CDL-1

FACE SHEET
FOR FILING DOCUMENTS
WITH THE LEGISLATIVE REFERENCE BUREAU

(Pursuant to Commonwealth Documents Law)

DO NOT WRITE IN THIS SPACE

Copy below is hereby approved as to form and legality. Attorney General By: _____ (Deputy Attorney General) _____ Date of Approval ☐ Check if applicable Copy not approved. Objections attached.	Copy below is hereby certified to be a true and correct copy of a document issued, prescribed or promulgated by: DEPARTMENT OF HUMAN SERVICES (Agency) LEGAL COUNSEL: Kathleen A. Morgan DOCUMENT/FISCAL NOTE NO. 14-540 DATE OF ADOPTION: _____ BY: Teresa D. Miller TITLE: SECRETARY OF HUMAN SERVICES (Executive Officer, Chairman or Secretary)	Copy below is hereby approved as t Form and legality. Executive or Independent Agencies. BY: Marisa H.J. Lehr AUG 23 2018 Date of Approval (Deputy General Counsel) (Chief Counsel, Independent Ag (Strike inapplicable title) ☐ Check if applicable. No Attorney General approval or objection within 30 days after submission.

NOTICE OF FINAL-FORM RULEMAKING

DEPARTMENT OF HUMAN SERVICES

OFFICE OF DEVELOPMENTAL PROGRAMS

Home and Community-Based [Supports]Services and Licensing

[55 Pa.Code Chapter 51. Office of Developmental Programs Home and Community-Based Services]
[55 Pa.Code Chapter 2380. Adult Training Facilities]
[55 Pa.Code Chapter 2390. Vocational Facilities.]
[55 Pa.Code Chapter 6100. Support for Individuals with an Intellectual Disability or Autism]
[55 Pa.Code Chapter 6200. Room and Board Charges]
[55 Pa.Code Chapter 6400. Community Homes for Individuals with an Intellectual Disability or Autism]
[55 Pa.Code Chapter 6500. Family Living Homes]

DEPARTMENT OF HUMAN SERVICES

[55 PA. CODE CHS. 51, 2380, 2390, 6100, 6200, 6400 AND 6500]

Home and Community-Based Services and Licensing

The Department of Human Services (Department), by this order, adopts the regulation set forth in Annex A pursuant to the authority of sections 201(2), 403(b), 403.1(a) and (b), 911 and 1021 of the Human Services Code (62 P.S. §§ 201(2), 403(b), 403.1(a) and (b), 911 and 1021) and section 201(2) of the Mental Health and Intellectual Disability Act of 1966 (50 P.S. § 4201(2)). Notice of proposed rulemaking was published at 46 Pa.B. 7061 (November 5, 2016). Advance notice of final rulemaking regarding § 6100.571 (relating to fee schedule rates) was published at 47 Pa.B. 4831 (August 19, 2017).

Purpose of Regulation

The purpose of the final-form regulation is to support individuals with an intellectual disability or autism to live and participate in the life of their community, to achieve greater independence and to have opportunities enjoyed by all citizens of this Commonwealth. The final-form regulation strengthens community services and supports to promote person-centered approaches, community integration, personal choice, quality in service delivery, health and safety protections, competitive integrated employment, accountability in the utilization of resources and innovation in service design.

The final-form regulation governs the program, operational and fiscal aspects of the following: (a) home and community-based services (HCBS) provided through the 1915(c) waiver programs; (b) Medicaid State plan HCBS for individuals with an intellectual disability or autism, including targeted support management; and (c) services funded exclusively by grants to counties under the Mental Health and Intellectual Disability Act of 1966 (50 P.S. §§ 4101—4704) or Article XIV-B of the Human Services Code (62 P.S. §§ 1401-B—1410-B), commonly referred to as "base-funding." The final-form regulation amends the licensing regulations in Chapters 2380, 2390, 6400 and 6500 to make them compatible with Chapter 6100 in the areas of training, rights, individual planning, incident management, restrictive procedures and medication administration. The licensing regulations encompass health, safety and well-being protections for individuals with a disability or autism who receive services in a licensed adult training facility, vocational facility, community home or life sharing home. The final-form regulation rescinds and replaces Chapters 51 and 6200 with Chapter 6100.

The final-form regulation is needed to continue the Commonwealth's eligibility for Federal financial participation in the HCBS waiver programs. See 42 CFR Part 441, Subpart G (relating to home and community-based services: waiver requirements). The final-form regulation protects the health, safety and well-being of the individuals receiving services in individual-directed, family-based, community residential and day programs funded through the Federal waivers, the Commonwealth's Title XIX State plan

and base-funding, as well as individuals who receive services in community residential and day programs funded through private pay or another funding source.

Background

ODP currently administers four 1915(c) “waivers.” The term “waiver” in this context refers to administering a program under the authority of Section 1915(c) of the Social Security Act that permits a state to waive Medicaid requirements on comparability, statewideness and income and resource rules in order to furnish an array of home and community-based services that promote community living and avoid institutionalization. Waiver services complement and supplement services available through the Medicaid State plan and other Federal, State and local public programs, as well as the supports that families and communities provide to individuals.

States have flexibility in designing waivers, including the options to determine the target groups of Medicaid beneficiaries who receive services through each waiver; specify the services to support waiver participants in the community; allow participants to self-direct services; determine qualifications of waiver providers; design strategies to assure the health and well-being of waiver participants; manage a waiver to promote the cost-effective delivery of HCBS; and, develop and implement a quality improvement strategy.

In order to operate a 1915(c) waiver program, states submit a waiver application to the Federal Centers for Medicare and Medicaid Services (CMS). After initial approval of a waiver application by CMS, each waiver must be renewed every 5 years. Changes to provisions in the waivers may be submitted with a waiver renewal application or at any time through a waiver amendment process. Initial waiver applications, waiver renewal applications and amendments that contain substantive changes must follow the public comment process as outlined in the CMS guidance, found at *Application for a § 1915(c) Home and Community-Based Waiver, Instructions, Technical Guide and Review Criteria, § 6-I: Public Input.*

Services in the waivers must be provided by Medicaid providers that meet the qualification standards outlined in the waiver application. Each provider of waiver services must also sign a Medicaid provider agreement prior to furnishing services under the waiver. See 42 CFR § 431.107 (relating to required provider agreement).

Affected Individuals and Organizations

Chapter 6100 applies to a broad scope of programs receiving Commonwealth and Federal funds. The final-form regulation applies to 1,060 HCBS and base-funding service provider agencies providing services to more than 53,000 individuals with an intellectual disability or autism. Chapter 6100 applies to the Office of Developmental Programs (ODP) service system, including those facility-based services that are licensed and funded by the Department under Chapters 2380, 2390, 6400 and 6500, as

well as many services that are funded, but that do not require licensure under Articles IX and X of the Human Services Code. See §§ 201(2), 403(b), 403.1(a) and (b), 911 and 1021 of the Human Services Code (62 P.S. §§ 201(2), 403(b), 403.1(a) and (b), 911 and 1021).

Chapter 2380 contains licensing regulations to protect the health, safety and well-being of adults served in Pennsylvania's 416 licensed adult day training facilities with a maximum Statewide licensed capacity of 26,429 individuals. Chapter 2380 contains the minimum requirements that apply regardless of the payment agency. For instance, Chapter 2380 applies to a facility that provides services exclusively to individuals with blindness, deafness or a mental illness, including those facilities that are not funded by the Department through the ODP service system. Services for some individuals, and services provided by some facilities, are funded exclusively through private insurance, private-pay or out-of-state sources. Providers funded by the Department through the ODP waiver programs must enroll in the Medical Assistance Program, sign a Medical Assistance provider agreement and sign an ODP waiver provider agreement. The number of licensed adult day training facilities in which there is no ODP waiver provider agreement is 15.

Chapter 2390 contains licensing regulations to protect the health, safety and well-being of adults served in Pennsylvania's 166 licensed vocational facilities with a maximum Statewide licensed capacity of 21,754 individuals. Chapter 2390 contains the minimum requirements that apply regardless of the payment agency. For instance, Chapter 2390

applies to a facility that provides services exclusively to individuals with blindness, deafness or a mental illness, including those facilities that are not funded by the Department through the ODP service system. Services for some individuals, and services provided by some facilities, are funded exclusively through private insurance, private-pay or out-of-state sources. The number of licensed vocational facilities in which there is no ODP waiver provider agreement is nine.

Chapter 6400 contains licensing regulations to protect the health, safety and well-being of children and adults served in Pennsylvania's 5,413 licensed community homes for individuals with an intellectual disability or autism with a maximum Statewide licensed capacity of 18,713 individuals. Chapter 6400 contains the minimum requirements that apply regardless of the payment agency. For instance, Chapter 6400 applies to a facility that provides services exclusively to individuals who are not funded by the Department through the ODP service system. Services for some individuals, and services provided by some facilities, are funded exclusively through private insurance, private-pay or out-of-state sources. The number of licensed community homes in which there is no ODP waiver provider agreement is 113.

Chapter 6500 contains licensing regulations to protect the health, safety and well-being of children and adults served in Pennsylvania's 1,583 licensed life sharing homes for individuals with an intellectual disability or autism with a maximum Statewide licensed capacity of 2,504 individuals. Chapter 6500 contains the minimum requirements that

apply regardless of the payment agency. There are fewer than ten privately-funded licensed life sharing homes.

These five chapters govern providers of the services covered under Chapter 6100 and providers licensed under Chapters 2380, 2390, 6400 and 6500; however, other interested and affected parties include the individuals who receive services; the families and friends of the individuals who receive services; advocates who provide support and representation for the individuals to assure that their rights are protected; county governments that provide authorization for the use of base-funding under Chapter 6100; and the designated managing entities, which are often county governments that are delegated certain functions by the Department to oversee the provision of the HCBS.

Accomplishments and Benefits

The final-form regulation strengthens community services by promoting person-centered approaches, community integration, personal choice, quality in service delivery, health and safety protections, competitive integrated employment, accountability in the utilization of resources and innovation in service design.

Benefits for individuals, families and advocates include strengthened individual rights and service involvement; strict involuntary discharge conditions and procedures; the prohibition of restraints except for the emergency use of a protective physical hold; a team, including a behavior specialist, to approve the use of a restrictive procedure prior

to use; strengthened health and safety protections; equitable program and operational standards for programs serving individuals with an intellectual disability or autism; and the administration of medication by trained staff persons.

Benefits for providers include the reduced administrative burden by coordinating multiple chapters of departmental regulations; the inclusion of autism programs in the core standards to alleviate the administrative burden of managing dual processes; the significant reduction in the conflict of interest protocol requirements; the change in the reserved capacity provision to provide increased reimbursement through modified fee schedule rates to support the return of an individual after extended medical, hospital or therapeutic leave; clarity of the documentation required to support a claim for payment; implementation of a 3-year update of the data used to establish the fee schedule rates; the delineation of specific factors to be examined and used to develop fee schedule rates; elimination of the requirement to report and deduct donations; and significant reduction and simplification of the cost-based payment requirements.

Benefits for county intellectual disability and autism programs include clarity and compatibility of roles for the support coordinators, base-funding support coordinators and targeted support managers; deletion of conflicting individual plan time frames between the Federal waivers and the multiple chapters of regulations; acknowledgement of the county human rights committees; and the strengthened regulation of exclusively base-funding services. The final-form regulation provides consistent program and operational requirements across the ODP service system on a

Statewide basis to support the ease of individual transitions from county to county, as well as individual transitions across the various funding sources. The final-form regulation eases individual transitions from services funded through base-funding only to HCBS Federal funding.

Additional benefits of the regulation include compliance with the Federal requirements to support continued Federal HCBS funding; the reduced volume of regulations with improved coordination efforts across multiple chapters of regulations providing an opportunity for streamlined compliance monitoring; consistent program requirements and health and safety protections for the individuals across multiple funding sources; the alignment of intellectual disability and autism standards to the benefit of both programs; and the establishment of a baseline of core values across multiple programs.

Fiscal Impact

The provider's regulatory compliance management and associated self-monitoring costs will be reduced. By simplifying and shortening the length of the final-form regulation, and by coordinating the program and operational requirements across multiple chapters of licensing regulations as well as across multiple funding streams, the complexity of regulatory compliance management is significantly simplified. The reduced cost impact for a provider will vary based on the pay scale and number of management positions devoted to regulatory compliance management.

Some new costs will be associated with the regulation regarding background checks since a wider net has been cast as to who shall submit a background check. This provision is strongly supported by many individuals and advocates. It is also required under recent amendments to the Child Protective Services Law. In the final-form regulation, all persons who provide services that are funded by the Department through the ODP service system must submit a background check to identify any history of abuse, assault, theft or other crimes that may impact the well-being of an individual receiving services. The fee for a Pennsylvania State police background check is $8.00. The fee for a Pennsylvania child abuse check is $8.00, which is rarely required since approximately 87% of the individuals who receive services under Chapter 6100 are adults. The fee for a Federal Bureau of Investigation (FBI) check is $25.75, which includes fingerprinting.

For a person who will provide services to adults, the Older Adults Protective Services Act requires an FBI check only if the person lived outside of Pennsylvania within the past 2 years. See 35 P.S. § 10225.502(a)(2). The Child Protective Services Law requires an FBI check for all paid staff who provide services to children. See 23 Pa.C.S. § 6344(b)(3) (relating to employees having contact with children; adoptive and foster parents). The Child Protective Services Law also requires an FBI check for volunteers who have lived outside of Pennsylvania within the previous 10 years. See 23 Pa.C.S. § 6344.2 (relating to volunteers having contact with children). The impact of this requirement is limited, however, since only 13% of the individuals covered by the final-form regulation are children. The cost of the background check for the majority of

prospective staff persons is $8.00. The cost of the background check may be borne by the job applicant or by the provider agency. The overall cost impact relating to background checks will vary, as some providers already require background checks on all persons, thus negating or minimizing the cost impact. The increased background check costs are factored into the new HCBS rates.

Significant additional revenue to the providers will result immediately from the revised § 6100.55 (relating to reserved capacity) that changes the providers' approved program capacity to allow for an increase in the providers' rates for the time period of an individual's extended absence because of medical, hospital or therapeutic leave.

Some new costs will be associated with the final-form regulation regarding staff training since more staff persons must receive training in areas such as rights, abuse prevention and incident reporting. It is critical that all persons who provide services, including ancillary services, have the minimum training necessary to identify and know what to do if they observe abuse, an incident or a violation of rights. The Department has developed and will offer online training courses free of charge related to the required core training topics, such as individual rights protections, abuse prevention and incident reporting. While use of the departmental online training courses is optional, these courses meet the requirements of the final-form regulation, while saving training development costs for providers. Annual training can be provided on the job as part of the staff person's scheduled work day, through supervisory conferences, staff meetings or training provided for individuals and staff persons at the same time. For an ancillary

position, an average of 1 hour of training must be provided each month, which can be provided on the job. For instance, an administrative staff person may complete an online course on the agency's new word processing software; a fiscal staff person may complete an online course on the agency's required accounting methods; a maintenance staff person may be taught the Federal Occupational Safety and Health Administration (OSHA) rules for safe use of a new lawn care machine by asupervisor; or a dietary staff person may watch and learn new cooking techniques or recipes from a televised cooking show. Many providers will experience no increase in training costs as they already provide incident management, abuse reporting and other value-based training to all staff, including ancillary staff; however, for those providers who do not currently train ancillary staff, the fee schedule rates provide sufficient HCBS reimbursement for the training of all staff positions.

Cost savings related to staff training in § 6100.143 (relating to annual training) will be realized over the course of the first year of implementation of the new regulation with the reduction of the number of training hours from 40 hours to 24 hours for support coordinators and from 24 to 12 hours for chief executive officers.

A requirement that the human rights team include a professional who has a recognized degree, certification or license relating to behavior support who did not develop the behavior support component of the plan is added to the final-form regulation as suggested by public comment. See §§ 2380.154, 2390.174, 6100.344, 6400.194 and 6500.164. The qualifications of the behavior specialist are intentionally broad to permit

an array of professionals to serve in this capacity. Many providers already employ or contract with a behavior specialist to provide consultation to develop and review individual plans for individuals for whom a restrictive procedure is appropriate. If the provider does not have a behavior specialist on staff or under contract, the provider may utilize a county mental health, intellectual disability and autism program human rights team (county team) or coordinate with other providers to share this position. If the provider has a behavior specialist or if a county team is used, there will be no new costs to implement this section. For a provider that provides services to multiple individuals for whom restrictive procedures are used and that employs or contracts directly with a behavior specialist to meet this requirement, the annual program-wide cost is estimated at $6,048, based on an hourly rate of $84, meeting twice monthly for 3 hours per meeting, during all 12 months of a year.

A requirement is added for a behavior specialist to develop the behavior support component of an individual plan if a physical restraint will be used or if a restrictive procedure will be used to modify an individual's rights. See §§ 2380.155(d), 2390.175(d), 6100.345(d), 6400.195(d) and 6500.165(d). The estimated cost for a behavior specialist to develop the behavior support component of an individual plan is $1,680 per individual, based on an hourly rate of $84, and providing an average of 20 hours of observation and consultation necessary to design the initial individual plan. The increased behavior specialist consultation costs are factored into the new HCBS rates.

Cost savings will result from the development of a new modified medication administration training course in § 6100.468(d) (relating to medication administration training) for those providers who have been providing the full medication administration training course for all life sharers and others who will now be eligible for the shortened, modified course. This cost reduction will be realized over the course of the first year of implementation of the new regulation. Numerous life sharing provider agencies already require completion of the full medication administration training course by their life sharers, so completion of the new modified training course will be a cost reduction. The cost of the certified train-the-trainer program is paid by the Department for a certified medication administration trainer who assists the life sharer through the modified medication administration training course. For those life sharing provider agencies who do not currently complete the medication administration training course, a slight cost increase will result; however, the cost will be minimal as the new modified training course will take only several hours to complete online and the cost is factored into the new HCBS rates.

Beginning in January 2018, the current cost-based system for residential HCBS converted to a fee schedule rate, resulting in significant cost-savings for the providers and reduced administration costs for the Department. The fee schedule rates were determined based upon the cost to deliver each service and based upon the factors addressed in § 6100.571(b) (relating to fee schedule rates). The provider will realize an administrative cost savings since the provider is no longer required to complete and

submit detailed cost reports, nor do providers need to track and monitor cost-based regulatory compliance data. The requirements contained in the current §§ 51.71—51.103 and in the final-form §§ 6100.641—6100.672 no longer apply for residential services, since the payment methodology transitioned to a fee schedule rate in January 2018. The Department will realize a cost savings through the reduction of the administrative review and approval of cost reports.

The reporting of donation section formerly at § 51.82 (relating to revenues that off-set allowable costs) is deleted. This results in additional revenue to the provider, because the provider no longer has to declare and deduct donations from the cost reports.

Paperwork Requirements

Decreased paperwork will result from the reduction of the provider's regulatory compliance efforts due to the coordination of multiple chapters of regulations and the reduction in the number of regulations. An opportunity is provided for the Department and the county programs to better coordinate and reduce duplicative monitoring efforts between licensing and waiver compliance management; this monitoring reduction will reduce paperwork for the provider, the county program, the designated managing entity and the Department.

Decreased provider paperwork will result from the elimination of the specific requirements regarding the content of the conflict of interest policy in § 6100.53 (relating

to conflict of interest). In the current § 51.33 (relating to conflict of interest), there are detailed requirements regarding five areas governing an internal conflict of interest protocol and disclosure to the Department. The final-form regulation requires only that the provider develop and implement a policy. There are no longer any requirements as to the content of the policy or submission to the Department.

Quality management plans and the quality management monitoring cycle is extended from the current 2-year cycle to a 3-year cycle, reducing paperwork requirements.

Increased paperwork for the provider may result from the expansion of the scope of the persons for which background checks and training is required. Many providers already require and track background checks and training across a larger segment of employees than was previously required, thus minimizing the paperwork increase for many providers. In addition, better protections for the individuals who receive services outweighs any increase in paperwork related to the background check.

The individual plan in § 6100.223 (relating to content of the individual plan) is significantly simplified and the process is streamlined, thus reducing paperwork.

Decreased provider paperwork will result from the elimination of duplicate and conflicting incident reporting requirements for licensing and waiver compliance. In § 6100.401 (relating to types of incidents and timelines for reporting), incident reports for emergency room visits and non-prescribed over-the-counter medication errors are

no longer required, reducing the number of incidents to be reported. Also eliminated is the provider paperwork required by the licensing regulations to maintain a record of incidents that are not reportable, such as minor illnesses. While many providers will choose to retain this documentation as best practice, the Department will no longer review this documentation for regulatory compliance.

The reporting of donation section formerly at § 51.82 (relating to revenues that off-set allowable costs) is deleted. This results in a reduction of paperwork for the provider, as well as additional revenue to providers, because a provider does not have to declare and deduct donations from the cost reports.

In § 6100.686 (relating to room and board rate), the paperwork required to complete the proration of the board costs is reduced from the current daily proration requirement in § 51.121(d)(2) to a consecutive period of 8 or more days in the final-form regulation. This regulation change will result in reduced paperwork for the provider.

Public Comment

A total of 345 public comments were received in response to the proposed rulemaking. Of those 345 comments, approximately 200 were unique comments, while approximately 145 were either full or partial duplicates from the same agency or another organization. The comments received represented the following individuals or groups:

2 individuals; 13 families; 4 legislators; 6 advocates; 4 universities; 8 county governments; 4 provider associations; 291 providers; with the remaining comments received from other or unidentified sources. These numbers are estimates as some commentators represent more than one constituency group.

A total of 90 public comments were received in response to the advance notice of final rulemaking. Of those 90 comments, approximately 36 were unique comments, while approximately 54 were duplicates from the same agency or another organization. The comments on the advance notice of final rulemaking represented the following individuals or groups: 7 families; 3 advocates; 4 provider associations; 69 providers; with the remaining 7 comments received from other or unidentified sources.

The Department has continuously supported, encouraged and managed an active and open community participation process throughout the development of the proposed rulemaking and the final-form regulation. The Department values, commends and greatly appreciates the expertise, time and attention contributed by the public commentators, and in particular the regulation work group (work group) comprised of 45 persons representing a broad range of interests, experiences and ideas, including individuals, families, advocates, universities, county programs, providers and provider organizations. The work group met for 13 days over a 3-year period to advise the Department of its collective and individual concerns and suggestions, cultivate constructive dialogue and promote an understanding of the views of others.

Following the close of the proposed rulemaking public comment period, a 3-day meeting of the work group was convened to discuss the public comments relating to the 20 regulatory areas that were of most concern to the public commentators. In many sections of the final-form regulation, a diversity of opinions continues to be evident; however, for several regulatory areas, including consistency across the four licensing chapters and Chapter 6100, children's services and quality management, reasonable agreement was reached.

On October 18, 2017, a work group meeting was held to review 11 specific portions of the final-form regulation and discuss implementation planning with the external stakeholders.

The advice of the work group and the public comments received in response to the proposed rulemaking and the advance notice of final rulemaking were thoroughly analyzed and considered as the Department prepared the final-form regulation.

During the course of the development of the final-form regulation, more than 40 meetings were held with Statewide and regional self-advocacy, advocacy, family, provider and county organizations to review and discuss specific areas of the regulation. These discussions focused on the constituent issues that are important to the affected parties. The Department values the constructive advice and the unique perspectives provided during these meetings and the final-form regulation encompasses these views.

Discussion of Comments and Major Changes

Following is a summary of the substantive comments received within the public comment period following publication of the proposed rulemaking, substantive comments received in response to the advance notice of final rulemaking and the Department's response to those comments. A summary of the major changes from proposed rulemaking is included. In addition to the major changes listed, the Department made changes in the preparation of the final-form regulation, including correcting typographical errors, reformatting to enhance readability and revising language to enhance clarity and conform to the changes made in response to comments. If a comment was received addressing both Chapter 6100 and one or more of the four licensing chapters, it is recorded under Chapter 6100; however, the applicable sections in all five chapters are listed in the following comment and response discussion.

General—Cross-system regulatory approach

More than 50 commentators, plus numerous form letters from commentators representing families, advocates, county government, universities and providers, commend the Department for aligning the four chapters of licensing regulations and the chapter of program, operational and payment regulations to remove the conflicts and inconsistences across the service system. The commentators ask the Department to maintain this consistency across all five chapters as changes are made to the final-form

regulation. The Independent Regulatory Review Commission (IRRC) and numerous providers recognize and appreciate the extensive effort of the Department to align and amend the five chapters of regulations simultaneously.

A few commentators support consistency across the five chapters, but request that the four licensing chapters be combined and collapsed into Chapter 6100.

Response

Four existing chapters of licensing regulations govern many of the same facilities that are also funded through the Federal waivers, the Commonwealth's Title XIX State plan and base-funding allocations. To provide consistency among the HCBS provisions and the four licensing chapters, the final-form regulation includes revisions to the four licensing chapters to promulgate corresponding requirements for six major program and operational areas, including staff training, rights, incident management, individual plans, restrictive procedures and medication administration. As requested, the Department made corresponding changes from proposed rulemaking to the final-form regulation across all five chapters.

The Department appreciates the support of the regulated community and other affected parties to align the five chapters of regulations. While this was a massive undertaking, this alignment will reduce compliance management efforts at the provider, county and State levels. The time saved in the coordination of regulatory management functions

will permit all levels of the service system to focus on improving the quality of services to the individuals.

Five chapters must be maintained as the statutory authority for the four licensing chapters differs from the statutory authority for Chapter 6100. While there is some overlap of the applicability of the five chapters, there is not a complete overlap. Each chapter must stand alone to address the variant statutory authority, purpose and scope of the chapters. The Affected Individuals and Organizations section of this preamble explains the differences in the applicability of Chapter 6100 and the four licensing chapters.

General—Consistency of terms and provisions across the five chapters

The IRRC and several commentators note that while consistency across all five chapters is supported, some terminology differs and not all sections are identical in format or language across the five chapters. In particular, the IRRC asks why § 6100.404 (relating to final incident report) is not mirrored in the four licensing chapters.

Response

Some differences in terminology between the four licensing chapters and Chapter 6100 are necessary because of the different approaches to the comprehensiveness of the

amendments to the final-form regulation. Chapter 6100 is a new chapter; there is no existing language or format restriction for a new regulatory chapter; however, the amendments to Chapters 2380, 2390, 6400 and 6500 amend only the portions of those chapters relating to staff training, individual rights, incident management, individual plans, restrictive procedures and medication administration. The majority of the requirements in the four licensing chapters are not proposed for amendment. Therefore, the changes to the four licensing chapters must be folded into the existing regulatory format, adapting to language used in the existing chapters.

In response to the specific example provided by the IRRC, the final incident report requirement in § 6100.404 is carried over into the four licensing chapters. See final-form regulation §§ 2380.17(i)-(j), 2390.18(i)-(j), 6400.18(i)-(j) and 6500.20(i)-(j). This is an example of how the amendments in the licensing chapters must conform to the existing format of the four licensing chapters. In Chapter 6100, a separate stand-alone section, § 6100.404, is included to address the final incident report; however, due to existing formatting constraints, the licensing chapters include these requirements as subsections (i) and (j) under a broad incident report and investigation section.

In the example that the IRRC provides, the term “provider” is used in § 6100.404 consistent with its use throughout Chapter 6100; however, § 2380.17 (relating to incident report and investigation) uses the term “facility” since the term “facility” is necessary to maintain compatibility with the language used throughout Chapter 2380.

Because Chapter 2380 is not being revised in its entirety, the amended terminology must be consistent with the terms used in the existing Chapter 2380.

In some cases, the Department intentionally does not carry the requirements of Chapter 6100 over to the four licensing chapters if the requirements relate only to those services that the Department funds through the ODP service system. The Affected Individuals and Organizations section of this preamble explains the differences in the applicability of Chapter 6100 and the four licensing chapters. For example, § 6100.226 (relating to documentation of claims) is an important section detailing how to document a claim for purposes of reimbursement; however, since some licensed facilities are not funded by the Department through the ODP service system, this section does not apply for purposes of licensing.

In other cases, the final-form regulation intentionally excludes or changes certain Chapter 6100 requirements from the licensing chapters in an attempt to distinguish the requirements for an ODP service system funded by the Department and one that receives no such funding. In preparing the final-form regulation, the differences were carefully reviewed, and where possible and appropriate, the final-form regulation aligns the five chapters. In the example relating to § 6100.404, the licensing regulations include the option of submitting an incident on a paper form, rather than through the Department's online information management system because some licensed facilities do not have access to the ODP online incident reporting system. This difference

remains. See the comments and responses for each individual section further explaining the differences and similarities of the five chapters.

General—Achievement of consensus

The IRRC commends the Department for convening numerous meetings with various stakeholders; however, the IRRC questions why consensus among the stakeholders was not reached. The IRRC asks the Department to attempt to strike the appropriate balance of protecting the public health, safety and well-being while addressing the concerns of the regulated community.

Response

The Department agrees with the IRRC that the role of an effective regulator is always to strike the balance of the needs, concerns, benefits and risks of the affected stakeholders. This regulation is no different. While at the surface there may seem to be overwhelming discourse among the stakeholders, at the heart of the discussion are the core shared vision and strongly held values to provide the highest quality service to the individual.

The regulatory development process was open and inclusive, providing commentators with multiple opportunities over a 3-year period to express their opinions based on their own experiences and frames of reference. The experiences and priorities of an

individual who has an intellectual disability or autism and who lives in a community home are inherently different from the provider that provides services to the individual, or from the county program that is responsible for the oversight of a large number of diverse providers and individuals with specific needs and preferences. The Department views these professional, personal and practical differences in perspective, and the opportunities for stakeholders to continuously discuss policies, practices and operations, as the most vibrant asset of the ODP service system. While full consensus is not reached on numerous topics, including staff training, background checks, rights, restrictive procedures and payment methodologies, the rich discussion and diverse perspectives shared openly by persons and groups helped to advise the Department in its deliberation and decision-making process.

The Department believes that the final-form regulation strikes an appropriate balance between protecting the health, safety and well-being of the individuals who receive services, with fair and deliberate consideration given to the administrative and economic impact on the regulated community.

General—Compliance with applicable statutes and regulations

A provider and a university request that compliance with the Americans with Disabilities Act (ADA) be mandated in the regulation. A commentator asks to explain what is included in § 2390.24 (relating to applicable statutes and regulations).

Response

The Department appreciates this comment and supports rigorous and continuous compliance with the ADA. See Americans with Disabilities Act, Pub. L. No. 101-336, as amended, 42 U.S.C.A. §§ 12101—12213. Compliance with the ADA, as well as all applicable Federal, State and local statutes, regulations and ordinances is required across all five chapters. To emphasize that all laws must be followed, and in keeping with the recommendation to align all five chapters, the Department added § 6100.52 (relating to applicable statutes and regulations) to reference compliance with other applicable statutes, regulations and ordinances as proposed in §§ 2380.26, 2390.24, 6400.24 and 6500.25. Other applicable statutes, regulations and ordinances include any statute, regulation or ordinance that applies to the provider, such as requirements governing Department of State professional licensing, Federal and State wage and hour provisions, local wage standards, Department of Revenue tax law, Department of Environmental Protection safe waste disposal, child and adult protective services, fair housing, insurance, Workforce Innovations and Opportunities Act and OSHA health and safety rules.

General—Inclusion of autism services

A few advocacy organizations, a county government and a provider support the inclusion of autism services within the five chapters of regulations. One advocacy organization asked the Department go a step further and include programs serving

individuals with other disabilities and medical conditions, including cerebral palsy, muscular dystrophy, spina bifida, paralysis and respiratory disease. Several commentators ask that there be no exemptions from Chapter 6100 for autism services.

Response

The Department agrees with the positive movement to align services for individuals with autism with services for individuals with an intellectual disability. While the types of treatment, interventions and services vary based on individual needs, an individual with autism and an individual with an intellectual disability share similar protection and funding needs. It is reasonable and efficient to combine these two disability types into comprehensive and coordinated program, operational, funding and licensing regulations. The majority of providers of autism services also provide intellectual disability services. Further, given the significant co-occurrence of intellectual disability and autism diagnoses, alignment of services will result in better coordination and quality of services for an individual with co-occurring diagnoses.

Amendments have been made to Chapters 6400 and 6500 to include autism in the scope of licensing for community homes for individuals with an intellectual disability or autism. See the amended title of Chapter 6400 and §§ 6400.1—6400.4 and 6400.15 and §§ 6500.1—6500.4. Because the current regulation at § 2380.3 (relating to definitions; definition of individual) and § 2390.5 (relating to definitions; definition of

disabled adult) specifically includes autism, no changes were made to Chapters 2380 and 2390.

Based on public comment, the exemptions for autism services in proposed § 6100.801 (relating to adult autism waiver) have been deleted. The proposed five exemptions are no longer necessary for autism services.

While the Department recognizes the need for services for individuals with other types of disabilities and medical conditions, the regulation encompasses only individuals provided services through the ODP service system.

General—Children's services

The IRRC and several commentators ask the Department to convene a subgroup as part of future stakeholder meetings to focus on addressing children's issues, such as facility use by children, engagement of parents or guardians of minor children, preadmission determinations and planning, education and coordination with other state agencies. Commentators from universities, families, advocacy organizations and providers ask the Department to promote permanency planning to move children from institutional settings to life sharing homes, small family settings and very small community homes. Commentators ask the Department to address rights, planning, data sharing across service systems, parental decision-making and finances for children.

Response

The Department agrees and adds §§ 6100.56, 6400.25 and 6500.26 (relating to children's services) to address children's rights, decision-making and planning and to require the individual plan to include outcomes related to strengthening or securing a permanent caregiving relationship for the child. The Department is committed to continuously improve the planning, communication and data sharing for children's services across the Department and will seek stakeholder input on children's issues, as necessary, in the future.

General—Definitions

Numerous commentators suggest relocating definitions and adding definitions. One commentator asks to place all definitions in one chapter, rather than list definitions in each of the five chapters. Several commentators, plus numerous form letters from commentators, ask to locate all definitions in the beginning of each chapter, rather than disperse the definitions throughout the chapter. The IRRC asks to locate the definitions that apply throughout a chapter to the general definition section. The IRRC asks to locate definitions to the beginning of a particular section, if the definition applies only to one section. The IRRC asks that terms be used consistently across the chapters.

Response

The Department follows the guidelines for the location of the definitions as described by the Pennsylvania Code and Bulletin Style Manual, Fifth Edition as published by the Legislative Reference Bureau, § 2.11 (relating to definition section).

Terms are used consistently throughout each chapter; however, due to the nature of the amendments of the five chapters, sometimes different terms are used in Chapter 6100 and the four licensing chapters to adapt to the existing language of the licensing chapters. For example, in § 6100.404 (relating to final incident report) the term "provider" is used consistent with its use throughout Chapter 6100; however, § 2380.17 (relating to incident report and investigation) uses the term "facility;" the term "facility" is necessary to maintain compatibility with the language used throughout Chapter 2380. Because Chapter 2380 is not being revised in its entirety, the amended terminology must be consistent with the existing terms used in Chapter 2380.

Definitions of "cost report," "health care practitioner," "individual plan," "life sharer," "service," "support," "TSM-targeted support management," and "volunteer" are added to § 6100.3 (relating to definitions). Definitions of "health care practitioner," "individual plan" and "volunteer" are added to §§ 2380.3, 2390.5 and 6400.4 (relating to definitions). Definitions of "health care practitioner," "individual plan," and "life sharing home or home" are added to § 6500.4 (relating to definitions). Several of the requested

definitions are not added as the dictionary meaning applies or because the term is not used in the chapter.

General—Terminology

Several commentators, plus numerous form letters from commentators, recommend the use of terms other than “client,” “facility” and “program.” The commentators suggest the use of “individual,” “home” and “provider.”

Response

Chapter 6100 does not use the term “facility” or “client;” rather, Chapter 6100 uses the terms “service location,” “individual” and “provider.” The term “program” is used only in a broad sense referencing a special program type, such as agency with choice (AWC) or vendor goods and services; an HCBS program; or a county program.

As discussed previously, the four licensing chapters must continue to use terms as used throughout the existing chapters. The term “facility” is necessary to maintain compatibility with the language used throughout Chapter 2380. The term “client” is necessary to maintain compatibility throughout Chapter 2390.

General—Changes to licensing regulations not subject to revision

Numerous commentators and the IRRC suggest changes to sections of the licensing regulations that are not proposed for revisions. For example, the IRRC and a few commentators suggest changes to the program specialist qualifications in §§ 2380.33(c), 2390.33(c) and 6400.44(c) (relating to program specialist). The IRRC and other commentators ask to explain the inconsistencies of the program specialist qualifications across the licensing chapters and why work experience is not included as a qualification. The IRRC asks to explain the apparent staff ratio conflicts in § 2380.35 (relating to staffing). A commentator suggests changes to the staffing ratios in § 2380.35. The IRRC asks about the differences between a full and partial assessment in §§ 2380.181, 2390.151, 6400.181 and 6500.151.

Response

In accordance with the act of July 31, 1968 (P.L. 769, No. 240) (45 P.S. § 1202), known as the Commonwealth Documents Law, the Department may make "such modifications to the proposed text as published pursuant to section 201 as do not enlarge its original purpose." 45 P.S. § 1202. The Department is therefore prohibited from making substantive changes to sections of regulations if no substantive revisions were proposed. In the examples of §§ 2380.33(c) and 6400.44(c), amendments were proposed to §§ 2380.33(b) and 6400.44(b) only. The Legislative Reference Bureau printed the existing subsection (c)

for clarity purposes only. In the example of § 2380.35, the only proposed change was non-substantive in nature changing the term “ISP” to “PSP;” therefore, the Department is prohibited from making substantive changes to this section.

The Department is prohibited from making substantive changes to the final-form regulation if no substantive changes were proposed, including for example §§ 2380.33(a), 2380.35(b), 2380.36(b), 2380.36(c) and 2380.181(b).

In response to the comment about the inconsistency of the program specialist qualifications, the applicability and services for the four licensing chapters vary greatly, warranting differences in staff qualifications, titles and ratios. Work experience alone without higher education is not acceptable for a program specialist, due to the professional duties and responsibilities of the program specialist. In response to the comment about the conflicting requirements regarding the adult training facility staff ratios, the staff ratio requirements for adult training facilities have been in effect since 1993 with no conflict or concern.

Both §§ 2380.35(a) and 2380.35(c) apply, without conflict. The requirement of one direct service worker for every six individuals in subsection (a) requires the staff person to be “physically present,” meaning in the same room or program area. The requirement of two staff persons being present at all times in subsection (c) requires the staff person to be present in the facility and not necessarily physically present with individuals. This is required so there is staff back-up in the event of an emergency.

No substantive revisions were proposed to § 2390.151 (relating to assessment), so the Department is prohibited from making substantive changes in the final-form regulation. Section 2390.151(a) refers to an initial assessment and updated assessment. The updated assessment contains updated information from the initial assessment based on the individual's needs.

General—Language

Numerous commentators suggest revised language for multiple sections of the proposed regulation, such as revised language to: delete "the purpose of this chapter is to" and substitute alternate language using the verb "governs" in § 6100.1 (relating to purpose), add new language to § 6100.1 regarding the provisions of the subsections, use both the male and female gender and change the use of the terms "shall", "must" and "will."

Response

The Department reviewed and considered all suggested language changes. In some cases, the suggested revised language is used in the final-form regulation; however, in many cases the suggested language changes the intent of the regulation with no corresponding explanatory comment, the added language is unnecessary or the proposed rewrite violates the drafting procedures of the Pennsylvania Code and Bulletin Style Manual, including Pennsylvania Code formatting; use of plural versus singular;

and the use of terminology such as “each,” “any,” “a,” “an,” “shall,” “may,” “will” and “must.” See Pennsylvania Code and Bulletin Style Manual, Fifth Edition, 2014, Legislative Reference Bureau.

General—Chapter 6100

The IRRC, a provider association and numerous form letters from commentators state that there are conflicts between the Federal waivers and the proposed regulation. The IRRC also states that commentators request intended mandatory provisions of the Federal waivers be reflected in the regulation consistent with State statute and applicable case law. The commentators state that the mandatory provisions in the waivers cannot be adopted by reference in a regulation. The IRRC asks the Department to conform to the intent of the General Assembly to set clear standards for the regulated community.

Response

In response to questions about the Department’s authority to enforce the Federal waivers through incorporation by reference in the regulation, the Department decided to delete such references throughout Chapter 6100. There is no conflict between the Federal waivers and the final-form regulation, and therefore it is unnecessary to address any conflict. In addition, CMS requirements related to quality management, health and

safety, incident management, individual rights, individual planning, HCBS settings, rate setting and provider enrollment are addressed in Chapter 6100. See 42 CFR §§ 441.300—441.310; 441.350—441.365.

§ 6100.1(a)—Purpose

A provider association, plus numerous form letters from commentators, request the addition of payment requirements to the purpose statement.

Response

The Department has added payment requirements to the purpose statement.

§ 6100.1(b)—Purpose

Commentators suggested adding a reference to the Department's Everyday Lives document.

Response

The Department appreciates the acknowledgement of the Everyday Lives document as revised and reissued in July 2016; however, the Everyday Lives document is non-regulatory and as such is not appropriate to reference in regulation.

§ 6100.2—Applicability

One commentator asks to clarify that Chapter 6100 applies only to ODP-funded programs and that the chapter does not apply to individuals funded through other states or individuals funded through private funds, private insurance, schools or child welfare systems. One commentator asks for a much broader scope for Chapter 6100, including children's service waivers, the Omnibus Budget Reconciliation Act (OBRA) waiver, the Office of Long Term Living waiver, the Community HealthChoices (CHC) waiver, State-plan applied behavioral analysis services and Chapter 3800 (relating to child residential and day treatment facilities). One commentator asks to exempt services for older adults.

Response

Section 6100.2 (relating to applicability) is clear. Chapter 6100 does not apply to individuals funded by other states or individuals funded through private funds or private insurance. The chapter does not apply to funding provided through a source, including managed care or a Federal waiver program that is not funded through the Department for individuals with an intellectual disability or autism. The chapter applies if a child receives services in a child residential facility governed by Chapter 3800, for which HCBS funding is provided by the Department for individuals with an intellectual disability or autism. The ODP adult autism waiver does not include services for children. The

chapter applies to older adults if the services are funded through the Department for individuals with an intellectual disability or autism.

§ 6100.2(c)—Applicability

A county government association and numerous individual county governments commend the Department for developing a foundational set of regulations, including base-funding, to emphasize the crucial components of services such as the person-centered planning process. A few commentators ask to emphasize that Chapter 4300 (relating to county mental health and intellectual disability fiscal manual) continues to govern the fiscal operations of base-funding services and that the county intellectual disability and autism programs have flexibility to cover needed services with base-funding. A provider asks that Chapter 6100 not apply to base-funding services, arguing that Chapter 4300 is sufficient. A few providers ask to delete Chapter 4300 and apply the Chapter 6100 payment provisions to base-funding. A provider association asks to allow regulatory waivers for base-funding services to continue to permit flexibility.

Response

Chapter 4300 continues to apply to base-funding services to provide a method for a county intellectual disability and autism program to fund a special service for an individual if an HCBS is not available or if the individual is not eligible for an HCBS.

County intellectual disability and autism programs continue to have flexibility to cover needed services with base-funding.

Chapter 4300 is appropriate for base-funding only services since this chapter provides a baseline of payment provisions that are unencumbered by Federal regulation and procedures.

The program requirements of Chapter 6100, including criminal history record checks in § 6100.47 (relating to criminal history checks); staff training in §§ 6100.141—6100.143 (relating to training); individual planning in §§ 6100.221—6100.225; and restrictive procedures in §§ 6100.341—6100.350 are important protections for all individuals regardless of the ODP funding sources. Conformity of program requirements across funding sources permits a seamless and efficient transition as an individual transitions from one funding source to another within the ODP service system.

With respect to the comment on the need for regulatory waivers, such waivers are permitted in accordance with § 6100.43 (relating to regulatory waiver).

§ 6500.3(f)(1)—Applicability

An advocacy organization objects to the exclusion of services provided by relatives in licensed life sharing homes.

Response

The private home of a person who is rendering services to a relative is a statutory exemption in Article X of the Human Services Code. See 62 P.S. § 1001, definition of mental health establishment. Chapter 6100 applies to services provided by a relative, such as unlicensed life sharing that is exempt from licensure under Chapter 6500.

§ 6100.3—Definition of cost report

In accordance with comments from the IRRC, the definition of "cost report" is relocated from proposed § 6100.643(a) (relating to submission of cost report) to § 6100.3 (relating to definitions) since this term is used in several sections of the chapter. The definition of "cost report" is unchanged from the proposed rulemaking.

§ 6100.3—Definition of designated managing entity

One commentator supports change of the term "administrative entity" to "designated managing entity" to emphasize management function and the authority to act. One commentator asks not to use the acronym DME, as DME means durable medical equipment in other departmental programs.

Response

No change is made to this definition. DME is not used in the proposed rulemaking or the final-form regulation.

§ 6100.3—Definitions of eligible cost, natural support and OVR

The terms “eligible cost” and “natural support” and the acronym “OVR” are deleted as these terms and acronyms are no longer used in this chapter.

§ 6100.3—Definition of family

Several commentators ask to delete the term “family” and the definition of “family,” but rather to refer to persons designated by the individual throughout the regulation, as applicable.

Response

This change is made. The individual may choose to involve, or not to involve, specific family members, friends or advocates in planning activities and decision-making. Necessary and appropriate references to family, such as in § 6100.53 (relating to conflict of interest), are changed to relative.

§§ 2380.3, 2390.5, 6100.3, 6400.4 and 6500.4—Definition of individual plan

The acronym “PSP” is changed to “individual plan” because it reflects current ODP service system terminology. A definition of “individual plan” is added in each section.

§ 6100.3—Definition of life sharer

In consideration of the possible unintended consequences related to employee-employer relationships, a definition of “life sharer” is added to clarify that the term includes both an employee life sharer and a contracted life sharer.

§ 6100.3—Definitions of support and service

A few commentators agree to the proposed term “support” throughout the chapter; however, several commentators, plus numerous form letters from commentators, ask to use the term “service” rather than “support.” Several commentators ask to define the terms “service” and “support.” Several commentators ask to use a different term than “natural support” for one who provides unpaid and informal assistance.

Response

The terms “support” and “service” are defined. “Service” means a paid HCBS, support coordination, TSM, agency with choice, organized health care delivery system, vendor goods and services and base-funding while “support” means an unpaid activity or assistance provided to an individual that is not planned or arranged by a provider. When used as a verb, “support” is changed to “assist.” These changes in terminology are applied consistently to numerous sections of the final-form regulation. The term “natural support” is deleted.

§§ 2380.3, 2390.5, 6100.3 and 6400.4—Definition of volunteer

Numerous commentators and the work group ask to add a definition of “volunteer” to mean a person who engages in an activity that is an organized and scheduled component of the service system and who is not compensated for such activity.

Response

This change is made. “Volunteer” is defined to mean a person who is an organized and scheduled component of the service system who does not receive compensation, but who provides a service through the provider that recruits, plans and organizes duties and assignments. A volunteer does not include a person who provides intermittent and ancillary assistance, such as housekeeping or entertainment. A volunteer does not include an individual’s friends or relatives, unless they work as part of an organized volunteer program.

A definition of “volunteer” is not added to Chapter 6500 because the term “volunteer” is not used in the same context in which it is defined in the other chapters. Volunteers are not part of the routine service system for life sharing homes.

§§ 2380.3, 2390.5, 6100.3, 6400.4 and 6500.4—Definitions of abuse, neglect and exploitation

Several commentators ask to add the definitions of “abuse,” “neglect” and “exploitation.”

Response

These definitions are not added. The terms “abuse,” “neglect” and “exploitation” are defined differently in the applicable statutes and regulations. For example, in the Child Protective Services Law (23 Pa.C.S. § 6303), the term “child abuse” includes forms of both neglect and exploitation; while in the Adult Protective Services Act (35 P.S. § 10210.103) and the Older Adults Protective Services Act (35 P.S. § 10225.103), the terms “abandonment,” “abuse,” “exploitation” and “neglect” are defined separately. The intent of this section is to use the broad term “abuse” and reference the applicable statutes and regulations, including the Adult Protective Services Act (35 P.S. §§ 10210.101—10210.704) and applicable regulations, the Child Protective Services Law (23 Pa.C.S. §§ 6301—6386) and applicable regulations and the Older Adults Protective Services Act (35 P.S. §§ 10225.101—10225.5102) and applicable regulations. As Pennsylvania’s protective services laws and terms evolve, the broad reference to applicable statutes and regulations will remain current. Citing and defining the various terms used in existing statutes and regulations serves no purpose and may quickly antiquate the final-form regulation.

§ 6500.4—Definitions

A provider association asks to delete all references to “staff,” as there are no staff in life sharing.

Response

The term “staff” is not used in any of the proposed definitions; however, the life sharing specialist and other life sharing agency staff are considered staff persons and as such there are some uses of “staff” in this chapter.

§ 6100.41—Appeals

One commentator suggests that provider appeals not be limited to Chapter 41 (relating to medical assistance provider appeal procedures).

Response

No change is made. Provider appeals are regulated in Chapter 41, which provides detailed provisions governing the practice and procedures in medical assistance provider appeals commencing on or after November 25, 2006. See 55 Pa. Code § 41.1

(relating to scope). Adding additional appeal processes would create duplicative and potentially conflicting processes and is unnecessary.

§ 6100.42(a)—Monitoring compliance

Several commentators request that only one designated managing entity review a provider, rather than multiple designated managing entities. A few commentators suggest a coordinated effort between licensing, fiscal auditing and provider monitoring. Several commentators suggest that this section be renamed “provider performance review.” A provider association, plus numerous form letters from commentators, ask to clarify that only department pre-approved monitoring methods be used and that the specific time frames for the various monitoring functions be included.

Response

No change is made to this subsection.

One objective in aligning multiple chapters of regulations is to improve coordination and implement a more streamlined approach to provider monitoring. The Department will typically assign one designated managing entity to monitor regulatory compliance. The Department maintains the authority to assign more than one designated managing entity in situations that warrant such an assignment due to the size and geographic coverage of a provider.

This section is properly named since it addresses multiple types of reviews and audits. The Department will determine the appropriate monitoring tools, methods and time frames. The monitoring tools, methods and time frames are not specified in the regulation because they are subject to change based on Federal and State requirements relating to auditing assurances.

§ 6100.42(b)—Monitoring compliance

A few commentators ask to delete this proposed subsection as it is too vague.

Response

This subsection is shortened and clarified to allow the Department and the designated managing entity free and full access to the provider's policies and records and the individuals receiving services in accordance with this chapter.

§ 6100.42(c)—Monitoring compliance

A few advocates and a provider ask to delete the three time frames.

Response

The Department agrees and has made this change.

§ 6100.42(d)—Monitoring compliance

A provider association, plus numerous form letters from commentators, ask to delete the reference to the required format of the various regulatory agencies and allow the provider to determine a reasonable format for submission of the corrective action plan.

Response

No change is made. Each monitoring agency, such as the Department's Bureau of Financial Operations for financial audits and the ODP for provider monitoring, has a data collection format to provide for efficient and automated data collection, tracking, review and analysis.

§ 6100.42(e)—Monitoring compliance

The IRRC and several providers ask to explain why a corrective action plan is required for an alleged violation. A few commentators object to the time frame for submission of a corrective action plan. One commentator asks to mandate that the provider and the Department work in cooperation to develop the corrective action plan. Several

commentators, plus numerous form letters from commentators, ask to change the term "violation" to "non-compliance."

Response

The intent of the proposed language "alleged violation" is to allow the provider an opportunity to challenge the alleged non-compliance on the corrective action plan form prior to deeming the non-compliance final. To clarify, the language is revised to reference a preliminary determination of non-compliance, rather than an alleged violation. If the Department or a designated managing entity preliminarily determines non-compliance with this chapter, the provider may respond with a challenge to the preliminary determination by providing evidence of regulatory compliance, prior to completing the corrective action plan.

No timeline for return of a corrective action plan is prescribed in either the proposed rulemaking or the final-form regulation. The timelines for completing the corrective action plan will be determined by the Department based on the number and types of non-compliance.

The Department will assist and advise the provider in the development of an effective corrective action plan as necessary to achieve and maintain regulatory compliance.

The term "violation" is changed to "non-compliance."

§ 6100.42(h), (i)—Monitoring compliance

Several commentators ask to delete these subsections as they are overly prescriptive, unnecessary and conflict with the requirements relating to eligible cost.

Response

These two subsections are deleted.

§ 6100.42(i) (§ 6100.42(k) in proposed rulemaking)—Monitoring compliance

A provider association, plus numerous form letters from commentators, ask the Department to specify the time period for keeping documentation.

Response

The time period for retaining all records, including the regulatory compliance documentation, is specified in § 6100.54 (relating to recordkeeping).

§ 6100.43(a)—Regulatory waiver

A few county governments and a family representative support the proposed regulatory waiver section and agree that waivers should be prohibited for rights and restrictive

procedures. A few additional families and a provider support the prohibition of waivers on the rights section. A provider association believes that the waiver conditions in proposed subsection (c)(2) and (c)(3) are unnecessary and that there should be no list of regulations for which a waiver may not be granted. A provider association, plus numerous form letters from commentators, ask to allow waivers for rights and restrictive procedures to address the needs of individuals such as an individual with Prader Willi syndrome or an individual who is a sexual offender. A few providers and families request clarification regarding § 6100.223(8) and (9) (relating to content of the individual plan), suggesting that any modification of rights relating to a significant health and safety risk to the individual or others be addressed through the individual plan process.

A few providers believe this section focuses on penalties and remedial actions. A few providers ask the Department to respond timely to waiver requests. A provider association asks to relocate the prohibitions for a waiver to each applicable section, rather than state the waiver requirements together near the beginning of the chapter. A few provider associations, plus numerous form letters from commentators, ask to change the term “waiver” to “exception.”

Response

As suggested, the reference to the Federally-approved waivers in proposed subsection (c)(3) is removed. No other changes are made.

The granting of waivers is at the sole discretion of the Department. The Department is not obligated to entertain regulatory waivers, nor does the provider have the right to a waiver; however, in the spirit of openness and cooperation, the Department desires to permit providers the opportunity to request a waiver in certain circumstances and for certain sections of the regulation. The majority of the regulatory requirements of this chapter are open to a request for a waiver; only the administration requirements, individual rights and restrictive procedures are excluded from requests for waivers since these sections provide the framework for the HCBS program and protect the individuals from mistreatment and abuse.

As suggested by commentators and the work group, the concerns expressed regarding specific risks to an individual's health and safety such as an individual with an eating disorder, food allergy, criminal behavior and other behavior that creates a serious health and safety risk to the individual or others are addressed in § 6100.223(8) and (9). The individual plan team will appropriately address the protection needs of an individual relating to specific behaviors that may pose a significant health and safety risk to the individual or others. Addressing the specific significant health and safety needs of the individual through the planning process is more appropriate, timely and reasonable than utilizing a formal departmental waiver process.

This section does not focus on remedial action; rather, the Department is permitting a provider the option to request a regulatory waiver.

The Department will respond timely to each waiver request. Providers can speed the review and decision on a waiver request by using the Department's required form and completing each section of the form accurately and thoroughly.

The section on waivers is properly located near the beginning of the chapter under General Requirements, rather than dispersing and repeating the requirements and prohibitions throughout the chapter. The term "waiver" is correct based on the provision in 1 Pa. Code § 35.18 (relating to petitions for issuance, amendment, waiver or deletion of regulations) governing the submission of waiver requests.

§ 6100.43(c)—Regulatory waiver

A provider association, plus numerous form letters from commentators, ask the Department to recognize that there are times when a request for a waiver may infringe on community integration and independence to protect the health and safety of the individual. A provider asks the Department to require waivers to be added to the individual plan.

Response

The conditions for a waiver include the requirement that the provider demonstrate how granting of the waiver will increase either person-centered approaches, integration, independence, choice or community participation for an individual or a group of

individuals. The waiver justification must show how any one or more of these criteria is met.

While a regulatory waiver may be appropriate to discuss during the individual plan meeting, inclusion of the waiver decision in the individual plan is not a regulatory requirement. Including specific regulatory waivers in each applicable individual plan is an unnecessary administrative burden on the provider. A regulatory waiver may relate to an individual, but more likely may apply to a group of individuals within the provider agency. A regulatory waiver involves formal processes and compliance monitoring that occur outside the individual planning process. The individual plan includes the services and supports necessary to assist the individual to achieve the desired outcomes. If a regulatory waiver relates to an individual's services and supports, the individual plan will reference the existence of a regulatory waiver in describing the services and supports.

§ 6100.43(d)—Regulatory waiver

A provider association and several providers ask to issue non-expiring waivers, rather than require an annual waiver renewal, putting a provider at risk of a regulatory citation.

Response

The Department will include an expiration date for each waiver that is granted; however, some waivers may be granted based on a certain condition and not necessarily contain

a precise end date. It is the provider's responsibility to monitor compliance with the waiver conditions, track the waiver expiration date, if applicable, assess the need for a continuation of the waiver and request a waiver renewal. There is no annual waiver renewal requirement provided in the final-form regulation. Section 6100.43(d) is written to account for both time-limited and extended time regulatory waiver situations.

§ 6100.43(e)—Regulatory waiver

A provider association asks for a clear time frame for the individual to respond and to limit the time frame to no more than 45 days. An advocacy organization and a provider ask to allow a shorter time frame for an individual response, if all parties agree.

Response

This subsection was revised to eliminate the requirement for the individuals to review and respond to the request. The individual receives notification of the waiver request only. The proposed time frames created an unnecessary administrative burden on providers and individuals.

§ 6100.43(f), (g), (h) and (i)—Regulatory waiver

The IRRC, a provider association, plus numerous form letters from commentators and a few providers, ask to provide an exception to the time frames or to presume the waiver

will be granted with a follow-up to formally secure the waiver in the case of immediate jeopardy to the individual's health and safety.

Response

In response to comments, proposed subsections (f), (g), (h) and (i) are deleted. Section 6100.43 is simplified to clarify the steps in requesting and obtaining a waiver. There is no longer a requirement to submit the waiver to individuals in advance of the submission of the waiver request. A copy of the waiver is shared with the individuals at the same time it is submitted to the Department; therefore, an exception to the time frames is not necessary. Each waiver request must be reviewed by the Department to assure the protection of the health and safety of the individual; a waiver cannot be presumed granted. The Department will conduct an expedited review and decision in the case of immediate jeopardy to an individual's health and safety. The removal of the time frames in the proposed § 6100.43(d) allows a fast-track waiver decision by both the provider and the Department.

§ 6100.43(l)—Regulatory waiver

A provider asks how compliance with the notification requirement will be measured and tracked by the Department.

Response

Subsection (l) is deleted because it is redundant. A provider must notify affected individuals as required in § 6100.43(f). It will not be necessary to measure or track regulatory compliance regarding notification.

§ 6100.44—Innovation project

Numerous commentators applaud the Department for encouraging new ideas to emerge and promoting innovation to increase integration, independence and choice. A provider association, plus numerous form letters from commentators, note that innovation opportunities could be moot if sufficient waiver funding is not available. A provider suggests that true innovation lies outside the realm of regulation and that innovation should be addressed by a departmental bulletin and not through regulation. Several commentators ask that the innovation projects be made public to share new ideas and successful models. A few county governments ask that an approved innovation project be shared with the County Intellectual Disability and Autism Office. A commentator asks for a standard form for submission of an innovation project proposal. An advocacy organization and a few providers ask for innovation projects to be granted on a permanent basis.

Response

The Department supports and promotes new and innovative service concepts, staffing designs, community integration approaches and person-centered models.

An approved innovation project is public information and will be shared with the affected County Intellectual Disability and Autism Offices.

Because this is a proposal for a new and different service model, it does not lend itself to a Department-mandated form; however, a provider should follow the outline in this section to be certain all components are addressed in the proposal.

The Department notes that there is no current appropriation for HCBS innovation projects and that all approvals to use HCBS monies must meet the Federal waiver requirements.

The Department is not prohibited from addressing innovation projects through a departmental bulletin.

§ 6100.44(b)-(d)—Innovation project

Several commentators ask to add or delete items from the list of the components of an innovation project proposal. Commentators suggest the deletion of the proposed *§* 6100.44(b)(1)-(5), (d) and (f). A provider association, plus numerous form letters from commentators, state that it is unnecessary to create a new committee, but rather the agency's board may satisfy this requirement. A commentator asks to combine § 6100.44(b)(8)-(10). Commentators suggest the additions of business partners and employment.

Response

Several changes are made to shorten and simplify this section. Proposed subsections (b)(2), (b)(14), (b)(15), (c), (d)(3), (e), (f) and (g) are deleted because those proposed provisions are cumbersome and unnecessary. Final-form regulation subsections (b)(1)-(10), (c)(1)-(4) and (d) ((b)(1), (b)(3)-(5), (d)(1)-(2) and (d)(4)-(5) in proposed rulemaking) are retained because they provide important conditions that must be described and reviewed for the Department to consider an innovation project.

Proposed subsection (b)(8)-(10) are shortened and collapsed into one paragraph. The reference to an advisory committee in the proposed subsection (b)(8) is deleted; this allows the provider's board or another existing group to advise the innovation project in the final-form regulation subsection (b)(7). Community partners in the final-form

regulation subsection (b)(7) include business partners. While an innovation project may address employment, it is not a necessary component for each innovation project.

§ 6100.45—Quality management

Numerous commentators suggest that the proposed quality management requirements are vague, burdensome and overly prescriptive. The IRRC and numerous commentators state that the proposed requirements will result in increased paperwork to track the data, particularly for proposed § 6100.45(b)(1), (6) and (7). Commentators state that mandating performance data review in the proposed nine areas will require a new part-time staff positon to enter, track and monitor the quality management data. Commentators argue that the specific and detailed plan components will reduce the agency's ownership of the plan. Some suggest issuing a departmental bulletin as best practice, rather than attempting to mandate quality management practices through regulation.

A provider association, plus numerous form letters from commentators and ten providers, state that progress outcomes should be evaluated through the individual planning process, rather than through the quality management process.

Many providers object to requiring individual, family and staff satisfaction surveys. A university, a family group and an advocacy organization support the new requirement for family and individual satisfaction surveys.

A provider association, plus numerous form letters from commentators, request that the quality management form not be mandated.

The IRRC asks the Department to address the reasonableness of and need for the quality management review requirement, as well as the economic impact of this proposed requirement.

Response

The Department listened to the overwhelming public objections to this section and significantly reduced the content and specificity of this section. The proposed list of nine specific areas to be reviewed and evaluated in the quality management plan is restructured and reduced to five broad components, including performance measures; performance improvement targets and strategies; feedback methods, including feedback from individuals and staff; data sources; and the role of the quality management staff. These five broad component areas allow the provider significant discretion to design a quality management plan that meets the provider's needs to target specific goals and establish priorities. While quality management review regulatory provisions are essential, the detail contained in the proposed rulemaking is not necessary. A departmental bulletin may provide best practice recommendations, but the basic provisions for a provider to maintain a quality management program must be in regulation to provide an enforceable mandate.

Quality management is a systemic overview of the provider's organization as a whole, including its processes, procedures, system outcomes and areas for improvement. The individual planning process focuses on the specific strengths, preferences and services for each individual. As suggested, an individual's progress and outcomes will continue to be reviewed through the individual planning process.

The proposed requirement for the provider to conduct individual, family and staff satisfaction surveys is deleted in response to comments; however, the provider's quality management plan must include the provider's methods to obtain feedback relating to personal experience from individuals, staff persons and other affected parties.

Use of a departmental quality management form is not required.

Although no specific comments were received asking to change the quality management review timeline, based on numerous comments asking to reduce the overall quality management requirements, the Department extended the timeline for analysis and revision of the quality management plan from 2 years to 3 years, to align the provider's quality management analysis and revisions with the provider monitoring cycle.

No new staff positions are required and no added paperwork is necessary to meet § 6100.45, since the providers currently have a quality management plan in accordance with prior departmental guidance and direction. Given the revisions of this section,

particularly to delete the proposed requirements for trend analysis of data and satisfaction surveys and the requirement to review and document progress on the quality management plan quarterly, there is no economic impact related to compliance with § 6100.45.

§ 6100.46—Protective services

The IRRC, an advocacy organization and a family ask why the terms “neglect” and “exploitation” are not included in this section. The IRRC notes that these two terms are used in the incident management sections of the five chapters. The IRRC asks the reasonableness of not including “neglect” and “exploitation” in this section and how this protects the public health, safety and well-being.

The IRRC and several providers ask to take into account other possible outcomes of an investigation such as an inconclusive and unconfirmed finding. A few provider associations, plus numerous form letters from commentators and several providers, mention that some abuse allegations are reported to multiple State agencies and by multiple sources; clarification is requested regarding the need for multiple reports.

The IRRC and several providers ask if the Department considered restricting the staff person, consultant, intern or volunteer from having access to any individual and not just the alleged victim. A provider asks to delete this restriction to separate the alleged abuser from the alleged victim and permit the alleged abuser to be present with the

alleged victim before the investigation is concluded. A provider association, plus numerous form letters from commentators and a provider, ask not to usurp the provider's disciplinary action, but rather to lift the restriction after the provider concludes the internal investigation. The IRRC asks the Department to explain the reasonableness of this provision and how the public health, safety and well-being is protected. A county government commentator asks that timelines be established for the dates of the criminal history checks.

A family and an advocacy organization ask that families be informed of the abuse allegation. A provider asks that the support coordinator be informed of the abuse allegation. A provider association states that the reporting in § 6100.46(c) is redundant of the incident reporting in §§ 6100.401—6100.405. Several providers ask to clarify the county program responsibility in § 6100.46(c)(5) if no funds are received from the county program.

Response

The terms "abuse," "neglect" and "exploitation" are defined differently in the applicable statutes and regulations. For example, in the Child Protective Services Law (23 Pa.C.S. § 6303), the term "child abuse" includes forms of both neglect and exploitation; while in the Adult Protective Services Act (35 P.S. § 10210.103) and the Older Adults Protective Services Act (35 P.S. § 10225.103), the terms "abandonment," "abuse," "exploitation" and "neglect" are defined separately. The intent of this section is to use the broad term

"abuse" and reference the applicable statutes and regulations, including the Adult Protective Services Act (35 P.S. §§ 10210.101—10210.704), the Child Protective Services Law (23 Pa.C.S. §§ 6301—6386), the Older Adults Protective Services Act (35 P.S. §§ 10225.101—10225.5102) and applicable regulations. As Pennsylvania's protective services laws and terms evolve, the broad reference to applicable statutes and regulations will remain current. Citing and defining the variable terms used in existing protective services statutes and regulations serves no purpose and may quickly antiquate Chapter 6100. It is reasonable and appropriate to protect the public health, safety and well-being by relying on the applicable protective services statutes and regulations to govern the scope, types and definitions of abuse for the purposes of abuse reporting and investigation.

As the IRRC notes, the terms "neglect" and "exploitation" are used in the incident management sections of the five chapters. See §§ 2380.17, 2390.18, 6100.401, 6400.18 and 6500.20. It is necessary to list all possible types of abuse-related incidents, including "neglect" and "exploitation," in the incident management sections of the regulations, since incident management is generally governed through regulation, rather than by other applicable protective services statutes and regulations.

The Department clarified that the staffing restriction is lifted if there is an inconclusive finding by the authorized investigating agency.

In § 6100.46(b), the use of the term “an” in the phrase “…may not have direct contact with an individual until the investigation is concluded …” includes any individual and not just the alleged victim. The term “an” means “any” in accordance with the Pennsylvania Code and Bulletin Style Manual, Fifth Edition, § 9.3(a) (relating to use of “a,” “an,” “the,” “each” and “every”). This subsection prohibits an alleged perpetrator of abuse from having direct contact with any individual until the investigation by the authorized investigating agency concludes that no abuse occurred or that the findings are inconclusive. Findings from an internal provider investigation are not sufficient to permit an alleged perpetrator of abuse to work directly with individuals. The provider’s disciplinary process complements, but does not replace the protections from abuse afforded by statutes and regulations. This provision protects the health, safety and well-being of the individuals by restricting the alleged perpetrator from access to all individuals while under an abuse investigation.

The due dates of the various criminal history checks are governed by applicable statutes and regulations; this is not under the Department’s purview to alter.

In many cases, the family will be informed of an allegation of abuse in accordance with § 6100.46(c)(2); however, the ultimate decision of whether to inform a family member of an allegation of abuse lies with the adult individual. If the individual is a child, the child’s parent or legal guardian will be informed of the alleged abuse in accordance with § 6100.56 (relating to children’s services).

The support coordinator receives notice of incidents, including abuse reports, through the Department's electronic incident management system.

The term "household member" is added to § 6100.46(b) to address a person living in a life sharing home who may pose a risk to an individual. The term "abuse" is removed before the term "investigation" in § 6100.46(b) because it is unnecessary. In § 6100.46(c)(5), the term "if applicable" is added to clarify that this does not apply if no funds are received from the county program.

The abuse reporting required in § 6100.46(c) is governed by State law. The incident reporting in §§ 6100.401—6100.405 is required by the Department to maintain Federal financial participation, to monitor the provision of HCBS and to protect the health and safety of the individuals.

There are multiple State statutes and regulations that require specific types of abuse reporting to different State agencies. This final-form regulation creates no administrative or operational burden regarding abuse reporting, other than that which already exists in law.

Compliance with the final-form regulation can be reasonably met; the requirements are consistent with applicable statutes and regulations. The final-form regulation is essential to protect the health, safety and well-being of the individuals who receive HCBS.

§ 6100.47—Criminal history checks

The IRRC asks the Department to define “household members” and “natural supports,” clarify applicability to natural supports and clarify who is exempt from the criminal history checks.

A provider association, plus numerous form letters from commentators, ask to clarify that criminal history checks are not required for children.

There are strong and differing opinions regarding the persons who should be required to have criminal history checks. A home care provider states that it will cost $42 per person to complete the checks. A family organization, an advocacy organization, a family and a provider ask to exempt unpaid household members. Several providers ask to exempt all household members from the criminal history check requirement in subsection (b)(1) of the proposed rulemaking. A provider organization, plus numerous form letters from commentators, ask that only staff persons who have direct contact with individuals be required to obtain the checks, while several providers specifically disagree with the same provider association and support broad-based checks for all staff positions, including ancillary staff. One family, an advocacy organization and a few providers ask to exempt volunteers, as this will discourage community involvement. An advocacy organization supports checks for all volunteers, life sharers and household members. A provider association believes that reference to the Adult Protective Services Act is errantly missing.

Response

The term “natural support” is no longer used in this chapter; rather, “support” is defined based on the activity, rather than the person who provides the support.

The term “household member” is not defined. In accordance with the Pennsylvania Code and Bulletin Style Manual, Fifth Edition, § 2.11 (relating to definition section), a word used in its dictionary meaning may not be defined. This chapter intends no special meaning of the terms “household” or “member.” The Merriam-Webster dictionary defines “household” as “a social unit composed of those living together in the same dwelling.” The Merriam-Webster dictionary defines “member” as “one of the individuals composing a group.” See *Merriam-Webster.com*. Merriam-Webster, n.d. Web. 29 June 2017.

Clarification is added to final-form § 6100.47(a)(3) that only adult household members require checks and not children. Further clarification of the applicability of subsection (a)(3) includes those adult household members residing in licensed and unlicensed life sharing homes and in out-of-home overnight respite services.

At the IRRC’s request, final-form subsection (c) states more clearly those who are not required to obtain the criminal history checks.

