employees are being sent to an in-service outside of the agency, the agency will pay the registration fee, wages, and other applicable expenses. If an employee is choosing or requesting to attend an in-service outside of the agency, it is at the discretion of the Employee Relations Director as to whether or not the agency will reimburse the employee the registration fee and other applicable expenses. It is also at the discretion of the Employee Relations Director whether the employee will receive in-service credit for the training.

Section: Services	Last Review Date: 1/2014, 10/2016
Topic: Transportation Services Policy	Revision: Draft 08/2014

It is of utmost importance to ensure the safety of the individuals served as well as staff during transportation. It is the responsibility of the Harry Meyering Center (HMC) staff to assist in transporting, handling, and transferring persons served in a manner consistent with their Community Service and Support Plan and/or Addendum.

Section: Services	Last Review Date: 1/2014, 10/2016
Topic: Transportation Services Procedure	Revision: Draft 8/2014

The Harry Meyering Center (HMC) requires that employees in most positions have a valid driver's license and a good driving record. The Employee Relations Director can use their discretion to approve any exceptions.

Upon hire, new employees shall provide written permission for HMC's insurance provider to check their driving record. Employees are expected to have and maintain a driving record that is insurable by HMC's insurance. Employees with a poor driving record, as determined by HMC's insurance provider, will not be allowed to drive HMC vehicles or their own vehicle for job-related tasks. Failure to provide or maintain an insurable record may result in the loss of one's position if driving for the agency is part of the job requirements. The insurance provider will review driving records annually.

Proof of insurance shall be required for employees using their personal vehicle for company business. All employees that use their personal vehicle for HMC will be required to keep it in good working condition.

All staff that drive HMC's vehicles or their own personal vehicle for their position will be required to take Defensive Driving within one month of hire. A refresher course is required every three years thereafter.

The Physical Plant Manager, or designate, will ensure the safety of vehicles owned or leased by HMC and maintain them in good condition. Standard practices for vehicle maintenance and inspection are as follows:

- Vehicles will be kept clean interiorly and exteriorly.
- Eating, drinking, or smoking is not allowed inside vehicles at any time.
- Vehicles are maintained with working heat, air-conditioning, cruise control, and radios as possible for the use of the individuals served.
- All potential mechanical problems shall be reported by staff immediately.
- Staff will report all accidents immediately. Accident reports will be reviewed by the Safety Committee, and as necessary, post accident training will be provided.
- Staff will report all vehicle maintenance concerns to the Physical Plant Director or maintenance staff.
- Treat the vehicle respectfully – employees will be held accountable for any damage done due to negligence or improper use.
- Insurance covers the employee when using agency vehicles, but expects that employees drive within parameters of the law. HMC will not pay for any tickets incurred by employees, and disciplinary procedures will be followed for careless driving.

For contracted transportation, all required documentation shall be completed and submitted prior to the first scheduled trip. Staff will arrange ongoing use of contracted transportation. Staff can also assist individuals served with arranging transportation on their own.

When there is a change in staff following the transporting of an individual served, the transporting staff will ensure that the next party responsible is present before leaving.

Anyone riding in a moving vehicle is required to wear seatbelts and/or child safety restraints.

Staff is prohibited by state law section [169.475](#) to compose, send, or receive an electronic message while operating a motor vehicle.

Individuals served that utilize a wheelchair will be transported according to the safety guidelines of the manufacturer. This includes, but is not limited to, safe operation and regular maintenance of lift equipment, checks of straps to secure the wheelchair to the floor of the vehicle, and use of adaptive seating equipment when appropriate. Staff that will be transporting individuals served will be trained on the proper way to secure wheelchairs, and will demonstrate competency prior to transporting individuals served in wheelchairs.

Staff will receive training on each person's transferring or handling requirements and equipment utilized prior to transferring or transporting anyone. Transfers and handling of individuals served will be done in a manner that ensures their dignity and privacy. Any concerns regarding transportation, transfers, and handling will be promptly communicated to the Program Manager and/or Program Director. Concerns will be addressed immediately if the health and safety of the individual served is at risk.

When equipment used by an individual served is needed, the equipment will be placed by staff in a safe location of the vehicle. If a vehicle does not have a designated storage space, staff will place the equipment in an area of the vehicle where it can be secured to limit shifting during transport.

