PROGRAM 245D
POLICIES
&
PROCEDURES

Contents

1 ADMISSION POLICY AND PROCEDURES

1.00 Purpose:

The purpose of this policy is to establish procedures that ensure continuity of care during admission or service initiation including Merrick's admission criteria and processes.

2.00 Application:

This policy applies to each person initiating service and each client of Merrick, Inc., (hereinafter "Company").

3.00 Policy Statement:

Services may be provided by the Company 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. The Company may provide services to persons with disabilities, including, but not limited to, intellectual or developmental disabilities, brain injury, mental illness, age-related impairments, or physical, sensory, and medical conditions when the Company is able to meet the person's needs.

Documentation from the admission/service initiation, assessments, and service planning processes related to the Company's service provision for each client and as stated within this policy will be maintained in the client's record.

4.00 Procedures:

4.10 Admission criteria:

4.11 Certain criteria will be used by the Company to determine whether the company is able to provide 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 includes:

4.111 Person must have been screened and authorized for services in accordance with Minnesota Statutes, section 245D.03, subdivision 1.

4.112 Persons 18 years of age or older will be considered for services regardless of race, color, creed, gender, national origin, religion, HIV/HBV status, affectional preference, public assistance status, or marital status.

4.113 Persons will not be denied services based exclusively on the basis of the type of residential services they are receiving, on the basis of the client's severity of disability, lack of communication skills, independent living skills, behavioral disorders, or past history to make progress.

4.114 Reasonable accommodations shall be made as required under the American Disabilities Act.

4.12 When a person and/or legal representative requests services from the Company, a refusal to admit the person must be based upon an evaluation of the person's assessed needs and the Company's lack of capacity to meet those needs.

4.13 The Company must not refuse to admit a person solely upon the type of residential services the person is receiving or solely on the person's:

4.131 Severity of disability.

4.132 Orthopedic or neurological handicaps.

4.133 Sight or hearing impairments.

4.134 Lack of communication skills.

4.135 Physical disabilities.

4.136 Toilet habits.

4.137 Behavioral disorders.

4.138 Past failures to make progress.

4.14 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 Designated Coordinator and/or Designated Manager or designee.

4.15 In the event that a person meets the criteria for admission and the program does not have an opening that meets their service needs, the person will be placed on a waiting list and will be notified when an appropriate opening becomes available.

4.20 Admission process and requirements:

4.21 In the event of an emergency service initiation, the Company must ensure that employee training on the client's needs occurs within 72 hours of the employee first having unsupervised contact with the client. The Company must document the reason for the unplanned or emergency service initiation and maintain the documentation in the person's record.

4.22 Prior to, or upon the initiation of services, the Designated Coordinator and/or Designated Manager will develop, document, and implement the Individual Abuse Prevention Plan according to MN Statutes, section 245A.65, subdivision 2.

4.23 The Designated Coordinator and/or Designated Manager will ensure that during the admission process the following will occur:

4.231 Each client and/or legal representative is provided with the written list of the Client Rights that identifies the client's rights according to MN Statutes, section 245D.04, subdivisions 2 and 3.

4.2311 An explanation will be provided on the day of service initiation or within five (5) working days of service initiation and annually thereafter.

4.2312 Reasonable accommodations will be made, when necessary, to provide this information in other formats or languages to facilitate understanding of the rights by the client and/or legal representative.

4.2313 Clients will be advised of the Company's Program Abuse Prevention Plan within 24 hours of service admission unless they would benefit more from a later explanation that will be completed within 72 hours.

4.2314 An explanation of and provision of a copy of the Policy and Procedure on Reporting and Reviewing of Maltreatment of Vulnerable Adults will be provided to the client and/or legal representative and case manager within 24 hours of admission unless they would benefit more from a later explanation that will be completed within 72 hours.

4.232 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 client and/or legal representative and case manager:

4.2332 Policy and Procedure on Grievances

4.2322 Policy and Procedure on Temporary Service Suspension

4.2323 Policy and Procedure on Data Privacy

4.2324 Policy and Procedure on Emergency Use of Manual Restraint

4.2325 Policy and Procedure on Service Termination

4.2326 Policy and Procedure on Reporting and Reviewing of Maltreatment of Minors

4.233 Within five (5) business days of service initiation, and annually thereafter, the Company will obtained written authorization from the client and/or legal representative for the following:

4.2331 Authorization for Medication and Treatment Administration

4.2332 Agreement and Authorization for Injectable Medications

4.2333 Authorization to Act in an Emergency

4.2334 Standard Release of Information

4.2335 Specific Release of Information

4.2336 Safekeeping of Funds and Personal Property

4.2337 The Admission Form and Data Sheet (signed by the client and/or legal representative and includes the date of admission or readmission, identifying information, and contact information for members of the support team and others as identified by the client and/or legal representative).

4.24 During the admission meeting, the support team and other people as identified by the client and/or legal representative team will discuss:

4.241 The Company'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 Coordinated Service and Support Plan Addendum.

4.242 Desired frequency of progress reports and progress review meetings (minimum annually).

4.243 Initial *funds and personal property authorization* and the Designated Coordinator and/or Designated Manager will survey, document, and implement the preferences of the client 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.

4.244 If a client's licensed health care professional or mental health professional has determined that a manual restraint would be medically or psychologically contraindicated, the Company 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.

4.30 Admission process follow up and timelines:

4.31 The Designated Coordinator and/or Designated Manager or designee will ensure that the client's other providers, medical and mental health care professionals, and vendors are notified of the change in address and phone number.

4.32 The Designated Coordinator and/or Designated Manager or designee will ensure that the client's record is assembled according to company standards.

4.33 Within 15 calendar days of service initiation, the Designated Coordinator and/or Designated Manager will complete a preliminary Coordinated Service and Support Plan Addendum that is based upon Coordinated Service and Support Plan. At this time, the client's name and date of admission will be added to the Admission and Discharge Register maintained by the Designated Coordinator and/or Designated Manager.

4.34 The following will be completed for clients admitted after January 1, 2014 requiring a Positive Support Transition Plan for the emergency use or planned use of restrictive interventions prohibited under MN Statutes, chapter 245D:

4.341 The Positive Support Transition Plan must be developed and implemented within 30 calendar days of service initiation.

4.342 No later than 11 months after implementation date, the plan must be phased out.

4.35 Before the 45-day meeting, the Designated Coordinator and/or Designated Manager will complete the Self-Management Assessment regarding the client's ability to self-manage in health and medical needs, personal safety, and symptoms or behavior. This assessment will be based on the client's status within the last 12 months at the time of service initiation.

4.36 Within 45 calendar days of service provision, or 60 calendar days of service initiation, whichever is shorter, the support team and other people as identified by the client and/or legal representative must meet and use the Coordinated Service and Support Plan, relevant assessments, and any person-centered planning documents to complete the following:

4.361 The scope of services to be provided to support the client's daily needs and activities.

4.362 Outcomes and necessary supports to accomplish the outcomes.

4.363 The client's preference for how services and supports are provided including how the Company will support the client to have make choices about their program schedule.

4.364 Whether the current service setting is the most integrated setting available and appropriate for the client.

4.365 Opportunities to develop and maintain essential and life-enriching skills, abilities, strengths, interests, and preferences.

4.366 Opportunities for access, participation, and inclusion in preferred community activities.

4.367 Opportunities to develop and strengthen personal relationships with others of the client's choice in the community.

4.368 Opportunities to work at competitively paying jobs in the community.

4.369 How services for this client will be coordinated across 245D licensed providers and members of the support team to ensure continuity of care and coordination of services for the client.

4.37 Within 10 working days of the 45-day meeting, the Designated Coordinator and/or Designated Manager will develop a service plan that documents outcomes and supports for the client based upon the assessments completed at the 45-day meeting.

4.38 Within 20 working days of 45-day meeting, the Designated Coordinator and/or Designated Manager will submit to and obtain dated signatures from the client and/or legal representative and case manager to document completion and approval of the assessment and Coordinated Service and Support Plan Addendum.

4.39 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.

4.40 At the 45-day meeting, and annually thereafter, the client and/or legal representative, case manager, and other people as identified by the client are to discuss how technology might be used to meet their desired outcomes and summarize in the *Coordinated Service and Support Plan* and/or *Coordinated Service and Support Plan Addendum*. The summary will include a statement regarding any decision that is made regarding the use of technology and a description of any further research that needs to be completed before a decision is finalized.

Policy reviewed and authorized on 02/18/2022 by:

John Wayne Barker, Executive Director

2 ALZHEIMER'S OR RELATED DISORDERS POLICY

1.00 PURPOSE:

The purpose of this policy is to establish guidelines for training provided by Merrick, Inc., (hereinafter "Company") to its employees assigned to support clients diagnosed with Alzheimer's or related disorders as required in Minnesota Statutes, section 245A.04, subdivision 12.

2.00 APPLICATION:

This policy applies to all clients enrolled and employees assigned to support clients diagnosed with Alzheimer's or related disorders.

3.00 POLICY:

The Company will provide training in dementia care to any employee regularly scheduled to support clients diagnosed with Alzheimer's or related disorders.
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4.00 PROCEDURES:

4.10 All Company employees regularly assigned to support clients diagnosed with Alzheimer's or related disorders will complete the following training:
- 4.11 An explanation of Alzheimer's disease and related disorders;
- 4.12 Assistance with activities of daily living;
- 4.13 Problem solving with challenging behaviors; and
- 4.14 Communication skills.

4.20 When requested by a client/guardian, the Company shall provide, in written or electronic form, a description of the dementia training curriculum, the categories of employees trained, and the frequency of training.

Policy reviewed and authorized on 02/18/2022 by:

John Wayne Barker, Executive Director

3 CLIENT GRIEVANCE POLICY

1.00 Purpose

The purpose of this policy is to promote client rights by providing them and/or their legal representatives with a simple process to address grievances.

2.00 Application

This policy applies to each client from Merrick, Inc., or their legal representative, and any individual who is either employed by, volunteers, or has a service agreement with Merrick, Inc.

3.00 Policy Statement

Each client and/or legal representative will be encouraged and assisted in continuously sharing ideas and expressing concerns in informal discussions with management employees 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 client and/or legal representative feel an issue or grievance has not or cannot be resolved through informal discussion, they are to be reminded of their option to file formal grievance. Employees and clients and/or legal representatives will receive training regarding the informal and formal grievance procedure. This policy will be provided, orally and in writing, to all clients and/or their legal representatives. If a client and/or legal representative feel that their formal grievance has not or cannot be resolved by an employee, they may bring their grievance to the Executive Director by contacting:

John Wayne Barker
3210 Labore Road, Vadnais Heights, Minnesota 55110
651.789.6209 or jwb@merrickinc.org

The Program Director will ensure that during the service initiation process that there is orientation for the client and/or legal representative to the company's policy on addressing grievances. When requested by the client or their legal representative, at the company's sole discretion interpretative services may be provided throughout the grievance process for client's that do not communicate verbally or speak English. If desired, assistance from an outside agency (i.e., ARC, MnDLC, or MN Office of the Ombudsman) may be sought to assist with the grievance.

Clients 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.

4.00 Procedure

4.10 Reporting grievances:

4.11 All grievances affecting a client's health and safety will be responded to immediately by the Employee or Assistant Program Director (APD) . Grievances not resolved to a client's satisfaction may become a grievance using the process outlined in 4.20.

4.12 Any employee aware of a client's unresolved grievance can assist them to initiate the formal grievance policy by contacting their APD.

4.13 At least annually, each client will be informed of who is on their support team and can assist them in resolving grievances or grievances.

4.20 Making a formal grievance:

4.21 All grievances affecting a client's health and safety will be responded to immediately by the APD.

4.22 Employees will immediately inform the APD of any grievances and will follow this policy and procedure. If at any time, employee assistance is requested in the grievance process, it will be provided. Additional information on outside agencies that can also provide assistance to the client and/or legal representative are listed at the end of this policy.

4.23 If for any reason a client and/or legal representative chooses to use the formal grievance process, they will then notify in writing or discuss the formal grievance process with the APD.

4.24 When a formal grievance is made, the APD will initially respond in writing to the person that initiated the grievance within 14 calendar days of receipt.

4.25 The APD will first determine if the situation qualifies as a grievance. If not, this determination will be forwarded to both the reporter and the Program Director and the grievance closed. If the reporter is pleased with the response given and does not request a reconsideration within 5 working days a satisfactory response will be documented in their file and the grievance closed. If the reporter is not pleased with the response, within 5 working days from the receipt the reporter can submit additional information for reconsideration directly to the Program Director. After reviewing the additional information the Program Director will either instruct the investigator to conduct a full investigation or advise the reporter that the situation does not qualify as a grievance and the case closed. There is no procedural reconsideration of this determination.

4.26 If the client and/or the legal representative are not satisfied with the APD'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.

4.27 All grievances must and will be resolved within 30 calendar days of receipt. If it is not possible the Executive Director will document the reason for the delay and the plan for the resolution.

4.28 If the client and/or legal representative believe their rights have been violated, they retain the option of contacting the MAARC at any time in this process. 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.

4.30 Grievance review:

4.31 As part of the grievance review and resolution process, a grievance review will be completed by the Program Director and documented by using the *Internal Review* form regarding the grievance. The grievance review will include an evaluation of whether:

4.311 Related policies and procedures were followed.

4.312 The policies and procedures were adequate.

4.313 There is a need for additional employee training.

4.314 The grievance is similar to past grievances with the clients, employees, or services involved.

4.315 There is a need for corrective action by the company to protect the health and safety of clients.

4.32 Based upon the results of the grievance review the company will develop, document, and implement an action plan designed to correct current lapses and prevent future lapses in performance by employees or the company, if any.

4.33 A written summary of the grievance and a notice of the grievance resolution to the client and/or legal representative and case manager will be provided by using the *Grievance Summary and Resolution Notice* form. This summary will:

4.331 Identify the nature of the grievance and the date it was received.

4.332 Include the results of the grievance review.

4.333 Identify the grievance resolution, including any corrective action.

4.40 Archival.

4.41 The *Grievance Summary and Resolution Notice* will be maintained in the client's record.

STATE AND COUNTY ADVOCACY AGENCIES

ARC Northland	(218) 726-4725	424 W Superior St; Suite 201, Duluth, MN 55802 www.arcnorthland.org cbourdage@arcnorthland.org
ARC MN	(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 Ave W, Suite 110, St. Paul, MN 55114 www.arcgreatertwincities.org info@arcgreatertwincities.org
Disability Law Center/Legal Aid Society	(612) 332-1441	430 1st Ave North, Minneapolis, MN 55401 www.mndlc.org website@mylegalaid.org
MN DHS Department of Licensing	(651) 431-6500	444 Lafayette Road, St. Paul, MN 55115 www.mn.gov/dhs/general-public/licensing/ dhs.info@state.mn.us
MN Office of the Ombudsman for MH/DD	(651) 757-1800 (800) 657-3506	121 7th Place East, Suite 420, Metro Square Building, St. Paul, MN 55101 www.ombudmhdd.state.mn.us ombudsman.mhdd@state.mn.us
MN Office of the Ombudsman for Long-Term Care	(651) 431-2555 (800) 657-3591	P.O. Box 64971, St. Paul, MN 55164 www.dhs.state.mn.us/main dhs.info@state.mn.us
Local County Social Service Agency: ask for either child protection or adult protection dependent upon the age of the person	Individual telephone number per county: See *	Individual addresses per county: See * Telephone book www.yellowpages.com https://edocs.dhs.state.mn.us/lfserver/Public/DHS-0005-ENG

MN AREA ON AGING:

	MN Area on Aging	Telephone Numbers	Address and Email Address: http://mn4a.org/aaas/
1.	Arrowhead Area Agency on Aging	Main: 218-722-5545 Toll Free: 1-800-232-0707 Fax: 218-529-7592	221 West 1st Street Duluth, Minnesota 55802 Serves: Aitkin, Carlton, Cook, Itasca, Koochiching, Lake & St. Louis counties.
2.	Central MN Council on Aging	Main: 320-253-9349 Fax: 320-253-9576	1301 W St. Germain Street, SE St. Cloud, Minnesota 56301-3456 Serves: Benton, Cass, Chisago, Crow Wing, Isanti, Kanabec, Mille Lacs, Morrison, Pine, Sherburne, Stearns, Todd, Wadena, & Wright counties.
3.	Land of the Dancing Sky Area Agency on Aging	Main: 218-745-6733	109 South Minnesota Street Warren, Minnesota 56762 Serves: Becker, Beltrami, Clay, Clearwater, Douglas, Grant, Hubbard, Kittson, Lake of the Woods, Mahnomen, Marshall, Norman, Otter Tail, Pennington, Polk, Pope, Red Lake, Roseau, Stevens, Traverse & Wilkin.
4.	Metropolitan Area Agency on Aging	Main: 651-641-8612 Fax: 651-641-8618	2365 N McKnight Road, Suite 3 North St. Paul, Minnesota 55109 Serves: Anoka, Carver, Dakota, Hennepin, Ramsey, Scott, & Washington counties
5.	MN Chippewa Tribe Area Agency on Aging	Main: 218-335-8586 Toll Free: 1-888-231-7886 Fax: 218-335-8080	PO Box 27 Cass Lake, Minnesota 56633 Serves: Bois Forte, Grand Portage, Leech Lake, & White Earth reservations
6.	MN River Area Agency on Aging	Mankato Office: Main: 507-389-8879 Fax: 507-387-7105 Slayton Office: Main: 507-836-8547 Fax: 507-836-8866	***Mankato Office*** 10 Civic Center Plaza, Suite 3 PO Box 3323 Mankato MN 56002-3323 ***Slayton Office*** 2401 Broadway Avenue, Suite 2 Slayton, MN 56172-114
7.	Southeastern MN Area Agency on Aging	Main: 507-288-6944 Fax: 507-288-4823	421 SW First Avenue, Room 201 Rochester, Minnesota 55902 Serves: Dodge, Fillmore, Freeborn, Goodhue, Houston, Mower, Olmsted, Rice, Steele, Wabasha, & Winona counties

Policy reviewed and authorized on 02/18/2022 by:

John Wayne Barker, Executive Director

4 DATA PRIVACY POLICY

1.00 PURPOSE

Merrick, Inc., recognizes the right of each client in this program to confidentiality and data privacy. This policy provides general guidelines and principles for safeguarding client rights to data privacy under section 245D.04, subdivision 3(a) and access to their records under section 245D.095, subdivision 4, of the 245D Home and Community-based Services Standards.