All staff positions require criminal history checks, including ancillary staff who have no direct contact with an individual. Staff persons who do not have direct contact with individuals may have access to individual records, property or monies providing an opportunity for inappropriate behavior, abuse or criminal activity.

The fee for a Pennsylvania State Police background check is $8.00. The fee for a Pennsylvania child abuse check is $8.00, which is rarely required as approximately 87% of the individuals who receive services under this chapter are adults. The fee for an FBI check is $25.75, which includes fingerprinting. For a person who will provide services to adults, an FBI check is required only if the person lived outside of Pennsylvania within the past 2 years. See 35 P.S. § 10225.502(a)(2). The Child Protective Services Law (See 23 Pa.C.S. § 6344(b)(3)) requires an FBI check for all paid staff who serve children, and also for volunteers who have lived outside of Pennsylvania within the previous 10 years. The impact of this requirement is limited, however, since only 13% of the individuals covered by the final-form regulation are children. The cost for the majority of prospective staff persons is $8.00. The cost for the background check may be borne by the job applicant or by the provider agency. The cost of conducting criminal history checks for prospective staff is factored into the new HCBS rates.

As discussed with the work group, a “volunteer” is defined as a person who is an organized and scheduled component of the service system and who does not receive compensation, but who provides a service through the provider that recruits, plans and organizes duties and assignments. A volunteer does not include a person who provides

intermittent and ancillary assistance, such as sweeping the floors or playing the piano. A volunteer does not include an individual's friends or relatives, unless they work as part of an organized volunteer program. With this clear and narrow definition of "volunteer," the Department determined that background checks must be completed for volunteers to protect the health and safety of the individuals.

Reference to the Adult Protective Services Act is not errantly missing in this section. The Adult Protective Services Act governs the reporting and investigating of abuse, but the law does not require criminal history background checks.

§ 6100.48—Funding, hiring, retention and utilization

A provider association, plus numerous form letters from commentators, ask to reference the Adult Protective Services Act.

A provider association, plus numerous form letters from commentators, ask to discuss the relevant court decisions under the Older Adults Protective Services Act.

Response

Reference to the Adult Protective Services Act is not appropriate for this section as the Adult Protective Services Act governs the reporting and investigating of abuse, but not criminal history checks, the provider's duties relating to the disposition of such checks or hiring.

This section is shortened to require compliance with applicable statutes and regulations. The governing statutes and regulations determine the affected staff persons.

The Department will provide further information on the application of applicable protective service court decisions, statutes and regulations.

§ 6100.49—Child abuse history certification

A commentator requests that the exact requirements of the Child Protective Services Law be specified in the regulation.

Response

The implementation requirements of the Child Protective Services Law are specified in 55 Pa. Code Chapter 3490 (relating to protective services). It is unnecessary to repeat the regulatory provisions in Chapter 6100.

§ 6100.50—Communication

A university and a few county governments strongly support this section as proposed. A provider association asks to clarify that this applies only to the extent understood by the individual. Several providers ask who will pay for these communication services. A provider suggests that this section apply only to licensed facilities and not to all HCBS.

An advocacy organization and a few providers ask the Department to provide all forms in all languages, including Braille. A family member asks that the individual be given the option of using assistive communication technology. A provider advises that not all individuals are able to communicate and make informed decisions, even with the use of auxiliary aids. An advocacy organization asks to reference the ADA that requires public accommodations, including the use of auxiliary aids and services when necessary. The same advocacy organization asks to require that auxiliary devices be maintained in working order. A few providers ask to require a physician's order for any communication device. A provider asks to require evaluations by a speech pathologist. A county government asks to mandate that the provider support the use of auxiliary devices.

Response

The Department appreciates the helpful and diverse comments on the topic of communication. Effective and ongoing communication is key to individual learning, developing relationships, expressing choice and reporting harm and is essential to the success of the staff providing the services. If staff persons understand the individual's choices, preferences and dislikes, they will provide services that are effective and person-centered. Every individual has the capacity to communicate through speech, gestures, eye contact or the use of assistive technology.

The commentator is correct that communication must be understood by the individual, to the extent the material can be understood; however, no added regulatory language is necessary. This section applies to all HCBS in order to protect the health, safety and well-being of the individuals.

Proposed subsection (b) is deleted as unnecessary and potentially creating confusion and duplication in provider responsibilities regarding communication. The support coordinator's role includes assuring that an individual's communication needs are met. The individual plan specifies the need, types of devices and services and funding sources to cover needed devices and services. The individual has the option of using assistive technology, but appropriate and necessary assistive technology must be offered.

The Department supports rigorous and continual compliance with the ADA. Compliance with the ADA is required. See § 6100.52 (relating to applicable statutes and regulations).

Communication devices must be maintained in working order in accordance with *§ 6100.442(b) (relating to physical accessibility).*

While a physician or speech pathologist may be helpful to diagnose and treat certain types of auditory conditions, not all individuals with a communication need require an intervention or assessment by a licensed professional. For instance, some

communication needs are language-based or behavioral in nature, and staff persons and others familiar with the individual on a daily basis are able to assess and address the communication needs. Some individuals with communication needs benefit from technology, such as communication boards and computers.

The cost of translation to languages other than English is included in the fee schedule rates.

The Department will issue any mandated forms that are used by individuals and families, such as the request for a regulatory waiver and the room and board residency agreement, in Spanish as well as in English and in any other language upon request.

§ 6100.51—Complaints by an individual (Grievances in proposed rulemaking)

A few county governments ask to use the term “complaint” rather than “grievance,” as “grievance” implies the denial of health care services. An advocacy organization asks to clarify that this section applies to complaints submitted by or on behalf of an individual and not to staff person complaints. The same advocacy organization asks that the individual be able to elevate the complaint to the designated managing entity or to the Department. A provider organization, plus numerous form letters from commentators, ask that this section apply only to complaints about an HCBS. A family organization asks that the individual and the family be informed of the process to submit a complaint, that an individual may also submit complaints to the designated managing

entity and the Department and that the support coordinator be required to support the individual throughout the complaint process. A provider asks to add a requirement that the individual sign a statement that an explanation of the complaint process was provided. A provider association and a few advocacy organizations ask to clarify the process if a complaint is anonymous. A provider association and a few providers ask to explain the process to be followed if a complaint is a comment, phone call or in writing. A few provider associations and a few providers, plus numerous form letters from commentators, state that the timelines are unreasonable. The IRRC asks the Department to explain why the timelines are reasonable.

Response

The term “grievance” is changed to “complaint.” Subsection (a) is revised to clarify that a complaint relates to a service that is submitted by or on behalf of an individual; it does not include a complaint about a non-HCBS issue or a staff person complaint.

The role of the support coordinator relating to the filing and managing of complaints is not specified in this section; however, in accordance with § 6100.803(a) (relating to support coordination, targeted support management and base-funding support coordination), the support coordinator provides services and supports to locate, coordinate and monitor needed HCBS and other support, which includes providing support to the individual, as needed, throughout the complaint process.

In subsection (b), the individual, and persons designated by the individual, are informed about the right to file a complaint and the procedures to file a complaint upon initial delivery of an HCBS and annually thereafter. While the provider must document compliance with this subsection, in an effort to reduce paperwork, a written signed statement is recommended, but not required.

Subsection (g) is clarified to explain that a complaint as used in this chapter is one submitted by an individual or on behalf of an individual. Subsection (g) explains that a complaint may be received in any format, including oral or written.

Subsection (g) includes anonymous complaints since an anonymous complaint may contain valid concerns to be addressed by the provider; however, the name of the complainant cannot be recorded in paragraph (g)(1) as addressed by the phrase "if known." The follow-up report to the complainant in the new subsection (h) cannot be conducted for an anonymous complaint.

The timeline for the complaint resolution is extended from 21 to 30 days as specified in the new subsection (h). In the unusual event that a provider is unable to resolve the complaint within 30 days due to circumstances outside the provider's control, such as a critical witness that is not reachable or a pending external investigation, the provider should document the circumstances outside the provider's control that prevented the complaint resolution and resolve the complaint immediately following the receipt of the outstanding information. The Department believes the revised timeline is reasonable, allowing sufficient time to investigate and resolve the complaint.

The family member is informed of the complaint findings as specified in the new subsection (h) if the family member reported the complaint on behalf of the individual. Complaints about an HCBS may be submitted to a designated managing entity or the Department; however, the complaint should first be reported to the provider for prompt resolution.

§§ 2380.156, 2390.176, 6100.52, 6400.196 and 6500.166—Rights team in proposed rulemaking

Numerous commentators representing families, universities, advocacy organizations, county governments, providers and a few provider associations, plus numerous form letters from commentators, object to all or a portion of the proposed § 6100.52 (relating to rights team). While several commentators support the concept of an independent and overarching rights team, the commentators are unanimous that the proposed regulation missed the mark and overextended the role and practical reality of mandating such a team under the purview of a provider.

The IRRC asks to explain the unnecessary bureaucratic layer, additional administrative duties, costs and paperwork imposed by this proposed section. Numerous commentators state that the proposed role of the rights team overlaps and duplicates the roles and procedures of the restrictive procedure process in Chapters 2380, 6400 and 6500; the incident management process in the proposed §§ 6100.401—6100.405; the quality management process in the proposed § 6100.45 (relating to quality

management) and the individual plan process in the proposed §§ 6100.221—6100.224. The IRRC asks if the duties in § 6100.52(b)(2)(ii) and (iii) are beyond the scope of the rights team. The IRRC asks if the rights team members have the skills to resolve certain behaviors that may be directly linked to a particular disability. The IRRC asks if the rights team must meet every 3 months if there are no incidents. Other commentators object to a team meeting every 3 months stating that less frequent or more frequent team reviews may be necessary. Several commentators suggest reviews every 6 months. A county government states that it has an internal rights team that meets eight times per quarter to review incidents and study trends. Another county government states that the team must be independent and conflict free, rather than directed by a provider who may be self-serving. A provider association, plus numerous form letters from commentators, suggest that an individual be included as a member of the rights team on a case-by-case basis. The IRRC asks to explain the need for and reasonableness of this section.

Response

The Department agrees the proposed sections are not necessary or reasonable as drafted and they are deleted; relevant sections are revised and relocated to §§ 6100.344 (relating to human rights team) and 6100.345 (relating to behavior support component of the individual plan). Similar changes are made in applicable sections of the final-form regulation for Chapters 2380, 2390, 6400 and 6500. While the concept of a comprehensive and objective team of professionals to review and analyze rights

violations and the use of restraints was developed and supported in concept by the work group, creating and regulating such a comprehensive team through regulatory chapters that apply only to providers of services is not practical. The concept of an individual, person-centered team and that of a broad-based team of objective professionals completing a systemic analysis were confused, creating a team that was duplicative and impractical.

The review and analysis of rights violations are appropriately governed by §§ 2380.19, 2390.19(d)-(h), 6100.405, 6400.20 and 6500.22 relating to incident analysis.
As suggested by numerous commentators, the Department retains and extends the current licensing requirements in §§ 2380.154, 6400.194 and 6500.164 (relating to restrictive procedure review committee) to Chapters 2390 and 6100 regarding the review of the use of restraints and restrictive procedures. See §§ 2380.154, 2390.174, 6100.344, 6400.194, and 6500.164.

The broad-based systemic review of potential rights issues and restraint use will be addressed by the county human rights committees, required as part of the county mental health and intellectual disability programs operating agreements, rather than through this chapter that applies to providers.

In response to the comments from the IRRC and others about the frequency of the team meetings, § 6100.345 requires the behavior support component of the individual plan to be reviewed and revised as necessary by the human rights team, according to the time

frame established by the team, not to exceed 6 months between reviews. This allows the team to establish a review schedule based on the needs of the individual.

§ 6100.53—Conflict of interest

The IRRC asks if a person serving on a governing body who is a friend or family member of an individual must disclose the relationship. An advocacy organization asks to retain the specificity in current § 51.33 (relating to conflict of interest). A provider association, plus numerous form letters from commentators, ask to delete subsection (b) for clarity. An advocacy organization, a family member, a provider association and a provider support individuals and families serving on governing boards.

Response

A friend or relative of the individual does not need to disclose the person's relationship with an individual in order to preserve the confidentiality of the relationship. The Department supports the inclusion of individuals, friends and relatives on the governing body board to provide practical guidance and a real life experience and perspective to the board's deliberations.

A change is made to subsection (a) to delete the review and approval by the provider's full governing board, since not all provider agencies have a governing board and because the final-form regulation does not generally require approval of provider

policies by the board. Subsection (b) is retained; the provider must comply with its own conflict of interest policy. In subsection (c), "if applicable" is added, since there may be no governing board.

§ 6100.54—Recordkeeping

The IRRC asks how and where the records in subsection (d) will be maintained. A few provider associations, plus numerous form letters from commentators, ask to clarify that electronic records are permissible. A county government asks to clarify where the records go when a provider closes. A few providers state that this section is redundant of the Health Insurance Portability and Accountability Act (HIPAA). A provider association, plus numerous form letters from commentators, ask to assure compliance with HIPAA regarding release of records to government entities. A provider states that this section conflicts with HIPAA. A provider asks to clarify that disability rights advocates and CMS have access to provider records. Several providers support the 4-year retention requirement as reasonable.

Response

No substantive change is made to this section. The Department does not regulate where or in what format the records are kept to allow flexibility for the provider to establish and maintain an effective and efficient recordkeeping system. Electronic records are permitted. Records must be made available for service provision and for

review by the Department and other authorized monitoring agencies, but the record location and record format is intentionally not specified.

In response to the question about where records go when a provider closes, § 6100.307 (relating to transfer of records) is applicable.

This section complies with HIPAA. In accordance with HIPAA, health care oversight agencies, including government licensing and monitoring agencies and the Federally-authorized Disability Rights Pennsylvania, have full and immediate access to individual records. No permission or authorization is required. See disclosure as required by law at 45 CFR § 164.512(a) (relating to uses and disclosures required by law); disclosure to the Department at 62 P.S. § 1016; disclosure to Disability Rights Pennsylvania at 42 U.S.C.A. § 15043; and disclosure to health oversight agency at 45 CFR § 164.512(d) (relating to uses and disclosures for which an authorization or opportunity to agree or object is not required).

§ 6100.55—Reserved capacity

A few families and providers support the right for an individual to return home after hospital or therapeutic leave. A provider association asks to add medical leave. A provider states that it is costly to fund vacancies. A few provider associations, plus numerous form letters from commentators, and an advocacy organization support the concept to return home, but ask that sufficient funds be provided to hold a vacancy.

The commentators ask how the provider will be paid for days when an individual is absent. A commentator asks that partial reimbursement be provided when an individual is absent.

Response

The Department made significant changes to this section to address the commentators' concerns. The changes to approved program capacity allow for an adjustment to the provider's rate for the time period of the individual's extended medical, hospital or therapeutic leave. This rate adjustment allows an individual to return home, while providing appropriate compensation to the provider. This revision was shared with the work group in March 2017 for review and comment; the response from the work group was favorable.

In addition, medical leave is added to hospital and therapeutic leave under subsection (b).

§ 6100.81—HCBS provider requirements

A provider association notes that a license from the Department of Health is rarely required. Another provider association is reluctant to support the provision for the Department's pre-enrollment training since the training course is unknown. A provider asks the Department to complete a timely review of enrollment documents. A few

county governments ask if a currently sanctioned provider can be enrolled or if a provider with previous sanctions can be enrolled.

Response

In subsection (a), the Department revised the language to clarify that the provider shall meet the qualifications for each HCBS the provider intends to provide. This is a language form change, and not a substantive change.

In subsections (b)(4) and (c), while rare, a health care facility license such as a home health care agency license, may be required. The reference to a particular department is changed to reference the applicable State licensure agency.

The Department's pre-enrollment training program is designed to assure that the applicant is knowledgeable and aware of the provider requirements. The Department's pre-enrollment training program has been utilized since March 2016; providers across Pennsylvania are familiar with this training program.

The Department is committed to performing a timely review; however, applicants are strongly encouraged to submit a full, error-free and complete application package to provide for a timely review and approval process.

In response to the comment asking to clarify whether a currently sanctioned provider can be enrolled or if a provider with previous sanctions can be enrolled, § 6100.81(d) is revised to delete the automatic disenrollment; rather, the Department may deny provider enrollment if the Department has issued a sanction under §§ 6100.741—6100.744. See § 6100.743 (relating to consideration as to type of sanction utilized) for the criteria the Department will use to determine whether provider enrollment will be denied or if other sanctions will be applied.

§ 6100.82—HCBS enrollment documentation (HCBS documentation in proposed rulemaking)

A provider association asks to include the right to a willing and qualified provider and that there is no individual cost limit in Pennsylvania. Another provider association, plus numerous form letters from commentators, ask to combine §§ 6100.81 and 6100.82. A few county governments ask to retitle this section as qualification documentation.

Response

In this section, the term “operate” is corrected to “provide.” The citation in § 6100.82(7) is changed to encompass applicable statutes and regulations. The right to a willing and qualified provider is addressed in § 6100.182 (relating to rights of the individual). The Department did not combine the two sections since shorter and distinct sections are

easier to read. In addition, the Department changed the title of the section to “HCBS enrollment documentation” to accurately reflect the provisions of this section.

The Department did not include language on the lack of an individual cost limit because the cost limit relates to the HCBS waiver application and the comparison of HCBS waiver costs to institutional services. It is a function of the Department’s HCBS waiver application to and approval from the Federal government and not a matter to be regulated by a State requirement.

§ 6100.85—Ongoing HCBS provider qualifications in proposed rulemaking

A provider association, plus numerous form letters from commentators, ask that this section be consistent with State law regarding the applicability and enforcement of departmental policies and procedures through the adoption of regulations and that subsection (b) be consistent with the 5-year waiver renewal. Another provider association, plus numerous form letters from commentators, ask the Department to specify the frequency of the intervals in subsection (b). A few county governments ask that the requirements in subsection (d) apply to all staff persons, including fiscal staff persons, and not just those who come into contact with an individual. An advocacy organization and a few providers ask to clarify the system of award management and to restrict employment and access to any person on this list.

Response

This section is deleted entirely because it is unnecessary to state these requirements in this chapter. The medical assistance provider application process under §§ 1101.41—1101.43 (relating to participation) applies.

§ 6100.85 (§ 6100.86 in proposed rulemaking) —Delivery of HCBS

A provider association, plus numerous form letters from commentators, ask to clarify that this section does not limit a provider's ability to conduct private-pay business and that the provisions apply only to HCBS and base-funding. The same provider association asks if the reference to the individual plan in the proposed subsection (d) refers to the whole plan, including staffing ratios and the frequency and duration of services. Another provider association asks to delete this subsection as unnecessary.

Response

As previously stated, in response to questions about the Department's authority to enforce the Federal waivers through incorporation by reference in the regulation, the Department decided to delete such references throughout Chapter 6100. Therefore, proposed subsection (b) is deleted. In response to the private-pay comment, as stated in § 6100.2 (relating to applicability), this chapter applies to HCBS and base-funding and does not apply to privately-funded programs, services and placements. The

requirement to deliver the services specified in the individual plan in subsection (c) applies to the entire plan.

Subsection (d) (proposed subsection (c)) is necessary for the Department to monitor and enforce that HCBS are delivered in accordance with the service needs authorized in the individual plans and to ensure health and safety protections for individuals.

§§ 2380.37, 2390.40, 6100.141, 6400.50 and 6500.48—Training records (Annual training plan at §§ 2380.37, 2390.40, 6100.141, 6400.50 and 6500.46 in proposed rulemaking)

Several commentators support the latitude given to providers to design their own training plan. Numerous comments from providers and provider associations object to the proposed annual training plan as overly prescriptive. Comments from a university, an individual, a family and a few providers support the requirement for an annual training plan. The IRRC questions the feasibility and reasonableness of the annual training plan and how the plan protects the health, safety and well-being of the individuals who receive services.

Response

The proposed concept of the annual training plan was developed by the work group in response to concerns that mandated training should require a few core courses for all

staff positions, with special topics provided based upon the staff person's job duties and experience. The annual training plan was intended as the provider's self-designed blueprint to plan, organize and deliver comprehensive and purposeful staff training for the upcoming year, while specifying only four core courses related to person-centered practices, incident management, individual rights and abuse prevention and reporting to be provided to all staff. In response to public comments, the proposed requirement for an annual training plan is deleted. The Department encourages providers to assess staff training needs on an annual basis, plan the targeted training courses well in advance of the training dates and acquire or provide the targeted training at appropriate intervals.

With the deletion of the annual training plan, the phrase "related to job skills and knowledge" is added to the annual training requirements at § 6100.143(a) (relating to annual training) to clarify what is counted as part of annual training hours.

§§ 2380.38—2380.39, 2390.48—2390.49, 6100.142—6100.143, 6400.51—6400.52 and 6500.46—6500.47—Orientation and annual training

Numerous comments were received on the topic of orientation and annual training. Public comments on the proposed orientation and annual training requirements vary widely. The IRRC asks the Department to explain how the orientation and annual training requirements relate to all services, provider types and service delivery models, as well as the need for and reasonableness of the training requirements. Several

commentators, including a provider association, plus numerous form letters from commentators, applaud the Department for making the training requirements uniform and compatible across all types of licensed facilities, HCBS funding and base-funding.

A commentator objects to the training and certification requirements as they are cost prohibitive and unrealistic given the amount of industry turnover in direct care staff. The same commentator also states the changes imply a professional level of education and there is no evidence to support these added costs are compensated by the rates.

Several commentators cite an increased cost to provide and attend the training as the reason they object to the orientation and annual training. Several providers ask the Department to develop and offer the core training courses, free of charge. A family group asks that training be provided face-to-face, if possible.

Numerous commentators, including providers, county governments, advocacy organizations, families and individuals, support the applicability of the four core courses across the full range of staff positions, including ancillary positions such as maintenance, clerical, administrative, housekeeping, dietary, management and fiscal staff positions, while numerous providers suggest that the training audience be reduced to only those staff positions that provide direct service to individuals.

Numerous commentators support the requirement to provide training for all consultants, interns, volunteers and household members with no exceptions, while others ask to

exempt all or some consultants, interns, volunteers or household members. An advocacy organization supports the proposed training exemption for natural supports.

Numerous commentators support the four core training courses, while others ask to add or delete a core course. Some suggest requiring training only in abuse prevention or community relationships. Some ask to require training in the individual plan, cultural competency, emergency management, provider billing, Everyday Lives and employment. A family organization and a group of individuals ask to require training in positive interventions as one of the core courses required for all staff.

Several commentators ask to exempt consultants and clinicians who are professionally licensed. The IRRC asks if consultants must complete the required orientation for each provider with whom they contract or if the training is portable.

Numerous commentators support the annual training hours as proposed with 24 hours for direct care staff and 12 hours for ancillary staff. Several commentators applaud the reduction in training hours for the chief executive officer from 24 hours annually as specified in current §§ 2380.36(b), 2390.40(b) and 6400.46(c) (relating to staff training) to 12 hours annually. Several commentators ask for reduced hours for part-time direct service staff. A provider association and numerous form letters from commentators ask that the specification for 8 hours of training in the core courses in the proposed § 6100.143(c) be deleted. A provider asks to reduce the hours in § 6100.143(c) from 8 to 4 hours.

A provider association, plus numerous form letters from commentators, ask to specify how long training records must be kept.

A provider association asks to require no annual training for life sharers and to consider the unintended employer relationship and consequences for Internal Revenue Service implications. The same provider association contends that requiring training for life sharers supports a medical model.

Response

The Department values the discussion and diversity of opinions relating to the mandated minimum orientation and annual training requirements within the HCBS, base-funding and licensing service systems. The Department agrees with the commentators who support the uniform and compatible training requirements across all types of licensed facilities, HCBS funding and base-funding. The uniform training requirements are of great benefit to both providers and individuals. The individual benefits by receiving services from staff who receive consistent training. The provider benefits through the Department's design and offering of universal core courses that encompass all of its staff and by having trained staff who may seamlessly transfer to other services and facilities within its own operations. The training consolidation and uniformity across services will result in reduced training costs as staff may transfer from one service to another within the same provider organization with no added training costs. The core training courses relating to person-centered approaches, rights, abuse

and incidents are portable and as such will transfer from one provider to another, thus reducing training costs for new hires transferring across provider agencies.

Certain training requirements do not apply to special program types, based upon the needs of the individuals who receive services in the specific program. The training requirements that do not apply for an agency with choice include the number of annual training hours in § 6100.143 (relating to annual training), the training course in § 6100.143(c)(5) and the requirements for training in §§ 6100.141—6100.143 (relating to training records, orientation and annual training) for staff persons who work fewer than 30 days in a 12-month period. See § 6100.802(b)(3) (relating to agency with choice). The training requirements in §§ 6100.141—6100.143 do not apply for an organized health care delivery system and vendor goods and services. See §§ 6100.804(b)(2) and 6100.806(b)(5) (relating to organized health care delivery system; and vendor goods and services).

The cost for staff training is included in the fee schedule rates. Further, the final-form regulation does not address or increase the education or certification requirements for direct service professionals.

The Department has developed and will offer online training courses free of charge related to the required core training topics specified in §§ 2380.38—2380.39, 2390.48—2390.49, 6100.142—6100.143, 6400.51—6400.52 and 6500.46—6500.47. While use of the departmental courses is optional, these courses meet the requirements of the regulations, while saving training development costs for providers. The courses

may be provided face-to-face or through online teaching and testing. Many providers will experience no increase in training costs as they already provide incident management, abuse reporting and other value-based training to all staff, including ancillary staff; however, for those providers who do not currently train ancillary staff, the fee schedule rates provide sufficient HCBS reimbursement for the training of all staff positions. The core courses are required for all staff even if a staff person does not interact directly with an individual. For example, ancillary staff may overhear an incident of abuse over the telephone, observe possible theft while reviewing the individual's finances or hear a threat to an individual through an open window while landscaping. The training requirements are reasonable because in the course of employment a staff person serving in any position may encounter an individual who receives services; the staff person must understand how to interact appropriately with the individual. While a staff person may not have direct contact with an individual, the staff person requires a basic level of training on the required topics, since the staff person may be in a position of decision-making or implementation related to the physical location where services are delivered or about the financial or administrative polices or procedures.

As specified in §§ 2380.39, 2390.49, 6100.143, 6400.52 and 6500.47, annual training can be provided on the job as part of the staff person's scheduled work day, through supervisory conferences, staff meetings or training provided for individuals and staff persons at the same time. For an ancillary position, an average of 1 hour of training must be provided each month, which can be provided on the job. For instance, an office staff person may complete an online course on the agency's new word processing

software, a fiscal staff person may complete an online course on the agency's required accounting methods, a maintenance staff person may be taught the OSHA rules for safe use of a new lawn care machine by a supervisor or a dietary staff person may watch and learn new cooking techniques or recipes from a televised cooking show. Staff in all positions and at all experience levels benefit from learning about their specific jobs as well as about the services provided to the individuals by the provider agency. These requirements adequately protect the public health and safety by providing the core training elements for the provision of services within the HCBS system and allowing the provider to customize the training content to specifically address the needs of the individuals who receive services and the staff person's specific job duties.

Based on public comments, two courses have been added in § 6100.143(c)(5) and (6), and in the related four licensing chapters, as core courses required as part of annual training for direct service positions. All staff who work directly with individuals must complete training on the safe and appropriate use of behavior supports, as well as the implementation of the individual plan for the individuals for whom services are provided. Basic competency relating to the appropriate use of behavior supports by direct service professionals is critical to protect the health and safety of the individuals with an intellectual disability or autism across all service types, provider types and service delivery methods. All individuals who receive services have an individual plan that identifies the need for services and supports, the services and supports to be provided and the expected outcomes. Each direct service professional must be familiar with the individual plan for the individual for whom they provide services. Requiring annual

training ensures that each direct service professional receives at least the minimum level of training on the updates and revisions to the individual plan.

In response to recommendations by the work group, ancillary staff who are employed or contracted by a building owner who is not the provider are exempt from training. In response to comments and recommendations by the work group, consultants who provide an HCBS for fewer than 30 days within a 12-month period and who are professionally licensed, registered or certified in the health care or social services fields by the Department of State are exempt from training. Training hours completed by licensed, registered or certified health care or social service professionals as part of their license, registration or certificate requirements count toward their annual training. Household members who do not provide a reimbursed service are exempt from training.

A volunteer who works alone with individuals must complete the training; however, “volunteer” is defined as a person who does not receive compensation, but who provides a service through an organization or provider that recruits, plans and organizes duties and assignments. A volunteer is an organized and scheduled component of the service and support system. A volunteer does not include a person who provides intermittent and ancillary assistance, such as sweeping the floors or playing the piano. A volunteer does not include an individual’s friends or relatives, unless they work as part of an organized volunteer program. This new definition will exclude the occasional and unplanned assistance from a community member who wishes to contribute occasional and unscheduled time. Volunteers who are never alone with individuals do not require

training since they do not have the responsibility to report abuse or incidents, and they will be under the watchful eye of trained staff.

In response to public comments, the requirement in §§ 2380.39, 2390.49, 6100.143, 6400.52 and 6500.47 for 8 hours of the annual training hours to be provided in the core courses is deleted. While all staff must complete training in the core areas annually, the provider may determine the scope and length of the training necessary based upon the staff position and the staff experience level. For example, a direct care professional who has been employed for 2 years may complete 2 hours on abuse prevention and reporting, while a fiscal staff person may complete only 15 minutes on the same subject. The provider may tailor and adapt the core training topics to the needs of each staff position.

Proposed § 6100.144 (relating to natural supports) is deleted. This chapter does not apply to persons who provide a support, defined as an unpaid activity or assistance provided to an individual that is not planned or arranged by a provider.

In response to the question about the length of record retention, see § 6100.54 (relating to recordkeeping) that requires records to be kept for 4 years from the fiscal year end, until audits and litigation are resolved and in accordance with Federal and State statutes and regulations; this section applies to all records of the provider, including training records.

Annual training is critical for life sharers who provide service in an occasionally isolated setting with little day-to-day oversight. The life sharer must know the duties to report abuse and incidents, as well as person-centered approaches and individual rights. Further, none of the required training areas are health-care related. The training requirements may be factored into contracts with life sharers.

The specific reference to “household members” is deleted since household members are direct service professionals if they provide an HCBS.

§§ 2380.21, 2390.21, 6100.181, 6400.31 and 6500.31—Individual rights; Client rights; Exercise of rights

A group of individuals, a family organization and a county government applaud the expansion of rights and the alignment with the CMS regulation in 42 CFR §§ 441.300—441.310 and fully support the rights as proposed. A group of individuals ask to add the right to free assembly, the right to complain and the right to seek help from the government. An advocacy organization and a family support the clarification on guardianship. A university and a provider association ask to require the provider to inform individuals about how and to whom to report a violation of rights.
A provider association asks to delete the word “continually” in proposed subsection (b) as it is subjective.

A provider association asks not to duplicate the civil rights survey process completed under licensing.

A county government asks to require a mediation process if there is disagreement between a legal guardian and the provider. A provider asks to delete proposed subsections (e) and (f) since all court orders must be followed. An advocacy organization offers an extensive rewrite of proposed subsections (e)-(g) to clarify the role of the provider to obtain a court order to limit the guardian's participation and to request the guardian to honor the individual's wishes to the greatest extent possible.

Response

The right of an individual to complain is addressed in § 6100.51 (relating to complaints by an individual), which affirms the right to file a complaint and also provides a clear process regarding the filing of complaints. While the right to free assembly and to seek help from the government are essential rights, these rights are not specific to the individuals who receive services in HCBS and require no procedural standards. These rights are afforded to the general public and therefore, are not necessary to specify in the Department's regulations.

In response to comments, proposed subsection (b) is deleted; the requirement to educate, assist and provide the accommodations necessary is added to the new subsection (b); and the conditions of guardianship are clarified in subsection (e).

Subsection (e) is retained to provide clarity that court orders must be followed and take precedence over the regulatory requirements regarding the exercise of rights. Subsection (f) is retained for the Department to monitor whether providers are allowing legal guardians to exercise their rights with respect to assisting individuals.

With respect to the request for required mediation, the Department believes that the established processes for individual complaints and the individual planning processes are sufficient safeguards to deal with disputes between a legal guardian and a provider.

No changes will occur relating to the Department's civil rights survey that occurs as part of the licensing application process. While the Department's civil rights survey gathers broad-based compliance data, the on-site licensing inspection measures compliance with civil rights practice as specified in § 6100.182(a) and (b) (relating to rights of the individual).

§§ 2380.21, 2390.21, 6100.182, 6400.32 and 6500.32—Individual rights; Client rights; Rights of the individual

A university and a county government support this section as proposed. A provider association, plus numerous form letters from commentators, and a provider state that subsection (d) regarding dignity and respect is too vague. A family organization asks to add the following to the list of rights: human rights, communication in one's native language, pursuit of romantic relationships, marry the person of choice, have children

and seek employment to support themselves. An advocacy organization asks to add the right to auxiliary aids and services. A provider organization asks to add the right to be educated about choices and consequences. A provider association asks to clarify in subsection (e) that the individual's choice may not jeopardize another person's health and safety and a few providers and a family ask how the individual plan section applies to this right.

A provider association, plus numerous form letters from commentators, and a provider ask for health and safety exceptions regarding subsections (f), (g), (h) and (i).

Several commentators ask how subsection (g) regarding the individual's control over his own schedule aligns with the Federal waiver provision regarding the community integration percentage. The IRRC asks how subsection (g) aligns with the Department's proposed plan for services to be in the community 75% of the time and the feasibility of this proposed requirement. A provider association, plus numerous form letters from commentators, agree in concept with subsection (g), but question how it will be applied given the staffing costs.

A university asks to add the right for the individual to lead the development of the individual plan in subsection (n).

Response

In response to the comment regarding the vagueness of subsection (d), requiring that the individual be treated with dignity and respect, the Department has effectively administered this regulatory provision in various departmental licensing regulatory chapters since 1999. See §§ 3800.32(c), 2600.42 (c) and 2800.42(c) (relating to specific rights). The words "dignity and respect" are intrinsic to the protections of the health, safety and human rights of the individuals. Dignity and respect are essential factors in how an individual is addressed, how services are provided and how the individual's possessions are managed. In accordance with the Pennsylvania Code and Bulletin Style Manual, Fifth Edition, § 2.11 (relating to definition section), a word used in its dictionary meaning may not be defined. This chapter intends no special meaning of the terms "dignity" and "respect." The Merriam-Webster dictionary defines "dignity" as "the quality or state of being worthy, honored, or esteemed." The Merriam-Webster dictionary defines "respect" as "high or special regard." See *Merriam-Webster.com.* Merriam-Webster, n.d. Web. 29 June 2017.

While the additional rights suggested are valued and important rights, these rights fall under "legal and civil rights" afforded to all citizens as stated in § 6100.182(b). Therefore, the Department did not add additional specific rights.

Subsection (e), regarding the right to make choices, is applied in accordance with § 6100.184(a)-(c) (relating to negotiation of choices), which provides for a procedure to negotiate and resolve differences between individuals.

Subsections (f), (g), (h) and (i) are applied through the modification of rights in accordance with §§ 6100.184(c), 6100.223(9), 6400.33, 6400.185(6), 6500.33 and 6500.155(6) that address the modification of rights by the individual plan team if there is a significant health and safety risk to the individual or others. A new paragraph is added under § 6100.184(c) to address the modification of rights through the individual plan process.

Subsection (g) provides the right for the individual to control the individual's own schedule and activities. This includes the right to choose to attend day programs and employment of the individual's choice. The individual's rights and choices are paramount and take top priority when making plans for services. Subsection (g) is applied in accordance with § 6100.184(a), based upon the individual's choices, staffing and the choices of the group living in the home.

The provision referenced by the IRRC about services provided in the community 75% of the time is not in the proposed rulemaking. There is no integration percentage mandated in this regulation. The proposed Federal waiver provisions included a plan for community integration, which has since been amended based on public comment. The community integration Federal waiver requirement has been reduced from the

proposed 75% community integration level to a 25% community integration level. The approved Federal waiver provides that 25% of an individual's services, on an average monthly basis, must be provided outside the licensed facility, effective July 1, 2019. Further, the waiver permits a variance if the individual chooses to spend less time in the community after having been provided with opportunities for community integration.

Subsection (o) is added to align with current §§ 2380.176, 2390.126, 6400.216 and 6500.185.

In response to the comment related to subsection (n), the individual directs the individual plan team in accordance with § 6100.222(a) (relating to the individual plan process).

§§ 6100.183, 6400.32 and 6500.32—Additional rights of the individual in a residential service location; rights of the individual

Regarding § 6100.183(a), the IRRC, a few provider associations, plus numerous form letters from commentators and several providers, ask what happens and who is liable if someone is injured or abused by a visitor and how this regulation protects the health, safety and well-being of the individuals. A provider association and several providers ask to remove the phrase "at any time" as it relates to a visitor. A provider association asks that an individual's rights cannot conflict with the rights of others. A provider supports the rights as proposed and suggests that visitation risks be addressed through

the individual planning process. A commentator asks that life sharing be able to set its own family visitation rules. A county government is concerned for vulnerable individuals where there is a reason to suspect that the implementation of rights may be manipulated by the provider. A university supports the residential rights as proposed and suggests that many of the rights in this subsection should be expanded to include day programs.

Regarding § 6100.183(c), a few county governments ask to mandate the right to internet access.

Regarding § 6100.183(d), the IRRC and a provider association, plus numerous form letters from commentators, ask how the right to manage one's own finances is implemented if the individual has a representative payee.

Regarding § 6100.183(e), a family emphasizes that the right to choose with whom to share a bedroom is required by CMS. A provider asks to add the phrase "whenever possible." Another provider asks to remove this right because of the possibility that the individual may change the individual's mind.

A provider asks to assure funding for compliance with § 6100.183(f). A group of commentators support the right of the individuals to decorate their own homes, as some homes look like they were professionally decorated and not where people live. A

county government asks that exercising this right not infringe on the rights of other individuals, such as hanging an offensive poster in the common living area.

The IRRC, numerous provider associations, form letters and providers express concern that § 6100.183(g), which permits the locking of a bedroom door, may create a health and safety risk by restricting staff access in the event of a fire or other emergency. Several providers ask that this right be applied based on an assessment of the individual's medical, intellectual and physical care needs. Several providers ask to require staff to knock before entering a bedroom, but not allow the locking of bedroom doors. A county government and a group of commentators support the right to lock one's own bedroom door to provide for privacy and since this is the individual's own home.

Regarding § 6100.183(i) ((h) in proposed rulemaking), a provider association, plus numerous form letters from commentators and numerous providers, ask how the needs of individuals with Prader Willi syndrome, special diets and allergies will be addressed.

Regarding § 6100.183(j) ((i) in proposed rulemaking), a provider association and a few providers ask that the right to make informed health care decisions apply only if the individual has the cognitive ability to understand the consequences of not following a doctor's orders.

Response

Subsection (a) remains unchanged, with the exception of a minor change to insert clarifying language. The provider is responsible to assure the health, safety and well-being of all individuals; this requires a careful balance of providing freedom of choice, while still protecting the individual and others. The right to receive scheduled and unscheduled visitors has been in place in residential licensing regulations for more than 2 decades. See current §§ 6400.33(g) and 6500.33(g) (relating to rights of the individual). This is a fundamental right of adults in residential living. The application of this regulation for children is governed by § 6100.56 (relating to children's services). Sections 6100.184, 6100.223(9), 6400.33, 6400.185(6), 6500.33, 6500.155(6) address the modification of rights by the individual plan team if there is a significant health and safety risk to the individual or others. This right applies equally for life sharing homes. The individual plan team includes the individual, persons designated by the individual and the support coordinator to assure that the individual's rights are protected. The rights in subsection (a) are not extended to day programs since these rights relate to residential services.

In response to IRRC's comment regarding provider liability, an individual has the right to make choices and accept risks in accordance with § 6100.182(e) (relating to rights of the individual). The provider is responsible to assess and implement services in a manner that mitigates risks as described in § 6100.222 (relating to individual plan process), § 6100.223 (relating to content of the individual plan) and § 6100.403 (relating to individual needs). In § 6100.184 (relating to negotiation of choices), § 6100.223 and

§ 6100.345 (relating to behavior support component of the individual plan), situations in which individual rights will require modification to assure health and safety are addressed. Provider liability is evaluated by the provider's adherence to the regulation governing rights and risk mitigation and whether the provider conducted due diligence in developing and implementing risk mitigation strategies.

The final-form regulation protects the public health, safety and well-being, while balancing the rights of the individual to enjoy the same liberties as all Pennsylvania citizens, through the enactment of requirements, including risk management strategies and rights modifications as necessary for the individual's health and safety protection, individual planning, restrictive procedures and behavior support planning and incident reporting and investigation aimed at preventing recurrence. See §§ 6100.182, 6100.222, 6100.223, 6100.345 and 6100.403.

In the event that an individual is abused or injured by a visitor, the procedures for incident reporting and follow-up as specified in §§ 6100.401—6100.405 are required to be followed, including creating a plan to prevent recurrence of the event that may involve restricting the perpetrator's access to the individual. Current regulatory requirements at § 6400.33(g) protect an individual's right to receive scheduled and unscheduled visitors, communicate, associate and meet privately with family and persons of the individual's own choice. The final-form regulation does not create new risks for individuals who receive residential services.

While the right to internet access is not specifically addressed, internet access is included in the term “telecommunications” in subsection (c). Subsection (b) is revised to allow an individual to share the individual’s contact information with others at the individual’s own choosing.

Regarding subsection (d), if there is a representative payee, the representative payee makes financial decisions on behalf of the individual. An individual’s right to manage finances is not absolute where a representative payee is involved in managing finances. In fulfilling these responsibilities, it is expected that the representative payee will take into consideration the individual’s wishes, preferences and choices.

No change is made to subsection (e) regarding the sharing of a bedroom. If an individual changes the individual’s mind about the individual’s choice of a roommate, or for no roommate, the provider must honor the individual’s choice. An individual may not be forced to share a room with someone with whom the individual does not wish to share a room. Individual rights are intrinsic to the provision of services and factored into the fee schedule rates.

No change is made to subsection (f) regarding the right to refuse services. Individuals may decorate their own bedrooms and homes at their own expense. Sections 6100.184, 6400.33 and 6500.33 (relating to negotiation of choices) address disagreements regarding décor in the common areas of the home.

Subsection (g) requires the right to privacy in the individual's bedroom by locking the door. This provision aligns with the Federal regulation regarding privacy in sleeping units. See 42 CFR § 441.301(c)(4)(vi)(B) (relating to contents of request for a waiver). The Department appreciates the concern to keep an individual safe regarding the locking of a bedroom door in subsection (g). Proposed § 6100.443 (relating to access to the bedroom and the home) is deleted and the substantive provisions are placed in §§ 6100.183(g) and (h), 6400.32(r) and (s) and 6500.32(r) and (s) to implement the right to lock one's own bedroom door and have a key to one's home. The regulation is reworded as the right to lock one's door, rather than the condition that each door have a lock as proposed in § 6100.443. While this language change is a subtle difference, this change creates a right and choice for an individual, rather than a necessary physical site provision for all individuals. This right may be modified in accordance with §§ 6100.184, 6100.223(9), 6100.345(d) and related sections of Chapters 6400 and 6500, that address the modification of rights by the individual plan team if there is a significant health and safety risk to the individual or others. The ability to modify this right allows each individual circumstance to be taken into consideration, including the need to protect the health, safety and well-being of individuals.

Individual's privacy rights need to be respected. The provisions in subsection (g)(2) permitting access to the individual's room in the event of an emergency, and in subsection (g)(3) requiring assistive technology to enable the individual to unlock the individual's own door, protect the health, safety and well-being of the individual by

permitting emergency egress. See the discussion of the public comments in response to § 6100.443—Access to the bedroom and the home in proposed rulemaking.

Regarding the right to access food under subsection (i) ((h) in proposed rulemaking), the needs of an individual who has Prader Willi syndrome, a life sustaining special diet or a life threatening allergy are addressed through the modification of rights in accordance with §§ 6100.184, 6100.223(9), 6400.33, 6400.185(6), 6500.33, 6500.155(6). These sections address the modification of rights by the individual plan team if there is a significant health and safety risk to the individual or others. Rights may be modified only if the medical condition creates a significant and immediate health and safety risk and not for a physician recommended diet such as weight loss or sugar intake. An adult individual has the right, as any other adult without an intellectual disability or autism, to choose not to lose weight, to eat foods that are unhealthy and to eat foods to which the individual is allergic, provided such action does not jeopardize the individual's immediate life safety.

Regarding the right to make informed health care decisions under subsection (j) ((i) in proposed rulemaking), the term "informed" is removed from the final-form regulation, since an individual may make the individual's own health care decisions, unless a court has appointed a legal guardian to make health care decisions on behalf of the individual.

§§ 2380.21, 2390.21, 6100.184, 6400.33 and 6500.33—Individual rights; Client rights; Negotiation of choices

A group of individuals, a few county governments, a few provider associations, plus numerous form letters from commentators, and a few providers support this section as proposed. A university asks that these provisions not permit a loophole for providers to abide by the group's rights to override an individual's rights. A provider and a family ask to explain how the rights section relates to the individual plan section on modification of rights. A group of individuals asks the Department to provide training on this topic. A county government association offers to provide training on the balancing and protection of individual rights. A provider states that rights are not one-size-fits-all and even the freest of men have limits on rights and choices. A provider asks to address the right to take risks. A provider asks not to overstate that rights cannot be violated as this is not true, citing an individual who has Prader Willi syndrome and a medical dietary restriction. A few providers ask to mandate that the support coordinator be involved in the negotiation of choices. A few providers ask to mandate that the individual plan team be involved in the negotiation of an individual's choices. The IRRC and a provider association, plus numerous form letters from commentators, ask the Department to clarify what happens when negotiations fail, who makes the ultimate decision and how regulatory compliance is to be documented.

Response

In response to comments, subsection (c) is added to explain how this section relates to § 6100.223(9) (relating to content of the individual plan). An individual's rights may be modified by the individual plan team only to the extent necessary to mitigate significant health and safety risks to the individual or others. The Department will work with the county government association to provide training to support the balance of rights for all individuals.

The provider has the responsibility to apply subsection (b). The provider develops a procedure to manage the negotiation process, including what happens if negotiations fail. The provider's procedures will determine if and how the support coordinator and the individual plan team will be involved. If there is an unresolved issue at the provider level, the provider may specify in its procedures how issues are resolved. For example, the procedures could specify that an agreement has been reached with the county mental health and intellectual disability and autism office for the county office to serve as the arbitrator, that counsel may be sought from another independent source or that consultation with the various individual plan teams or the support coordinators will occur to resolve the matter. The responsibility to protect the rights of all individuals lies with the provider.

Documentation of the individual plan revisions and notes from the various individual plan meetings and negotiations are required under § 6100.225 (relating to base-funding

support coordination, base-funding and TSM) and will be reviewed to assess regulatory compliance. Interviews with staff persons and individuals may also occur to measure regulatory compliance.

§§ 2380.21, 2390.21, 6100.185, 6400.34 and 6500.34—Individual rights; Client rights; Informing of rights

The IRRC asks if the Department considered requiring providers to inform the individual about how to report when rights are being violated. A group of individuals asks to require notice of rights to be provided monthly, rather than annually.

Response

The requested change to require providers to inform the individual about how to report a rights violation is added at § 6100.185(a). The Department supports the principle that explaining and applying rights is an everyday activity, rather than a formality that occurs once a year; however, the prescribed regulatory mandate remains on an annual basis because it is reasonable for it to occur during the individual plan team meeting.

§ 6100.186—Facilitating personal relationships

The IRRC, a provider association, plus numerous form letters from commentators, and several other commentators are concerned that the proposed language implies that the

provider must make all accommodations without acknowledgement of feasibility, reasonableness or economic impact, without addressing what is necessary or when it is necessary. A provider association asks to clarify the family's role in decision-making. Another provider association asks to omit this section as there is too much variance in family dynamics. A provider association and numerous form letters from commentators ask that the nature of family involvement be determined at the individual plan meeting; a provider specifically disagrees with the same provider association and supports the section as proposed. An advocacy organization suggests that this requirement is more appropriate for residential settings. An advocacy organization states that although family involvement is generally a good idea, some individuals do not wish their families be involved; it is important to maintain the designation by the individual as used throughout the proposed rulemaking. A family association acknowledges that while there are some unhealthy family relationships, the core involvement of family should not be threatened by these few unhealthy relationships.

Response

Multiple revisions are made to this section relating to accommodations for visits and activities. Subsections (a) and (b), as amended, are reasonable and feasible requirements for the provider to incorporate into its daily routines and operations and will not result in additional costs beyond the services and activities factored into the fee schedule rates. As amended, subsection (a) requires providers to facilitate and make accommodations to assist an individual. There is no requirement to meet all of a

family's demands or special requests, but rather to facilitate and make accommodations to assist the individual to visit with and participate in activities with family or friends. This may mean holding a meeting at a time convenient to the family such as after work hours, inviting the family well in advance of a special holiday party, providing private space for a family visit or helping the individual to make travel plans to visit a friend. Providing accommodations for an individual to spend time with those the individual cares about will provide for a better quality of life, improved independence with reduced reliance on formal HCBS and productive outcomes for daily living.

Subsection (c) is added to clarify that the provider should presume family involvement unless the individual indicates otherwise. The individual's preferences to involve, or not to involve, family must be honored for each activity and for each incidence of potential involvement. The choice to involve, or not to involve, family remains with the individual. This section allows sufficient discretion to honor choices and to address the differences in family dynamics. The individual plan process is one avenue to address significant family involvement issues, but each incident of facilitating relationships is not required to be addressed through the formal individual plan process. While more prevalent in a residential setting, the issue of facilitating relationships applies to both residential and non-residential settings.

§§ 2380.182, 2390.152, 6100.221, 6400.182 and 6500.152—Development, annual update and revision of the individual plan; Development of the individual plan

The IRRC and a provider association, plus numerous form letters from commentators, ask to define the terms "service implementation plan," "support coordinator" and "targeted support coordinator." Several commentators applaud the person-centered planning focus. A family association and a university support the proposed term "individual support plan." A county government asks to add futures planning and to focus on the person rather than the planning process. A provider association, plus numerous form letters from commentators, a family association, a family and a provider support the requirement for one approved and authorized plan.

Response

The term "service implementation plan" is revised to clarify that this is a provider's implementation plan. This term is defined and explained in § 6100.221(g). This term is not used in Chapters 2380, 2390, 6400 or 6500; therefore, no definition is necessary in these chapters.

The terms "support coordination" and "targeted support management" are defined in § 6100.803(a) and (b) (relating to support coordination, targeted support management and base-funding support coordination). These terms are not used in Chapters 2380, 2390, 6400 or 6500; therefore, no definitions are necessary in these chapters.

Clarification is added that this section applies to base-funding support coordinators.

The term for “plan” has evolved over the years. In the early 1990s, the term “individual program plan” was used. In the early 2010s, the term was changed to “individual service plan.” The proposed rulemaking uses the term “individual support plan” to reflect the supportive nature of the services. The term “individual plan” is used in the final-form regulation to keep the language simple and in plain English. Because the regulation term is only two words, the acronym is no longer used. “Individual plan” is defined in § 6100.3 (relating to definitions).

§ 6100.221(c) (§§ 6100.221(d), 6100.221(e) and 6100.221(f) in proposed rulemaking)—Development of individual plan

The IRRC and several commentators ask why there is no timeline for completion of an assessment in Chapter 6100, what areas are required in the assessment and who is responsible for competing the assessment. The IRRC asks to address the economic and fiscal impact on the regulated community.

The IRRC and several commentators ask why the provision in § 6100.221(c) ((d) in proposed rulemaking), regarding the development of the individual plan prior to the individual receiving a reimbursed service, appears to be inconsistent with the provisions relating to the timing of the individual plan completion in Chapters 2380, 2390, 6400 and 6500.

Response

Assessments are not regulated in Chapter 6100 since the provider is not responsible for completing the assessment. Assessments are completed by an outside agency under contract with the Department. There is no economic or fiscal impact on the regulated community related to completion of an assessment.

The differences in the requirements for the timing of the individual plan completion between the five chapters is based on the varying governing laws and the scope of the chapters. Chapter 6100 governs HCBS for which Federal funding is received, and thus, the Federal regulations apply, including the need for a plan prior to the provision of services. See 42 CFR § 441.301(c)(2)(ix) (relating to contents of request for a waiver). The licensing regulations, including Chapters 2380, 2390, 6400, and 6500, govern licensed facilities that may or may not receive Federal funding; therefore, the timing of the individual plan completion differs. Based on public comment, the timing of the individual plan completion for the four licensing chapters is revised to reconcile the timing of the assessment and the individual plan. See the discussion under §§ 2380.182, 2390.152, 6400.182 and 6500.152.

§§ 2380.182, 2390.152, 6400.182 and 6500.152—Development, annual update and revision of the individual plan

Several commentators ask to clarify the proposed contradictory timelines for completing the assessment and individual plan in the four chapters of licensing regulations.

Response

Since the assessment must be completed within 60 days of admission in the four licensing chapters, the timeline for completing the individual plan is revised from 60 days to 90 days in subsection (b) to allow 30 days following the completion of the assessment to complete the individual plan.

§§ 2380.182, 2390.152, 6100.221(d), 6400.182 and 6500.152 (§ 6100.221(e) in proposed rulemaking)—Development, annual update and revision of the individual plan; development of the individual plan

The IRRC and an advocacy organization ask that the individual plan be revised annually.

Response

The individual plan must be revised annually; however, since this is a requirement for the support coordinator, this requirement is located in § 6100.225(a) (relating to support coordination, base-funding support coordination and TSM). In addition to the requirement to revise the individual plan annually, § 6100.221(d) requires that the individual plan be revised when an individual's needs or service system changes and upon the request of an individual.

§§ 2380.182, 2390.152, 6100.221(e), 6400.182 and 6500.152 (§ 6100.221(f) in proposed rulemaking)—Development, annual update and revision of the individual plan; Development of individual plan

A provider association, plus numerous form letters from commentators, ask to delete this subsection regarding the need for the individual plan to be based on a current assessment. No reason is given for this proposed deletion.

Response

No change is made since this subsection is needed to assure that the individual plan is developed based on current and relevant historical and clinical data.

§§ 2380.182, 2390.152, 6100.221, 6400.182 and 6500.152 (§ 6100.221(h) in proposed rulemaking)—Development, annual update and revision of the individual plan; development of the individual plan

A provider asks to use its own form. Another provider asks to be permitted to request an update to the plan.

Response

The proposed subsection (h) that required an individual plan to be documented on a form specified by the Department is deleted as it is unnecessary.

§ 2390.153(b)—Individual plan team

The IRRC and several commentators ask why a minimum of three persons must attend the team meeting.

Response

The team described in subsection (a) includes approximately seven members representing various disciplines. Requiring a minimum of three team members who are involved in the individual's services or who are knowledgeable about the individual's

needs is reasonable and necessary to develop an individual plan that is meaningful. This requirement has been codified in Chapter 2390 since 2010. See 40 Pa.B. 4935; § 2390.154(b) (relating to plan team participation).

§§ 2380.184, 2390.154, 6100.222, 6400.184 and 6500.154—Individual plan process

A provider association and a provider ask to explain "directed by the individual" in subsection (a). A provider association, plus numerous form letters from commentators, ask to remove "maximum" in subsection (b)(4). The IRRC and several commentators ask the Department to explain who is responsible for the individual plan process, how providers will demonstrate compliance with subsection (b)(5) and which guidelines are referenced in subsection (b)(9). A university supports subsection (b)(7) regarding communication in a clear and understandable language. An advocacy organization asks to delete subsection (b)(8), (9) and (10) since the provisions are best practice and non-regulatory. A provider supports the inclusion of subsection (b)(8) relating to cultural considerations. An advocacy organization asks to clarify that if there is a disagreement between the individual and the support coordinator, the support coordinator must provide the service as requested or issue a formal denial with a right of appeal. The same advocacy organization asks to add that the individual need not sign the individual plan until the individual is satisfied with the plan. An advocacy organization asks to require the provision of auxiliary aids and services to ensure effective communication.

Response

Subsection (a) is revised to clarify that the individual directs the plan to the extent possible and as desired by the individual.

Subsection (b)(2), (3) and (4) is clarified to use active voice and to reflect changes in other sections of the final-form regulation relating to persons designated by the individual.

The term “maximum” is deleted from subsection (b)(4).

The support coordinator is responsible to plan, schedule and direct the individual plan process as specified in § 6100.225 (relating to support coordination, base-funding support coordination and TSM).

Compliance with subsection (b)(5) will be measured by interviewing the individual and other individual plan members. No paper documentation is necessary. The proposed term “informed” is deleted because it is unnecessary.

The guidelines in subsection (b)(9) are the support coordination agency’s procedures to resolve disagreements.

Subsection (b)(8), (9) and (10) is retained as appropriate individual protections; however, (b)(11) is deleted as unnecessary.

An individual maintains the right to appeal the individual plan in accordance with 55 Pa. Code § 275.1 (relating to policy), whether the individual signs or does not sign the individual plan.

§§ 2380.185, 2390.155, 6100.223, 6400.185 and 6500.155—Content of the individual plan

Several county governments, a county association, a family organization and an advocacy organization ask to reduce the length of the individual plan, relocating many of the requirements to a record section. A group of individuals and a university support the full comprehensive individual plan. A provider association, plus numerous form letters from commentators, state that the individual plan content is rigid and conflicts with the Everyday Lives goal of simplifying the plan. Commentators ask to add to the content the following items: assessment for self-administration of medications, family relationship map, family medical history, the individual's lifetime medical history, medical diagnoses, management of personal funds, need for behavior support and housing goals. Commentators ask to delete proposed paragraphs (10), (11), (12), (14), (15), (16), (17), (18), (19) and (21). The IRRC and several commentators ask to clarify how proposed paragraph (11) supports the concept of person-centered planning. Several commentators request that employment not be required for all individuals, particularly

seniors and children. The IRRC, a university and a provider association, plus numerous form letters from commentators, ask to delete or explain the reasonableness and need for proposed paragraph (17). The work group, several providers and an advocacy organization ask to address and permit electronic signatures in paragraph (21). Several commentators ask to reorder the paragraphs.

Response

Many changes are made to this section to reduce the volume and complexity of the individual plan and relocate multiple items, such as health care information, choice of provider and financial information in proposed paragraphs (15), (16) and (18) to § 6100.225(c) (relating to support coordination, base-funding support coordination and TSM). No new items are added to the content of the plan because they are unnecessary.

In response to the comment on the individual plan content being rigid and conflicting with the Everyday Lives goal, the Department believes the content areas identified in the regulation provide necessary information to establish preferences, desired outcomes and necessary services and supports for necessary health and safety protections for individuals.

The requirement relating to employment in § 6100.223(7) (§ 6100.223(11) in proposed rulemaking), is revised to apply only to those individuals of employment age, to exclude

children and seniors who do not wish to work. The terms “active pursuit of” is also deleted from this paragraph; however, “competitive integrated employment as a first priority” is maintained because the requirement supports the concept of person-centered approaches by providing opportunities for each individual to be employed in an integrated work environment, based on the aptitudes, needs and choices of the individual. The content of the individual plan also is reduced for the four licensing chapters because some of the facilities licensed under Chapters 2380, 2390, 6400 and 6500 are not funded through the ODP service system and some licensed facilities do not provide services to individuals with an intellectual disability or autism.

Proposed paragraph (20) regarding the person responsible to monitor the plan is deleted as unnecessary. The signatures in proposed paragraph (21) are no longer required on the individual plan; rather, the list of persons who attended the plan meeting are documented in the record in § 6100.225(c).

Paragraphs (8) and (9) ((13) and (14) in proposed rulemaking) are revised to coincide with changes made to § 6100.184(c) (relating to negotiation of choices) and § 6100.348 (relating to physical restraint).

§ 6100.225—Support coordination, base-funding support coordination and TSM

A provider association, plus numerous form letters from commentators, express appreciation for the removal of the individual plan timelines specified in the current

regulations. A few county governments ask to add that the support coordinator must monitor individual services at the frequency required by the Department.

Response

No substantive change is made. The frequency of support coordination monitoring is not governed by this chapter; rather, the frequency of support coordination monitoring is addressed in the Federal waivers.

Subsection (c) is added to address individual record requirements moved from the content of the individual plan in § 6100.223 (relating to content of the individual plan).

No additions are made to Chapters 2380, 2390, 6400 and 6500 since individual record requirements are adequately addressed in §§ 2380.173, 2390.124, 6400.213 and 6500.182.

§ 6100.226—Documentation of claims

The IRRC and numerous commentators ask to simplify, clarify and reduce the paperwork required to document a medical assistance claim for service delivery. A provider association asks for a standard claim form. The IRRC and numerous commentators ask if documentation is required each time a service is delivered, including whether documentation relates to amount, frequency and duration or to units.

Several providers state that daily documentation disrupts services. The IRRC asks how this section applies to group living.

A provider association, plus numerous form letters from commentators and a few other providers, ask to delete subsections (c), (d), (e) and (f) as unnecessary and overly prescriptive.

In proposed subsection (f), the IRRC asks to clarify from what date the 3-month review is determined. Several commentators ask to explain the difference between a claim and a progress note. A few county governments ask to require monthly progress notes. An advocacy organization and a few providers support 3-month progress notes.

Response

This section applies to residential services (commonly referred to as group living) as well as day program services.

Section 6100.226 is substantially revised and a new § 6100.227 (relating to progress notes) is added to address the public comments. The question about whether documentation is required each time a service is delivered, including whether the documentation relates to the amount, frequency and duration or to units is addressed in § 6100.226 (relating to documentation of claims). In response to comments received, the Department added § 6100.226(b)(1)-(3) that specifies how to document a claim.

The Department standardized the documentation required to submit an HCBS claim. As requested by commentators, § 6100.226 distinguishes claim documentation from progress notes in § 6100.227. Section 6100.227(a) addresses the question about the date from which the 3-month review begins; the 3-month review begins on the date of the initial claim related to the individual.

§ 6100.261—Access to the community

The IRRC notes that the term “ongoing” in subsection (b) is subjective and asks that the Department define or delete the term. In subsection (c), the IRRC and a provider association, plus numerous form letters from commentators, ask how providers will determine the degree of community access and what standards the regulated community is expected to meet.

Response

Proposed subsections (b) and (c) are deleted as unnecessary.

§ 6100.262—Employment

A provider association, plus numerous form letters from commentators, ask to delete subsection (a) and the reference to the individual plan in subsection (c) and and supports coordinator responsibilities in subsection (d). A few advocacy organizations, a

provider and a provider association ask to exempt seniors and children from the work requirements. A university supports this requirement for employment first. An advocacy organization and a provider association ask to delete subsection (b) as this causes unnecessary delays. Other commentators suggest that the regulation should permit the right not to work, require that the individual be given information about employment, require that employment be specified in the individual plan and require the support coordinator to provide information regarding the Office of Vocational Rehabilitation.

Response

Subsection (a) is clarified to provide information about employment options that are appropriate to the individual to address the concerns regarding seniors and children who are not of employment age. Proposed subsections (b), (c) and (d) are deleted. To further clarify, a definition of “competitive integrated employment” is added.

§ 6100.263—Education in proposed rulemaking

A few commentators ask to explain the financial limits to provide this service, clarify what is meant by life-long learning, clarify who is responsible to provide these services, require access to education regardless of whether an individual has a high school diploma and provide information about education opportunities. A university supports this requirement as proposed.

Response

While the Department supports the opportunity for educational opportunities for all individuals, this section is deleted as unnecessary and beyond the funding available through the ODP service system.

§ 6100.301—Individual choice

A university asks to change the title of this center heading to “change of support providers,” add the right to choose and add information regarding where and how to report if this right is violated. A provider asks to relabel this center heading as “transition to a new provider.” A provider association, plus numerous form letters from commentators, ask to relabel this center heading as “transition of services.” A provider association, plus numerous form letters from commentators and another provider, ask to clarify that this section applies to a change of a support coordinator as well as a direct service provider. A few county governments support this role for the support coordinator.

Response

The title of this center heading is changed to “TRANSITION TO A NEW PROVIDER” to clarify that the transition relates to the provider. Minor edits are made to this section to enhance clarity. This section applies to a support coordination organization as well as a

direct service provider. Additional reporting requirements are unnecessary and individuals have a right to choose a provider as set forth in § 6100.182(j) (relating to rights of the individual).

§ 6100.302—Cooperation during individual transition

A university supports this section as proposed. An advocacy organization asks to require an individual plan meeting prior to a transition. A provider asks that these functions be the role of the support coordinator. A provider association, plus numerous form letters from commentators and several other providers, support that transportation should be a shared responsibility arranged by the current and the potential new provider and that it is essential that the providers cooperate with each other. A provider association, plus numerous form letters from commentators and another provider, state that it is not the current provider's responsibility to arrange for transportation to find or visit other service locations.

Response

The title of this section is changed to "Cooperation during individual transition" to better capture the intent of this section.

An individual plan meeting is not always required prior to a transition because of ongoing discussions and working relationships amongst the involved parties. The

support coordinator is involved, but is not responsible to arrange and provide transportation to visit other service locations. The Department agrees that the visits to other service locations are a shared responsibility between the current and the new provider, as stated in subsection (a). It is the provider's responsibility to assist the individual to find and visit other service locations.

§ 6100.303—Involuntary transfer or change of provider (Reasons for a transfer or change in a provider in proposed rulemaking)

An advocacy organization asks that an individual should never have to move due to insufficient funds. A county government asks to delete the phrase "with the provision of supplemental support" in subsection (a)(2). A university asks to omit subsection (a)(3) as a reason for involuntary discharge, stating that the ADA requires physical accommodations. A few provider associations, plus numerous form letters from commentators and several providers, request that the following reasons for involuntary discharge be added in subsection (a): irreconcilable disagreement with families or individuals, insufficient funds, natural disasters, staff changes, situations beyond a provider's control, provider liability, stress, intimidation of others, danger to self or others, service location closure, hospitalization and abuse. A county government and a family association ask to state that discharge may not occur due to hospitalization, illness or therapeutic leave. A provider requests the ability to anonymously refuse service. A provider association asks to change the term "retaliation" to "response" in subsection (b).

Response

The title of this section is changed to “Involuntary transfer or change of provider” to better capture the intent of this section. Insufficient funds is not a permitted reason for involuntary discharge in subsection (a). The phrase “with the provision of supplemental support” in subsection (a)(2) is retained; this means that an individual may not be discharged due to a change in needs without the provider first attempting to provide supplemental services. Subsection (a)(4) is added to address the commentators’ concerns that a closure of a service location, such as in response to a natural disaster, is also a legitimate reason for the individual to transfer. The other reasons suggested as allowable reasons for involuntary discharge such as family disagreements, staff changes and hospitalization are not appropriate bases for involuntary discharge. Discharge may not occur due to illness or during medical, hospital or therapeutic leave. The Department is unsure of the intent of the comment requesting the ability to deny a service anonymously. The term “retaliation” is changed to “response” in subsection (b) as suggested and “filing a grievance” is changed to “filing a complaint” to conform to the changes made to § 6100.51 (relating to complaints by an individual).

§ 6100.304—Written notice

A provider asks why an individual must provide notice of a transition. A provider association, plus numerous form letters from commentators, support the requirement in proposed subsection (a) for the individual to provide at least 30 days’ notice of

departure. A provider association and a provider ask that not all individual team members be involved in the transition. Another provider association asks to identify which team member provides the notice.

In proposed subsection (b), the IRRC and numerous providers ask to allow transitions to occur sooner if agreed to by both parties and account for emergencies where the individual's or another's immediate health and safety may be at risk. A provider asks that written notice be addressed through the individual plan meetings. A provider asks to change 45 days' notice to only 10 days' notice. A provider association, plus numerous form letters from commentators, ask to change 45 days' notice to 30 days' notice. A county government supports the 45 days' notice. An advocacy organization asks to change the 45 days' notice to 90 days' notice. A family association asks that the family be informed of all transitions.

Response

The proposed subsection (a) is deleted since the individual has the right to leave a service or facility at any time without notice. The provider may encourage, but not require, that notice of departure be provided.

The time frame in subsection (a) ((b) in proposed rulemaking) remains at 45 days for provider notification to allow sufficient time for the individual and others to prepare for transition and select a new and appropriate service location. The family is notified of

the transition in accordance with subsection (a)(2) ((b)(2) in proposed rulemaking) if the individual wishes that the family be notified.

Final-form subsection (b) is added to allow for a transfer earlier than the 45 days to protect the health and safety of the individual or others.

§ 6100.305—Continuation of service

A provider association, plus numerous form letters from commentators, ask that a time limit be established as to how long the provider must support the individual, require the Department to act quickly and to specify the process for obtaining departmental approval. Another provider association states that this is detrimental to housemates if a willing provider is not found timely. Another provider association, plus numerous form letters from commentators, state that there are cases where additional resources will be required to continue services and that an avenue to bill the Department should be provided. A provider supports this section, stating that the current provider must maintain HCBS to assure safety and a smooth transition. A few providers ask for the ability to immediately suspend service. A provider is concerned that the necessary staffing may not be available.

Response

Approval by the Department is deleted as the continuity of service is generally managed by the designated managing entity and the support coordinator, rather than the Department. No other changes are made to this section in order to protect the health and safety of the individual during transition. The residential fee schedule rates include adequate funding to cover the cost of added staffing and services during the transition period.

§ 6100.306—Transition planning

A provider association, plus numerous form letters from commentators, ask to delete this section since this is addressed in § 6100.302 (relating to cooperation during individual transition). A provider requests specification about the use of equipment and dietary needs to ensure health and safety.

Response

This section is not duplicative of § 6100.302. Section 6100.302 addresses the cooperation between the current and new providers. This section addresses the role of the support coordinator in planning the transition meetings. The needs of the individual, including the use of equipment and dietary needs, must be addressed during the transition period. See § 6100.305 (relating to continuation of service).

§ 6100.307—Transfer of records

A provider association, plus numerous form letters from commentators, ask that the individual be required to give a signed release to transfer the records and to address HIPAA confidentiality provisions in sharing records from one provider to another. The same provider association asks how much of the record must be transferred. A family asks that the record copies be provided without cost. A provider association, plus numerous form letters from commentators, ask to delete this section and combine the provisions with § 6100.302 (relating to cooperation during individual transition).

Response

Disclosure of health care information for purposes of case management and care coordination is considered treatment, payment or health care operations for which specific authorization is not required. See 45 CFR § 164.506 (relating to uses and disclosures to carry out treatment, payment, or health care operations). There is no HIPAA violation in transferring records from the current to the new provider. In response to the question of how much of the record must be transferred, the term "complete" is added to subsection (a). There is no cost to the individual for the record transfer between providers.

This section is not duplicative of § 6100.302. Section 6100.302 addresses the cooperation between the current and new providers during transition. This section addresses the transfer of records following transition.

§§ 2380.151—2380.160; 2390.171—2390.180; 6100.341—6100.350; 6400.191—6400.200 and 6500.161—6500.170—RESTRICTIVE PROCEDURES (POSITIVE INTERVENTION in proposed rulemaking)

Several commentators ask to retitle this section as “behavioral intervention,” “positive behavior supports” or “safe behavior management.” Several commentators support the title as “positive intervention.”

General comments relating to proposed § 6100.52 (relating to rights team) suggest that the basic provisions regarding the use of restraints and restrictive procedures in current §§ 2380.151—2380.165, 6400.191—6400.206 and 6500.161—6500.176 be retained.