If there is an emergency while driving, staff will follow emergency response procedures to ensure the safety of the individual's served. This includes pulling the vehicle over, stopping in a safe area as quickly as possible, and using a cell phone or community resource to call 911 if needed. If a medical emergency were to occur, staff will call 911 and then follow first aid and/or CPR protocol according to their training.

Staff will be prepared for emergencies to ensure safety. Vehicles will be equipped with the following in case of emergency:

- Name and phone number of person to call in case of emergency
- First aid kit and handbook
- Proof of insurance card and vehicle registration
- Seasonal and emergency supplies

While transporting more than one person served and physical aggression occurs, staff will pull over and stop as quickly and safely as possible, redirect the individual served, and attempt to contact another staff person, on-call, Building Charge (for Homestead) and 911 if necessary.

In the event of a severe weather emergency, staff will take the following actions:

- Monitor weather conditions by listening to local television, radio, or weather radio for warnings and watches
- Follow directions for the need to change plans and activities, or seek emergency shelter
- Inform individuals served why plans and activities have changed, assist passengers in remaining calm

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

Section: Operations	Review Date: 1/2014
Topic: Tuberculosis Procedure	Revision:

The Tuberculosis (TB) Infection Control Program and Plan (ICPP) is a part of the Harry Meyering Center's (HMC) Safety Committee. The Safety Committee Chair is assigned to be the supervisor responsible for the plan which includes:

- Completing TB risk assessment worksheets
- Determining HMC's risk classification
 - Based on results of risk assessment worksheets, HMC's risk is low.
- Overseeing all aspects of the TB ICPP

The committee will meet biannually to review and/or update the ICPP.

Who Needs to be Screened?

- New employees hired for Homestead or Prairie's Edge including:
 - Those vaccinated for bacille Calmette-Guerin (BCG)
 - Pregnant and nursing women
 - Individuals served at time of admission
 - Those with a history of a positive tuberculin skin test (TST), unless appropriate documentation can be provided. This would include documentation showing the results of the positive TST and the subsequent chest x-ray.

Investigation of Active TB:

- If an individual served or an employee are known, or suspected, to have active TB, a report will be made to the Minnesota Department of Health and Blue Earth County.
- Appropriate follow-up will be arranged by those entities to assist in a community contact investigation.

Employee Training and Education:

- All staff will receive training and education regarding TB during their new employee orientation
- On-going training will be provided during HMC's annual Infection Control training

Section: Operations	Review Date: 1/2014
Topic: Tuberculosis Procedure – Employees	Revision:

Screening Process:

- There are two components of baseline screening:
 - Administration of either a two-step tuberculin skin test (TST) or a single TB blood test upon hire, or within three months prior to date of hire. Written documentation must be provided that includes the administration date as well as the results.
 - Assessment for current symptoms of active TB disease
- If the initial TST is negative, a second TST will be administered one to three weeks later
- Employees are able to work during this time
- Reports will be maintained in the employee files
- Serial testing is not needed in low risk settings unless an exposure occurs
- Employees with extra pulmonary TB disease usually do not need to be excluded from the workplace unless they also have TB of the respiratory tract
- Employees should be excluded from the workplace if they have:
 - Suspected active TB disease
 - Confirmed active TB disease
 - Draining TB skin lesion
- Employees should be allowed to return to work following a case of active TB only when all of the following criteria have been met:
 - Two consecutive acid-fast bacillus (AFB)-negative sputum samples
 - Response to TB treatment
 - Determined to be non-infectious by a physician

Procedure for a Positive Step One TST:

- In the absence of symptoms for active TB, employees will be evaluated by a physician prior to having any contact with individuals served to rule out a diagnosis of active TB.
 - Evaluation will include a chest x-ray
 - Pregnant women can have a chest radiograph using an abdominal shield
- Employees will not be allowed in the workplace until a diagnosis of active TB can ruled out
- Staff should be aware of whether their own medical status (immunosuppressed) places them at higher risk for developing TB.

Procedure for a Positive Step Two TST:

- An employee must be evaluated by a physician to rule out a diagnosis of active TB in the absence of any symptoms.
- Evaluation will include a chest x-ray
- The employee will be excluded from the workplace until the diagnosis of active TB is ruled out
 - ❖ If an employee is suspected of having, or has, active TB following a positive TST, Harry Meyering Center (HMC) will pay for the initial chest x-ray. HMC is not responsible for paying for the subsequent treatment and additional testing that may be required unless the exposure

happened while the employee was working for HMC. The employee would then be covered through Worker's Comp.