2.00 APPLICATION

This policy applies to each client from Merrick, Inc., and any individual who is either employed by, volunteers, or has a service agreement with Merrick, Inc.

3.00 POLICY STATEMENT

Merrick, Inc., 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. The company will also follow guidelines for data privacy as set forth in the Health Insurance Portability and Accountability Act (HIPAA) to the extent the company 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.

4.00 PROCEDURES

4.10 Private data

4.11 Private data includes all information on persons that has been gathered by this program or from other sources for program purposes as contained in an individual data file, including their presence and status in this program.

4.12 Data is private if it is about clients and is classified as private by state or federal law. Only the following persons are permitted access to private data:

4.121 The individual who is the subject of the data or their legal representative.

4.122 Anyone to whom the individual gives signed consent to view the data.

4.123 Employees of the welfare system whose work assignments reasonably require access to the data. This includes employees in this program.

4.124 Anyone the law says can view the data.

4.125 Data collected within the welfare system about clients are considered welfare data. Welfare data is private data on clients; including medical and/or health data. Agencies in the welfare system include, but are not limited to: Department of Human Services; local social services agencies, including a person's case manager; county welfare agencies; human services boards; the Office of Ombudsman for Mental Health and Developmental Disabilities; and persons and entities under contract with any of the above agencies; this includes this program and other licensed caregivers jointly providing services to the same person.

4.126 Once informed consent has been obtained from the person, or their legal representative, there is no prohibition against sharing welfare data with other persons or entities within the welfare system for the purposes of planning, developing, coordinating, and implementing needed services.

4.13 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.

4.20 Providing Notice

4.21 At the time of service initiation, the client and his/her legal representative, if any, will be notified of this program's data privacy policy. The Program Director or Program Plan Coordinator will document that this information was provided to the client and/or their legal representative in the client's record, and that a copy of this policy was provided to them and their legal representative, if any.

4.30 Obtaining Informed Consent or Authorization for Release of Information

4.31 At the time informed consent is being obtained employees must tell the person or the legal representative the following:

4.311 Why the data is being collected.

4.312 How the agency intends to use the information.

4.313 Whether the individual may refuse or is legally required to furnish the information.

4.314 What known consequences may result from either providing or refusing to disclose the information, with whom the collecting agency is authorized by law to share the data, and what the person can do if they believe the information is incorrect or incomplete.

4.315 How the individual can see and get copies of the data collected about them, and any other rights that the person may have regarding the specific type of information collected.

4.32 A proper informed consent or authorization for release of information form must include these factors (unless otherwise prescribed by the HIPAA Standards of Privacy of Individually Identifiable Health Information 45 C.F.R. section 164):

4.321 Be written in plain language;

4.322 Be dated;

4.323 Designate the particular agencies or person(s) who will get the information;

4.324 Specify the information which will be released;

4.325 Indicate the specific agencies or person who will release the information;

4.326 Specify the purposes for which the information will be used immediately and in the future;

4.327 Contain a reasonable expiration date of no more than one year; and

4.328 Specify the consequences for the person by signing the consent form, including:

- Why I am being asked to release this information.
- I do not have to consent to the release of this information, but not doing so may affect this program's ability to provide needed services to me.
- If I do not consent, the information will not be released unless the law otherwise allows it.
- I may stop this consent with a written notice at any time, but this written notice will not affect information this program has already released.
- The person(s) or agency(ies) who get my information may be able to pass it on to others.
- If my information is passed on to others by this program, it may no longer be protected by this authorization.
- This consent will end one year from the date I sign it, unless the law allows for a longer period."

4.329 Maintain all informed consent documents in the client's record.

4.40 Employee Access to Private Data

4.41 This policy applies to all program employees, volunteers, and persons or agencies under contract with this program (paid or unpaid).

4.42 Employees do not automatically have access to private data about the clients served by this program or about other employees or agency personnel. Employees must have a specific work function need for the information. Private data about clients are available

only to those program employees whose work assignments reasonably require access to the data or who are authorized by law to have access to the data.

4.43 Any written or verbal exchanges about a client's private information by employees with other employees or any other persons will be done in such a way as to preserve confidentiality, protect data privacy, and respect the dignity of the client whose private data is being shared.

4.44 As a general rule, doubts about the correctness of sharing information should be referred to the client's Program Director

4.50 client access to private data

4.51 Clients or their legal representatives have a right to access and review the client record.

4.52 An employeewill be present during the review and will make an entry in the client's progress notes as to the client who accessed the record, date and time of review, and list any copies made from the record.

4.53 An client may challenge the accuracy or completeness of information contained in the record. Employees will refer the clientto the grievance policy for lodging a complaint.

4.54 Clients may request copies of pages in their record.

4.55 No client, legal representative, employee, or anyone else may permanently remove or destroy any portion of the client's record.

4.60 Case manager access to private data

4.61 A client's case manager and the foster care licensor have access to the records of clients served by the program under section 245D.095, subd. 4.

4.70 Emergencies

4.71 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 client or other individuals or persons. The Program Director and/or Program Plan Coordinator will ensure the documentation of 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; and when and how the client and/or legal representative was informed of the disclosed information.

4.80 Requesting Information from Other Licensed Caregivers or Primary Health Care Providers

4.81 Complete the attached release of information authorization form. Carefully list all the consults, reports or assessments needed, giving specific dates whenever possible. Also, identify the purpose for the request.

4.82 Clearly identify the recipient of information. If information is to be sent to the program's health care consultant or other employees at the program, include Attention: (name of person to receive the information), and the name and address of the program.

4.83 Assure informed consent to share the requested private data with the person or entity has been obtained from the client or their legal representative.

4.84 Keep the document in the client's record.

4.90 The Program Director and/or Program Plan Coordinator will ensure that all information for clients are 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.

4.100 All employees will receive training at orientation and annually thereafter on this policy and their responsibilities related to complying with data privacy practices.

Policy reviewed and authorized on 02/18/2022 by:

John Wayne Barker, Executive Director

5 EMERGENCY USE OF MANUAL RESTRAINTS POLICY

1.00 PURPOSE:

The purpose of this policy is to promote the rights of clients served by this program and to protect their health and safety during the emergency use of manual restraints.

"Emergency Use of Manual Restraint" (EUMR) means using a manual restraint when a client poses an imminent risk of physical harm to self or others and it is the least restrictive intervention that would achieve safety. Property damage, verbal aggression, or a client's refusal to receive or participate in treatment or programming on their own, does not constitute an emergency.

2.00 APPLICATION:

This policy applies to each client of Merrick, Inc., and any individual who is either employed by, volunteers, or has a service agreement with Merrick, Inc.

3.00 POLICY STATEMENT:

Merrick, Inc., will comply to the fullest extent possible with rules and regulations governing EUMR.

4.00 PROCEDURES:

4.10 Positive support strategies and techniques required.

4.11 The following positive support strategies and techniques must be used to the extent possible in an attempt to de-escalate a client's behavior before it poses an imminent risk of physical harm to self or others:

- Follow individualized strategies in a client's coordinated service and support plan (CSSP) and coordinated service and support plan addendum (CSSP-A);
- Shift the focus by verbally redirecting the client to a desired alternative activity;
- Model desired behavior;
- Reinforce appropriate behavior;
- Offer choices, including activities that are relaxing and enjoyable to the client;
- Use positive verbal guidance and feedback;
- Actively listen to the client and validate their feelings;
- Create a calm environment by reducing sound, lights, and other factors that may agitate the client;
- Speak calmly with reassuring words and consider volume, tone, and non-verbal communication;
- Simplify a routine or discontinue until the client is calm and agrees to participate;
- Respect the client's need for physical space and/or privacy; or
- Have a preferred employee help the client attempt to de-escalate their behavior.

4.12 The program will develop a positive support transition plan on the forms and in manner prescribed by the Commissioner and within the required timelines for each client served when required in order to:

4.121 Eliminate the use of prohibited procedures as identified in 4.30 of this policy;

4.122 Avoid the EUMR as identified in 1.00 of this policy;

4.123 Prevent the client from physically harming self or others; or

4.124 Phase out any existing plans for the emergency or programmatic use of restrictive interventions prohibited.

4.20 Permitted actions and procedures

4.21 Use of the following instructional techniques and intervention procedures used on an intermittent or continuous basis are permitted by this program. When used on a continuous basis, it must be addressed in a client's CSSP-A. Any use of manual restraint as a permitted action or procedure must comply with the restrictions stated in section 4.50 of this policy - "Conditions for Emergency Use of Manual Restraint".

4.22 Physical contact or instructional techniques must be use the least restrictive alternative possible to meet the needs of the client and may be used to:

4.221 Calm or comfort a client by holding the person with no resistance from that person;

4.222 Protect a client known to be at risk or injury due to frequent falls as a result of a medical condition;

4.223 Facilitate the client's completion of a task or response when the client does not resist or their resistance is minimal in intensity and duration;

4.224 Block or redirect a client's limbs or body without holding them or limiting their movement to interrupt their behavior that may result in injury to self or others with less than 60 seconds of physical contact by an employee; or

4.225 Redirect a client's behavior when the behavior does not pose a serious threat to the client or others and the behavior is effectively redirected with less than 60 seconds of contact by an employee.

4.23 Restraint may be used as an intervention procedure to:

4.231 Allow a licensed health care professional to safely conduct a medical examination or to provide medical treatment ordered by a licensed health care professional to a client;

4.232 Assist in the safe evacuation or redirection of a client in the event of an emergency and the client is at imminent risk of harm; or

4.233 Position a client with physical disabilities in a manner specified in their CSSP-A.

4.30 Prohibited Procedures

4.31 Use of the following procedures as a substitute for adequate staffing, for a behavioral or therapeutic program to reduce or eliminate behavior, as punishment, or for employee convenience, is prohibited by this program:

- Chemical restraint;
- Manual restraint;
- Mechanical restraint;
- Time out;
- Seclusion;
- Prone restraint;
- Faradic shock;
- Speaking to a client in a manner that ridicules, demeans, threatens or is abusive;
- Using physical intimidation/show of force;
- Denying or restricting a client's access to equipment and devices such as wheelchairs, walkers, hearing aids and communication boards that facilitate their functioning;
- Using painful techniques;
- Hyperextending or twisting a client's body parts;
- Tripping or pushing a client;
- Using punishment of any kind;
- Requiring a client to assume and maintain a specified physical position or posture;
- Using forced exercise;
- Totally or partially restricting a client's senses;
- Presenting intense sounds, lights other sensory stimuli;
- Using a noxious smell, taste, substance or spray;
- Requiring a client to earn normal goods and services;
- Using token programs that include response cost;
- Using a client to discipline another client; or
- Using any action or procedure that is medically or psychologically contraindicated.

4.311 Chemical restraint: Chemical restraint" means the administration of a drug or medication to control a client's behavior or restrict their freedom of movement and is not a standard treatment or dosage for the client's medical or psychological condition.

4.312 Manual restraint: "Manual restraint" means physical intervention intended to hold a client immobile or limit their voluntary movement by using body contact as the only source of physical restraint (emergency use of manual restraint is permitted when specific criteria as defined by 245D are met).

4.313 Mechanical restraint: Except for devices worn by the client that trigger electronic alarms to warn employees that a client is leaving a room or area, which do not, in an of themselves, restrict freedom of movement, or the use of adaptive aids or equipment or orthotic devices ordered by a health care professional used to treat or manage a medical condition, "Mechanical restraint" means the use of devices, materials, or equipment attached or adjacent to the client's body, or the use of practices that are intended to restrict freedom of movement or normal access to one's body or body parts, or limits their voluntary movements or holds them immobile as an intervention precipitated by their behavior. The term applies to the use of mechanical restraints used to prevent injury with client who engage in self-injurious behavior, such as head-banging, gouging, or other actions resulting in tissue damage that have caused or could cause medical problems resulting from the self-injury.

4.314 Time out: "Time out" means the involuntary removal of a client for a period of time to a designated area from which the client is not prevented from leaving. For the purpose of this chapter, "time out" does not mean voluntary removal or self-removal for the purpose of calming, prevention of escalation, or de-escalation of behavior; not does it mean taking a brief break or rest from an activity for the purpose of providing the person an opportunity to regain self-control.

4.315 Seclusion: "Seclusion" means: (1) removing a client involuntarily to a room from which exit is prohibited by an employee or a mechanism such as a lock, a device, or an object positioned to hold the door closed or otherwise prevent the client from leaving the room; or (2) otherwise involuntarily removing or separating a client from an area, activity, situation, or social contact with others and blocking or preventing their return.

4.40 Manual Restraints Allowed in Emergencies

4.41 This program allows the following manual restraint procedures to be used on an emergency basis when a client's conduct poses an imminent risk of physical harm to self or others and less restrictive strategies have not achieved safety:

4.411 Physical escort when the client is resistive;

4.412 One arm, one employee standing;

4.413 One arm, one employee standing with the free arm managed;

4.414 Two arm, one employee standing;

4.415 One arm or two arm, one employee standing with one employee assisting from one side;

4.416 One arm or two arm, one employee standing with two employees assisting, one from each side; and

4.417 Use of employee's hand (s), arm(s) or body contact to hold a client's hand(s), arm(s) or body immobile when that intervention is the least intrusive or physical space does not permit implementation of procedures 4.411 – 4.416.

4.42 The program will not allow the use of a manual restraint procedure with a client when it has been determined by their physician or mental health provider to be medically or psychologically contraindicated.

4.421 This program will complete an assessment of whether the allowed procedures are contraindicated for each client as part of the service planning required under section 245D.071, subdivision 2, for clients of basic support services; or the assessment and initial service planning required under section 245D.071, subdivision 3, for clients of intensive support services.

4.422 The statement of whether or not a manual restraint would be medically or psychologically contraindicated will be completed as part of service initiation planning.

4.50 Conditions for EUMR

4.51 EUMR must meet the following conditions:

4.511 Immediate intervention must be needed to protect the client or others from imminent risk of physical harm;

4.512 The type of manual restraint used must be the least restrictive intervention to eliminate the immediate risk of harm and effectively achieve safety; and

4.513 The EUMR must end when the threat of harm ends.

4.52 The following conditions, on their own, are not conditions for EUMR:

4.521 The client is engaging in property destruction that does not cause imminent risk of physical harm;

4.522 The client is engaging in verbal aggression with employees or others; or

4.523 A client's refusal to receive or participate in treatment or programming.

4.60 Restrictions When Implementing EUMR

4.61 EUMR must not:

4.611 Be implemented with a client in a manner that constitutes abuse or neglect;

4.612 Be implemented in a manner that violates a client's rights and protection;

4.613 Be implemented in a manner that is contraindicated for any of the client's known medical or psychological limitations;

4.614 Restrict a client's normal access to a nutritious diet, drinking water, adequate ventilation, necessary medical care, ordinary hygiene facilities, normal sleeping conditions, or necessary clothing;

4.615 Restrict a client's normal access to any protection required by state licensing standards and federal regulations governing this program;

4.616 Deny a client visitation or ordinary contact with legal counsel, a legal representative, or next of kin;

4.617 Be used as a substitute for adequate staffing, for the convenience of employees, as punishment, or as a consequence if the client refuses to participate in the treatment or services provided by this program;

4.618 Use prone restraint. "Prone restraint" means use of manual restraint that places a client in a face-down position. It does not include brief physical holding of a client who, during an EUMR, rolls into a prone position, and they are restored to a standing, sitting, or side-lying position as quickly as possible; or

4.619 Apply back or chest pressure while a client is in a prone (meaning face-down) or supine (meaning a face-up) position, or a side-lying position.