General comments on restrictive procedures include enthusiastic support for limiting restraints to only emergency health and safety situations, support for the move to a restraint-free environment, reinforcing acceptable behaviors, a desire to rewrite this entire section by a clinician, support for behavior intervention with the use of core teams and requesting the same restrictive procedure provisions across all four licensing chapters and Chapter 6100.

Response

The title of this center heading is changed to “RESTRICTIVE PROCEDURES” to best describe the content of the sections.

The Department reconsiders its approach to this section and concurs with commentators who suggest the retention of §§ 2380.151—2380.165, 6400.191—6400.206 and 6500.161—6500.176 as the underpinning for this section on restrictive procedures, and further applying the same provisions to Chapters 2390 and 6100 to provide continuity of health and safety protections and continuity of services across the intellectual disability and autism service system. Many sections and principles relating to restrictive procedures in the licensing regulations for community homes, life sharing homes and adult training facilities are retained, updated and transferred to Chapters 2390 and 6100.

The Department appreciates and acknowledges the overwhelming support from individuals, county governments, providers, families, advocates and universities to move toward a restraint-free environment. While the regulations set the minimum standards for the prohibitions of restraints, and require protections for the use of restrictive procedures, it is the intellectual disability and autism community as a whole moving forward with shared values and principles that will continue to make a difference to reduce the use of harmful acts and controlling practices that take away an individual’s

freedom, pride and dignity through the use of restraints and harmful restrictive procedures.

The Department has carefully reviewed all comments regarding the use of restraints and restrictive procedures and the Department's clinicians and other behavior health experts have been consulted and have advised relating to best practices on the use of restraints and restrictive procedures. The final-form regulation conforms to the experts' recommendations.

§§ 2380.151, 2390.171, 6100.341, 6400.191 and 6500.161—Definition of restrictive procedures (Use of a positive intervention in proposed rulemaking)

Numerous commentators object to the proposed term "dangerous behavior" as used to determine the circumstances under which a physical restraint may be used.

Response

The term "dangerous behavior" is deleted throughout the regulation. The term "restrictive procedure" and the corresponding definitions in the current §§ 2380.151, 6400.191 and 6500.161 (relating to definition of restrictive procedures) are maintained and adopted in §§ 2390.171 and 6100.341 (relating to definition of restrictive procedures).

§§ 2380.152, 2390.172, 6100.342, 6400.192 and 6500.162—Written policy

The requirement for the provider to develop and implement a written policy describing the use of restrictive procedures as contained in the current §§ 2380.152, 6400.192 and 6500.162 (relating to written policy) is maintained and adopted in §§ 2390.172 and 6100.342 (relating to written policy).

§§ 2380.153, 2390.173, 6100.343, 6400.193 and 6500.163—Appropriate use of restrictive procedures

A county government asks to strike the reference to reinforcing appropriate behavior as this is a concept of applied behavior analysis and can be a stimulus to increase the likelihood of a behavior. A provider suggests that a clinician be consulted, rather than requiring the use of the least intrusive method. A provider suggests that behavior plans for individuals with autism often include restrictive procedures and restraints as part of the treatment program.

Response

The overarching parameters for the use of restrictive procedures as contained in the current §§ 2380.153, 6400.193 and 6500.163 (relating to appropriate use of restrictive procedures) are maintained and adopted in §§ 2390.173 and 6100.343 (relating to appropriate use of restrictive procedures; appropriate use of a restrictive procedure).

The term “reinforcing appropriate behavior” is no longer used based on the concerns raised regarding applied behavior analysis by the county government. A clinician may not override the fundamental principle of applying the least restrictive method necessary to achieve the desired behavior. The use of physical restraints and restrictive procedures is not an acceptable part of the treatment plan for individuals with autism unless a behavior support clinical team has reviewed and approved the entire plan. Restraints prohibited by this final-form regulation are not permitted for use on an individual with autism.

§§ 2380.154, 2390.174, 6100.344, 6400.194 and 6500.164—Human rights team

As discussed in this preamble in §§ 2380.156, 2390.176, 6100.52, 6400.196 and 6500.166 —Rights team in proposed rulemaking, numerous commentators representing families, universities, advocacy organizations, county governments, providers and a few provider associations, plus numerous form letters from commentators, object to all or a portion of the proposed § 6100.52 (relating to rights team). The IRRC and other commentators state that the proposed role of the rights team overlaps and duplicates the roles and procedures of the restrictive procedure process in Chapters 2380, 6400 and 6500.

A university, a provider association and an advocacy organization suggest that the individual plan team is not qualified to write the behavior support component of an

individual plan. A university suggests that a functional behavior analyst should write the behavior support component of the plan.

Response

As suggested by numerous commentators, the Department retains, adapts and extends the current licensing requirements in current §§ 2380.154, 6400.194 and 6500.164 (relating to restrictive procedure review committee) to Chapters 2390 and 6100 regarding the review of the use of restraints and restrictive procedures. The new §§ 2380.154, 2390.174, 6100.344, 6400.194, and 6500.164 carry forward the current licensing requirements for a team with a majority of persons who do not provide direct services to the individual and require a record of the team meetings to be kept. In response to comments about the qualifications of the individual plan team, and the comment suggesting that a functional behavior analyst write the behavior support component of the plan, a new requirement is added to require the human rights team to include a behavior specialist who was not involved in the development of the behavior support component of the plan. This requirement is consistent with the current licensing regulations requiring "other professionals, as appropriate" to participate on the team. See §§ 2380.155(b), 6400.195(b) and 6500.165(b) (relating to restrictive procedure plan). The qualifications of the behavior specialist are intentionally broad to permit an array of professionals to serve in this capacity. The concept of a behavior specialist was shared with the work group in March 2017 and there were no objections.

§§ 2380.155, 2390.175, 6100.345, 6400.195 and 6500.165—Behavior support component of the individual plan (§ 6100.342 (relating to PSP) in proposed rulemaking)

A university supports the behavior support component as part of the individual plan. A provider association, plus numerous form letters from commentators, ask to require a baseline of the behavior being addressed in the plan. A provider asks if this plan replaces the crisis behavior plan. A provider association, plus numerous form letters from commentators, ask to delete the term "functional analysis." A provider association and several providers ask to use the term "functional assessment." The IRRC asks to define "functional analysis," clarify who is responsible for completing the functional analysis and explain how these requirements will be implemented. A provider asks to require speech therapy services. An advocacy organization asks to require necessary auxiliary aids and services.

Response

This section is revised to maintain and apply the current §§ 2380.155, 6400.195 and 6500.165 (relating to restrictive procedure plan) in Chapters 2390 and 6100. The current requirements, including the plan, the review of the plan at least every 6 months and the content of the plan, are similar to the current Chapter 2380, 6400 and 6500 requirements. Subsection (d) is added to § 6100.345, consistent with current §§ 2380.155(b), 6400.195(b) and 6500.165(b) which require the participation of other appropriate professionals in the development of the behavior support component of the

individual plan (the licensing chapters refer to this plan as the “restrictive procedure plan”). The term “functional analysis” has been replaced with “an assessment of the behavior, including the suspected reason for the behavior” in response to public comment. As specified in subsection (a), the human rights team reviews and approves the behavior support component of the individual plan prior to the use of a restrictive procedure.

Subsection (d) addresses who must develop the behavior support component of the individual plan if a physical restraint is used, or if a restrictive procedure is used to modify an individual’s rights in accordance with § 6100.223(9) (relating to content of the individual plan). Neither current regulation nor proposed rulemaking reference a crisis behavior plan. The behavior support component of the plan at times includes a crisis plan section. The behavior support component of the individual plan is implemented by the provider in accordance with the individual plan.

With respect to the comments on requiring speech therapy services and auxiliary aids and services, each individual plan process governs how these services are identified and authorized. It is unnecessary to address these services in the behavior support component of the individual plan.

§§ 2380.156, 2390.176, 6100.346, 6400.196 and 6500.166—Staff training

A family association asks that persons applying a restraint be properly trained. A provider association, plus numerous form letters from commentators, ask to clarify the content of staff training.

Response

The requirements in current §§ 2380.156(b), (c) and (d); 6400.196(b), (c) and (d); and 6500.166(b), (c) and (d) are retained and adopted in §§ 2390.176 and 6100.346 (relating to staff training). The requirements in current §§ 2380.156(a), 6400.196(a) and 6500.166(a) regarding training in the use of behavior supports are addressed in the final-form §§ 2380.39(c)(5), 2390.49(c)(5), 6100.143(c)(5), 6400.52(c)(5) and 6500.47(b)(5).

§§ 2380.157, 2390.177, 6100.347, 6400.197 and 6500.167—Prohibited procedures (§ 6100.343 (relating to prohibition of restraints) in proposed rulemaking)

A group of individuals, a university, an advocacy organization, a county government and several providers support the restraint prohibitions as proposed. A provider association, plus numerous form letters from commentators, ask to allow bite release techniques in paragraph (3). A provider association, plus numerous form letters from commentators and several providers, ask to allow helmets to prevent self-injury and wheelchair belts

for positioning in paragraph (5). A provider association and a few providers ask to allow post-surgical care and casts for healing in paragraph (5). A provider asks under what circumstances bedrails are allowed in paragraph (5). Another provider asks if geriatric chairs are allowed in paragraph (5). A provider asks to remove the qualifier "as long as the individual can safely remove the device" in paragraph (5). The IRRC and several providers ask for an exclusion for doctor-prescribed mechanical restraints in paragraph (5). Several providers ask to permit the initial 3-month use of mechanical restraints in paragraph (5).

Response

The Department agrees with the commentators who support the movement to reduce and eliminate the use of restraints through the use of alternative positive interventions and appropriate behavior supports.

Paragraph (1) is revised, consistent with current §§ 2380.157, 6400.197 and 6500.167 (relating to seclusion), to clarify that use of a foot pressure lock or holding a door shut is prohibited.

Paragraph (3) is revised to clarify that a clinically-accepted bite release technique is permitted.

Paragraph (4) is revised, consistent with §§ 2380.159, 6400.199 and 6500.169 (relating to chemical restraints), to clarify that an ongoing program of medication and medication prescribed for a stressful event are permitted.

Paragraph (5) is revised to clarify that the following procedures are permitted: a seat belt during movement or transportation, post-surgical and wound care, and a device used for balance or positioning if the device is removed upon the request of the individual and if there is periodic relief from the device. This paragraph also clarifies that a device used for protection during a seizure is permitted if the device is removed upon request of the individual and if there is periodic relief from the device. The ability to remove a device and to provide periodic relief from the device is critical to provide health and safety protection for the individual.

Paragraph (5) is revised to clarify that a bedrail that restricts the movement or function of an individual is prohibited. As proposed, use of a geriatric chair is prohibited.

Paragraph (5) does not permit a health care practitioner to override the individual health and safety protections of this section. A health care practitioner may not be properly educated, or may hold different beliefs on the physical and psychological short-term and long-term risks to an individual. The protection from the use of unauthorized restraint as specified in the final-form regulation is absolute. Regulatory waivers are not permitted regarding this section.

Paragraph (5) does not permit the initial 3-month use of a mechanical restraint because the risk to the individual during the use of a mechanical restraint is significant, the use of a mechanical restraint is cruel and inhumane and alternative positive interventions and behavior supports are effective alternatives to restraint.

The proposed requirements related to physical restraint are relocated to §§ 2380.158, 2390.178, 6100.348, 6400.198 and 6500.168.

§§ 2380.158, 2390.178, 6100.348, 6400.198 and 6500.168—Physical restraint

(§ 6100.344 (relating to permitted interventions) in proposed rulemaking)

A university, an advocacy organization and a family support the proposed limitations on physical restraints. A provider association, plus numerous form letters from commentators and another provider, ask to clarify the terms “physical restraint” and “manual restraint.” A provider association, plus numerous form letters from commentators, ask to permit verbal redirection and prompts. A provider association and several providers support the reduction from 30 minutes to 15 minutes for use of a physical restraint. Another provider association, plus numerous form letters from commentators, ask to clarify that a physical restraint may not be used for more than 15 minutes in any 2-hour period. A county government and a provider suggest that a physical restraint be permitted for 30 minutes in a 2-hour period to support individuals with difficult behaviors and to protect other individuals and staff. A provider suggests allowing a physical restraint for no more than 15 minutes consecutively and no more

than 30 minutes in a 2-hour period. A provider asks to allow waivers for the use of physical restraints. The IRRC and several commentators suggest that proposed § 6100.345(c) and (g) are redundant.

Response

The term “manual restraint” is not used in the final-form regulation. The term “physical restraint” is used and is defined in subsection (a).

Verbal redirection and physical prompts are specifically permitted in subsection (b).

The time period for use of a physical restraint is increased from 15 minutes to 30 minutes consistent with current §§ 2380.161, 6400.202 and 6500.172 (relating to manual restraints). As suggested, the final-form regulation clarifies that the 30minute time period applies cumulatively within a 2-hour period.

The protection from the use of unauthorized restraint as specified in the final-form regulation is absolute. Regulatory waivers of this section are not permitted. Proposed § 6100.344(c) and (g) are redundant and are deleted.

§§ 2380.159, 2390.179, 6100.349, 6400.199 and 6500.169—Emergency use of a physical restraint

A few providers ask to allow the use of physical restraints in emergency situations.

Response

A section is added to permit the use of a physical restraint in an unanticipated, emergency basis, not to exceed twice in a 6-month period. This requirement is the same as the current §§ 2380.163, 6400.204 and 6500.174 (relating to emergency use of exclusion and manual restraints).

§§ 2380.160, 2390.180, 6100.350, 6400.200 and 6500.170—Access to or the use of an individual's personal property; Access to or the use of a client's personal property

A few provider associations, plus numerous form letters from commentators, state that there are individuals who understand the consequences of making restitution for damages and the individual plan should allow for this. Another provider asks to collect a security deposit to pay for damages. Another provider raises the legal obligation of an agreement. A county government, a family and several providers ask to require restitution for damages so an individual can understand consequences of actions. A provider association, plus numerous form letters from commentators, suggest that payment be made only if there is a legal order to make restitution and that the

representative payee must consent. Yet another provider states that this provision conflicts with the lease requirement. A few advocacy organizations object to the consent provision as it is difficult to view any consent as knowing and voluntary. Other providers ask that the support coordinator or the individual plan team witness the consent.

Response

The provision is not about understanding or teaching the consequences of one's action, but rather the illegality of taking a person's money without consent. Consent may be provided by the individual or the individual's representative payee in the presence of and with the assistance of the support coordinator.

A revision is made to subsection (b) to clarify that the provisions apply if there is no court-ordered restitution. If there is a court-ordered restitution, the court order applies.

§§ 2380.17, 2390.18, 6100.401, 6400.18 and 6500.20—Incident report and investigation; Types of incidents and timelines for reporting

A university supports the broad application of the incident management provisions across all five chapters. A provider association, plus numerous form letters from commentators, ask to remove the incident provisions from the regulations and instead issue policy. An advocacy organization asks that all providers of HCBS, including all

paid household members and life sharers, be required to report incidents. A county government asks that this section apply to person and family directed services.

The IRRC and several commentators ask to explain the difference between alleged and suspected incidents.

The IRRC, several providers and a provider association, plus numerous form letters from commentators, suggest allowing 72 hours to report medication errors and the use of restraints. A provider supports the 24-hour reporting timeline for all incidents.

A provider supports the proposed list of incidents. The IRRC asks why the list of incidents is significantly expanded, the reasonableness of the expanded list and the fiscal and economic impact of such expansion. A few providers ask to clarify the meaning of a suicide attempt. A county government and a provider ask if a psychiatric hospitalization or a hospital observation with no admission is reportable. A county government and a few providers ask to delete the requirement to report emergency room visits. A county government asks if abuse to an individual by another individual is reportable. A few providers ask to clarify that a missing individual is one who is missing for more than 24 hours or in jeopardy if missing for any period of time. A few providers ask not to report the closure of a facility as no investigation is required. A provider association, plus numerous form letters from commentators, ask not to report over-the-counter medication errors. A provider asks to delete all medication errors. An advocacy organization and a family ask to report only significant medication errors.

Numerous providers and county governments ask to delete a critical event as this is covered by other categories.

A provider asks that reports be submitted on the victim as well as the perpetrator of the abuse. A provider asks that this section apply only while the individual is under the supervision of the provider and not while home with family or on leave.

A county government asks that all incident reports be submitted through the Department's online information management system, rather than by paper.

In subsection (c) ((b) in proposed rulemaking), the IRRC asks why an individual must be sent a report if the incident relates to the individual and to ensure the notice requirements are clear and reasonable. The IRRC, a provider association, plus numerous form letters from commentators, ask to clarify "immediately report;" the provider association suggests a 2, 4 or 6 hour reporting timeline.

In subsection (e) ((d) in proposed rulemaking), numerous commentators, including county governments and providers, ask to permit an abbreviated notice to protect confidentiality. An advocacy organization commends the Department for making incident notices available to individuals and their designees. A few providers ask not to release incident reports to individuals and families.

Response

Incident management procedures are promulgated as regulation rather than policy to provide the basis for the Department's measurement and enforcement of the requirements.

The Department did not make any change to the release of incident reports to individuals and family members. Individuals and others designated by individuals are permitted to have access to records pertaining to HCBS, including incident reports. Protections are in place to allow for appropriate redaction of such records to protect the privacy of other individuals receiving HCBS.

An "alleged" incident is a situation when a person has stated that an incident occurred, but the evidence has not yet been confirmed to verify that an incident did occur. A "suspected" incident is a situation where there has been no direct observation or evidence of an incident, but someone has a suspicion that an incident occurred. All incidents, whether they occurred, are alleged to have occurred or if there is a suspicion of such occurrence, must be reported in accordance with the timelines in the final-form regulation. These terms are not defined in the final-form regulation as the dictionary definitions apply.

The change to the reporting timeline for restraints and medication errors is made.

The list of incidents to be reported in § 6100.401 (relating to types of incidents and timelines for reporting) is consistent with the statement of policy codified at §§ 6000.921—6000.923 (relating to incident management). This statement of policy has been in effect since 2004. The list of incidents is not expanded, and in fact, emergency room visits and certain types of medication errors have been eliminated from the list of incidents to be reported.

"Suicide attempt" is clarified to mean "a physical act to complete suicide." An "inpatient psychiatric hospitalization" is an inpatient admission to a hospital, and therefore is reportable. A hospital observation for which there is no admission is not reportable. An emergency room visit is deleted from the list of reportable incidents. "Abuse" is clarified to include abuse to an individual by another individual; this practice of considering abuse to an individual by another individual as abuse has been in place for years within the Department. "Missing individual" is clarified as suggested. Law enforcement activity and fire are clarified to narrow the reporting parameters. An emergency closure of a facility is reportable to provide notice to the Department, counties, the designated managing entity and others. The types of medication errors to be reported are narrowed to require reports only for medications ordered by a health care practitioner, rather than routine over-the-counter medications. The requirement to report a "critical event" is deleted.

An incident report does not necessarily apply to one individual; rather, the incident may be facility-wide, such as a fire or closure, or it may relate to multiple individuals.

Incidents must be reported while the individual is under the supervision of the provider and not while on medical, hospital or therapeutic leave.

All incident reporting under Chapter 6100 occurs through the Department's online information management system; however, since some facilities governed by Chapters 2380, 2390, 6400 and 6500 are not funded by the Department through the ODP service system and do not have access to the online reporting system, paper reports are allowed for the four licensing chapters.

In subsection (c), an incident report may be submitted relating to the individual for which the individual or the individual's designated person is unaware; for example, the financial staff discovers a theft of individual funds for which the individual has no knowledge or a visitor reports a potential violation of individual rights for which the individual is unaware. A copy of the incident report does not need to be provided to the individual or to the person designated by the individual if the individual is already aware of the incident. The term "immediately" is revised to "within 24 hours of discovery of an incident relating to the individual."

In subsection (e), a revision is made to allow the submission of a summary of the incident, rather than the actual report.

§§ 2380.17, 2390.18, 6100.402, 6400.18 and 6500.20—Incident report and investigation; Incident investigation

The IRRC and numerous commentators object to the proposed rulemaking requiring that a certified investigator investigate each incident; rather, they ask to report only certain more serious incidents, citing an extreme administrative burden. A provider association, plus numerous form letters from commentators, ask that abuse to an individual by another individual be investigated by a certified investigator only if there is a serious injury.

An advocacy organization asks to require the use of auxiliary aids to communicate between the individual and the investigator.

An adult day training facility asks to clarify that forms may be submitted by paper for adult training facilities.

Response

Subsection (c) is revised to specify the more serious types of incidents that require investigation by a certified investigator. All cases of abuse must be investigated by a certified investigator, including all cases of abuse to an individual by another individual, to discover and remedy the underlying cause of the abuse.

Communication aids and devices must be used if necessary in accordance with § 6100.50 (relating to communication).

In accordance with final-form § 2380.17(b), incident report forms may be submitted by paper for adult training facilities.

§§ 2380.18, 2390.19, 6100.403, 6400.19 and 6500.21—Incident procedures to protect the individual; Incident procedures to protect the client; Individual needs

A provider association, plus numerous form letters from commentators, ask to omit the support coordinator from subsection (c) relating to revision of the individual plan if indicated by the incident as the support coordinator is on the individual plan team.

Response

This change is made.

§§ 2380.17, 2390.18, 6100.404, 6400.18 and 6500.20—Incident report and investigation; Final incident report

A provider association, plus numerous form letters from commentators, ask to allow an extension if needed for collection of evidence such, as witness statements, police investigation results or lab results.

Response

This change is made.

Subsections (b)(3) and (b)(4) are reordered for clarity. Final-form subsection (b)(4) is revised to address the need to prevent the recurrence of the incident.

§§ 2380.19, 2390.19, 6100.405, 6400.20 and 6500.22—Incident analysis; Incident procedures to protect the client

A county government supports the requirement for incident analysis. A provider association, plus numerous form letters from commentators, ask that incident analysis be the responsibility of the individual plan team. A provider association, plus numerous form letters from commentators and a few other commentators, object to the root cause analysis in subsection (a)(1). A provider association, plus numerous form letters from commentators, state that the corrective action in subsection (a)(2) is not always necessary. The IRRC and several providers object to the 3-month review in subsection (b), stating that this is a four-fold increase in the current annual review. The IRRC asks if this review is duplicative of the quality management process. A provider asks to change “analyze” to “monitor” in subsection (e). A provider association, plus numerous form letters from commentators, ask to delete “continuously” in subsection (e).

Several adult training facilities and vocational facilities suggest that the incident analysis is duplicative of the incident review process and the civil rights review process that is required through licensing. The same facilities state that the incident analysis is already done by the certified investigator. The same commentators suggest that 3 months is too frequent for incident analysis. An adult training facility states that it is challenging to determine the likelihood of recurrence. An adult day training facility asks that the list of incidents be the same across all five chapters.

Response

Incident analysis is a core function of the provider agency. The provider analyzes all incidents from a broad-based systemic perspective to determine whether there are patterns or trends within the organization.

In subsection (a), “root cause” is changed to “cause” and “corrective action” is modified by “if indicated.” In subsection (e), “analyze” is changed to “monitor” and “continuously” is deleted.

This final-form regulation is not a four-fold increase in incident analysis and no new costs are associated with this section. Section 6000.984 (relating to provider incident management quarterly reports) requires a 3-month incident review; this statement of policy has been in effect since 2004. With the substantive changes to § 6100.45 (relating to quality management), there is no redundancy with the incident analysis process.

Regarding the comments by the adult day training and vocational facilities, the incident analysis is a systemic review of all incidents that occurred over the past 3 months to determine if a facility-wide action may be appropriate. This analysis is not duplicative of either the civil rights review that measures compliance with applicable civil rights laws or the certified investigator review that examines the circumstances of a particular, singular incident. Section 6000.984 requires a 3-month incident review; this statement of policy has been in effect for all ODP-funded adult training facilities since 2004. The list of reportable incidents is the same across all five chapters in the final-form regulation.

§ 6100.441—Request for and approval of changes

A provider asks the Department to issue a decision in 24 hours. A provider association, plus numerous form letters from commentators, ask to allow rapid placement through an expedited approval process. A provider association, plus numerous form letters from commentators, ask to clarify the difference between program and licensed capacity. A provider asks to allow excess capacity such as in respite care.

Response

This section is modified to apply to all types of service locations. The term “setting” is changed to “service location” to align with the term “service” as defined in this chapter and the Merriam-Webster dictionary definition of “location.” See *Merriam-Webster.com*. Merriam-Webster, n.d. Web. 28 June 2017.

The Department, through its regional offices, will continue to respond rapidly to emergency requests to change program capacity. To expedite the Department's approval, a provider should use the Department's required form, complete all portions of the form clearly and in detail and submit it to the Regional ODP, noting that this is an emergency request.

Program capacity is the number of individuals who may occupy a service location for the purposes of Department funding for the ODP service system. Licensed capacity is the maximum number of individuals who receive services at any one time in accordance with the facility's license under Chapters 2380, 2390, 6400 or 6500. Neither program capacity nor licensed capacity may be exceeded for respite care.

§ 6100.442—Physical accessibility

A county government supports the alignment with the CMS regulation in 42 CFR §§ 441.300—441.310. A university supports the accommodation and the assistive equipment provision. An advocacy organization states that this does not go far enough to ensure physical accessibility; the association asks to train all staff in the use of mobility equipment, assure the equipment is repaired timely and require a loaned device while the equipment is being repaired. A provider association, plus numerous form letters from commentators, state that this requirement causes a provider to incur significant and non-recognized costs. Another provider association, plus numerous

form letters from commentators, ask that this section be qualified as only those accommodations that are reasonable and listed in the individual plan.

Response

No change is made to this section. Accessibility accommodations are governed by the ADA.

Maintenance of mobility equipment is appropriately specified in subsection (b).

§ 6100.443—Access to the bedroom and the home in proposed rulemaking

A county association, a university and a county government support this proposed requirement; they ask to determine applicability through the individual plan team. A few providers ask to apply this section based on the individual plan team. A provider association, plus numerous form letters from commentators, ask to revise this section based on the CMS regulation in 42 CFR §§ 441.300—441.310. The IRRC and numerous commentators ask how the proposed requirements will be implemented in the context of health and safety; they ask to explain “appropriate persons” and “authorized persons” as to who has access and how express permission is obtained for each instance of access to the bedroom. A provider association, plus numerous form letters from commentators, express concern regarding the fire safety risk if an individual locks the individual’s door; an exception is requested for safety if an individual cannot

open the lock; the association believes that kind, caring staff will assure privacy without door locks. The same provider association asks for staff access to provide personal care, in the event of a fire and to prevent hoarding and illegal activity. The same provider association believes locks make the facility more institutional and less homelike. Several providers ask that staff responsible for care have keys to provide emergency access in the case of a fire or medical emergency and to meet care needs. A few providers support locks on bedroom doors, but not locks to the house; they are concerned of the safety risk if the key is lost. Another provider disagrees and supports keys to the entrance to the home, but not to the bedrooms.

Response

This section is deleted and the substantive content is relocated to § 6100.183(g) (relating to additional rights of the individual in a residential service location). The language is revised to provide the right to lock a bedroom door, rather than the express requirement to require a lock on each bedroom door.

The individual plan team will address modification of this right in accordance with § 6100.223(9) (relating to content of the individual plan) if there is a significant health and safety risk.

If the individual cannot open a standard lock, the provider must offer and provide an alternative locking system appropriate for the individual, such as an electronic card, key pad, touch pad, motion detector or voice command.

An individual has the right to lock and unlock the individual's bedroom door and the door to the home. This practice and right to lock a door to provide privacy of person and possessions is consistent with the rights that all citizens have in their own homes. Access by staff is permitted in an emergency, such as a fire, and with express permission by the individual. In instances where an individual's health and safety may be compromised, the individual plan team may design and implement a rights modification in accordance with § 6100.184 (relating to negotiation of choices) and § 6100.223.

The terms "appropriate" and "authorized" are removed; clarification is added that a direct service professional who provides services to an individual should have keys.

§ 6100.444—Lease or ownership in proposed rulemaking

A group of individuals and a university support the lease provision as proposed. The IRRC and numerous commentators question the terms "lease," "landlord" and "tenant" as these terms may trigger undesired consequences regarding tax law, legal proceedings, zoning restrictions, eviction, binding contracts and security deposits. A provider association, plus numerous form letters from commentators, ask the

Department to develop a model lease. Another provider association, plus numerous form letters from commentators, ask to use the standard room and board agreement in place of the lease. A few providers ask to exempt life sharing homes from this requirement.

Response

This section is deleted. The room and board residency agreement in § 6100.687 (relating to completing and signing the room and board residency agreement) will be used in place of the lease.

§ 6100.443 (§ 6100.445 in proposed rulemaking)—Integration

The IRRC and a few commentators ask to explain how the same degree of community access and choice will be applied and measured. A provider asks for a health and safety exemption. A university supports this section.

Response

No substantive change is made. The Commonwealth is mandated to meet this Federal regulation to continue to be eligible for $1.8 billion in Federal waiver funds. See 42 CFR §§ 441.301(c)(4)(i) and 441.310 (relating to home and community-based services waiver requirements).

§ 6100.444 (§ 6100.446 in proposed rulemaking)—Size of service location

The IRRC and an advocacy organization state that program quality cannot and should not be defined by the number of persons served. The IRRC asks to explain the reasonableness, the need to limit the number of persons served and the economic impact of this regulation. A university, a group of individuals and a family association strongly support the proposed regulation and ask that large congregate care settings be phased out in a purposeful manner, proposing the date of 2025 to impose the size restrictions on both new and existing day and residential programs. The same groups ask to require downsizing with annual decreases immediately until the size of 4 for residential programs and 15 for day programs is reached for all service locations. An advocacy organization supports the proposed size limits, but asks that a relocation maintaining the current capacity not be allowed. A county government supports the proposed size limits for new service locations, allowing existing service locations to continue to operate at their current size. A provider believes it is illegal for the Department to control private space. Another provider states this is a positive change. A provider association, plus numerous form letters from commentators, state that the CMS does not impose size limits and that consideration must be given to the additional staff, facility costs and workforce shortages. Another provider association, plus numerous form letters from commentators, express concern that funding will not keep up with the capacity reductions. A third provider association is unsure if size limits are legal and believes that any limit is arbitrary. A few providers ask to delete all size caps, but rather regulate size through the Federal waivers.

Regarding subsection (a), a university comments that existing homes with more than four individuals should be required to downsize. Regarding subsection (b), a university and a family group support the size limit of four for newly funded residential service locations. An advocacy organization generally supports the residential capacity of four, but requests that side-by-side living with eight individuals be permitted to provide choice and independence with minimal support. A provider asks to limit size to 8 to permit economies of scale, stating that Virginia allows 12 individuals in a residential setting. A provider asks to set the residential size limit at six. A provider asks to consider the cost of transportation and the hardship on families. Several providers question if their current four-by-four or eight-by-eight side-by-side residential units are permitted to continue to operate.

Regarding subsection (c), the IRRC states that commentators assert that limiting newly funded day facilities will dramatically increase the cost per unit/per individual. The IRRC asks if the Department considered making a distinction between program licensing roster capacity and daily attendance. A legislator objects to the size of 15 for day programs as the size limit is a one-size-fits-all approach that severely affects cost effectiveness, makes it impossible for providers to open new programs, limits options for consumers and ignores the diversity of the State regarding rural, suburban and urban areas. A university asks to change the effective date for the day program size limit to the effective date of the regulations, rather than the Federal deadline of March 2019. An advocacy organization asks to cease funding of all licensed day programs effective July 2017 to support community participation and Everyday Lives. A provider asserts

that no program can make money with a size limit of 15. Another provider asks that a size limit of 15 be imposed effective July 1, 2017. A provider asks to apply the size requirement based on the number of individuals who receive services at any one time. A provider asks to limit the size to 30 to maximize the staffing ratios in Chapters 2380 and 2390. Another provider states that the size limit will force the development of more sites and create pick up and drop off scheduling issues. A provider association, plus numerous form letters from commentators, and several providers assert that the size limit of 15 is arbitrary and insufficient to sustain a service location, that this eliminates choice of program and that the size of 15 does not coincide with the staffing ratios in Chapters 2380 and 2390 at 1:6 and 1:15. The same provider association asks to allow legacy programs to relocate and maintain their size after March 2019.

Response

The Department respects, appreciates and values the comments relating to the quality of life experienced in small homelike, community integrated settings, as well as the desire to provide options for an individual to choose the services that best meet the individual's needs. The vast diversity of opinions and beliefs surrounding the size of service locations is acknowledged and embraced as part of the ever-growing and evolving intellectual disability and autism service system. The final-form regulation strikes a balance of the desires by the advocacy community for enhanced community integration and the economic and choice concerns of the providers.

Regarding subsection (a)(1), existing side-by-side residential units operating in accordance with the Federal waivers and licensing regulations are permitted to continue to operate. Regulatory waivers may be considered for existing, unique side-by-side settings.

In subsection (c), the size limit for new day programs that are newly funded on or after March 17, 2019 is increased to 25 individuals. This subsection clarifies that the size limit applies liberally based on the number of individuals present in the service location at any one time, rather than by program capacity or licensed capacity. For example, by alternating schedules and by providing community integration activities in small groups for part of the day, a service location may serve a total of 100 individuals, with only 25 individuals present in the service location at any one time. Proposed subsection (c)(2) is deleted as unnecessary due to the revision of subsection (c).

The Department did not make changes to the March 2019 effective date for the program size limits because the Department worked with stakeholders in determining to comply with the Federal government deadline. The Department and many stakeholders believe that the March 2019 effective date is reasonable.

The costs to operate smaller settings, including transportation and staffing costs, are included in the fee schedule rates. Through increased community opportunities, such as active involvement with local activities and clubs, job coaching to teach employment skills, competitive employment opportunities and educational activities, individuals will

feel greater pride, self-worth and acceptance, enhancing the individual's quality of life. As community integration increases, the community at large will become more accepting of people with disabilities.

Research on service location size demonstrates that size does impact multiple quality of life dimensions and outcomes. The National Council on Disability's 2015 report "Home and Community-Based Services: Creating Systems for Success at Home, at Work and in the Community" concluded that "Small, personalized, settings increase opportunities for personal satisfaction, choice, self-determination, community participation and feelings of well-being. Small settings are similarly associated with decreases in (1) the use of services, (2) feelings of loneliness and (3) service-related personnel and other costs."

This conclusion was echoed in a 2014 policy research brief by Nord, et al. "Residential Size and Individual Outcomes: An Assessment of Existing National Core Indicators Research." Nord reviewed National Core Indicator (NCI) studies published over the last decade, examining numerous outcomes for people with an intellectual disability living in different residential settings. The review found that, across all outcome areas, smaller settings, on average, produce better quality of life outcomes for people with an intellectual disability and concluded that "people living in their own homes, family homes, host family homes or in small agency residences (six or fewer residents) ranked consistently better in achieving positive outcomes than moderate size (7-15 residents) and large agency residences and institutions (more than 15 residents). Also, people

living in their own homes, small agency residences, and host family homes reported more independence and more satisfaction with their lives."

In relation to the economic impact of the size limitations for day facilities in the final-form regulation, roughly 40% of day facilities funded by the Department currently serve 25 or fewer individuals, demonstrating that smaller facilities are fiscally sustainable. These facilities are located in rural, suburban and urban areas. Given the exemptions for existing facilities with application of the size limits only to new facilities, as well as a fee schedule rate structure that accounts for an individual's needs, there is no negative economic impact to the regulated community.

§ 6100.445 (§ 6100.447 in proposed rulemaking)—Locality of service location

In subsection (a), the IRRC asks to set a measurable standard or delete "in close proximity." A provider association, plus numerous form letters from commentators, a few county governments and several providers ask to define "close proximity," considering the necessary difference for urban and rural settings. An advocacy organization and a family ask to allow facilities to be located near nursing facilities and hospitals. A university supports the alignment with the CMS regulation in 42 CFR §§ 441.300—441.310.

In subsection (b), the IRRC asks how the limit of 10% was established and to explain the reasonableness and economic impact on residential facilities. The IRRC and a few

housing experts assert that the 10% restriction virtually eliminates housing opportunities for Medicaid waiver enrollees with non-physical disabilities to live in certain urban communities and that this is a profoundly unfunded mandate. The housing experts suggest that the regulation unnecessarily limits housing choices, with the extreme shortage of affordable housing further limiting choice. A university supports the proposed 10% limit for group housing. A provider association, plus numerous form letters from commentators, ask to revise the 10% cap so that common sense prevails; the association maintains that it is impossible to apply this standard for a building with fewer than ten units, it is a violation to tell a person where he cannot live and 10% is illogical since 19% of people have a disability. Another provider association, plus numerous form letters from commentators, ask to reconsider the 10% maximum as this forces people into large complexes, since not even one person could live in a four unit building. A few county governments ask to set different standards for small buildings, since the 10% maximum does not work for a small building; the county governments support the intent of the proposed regulation as integration without saturation. A provider supports subsection (b) in concept, but asserts that it is impossible to know the concentration of occupants in a private apartment building. A provider asks that 10% be increased to 20%. A provider asks how this applies to urban rowhomes.

In proposed subsections (c) and (d), a provider association, plus numerous form letters from commentators, ask to require no Department approval. A few county governments comment that the CMS prohibits funding for intermediate care facilities and ask to reinforce that the Department must approve transition plans in advance. An advocacy

organization asks to add that with the approval of the Department's deaf service coordinator, the Department may allow eight individuals with similar hearing needs to live in close proximity to prevent social isolation.

Response

Although the Department solicited comments on the appropriate description of "close proximity" in the proposed rulemaking preamble, as well as through multiple public forums, no suggestion regarding a precise measurable standard was offered. The Department understands the challenge of establishing a measurable standard for a variety of urban, rural and suburban localities. The commentators at large did not object to a standard on proximity; rather, the objection is to the term "in close proximity." Subsection (a) is therefore revised to delete "or in close proximity" and governs the locality of the service location by the term "adjacent," for which there were no objections. The plain meaning of "adjacent" as defined by West's Encyclopedia of American Law, as "parcels of land not widely separated" applies. See West's Encyclopedia of American Law, Edition 2. Copyright 2008. Michigan: The Gale Group, Inc.

It is reasonable and necessary for the Department to provide HCBS to individuals with an intellectual disability and autism in integrated community settings. The Department is mandated to meet the Federal regulation governing community integration in HCBS settings to continue to be eligible for Federal financial participation. Under Federal

regulations, each state must establish measurable standards for providers of HCBS. Without a regulation governing the proximity of service locations, the Department risks establishing segregated service locations that would be ineligible for Federal financial participation. See 42 CFR 441.300—441.310.

Also in subsection (a), hospitals, nursing facilities and health and human service institutions are deleted from the list of locations for which a facility may not be located nearby.

Subsection (b) is revised to increase the limit on the number of units from 10% to 25% and to apply the limit to the building, rather than the development. The 25% limit is based on the Federal Housing and Urban Development standard regarding supportive housing for persons with disabilities at 42 U.S.C.A. § 8013(b)(3)(B)(ii), regarding supportive housing for persons with disabilities. That provision requires that the total number of multi-family housing dwelling units where rental assistance is provided for supportive housing for persons with disabilities may not exceed 25% of the total.

In response to the concern about applying a percentage to a small apartment building, the resulting percentage is rounded up. For example, in a building with ten units, 25% is 2½ rounded to three; with four units, 25% is one; with three units, 25% is ¾ rounded to one; with two units, 25% is ½ rounded to one.

Subsection (d) is deleted as it is duplicative of § 6100.444(b)(2) (relating to size of service location). As stated by the county governments, departmental approval must be obtained in advance for any intermediate care facility conversion to assure eligibility of Federal waiver funds. A regulatory waiver will be entertained regarding the special needs of the deaf community.

§§ 2380.121—2380.128; 2390.191—2390.198; 6100.461—6100.469; 6400.161—6400.168 and 6500.131—6500.138—MEDICATION ADMINISTRATION; MEDICATIONS

The IRRC, a provider association, plus numerous form letters from commentators and several providers, question the codification of medication administration requirements in regulations. The provider association suggests that rather than promulgate regulations, the Department's medication administration training course and manual be followed to prescribe medication practices. This alternative to regulations is suggested to permit updates to medication procedures as new health care information and technology emerge.

The IRRC asks how the regulation will be updated as new health care information, practice and technology emerge.

A provider association, several providers and the IRRC ask the Department to correct discrepancies between the proposed rulemaking and the Department's medication administration training course manual.

Several providers suggest that the medication sections of the regulation are overly prescriptive and detailed.

A few county governments support the addition of medication administration for vocational facilities.

Response

Medication requirements have been codified in departmental regulations since 1991. See §§ 6400.161—6400.169 and 6500.131—6500.138 at 21 Pa.B. 3595-3647 (August 10, 1991). The 1991 regulations, and the subsequent departmental regulations specified in §§ 2380.121—2380.129, 2600.181—2600.191, 2800.181—2800.191, 3800.181—3800.189, 6400.161—6400.169 and 6500.131—6500.138 provide critical health and safety protections for individuals in the areas of safe medication storage and handling, reporting of adverse reactions and medication errors, medication administration tracking and medication administration training for non-medically licensed staff persons. As suggested by the unanimous and overwhelming comments requesting consistency and continuity across the five chapters of intellectual disability regulations, the final-form regulation codifies existing medication requirements into Chapters 2390 and 6100 and updates the requirements across Chapters 2380, 2390, 6100, 6400 and 6500. Enforcement of medication protections is critical to ensure the health and safety of the individuals who receive services in the programs governed by Chapters 2380, 2390, 6100, 6400 and 6500.

In response to concerns that the regulations contain requirements likely to be governed or amended by other State agencies or new statutes, the Department conducted a careful review and found three requirements that warranted revision. The requirement for the content of a pharmacy label is unnecessary, as this is governed by applicable pharmacy regulation in 49 Pa. Code § 27.18(d) (relating to standards of practice); therefore, proposed §§ 2380.124, 2390.194, 6100.464, 6400.164 and 6500.134 are deleted. The regulation in 49 Pa. Code § 27.18(d) requires that a container in which a prescription drug or device is sold or dispensed include the following: the name, address, telephone number and DEA number of the pharmacy; the name of the patient; full directions for the use of its contents; the name of the prescriber; the serial number of the prescription and the date originally filled; the trade or brand name of the drug, strength, dosage form and quantity dispensed; if a generic drug is dispensed, the manufacturer's name or suitable abbreviation of the manufacturer's name; and on controlled substances, the statement: ''Caution: Federal law prohibits the transfer of this drug to any person other than the patient for whom it was prescribed.''

The Department also updated the provision relating to the acceptance of oral orders received by a health care practitioner in final-form §§ 2380.124(e), 2390.194(e), 6100.464(e), 6400.164(e) and 6500.134(e). While the use of oral orders has lessened with the advent of written email orders, these sections are updated to reference the standards of the Department of State.

Sections 2380.122(b)(2)(vi), 2390.192(b)(2)(vi), 6100.462(b)(2)(vi), 6400.162(b)(2)(vi) and 6500.132(b)(2)(vi) which specify the types of medications, procedures and treatments that are permitted to be administered under the Department's medication administration training course, have been modified to permit the administration of any new medications, injections, procedures and treatment as permitted by State statutes and regulations.

The final-form regulation will be amended in accordance with applicable statutes and regulations as new medical information, practice and technology emerge.

The Department conducted a thorough review of its medication administration training course manual and made several edits to coincide with the final-form regulation. Several important updates were made to the course manual. The final-form regulation and the medication administration training course manual are consistent.

The final-form regulation regarding medication administration is shortened from proposed rulemaking and is generally less prescriptive than the existing regulations at §§ 2380.121—2380.129, 2600.181—2600.191, 2800.181—2800.191, 3800.181—3800.189, 6400.161—6400.169 and 6500.131—6500.138. In response to concerns about the codified practice becoming obsolete, the Department will continuously review the practice and amend the regulation if the requirements become obsolete.

§§ 2380.121, 2390.191, 6100.461, 6400.161 and 6500.131—Self-administration

A provider asks to strike “as needed” in subsection (a). A provider association, plus numerous form letters from commentators, assert that subsection (b) is incorrect and conflicts with subsection (e)(1)-(4). The same provider association asks to require that the assistive technology in subsection (c) be documented in the individual plan. A county government supports the requirement in subsection (c) to require a provider to provide or arrange for assistive technology.

Response

The qualifier “as needed” is helpful to explain that not all individuals require medication assistance. Subsections (b) and (e) are neither incorrect nor in conflict; the confusion may lie with the previous version of the medication administration training course manual that included different standards for self-administration. This discrepancy in the course manual has been corrected to match the final-form regulation. A staff person may provide reminders and offer the medication at prescribed times to an individual who is self-administering. Subsection (e)(3) is revised to clarify this requirement.

The need for assistance with medication administration should be assessed by the individual plan team and documented in the individual plan.

§§ 2380.122, 2390.192, 6100.462, 6400.162 and 6500.132—Medication administration

A provider association, plus numerous form letters from commentators, ask to allow the administration of oxygen, catheterizations, tube feedings and similar treatment in accordance with State statutes and regulations.

A few county governments and a provider ask to assure that there is sufficient capacity to train all required staff persons.

The IRRC and numerous commentators ask the meaning of an “00.163.163” order.

The IRRC and numerous commentators ask that licensed life sharing homes be exempted from the medication administration training requirements under § 6500.132.

The IRRC asks the Department to explain the need for, reasonableness of and fiscal impact of requiring this intensive training course for licensed life sharing homes.
A provider association asks that a nurse be required to give injections in vocational facilities.

Response

Subsection (b)(2)(vi) is revised to allow the administration of medications, injections, procedures and treatments in accordance with applicable statutes and regulations.

The Department's contractor providing the medication administration train-the-trainer course has increased its training capacity and is equipped to handle the new influx of trainees.

The term "00.163.163" order was a typographical error; the error is corrected.

The Department clarified in subsection (b)(1) that any person who is so authorized by the Department of State may administer medication.

While basic training regarding safe medication handling, storage and administration is necessary to protect the individuals to whom services are provided in life sharing, in § 6100.468(b) (relating to medication administration training), both licensed and unlicensed life sharing homes will complete a shorter, modified, family-friendly medication administration training course in place of the full comprehensive course. Numerous life sharing provider agencies already require completion of the full medication administration training course by their life sharers, so completion of the new modified course may be a cost reduction. The cost of the certified train-the-trainer program is paid by the Department for a certified medication administration trainer who assists the life sharer through the modified medication administration training course.

Only injections of insulin and epinephrine are permitted by trained staff persons who are not nurses. This provision has been effectively applied in other types of licensed human service facilities for more than 10 years.

§§ 2380.123, 2390.193, 6100.463, 6400.163 and 6500.133—Storage and disposal of medications

A family asks to regulate nonprescription medications. A provider association, plus numerous form letters from commentators, ask to administer medications immediately and not permit a 2-hour wait. An advocacy organization asks to extend the 2-hour period to allow for the transfer of medications into daily pill containers for individuals who attend day activities. A provider association, plus numerous form letters from commentators, support allowing epinephrine and epinephrine injectors to be kept unlocked and ask to allow individuals who are self-administering to place the individual's own medications in pill reminder dispensers. An adult training facility states that providing certified medication staff while the individual is out of the facility is a challenge. An adult day training facility asks that self-administering medications be kept locked and not carried or held by the individual.

Response

Nonprescription medications are regulated in subsection (a) regarding storage in the original container to protect the individual from taking an unknown or mislabeled substance.

The 2-hour time frame between removal of a medication from its original container and administration of the medication is deleted. Medication must be administered immediately upon its removal from the original container.

Sections 6100.463(b), 6400.163(b) and 6500.133(b) are revised to permit the transfer of a medication by a staff person into a daily dispenser for an individual to take to a community activity for administration the same day. Ideally, a pharmacy will prepackage daily medication into a separate container or blister pack so that staff and individuals do not have to handle the medication. The provider should ask the pharmacy to prepare multiple containers or blister packs of medication for anticipated travel or time away from the home during the day. Transfer of medications into containers is not permitted in day facilities; this practice is not necessary since the individual is at the day facility for only a portion of the day.

Subsection (h) is amended to encompass all applicable drug disposal statutes and regulations.

As described in subsection (i), this section does not apply to individuals who are self-administering; the proposed exemptions are broadened to encompass subsections (e), (g) and (h).

Staff persons responsible for administration of medication who accompany the individual while the individual is away from the service location must complete the

medication administration training course. This should not be an extra burden, as the staff persons who accompany the individual into the community are likely the same trained staff persons who work in the service location.

An individual who is capable of self-administration may carry the individual's medication in a pill box or other container. If there is concern about access to the medication by other individuals who are not capable of self-administration, the individual plan team should design a solution to provide independence to the self-administering individual, while at the same time protecting others. In an adult day facility, a solution to provide independence may be to provide lockers with keys for individuals, so they may lock their belongings with free access at any time.

§§ 2380.124, 2390.194, 6100.464, 6400.164 and 6500.134—Labeling of medications in proposed rulemaking

Numerous commentators suggest deletion of the specification of the content of the medication label, as the content of the medication label is a pharmacy standard.

Response

The requirements regarding the content of the medication label are deleted. The requirement for a prescription medication to be labeled with a label issued by a

pharmacy is retained and relocated to §§ 2380.123(a), 2390.193(a), 6100.463(a), 6400.163(a) and 6500.133(a).

§§ 2380.124, 2390.194, 6100.464, 6400.164 and 6500.134 (§§ 2380.125, 2390.195, 6100.465, 6400.165 and 6500.135 in proposed rulemaking)—Prescription medications

The IRRC and several commentators ask to allow electronic prescriptions.

A provider association, plus numerous form letters from commentators, ask to allow a licensed practical nurse (LPN) to accept an oral order, as this is within the scope of practice as specified by the State Board of Nursing.

In § 6500.135(e), a provider association asks why a life sharer cannot accept oral orders.

Response

Pursuant to 55 Pa. Code § 1101.66a (relating to clarification of the terms “written” and “signature”—statement of policy), a written prescription currently includes an electronic prescription; no regulation change is necessary.

While the use of oral orders has lessened with the advent of written electronic orders, subsection (e) is revised to permit oral orders to be accepted by persons who are so

authorized by the Department of State. This includes the provision for an LPN to accept oral orders.

In § 6500.134(e) (§ 6500.135(e) in proposed rulemaking), a life sharer is permitted to accept oral orders in accordance with regulations by the Department of State allowing only certain health care professionals to accept oral orders; however, given a prescriber's ability to fax or email a new prescription to a life sharer, this is not an obstacle to the provision of services.

§§ 2380.125, 2390.195, 6100.465, 6400.165 and 6500.135 (§§ 2380.126, 2390.196, 6100.466, 6400.166 and 6500.136 in proposed rulemaking)—Medication record

A few providers ask to delete the title of the prescriber. A few providers state the time frame for reporting over the weekend is not realistic. A provider asks to allow reports to a health care practitioner to include a nurse. A provider asks to clarify that a refusal to take a medication is not a medication error.

Response

The title of the prescriber in subsection (a)(2) is deleted.

Subsection (c) is revised to delete the specified reporting time frame and rely on the prescriber to direct the report. A refusal to take a medication must be reported to the prescriber only if the prescriber so directs, or if there is harm to the individual.

A refusal to take a medication is not a medication error, and therefore, a refusal to take a medication is not reportable to the Department as a medication error. Section 6100.466(a) (relating to medication errors) describes the specific conditions that constitute a medication error; the description of a medication error does not include an individual's refusal to take a medication.

§§ 2380.126, 2390.196, 6100.466, 6400.166 and 6500.136 (§§ 2380.127, 2390.197, 6100.467, 6400.167 and 6500.137 in proposed rulemaking)—Medication errors

A provider asks to change "amount" to "dose." A provider association, plus numerous form letters from commentators and several providers, ask to delete the requirement to report medication errors to the prescriber.

Response

The term "amount" is changed to "dose." Two additional types of medication errors as specified in the medication administration training course manual are added: wrong position and improper medication. The reporting of medication errors in subsections (b) and (c) is modified to delete the timeline for reporting and clarify that errors must be

reported to the prescriber only under certain circumstances. Documentation of medication errors is properly recorded as an incident and in the record, not as part of the individual plan.

§§ 2380.128, 2390.198, 6100.468, 6400.168 and 6500.138 (§§ 2380.129, 2390.199, 6100.469, 6400.169 and 6500.139 in proposed rulemaking)—Medication administration training

The IRRC and a university ask to define "certified health care professional." A university asks to require additional training for topical medication. A provider association, plus numerous form letters from commentators, ask to allow the administration of epinephrine injections by untrained staff and to allow naloxone administration. Another provider association, plus numerous form letters from commentators, state that requiring epinephrine training adds significant cost. A provider supports the epinephrine addition. A few provider associations, plus numerous form letters from commentators, ask to exempt life sharers from the medication administration training course. Several providers, a county government and an advocacy organization ask that life sharers complete the full medication administration training course. A provider suggests a less stringent course for life sharers.

Response

"Certified health care practitioner" is changed to "Health care practitioner" and is clarified and described in subsection(c)(2) as a professional who is licensed, certified or registered by the Department of State in the health care field. Clarification is added to subsection (a) to allow the administration of other medications, injections, procedures and treatments as governed by statutes and regulations. In subsection (d), a shorter, modified, family-friendly medication administration training course has been developed for life sharers and other settings that are not licensed by the Department, providing protections to the individual, while not creating onerous training requirements on small settings.

The frequency of training recertification in the use of auto-injectors for the administration of epinephrine is modified from every 12 months to every 24 months to coincide with the Certified Pulmonary Resuscitation (CPR) course recertification. Training in the use of auto-injectors for the administration of epinephrine is now being taught as part of the American Heart Association and American Red Cross CPR training courses. This is a benefit for providers who will not have to plan and budget for two separate training courses.

Requiring additional training for the administration of a topical medication through the regulations is not necessary. The administration of topical medications, such as eye drops, ear drops and ointments, is properly addressed in the Department's medication

administration training course by directing the certified medication trainer to obtain and follow the specific instructions of the individual's health care practitioner.

§ 6100.469 (§ 6100.470 in proposed rulemaking)—Exceptions

A provider association, plus numerous form letters from commentators, support the proposed relative exemption. A county government and an advocacy organization ask that medication administration training be required for adult family members who provide an HCBS.

Response

This section is clarified to provide that an adult relative of an individual is exempt from the medication administration training requirements, except for an adult relative of an individual who receives services in an unlicensed life sharing home or in a licensed facility. An exemption from the medication administration provisions is added for respite care and job coaches who provide fewer than 30 days of HCBS in a 12-month period.

§§ 6100.481—6100.672—GENERAL PAYMENT PROVISIONS, FEE SCHEDULE AND COST-BASED RATES AND ALLOWABLE COSTS

The IRRC asks the Department's authority for setting fees by establishing a fee published as a notice in the *Pennsylvania Bulletin*. A provider association, plus

numerous form letters from commentators, and several providers assert that these provisions, read in conjunction with § 6100.571 (relating to fee schedule rates), enable the Department to establish rates apart from and without compliance with an approved rate setting methodology that explains in reasonable detail the factors actually relied upon to set rates, how the factors were developed and utilized to set rates and the basis for the assumptions and presumptions relied upon to set rates. The commentators ask for more detail to understand how the new rates will operate, including specifications and metrics. Commentators ask how staff salaries and benefits will equate with the rates; without a qualified and stable work force, the regulation is for naught. An advocacy organization asks that rates be consistent across all programs, including autism.

Commentators cite 42 U.S.C.A. §1396a(a)(13)(A), regarding state plan requirements for public process in rate setting, and the decision in Christ the King Manor, Inc. v. Secretary of U.S. Dept. of Health & Human Servs., et al., 730 F.3d 291 (3d Cir. 2013) (Christ the King Manor) and two other cases for the proposition that the Department must adopt a rate setting methodology that is reasonable, considers more than simple budgetary factors, results in payments to providers that are sufficient to meet individuals' needs, addresses provider viability and allows for a retained revenue factor.

The IRRC states that is it unclear how or whether there is public input in the Department's rate setting process and asks how the Department's approach is consistent with the cited court case and State and Federal law. The IRRC specifically

asks how § 6100.481(b) (relating to departmental rates and classifications), which provides that the Department will establish fees by publication in the *Pennsylvania Bulletin,* is consistent with Federal law. The IRRC also asks how the Federal waiver process operates.

A legislator is concerned that the rates for both fee schedule and cost-based have stayed the same for at least five years, although the costs in the programs have increased. The same commentator is concerned that a review of the rates every five years is not sufficient to meet the annual increases faced by providers.

A few providers ask to remove all rate setting provisions from the final-form regulation, as the Department's duties are non-regulatory.

A provider association and several providers ask that the rates keep up with inflation and that an automatic cost-of-living increase be mandated in regulation.

Response

As noted under 42 U.S.C.A. § 1396a(a)(13)(A), the Department must provide public notice of the methodologies that underlie the rates and the justification used to establish the rates. Further, the Department must adopt a rate setting methodology that is reasonable, considers more than simple budgetary factors, results in payments to providers that are sufficient to meet individuals' needs, addresses provider viability and

allows a retained revenue factor. The Department acknowledges the applicability of cited Federal statutory provisions, specifically 42 U.S.C.A. §§ 1396a(a)(13)(A) and 1396a(a)(30)(A), as they relate to Medicaid State plan requirements. In its approved HCBS waivers under rate determination methods, the Department establishes the fee schedule rates to fund services at a level sufficient to ensure access, encourage provider participation and promote provider choice, while ensuring cost effectiveness and fiscal accountability.

In accordance with 42 CFR § 441.304(e) (relating to duration, extension and amendment of a waiver), the Department provides public notice by publishing in the *Pennsylvania Bulletin* a description of its rate setting methodology, including a discussion of the specific data and data sources used and the rate setting factors. See § 6100.571(d) (relating to fee schedule rates). Section 6100.571(a) requires that payment rates are consistent with efficiency, economy and quality of care. In addition, under general medical assistance payment regulations, fee schedule rates, procedures and services are authorized to be added or deleted by publication of a notice in the *Pennsylvania Bulletin*. See 55 Pa. Code § 1150.61(a) (relating to guidelines for fee schedule changes).

In addition, the cost-based rates and allowable costs are specifically identified in §§ 6100.641—6100.672. The Department publishes a notice in the *Pennsylvania Bulletin* relating to the cost-based rate methodology, including outlier analysis, vacancy

factor and rate assignment processes. See § 6100.645(e) (relating to rate setting). The Department looked to the CMS guidance in identifying the factors used to develop rates. See *Fee Schedule HCBS Setting: Developing a Rate for Direct Support Workers* at https://www.medicaid.gov/medicaid/hcbs/downloads/hcbs-1a-ffs-rate-setting.pdf and *Rate Methodology in a FFS HCBS Structure* at https://www.medicaid.gov/medicaid/hcbs/downloads/rate-setting-methodology.pdf.

The commentators' reliance on Christ the King Manor is misplaced because under these regulations, the rates apply to waiver services and do not contain a budget adjustment factor (BAF). Christ the King Manor involved litigation against the Federal Department of Health and Human Services (HHS) and the Department that challenged HHS's approval of the Department's Medicaid State plan amendment that applied a BAF to nursing facility reimbursement rates. The BAF decreased nursing facility provider rates, as established by the Department's case-mix payment regulations, by more than 9%. The nursing facility providers that brought the action claimed HHS improperly approved the BAF Medicaid State plan amendment by failing to take into consideration the quality of care factor required under 42 U.S.C.A. § 1396a(a)(30)(A). The providers further claimed that the Department's notice announcing the BAF failed to comply with the notice content requirements of 42 U.S.C.A. § 1396a(a)(13)(A).

The Court determined that the Department satisfied the public process and notice content requirements of 42 U.S.C.A. § 1396a(a)(13)(A), but that HHS failed to properly conclude, on the evidence before it, that the Department complied with 42 U.S.C.A. § 1396a(a)(30)(A). Specifically, the Court found that it could not "discern from the record a reasoned basis for the agency's decision" in approving the BAF Medicaid State plan amendment. Christ the King Manor, 730 F.3d at 314. HHS's treatment of the Department's overall increase in appropriations for nursing facility providers and the Department's assertions that payment rates are sufficient to ensure continued access to nursing facility services, were not sufficient evidence for HHS to determine compliance with 42 U.S.C.A. § 1396a(a)(30)(A). Id. at 313-315. The case was remanded and HHS reconsidered its determination and again approved the Department's Medicaid State plan amendment. Subsequent litigation resulted in judgment in favor of HHS.

Therefore, Christ the King Manor has no application to the Chapter 6100 rate setting process because Chapter 6100 does not relate to Medicaid State plan services and does not contain a BAF. In addition, Chapter 6100 specifically identifies the factors considered for rate setting purposes and employs a public process to establish rates.

In response to questions about the Department's authority to enforce the waivers through incorporation by reference in the regulation, proposed § 6100.481(a)(6) that referenced the Federal waivers is deleted.

In response to IRRC's question on how the Federal waiver process operates, please refer to the Background section of this preamble.

Section 6100.481(c) and (d) is revised to clarify that the fee is per unit of an HCBS.

Section 6100.571(a) is significantly revised to address the concerns of the commentators. See discussion relating to comments and the specific changes to the final-form regulation in § 6100.571(a)–(e).

Section 6100.571(c) mandates that the market-based data be updated every 3 years.

A cost-of-living increase is not included in the final-form regulation as the General Assembly appropriates HCBS funds through the Commonwealth's annual budgeting process.

§ 6100.482—Payment

A provider maintains that Chapters 1101 and 1150 apply to medical services and not to an HCBS. A provider association, plus numerous form letters from commentators, and a provider ask to permit flexibility, backdating and emergency exceptions in the frequency and duration statement. A provider association asks to change "and" to "or" in subsection (h). A provider asks to extend services beyond the individual plan.

Response

Chapter 1101 contains the general requirements that apply to providers enrolled in the medical assistance program. To be an HCBS provider, medical assistance program enrollment is required; therefore, Chapter 1101 applies to HCBS. See § 6100.81(b)(1) (relating to HCBS provider requirements), which requires an HCBS provider to comply with Chapter 1101.

The Department agrees with the commentator that Chapter 1150 does not apply to HCBS, because Chapter 1150 applies to medical assistance provider payment provisions and not to HCBS. Chapter 6100 governs the payment provisions for HCBS.

Consistent with previously discussed comments and changes, in response to questions about the Department's authority to enforce the waivers, subsection (a) is revised to delete reference to the Federal waivers.

Subsection (c) is revised so that the amount, duration and frequency is as approved and documented in the individual plan; services must be specified in an approved individual plan in order to be reimbursable by the CMS. Sections 6100.223(6) (relating to content of the individual plan) and 6100.226 (relating to documentation of claims) provide reasonableness and clarity regarding the application of claims documentation to the extent permitted by the CMS.

In subsection (h), the term “and” is changed to “or” as suggested.

§ 6100.483—Title of a residential building in proposed rulemaking

A provider association, plus numerous form letters from commentators, and a few providers ask to delete this section as unnecessary as the title to real estate acquired by a provider clearly remains with the provider who owns it.

Response

This section is deleted as unnecessary.

§ 6100.484 (§ 6100.485 in proposed rulemaking)—Audits

A provider association, plus numerous form letters from commentators, an advocacy organization and several providers ask to reduce this list of audit standards as the list is overly inclusive, suggesting subsection (a)(1) and (a)(2) are sufficient.

Response

This section is revised to delete proposed (a)(4)-(j) as unnecessary since these standards and audit sources are governed by other State and Federal agencies and governing authorities. Subsection (a)(3) regarding the United States Office of

Management and Budget Circulars is retained as a primary authorized source of audit standards.

§ 6100.485 (§ 6100.487 in proposed rulemaking)—Loss or damage to property

A provider asks to limit the requirements of this section to only damage or loss that occurs during the provision of an HCBS. A provider association, plus numerous form letters from commentators, ask that the provider be required to replace property only if staff is negligent or if the damage or loss is otherwise the fault of the provider. The same provider asks to allow for repair of the damaged property, if possible. A provider asks to delete damage due to normal wear and tear.

Response

The proposed rulemaking and the final-form regulation limit the damage or loss to that which occurs during the provision of an HCBS. The section is revised to clarify that this provision applies only if the damage or loss is due to the provider's action or inaction; this does not include damage or loss caused by the individual. Repair of an item is allowed and is added to this section.

§ 6100.571(a)—Fee schedule rates

Numerous advocates, universities, county governments, providers, provider associations and the IRRC submitted comments on § 6100.571. A provider association, plus numerous form letters from commentators, ask the Department to obligate itself to use the data in proposed subsection (b) to develop the rates. The same provider association asks the Department to use the United States Department of Labor standards and labor statistics to develop the rates. An advocacy organization, a family and several providers ask to use a nationally recognized market-based index, such as the Consumer Price Index or Medicare Home Health Market Basket Index. An advocacy organization asks to specify the HCBS covered under each payment option, such as fee schedule and cost-based. A few providers ask the Department to apply the data provided by the ODP Bureau of Autism Services and Autism Services, Education, Resources and Training (ASERT) when developing the autism rates.

In response to the advance notice of final rulemaking, a commentator, plus numerous form letters from commentators, ask that the rates reflect the costs to provide quality care based on the documented needs of the individuals as set forth in the individual plans. Another commentator, plus numerous form letters from commentators, ask that a nationally recognized market index be used to adjust the rates annually. Another commentator, plus numerous form letters from commentators, ask that an annual inflation factor be required The same commentator asks to require the Department to include in its annual budget to the Governor the funding necessary to support the

Medicare Home Health Market Basket Index to recalculate the fee schedule rates and update the rates to the following fiscal year.

Response

Subsection (a) is revised to clarify that the Department will establish fee schedule rates using a market-based approach so that payments are consistent with efficiency, economy and quality of care and sufficient to enlist enough providers so that services are available to at least the extent that such services are available to the general population in the geographic area.

The fee schedule rates cannot be based upon the needs specified in individual plans. The CMS requires that the fee schedule rate methodology result in a consistent rate paid to all providers of the same service. There are more than 53,000 individuals receiving HCBS and their needs are continuously changing. As specified in § 6100.571(b)(1), rates are based on levels of need to account for individuals with more intense staffing, behavioral, medical and other needs.

The specific market-based index is not specified in the regulation; rather, the Department will establish fee schedule rates using a market-based approach based on the following factors: the service needs of the individuals; staff wages; staff-related expenses; productivity; occupancy; direct and indirect program and administrative expenses; geographic costs; the Federally-approved HCBS definitions in the waiver; the

cost of implementing Federal and State statutes and regulations and local ordinances; and other factors that impact costs. The Department will update this data at least every 3 years as specified in subsection (c).

In addition, an annual inflation factor is not included in the final-form regulation. The General Assembly appropriates HCBS funds through the Commonwealth's annual budgeting process. The frequency of the data update addresses concerns related to the potential of increased costs over time. Previous drafts of the proposed regulation included a periodic data update and a 4-year data update. Further, the Department may choose to update the data more frequently than every 3 years.

Unnecessary restrictions specifying the types of HCBS covered under each payment option, such as fee schedule and cost-based, are not codified in the regulation to permit a change to payment methodologies as new and innovative payment methodologies and services emerge.

The same general methodology described in § 6100.571 (relating to fee schedule rates) is used to set rates for autism services.

§ 6100.571(b) (§ 6100.571(c) in proposed rulemaking)—Fee schedule rates

A university supports the enumerated factors used to establish rates.

The IRRC asks the Department to clarify the term “consider” to set binding norms of general applicability and future effect, to set clear standards of compliance and to provide predictability for the regulated community. An advocacy organization and a provider association, plus numerous form letters from commentators, ask that the Department mandate itself to take the factors into account, rather than to simply review and consider the factors.

In subsection (b)(2) ((c)(2) in proposed rulemaking), a university asks to use staff wages commensurate with work, skills and competency requirements. In subsection (b)(2), the university asks to limit executive salaries based on the funding level and services provided. In subsection (b)(3) ((c)(3) inproposed rulemaking), the university asks to add staff training costs.

A commentator is concerned about an individual’s unexpected and unpredictable decline that is limited to a supports intensity scale (SIS) score that is reviewed every 5 years; even with a request for a new assessment, it will take time to obtain an updated SIS score, while the cost of providing additional services is placed on the provider with no guarantee of reimbursement. Several providers ask what happens if an individual’s service needs change more often than every 3 years.

The IRRC and several commentators ask to delete subsection (b)(7) ((c)(7) in proposed rulemaking) since services may be provided outside the geographic region where the

provider's office is located. The IRRC asks to explain the reasonableness of this subsection.

A provider association proposes an extensive rewrite of this subsection to require an update of the data every 3 years to reflect current costs, require the Department to publish a rate setting methodology describing the process and the rates in detail and apply the Medicare Home Health Market Basket Index.

In response to the advance notice of final rulemaking, one commentator asks that staff expenses factor in actual expenses based on the annual cost reports submitted by providers, including administrative costs higher than 15%, staff training and flexibility in the rates based on staff ratios. A commentator asks to include market costs for housing, utilities, food and geographic data related to a living wage. A commentator asks for detail in the kinds of data to be used and that data relate to the intellectual disability service system. A commentator supports the inclusion of staff benefits, training, recruitment and service needs. A commentator, plus numerous form letters from commentators, ask that service needs reflect the specific needs in each individual plan. A few commentators believe that the proposed factors reflect the needs of a group setting operated by a large provider, and that the factors are not relevant for a residence for one individual or for a small provider. A provider association, plus numerous form letters from commentators, ask to qualify staff benefits as health care and retirement benefits and refer to benefits using the term "such as" rather than "including." A commentator states that the current staff training rates are well below

actual costs; the commentator asks that the rates reflect the costs to acquire the required skills and the costs to administer medication and medical procedures.

In response to the advance notice of final rulemaking, a commentator, plus numerous form letters from commentators, ask to clarify “occupancy” and “direct and indirect” expenses.

In response to the advance notice of final rulemaking, one commentator asks how subsection (b)(7) ((c)(7) in proposed rulemaking) permits a single Statewide rate. A commentator states that the legislature defines the classes of cities based on population. Several commentators oppose one Statewide rate, requesting that the southeast area of the State, and in particular Philadelphia, receive higher rates than the rest of the State based on local ordinances requiring higher minimum wages, insurance rates and wage taxes.

In response to the advance notice of final rulemaking, a commentator asks to add that cost components reflect reasonable and necessary costs.

In response to the advance notice of final rulemaking, a commentator asks that ramp up costs be factored in by adding another factor or in some other way.

Response

The Department is sensitive to the concerns that rate setting may produce rates below the providers' costs and that established rates may not increase at the same pace to reflect changes in the costs to provide services. Subsection (b) is revised to require the Department to "examine and use" the specified factors in establishing the fee schedule rates.

The Department follows the CMS guidance for establishing fee schedules found at *Rate Methodology in a FFS HCBS Structure* at https://www.medicaid.gov/medicaid/hcbs/downloads/rate-setting-methodology.pdf. In accordance with this guidance, the calculation of the staff wages factor in education, experience, licensure and certification and data from the Bureau of Labor Statistics for Pennsylvania. The suggested clarification to include education, experience, licensure requirements and certification requirements is added to subsection (b)(2) ((c)(2) in proposed rulemaking).