Employees Suspected of Having Active TB:

- Prompt evaluation by a physician
- The following signs and symptoms could be related to a diagnosis of TB:
 - Prolonged cough (over three weeks)
 - Night Sweats
 - Weight loss / poor appetite
 - Chest pain
 - Hemoptysis (bloody sputum)
 - Fever / chills
 - Fatigue

Appropriate diagnostic measures will be conducted at a medical facility for employees in whom active TB is suspected. The employee will not return to work until a diagnosis of TB has been ruled out, the employee is on therapy, and/or determination has been made that the employee is non-infectious.

The following must be done before an employee with active TB can return to work:

- Documentation is received by HMC that the employee is receiving adequate therapy
- Cough has resolved
- Employee has had three consecutive negative sputum smears collected on different days

After work duties have resumed, and while the employee remains on anti-TB therapy, HMC must receive periodic documentation from the health care provider. This documentation must show that the employee is being maintained on the effective drug therapy for the recommended time period and that the sputum AFB smears continue to be negative.

Employees that have TB at sites other than the lung or larynx usually do not need to be excluded from the workplace if a diagnosis of concurrent pulmonary TB has been ruled out.

Conducting a Problem Evaluation:

- If an employee develops active TB, the case will be evaluated to determine the likelihood that it resulted from occupational transmission, to identify possible causes, and to implement appropriate interventions should the transmission have occurred from within the workplace.
- All contacts of the employee should be identified and evaluated for TB

Employees receiving preventive treatment for latent TB infection should not be restricted from their usual work activities.

Section: Operations	Review Date: 1/2014
Topic: Tuberculosis Procedure – Individuals Served	Revision:

Screening Process:

- Baseline TB screening will be done upon admission and includes:
 - Two-step TST or a single TB blood test
 - Assessment for current symptoms of active TB
 - Must be found free from communicable disease by a physician
- Individuals served will also be monitored on an on-going basis for signs of illness by employees and nursing staff
 - Quarterly Health Assessments are completed by the Harry Meyering Center (HMC) nurses
 - All residents of Homestead and Prairie's Edge must be found free from communicable disease at an annual physical exam by a physician
- Serial testing is not needed unless exposure occurs

Individuals Served Suspected of Having Active TB:

- Individuals served exhibiting the following signs and/or symptoms will receive a prompt evaluation by a physician:
 - Prolonged cough (more than three weeks)
 - Night sweats
 - Weight loss / poor appetite
 - Chest pain
 - Hemoptysis (bloody sputum)
 - Fever / chills
 - Fatigue

Appropriate diagnostic measures will be conducted at a medical facility when active TB is suspected. The individual served will not return to HMC until a diagnosis of TB has been ruled out or they are on therapy and a determination has been made that they are non-infectious.

Conducting a Problem Evaluation:

- If an individual served develops active TB, the transmission of TB should be investigated thoroughly to determine the cause and exposure
- All contacts of the individual served should be identified and evaluated for TB
- Early identification of individuals served with TB symptoms is important so that prompt transfer to a proper medical facility can be made.

Section: Operations	Review Date: 1/2014
Topic: Universal Precautions Policy	Revision:

Policy Statement

It is the policy of the Harry Meyering Center (HMC) that all employees adhere to universal precautions when helping, treating or caring for individuals served and/or employees. The precautions are in place to protect employees from potential diseases or illnesses that can be transmitted through blood or body fluids containing blood.

Scope

Universal precautions refer to treating all human blood and other potentially infectious materials as if they are known to be infected with a bloodborne pathogen. Universal precautions involve the following:

- Maintaining personal hygiene (hand washing)
- Using [personal protective equipment \(PPE\)](#)
- Disposing of contaminated materials appropriately
- Following proper sanitation procedures

All resources needed for protection from potentially infectious materials will be provided and/or cleaned at no cost to the employee.