4.70 Monitoring EUMR

4.71 The program must monitor a client's health and safety during an EUMR to ensure the following:

4.711 Only manual restraints allowed in this policy are implemented;

4.712 Manual restraints that have been determined to be contraindicated for a client are not implemented with that client;

4,713 Allowed manual restraints are implemented only by employees trained in their use;

4.714 The restraint is being implemented properly as required; and

4.715 The mental, physical, and emotional condition of the client who is being manually restrained is being assessed and intervention is provided when necessary to maintain the client's health and safety and prevent injury to the client, employee involved, or others involved.

4.72 When possible, an employee who is not implementing the EUMR must monitor the procedure.

4.73 A monitoring form, as approved by the Department of Human Services, must be completed for each incident involving EUMR.

4.80 Reporting EUMR

4.81 Within 24 hours of an EUMR, the legal representative and the case manager must receive verbal notification of the occurrence as required under the incident response and reporting requirements in the 245D HCBS Standards, section 245D.06, subdivision 1.

When the EUMR involves more than one client, the incident report made to the legal representative and the case manager must not disclose personally identifiable information about any other client or employee unless the program has the consent of the client or employee.

4.82 Within 3 calendar days after an EUMR, the employee who implemented the EUMR must report in writing to an Assistant Program Director or Program Director, the following information:

4.821 Who was involved in the incident leading up to the EUMR including the names of employees and clients who were involved;

4.822 A description of the physical and social environment, including who was present before and during the incident leading up to the EUMR;

4.823 A description of what less restrictive alternative measures were attempted to de-escalate the incident and maintain safety before the EUMR was implemented. This description must identify when, how, and how long the alternative measures were attempted before the manual restraint was implemented;

4.824 A description of the mental, physical, and emotional condition of the client who was manually restrained, leading up to, during, and following the EUMR;

4.825 A description of the mental, physical, and emotional condition of the other clients involved leading up to, during, and following the EUMR;

4.826 Whether there was any injury to the client who was restrained before or as a result of the EUMR;

4.827 Whether there was any injury to other clients and employees, before or as a result of the EUMR; and

4.828 Whether there was a debriefing with the employees and, if not contraindicated, with the client who was restrained and other clients and employees who were involved in or who witnessed the restraint, following the incident. Include the outcome of the debriefing. If the debriefing was not conducted at the time the incident report was made, the report should identify whether a debriefing is planned.

4.83 A copy of this report must be maintained in the client's record. The record must be uniform and legible.

4.84 Each single incident of EUMR must be reported separately. A single incident is when the following conditions have been met:

4.841 After implementing the EUMR employees attempt to release the client at the moment an employee believes the client'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;

4.842 Upon the attempt to release the restraint, the client's behavior immediately re-escalates; and employees must immediately re-implement the manual restraint in order to maintain safety.

4.90 Internal Review of Emergency Use of Manual Restraint

4.91 Within 5 business days after the date of an EUMR the program must complete and document an internal review of the report prepared by the employee who implemented the manual restraint.

4.92 The internal review must include an evaluation of whether:

4.921 The client's service and support strategies need to be revised;

4.922 Related policies and procedures were followed;

4.923 The policies and procedures were adequate;

4.924 There is need for additional employee training;

4.925 The reported event is similar to past events with the clients, employees, or the services involved; and

4.926 There is a need for corrective action by the program to protect the health and safety of clients.

4.93 Based on the results of the internal review, the program must develop, document, and implement a corrective action plan for the program designed to correct current lapses and prevent future lapses in performance by employees or the program.

4.94 The corrective action plan, if any, must be implemented within 30 days of the internal review being completed by an Assistant Program Director or Program Director.

4.95 An Assistant Program Director or Program Director is responsible for conducting the internal review and for ensuring that corrective action is taken, when determined necessary.

4.100 Expanded Support Team Review of Emergency Use of Manual Restraint

4.101 Within 5 working days after the completion of the internal review, the program must discuss the incident with the expanded support team to:

4.1011 Define the antecedent or event that gave rise to the behavior resulting in the manual restraint; and

4.1012 Identify the perceived function the behavior served.

4.1013 Determine whether the client's CSSP-A needs to be revised to positively and effectively help them maintain stability and/or reduce or eliminate future occurrences of manual restraint.

4.102 The program must maintain a written summary of the expanded support team's discussion and decisions in the client's record.

4.103 An Assistant Program Director or Program Director, is responsible for conducting the expanded support team review and for ensuring that the client's CSSP-A is revised, when determined necessary.

4.200 External Review and Reporting of Emergency Use of Manual Restraint

4.201 Within 5 working days after the completion of the expanded support team review, the program must submit the following to the Department of Human Services using the online Behavior Intervention Reporting Form or BIRF (DHS form 5148) which automatically routes the report to the Office of the Ombudsman for Mental Health and Developmental Disabilities:

4.2011 Report of the EUMR;

4.2012 The internal review and corrective action plan; and

4.2013 Written summary of the expanded support team review.

4.202 A full copy of the completed BIRF must be sent to each member of the expanded support team within twenty-four (24) hours of submission.

4.300 Employee Training

4.301 Before employees may implement manual restraints on an emergency basis the program must provide the training required in this section. Training on these topics received from other sources may count toward these requirements if received in the 12-month period before the employee's date of hire.

4.302 Orientation and annual training as required in Minnesota Statutes, section 245D.09. Documentation of the training received and date of first unsupervised direct contact and employee's competency must be maintained in their training record.

4.303 Before having unsupervised direct contact with clients by the program, the program must provide instruction on prohibited procedures that address the following:

4.3031 What constitutes the use of chemical restraint, seclusion, time out, manual restraint and mechanical restraint;

4.3032 Employee responsibilities related to ensuring prohibited procedures are not used;

4.3033 Why such prohibited procedures are not effective for reducing or eliminating symptoms or undesired behavior;

4.3034 Why prohibited procedures are not safe; and

4.3035 The safe and correct use of manual restraint on an emergency basis according to the requirements in the 245D HCBS Standards, section 245D.061 and this policy.

4.304 Within 60 days of hire the program must provide instruction on the following topics, before an employee is permitted to implement an EUMR:

4.3041 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;

4.3042 De-escalation methods, positive support strategies, and how to avoid power struggles;

4.3043 Simulated experiences of administering and receiving manual restraint procedures allowed by the program on an emergency basis;

4.3044 How to properly identify thresholds for implementing and ceasing restrictive procedures;

4.3045 How to recognize, monitor, and respond to the client's physical signs of distress, including positional asphyxia;

4.3046 The physiological and psychological impact on the client and employee when restrictive procedures are used; and

4.3047 The communicative intent of behaviors.

Policy reviewed and authorized on 02/18/2020 by:

John Wayne Barker, Executive Director

6 GUIDING PRINCIPLES OF MERRICK PROGRAM SERVICES

Services at Merrick, Inc., are guided by our core beliefs of: Self-Determination ~ being responsible for one's choices and actions; Economic Fairness ~ balanced action between parties; and Civic Responsibility ~ action that contributes to the common good.

Through person-centered planning, a self-discovery process, and self-advocacy activities clients at Merrick, Inc., are finding their place in the world and leading more self-determined lives by:

- Engaging in meaningful life enrichment and therapeutic activities;
- Working in desired and meaningful jobs;
- Being actively engaged in their communities;
- Building relationships; and
- Enhancing personal skills.

Merrick, Inc., offers 5 full days of 6 hours or less of service, with non-medical transportation, and attendance is voluntary. There are many choices of services and schedules that are based on personal preference and sometimes limited by funding situations. These services include:

- Day Support Services. Provides individualized in-center and community based training and support services that help clients maintain essential and personally enriching life skills so they can access and participate in activities they prefer in the community which include; community inclusion; direct and indirect therapies including horticulture, music, recreation, and yoga therapy; arts and crafts; sensory activities; positive behavior support planning; augmented communication including assistive technology and American Sign Language; and enriched staff to client ratios to support needs including self-care, mobility, visual or hearing impairments, and/or history of intense maladaptive behaviors, (e.g. development, physical aggression, property destruction, self-injurious behavior, or co-diagnosis of mental illness).

- Prevocational Services. Provides center-based work skills training and support services that focus on strengthening clients 'fundamental work skills, and achieving individualized work skill goals through meaningful work experiences and vocational training, and advance clients toward competitively paid employment. This service offers clients the opportunity to work on contracts completed at our building in Vadnais Heights, or employer-based options for placement of clients and work crews at the business location. Another area of focus is life enrichment activities – creating opportunities for clients to articulate their needs and desires, build relationships, participate in social opportunities, develop leadership skills, and reach personal goals.

- DTH Services. Provide licensed supports, work and life enriching and satisfying activities that are offered in Day Support and Prevocational Services listed above. To be eligible for DT&H services a person must reside in an ICF/DD and have their health and safety in the community addressed in their plan of care.

- Employment Services. This services provides the following activities to clients interested in exploring employment interests; developing skills to secure competitive, meaningful and sustained employment; and ongoing support for success:

1. Assessment that takes them through a process that will help them and us learn what they value in life and work. What jobs they would like to consider, what skills they have, and what barriers exist.
2. Opportunity for clients to visit different job sites to better ensure they can make an informed choice.
3. Career Developmental Plan that for each client they support that focuses on their work and soft skills that need improvement to have success in their employment of choice.
4. Assistance in the hiring process, negotiation of employment, completion of orientation, and ongoing intermittent support to the specific needs of the employer and client.
5. Clients hired directly by the employer are permitted to use services to further develop work and soft skills needed to maintain their current job and/or consider other options.

- Remote Services. Merrick may provide the services listed above remotely in a limited capacity when requested by the client and their representatives and when the resources needed to provide them are available.

- Vocational Rehabilitation Services (VRS). Funded by the Minnesota Department of Employment and Economic Development, VRS empowers people with disabilities to achieve their goals for competitive, integrated employment and career development. These services, which vary by individual needs, could include job counseling, job search assistance, training, and job placement services. VRS continue for as long as individuals are making progress toward employment goals and provides for follow-up services to maintain, regain or advance in employment consistent with the person's interests, strengths, resources, and priorities.

Dignity and Respect are an important part of how services are delivered and are achieved through the following practices:

<u>Personal Support</u>

- Assistance with personal cares is offered as specified in the CSSP-A. When assisting someone with these cares, employees are trained to offer dignity and respect by first asking the client what help they would like and/or need. For those who cannot communicate needed help, employees will follow their individual plan and talk to the client to let them know what they are doing with each step. They will make sure cares are completed ensuring privacy, encouraging clients to close doors, offering gender specific assistance when requested, teaching personal hygiene skills, and provide training on use of equipment as appropriate.

- Lifts/standers/etc. We have various mechanical and manual lifts and standers for those who cannot fully ambulate or transfer independently. Employees receive training specific to each client's needs as indicated in their CSSP-A.

- Lunch help. Clients are offered the opportunity to be as independent as possible throughout their day and especially during breaks and lunch. They may take a break or eat their lunch at any time they choose and the supervision specified in their CSSP-A can be provided. Clients can prepare their own lunches;, have access to a microwave; use their own adaptive utensils, plates, and cups; request/agree to use a clothing protector; clean themselves, their table, and lunch dishes; and assistance will be offered only as requested or needed.

Independence

Our program encourages clients to be independent by using graduated assistance to first offer a visual prompt, followed by a verbal, partial assistance, hand over hand, or full physical to complete tasks. All program employees are trained to follow a client's CSSP-A which does indicate the level of support needed in areas of vulnerability and is used to train employees.

Proactive Approaches and Crisis Intervention

When interacting with clients our employees are trained to be professional and follow specific interactional styles as written in a client's CSSP-A. If a client needs a specific type of augmented communication or assistive technology, employees will learn their verbal and non-verbal communication techniques. They will speak directly to and not at clients, will ask and not direct, will remain positive, and offer information and praise in accordance with the Positive Supports Rule. Employees will receive initial and annual training on use of positive supports and approved interventions in accordance with this rule.

Accessibility/Choice

Lockers are available for clients to store their belongings during the program day. They will have access to their personal items at all times, unless restricted in their CSSP-A, and may bring a lock to secure their locker if they choose. Clients have private access to a free telephone in the Kenny room or a private office for local calls and long-distance calls made are collect or paid for by the client.

Daily Schedule

- Clients have individualized schedules or preferred routines/tasks/jobs that have been identified at IDT meetings and are included in PCP assessments and CSSP-A which all employees supporting the client must review.
- Clients have the opportunity verbalize choices/or use assistive technology to express their preferences and needs.
- Openings for centered-based and crews are posted in the Commons and are available to all clients who receive Prevocational or Employment Services.

Community Inclusion

- Community activities are scheduled and planned based on client needs and suggestions. A monthly calendar of activities is provided to clients to keep them informed of community events choices.
- Multiple binders with choices of accessible community activities are available.
- Scheduled rides are offered daily to give access to community activities.
- Public transportation can be arranged for those certified and wanting to manage their rides to and from the program.

Policy reviewed and authorized on 02/18/2022 by:

John Wayne Barker, Executive Director

7 INCIDENT RESPONSE, REPORTING AND REVIEW POLICY

1.00 PURPOSE:

The purpose of this policy is to respond to, report, and review all incidents that occur while providing services in a timely and effective manner in order to protect the health and safety of clients.

2.00 APPLICATION:

This policy applies to each client enrolled at Merrick, Inc., and any individual who is either employed by, volunteers, or has a consulting agreement with Merrick, Inc.

3.00 POLICY STATEMENT:

Merrick, Inc., will comply to the fullest extent possible with rules and regulations governing incident response, reporting and review of incidents involving clients being served within the scope of our license.

4.00 PROCEDURES:

4.10 Definitions:

4.11 “Incident" means an occurrence which involves a person and requires the program to make a response that is not part of the program’s ordinary provision of services to that person, and includes:

4.12 Serious injury of a client; as determined by MN Statutes, section 245.91, subdivision 6, including:

4.121 Fractures, dislocations, avulsion of teeth, injuries to the eyeball, irreversible mobility, or evidence of internal injuries;

4.122 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 pursued;

4.123 Lacerations involving injuries to tendons or organs and those for which complications are present;

4.124 Extensive second degree or third degree burns and other burns for which complications are present;

4.125 Extensive second degree or third degree frostbite, and other frostbite for which complications are present;

4.126 Ingestion of foreign substances and objects that are harmful;

4.127 Near drowning;

4.128 Heat exhaustion or sunstroke;

4.129 Attempted Suicide; and

4.120 Complications of medical treatment or previous injury.

4.13 All other injuries that require a medical assessment by a healthcare professional or are 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 medical treatment for an injury.

4.14 A client's death.

4.15 Any medical emergencies, 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.

4.16 Any mental health crisis that requires the program to call 911 or a mental health crisis intervention team, or a similar mental health response team or service when available and appropriate.

4.17 An act or situation involving a person that requires to program to call 911, law enforcement, or the fire department.

4.18 A client's unauthorized or unexplained absence from a program.

4.19 Conduct by a client against another client that:

4.191 Is so severe, pervasive, or objectively offensive that it substantially interferes with a client's opportunities to participate in or receive service or support;

4.192 Places the client in actual and reasonable fear of harm;

4.193 Places the client in actual and reasonable fear of damage to property of the person; or

4.194 Substantially disrupts the orderly operation of the program.

4.111 Any sexual activity between client involving force or coercion.

4.1111 "Force" means the infliction, attempted infliction, or threatened infliction by the actor of bodily or commission or threat of any other crime by the actor against the complainant or another, harm which (a) causes the complainant to reasonably

believe that the actor has the present ability to execute the threat and (b) if the actor does not have a significant relationship to the complainant, also causes the complainant to submit.

4.1112 "Coercion" means words or circumstances that cause the complainant reasonably to fear that the actor will inflict bodily harm upon, or hold in confinement, the complainant or another, or force the complainant to submit to sexual penetration or contact, but proof of coercion does not require proof of a specific act or threat).

4.112 Any emergency use of manual restraint.

4.113 A report of alleged or suspected vulnerable adult maltreatment under MN Statutes, section 626.557 or Chapter 260E.

4.20 Response Procedures:

4.21 Serious injury

4.211 In the event of a serious injury, employees will provide emergency first aid following instructions received during training.

4.212 Summon additional employees, if they are immediately available, to assist in providing emergency first aid or seeking emergency medical care.

4.213 Follow Medical Emergency-Non 911 or Medical Emergency 911 plan located on phone card.

4.22 Death

4.221 If employees are alone, immediately call 911 and follow directives given to you by the emergency responder.

4.222 If there is another person(s) with you, ask them to call 911, and follow directives given to you by the emergency responder.