Data sources that include data for staff positions comparable to the staff positions in the intellectual disability and autism system are used since there are no national intellectual disability or autism staffing data sources. In accordance with the CMS guidance, found at *Rate Methodology in a FFS HCBS Structure*, the fee schedule is developed according to service levels; the data sources use U.S. Bureau of Labor Statistics data by job classification. In addition, the commentators' assertions about staffing costs are

not accurate; residential rates are based on the acuity of the individual and thus reflect staffing costs in both individual and group settings and for large and small providers. The cost to learn and maintain required skills, including medication administration and the provision of health care, is addressed in paragraphs (1), (2), (3) and (8). Therefore, these costs are factored into the rates.

In subsection (b)(3) ((c)(3) in proposed rulemaking), the requested change to add staff benefits, training, recruitment and supervision costs is made. Staff training costs are examined and used as an important factor to determine the fee schedule rates for program support costs and training time, as provided by the CMS guidance found at *Rate Methodology in a FFS HCBS Structure*. Staff training costs are appropriately and adequately addressed in paragraphs (1), (2), (3) and (8). The term "benefits" is not qualified since the commentator's requested language suggests that the types of benefits to be considered may be limited to health care and retirement; benefits may also include family leave, sick leave and vacation leave. The term "including" is appropriate since it means that the Department must consider benefits; the term "such as" suggested by the commentator means that benefits may or may not be considered. Therefore, the Department did not make the change.

In subsection (b)(6) ((c)(6) in proposed rulemaking), administrative-related costs, which encompass executive salaries, are calculated in accordance with the CMS guidance for establishing fee schedules found at *Rate Methodology in a FFS HCBS Structure*. As such, in subsection (b)(6) ((c)(6) in proposed rulemaking), there is no specific restriction

regarding executive salaries. As suggested by a provider association, program expenses are clarified to include both direct and indirect expenses.

In subsection (b)(4) and (b)(5) ((c)(4) and (c)(5) in proposed rulemaking), “productivity” and “occupancy” are defined. Productivity and occupancy vary by the service type. In the publication of the fee schedule notice, detail is provided for each factor with an opportunity for public comment. Separate from the rate setting process, but related to occupancy, if residential occupancy is decreased due to a vacancy, the Department has a procedure to adjust the rates accordingly. See § 6100.55 (relating to reserved capacity).

Subsection (b)(7) ((c)(7) in proposed rulemaking) regarding geographic region is revised to require the factor to apply to the geographic location of where the HCBS is provided, rather than the office location of the provider agency. The regulatory language requires that geographic costs based on location be considered, but it does not require the establishment of varied geographic rates. For fiscal year 2017-2018, the data supports one Statewide rate.

In subsection (b)(8) ((c)(8) in proposed rulemaking), “reasonable and necessary” costs are included as suggested by the commentators.

Subsection (b)(9) ((c)(9) in proposed rulemaking) requires consideration of local ordinances, such as minimum wage and wage tax requirements, that contribute to costs

for any of the preceding factors. Minimum wage and the wage tax requirements, such as those referenced for Philadelphia, were specifically considered when developing the language for subsection (b)(9).

Ramp up costs, also known as start-up costs, are addressed on a case-by-case basis. The need for start-up costs is infrequent and varies based on a limited number of users in the system; therefore, it is not appropriate to address start-up costs as part of the fee schedule.

In response to the concern about SIS assessments and the ability to quickly adapt to changing individual needs and adjust the fee schedule rate accordingly, the service needs of the individual are not dependent on or related to the 3-year data update in subsection (c); rather, if an individual's acuity level changes, the accompanying fee schedule rate may be assigned. SIS assessments are routinely conducted every 5 years for individuals receiving HCBS. While a SIS assessment is required to evaluate and validate the change in needs, an assessment will occur promptly if the request for reassessment indicates a significant change in the individual's health and safety needs. The Department considers a significant change any major change in an individual's life that has a lasting impact on the individual's service needs, is anticipated to last more than 6 months, and makes the individual's SIS assessment inaccurate and no longer current. Types of changes that may be considered include health status; behavioral issues; skills and ability; or the availability of technology. These are changes that the individual experiences that may cause the individual's service needs to increase or

decrease. For example, an individual could have a change in the individual's medical condition that requires more intensive supports; or, an individual could receive new assistive technology and, therefore, have less intense service needs than before acquiring the new technology.

§ 6100.571(c) (§ 6100.571(b) in proposed rulemaking)—Fee schedule rates

A provider association, plus numerous form letters from commentators, ask to use the term "rebase" rather than "refresh." A county government, a provider association and a provider support the 3-year data refresh. An advocacy organization, a few provider associations, plus numerous form letters from commentators and several providers, ask to refresh the data every year; they state that anything less frequent than 1 year is unfair and forces a provider to compromise the quality of care or operate at a loss. A few provider associations, plus numerous form letters from commentators, and several providers ask that an annual cost-of-living increase be mandated in the regulation.

In response to the advance notice of final rulemaking, several commentators ask to update the data used to develop the rates annually, rather than every 3 years.

Response

The section is simplified to use the term "update" rather than "refresh" or "rebase." The term "update" is the appropriate term, as it requires the Department to revise, examine

and use the data in the rate setting process. "Rebase" is a term used in cost-based methodology and is not appropriate in a fee schedule system.

The frequency of the data update remains as proposed as at least every 3 years. Previous drafts of the proposed regulation included a periodic update and a 4-year data update. The cost to the Commonwealth to conduct a data update is about $500,000. More frequent data updates will not produce sufficient variation in the data to warrant the added expense to the system that is better spent on delivering HCBS to individuals. The Department may update the data more frequently than every 3 years, as the language requires the update to be done "at least every 3 years."

A cost-of-living increase is not included in the final-form regulation as the General Assembly appropriates HCBS funds through the Commonwealth's annual budgeting process.

§ 6100.571(d)—Fee schedule rates

See comments discussed in *§§ 6100.481—6100.647—GENERAL PAYMENT PROVISIONS, FEE SCHEDULE AND COST-BASED RATES AND ALLOWABLE COSTS*.

A provider asks to allow providers 30 days to comment on the proposed rates.

In response to the advance notice of final rulemaking, a commentator asks to revise the term “summary,” stating that a “summary” is not sufficient. The same commentator asks the Department to publish a second notice to address the public comments.

The IRRC, another commentator, plus numerous form letters from commentators, ask that if a formula is not adopted in the regulation, the Department must be clear and precise in explaining all the factors and data used to calculate the rates. The same commentator suggests that a new regulatory section be added to regulate the SIS score.

Response

Significant changes are made to this subsection. The term “summary” has been changed to “description” to better prescribe the level of detail to be provided in the Department’s notice. The Department will publish a description of its rate setting methodology as a notice in the *Pennsylvania Bulletin* for public review and comment. The description will include a discussion of the use of the factors in subsection (b) to establish the fee schedule rates, a discussion of the data and data sources used and the fee schedule rates.

While the public comment period is not specified in the regulation, a public comment period of 30 days will be provided to the extent practicable.

In the final-form subsection (e), the Department will make available to the public a summary of the public comments received in response to the notice in final-form subsection (d) and the Department's response to the public comments.

A new section relating to the SIS scale may not be added to the final-form regulation as this new provision would enlarge the purpose of the proposed rulemaking, which is prohibited by the act of July 31, 1968 (P.L. 769, No. 240) (45 P.S. § 1202), known as the Commonwealth Documents Law. The Department may make "such modifications to the proposed text as published pursuant to section 201 as do not enlarge its original purpose." 45 P.S. § 1202.

§ 6100.641—Cost-based rate

An advocacy organization and a provider ask why this section refers to residential services when the Department plans to move to a fee schedule system.

Response

Subsection (b), which referred to residential services, is deleted.

§ 6100.642—Assignment of rate

An advocacy organization asserts that basing rates on cost reports means that the rates do not reflect actual costs, current costs or the wishes of the individuals. Another

advocacy organization and a family assert that using area adjusted rates in subsections (b) and (c) will be a disincentive for providers from serving individuals with higher needs. A provider asks to determine rates based on the region and not using a Statewide model. An advocacy organization asserts that assigning the lowest rate in subsection (d) penalizes individuals and leads to deterioration in the quality of services.

Response

The Department agrees with the comments that basing rates on cost reports is not the most effective payment methodology for intellectual disability and autism services, that the cost-based methodology may be a disincentive for providers to serve individuals with higher needs and that assigning the lowest cost-based rate may affect quality of services; therefore, the Department transitioned from a cost-based system to a fee schedule system for residential services effective January 1, 2018. The fee schedule rates consider the needs of the individual as one of the factors in establishing rates. See § 6100.571 (relating to fee schedule rates). Sections 6100.641—6100.672 continue to be necessary for transportation services and for any future HCBS for which a cost-based system is appropriate.

The comment relating to determining rates based on regions is addressed in § 6100.571(b)(7) that requires the Department to examine and use data regarding geographic costs, based on the location where the HCBS is provided, as one of the factors in establishing the fee schedule rates. While a single Statewide rate is not

prohibited by subsection (b)(7), geographic costs must be examined and used in establishing the rates.

§ 6100.643—Submission of cost report

The definition of “cost report” is relocated to § 6100.3 (relating to definitions).

§ 6100.645—Rate setting

An advocacy organization states that the use of the outlier analysis has led to substantial reductions in rates for individuals with the most intensive service needs and that services have been denied, violating unspecified provisions of Title XIX of the Social Security Act.

Response

The requirement in subsection (e) ((f) in proposed rulemaking) regarding the outlier analysis does not result in a denial of services.

Consistent with previous comments and changes, in response to questions about the Department’s authority to enforce the waivers through incorporation by reference in the regulation, proposed subsection (e) is deleted as it references the Federal waivers.

Subsection (e) ((f) in proposed rulemaking) is revised to clarify that the Department's review of the cost report is the Statewide process used to review the cost reports.

§ 6100.646—Cost-based rates for residential service

A provider association, plus numerous form letters from commentators, ask to clarify what happens when a unit cost is identified as an outlier and how a vacancy factor will be calculated. A provider association, plus numerous form letters from commentators and a few providers, ask to divide a provider's allowable costs by the provider's billed days. A provider association and a provider ask that the vacancy factor assessment and the percentage be based on current and historical data.

Response

Effective January 1, 2018, with the transition of residential rates to the fee schedule, this section no longer applies to residential service rates. For fee schedule rates, occupancy is a factor used in calculating the rates. See § 6100.571 (relating to fee schedule rates).

In response to the comments about outliers and vacancy factors, the Department previously identified a unit cost as an outlier when that unit cost was at least one standard deviation outside the average unit cost as compared to other cost reports submitted. A vacancy factor is defined in § 6100.3 (relating to definitions) as an

adjustment to the full capacity rate to account for days when residential service providers cannot bill due to an individual not receiving services. The vacancy factor for residential habilitation was previously calculated based on historical data for all residential service locations, as the current data will not have undergone an independent audit. The unit cost was previously calculated as reported on the cost report, rather than as costs divided by billed days.

§ 6100.647—Allowable costs

A provider association, plus numerous form letters from commentators and a provider, ask to delete this section as vague and unnecessary. A provider asks that payment be made for outcomes delivered, rather than by cost reports. A few providers state that this should not apply once the conversion is made to the fee schedule.

Response

This section is retained as necessary to govern transportation services and allow for use of a cost-based system in the future, if deemed appropriate. The section provides sufficient detail by specifying the requirements for the best price by a prudent buyer, relating the cost to the administration of the HCBS, the allocation and distribution of costs, reference to and criteria for allowable costs and transactions between related parties.

The comment suggesting payment for outcomes delivered, rather than by cost reports, is supported. The Department has converted residential services from a cost-based payment methodology to a fee schedule payment methodology, effective January 1, 2018.

As discussed previously, in response to questions about the Department's authority to enforce the waivers, the reference to the Federal waivers in subsection (d) is deleted.

§ 6100.648—Donations in proposed rulemaking

The IRRC, a few provider associations, plus numerous form letters from commentators and several providers, ask why limitations on donations are imposed in a single payer system in which the Department does not participate in fundraising efforts.

Response

The proposed section regarding donations is deleted.

§ 6100.648 (§ 6100.486 in proposed rulemaking)—Bidding

The IRRC and other commentators request this provision not apply to a fee schedule model. The IRRC asks why a provider must obtain supplies and equipment using a

competitive bidding process. A few providers ask to set the threshold at $25,000; a few other providers ask to limit the bidding to new purchases over $10,000.

Response

This section does not apply to a fee schedule payment system; as such, the section is relocated from the general payment section to apply only to the cost-based provisions in § 6100.648 (relating to bidding). A bidding process is necessary for a cost-based program to assure that fair and reasonable prices are paid. The $10,000 limit is fair and reasonable. The standards for bidding assure fiscal accountability in the careful and prudent use of State and Federal taxpayer dollars, similar to obtaining several private contractor bids for a home renovation project. The bidding provision applies only to cost-based services.

§ 6100.650—Consultants

The IRRC and commentators ask why the written agreement with a consultant in subsection (b)(3) must include the method of payment and why benefits are not allowable in proposed subsection (c). The IRRC asks to explain the reasonableness and fiscal impact of these provisions.

Response

In subsection (b), executing written consultant agreements that include the method of payment is a common and acceptable business practice. There is no economic or fiscal impact for this provision as most providers already execute such contracts. Written agreements are necessary to provide fiscal accountability for the public funds.

Subsection (c) governing benefits is deleted. Benefits for a consultant are allowable if the costs are built into the contractor's fee; this occurs through the contractor's agreement with the provider. For example, a contractor's fee may include the cost of vacation time, retirement, health benefits, travel expenses or other benefits built into the overall consultant fee.

§ 6100.651—Governing board

A university asks to require training on the CMS regulation in 42 CFR §§ 441.300—441.310 and Statewide transition for the governing board members.

Response

The specific types of governing board training suggested are supported by the Department, but are not appropriate for regulation.

Clarification is added to subsection (c)(1) regarding the lack of restriction to supplement the expenses of the board.

§ 6100.652—Compensation

The IRRC asks the Department to explain why a bonus or severance payment that is part of a severance package is not allowable and the fiscal impact of this restriction. A provider association, plus numerous form letters from commentators, ask to allow bonuses and severance not to exceed a 3-month salary. Another provider association, plus numerous form letters from commentators, ask to combine subsections (b) and (c). A third provider association asks to delete subsection (b), stating that Circular A122 allows severance pay in certain circumstances. A provider states that this is the cost of doing business and should be allowed.

Response

Subsection (b) is clarified to state that a bonus that is not part of a compensation package is not allowed. If the bonus or severance is part of a compensation plan, agreement or package, it is permitted with no limitations. The intent of this provision is to limit the use of taxpayer dollars for unplanned bonuses and severances. This limits the amount of unplanned high-level bonuses, often known as golden parachutes, to reduce the cost impact on the Commonwealth, allowing HCBS funds to be dedicated to providing HCBS to the individuals.

The Department did not combine subsections (b) and (c) since shorter and distinct sections are easier to read.

§ 6100.657—Rental of administrative equipment and furnishing

Consistent with current practice, this section is clarified to apply to administrative equipment and furnishings.

§ 6100.659—Rental of administrative space

Regarding subsection (a), a provider association, plus numerous form letters from commentators, suggest that there should be no difference in an allowable cost for administrative space due to the relationship with the lessor; the rental charge should be the same whether the lessor is a related party or not.

In subsection (a)(1), a provider suggests that it is not practical to ask a lessor to put this language in its lease; it is the provider's duty to get the best rates on the leased space. A few other providers agree and ask to delete this requirement.

A few providers ask to delete the word "minimum" in subsection (c).

Response

These changes are made. Subsection (a)(1) is changed to reflect that there is no difference in an allowable cost for administrative space due to the relationship with the lessor. Further, subsection (a)(1) is changed to eliminate the requirement regarding the lease with a related or an unrelated party. Subsection (c) is changed to delete the requirement that expenses relate to the minimum amount of space necessary.

§ 6100.660—Occupancy expenses for administrative buildings

A few providers ask to strike the requirement to document utility costs at fair market value as the provider has little control over these costs. A provider association asks to add maintenance costs as an allowable expense.

Response

These changes are made.

§ 6100.661—Administrative fixed assets

The IRRC and several commentators state that subsection (h) does not consider that there may be fixed assets that are ineligible, in support of homes and reimbursed as ineligible on the fee schedule, and other assets that are eligible in support of

administration and reflected on the cost report. The IRRC asks to explain the reasonableness and the economic impact of this provision.

Regarding subsection (i)(2), a provider association, plus numerous form letters from commentators, ask to clarify that (i)(2) applies as related to the eligible waiver program. The same provider association believes that in subsection (i)(3), an annual inventory is burdensome and should be completed at the discretion of the provider.

Response

Subsection (h) is revised to require the provider to apply the revenue amount received through the disposal of a fixed asset to any eligible or ineligible expenditure. This provision allows providers to apply revenue from disposal of fixed assets to any expenditure described in § 6100.647 (relating to allowable costs) or apply the revenue to expenditures that fall outside the definition of allowable costs, but occur in the course of providing HCBS. With this change, there is no economic impact for this provision.

Subsection (i)(2) is revised to clarify that this applies to eligible HCBS expenditures.

Subsection (i)(3) is revised to delete the timing of the annual inventory; however, an annual inventory is necessary for public fund accountability and audit purposes.

§ 6100.662—Motor vehicles

Several providers state that maintaining a daily log is unnecessary and onerous. A few providers ask to require documentation of fair market value. A provider association, plus numerous form letters from commentators, ask to specify how a provider must analyze and compare vehicle rental versus purchase.

Response

No changes are made to this section. A daily log is necessary for medical assistance billing purposes. The methodology used to compare rental and purchase costs is at the discretion of the provider. The provider will compare rental and purchase costs and select the most practicable and economical alternative.

§ 6100.663—Administrative buildings

In subsection (b), a provider asks that fixed assets be defined to exclude real estate and to delete the concept of funded equity.

Regarding subsection (c), the IRRC and several commentators ask to explain the basis upon which an approval will be granted and how a provider may appeal a disapproval. A provider association, plus numerous form letters from commentators, assert that the provider should not have to obtain permission to make improvements.

In subsection (f), several commentators ask to define “funded equity” so that it does not apply to equity built or acquired through donation or fundraising. The IRRC states that other commentators ask for subsection (f) to be deleted. The IRRC asks the Department to clarify its intent and to explain the reasonableness of this provision.

A provider association, plus numerous form letters from commentators, ask to delete subsection (g) as unnecessary since the title remains with the provider that owns it.

Response

The definition of “fixed asset” is found at § 6100.3 (relating to definitions). The definition excludes real estate. The concept of “funded equity” is deleted from subsection (f).

Subsection (c) is revised to include renovations for more than 25% of the current real estate value, which will significantly increase the threshold amount requiring approval.

For any future HCBS that are reimbursed on a cost-basis, the Department’s approval of the renovation is based upon the need for the administrative building and the reasonableness of the costs.

A provider may appeal a disapproval in accordance with Chapter 41 (relating to medical assistance provider appeal procedures).

Subsections (f) and (g) are deleted since the provisions are unnecessary.

§ 6100.664—Residential vacancy

A provider states that the regulation should not have an open-ended reference to a vacancy rate. A provider asks to delete the reference to a vacancy rate. Yet another provider asks to delete the vacancy rate in favor of a rate calculated by dividing actual allowable costs by the billed units of service. A few providers ask not to be penalized when an individual is on medical, hospital or therapeutic leave. A few county governments support the clarification in subsection (e) regarding transfers of individuals due to absence.

Response

It is unclear what the commentator intended by using the term "vacancy rate." There is no specific payment rate or payment for vacancy as such a payment would not be eligible for Federal financial participation; rather, the rates reflect assumptions such as a "vacancy factor" related to non-billable time, due to vacancies when an individual is on medical, hospital or therapeutic leave. If the term is intended to capture the percentage of time the individual is absent from receiving a service, and thus non-billable time for the provider, then the term "vacancy factor" is the appropriate term. The term “residential habilitation vacancy” is changed to “residential vacancy” to align with

language in the Federal waivers and to be consistent with the term as used in this chapter.

The comment regarding vacancy rate during medical, hospital or therapeutic leave is appropriately addressed in the change to § 6100.55 (relating to reserved capacity). Provisions related to transfer of individuals are addressed in §§ 6100.302—6100.303 (relating to cooperation during individual transition; and involuntary transfer or change of provider).

Subsections (c), (d) and (e) are deleted as unnecessary in this section, since the proposed concepts are appropriately and adequately addressed in § 6100.55 and § 6100.303.

§ 6100.665—Indirect costs

A provider association and a few providers ask to omit the reference to the Federal Circulars and the cross-reference to Generally Accepted Accounting Principles (GAAP) in § 6100.647 (relating to allowable costs), as redundant.

Response

Reference to the Office of Management and Budget Circulars and the related guidance for purposes of clarifying indirect costs is not redundant and remains unchanged.

Subsection (e) is deleted as unnecessary.

§ 6100.666—Moving expenses

A provider association, plus numerous form letters from commentators, ask to remove the requirement for prior approval.

Response

This change is made.

§ 6100.668—Insurance

A provider asks to require malpractice and board insurance. A provider asks to remove paragraphs (1)-(7) and require only minimum insurances.

Response

No change is made. The list of minimum insurances is reasonable and necessary to protect the public. The Department supports the provider's choice to maintain malpractice and board insurance, but this is not a mandated requirement.

§ 6100.669—Other allowable costs

An advocacy organization and a university ask to add the cost of auxiliary aids and services, including qualified interpreters.

A provider believes it is reasonable to divide the cost of legal fees between the provider and the Department if a settlement is reached. A provider association, plus numerous form letters from commentators and several providers, ask that when a provider in good faith challenges a departmental action and the parties resolve the dispute to avoid the cost and uncertainty of the litigation, the legal fees incurred by the provider must be compensated by the Department.

Response

The costs for auxiliary aids and interpreters is an allowable cost if the costs are not otherwise covered as an HCBS.

Based on long-standing Department policy, the cost to file suit against the Department is not an allowable cost if a settlement results; such cost may not be borne by taxpayers. As stated by the commentators, if a settlement is reached, much of the litigation cost is avoided.

§ 6100.670—Start-up cost

A county government supports this section, including the expansion of conditions under which start-up costs may be requested. An advocacy organization asks that the Department affirm that adequate start-up funds will be available and that funds will be available to acquire assets, including accessibility modifications. A provider asks to advance up to 25% of the first annual budget for start-up. A provider association, plus numerous form letters from commentators and a few providers, support the use of start-up funds for a business in a new geographic area, but ask that the amount for start-up must be reasonable.

Response

The expanded list of activities eligible for start-up costs remain. The authorization specifications in subsections (b) and (c) are deleted since these provisions do not require regulatory oversight. The Department cannot commit to the level of start-up funding available, as the Department's funding level is part of the Department's general appropriation subject to budget enactment.

§ 6100.672(a)—Cap on start-up cost

A provider association, plus numerous form letters from commentators, support the removal of the $5,000 cap and ask to base the limit on the needs of each individual.

Another provider association and a few providers ask to set a cap at $40,000, but remind the Department that raising the cap is only useful if more funds are allocated to the Department's start-up fund. A provider states that costs can reach $100,000 for accessibility renovations such as ramps, showers and fully accessible homes.

Response

A specific cap amount was not proposed by the Department. A change is made to clarify that the Department will establish a start-up cap annually. The Department cannot commit to the level of start-up funding available, as the Department's funding level is part of the Department's general appropriation subject to budget enactment.

§ 6100.681—Room and board applicability

The IRRC and a provider association, plus numerous form letters from commentators, assert that this section should apply only to licensed facilities and not to unlicensed or apartment settings. The IRRC asks to explain the reasonableness of this provision. A provider association, plus numerous form letters from commentators, ask to provide guidelines regarding what is included in room and board.

Response

The section is clarified to apply to provider-owned or provider-leased residential service locations and to life sharing homes that are not owned or leased by the individual. This section does not apply to most family settings, since the provider does not own or lease the property. Organized health care delivery systems and support coordination organizations are exempt from this section. See §§ 6100.804(b)(6)) (relating to organized health care delivery system) and 6100.803(d)(5)) (relating to support coordination, targeted support management and base-funding support coordination). These sections are intended to protect an individual's financial independence and security in situations where the individual has a financial relationship with the provider (whether licensed or unlicensed) because the provider owns or leases the residential service location.

In response to the comments, § 6100.684(d) (relating to actual provider room and board cost) clarifies what is included in room and board costs.

§ 6100.682—Assistance to the individual

A provider states that the responsible party is the family or support coordinator. A provider association and a provider state that the phrase "if desired by the individual" is not consistent with landlord-tenant agreements that bind a lessee through an agreement.

Response

This section applies to individuals who reside in provider-owned or leased residential service locations and in life sharing homes that are not owned or leased by the individual. The support coordinator is responsible for assisting the individual to apply for supplemental security income (SSI) benefits. In addition, providing SSI benefit assistance to individuals has been done by providers for decades in accordance with Chapter 6200 (relating to room and board charges).

The phrase “if desired by the individual” in subsection (b) is deleted; if an appeal is not filed and no SSI is received, the provider may not get paid, since room and board is collected based on available income. The application for benefits, and the subsequent appeal if SSI benefits are denied, is necessary. Subsection (d) is relocated from proposed § 6100.687 (relating to documentation).

Proposed § 6100.444 (relating to lease or ownership) is deleted; further, all references to leases are deleted in response to public comment.

§ 6100.684—Actual provider room and board cost

A provider association, plus numerous form letters from commentators, ask to require a new room and board contract once each year, rather than each time a contract is signed. The same provider association asks if the room and board costs are calculated

per site or in the aggregate; the association recommends that costs be done in the aggregate. Another provider association asks to clarify the documented value of room and board. A provider states that this proposed section regarding actual room and board costs will make U.S. Department of Housing and Urban Development (HUD) vouchers more difficult for supported living.

Response

While the provider must recalculate the room and board costs when a new contract is signed; changes outside of the annual renewal are unlikely. A change most often occurs due to a move to a new location and then room and board must be recalculated. If the new contract is due to a change in representative payee assignment, the costs are re-verified and the agreement is re-signed.

Costs are based on the actual room and board costs for a specific location, not in the aggregate. This process has been in effect under Chapter 6200 for more than 2 decades. The justification for using site specific costs, rather than total costs allocated across all sites, is that an individual should only be liable for the room and board the individual receives. If the costs are allocated across all sites, then costs associated with an individual who has a higher level of need, such as an individual who has a special diet, would be shared with other individuals who do not receive the benefit of those additional costs.

Subsection (a) is clarified to specify the actual documented room and board costs at the individual's residential service location.

In supported living, the residential service location is not provider-owned or provider-leased, so §§ 6100.681—6100.694 do not apply. Section 6100.684 does not interfere with or make HUD participation difficult for supported living, since this section does not apply to supported living services. Supported living services may be provided in any setting, regardless of HUD funding.

§ 6100.685—Benefits

A provider association, plus numerous form letters from commentators, ask that the provider be required to notify the representative payee if benefits are received. Another provider association asserts that because utilities are in the provider's name, energy assistance cannot offset expenses for the provider. The provider association also states that the individual is entitled to the rent rebate, so rent rebates should not be part of the provider's expense. In subsection (a), a provider asks that applying for benefits be optional, rather than mandatory. A provider association states that subsection (b) contradicts subsection (c).

Response

Since the individual or the representative payee applies for the benefits, the individual and representative payee are notified by the benefit agency. The Department is uncertain why the provider association asks to mandate additional paperwork.

The concern that a rent rebate may not be retained by the provider is a misunderstanding of how to apply for such benefits. If the application is completed as "group living," the rent rebate or food assistance is retained and used by the provider. This service helps the provider to offset the costs of room and board, if the application is completed accurately. The benefit monies are retained by the provider and must be subtracted from the actual room and board costs for a specific location before calculating the individual's share of room and board.

When applying for a rent rebate as a group living arrangement, other assistance benefits, such as energy assistance, may also be available and should be identified by the county assistance office. These additional benefits could help offset the costs charged to individuals, and, as such, the application for benefits is not optional.

Subsection (c) is clarified to state that the benefits are not considered part of the individual's income.

Subsections (b) and (c) are not contradictory; (b) requires deducting the value of the benefits from the room and board costs, while (c) states that benefits may not be considered as part of the individual's income.

The term "food stamps" is updated to "food and nutrition assistance."

§ 6100.686—Room and board rate

A provider states that proration should not occur until after a period of 2 weeks on leave from the residence to limit the proliferation of administrative work generated by the shorter period. A provider asks to make this provision consistent with the landlord-tenant relationship where no proration of payment occurs. A provider association, plus numerous form letters from commentators, support the change to 8 days; the change from every day to 8 days is an improvement. A few providers ask the Department to set a minimum amount the individual retains as $30. A provider association asks the Department to post the minimum amount retained by the individual in a departmental bulletin.

Response

As supported by the provider association comment, the administrative paperwork is reduced from the current daily proration requirement in § 51.121(d)(2) (relating to room and board) to 8 days in the final-form regulation. While there was one public comment

about extending the proration requirement to 2 weeks, discussions with stakeholders support the decision to move from daily to 8 days. The landlord-tenant provision in the proposed § 6100.444 (relating to lease or ownership) is deleted. Note that only board is prorated; room costs are not prorated.

The minimum amount to be retained by the individual is established by the U.S. Social Security Administration (SSA), so it should not be set in State regulation. While the minimum amount is currently $30, this amount may be changed by the SSA. As requested by the commentator, when the SSA changes the minimum amount to be retained by the individual, the change will be announced to the providers and other affected parties.

A clarification is added to subsections (a) and (b) that the room and board rate is established using the SSI maximum rate, plus the Pennsylvania supplement. This same clarification is also made in § 6100.688 (relating to modifications to the room and board residency agreement).

§ 6100.687—Documentation in proposed rulemaking

A provider association asks to delete this requirement as duplicative.

Response

This section is deleted; the necessary documentation requirement is relocated to § 6100.682(d) (relating to assistance to the individual).

§ 6100.687 (§ 6100.688 in proposed rulemaking)—Completing and signing the room and board residency agreement

An advocacy organization asks to require the use of auxiliary aids and services. A few providers ask to publish the room and board agreement in the chapter. A provider asks not to specify a form since HUD has its own required lease. A few county governments ask if the representative payee for social security benefits or a power of attorney can sign the room and board residency agreement.

Response

Communication is addressed in § 6100.50 (relating to communication). Auxiliary aids and services and language interpreters must be provided if required by the individual. The required room and board residency agreement form will be available to the public, but it will not be published in the chapter to allow for timely adjustments as Federal and State statutes and regulations change. The room and board sections of the final-form regulation do not apply to HUD housing, since HUD housing is not owned or leased by the provider. In subsection (c), a representative payee or a financial power of attorney

may sign the room and board residency agreement; the term “designated person for the individual’s benefits” includes any person that the individual designates, including a representative payee. Clarification is added to subsection (c) that if an individual has a designated person for the individual’s benefits, the designated person signs the room and board residency agreement.

§ 6100.689 (§ 6100.690 in proposed rulemaking)—Copy of room and board residency agreement

A provider association, plus numerous form letters from commentators, ask to require the provider to give a copy of the agreement to the support coordinator and the representative payee.

Response

The support coordinator does not need a copy of the agreement because the support coordinator is not responsible for the provider’s billing of room and board charges. While providing a copy of the agreement to the representative payee who signed the form is recommended, the Department does not believe it is necessary to create a regulatory compliance item for paperwork verification.

§ 6100.690 (§ 6100.691 in proposed rulemaking)—Respite care

A provider association, plus numerous form letters from commentators, ask to explain what “30 days or less” means. A few providers ask to allow the provider to charge a fee to the individual if it is past 30 days, as this is a financial hardship on the provider.

Response

The reference to the time period is deleted. This is not a financial hardship on the provider because the most appropriate service to authorize when an individual is receiving more than 30 days of service in a residential setting is residential habilitation or life sharing. The rates for residential habilitation and life sharing are higher than the respite care rate.

§ 6100.691 (§ 6100.692 in proposed rulemaking)—Hospitalization

A few provider associations, plus numerous form letters from commentators, ask to delete this section or clarify that the Department is responsible for payment after 30 continuous days of absence as this is a financial hardship on the provider. A provider association asserts that if an individual is hospitalized for more than 30 days, the individual is placed in reserved capacity, but the individual’s belongings stay in the home and no one else may receive services in that room; the provider association believes that the provider should continue to charge room and board for the room since the space cannot be used. A provider asks to continue to bill for the ineligible portion.

A provider asks to make this section consistent with the landlord-tenant provisions. The IRRC asks to address the reasonableness, need for and economic or fiscal impacts of this section.

Response

Allowing the provider to bill for the leave days is of grave consequence to the individuals who do not have the financial resources for payment. After debate and deliberation, the financial concerns expressed by the commentators are addressed in § 6100.55 (relating to reserved capacity). Section 6100.55 provides financial relief to providers by adjusting the approved program capacity to allow for an increase in the provider's rates for the time period of the individual's medical, hospital or therapeutic leave.

Section 6100.691 (relating to hospitalization), requiring that the provider may not charge room and board after 30 consecutive days of an individual being in a hospital or rehabilitation facility, is retained as necessary and reasonable to protect the individual's resources and assets. The economic and fiscal impact is minimized with the addition of § 6100.55 that allows an increase in the provider's rates during this period of extended stay at a hospital or rehabilitation facility.

§ 6100.692 (§ 6100.693 in proposed rulemaking)—Exception

A provider association, plus numerous form letters from commentators, ask to add the qualifier “unless the provider is paying for the food/nutritional supplement.”

Response

No change is made to the section. The provider is not permitted to pay for the food or nutritional supplements with HCBS funds. “Nutritional supplements” are now part of room and board costs. The Department will either cover the costs with medical assistance funds or, if medical assistance is denied, the provider may request a regulatory waiver to cover the cost of the food or nutritional supplements.

§ 6100.693 (§ 6100.694 in proposed rulemaking)—Delay in an individual’s income

The IRRC asks to clarify the meaning of “small amount” to set a measureable standard.

A provider association asks that rent be billed during the time when an individual’s income is delayed and to require back rent; the provider association asks to disallow the option of billing rent to an individual without current income.

Response

The term “small amount” is changed to “negotiated amount;” this amount is negotiated between the provider and the individual or person designated by the individual, based on the individual’s ability to pay. The provider will work with the individual to determine how much, if any, may be paid until the income source resumes. While the provider must still send a bill, paragraph (1) allows the provider the option to charge no amount or a partial amount until income resumes.

§ 6100.694—Managing individual finances

A university asks to prohibit a provider from charging a fee for managing an individual’s finances or for serving as an individual’s financial representative. The university asserts that an individual should have access to all of the individual’s funds without paying a fee for representative payee support. In addition, the provider should provide support to the individual to manage finances free of charge.

Response

A new provision is added to address the concern of the commentator. Although the SSA allows certain organizations to collect a monthly fee from an individual for expenses incurred in providing financial services, this is not permitted in the HCBS program. This is not a new expense and there is no fiscal impact since providers are

reimbursed for managing an individual's finances as part of their rate. Management of the individual's payments guarantees the provider the prompt and reliable collection of room and board payments.

§ 6100.711—Fee for the ineligible portion of residential service

The IRRC asks that similar and appropriate comments that are made to § 6100.571 be made to this section. A provider asks to use identical provisions as in § 6100.571. An advocacy organization asks to assure that ineligible rates, together with contributions from the individual and other benefits, are sufficient to cover the cost of room and board, including wear and tear. A provider association, plus numerous form letters from commentators, ask to delete this section since § 6100.571 covers this. Comments similar to those regarding § 6100.571, including using the rates reflected by the data and using a market-based approach, including a provision for an application of the Consumer Price Index or Medicare Home Health Market Basket Index, were received. A few providers ask to include a vacancy factor in the residential ineligible fee schedule.

Response

Changes similar to those made in § 6100.571 are made to this section regarding the ineligible portion of residential services. The list of factors in subsection (c) differs from § 6100.571(b), since the scope of the fees differ. The proposed factors of service needs of the individuals, staff wages, staff-related expenses and productivity are

deleted since they do not apply to the ineligible portion of payment for residential services. A new factor of meals for staff persons is added. A vacancy factor is included under subsection (c)(1) regarding occupancy.

Section 6100.711 must be retained as this section applies to fees for the non-eligible portion of residential service, while § 6100.571 applies to the eligible portion of residential services. See the discussion regarding the data and market-based approach under the previous response regarding § 6100.571.

§ 6100.741—Sanctions

A provider association asks to use the terms “compliance,” “remedies” and “remediation” because the terms “enforcement” and “sanctions” are outdated. A provider association and a provider ask to use positive terms aimed at compliance, since these are not licensing regulations.

A provider association, plus numerous form letters from commentators, ask to specify the time period that applies in subsection (b)(1). The same provider association asks to weigh the regulatory violations in subsection (b)(1) so each section does not carry the same weight when enforcing, extend the time frame in subsection (b)(2), as 10 days is too short to develop a meaningful plan, require free and full legal and authorized access in subsection (b)(5) and apply the appeal provisions in Chapter 1101 (relating to general provisions).

Response

The terms “enforcement” and “sanction” are the correct terms when specifying the Department’s authority and powers to enforce this chapter. As discussed previously in § 6100.42(e) (relating to monitoring compliance), the term “violation” is changed to “non-compliance.” Although governed by different authorizing statutes, as with the Department’s licensing regulations, enforcement of Chapter 6100 will occur.

No time period is added in subsection (b)(1); this applies to any non-compliance with this chapter; this does not apply if the Department has verified in writing that a non-compliance is fully corrected. The Department will consider developing a weighted measurement tool and system; however, in order to develop a valid weighting tool, the final-form regulation should be in effect and implemented for several years to gain an understanding of the regulatory compliance relationship between the various sections of the regulation and to determine which sections are more reliable predictors of performance.

No timeline for return of a corrective action plan is prescribed in either the proposed rulemaking or the final-form regulation; the time frame for completing the corrective action plan will be determined by the Department based on the number and types of non-compliance issues.

The substantive provisions of subsection (b)(5) are not changed; the Department and the designated managing entity have full and free access to the provider's records and the individuals receiving services. There are no statutory or regulatory restrictions or limitations to departmental or designated managing entity access. Denial of access or delaying access may result in a sanction in accordance with § 6100.741.

Applicable appeal procedures are addressed under § 6100.41 (relating to appeals). Specifically, that provision refers to Chapter 41 (relating to medical assistance provider appeal procedures), which incorporates by reference the actions identified as appealable actions. See § 41.3(a) (relating to definitions).

§ 6100.742—Array of sanctions

A provider association, plus numerous form letters from commentators, suggest deletion of paragraph (6); however, no rationale is provided. Another provider association, plus numerous form letters from commentators, ask for a graduated application of sanctions, stating that different sanctions may be effective for different non-compliance issues. The same provider association asks what happens if the provider cannot cover the costs to appoint a master and what types of non-compliance might result in this action.

Response

The Department agrees that different sanctions will be effective in different circumstances and for different types of non-compliance issues. The Department will

apply the level of sanction necessary to obtain the desired remedy. In paragraph (6), the appointment of a master can be especially useful for a large provider that has multiple, serious and systemic non-compliance issues related to mismanagement.

§ 6100.743—Consideration as to type of sanction utilized

A provider association, plus numerous form letters from commentators, assert that the Department may not act with a capricious disregard of the facts that underlie a non-compliance issue. The provider association also asserts the Department's consideration of variables in determining a sanction is unsupported in law; the Department wrongly assumes unfettered discretion; and the Department does not have full discretion to take action in an otherwise unregulated environment.

Another provider association asks to delete subsections (a) and (b). A provider asks that the remedy relate to the scope of the infraction. Another provider asks the Department to act consistently and reasonably at all times, based on facts and not discretion.

A provider asks to clarify the appeal process.

The IRRC asks the Department to explain its authority.

Response

Subsection (a) is revised to clarify that the Department may impose one or more of the sanctions in § 6100.742 (relating to array of sanctions), based on the Department's review of the facts and circumstances specified in § 6100.741(b) (relating to sanctions). The decision to vary the sanction based on the facts and circumstances of each case is within the Department's powers and duties. See 62 P.S. § 201(2) of the Human Services Code, providing the Department with broad authority to promulgate regulations, establish and enforce standards. There is no "one size fits all" approach to enforcement, as supported by the comment by another provider association in § 6100.742, requesting a graduated application of sanctions, stating that different sanctions may be more effective for different types of non-compliance issues. The Department will assess the circumstance of each non-compliance issue and apply the level of sanction necessary to obtain the desired remedy.

Subsection (c) is revised to refer to "factors," rather than "variables," since the term "factors" is more precise and clear. Subsection (c) is further revised to change the term "may" to "will" to require the Department to consider the factors when determining and implementing a sanction or combination of sanctions.

Appeals of sanctions issued in accordance with the final-form regulation are made in accordance with Chapter 41 as specified in § 6100.41.

§ 6100.801 (§ 6100.802 in proposed rulemaking)—Adult autism waiver

A university asks to apply all sections of this chapter to the adult autism waiver.

Response

This change is made. There are no exclusions or exceptions for services provided under the adult autism waiver. The few proposed exemptions are no longer necessary or applicable.

§ 6100.802—Agency with choice

Several providers, a family association and an advocacy organization ask to delete an agency with choice (AWC) from the scope of the final-form regulation, arguing that an AWC is similar to the vendor-fiscal model that is exempt. Numerous commentators request additional AWC exemptions, including criminal history checks, communication, the human rights team, reserved capacity, individual residential rights and incident analysis. Other commentators support the requirements for training, rights, individual plans and positive intervention.

A provider asks that an AWC be required to have standardized policies and procedures and that the AWC be transparent in its complaint process.

Numerous commentators, including provider associations, providers, families and advocates, ask to exempt an AWC from staff orientation, annual staff training or both. Reasons for a training exemption include the following: orientation is sufficient, communication with families is more important that formal training, many staff are part-time employees, training creates barriers to flexibility and choice, training is an undue hardship for families, training will reduce service to families, the unit rate does not support training and training must be individualized for each individual.

Response

AWC will continue to be regulated under this chapter. Vendor-fiscal, employer-agent and AWC are distinct types of financial management service providers. The most significant distinction is that the AWC is a co-managing employer model and, as such, the AWC has a primary role in providing quality services and ensuring compliance with basic program requirements, such as incident reporting and individual rights.

The cost for 32 hours of training per participant, per year is included in the AWC rates effective July 1, 2017. This rate increase is intended to cover multiple staff providing various services. AWC staff must complete the orientation in § 6100.142 (relating to orientation); while the core training topics are specified, there are no minimum number of hours required for this orientation.

The following exemptions are added for AWC staff in subsection (b)(3)(i)-(iii): the minimum number of annual training hours, the training course regarding the safe and

appropriate use of behavior supports and the training for staff who work fewer than 30 days in a 12-month period.

To provide health and safety protections to the individuals who receive services through an AWC, the general provisions, general requirements, individual rights, individual plan, restrictive procedures and incident management provisions apply.

In response to the comment asking that the AWC be required to have standardized policies and procedures, the Department did not make this change since standardized policies are not required for other HCBS and it would create a potential administrative burden for the AWC. In response to the comment that the AWC be transparent in its complaint process, the complaint procedures in § 6100.51 (relating to complaints by an individual) apply to an AWC.

§ 6100.802 (§ 6100.803 in proposed rulemaking)—Support coordination, targeted support management and base-funding support coordination

A few providers ask the Department to provide the standard support coordinator training course. Under subsection (e)(1), a provider suggests that all the required training cannot be completed in 24 hours. A university asks to require training on person-directed services. A provider association, plus numerous form letters from commentators, ask to include the cost of training in rate setting.

Under subsection (e)(2), commentators ask to explain why the responsibility for a support coordinator is distinguished from the incident reporting expectations of other types of providers under §§ 6100.401—6100.403. Commentators ask if "report" means to file an incident report through the Department's reporting system and with other appropriate State-mandated entities. A university and a few advocacy organizations ask to delete the language that states the support coordinator must report only what the support coordinator observes directly. The university and an advocacy organization assert that the proposed regulation places individuals at significant risk; the support coordinator must report all incidents whether the support coordinator observes the occurrence directly or if the incident comes to the support coordinator's attention by any means. A provider association, plus numerous form letters from commentators, support the provision as proposed that requires a support coordinator to report only those incidents he observes directly.

The IRRC asks to clarify where and how the reporting will be done. The IRRC asks to explain the reasonableness of setting the responsibilities for a support coordinator apart from the expectations for other providers.

Under subsection (e)(3) in proposed rulemaking, a county government suggests that a 6-month review is too frequent. The IRRC asks to address the reasonableness of this provision.

A provider asks to ensure the standards for individual plans are consistent across all support coordination agencies.

A university and an advocacy organization ask to require the support coordinator to meet with the individual at least quarterly to complete a wellness check and assure that services are provided in accordance with the individual plan.

Response

The Department will continue to provide the mandated training courses for support coordinators. While the Department understands that teaching the training material for the required areas may take more than 24 hours, the length of the training course is at the discretion of the support coordination agency based on the needs of the support coordinator. For example, a veteran support coordinator may be able to take an abbreviated course to refresh on the material previously learned. Training on the application of person-centered approaches is required for a support coordinator under §§ 6100.142—6100.143 (relating to orientation; and annual training). The cost of staff training for a support coordinator is included in the fee schedule rates.

Subsection (e)(2) is revised to require a support coordinator, targeted support manager and a base-funding support coordinator to report all incidents, unless the incident was already reported and documented by another source. For example, if an incident has already been reported by a staff person to the Department and to other required

reporting entities, and the support coordinator verifies that the incident has been properly reported, it is unnecessary for the support coordinator to reenter the incident report. There are no differences in the reporting requirements for a support coordinator and a staff person working in another type of service. The support coordinator reports an incident through the Department's online information management system. In response to the question from the IRRC about the reasonableness of setting the responsibilities for support coordinators apart from the expectations for other providers, the Department has amended this section to require that the responsibilities for reporting incidents are the same for all providers.

The requirements in proposed subsection (e)(3) and (e)(4) regarding documentation of continued need and enhanced staffing are deleted as unnecessary and overly prescriptive. These assessment areas are adequately covered in the individual plan process.

The requirements for the content of individual plans as specified in § 6100.223 (relating to content of the individual plan) apply to all support coordination agencies.

The duties of the support coordinator regarding the individual plan are specified in § 6100.225 (relating to support coordination, base-funding support coordination and TSM). An annual review of the individual plan is required at a minimum. Additional individual plan reviews are required when there is a change in the individual's needs. A

specific requirement for a quarterly wellness check for each individual is not added because the needs of each individual vary greatly.

§ 6100.803 (§ 6100.804 in proposed rulemaking)—Organized health care delivery system

Several providers and a family ask to exempt an organized health care delivery system (OHCDS) from this chapter, asserting that the regulations apply only to licensed providers.

Numerous commentators request additional OHCDS exemptions, including criminal history checks, the human rights team, reserved capacity, individual rights and incident management. Other commentators support the requirements for training, rights, individual plans and positive intervention.

Numerous commentators, including a provider association, plus numerous form letters from commentators, providers, families and advocates, ask to exempt vendors from staff orientation, annual staff training or both.

Response

The final-form regulation applies to both licensed and unlicensed providers that provide HCBS or base-funding only services. While an OHCDS must be regulated under this

chapter to protect the health and safety of the individuals receiving HCBS, upon reconsideration of this special program, the Department is exempting OHCDS from the criminal history checks for public transportation and indirect services, training, incident analysis and medication administration requirements because an OHCDS purchases goods or services approved in an individual's plan from generic community businesses, such as public transit, retail stores and general contractors for home adaptations, and does not directly provide the services.

§ 6100.804 (§ 6100.805 in proposed rulemaking)—Base-funding

A provider association supports the application of this chapter, with the exceptions specified in § 6100.805, to base-funding only services.

Response

The Department appreciates the comment supporting the application of Chapter 6100 to base-funding only services, with the exceptions specified in § 6100.805. The application of Chapter 6100 to based-funding only services, with the noted exceptions, provides equitable health and safety protections for the individuals across the ODP service system, while making it easier for an individual to transition through the various funding mechanisms.

The Department added subsection (b)(6) to clarify that the section on transition applies to base-funding only services, because transition is an important function of base-funding only services when an individual transitions from one funding source to another funding source.

§ 6100.805 (§ 6100.806 in proposed rulemaking)—Vendor goods and services

A provider asks to exempt vendors from this chapter, asking that the Department regulate and monitor vendors outside of regulation.

A few providers and an advocacy organization ask to exempt vendors from annual staff training. Numerous commentators request additional vendor exemptions, including criminal history checks, human rights team, reserved capacity, individual rights and incident analysis.

Several providers ask how this requirement will be applied to respite camps. An advocacy organization, a family group and a provider ask to exempt families who must make a down payment or pay a fee prior to service delivery at a respite camp.

Response

The final-form regulation applies to vendor goods and services; there is no alternate method to require and enforce compliance except through regulation. While vendor goods and services must be regulated under this chapter to protect the health and

safety of the individuals receiving HCBS, upon reconsideration of this special program, the Department is exempting vendors from the criminal history checks for public transportation and indirect goods and services.

Broad vendor exemptions from the requirements for criminal history checks, human rights team, reserved capacity, individual rights and incident analysis are not added, because these provisions are important health and safety protections for the individuals since certain vendors provide direct services to individuals.

Regarding the request to clarify how the regulation applies to respite camps, the sections regarding individual plans, individual rights, restrictive procedures, incident management and medication administration apply only to non-integrated respite camps that serve 25% or more people with disabilities.

Regulatory Review Act

Under § 5.1(a) of the Regulatory Review Act (71 P.S. § 745.5a(a)), on the Department submitted a copy of this regulation to the Independent Regulatory Review Commission (IRRC) and to the Chairpersons of the House Committee on Human Services and the Senate Committee on Health and Human Services. In compliance with the Regulatory Review Act, the Department also provided the Committees and the IRRC with copies of all public comments received, as well as other documents.

In preparing the final-form regulation, the Department reviewed and considered comments received from the Committees, the IRRC and the public.

In accordance with § 5.1(j.1) and (j.2) of the Regulatory Review Act, this regulation was deemed approved by the Committees on . The IRRC met on and approved the regulation.

In addition to submitting the final-form regulation, the Department has provided the IRRC and Committees with a copy of the Regulatory Analysis Form prepared by the Department. A copy of this form is available to the public upon request.

Order

The Department finds:

(a) The public notice of intention to adopt and amend the administrative regulation by this Order has been given pursuant to §§ 201 and 202 of the Commonwealth Documents Law (45 P.S. §§ 1201 and 1202) and the regulations at 1 Pa. Code §§ 7.1 and 7.2.

(b) That the adoption of this regulation in the manner provided by the Order is necessary and appropriate for the administration and enforcement of §§ 201(2), 403(b), 403.1(a) and (b), 911 and 1021 of the Human Services Code (62 P.S. §§ 201(2), 403(b), 403.1(a) and (b), 911 and 1021) and § 201(2) of the Mental Health and Intellectual Disability Act of 1966 (50 P.S. § 4201(2)).

The Department acting pursuant to §§ 201(2), 403(b), 403.1(a) and (b), 911 and 1021 of the Human Services Code (62 P.S. §§ 201(2), 403(b), 403.1(a) and (b), 911 and 1021) and § 201(2) of the Mental Health and Intellectual Disability Act of 1966 (50 P.S. § 4201(2)) orders:

(a) The regulation of the Department is adopted and amended to read as set forth in Annex A of this Order.

(b) The Secretary of the Department shall submit this Order and Annex A to the Offices of General Counsel and the Attorney General for approval as to legality and form as required by law.

(c) The Secretary of the Department shall certify and deposit the Order and Annex A with the Legislative Reference Bureau as required by law.

(d) This Order shall take effect as follows:

(1) Upon publication as final-form rulemaking for §§ 6100.55 (relating to reserved capacity), 6100.226 (relating to documentation of claims), 6100.227 (relating to progress notes), 6100.481—6100.485 (relating to general payment provisions), 6100.571 (relating to fee schedule rates), 6100.641—6100.672 (relating to cost-based rates and allowable costs), 6100.741—6100.744 (relating to enforcement), 6100.802 (relating to agency with choice), 6100.804 (relating to organized health care delivery system) and 6100.806 (relating to vendor goods and services).

(2) March 17, 2019 for § 6100.444(c) (relating to size of service location).

(3) 120 days following publication of the final-form regulation for the sections of the final-form regulation not listed in (1)-(2).

Annex A

TITLE 55. PUBLIC WELFARE

PART I. DEPARTMENT OF HUMAN SERVICES

Subpart E. HOME AND COMMUNITY-BASED SERVICES

CHAPTER 51. [OFFICE OF DEVELOPMENTAL PROGRAMS HOME AND COMMUNITY-BASED SERVICES] (Reserved)

§§ 51.1—51.4. (Reserved).

§§ 51.11—51.17. (Reserved).

§ 51.17a. (Reserved).

§§ 51.18—51.34. (Reserved).

§§ 51.41—51.48. (Reserved).

§§ 51.51—51.53. (Reserved).

§ 51.61. (Reserved).

§ 51.62. (Reserved).

§§ 51.71—51.75. (Reserved).

§§ 51.81—51.103. (Reserved).

§ 51.111. (Reserved).

§§ 51.121—51.128. (Reserved).

§ 51.131. (Reserved).

§ 51.141. (Reserved).

§§ 51.151—51.157. (Reserved).

PART IV. ADULT SERVICES MANUAL

Subpart D. NONRESIDENTIAL AGENCIES/FACILITIES/SERVICES

CHAPTER 2380. ADULT TRAINING FACILITIES

GENERAL PROVISIONS

§ 2380.3. Definitions.

The following words and terms, when used in this chapter, have the following meanings, unless the context clearly indicates otherwise:

Adult—A person 18 years of age or older.

Adult training facility or *facility*—A building or portion of a building in which services are provided to four or more individuals, who are 59 years of age or younger and who do not have a dementia-related disease as a primary diagnosis, for part of a 24-hour day, excluding care provided by relatives. Services include the provision of functional activities, assistance in meeting personal needs and assistance in performing basic daily activities.

[*Content discrepancy*—A difference between what was determined at the ISP meeting by the plan team and what is documented in the written ISP.]

Department—The Department of Human Services of the Commonwealth.

Direct service worker—A person whose primary job function is to provide services to an individual who attends the ~~provider's~~ facility.

[*Documentation*—Written statements that accurately record details, substantiate a claim or provide evidence of an event.]

Fire safety expert—A local fire department, fire protection engineer, State certified fire protection instructor, college instructor in fire science, county or State fire school, volunteer fire person trained by a county or State fire school or an insurance company loss control representative.

HEALTH CARE PRACTITIONER—A PERSON WHO IS AUTHORIZED TO PRESCRIBE MEDICATIONS PURSUANT TO A LICENSE, REGISTRATION OR CERTIFICATION BY THE DEPARTMENT OF STATE.

[*ISP—Individual Support Plan*—The comprehensive document that identifies services and expected outcomes for an individual.]

Individual—An adult with disabilities who receives care in an adult training facility and who has developmental needs that require assistance to meet personal needs and to perform basic daily activities. Examples of adults with disabilities include adults who exhibit one or more of the following:

(i) A physical disability such as blindness, visual impairment, deafness, hearing impairment, speech or language impairment, or a physical handicap.

(ii) A mental illness.

(iii) A neurological disability such as cerebral palsy, autism or epilepsy.

(iv) An intellectual disability.

(v) A traumatic brain injury.

INDIVIDUAL PLAN—A COORDINATED AND INTEGRATED DESCRIPTION OF ACTIVITIES AND SERVICES FOR AN INDIVIDUAL.

[*Outcomes*—Goals the individual and individual's plan team choose for the individual to acquire, maintain or improve.

Plan lead—The program specialist or family living specialist, as applicable, when the individual is not receiving services through an SCO.

Plan team—The group that develops the ISP.]

~~*PSP*—Person-centered support plan.~~

~~*Provider*—An entity or person that enters into an agreement with the Department to deliver a service to an individual.~~

Restraint—A physical, chemical or mechanical intervention used to control acute, episodic behavior that restricts the movement or function of the individual or a portion of the individual's body, including an intervention approved as part of the ~~PSP~~ INDIVIDUAL PLAN or used on an emergency basis.

~~*SC—Supports coordinator*—An SCO employee whose primary job functions are to locate, coordinate and monitor services provided to an individual when the individual is receiving services from an SCO.~~

~~*SCO—Supports coordination organization*—A provider that delivers the services of locating, coordinating and monitoring services provided to an individual.~~

Services—Actions or assistance provided to the individual to support the achievement of an outcome.

VOLUNTEER—A PERSON WHO IS AN ORGANIZED AND SCHEDULED COMPONENT OF THE SERVICE SYSTEM AND WHO DOES NOT RECEIVE COMPENSATION, BUT WHO PROVIDES A SERVICE THROUGH THE FACILITY THAT RECRUITS, PLANS AND ORGANIZES DUTIES AND ASSIGNMENTS.

GENERAL REQUIREMENTS

§ 2380.17. [Reporting of unusual incidents.] Incident report and investigation.

[(a) An unusual incident is:

(1) Abuse or suspected abuse of an individual.

(2) Injury, trauma or illness requiring inpatient hospitalization, that occurs while the individual is at the facility or under the supervision of the facility.

(3) A suicide attempt by an individual.

(4) A violation or alleged violation of an individual's rights.

(5) An individual whose absence is unaccounted for, and is therefore presumed to be at risk.

(6) The misuse or alleged misuse of an individual's funds or property.

(7) An outbreak of a serious communicable disease, as defined in 28 Pa. Code § 27.2 (relating to specific identified reportable diseases, infections and conditions) to the extent that confidentiality laws permit reporting.

(8) An incident requiring the services of a fire department or law enforcement agency.

(9) A condition, except for snow or ice conditions, that results in closure of the facility for more than 1 scheduled day of operation.

(b) Written policies and procedures on the prevention, reporting, investigation and management of unusual incidents shall be developed and kept at the facility.

(c) The facility shall orally notify, within 24 hours after abuse or suspected abuse of an individual or an incident requiring the services of a fire department or law enforcement agency occurs:

(1) The county mental health and intellectual disability program of the county in which the facility is located if the individual involved in the unusual incident has mental illness or an intellectual disability.

(2) The funding agency.

(3) The appropriate regional office of the Department.

(d) The facility shall initiate an investigation of the unusual incident and complete and send copies of an unusual incident report on a form specified by the Department, within 72 hours after an unusual incident occurs, to:

(1) The county mental health and intellectual disability program of the county in which the facility is located if the individual involved in the unusual incident has mental illness or an intellectual disability.

(2) The funding agency.

(3) The appropriate regional office of the Department.

(e) At the conclusion of the investigation the facility shall send a copy of the final unusual incident report to:

(1) The county mental health and intellectual disability program of the county in which the facility is located if the individual involved in the unusual incident has mental illness or an intellectual disability.

(2) The funding agency.

(3) The appropriate regional office of the Department.

(f) A copy of unusual incident reports relating to an individual shall be kept in the individual’s record.

(g) A copy of unusual incident reports relating to the facility itself, such as those requiring the services of a fire department, shall be kept.

(h) The individual's family, if appropriate, and the residential services provider, if applicable, shall be immediately notified in the event of an unusual incident relating to the individual.]

(a) The facility shall report the following incidents, alleged incidents and suspected incidents ~~in~~ THROUGH the Department's information management system or on a form specified by the Department within 24 hours of discovery by a staff person:

(1) Death.

(2) ~~Suicide attempt.~~ A PHYSICAL ACT BY AN INDIVIDUAL IN AN ATTEMPT TO COMPLETE SUICIDE.

(3) Inpatient admission to a hospital.

(4) ~~Visit to an emergency room.~~

~~(5)~~ Abuse, INCLUDING ABUSE TO AN INDIVIDUAL BY ANOTHER INDIVIDUAL.

~~(6)~~ (5) Neglect.

~~(7)~~ (6) Exploitation.

~~(8)~~ (7) An individual who is missing for more than 24 hours or who could be in jeopardy if missing ~~at all~~ FOR ANY PERIOD OF TIME.

~~(9)~~ (8) Law enforcement activity THAT OCCURS DURING THE HOURS OF FACILITY OPERATION.

~~(10)~~ (9) Injury requiring treatment beyond first aid.

~~(11)~~ (10) Fire requiring the services of the fire department. THIS PROVISION DOES NOT INCLUDE FALSE ALARMS.

~~(12)~~ (11) Emergency closure.

~~(13) Use of a restraint.~~

~~(14)~~ (12) Theft or misuse of individual funds.

~~(15)~~ (13) A violation of individual rights.

(B) THE FACILITY SHALL REPORT THE FOLLOWING INCIDENTS, ALLEGED INCIDENTS AND SUSPECTED INCIDENTS THROUGH THE DEPARTMENT'S

INFORMATION MANAGEMENT SYSTEM OR ON A FORM SPECIFIED BY THE DEPARTMENT WITHIN 72 HOURS OF DISCOVERY BY A STAFF PERSON:

(1) USE OF A RESTRAINT.

(2) A MEDICATION ERROR AS SPECIFIED IN § 2380.126 (RELATING TO MEDICATION ERRORS), IF THE MEDICATION WAS ORDERED BY A HEALTH CARE PRACTITIONER.

~~(b)~~ (C) The individual and ~~the~~ persons designated by the individual shall be notified ~~immediately upon~~ WITHIN 24 HOURS OF discovery of an incident relating to the individual.

~~(c)~~ (D) The facility shall keep documentation of the notification in subsection ~~(b)~~ (C).

~~(d)~~ (E) The incident report, OR A SUMMARY OF THE INCIDENT, THE FINDINGS AND THE ACTIONS TAKEN, redacted to exclude information about another individual and the reporter, unless the reporter is the individual who receives the report, shall be available to the individual and persons designated by the individual, upon request.

~~(e)~~ (F) The facility shall take immediate action to protect the health, safety and well-being of the individual following the initial knowledge or notice of an incident, alleged incident ~~and~~ OR suspected incident.

~~(f)~~ (G) The facility shall initiate an investigation of an incident, ALLEGED INCIDENT OR SUSPECTED INCIDENT within 24 hours of discovery by a staff person.

~~(g)~~ (H) A Department-certified incident investigator shall conduct the ~~incident~~ investigation of the ~~incident listed in subsection (a).~~ FOLLOWING INCIDENTS:

(1) DEATH THAT OCCURS DURING THE PROVISION OF SERVICE.

(2) INPATIENT ADMISSION TO A HOSPITAL AS A RESULT OF AN ACCIDENTAL OR UNEXPLAINED INJURY OR AN INJURY CAUSED BY A STAFF PERSON, ANOTHER INDIVIDUAL OR DURING THE USE OF A RESTRAINT.

(3) ABUSE, INCLUDING ABUSE TO AN INDIVIDUAL BY ANOTHER INDIVIDUAL.

(4) NEGLECT.

(5) EXPLOITATION.

(6) INJURY REQUIRING TREATMENT BEYOND FIRST AID AS A RESULT OF AN ACCIDENTAL OR UNEXPLAINED INJURY OR AN INJURY CAUSED BY A STAFF PERSON, ANOTHER INDIVIDUAL OR DURING THE USE OF A RESTRAINT.

(7) THEFT OR MISUSE OF INDIVIDUAL FUNDS.

(8) A VIOLATION OF INDIVIDUAL RIGHTS.

~~(h)~~ (I) The facility shall finalize the incident report ~~in~~ THROUGH the Department's information management system or on a form specified by the Department within 30 days of discovery of the incident by a staff person UNLESS THE FACILITY NOTIFIES THE DEPARTMENT IN WRITING THAT AN EXTENSION IS NECESSARY AND THE REASON FOR THE EXTENSION.

~~(i)~~ (J) The facility shall provide the following information to the Department as part of the final incident report:

(1) Additional detail about the incident.

(2) The results of the incident investigation.

(3) ~~A description of the corrective action taken in response to an incident~~ ACTION TAKEN TO PROTECT THE HEALTH, SAFETY AND WELL-BEING OF THE INDIVIDUAL.

(4) ~~Action taken to protect the health, safety and well-being of the individual.~~
A DESCRIPTION OF THE CORRECTIVE ACTION TAKEN IN RESPONSE TO AN INCIDENT AND TO PREVENT RECURRENCE OF THE INCIDENT.

(5) The person responsible for implementing the corrective action.

(6) The date the corrective action was implemented or is to be implemented.

§ 2380.18. [Reporting of deaths.] Incident procedures to protect the individual.

[(a) The facility shall complete and send copies of a death report on a form specified by the Department, within 24 hours after a death of an individual that occurs at the facility or while under the supervision of the facility, to:

(1) The county mental health and intellectual disability program of the county in which the facility is located if the individual had mental illness or an intellectual disability.

(2) The funding agency.

(3) The regional office of the Department.

(b) The facility shall investigate and orally notify, within 24 hours after an unusual or unexpected death occurs:

(1) The county mental health and intellectual disability program of the county in which the facility is located if the individual had mental illness or an intellectual disability.

(2) The funding agency.

(3) The regional office of the Department.

(c) A copy of death reports shall be kept in the individual's record.

(d) The individual's family, and the residential service provider, if applicable, shall be immediately notified in the event of a death of an individual.]

(a) In investigating an incident, the facility shall review and consider the following needs of the affected individual:

(1) Potential risks.

(2) Health care information.

(3) Medication history and current medication.

(4) Behavioral health history.

(5) Incident history.

(6) Social needs.

(7) Environmental needs.

(8) Personal safety.

(b) The facility shall monitor an individual's risk for recurring incidents and implement corrective action, as appropriate.

(c) The facility shall work cooperatively with the ~~PSP~~ INDIVIDUAL PLAN team to revise the ~~PSP~~ INDIVIDUAL PLAN if indicated by the incident ~~investigation~~.

§ 2380.19. [Record of incidents.] Incident analysis.

[The facility shall maintain a record of an individual's illnesses, traumas and injuries requiring medical treatment but not inpatient hospitalization, and seizures that occur at the facility or while under the supervision of the facility.]

(a) The facility shall complete the following for each confirmed incident:

(1) Analysis to determine the ~~root~~ cause of the incident.

(2) Corrective action, IF INDICATED.

(3) A strategy to address the potential risks to the ~~affected~~ individual.

(b) The facility shall review and analyze incidents and conduct AND DOCUMENT a trend analysis at least every 3 months.

(c) The facility shall identify and implement preventive measures to reduce:

(1) The number of incidents.

(2) The severity of the risks associated with the incident.

(3) The likelihood of an incident recurring.

(d) The facility shall educate staff persons and the individual based on the circumstances of the incident.

(e) The facility shall ~~analyze~~ MONITOR incident data ~~continuously~~ and take actions to mitigate and manage risks.

§ 2380.21. [Civil] Individual rights.

[(a) An individual may not be discriminated against because of race, color, religious creed, disability, handicap, ancestry, national origin, age or sex.

(b) The facility shall develop and implement civil rights policies and procedures. Civil rights policies and procedures shall include the following:

(1) Nondiscrimination in the provision of services, admissions, placements, facility usage, referrals and communications with individuals who are nonverbal or non-English speaking.

(2) Physical accessibility and accommodation for individuals with physical disabilities.

(3) The opportunity to lodge civil rights complaints.

(4) Informing individuals on their right to register civil rights complaints.]

(a) An individual may not be deprived of rights as provided under subsections (b)~~—(s)~~ (Q).

(b) ~~An individual shall be continually supported to exercise the individual's rights.~~

~~(c) An individual shall be provided the support and~~ THE FACILITY SHALL EDUCATE, ASSIST AND PROVIDE THE accommodation necessary ~~to be able to~~ FOR THE INDIVIDUAL TO understand ~~and actively exercise~~ the individual's rights.

~~(d)~~ (C) An individual may not be reprimanded, punished or retaliated against for exercising the individual's rights.

~~(e)~~ (D) A court's written order that restricts an individual's rights shall be followed.

~~(f)~~ (E) A court-appointed legal guardian may exercise rights and make decisions on behalf of an individual in accordance with ~~a court order~~ THE CONDITIONS OF GUARDIANSHIP AS SPECIFIED IN THE COURT ORDER.

~~(g)~~ (F) An individual who has a court-appointed legal guardian, or who has a court order restricting the individual's rights, shall be involved in ~~decision-making~~ DECISION-MAKING in accordance with the court order.

~~(h)~~ (G) An individual has the right to designate persons to assist in ~~decision-making~~ DECISION-MAKING AND EXERCISING RIGHTS on behalf of the individual.

~~(i)~~ (H) An individual may not be discriminated against because of race, color, creed, disability, religious affiliation, ancestry, gender, gender identity, sexual orientation, national origin or age.

~~(j)~~ (I) An individual has the right to civil and legal rights afforded by law, including the right to vote, speak freely, ~~and~~ practice the religion of ~~his~~ THE INDIVIDUAL'S choice ~~or to~~ AND practice no religion.

~~(k)~~ (J) An individual may not be abused, neglected, mistreated, exploited, abandoned or subjected to corporal punishment.

~~(l)~~ (K) An individual shall be treated with dignity and respect.

~~(m)~~ (L) An individual has the right to make choices and accept risks.

~~(n)~~ (M) An individual has the right to refuse to participate in activities and ~~supports~~ SERVICES.

~~(o)~~ (N) An individual has the right to privacy of person and possessions.

~~(p)~~ (O) An individual has the right of access to and security of the individual's possessions.

~~(q)~~ (P) An individual has the right to voice concerns about the supports SERVICES the individual receives.

~~(r)~~ (Q) An individual has the right to participate in the development and implementation of the ~~PSP~~ INDIVIDUAL PLAN.

~~(s)~~ (R) An individual's rights shall be exercised so that another individual's rights are not violated.

~~(t)~~ (S) ~~Choices shall be negotiated by~~ THE FACILITY SHALL ASSIST the affected individuals TO NEGOTIATE CHOICES in accordance with the facility's procedures for the individuals to resolve differences and make choices.

(T) AN INDIVIDUAL'S RIGHTS MAY ONLY BE MODIFIED IN ACCORDANCE WITH § 2380.185 (RELATING TO CONTENT OF THE INDIVIDUAL PLAN) TO THE EXTENT NECESSARY TO MITIGATE A SIGNIFICANT HEALTH AND SAFETY RISK TO THE INDIVIDUAL OR OTHERS.

(u) The facility shall inform and explain individual rights AND THE PROCESS TO REPORT A RIGHTS VIOLATION to the individual, and persons designated by the individual, upon admission to the facility and annually thereafter.

(v) The facility shall keep a copy of the statement signed by the individual or the individual's court-appointed legal guardian, acknowledging receipt of the information on individual rights.

§ 2380.26. Applicable ~~laws~~ STATUTES and regulations.

The facility shall comply with applicable ~~Federal, State and local laws, regulations and ordinances~~ FEDERAL AND STATE STATUTES AND REGULATIONS AND LOCAL ORDINANCES.

STAFFING

§ 2380.33. Program specialist.

(a) At least [one] 1 program specialist shall be assigned for every 30 individuals, regardless of whether they meet the definition of individual in § 2380.3 (relating to definitions).

(b) The program specialist shall be responsible for the following:

[(1) Coordinating and completing assessments.

(2) Providing the assessment as required under § 2380.181(f) (relating to assessment).

(3) Participating in the development of the ISP, including annual updates and revisions of the ISP.

(4) Attending the ISP meetings.

(5) Fulfilling the role of plan lead, as applicable, under §§ 2380.182 and 2380.186(f) and (g) (relating to development, annual update and revision of the ISP; and ISP review and revision).

(6) Reviewing the ISP, annual updates and revisions under § 2380.186 for content accuracy.

(7) Reporting content discrepancy to the SC or plan lead, as applicable, and plan team members.