Section: Operations	Review Date: 1/2014
Topic: Universal Precautions Procedure	Revision:

- Hand washing is the single most important practice for preventing the spread of disease and infection. Proper hand washing will be completed as a part of regular work practice and routine, regardless of the presence or absence of any recognized disease and infection. Staff is expected to assist persons served to ensure regular hand washing. Hand washing will occur often and will include thorough use of water, soap, rubbing hands vigorously together for 20 seconds, rinsing and drying completely.
- Staff will ensure that their coughs and sneezes are appropriately covered. Appropriately covered means coughing or sneezing into their elbows. Staff is expected to assist persons served to understand and use appropriate means to cover their coughs and sneezes.
- Gloves will be used as a barrier between hands and any potential source of infection. Gloves must be worn when contact with high risk bodily fluids can be reasonably anticipated. Following each task, gloves should immediately be removed and disposed of properly. Fresh gloves will be used for each situation and for each person served.
- Eye protection may be made available whenever splashes or drops of high risk bodily fluids are anticipated. This can include, but is not limited to, oral hygiene procedures and clean up of large amounts of high risk bodily fluids.
- If necessary, a fluid resistant gown may be provided for staff to wear as a barrier during clean up of high volume fluids.
- When handling linen and clothing contaminated with high risk bodily fluids, staff will wear gloves at all times. Contaminated laundry will be cleaned in the washing machine and dried in the dryer separate from non-contaminated laundry.
- Staff will use gloves and an approved disinfecting solution according to the directions when cleaning a contaminated surface.
- Staff is to use extreme, deliberate precaution in handling contaminated needles and sharps. Contaminated needles will not be bent or recapped. All needles and sharps will be disposed of in an appropriate sharps container.
- Specimens obtained for medical testing or procedures containing high risk bodily fluids or other potentially infectious material must be handled with gloves, placed in a sealed container to prevent leakage, and labeled with the person's name and the type of specimen. If refrigeration is required, the specimen will be placed inside a second sealed container and separated from any refrigerated foods.

Compliance

- Staff is responsible to adhere to universal precaution procedures. If there are obstacles to the implementation of universal precaution procedures, they will be immediately brought to the attention of the Program Director or their designee who will then develop and implement solutions as necessary.
- At a minimum, gloves, disinfectant, and appropriate cleaning supplies and materials will be available at the program site.
- Staff will receive training at orientation and annually thereafter on universal precaution procedures, infection control and blood borne pathogens.

Section: Operations	Review Date: 1/2014
Topic: Exposure Incident Procedure	Revision:

An exposure incident refers to when a person is exposed to the blood or body fluid of another person. If an exposure incident occurs, it must be promptly reported to the On-Call designate at one of the following numbers:

- ICF On-Call: 507-340-2197
- SLS On-Call: 507-340-3535
- SILS On-Call: call the SILS office if during regular business hours at 507-625-7398 or the on-call after hours at 507-317-4342

The Human Resources Director also needs to be called at 507-388-8972 and a message can be left if the incident occurs after business hours. An immediate and confidential medical evaluation, along with follow-up, will be conducted within 24 hours of exposure. An [exposure report](#) needs to be completed by the end of the work shift and must accompany staff at their medical evaluation. If applicable, the legal representative of an individual served will be notified and appropriate consent will be obtained for testing and/or treatment.

Section: Services	Review Date: 1/2014, 10/2016
Topic: Visitors Procedure	Revision:

Employees need to know the name and other pertinent information of anyone associating with an individual served by the Harry Meyering Center (HMC). Information may include; address, phone number, relationship with individual.

ICF or SLS:

Individuals served in the ICF or SLS settings should not get in the vehicle of anyone unknown to the employee, legal representative, and his/her family. Employees may provide transportation for the individual served to meet an acquaintance at a prearranged destination.

If the employee has no prior instructions and is concerned for any reason about the individual served associating with another person, the employee should limit access, provide staff supervision, or invite the acquaintance to the HMC program site so continual supervision can be provided. Any concerns should be communicated to the on-call designate or appropriate supervisor as soon as possible.

SILS/In-Home:

Individuals served by HMC's SILS/In-Home Program receive advice and participate in discussions regarding personal safety from their staff. Quarterly, staff reviews formal emergency procedures with each individual.

Section: Services	Review Date: 1/2014, 10/2016
Topic: Volunteer Policy	Revision:

Volunteers include persons engaged in casual or intermittent activity, as well as those who are volunteering as a part of their education. They receive no monetary compensation for their volunteer work. Parental or legal guardian permission is required for persons under the age of eighteen.