4.23 Medical emergency, unexpected serious illness, or significant unexpected change in an illness or medical condition

4.231 Assess if the client requires the program to call 911, seek physician treatment, or hospitalization.

4.232 When and employee believes that a client is experiencing a life threatening medical emergency they must follow Medical Emergency-911 plan written on phone card.

4.233 Employees will provide emergency first aid as trained or directed until further emergency medical care arrives at the program or the client is taken to a physician or hospital for treatment.

4.24 Mental health crisis

4.241 When an employee believes that a client is experiencing a mental health crisis they must follow Behavior Emergency plan written on phone card.

4.25 Requiring 911, law enforcement, or fire department

4.251 For incidents requiring law enforcement or the fire department, employees will call 911.

4.252 For non-emergency incidents requiring law enforcement, employees will call the Vadnais Heights Police non-emergency number: 651.484.3366.

4.253 For non-emergency incidents requiring the fire department, employees will call the Vadnais Heights Fire Department non-emergency number: 651.204-6030.

4.254 employees will explain to the need for assistance to the emergency personnel. They will answer all questions asked and follow instruction given by the emergency personnel responding to the call.

4.26 Unauthorized or unexplained absence. When a client is determined to be missing or has an unauthorized or unexplained absence, employees will take the following steps:

4.261 If the client has a specific plan outlined in his/her Coordinated Services and Support Plan Addendum to address strategies in the event of unauthorized or unexplained absences that procedure should be implemented immediately, unless special circumstances warrant otherwise.

4.262 If the client is missing from an onsite service area, employees will follow Onsite Missing Persons information written on Phone Card.

4.263 If the client is missing from an offsite service location, employees will follow the Offsite Missing person's information written on the Phone Card or located in the offsite community book.

4.264 A current photo will be kept in each client's file and made available to law enforcement.

4.265 When the client is found employees will return the client to the service site, or make necessary arrangements for them to be returned to the service site.

4.27 Conduct of the client. When a client is exhibiting conduct against another client that is so severe, pervasive, or objectively offensive that it substantially interferes with a client's opportunities to participate in or receive service or support; places the client in actual and reasonable fear of harm; places the client in actual and reasonable fear of damage to property of the client; or substantially disrupts the orderly operation of the program, employees will take the following steps:

4.271 Summon additional employees, if available. If injury to a client has occurred or there is eminent possibility of injury to a client, implement approved therapeutic intervention procedures following the policy on emergency use of manual restraints (see EUMR Policy).

4.272 As applicable, implement the Coordinated Service and Support Plan Addendum for the client.

4.273 After the situation is brought under control, question the client(s) as to any injuries and visually observe their condition for any signs of injury. If injuries are noted, provide necessary treatment and contact medical personnel if indicated.

4.28 Sexual activity involving force or coercion. If a client is involved in sexual activity with another client and that sexual activity involves force or coercion, employees will take the following steps:

4.281 Instruct the client in a calm, matter-of-fact, and non-judgmental manner to discontinue the activity. Do not react emotionally to the client's interaction. Verbally direct each client to separate area.

4.282 If the client does not respond to a verbal redirection, intervene to protect them from force or coercion, following the EUMR Policy as needed.

4.283 Summon additional employees if necessary and feasible.

4.284 If the clients are unclothed, provide them with appropriate clothing. Do not have them redress in the clothing that they were wearing.

4.285 Do not allow them to bathe or shower until law enforcement has responded and cleared this action.

4.286 Contact law enforcement as soon as possible and follow all instructions. lf the client(s) expresses physical discomfort and/or emotional distress, or for other reasons you feel it necessary, contact medical personnel as soon as possible. Follow all directions provided by medical personnel.

4.29 Emergency use of manual restraint (EUMR) and/or Maltreat of a Vulnerable Adult.

4.291 Follow the EUMR Policy.

4.292 Follow the Maltreatment of Vulnerable Adults Reporting and Internal Review Policy.

4.30 Reporting Procedures:

4.31 Completing a report. Incident reports will be completed as soon possible after the occurrence, but no later than 24 hours after the incident occurred or the program became aware of the occurrence. The written report will include:

4.311 The name of the client(s) involved in the incident;

4.312 The date, time, and location of the incident;

4.313 A description of the incident;

4.314 A description of the response to the incident and whether a client's coordinated service and support plan addendum or program policies and procedures were implemented as applicable;

4.315 The name of the employee(s) who responded to the incident; and the results of the review of the incident (see section IV).

4.316 When the incident involves more than one client, this program will not disclose personally identifiable information about any other client when making the report to the legal representative or designated emergency contact and case manager, unless this program has consent of the client. The written report will not contain the name or initials of the other client(s) involved in the incident.

4.32 Reporting incidents to team members

4.321 All reportable incidents must be reported to client's legal representative or designated emergency contact and case manager:

a. within 24 hours of the incident occurring while services were provided;
b. within 24 hours of discovery or receipt of information that an incident occurred; or
c. as otherwise directed in a client's coordinated service and support plan or coordinated service and support plan addendum.

4.322 This program will not report an incident when it knows that the incident has already been reported.

4.323 Any emergency use of manual restraint of a client must be verbally reported to the client's legal representative or designated emergency contact and case manager within 24 hours of the occurrence. The written report must be completed according to the requirements in the program's emergency use of manual restraints policy.

4.33 Additional reporting requirements for deaths and serious injuries

4.331 A report of the death or serious injury of a client must be reported to both the Department of Human Services Licensing Division and the Office of Ombudsman for Mental Health and Developmental Disabilities. A report is to be made using either the Office of the Ombudsman's *Death Report webform* or *Serious Injury webform* or the facsimile *Death Reporting Form* or *Serious Injury Form* along with the *Death or Serious Injury Report FAX Transmission Cover Sheet.*

4.332 The report must be made within 24 hours of the death or serious injury occurring while services were provided or within 24 hours of receipt of information that the death or serious injury occurred.

4.333 This program will not report a death or serious injury when it has a reason to know that the death or serious injury has already been reported to the required agencies.

4.334 In the case of a death of the death of a client while Merrick, Inc., was providing service within the scope of its license, or if Merrick, Inc., was not providing service within the scope of its license and there is no other licensed caregiver., Merrick, Inc., will provide the client's next of kin with a copy of the Ombudsman's "Dear Newly Bereaved" Notification letter.

4.34 Additional reporting requirements for maltreatment

4.341 When reporting maltreatment, this program must inform the case manager of the report unless there is reason to believe that the case manager is involved in the suspected maltreatment.

4.342 The report to the case manager must disclose the nature of the activity or occurrence reported and the agency that received the maltreatment report.

4.35 Additional reporting requirements for emergency use of manual restraint (EUMR)

4.351 Follow the EUMR Policy.

4.40 Reviewing Procedures:

4.41 Conducting a review of incidents and emergencies

4.411 This program will complete a review of all incidents.

4.412 Except for review of allegations of maltreatment, the review of incidents will be completed by a Program Director or Assistant Program Director. Allegations of maltreatment will be reviewed by a Program Director or by an individual

designated by the Executive Director if a Program Director is unable or is not permitted to conduct that review.

4.413 The review will be completed within:
a. 30 calendar days of a report made to the Minnesota Adult Abuse Reporting Center (MAARC);
b. 30 calendar days of any other incident that requires an internal review; or
c. 5 business days after the date of the emergency use of manual restraint.

4.414 The review will ensure that the written report provides a written summary of the incident.

4.415 The review will identify trends or patterns, if any, and determine if corrective action is needed.

4.416 When corrective action is needed, an employee will be assigned to take the corrective action within a specified time period.

4.42 Conducting an internal review of deaths and serious injuries, allegations of maltreatment, and emergency use of manual restraint.

This program will conduct an internal review of all deaths and serious injuries, allegations of maltreatment, and emergency use of manual restraint that occurred while services were being provided if they were not reported as alleged or suspected maltreatment (refer to the Vulnerable Adults Maltreatment Reporting and Internal Review Policy and Internal Review Policy when alleged or suspected maltreatment has been reported).

The review will be completed by a Program Director an individual designated by the Executive Director.

The review will be completed within 30 calendar days of the death or serious injury, within 30 calendar days of the date when it became known there was an allegation of maltreatment, or within 5 business days of an emergency use of manual restraint. The internal review must include an evaluation of whether:

4.421 Related policies and procedures were followed;

4.422 The policies and procedures were adequate;

4.423 There is need for additional employee training;

4.424 The reported event is similar to past events with the clients or the services involved to identify incident patterns; and

4.425 There is need for corrective action by the program to protect the health and safety of the clients and to reduce future occurrences.

4.426 Based on the results of the internal review, the program must develop, document, and implement a corrective action plan designed to correct current lapses and prevent future lapses in performance by employees or the program, if any.

4.427 The internal review of all incidents of emergency use of manual restraints must also determine if there is a need to revise the person's service and support plan.

4.428 The internal review must be made accessible to the Commissioner immediately upon the Commissioner's request for internal reviews regarding maltreatment.

4.50 Record Keeping Procedures:

4.51 The review of an incident will be documented on the incident reporting form and will include identifying trends or patterns and corrective action if needed.

4.52 Incident reports will be maintained in the client's record. The record must be uniform and legible.

Policy reviewed and authorized on 02/18/2022 by:

John Wayne Barker, Executive Director

8 MALTREATMENT OF VULNERABLE ADULTS REPORTING AND INTERNAL REVIEW POLICY

1.00 PURPOSE:

The purpose of this policy is to detail the administration procedures used to enforce the requirements of Minnesota's Vulnerable Adult Act and Minnesota Statutes (MS), Section 245A.65.

2.00 APPLICATION:

This policy applies to each client enrolled at Merrick, Inc., and any individual who is either employed by, volunteers, or has a service agreement with Merrick, Inc.

3.00 POLICY STATEMENT:

Action shall be taken to reduce or eliminate the likelihood of maltreatment, but does not preclude a client's right to risk in habilitation programming and to engage in the process of establishing typical patterns of activity. Merrick, Inc., will cooperate to the fullest extent possible with the Minnesota Adult Abuse Reporting Center (MAARC) and the Lead Administrative Agency in the process of minimizing risks, and with the reporting and investigating of suspected maltreatment.

4.00 PROCEDURES:

4.10 Reporting suspected maltreatment of a vulnerable adult:

4.11 As a mandated reporter, if you know or suspect that a vulnerable adult has been maltreated, you must report it immediately. Immediately means as soon as possible, but no longer than 24 hours from the time initial knowledge that the incident occurred has been received.

4.20 Making an external or an internal report:

4.21 You may make an external report by calling the MAARC at 844-880-1574 or using the online reporting tool @ mn.gov/dhs/reportadultabuse.

4.22 Internal Reports can be made to an Assistant Program Director or Program Director or designee.

4.23 If the employee in 4.22 is involved in the alleged or suspected maltreatment, you must report to another Merrick, Inc., designated internal reporter who is not involved in the alleged or suspected maltreatment.

4.30 Internal report:

4.31 When an internal report is received, the designated internal reporter is responsible for deciding if a report to MAARC is required and, if required, filing the report. If that employee is involved in the suspected maltreatment, another designated internal reporter will assume responsibility for deciding if the report must be forwarded to MAARC.

4.32 The report to MAARC must be as soon as possible, but no longer than 24 hours from the time initial knowledge that the incident occurred has been received. If you have reported internally, you must receive, within two working days, a written notice that tells you whether or not your report has been forwarded to MAARC. The written notice must be given to you in a manner that protects your confidentiality as a reporter. It shall inform you that if you are not satisfied with the action taken by the facility on whether to report the incident to MAARC you may still make an external report to MAARC. It must also inform you that you are protected against retaliation by the program if you make a good faith report to MAARC.

4.40 What to report:

4.41 Definitions of maltreatment of vulnerable adults are contained in Minnesota Statutes, section 626.5572 and are attached to this policy.

4.42 An external or internal report should contain enough information to identify the vulnerable adult, the caregiver, the nature and extent of the suspected maltreatment, any evidence of previous maltreatment, the name and address of the reporter, the time, date, and location of the incident, and any other information that the reporter believes might be helpful in investigating the suspected maltreatment.

4.50 Failure to Report:

4.51 A mandated reporter who negligently or intentionally fails to report suspected maltreatment of a vulnerable adult is liable for damages caused by the failure to report.

4.60 Internal Review:

4.61 When the program knows that an internal or external report of alleged or suspected maltreatment has been made, the program must complete an internal review and take corrective action, if necessary, to protect the health and safety of vulnerable adults.

4.62 The internal review must include an evaluation of whether:

4.621 related policies and procedures were followed;

4.622 the policies and procedures were adequate;

4.623 there is a need for additional employee training;

4.624 the reported event is similar to past events with the vulnerable adults or the services involved; and

4.625 there is a need for corrective action by the program to protect the health and safety of vulnerable adults.

4.63 The internal review will be completed within 30 calendar days of the report to MAARC.

4.64 The internal review must be made accessible to the Commissioner immediately upon the Commissioner's request for internal reviews regarding maltreatment.

4.70 Primary and secondary person or position to ensure internal reviews are completed:

4.71 Internal Reviews of allegations of maltreatment can be conducted by an Assistant Program Director, a Program Director, or an individual designated by the Executive Director.

4.72 If an employee in a position listed above is involved in the alleged or suspected maltreatment, the internal review will be completed by another person designated by the Executive Director.

4.80 Documentation of the internal review:

4.81 The program must document completion of the internal review and provide documentation of the review to the DHS upon the commissioner's request.

4.90 Corrective action plan:

4.91 Based on the results of the internal review, the program must develop, document, and implement a corrective action plan designed to correct current lapses and prevent future lapses in performance by individuals or the program, if any.

4.100 Orientation for clients

4.101 The program shall provide an orientation of the internal and external reporting procedures to all clients. The orientation shall include the telephone number for the MAARC. A client's legal representative must be notified of the orientation.

4.102 The program shall provide this orientation for each new client within 24 hours of admission, or for clients who would benefit more from a later orientation, the orientation may take place within 72 hours.

4.200 Employee training

4.201 The program shall ensure that each new mandated reporter receives an orientation within 72 hours of first providing direct contact services to a vulnerable adult and annually thereafter. The orientation and annual review shall inform the mandated reporter of the reporting requirements and definitions under Minnesota Statutes, sections 626.557 and 626.5572, the requirements of Minnesota Statutes, section 245A.65, the program's

program abuse prevention plan, and all internal policies and procedures related to the prevention and reporting of maltreatment of clients.

4.202 The program must document the provision of this training, monitor implementation by employees of, and ensure that the policy is readily accessible to employees, as specified under Minnesota Statutes, section 245A.04, subdivision 14.

Policy reviewed and authorized on 02/18/2022 by:

John Wayne Barker, Executive Director

THIS REPORTING POLICY SHALL BE POSTED IN A PROMINENT LOCATION, AND BE MADE AVAILABLE UPON REQUEST.

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. 2 Abuse.
"Abuse" means:
(a) An act against a vulnerable adult that constitutes a violation (includes any action that meets the elements of the crime, regardless of whether there is a criminal proceeding or conviction) 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.

(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 employee 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 employee, 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. 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. 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 employee 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).

Human Rights Committee Review: 07/17/2015
Board Approved 03/11/01
Policy reviewed and authorized on 10/11/2019 by:

John Wayne Barker, Executive Director

9 MISSING PERSON PROCEDURES

A. ON-SITE PROCEDURES:

When a client attending Merrick, Inc., is determined to be missing, or has an unauthorized absence, the following steps are to be followed:

1. If the client has a specific plan outlined in their Coordinated Services and Support Plan Addendum (CSSP-A) with strategies in the event of "elopement", or "unauthorized absence", that procedure should be implemented unless special circumstances warrant otherwise.

2. Employees will notify their Assistant Program Director (APD) who will coordinate an immediate and thorough search of the building and surrounding area where the client was last sighted. The APD will notify Dispatch, who will make building and phone pages requesting employees to report any sightings of the missing client.

3. If the client is not located on the premises within 15-minutes, Dispatch will coordinate with the APD to assign employees to conduct a search within a 1-mile radius of the last known sighting of the client and designate a dedicated phone number.

4. If 30-minutes have passed without finding the client, the APD will notify the Program Director and provide the following information to Dispatch to use when contacting 911.
   - Name of caller and purpose of call;
   - Home address of client;
   - Description of client, including: name, age, gender, race, height, weight, color of hair, eye color, etc., (current photo is located in the client's blue file and should be made available to authorities);
   - Identification of clothing worn;
   - Description of distinguishing characteristics, (i.e., limp, scars, or peculiarities);
   - Detail of last known whereabouts and timeframe;
   - Summarize relevant medical information; and
   - Description of functional abilities, survival skills, communication, tendencies, possible places to check.