(8) Implementing the ISP as written.

(9) Supervising, monitoring and evaluating services provided to the individual.

(10) Reviewing, signing and dating the monthly documentation of an individual's participation and progress toward outcomes.

(11) Reporting a change related to the individual's needs to the SC or plan lead, as applicable, and plan team members.

(12) Reviewing the ISP with the individual as required under § 2380.186.

(13) Documenting the review of the ISP as required under § 2380.186.

(14) Providing the documentation of the ISP review to the SC or plan lead, as applicable, and plan team members as required under § 2380.186(d).

(15) Informing plan team members of the option to decline the ISP Review documentation as required under § 2380.186(e).

(16) Recommending a revision to a service or outcome in the ISP as provided under § 2380.186(c)(4).

(17) Coordinating the services provided to an individual.

(18) Coordinating the training of direct service workers in the content of health and safety needs relevant to each individual.

(19) Developing and implementing provider services as required under § 2380.188 (relating to provider services).]

(1) Coordinating the completion of assessments.

(2) Participating in the ~~PSP~~ INDIVIDUAL PLAN process, ~~PSP~~ development, ~~PSP~~ team reviews and ~~the~~ implementation ~~of the PSP~~ in accordance with this chapter.

(3) Providing and supervising activities for the individuals in accordance with the ~~PSPs~~ INDIVIDUAL PLANS.

(4) Supporting the integration of individuals in the community.

(5) Supporting individual communication and involvement with families and friends.

(c) A program specialist shall have one of the following groups of qualifications:

(1) A master's degree or above from an accredited college or university and 1 year of work experience working directly with persons with disabilities.

(2) A bachelor's degree from an accredited college or university and 2 years of work experience working directly with persons with disabilities.

(3) An associate's degree or 60 credit hours from an accredited college or university and 4 years of work experience working directly with persons with disabilities.

§ 2380.35. Staffing.

(a) A minimum of one direct service worker for every six individuals shall be physically present with the individuals at all times individuals are present at the facility, except while staff persons are attending meetings or training at the facility.

(b) While staff persons are attending meetings or training at the facility, a minimum of one staff person for every ten individuals shall be physically present with the individuals at all times individuals are present at the facility.

(c) A minimum of two staff persons shall be present with the individuals at all times.

(d) An individual may be left unsupervised for specified periods of time if the absence of direct supervision is consistent with the individual's assessment and is part of the [individual's ISP] ~~PSP~~ INDIVIDUAL PLAN, as an outcome which requires the achievement of a higher level of independence.

(e) The staff qualifications and staff ratio as specified in the [ISP] ~~PSP~~ INDIVIDUAL PLAN shall be implemented as written, including when the staff ratio is greater than required under subsections (a), (b) and (c).

(f) An individual may not be left unsupervised solely for the convenience of the facility or the direct service worker.

§ 2380.36. [Staff] Emergency training.

[(a) The facility shall provide orientation for staff persons relevant to their responsibilities, the daily operation of the facility and policies and procedures of the facility before working with individuals or in their appointed positions.

(b) The chief executive officer shall have at least 24 hours of training relevant to human services or administration annually.

(c) Program specialists and direct service workers who are employed for more than 40 hours per month shall have at least 24 hours of training relevant to human services annually.

(d) Program specialists and direct service workers shall have training in the areas of services for people with disabilities and program planning and implementation, within 30 calendar days after the day of initial employment or within 12 months prior to initial employment.

(e)] (a) Program specialists and direct service workers shall be trained before working with individuals in general firesafety, evacuation procedures, responsibilities during fire drills, the designated meeting place outside the building or within the fire safe area in the event of an actual fire, smoking safety procedures if individuals or staff persons smoke at the facility, the use of fire extinguishers, smoke detectors and fire alarms, and notification of the local fire department as soon as possible after a fire is discovered.

[(f)] (b) Program specialists and direct service workers shall be trained annually by a firesafety expert in the training areas specified in subsection [(f)] (a).

[(g)] (c) There shall be at least [one] 1 staff person for every 18 individuals, with a minimum of [two] 2 staff persons present at the facility at all times who have been trained by an individual certified as a trainer by a hospital or other recognized health care organization, in first aid, Heimlich techniques and cardio-pulmonary resuscitation

within the past year. If a staff person has formal certification from a hospital or other recognized health care organization that is valid for more than 1 year, the training is acceptable for the length of time on the certification.

[(h) Records of orientation and training, including the training source, content, dates, length of training, copies of certificates received and staff persons attending, shall be kept.]

§ 2380.37. ~~Annual training plan.~~ TRAINING RECORDS.

~~(a) The facility shall design an annual training plan based on the needs of the individuals as specified in the individuals' PSPs, other data and analysis indicating staff person training needs and as required under § 2380.39 (relating to annual training).~~

~~(b) The annual training plan must include the orientation program as specified in § 2380.38 (relating to orientation program).~~

~~(c) The annual training plan must include training aimed at improving the knowledge, skills and core competencies of the staff persons to be trained.~~

~~(d) The annual training plan must include the following:~~

~~(1) The title of the position to be trained.~~

~~(2) The required training courses, including training course hours, for each position.~~

(A) RECORDS OF ORIENTATION AND TRAINING, INCLUDING THE TRAINING SOURCE, CONTENT, DATES, LENGTH OF TRAINING, COPIES OF CERTIFICATES RECEIVED AND PERSONS ATTENDING, SHALL BE KEPT.

(B) THE FACILITY SHALL KEEP A TRAINING RECORD FOR EACH PERSON TRAINED.

§ 2380.38. Orientation ~~program~~.

(a) Prior to working alone with individuals, and within 30 days after hire, the following shall complete the orientation ~~program~~ as described in subsection (b):

(1) Management, program, administrative and fiscal staff persons.

(2) Dietary, housekeeping, maintenance and ancillary staff persons. THIS PROVISION DOES NOT INCLUDE A PERSON WHO PROVIDES DIETARY, HOUSEKEEPING, MAINTENANCE OR ANCILLARY SERVICES, IF THE PERSON IS EMPLOYED OR CONTRACTED BY THE BUILDING OWNER AND THE LICENSED FACILITY DOES NOT OWN THE BUILDING.

(3) Direct service workers, including full-time and part-time staff persons.

(4) Volunteers who will work alone with individuals.

(5) Paid and unpaid interns who will work alone with individuals.

(6) Consultants AND CONTRACTORS who ARE PAID OR CONTRACTED BY THE FACILITY AND WHO will work alone with individuals, EXCEPT FOR CONSULTANTS AND CONTRACTORS WHO PROVIDE A SERVICE FOR FEWER THAN 30 DAYS WITHIN A 12-MONTH PERIOD AND WHO ARE LICENSED, CERTIFIED OR REGISTERED BY THE DEPARTMENT OF STATE IN A HEALTH CARE OR SOCIAL SERVICE FIELD.

(b) The orientation ~~program~~ must encompass the following areas:

(1) The application of person-centered practices, ~~including respecting rights, facilitating~~ community integration, ~~honoring~~ INDIVIDUAL choice and supporting individuals ~~in maintaining~~ TO DEVELOP AND MAINTAIN relationships.

(2) The prevention, detection and reporting of abuse, suspected abuse and alleged abuse in accordance with ~~sections 701—708 of~~ the Older Adults Protective Services Act (35 P.S. §§ ~~10225.701—10225.708~~10225.101—10225.5102), THE CHILD PROTECTIVE SERVICES LAW (23 Pa. C.S. §§ 6301—6386) (~~relating to Child Protective Services Law~~), the Adult Protective Services Act (35 P.S. §§ 10210.101—10210.704) and applicable protective services regulations.

(3) Individual rights.

(4) Recognizing and reporting incidents.

(5) Job-related knowledge and skills.

§ 2380.39. Annual training.

(a) The following ~~staff persons~~ shall complete 24 hours of training RELATED TO JOB SKILLS AND KNOWLEDGE each year:

(1) Direct service workers~~, including full-time and part-time staff persons~~.

(2) Direct supervisors of direct service workers.

(3) Positions required by this chapter.

(b) The following staff persons shall complete 12 hours of training each year:

(1) Management, program, administrative and fiscal staff persons.

(2) Dietary, housekeeping, maintenance and ancillary staff persons. THIS PROVISION DOES NOT INCLUDE A PERSON WHO PROVIDES DIETARY, HOUSEKEEPING,

MAINTENANCE OR ANCILLARY SERVICES, IF THE PERSON IS EMPLOYED OR CONTRACTED BY THE BUILDING OWNER AND THE LICENSED FACILITY DOES NOT OWN THE BUILDING.

(3) Consultants AND CONTRACTORS who ARE PAID OR CONTRACTED BY THE FACILITY AND WHO work alone with individuals, EXCEPT FOR CONSULTANTS AND CONTRACTORS WHO PROVIDE A SERVICE FOR FEWER THAN 30 DAYS WITHIN A 12-MONTH PERIOD AND WHO ARE LICENSED, CERTIFIED OR REGISTERED BY THE DEPARTMENT OF STATE IN A HEALTH CARE OR SOCIAL SERVICE FIELD.

(4) Volunteers who work alone with individuals.

(5) Paid and unpaid interns who work alone with individuals.

(c) ~~A minimum of 8 hours of the~~ THE annual training hours specified in subsections (a) and (b) must encompass the following areas:

(1) The application of person-centered practices, ~~including respecting rights, facilitating~~ community integration, ~~honoring~~ INDIVIDUAL choice and supporting individuals ~~in maintaining~~ TO DEVELOP AND MAINTAIN relationships.

(2) The prevention, detection and reporting of abuse, suspected abuse and alleged abuse in accordance with ~~sections 701—708 of~~ the Older Adults Protective Services Act

(35 P.S. §§ ~~10225.701—10225.708~~10225.101—10225.5102), THE CHILD PROTECTIVE SERVICES LAW (23 Pa. C.S. §§ 6301—6386) ~~(relating to Child Protective Services Law)~~, the Adult Protective Services Act (35 P.S. §§ 10210.101—10210.704) and applicable protective services regulations.

(3) Individual rights.

(4) Recognizing and reporting incidents.

(5) The safe and appropriate use of ~~positive interventions~~ BEHAVIOR SUPPORTS if the ~~staff~~ person ~~will provide a support to an individual with a dangerous behavior~~ WORKS DIRECTLY WITH AN INDIVIDUAL.

(6) IMPLEMENTATION OF THE INDIVIDUAL PLAN IF THE PERSON WORKS DIRECTLY WITH AN INDIVIDUAL.

~~(d) The balance of the annual training hours shall be in areas identified by the facility in the facility's annual training plan as required under § 2380.37 (relating to annual training plan).~~

~~(e) All training, including those training courses identified in subsections (c) and (d), must be included in the provider's annual training plan.~~

~~(f) Records of orientation and training, including the training source, content, dates, length of training, copies of certificates received and persons attending, shall be kept.~~

~~(g) A training record for each person trained shall be kept.~~

MEDICATIONS

§ 2380.121. [Storage of medications.] Self-administration.

[(a) Prescription and nonprescription medications shall be kept in their original containers, except for medications of individuals who self-administer medications and keep their medications in personal daily or weekly dispensing containers.

(b) Prescription and nonprescription medications shall be kept in an area or container that is locked.

(c) Prescription medications stored in a refrigerator shall be kept in a separate locked container.

(d) Prescription and nonprescription medications shall be stored under proper conditions of sanitation, temperature, moisture and light.

(e) Discontinued prescription medications shall be returned to the individual's family or residential program for proper disposal.]

(a) The facility shall provide an individual who has a prescribed medication with assistance, as needed, for the individual's self-administration of the medication.

(b) Assistance in the self-administration of medication includes helping the individual to remember the schedule for taking the medication, offering the individual the medication at the prescribed times, opening a medication container and storing the medication in a secure place.

(c) The facility shall provide or arrange for assistive technology to ~~support the individual's self-administration of~~ ASSIST THE INDIVIDUAL TO SELF-ADMINISTER medications.

(d) The ~~PSP~~ INDIVIDUAL PLAN must identify if the individual is unable to self-administer medications.

(e) To be considered able to self-administer medications, an individual shall do all of the following:

(1) Recognize and distinguish the individual's medication.

(2) Know how much medication is to be taken.

(3) Know when the medication is to be taken. ~~This knowledge may include reminders~~ ASSISTANCE MAY BE PROVIDED BY STAFF PERSONS TO REMIND THE INDIVIDUAL of the schedule and ~~offering~~ TO OFFER the medication at the prescribed times as specified in subsection (b).

(4) Take or apply the individual's own medication with or without the use of assistive technology.

§ 2380.122. [Labeling of medications.] Medication administration.

[(a) The original container for prescription medications shall be labeled with a pharmaceutical label that includes the individual's name, the name of the medication, the date the prescription was issued, the prescribed dose and the name of the prescribing physician.

(b) Nonprescription medications, except for medications of individuals who self-administer medications, shall be labeled with the original label.]

(a) A facility whose staff persons are qualified to administer medications as specified in subsection (b) may provide medication administration for an individual who is unable to self-administer ~~his~~ THE INDIVIDUAL'S prescribed medication.

(b) A prescription medication that is not self-administered shall be administered by one of the following:

(1) A licensed physician, licensed dentist, licensed physician's assistant, registered nurse, certified registered nurse practitioner, licensed practical nurse ~~or~~, licensed paramedic OR OTHER HEALTH CARE PROFESSIONAL WHO IS LICENSED, CERTIFIED OR REGISTERED BY THE DEPARTMENT OF STATE TO ADMINISTER MEDICATIONS.

(2) A person who has completed the medication administration ~~training~~ COURSE REQUIREMENTS as specified in § 2380.129 (relating to medication administration training) for the medication administration of the following:

(i) Oral medications.

(ii) Topical medications.

(iii) Eye, nose and ear drop medications.

(iv) Insulin injections.

(v) Epinephrine injections for insect bites or other allergies.

(VI) MEDICATIONS, INJECTIONS, PROCEDURES AND TREATMENTS AS PERMITTED BY APPLICABLE STATUTES AND REGULATIONS.

(c) Medication administration includes the following activities, based on the needs of the individual:

(1) Identify the correct individual.

(2) Remove the medication from the original container.

(3) ~~Crush or split~~ PREPARE the medication as ordered by the prescriber.

(4) Place the medication in a medication cup or other appropriate container, or into the individual's hand, mouth or other route as ordered by the prescriber.

(5) If indicated by the prescriber's order, measure vital signs and administer medications according to the prescriber's order.

(6) Injection of insulin ~~or~~ AND INJECTION OF epinephrine in accordance with this chapter.

§ 2380.123. [Use of prescription medications.] Storage and disposal of medications.

[(a) Prescription medications shall only be used by the individual for whom the medication was prescribed.

(b) If a medication is prescribed to treat symptoms of a diagnosed psychiatric illness, there shall be a written protocol as part of the ISP to address the social, emotional and environmental needs of the individual related to the symptoms of the psychiatric illness.]

(a) Prescription and nonprescription medications shall be kept in their original labeled containers. PRESCRIPTION MEDICATIONS SHALL BE LABELED WITH A LABEL ISSUED BY A PHARMACY.

(b) A prescription medication may not be removed from its original labeled container ~~more than 2 hours~~ in advance of the scheduled administration.

(c) If insulin or epinephrine is not packaged in an individual dose container, assistance with or the administration of the injection shall be provided immediately upon removal of the medication from its original labeled container.

(d) Prescription medications and syringes, with the exception of epinephrine and epinephrine auto-injectors, shall be kept in an area or container that is locked.

(e) Epinephrine and epinephrine auto-injectors shall be stored safely and kept easily accessible at all times. The epinephrine and epinephrine auto-injectors shall be easily accessible to the individual if the epinephrine is self-administered or to the staff person who is with the individual if a staff person will administer the epinephrine.

(f) Prescription medications stored in a refrigerator shall be kept in an area or container that is locked.

(g) Prescription medications shall be stored in an organized manner under proper conditions of sanitation, temperature, moisture and light and in accordance with the manufacturer's instructions.

(h) Prescription medications that are discontinued or expired shall be destroyed in a safe manner according to ~~the Department of Environmental Protection and~~ applicable Federal and State STATUTES AND regulation~~s~~.

(i) ~~Subsections (a) – (d) and (f) do~~ THIS SECTION DOES not apply for an individual who self-administers medication and stores the medication on ~~his~~ THE INDIVIDUAL'S person or in the individual's private property, such as a purse or backpack.

§ 2380.124. ~~[Medication log.]~~ ~~Labeling of medications.~~ (RESERVED).

~~[~~(a) A medication log listing the medications prescribed, dosage, time and date that prescription medications, including insulin, were administered, and the name of the person who administered the prescription medication or insulin shall be kept for each individual who does not self-administer medication.

(b) The information specified in subsection (a) shall be logged immediately after each individual's dose of medication.

(c) A list of prescription medications, the prescribed dosage, special instructions and the name of the prescribing physician shall be kept for each individual who self-administers medication.~~]~~

~~The original container for prescription medications must be labeled with a pharmacy label that includes the following:~~

~~(1) The individual's name.~~

~~(2) The name of the medication.~~

~~(3) The date the prescription was issued.~~

~~(4) The prescribed dosage and instructions for administration.~~

~~(5) The name and title of the prescriber.~~

§ 2380.125. [Medication errors.] Prescription medications.

[Documentation of medication errors and follow-up action taken shall be kept.]

(a) A prescription medication shall be prescribed in writing by an authorized prescriber.

(b) A prescription order shall be kept current.

(c) A prescription medication shall be administered as prescribed.

(d) A prescription medication shall be used only by the individual for whom the prescription was prescribed.

(e) Changes in medication may only be made in writing by the prescriber or, in the case of an emergency, an alternate prescriber, except for circumstances in which oral orders may be accepted by a ~~registered nurse in accordance with regulations of the Department of State~~ HEALTH CARE PROFESSIONAL WHO IS LICENSED, CERTIFIED OR REGISTERED BY THE DEPARTMENT OF STATE TO ACCEPT

ORAL ORDERS. The individual's medication record shall be updated as soon as a written notice of the change is received.

(f) IF A MEDICATION IS PRESCRIBED TO TREAT SYMPTOMS OF A DIAGNOSED PSYCHIATRIC ILLNESS, THERE SHALL BE A WRITTEN PROTOCOL AS PART OF THE INDIVIDUAL PLAN TO ADDRESS THE SOCIAL, EMOTIONAL AND ENVIRONMENTAL NEEDS OF THE INDIVIDUAL RELATED TO THE SYMPTOMS OF THE PSYCHIATRIC ILLNESS.

§ 2380.126. [Adverse reaction.] Medication record.

[If an individual has a suspected adverse reaction to a medication, the facility shall notify the prescribing physician and the family or residential program immediately. Documentation of adverse reactions shall be kept.]

(a) A medication record shall be kept, including the following for each individual for whom a prescription medication is administered:

(1) Individual's name.

(2) Name ~~and title~~ of the prescriber.

(3) Drug allergies.

(4) Name of medication.

(5) Strength of medication.

(6) Dosage form.

(7) Dose of medication.

(8) Route of administration.

(9) Frequency of administration.

(10) Administration times.

(11) Diagnosis or purpose for the medication, including pro re nata.

(12) Date and time of medication administration.

(13) Name and initials of the person administering the medication.

(14) Duration of treatment, if applicable.

(15) Special precautions, if applicable.

(16) Side effects of the medication, if applicable.

(b) The information in subsection (a)(12) and (13) shall be recorded in the medication record at the time the medication is administered.

(c) If an individual refuses to take a prescribed medication, the refusal shall be documented on the medication record. The refusal shall be reported to the prescriber ~~within 24 hours, unless otherwise instructed by the prescriber. Subsequent refusals to take a prescribed medication shall be reported as required~~ AS DIRECTED by the prescriber OR IF THERE IS HARM TO THE INDIVIDUAL.

(d) The directions of the prescriber shall be followed.

§ 2380.127. [Administration of medications.] Medication errors.

[(a) Prescription medications and injections of a substance not self-administered by individuals shall be administered by one of the following:

(1) A licensed physician, licensed dentist, certified physician's assistant, registered nurse or licensed practical nurse.

(2) A graduate of an approved nursing program functioning under the direct supervision of a professional nurse who is present in the facility.

(3) A student nurse of an approved nursing program functioning under the direct supervision of a member of the nursing school faculty who is present in the facility.

(4) A staff person who meets the criteria in § 2380.128 (relating to medication administration training), for the administration of oral, topical and eye and ear drop prescription medications and insulin injections.

(b) Prescription medications and injections shall be administered according to the directions specified on the prescription.]

(a) Medication errors include the following:

(1) Failure to administer a medication.

(2) Administration of the wrong medication.

(3) Administration of the wrong ~~amount~~ DOSE of medication.

(4) Failure to administer a medication at the prescribed time, which exceeds more than 1 hour before or after the prescribed time.

(5) Administration to the wrong person.

(6) Administration through the wrong route.

(7) ADMINISTRATION WHILE THE INDIVIDUAL IS IN THE WRONG POSITION.

(8) IMPROPER PREPARATION OF THE MEDICATION.

(b) Documentation of medication errors, follow-up action taken and the prescriber's response, IF APPLICABLE, shall be kept in the individual's record.

(C) A MEDICATION ERROR SHALL BE REPORTED AS AN INCIDENT AS SPECIFIED IN § 2380.17(B) (RELATING TO INCIDENT REPORT AND INVESTIGATION).

(D) A MEDICATION ERROR SHALL BE REPORTED TO THE PRESCRIBER UNDER ANY OF THE FOLLOWING CONDITIONS:

(1) AS DIRECTED BY THE PRESCRIBER.

(2) IF THE MEDICATION IS ADMINISTERED TO THE WRONG PERSON.

(3) IF THERE IS HARM TO THE INDIVIDUAL.

§ 2380.128. [Medication administration training.] Adverse reaction.

[(a) A staff person who has completed and passed the Department's Medications Administration Course is permitted to administer oral, topical and eye and ear drop prescription medications.

(b) A staff person who has completed and passed the Department's Medications Administration Course and who has completed and passed a diabetes patient education program within the past 12 months that meets the National Standards for Diabetes Patient Education Programs of the National Diabetes Advisory Board, 7550 Wisconsin Avenue, Bethesda, Maryland 20205, is permitted to administer insulin injections to an individual who is under the care of a licensed physician who is monitoring the diabetes.

(c) Medications administration training of staff persons shall be conducted by an instructor who has completed and passed the Medications Administration Course for trainers and is certified by the Department to train staff persons.

(d) A staff person who administers prescription medications or insulin injections to individuals shall complete the Medications Administration Course Practicum annually.

(e) Documentation of the dates and locations of medications administration training for trainers and staff persons and the annual practicum for staff persons shall be kept.]

(a) If an individual has a suspected adverse reaction to a medication, the facility shall immediately consult a health care practitioner or seek emergency medical treatment.

(b) An adverse reaction to a medication, the health care practitioner's response to the adverse reaction and the action taken shall be documented.

§ 2380.129. [Self-administration of medications.] Medication administration training.

[(a) To be considered capable of self-administration of medications, an individual shall:

(1) Be able to recognize and distinguish the individual's own medication.

(2) Know how much medication is to be taken.

(3) Know when the medication is to be taken.

(b) Insulin that is self-administered by an individual shall be measured by the individual or by licensed or certified medical personnel.]

(a) A staff person who has successfully completed a Department-approved medications administration course, including the course renewal requirements, may administer ~~the~~ following:

~~(1) Oral medications.~~

~~(2) Topical medications.~~

~~(3) Eye, nose and ear drop medications.~~ MEDICATIONS, INJECTIONS, PROCEDURES AND TREATMENTS AS SPECIFIED IN § 2380.122 (RELATING TO MEDICATION ADMINISTRATION).

(b) A staff person may administer insulin injections following successful completion of both:

(1) The MEDICATION ADMINISTRATION course specified in subsection (a).

(2) A Department-approved diabetes patient education program within the past 12 months.

(c) A staff person may administer an epinephrine injection by means of an auto-injection device in response to anaphylaxis or another serious allergic reaction following successful completion of both:

(1) The MEDICATION ADMINISTRATION course specified in subsection (a).

(2) Training WITHIN THE PAST 24 MONTHS relating to the use of an auto-injection epinephrine injection device provided by a ~~licensed, registered or certified health care~~ professional ~~within the past 12 months~~ WHO IS LICENSED, CERTIFIED OR REGISTERED BY THE DEPARTMENT OF STATE IN THE HEALTH CARE FIELD.

(d) A record of the training shall be kept, including the person trained, the date, source, name of trainer and documentation that the course was successfully completed.

~~[~~RESTRICTIVE PROCEDURES~~]~~ ~~POSITIVE INTERVENTION~~

§ 2380.151. ~~[~~Definition of restrictive procedures.~~]~~ ~~Use of a positive intervention.~~

~~[~~A restrictive procedure is a practice that does one or more of the following:

(1) Limits an individual's movement, activity or function.

(2) Interferes with an individual's ability to acquire positive reinforcement.

(3) Results in the loss of objects or activities that an individual values.

(4) Requires an individual to engage in a behavior that the individual would not engage in given freedom of choice.~~]~~

(a) A positive intervention shall be used to prevent, modify and eliminate a dangerous behavior when the behavior is anticipated or occurring.

(b) The least intrusive method shall be applied when addressing a dangerous behavior. For each incidence of a dangerous behavior, every attempt shall be made to modify and eliminate the behavior.

(c) As used in this section, the following words and terms have the following meanings, unless the context clearly indicates otherwise:

Dangerous behavior—An action with a high likelihood of resulting in harm to the individual or others.

Positive intervention—An action or activity intended to prevent, modify and eliminate a dangerous behavior. This includes improved communications, reinforcing appropriate behavior, an environmental change, recognizing and treating physical and behavioral health symptoms, voluntary physical exercise and other wellness practices, redirection, praise, modeling, conflict resolution and de-escalation.

§ 2380.152. ~~[~~Written policy.~~]~~ ~~PSP.~~

~~[A THE FACILITY SHALL DEVELOP AND IMPLEMENT A written policy that defines the prohibition or use of specific types of restrictive procedures, describes the circumstances in which restrictive procedures may be used, the STAFF persons who may authorize the use of restrictive procedures, AND a mechanism to monitor and control the use of restrictive procedures. and a process for the individual and family to review the use of restrictive procedures shall be kept at the facility.]~~

~~If the individual has a dangerous behavior as identified in the PSP, the PSP must include the following:~~

~~(1) The specific dangerous behavior to be addressed.~~

~~(2) A functional analysis of the dangerous behavior and the plan to address the reason for the behavior.~~

~~(3) The outcome desired.~~

~~(4) A description of the positive intervention aimed at preventing, modifying or eliminating the dangerous behavior and the circumstances under which the intervention is to be used.~~

~~(5) A target date to achieve the outcome.~~

~~(6) Health conditions that require special attention.~~

§ 2380.153. [Appropriate use of restrictive procedures.] ~~Prohibition of restraints.~~

[(a) A restrictive procedure may not be used as retribution, for the convenience of staff persons, as a substitute for a program or in a way that interferes with the individual's developmental program.

(b) For each incident requiring a restrictive procedure:

(1) Every attempt shall be made to anticipate and de-escalate the behavior using methods of intervention less intrusive than a restrictive procedure.

(2) A restrictive procedure may not be used unless less restrictive techniques and resources appropriate to the behavior have been tried but have failed.]

~~The following procedures are prohibited:~~

~~(1) Seclusion, defined as involuntary confinement of an individual in a room or area from which the individual is physically prevented or verbally directed from leaving.~~

(2) Aversive conditioning, defined as the application of startling, painful or noxious stimuli.

(3) Pressure point techniques, defined as the application of pain for the purpose of achieving compliance.

(4) A chemical restraint, defined as use of drugs or chemicals for the specific and exclusive purpose of controlling acute or episodic aggressive behavior. A chemical restraint does not include a drug ordered by a health care practitioner or dentist to treat the symptoms of a specific mental, emotional or behavioral condition, or as pretreatment prior to a medical or dental examination or treatment.

(5) A mechanical restraint, defined as a device that restricts the movement or function of an individual or portion of an individual's body. Mechanical restraints include a geriatric chair, handcuffs, anklets, wristlets, camisole, helmet with fasteners, muffs and mitts with fasteners, restraint vest, waist strap, head strap, papoose board, restraining sheet, chest restraint and other locked restraints.

(i) The term does not include a device prescribed by a health care practitioner that is used to provide post-surgical care, proper balance or support for the achievement of functional body position.

~~(ii) The term does not include a device prescribed by a health care practitioner to protect the individual in the event of a seizure, as long as the individual can easily remove the device.~~

~~(6) A manual restraint, defined as a hands-on physical method that restricts, immobilizes or reduces an individual's ability to move his arms, legs, head or other body parts freely, on a nonemergency basis, or for more than 15 minutes within a 2-hour period. A manual restraint does not include physically prompting, escorting or guiding an individual to provide a support as specified in the individual's PSP.~~

~~(7) A prone position manual restraint.~~

~~(8) A manual restraint that inhibits digestion or respiration, inflicts pain, causes embarrassment or humiliation, causes hyperextension of joints, applies pressure on the chest or joints, or allows for a free fall to the floor.~~

§ 2380.154. [Restrictive procedure review committee.] ~~Permitted interventions.~~ HUMAN RIGHTS TEAM.

[(a) If a restrictive procedure is used, there shall be a restrictive procedure review committee.

(b) The restrictive procedure review committee shall include a majority of persons who do not provide direct services to the individual.

(c) The restrictive procedure review committee shall establish a time frame for review and revision of the restrictive procedure plan, not to exceed 6 months between reviews.
(d) A written record of the meetings and activities of the restrictive procedure review committee shall be kept.]

~~(a) Voluntary exclusion, defined as an individual voluntarily removing himself from his immediate environment and placing himself alone to a room or area, is permitted in accordance with the individual's PSP.~~

~~(b) A physical protective restraint may be used only in accordance with § 2380.153(6)—(8) (relating to prohibition of restraints).~~

~~(c) A physical protective restraint may not be used until §§ 2380.39(c)(5) and 2380.185(9) (relating to annual training; and content of the PSP) are met.~~

~~(d) A physical protective restraint may only be used in the case of an emergency to prevent an individual from injuring the individual's self or others.~~

~~(e) A physical protective restraint may not be used as a behavioral intervention, consequence, retribution, punishment, for the convenience of staff persons or as a substitution for individual support.~~

~~(f) A physical protective restraint may not be used for more than 15 minutes within a 2-hour period.~~

~~(g) A physical protective restraint may only be used by a staff person who is trained as specified in § 2380.39.~~

~~(h) As used in this section, a "physical protective restraint" is a hands-on hold of an individual.~~

(A) IF A RESTRICTIVE PROCEDURE IS USED, THE FACILITY SHALL USE A HUMAN RIGHTS TEAM. THE FACILITY MAY USE A COUNTY MENTAL HEALTH AND INTELLECTUAL DISABILITY PROGRAM HUMAN RIGHTS TEAM THAT MEETS THE REQUIREMENTS OF THIS SECTION.

(B) THE HUMAN RIGHTS TEAM SHALL INCLUDE A PROFESSIONAL WHO HAS A RECOGNIZED DEGREE, CERTIFICATION OR LICENSE RELATING TO BEHAVIORAL SUPPORT, WHO DID NOT DEVELOP THE BEHAVIOR SUPPORT COMPONENT OF THE INDIVIDUAL PLAN.

(C) THE HUMAN RIGHTS TEAM SHALL INCLUDE A MAJORITY OF PERSONS WHO DO NOT PROVIDE DIRECT SERVICES TO THE INDIVIDUAL.

(D) A RECORD OF THE HUMAN RIGHTS TEAM MEETINGS SHALL BE KEPT.

§ 2380.155. [Restrictive procedure plan.] ~~**Access to or the use of an individual's personal property.**~~ **BEHAVIOR SUPPORT COMPONENT OF THE INDIVIDUAL PLAN.**

[(a) For each individual for whom restrictive procedures may be used, a restrictive procedure plan shall be written prior to the use of restrictive procedures.

(b) The restrictive procedure plan shall be developed and revised with the participation of the program specialist, the individual's direct care staff, the interdisciplinary team, as appropriate, and other professionals, as appropriate.

(c) The restrictive procedure plan shall be reviewed, and revised if necessary, according to the time frame established by the restrictive procedure review committee, not to exceed 6 months.

(d) The restrictive procedure plan shall be reviewed, approved, signed and dated by the chairperson of the restrictive procedure review committee and the program specialist,

prior to the use of a restrictive procedure, whenever the restrictive procedure plan is revised and at least every 6 months.

(e) The restrictive procedure plan shall include:

(1) The specific behavior to be addressed and the suspected antecedent or reason for the behavior.

(2) The single behavioral outcome desired, stated in measurable terms.

(3) Methods for modifying or eliminating the behavior, such as changes in the individual's physical and social environment, changes in the individual's routine, improving communications, teaching skills and reinforcing appropriate behavior.

(4) Types of restrictive procedures that may be used and the circumstances under which the procedures may be used.

(5) A target date for achieving the outcome.

(6) The amount of time the restrictive procedure may be applied, not to exceed the maximum time periods specified in this chapter.

(7) Physical problems that require special attention during the use of the restrictive procedure.

(8) The name of the staff person or staff position responsible for monitoring and documenting progress with the plan.

(f) The restrictive procedure plan shall be implemented as written.

(g) Copies of the restrictive procedure plan shall be kept in the individual's record.]

~~(a) Access to or the use of an individual's personal funds or property may not be used as a reward or punishment.~~

~~(b) An individual's personal funds or property may not be used as payment for damages unless the individual consents to make restitution for the damages as follows:~~

~~(1) A separate written consent by the individual is required for each incidence of restitution.~~

~~(2) Consent shall be obtained in the presence of the individual, a person designated by the individual and in the presence of and with the support of the support coordinator or targeted support manager.~~

~~(3) There may not be coercion in obtaining the consent of an individual.~~

~~(4) The facility shall keep a copy of the individual's written consent.~~

(A) FOR EACH INDIVIDUAL FOR WHOM A RESTRICTIVE PROCEDURE MAY BE USED, THE INDIVIDUAL PLAN SHALL INCLUDE A COMPONENT ADDRESSING BEHAVIOR SUPPORT THAT IS REVIEWED AND APPROVED BY THE HUMAN RIGHTS TEAM IN § 2380.154 (RELATING TO HUMAN RIGHTS TEAM), PRIOR TO USE OF A RESTRICTIVE PROCEDURE.

(B) THE BEHAVIOR SUPPORT COMPONENT OF THE INDIVIDUAL PLAN SHALL BE REVIEWED AND REVISED AS NECESSARY BY THE HUMAN RIGHTS TEAM, ACCORDING TO THE TIME FRAME ESTABLISHED BY THE TEAM, NOT TO EXCEED 6 MONTHS BETWEEN REVIEWS.

(C) THE BEHAVIOR SUPPORT COMPONENT OF THE INDIVIDUAL PLAN SHALL INCLUDE:

(1) THE SPECIFIC BEHAVIOR TO BE ADDRESSED.

(2) AN ASSESSMENT OF THE BEHAVIOR, INCLUDING THE SUSPECTED REASON FOR THE BEHAVIOR.

(3) THE OUTCOME DESIRED.

(4) A TARGET DATE TO ACHIEVE THE OUTCOME.

(5) METHODS FOR FACILITATING POSITIVE BEHAVIORS SUCH AS CHANGES IN THE INDIVIDUAL'S PHYSICAL AND SOCIAL ENVIRONMENT, CHANGES IN THE INDIVIDUAL'S ROUTINE, IMPROVING COMMUNICATIONS, RECOGNIZING AND TREATING PHYSICAL AND BEHAVIOR HEALTH CONDITIONS, VOLUNTARY PHYSICAL EXERCISE, REDIRECTION, PRAISE, MODELING, CONFLICT RESOLUTION, DE-ESCALATION AND TEACHING SKILLS.

(6) TYPES OF RESTRICTIVE PROCEDURES THAT MAY BE USED AND THE CIRCUMSTANCES UNDER WHICH THE PROCEDURES MAY BE USED.

(7) THE AMOUNT OF TIME THE RESTRICTIVE PROCEDURE MAY BE APPLIED.

(8) THE NAME OF THE STAFF PERSON RESPONSIBLE FOR MONITORING AND DOCUMENTING PROGRESS WITH THE BEHAVIOR SUPPORT COMPONENT OF THE INDIVIDUAL PLAN.

(D) IF A PHYSICAL RESTRAINT WILL BE USED OR IF A RESTRICTIVE PROCEDURE WILL BE USED TO MODIFY AN INDIVIDUAL'S RIGHTS IN § 2380.185(6) (RELATING TO CONTENT OF THE INDIVIDUAL PLAN) THE BEHAVIOR SUPPORT COMPONENT OF THE INDIVIDUAL PLAN SHALL BE DEVELOPED BY A PROFESSIONAL WHO HAS A RECOGNIZED DEGREE, CERTIFICATION OR LICENSE RELATING TO BEHAVIORAL SUPPORT.

§ 2380.156. [Staff training.] ~~Rights team.~~

[(a) If a restrictive procedure is used, at least one staff person shall be available when the restrictive procedure is used who has completed training within the past 12 months in the use of and ethics of using restrictive procedures including the use of alternate positive approaches.

(b) A staff person responsible for developing, implementing or managing a restrictive procedure plan shall be trained in the use of the specific techniques or procedures that are used.

(c) If manual restraint or exclusion is used, the staff person responsible for developing, implementing or managing a restrictive procedure plan shall have experienced the use of the specific techniques or procedures directly on themselves.

(d) Documentation of the training program provided, including the staff persons trained, dates of the training, description of the training and the training source, shall be kept.]

~~(a) The facility shall have a rights team. The facility may use a county mental health and intellectual disability program rights team that meets the requirements of this section.~~

~~(b) The role of the rights team is to:~~

~~(1) Review each incident, alleged incident and suspected incident of a violation of individual rights as specified in § 2380.21 (relating to individual rights).~~

~~(2) Review each incidence of the use of a restraint to:~~

~~(i) Analyze systemic concerns.~~

~~(ii) Design positive supports as an alternative to the use of a restraint.~~

~~(iii) Discover and resolve the reason for an individual's behavior.~~

~~(c) Members of the rights team shall include the affected individual, persons designated by the individual, a family member or an advocate if the individual is unable to speak for himself, the individual's support coordinator, a representative from the funding agency if applicable and a facility representative.~~

~~(d) Members of the rights team shall be comprised of a majority who do not provide direct support to the individual.~~

~~(e) If a restraint was used, the individual's health care practitioner shall be consulted.~~

~~(f) The rights team shall meet at least once every 3 months.~~

~~(g) The rights team shall report its recommendations to the individual's PSP team.~~

~~(h) The facility shall keep documentation of the rights team meetings and the decisions made at the meetings.~~

(A) A STAFF PERSON WHO IMPLEMENTS OR MANAGES A BEHAVIOR SUPPORT COMPONENT OF AN INDIVIDUAL PLAN SHALL BE TRAINED IN THE USE OF THE SPECIFIC TECHNIQUES OR PROCEDURES THAT ARE USED.

(B) IF A PHYSICAL RESTRAINT WILL BE USED, THE STAFF PERSON WHO IMPLEMENTS OR MANAGES THE BEHAVIOR SUPPORT COMPONENT OF THE INDIVIDUAL PLAN SHALL HAVE EXPERIENCED THE USE OF THE PHYSICAL RESTRAINT DIRECTLY ON THE STAFF PERSON.

(C) DOCUMENTATION OF THE TRAINING PROVIDED, INCLUDING THE STAFF PERSONS TRAINED, DATES OF TRAINING, DESCRIPTION OF TRAINING AND TRAINING SOURCE, SHALL BE KEPT.

§§ 2380.157—2380.165. (Reserved).

§ 2380.166. PROHIBITED PROCEDURES.

THE FOLLOWING PROCEDURES ARE PROHIBITED:

(1) SECLUSION, DEFINED AS INVOLUNTARY CONFINEMENT OF AN INDIVIDUAL IN A ROOM OR AREA FROM WHICH THE INDIVIDUAL IS PHYSICALLY PREVENTED OR VERBALLY DIRECTED FROM LEAVING. SECLUSION INCLUDES PHYSICALLY HOLDING A DOOR SHUT OR USING A FOOT PRESSURE LOCK.

(2) AVERSIVE CONDITIONING, DEFINED AS THE APPLICATION OF STARTLING, PAINFUL OR NOXIOUS STIMULI.

(3) PRESSURE-POINT TECHNIQUES, DEFINED AS THE APPLICATION OF PAIN FOR THE PURPOSE OF ACHIEVING COMPLIANCE. A PRESSURE-POINT TECHNIQUE DOES NOT INCLUDE A CLINICALLY-ACCEPTED BITE RELEASE TECHNIQUE THAT IS APPLIED ONLY AS LONG AS NECESSARY TO RELEASE THE BITE.

(4) A CHEMICAL RESTRAINT, DEFINED AS USE OF A DRUG FOR THE SPECIFIC AND EXCLUSIVE PURPOSE OF CONTROLLING ACUTE OR EPISODIC AGGRESSIVE BEHAVIOR. A CHEMICAL RESTRAINT DOES NOT INCLUDE A DRUG ORDERED BY A HEALTH CARE PRACTITIONER OR DENTIST FOR THE FOLLOWING USE OR EVENT:

(I) TREATMENT OF THE SYMPTOMS OF A SPECIFIC MENTAL, EMOTIONAL OR BEHAVIORAL CONDITION.

(II) PRETREATMENT PRIOR TO A MEDICAL OR DENTAL EXAMINATION OR TREATMENT.

(III) AN ONGOING PROGRAM OF MEDICATION.

(IV) A SPECIFIC, TIME-LIMITED STRESSFUL EVENT OR SITUATION TO ASSIST THE INDIVIDUAL TO CONTROL THE INDIVIDUAL'S OWN BEHAVIOR.

(5) A MECHANICAL RESTRAINT, DEFINED AS A DEVICE THAT RESTRICTS THE MOVEMENT OR FUNCTION OF AN INDIVIDUAL OR PORTION OF AN INDIVIDUAL'S BODY. A MECHANICAL RESTRAINT INCLUDES A GERIATRIC CHAIR, A BEDRAIL THAT RESTRICTS THE MOVEMENT OR FUNCTION OF THE INDIVIDUAL, HANDCUFFS, ANKLETS, WRISTLETS, CAMISOLE, HELMET WITH FASTENERS, MUFFS AND MITTS WITH FASTENERS, RESTRAINT VEST, WAIST STRAP, HEAD STRAP, RESTRAINT BOARD, RESTRAINING SHEET, CHEST RESTRAINT AND OTHER SIMILAR DEVICES. A MECHANICAL RESTRAINT DOES NOT INCLUDE THE USE OF A SEAT BELT DURING MOVEMENT OR TRANSPORTATION. A MECHANICAL RESTRAINT DOES NOT INCLUDE A DEVICE PRESCRIBED BY A HEALTH CARE PRACTITIONER FOR THE FOLLOWING USE OR EVENT:

(I) POST-SURGICAL OR WOUND CARE.

(II) BALANCE OR SUPPORT TO ACHIEVE FUNCTIONAL BODY POSITION, IF THE INDIVIDUAL CAN EASILY REMOVE THE DEVICE OR IF THE DEVICE IS REMOVED BY A STAFF PERSON IMMEDIATELY UPON THE REQUEST OR INDICATION BY THE INDIVIDUAL, AND IF THE INDIVIDUAL PLAN INCLUDES PERIODIC RELIEF OF THE DEVICE TO ALLOW FREEDOM OF MOVEMENT.

(III) PROTECTION FROM INJURY DURING A SEIZURE OR OTHER MEDICAL CONDITION, IF THE INDIVIDUAL CAN EASILY REMOVE THE DEVICE OR IF THE DEVICE IS REMOVED BY A STAFF PERSON IMMEDIATELY UPON THE REQUEST OR INDICATION BY THE INDIVIDUAL, AND IF THE INDIVIDUAL PLAN INCLUDES PERIODIC RELIEF OF THE DEVICE TO ALLOW FREEDOM OF MOVEMENT.

§ 2380.167. PHYSICAL RESTRAINT.

(A) A PHYSICAL RESTRAINT, DEFINED AS A MANUAL METHOD THAT RESTRICTS, IMMOBILIZES OR REDUCES AN INDIVIDUAL'S ABILITY TO MOVE THE INDIVIDUAL'S ARMS, LEGS, HEAD OR OTHER BODY PARTS FREELY, MAY ONLY BE USED IN THE CASE OF AN EMERGENCY TO PREVENT AN INDIVIDUAL FROM IMMEDIATE PHYSICAL HARM TO THE INDIVIDUAL OR OTHERS.

(B) VERBAL REDIRECTION, PHYSICAL PROMPTS, ESCORTING AND GUIDING AN INDIVIDUAL ARE PERMITTED.

(C) A PRONE POSITION PHYSICAL RESTRAINT IS PROHIBITED.

(D) A PHYSICAL RESTRAINT THAT INHIBITS DIGESTION OR RESPIRATION, INFLICTS PAIN, CAUSES EMBARRASSMENT OR HUMILIATION, CAUSES HYPEREXTENSION OF JOINTS, APPLIES PRESSURE ON THE CHEST OR JOINTS OR ALLOWS FOR A FREE FALL TO THE FLOOR IS PROHIBITED.

(F) A PHYSICAL RESTRAINT MAY NOT BE USED FOR MORE THAN 30 CUMULATIVE MINUTES WITHIN A 2-HOUR PERIOD.

§ 2380.168. EMERGENCY USE OF A PHYSICAL RESTRAINT.

IF A PHYSICAL RESTRAINT IS USED ON AN UNANTICIPATED, EMERGENCY BASIS, §§ 2380.154 AND 2380.155 (RELATING TO HUMAN RIGHTS TEAM; AND BEHAVIOR SUPPORT COMPONENT OF THE INDIVIDUAL PLAN) DO NOT APPLY UNTIL AFTER THE RESTRAINT IS USED FOR THE SAME INDIVIDUAL TWICE IN A 6-MONTH PERIOD.

§ 2380.169. ACCESS TO OR THE USE OF AN INDIVIDUAL'S PERSONAL PROPERTY.

(A) ACCESS TO OR THE USE OF AN INDIVIDUAL'S PERSONAL FUNDS OR PROPERTY MAY NOT BE USED AS A REWARD OR PUNISHMENT.

(B) AN INDIVIDUAL'S PERSONAL FUNDS OR PROPERTY MAY NOT BE USED AS PAYMENT FOR DAMAGES UNLESS THE INDIVIDUAL CONSENTS TO MAKE RESTITUTION FOR THE DAMAGES. THE FOLLOWING CONSENT PROVISIONS APPLY UNLESS THERE IS A COURT-ORDERED RESTITUTION:

(1) A SEPARATE WRITTEN CONSENT IS REQUIRED FOR EACH INCIDENCE OF RESTITUTION.

(2) CONSENT SHALL BE OBTAINED IN THE PRESENCE OF THE INDIVIDUAL OR A PERSON DESIGNATED BY THE INDIVIDUAL.

(3) THE FACILITY MAY NOT COERCE THE INDIVIDUAL TO PROVIDE CONSENT.

RECORDS

§ 2380.173. Content of records.

Each individual's record must include the following information:

(1) Personal information including:

(i) The name, sex, admission date, birthdate and [social security] Social Security number.

(ii) The race, height, weight, color of hair, color of eyes and identifying marks.

(iii) The language or means of communication spoken or understood by the individual and the primary language used in the individual's natural home, if other than English.

(iv) Religious affiliation.

(v) A current, dated photograph.

(2) [Unusual incident] Incident reports related to the individual.

(3) Physical examinations.

(4) Assessments as required under § 2380.181 (relating to assessment).

[(5) A copy of the invitation to:

(i) The initial ISP meeting.

(ii) The annual update meeting.

(iii) The ISP revision meeting.

(6) A copy of the signature sheet for:

(i) The initial ISP meeting.

(ii) The annual update meeting.

(iii) The ISP revision meeting.

(7) A copy of the current ISP.

(8) Documentation of ISP reviews and revisions under § 2380.186 (relating to ISP review and revision), including the following:

(i) ISP review signature sheets.

(ii) Recommendations to revise the ISP.

(iii) ISP revisions.

(iv) Notices that the plan team member may decline the ISP review documentation.

(v) Requests from plan team members to not receive the ISP review documentation.

(9) Content discrepancies in the ISP, the annual update or revision under § 2380.186.]

(5) ~~[PSP]~~ INDIVIDUAL PLAN documents as required by this chapter.

[(10) Restrictive procedure protocols and] ~~(6) Positive intervention records related to the individual.~~

[(11)] ~~(7)~~ (6) Copies of psychological evaluations, if applicable.

PROGRAM

§ 2380.181. Assessment.

* * * * *

(b) If the program specialist is making a recommendation to revise a service or outcome in the [ISP as provided under § 2380.186(c)(4) (relating to ISP review and revision)] ~~PSP~~ INDIVIDUAL PLAN, the individual shall have an assessment completed as required under this section.

* * * * *

(f) The program specialist shall provide the assessment to the ~~SC~~ [or plan lead] ~~, as applicable, and~~ [plan] ~~PSP~~ INDIVIDUAL plan team members at least 30 calendar days prior to [an ISP meeting for the development, annual update and revision of the ISP under §§ 2380.182, 2390.152, 6400.182 and 6500.152 (relating to development, annual update and revision of the ISP)] ~~a PSP~~ THE INDIVIDUAL PLAN meeting.

§ 2380.182. ~~Development~~ [, annual update and revision of the ISP] ~~of the PSP.~~ DEVELOPMENT, ANNUAL UPDATE AND REVISION OF THE INDIVIDUAL PLAN.

[(a) An individual shall have one ISP.

(b) When an individual is not receiving services through an SCO and does not reside in a home licensed under Chapter 6400 or 6500 (relating to community homes for individuals with an intellectual disability; and family living homes), the adult training facility program specialist shall be the plan lead when one of the following applies:

(1) The individual attends a facility licensed under this chapter.

(2) The individual attends a facility licensed under this chapter and a facility licensed under Chapter 2390 (relating to vocational facilities).

(c) The plan lead shall be responsible for developing and implementing the ISP, including annual updates and revisions.

(d) The plan lead shall develop, update and revise the ISP according to the following:

(1) The ISP shall be initially developed, updated annually and revised based upon the individual's current assessment as required under §§ 2380.181, 2390.151, 6400.181 and 6500.151 (relating to assessment).

(2) The initial ISP shall be developed within 90 calendar days after the individual's admission date to the facility.

(3) The ISP, annual updates and revisions shall be documented on the Department-designated form located in the Home and Community Services Information System (HCSIS) and also on the Department's web site.

(4) An invitation shall be sent to plan team members at least 30 calendar days prior to an ISP meeting.

(5) Copies of the ISP, including annual updates and revisions under § 2380.186 (relating to ISP review and revision), shall be provided as required under § 2380.187 (relating to copies).]

(a) ~~An individual shall have one approved and authorized PSP at a given time.~~

~~(b) An individual's service implementation plan must be consistent with the PSP in subsection (a).~~

~~(c)~~ The ~~support coordinator, targeted support manager or~~ program specialist shall coordinate the development of the ~~PSP~~ INDIVIDUAL PLAN, including revisions, ~~in cooperation~~ with the individual and the ~~individual's PSP~~ INDIVIDUAL PLAN team.

~~(d)~~ (B) The initial ~~PSP~~ INDIVIDUAL PLAN shall be developed based on the individual assessment within ~~60 days~~ 90 DAYS of the individual's date of admission to the facility.

~~(e)~~ (C) The ~~PSP~~ INDIVIDUAL PLAN shall be initially developed, revised annually and revised when an individual's needs change based upon a current assessment.

~~(f)~~ (D) The individual~~,~~ and persons designated by the individual~~,~~ shall be involved ~~in~~ and supported in the INITIAL development and revisions of the ~~PSP~~ INDIVIDUAL PLAN.

~~(g) The PSP, including revisions, shall be documented on a form specified by the Department.~~

§ 2380.183. [Content of the ISP.] ~~The PSP~~ INDIVIDUAL PLAN team.

[The ISP, including annual updates and revisions under § 2380.186 (relating to ISP review and revision), must include the following:

(1) Services provided to the individual and expected outcomes chosen by the individual and individual's plan team.

(2) Services provided to the individual to increase community involvement, including work opportunities as required under § 2380.188 (relating to provider services).

(3) Current status in relation to an outcome and method of evaluation used to determine progress toward that expected outcome.

(4) A protocol and schedule outlining specified periods of time for the individual to be without direct supervision, if the individual's current assessment states the individual may be without direct supervision and if the individual's ISP includes an expected outcome which requires the achievement of a higher level of independence. The protocol must include the current level of independence and the method of evaluation used to determine progress toward the expected outcome to achieve the higher level of independence.

(5) A protocol to address the social, emotional and environmental needs of the individual, if medication has been prescribed to treat symptoms of a diagnosed psychiatric illness.

(6) A protocol to eliminate the use of restrictive procedures, if restrictive procedures are utilized, and to address the underlying causes of the behavior which led to the use of restrictive procedures including the following:

(i) An assessment to determine the causes or antecedents of the behavior.

(ii) A protocol for addressing the underlying causes or antecedents of the behavior.

(iii) The method and timeline for eliminating the use of restrictive procedures.

(iv) A protocol for intervention or redirection without utilizing restrictive procedures.

(7) Assessment of the individual's potential to advance in the following:

(i) Vocational programming.

(ii) Community involvement.

(iii) Competitive community-integrated employment.]

(a) The ~~PSP~~ INDIVIDUAL PLAN shall be developed by an interdisciplinary team, including the following:

(1) The individual.

(2) Persons designated by the individual.

(3) The individual's direct care staff persons.

(4) The program specialist.

(5) The program specialist for the individual's residential program, if applicable.

(6) Other specialists such as health care, behavior management, speech, occupational and physical therapy as appropriate for the ~~individual~~ INDIVIDUAL'S needs.

(b) At least three members of the ~~PSP~~ INDIVIDUAL PLAN team, in addition to the individual and persons designated by the individual, shall be present at a ~~PSP~~ meeting at which the ~~PSP~~ INDIVIDUAL PLAN is developed or revised.

(c) ~~Members of the PSP team who attend the meeting shall sign and date the PSP.~~ THE LIST OF PERSONS WHO PARTICIPATED IN THE INDIVIDUAL PLAN MEETING SHALL BE KEPT.

§ 2380.184. [Plan team participation.] ~~The PSP~~ INDIVIDUAL PLAN process.

[(a) The plan team shall participate in the development of the ISP, including the annual updates and revisions under § 2380.186 (relating to ISP review and revision).

(1) A plan team must include as its members the following:

(i) The individual.

(ii) A program specialist or family living specialist, as applicable, from each provider delivering a service to the individual.

(iii) A direct service worker who works with the individual from each provider delivering a service to the individual.

(iv) Any other person the individual chooses to invite.

(2) If the following have a role in the individual's life, the plan team may also include as its members, as applicable, the following:

(i) Medical, nursing, behavior management, speech, occupational or physical therapy specialists.

(ii) Additional direct service workers who work with the individual from each provider delivering services to the individual.

(iii) The individual's parent, guardian or advocate.

(b) At least three plan team members, in addition to the individual, if the individual chooses to attend, shall be present for an ISP, annual update and ISP revision meeting.

(c) A plan team member who attends a meeting under subsection (b) shall sign and date the signature sheet.]

The ~~PSP~~ INDIVIDUAL PLAN process shall:

(1) Provide ~~necessary~~ information and support to ensure that the individual directs the ~~PSP~~ INDIVIDUAL PLAN process to the ~~maximum~~ extent possible.

(2) Enable the individual to make ~~informed~~ choices and decisions.

(3) ~~Be conducted to reflect~~ REFLECT what is important to the individual to ensure that ~~supports~~ SERVICES are delivered in a manner reflecting individual preferences and ensuring the individual's health, safety and well-being.

(4) ~~Be timely in relation to the individual's needs and occur~~ OCCUR TIMELY at intervals, times and locations of choice and convenience to the individual and to persons designated by the individual.

(5) Be communicated in clear and understandable language.

(6) Reflect cultural considerations of the individual.

(7) Include guidelines for solving disagreements among the ~~PSP~~ INDIVIDUAL PLAN team members.

(8) Include a method for the individual to request updates to the ~~PSP~~ INDIVIDUAL PLAN.

§ 2380.185. [Implementation of the ISP.] Content of the ~~PSP~~ INDIVIDUAL PLAN.

[(a) The ISP shall be implemented by the ISP'S start date.

(b) The ISP shall be implemented as written.]

The ~~PSP~~ INDIVIDUAL PLAN, including revisions, must include the following:

(1) The individual's strengths ~~and~~, functional abilities AND SERVICE NEEDS.

(2) ~~The individual's individualized clinical and support needs.~~

~~(3)~~ The individual's ~~goals and~~ preferences related to relationships, COMMUNICATION, community participation, employment, ~~income and savings,~~ health care, wellness and education.

~~(4)~~ (3) ~~Individually identified, person-centered~~ THE INDIVIDUAL'S desired outcomes.

~~(5)~~ (4) ~~Supports~~ SERVICES to assist the individual to achieve desired outcomes.

~~(6) The type, amount, duration and frequency for the support specified in a manner that reflects the assessed needs and choices of the individual. The schedule of support delivery shall be determined by the PSP team.~~

~~(7) Communication mode, abilities and needs.~~

~~(8) Opportunities for new or continued community participation.~~

~~(9) Risk factors, dangerous behaviors and risk mitigation strategies, if applicable.~~

(5) RISKS TO THE INDIVIDUAL'S HEALTH, SAFETY OR WELL-BEING, BEHAVIORS LIKELY TO RESULT IN IMMEDIATE PHYSICAL HARM TO THE INDIVIDUAL OR OTHERS AND RISK MITIGATION STRATEGIES, IF APPLICABLE.

~~(10)~~ (6) Modification of individual rights as necessary to mitigate ~~risks~~ SIGNIFICANT HEALTH AND SAFETY RISKS TO THE INDIVIDUAL OR OTHERS, if applicable.

~~(11) Health care information, including a health care history.~~

~~(12) Financial information including how the individual chooses to use personal funds.~~

~~(13) The person responsible for monitoring the implementation of the PSP.~~

§ 2380.186. [ISP review and revision.] Implementation of the ~~PSP~~ INDIVIDUAL PLAN.

[(a) The program specialist shall complete an ISP review of the services and expected outcomes in the ISP specific to the facility licensed under this chapter with the individual every 3 months or more frequently if the individual's needs change which impact the services as specified in the current ISP.

(b) The program specialist and individual shall sign and date the ISP review signature sheet upon review of the ISP.

(c) The ISP review must include the following:

(1) A review of the monthly documentation of an individual's participation and progress during the prior 3 months toward ISP outcomes supported by services provided by the facility licensed under this chapter.

(2) A review of each section of the ISP specific to the facility licensed under this chapter.

(3) The program specialist shall document a change in the individual's needs, if applicable.

(4) The program specialist shall make a recommendation regarding the following, if applicable:

(i) The deletion of an outcome or service to support the achievement of an outcome which is no longer appropriate or has been completed.

(ii) The addition of an outcome or service to support the achievement of an outcome.

(iii) The modification of an outcome or service to support the achievement of an outcome in which no progress has been made.

(5) If making a recommendation to revise a service or outcome in the ISP, the program specialist shall complete a revised assessment as required under § 2380.181(b) (relating to assessment).

(d) The program specialist shall provide the ISP review documentation, including recommendations, if applicable, to the SC or plan lead, as applicable, and plan team members within 30 calendar days after the ISP review meeting.

(e) The program specialist shall notify the plan team members of the option to decline the ISP review documentation.

(f) If a recommendation for a revision to a service or outcome in the ISP is made, the plan lead as applicable, under §§ 2380.182(b) and (c), 2390.152(b) and (c), 6400.182(b) and (c), 6500.152(b) and (c) (relating to development, annual update and revision of the ISP), shall send an invitation for an ISP revision meeting to the plan team members within 30 calendar days of receipt of the recommendation.

(g) A revised service or outcome in the ISP shall be implemented by the start date in the ISP as written.]

The facility shall implement the ~~PSP~~ INDIVIDUAL PLAN, including revisions.

§ 2380.187. [Copies.] (Reserved).

[A copy of the ISP, including the signature sheet, shall be provided to plan team members within 30 calendar days after the ISP annual update and ISP revision meetings.]

§ 2380.188. [~~Provider~~ FACILITY services.] ~~(Reserved).~~

~~[~~(a) The facility shall provide services including assistance, training and support for the acquisition, maintenance or improvement of functional skills, personal needs, communication and personal adjustment.

(b) The facility shall provide opportunities and support to the individual for participation in community life, including work opportunities.

(c) The facility shall provide services to the individual as specified in the ~~individual's ISP~~ INDIVIDUAL PLAN.

(d) The facility shall provide services that are age and functionally appropriate to the individual.~~]~~

CHAPTER 2390. VOCATIONAL FACILITIES

GENERAL PROVISIONS

§ 2390.5. Definitions.

The following words and terms, when used in this chapter, have the following meanings, unless the context clearly indicates otherwise:

Abusive act—An act or omission of an act that willfully deprives a client of rights or which may cause or causes actual physical injury or emotional harm to a client.

Certificate of compliance—A document issued to a legal entity permitting it to operate a vocational facility at a given location, for a specific period of time, according to appropriate regulations of the Commonwealth.

Chief executive officer—The staff person responsible for the general management of the facility. Other terms such as “program director” or “administrator” may be used as long as the qualifications specified in § 2390.32 (relating to chief executive officer) are met.

Client—A disabled adult receiving services in a vocational facility.

Competitive employment—A job in a regular work setting with an employee-employer relationship, in which a disabled adult is hired to do a job that other nondisabled employees also do.

[*Content discrepancy*—A difference between what was determined at the ISP meeting by the plan team and what is documented in the written ISP.]

Criminal abuse—Crimes against the person such as assault and crimes against the property of the client such as theft or embezzlement.

Department—The Department of Human Services of the Commonwealth.

Direct service worker—A person whose primary job function is to provide services to a client who attends the ~~provider's~~ facility.

Disabled adult—

(i) A person who because of a disability requires special help or special services on a regular basis to function vocationally.

(ii) The term includes persons who exhibit any of the following characteristics:

(A) A physical disability, such as visual impairment, hearing impairment, speech or language impairment, or other physical handicap.

(B) Social or emotional maladjustment.

(C) A neurologically based condition such as cerebral palsy, autism or epilepsy.

(D) An intellectual disability.

[*Documentation*—Written statements that accurately record details, substantiate a claim or provide evidence of an event.]

Handicapped employment—A vocational program in which the individual client does not require rehabilitation, habilitation or ongoing training to work at the facility.

HEALTH CARE PRACTITIONER—A PERSON WHO IS AUTHORIZED TO PRESCRIBE MEDICATIONS PURSUANT TO A LICENSE, REGISTRATION OR CERTIFICATION BY THE DEPARTMENT OF STATE.

[*ISP—Individual Support Plan*—The comprehensive document that identifies services and expected outcomes for a client.

Interdisciplinary team—A group of persons representing one or more service areas relevant to identifying a client's needs, including at a minimum the county case manager if the client is funded through the county mental health and intellectual disability program, the client and the program specialist.

Outcomes—Goals the client and client's plan team choose for the client to acquire, maintain or improve.

Plan lead—The program specialist or family living specialist, as applicable, when the client is not receiving services through an SCO.

Plan team—The group that develops the ISP.]

INDIVIDUAL PLAN—A COORDINATED AND INTEGRATED DESCRIPTION OF ACTIVITIES AND SERVICES FOR A CLIENT.

~~*PSP*—Person-centered plan.~~

~~*Provider*—An entity or person that enters into an agreement with the Department to deliver a service to a client.~~

[*Restrictive procedure*—A practice that limits a client's movement, activity or function; interferes with a client's ability to acquire positive reinforcement; results in the loss of

objects or activities that a client values; or requires a client to engage in a behavior that the client would not engage in given freedom of choice.]

Restraint—A physical, chemical or mechanical intervention used to control acute, episodic behavior that restricts the movement or function of the ~~individual~~ CLIENT or a portion of the ~~individual's~~ CLIENT'S body, including an intervention approved as part of the ~~PSP~~ INDIVIDUAL PLAN or used on an emergency basis.

~~*SC—Supports coordinator*—An SCO employee whose primary job functions are to locate, coordinate and monitor services provided to a client when the client is receiving services from an SCO.~~

VOLUNTEER—A PERSON WHO IS AN ORGANIZED AND SCHEDULED COMPONENT OF THE SERVICE SYSTEM AND WHO DOES NOT RECEIVE COMPENSATION, BUT WHO PROVIDES A SERVICE THROUGH THE FACILITY THAT RECRUITS, PLANS AND ORGANIZES DUTIES AND ASSIGNMENTS.

* * * * *

GENERAL REQUIREMENTS

§ 2390.18. [Unusual incident report.] Incident report and investigation.

[(a) An unusual incident report shall be completed by the facility on a form specified by the Department for a serious event, including death of a client, injury or illness of a client requiring inpatient hospitalization, or a fire requiring the services of a fire department. The facility shall send copies of the report to the regional office of the Department and the funding agency within 24 hours after the event occurs. A copy of unusual incident reports shall be kept on file by the facility.

(b) If an unusual incident occurs during a weekend, the regional office of the Department and the funding agency shall be notified within 24 hours after the event occurs and the unusual incident report shall be sent on the first business day following the event.]

(a) The facility shall report the following incidents, alleged incidents and suspected incidents ~~in~~ THROUGH the Department's information management system or on a form specified by the Department within 24 hours of discovery by a staff person:

(1) Death.

(2) ~~Suicide attempt~~ A PHYSICAL ACT BY A CLIENT IN AN ATTEMPT TO COMPLETE SUICIDE.

(3) Inpatient admission to a hospital.

(4) ~~Visit to an emergency room.~~

~~(5)~~ Abuse, INCLUDING ABUSE TO A CLIENT BY ANOTHER CLIENT.

~~(6)~~ (5) Neglect.

~~(7)~~ (6) Exploitation.

~~(8)~~ (7) ~~An individual~~ A CLIENT who is missing for more than 24 hours or who could be in jeopardy if missing ~~at all~~ FOR ANY PERIOD OF TIME.

~~(9)~~ (8) Law enforcement activity THAT OCCURS DURING THE HOURS OF FACILITY OPERATION.

~~(10)~~ (9) Injury requiring treatment beyond first aid.

~~(11)~~ (10) Fire requiring the services of the fire department. THIS PROVISION DOES NOT INCLUDE FALSE ALARMS.

~~(12)~~ (11) Emergency closure.

~~(13) Use of a restraint.~~

~~(14)~~ (12) Theft or misuse of ~~individual~~ CLIENT funds.

~~(15)~~ (13) A violation of ~~individual~~ CLIENT rights.

(B) THE FACILITY SHALL REPORT THE FOLLOWING INCIDENTS, ALLEGED INCIDENTS AND SUSPECTED INCIDENTS THROUGH THE DEPARTMENT'S INFORMATION MANAGEMENT SYSTEM OR ON A FORM SPECIFIED BY THE DEPARTMENT WITHIN 72 HOURS OF DISCOVERY BY A STAFF PERSON:

(1) USE OF A RESTRAINT.

(2) A MEDICATION ERROR AS SPECIFIED IN § 2390.196 (RELATING TO MEDICATION ERRORS), IF THE MEDICATION WAS ORDERED BY A HEALTH CARE PRACTITIONER.

~~(b)~~ (C) The ~~individual~~ CLIENT and ~~the~~ persons designated by the ~~individual~~ CLIENT shall be notified ~~immediately upon~~ WITHIN 24 HOURS OF discovery of an incident relating to the ~~individual~~ CLIENT.

~~(c)~~ (D) The facility shall keep documentation of the notification in subsection ~~(b)~~ (C).

~~(d)~~ (E) The incident report, OR A SUMMARY OF THE INCIDENT, THE FINDINGS AND THE ACTIONS TAKEN, redacted to exclude information about another ~~individual~~ CLIENT and the reporter, unless the reporter is the ~~individual~~ CLIENT who receives the report, shall be available to the ~~individual~~ CLIENT and persons designated by the ~~individual~~ CLIENT, upon request.

~~(e)~~ (F) The facility shall take immediate action to protect the health, safety and well-being of the ~~individual~~ CLIENT following the initial knowledge or notice of an incident, alleged incident ~~and~~ OR suspected incident.

~~(f)~~ (G) The facility shall initiate an investigation of an incident, ALLEGED INCIDENT OR SUSPECTED INCIDENT within 24 hours of discovery by a staff person.

~~(g)~~ (H) A Department-certified incident investigator shall conduct the ~~incident~~ investigation of the ~~incident listed in subsection (a).~~ FOLLOWING INCIDENTS:

(1) DEATH THAT OCCURS DURING THE PROVISION OF SERVICE.

(2) INPATIENT ADMISSION TO A HOSPITAL AS A RESULT OF AN ACCIDENTAL OR UNEXPLAINED INJURY OR AN INJURY CAUSED BY A STAFF PERSON, ANOTHER CLIENT OR DURING THE USE OF A RESTRAINT.

(3) ABUSE, INCLUDING ABUSE TO A CLIENT BY ANOTHER CLIENT.

(4) NEGLECT.

(5) EXPLOITATION.

(6) INJURY REQUIRING TREATMENT BEYOND FIRST AID AS A RESULT OF AN ACCIDENTAL OR UNEXPLAINED INJURY OR AN INJURY CAUSED BY A STAFF PERSON, ANOTHER CLIENT OR DURING THE USE OF A RESTRAINT.

(7) THEFT OR MISUSE OF CLIENT FUNDS.

(8) A VIOLATION OF CLIENT RIGHTS.

~~(h)~~ (I) The facility shall finalize the incident report ~~in~~ THROUGH the Department's information management system or on a form specified by the Department within 30 days of discovery of the incident by a staff person UNLESS THE FACILITY NOTIFIES THE DEPARTMENT IN WRITING THAT AN EXTENSION IS NECESSARY AND THE REASON FOR THE EXTENSION.

~~(i)~~ (J) The facility shall provide the following information to the Department as part of the final incident report:

(1) Additional detail about the incident.

(2) The results of the incident investigation.

(3) ~~A description of the corrective action taken in response to an incident.~~ ACTION TAKEN TO PROTECT THE HEALTH, SAFETY AND WELL-BEING OF THE CLIENT.

(4) ~~Action taken to protect the health, safety and well-being of the individual.~~
A DESCRIPTION OF THE CORRECTIVE ACTION TAKEN IN RESPONSE TO AN INCIDENT AND TO PREVENT RECURRENCE OF THE INCIDENT.

(5) The person responsible for implementing the corrective action.

(6) The date the corrective action was implemented or is to be implemented.

§ 2390.19. [Abuse.] Incident procedures to protect the ~~individual~~ CLIENT.

[(a) Abusive acts against clients are prohibited.

(b) Staff or clients witnessing or having knowledge of an abusive act to a client shall report it to the chief executive officer or designee within 24 hours.

(c) The chief executive officer or designee shall investigate reports of abuse and prepare and send a report to the regional office of the Department and the funding agency within 24 hours of the initial report. If the initial report occurs during a weekend, the regional office of the Department and the funding agency shall be notified within 24 hours after the initial report and the abuse investigation report shall be sent on the first business day following the initial report. The report shall either support or deny the allegation and make recommendations for appropriate action. The chief executive officer or designee shall implement changes immediately to prevent abuse in the future.