The Harry Meyering Center will ensure that volunteers who provide direct support services to persons served by the program receive the training, orientation, and supervision necessary to fulfill their responsibilities. HMC will complete a background study according to the requirements in sections [245C.03, subdivision 1](#), and [245C.04](#). HMC must maintain documentation that the applicable requirements have been met.

Section: Services	Review Date: 1/2014, 10/2016
Topic: Volunteer Procedure	Revision:

Introductory Orientation by the Activities Coordinator or Director of Program Services includes:

- Agency philosophy, mission and values
- Volunteer responsibilities and limitations
- Supervisor's role
- Policies and Procedures
 - Protection of Vulnerable Adults Policy and Procedure
 - Maltreatment of Minors (if applicable) Policy and Procedure
 - Substance Abuse Policy and Procedure
 - Social Media Policy and Procedure
 - Professionalism Procedure
 - Cell Phone Policy
 - Personal Appearance Policy
 - Rights of Individuals Served Policy
 - Confidentiality/HIPAA/Data Privacy

Site Orientation may include the following as applicable:

- Individual vulnerabilities and plans of individuals served
- Information about the individual served that will be necessary to perform the tasks requested. This could include, but is not limited to, medications, health issues, behavioral concerns, communication, preferences, goals and methodologies, etc.
- Information concerning best practices in working with the individual(s) they are working with
- Emergency Use of Manual Restraint

Volunteers will not be asked to complete the following:

- Complete personal cares (i.e., bathing, toileting, dressing, oral cares, etc).
- Intervene in behavioral situations.
- Complete medically related procedures.
- Be alone with an individual served (unless background study has been completed)
- Drive Harry Meyering Center vehicles.

Section: Services	Review Date: 10/2015, 8/2016, 10/2017, 10/2018
Topic: Protection of Vulnerable Adults	Revision:

PURPOSE

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

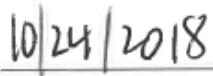
POLICY

Staff who are mandated reporters must report all of the information they know regarding an incident of known or suspected maltreatment, either internally or externally, in order to meet their reporting requirements under law. All staff of the Harry Meyering Center (HMC) who encounters maltreatment of a vulnerable adult will take immediate action to ensure the safety of the individual(s) served. Maltreatment of vulnerable adults is defined as abuse, neglect, or financial exploitation and will refer to the specific definitions from [Minnesota statute, section 626.5572](#) at the end of this policy.

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



 President, Board of Directors



 Date

Section: Services	Review Date: 10/2015, 10/2018
Topic: Protection of Vulnerable Adults Procedure	Revision: 8/2016

For purposes of this procedure, the term “immediately,” when referring to reporting, holds the below definition for each program:

- **ICF (Homestead, Prairie’s Edge, and South) - means there is no delay between staff awareness of the occurrence and reporting to the administrator or other officials unless the situation is unstable in which case reporting should take place as soon as the safety of the individuals is assured.**
- **SLS/SILS – Within 24 hours**

Employees, who become aware of maltreatment or the possibility of maltreatment of a vulnerable adult, age 18 or older, will take immediate action to ensure the safety of the person or persons. If staff knows or suspects that a vulnerable adult is in immediate danger they will call 911.

Employees will continue to protect the vulnerable adult from maltreatment during the reporting, investigation, internal review process, and until a corrective plan of action is implemented, as applicable.

REPORTING PROCEDURES

- A. Reports are to be filed immediately (within 24 hours) when a mandated reporter:
 - Has reasonable cause to believe that a vulnerable adult is being, or has been, abused, neglected or financially exploited.
 - Has knowledge that a vulnerable adult has sustained a physical injury which is not reasonably explained.
 - Has knowledge that a vulnerable adult has harm or injury which required medical attention and/or adverse side effects which interfered with their normal daily routine and activities as a result of a medication/treatment error.
 - Has knowledge of an incident which constitutes a reportable therapeutic error.
- B. If a staff knows or suspects that maltreatment of a vulnerable adult has occurred, they must make a report immediately (within 24 hours) either internally or externally. When the suspected maltreatment is reported internally, the facility remains responsible for immediate reporting to the Minnesota Adult Abuse Reporting Center (MAARC) if deemed necessary. If staff choose to make a report directly to an external agency, they must make the report by notifying the MAARC through one of the following methods:
 - Online (preferred) by going to <https://mn.gov/dhs/reportadultabuse/>
 - Phone: 1-844-880-1574 this number will be answered 24 hours a day, seven days a week.
 - When staff is reporting the alleged or suspected maltreatment, either internally or externally, staff will include as much information as known and will cooperate with any subsequent investigation.
- C. HMC shall post a copy of the internal and external reporting policies and procedures, including the telephone number of the MAARC in a prominent location in the program and have it available upon request to the mandated reporter(s), individuals served, and the person’s legal representative(s).