5. The Program Director or designee will assume responsibility for coordinating efforts with all others involved, and instruct the APD assigned to the client to immediately contact:
   - The client's case manager/or county emergency number; and
   - The client's legal representative and residential caregiver.

6. The employee search effort will continue until the client's whereabouts is determined, or the Program Director or legal guardian calls off the search.

7. If the client is not found within 2 hours of being missing, the Program Director will notify the Executive Director who will determine what other resources or actions will be deployed to assist in the search (i.e., contact media).

8. After the client is found, the Program Director will notify the APD, legal representative, client's case manager, residential caregiver, the police, and MAARC of the results.

9. The employee that was supporting the client when they went missing will assist the APD in completing an Incident/Accident Report form within required timeframe in accordance with the Incident Response and Reporting Policy.

B. OFF-SITE PROCEDURES:

When a client attending Merrick, Inc., is off-site and determined to be missing, or has an unauthorized absence, the following steps are to be followed:

1. The Employee last with the missing client is to contact the Assistant Program Director (APD) who will immediately contact the Program Director and Dispatch to help coordinate search efforts.

2. If the client has a specific plan outlined in their CSSP-A with strategies in the event of "elopement", or "unauthorized absence", that procedure should be implemented unless special circumstances warrant otherwise.

3. The APD will coordinate an immediate and thorough search of the surrounding area where the client was last sighted and designate a dedicated phone number.

4. If the client is not located within 30-minutes, the APD will notify the Program Director and provide the following information for Dispatch to use when calling 911. Merrick, Inc., Dispatch will coordinate with the APD to assign employees to conduct a search within a 1-mile radius of the last known sighting of the client. If two employees are available, one must always stay with the remaining clients.
   - Name of caller and purpose of call;
   - Home address of client;
   - Description of client, including: name, age, gender, race, height, weight, color of hair, eye color, etc., (current photo is located in the client's blue file and should be made available to authorities);
   - Identification of clothing worn;
   - Description of distinguishing characteristics, (i.e., limp, scars, or peculiarities);
   - Detail last known whereabouts and timeframe;
   - Summarize relevant medical information; and
   - Description of functional abilities, survival skills, communication, tendencies, possible places to check.

5. The Program Director or designee will assume responsibility for coordinating efforts with all others involved, and instruct the APD assigned to the client to immediately contact:
   - The client's case manager/or county emergency number; and
   - The client's legal representative and residential caregiver.

6. The employee search effort will continue until the client's whereabouts is determined, or the Program Director or legal guardian calls off the search.

7. If the client is not found within 2 hours of being missing the Program Director will notify the Executive Director, who will determine what other resources or actions will be deployed to assist in the search i.e. (contact media)

8. After the client is found, the Program Director will notify the APD, legal representative, client's case manager, residential caregiver, the police, and MAARC of the results.

9. the employee that was supporting the client when they went missing will assist the APD in completing an Incident/Accident Report form within required timeframe in accordance with the Incident Response and Reporting Policy.

Policy reviewed and authorized on 02/18/2022 by:

John Wayne Barker, Executive Director

10 PERSON-CENTERED PLANNING POLICY

1.00 PURPOSE

The purpose of this policy is to ensure services and supports adhere to the principles covered within the following 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. Services and supports are to address these domains in a manner that encourages self-determination, focuses on preferences, respects cultural background, promotes skill development, and allows for a balance between risk and opportunity.

2.00 APPLICATION

This policy will direct our efforts to support clients in achieving personally defined outcomes in the most inclusive community setting desired; ensure delivery of life enriching services and supports in a manner that reflects personal preferences and talents; honor choices; and protect their health, safety and welfare.

3.00 POLICY STATEMENT

Services are provided in a manner that supports the client's preferences and daily needs with activities that accomplish the person's personal goals and services outcomes.

4.00 PROCEDURES

4.10 Person-centered service planning and delivery which:
- 4.11 Identifies and supports what is important to the client as well as what is important for the client, including preferences for when, how, and by whom direct support services are provided;
- 4.12 Uses that information to identify outcomes the person desires; and
- 4.13 Respects each client's history, dignity, and cultural background.

4.20 Self-determination which supports and provides:
- 4.21 Opportunities for the development and exercise of functional and age-appropriate skills, decision making and choice, personal advocacy, and communication; and
- 4.22 The affirmation and protection of each client's civil and legal rights.

4.30 Provided in the most integrated setting appropriate to the client with inclusive service delivery that supports, promotes, and allows:
- 4.31 Inclusion and participation in the client's community as desired and in a manner that enables them to have typical interactions interact with nondisabled persons; develop and strengthen personal relationships with others of the client's choice in the community; and become a valued community member;
- 4.32 Opportunities for self-sufficiency as well as developing and maintaining social relationships and natural supports;

4.33 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 client to engage in activities of their own choosing that may otherwise present a risk to the client's health, safety, or rights; and

4.34 Options to move from day services to competitive employment in the community.

4.40 Review of Person-Centered Process which:

4.41 Is reviewed at least every six months with the client, others identified by the person and/or their guardian and is approved by the Program Director; and

4.42 Identifies and addresses improvements to be made that are in accordance with 245D.07 and Rule 9544.0030.

Policy reviewed and authorized on 02/18/2022 by:

John Wayne Barker, Executive Director

11 PET THERAPY POLICY

1.00 PURPOSE:

Animal-assistance activities (hereinafter "pet therapy") offers clients in our program the opportunity to engage in positive animal interactions that may also offer additional benefits such as increasing their social interactions, improving their motor skills, and enhancing their physical/emotional well-being. It is the company's desire to provide pet therapy for clients in a manner that is both safe and enjoyable.

2.00 APPLICATION:

This policy applies to all employees, clients, and therapy pet handlers.

3.00 POLICY STATEMENT:

Pet therapy is offered as an option for those clients that are interested in interacting with therapy animals. Only dogs and/or cats certified as a trained animal (no personal pets) will be permitted.

4.00 PROCEDURE:

4.10 Only the Transportation & Facility Manager can approve the use of a trained animal in the program. The trained animal is not permitted in food storage or serving areas.

4.20 The Transportation & Facility Manager will require the following documentation to be on file at the corporate office before the trained animal is permitted on-site:

- Documentation of proof of current vaccinations;
- Proof of liability coverage;
- Most recent annual examination by a licensed veterinarian verifying the trained animal is free of any communicable diseases and parasites;
- Certification that both the animal and the handler have successfully completed a therapeutic training program; and
- An agreement outlining the purpose and cost of the pet therapy service.

4.30 The therapy animal will be under the direct and continuous supervision and control of the handler at all times.

4.40 The visit by the trained animal will be posted on the activity calendar and clients with a known fear of animals will be advised and offered the option to be supervised in a different area of the program.

Policy reviewed and authorized on 02/18/2022 by:

John Wayne Barker, Executive Director

12 PROGRAM ABUSE PREVENTION PLAN - 3210 LABORE ROAD

POPULATION ASSESSMENT:

1. Merrick, Inc., provides services to clients 21 years of age and older. Based on the 2022 demographics data**,** the youngest client in this program is 21 and the oldest is 87.

2. The program will reduce the potential of abuse and/or harm to clients related to their age in the following manner:
   - Encourage age-appropriate interactions with others;
   - Follow age-related instructions within the Individual Abuse Prevention Plan; and
   - Respond to age-related abuse or harm trends that emerge from the analysis of incident reports.

3. Based on demographic data from 2020, 54% of our clients are men and 46% are women.

4. The program will reduce the potential of abuse and/or harm to clients related to their gender in the following manner:
   - Encourage gender-appropriate interactions with others;
   - Follow gender-related instructions within the Individual Abuse Prevention Plan or Coordinated Services and Support Plan Addendum; and
   - Respond to any gender-related abuse and/or harm trends that emerge from the analysis of incident reports.

5. Range of cognitive functioning includes:
   - Clients with a diagnosis of a related-condition, indicating their needs are similar to persons with a diagnosis of a developmental disability.
   - Clients with a developmental disability including those with a diagnosis of:
     - Dementia and Alzheimer's Disease and related conditions;
     - Autism Spectrum Disorder;
     - Intellectual Disorder (Intellectual Disability) and related conditions such as epilepsy and cerebral palsy;
     - Traumatic Brain Injury; and
     - Mental Illness; depression, schizophrenia, intermittent explosive disorder, and bipolar.
   - Recipients with limitations in cognitive functioning from benign to significant.

6. The program will reduce the potential of abuse and/or harm to clients related to their cognitive functioning in the following manner:
   - Each client is considered a vulnerable adult and has an Individual Abuse Prevention Plan. The plan is intended to reduce the potential for abuse and/or harm, including potential for abuse and/or harm related to their cognitive functioning.
   - Employees must be competent to perform assigned duties for clients to meet identified needs which, to varying degrees, are impacted by their cognitive functioning.
   - Internal reviews are conducted and corrective action taken if it is found that the potential for or actual abuse and/or harm are related to the cognitive functioning of clients.

7. The range of physical and emotional health of clients is as follows:

- More than 90% of the clients have been fully vaccinated against Covid-19 and their physical health can range from no limitations to being medically fragile.
- The mental health of clients can range from no mental health diagnosis to one or more diagnoses from the Diagnostic and Statistical Manual of Mental Disorders.
- As with the general population, there can be time-limited occasions of need within any area of physical and emotional health.

8. The program will reduce the potential of abuse and/or harm to clients related to their physical and emotional health in the following manner:
   - Each client is considered a vulnerable adult and has an Individual Abuse Prevention Plan. The plan is intended to reduce the potential for abuse and/or harm, including potential for abuse and/or harm related to their physical and emotional health.
   - Employees must be competent to perform assigned duties for clients to meet identified needs; those needs, to varying degrees, are impacted by their physical and emotional health.
   - Internal reviews are conducted and corrective action taken if it is found that the potential for or actual abuse and/or harm are related to the physical and emotional health of clients.
   - Formal plans responding to factors that risk the health and safety of clients will be developed and implemented in accordance with licensing standards or mandates as needed.

9. The range of adaptive/maladaptive behavior(s) of clients is as follows:
   - Limitations in a client's adaptive behavior can range from minor to major.
   - The display of maladaptive behavior may range from non-existent to frequent display of one or more maladaptive behaviors.
   - As with the general population the display of maladaptive behavior can be short-lived or long-term in nature. Clients with ongoing or intense behaviors can be suspended or terminated from services per Merrick's Service Termination and Service Suspension Policies.

10. The program will reduce the potential of abuse and/or harm to clients related to their adaptive/maladaptive behavior(s) in the following manner:
    - Each client is considered a vulnerable adult and has an Individual Abuse Prevention Plan. The plan is intended to reduce the potential for abuse and/or harm, including potential for abuse and/or harm related to their adaptive/maladaptive behavior.
    - Employees must be competent to perform assigned duties for clients to meet identified needs; those needs, to varying degrees, are impacted by the client's adaptive/maladaptive behavior.
    - Internal reviews are conducted and corrective action taken if it is found that the potential for or actual abuse and/or harm are related to adaptive/maladaptive behavior.

11. The need for specialized programs of care for clients is as follows:
    - Merrick- s offers a variety of therapeutic non-work activities based on client need and interest.
    - Merrick- offers a structured environment and behavioral supports and programming based on client need and interest.
    - Medication Administration is under the supervision of an RN Consultant.

12. The program will reduce the potential of abuse and/or harm to clients related to their need for specialized programs of care in the following manner:

- There are a sufficient number of trained Medication Passers assigned to oversee the medication administration needs of the clients. The RN Consultant will provide consultation and monthly reviews of client's health status, health education, medication procedures, and will train personnel to medication administration.
- All employees of receive training in First Aid, CPR, and use of a Defibrillator (AED).

13. The need for specific employee training to meet individual service needs is as follows:
    - Prior to working with a client for whom an employee has assigned responsibilities, that employee must receive training sufficient to achieve competency addressing specific service needs of that client.
    - When there is a change in client needs for which an employee is responsible, that employee must receive training sufficient to achieve competency addressing specific service needs of that client.

14. The program will reduce the potential of abuse and/or harm to clients related to the need for specific employee training designed to meet client service needs in the following manner:
    - Prior to working with clients diagnosed with dementia, information on dementia and Alzheimer's disease is provided and employees are to apply this information into the daily interactions and support of clients.
    - All employees are trained in CPR, First Aid, and use of a AED. First Aid kits are located in Enhanced Services, Utility Services, Alternative Services, the Commons, on-site Recycling and Document Destruction, the Administrative office, in all company vehicles, and 3 kits are available when transporting clients in personal cars. The building has two AED units with one located on the wall outside Alternative Services and one in the hallway outside of the Executive Director's office.
    - Prior to working with clients who require the use of specialized equipment such as a stander or Hoyer lift, employees receive training sufficient to achieve competency on proper techniques of lifting and using the required adaptive equipment. Employees will demonstrate competencies on proper lifting techniques and using the required adaptive equipment, and that competency will be documented in the employee's training file.

15. The program maintains files of reports submitted to the Minnesota Adult Abuse Reporting Center and, if received, disposition of those reports by the Department of Human Services in order to minimize the future risk of abuse to clients.

16. The program will conduct internal reviews when there is an allegation of maltreatment and, as warranted, take corrective action to prevent maltreatment in the future.

17. The Program will make reports to the MAARC when the vulnerable adult is susceptible to abuse outside the scope or control of the licensed services. The program will notify IDT members who will collectively decide and make referrals to outside agencies when needed.

PHYSICAL PLANT ASSESSMENT:

1. The following is a summary of the condition and design of the facility as it relates to safety for the clients. The 3210 Labore site was completely renovated in 2003 and has 52,000 square feet not

including the attached greenhouse on the east side of the building. With client input, the building has wide hallways and barrier-free environments. The building is wheelchair accessible with ground level exits to interior evacuation zones and to the outside. Non-grade-level south exits are addressed in the evacuation plan. The Commons space is approximately 3,500 square feet in size and features 10 x 10 sized windows that create light filled space for the clients. The three primary program services have approximately 11,000 square feet with skylights to add natural lighting. Each primary area is denoted in the hallway with a specific color for easily identification; green is Administration, purple is Utility, gold is Alternative, blue is Enhanced, and orange is Transportation. Restrooms are located within the Commons, Utility, Alternative, Enhanced, Recycling, Document Destruction and Administrative areas for better supervision of recipients.

Those clients working specifically in the Document Shredding and Plastic Recycling areas have been assessed in their skills to operate machinery. Enhanced and Alternative Services have doors that are locked from both sides with key code access. Clients gain access by asking for and receiving the door code when demonstrating safe entry and exit, or by asking and employee to assist them, and are denied access only when necessary to protect the safety of a client. The risk factors that indicate the need for locked doors include recipients with a physical or developmental disability including those with a diagnosis of:

- Dementia and Alzheimer's Disease and related conditions;
- Autism Spectrum Disorder;
- Intellectual Disorder (Intellectual Disability) and related conditions such as epilepsy and cerebral palsy;
- Traumatic Brain Injury;
- Mental Illness; depression, schizophrenia, intermittent explosive disorder, and bipolar; and
- Recipients with limitations in mental functioning from benign to significant.

The locked doors are not used as a substituted for client supervision or interaction and have a magnetic seal that is automatically disengaged whenever the fire alarm is activated. The building is equipped with hard-wire smoke detectors and sprinklers, and meets current licensing and fire code standards. Clients have private access to and use of a non-coin-operated telephone for local calls and long distance calls made are collect or paid for by the person. This phone is located in the Sean Kenny room.

2. The program will reduce the potential of abuse and/or harm to clients related to the condition and design of the facility in terms of their safety in the following manner:
   - Quarterly fire drills are conducted to practice evacuation procedures.
   - To address general maintenance, Merrick contracts for these services 18 - 20 hours per week or as needed. If there are maintenance concerns, employees can email AAAFix@merrickinc.org which alerts internal maintenance of the issue and urgency of the repair.
   - A portable Hoyer lift is available for clients who need assistance moving safely from one location to another.
3. The small meeting room in the program area can be sometimes difficult to supervise. To address this signage has been mounted on the wall outside the Program Conference room to indicate if the room is occupied or unoccupied.

4. The program will reduce the potential of abuse and/or harm to clients related to the areas of the facility that are difficult to supervise as follows:
   - The door will be propped open when not in use. When in use, the signage on the door will reflect that a meeting or program activity is taking place.
   - When not in use, the dangerous supplies and chemicals used for cleaning or laundry purposes are stored in either the locked laundry room or locked janitorial closet. Cleaning supplies and chemical used by the cleaning crew are locked in their cart cabinet when they are not in the direct vicinity of the cart.
   - The medication storage and disposal procedures are identified within the Medication Administration Policy.