(d) Incidents of criminal abuse shall be reported immediately to law enforcement authorities.]

(a) In investigating an incident, the facility shall review and consider the following needs of the affected ~~individual~~ CLIENT:

(1) Potential risks.

(2) Health care information.

(3) Medication history and current medication.

(4) Behavioral health history.

(5) Incident history.

(6) Social needs.

(7) Environmental needs.

(8) Personal safety.

(b) The facility shall monitor ~~an individual's~~ A CLIENT'S risk for recurring incidents and implement corrective action, as appropriate.

(c) The facility shall work cooperatively with the ~~PSP~~ INDIVIDUAL PLAN team to revise the ~~PSP~~ INDIVIDUAL PLAN if indicated by the incident ~~investigation~~.

(d) The facility shall complete the following for each confirmed incident:

(1) Analysis to determine the ~~root~~ cause of the incident.

(2) Corrective action IF INDICATED.

(3) A strategy to address the potential risks to the ~~affected individual~~ CLIENT.

(e) The facility shall review and analyze incidents and conduct AND DOCUMENT a trend analysis at least every 3 months.

(f) The facility shall identify and implement preventive measures to reduce:

(1) The number of incidents.

(2) The severity of the risks associated with the incident.

(3) The likelihood of an incident recurring.

(g) The facility shall educate staff persons and the ~~individual~~ CLIENT based on the circumstances of the incident.

(h) The facility shall ~~analyze~~ MONITOR incident data ~~continuously~~ and take actions to mitigate and manage risks.

§ 2390.21. [Civil] ~~Individual~~ CLIENT rights.

[(a) A client may not be discriminated against because of race, color, religious creed, disability, handicap, ancestry, national origin, age or sex, nor be deprived of civil or legal rights.

(b) A facility shall develop and implement civil rights policies and procedures. Civil rights policies and procedures include the following:

(1) Nondiscrimination in the provision of services, admissions, placement, facility usage, referrals and communication with non-English speaking clients.

(2) Program accessibility and accommodation for disabled clients.

(3) The opportunity to lodge civil rights complaints.

(4) Orientation for clients on their rights to register civil rights complaints.]

(a) ~~An individual~~ A CLIENT may not be deprived of rights as provided under subsections (b) ~~—(s)~~ (Q).

(b) ~~An individual shall be continually supported to exercise the individual's rights.~~

~~(c)~~ THE FACILITY SHALL EDUCATE, ASSIST AND PROVIDE THE ~~An individual shall be provided the support and~~ accommodation necessary ~~to be able~~ FOR THE CLIENT to understand ~~and actively exercise the individual's~~ THE CLIENT'S rights.

~~(d)~~ (C) ~~An individual~~ A CLIENT may not be reprimanded, punished or retaliated against for exercising the ~~individual's~~ CLIENT'S rights.

~~(e)~~ (D) A court's written order that restricts ~~an individual's~~ A CLIENT'S rights shall be followed.

~~(f)~~ (E) A court-appointed legal guardian may exercise rights and make decisions on behalf of ~~an individual~~ A CLIENT in accordance with ~~a court order~~ THE CONDITIONS OF GUARDIANSHIP AS SPECIFIED IN THE COURT ORDER.

~~(g)~~ (F) ~~An individual~~ A CLIENT who has a court-appointed legal guardian, or who has a court order restricting the ~~individual's~~ CLIENT'S rights, shall be involved in ~~decision making~~ DECISION-MAKING in accordance with the court order.

~~(h)~~ (G) ~~An individual~~ A CLIENT has the right to designate persons to assist in ~~decision making~~ DECISION-MAKING AND EXERCISING RIGHTS on behalf of the ~~individual~~ CLIENT.

~~(i)~~ (H) ~~An individual~~ A CLIENT may not be discriminated against because of race, color, creed, disability, religious affiliation, ancestry, gender, gender identity, sexual orientation, national origin or age.

~~(j)~~ (I) ~~An individual~~ A CLIENT has the right to civil and legal rights afforded by law, including the right to vote, speak freely, ~~and~~ practice the religion of ~~his~~ THE CLIENT'S choice ~~or to~~ AND practice no religion.

~~(k)~~ (J) ~~An individual~~ A CLIENT may not be abused, neglected, mistreated, exploited, abandoned or subjected to corporal punishment.

~~(l)~~ (K) ~~An individual~~ A CLIENT shall be treated with dignity and respect.

~~(m)~~ (L) ~~An individual~~ A CLIENT has the right to make choices and accept risks.

~~(n)~~ (M) ~~An individual~~ A CLIENT has the right to refuse to participate in activities and ~~supports~~ SERVICES.

~~(o)~~ (N) ~~An individual~~ A CLIENT has the right to privacy of person and possessions.

~~(p)~~ (O) ~~An individual~~ A CLIENT has the right of access to and security of the ~~individual's~~ CLIENT'S possessions.

~~(q)~~ (P) ~~An individual~~ A CLIENT has the right to voice concerns about the ~~supports~~ SERVICES the ~~individual~~ CLIENT receives.

~~(r)~~ (Q) ~~An individual~~ A CLIENT has the right to participate in the development and implementation of the ~~PSP~~ INDIVIDUAL PLAN.

~~(s)~~ (R) ~~An individual's~~ A CLIENT'S rights shall be exercised so that another ~~individual's~~ CLIENT'S rights are not violated.

~~(t)~~ (S) THE FACILITY SHALL ASSIST ~~Choices shall be negotiated by~~ the affected ~~individuals~~ CLIENTS TO NEGOTIATE CHOICES in accordance with the facility's procedures for the ~~individuals~~ CLIENTS to resolve differences and make choices.

(T) A CLIENT'S RIGHTS MAY ONLY BE MODIFIED IN ACCORDANCE WITH § 2390.155 (RELATING TO CONTENT OF THE INDIVIDUAL PLAN) TO THE EXTENT NECESSARY TO MITIGATE A SIGNIFICANT HEALTH AND SAFETY RISK TO THE CLIENT OR OTHERS.

(u) The facility shall inform and explain ~~individual~~ CLIENT rights AND THE PROCESS TO REPORT A RIGHTS VIOLATION to the ~~individual~~ CLIENT, and persons designated by the ~~individual~~ CLIENT, upon admission to the facility and annually thereafter.

(v) The facility shall keep a copy of the statement signed by the ~~individual~~ CLIENT, or the ~~individual's~~ CLIENT'S court-appointed legal guardian, acknowledging receipt of the information on ~~individual~~ CLIENT rights.

§ 2390.24. Applicable ~~laws~~ STATUTES and regulations.

The facility shall comply with applicable ~~Federal, State and local laws, regulations and ordinances~~ FEDERAL AND STATE STATUTES AND REGULATIONS AND LOCAL ORDINANCES.

STAFFING

§ 2390.33. Program specialist.

(a) A minimum of [one] 1 program specialist for every 45 clients shall be available when clients are present at the facility.

(b) The program specialist shall be responsible for the following:

[(1) Coordinating and completing assessments.

(2) Providing the assessment as required under § 2390.151(f) (relating to assessment).

(3) Participating in the development of the ISP, including annual updates and revisions of the ISP.

(4) Attending the ISP meetings.

(5) Fulfilling the role of plan lead, as applicable, under §§ 2390.152 and 2390.156(f) and (g) (relating to development, annual update and revision to the ISP; and ISP review and revision).

(6) Reviewing the ISP, annual updates and revisions for content accuracy.

(7) Reporting content discrepancy to the SC or plan lead, as applicable, and plan team members.

(8) Implementing the ISP as written.

(9) Supervising, monitoring and evaluating services provided to the client.

(10) Reviewing, signing and dating the monthly documentation of a client's participation and progress toward outcomes.

(11) Reporting a change related to the client's needs to the SC or plan lead, as applicable, and plan team members.

(12) Reviewing the ISP with the client as required under § 2390.156.

(13) Documenting the review of the ISP as required under § 2390.156.

(14) Providing documentation of the ISP review to the SC or plan lead, as applicable, and plan team members as required under § 2390.156(d).

(15) Informing plan team members of the option to decline the ISP review documentation as required under § 2390.156(e).

(16) Recommending a revision to a service or outcome in the ISP as provided under § 2390.156(c)(4).

(17) Coordinating the services provided to a client.

(18) Coordinating the training of direct service workers in the content of health and safety needs relevant to each client.

(19) Developing and implementing provider services as required under § 2390.158 (relating to provider services).]

(1) Coordinating the completion of assessments.

(2) Participating in the ~~PSP~~ INDIVIDUAL PLAN process, ~~PSP~~ development, ~~PSP~~ team reviews and ~~the~~ implementation ~~of the PSP~~ in accordance with this chapter.

(3) Providing and supervising activities for the ~~individuals~~ CLIENTS in accordance with the ~~PSPs~~ INDIVIDUAL PLANS.

(4) Supporting the integration of ~~individuals~~ CLIENTS in the community.

(5) Supporting ~~individual~~ CLIENT communication and involvement with families and friends.

(c) A program specialist shall meet one of the following groups of qualifications:

(1) Possess a master's degree or above from an accredited college or university in Special Education, Psychology, Public Health, Rehabilitation, Social Work, Speech Pathology, Audiology, Occupational Therapy, Therapeutic Recreation or other human services field.

(2) Possess a bachelor's degree from an accredited college or university in Special Education, Psychology, Public Health, Rehabilitation, Social Work, Speech Pathology, Audiology, Occupational Therapy, Therapeutic Recreation or other human services field; and 1 year experience working directly with disabled persons.

(3) Possess an associate's degree or completion of a [2 year] 2-year program from an accredited college or university in Special Education, Psychology, Public Health, Rehabilitation, Social Work, Speech Pathology, Audiology, Occupational Therapy, Therapeutic Recreation or other human services field; and 3 years experience working directly with disabled persons.

(4) Possess a license or certification by the State Board of Nurse Examiners, the State Board of Physical Therapists Examiners, or the Committee on Rehabilitation Counselor Certification or be a licensed psychologist or registered occupational therapist; and 1 year experience working directly with disabled persons.

§ 2390.39. Staffing.

(a) A minimum of two staff shall be present at the facility when [10] ten or more clients are present at the facility.

(b) A minimum of one staff shall be present at the facility when fewer than [10] ten clients are present at the facility.

(c) If 20 or more clients are present at the facility, there shall be at least [one] 1 staff present at the facility who meets the qualifications of program specialist.

(d) A client may be left unsupervised for specified periods of time if the absence of direct supervision is consistent with the client's assessment and is part of the client's [ISP] ~~PSP~~ INDIVIDUAL PLAN, as an outcome which requires the achievement of a higher level of independence.

(e) The staff qualifications and staff ratio as specified in the [ISP] ~~PSP~~ INDIVIDUAL PLAN shall be implemented as written, including when the staff ratio is greater than required under subsections (a), (b) and (c).

(f) A client may not be left unsupervised solely for the convenience of the facility or the direct service worker.

§ 2390.40. [Staff training.] ~~Annual training plan~~ TRAINING RECORDS.

[(a) A facility shall provide orientation for staff relevant to their appointed positions. Staff shall be instructed in the daily operation of the facility and policies and procedures of the agency.

(b) Staff in positions required by this chapter shall have at least 24 hours of training relevant to vocational or human services annually.

(c) Records of orientation and training, including dates held and staff attending, shall be kept on file.]

~~(a) The facility shall design an annual training plan based on the needs of the individuals as specified in the individuals' PSPs, other data and analysis indicating staff person training needs and as required under § 2390.49 (relating to annual training).~~

~~(b) The annual training plan must include the orientation program as specified in § 2390.48 (relating to orientation program).~~

~~(c) The annual training plan must include training aimed at improving the knowledge, skills and core competencies of the staff persons to be trained.~~

~~(d) The annual training plan must include the following:~~

~~(1) The title of the position to be trained.~~

~~(2) The required training courses, including training course hours, for each position.~~

(A) RECORDS OF ORIENTATION AND TRAINING, INCLUDING THE TRAINING SOURCE, CONTENT, DATES, LENGTH OF TRAINING, COPIES OF CERTIFICATES RECEIVED AND PERSONS ATTENDING, SHALL BE KEPT.

(B) THE FACILITY SHALL KEEP A TRAINING RECORD FOR EACH PERSON TRAINED.

§ 2390.48. Orientation ~~program~~.

(a) Prior to working alone with ~~individuals~~ CLIENTS, and within 30 days after hire, the following shall complete the orientation ~~program~~ as described in subsection (b):

(1) Management, program, administrative and fiscal staff persons.

(2) Dietary, housekeeping, maintenance and ancillary staff persons. THIS PROVISION DOES NOT INCLUDE A PERSON WHO PROVIDES DIETARY, HOUSEKEEPING, MAINTENANCE OR ANCILLARY SERVICES, IF THE PERSON IS EMPLOYED OR CONTRACTED BY THE BUILDING OWNER AND THE LICENSED FACILITY DOES NOT OWN THE BUILDING.

(3) Direct service workers, including full-time and part-time staff persons.

(4) Volunteers who will work alone with ~~individuals~~ CLIENTS.

(5) Paid and unpaid interns who will work alone with ~~individuals~~ CLIENTS.

(6) Consultants AND CONTRACTORS who ARE PAID OR CONTRACTED BY THE FACILITY AND WHO will work alone with ~~individuals~~ CLIENTS, EXCEPT FOR CONSULTANTS AND CONTRACTORS WHO PROVIDE A SERVICE FOR FEWER THAN 30 DAYS WITHIN A 12-MONTH PERIOD AND WHO ARE LICENSED, CERTIFIED OR REGISTERED BY THE DEPARTMENT OF STATE IN A HEALTH CARE OR SOCIAL SERVICE FIELD.

(b) The orientation ~~program~~ must encompass the following areas:

(1) The application of person-centered practices, ~~including respecting rights, facilitating~~ community integration, ~~honoring~~ CLIENT choice and supporting ~~individuals in maintaining~~ CLIENTS TO DEVELOP AND MAINTAIN relationships.

(2) The prevention, detection and reporting of abuse, suspected abuse and alleged abuse in accordance with ~~sections 701—708 of~~ the Older Adults Protective Services Act (35 P.S. §§ ~~10225.701—10225.708~~ 10225.101—10225.5102), THE CHILD PROTECTIVE SERVICES LAW (23 Pa.C.S. §§ 6301—6386) ~~(relating to Child~~

~~Protective Services Law)~~, the Adult Protective Services Act (35 P.S. §§ 10210.101—10210.704) and applicable protective services regulations.

(3) ~~Individual~~ CLIENT rights.

(4) Recognizing and reporting incidents.

(5) Job-related knowledge and skills.

§ 2390.49. Annual training.

(a) The following ~~staff persons, including full-time and part-time staff persons,~~ shall complete 24 hours of training RELATED TO JOB SKILLS AND KNOWLEDGE each year:

(1) ~~Floor supervisors.~~

~~(2)~~ Direct supervisors of floor supervisors.

~~(3)~~ (2) Positions required by this chapter.

(b) The following ~~staff persons~~ shall complete 12 hours of training each year:

(1) Management, program, administrative and fiscal staff persons.

(2) Dietary, housekeeping, maintenance and ancillary staff persons. THIS PROVISION DOES NOT INCLUDE A PERSON WHO PROVIDES DIETARY, HOUSEKEEPING, MAINTENANCE OR ANCILLARY SERVICES, IF THE PERSON IS EMPLOYED OR CONTRACTED BY THE BUILDING OWNER AND THE LICENSED FACILITY DOES NOT OWN THE BUILDING.

(3) Consultants AND CONTRACTORS who ARE PAID OR CONTRACTED BY THE FACILITY AND WHO work alone with ~~individuals~~ CLIENTS, EXCEPT FOR CONSULTANTS AND CONTRACTORS WHO PROVIDE A SERVICE FOR FEWER THAN 30 DAYS WITHIN A 12-MONTH PERIOD AND WHO ARE LICENSED, CERTIFIED OR REGISTERED BY THE DEPARTMENT OF STATE IN A HEALTH CARE OR SOCIAL SERVICE FIELD.

(4) Volunteers who work alone with ~~individuals~~ CLIENTS.

(5) Paid and unpaid interns who work alone with ~~individuals~~ CLIENTS.

(c) ~~A minimum of 8 hours of the~~ THE annual training hours specified in subsections (a) and (b) must encompass the following areas:

(1) The application of person-centered practices, including ~~respecting rights, facilitating~~ community integration, ~~honoring~~ CLIENT choice and supporting ~~individuals in maintaining~~ CLIENTS TO DEVELOP AND MAINTAIN relationships.

(2) The prevention, detection and reporting of abuse, suspected abuse and alleged abuse in accordance with ~~sections 701—708 of~~ the Older Adults Protective Services Act (35 P.S. §§ ~~10225.701—10225.708~~ 10225.101—10225.5102), THE CHILD PROTECTIVE SERVICES LAW (23 Pa.C.S. §§ 6301—6386) ~~(relating to Child Protective Services Law)~~, the Adult Protective Services Act (35 P.S. §§ 10210.101—10210.704) and applicable protective services regulations.

(3) ~~Individual~~ CLIENT rights.

(4) Recognizing and reporting incidents.

(5) The safe and appropriate use of ~~positive interventions~~ BEHAVIOR SUPPORTS if the ~~staff~~ person ~~will provide a support to an individual with a dangerous behavior~~ WORKS DIRECTLY WITH A CLIENT.

(6) IMPLEMENTATION OF THE INDIVIDUAL PLAN IF THE PERSON WORKS DIRECTLY WITH A CLIENT.

~~(d) The balance of the annual training hours must be in areas identified by the facility in the facility's annual training plan as required under § 2390.40 (relating to annual training plan).~~

~~(e) All training, including those training courses identified in subsections (c) and (d), must be included in the provider's annual training plan.~~

~~(f) Records of orientation and training, including the training source, content, dates, length of training, copies of certificates received and persons attending, shall be kept.~~

~~(g) A training record for each person trained shall be kept.~~

CLIENT RECORDS

§ 2390.124. Content of records.

Each client's record must include the following information:

(1) The name, sex, admission date, birthdate and place, [social security] Social Security number and dates of entry, transfer and discharge.

(2) The name, address and telephone number of parents, legal guardian and a designated person to be contacted in case of an emergency.

(3) The name and telephone number of a physician or source of health care.

(4) Written consent from the client, parent or guardian for emergency medical treatment.

(5) Physical examinations.

(6) Assessments as required under § 2390.151 (relating to assessment).

(7) A copy of the vocational evaluations, if applicable.

[(8) A copy of the invitation to:

(i) The initial ISP meeting.

(ii) The annual update meeting.

(iii) The ISP revision meeting.

(9) A copy of the signature sheet for:

(i) The initial ISP meeting.

(ii) The annual update meeting.

(iii) The ISP revision meeting.

(10) A copy of the current ISP.

(11) Documentation of ISP reviews and ISP revisions under § 2390.156 (relating to ISP review and revision), including the following:

(i) ISP Review signature sheets.

(ii) Recommendations to revise the ISP.

(iii) ISP revisions.

(iv) Notices that the plan team member may decline the ISP review documentation.

(v) Requests from plan team members to not receive the ISP review documentation.

(12) Content discrepancy in the ISP, the annual update or revision under § 2390.156.]

(8) ~~PSP~~ INDIVIDUAL PLAN documents as required by this chapter.

[(13) Restrictive procedure protocols and] (9) ~~Positive intervention records related to the client.~~

[(14) Unusual incident] ~~(10)~~ Incident reports related to the client.

[(15)] ~~(11)~~ (10) Copies of psychological evaluations, if applicable.

[(16)] ~~(12)~~ (11) Vocational evaluations as required under § 2390.159 (relating to vocational evaluation).

PROGRAM

§ 2390.151. Assessment.

* * * * *

(b) If the program specialist is making a recommendation to revise a service or outcome in the [ISP as provided under § 2390.156(c)(4) (relating to ISP review and revision)] ~~PSP~~ INDIVIDUAL PLAN, the client shall have an assessment completed as required under this section.

*** * * * ***

(f) The program specialist shall provide the assessment to the ~~SC or plan lead, as applicable, and~~ INDIVIDUAL plan team members at least 30 calendar days prior to [an ISP] ~~a PSP meeting for the development, annual update and revision of the~~ [ISP] ~~PSP~~

~~under §§ 2380.182, 2390.152, 6400.182 and 6500.152 (relating to development~~ [, annual update and revision of the ISP] ~~of the PSP)~~ THE INDIVIDUAL PLAN meeting.

§ 2390.152. ~~Development~~ [, annual update and revision of the ISP] ~~of the PSP~~. DEVELOPMENT, ANNUAL UPDATE AND REVISION OF THE INDIVIDUAL PLAN.

[(a) A client shall have one ISP.

(b) When a client is not receiving services through an SCO and is not receiving services in a facility or home licensed under Chapters 2380, 6400 or 6500 (relating to adult training facilities; community homes for individuals with an intellectual disability; and family living homes), the vocational facility program specialist shall be the plan lead.

(c) The plan lead shall be responsible for developing and implementing the ISP, including annual updates and revisions.

(d) The plan lead shall develop, update and revise the ISP according to the following:

(1) The ISP shall be initially developed, updated annually and revised based upon the client's current assessment as required under §§ 2380.181, 2390.151, 6400.181 and 6500.151 (relating to assessment).

(2) The initial ISP shall be developed within 90 calendar days after the client's admission date to the facility.

(3) The ISP, annual updates and revisions shall be documented on the Department-designated form located in the Home and Community Services Information System (HCSIS) and also on the Department's web site.

(4) An invitation shall be sent to plan team members at least 30 calendar days prior to an ISP meeting.

(5) Copies of the ISP, including annual updates and revisions under § 2390.156 (relating to ISP review and revision), shall be provided as required under § 2390.157 (relating to copies).]

(a) ~~An individual shall have one approved and authorized PSP at a given time.~~

~~(b) An individual's service implementation plan must be consistent with the PSP in subsection (a).~~

~~(c)~~ The ~~support coordinator, targeted support manager or~~ program specialist shall coordinate the development of the ~~PSP~~ INDIVIDUAL PLAN, including revisions, ~~in cooperation~~ with the ~~individual~~ CLIENT and the ~~individual's PSP~~ INDIVIDUAL PLAN team.

~~(d)~~ (B) The initial ~~PSP~~ INDIVIDUAL PLAN shall be developed based on the ~~individual~~ CLIENT assessment within ~~60 days~~ 90 DAYS of the ~~individual's~~ CLIENT'S date of admission to the facility.

~~(e)~~ (C) The ~~PSP~~ INDIVIDUAL PLAN shall be initially developed, revised annually and revised when ~~an individual's~~ A CLIENT'S needs change based upon a current assessment.

~~(f)~~ (D) The ~~individual~~ CLIENT and persons designated by the ~~individual~~ CLIENT shall be involved ~~in~~ and supported in the INITIAL development and revisions of the ~~PSP~~ INDIVIDUAL PLAN.

~~(g) The PSP, including revisions, shall be documented on a form specified by the Department.~~

§ 2390.153. [Content of the ISP.] ~~The PSP~~ INDIVIDUAL PLAN team.

[The ISP, including annual updates and revisions under § 2390.156 (relating to ISP review and revision) must include the following:

(1) Services provided to the client and expected outcomes chosen by the client and client's plan team.

(2) Services provided to the client to develop the skills necessary for promotion into a higher level of vocational programming or into competitive community-integrated employment as required under § 2390.158 (relating to provider services).

(3) Current status in relation to an outcome and method of evaluation used to determine progress toward that expected outcome.

(4) A protocol and schedule outlining specified periods of time for the client to be without direct supervision, if the client's current assessment states the client may be without direct supervision and if the client's ISP includes an expected outcome which requires the achievement of a higher level of independence. The protocol must include the current level of independence and the method of evaluation used to determine progress toward the expected outcome to achieve a higher level of independence.

(5) A protocol to address the social, emotional and environmental needs of the client, if medication has been prescribed to treat symptoms of a diagnosed psychiatric illness.

(6) A protocol to eliminate the use of restrictive procedures, if restrictive procedures are utilized, and to address the underlying causes of the behavior which led to the use of restrictive procedures including the following:

(i) An assessment to determine the causes or antecedents of the behavior.
(ii) A protocol for addressing the underlying causes or antecedents of the behavior.

(iii) The method and timeline for eliminating the use of restrictive procedures.

(iv) A protocol for intervention or redirection without utilizing restrictive procedures.

(7) Assessment of the client's potential to advance in the following:

(i) Vocational programming.

(ii) Competitive community-integrated employment.]

(a) The ~~PSP~~ INDIVIDUAL PLAN shall be developed by an interdisciplinary team, including the following:

(1) The ~~individual~~ CLIENT.

(2) Persons designated by the ~~individual~~ CLIENT.

(3) The ~~individual's~~ CLIENT'S direct care staff persons.

(4) The program specialist.

(5) The program specialist for the ~~individual's~~ CLIENT'S residential program, if applicable.

(6) Other specialists such as health care, behavior management, speech, occupational and physical therapy as appropriate for the ~~individual~~ CLIENT'S needs.

(b) At least three members of the ~~PSP~~ INDIVIDUAL PLAN team, in addition to the ~~individual~~ CLIENT and persons designated by the ~~individual~~ CLIENT, shall be present at a ~~PSP~~ meeting at which the ~~PSP~~ INDIVIDUAL PLAN is developed or revised.

(c) ~~Members of the PSP team who attend the meeting shall sign and date the PSP.~~ THE LIST OF PERSONS WHO PARTICIPATED IN THE INDIVIDUAL PLAN MEETING SHALL BE KEPT.

§ 2390.154. [Plan team participation.] ~~The PSP~~ INDIVIDUAL PLAN process.

[(a) The plan team shall participate in the development of the ISP, including the annual updates and revisions under § 2390.156 (relating to ISP review and revision).

(1) A plan team must include as its members the following:

(i) The client.

(ii) A program specialist or family living specialist, as applicable, from each provider delivering a service to the client.

(iii) A direct service worker who works with the client from each provider delivering a service to the client.

(iv) Any other person the client chooses to invite.

(2) If the following have a role in the client's life, the plan team may also include as its members, as applicable, the following:

(i) Medical, nursing, behavior management, speech, occupational or physical therapy specialists.

(ii) Additional direct service workers who work with the client from each provider delivering services to the client.

(iii) The client's parent, guardian or advocate.

(b) At least three plan team members, in addition to the client, if the client chooses to attend, shall be present for the ISP, annual update and ISP revision meetings.

(c) A plan team member who attends an ISP meeting under subsection (b) shall sign and date the signature sheet.]

The ~~PSP~~ INDIVIDUAL PLAN process shall:

(1) Provide ~~necessary~~ information and support to ensure that the ~~individual~~ CLIENT directs the ~~PSP~~ INDIVIDUAL PLAN process to the ~~maximum~~ extent possible.

(2) Enable the ~~individual~~ CLIENT to make ~~informed~~ choices and decisions.

(3) ~~Be conducted to reflect~~ REFLECT what is important to the ~~individual~~ CLIENT to ensure that ~~supports~~ SERVICES are delivered in a manner reflecting individual preferences and ensuring the ~~individual's~~ CLIENT'S health, safety and well-being.

(4) ~~Be timely and occur~~ OCCUR TIMELY at intervals, times and locations of choice and convenience to the ~~individual~~ CLIENT and to persons designated by the ~~individual~~ CLIENT.

(5) Be communicated in clear and understandable language.

(6) Reflect cultural considerations of the ~~individual~~ CLIENT.

(7) Include guidelines for solving disagreements among the ~~PSP~~ INDIVIDUAL PLAN team members.

(8) Include a method for the ~~individual~~ CLIENT to request updates to the ~~PSP~~ INDIVIDUAL PLAN.

§ 2390.155. [Implementation of the ISP.] Content of the ~~PSP~~ INDIVIDUAL PLAN.

[(a) The ISP shall be implemented by the ISP's start date.

(b) The ISP shall be implemented as written.]

The ~~PSP~~ INDIVIDUAL PLAN, including revisions, must include the following:

(1) The ~~individual's~~ CLIENT'S strengths ~~and~~, functional abilities AND SERVICE NEEDS.

(2) ~~The individual's individualized clinical and support needs.~~

~~(3)~~ The ~~individual's goals and~~ CLIENT'S preferences related to relationships, COMMUNICATION, community participation, employment, ~~income and savings,~~ health care, wellness and education.

~~(4)~~ (3) ~~Individually identified, person-centered~~ THE CLIENT'S desired outcomes.

~~(5)~~ (4) ~~Supports~~ SERVICES to assist the ~~individual~~ CLIENT to achieve desired outcomes.

~~(6) The type, amount, duration and frequency for the support specified in a manner that reflects the assessed needs and choices of the individual. The schedule of support delivery shall be determined by the PSP team.~~

~~(7) Communication mode, abilities and needs.~~

~~(8) Opportunities for new or continued community participation.~~

~~(9) Risk factors, dangerous behaviors and risk mitigation strategies, if applicable.~~

(5) RISKS TO THE CLIENT'S HEALTH, SAFETY OR WELL-BEING, BEHAVIORS LIKELY TO RESULT IN IMMEDIATE PHYSICAL HARM TO THE CLIENT OR OTHERS AND RISK MITIGATION STRATEGIES, IF APPLICABLE.

~~(10)~~ (6) Modification of ~~individual~~ CLIENT rights as necessary to mitigate ~~risks~~ SIGNIFICANT HEALTH AND SAFETY RISKS TO THE CLIENT OR OTHERS, if applicable.

~~(11) Health care information, including a health care history.~~

~~(12) Financial information including how the individual chooses to use personal funds.~~

~~(13) The person responsible for monitoring the implementation of the PSP.~~

§ 2390.156. [ISP review and revision.] Implementation of the ~~PSP~~ INDIVIDUAL PLAN.

[(a) The program specialist shall complete an ISP review of the services and expected outcomes in the ISP specific to the facility licensed under this chapter with the client every 3 months or more frequently if the client's needs change which impacts the services as specified in the current ISP.

(b) The program specialist and client shall sign and date the ISP review signature sheet upon review of the ISP.

(c) The ISP review must include the following:

(1) A review of the monthly documentation of a client's participation and progress during the prior 3 months toward ISP outcomes supported by services provide by the facility licensed under this chapter.

(2) A review of each section of the ISP specific to the facility licensed under this chapter.

(3) The program specialist shall document a change in the client's needs, if applicable.

(4) The program specialist shall make a recommendation regarding the following, if applicable:

(i) The deletion of an outcome or service to support the achievement of an outcome which is no longer appropriate or has been completed.

(ii) The addition of an outcome or service to support the achievement of an outcome.

(iii) The modification of an outcome or service to support the achievement of an outcome in which no progress has been made.

(5) If making a recommendation to revise a service or outcome in the ISP, the program specialist shall complete a revised assessment as required under § 2390.151(b) (relating to assessment).

(d) The program specialist shall provide the ISP review documentation, including recommendations if applicable, to the SC or plan lead, as applicable, and plan team members within 30 calendar days after the ISP review meeting.

(e) The program specialist shall notify the plan team members of the option to decline the ISP review documentation.

(f) If a recommendation for a revision to a service or outcome in the ISP is made, the plan lead, as applicable, under §§ 2380.182(b) and (c), 2390.152(b) and (c), 6400.182(b) and (c), 6500.152(b) and (c) (relating to development, annual update and

revision of the ISP), shall send an invitation for an ISP revision meeting to the plan team members within 30 calendar days of receipt of the recommendation.

(g) A revised service or outcome in the ISP shall be implemented by the start date in the ISP as written.]

The facility shall implement the ~~PSP~~ INDIVIDUAL PLAN, including revisions.

§ 2390.157. [Copies.] (Reserved).

[A copy of the ISP, ISP annual update and ISP revision, including the signature sheet, shall be provided to plan team members within 30 calendar days after the ISP, ISP annual update and ISP revision meetings.]

§ 2390.158. [Provider services.] ~~(Reserved).~~ FACILITY SERVICES.

[(a) The facility shall provide services including work experience and other developmentally oriented, vocational training designed to develop the skills necessary for promotion into a higher level of vocational programming or competitive community-integrated employment.

(b) The facility shall provide opportunities and support to the client for participation in community life, including competitive community-integrated employment.

(c) The facility shall provide services to the client as specified in the client's ~~ISP~~ INDIVIDUAL PLAN.

(d) The facility shall provide services that are age and functionally appropriate to the client.~~]~~

~~POSITIVE INTERVENTION~~ RESTRICTIVE PROCEDURES

§ 2390.171. ~~Use of a positive intervention.~~ DEFINITION OF RESTRICTIVE PROCEDURES.

~~(a) A positive intervention shall be used to prevent, modify and eliminate a dangerous behavior when the behavior is anticipated or occurring.~~

~~(b) The least intrusive method shall be applied when addressing a dangerous behavior. For each incidence of a dangerous behavior, every attempt shall be made to modify and eliminate the behavior.~~

~~(c) As used in this section, the following words and terms have the following meanings, unless the context clearly indicates otherwise:~~

~~*Dangerous behavior*—An action with a high likelihood of resulting in harm to the individual or others.~~

~~*Positive intervention*—An action or activity intended to prevent, modify and eliminate a dangerous behavior. This includes improved communications, reinforcing appropriate behavior, an environmental change, recognizing and treating physical and behavioral health symptoms, voluntary physical exercise and other wellness practices, redirection, praise, modeling, conflict resolution and de-escalation.~~

A RESTRICTIVE PROCEDURE IS A PRACTICE THAT DOES ONE OR MORE OF THE FOLLOWING:

(1) LIMITS A CLIENT'S MOVEMENT, ACTIVITY OR FUNCTION.

(2) INTERFERES WITH A CLIENT'S ABILITY TO ACQUIRE POSITIVE REINFORCEMENT.

(3) RESULTS IN THE LOSS OF OBJECTS OR ACTIVITIES THAT A CLIENT VALUES.

(4) REQUIRES A CLIENT TO ENGAGE IN A BEHAVIOR THAT THE CLIENT WOULD NOT ENGAGE IN GIVEN FREEDOM OF CHOICE.

§ 2390.172. ~~PSP.~~ WRITTEN POLICY.

~~If the individual has a dangerous behavior as identified in the PSP, the PSP must include the following:~~

~~(1) The specific dangerous behavior to be addressed.~~

~~(2) A functional analysis of the dangerous behavior and the plan to address the reason for the behavior.~~

~~(3) The outcome desired.~~

~~(4) A description of the positive intervention aimed at preventing, modifying or eliminating the dangerous behavior and the circumstances under which the intervention is to be used.~~

~~(5) A target date to achieve the outcome.~~

~~(6) Health conditions that require special attention.~~

THE FACILITY SHALL DEVELOP AND IMPLEMENT A WRITTEN POLICY THAT DEFINES THE PROHIBITION OR USE OF SPECIFIC TYPES OF RESTRICTIVE PROCEDURES, DESCRIBES THE CIRCUMSTANCES IN WHICH A RESTRICTIVE PROCEDURE MAY BE USED, THE STAFF PERSONS WHO MAY AUTHORIZE THE USE OF A RESTRICTIVE PROCEDURE AND A MECHANISM TO MONITOR AND CONTROL THE USE OF RESTRICTIVE PROCEDURES.

§ 2390.173. ~~Prohibition of restraints.~~ APPROPRIATE USE OF RESTRICTIVE PROCEDURES.

~~The following procedures are prohibited:~~

~~(1) Seclusion, defined as involuntary confinement of an individual in a room or area from which the individual is physically prevented or verbally directed from leaving.~~

~~(2) Aversive conditioning, defined as the application of startling, painful or noxious stimuli.~~

~~(3) Pressure point techniques, defined as the application of pain for the purpose of achieving compliance.~~

~~(4) A chemical restraint, defined as use of drugs or chemicals for the specific and exclusive purpose of controlling acute or episodic aggressive behavior. A chemical restraint does not include a drug ordered by a health care practitioner or dentist to treat the symptoms of a specific mental, emotional or behavioral condition, or as pretreatment prior to a medical or dental examination or treatment.~~

~~(5) A mechanical restraint, defined as a device that restricts the movement or function of an individual or portion of an individual's body. Mechanical restraints include a geriatric chair, handcuffs, anklets, wristlets, camisole, helmet with fasteners, muffs and mitts with~~

fasteners, restraint vest, waist strap, head strap, papoose board, restraining sheet, chest restraint and other locked restraints.

(i) The term does not include a device prescribed by a health care practitioner that is used to provide post-surgical care, proper balance or support for the achievement of functional body position.

(ii) The term does not include a device prescribed by a health care practitioner to protect the individual in the event of a seizure, as long as the individual can easily remove the device.

(6) A manual restraint, defined as a hands-on physical method that restricts, immobilizes or reduces an individual's ability to move his arms, legs, head or other body parts freely, on a nonemergency basis, or for more than 15 minutes within a 2-hour period. A manual restraint does not include physically prompting, escorting or guiding an individual to provide a support as specified in the individual's PSP.

(7) A prone position manual restraint.

(8) A manual restraint that inhibits digestion or respiration, inflicts pain, causes embarrassment or humiliation, causes hyperextension of joints, applies pressure on the chest or joints, or allows for a free fall to the floor.

(A) A RESTRICTIVE PROCEDURE MAY NOT BE USED AS RETRIBUTION, FOR THE CONVENIENCE OF STAFF PERSONS, AS A SUBSTITUTE FOR A PROGRAM OR IN A WAY THAT INTERFERES WITH THE CLIENT'S DEVELOPMENTAL PROGRAM.

(B) FOR EACH USE OF A RESTRICTIVE PROCEDURE:

(1) EVERY ATTEMPT SHALL BE MADE TO ANTICIPATE AND DE-ESCALATE THE BEHAVIOR USING TECHNIQUES LESS INTRUSIVE THAN A RESTRICTIVE PROCEDURE.

(2) A RESTRICTIVE PROCEDURE MAY NOT BE USED UNLESS LESS RESTRICTIVE TECHNIQUES AND RESOURCES APPROPRIATE TO THE BEHAVIOR HAVE BEEN TRIED BUT HAVE FAILED.

§ 2390.174. ~~Permitted interventions.~~ HUMAN RIGHTS TEAM.

~~(a) Voluntary exclusion, defined as an individual voluntarily removing himself from his immediate environment and placing himself alone to a room or area, is permitted in accordance with the individual's PSP.~~

~~(b) A physical protective restraint may be used only in accordance with § 2390.173(6)—(8) (relating to prohibition of restraints).~~

~~(c) A physical protective restraint may not be used until §§ 2390.49(c)(5) and 2390.155(9) (relating to annual training; and content of the PSP) are met.~~

~~(d) A physical protective restraint may only be used in the case of an emergency to prevent an individual from injuring the individual's self or others.~~

~~(e) A physical protective restraint may not be used as a behavioral intervention, consequence, retribution, punishment, for the convenience of staff persons or as a substitution for individual support.~~

~~(f) A physical protective restraint may not be used for more than 15 minutes within a 2-hour period.~~

~~(g) A physical protective restraint may only be used by a staff person who is trained as specified in § 2390.49.~~

~~(h) As used in this section, a "physical protective restraint" is a hands-on hold of an individual.~~

(A) IF A RESTRICTIVE PROCEDURE IS USED, THE FACILITY SHALL USE A HUMAN RIGHTS TEAM. THE FACILITY MAY USE A COUNTY MENTAL HEALTH AND INTELLECTUAL DISABILITY PROGRAM HUMAN RIGHTS TEAM THAT MEETS THE REQUIREMENTS OF THIS SECTION.

(B) THE HUMAN RIGHTS TEAM SHALL INCLUDE A PROFESSIONAL WHO HAS A RECOGNIZED DEGREE, CERTIFICATION OR LICENSE RELATING TO BEHAVIORAL SUPPORT, WHO DID NOT DEVELOP THE BEHAVIOR SUPPORT COMPONENT OF THE INDIVIDUAL PLAN.

(C) THE HUMAN RIGHTS TEAM SHALL INCLUDE A MAJORITY OF PERSONS WHO DO NOT PROVIDE DIRECT SERVICES TO THE CLIENT.

(D) A RECORD OF THE HUMAN RIGHTS TEAM MEETINGS SHALL BE KEPT.

§ 2390.175. ~~Access to or the use of an individual's personal property.~~ BEHAVIOR SUPPORT COMPONENT OF THE INDIVIDUAL PLAN.

~~(a) Access to or the use of an individual's personal funds or property may not be used as a reward or punishment.~~

~~(b) An individual's personal funds or property may not be used as payment for damages unless the individual consents to make restitution for the damages as follows:~~
~~(1) A separate written consent by the individual is required for each incidence of restitution.~~

~~(2) Consent shall be obtained in the presence of the individual, a person designated by the individual and in the presence of and with the support of the support coordinator or targeted support manager.~~

~~(3) There may not be coercion in obtaining the consent of an individual.~~

~~(4) The facility shall keep a copy of the individual's written consent.~~

(A) FOR EACH CLIENT FOR WHOM A RESTRICTIVE PROCEDURE MAY BE USED, THE INDIVIDUAL PLAN SHALL INCLUDE A COMPONENT ADDRESSING BEHAVIOR SUPPORT THAT IS REVIEWED AND APPROVED BY THE HUMAN RIGHTS TEAM IN § 2390.174 (RELATING TO HUMAN RIGHTS TEAM), PRIOR TO USE OF A RESTRICTIVE PROCEDURE.

(B) THE BEHAVIOR SUPPORT COMPONENT OF THE INDIVIDUAL PLAN SHALL BE REVIEWED AND REVISED AS NECESSARY BY THE HUMAN RIGHTS TEAM, ACCORDING TO THE TIME FRAME ESTABLISHED BY THE TEAM, NOT TO EXCEED 6 MONTHS BETWEEN REVIEWS.

(C) THE BEHAVIOR SUPPORT COMPONENT OF THE INDIVIDUAL PLAN SHALL INCLUDE:

(1) THE SPECIFIC BEHAVIOR TO BE ADDRESSED.

(2) AN ASSESSMENT OF THE BEHAVIOR, INCLUDING THE SUSPECTED REASON FOR THE BEHAVIOR.

(3) THE OUTCOME DESIRED.

(4) A TARGET DATE TO ACHIEVE THE OUTCOME.

(5) METHODS FOR FACILITATING POSITIVE BEHAVIORS SUCH AS CHANGES IN THE CLIENT'S PHYSICAL AND SOCIAL ENVIRONMENT, CHANGES IN THE CLIENT'S ROUTINE, IMPROVING COMMUNICATIONS, RECOGNIZING AND TREATING PHYSICAL AND BEHAVIOR HEALTH CONDITIONS, VOLUNTARY PHYSICAL EXERCISE, REDIRECTION, PRAISE, MODELING, CONFLICT RESOLUTION, DE-ESCALATION AND TEACHING SKILLS.

(6) TYPES OF RESTRICTIVE PROCEDURES THAT MAY BE USED AND THE CIRCUMSTANCES UNDER WHICH THE PROCEDURES MAY BE USED.

(7) THE AMOUNT OF TIME THE RESTRICTIVE PROCEDURE MAY BE APPLIED.

(8) THE NAME OF THE STAFF PERSON RESPONSIBLE FOR MONITORING AND DOCUMENTING PROGRESS WITH THE BEHAVIOR SUPPORT COMPONENT OF THE INDIVIDUAL PLAN.

(D) IF A PHYSICAL RESTRAINT WILL BE USED OR IF A RESTRICTIVE PROCEDURE WILL BE USED TO MODIFY A CLIENT'S RIGHTS IN § 2390.155(6) (RELATING TO CONTENT OF THE INDIVIDUAL PLAN) THE BEHAVIOR SUPPORT COMPONENT OF THE INDIVIDUAL PLAN SHALL BE DEVELOPED BY A PROFESSIONAL WHO HAS A RECOGNIZED DEGREE, CERTIFICATION OR LICENSE RELATING TO BEHAVIORAL SUPPORT.

§ 2390.176. ~~Rights team.~~ STAFF TRAINING.

~~(a) The facility shall have a rights team. The facility may use a county mental health and intellectual disability program rights team that meets the requirements of this section.~~

~~(b) The role of the rights team is to:~~

~~(1) Review each incident, alleged incident and suspected incident of a violation of individual rights as specified in § 2390.21 (relating to individual rights).~~

~~(2) Review each incidence of the use of a restraint as specified in §§ 2390.171—2390.174 to:~~

~~(i) Analyze systemic concerns.~~

~~(ii) Design positive supports as an alternative to the use of a restraint.~~

~~(iii) Discover and resolve the reason for an individual's behavior.~~

~~(c) Members of the rights team shall include the affected individual, persons designated by the individual, a family member or an advocate if the individual is unable to speak for himself, the individual's support coordinator, a representative from the funding agency, if applicable, and a facility representative.~~

~~(d) Members of the rights team shall be comprised of a majority who do not provide direct support to the individual.~~

~~(e) If a restraint was used, the individual's health care practitioner shall be consulted.~~

~~(f) The rights team shall meet at least once every 3 months.~~

~~(g) The rights team shall report its recommendations to the affected PSP team.~~

~~(h) The facility shall keep documentation of the rights team meetings and the decisions made at the meetings.~~

(A) A STAFF PERSON WHO IMPLEMENTS OR MANAGES A BEHAVIOR SUPPORT COMPONENT OF AN INDIVIDUAL PLAN SHALL BE TRAINED IN THE USE OF THE SPECIFIC TECHNIQUES OR PROCEDURES THAT ARE USED.

(B) IF A PHYSICAL RESTRAINT WILL BE USED, THE STAFF PERSON WHO IMPLEMENTS OR MANAGES THE BEHAVIOR SUPPORT COMPONENT OF THE INDIVIDUAL PLAN SHALL HAVE EXPERIENCED THE USE OF THE PHYSICAL RESTRAINT DIRECTLY ON THE STAFF PERSON.

(C) DOCUMENTATION OF THE TRAINING PROVIDED, INCLUDING THE STAFF PERSONS TRAINED, DATES OF TRAINING, DESCRIPTION OF TRAINING AND TRAINING SOURCE, SHALL BE KEPT.

§ 2390.177. PROHIBITED PROCEDURES.

THE FOLLOWING PROCEDURES ARE PROHIBITED:

(1) SECLUSION, DEFINED AS INVOLUNTARY CONFINEMENT OF A CLIENT IN A ROOM OR AREA FROM WHICH THE CLIENT IS PHYSICALLY PREVENTED OR VERBALLY DIRECTED FROM LEAVING. SECLUSION INCLUDES PHYSICALLY HOLDING A DOOR SHUT OR USING A FOOT PRESSURE LOCK.

(2) AVERSIVE CONDITIONING, DEFINED AS THE APPLICATION OF STARTLING, PAINFUL OR NOXIOUS STIMULI.

(3) PRESSURE-POINT TECHNIQUES, DEFINED AS THE APPLICATION OF PAIN FOR THE PURPOSE OF ACHIEVING COMPLIANCE. A PRESSURE-POINT

TECHNIQUE DOES NOT INCLUDE A CLINICALLY-ACCEPTED BITE RELEASE TECHNIQUE THAT IS APPLIED ONLY AS LONG AS NECESSARY TO RELEASE THE BITE.

(4) A CHEMICAL RESTRAINT, DEFINED AS USE OF A DRUG FOR THE SPECIFIC AND EXCLUSIVE PURPOSE OF CONTROLLING ACUTE OR EPISODIC AGGRESSIVE BEHAVIOR. A CHEMICAL RESTRAINT DOES NOT INCLUDE A DRUG ORDERED BY A HEALTH CARE PRACTITIONER OR DENTIST FOR THE FOLLOWING USE OR EVENT:

(I) TREATMENT OF THE SYMPTOMS OF A SPECIFIC MENTAL, EMOTIONAL OR BEHAVIORAL CONDITION.

(II) PRETREATMENT PRIOR TO A MEDICAL OR DENTAL EXAMINATION OR TREATMENT.

(III) AN ONGOING PROGRAM OF MEDICATION.

(IV) A SPECIFIC, TIME-LIMITED STRESSFUL EVENT OR SITUATION TO ASSIST THE CLIENT TO CONTROL THE CLIENT'S OWN BEHAVIOR.

(5) A MECHANICAL RESTRAINT, DEFINED AS A DEVICE THAT RESTRICTS THE MOVEMENT OR FUNCTION OF A CLIENT OR PORTION OF A CLIENT'S BODY. A

MECHANICAL RESTRAINT INCLUDES A GERIATRIC CHAIR, A BEDRAIL THAT RESTRICTS THE MOVEMENT OR FUNCTION OF THE CLIENT, HANDCUFFS, ANKLETS, WRISTLETS, CAMISOLE, HELMET WITH FASTENERS, MUFFS AND MITTS WITH FASTENERS, RESTRAINT VEST, WAIST STRAP, HEAD STRAP, RESTRAINT BOARD, RESTRAINING SHEET, CHEST RESTRAINT AND OTHER SIMILAR DEVICES. A MECHANICAL RESTRAINT DOES NOT INCLUDE THE USE OF A SEAT BELT DURING MOVEMENT OR TRANSPORTATION. A MECHANICAL RESTRAINT DOES NOT INCLUDE A DEVICE PRESCRIBED BY A HEALTH CARE PRACTITIONER FOR THE FOLLOWING USE OR EVENT:

(I) POST-SURGICAL OR WOUND CARE.

(II) BALANCE OR SUPPORT TO ACHIEVE FUNCTIONAL BODY POSITION, IF THE CLIENT CAN EASILY REMOVE THE DEVICE OR IF THE DEVICE IS REMOVED BY A STAFF PERSON IMMEDIATELY UPON THE REQUEST OR INDICATION BY THE CLIENT, AND IF THE INDIVIDUAL PLAN INCLUDES PERIODIC RELIEF OF THE DEVICE TO ALLOW FREEDOM OF MOVEMENT.

(III) PROTECTION FROM INJURY DURING A SEIZURE OR OTHER MEDICAL CONDITION, IF THE CLIENT CAN EASILY REMOVE THE DEVICE OR IF THE DEVICE IS REMOVED BY A STAFF PERSON IMMEDIATELY UPON THE REQUEST OR INDICATION BY THE CLIENT, AND IF THE INDIVIDUAL PLAN INCLUDES PERIODIC RELIEF OF THE DEVICE TO ALLOW FREEDOM OF MOVEMENT.

§ 2390.178. PHYSICAL RESTRAINT.

(A) A PHYSICAL RESTRAINT, DEFINED AS A MANUAL METHOD THAT RESTRICTS, IMMOBILIZES OR REDUCES A CLIENT'S ABILITY TO MOVE THE CLIENT'S ARMS, LEGS, HEAD OR OTHER BODY PARTS FREELY, MAY ONLY BE USED IN THE CASE OF AN EMERGENCY TO PREVENT A CLIENT FROM IMMEDIATE PHYSICAL HARM TO THE CLIENT OR OTHERS.

(B) VERBAL REDIRECTION, PHYSICAL PROMPTS, ESCORTING AND GUIDING A CLIENT ARE PERMITTED.

(C) A PRONE POSITION PHYSICAL RESTRAINT IS PROHIBITED.

(D) A PHYSICAL RESTRAINT THAT INHIBITS DIGESTION OR RESPIRATION, INFLICTS PAIN, CAUSES EMBARRASSMENT OR HUMILIATION, CAUSES HYPEREXTENSION OF JOINTS, APPLIES PRESSURE ON THE CHEST OR JOINTS OR ALLOWS FOR A FREE FALL TO THE FLOOR IS PROHIBITED.

(E) A PHYSICAL RESTRAINT MAY NOT BE USED FOR MORE THAN 30 CUMULATIVE MINUTES WITHIN A 2-HOUR PERIOD.

§ 2390.179. EMERGENCY USE OF A PHYSICAL RESTRAINT.

IF A PHYSICAL RESTRAINT IS USED ON AN UNANTICIPATED, EMERGENCY BASIS, §§ 2390.174 AND 2390.175 (RELATING TO HUMAN RIGHTS TEAM; AND BEHAVIOR SUPPORT COMPONENT OF THE INDIVIDUAL PLAN) DO NOT APPLY UNTIL AFTER THE RESTRAINT IS USED FOR THE SAME CLIENT TWICE IN A 6-MONTH PERIOD.

§ 2390.180. ACCESS TO OR THE USE OF A CLIENT'S PERSONAL PROPERTY.

(A) ACCESS TO OR THE USE OF A CLIENT'S PERSONAL FUNDS OR PROPERTY MAY NOT BE USED AS A REWARD OR PUNISHMENT.

(B) A CLIENT'S PERSONAL FUNDS OR PROPERTY MAY NOT BE USED AS PAYMENT FOR DAMAGES UNLESS THE CLIENT CONSENTS TO MAKE RESTITUTION FOR THE DAMAGES. THE FOLLOWING CONSENT PROVISIONS APPLY UNLESS THERE IS A COURT-ORDERED RESTITUTION:

(1) A SEPARATE WRITTEN CONSENT IS REQUIRED FOR EACH INCIDENCE OF RESTITUTION.

(2) CONSENT SHALL BE OBTAINED IN THE PRESENCE OF THE CLIENT OR A PERSON DESIGNATED BY THE CLIENT.

(3) THE FACILITY MAY NOT COERCE THE CLIENT TO PROVIDE CONSENT.

MEDICATION ADMINISTRATION

§ 2390.191. Self-administration.

(a) The facility shall provide ~~an individual~~ A CLIENT who has a prescribed medication with assistance, as needed, for the ~~individual's~~ CLIENT'S self-administration of the medication.

(b) Assistance in the self-administration of medication includes helping the ~~individual~~ CLIENT to remember the schedule for taking the medication, offering the ~~individual~~ CLIENT the medication at the prescribed times, opening a medication container and storing the medication in a secure place.

(c) The facility shall provide or arrange for assistive technology to ~~support the individual's self-administration of~~ ASSIST THE CLIENT TO SELF-ADMINISTER medications.

(d) The ~~PSP~~ INDIVIDUAL PLAN must identify if the ~~individual~~ CLIENT is unable to self-administer medications.

(e) To be considered able to self-administer medications, ~~an individual~~ A CLIENT shall do all of the following:

(1) Recognize and distinguish the ~~individual's~~ CLIENT'S medication.

(2) Know how much medication is to be taken.

(3) Know when the medication is to be taken. ~~This knowledge may include reminders~~ ASSISTANCE MAY BE PROVIDED BY STAFF PERSONS TO REMIND THE CLIENT of the schedule and ~~offering~~ TO OFFER the medication at the prescribed times as specified in subsection (b).

(4) Take or apply the ~~individual's~~ CLIENT'S own medication with or without the use of assistive technology.

§ 2390.192. Medication administration.

(a) A facility whose staff persons are qualified to administer medications as specified in subsection (b) may provide medication administration for ~~an individual~~ A CLIENT who is unable to self-administer ~~his~~ THE CLIENT'S prescribed medication.

(b) A prescription medication that is not self-administered shall be administered by one of the following:

(1) A licensed physician, licensed dentist, licensed physician's assistant, registered nurse, certified registered nurse practitioner, licensed practical nurse ~~or~~, licensed paramedic OR OTHER HEALTH CARE PROFESSIONAL WHO IS LICENSED, CERTIFIED OR REGISTERED BY THE DEPARTMENT OF STATE TO ADMINISTER MEDICATIONS.

(2) A person who has completed the medication administration ~~training~~ COURSE REQUIREMENTS as specified in ~~§ 2390.199~~ § 2390.198 (relating to medication administration training) for the medication administration of the following:

(i) Oral medications.

(ii) Topical medications.

(iii) Eye, nose and ear drop medications.

(iv) Insulin injections.

(v) Epinephrine injections for insect bites or other allergies.

(VI) MEDICATIONS, INJECTIONS, PROCEDURES AND TREATMENTS AS PERMITTED BY APPLICABLE STATUTES AND REGULATIONS.

(c) Medication administration includes the following activities, based on the needs of the ~~individual~~ CLIENT:

(1) Identify the correct ~~individual~~ CLIENT.

(2) Remove the medication from the original container.

(3) ~~Crush or split~~ PREPARE the medication as ordered by the prescriber.

(4) Place the medication in a medication cup or other appropriate container, or into the ~~individual's~~ CLIENT'S hand, mouth or other route as ordered by the prescriber.

(5) If indicated by the prescriber's order, measure vital signs and administer medications according to the prescriber's order.

(6) Injection of insulin ~~or~~ AND INJECTION OF epinephrine in accordance with this chapter.

§ 2390.193. Storage and disposal of medications.

(a) Prescription and nonprescription medications shall be kept in their original labeled containers. PRESCRIPTION MEDICATIONS SHALL BE LABELED WITH A LABEL ISSUED BY THE PHARMACY.

(b) A prescription medication may not be removed from its original labeled container ~~more than 2 hours~~ in advance of the scheduled administration.

(c) If insulin or epinephrine is not packaged in an individual dose container, assistance with or the administration of the injection shall be provided immediately upon removal of the medication from its original labeled container.

(d) Prescription medications and syringes, with the exception of epinephrine and epinephrine auto-injectors, shall be kept in an area or container that is locked.

(e) Epinephrine and epinephrine auto-injectors shall be stored safely and kept easily accessible at all times. The epinephrine and epinephrine auto-injectors shall be easily accessible to the ~~individual~~ CLIENT if the epinephrine is self-administered or to the staff person who is with the ~~individual~~ CLIENT if a staff person will administer the epinephrine.

(f) Prescription medications stored in a refrigerator shall be kept in an area or container that is locked.

(g) Prescription medications shall be stored in an organized manner under proper conditions of sanitation, temperature, moisture and light and in accordance with the manufacturer's instructions.

(h) Prescription medications that are discontinued or expired shall be destroyed in a safe manner according to the ~~Department of Environmental Protection and~~ applicable Federal and State STATUTES AND regulation~~s~~.

(i) ~~Subsections (a)—(d) and (f) do~~ THIS SECTION DOES not apply for ~~an individual~~ A CLIENT who self-administers medication and stores the medication on ~~his~~ THE CLIENT'S person or in the ~~individual's~~ CLIENT'S private property, such as a purse or backpack.

§ 2390.194. ~~Labeling of medications.~~

~~The original container for prescription medications must be labeled with a pharmacy label that includes the following:~~

~~(1) The individual's name.~~

~~(2) The name of the medication.~~

~~(3) The date the prescription was issued.~~

~~(4) The prescribed dosage and instructions for administration.~~

~~(5) The name and title of the prescriber.~~

~~§ 2390.195.~~ Prescription medications.

(a) A prescription medication shall be prescribed in writing by an authorized prescriber.

(b) A prescription order shall be kept current.

(c) A prescription medication shall be administered as prescribed.

(d) A prescription medication shall be used only by the ~~individual~~ CLIENT for whom the prescription was prescribed.

(e) Changes in medication may only be made in writing by the prescriber or, in the case of an emergency, an alternate prescriber, except for circumstances in which oral orders may be accepted by a ~~registered nurse in accordance with regulations of the Department of State~~ HEALTH CARE PROFESSIONAL WHO IS LICENSED, CERTIFIED OR REGISTERED BY THE DEPARTMENT OF STATE TO ACCEPT ORAL ORDERS. The ~~individual's~~ CLIENT'S medication record shall be updated as soon as a written notice of the change is received.

~~§ 2390.196.~~ § 2390.195. Medication record.

(a) A medication record shall be kept, including the following for each ~~individual~~ CLIENT for whom a prescription medication is administered:

(1) ~~Individual's~~ CLIENT'S name.

(2) Name ~~and title~~ of the prescriber.

(3) Drug allergies.

(4) Name of medication.

(5) Strength of medication.

(6) Dosage form.

(7) Dose of medication.

(8) Route of administration.

(9) Frequency of administration.

(10) Administration times.

(11) Diagnosis or purpose for the medication, including pro re nata.

(12) Date and time of medication administration.

(13) Name and initials of the person administering the medication.

(14) Duration of treatment, if applicable.

(15) Special precautions, if applicable.

(16) Side effects of the medication, if applicable.

(b) The information in subsection (a)(12) and (13) shall be recorded in the medication record at the time the medication is administered.

(c) If ~~an individual~~ A CLIENT refuses to take a prescribed medication, the refusal shall be documented on the medication record. The refusal shall be reported to the prescriber ~~within 24 hours, unless otherwise instructed by the prescriber. Subsequent refusals to take a prescribed medication shall be reported as required~~ AS DIRECTED by the prescriber OR IF THERE IS HARM TO THE CLIENT.

(d) The directions of the prescriber shall be followed.

~~§ 2390.197.~~ § 2390.196. Medication errors.

(a) Medication errors include the following:

(1) Failure to administer a medication.

(2) Administration of the wrong medication.

(3) Administration of the wrong ~~amount~~ DOSE of medication.

(4) Failure to administer a medication at the prescribed time, which exceeds more than 1 hour before or after the prescribed time.

(5) Administration to the wrong person.

(6) Administration through the wrong route.

(7) ADMINISTRATION WHILE THE CLIENT IS IN THE WRONG POSITION.

(8) IMPROPER PREPARATION OF THE MEDICATION.

(b) Documentation of medication errors, follow-up action taken and the prescriber's response, IF APPLICABLE, shall be kept in the ~~individual's~~ CLIENT'S record.

(C) A MEDICATION ERROR SHALL BE REPORTED AS AN INCIDENT AS SPECIFIED IN § 2390.18(B) (RELATING TO INCIDENT REPORT AND INVESTIGATION).

(D) A MEDICATION ERROR SHALL BE REPORTED TO THE PRESCRIBER UNDER ANY OF THE FOLLOWING CONDITIONS:

(1) AS DIRECTED BY THE PRESCRIBER.

(2) IF THE MEDICATION IS ADMINISTERED TO THE WRONG PERSON.

(3) IF THERE IS HARM TO THE CLIENT.

~~§ 2390.198.~~ § 2390.197. Adverse reaction.

(a) If ~~an individual~~ A CLIENT has a suspected adverse reaction to a medication, the facility shall immediately consult a health care practitioner or seek emergency medical treatment.

(b) An adverse reaction to a medication, the health care practitioner's response to the adverse reaction and the action taken shall be documented.

~~§ 2390.199.~~ § 2390.198. Medication administration training.

(a) A staff person who has successfully completed a Department-approved medication~~s~~ administration course, including the course renewal requirements, may administer ~~the~~ following:

~~(1) Oral medications.~~

~~(2) Topical medications.~~

~~(3) Eye, nose and ear drop medications.~~ MEDICATIONS, INJECTIONS, PROCEDURES AND TREATMENTS AS SPECIFIED IN § 2390.192 (RELATING TO MEDICATION ADMINISTRATION).

(b) A staff person may administer insulin injections following successful completion of both:

(1) The MEDICATION ADMINISTRATION course specified in subsection (a).

(2) A Department-approved diabetes patient education program within the past 12 months.

(c) A staff person may administer an epinephrine injection by means of an auto-injection device in response to anaphylaxis or another serious allergic reaction following successful completion of both:

(1) The MEDICATION ADMINISTRATION course specified in subsection (a).

(2) Training WITHIN THE PAST 24 MONTHS relating to the use of an auto-injection epinephrine injection device provided by a ~~licensed, registered or certified~~ health care professional WHO IS LICENSED, CERTIFIED OR REGISTERED BY THE DEPARTMENT OF STATE IN THE HEALTH CARE FIELD. ~~within the past 12 months.~~

(d) A record of the training shall be kept, including the person trained, the date, source, name of trainer and documentation that the course was successfully completed.

PART VIII. INTELLECTUAL DISABILITY AND AUTISM MANUAL

Subpart C. ADMINISTRATION AND FISCAL MANAGEMENT

CHAPTER 6100. [SUPPORT] SERVICES FOR INDIVIDUALS WITH AN INTELLECTUAL DISABILITY OR AUTISM

GENERAL PROVISIONS

Sec.

GENERAL REQUIREMENTS

6100.50. Communication.

6100.51. [Grievances.] Complaints by an individual.

6100.52. [Rights team.] Applicable statutes and regulations.

6100.53. Conflict of interest.

6100.54. Recordkeeping.

6100.55. Reserved capacity.

6100.56. Children's services.

ENROLLMENT

6100.81. HCBS provider requirements.

6100.82. HCBS enrollment documentation.

6100.83. Submission of HCBS qualification documentation.

6100.84. Provision, update and verification of information.

6100.85. [Ongoing HCBS provider qualifications.

6100.86.] Delivery of HCBS.

TRAINING

6100.141. [Annual training plan.] Training records.

6100.142. Orientation [program].

6100.143. Annual training.

[6100.144. Natural supports.]

INDIVIDUAL RIGHTS

6100.181. Exercise of rights.

6100.182. Rights of the individual.

6100.183. Additional rights of the individual in a residential [facility] service location.

6100.184. Negotiation of choices.

6100.185. Informing of rights.

6100.186. [Role of family and friends] Facilitating personal relationships.

[PERSON-CENTERED SUPPORT] INDIVIDUAL PLAN

6100.221. Development of the [PSP] individual plan.

6100.222. [The PSP] Individual plan process.

6100.223. Content of the [PSP] individual plan.

6100.224. Implementation of the [PSP] individual plan.

6100.225. Support coordination, base-funding support coordination and TSM.

6100.226. Documentation of [support delivery] claims.

6100.227. Progress notes.

[EMPLOYMENT, EDUCATION AND] COMMUNITY PARTICIPATION AND EMPLOYMENT

6100.261. Access to the community.

6100.262. Employment.

[6100.263. Education.]

TRANSITION TO A NEW PROVIDER

6100.301. Individual choice.

6100.302. [Transition to a new provider] Cooperation during individual transition.

6100.303. [Reasons for a transfer or change in a provider.] Involuntary transfer or change of provider.

6100.304. Written notice.

6100.305. Continuation of [support] service.

6100.306. Transition planning.

6100.307. Transfer of records.

[POSITIVE INTERVENTION] RESTRICTIVE PROCEDURES

6100.341. [Use of a positive intervention.

6100.342. PSP.

6100.343. Prohibition of restraints.

6100.344. Permitted interventions.

6100.345. Access to or the use of an individual's personal property.] Definition of a restrictive procedure.

6100.342. Written policy.

6100.343. Appropriate use of a restrictive procedure.

6100.344. Human rights team.

6100.345. Behavior support component of the individual plan.

6100.346. Staff training.

6100.347. Prohibited procedures.

6100.348. Physical restraint.

6100.349. Emergency use of a physical restraint.

6100.350. Access to or the use of an individual's personal property.

INCIDENT MANAGEMENT

6100.401. Types of incidents and timelines for reporting.

6100.402. Incident investigation.

6100.403. Individual needs.

6100.404. Final incident report.

6100.405. Incident analysis.

PHYSICAL ENVIRONMENT OF HCBS

6100.441. Request for and approval of changes.

6100.442. Physical accessibility.

6100.443. [Access to the bedroom and the home.] Integration.

[6100.444. Lease or ownership.

6100.445. Integration.

6100.446. Facility characteristics relating to size of facility.] 6100.444. Size of service location.

[6100.447. Facility characteristics relating to location of facility.] 6100.445. Locality of service location.

MEDICATION ADMINISTRATION

6100.461. Self-administration.

6100.462. Medication administration.

6100.463. Storage and disposal of medications.

6100.464. [Labeling of medications.

6100.465.] Prescription medications.

[6100.466.] 6100.465. Medication [records] record.

[6100.467.] 6100.466. Medication errors.

[6100.468.] 6100.467. Adverse reaction.

[6100.469.] 6100.468. Medication administration training.

[6100.470. Exception for family members.] 6100.469. Exceptions.

GENERAL PAYMENT PROVISIONS

6100.481. Departmental rates and classifications.

6100.482. Payment.

6100.483. [Title of a residential building.

6100.484.] Provider billing.

[6100.485.] 6100.484. Audits.

[6100.486. Bidding.

6100.487.] 6100.485. Loss or damage to property.

FEE SCHEDULE

6100.571. Fee schedule rates.

COST-BASED RATES AND ALLOWABLE COSTS

6100.641. Cost-based rate.

6100.642. Assignment of rate.

6100.643. Submission of cost report.

6100.644. Cost report.

6100.645. Rate setting.

6100.646. Cost-based rates for residential [habilitation] service.

6100.647. Allowable costs.

6100.648. [Donations.] Bidding.

6100.649. Management fees.

6100.650. Consultants.

6100.651. Governing board.

6100.652. Compensation.

6100.653. Training.

6100.654. Staff recruitment.

6100.655. Travel.

6100.656. Supplies.

6100.657. Rental of administrative equipment and furnishing.

6100.658. Communication.

6100.659. Rental of administrative space.

6100.660. Occupancy expenses for administrative buildings.

6100.661. [Fixed] Administrative fixed assets.

6100.662. Motor vehicles.

6100.663. [Fixed assets of administrative] Administrative buildings.

6100.664. Residential [habilitation] vacancy.

6100.665. Indirect costs.

6100.666. Moving expenses.

6100.667. Interest expense.

6100.668. Insurance.

6100.669. Other allowable costs.

6100.670. Start-up cost.

6100.671. Reporting of start-up cost.

6100.672. Cap on start-up cost.

ROOM AND BOARD

6100.681. Room and board applicability.

6100.682. [Support] Assistance to the individual.

6100.683. No delegation permitted.

6100.684. Actual provider room and board cost.

6100.685. Benefits.

6100.686. Room and board rate.

6100.687. [Documentation.

6100.688.] Completing and signing the room and board residency agreement.

[6100.689.] 6100.688. Modifications to the room and board residency agreement.

[6100.690.] 6100.689. Copy of room and board residency agreement.

[6100.691.] 6100.690. Respite care.

[6100.692.] 6100.691. Hospitalization.

[6100.693.] 6100.692. Exception.

[6100.694.] 6100.693. Delay in an individual's income.

6100.694. Managing individual finances.

DEPARTMENT-ESTABLISHED FEE FOR INELIGIBLE PORTION OF RESIDENTIAL SERVICE

6100.711. Fee for the ineligible portion of residential [habilitation] service.

ENFORCEMENT

6100.741. Sanctions.

6100.742. Array of sanctions.

6100.743. Consideration as to type of sanction utilized.

6100.744. Additional conditions and sanctions.

SPECIAL PROGRAMS

6100.801. [Adult autism waiver.]

[6100.802.] Agency with choice.

[6100.803.] 6100.802. Support coordination, targeted support management and [base-funded] base-funding support coordination.

[6100.804.] 6100.803. Organized health care delivery system.

[6100.805. Base-funded support.] 6100.804. Base-funding.

[6100.806.] 6100.805. Vendor goods and services.

GENERAL PROVISIONS

§ 6100.1. Purpose.

(a) The purpose of this chapter is to specify the payment, program and operational requirements for applicants and providers of HCBS and [supports] services to individuals provided through base-funding.

(b) This chapter [supports] assists individuals with an intellectual disability or autism to achieve greater independence, choice and opportunity in their lives through the effective and efficient delivery of HCBS and [supports] services to individuals provided through base-funding.

§ 6100.2. Applicability.

(a) This chapter applies to HCBS provided through waiver programs under section 1915(c) of the Social Security Act (42 U.S.C.A. § 1396n(c)) for individuals with an intellectual disability or autism.

(b) This chapter applies to State plan HCBS for individuals with an intellectual disability or autism.

(c) This chapter applies to intellectual disability programs, staffing and individual [supports] services that are funded exclusively by grants to counties under the Mental Health and Intellectual Disability Act of 1966 (50 P.S. §§ 4101—4704) or Article XIV-B of the Human Services Code (62 P.S. §§ 1401-B—1410-B).