SLS AND SILS

Verbal or physical aggression occurring between vulnerable adults of a facility, or self-abusive behavior by these persons does not constitute abuse unless the behavior causes serious harm. HMC shall record incidents of aggression and self-abusive behavior to facilitate review by licensing agencies and county and local welfare agencies.

ICF – HOMESTEAD, PRAIRIE’S EDGE and TKS SOUTH

Physical aggression occurring between vulnerable adults in the Intermediate Care Facility (ICF) program will be reported as maltreatment. Self-abusive behavior does not constitute abuse unless the behavior causes serious harm, in which case a maltreatment report will be filed. HMC shall record incidents of aggression and self-abusive behavior to facilitate review by licensing agencies and county and local welfare agencies.

EXTERNAL REPORTING PROCEDURE

- A. A mandated reporter shall report immediately and directly to the MAARC or law enforcement. The responsibility to ensure that the report reaches the outside investigative authority remains with the mandated reporter.
- B. If verbally reporting the alleged or suspected maltreatment, staff will include as much information as known and will cooperate with any subsequent investigation.

INTERNAL REPORTING PROCEDURE

- A. Mandated reporters are required to fill out an Incident Report and make proper notifications to internal persons starting with the Program Manager and/or Program Director, or in their absence, respective program on-call personnel.
- B. Notify the appropriate persons immediately, as stated above. If designate is involved in or suspected of maltreatment, the next highest positioned person of authority will be responsible for receiving the report. The report is NOT given to the alleged perpetrator.
- C. Transfer document to personnel notified in confidential manner.
- D. The person receiving the report will immediately fill out the online form or call the MAARC. If designate is involved in or suspected of maltreatment, the next highest positioned person of authority will be responsible for completing the Internal Review and reporting to the MAARC. The report is NOT given to the alleged perpetrator.
- E. Designate will ensure that an Incident and Emergency Report form has been completed.
- F. The Program Director or designee will immediately notify the Executive Director, legal representative(s) of the individual served and case manager within 24 hours. The report will not be shared with a person if there is a reason to believe they are involved in or suspected of the maltreatment. The information shared with the legal representative and case manager will include the nature of the activity or occurrence reported, the agency that receives the report.
- G. Within two working days, written notice via the Notification to Internal Reporter will be given to the mandated reporter in a confidential manner stating whether the facility has reported the incident to the MAARC. The mandated reporter will be informed of his/her rights under the law if the MAARC has not been notified. The notice further states that if the reporter is not satisfied with the facility decision on whether or not to report externally, the reporter may still make an external report to the MAARC and that the reporter is protected against any retaliation for a good faith report made to the MAARC.