ENVIRONMENTAL ASSESSMENT:

1. The following is a summary of the facility location including information about the neighborhood and community that the facility is located. Merrick, Inc. is located in Vadnais Heights, Minnesota. There are a number of commercial businesses in the area, ranging from small to large and residential areas to north, south and west of the facility. The facility parking lot entrance is adjacent to Labore Road, a street with a moderate level of traffic. There is light foot traffic on Labore Road.

2. The program will reduce the potential of abuse and/or harm to clients related to the location of the facility, including factors about the neighborhood and community in the following manner:
   - Program does provide and coordinate transportation to and from the facility. Vehicles with hydraulic lifts to accommodate passengers using wheelchairs are available within the service area.
   - The Ramsey County Sheriff's Department provides law enforcement services to the Vadnais Heights community. The non-emergency phone number is (651) 767-0604.
   - The Vadnais Heights Fire Department provides fire protection, fire safety education and emergency response to the Vadnais Heights community. The non-emergency phone number is (651) 204-6030

3. The type of grounds and terrain that surround the facility include a nature preserve located to the north and to the east of the facility. A building complex and Interstate 694 are located to the south and Labore Road to the west. There is a chain link fence to the south, between the business complex and Interstate 694, and along the nature preserve to the east of the facility. The H. B. Fuller business campus is adjacent to the nature preserve to the north, and there is also a chain link fence between the nature preserve and the Merrick property. Walkways provide an even surface for entrance to the facility.

4. The program will reduce the potential of abuse and/or harm to clients related to the type of grounds and terrain that surround the facility in the following manner:
   - During loading and unloading of vehicles assigned employees are stationed outside. Only a limited number of vehicles can be unloaded/loaded at a time to ensure the safety of clients coming and going from the building.

5. Internal programming provided at the program includes:

- Day Support, Pre-vocational, DTH, Employment Support Services, and Life Enrichment activities (i.e. social skills, music, art, yoga, community inclusion activities, walking activities, therapies, academics, exercise, volunteerism, and horticulture);
- Assistive technology is available in all areas to promote increased communication and socialization; and
- Self-Advocacy activities are offered to promote empowerment, self-determination, choice, and leadership skills.

6. The program will reduce the potential of abuse and/or harm to clients through the type of internal programming provided at the program in the following manner:
   - Staffing ratios, employee qualifications, and daily routines address the needs of clients to best ensure their successful and safe participation in services.
   - A Self-Management Assessment is completed on each client identifying their independence to respond to emergency situations and the staff-to-client ratio to be assigned to the client.

7. Each client has been assigned a staff-to-client ratio to meet their needs. The daily schedule reflects this information to ensure the staff-to-client ratio is met daily.

8. The Assistant Program Director or designee are responsible for reviewing, developing, and monitoring daily schedules to ensure the staffing pattern reflects what is identified for each client to reduce the potential of abuse and/or harm. The Assistant Program Director or designee is also responsible for orientating and training volunteers to understand their role to the clients, social boundaries, activity engagement, and information about the population served.

PROGRAM ASSURANCES:

A. Clients are provided with an orientation to the Program Abuse Prevention Plan. This orientation must be within 24 hours of admission or within 72 hours for clients who would benefit from a later orientation.

B. Merrick, Inc.'s Board of Trustees must review the Program Abuse Prevention Plan at least annually.

C. A copy of the Program Abuse Prevention Plan must be posted in a prominent place in the each client program area and be available, upon request, to mandated reporters, clients, and their legal representatives.

D. The plan must include a statement of measures to be taken to minimize the risk of abuse to the vulnerable adult(s) or when the need for additional measures is identified. This includes identifying referrals that are made when the vulnerable adult is susceptible to abuse outside the scope or control of the licensed services.

E. If the assessment indicates that the vulnerable adult does not need specific risk reduction measures in addition to those identified in the Program Abuse Prevention Plan, the Individual Abuse Prevention Plan must document this determination.

F. In addition to the Program Abuse Prevention Plan, an Individual Abuse Prevention Plan within the Individual Program Plan must be developed for each new client. A review of the Individual Abuse Prevention Plan must be done as part of the review of the program plan. The client must participate in the development of their Individual Abuse Prevention Plan to the best of their abilities. All Individual Abuse Prevention Plans must be reviewed at least annually by the support team.

Board Approved XX/XX/2022
Policy reviewed and authorized on XX/XX/2022 by:

John Wayne Barker, Executive Director

13 PROGRAM ABUSE PREVENTION PLAN - FRANKLIN BUILDING

POPULATION ASSESSMENT:

1. Merrick, Inc., provides services to clients 21 years of age and older. Based on the 2022 demographic data**,** the youngest service recipient is 22 and the oldest is 80.

2. The program will reduce the potential of abuse and/or harm to clients related to their age in the following manner:
   - Encourage age-appropriate interactions with others.
   - Follow age-related instructions with the Individual Abuse Prevention Plan.
   - Respond to age-related abuse or harm trends that emerge from the analysis of incident reports.

3. Based on demographic data from 2020, 47% of clients are men and 53% are women.

4. The program will reduce the potential of abuse and/or harm to clients related to their gender in the following manner:
   - Encourage gender-appropriate interactions with others.
   - Follow gender-related instructions with the Individual Abuse Prevention Plan or Coordinated Services and Support Plan Addendum.
   - Respond to any gender-related abuse and/or harm trends that emerge from the analysis of incident reports.

5. Range of cognitive functioning includes:
   - Clients with a diagnosis of a related-condition, indicating their needs are similar to persons with a diagnosis of a developmental disability.
   - Clients with a developmental disability include those with a diagnosis of:
     - Dementia and Alzheimer's Disease and related conditions;
     - Autism Spectrum Disorder;
     - Intellectual Disorder (Intellectual Disability) and related condition such as epilepsy and cerebral palsy;
     - Traumatic Brain Injury; and
     - Mental Illness; depression, schizophrenia, intermittent explosive disorder, and bipolar disorders.
   - Recipients with imitations in cognitive functioning can range from benign to significant.

6. The program will reduce the potential of abuse and/or harm to clients related to their mental functioning in the following manner:
   - Each client is considered a vulnerable adult and has an Individual Abuse Prevention Plan that is intended to reduce the potential for abuse and/or harm, including potential for abuse and/or harm related to their cognitive functioning.
   - Employees must be competent to perform assigned duties for the clients they are assigned to support and their cognitive functioning needs.
   - Internal reviews are conducted and corrective action taken if it is found that the potential for or actual abuse and/or harm are related to the cognitive functioning of clients.

7. The range of physical and emotional health of clients is as follows:
   - The physical health of clients can range from no limitations to being medically fragile.
   - The mental health of clients can range from no mental health diagnosis to one or more diagnoses from the Diagnostic and Statistical Manual of Mental Disorders.
   - As with the general population, there can be time-limited occasions of need within the area of physical and emotional health.

8. The program will reduce the potential of abuse and/or harm to the physical and emotional health of clients in the following manner:
   - More than 90% of the clients have been fully vaccinated against Covid-19 and their physical health can range from no limitations to being medically fragile.
   - Each client is considered a vulnerable adult and has an Individual Abuse Prevention Plan that is intended to reduce the potential for abuse and/or harm, including potential for abuse and/or harm related to the individual's physical and emotional health.
   - Employees must be competent to perform assigned duties for the clients they are assigned to support and their physical and emotional health needs.
   - Internal reviews are conducted, and corrective action taken, if it is found that the potential for or actual abuse and/or harm are related to the physical and emotional health of clients.
   - Formal plans responding to factors that risk the health and safety of clients will be developed and implemented in accordance with licensing standards or mandates as needed.

9. The range of adaptive/maladaptive behavior(s) for clients is as follows:
   - Limitations in a client's adaptive behavior can range from minor to major.
   - The display of maladaptive behavior may range from non-existent to frequent display of one or more maladaptive behaviors.
   - As with the general population, the display of maladaptive behavior can be short- or long-term in nature. Clients with ongoing or intense behaviors can be suspended or terminated from our program per Merrick's Service Termination and Service Suspension Policies.

10. The program will reduce the potential of abuse and/or harm to clients with adaptive/maladaptive behavior(s) served in the following manner:
    - Each client is considered a vulnerable adult and has an Individual Abuse Prevention Plan that is intended to reduce the potential for abuse and/or harm, including potential for abuse and/or harm related to their adaptive/maladaptive behavior.
    - Employees must be competent to perform assigned duties for the clients they are assigned to support and their adaptive/maladaptive behavior needs.
    - Internal reviews are conducted and corrective action taken if it is found that the potential for or actual abuse and/or harm are related to adaptive/maladaptive behavior.

11. Describe the need for specialized programs of care for clients.
    - Our-Day Support Services offers individualized community based training and support services to help clients to develop and maintain needed and personally preferred enriching life skills so they can effectively access and participate in meaningful activities they prefer in their communities. These include a variety of therapeutic non-work activities including music therapy, pet therapy, horticulture, and community inclusion based on client need and interest.
    - Medication Administration is under the supervision of a RN Consultant.

12. The program will reduce the potential of abuse and/or harm to clients needing specialized programs of care in the following manner:
    - Trained Medication Passers are assigned to oversee the medication administration needs of the clients. The RN Consultant will provide consultation and monthly reviews of clients' health status, health education, medication procedures, and the training of personnel to medication administration.
    - All employees are trained in First Aid, CPR, and use of an AED.

13. The need for specific employee training to meet individual service needs are as follows:
    - Prior to working with a client for whom an employee has assigned responsibilities, that employee must receive training sufficient to achieve competency addressing specific service needs of that client. .
    - Employees will be trained on any changes to specific needs of the clients they are assigned to support.

14. The program will reduce the potential of abuse and/or harm to clients with specific service needs in the following manner:
    - All employees are trained in First Aid, CPR, and use of an AED. The First Aid kit and AED is located on the wall in the media room.
    - Employees review information on dementia and Alzheimer's disease prior to supporting clients with a diagnosis of dementia and/or Alzheimer's disease.
    - Employees are trained on the use of specialized equipment (i.e., standers, wheelchairs, lifts, etc.) and demonstrate competency before using the specialized equipment with clients and competency will be documented in the employee's training file.

15. The program maintains files of reports submitted to the Minnesota Adult Abuse Reporting Center and, if received, disposition of those reports by the Department of Human Services in order to minimize the future risk of abuse to clients.

16. The program will conduct internal reviews when there is an allegation of maltreatment and, as warranted, take corrective action to prevent maltreatment in the future.

PHYSICAL PLANT ASSESSMENT:

1. The following is a summary of the condition and design of the facility as it relates to safety for the clients. The Franklyn site in North St. Paul is a leased site and it was completely renovated in 2012. Program space leased is about 6,000 square feet within the Franklyn Business Center. With service recipient input, it has open and barrier-free environments. The building is wheelchair accessible with ground level exits to interior evacuation zones and to the outside. Four of the five primary program activity areas have at least two windows for natural lighting. The building is equipped with hard-wire smoke detectors and sprinklers, and meets current licensing and fire code standards. A non-coin operated portable telephone with posted emergency numbers is located in the computer area but is mobile to be used throughout the building accessible to clients and employees. All restroom stalls are equipped with a doorbell chime that informs employees if a client needs

assistance. All chemicals (i.e. cleaning, laundry) are stored in a keyed locked storage closet. Cleaning and laundry is conducted during non-program hours.
Medications are stored per the Medication Administration Policy. Employees are instructed to keep their own personal medications locked up in their lockers or in their personal vehicles. In the media room, there is an operable flashlight next to the AED kit, in case of a power outage. A battery operated NOAA radio is located in the kitchen on the window sill. The exterior doors are equipped with a keypad requiring a passcode to exit (except in case of a fire alarm when all doors would be accessible) and all exterior doors emit an audible alarm.

2. The program will reduce the potential of abuse and/or harm to clients related to the condition and design of the facility in terms of safety for clients in the following manner:
   - To address general maintenance, Merrick contracts for these services1-2 hours per week or as needed. If there are maintenance concerns, employees can email AAA Fix which serves to identify the issue and prioritize being addressed.
   - A portable Hoyer lift is available for clients who need assistance moving safely from one location to another.

3. Describe any areas of the program area that are difficult to supervise. There is a small room adjacent to the front program area that has a door. When not in use, the door is open. If a client chooses to go in the room to be in a quieter area, employees will frequently monitor the status of the client and encourage them to rejoin activities.

4. The program will reduce the potential of abuse and/or harm to clients related to the areas of the program that are difficult to supervise in the following manner:
   - The dangerous supplies and chemicals are not in use for cleaning or laundry purposes, the items are stored in the locked janitorial closet. The medication storage and disposal procedures are identified within the Medication Administration Policy.
   - On a daily basis, employees clean the program areas once the clients have left for the day.
   - Deep cleaning is completed weekly by employees when clients are not present.

ENVIRONMENTAL ASSESSMENT:

1. The following is a summary of the program including information about the North St. Paul neighborhood and community. There are several commercial businesses located within the Franklyn Center. The general public uses separate entrances to access those businesses within the complex. There are a number of commercial businesses in the area, ranging from small to large and residential areas to north, south and west of the program. These businesses include the Community Center, library, post office, newspaper business, VFW, barber shop, restaurants, small retail businesses, senior apartments and complexes, taverns, post office, etc. The fire station is located just a block away southeast from the Franklyn Center. The police station is located four blocks away northeast of the center. The Franklyn Business Center is located just 3 blocks west of the center of town with the only controlled signaled light in downtown North St. Paul.

   The program parking lot entrance is adjacent to 7th Avenue East, a street with a moderate level of traffic during daytime hours. Traffic on 7th Avenue East has a 35 MPH speed limit. There is light foot traffic on the sidewalk just south of the building. The front entrance is about 15 feet from the curb of 7th Avenue East. There is a section of the sidewalk in front of the entrance that is level to

the parking lot for access to those with mobility challenges. On a daily basis, employees are assigned to assist clients getting off and on their vehicles. There are sidewalks on both sides of the streets on 7th Avenue East. To walk to the library and Community Center just a half a block northwest of the Franklyn site, clients and employees would walk through the parking lot to a less traveled service road. The west parking lot of the Franklyn Center is paved, however, to walk to the library and Community Center would be considered uneven terrain. There are no railroads, ponds, rivers, or other bodies of water within the immediate area.

2. The program will reduce the potential of abuse and/or harm to clients related to the location of the program, including factors about the neighborhood and community in the following manner:
   - Program does provide and coordinate transportation to and from the program. Vehicles with hydraulic lifts to accommodate passengers using wheelchairs are available within the service area.
   - The police and fire stations are both located within a block and 4 blocks, respectively.

3. The type of grounds and terrain that surround the facility includes the following:
   - Walkways and cut-away curbs provide an even surface for entrance to the front entrance of the Franklyn program.

4. The program will reduce the potential of abuse and/or harm to clients related to the type of surrounding grounds and terrain in the following manner:
   - Employees are assigned to assist with the unloading and loading of vehicles bringing clients to the program. Only one vehicle will be unloaded/loaded at a time.
   - When going to the library and Community Center, employees will guide and provide verbal cues for clients to maneuver around the uneven terrain to reach the entrance of these two locations.

5. Internal programming provided at this Day Support Service site includes:
   - Iindividualized community based training and support services (i.e. social skills, music, art, yoga, community inclusion activities, walking activities, therapies, academics, exercise, volunteerism, and horticulture) to help clients develop and maintain needed and personally preferred enriching life skills so they can effectively access and participate in meaningful activities they prefer in their communities.
   - Assistive technology is incorporated into daily routines to promote communication and socialization.
   - Self-Advocacy activities are offered to promote empowerment, self-determination, choice, and leadership skills.

6. The program will reduce the potential of abuse and/or harm to clients through the type of internal programming provided in the following manner:
   - Staffing ratios, employee qualifications, and daily routines address the needs of clients to best ensure their successful and safe participation in activities.
   - A Self-Management Assessment is completed on each client identifying their independence to respond to emergency situations and the staff-to-client ratio needed.

7. Each client has been assigned a staff-to-client ratio to meet their health and safety needs. The daily schedule reflects this information to ensure the staff-to-client ratio of the clients is met daily.

8. Assistant Program Director (APD)or designee is responsible for reviewing, developing, and monitoring daily schedules to ensure the staffing pattern reflects what is identified for each client**.** The APD is responsible for orientating and training volunteers to understand their role to the clients, social boundaries, activity engagement, and information about the population served.

PROGRAM ASSURANCES:

A. clients are provided with an orientation to the Program Abuse Prevention Plan. This orientation must be within 24 hours of admission or within 72 hours for clients who would benefit from a later orientation.

B. Merrick, Inc.'s Board of Trustees must review the Program Abuse Prevention Plan at least annually.

C. A copy of the Program Abuse Prevention Plan must be posted in a prominent place in the program area and be available, upon request, to mandated reporters, clients, and their legal representatives.

D. The plan must include a statement of measures to be taken to minimize the risk of abuse to the vulnerable adult(s) or when the need for additional measures is identified. This includes identifying referrals that are made when the vulnerable adult is susceptible to abuse outside the scope or control of the licensed services.