(d) This chapter does not apply to the following:

(1) Intermediate care facilities licensed in accordance with Chapter 6600 (relating to intermediate care facilities for individuals with an intellectual disability) [, except as provided under § 6100.447(d) (relating to facility characteristics relating to location of facility] .

(2) Hospitals licensed in accordance with 28 Pa. Code Chapters 101—158 (relating to general and special hospitals).

(3) Nursing facilities licensed in accordance with 28 Pa. Code Chapters 201—211 (relating to long-term care facilities).

(4) Personal care homes licensed in accordance with Chapter 2600 (relating to personal care homes).

(5) Assisted living residences licensed in accordance with Chapter 2800 (relating to assisted living residences).

(6) Mental health facilities licensed in accordance with Chapters 5200, 5210, 5221, 5230, 5300 and 5320.

(7) Privately-funded programs, [supports] services and placements.

(8) [Placements by other states into this Commonwealth.] Services funded by other states and provided to individuals in the Commonwealth.

(9) A vendor fiscal employer agent model for [an individual-directed] self-directed financial management service.

(10) The adult community autism program that is funded and provided in accordance with the Federally-approved 1915(a) waiver program.

§ 6100.3. Definitions.

The following words and terms, when used in this chapter, have the following meanings, unless the context clearly indicates otherwise:

Allowable cost—Expenses considered reasonable, necessary and related to the [support] service provided.

Applicant—An entity that is in the process of enrolling in the Medical Assistance program as a provider of HCBS.

[*Base-funded support*] *Base-funding*—[A support funded] Reimbursement provided exclusively by a grant to a county under the Mental Health and Intellectual Disability Act of 1966 (50 P.S. §§ 4101—4704) or Article XIV-B of the Human Services Code (62 P.S. §§ 1401-B—1410-B).

Corrective action plan—A document that specifies the following:

(i) Action steps to be taken to achieve and sustain regulatory compliance.

(ii) The time frame by which corrections will be made.

(iii) The person responsible for taking the action step.

(iv) The person responsible for monitoring compliance with the corrective action plan.

Cost report—A data collection tool issued by the Department to collect expense and utilization information from a provider that may include supplemental schedules or addenda as requested by the Department.

Department—The Department of Human Services of the Commonwealth.

Designated managing entity—An entity that enters into an agreement with the Department to perform administrative functions delegated by the Department, as the Department's designee. For base-funding, this includes the county mental health and intellectual disability program.

[*Eligible cost*—Expenses related to the specific procedure codes for which the Department receives Federal funding.

Family—A natural person that the individual considers to be part of his core family unit.]

Fixed asset—A major item, excluding real estate, which is expected to have a useful life of more than 1 year or that can be used repeatedly without materially changing or impairing its physical condition through normal repairs, maintenance or replacement of components.

HCBS—Home and community-based [*support*] *service*—An activity, [service,] assistance or product provided to an individual that is funded through a Federally-approved waiver program or the State plan.

Health care practitioner—A person who is authorized to prescribe medications pursuant to a license, registration or certification by the Department of State.

Individual—A woman, man or child who receives a home and community-based [intellectual disability or autism support] service or [base-funded support] base-funding service.

Individual plan—A coordinated and integrated description of person-centered activities, including services and supports for an individual.

Life sharer—An employee or a contracted person who shares a common home and daily life experience with an individual, providing service and support as needed in both the home and the community.

[*Natural support*—An activity or assistance that is provided voluntarily to the individual instead of a reimbursed support.

OVR—The Department of Labor and Industry's Office of Vocational Rehabilitation.

PSP—Person-centered support plan.]

Provider—The person, entity or agency that is contracted or authorized to deliver the [support] service to the individual.

Restraint—A physical, chemical or mechanical intervention used to control acute, episodic behavior that restricts the movement or function of the individual or a portion of

the individual's body, including an intervention approved as part of the [PSP] individual plan or used on an emergency basis.

SSI—Supplemental security income.

State plan—The Commonwealth's approved Title XIX State Plan.

[*Support*] *Service*—An activity, [service,] assistance or product provided to an individual [that is provided] and paid through a Federally-approved waiver program, the State plan or base-funding. A [support] service includes an HCBS, support coordination, TSM, agency with choice, organized health care delivery system, and vendor goods and services [, and base-funding support], unless specifically exempted in this chapter.

Support—An unpaid activity or assistance provided to an individual that is not planned or arranged by a provider.

TSM—Targeted support management.

Vacancy factor—An adjustment to the full capacity rate to account for days when the residential [habilitation] service provider cannot bill due to an individual not receiving [supports] services.

VOLUNTEER—A PERSON WHO IS AN ORGANIZED AND SCHEDULED COMPONENT OF THE SERVICE SYSTEM AND WHO DOES NOT RECEIVE COMPENSATION, BUT WHO PROVIDES A SERVICE THROUGH THE PROVIDER THAT RECRUITS, PLANS AND ORGANIZES DUTIES AND ASSIGNMENTS.

GENERAL REQUIREMENTS

§ 6100.41. Appeals.

Appeals related to this chapter shall be made in accordance with Chapter 41 (relating to medical assistance provider appeal procedures).

§ 6100.42. Monitoring compliance.

(a) The Department and the designated managing entity may monitor compliance with this chapter at any time through an audit, provider monitoring or other monitoring method.

(b) [The provider's policies, procedures, records and invoices may be reviewed, and the provider may be required to provide an explanation of its policies, procedures, records and invoices, related to compliance with this chapter or applicable Federal or State statutes and regulations, during an audit, provider monitoring or other monitoring method.] <u>The provider shall provide the Department and the designated managing entity</u>

free and full access to the provider's policies and records and the individuals receiving services in accordance with this chapter.

(c) The provider shall cooperate with the [Department and the] designated managing entity and provide the requested compliance documentation in the format required by the Department [prior to, during and following an audit, provider monitoring or other monitoring method].

(d) The provider shall cooperate with authorized Federal and State regulatory agencies and provide the requested compliance documentation in the format required by the regulatory agencies.

(e) The provider shall complete a corrective action plan for [a violation] non-compliance or [an alleged violation] a preliminary determination of non-compliance of this chapter in the time frame required by the Department.

(f) The provider shall complete the corrective action plan on a form specified by the Department.

(g) The Department or the designated managing entity may issue a directed corrective action plan to direct the provider to complete a specified course of action to correct [a violation] non-compliance or [alleged violation] a preliminary determination of non-compliance of this chapter.

(h) [The directed corrective action plan in subsection (g) may include the following:

(1) The acquisition and completion of an educational program, in addition to that required under §§ 6100.141—6100.144 (relating to training).

(2) Technical consultation.

(3) Monitoring.

(4) Audit.

(5) Oversight by an appropriate agency.

(6) Another appropriate course of action to correct the violation.

(i) The directed corrective action plan shall be completed by the provider at the provider's expense and is not eligible for reimbursement from the Department.

(j)] The provider shall comply with the corrective action plan and directed corrective action plan as approved by the Department or the designated managing entity.

[(k)] (i) The provider shall keep documentation relating to an audit, provider monitoring or other monitoring method, including [supporting] compliance documents.

§ 6100.43. Regulatory waiver.

(a) A provider may submit a request for a waiver of a section, subsection, paragraph or subparagraph of this chapter, except for the following:

(1) Sections 6100.1—6100.3 (relating to general provisions).

(2) Sections 6100.41—[6100.55] 6100.56 [(relating to general requirements)] .

(3) Sections 6100.181—6100.186 [(relating to individual rights)] .

(4) Sections 6100.341—[6100.345] 6100.350 [(relating to positive intervention)] .

(b) The waiver shall be submitted on a form specified by the Department.

(c) The Secretary of the Department or the Secretary's designee may grant a waiver if the following conditions are met:

(1) There is no jeopardy to an individual's health, safety and well-being.

(2) An individual or group of individuals benefit from the granting of the waiver through increased [person-centeredness] person-centered practices, integration, independence, choice or community opportunities for individuals.

(3) [There is not a violation of the Department's Federally-approved waivers and waiver amendments, or the State plan, as applicable.

(4)] Additional conditions deemed appropriate by the Department.

(d) The Department will specify an effective date and an expiration date for a waiver that is granted.

(e) [At least 45 days prior to the submission of a request for a waiver the] The provider shall provide a written copy of the waiver request to the affected individuals, and to persons designated by the individuals [, allowing at least 20 days for review and comment to the provider, the designated managing entity and the Department] before or at the same time the waiver request is submitted to the Department.

(f) [If the request for a waiver involves the immediate protection of an individual's health and safety, the provider shall provide a written copy of the waiver request to the affected individuals, and to persons designated by the individuals, at least 24 hours prior to the submission of the request for a waiver, allowing at least 20 hours for review and comment to the provider, the designated managing entity and the Department.

(g) The provider shall discuss and explain the request for a waiver with the affected individuals, and with persons designated by the individuals.

(h) The request for a waiver submitted to the Department must include copies of comments received by the individuals and by persons designated by the individuals.

(i)] The provider shall notify the affected individuals, and persons designated by the individuals, of the Department's waiver decision.

[(j)] (g) The provider shall submit a request for the renewal of a waiver at least 60 days prior to the expiration of the waiver.

[(k)] (h) A request for the renewal of a waiver shall follow the procedures in subsections (a)—[(j)] (g).

[(l) The provider shall notify an individual not previously notified under this section of an existing waiver that affects the individual.]

§ 6100.44. Innovation project.

(a) A provider may submit a proposal to the Department to demonstrate an innovative project on a temporary basis.

(b) The innovation project proposal must include the following:

(1) A comprehensive description of how the innovation encourages best practice and promotes the mission, vision and values of [person-centeredness] person-centered practices, integration, independence, choice and community opportunities for individuals.

(2) [A description of the positive impact on the quality of life including the impact on individual choice, independence and person-centeredness.

(3)] A discussion of alternate health and safety protections, if applicable.

[(4)] (3) The number of individuals included in the innovation project.

[(5)] (4) The geographic location of the innovation project.

[(6)] (5) The proposed beginning and end date for the innovation project.

[(7)] (6) The name, title and qualifications of the manager who will oversee and monitor the innovation project.

[(8)] (7) A description of [the advisory committee] who will advise the innovation project[.

(9) A description of] , how individuals will be involved in [designing and] evaluating the success of the innovation project [.

(10) The] and the community partners who will be involved in implementing the innovation project.

[(11)] (8) A request for a waiver form as specified in § 6100.43 (relating to regulatory waiver), if applicable.

[(12)] (9) Proposed changes to [supports] services.

[(13)] (10) A detailed budget for the innovation project.

[(14) A description of who will have access to information on the innovation project.

(15) The impact on living wage initiatives for direct support professionals, if applicable.]

(c) [The innovation project must comply with the Department's Federally-approved waivers and waiver amendments, or the State plan, as applicable.

(d)] The Deputy Secretary for the Office of Developmental Programs of the Department will review a proposal for an innovation project in accordance with the following criteria:

(1) The effect on an individual's health, safety and well-being.

(2) The benefit from the innovation project to an individual or group of individuals by providing increased [person-centeredness] person-centered practices, integration, independence, choice and community opportunities for individuals.

(3) [Compliance with the Department's Federally-approved waivers and waiver amendments, or the State plan, as applicable.

(4)] The soundness and viability of the proposed budget.

[(5)] (4) Additional criteria the Department deems relevant to its review, funding or oversight of the specific innovation project proposal.

[(e) If the innovation project proposal is approved by the Deputy, the provider shall be subject to the fiscal procedures, reporting, monitoring and oversight as directed by the Department.

(f) The provider shall submit a comprehensive annual report to the Department, to be made available to the public, at the Department's discretion.

(g) The annual report must include the following:

(1) The impact on the quality of life outcomes for individuals.

(2) Budget.

(3) Costs.

(4) Cost benefit analysis.

(5) Other relevant data, evaluation and analysis.

(h)] (d) The Department may expand, renew or continue an innovation project, or a portion of the project, at its discretion.

§ 6100.45. Quality management.

(a) The provider shall develop and implement a quality management plan [on a form specified by the Department].

(b) [The provider shall conduct a review of performance data in the following areas to evaluate progress and identify areas for performance improvement:

(1) Progress in meeting the desired outcomes of the PSP.

(2) Incident management, to encompass a trend analysis of the incident data including the reporting, investigation, suspected causes and corrective action taken in response to incidents.

(3) Performance in accordance with 42 CFR 441.302 (relating to state assurances).

(4) Grievances, to encompass a trend analysis of the grievance data.

(5) Individual and family satisfaction survey results and informal comments by individuals, families and others.

(6) An analysis of the successful learning and application of training in relation to established core competencies.

(7) Staff satisfaction survey results and suggestions for improvement.

(8) Turnover rates by position and suspected causes.

(9) Licensing and monitoring reports.

(c) The quality management plan must identify the plans for systemic improvement and measures to evaluate the success of the plan.

(d) The provider shall review and document progress on the quality management plan quarterly.]

The quality management plan shall include the following:

(1) Performance measures.

(2) Performance improvement targets and strategies.

(3) Methods to obtain feedback relating to personal experience from individuals, staff persons and other affected parties.

(4) Data sources used to measure performance.

(5) Roles and responsibilities of the staff persons related to the practice of quality management.

[(e)] (c) The provider shall analyze and revise the quality management plan every [2] 3 years.

§ 6100.46. Protective services.

(a) Abuse, suspected abuse and alleged abuse of an individual, regardless of the alleged location or alleged perpetrator of the abuse, shall be reported and managed in accordance with the following:

(1) The Adult Protective Services Act (35 P.S. §§ 10210.101—10210.704) and applicable regulations.

(2) The Child Protective Services Law (23 Pa.C.S. §§ 6301—6386) [(relating to Child Protective Services Law)] and applicable regulations.

(3) The Older Adults Protective Services Act (35 P.S. §§ 10225.101—10225.5102) and applicable regulations.

(b) If there is an incident of abuse, suspected abuse or alleged abuse of an individual involving a staff person, household member, consultant, intern or volunteer, the involved staff person, household member, consultant, intern or volunteer may not have direct contact with an individual until the [abuse] investigation is concluded and the investigating agency has confirmed that no abuse occurred or that the findings are inconclusive.

(c) In addition to the reporting required under subsection (a), the provider shall immediately report the abuse, suspected abuse or alleged abuse to the following:

(1) The individual.

(2) Persons designated by the individual.

(3) The Department.

(4) The designated managing entity.

(5) The county government office responsible for the intellectual disability program, if applicable.

§ 6100.47. Criminal history checks.

(a) Criminal history checks shall be completed for the following:

(1) Full-time and part-time staff persons in any staff position.

(2) Support coordinators, targeted support managers and base-funding support [managers] coordinators.

[(b) Criminal history checks shall be completed for the following persons who provide a support included in the PSP:

(1) Household members] (3) Adult household members [who have direct contact with an individual] residing in licensed and unlicensed life sharing homes and in out-of-home overnight respite service.

[(2)] (4) Life sharers.

[(3)] (5) Consultants, paid and unpaid interns and volunteers who provide a service.

[(4) Paid or unpaid interns.

(5) Volunteers.

(c)] (b) Criminal history checks as specified in [subsections] subsection (a) [and (b)] shall be completed in accordance with the following:

(1) The Older Adults Protective Services Act (35 P.S. §§ 10225.101—10225.5102) and applicable regulations.

(2) The Child Protective Services Law (23 Pa.C.S. §§ 6301—6386) [(relating to Child Protective Services Law)] and applicable regulations.

[(d)] (c) This section does not apply to [natural supports] an individual and a person who provides a support. This does not exempt those adult household members requiring a criminal history check in subsection (a)(3).

§ 6100.48. Funding, hiring, retention and utilization.

[(a)] Funding, hiring, retention and utilization of persons who provide a reimbursed [support] service shall be in accordance with the applicable provisions of the Older Adults Protective Services Act (35 P.S. §§ 10225.101—10225.5102), 6 Pa. Code Chapter 15 (relating to protective services for older adults), the Child Protective Services Law (23 Pa.C.S. §§ 6301—6386) [(relating to Child Protective Services Law)] and Chapter 3490 (relating to protective services). [This subsection applies to the following:

(1) Household members who have direct contact with an individual.

(2) Full-time and part-time staff persons in any staff position.

(3) Life sharers.

(4) Consultants.

(5) Paid or unpaid interns.

(6) Volunteers.

(7) Support coordinators, targeted support managers and base-funding support coordinators.

(b) Subsection (a) does not apply to natural supports.]

§ 6100.49. Child abuse history certification.

A child abuse history certification shall be completed in accordance with the Child Protective Services Law (23 Pa.C.S. §§ 6301—6386) [(relating to Child Protective Services Law)] and applicable regulations.

§ 6100.50. Communication.

[(a)] Written, oral and other forms of communication with the individual, and persons designated by the individual, shall occur in a language and means of communication understood by the individual or a person designated by the individual.

[(b) The individual shall be provided with the assistive technology necessary to effectively communicate.]

§ 6100.51. [Grievances] Complaints by an individual.

(a) The provider shall develop procedures to receive, document and manage [grievances] complaints about a service that are submitted by or on behalf of an individual. This section does not apply to a complaint submitted by a staff person.

(b) The provider shall inform the individual, and persons designated by the individual, upon initial entry into the provider's program and annually thereafter of the right to file a [grievance] complaint and the procedure for filing a [grievance] complaint.

(c) The provider shall permit and respond to an oral [and] or written [grievances] complaint from any source, including an anonymous source, regarding the delivery of a [support] service.

(d) The provider shall assure that there is no retaliation or threat of intimidation relating to the filing or investigation of [grievances] a complaint.

(e) If an individual indicates the desire to file a [grievance] complaint in writing, the provider shall offer and provide assistance to the individual to prepare and submit the written [grievance] complaint.

(f) The [providers] provider shall document and manage [grievances] a complaint, including a repeated [grievances] complaint.

(g) The provider shall document the following information for each [grievance,] complaint, including an oral, written and anonymous [grievances] complaint, [from any source] submitted by or on behalf of an individual:

(1) The name, position, telephone, e-mail address and mailing address of the initiator of the [grievance] complaint, if known.

(2) The date and time the [grievance] complaint was received.

(3) The date of the occurrence, if applicable.

(4) The nature of the [grievance] complaint.

(5) The provider's investigation process [and], findings [relating to the grievance.

(6) The provider's] and actions to [investigate and] resolve the [grievance] complaint, if applicable.

[(7)] (6) The date the [grievance] complaint was resolved.

(h) [The grievance shall be resolved within 21 days from the date the grievance was received.

(i) The initiator of the grievance shall be provided a written notice of the resolution or findings within 30 days from the date the grievance was received.] The provider shall resolve the complaint and report the findings or resolution to the complainant within 30 days of the date the complaint was submitted.

§ 6100.52. Applicable statutes and regulations. [Rights team.

(a) The provider shall have a rights team. The provider may use a county mental health and intellectual disability program rights team that meets the requirements of this section.

(b) The role of the rights team is to:

(1) Review each incident, alleged incident and suspected incident of a violation of individual rights as specified in §§ 6100.181—6100.186 (relating to individual rights).

(2) Review each use of a restraint as defined in §§ 6100.341—6100.345 (relating to positive intervention) to:

(i) Analyze systemic concerns.

(ii) Design positive supports as an alternative to the use of a restraint.

(iii) Discover and resolve the reason for an individual's behavior.

(c) Members of the rights team shall include the affected individual, persons designated by the individual, a family member or an advocate appointed by the designated managing entity if the individual is unable to speak for himself, the individual's support coordinator or targeted support manager, a representative from the designated managing entity and a provider representative.

(d) Members of the rights team shall be comprised of a majority who do not provide direct support to the individual.

(e) If a restraint was used, the individual's health care practitioner shall be consulted.

(f) The rights team shall meet at least once every 3 months.

(g) The rights team shall report its recommendations to the affected PSP team.

(h) The provider shall document the rights team meetings and the decisions made at the meetings.]

The provider shall comply with applicable Federal and State statutes and regulations and local ordinances.

§ 6100.53. Conflict of interest.

(a) The provider shall develop a conflict of interest policy [that is reviewed and approved by the provider's full governing board].

(b) The provider shall comply with the provider's conflict of interest policy.

(c) An individual or a friend or [family member] relative of an individual may serve on the governing board, if applicable.

§ 6100.54. Recordkeeping.

(a) The provider shall keep individual records confidential and in a secure location.

(b) The provider may not make individual records accessible to anyone other than the Department, the designated managing entity, and the support coordinator, targeted support manager or [base-funded] base-funding support coordinator without the written consent of the individual, or persons designated by the individual.

(c) Records, documents, information and financial books as required under this chapter shall be kept by the provider in accordance with the following:

(1) For at least 4 years from the Commonwealth's fiscal year-end or 4 years from the provider's fiscal year-end, whichever is later.

(2) Until any audit or litigation is resolved.

(3) In accordance with applicable Federal and State statutes and regulations.

(d) If a program is completely or partially terminated, the records relating to the terminated program shall be kept for at least 5 years from the date of termination.

§ 6100.55. Reserved capacity.

(a) Except as provided under subsection (b), the provider may not limit an individual's medical, hospital or therapeutic leave days.

(b) [An individual has the right to return to the individual's residential habilitation location following] The provider shall reserve an individual's residential placement during the individual's medical, hospital or therapeutic leave [in accordance with reserved capacity timelines specified in the Department's Federally-approved waivers and waiver amendments] not to exceed 180 days from the individual's departure from the residential service location.

(c) The Department may approve an adjustment to the provider's program capacity not to exceed 150 days of an individual's medical, hospital or therapeutic leave from the residential service location.

§ 6100.56. Children's services.

(a) This chapter shall apply to HCBS and base-funding services for children.

(b) The child, the child's parents and the child's legal guardian shall be provided the opportunity to participate in the exercise of rights, decision-making and individual plan activities, unless otherwise prohibited by court order.

(c) The provisions of this chapter regarding rights, decision-making and individual plan activities shall be implemented in accordance with generally accepted, age-appropriate parental decision-making and practices for children, including bedtimes, privacy, school attendance, study hours, visitors and access to food and property, and do not require a modification of rights in the individual plan in accordance with § 6100.223 (relating to content of the individual plan).

(d) The individual plan in § 6100.223 shall include desired outcomes relating to strengthening or securing a permanent caregiving relationship for the child.

(e) An unrelated child and adult may share not a bedroom.

(f) For purposes of this section, a child is an individual who is under 18 years of age.

ENROLLMENT

§ 6100.81. HCBS provider requirements.

(a) The provider shall [be qualified by the Department] meet the qualifications for each HCBS the provider intends to provide, prior to providing the HCBS.

(b) Prior to enrolling as a provider of HCBS, and on an ongoing basis following provider enrollment, the applicant or provider shall comply with the following:

(1) Chapter 1101 (relating to general provisions).

(2) The Department's monitoring documentation requirements as specified in § 6100.42 (relating to monitoring compliance).

(3) The Department's pre-enrollment provider training.

(4) Applicable licensure regulations, including Chapters 2380, 2390, 3800, 5310, 6400, 6500 and 6600[,] ; [Department of Health licensure regulations in] 28 Pa. Code Chapters 51, 601 and 611 (relating to general information; home health care agencies; and home care agencies and home care registries) and [any] other applicable licensure regulations.

(c) Evidence of compliance with applicable licensure regulations in subsection (b)(4) is the possession of a valid regular license issued by the [Department or the Department of Health] appropriate state licensure agency.

(1) If the applicant possesses a provisional license for the specific HCBS for which the applicant is applying, the applicant is prohibited from enrolling in the HCBS program for that specific HCBS.

(2) This subsection does not prohibit a provider that possesses a provisional license from continuing participation in the HCBS program once a provider is enrolled.

(d) [An applicant may not be enrolled as a provider of HCBS if] If the Department issued a sanction in accordance with §§ 6100.741—6100.744 (relating to enforcement), the Department may deny enrollment as a provider of HCBS.

§ 6100.82. HCBS enrollment documentation.

An applicant who wishes to [operate] provide an HCBS in accordance with this chapter shall complete and submit the following completed documents to the Department:

(1) A provider enrollment application on a form specified by the Department.

(2) An HCBS waiver provider agreement on a form specified by the Department.

(3) Copies of current licenses as specified in [§ 6100.81(b)(4)] § 6100.81(c) (relating to HCBS provider requirements).

(4) Verification of compliance with § 6100.47 (relating to criminal history checks).

(5) Verification of completion of the Department's monitoring documentation.

(6) Verification of completion of the Department's pre-enrollment provider training.

(7) Documents required in accordance with [the Patient Protection and Affordable Care Act (Pub.L. No. 111-148)] applicable Federal and State statutes and regulations.

§ 6100.83. Submission of HCBS qualification documentation.

The provider of HCBS shall submit written qualification documentation to the designated managing entity or to the Department at least 60 days prior to the expiration of its current qualification.

§ 6100.84. Provision, update and verification of information.

The provider of HCBS shall provide, update and verify information within the Department's system as part of the initial and ongoing qualification processes.

§ 6100.85. [Ongoing HCBS provider qualifications.

(a) The provider shall comply with the Department's Federally-approved waivers and waiver amendments, or the State plan, as applicable.

(b) The provider's qualifications to continue providing HCBS will be verified at intervals specified in the Federally-approved waiver, including applicable Federally-approved waiver amendments, or the State plan, as applicable.

(c) The Department may require a provider's qualifications to be verified for continued eligibility at an interval more frequent than the Federally-approved waiver, including applicable Federally-approved waiver amendments, or the Medical Assistance State plan, due to one of the following:

(1) Noncompliance with this chapter as determined by monitoring as specified in § 6100.42 (relating to monitoring compliance).

(2) Noncompliance with a corrective action plan, or a directed correction action plan, as issued or approved by the designated managing entity or the Department.

(3) The issuance of a provisional license by the Department.

(4) Improper enrollment in the HCBS program.

(d) Neither a provider nor its staff persons who may come into contact with an individual may be listed on the Federal or State lists of excludable persons such as the following:

(1) System for award management.

(2) List of excludable persons, individuals and entities.

(3) Medicheck list.

§ 6100.86.] Delivery of HCBS.

(a) The provider shall deliver only the HCBS for which the provider is determined to be qualified by the designated managing entity or the Department.

(b) [The provider shall deliver the HCBS in accordance with the Federally-approved waiver, including applicable Federally-approved waiver amendments, and the Medical Assistance State plan, as applicable.

(c)] The provider shall deliver only the HCBS to an individual who is authorized to receive that HCBS.

[(d)] (c) The provider shall deliver the [support] HCBS in accordance with the [individual's PSP] individual plan.

TRAINING

§ 6100.141. [Annual training plan] Training records.

(a) [The provider shall design an annual training plan based on the needs of the individuals as specified in the individuals' PSPs, the provider's quality management plan and other data and analysis indicating training needs.

(b) The annual training plan must include the provider's orientation program as specified in § 6100.142 (relating to orientation [program]).

(c) The annual training plan must include training aimed at improving the knowledge, skills and core competencies of the staff persons and others to be trained.

(d) The annual training plan must include the following:

(1) The title of the position to be trained.

(2) The required training courses, including training course hours, for each position.

(e)] Records of orientation and training, including the training source, content, dates, length of training, copies of certificates received and persons attending, shall be kept.

[(f)] (b) The provider shall keep a training record for each person trained.

§ 6100.142. Orientation [program].

(a) Prior to working alone with individuals, and within 30 days after hire or starting to provide a service or support to an individual, the following shall complete the orientation [program] as described in subsection (b):

(1) Management, program, administrative and fiscal staff persons.

(2) Dietary, housekeeping, maintenance and ancillary staff persons. This provision does not include a person who provides dietary, housekeeping, maintenance or ancillary services, if the person is employed or contracted by the building owner and the licensed facility does not own the building.

(3) Direct [support staff persons,] service professionals, including full-time and part-time staff persons.

(4) [Household members who will provide a reimbursed support to the individual.

(5)] Life sharers.

[(6)] (5) Volunteers who will work alone with individuals.

[(7)] (6) Paid and unpaid interns who will work alone with individuals.

[(8)] (7) Consultants and contractors who are paid or contracted by the provider and who will work alone with individuals, except for consultants and contractors who provide an HCBS or a base-funding service for fewer than 30 days within a 12-month period and who are licensed, certified or registered by the Department of State in a health care or social service field.

(b) The orientation [program] must encompass the following areas:

(1) The application of person-centered practices, [including respecting rights, facilitating] community integration, [honoring] individual choice and [supporting] assisting individuals [in maintaining] to develop and maintain relationships.

(2) The prevention, detection and reporting of abuse, suspected abuse and alleged abuse in accordance with the Older Adults Protective Services Act (35 P.S. §§ 10225.101—10225.5102), 6 Pa. Code Chapter 15 (relating to protective services for older adults), the Child Protective Services Law (23 Pa.C.S. §§ 6301—6386) [(relating to Child Protective Services Law)], the Adult Protective Services Act (35 P.S. §§ 10210.101—10210.704) and applicable protective services regulations.

(3) Individual rights.

(4) Recognizing and reporting incidents.

(5) Job-related knowledge and skills.

§ 6100.143. Annual training.

(a) The following [persons] shall complete 24 hours of training related to job skills and knowledge each year:

(1) Direct [support staff persons] service professionals [, including household members] and life sharers who provide [a reimbursed support] an HCBS or base-funding service to the individual.

(2) Direct supervisors of direct [support staff persons] service professionals.

(b) The following [staff persons and others] shall complete 12 hours of training each year:

(1) Management, program, administrative, fiscal, dietary, housekeeping, maintenance and ancillary staff persons. This provision does not include a person who provides dietary, housekeeping, maintenance or ancillary services, if the person is employed or contracted by the building owner and the licensed facility does not own the building.

(2) Consultants and contractors who [provide reimbursed supports to an individual] are paid or contracted by the provider and who work alone with individuals, except for consultants and contractors who provide an HCBS or base-funding service for fewer than 30 days within a 12-month period and who are licensed, certified or registered by the Department of State in a health care or social service field.

(3) Volunteers who [provide reimbursed supports to an individual and who] work alone with individuals.

(4) Paid and unpaid interns who [provide reimbursed supports to an individual and who] work alone with individuals.

(c) [A minimum of 8 hours of the] The annual training hours specified in subsections (a) and (b) must encompass the following areas:

(1) The application of person-centered practices, [including respecting rights, facilitating] community integration, [honoring] individual choice and [supporting] assisting individuals [in maintaining] to develop and maintain relationships.

(2) The prevention, detection and reporting of abuse, suspected abuse and alleged abuse in accordance with the Older Adults Protective Services Act (35 P.S. §§ 10225.101—10225.5102), 6 Pa. Code Chapter 15 (relating to protective services for older adults), the Child Protective Services Law (23 Pa.C.S. §§ 6301—6386) [(relating

to Child Protective Services Law)], the Adult Protective Services Act (35 P.S. §§ 10210.101—10210.704) and applicable protective services regulations.

(3) Individual rights.

(4) Recognizing and reporting incidents.

(5) The safe and appropriate use of [positive interventions] behavior supports if the person [will provide a support to an individual with a dangerous behavior] works directly with an individual.

(6) Implementation of the individual plan if the person provides an HCBS or base-funding service.

[(d) The balance of the annual training hours must be in areas identified by the provider in the provider's annual training plan in § 6100.141 (relating to annual training plan).

(e) All training, including the training courses identified in subsections (c) and (d), must be included in the provider's annual training plan.

§ 6100.144. Natural supports.

Sections 6100.141—6100.143 (relating to annual training plan; orientation program; and annual training) do not apply to natural supports.]

INDIVIDUAL RIGHTS

§ 6100.181. Exercise of rights.

(a) An individual may not be deprived of rights as provided under §§ 6100.182 and 6100.183 (relating to rights of the individual; and additional rights of the individual in a residential [facility] service location).

(b) [An individual shall be continually supported to exercise the individual's rights.

(c) An individual shall be provided the support and] The provider shall educate, assist and provide the accommodation necessary [to be able to] for the individual to make choices and understand [and actively exercise] the individual's rights.

[(d)] (c) An individual may not be reprimanded, punished or retaliated against for exercising the individual's rights.

[(e)] (d) A court's written order that restricts an individual's rights shall be followed.

[(f)] (e) A court-appointed legal guardian may exercise rights and make decisions on behalf of an individual in accordance with [a court order] the conditions of guardianship as specified in the court order.

[(g)] (f) An individual who has a court-appointed legal guardian, or who has a court order restricting the individual's rights, shall be involved in [decision making] decision-making in accordance with the court order.

[(h)] (g) An individual has the right to designate persons to assist in [decision making] decision-making and exercising rights on behalf of the individual.

§ 6100.182. Rights of the individual.

(a) An individual may not be discriminated against because of race, color, creed, disability, religious affiliation, ancestry, gender, gender identity, sexual orientation, national origin or age.

(b) An individual has the right to civil and legal rights afforded by law, including the right to vote, speak freely, [and] practice the religion of [his] the individual's choice [or to] and practice no religion.

(c) An individual may not be abused, neglected, mistreated, exploited, abandoned or subjected to corporal punishment.

(d) An individual shall be treated with dignity and respect.

(e) An individual has the right to make choices and accept risks.

(f) An individual has the right to refuse to participate in activities and [supports] services.

(g) An individual has the right to control the individual's own schedule and activities.

(h) An individual has the right to privacy of person and possessions.

(i) An individual has the right of access to and security of the individual's possessions.

(j) An individual has the right to choose a willing and qualified provider.

(k) An individual has the right to choose where, when and how to receive needed [supports] services.

(l) An individual has the right to voice concerns about the [supports] services the individual receives.

(m) An individual has the right to assistive devices and [support] services to enable communication at all times.

(n) An individual has the right to participate in the development and implementation of the [PSP] individual plan.

(o) An individual and persons designated by the individual have the right to access the individual's record.

§ 6100.183. Additional rights of the individual in a residential [facility] service location.

(a) An individual has the right to receive scheduled and unscheduled visitors, and to communicate and meet privately with [persons of the individual's choice] whom the individual chooses, at any time.

(b) An individual has the right to unrestricted access to send and receive mail and other forms of communications, unopened and unread by others, including the right to share contact information with whom the individual chooses.

(c) An individual has the right to unrestricted and private access to telecommunications.

(d) An individual has the right to manage and access the individual's ~~own~~ finances.

(e) An individual has the right to choose persons with whom to share a bedroom.

(f) An individual has the right to furnish and decorate the individual's bedroom and the common areas of the home in accordance with § [§] 6100.184 [and 6100.444(b)] (relating to negotiation of choices [; and lease or ownership]).

(g) An individual has the right to lock the individual's bedroom door.

(1) Locking may be provided by a key, access card, keypad code or other entry mechanism accessible to the individual to permit the individual to lock and unlock the door.

(2) Access to an individual's bedroom shall be provided only in a life-safety emergency or with the express permission of the individual for each incidence of access.

(3) Assistive technology shall be provided as needed to allow the individual to lock and unlock the door without assistance.

(4) The locking mechanism shall allow easy and immediate access by the individual and staff persons in the event of an emergency.

(5) Direct service professionals who provide service to the individual shall have the key or entry device to lock and unlock the door.

(h) An individual has the right to have a key, access card, keypad code or other entry mechanism to lock and unlock an entrance door of the home.

(1) Assistive technology shall be provided as needed to allow the individual to lock and unlock the door without assistance.

(2) The locking mechanism shall allow easy and immediate access by the individual and staff persons in the event of an emergency.

(3) Direct service professionals who provide service to the individual shall have the key or entry device to lock and unlock the door.

(i) An individual has the right to access food at any time.

[(i)] (j) An individual has the right to make [informed] health care decisions.

§ 6100.184. Negotiation of choices.

(a) An individual's rights shall be exercised so that another individual's rights are not violated.

(b) [Choices shall be negotiated by] The provider shall assist the affected individuals to negotiate choices in accordance with the provider's procedures for the individuals to resolve differences and make choices.

(c) An individual's rights may only be modified in accordance with § 6100.223(9) (relating to content of the individual plan) to the extent necessary to mitigate a significant health and safety risk to the individual or others.

§ 6100.185. Informing of rights.

(a) The provider shall inform and explain individual rights and the process to report a rights violation to the individual, and persons designated by the individual, upon entry into the program and annually thereafter.

(b) The provider shall keep a statement signed by the individual, or the individual's court-appointed legal guardian, acknowledging receipt of the information on individual rights.

§ 6100.186. [Role of family and friends] Facilitating personal relationships.

(a) The provider shall facilitate and make [the] accommodations [necessary] to [support] assist an [individual's visits] individual to visit with [family, friends and others] whom the individual chooses, at the direction of the individual.

(b) The provider shall facilitate and make [the] accommodations [necessary] to involve the [individual's family, friends and others] persons designated by the individual in [decisionmaking] decision-making, planning and [other] activities, at the direction of the individual.

(c) The provider shall facilitate the involvement of the individual's relatives and friends, unless the individual indicates otherwise.

[PERSON-CENTERED SUPPORT] INDIVIDUAL PLAN

§ 6100.221. Development of the [PSP] individual plan.

(a) An individual shall have one approved and authorized [PSP] individual plan that identifies the need for services and supports, the services and supports to be provided and the expected outcomes.

(b) [An individual's service implementation plan must be consistent with the PSP in subsection (a).

(c)] The support coordinator, base-funding support coordinator or targeted support manager shall be responsible for the development of the [PSP,] individual plan, including revisions, in cooperation with the individual and the [individual's PSP] individual plan team.

[(d)] (c) The initial [PSP] individual plan shall be developed prior to the individual receiving a reimbursed [support] service.

[(e)] (d) The [PSP] individual plan shall be revised when an individual's needs or [support] service system changes and upon the request of an individual.

[(f)] (e) The initial [PSP] individual plan and [PSP] individual plan revisions must be based upon a current assessment.

[(g)] (f) The individual and persons designated by the individual shall be involved [in] and [supported] assisted in the initial development and revisions of the [PSP] individual plan.

[(h) The initial PSP and PSP revisions shall be documented on a form specified by the Department.]

(g) The provider's implementation plan, if applicable, must be consistent with the individual plan in subsection (a). The provider's implementation plan is a detailed description of the specific activities to assist the individual to achieve the broader desired outcomes of the individual plan.

§ 6100.222. [The PSP] Individual plan process.

(a) The [PSP] individual plan process shall be directed by the individual to the extent possible and as desired by the individual.

(b) The [PSP] individual plan process shall:

(1) Invite and include persons designated by the individual.

(2) [Provide accommodation and facilitation to enable the individual's family, friends and others] Facilitate and assist persons designated by the individual to attend the [PSP] individual plan meeting, [at the direction of] as desired by the individual.

(3) [Be conducted to reflect] Reflect what is important to the individual to ensure that services and supports are delivered in a manner reflecting individual preferences and ensuring the individual's health, safety and well-being.

(4) Provide [necessary] information and [support] assistance to ensure that the individual directs the [PSP] individual plan process to the [maximum] extent possible.

(5) Enable the individual to make [informed] choices and decisions.

(6) [Be timely in relation to the needs of the individual and occur] Occur timely at intervals, times and locations of choice and convenience to the individual and to persons designated by the individual.

(7) Be communicated in clear and understandable language.

(8) Reflect cultural considerations of the individual.

(9) [Specify and follow] Include guidelines for solving disagreements among the [PSP] individual plan team members.

(10) Establish a method for the individual to request updates to the [PSP] individual plan.

[(11) Record the alternative supports that were considered by the individual.]

§ 6100.223. Content of the [PSP] individual plan.

The [PSP] individual plan must include the following:

(1) The individual's strengths [and] , functional abilities and need for services and supports.

(2) [The individual's assessed clinical and support needs.

(3)] The individual's [goals and] preferences related to relationships, community living, communication, community participation, employment, income and savings, health care, wellness and education.

[(4)] (3) [Individually identified, person-centered] The individual's desired outcomes.

[(5)] (4) [Support] Service and support necessary to assist the individual to achieve the desired outcomes.

[(6)] (5) The provider of the service and support.

[(7) Natural supports.

(8)] (6) The [type,] amount, duration and frequency for the [support] service specified in a manner that reflects the [assessed] needs and [choices] preferences of the individual. The schedule of [support] service delivery shall be determined by the [PSP] individual plan team and provide sufficient flexibility to provide choice by the individual.

[(9) The individual's communication mode, abilities and needs.

(10) Opportunities for new or continued community participation.

(11) Active pursuit of competitive,] (7) Competitive integrated employment as a first priority, for individuals of employment age in accordance with applicable Federal and State statutes and regulations, before other [activities or supports] services are considered.

[(12) Education and learning history and goals.

(13)] (8) [The level of needed support, risk factors, dangerous] Risks to the individual's health, safety or well-being, behaviors likely to result in immediate physical harm to the individual or others and risk mitigation strategies, if applicable.

[(14)] (9) Modification of individual rights as necessary to mitigate [risks] a significant health and safety risk to the individual or others, if applicable.

[(15) Health care information, including a health care history.

(16) The individual's choice of the provider and setting in which to receive supports.

(17) Excluded, unnecessary or inappropriate supports.

(18) Financial information, including how the individual chooses to use personal funds.

(19)] (10) A [back-up] plan to identify a needed service or support as identified by the [PSP] individual plan team if the absence of [the designated support person] staffing would place the individual at a health [and] or safety risk.

[(20) The person responsible for monitoring the implementation of the PSP.

(21) Signatures of the PSP team members and the date signed.]

§ 6100.224. Implementation of the [PSP] individual plan.

The provider identified in the [PSP] individual plan shall implement the [PSP,] individual plan, including revisions.

§ 6100.225. Support coordination, base-funding support coordination and TSM.

(a) A support coordinator, base-funding support coordinator or targeted support manager shall assure the completion of the following activities when developing an initial [PSP] individual plan and the annual review of the [PSP] individual plan:

(1) Coordination of information gathering and assessment activity, which includes the results from assessments prior to the initial and annual [PSP] individual plan meeting.

(2) Collaboration with the individual and persons designated by the individual to coordinate a date, time and location for initial and annual [PSP] individual plan meetings.

(3) Distribution of meeting invitations to [PSP] individual plan team members.

(4) Facilitation of the [PSP] individual plan meeting, or [the provision of support] assistance for an individual who chooses to facilitate [his] the individual's own meeting.

(5) Documentation of agreement with the [PSP] individual plan from the individual, persons designated by the individual and other team members.

(6) Documentation and submission of the [PSP] individual plan reviews, and revisions to the [PSP] individual plan, to the Department and the designated managing entity for approval and authorization.

(7) If the [PSP] individual plan is returned for revision, resubmission of the amended [PSP] individual plan for approval and authorization.

(8) Distribution of the [PSP] individual plan to the [PSP] individual plan team members who do not have access to the Department's information management system.

(9) Revision of the [PSP] individual plan when there is a change in an individual's needs.

(b) A support coordinator, base-funding support coordinator or targeted support manager shall monitor the implementation of the [PSP] individual plan, as well as the health, safety and well-being of the individual, using the Department's monitoring tool.

(c) A support coordinator, base-funding support coordinator or targeted support manager shall maintain a current record for each individual, including the following:

(1) Health care information, including diagnosis, a medical history since birth and medical records.

(2) Evidence of the individual's choice of provider and service location.

(3) Financial information, including how the individual chooses to use personal funds.

(4) The individual's court-appointed legal guardian, power of attorney, representative payee and designated persons for purposes of this chapter, if applicable.

(5) The list of persons who participated in the individual plan team meetings.

§ 6100.226. Documentation of [support delivery] claims.

(a) Documentation [of support delivery related] to provide a record of services delivered to an individual shall be prepared by the provider for the [purposes] purpose of substantiating a claim.

(b) [Documentation of support delivery must relate to the implementation of the PSP rather than the individual's service implementation plan as specified in § 6100.221(b) (relating to development of the PSP).

(c)] The provider shall document [support] service delivery [each time a support] on the date the service is delivered.

(1) A service note shall be completed for each continuous span of billing units or each day unit.

(2) A new service note shall be completed when there is an interruption of service within a 24-hour period, if service is reinitiated within that 24-hour period, except for a service that is billed as a day unit.

(3) If there is a change in the staff person providing the service or a change in shift involving multiple staff persons during a 24-hour period, a new service note shall be completed, except for a service that is billed as a day unit.

[(d) Documentation of support delivery may be made on the same form if multiple supports are provided to the same individual, by the same provider and at the same location.

(e)] (c) Documentation of [support] service delivery must include the following:

(1) The name of the individual.

(2) The name of the provider.

(3) The date of the service delivery.

(4) The date, name [, title] and signature of the person completing the documentation.

[(4)] (5) [A summary documenting what support was delivered] Identification of the service delivered, the nature or description of the activities involved in the service, who delivered the [support] service [, when the support was delivered] and where the [support] service was delivered.

[(5) The amount, frequency and duration of the support as specified in the PSP.] (6) The total number of units of service delivered from the beginning to the end of the service on the specified date.

[(6) The outcome of the support delivery.

(7) A record of the time worked, or the time that a support was delivered, to support the claim.

(f) The provider, in cooperation with the support coordinator or the targeted support manager and the individual, shall complete a review of the documentation of support delivery for each individual, every 3 months, and document the progress made to achieving the desired outcome of the supports provided.

(g) The provider shall keep documentation of support delivery.]

(d) The provider shall maintain a record of the time worked or the time that a service was delivered to support the claim.

(e) The amount, frequency and duration of the service delivered shall be consistent with the individual plan.

(f) Documentation of claims, including supporting documentation, shall be kept.

§ 6100.227. Progress notes.

(a) The provider, in cooperation with the support coordinator, base-funding support coordinator or targeted support manager, and the individual, shall review the documentation of service delivery in § 6100.226 (relating to documentation of claims) and document the progress made to achieve the desired outcome of the service provided, at least every 3 months, beginning with the date of the initial claim relating to service for the individual.

(b) The documentation of progress in subsection (a) shall be verified through the observation of service delivery and discussion with the individual or the person designated by the individual, as appropriate.

(c) The documentation of progress in subsection (a) shall include the following:

(1) If the service was provided in accordance with the individual plan.

(2) If the service met the needs and preferences of the individual.

(3) How progress will be addressed, if there was a lack of progress on a desired outcome.

(4) Impact on the individual's health, safety, well-being, preferences and routine.

(d) Documentation of progress notes shall be kept.

[EMPLOYMENT, EDUCATION AND] COMMUNITY PARTICIPATION AND EMPLOYMENT

§ 6100.261. Access to the community.

[(a)] The provider shall provide the individual with the [support] assistance necessary to access the community in accordance with the [individual's PSP] individual plan.

[(b) The individual shall be provided ongoing opportunities and support necessary to participate in community activities of the individual's choice.

(c) The individual shall be afforded the same degree of community access and choice as an individual who is similarly situated in the community, who does not have a disability and who does not receive an HCBS.]

§ 6100.262. Employment.

(a) The [individual shall have] provider shall provide active and ongoing opportunities, information about employment options appropriate for the individual and the [supports] services necessary to seek and retain [employment and work in] competitive [,] integrated [settings] employment.

(b) [Authorization for a new prevocational support for an individual who is under 25 years of age shall be permitted only after a referral is made to the OVR and the OVR either determines that the individual is ineligible or closes the case.

(c) At the annual PSP revision, the individual shall be offered appropriate opportunities related to the individual's skills and interests, and encouraged to seek competitive, integrated employment.

(d) The support coordinator or targeted support manager shall provide education and information to the individual about competitive, integrated employment and the OVR services.]

Competitive integrated employment is work performed on a full-time or part-time basis, including self-employment for which an individual is:

(1) Compensated at not less than Federal minimum wage requirements or State or local minimum wage law, whichever is higher, and not less than the customary rate paid by the employer for the same or similar work performed by persons without a disability.

(2) At a location where the employee interacts with people without a disability, not including supervisory personnel or persons who are providing services to such employee.

(3) Presented, as appropriate, opportunities for similar benefits and advancement like those for other employees without a disability and who have similar positions.

[§ 6100.263. Education.

If identified in the individual's PSP as necessary to support the individual's pursuit of a competitive, integrated employment outcome or identified in the individual's PSP for employment approved by the OVR, an individual shall have access to a full range of options that support participation in the following post-secondary education:

(1) Technical education.

(2) College and university programs.

(3) Lifelong learning.

(4) Career development.]

TRANSITION TO A NEW PROVIDER

§ 6100.301. Individual choice.

(a) [Influence] A provider may not [be exerted by a provider] exert influence when the individual is considering a transition to a new provider.

(b) [An individual shall be supported by the] The support coordinator, base-funding support coordinator or the targeted support manager shall assist the individual in exercising choice in transitioning to a new provider.

(c) An individual's choice to transition to a new provider shall be accomplished in the time frame desired by the individual, to the extent possible and in accordance with this chapter.

§ 6100.302. [Transition to a new provider] Cooperation during individual transition.

(a) When an individual transitions to a new provider, the current provider and new provider shall cooperate with the Department, the designated managing entity and the support coordinator, base-funding support coordinator or the targeted support manager during the transition between providers.

(b) The current provider shall:

(1) Participate in transition planning to aid in the successful transition to the new provider.

(2) Arrange for transportation of the individual to visit the new provider, if transportation is included in the [support] service.

(3) [Close] Resolve pending incidents in the Department's information management system.

§ 6100.303. [Reasons for a transfer or change in a provider.] Involuntary transfer or change of provider.

(a) The following are the only grounds for a change in a provider or a transfer of an individual against the individual's wishes:

(1) The individual is a danger to the individual's self or others, at the particular [support] service location, even with the provision of supplemental [supports] services.

(2) The individual's needs have changed, advanced or declined so that the individual's needs cannot be met by the provider, even with the provision of supplemental [supports] services.

(3) Meeting the individual's needs would require a significant alteration of the provider's program or building.

(4) Closure of the service location.

(b) The provider may not [change a support provider or] transfer an individual to another service provider against the individual's wishes in response to an individual's exercise of rights, voicing choices or concerns or in [retaliation] response to [filing a grievance] a complaint.

§ 6100.304. Written notice.

(a) [If the individual chooses another provider, the PSP team shall provide written notice to the following at least 30 days prior to the transition to a new provider:

(1) The provider.

(2) The individual.

(3) Persons designated by the individual.

(4) The PSP team members.

(5) The designated managing entity.

(6) The support coordinator or targeted support manager.

(b)] If the provider is no longer able or willing to provide a [support] service for an individual in accordance with § 6100.303 (relating to [reasons for a transfer or change in a provider] involuntary transfer or change of provider), the provider shall provide written notice to the following at least 45 days prior to the date of the proposed change [in support] of provider or transfer:

(1) The individual.

(2) Persons designated by the individual.

(3) The [PSP] individual plan team members.

(4) The designated managing entity.

(5) The support coordinator, base-funding support coordinator or targeted support manager.

(6) The Department.

(b) The Department or designated managing entity may authorize a transfer or change date earlier than the date specified in subsection (a) to protect the health and safety of the individual or others.

(c) The provider's written notice specified in subsection [(b)] (a) must include the following:

(1) The individual's name and master client index number.

(2) The current provider's name, address and master provider index number.

(3) The [support] service that the provider is unable or unwilling to provide [or for which the individual chooses another provider].

(4) The location where the [support] service is currently provided.

(5) The reason the provider is no longer able or willing to provide the [support] service as specified in § 6100.303.

(6) A description of the efforts made to address or resolve the issue that has led to the provider becoming unable or unwilling to provide the [support] service [or for which the individual chooses another provider].

(7) Suggested time frames for transitioning the delivery of the [support] service to the new provider.

§ 6100.305. Continuation of [support] service.

The provider shall continue to provide the authorized [support] service during the transition period to ensure continuity of [care] service until a new provider is approved [by the Department] and the new [support] service is in place, unless otherwise directed by the Department or the designated managing entity.

§ 6100.306. Transition planning.

The support coordinator, base-funding support coordinator or targeted support manager shall coordinate the transition planning activities, including scheduling and participating in all transition planning meetings, during the transition period.

§ 6100.307. Transfer of records.

(a) The provider shall transfer a copy of the complete individual record to the new provider prior to the day of the transfer.

(b) The previous provider shall maintain the original individual record in accordance with § 6100.54 (relating to recordkeeping).

[POSITIVE INTERVENTION] RESTRICTIVE PROCEDURES

§ 6100.341. [Use of a positive intervention.

(a) A positive intervention shall be used to prevent, modify and eliminate a dangerous behavior when the behavior is anticipated or occurring.

(b) The least intrusive method shall be applied when addressing a dangerous behavior. For each incidence of a dangerous behavior, every attempt shall be made to modify and eliminate the behavior.

(c) As used in this section, the following words and terms have the following meanings, unless the context clearly indicates otherwise:

Dangerous behavior—An action with a high likelihood of resulting in harm to the individual or others.

Positive intervention—An action or activity intended to prevent, modify and eliminate a dangerous behavior. This includes improved communication, reinforcing appropriate behavior, an environmental change, recognizing and treating physical and behavioral health symptoms, voluntary physical exercise, wellness practice, redirection, praise, modeling, conflict resolution and de-escalation.

§ 6100.342. PSP.

If the individual has a dangerous behavior as identified in the PSP, the PSP must include the following:

(1) The specific dangerous behavior to be addressed.

(2) A functional analysis of the dangerous behavior and the plan to address the reason for the behavior.

(3) The outcome desired.

(4) A description of the positive intervention aimed at preventing, modifying or eliminating the dangerous behavior and the circumstances under which the intervention is to be used.

(5) A target date to achieve the outcome.

(6) Communication needs.

(7) Health conditions that require special attention.

§ 6100.343. Prohibition of Restraints.] Definition of restrictive procedures.

A restrictive procedure is a practice that does one or more of the following:

(1) Limits an individual's movement, activity or function.

(2) Interferes with an individual's ability to acquire positive reinforcement.

(3) Results in the loss of objects or activities that an individual values.

(4) Requires an individual to engage in a behavior that the individual would not engage in given freedom of choice.

§ 6100.342. Written policy.

The provider shall develop and implement a written policy that defines the prohibition or use of specific types of restrictive procedures, describes the circumstances in which a restrictive procedure may be used, the staff persons who may authorize the use of a restrictive procedure and a mechanism to monitor and control the use of restrictive procedures.

§ 6100.343. Appropriate use of restrictive procedures.

(a) A restrictive procedure may not be used as retribution, for the convenience of staff persons or as a substitute for staffing or appropriate services.

(b) For each use of a restrictive procedure:

(1) Every attempt shall be made to anticipate and de-escalate the behavior using techniques less intrusive than a restrictive procedure.

(2) A restrictive procedure may not be used unless less restrictive techniques and resources appropriate to the behavior have been tried but have failed.

§ 6100.344. Human rights team.

(a) If a restrictive procedure is used, the provider shall use a human rights team. The provider may use a county mental health and intellectual disability program human rights team that meets the requirements of this section.

(b) The human rights team shall include a professional who has a recognized degree, certification or license relating to behavior support, who did not develop the behavior support component of the individual plan.

(c) The human rights team shall include a majority of persons who do not provide direct services to the individual.

(d) A record of the human rights team meetings shall be kept.

§ 6100.345. Behavior support component of the individual plan.

(a) For each individual for whom a restrictive procedure may be used, the individual plan shall include a component addressing behavior support that is reviewed and approved by the human rights team in § 6100.344 (relating to human rights team), prior to use of a restrictive procedure.

(b) The behavior support component of the individual plan shall be reviewed and revised as necessary by the human rights team, according to the time frame established by the team, not to exceed 6 months between reviews.

(c) The behavior support component of the individual plan shall include:

(1) The specific behavior to be addressed.

(2) An assessment of the behavior, including the suspected reason for the behavior.

(3) The outcome desired.

(4) A target date to achieve the outcome.

(5) Methods for facilitating positive behaviors such as changes in the individual's physical and social environment, changes in the individual's routine, improving communications, recognizing and treating physical and behavioral health conditions, voluntary physical exercise, redirection, praise, modeling, conflict resolution, de-escalation and teaching skills.

(6) Types of restrictive procedures that may be used and the circumstances under which the procedures may be used.

(7) The amount of time the restrictive procedure may be applied.

(8) The name of the staff person responsible for monitoring and documenting progress with the behavior support component of the individual plan.

(d) If a physical restraint will be used or if a restrictive procedure will be used to modify an individual's rights in § 6100.223(9) (relating to content of the individual plan) the behavior support component of the individual plan shall be developed by a professional who has a recognized degree, certification or license relating to behavior support.

§ 6100.346. Staff training.

(a) A staff person who implements or manages a behavior support component of an individual plan shall be trained in the use of the specific techniques or procedures that are used.

(b) If a physical restraint will be used, the staff person who implements or manages the behavior support component of the individual plan shall have experienced the use of the physical restraint directly on the staff person.

(c) Documentation of the training provided, including the staff persons trained, dates of training, description of training and training source, shall be kept.

§ 6100.347. Prohibited procedures.

The following procedures are prohibited:

(1) Seclusion, defined as involuntary confinement of an individual in a room or area from which the individual is physically prevented or verbally directed from leaving. Seclusion includes physically holding a door shut or using a foot pressure lock.

(2) Aversive conditioning, defined as the application of startling, painful or noxious stimuli.

(3) Pressure-point techniques, defined as the application of pain for the purpose of achieving compliance. A pressure-point technique does not include a clinically-accepted bite release technique that is applied only as long as necessary to release the bite.

(4) A chemical restraint, defined as use of [drugs or chemicals] a drug for the specific and exclusive purpose of controlling acute or episodic aggressive behavior. A chemical restraint does not include a drug ordered by a health care practitioner or dentist for the following use or event:

(i) [to treat] Treatment of the symptoms of a specific mental, emotional or behavioral condition[, or as].

(ii) [pretreatment] Pretreatment prior to a medical or dental examination or treatment.

(iii) An ongoing program of medication.

(iv) A specific, time-limited stressful event or situation to assist the individual to control the individual's own behavior.

(5) A mechanical restraint, defined as a device that restricts the movement or function of an individual or portion of an individual's body. [Mechanical restraints include] A mechanical restraint includes a geriatric chair, a bedrail that restricts the movement or

function of the individual, handcuffs, anklets, wristlets, camisole, helmet with fasteners, muffs and mitts with fasteners, restraint vest, waist strap, head strap, [papoose] restraint board, restraining sheet, chest restraint and other [locked restraints] similar devices. A mechanical restraint does not include the use of a seat belt during movement or transportation. A mechanical restraint does not include a device prescribed by a health care practitioner for the following use or event:

(i) [The term does not include a device prescribed by a health care practitioner that is used to provide post-surgical care, proper balance or support for the achievement of functional body position] Post-surgical or wound care.

(ii) Balance or support to achieve functional body position, if the individual can easily remove the device or if the device is removed by a staff person immediately upon the request or indication by the individual, and if the individual plan includes periodic relief of the device to allow freedom of movement.

[(ii) The term does not include a device prescribed by a health care practitioner to protect the individual in the event of a seizure, as long as the individual can easily remove the device.] (iii) Protection from injury during a seizure or other medical condition, if the individual can easily remove the device or if the device is removed by a staff person immediately upon the request or indication by the individual, and if the individual plan includes periodic relief of the device to allow freedom of movement.

[(6) A manual restraint, defined as a hands-on physical method that restricts, immobilizes or reduces an individual's ability to move his arms, legs, head or other body parts freely, on a nonemergency basis, or for more than 15 minutes within a 2-hour period. A manual restraint does not include physically prompting, escorting or guiding an individual to a support as specified in the individual's PSP.

(7) A prone position manual restraint.

(8) A manual restraint that inhibits digestion or respiration, inflicts pain, causes embarrassment or humiliation, causes hyperextension of joints, applies pressure on the chest or joints, or allows for a free fall to the floor.

§ 6100.344. Permitted interventions.

(a) Voluntary exclusion, defined as an individual voluntarily removing himself from his immediate environment and placing himself alone to a room or area, is permitted in accordance with the individual's PSP.

(b) A physical protective restraint may be used only in accordance with § 6100.343(6)—(8) (relating to prohibition of restraints).

(c) A physical protective restraint may not be used until §§ 6100.143(c)(5) and 6100.223(13) (relating to annual training; and content of the PSP) are met.

(d) A physical protective restraint may only be used in the case of an emergency to prevent an individual from injuring the individual's self or others.

(e) A physical protective restraint may not be used as a behavioral intervention, consequence, retribution, punishment, for the convenience of staff persons or as a substitution for individual support.

(f) A physical protective restraint may not be used for more than 15 minutes within a 2-hour period.

(g) A physical protective restraint may only be used by a person who is trained as specified in § 6100.143(c)(5).

(h) As used in this section, a "physical protective restraint" is a hands-on hold of an individual.]

§ 6100.348. Physical restraint.

(a) A physical restraint, defined as a manual method that restricts, immobilizes or reduces an individual's ability to move the individual's arms, legs, head or other body parts freely, may only be used in the case of an emergency to prevent an individual from immediate physical harm to the individual or others.

(b) Verbal redirection, physical prompts, escorting and guiding an individual are permitted.

(c) A prone position physical restraint is prohibited.

(d) A physical restraint that inhibits digestion or respiration, inflicts pain, causes embarrassment or humiliation, causes hyperextension of joints, applies pressure on the chest or joints or allows for a free fall to the floor is prohibited.

(f) A physical restraint may not be used for more than 30 cumulative minutes within a 2-hour period.

§ 6100.349. Emergency use of a physical restraint.

If a physical restraint is used on an unanticipated, emergency basis, §§ 6100.344 and 6100.345 (relating to human rights team; and behavior support component of the individual plan) do not apply until after the restraint is used for the same individual twice in a 6-month period.

[§ 6100.345.] § 6100.350. Access to or the use of an individual's personal property.

(a) Access to or the use of an individual's personal funds or property may not be used as a reward or punishment.

(b) An individual's personal funds or property may not be used as payment for damages unless the individual consents to make restitution for the damages [as follows] . The following consent provisions apply unless there is a court-ordered restitution:

(1) A separate written consent is required for each incidence of restitution.

(2) Consent shall be obtained in the presence of the individual [,] or a person designated by the individual and in the presence of and with the [support] assistance of the support coordinator, base-funding support coordinator or targeted support manager.

(3) [There may not be coercion in obtaining the consent of an individual.] The provider may not coerce the individual to provide consent.

INCIDENT MANAGEMENT

§ 6100.401. Types of incidents and timelines for reporting.

(a) The provider shall report the following incidents, alleged incidents and suspected incidents through the Department's information management system within 24 hours of discovery by a staff person:

(1) Death.

(2) [Suicide attempt] A physical act by an individual in an attempt to complete suicide.

(3) Inpatient admission to a hospital.

(4) [Emergency room visit.

(5)] Abuse, including abuse to an individual by another individual.

[(6)] (5) Neglect.

[(7)] (6) Exploitation.

[(8) Missing individual] (7) An individual who is missing for more than 24 hours or who could be in jeopardy if missing for any period of time.

[(9)] (8) Law enforcement activity that occurs during the provision of a service or for which an individual is the subject of a law enforcement investigation that may lead to criminal charges against the individual.

[(10)] (9) Injury requiring treatment beyond first aid.

[(11)] (10) Fire requiring the services of the fire department. This provision does not include false alarms.

[(12)] (11) Emergency closure.

[(13) Use of a restraint.

(14)] (12) Theft or misuse of individual funds.

[(15)] (13) A violation of individual rights.

[(16) A medication administration error, including prescription and over the counter medication administration errors.

(17) A critical health and safety event that requires immediate intervention such a significant behavioral event or trauma.]

(b) The provider shall report the following incidents, alleged incidents and suspected incidents through the Department's information management system within 72 hours of discovery by a staff person:

(1) Use of a restraint.

(2) A medication error as specified in § 6100.466 (relating to medication errors), if the medication was ordered by a health care practitioner.

(c) The individual, and persons designated by the individual, shall be notified [immediately upon] within 24 hours of discovery of an incident relating to the individual.

[(c)] (d) The provider shall keep documentation of the notification in subsection [(b)] (c).

[(d)] (e) The incident report, or a summary of the incident, the findings and the actions taken, redacted to exclude information about another individual and the reporter, unless the reporter is the individual who receives the report, shall be available to the individual, and persons designated by the individual, upon request.

§ 6100.402. Incident investigation.

(a) The provider shall take immediate action to protect the health, safety and well-being of the individual following the initial knowledge or notice of an incident, alleged incident [and] or suspected incident.

(b) The provider shall initiate an investigation of an incident, alleged incident or suspected incident within 24 hours of discovery by a staff person.

(c) A Department-certified incident investigator shall conduct the investigation of the [incident listed in § 6100.401(a) (relating to types of incidents and timelines for reporting).] following incidents:

(1) Death that occurs during the provision of a service.

(2) Inpatient admission to a hospital as a result of an accidental or unexplained injury or an injury caused by a staff person, another individual or during the use of a restraint.

(3) Abuse, including abuse to an individual by another individual.

(4) Neglect.

(5) Exploitation.

(6) Injury requiring treatment beyond first aid as a result of an accidental or unexplained injury or an injury caused by a staff person, another individual or during the use of a restraint.

(7) Theft or misuse of individual funds.

(8) A violation of individual rights.

§ 6100.403. Individual needs.

(a) In investigating an incident, the provider shall review and consider the following needs of the affected individual:

(1) Potential risks.

(2) Health care information.

(3) Medication history and current medication.

(4) Behavioral health history.

(5) Incident history.

(6) Social needs.

(7) Environmental needs.

(8) Personal safety.

(b) The provider shall monitor an individual's risk for recurring incidents and implement corrective action, as appropriate.

(c) The provider shall work cooperatively with the [support coordinator or targeted support manager and the PSP] individual plan team to revise the [individual's PSP] individual plan if indicated by the incident.

§ 6100.404. Final incident report.

(a) The provider shall finalize the incident report [in] through the Department's information management system within 30 days of discovery of the incident by a staff person, unless the provider notifies the Department in writing that an extension is necessary and the reason for the extension.

(b) The provider shall provide the following information to the Department as part of the final incident report:

(1) Additional detail about the incident.

(2) The results of the incident investigation.

(3) [A description of the corrective action taken in response to an incident] Action taken to protect the health, safety and well-being of the individual.

(4) [Action taken to protect the health, safety and well-being of the individual.] A description of the corrective action taken in response to an incident and to prevent recurrence of the incident.

(5) The person responsible for implementing the corrective action.

(6) The date the corrective action was implemented or is to be implemented.

§ 6100.405. Incident analysis.

(a) The provider shall complete the following for each confirmed incident:

(1) Analysis to determine the [root] cause of the incident.

(2) Corrective action, if indicated.

(3) A strategy to address the potential risks to the individual.

(b) The provider shall review and analyze incidents and conduct and document a trend analysis at least every 3 months.

(c) The provider shall identify and implement preventive measures to reduce:

(1) The number of incidents.

(2) The severity of the risks associated with the incident.

(3) The likelihood of an incident recurring.

(d) The provider shall educate staff persons, others and the individual based on the circumstances of the incident.

(e) The provider shall [analyze] monitor incident data [continuously] and take actions to mitigate and manage risks.

PHYSICAL ENVIRONMENT OF HCBS

§ 6100.441. Request for and approval of changes.

(a) A [residential] provider shall submit a written request to the Department on a form specified by the Department and receive written approval from the Department prior to increasing or decreasing the Department-approved program capacity of a [residential facility] service location.

(b) To receive written approval from the Department as specified in subsection (a), the provider shall submit a description of the following:

(1) The circumstances surrounding the change.

(2) How the change will meet the [setting] service location size, staffing patterns, assessed needs and outcomes for the individuals.

(c) [If a facility is licensed as a community home for individuals with an intellectual disability or autism, the] The program capacity, as specified in writing by the Department, may not be exceeded. Additional individuals funded through any funding source, including private-pay, may not [live in the home] be provided services in the service location to exceed the Department-approved program capacity.

(d) A copy of the written request specified in subsections (a) and (b) shall be provided to the affected individuals, and persons designated by the individuals, prior to the submission to the Department.

(e) A copy of the Department's response to the written request specified in subsections (a) and (b) shall be provided to the affected individuals, and persons designated by the individuals, within 7 days following the receipt of the Department's response.

§ 6100.442. Physical accessibility.

(a) The provider shall provide for or arrange for physical site accommodations and assistive equipment to meet the health, safety and mobility needs of the individual.

(b) Mobility equipment and other assistive equipment shall be maintained in working order, clean, in good repair and free from hazards.

§ 6100.443. [Access to the bedroom and the home.

(a) In a residential facility, an individual shall have a lock with a key, access card, keypad code or other entry mechanism to unlock and lock the individual's bedroom door and the entrance of the home.

(b) Assistive technology, as needed, shall be used to allow the individual to open and lock the door without assistance.

(c) The locking mechanism shall allow easy and immediate access in the event of an emergency.

(d) Appropriate persons shall have the key and entry device to lock and unlock the doors to the bedroom and the home.

(e) Only authorized persons shall access the individual's bedroom.

(f) Access to an individual's bedroom shall be provided only in a life-safety emergency or with the express permission of the individual for each incidence of access.

§ 6100.444. Lease or ownership.

(a) In residential habilitation, the individual shall have a legally enforceable agreement such as the lease or residency agreement for the physical space, or ownership of the physical space, that offers the same responsibilities and protections from eviction that tenants have under The Landlord and Tenant Act of 1951 (68 P.S. §§ 250.101—250.602).

(b) Landlords may establish reasonable limits for the furnishing and decorating of leased space as long as the limits are not discriminatory and do not otherwise deny rights granted to tenants under applicable laws and regulations.

§ 6100.445.] Integration.

A [setting in which a support] service location [is provided] shall be integrated in the community and the individual shall have the same degree of community access and choice as an individual who is similarly situated in the community who does not have a disability and who does not receive an HCBS.

[§ 6100.446. Facility characteristics relating to size of facility] § 6100.444. Size of service location.

(a) A residential [facility] service location that serves primarily persons with a disability, which was funded in accordance with Chapter 51 prior to ____ (*Editor's Note*: The blank refers to the effective date of adoption of this [proposed rulemaking] final-form regulation), may not exceed a program capacity of eight.

(1) A duplex, two bilevel units and two side-by-side apartments are permitted as long as the total in both units does not exceed a program capacity of eight.

(2) With the Department's written approval, a residential [facility] service location with a program capacity of eight may move to a new location and retain the program capacity of eight.

(b) A residential [facility] service location that serves primarily persons with a disability, which is newly funded in accordance with this chapter on or after ____ (*Editor's Note*: The blank refers to the effective date of adoption of this [proposed] final-form rulemaking.), may not exceed a program capacity of four.

(1) A duplex, two bilevel units and two side-by-side apartments are permitted as long as the total in both units does not exceed a program capacity of four.

(2) With the Department's written approval, an intermediate care facility for individuals with an intellectual disability licensed in accordance with Chapter 6600 (relating to intermediate care facilities for individuals with an intellectual disability) with a licensed capacity of five, six, seven or eight individuals may convert to a residential [facility] service location funded in accordance with this chapter exceeding the program capacity of four.

(c) A day [facility] service location that serves primarily persons with a disability, which is newly-funded in accordance with this chapter on or after March 17, 2019, including an adult training facility licensed in accordance with Chapter 2380 (relating to adult training facilities) and a vocational facility licensed in accordance with Chapter 2390 (relating to

vocational facilities), may not [exceed a program capacity of 15 at any one time.] provide service to more than 25 individuals in the service location at any one time,

[.(1) The program capacity includes all individuals served by the facility] including individuals funded through any funding source such as private-pay.