INTERNAL REVIEW PROCEDURE

- A. When the Harry Meyering Center (HMC) has knowledge that an external or internal report of alleged or suspected maltreatment has been made, an investigation and internal review will be completed within a five (5) day timeframe (working days mean Monday – Friday, excluding state and Federal holidays). The Program Director is the primary individual responsible for ensuring that the investigation and the internal reviews are completed for reports of maltreatment. If there are reasons to believe that the Program Director(s) is involved in the alleged or suspected maltreatment, the Executive Director is the secondary individual responsible for ensuring that investigations and internal reviews are completed.
- B. It shall be the responsibility of the Program Director or their designee to coordinate the investigation and internal review of any case of maltreatment or suspected maltreatment within 24 hours and complete the Internal Review. If the Program Director is suspected of maltreatment, the Executive Director will coordinate the investigation. The results of the investigation must be received by the Program Director (or if Program Director is suspected of maltreatment, Executive Director) within five (5) working days. The Program Director (or if Program Director is suspected of maltreatment, Executive Director) will date the document as to when it was received.
- C. The person completing the internal review will:
 - Ensure an Incident and Emergency Report has been completed.
 - Coordinate any investigative efforts with the lead investigative agency by serving as the HMC contact, ensuring that staff cooperates, and that all records are available.
 - Ensure that the following items are addressed within the review.
 - Related policies and procedures were followed
 - The policies and procedures were adequate
 - There is a need for additional staffing
 - The reported event is similar to past events with the vulnerable adults or the services involved
 - There is a need for corrective action by the license holder to protect the health and safety of the report of maltreatment.
- D. Based upon the results of the internal review, HMC will develop, document, and implement a corrective action plan designed to correct lapses and prevent future lapses in performance by individuals or HMC, if any.
- E. When the investigation and review have been completed, the Program Director /Executive Director will determine appropriate corrective action, in the case of an employee, which could include termination.
- F. Internal reviews must be made accessible to the commissioner immediately upon the Commissioner's request for internal reviews regarding maltreatment.
- G. The Vulnerable Adult report form, the results of the internal investigation, resolution of the issue and all other pertinent data are to be kept in a locked file in the designated office.
- H. All records of reports which upon initial investigation cannot be substantiated or disproved to the satisfaction of the appropriate agency shall be kept for a period of four years. Those reports which are substantiated by appropriate agency shall be maintained for seven years. Reports found to be false shall be destroyed three years after the case is resolved. Data from reports which were not investigated by a lead agency and for which there is no final disposition will be maintained for three years from the date of the report.

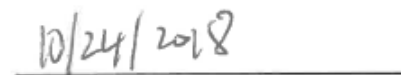
- I. The report will remain confidential within the agency and through the course of legal action as the law allows.

TRAINING

- A. The vulnerable adult shall receive orientation to the Internal Reporting Procedure within 24 hours of admission. The orientation shall include the name, telephone number, website, e-mail, and street addresses of protection and advocacy services, including the appropriate state appointed Ombudsman. If, for some reason, the person would benefit from a later orientation, the reason shall be documented, and the orientation shall be completed within 72 hours.
- B. The Internal Reporting Procedure shall be available to the individual served, their representatives, and mandated reporters upon request. The policy for protection of vulnerable adults shall be reviewed annually by employees and the HMC Board of Directors.
- C. Staff will receive training on this policy, section [245A.65](#) and sections [626.557](#) and [626.5572](#) and their responsibilities related to protecting individuals served from maltreatment and reporting maltreatment. This training must be provided within 72 hours of first providing direct contact services and annually thereafter.
- D. HMC shall post a copy of the internal and external reporting policies and procedures, including the telephone number of the MAARC in a prominent location in the program and have it available upon request to mandated reporters, individuals served, and the person's legal representatives.



President, Board of Directors



Date

Definitions

MINNESOTA STATUTES, SECTION 626.5572 DEFINITIONS

Subdivision 1.Scope.

For the purpose of section [626.557](#), the following terms have the meanings given them, unless otherwise specified.

Subd. 15.Maltreatment.

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

Subd. 2.Abuse.

"Abuse" means:

- (a) An act against a vulnerable adult that constitutes a violation of, an attempt to violate, or aiding and abetting a violation of:

- (1) assault in the first through fifth degrees as defined in sections [609.221](#) to [609.224](#);
 - (2) the use of drugs to injure or facilitate crime as defined in section [609.235](#);
 - (3) the solicitation, inducement, and promotion of prostitution as defined in section [609.322](#);
- and

- (4) criminal sexual conduct in the first through fifth degrees as defined in sections [609.342](#) to [609.3451](#).

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

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

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

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

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

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

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

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

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

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

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

Subd. 9. Financial exploitation.