E. If the assessment indicates that the vulnerable adult does not need specific risk reduction measures in addition to those identified in the Program Abuse Prevention Plan, the Individual Abuse Prevention Plan must document this determination.

F. In addition to the Program Abuse Prevention Plan, an Individual Abuse Prevention Plan must be developed for each new client. A review of the Individual Abuse Prevention Plan must be done as part of the review of the program plan. The client must participate in the development of the Individual Abuse Prevention Plan to the best of their abilities. All Individual Abuse Prevention Plans must be reviewed at least annually by the support team.

Board Approved XX/XX/2022
Policy reviewed and authorized on XX/XX/2022 by:

John Wayne Barker, Executive Director

14 SAFE MEDICATION ASSISTANCE ADMINISTRATION POLICY

1.00 PURPOSE

This policy establishes guidelines for employees to provide safe medication setup, assistance, and administration when:

- assigned responsibility to do so in the client's coordinated service and support plan (CSSP) or the CSSP addendum;
- using procedures established in consultation with a registered nurse, nurse practitioner, physician's assistant or medical doctor; and

2.00 APPLICATION

This policy applies to all employees and clients served by Merrick, Inc.

3.00 POLICY STATEMENT

3.10 Authorization to Administer

Medication administration is a duty that can only be performed or delegated by a licensed professional. For our purposes, the licensed R.N. Consultant retained by the company will supervise the procedure to delegate medication administration duties to employees. Interested employees must first successfully complete a certified medication administration course and present their certification to the R.N. Consultant. The R.N. Consultant will then provide specific on-site medication administration training that includes: (i) medication administration procedures; (ii) knowledge of medications administered and side effects; and (iii) location of medication resources. The R. N. Consultant will then schedule the employee to administer medication to clients and observe their performance. Only the R.N. Consultant can deem an employee qualified to perform medication administration and must document this determination in their personnel file. Only the following persons can administer medications to clients at Merrick, Inc:

- Physicians, Physician Assistant, Registered Nurses, or Licensed Professional Nurses authorized by the client's Interdisciplinary Team; and
- Employees that have successfully completed medication administration training and had skill observation procedures supervised by the R.N. Consultant before actually providing medication setup, assistance and administration.

3.20 Written Authorization

Written is required for medication administration or medication assistance, including psychotropic medications or injectable medications. Merrick, Inc., must obtain written authorization from the client or their legal representative before providing assistance with or administration of medications or treatments, including psychotropic medications and injectable medications. The authorization will remain in effect to administer medication unless it is withdrawn in writing and may be withdrawn at any time. If the client or their legal representation refuses to authorize Merrick, Inc., to administer medication, employees may not administer the medication. The program must report the refusal to authorize medication administration to the prescriber as expediently as possible.

4.00 PROCEDURES

Employees administering medications (hereinafter "TMP") to clients of Merrick, Inc., are to use the standards of practice explained in the following Medication Administration Practice Guidelines:

4.10 Medication setup;
4.20 Medication assistance;
4.30 Medication administration;
4.40 The Medication Administration Record;
4.50 Medication Supply:
- 4.51 Labeling of Medications;
- 4.52 Physician's Orders;
- 4.53 Drug References;
- 4.54 Administration of PRN Medications;
- 4.55 Administration of Short-Term Medications; and
- 4.56 Medication Destruction.

4.60 Medication Error Procedure;
4.70 Self-Administration of Medications;
4.80 Storage and Transportation of Medications; and
4.90 Psychotropic Medications.

4.10 Medication setup

When the program is responsible for medication setup the TMP must document the following in the client's medication administration record:

1. Dates of set-up
2. Name of medication;
3. Quantity of dose;
4. Times to be administered;
5. Route of administration at time of set-up; and
6. When the client will be away from Merrick, Inc., the TMP must document to whom the medications were given.

4.20 Medication assistance

When the program is responsible for medication assistance the TMP may:

1. Bring to the client and open a container of previously set up medications;
2. Empty the container into the client's hand;
3. Open and give the medications in the original container to the client;
4. Bring client liquids or food to accompany the medication; and
5. Provide reminders to take regularly scheduled medication or perform regularly scheduled treatments and exercises. Reminders to take medication can occur "in person, remotely, or through programming devices such as telephones, alarms, or medication boxes."

4.30 Medication administration

When administering medications, including psychotropic and injectable medications, a medication administration record (MAR) must be maintained for the client that includes the following:

1. Information on the current prescription label or the prescriber's current written or electronically recorded order or prescription that includes the client's name, description of the medication or treatment to be provided, and the frequency and other information needed to safely and correctly administer the medication or treatment to ensure effectiveness;
2. Information on any risks or other side effects that are reasonable to expect, and any contraindications to its use. This information must be readily available to all TMPs administering the medication;
3. The possible consequences if the medication or treatment is not taken or administered as directed; and
4. Instruction on when and to whom to report the following:
   - If a dose of medication is not administered or treatment is not performed as prescribed, whether by error by the TMP or the client or by refusal by the client; and
   - The occurrence of possible adverse reactions to the medication or treatment.

TMP must complete the following when responsible for medication administration:
1. Check the client's medication administration record (MAR);
2. Prepare the medications as necessary;
3. Administer the medication or treatment to the client according to the prescriber's order;
4. Document in the MAR:
   - The administration of the medication or treatment or the reason for not administering the medication or treatment;
   - Notation of any occurrence of a dose of medication not being administered or treatment not performed as prescribed, whether by error by the TMP or the client or by refusal by the client, or of adverse reactions, and when and to whom the report was made; and
   - Notation of when a medication or treatment is started, administered, changed, or discontinued.
5. Report any concerns about the medication or treatment, including side effects, effectiveness, or a pattern of the client refusing to take the medication or treatment as prescribed, to the prescriber or a nurse; and
6. Adverse reactions must be immediately reported to the prescriber or a nurse.

Administration Steps:
1. Wash hands before passing medications and between each client administration;
2. Assemble the needed equipment (medication cups, spoons, drinking cups, fluids, applesauce, etc.);
3. Read the medication administration sheet;
4. Locate the client's medication supply (check expiration date);
5. Compare the medication sheet to the order on the medication label (if there is a discrepancy, call a nurse BEFORE giving the medication);
6. For over the counter (OTC) medication, check the medication, name and strength from manufacture instructions;
7. Pour the medication into the container, without touching;
8. Check the medication sheet and the medication label again;
9. Recheck the medication sheet and label once more before returning the medication to storage;
10. Identify the client to receive the medications;
11. Administer the medication by the prescribed route/directions*;
12. Make sure the medication is fully swallowed and offer fluids after the medication is given if the client will allow;

13. Clean and replace the equipment;
14. Initial for the medications given; and
15. Wash hands.

* **Prescription medications will be given in accordance with the physician's orders and within 30 minutes either side of the assigned time unless a different timeframe is indicated in the physician's order. Administering a medication more than one (1) hour before or after the assigned time is considered a medication error. If there is a conflict with administering the medication(s) at the assigned time, the TMP will notify the R.N. Consultant and the client's home to develop an alternate plan.**

4.40 The Medication Administration Record.

A medication administration record (medication sheet) is kept for each client receiving medications at Merrick, Inc., to record all medication given. The paper medication sheet is to have all documentation in black ink only (no pencil, erasures, or White-Out to be used). The medication sheet will include the following information:

- client's name;
- month/year;
- medication name, strength, dose to be given, route, frequency;
- time of administration;
- the date the medication was started and if known, the date to discontinue; and
- special considerations - this area could address such things as criteria for giving a medication or how the client best takes a medication, etc.

Documentation Steps:

1. After the medications for each client are given, the TMP places their initials in the appropriate time/date box on their medication sheet.
2. If the medication is a controlled drug, two TMPs need to do a morning and afternoon count. This is to be done for as long as the medication is on company premises.
3. At the beginning of each month, each TMP must sign their name, initials and title to the top of each sheet, OR have signed an Annual Medication Initial Sheet, located in the front of each medication book.
4. The following codes are to be used on the medication sheet. The TMPs initials should accompany the appropriate code and any other additional information is documented on the back of the medication sheet.

A = absent from the program	X = medication error	R = client refused
H = medication held	/ = Merrick, Inc., closed	S = self- Administered
0 = documentation error	D/C = discontinued	

5. To begin a new medication:
   - Fill in all the information on the medication sheet as listed above from the physician's order. File the physician's order in the medication book;
   - In the boxes on the medication sheet, draw an arrow to the date the medication is to start;
   - Write the date the medication is to begin on this line;

- Record the date, the name/strength of the medication and the amount of medication received on the back of the medication sheet;
- Place the medication itself in the appropriate locked area;
- Notify other TMPs of this new order; and
- Any other communication regarding the start of the medication should also be documented on the back of the medication sheet.

6. Controlled Medications. If the medication received is a Schedule II or controlled medication, the usual information is transcribed onto the medication sheet and space will be designated for TMPs to record a daily count. This count must also be done upon receipt of the medication. Each time a new supply of the controlled medication is received, the following information needs to be logged on the back of the medication sheet:
   - date received;
   - name and strength of the medication;
   - prescription number;
   - quantity; and
   - signature of the TMP logging-in the controlled medication.

7. To discontinue a medication:
   - On paper sheet indicate the date the medication discontinued on the "Date Discontinued" line;
   - After the last dose given, write the abbreviation "D/C," the date, and your initials. Draw a line through the remaining days of the month (option to highlight discontinued order(s) in yellow);
   - Remove the medication from storage and send home with the van driver or write a note to residential employee that the medication is expired and they should come to get it (see **"4.56 Medication Destruction"**);
   - Indicate on the back of the medication sheet where the medication was moved to and any other communication regarding the stoppage;
   - Communicate the new order to other TMPs; and
   - Place the physician's order in the medication book.

Special Considerations:

Article I. Anytime there is a spillage or contamination of a medication, an explanatory note will be entered onto the back of the medication sheet. (see **"4.56 Medication Destruction"**);

Article II. With the exception of the emergency use of the epinephrine/Epi-pen injection or inhalers, only oral or topical medications will be administered by TMPs; and

Article III. Employees that support clients that may require the administration of the Epi-pen or an inhaler, will be trained by the R.N. Consultant on how and when to administer these treatments.

4.50 Medication Supply Requirements

- All routine medications will require a current prescription label, signed physician's order, and the medication supplied by the family or residence.

- A client who requires PRN medications will need to provide a signed physician's order and the medication supplied by the family or residence.
- Merrick, Inc., stocks acetaminophen (regular strength) for clients to use if they have the required physician's order on file.
- Expired medications with a specific expiration date will not be used after that date.
- When a medication supply is low or an expiration date is near, the residence(s) will be notified via the "Medication Reorder Form." If the replacement supply is not received, a follow-up phone call will be made to the residence. Upon receipt of the medication, the amount is documented by a TMP on the reorder form. The completed form is then filed in the client's file.

4.51 Labeling of Medications

4.511 All medications must have a pharmacy label, manufacturer's label, or an appropriately written label on the medication container.

4.512 External medications will be clearly marked "For External Use Only."

4.513 In the event a medication label is incomplete or the directions for administration are unclear, the TMP must clarify the orders with the residential nurse or our R.N. Consultant prior to administering the medication.

4.514 Pre-packed Medications. If a medication is prepackaged in an envelope, it must be labeled with the following information:

Data Fields	Example
(Client's name & date)	Mary Brown, 9/30/99
(Med/directions)	Depakote 500 mg i tab (o) at 12 noon
(Any special instructions)	Takes best with applesauce
(Person who set-up the med)	G. Steiner, RN

4.515 These prepackaged medications should be initialed by the TMP packaging the medication and after administration by the employee who actually gave the medication(s).

4.516 While off-site, the pre-packaged envelope(s) should be secured at all times (i.e. employee should keep on them or if a client self-administers, they need to be with the client at all times or kept in a locked storage area).

4.52 Physician Orders

Signed consent for medication administration must be on file.

4.521 All medications must be accompanied by a current prescription label or signed order by a physician or nurse practitioner (see 4.30.1). This is true for routinely given, short-term, and PRN medications.

4.522 Orders may be faxed or sent with the clients.

4.523 "Prescriber's order and written instructions" means the current prescription order or written instruction from the prescriber. Either the prescription label or the prescriber's written or electronically recorded order for the prescription is sufficient to constitute written instructions from the prescriber.

4.524 These documents must be current orders. Current is defined as dated within the last year with no other orders that supersede this order.

4.525 A copy of the current medication order(s) will be kept in the medication book. Expired orders are moved into the client's file when a more current order is received.

4.526 Copies of telephone orders can only be accepted by our R.N. Consultant and only for a time-limited basis. A final copy signed by the physician needs to go into the file.

4.527 Any questions regarding physicians' orders should be directed to a residential nurse or our R.N. Consultant.

4.53 Drug References

4.531 It is the responsibility of the TMP to be familiar with the clients receiving medications so they can administer medications safely. This would include how medications are best swallowed, any allergies, or emergency treatment interventions.

4.532 It is also the responsibility of the TMP to know the medication(s) they are administering, including the intended use, side effects, warnings or special directions for use.

4.533 There are drug references available for employees at each facility.

4.534 If a medication cannot be located in one of the references provided, information may be obtained from a pharmacy, our R.N. Consultant, or a residential employee/parent. Medication reference may be referenced on the internet with a reliable source such as hih.gov, drugs.com. Mayo clinic, webmd or FDA websites.

4.535 The TMP must report any concerns about the medication or treatment, including side effects, effectiveness, or pattern of the person refusing to take the medication or treatment at prescribed to the R.N. Consultant and the individual's home who should report to the prescriber.

4.536 Adverse reactions must be immediately reported to the R.N. Consultant, home and the prescriber.

4.54 Administration of PRN Medications.

Any "as needed/PRN" medications must have an accompanying physician's order on file. If there is no order, the medication cannot be administered.

4.541 The order must contain the indication for use (i.e. discomfort, fever, agitation). The medication then must only be given for that intended use.

4.542 If it is not known when the client received the last dose of the medication, this needs to be clarified by calling the client's family or residence.

4.543 If the PRN medication has a frequency of every 4 hours, and the client has been on-site for 4 or more hours, the medication can be given without calling.

4.544 When the frequency of the medication is limited to a certain number of doses, the family or residence should be contacted, so the most prudent use of the medication is followed.

4.545 The medication order may need to be written on the medication sheet. In the "time" column, "PRN" should be transcribed.

4.546 Follow the procedure for administration of medications.

4.547 After administering the PRN medication:

4.5471 Initial for the medication on the front of the medication sheet;
4.5472 On the back of the medication sheet indicate the date, time, medication, dose, route, and indication for use of the medication given;
4.5473 Approximately one hour after the medication was given, check with the client regarding the effectiveness of the medication and document this information on the back of the medication sheet; and
4.5474 Inform the family or residence regarding the use of the PRN, including dose, time and effectiveness; and document the details of the contact on the back of the medication sheet.

4.55 Administration of Short-Term Medications

4.551 In the event that a client is to receive a medication on a temporary basis, defined as 2 weeks or less, a physician's order is required.
4.552 It is acceptable for the residence to either:
4.5521 Send a supply for Merrick to administer in a pharmacy labeled bottle or card; or
4.5522 Pre-package enough doses in a properly labeled envelope; or
4.5523 Send a shared supply back and forth between the residence and work (least preferred).

4.56 Medication Destruction

4.561 All medications that are contaminated or discontinued will either be returned to the client's home or destroyed by Merrick's R.N. Consultant.
4.562 The medication(s) to be destroyed will be placed in a sealed envelope and labeled with the client's name, name of the medication, date, and the words "to be destroyed" written on the front of the envelope. An explanation may also be included on the envelope.
4.563 If the medication is sent home for destruction:
4.5631 The TMP(s) or a designated employee will call the home to inform them;
4.5632 The medication will be transported via transportation driver. If this is not possible, the medication will be destroyed on site (see 4.56.4 below).
4.5633 Do not send the medication home directly with the client; and
4.5634 All communication will be documented on the back of the client's current medication sheet.
4.564 If the medication destruction occurs on site:
4.5641 Medication destruction will be documented by the R.N. Consultant and one witness;
4.5642 This destruction will be documented on the back of the client's current medication sheet; and
4.5643 The information included in this documentation includes: the current date, name of the drug, strength, prescription number, number of tablets/amount of liquid being destroyed, mode of destruction, and the signature of the R.N. Consultant and witness.

Example: 9/30/99 Depakote 500mg Rx#34567 1 tab trash G. Steiner, RN/T. Miller, TMA

4.56.5 If a controlled medication is to be destroyed:

4.5651 A nurse and a pharmacist must destroy all scheduled medications and document this on a Certificate of Destruction form. Therefore, controlled medications will not be destroyed at Merrick, Inc.; and

4.5652 All discontinued or contaminated controlled medications will be returned to the client's home via a van driver in an envelope labeled with the client's name, the name of the medication, and the words "to be destroyed." A phone call to the home is to be made to alert of the on-coming medications. If this is not possible, the TMP will contact a residential employee to pick up the medication.