"Financial exploitation" means:

- (a) In breach of a fiduciary obligation recognized elsewhere in law, including pertinent regulations, contractual obligations, documented consent by a competent person, or the obligations of a responsible party under section [144.6501](#), a person:
- (1) engages in unauthorized expenditure of funds entrusted to the actor by the vulnerable adult which results or is likely to result in detriment to the vulnerable adult; or
 - (2) fails to use the financial resources of the vulnerable adult to provide food, clothing, shelter, health care, therapeutic conduct or supervision for the vulnerable adult, and the failure results or is likely to result in detriment to the vulnerable adult.
- (b) In the absence of legal authority a person:
- (1) willfully uses, withholds, or disposes of funds or property of a vulnerable adult;
 - (2) obtains for the actor or another the performance of services by a third person for the wrongful profit or advantage of the actor or another to the detriment of the vulnerable adult;
 - (3) acquires possession or control of, or an interest in, funds or property of a vulnerable adult through the use of undue influence, harassment, duress, deception, or fraud; or
 - (4) forces, compels, coerces, or entices a vulnerable adult against the vulnerable adult's will to perform services for the profit or advantage of another.
- (c) Nothing in this definition requires a facility or caregiver to provide financial management or supervise financial management for a vulnerable adult except as otherwise required by law.

Subd. 17. Neglect.

"Neglect" means:

- (a) The failure or omission by a caregiver to supply a vulnerable adult with care or services, including but not limited to, food, clothing, shelter, health care, or supervision which is:
- (1) reasonable and necessary to obtain or maintain the vulnerable adult's physical or mental health or safety, considering the physical and mental capacity or dysfunction of the vulnerable adult; and
 - (2) which is not the result of an accident or therapeutic conduct.
- (b) The absence or likelihood of absence of care or services, including but not limited to, food, clothing, shelter, health care, or supervision necessary to maintain the physical and mental health of the vulnerable adult which a reasonable person would deem essential to obtain or maintain the vulnerable adult's health, safety, or comfort considering the physical or mental capacity or dysfunction of the vulnerable adult.
- (c) For purposes of this section, a vulnerable adult is not neglected for the sole reason that:
- (1) the vulnerable adult or a person with authority to make health care decisions for the vulnerable adult under sections [144.651](#), [144A.44](#), chapter 145B, 145C, or 252A, or sections [253B.03](#) or [524.5-101](#) to [524.5-502](#), refuses consent or withdraws consent, consistent with that authority and within the boundary of reasonable medical practice, to any therapeutic conduct, including any care, service, or procedure to diagnose, maintain, or treat the physical or mental

condition of the vulnerable adult, or, where permitted under law, to provide nutrition and hydration parenterally or through intubation; this paragraph does not enlarge or diminish rights otherwise held under law by:

- (i) a vulnerable adult or a person acting on behalf of a vulnerable adult, including an involved family member, to consent to or refuse consent for therapeutic conduct; or
- (ii) a caregiver to offer or provide or refuse to offer or provide therapeutic conduct; or
- (2) the vulnerable adult, a person with authority to make health care decisions for the vulnerable adult, or a caregiver in good faith selects and depends upon spiritual means or prayer for treatment or care of disease or remedial care of the vulnerable adult in lieu of medical care, provided that this is consistent with the prior practice or belief of the vulnerable adult or with the expressed intentions of the vulnerable adult;
- (3) the vulnerable adult, who is not impaired in judgment or capacity by mental or emotional dysfunction or undue influence, engages in consensual sexual contact with:
 - (i) a person including a facility staff person when a consensual sexual personal relationship existed prior to the caregiving relationship; or
 - (ii) a personal care attendant, regardless of whether the consensual sexual personal relationship existed prior to the caregiving relationship; or
- (4) an individual makes an error in the provision of therapeutic conduct to a vulnerable adult which does not result in injury or harm which reasonably requires medical or mental health care; or
- (5) an individual makes an error in the provision of therapeutic conduct to a vulnerable adult that results in injury or harm, which reasonably requires the care of a physician, and:
 - (i) the necessary care is provided in a timely fashion as dictated by the condition of the vulnerable adult;
 - (ii) if after receiving care, the health status of the vulnerable adult can be reasonably expected, as determined by the attending physician, to be restored to the vulnerable adult's preexisting condition;
 - (iii) the error is not part of a pattern of errors by the individual;
 - (iv) if in a facility, the error is immediately reported as required under section [626.557](#), and recorded internally in the facility;
 - (v) if in a facility, the facility identifies and takes corrective action and implements measures designed to reduce the risk of further occurrence of this error and similar errors; and
 - (vi) if in a facility, the actions required under items (iv) and (v) are sufficiently documented for review and evaluation by the facility and any applicable licensing, certification, and ombudsman agency.

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

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