4.60 Medication Error Procedure

4.61 All employees are responsible for the detection of medication errors. An error includes:

- Medication administered to the wrong client;
- An incorrect route was used;
- An incorrect dose was given;
- Medication administered at the wrong time or date;
- The incorrect medication given; and
- The absence of medication documentation.

4.62 Notification and Documentation Steps:

- Upon discovering a medication error, our R.N. Consultant will be notified by phone.
- The client's family or residence will also be called regarding a medication error.
- A Medication Error Report and an Incident Report will be completed.
- The Medication Error Report will be routed to the Program Director and R.N. Consultant.
- An "X" will be placed on the medication sheet, as per the code legend located on the bottom of the medication sheet.
- All information and communication to others of the error will be documented on the back of the medication sheet and on the Medication Error Report.
- Excluding documentation errors, all other errors must be reported to Adult Protection and include a completed initial written report to the Adult Protection Worker.
- When assigned responsibility for medication assistance or medication administration, the program must report the following to the client's legal representative and case manager as they occur or as otherwise directed in the CSSP or CSSP addendum:

- any reports made to the client's physician or prescriber required of this policy;
- a client's refusal or failure to take or receive medication or treatment as prescribed; or
- concerns about a client's self-administration of medication or treatment.

4.63 Absence of Documentation:

- In the event a medication is not documented, every attempt will be made to contact the employee responsible for the administration of the medication to verify if the medication was given.
- A medication error form will be completed (see 4.65).

4.64 Review of the Medication Documentation and Error Reports

- The R.N. Consultant will review all medication administration records on a monthly basis and address any documentation issues.
- The R.N. Consultant will also review all Medication Error Reports on a monthly basis.

4.65 Correction Plan

- It is the responsibility of the R.N. Consultant and Transportation and Facilities Manager to determine appropriate action to reduce the occurrence of medication errors.
- This would include employees who commit medication errors frequently or with serious outcomes for the client(s).
- An educational plan will be developed by our R.N. Consultant and may include:
  - review of medication procedures with our R.N. Consultant;
  - administration and documentation of medications observed by our R.N. Consultant;
  - back-up system for double-checking the TMP until proficiency is obtained;
  - repeating a course in medication administration; or
  - if a TMP continues to demonstrate repeated inability to correctly administer medications, they will not be assigned the responsibility of medication administration.

4.66 Protocol Errors. A "Narrative Summary Medication Form--Protocol Error Documentation" is to be completed for any errors that result from protocols not being followed. Examples of protocol errors include, but are not limited to, the following situations:

- Medications not properly labeled;
- A current physician's order not supplied for a medication requested to be administered at Merrick, Inc.; or
- Unsafe handling or transportation of medications.

When the report is completed, it is then routed to the Transportation and Facilities for comment and forwarded to our R.N. Consultant for review and further comment. From this an action plan should be developed.

4.70 Storage and Transport of Medications

4.71 All medications to be administered by TMPs at Merrick, Inc., will be kept in a locked area.

- **Only TMPs will have a key to this area.**
- Medications requiring refrigeration will be kept in a locked box inside the general use refrigerator.
- Medications that are Schedule II controlled medications, will be double locked.
- All PRN medications kept on the vans must be in a locked box.

4.72 All medications and treatments will be stored in an optimal environment, which includes:

- proper sanitation;
- light;
- temperature (refrigerated temps must be between 36-46 degrees); and
- ventilation.

4.73 All medication containers will be kept closed in storage. Changes in color, odor, consistency, or suspected tampering will be reported to the client's family or residence. The medication will not be administered until permission is given.

4.74 The TMP will administer medications directly to the client. The medication will not be left unattended.

4.75 Any individualized security or storage of medications (i.e. at job sites), must be approved by our R.N. Consultant. This alternative procedure will be documented on the client's medication sheet.

4.76 The majority of medications to be administered are sent from a family or residence to Merrick via the individual's driver. The driver is responsible for delivering the medications they receive to either the persons unloading the vans or placing the meds in the Med Drop Box located outside of Alternative Services or at the entrance by Enhanced Services.

- The TMP's on site at Merrick are responsible for retrieving the medications, logging receipt of the medication, and storing it properly.
- Clients are not to bring medications in on their own (e.g. lunches, backpacks, etc.).

4.80 Psychotropic Medications.

In order to administer psychotropic medications at Merrick, Inc., the interdisciplinary team will provide written, measurable criteria for the use of the medication. Merrick, Inc., employees will supply the team with behavior data and information regarding the psychotropic medication usage if required by the prescriber. Psychotropic medications used on an on-going, programmatic basis and as treatment for a psychiatric diagnosis, will be administered in accordance with the physician's orders. If Merrick, Inc., is asked to monitor the psychotropic medications for a client, we must follow the Psychotropic Medication Monitoring Checklist in 4.82.

4.81 PRN Use of Psychotropic Medications. "As needed" use of psychotropic medications will be recorded on the medication sheet and documented in the same manner as all other PRN medications.

4.82 Psychotropic Medication Monitoring.

- 4.821 The documentation required to support the use of the medication will be housed with the residential provider.
- 4.822 Merrick, Inc., will provide referral assistance for the psychotropic medication monitoring in homes where nursing services do not exist.
- 4.823 We will also assist in the monitoring of medication effects and side effects, through observations while in the program.
- 4.824 All observations will be reported to the home on a regular basis.

Nurse Consultant Approved: _____

Policy reviewed and authorized on 02/18/2022 by:

John Wayne Barker, Executive Director

15 SEIZURE PROTOCOL

If a seizure occurs while the client is under the care of Merrick, Inc., employees are to follow the protocol outlined below and call 911 if any of the following are observed (unless the client has an individualized protocol to be followed):

1. The client has never had a seizure before.
2. Difficulty in breathing following a seizure or the client does not regain consciousness following a seizure.
3. The client has a second seizure immediately following the first.
4. The client has a seizure lasting more than five minutes.
5. The client is experiencing a high fever.
6. The client is experiencing heat exhaustion.
7. The client is pregnant.
8. The client has diabetes.
9. The client has heart disease.
10. The client sustained an injury prior to the seizure or during the seizure.
11. The seizure occurred in water.

The Assistant Program Director is responsible for: (i) completing a seizure form for the client's file; (ii) contacting the client's representative or home to notify them of the seizure activity;)iii) notifying the Nurse Consultant of the seizure; and (iiii) instructing the caregiver to notify the client's physician/medical provider.

Policy reviewed and authorized on 02/18/2022 by:

John Wayne Barker, Executive Director

16 CLIENT RIGHTS

When receiving services and supports from Merrick, Inc., I have the right to:

1. Take part in planning and evaluating the services that will be provided to me.

2. Have services and supports provided to me in way that respects me and considers my preferences.

3. Refuse or stop services and be informed about what will happen if I refuse or stop services.

4. Know, before I start to receive services from this program, if the program has the skills and ability to meet my need for services and supports.

5. Know the conditions and terms governing the provision of services, including the program's admission criteria, policies, and procedures related to temporary service suspension and service termination.

6. Have the program help coordinate my transfer to another provider to ensure continuity of care.

7. Know what services this program provides and how much they cost, regardless of who will be paying for the services, and to be notified if those costs change except for rate increases approved by the Legislature.

8. Know, before I start to receive services, if the cost of my care will be paid for by insurance, government funding, or other sources, and be told of any charges I may have to pay.

9. Have employees that are trained and qualified to meet my needs and support.

10. Have my personal, financial, service, health, and medical information kept private and be notified if these records have been shared outside of Merrick, Inc.

11. Have access to my records and recorded information that the program has about me as allowed by state and federal law, regulation, or rule.

12. Be free from abuse, neglect, or financial exploitation by the program or its employees.

13. Be free from employees trying to control my behavior by physically holding me or using a restraint to keep me from moving, giving me medication I don't want to take or that isn't prescribed for me, or putting me in time out or seclusion; except if and when manual restraint is needed in an emergency to protect me or others from physical harm.

14. Receive services in a clean and safe location.

15. Be treated with courtesy and respect and have my personal property protected.

16. Be allowed to reasonably follow my cultural practices and religion.

17. Be free from prejudice and harassment regarding my race, gender, age, disability, spirituality, and sexual orientation.

18. Be told about and to use the program's grievance policy and procedures, including knowing how to contact persons responsible for helping me to get my problems with the program fixed and how to file a social services appeal under the law.

19. Know the names, addresses and phone numbers of people who can help me, including the ombudsman, and to be given information about how to file a complaint with these offices.

20. Exercise my rights on my own or have a family member or another person help me exercise my rights, without retaliation from the program.

21. Give or not give written informed consent to take part in any research or experimental treatment.

22. Choose my own friends and associate with other persons of my choice in the community.

23. Have personal privacy as appropriate in my work place.

24. Have free, daily, private access to and use of a telephone for local calls, and long-distance calls made collect or paid for by me.

25. Receive and send mail and emails and not have them opened by anyone else unless I ask.

26. Visit alone with my spouse, family, legal counsel, religious guide, or others allowed in Minnesota Human Services Rights Act, Minnesota Statutes, section 363A.09.

27. Come and go from the program unless restrictions have been specified in my Community Services and Support Plan and/or Community Services and Support Plan Addendum.

28. Engage in chosen activities.

Policy reviewed and authorized on 02/18/2022 by:

John Wayne Barker, Executive Director

17 CLIENT FUNDS AND PERSONAL PROPERTY GUIDELINES

To ensure that guidelines are followed so that clients will retain the use and availability of their personal funds and property.

1. Employees must ensure the separation of client funds from any other funds of Merrick, Inc., and its employees.

2. Whenever assistance is needed with the safekeeping of client funds and/or property, employees must have written authorization by the client, their legal representative, and County Case Manager. Employees must document receipt and disbursement of the funds and property of the client, and follow any restrictions identified in the Coordinated Service and Support Plan and the Coordinated Service and Support Plan Addendum.

3. During the client's intake meeting prior to service initiation, and at the annual meeting, the Program Plan Coordinator will query, document, and implement the preferences of the client, their legal representative, and County Case Manager regarding the frequency of receiving statements that itemize receipts and disbursements of client funds or property.

4. Merrick, Inc., employers are restricted to engage in any of the following actions:
   - Borrow money from any client;
   - Purchase personal items with client funds;
   - Sell merchandise or personal services to a client;
   - Require clients to purchase items from Merrick, Inc., or
   - Use client funds in a manner that would violate section 256.04, or any other rules promulgated under this section.

5. Merrick, Inc., and/or its employees cannot accept power-of-attorney for any client of Merrick for any purpose.

6. Upon death of the clients, Merrick, Inc., must immediately return all personal funds or personal property to the person's legal representative or an executor of their estate in exchange for an itemized receipt.

7. All incidents of lost or stolen property of clients will be investigated with results documented in a master file managed by the Program Director.

Policy reviewed and authorized on 02/18/2022 by:

John Wayne Barker, Executive Director

18 SERVICE SUSPENSION NOTIFICATION POLICY

1.00 PURPOSE

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

2.00 APPLICATION

This policy applies to all clients of Merrick, Inc., (hereinafter "Company").

3.00 POLICY

It is the intent of the Company to ensure continuity of care and service coordination between members of the support team including, but not limited to the client, the legal representative and/or designated emergency contact, case manager, and other licensed caregivers, and other people identified by the client and/or legal representative during situations that may require or result in temporary service suspension.

4.00 PROCEDURES

The Company recognizes that *temporary service suspension* and *service termination* are two separate procedures. The Company must limit temporary service suspension to specific situations that are listed below. A temporary service suspension may eventually lead to service termination for specific situations that are listed in *Policy and Procedure on Service Termination*.

4.10 Consistent with MN Statutes, section 245D.10, subdivision 3, the Company limits temporary service suspension to situations in which:

- 4.11 The client'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;
- 4.12 The client has emergent medical issues that exceed the Company's ability to meet their needs; or
- 4.13 The program has not been paid for services.

4.20 Prior to giving notice of temporary services suspension, the Company must document actions taken to minimize or eliminate the need for service suspension. Action taken by the Company must include, at a minimum:

- 4.21 Consultation with the client's support team to identify and resolve issues leading to issuance of the suspension notice; and
- 4.22 A request to the client'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 client in the program (this requirement does not apply to temporary suspensions issued due to non-payment of services); and

4.23 If, based on the best interests of the client, the circumstances at the time of the notice were such that the Company was unable to take the actions listed above, the Company must document the specific circumstances and the reason for being unable to do so.

4.30 The notice of temporary service suspension must meet the following requirements:

4.31 Company must notify the client or their legal representative and case manager in writing of the intended temporary services suspension; and

4.32 The notice of temporary services suspension must be given on the first day services will be suspended; and

4.33 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 MN Statutes, section 245D.10, subdivision 3, paragraph (d); and why these measures failed to prevent the suspension.

4.40 During the temporary suspension period, the Company must:

4.41 Provide information requested by the client or case manager; and

4.42 Work with the support team to develop reasonable alternatives to protect the client and others and to support continuity of care; and

4.43 Maintain information about the temporary service suspension, including the written notice of temporary services suspension, in the client record.

4.50 If, based on a review by the client's support team, it is determined they no longer pose an imminent risk of physical harm to self or others, the client 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 client is receiving treatment related to the conduct that resulted in the service suspension, the support team must consider the recommendation of the licensed health professional, mental health professional, or other licensed professional involved in the client's care or treatment when determining whether they no longer pose an imminent risk of physical harm to self or others and can return to the program. If the support team makes a determination that is contrary to the recommendation of a licensed professional treating the client, the Company must document the specific reasons why a contrary decision was made.

Policy reviewed and authorized on 02/18/2022 by:

John Wayne Barker, Executive Director

19 SERVICE TERMINATION NOTIFICATION POLICY

1.00 PURPOSE

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

2.00 APPLICATION

This policy applies to all clients of service at Merrick, Inc., (hereinafter "Company").

3.00 POLICY

It is the intent of the Company to ensure continuity of care and service coordination between members of the support team including, but not limited to the client, the legal representative and/or designated emergency contact, case manager, and other licensed caregivers, and other people identified by the client and/or legal representative during situations that may require or result in service termination.

4.00 PROCEDURES

The Company recognizes that *temporary service suspension* and *service termination* are two separate procedures. The Company must limit service termination to specific situations that are listed below. A temporary service suspension may eventually lead to service termination for specific situations that are listed in *Policy and Procedure on Temporary Service Suspension*.

4.11 The Company must permit each client to remain in the program and must not terminate services unless:
- 4.11 The termination is necessary for the client's welfare and the program cannot meet their needs;
- 4.12 The safety of the client or others in the program is endangered and positive support strategies were attempted and have not achieved and effectively maintained safety for the client or others;
- 4.13 The health of the client or others in the program would otherwise be endangered;
- 4.14 The program has not been paid for services;
- 4.15 The program ceases to operate; or
- 4.16 The client has been terminated by the lead agency from waiver eligibility.

4.20 Prior to giving notice of service termination, the Company must document actions taken to minimize or eliminate the need for termination. Action taken by the Company must include, at a minimum:
- 4.21 Consultation with the clint's support team to identify and resolve issues leading to issuance of the termination notice; and
- 4.22 A request to the client'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 client in the program(this requirement does not apply to service termination issued due to non-payment of services); and

4.30 If, based on the best interests of the client, the circumstances at the time of the termination notice were such that the Company was unable to take the actions listed above, the Company must document the specific circumstances and the reason for being unable to do so.

4.40 The notice of service termination must meet the following requirements:

4.41 Company must notify the client or their person's legal representative and case manager in writing of the intended service termination;

4.42 The notice must include:

4.421 The reason for the action;

4.422 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, paragraph (c), and why these measures failed to prevent the termination or suspension;

4.423 The client's right to appeal the termination of services under MN Statutes, section 256.045, subdivision 3, paragraph (a); and

4.424 The client's right to seek a temporary order staying the termination of services according to the procedures in MN Statutes, section 256.045, subdivision 4(a) or 6 (c).

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

4.4251 At least 60 days prior to termination when the Company is providing intensive supports and services identified in section 245D.03, subdivision 1, paragraph (c);

4.4252 At least 30 days prior to termination for all other services licensed under Chapter 245D; and

4.4253 This termination notice may be given in conjunction with a notice of temporary services suspension.

4.43 During the service termination notice period, the Company must:

4.431 Provide information requested by the client or case manager; and

4.432 Work with the support team to develop reasonable alternatives to protect the client and others and to support continuity of care; and

4.433 Maintain information about the service termination, including the written notice of intended service termination, in the client record.

Policy reviewed and authorized on 02/18/2022 by:

John Wayne Barker, Executive Director