[(2) Additional individuals funded through any funding source, including private pay, may not be served in the day facility to exceed the program capacity of 15 individuals at any one time.

§ 6100.447. Facility characteristics relating to location of facility] § 6100.445. Locality of service location.

(a) A residential or day [facility] service location, which is newly-funded in accordance with this chapter on or after ____ (*Editor's Note*: The blank refers to the effective date of adoption of this [proposed rulemaking] final-form regulation.), notwithstanding the exceptions in § 6100.444(a)(1) and (b)(1) (relating to [requirements relating to] size of service location) may not be located adjacent [or in close proximity] to the following:

(1) Another human service residential [facility] service location.

(2) Another human service day [facility] service location serving primarily persons with a disability.

[(3) A hospital.

(4) A nursing facility.

(5) A health or human service public or private institution.]

(b) No more than [10%] 25% of the units in an apartment, condominium or townhouse [development] building may be [funded] newly-funded in accordance with this chapter on or after _____ (*Editor's Note*: The blank refers to the effective date of adoption of this final-form regulation.) The exceptions relating to a duplex, two bi-level units and two side-by-side apartments in § 6100.444.(a)(1) and (b)(1) apply.

(c) With the Department's written approval, a residential or day [facility] service location that is licensed in accordance with Chapter 2380, 2390, 6400 or 6500 prior to ____ (*Editor's Note*: The blank refers to the effective date of adoption of this [proposed rulemaking] final-form regulation.), and funded in accordance with Chapter 51 prior to ____ (*Editor's Note*: The blank refers to the effective date of adoption of this [proposed rulemaking] final-form regulation.), may continue to be eligible for HCBS participation.

[(d) With the Department's written approval, an intermediate care facility for individuals with an intellectual disability licensed in accordance with Chapter 6600 (relating to intermediate care facilities for individuals with an intellectual disability) with a licensed capacity of eight or less individuals may be eligible for HCBS participation.]

MEDICATION ADMINISTRATION

§ 6100.461. Self-administration.

(a) The provider shall provide an individual who has a prescribed medication with assistance, as needed, for the individual's self-administration of the medication.

(b) Assistance in the self-administration of medication includes helping the individual to remember the schedule for taking the medication, offering the individual the medication at the prescribed times, opening a medication container and storing the medication in a secure place.

(c) The provider shall provide or arrange for assistive technology to [support] assist the [individual's self-administration of] individual to self-administer medications.

(d) The [PSP] individual plan must identify if the individual is unable to self-administer medications.

(e) To be considered able to self-administer medications, an individual shall do all of the following:

(1) Recognize and distinguish the individual's medication.

(2) Know how much medication is to be taken.

(3) Know when the medication is to be taken. [This knowledge may include reminders] Assistance may be provided by staff persons to remind the individual of the schedule and [offering] to offer the medication at the prescribed times as specified in subsection (b).

(4) Take or apply the individual's own medication with or without the use of assistive technology.

§ 6100.462. Medication administration.

(a) A provider whose staff persons or others are qualified to administer medications as specified in subsection (b) may provide medication administration for an individual who is unable to self-administer the individual's prescribed medication.

(b) A prescription medication that is not self-administered shall be administered by one of the following:

(1) A licensed physician, licensed dentist, licensed physician's assistant, registered nurse, certified registered nurse practitioner, licensed practical nurse [or], licensed paramedic or other health care professional who is licensed, certified or registered by the Department of State to administer medications.

(2) A person who has completed the medication administration [training] course requirements as specified in [§ 6100.469] § 6100.468 (relating to medication administration training) for the medication administration of the following:

(i) Oral medications.

(ii) Topical medications.

(iii) Eye, nose and ear drop medications.

(iv) Insulin injections.

(v) Epinephrine injections for insect bites or other allergies.

(vi) Medications, injections, procedures and treatments as permitted by applicable statutes and regulations.

(c) Medication administration includes the following activities, based on the needs of the individual:

(1) Identify the correct individual.

(2) Remove the medication from the original container.

(3) [Crush or split] Prepare the medication as ordered by the prescriber.

(4) Place the medication in a medication cup or other appropriate container, or into the individual's hand, mouth or other route as ordered by the prescriber.

(5) If indicated by the prescriber's [00.163.163] order, measure vital signs and administer medications according to the prescriber's order.

(6) Injection of insulin [or] and injection of epinephrine in accordance with this chapter.

§ 6100.463. Storage and disposal of medications.

(a) Prescription and nonprescription medications shall be kept in their original labeled containers. Prescription medications shall be labeled with a label issued by a pharmacy.

(b) A prescription medication may not be removed from its original labeled container [more than 2 hours] in advance of the scheduled administration, except for the purpose of packaging the medication for the individual to take with the individual to a community activity for administration the same day the medication is removed from its original container.

(c) If insulin or epinephrine is not packaged in an individual dose container, assistance with or the administration of the injection shall be provided immediately upon removal of the medication from its original labeled container.

(d) Prescription medications and syringes, with the exception of epinephrine and epinephrine auto-injectors, shall be kept in an area or container that is locked.

(e) Epinephrine and epinephrine auto-injectors shall be stored safely and kept easily accessible at all times. The epinephrine and epinephrine auto-injectors shall be easily accessible to the individual if the epinephrine is self-administered or to the staff person who is with the individual if a staff person will administer the epinephrine.

(f) Prescription medications stored in a refrigerator shall be kept in an area or container that is locked.

(g) Prescription medications shall be stored in an organized manner under proper conditions of sanitation, temperature, moisture and light and in accordance with the manufacturer's instructions.

(h) Prescription medications that are discontinued or expired shall be destroyed in a safe manner according to [the Department of Environmental Protection and] applicable Federal and State statutes and [regulations] regulation.

(i) [Subsections (a)—(d) and (f) do] This section does not apply for an individual who self-administers medication and stores the medication in the individual's private bedroom or personal belongings.

§ 6100.464. [Labeling of medications.

The original container for prescription medications must be labeled with a pharmacy label that includes the following:

(1) The individual's name.

(2) The name of the medication.

(3) The date the prescription was issued.

(4) The prescribed dosage and instructions for administration.

(5) The name and title of the prescriber.]

§ 6100.465.] Prescription medications.

(a) A prescription medication shall be prescribed in writing by an authorized prescriber.

(b) A prescription order shall be kept current.

(c) A prescription medication shall be administered as prescribed.

(d) A prescription medication shall be used only by the individual for whom the prescription was prescribed.

(e) Changes in medication may only be made in writing by the prescriber or, in the case of an emergency, an alternate prescriber, except for circumstances in which oral orders may be accepted by a [registered nurse in accordance with regulations of the Department of State] health care professional who is licensed, certified or registered by the Department of State to accept oral orders. The individual's medication record shall be updated as soon as a written notice of the change is received.

[§ 6100.466.] § 6100.465. Medication [record s] record.

(a) A medication record shall be kept, including the following for each individual for whom a prescription medication is administered:

(1) Individual's name.

(2) Name [and title] of the prescriber.

(3) Drug allergies.

(4) Name of medication.

(5) Strength of medication.

(6) Dosage form.

(7) Dose of medication.

(8) Route of administration.

(9) Frequency of administration.

(10) Administration times.

(11) Diagnosis or purpose for the medication, including pro re nata.

(12) Date and time of medication administration.

(13) Name and initials of the person administering the medication.

(14) Duration of treatment, if applicable.

(15) Special precautions, if applicable.

(16) Side effects of the medication, if applicable.

(b) The information in subsection (a)(12) and (13) shall be recorded in the medication record at the time the medication is administered.

(c) If an individual refuses to take a prescribed medication, the refusal shall be documented on the medication record. The refusal shall be reported to the prescriber [within 24 hours, unless otherwise instructed by the prescriber. Subsequent refusals to take a prescribed medication shall be reported as required] as directed by the prescriber or if there is harm to the individual.

(d) The directions of the prescriber shall be followed.

[§ 6100.467.] § 6100.466. Medication errors.

(a) Medication errors include the following:

(1) Failure to administer a medication.

(2) Administration of the wrong medication.

(3) Administration of the wrong [amount] dose of medication.

(4) Failure to administer a medication at the prescribed time, which exceeds more than 1 hour before or after the prescribed time.

(5) Administration to the wrong person.

(6) Administration through the wrong route.

(7) Administration while the individual is in the wrong position.

(8) Improper preparation of the medication.

(b) A medication error shall be [immediately] reported as an incident as specified in § 6100.401 (relating to types of incidents and timelines for reporting) [and to the prescriber] .

(c) A medication error shall be reported to the prescriber under any of the following conditions:

(1) As directed by the prescriber.

(2) If the medication is administered to the wrong person.

(3) If there is harm to the individual.

[(c)] (d) Documentation of medication errors, follow-up action taken and the prescriber's response, if applicable, shall be kept in the individual's record.

[§ 6100.468.] § 6100.467. Adverse reaction.

(a) If an individual has a suspected adverse reaction to a medication, the provider shall immediately consult a health care practitioner or seek emergency medical treatment.

(b) An adverse reaction to a medication, the health care practitioner's response to the adverse reaction and the action taken shall be documented.

[§ 6100.469.] § 6100.468. Medication administration training.

(a) A person who has successfully completed a Department-approved [medications] medication administration course, including the course renewal requirements, may administer the [following:

(1) Oral medications.

(2) Topical medications.

(3) Eye, nose and ear drop medications] medications, injections, procedures and treatments as specified in § 6100.462(b)(2) (relating to medication administration).

(b) A person may administer insulin injections following successful completion of both:

(1) The medication administration course specified in subsection (a).

(2) A Department-approved diabetes patient education program within the past 12 months.

(c) A person may administer an epinephrine injection by means of an auto-injection device in response to anaphylaxis or another serious allergic reaction following successful completion of both:

(1) The medication administration course specified in subsection (a).

(2) Training within the past 24 months relating to the use of an auto-injection epinephrine injection device provided by a [licensed, registered or certified health care] professional [within the past 12 months] who is licensed, certified or registered by the Department of State in the health care field.

(d) The medication administration course in § 6100.462(b)(2) and subsection (a) will be a modified course for life sharers and service locations that are not licensed by the Department.

[d] (e) A record of the training shall be kept, including the person trained, the date, source, name of trainer and documentation that the course was successfully completed.

[§ 6100.470. Exception for family members] § 6100.469. Exceptions.

(a) Sections [6100.461—6100.463 and 6100.466—6100.469 do not apply to an adult relative of the individual who provides medication administration. An adult relative of the individual may administer medications to an individual without the completion of the Department-approved medications administration course.] 6100.461—6100.468 do not apply to the following:

(1) Respite care provided for fewer than 30 days in a 12-month period.

(2) Job coaching provided for fewer than 30 days in a 12-month period.

(b) Sections 6100.461—6100.468 apply to the administration of medication by an adult relative of an individual who receives services in the following:

(1) A service location that is licensed by the Department.

(2) An unlicensed life sharing home.

(c) Sections 6100.461—6100.468 do not apply to the administration of medication by an adult relative of an individual who receives services in a service location other than the service locations specified in subsection (b).

GENERAL PAYMENT PROVISIONS

§ 6100.481. Departmental rates and classifications.

(a) An HCBS will be paid based on one of the following:

(1) Fee schedule rates.

(2) Cost-based rates.

(3) Department-established fees for the ineligible portion of residential [habilitation] service.

(4) Managed care or other capitated payment methods.

(5) Vendor goods and services.

[(6) A method established in accordance with a Federally-approved waiver, including a Federally-approved waiver amendment.]

(b) The Department will establish a fee per unit of an HCBS as a Department-established fee by publishing a notice in the *Pennsylvania Bulletin*.

(c) The fee per unit of an HCBS is the maximum amount the Department will pay.

(d) The fee per unit of an HCBS applies to a specific location and to a specific HCBS.

(e) The provider may not negotiate a different fee or rate with a county mental health and intellectual disability program if there is a fee or rate for the same HCBS at the specific HCBS location.

§ 6100.482. Payment.

(a) The Department will only pay for an HCBS in accordance with this chapter [,Chapters 1101 and 1150] and Chapter 1101 (relating to general provisions) [; and MA Program payment policies), the Department's Federally-approved waivers and waiver amendments, and the State plan] .

(b) When a provision in Chapter 1101 [or 1150] is inconsistent with this chapter, this chapter applies.

(c) The Department will only pay for a reimbursable HCBS up to the maximum amount, duration and frequency as specified in the [individual's approved PSP] approved and documented individual plan and as delivered by the provider.

(d) If an HCBS is payable under a third-party medical resource, the provider shall bill the third-party medical resource in accordance with § 1101.64 (relating to third-party medical resources (TPR)) before billing a Federal or State-funded program.

(e) If the HCBS is eligible for payment under the State plan, the provider shall bill the program under the State plan before billing the HCBS waiver or State-funded programs.

(f) The provider shall document a third-party medical resource claim submission and denial for an HCBS under the State plan or a third-party medical resource agency.

(g) Medicaid payment, once accepted by the provider, constitutes payment in full.

(h) A provider who receives a supplemental payment for a [support] service that is included as a [support] service in the [PSP] individual plan, or that is eligible for payment as an HCBS, shall return the supplemental payment to the payer. If the payment is for an activity that is beyond the [supports] services specified in the [PSP] individual plan [and] or for an activity that is not eligible as an HCBS, the private payment from the individual or another person is permitted.

[(i) The Department will recoup payments that are not made in accordance with this chapter and the Department's Federally-approved waivers and waiver amendments.]

§ 6100.483. [Title of a residential building.

The title of a debt-free residential building owned by an enrolled provider shall remain with the enrolled provider.

§ 6100.484.] Provider billing.

(a) The provider shall submit claims in accordance with § 1101.68 (relating to invoicing for services).

(b) The provider shall use the Department's information system, and forms specified by the Department, to submit claims.

(c) The provider shall only submit claims that are substantiated by documentation as specified in § 6100.226 (relating to documentation of [support delivery] claims).

(d) The provider may not submit a claim for a [support] service that is inconsistent with this chapter, inappropriate to an individual's needs or inconsistent with the [individual's PSP] individual plan.

[§ 6100.485.] § 6100.484. Audits.

(a) The provider shall comply with the following audit requirements:

(1) 2 CFR Part 200 (relating to uniform administrative requirements, cost principles, and audit requirements for Federal awards).

(2) The Single Audit Act of 1984 (31 U.S.C.A. §§ 7501—7507.

(3) Applicable Office of Management and Budget Circulars and related applicable guidance issued by the United States Office of Management and Budget.

[(4) Applicable Federal and State statutes, regulations and audit requirements.

(b) A provider that is required to have a single audit or financial-related audit, as defined in Generally Accepted Government Auditing Standards, in accordance with 45 CFR 75.501(i) (relating to audit requirements) shall comply with the Federal audit requirements.

(c) The Department or the designated managing entity may require the provider to have the provider's auditor perform an attestation engagement in accordance with any of the following:

(1) Government Auditing Standards issued by the Comptroller General of the United States, known as Generally Accepted Government Auditing Standards.

(2) Standards issued by the Auditing Standards Board.

(3) Standards issued by the American Institute of Certified Public Accountants.

(4) Standards issued by the International Auditing and Assurance Standards Board.

(5) Standards issued by the Public Company Accounting Oversight Board.

(6) Standards of a successor organization to the organizations in paragraphs (1)—(5).

(d) The Department or the designated managing entity may perform an attestation engagement in accordance with subsection (c).

(e) A Federal or State agency may request the provider to have the provider's auditor perform an attestation engagement in accordance with subsection (c).

(f) The Department or the designated managing entity may perform nonaudit services such as technical assistance or consulting engagements.

(g) The Department or the designated managing entity may conduct a performance audit in accordance with the standards in subsection (c).

(h) The Department, a designated managing entity, an authorized Federal agency or an authorized State agency may direct the provider to have a performance audit conducted in accordance with the standards in subsection (c).

(i) A provider that is not required to have a single audit during the Commonwealth fiscal year shall keep records in accordance with subsection (c).

(j) The Department or the designated managing entity may perform a fiscal review of a provider.

§ 6100.486. Bidding.

(a) For a supply or equipment over $10,000, the provider shall obtain the supply or equipment using a process of competitive bidding or written estimates.

(b) The cost must be the best price made by a prudent buyer.

(c) If a sole source purchase is necessary, the provider shall keep records supporting the justification for the sole source purchase.

(d) As used in this section, a “sole source purchase” is one for which only one bid is obtained.

§ 6100.487.] § 6100.485. Loss or damage to property.

If an individual’s personal property is lost or damaged during the provision of an HCBS as a result of the provider’s action or inaction, the provider shall repair or replace the lost or damaged property, or pay the individual the replacement value for the lost or damaged property [, unless the damage or loss was the result of the individual’s actions] .

FEE SCHEDULE

§ 6100.571. Fee schedule rates.

(a) [Fee schedule rates will be established by the Department using a market-based approach based on current data and independent data sources.] The Department will establish fee schedule rates, based on the factors in subsection (b), using a market-based approach so that payments are consistent with efficiency, economy and quality of care and sufficient to enlist enough providers so that services are available to at least the extent that such services are available to the general population in the geographic area.

(b) [The Department will refresh the market-based data used in subsection (a) to establish fee schedule rates at least every 3 years.

(c) The market-based approach specified in subsection (a) will review and consider] In establishing the fee schedule rates in subsection (a) the Department will examine and use data relating to the following factors:

(1) The [support] service needs of the individuals.

(2) Staff wages, including education, experience, licensure requirements and certification requirements.

(3) Staff-related expenses, including benefits, training, recruitment and supervision.

(4) Productivity. Productivity is the amount of service delivered relative to the level of staffing provided.

(5) Occupancy. Occupancy is the cost related to occupying a space, including rent, taxes, insurance, depreciation and amortization expenses.

(6) [Program expenses] Direct and indirect program and administration-related expenses.

(7) Geographic costs based on the location where the HCBS is provided.

(8) [A review of] Federally-approved HCBS definitions in the waiver and determinations made about cost components that reflect [costs necessary and] reasonable and necessary costs related to the delivery of each HCBS.

(9) [A review of the] The cost of implementing [Federal, State and local statutes, laws, regulations and ordinances] applicable Federal and State statutes and regulations and local ordinances.

(10) Other [criteria] factors that impact costs.

(c) The Department will update the data used in subsection (b) at least every 3 years.

(d) The Department will publish [as a notice in the *Pennsylvania Bulletin* the factors in subsection (c) used to establish the rates and the fee schedule rates for public review and comment.] a description of its rate setting methodology used in subsection (a) as a notice in the *Pennsylvania Bulletin* for public review and comment. The description will include a discussion of the use of the factors in subsection (b) to establish the fee schedule rates; a discussion of the data and data sources used; and the fee schedule rates.

(e) [The Department will pay for fee schedule supports at the fee schedule rate determined by the Department.] The Department will make available to the public a summary of the public comments received in response to the notice in subsection (d) and the Department's response to the public comments.

COST-BASED RATES AND ALLOWABLE COSTS

§ 6100.641. Cost-based rate.

[(a)] Sections 6100.642—6100.672 apply to cost-based rates.

[(b) An HCBS eligible for reimbursement in accordance with §§ 6100.642—6100.672 includes residential habilitation and transportation.]

§ 6100.642. Assignment of rate.

(a) The provider will be assigned a cost-based rate for an existing HCBS at the location where the HCBS is delivered, with an approved cost report and audit, as necessary.

(b) If the provider seeks to provide a new HCBS, the provider will be assigned the area adjusted average rate of approved provider cost-based rates.

(c) A new provider with no historical experience will be assigned the area adjusted average rate of approved provider cost-based rates.

(d) If the provider fails to comply with the cost reporting requirements specified in this chapter after consultation with the Department, the provider will be assigned the lowest rate calculated Statewide based on all provider cost-based rates for an HCBS.

(e) Compliance with cost reporting requirements will be verified by the Department through a designated managing [agency] entity review or an audit, as necessary.

§ 6100.643. Submission of cost report.

(a) [A cost report is a data collection tool issued by the Department to collect expense and utilization information from a provider that may include supplemental schedules or addenda as requested by the Department.

(b)] The provider shall submit a cost report on a form specified by and in accordance with the instructions provided by the Department.

[(c)] (b) Unless a written extension is granted by the Department, the cost report or the cost report addenda shall be submitted to the Department on or before the last Thursday in October [for residential habilitation and] or on or before the last business day in the third week of February for transportation.

[(d)] (c) A provider with one master provider index number shall submit one cost report for the master provider index number.

[(e)] (d) A provider with multiple master provider index numbers may submit one cost report for all of its master provider index numbers or separate cost reports for each master provider index number.

[(f)] (e) The provider shall submit a revised cost report if the provider's audited financial statement is materially different from a provider's cost report by more than 1%.

§ 6100.644. Cost report.

(a) The provider shall complete the cost report to reflect the actual cost and the allowable administrative cost of the HCBS provided.

(b) The cost report must contain information for the development of a cost-based rate as specified on the Department's form.

(c) A provider of a cost-based service shall allocate eligible and ineligible allowable costs in accordance with the applicable Office of Management and Budget Circulars and related applicable guidance as issued by the United States Office of Management and Budget.

§ 6100.645. Rate setting.

(a) The Department will use the cost-based rate setting methodology to establish a rate for cost-based services for each provider with a Department-approved cost report.

(b) The approved cost report will be used as the initial factor in the rate setting methodology to develop the allowable costs for cost-based services.

(c) The provider shall complete the cost report in accordance with this chapter.

(d) The cost data submitted by the provider on the approved cost report will be used to set the cost-based rates.

[(e) The Department will adjust the cost report form and instructions based on changes in the support definitions in the Federally-approved waivers and waiver amendments from the prior cost reporting period.

(f)] (e) Prior to the effective date of the cost-based rates, the Department will publish as a notice in the *Pennsylvania Bulletin* the cost-based rate setting methodology, including the [cost report review,] Statewide process used to review the cost reports, outlier analysis, vacancy factor and rate assignment processes.

§ 6100.646. Cost-based rates for residential [habilitation] service.

(a) The Department will review unit costs reported on a cost report.

(b) The Department will identify a unit cost as an outlier when that unit cost is at least one standard deviation outside the average unit cost as compared to other cost reports submitted.

(c) The Department will apply a vacancy factor to residential [habilitation] service rates.

(d) A provider may request additional staffing costs above what is included in the Department-approved cost report rate for current staffing if there is a new individual entering the program who has above-average staffing needs or if an individual's needs have changed significantly as specified in the [individual's PSP] individual plan.

§ 6100.647. Allowable costs.

(a) A cost must be the best price made by a prudent buyer.

(b) A cost must relate to the administration or provision of the HCBS.

(c) A cost must be allocated and distributed to various HCBS or other lines of business among cost categories in a reasonable and fair manner and in proportion with the benefits provided to the HCBS or other lines of business among cost categories.

(d) Allowable costs must include costs specified in this chapter [and costs that are in accordance with the Department's Federally-approved waivers and waiver amendments] .

(e) To be an allowable cost, the cost must be documented and comply with the following:

(1) Applicable Federal and State statutes [,] and regulations [and policies] .

(2) Generally Accepted Government Auditing Standards and applicable Departmental procedures.

(f) A cost used to meet cost sharing or matching requirements of another Federally-funded program in either the current or a prior period adjustment is not allowable.

(g) Transactions involving allowable costs between related parties shall be disclosed on the cost report.

§ 6100.648. Bidding. [Donations.

(a) A provider may not report a donation that is restricted for a purpose other than for an allowable HCBS cost, and a donation that is unrestricted, but not used for an allowable HCBS cost.

(b) If an unrestricted donation is used for an allowable HCBS cost, the provider shall claim an expense and offsetting revenue for the donation.

(c) The provider shall report unrestricted donations used for an HCBS in accordance with the following:

(1) List the cash donation that benefits the direct or indirect expenditures on the cost report as income.

(2) Reduce gross eligible expenditures in calculating the amount eligible for Departmental participation by the amount of the donation.

(3) Fully disclose a noncash donation that exceeds $1,000, either individually or in the aggregate, including the estimated value and intended use of the donated item.

(4) If a donated item is sold, treat the proceeds from the sale as an unrestricted cash donation.]

(a) For a supply or equipment over $10,000, the provider shall obtain the supply or equipment using a process of competitive bidding or written estimates.

(b) The cost of the supply or equipment must be the best price paid by a prudent buyer.

(c) If only one bid is obtained for a purchase, the provider shall keep records justifying the cost-effectiveness of the purchase.

§ 6100.649. Management fees.

A cost included in the provider's management fees must meet the standards in § 6100.647 (relating to allowable costs).

§ 6100.650. Consultants.

(a) The cost of an independent consultant necessary for the administration or provision of an HCBS is an allowable cost.

(b) The provider shall have a written agreement with a consultant. The written agreement must include the following:

(1) The administration or provision of the HCBS to be provided.

(2) The rate of payment.

(3) The method of payment.

[(c) The provider may not include benefits as an allowable cost for a consultant.]

§ 6100.651. Governing board.

(a) Compensation for governing board member duties is not an allowable cost.

(b) Allowable costs for a governing board member include the following:

(1) Meals, lodging and transportation while participating in a board meeting or function.

(2) Liability insurance coverage for a claim against a board member that was a result of the governing board member performing official governing board duties.

(3) Training related to the delivery of an HCBS.

(c) Allowable expenses for governing board meals, lodging and transportation, paid through HCBS funding, are limited to the Commonwealth-established reimbursement limits applicable for Commonwealth employees.

(1) Nothing in this subsection restricts the amount [supplemented by the provider] a provider may supplement for expenses of the governing board.

(2) Nothing in this subsection applies Commonwealth-established policies and practices beyond the reimbursement limits for meals, lodging and transportation.

§ 6100.652. Compensation.

(a) Compensation for staff persons, including pension, health care and accrued leave benefits, is an allowable cost.

(b) A bonus or severance payment, that is [part of a separation] not part of a compensation package, is not an allowable cost.

(c) Internal Revenue Service statutes and regulations and applicable Office of Management and Budget Circulars and related applicable guidance as issued by the United States Office of Management and Budget apply regarding compensation, benefits, bonuses and severance payments.

§ 6100.653. Training.

The cost of staff person training related to the delivery of an HCBS is an allowable cost.

§ 6100.654. Staff recruitment.

The cost relating to staff recruitment is an allowable cost.

§ 6100.655. Travel.

(a) A travel cost, including meals, lodging and transportation for staff persons, is allowable.

(b) Allowable expenses for meals, lodging and transportation, paid through HCBS funding, are limited to the Commonwealth-established reimbursement limits applicable for Commonwealth employees.

(1) Nothing in this subsection restricts the amount [supplemented by the provider] a provider may supplement for staff person travel.

(2) Nothing in this subsection applies Commonwealth-established policies and practices beyond the reimbursement limits for meals, lodging and transportation.

§ 6100.656. Supplies.

The purchase of a supply is an allowable cost if the supply is used in the normal course of business and purchased in accordance with applicable Office of Management and

Budget Circulars and related applicable guidance as issued by the United States Office of Management and Budget.

§ 6100.657. Rental of administrative equipment and furnishing.

Rental of administrative equipment or furnishing is an allowable cost if the rental is more cost-efficient than purchasing.

§ 6100.658. Communication.

The following communication costs that [support] relate to the administration or provision of an HCBS are allowable costs:

(1) Telephone.

(2) Internet connectivity.

(3) Digital imaging.

(4) Postage.

(5) Stationary.

(6) Printing.

§ 6100.659. Rental of administrative space.

(a) The cost of rental of an administrative space, from a related or unrelated party for a programmatic purpose for an HCBS, is allowable, subject to the following:

(1) [A new lease with an unrelated party must contain a provision that the] The cost of rent may not exceed the rental charge for similar space in that geographical area.

(2) [The cost of rent under a lease with a related party is limited to the lessor's actual allowable costs as provided in § 6100.663 (relating to fixed assets of administrative buildings).

(3)] The rental cost under a sale-leaseback transaction, as described in Financial Accounting Standards Board Accounting Standards Codification Section 840-40, as amended, is allowable up to the amount that would have been allowed had the provider continued to own the property.

(b) The allowable cost amount may include an expense for the following:

(1) Maintenance.

(2) Real estate taxes as limited by § 6100.660 (relating to occupancy expenses for administrative buildings).

(c) The provider shall only include expenses related to the [minimum amount of] space [necessary] for the provision of the HCBS.

(d) A rental cost under a lease which is required to be treated as a capital lease under the Financial Accounting Standards Board Accounting Standards Codification Section 840-10-25-1, as amended, is allowable up to the amount that would have been allowed had the provider purchased the property on the date the lease agreement was executed.

(e) An unallowable cost includes the following:

(1) Profit.

(2) Management fee.

(3) A tax not incurred had the provider purchased the space.

§ 6100.660. Occupancy expenses for administrative buildings.

(a) The following costs are allowable costs for administrative buildings:

(1) The cost of a required occupancy-related tax and payment made instead of a tax.

(2) An associated occupancy cost charged to a specified service location. The associated occupancy cost shall be prorated in direct relation to the amount of space utilized by the service location.

(3) The cost of an occupancy-related tax or payment made instead of a tax, if it is stipulated in a lease agreement.

(4) The cost of a certificate of occupancy.

(5) Maintenance costs.

(b) [The provider shall keep documentation that a utility charge is at fair market value.

(c)] The cost of real estate taxes, net of available rebates and discounts, whether the rebate or discount is taken, is an allowable cost.

[(d)] (c) The cost of a penalty resulting from a delinquent tax payment, including a legal fee, is not an allowable cost.

§ 6100.661. [Fixed] Administrative fixed assets.

(a) A fixed asset cost used for administrative purposes is an allowable cost.

(b) The provider shall determine whether an allowable fixed asset shall be capitalized, depreciated or expensed in accordance with the following conditions:

(1) The maximum allowable fixed asset threshold as defined in applicable Office of Management and Budget Circulars and related applicable guidance as issued by the United States Office of Management and Budget.

(2) Purchases below the maximum allowable fixed asset threshold shall be expensed.

(c) The provider shall select the method used to determine the amount of depreciation charged in that year for the year of acquisition.

(d) The provider shall include depreciation based on the number of months or quarters the asset is in service or a half-year or full-year of depreciation expense.

(e) The provider may not change the method or procedure, including the estimated useful life and the convention used for an acquisition, for computing depreciation without prior written approval from the Department.

(f) The provider acquiring a new asset shall have the asset capitalized and depreciated in accordance with the Generally Accepted Government Auditing Standards. The provider shall continue using the depreciation method previously utilized by the provider for assets purchased prior to July 1, 2011.

(g) The provider shall keep the following:

(1) The title to any fixed assets that are depreciated.

(2) The title to any fixed assets that are expensed or loans amortized using Department funding.

(h) The provider shall [use income received when disposing of fixed assets to reduce gross eligible expenditures in determining the amount eligible for Departmental participation as determined by the cost report] apply the revenue amount received through the disposal of a fixed asset to any eligible or ineligible expenditure. This revenue amount is not reportable on the cost report.

(i) A provider in possession of a fixed asset shall do the following:

(1) Maintain a fixed asset ledger or equivalent document.

(2) Utilize reimbursement for loss, destruction or damage of a fixed asset by using the proceeds towards eligible [waiver program] HCBS expenditures.

(3) Perform an annual physical inventory [at the end of the funding period or Commonwealth fiscal year] . An annual physical inventory is performed by conducting a physical verification of the inventory listings.

(4) Document discrepancies between physical inventories or fixed asset ledgers.

(5) Maintain inventory reports and other documents in accordance with this chapter.

(6) Offset the provider's total depreciation expense in the period in which the asset was sold or retired from service by the gains on the sale of assets.

(j) The cost basis for depreciable assets must be determined and computed as follows:

(1) The purchase price if the sale was between unrelated parties.

(2) The seller's net book value at the date of transfer for assets transferred between related parties.

(3) The cost basis for assets of an agency acquired through stock purchase will remain unchanged from the cost basis of the previous owner.

(k) Participation allowance is permitted up to 2% of the original acquisition cost for fully depreciated fixed assets.

(1) Participation allowances shall only be taken for as long as the asset is in use.

(2) Participation amounts shall be used for maintaining assets, reinvestment in the program or restoring the program due to an unforeseen circumstance.

(3) Depreciation and participation allowance may not be expensed at the same time for the same asset.

§ 6100.662. Motor vehicles.

The cost of the purchase or lease of motor vehicles and the operating costs of the vehicles is an allowable cost in accordance with the following:

(1) The cost of motor vehicles through depreciation, expensing or amortization of loans for the purchase of a vehicle is an allowable expense. Depreciation and lease payments are limited in accordance with the annual limits established under section 280F of the Internal Revenue Code (26 U.S.C.A. § 280F).

(2) The provider shall keep a daily log detailing the use, maintenance and services activities of vehicles.

(3) The provider shall analyze the cost differences between leasing and purchase of vehicles and the most practicable economic alternative shall be selected.

(4) The provider shall keep documentation of the cost analysis.

(5) The personal use of the provider's motor vehicles is prohibited unless a procedure for payback is established and the staff person reimburses the program for the personal use of the motor vehicle.

§ 6100.663. [Fixed assets of administrative] Administrative buildings.

(a) An administrative building acquired prior to June 30, 2009, that is in use and for which the provider has an outstanding original loan with a term of 15 years or more is an allowable cost for the provider to continue to claim principal and interest payments for the administrative or nonresidential building over the term of the loan.

(b) The provider shall ensure a down payment made as part of the asset purchase shall be considered part of the cost of the administrative building or capital improvement and depreciated over the useful life of the administrative building or capital improvement.

(c) The provider shall receive prior written approval from the Department for a planned major renovation of an administrative building with a cost above 25% of the [original cost] current value of the administrative building being renovated.

(d) The provider shall use the depreciation methodology in accordance with § 6100.661 (relating to administrative fixed assets).

(e) The provider may not claim a depreciation allowance on an administrative building that is donated.

[(f) If an administrative building is sold or the provider no longer utilizes the administrative building for an HCBS, the Department shall recoup the funded equity either directly or through rate setting. As used in this subsection, “funded equity” is the value of property over the liability on the property.

(1) The provider shall be responsible for calculating the amounts reimbursed and the amounts shall be verified by an independent auditor.

(2) As an alternative to recoupment, with Department approval, the provider may reinvest the reimbursement amounts from the sale of the administrative or nonresidential building into any capital asset used in the program.

(g) The title of any administrative building acquired and depreciated shall remain with the enrolled provider.]

§ 6100.664. Residential [habilitation] vacancy.

(a) The Department will establish a vacancy factor for residential [habilitation] service that is included in the cost-based rate setting methodology.

(b) The vacancy factor for residential [habilitation] service shall be calculated based on all the provider's residential [habilitation] service locations.

[(c) The provider may not limit the individual's leave days.

(d) The grounds for a change in a provider or a transfer of an individual against the individual's wishes under § 6100.303 (relating to reasons for a transfer or a change in a provider) do not apply to a transfer under subsection (e).

(e) The provider may not transfer an individual due to the individual's absence until after the provider has received written approval from the Department.]

§ 6100.665. Indirect costs.

(a) An indirect cost is an allowable cost if the following criteria are met:

(1) The provider shall have a cost allocation plan.

(2) Costs are authorized in accordance with applicable Office of Management and Budget Circulars and related applicable guidance as issued by the United States Office of Management and Budget and § 6100.647 (relating to allowable costs).

(b) The provider shall consider the reason the cost is an indirect cost, as opposed to a direct cost, to determine the appropriate cost allocation based on the benefit to the HCBS.

(c) If a cost is identified as an indirect cost, the cost will remain an indirect cost as long as circumstances remain unchanged.

(d) The provider shall select an allocation method to assign an indirect cost in accordance with the following:

(1) The method is best suited for assigning a cost with a benefit derived.

(2) The method has a traceable cause and effect relationship.

(3) The cost cannot be directly attributed to an HCBS.

[(e) The provider shall allocate a general expense in a cost group that is more general in nature to produce a result that is equitable to both the Department and the provider.]

§ 6100.666. Moving expenses.

(a) The actual cost associated with the relocation of a [waiver support] service location is allowable.

(b) Moving expenses for an individual [is] are allowable [if the provider receives approval from the Department or the designated managing entity prior to the move] .

§ 6100.667. Interest expense.

(a) Short-term borrowing is a debt incurred by a provider that is due within 1 year.

(b) Interest cost of short-term borrowing from an unrelated party to meet actual cash flow requirements for the administration or provision of an HCBS is an allowable cost.

§ 6100.668. Insurance.

The cost for an insurance premium is allowable if it is limited to the minimum amount needed to cover the loss or provide for replacement value, including the following:

(1) General liability.

(2) Casualty.

(3) Property.

(4) Theft.

(5) Burglary insurance.

(6) Fidelity bonds.

(7) Rental insurance.

(8) Flood insurance, if required.

(9) Errors and omissions.

§ 6100.669. Other allowable costs.

(a) The following costs are allowable if they are related to the administration of HCBS:

(1) Legal fees with the exception of those listed in subsection (b).

(2) Accounting fees, including audit fees.

(3) Information technology costs.

(4) Professional membership dues for the provider, excluding dues or contributions paid to lobbying groups.

(5) Self-advocacy or advocacy organization dues for an individual, excluding dues or contributions paid to lobbying groups. This does not include dues paid to an organization that has as its members, or is affiliated with an organization that represents, individuals or entities that are not self-advocates or advocates.

(6) Auxiliary aids and services, including interpreters, that are not otherwise covered as an HCBS.

(b) Legal fees for prosecution of claims against the Commonwealth and expenses incurred for claims against the Commonwealth are not allowable unless the provider prevails at the hearing.

§ 6100.670. Start-up cost.

[(a)] A start-up cost shall be utilized only for a one-time activity related to one of the following:

(1) Opening a new location.

(2) Introducing a new product or [support] service.

(3) Conducting business in a new geographic area.

(4) Initiating a new process.

(5) Starting a new operation.

[(b) Within the approved waiver appropriation, a start-up cost may be approved and authorized by the Department in accordance with the Department's Federally-approved waivers and waiver amendments.

(c) A start-up cost shall be authorized in accordance with Standard Operating Procedure 98-5 issued by the American Institute of Certified Public Accountants (SOP 98-5), as amended.]

§ 6100.671. Reporting of start-up cost.

(a) A start-up cost that has been reimbursed by the Department shall be reported as income.

(b) A start-up cost within the scope of Standard Operating Procedure 98-5 shall be expensed as the costs are incurred, rather than capitalized.

§ 6100.672. Cap on start-up cost.

(a) A cap on start-up cost will be established annually by the Department.

(b) A [request for a] waiver in accordance with § 6100.43 (relating to regulatory waiver) may be requested if the waiver conditions in § 6100.43 and one of the following conditions are met:

(1) The start-up cost provides greater independence and access to the community for an individual.

(2) The start-up cost is necessary to meet life safety code standards.

(3) The cost of the start-up activity is more cost effective than an alternative approach.

ROOM AND BOARD

§ 6100.681. Room and board applicability.

Sections 6100.682—6100.694 apply for the room and board rate charged to the individual [for residential habilitation] in provider owned or leased residential service locations and in life sharing homes that are not owned or leased by the individual.

§ 6100.682. [Support] Assistance to the individual.

(a) If an individual is not currently receiving SSI benefits, the provider shall provide [support] assistance to the individual to contact the appropriate county assistance office.

(b) If an individual is denied SSI benefits, the provider shall assist the individual in filing an appeal [, if desired by the individual] .

(c) The provider shall assist the individual to secure information regarding the continued eligibility of SSI for the individual.

(d) The provider shall keep documentation of the individual's application for SSI benefits, the SSI eligibility determination and, if applicable, the appeal filed pursuant to subsection (b).

§ 6100.683. No delegation permitted.

The provider shall collect the room and board from the individual or the person designated by the individual directly and the provider may not delegate that responsibility.

§ 6100.684. Actual provider room and board cost.

(a) The total amount charged for the individual's share of room and board may not exceed the actual documented [value of] room and board [provided to the individual] costs at the individual's residential service location, minus the benefits received as specified in § 6100.685 (relating to benefits).

(b) The provider shall compute and document actual provider room and board costs each time an individual signs a new room and board residency agreement.

(c) The provider shall keep documentation of actual provider room and board costs.

(d) The following items are included as room and board costs:

(i) Standard toiletries, towels and bedding.

(ii) One telephone with local telephone service.

(iii) Internet service.

(iv) Cleaning products.

(v) Household furniture.

(vi) Food choices of the individual, with consideration of the food cost and nutrition, including the individual's preference, culture, religion and beliefs, and an individual's prescribed diet, if the prescribed diet is not covered by the individual's health care plan or another funding source.

(vii) Laundry of towels, bedding and the individual's clothing.

(viii) Lawn care, food preparation, maintenance and housekeeping, including staff wages and benefits, to perform these tasks.

(ix) Meals provided away from the residential service location that are arranged by a staff person in lieu of meals provided in the residential service location.

(x) Incontinence products, if the incontinence product is not covered by the individual's health care plan or another funding source.

(xi) Building and equipment repair, renovation and depreciation.

(xii) Rent, taxes, utilities and property insurance.

§ 6100.685. Benefits.

(a) The provider shall assist an individual in applying for energy assistance, rent rebates, food [stamps] and nutrition assistance and similar benefits.

(b) If energy assistance, rent rebates, food [stamps] and nutrition assistance or similar benefits are received, the provider shall deduct the value of these benefits from the documented actual provider room and board cost as specified in § 6100.684 (relating to actual provider room and board cost) before deductions are made to the individual's share of room and board costs.

(c) An individual's energy assistance, rent rebates, food [stamps] and nutrition assistance or similar benefits may not be considered as part of an individual's income [or resources] .

(d) The provider may not use the value of energy assistance, rent rebates, food [stamps] and nutrition assistance or similar benefits to increase the individual's share of room and board costs beyond actual room and board costs as specified in § 6100.684.

§ 6100.686. Room and board rate.

(a) If the actual provider room and board cost as specified in § 6100.684 (relating to actual provider room and board cost), less any benefits as specified in § 6100.685 (relating to benefits), is more than 72% of the SSI maximum rate plus the Pennsylvania supplement, the following criteria shall be used to establish the room and board rate:

(1) An individual's share of room and board may not exceed 72% of the SSI maximum rate plus the Pennsylvania supplement.

(2) The proration of board costs shall occur after an individual is on leave from the residence for a consecutive period of 8 days or more. This proration may occur monthly, quarterly or semiannually as long as there is a record of the board costs that were returned to the individual.

(b) If an individual has earned wages, personal income from inheritance, Social Security or other types of income, the provider may not assess the room and board cost for the individual in excess of 72% of the SSI maximum rate plus the Pennsylvania supplement.

(c) If available income for an individual is less than the SSI maximum rate, the provider shall charge 72% of the individual's available monthly income as the individual's monthly obligation for room and board.

(d) An individual shall receive at least the monthly amount as established by the [Commonwealth and the] Social Security Administration related to the specific type of residential service location, for the individual's personal needs allowance.

§ 6100.687. [Documentation.

If the actual provider room and board cost charged to an individual as specified in § 6100.684 (relating to actual provider room and board cost) is less than 72% of the SSI maximum rate, the provider shall keep the following documentation:

(1) The actual value of the room and board is less than 72% of the current maximum monthly benefit.

(2) The Social Security Administration's initial denial of the individual's initial application for SSI benefits and the upholding of the initial denial through at least one level of appeal.

§ 6100.688.] Completing and signing the room and board residency agreement.

(a) The provider shall ensure that a room and board residency agreement, on a form specified by the Department, is completed and signed by the individual annually.

(b) If an individual is adjudicated incompetent to handle finances, the individual's court-appointed legal guardian shall sign the room and board residency agreement.

(c) If an individual is 18 years of age or older and has a designated person for the individual's benefits, the designated person [and the individual] shall sign the room and board residency agreement.

(d) The room and board residency agreement shall be completed and signed in accordance with one of the following:

(1) Prior to an individual's admission to residential [habilitation] <u>service</u>.

(2) Prior to an individual's transfer from one residential [habilitation] service location or provider to another residential [habilitation] service location or provider.

(3) Within 15 days after an emergency residential [habilitation] service placement.

[§ 6100.689.] § 6100.688. Modifications to the room and board residency agreement.

(a) If an individual pays rent directly to a landlord, and food is supplied through a provider, the room provisions shall be deleted from the room and board residency agreement and the following shall apply:

(1) The individual shall pay 32% of the SSI maximum rate plus the Pennsylvania supplement for board.

(2) If an individual's income is less than the SSI maximum rate plus the Pennsylvania supplement, 32% of the available income shall be charged to fulfill the individual's monthly obligations for board.

(b) If an individual pays rent to a provider, but the individual purchases the individual's own food, the board provisions shall be deleted from the room and board residency agreement and the following shall apply:

(1) The individual shall pay 40% of the SSI maximum rate plus the Pennsylvania supplement for room.

(2) If an individual's income is less than the SSI maximum rate plus the Pennsylvania supplement, 40% of the available income shall be charged to fulfill the individual's monthly obligations for room.

[§ 6100.690.] § 6100.689. Copy of room and board residency agreement.

(a) A copy of the completed and signed room and board residency agreement shall be given to the individual, the individual's designated person and the individual's court-appointed legal guardian, if applicable.

(b) A copy of the completed and signed room and board residency agreement shall be kept in the individual's record.

[§ 6100.691.] § 6100.690. Respite care.

There may not be a charge for room and board to the individual for respite care. [if respite care is provided for 30 days or less in a Commonwealth fiscal year.]

[§ 6100.692.] § 6100.691. Hospitalization.

There may not be a charge for room and board to the individual after 30 consecutive days of being in a hospital or rehabilitation facility and the individual is [placed] considered in reserved capacity.

[§ 6100.693.] § 6100.692. Exception.

There may not be a charge for board to the individual if the individual does not take food by mouth.

[§ 6100.694.] § 6100.693. Delay in an individual's income.

If a portion or all of the individual's income is delayed for 1 month or longer, the following apply:

(1) The provider shall inform the individual, the individual's designated person or the individual's court-appointed legal guardian in writing that payment is not required or that only a [small] negotiated amount of room and board [payment s] payment is required until the individual's income is received.

(2) Room and board shall be charged to make up the accumulated difference between room and board paid and room and board charged according to the room and board residency agreement.

§ 6100.694. Managing individual finances.

The provider may not charge a fee for managing an individual's finances or for serving as an individual's designated financial representative.

DEPARTMENT-ESTABLISHED FEE FOR INELIGIBLE PORTION OF RESIDENTIAL SERVICE

§ 6100.711. Fee for the ineligible portion of residential [habilitation] service.

(a) The Department will establish a fee for the ineligible portion of payment for residential [habilitation] services.

(b) [The Department-established fee will be established using a market-based approach based on current data and independent data sources.] The fee in subsection (a) will be based on the factors in subsection (c) using a market-based approach so that payments are consistent with efficiency, economy and quality of care and sufficient to enlist

enough providers so that services are available to at least the extent that such services are available to the general population in the geographic area.

(c) [The Department will refresh the market-based data used in subsection (a) to establish Department-established fees at least every 3 years.

(d) The market-based approach specified in subsection (c) will review and consider] In establishing the fee in subsection (a) the Department will examine and use data relating to the following factors:

(1) [The support needs of the individuals.

(2) Staff wages.

(3) Staff-related expenses.

(4) Productivity.

(5)] Occupancy. Occupancy is the cost related to occupying a space, including rent, taxes, insurance, depreciation and amortization expenses.

[(6)] (2) Meals for staff persons.

(3) Custodial and maintenance expenses.

[(7)] (4) Geographic costs based on the location where the service is delivered.

[(8) A review of approved HCBS definitions and determinations made about cost components that reflect costs necessary and related to the delivery of each HCBS.

(9) A review of the cost of implementing Federal, State and local statutes, regulations and ordinances.

(10)] (5) Other [criteria] factors that impact costs.

(d) The Department will update the data used in subsection (c) at least every 3 years.

(e) The Department will publish [as a notice in the *Pennsylvania Bulletin* the factors in subsection (d) used to establish the rates and the fee schedule rates for public review and comment.] a description of its fee setting methodology used in subsection (b) as a notice in the *Pennsylvania Bulletin* for public review and comment. The description will include a discussion of the use of the factors in subsection (c) to establish the fee; a discussion of the data and data sources used; and the fee.

(f) [The Department will pay for Department-established fee supports at the fees determined by the Department.] The Department will make available to the public a

summary of the public comments received in response to the notice in subsection (e) and the Department's response to the public comments.

ENFORCEMENT

§ 6100.741. Sanctions.

(a) The Department has the authority to enforce compliance with this chapter through an array of sanctions.

(b) A sanction may be implemented by the Department for the following:

(1) [One or more regulatory violations of] Failure to comply with this chapter.

(2) Failure to submit an acceptable corrective action plan in accordance with the time frame specified by the Department and as specified in § 6100.42(e) (relating to monitoring compliance).

(3) Failure to implement a corrective action plan or a directed corrective action plan, including the compliance steps and the timelines in the plan.

(4) Fraud, deceit or falsification of documents or information related to this chapter.

(5) Failure to provide [free and full access to the Department, the designated managing entity, or other authorized Federal or State officials] the Department, the designated managing entity and other authorized Federal and State officials, free and full access to the provider's policies and records and the individuals receiving services in accordance with this chapter.

(6) Failure to provide documents or other information in a timely manner upon the request of the Department, the designated managing entity [,] or an authorized Federal or State agency.

§ 6100.742. Array of sanctions.

The Department may implement the following sanctions:

(1) Recouping, suspending or disallowing payment.

(2) Terminating a provider agreement for participation in an HCBS waiver program.

(3) Prohibiting the delivery of [supports] services to a new individual.

(4) Prohibiting the provision of specified [supports] services at a specified service location.

(5) Prohibiting the enrollment of a new [support] service location.

(6) Ordering the appointment of a master as approved by the Department, at the provider's expense and not eligible for reimbursement from the Department, to manage and direct the provider's operational, program and fiscal functions.

(7) Removing an individual from a [premise] service location.

§ 6100.743. Consideration as to type of sanction utilized.

(a) The Department [has full discretion to determine and implement the type of sanction it deems appropriate in each circumstance] may impose one or more of the sanctions in § 6100.742 (relating to array of sanctions), based on the Department's review of the facts and circumstances specified in § 6100.741(b) (relating to sanctions).

(b) The Department has the authority to implement a single sanction or a combination of sanctions.

(c) The Department [may] will consider the following [variables] factors when determining and implementing a sanction or combination of sanctions:

(1) The seriousness of the condition specified in § 6100.741(b).

(2) The continued nature of the condition specified in § 6100.741(b).

(3) The repeated nature of the condition specified in § 6100.741(b).

(4) A combination of the conditions specified in § 6100.741(b).

(5) The history of provisional licenses issued by the Department.

(6) The provider's history of compliance with this chapter, Departmental regulations such as licensure regulations and applicable regulations of other State and Federal agencies.

§ 6100.744. Additional conditions and sanctions.

In addition to sanctions and sanction conditions specified in this chapter, the provider is subject to the following:

(1) Sections 1101.74, 1101.75, 1101.76 and 1101.77.

(2) Other [Departmental] sanctions as provided by applicable [law] statutes and regulations.

§ 6100.801. [Adult autism waiver.

(a) The adult autism waiver is an HCBS Federal waiver program under section 1915(c) of the Social Security Act (42 U.S.C.A. § 1396n(c)) designed to provide community-based supports to meet the specific needs of adults with autism spectrum disorders.

(b) The following requirements of this chapter do not apply to the adult autism waiver program:

(1) Section 6100.441 (relating to request for and approval of changes) does not apply to the adult autism waiver program.

(2) Section 6100.481(d) (relating to Departmental rates and classifications).

(3) Section 6100.571(c)(5) (relating to fee schedule rates).

(4) Sections 6100.641—6100.672 (relating to cost-based rates and allowable costs).

(5) Section 6100.711(d)(7) (relating to fee for the ineligible portion of residential habilitation).]

[§ 6100.802.] Agency with choice.

(a) Agency with choice (AWC) is a type of [individual-directed] self-directed, financial management service in which the agency is the common law employer and the individual or [his] the individual's representative is the managing employer.

(b) The requirements in this chapter do not apply to an AWC, with the exception of the following provisions:

(1) General provisions as specified in §§ 6100.1—6100.3 (relating to general provisions).

(2) General requirements as specified in §§ 6100.41—6100.44 (relating to general requirements) and 6100.46— [6100.55] 6100.56.

(3) Training as specified in §§ 6100.141— [6100.144] 6100.143 (relating to training) [.], except for the following that do not apply:

(i) The number of annual training hours in § 6100.143 (relating to annual training).

(ii) The training course in § 6100.143(c)(5).

(iii) The requirements for training in §§ 6100.141—6100.143 for staff persons who work fewer than 30 days in a 12-month period.

(4) Individual rights as specified in §§ 6100.181—6100.186.

(5) [PSP] Individual plan as specified in §§ 6100.221—[6100.224] 6100.227.

(6) [Positive interventions] Restrictive procedures as specified in §§ 6100.341—[6100.345] 6100.350.

(7) Incident management as specified in §§ 6100.401—[6100.405] 6100.404 .

(c) The AWC shall ensure that the managing employer complies with the requirements of the managing employer agreement.

(d) The AWC shall fulfill unmet responsibilities of the managing employer.

(e) The AWC shall identify and implement corrective action for managing employer performance in accordance with the managing employer agreement.

(f) The AWC shall develop and implement procedures to ensure that the managing employer reports incidents in accordance with this chapter.

(g) The AWC shall process and provide vendor goods and services authorized by the Department or the designated managing entity covered by the monthly per individual administrative fee.

(h) The AWC shall distribute a customer satisfaction survey to individuals who receive the financial management services, collect and analyze survey responses [,] and act to improve services.

(i) If an AWC intends to close, a written notice shall be provided to the Department at least 60 days prior to the planned closure date. The written notice must include the following:

(1) The effective date of closure.

(2) A transition plan for each individual that affords choice.

(j) If an AWC intends to close, the provider shall complete the following duties:

(1) Provide suggested time frames for transitioning the individual to a new provider.

(2) Continue to provide financial management services to individuals in accordance with this chapter and the managing employer agreement until the date of the closure or until the Department directs otherwise.

(3) Notify each individual in writing of the closure.

(4) Prepare individual records for transfer to the selected provider within 14 days of the selected provider's accepting the transfer.

(5) Maintain data and records in accordance with this chapter until the date of the transfer.

§ 6100.802. [§ 6100.803.] Support coordination, targeted support management and [base-funded] base-funding support coordination.

(a) Support coordination is an HCBS Federal waiver program under section 1915(c) of the Social Security Act (42 U.S.C.A. § 1396n(c)) designed to provide community-based service and support to locate, coordinate and monitor needed HCBS and other support for individuals.

(b) Targeted support management (TSM) is a service under the State plan that is designed to provide community-based support to locate, coordinate and monitor needed service and support for an individual. TSM is not an HCBS.

(c) [Base-funded] Base-funding support coordination is a program designed to provide community-based service and support to locate, coordinate and monitor needed support for individuals who receive [support] a service through base-funding.

(d) The following requirements of this chapter do not apply to support coordination, TSM or [base-funded] base-funding support coordination.

(1) Section 6100.81(b)(4) (relating to HCBS provider requirements).

(2) [Section 6100.226(d)(6) (relating to documentation of support delivery)] Section 6100.227 (relating to progress notes).

(3) Section 6100.441 (relating to request for and approval of changes).

(4) Sections 6100.461— [6100.470] 6100.469.

(5) Sections 6100.641—6100.672, 6100.681—6100.694 and 6100.711 [(relating to cost-based rates and allowable costs; room and board; and fee for the ineligible portion of residential habilitation)].

(6) Section 6100.806 (relating to vendor goods and services).

(e) In addition to this chapter, the following requirements apply for support coordination, TSM and [base-funded] base-funding support coordination.

(1) In addition to the training and orientation required under §§ [6100.141] 6100.142—6100.143 (relating to [annual training plan;] orientation; [program;] and annual training),

a support coordinator, base-funding support coordinator, targeted support manager [,] and support coordinator supervisor [and targeted support manager supervisor] shall complete the following training within the first year of employment:

(i) Facilitation of person-centered planning.

(ii) Conflict resolution.

(iii) Human development over the lifespan.

(iv) Family dynamics.

(v) Cultural diversity.

(2) A support coordinator, base-funding support coordinator, targeted support manager [,] and support coordinator supervisor [and targeted support manager supervisor] shall report incidents, alleged incidents and suspected incidents as specified in §§ 6100.401—6100.403 (relating to types of incidents and timelines for reporting; incident investigation; and individual needs), [that the coordinator, manager or supervisor observes directly] unless the incident was reported and documented by another source.

[(3) If an individual is authorized for residential habilitation, the support coordinator or targeted support manager shall review and document if the individual continues to need the authorized level of residential habilitation every 6 months.

(4) If an individual is authorized for residential habilitation and a request for enhanced staffing is received, the support coordinator or targeted support manager shall review and document the following:

(i) The individual's need, and any change in need, including how the change affects the individual's health, safety and well-being.

(ii) Assessments used to support the need for enhanced staffing.

(iii) The specific enhanced staffing that will be provided to address the individual's needs.

(iv) The plan to reduce the enhanced staffing based on specific outcomes of the individual.

(v) The time frame and the staff person responsible for monitoring progress on the plan to reduce enhanced staffing.

(vi) The results of meetings held to re-evaluate the need for continued enhanced staffing.

(5)] (3) If a support coordination or TSM provider intends to close, a written notice shall be provided to the Department at least 90 days prior to the planned closure date. The written notice must include the following:

(i) The effective date of closure.

(ii) The intent to terminate the Medical Assistance provider agreement and the Medical Assistance waiver provider agreement.

(iii) A transition plan for each individual that affords individual choice.

(iv) A transition plan to transfer the provider's functions.

[(6)] (4) If a support coordination or TSM provider intends to close, the provider shall complete the following duties:

(i) Continue to provide support coordination, TSM or [base-funded] base-funding support coordination to individuals in accordance with this chapter until the date of the transfer or until the Department directs otherwise.

(ii) Transfer an individual to the selected provider only after the Department or the designated managing entity approves the individual's transition plan.

(iii) Prepare individual records for transfer to the selected provider within 14 days of the selected provider's accepting the transfer.

(iv) Maintain data and records in accordance with this chapter until the date of the transfer.

§ 6100.803. [§ 6100.804.] Organized health care delivery system.

(a) OHCDS is an organized health care delivery system. An OHCDS is an arrangement in which a provider that renders an HCBS chooses to offer a different vendor of an HCBS through a subcontract to facilitate the delivery of vendor goods or services to an individual.

(b) The following requirements of this chapter do not apply to an OHCDS:

(1) Sections 6100.47—6100.49 (relating to criminal history checks; funding, hiring, retention and utilization; and child abuse history certification) for public transportation and indirect services and supplies.

(2) Training as specified in §§ 6100.141—6100.143.

(3) Section 6100.405 (relating to incident analysis).

(4) Medication administration as specified in §§ 6100.461—6100.469.

(5) Section 6100.571 (relating to fee schedule rates).

[(2)] (6) Sections 6100.641—6100.672, 6100.681—6100.694 and 6100.711 [(relating to cost-based rates and allowable costs; room and board; and fee for the ineligible portion of residential habilitation)].

[(3)] (7) Section 6100.806 (relating to vendor goods and services).

(c) In addition to this chapter, the following requirements apply [for] to OHCDS.

(1) [The] An OHCDS shall:

(i) Be an enrolled Medical Assistance waiver provider.

(ii) Be enrolled in the [MMIS] Medicaid management information system.

(iii) Provide at least one Medical Assistance service.

(iv) Agree to provide the identified vendor goods or services to individuals.

(v) Bill the [MMIS] Medicaid management information system for the amount of the vendor goods or services.

(vi) Pay the vendor that provided the vendor goods or services the amount billed for in the [MMIS] Medicaid management information system.

(2) An OHCDS may bill a separate administrative fee [under] in accordance with the following:

(i) The administrative fee may not exceed the limit set by Federal requirements.

(ii) The administrative activities must be required to deliver the vendor good or HCBS to an individual and must be documented to [support] justify the separate administrative fee.

(3) [The] An OHCDS shall ensure that each vendor with which it contracts meets the applicable provisions of this chapter [and in accordance with the requirements specified in the Department's Federally-approved waivers and waiver amendments, and the State plan, as applicable] .

(4) Only vendor goods and services may be subcontracted through the OHCDS. A provider [who] that subcontracts shall have written agreements specifying the duties, responsibilities and compensation of the subcontractor.

(5) An OHCDS shall provide the Department with an attestation that the cost of the good or service is the same as or less than the cost charged to the general public.

[(d) As used in this section:

(1) OHCDS is an organized health care delivery system.

(2) MMIS is the Department's Medicaid management information statistics.]

§ 6100.804. [§ 6100.805.] [Base-funded support] Base-funding.

(a) A base-funding only [support] service is a State-only funded [, county program support] service provided through the county program to either an individual who is not eligible for an HCBS or for a support that is not eligible as an HCBS.

(b) The requirements in this chapter do not apply to base-funding only [supports] services, with the exception of the following provisions that do apply.

(1) General provisions as specified in §§ 6100.1—6100.3 (relating to general provisions).

(2) General requirements as specified in §§ 6100.41— [6100.55] 6100.56.

(3) Training as specified in §§ 6100.141— [6100.144] 6100.143 (relating to training).

(4) Individual rights as specified in §§ 6100.181—6100.186.

(5) [PSP] Individual plan as specified in §§ 6100.221— [6100.225] 6100.227.

(6) Transition as specified in §§ 6100.301—6100.307.

(7) [Positive interventions] Restrictive procedures as specified in §§ 6100.341—[6100.345] 6100.350.

[(7)] (8) Incident management as specified in §§ 6100.401—6100.405.

[(8) Medication s] (9) Medication administration as specified in §§ 6100.461—[6100.470] 6100.469.

[(9)] (10) Room and board as specified in §§ 6100.681—6100.694.

§ 6100.805. [§ 6100.806.] Vendor goods and services.

(a) A vendor is a directly-enrolled provider that sells goods or services to the general public, as well as to an HCBS program.

(b) The requirements in this chapter do not apply to vendor goods and services, with the exception of the following provisions that do apply.

(1) General provisions as specified in §§ 6100.1—6100.3 (relating to general provisions).

(2) General requirements as specified in §§ 6100.41—6100.44, 6100.46 (relating to protective services), 6100.47—6100.49 (relating to criminal history checks; funding, hiring, retention and utilization; and child abuse history certification) for services other than public transportation and indirect goods and services, 6100.51 (relating to complaints by an individual) and 6100.53— [6100.55] 6100.56.

(3) Enrollment as specified in §§ 6100.81—[6100.86] 6100.85.

(4) [PSP as specified in § 6100.226 (relating to documentation of support delivery).

(5) Training as specified in §§ 6100.141—6100.144 (relating to training).

(6)] Individual rights as specified in §§ 6100.181—6100.186for respite camps serving 25% or more people with disabilities.

[(7) PSP] (5) Individual plan as specified in §§ 6100.221—6100.226. [for respite] Respite camps serving [25% or more] fewer than 25% of people with disabilities are

exempt from §§ 6100.221— [6100.226] 6100.225 and 6100.227 (relating to progress notes).

[(8) Positive interventions] (6) Restrictive procedures as specified in §§ 6100.341—[6100.345] 6100.350 for respite camps serving 25% or more people with disabilities.

[(9)] (7) Incident management as specified in §§ 6100.401— [6100.405] 6100.404 (relating to incident management) for respite camps serving 25% or more people with disabilities.

[(10) Medications administration as specified in §§ 6100.461—6100.470 (relating to medication administration) for respite camps serving 25% or more people with disabilities.

(11)] (8) General payment provisions as specified in §§ 6100.481— [6100.487] 6100.485.

[(12)] (9) Enforcement as specified in §§ 6100.741—6100.744.

(c) Payment for vendor goods and services will only be made after a good or service is delivered.

(d) The vendor may charge an administrative fee either as a separate invoice or as part of the total general invoice.

(e) The administrative fee specified in subsection (d) may not exceed the limit set by Federal requirements.

(f) A vendor shall charge the same fee for an HCBS as the vendor charges to the general public for the same good or service.

(g) A vendor shall document the fee for the good or service charged to the general public and to the HCBS.

(h) A vendor shall ensure that a subcontractor, as applicable, provides the vendor good or service in accordance with this chapter [, the Department's Federally-approved waiver and waiver amendments, and the State plan, as applicable].

CHAPTER 6200. [ROOM AND BOARD CHARGES] (Reserved)

§§ 6200.1—6200.3. (Reserved).
§ 6200.3a. (Reserved).
§§ 6200.11—6200.20. (Reserved).
§§ 6200.31—6200.35. (Reserved).

Subpart E. RESIDENTIAL AGENCIES/FACILITIES/SERVICES

ARTICLE I. LICENSING/APPROVAL

CHAPTER 6400. COMMUNITY HOMES FOR INDIVIDUALS WITH AN INTELLECTUAL DISABILITY OR AUTISM

GENERAL PROVISIONS

§ 6400.1. Introduction.

This chapter is based on the principle of integration and the right of the individual with an intellectual disability or autism to live a life which is as close as possible in all aspects to the life which any member of the community might choose. For the individual with an intellectual disability or autism who requires a residential service, the design of the service shall be made with the individual's unique needs in mind so that the service will facilitate the [person's] individual's ongoing growth and development.

§ 6400.2. Purpose.

The purpose of this chapter is to protect the health, safety and well-being of individuals with an intellectual disability or autism, through the formulation, implementation and enforcement of minimum requirements for the operation of community homes for individuals with an intellectual disability or autism.

§ 6400.3. Applicability.

(a) This chapter applies to community homes for people with an intellectual disability or autism, except as provided in subsection (f).

(b) This chapter contains the minimum requirements that shall be met to obtain a certificate of compliance. A certificate of compliance shall be obtained prior to operation of a community home for individuals with an intellectual disability or autism.

(c) This chapter applies to profit, nonprofit, publicly funded and privately funded homes.

(d) Each home serving nine or more individuals shall be inspected by the Department each year and shall have an individual certificate of compliance specific for each building.

(e) Each agency operating one or more homes serving eight or fewer individuals shall have at least a sample of its homes inspected by the Department each year. The certificate of compliance issued to an agency shall specify the location and maximum capacity of each home the agency is permitted to operate.

(f) This chapter does not apply to the following:

(1) Private homes of persons providing care to a relative with an intellectual disability or autism.

(2) Residential facilities operated by the Department.

(3) Intermediate care facilities for individuals with an intellectual disability licensed by the Department in accordance with Chapter 6600 (relating to intermediate care facilities for individuals with an intellectual disability) or intermediate care facilities for individuals with other related conditions.

(4) Foster family care homes licensed by the Office of Children, Youth and Families of the Department that serve only foster care children.

(5) Summer camps.

(6) Facilities serving exclusively personal care home, drug and alcohol, mental health or domiciliary care residents.

(7) Residential homes for three or fewer people with an intellectual disability or autism who are 18 years of age or older and who need a yearly average of 30 hours or less direct staff contact per week per home.

(8) Child residential facilities which serve exclusively children, which are regulated under Chapter 3800 (relating to child residential and day treatment facilities).

(g) This chapter does not measure or assure compliance with other applicable ~~Federal, State and local statutes, regulations, codes and ordinances~~ FEDERAL AND STATE STATUTES AND REGULATIONS AND LOCAL ORDINANCES. It is the responsibility of the home to comply with other applicable ~~laws~~ STATUTES, regulations, codes and ordinances.

§ 6400.4. Definitions.

The following words and terms, when used in this chapter, have the following meanings, unless the context clearly indicates otherwise:

Agency—A person or legally constituted organization operating one or more community homes for people with an intellectual disability or autism serving eight or fewer individuals.

Autism—A developmental disorder defined by the edition of the *Diagnostic and Statistical Manual of Mental Disorders*, or its successor, in effect at the time the diagnosis is made. The term includes autistic disorder, Asperger's disorder and autism spectrum disorder.

Community home for individuals with an intellectual disability or autism (home)—A building or separate dwelling unit in which residential care is provided to one or more individuals with an intellectual disability or autism, except as provided in § 6400.3(f) (relating to applicability). Each apartment unit within an apartment building is considered a separate home. Each part of a duplex, if there is physical separation between the living areas, is considered a separate home.

[*Content discrepancy*—A difference between what was determined at the ISP meeting by the plan team and what is documented in the written ISP.]

Department—The Department of Human Services of the Commonwealth.

Direct service worker—A person whose primary job function is to provide services to an individual who resides in the ~~provider's residential~~ home.

[*Documentation*—Written statements that accurately record details, substantiate a claim or provide evidence of an event.]

Fire safety expert—A local fire department, fire protection engineer, State certified fire protection instructor, college instructor in fire science, county or State fire school, volunteer fire person trained by a county or State fire school or an insurance company loss control representative.

HEALTH CARE PRACTITIONER—A PERSON WHO IS AUTHORIZED TO PRESCRIBE MEDICATIONS PURSUANT TO A LICENSE, REGISTRATION OR CERTIFICATION BY THE DEPARTMENT OF STATE.

[*ISP—Individual Support Plan*—The comprehensive document that identifies services and expected outcomes for an individual.]

Individual—An individual with an intellectual disability or autism who resides, or receives residential respite care, in a home and who is not a relative of the owner of the home.

INDIVIDUAL PLAN—A COORDINATED AND INTEGRATED DESCRIPTION OF ACTIVITIES AND SERVICES FOR AN INDIVIDUAL.

Intellectual disability—Subaverage general intellectual functioning which originates during the developmental period and is associated with impairment of one or more of the following:

(i) Maturation.

(ii) Learning.

(iii) Social adjustment.

[*Outcomes*—Goals the individual and individual's plan team choose for the individual to acquire, maintain or improve.

Plan lead—The program specialist, when the individual is not receiving services through an SCO.

Plan team—The group that develops the ISP.]

~~*PSP*—Person-centered support plan.~~

~~*Provider*—An entity or person that enters into an agreement with the Department to deliver a service to an individual.~~

Relative—A parent, child, stepparent, stepchild, grandparent, grandchild, brother, sister, half brother, half sister, aunt, uncle, niece or nephew.

Restraint—A physical, chemical or mechanical intervention used to control acute, episodic behavior that restricts the movement or function of the individual or a portion of the individual's body, including an intervention approved as part of the ~~PSP~~ INDIVIDUAL PLAN or used on an emergency basis.

~~*SC—Supports coordinator*—An SCO employee whose primary job functions are to locate, coordinate and monitor services provided to an individual when the individual is receiving services from an SCO.~~

~~*SCO—Supports coordination organization*—A provider that delivers the services of locating, coordinating and monitoring services provided to an individual.~~

Services—Actions or assistance provided to the individual to support the achievement of an outcome.

VOLUNTEER—A PERSON WHO IS AN ORGANIZED AND SCHEDULED COMPONENT OF THE SERVICE SYSTEM AND WHO DOES NOT RECEIVE COMPENSATION, BUT WHO PROVIDES A SERVICE THROUGH THE FACILITY THAT RECRUITS, PLANS AND ORGANIZES DUTIES AND ASSIGNMENTS.

GENERAL REQUIREMENTS

§ 6400.15. Self-assessment of homes.

(a) The agency shall complete a self-assessment of each home the agency operates serving eight or fewer individuals, within 3 to 6 months prior to the expiration date of the agency's certificate of compliance, to measure and record compliance with this chapter.

(b) The agency shall use the Department's licensing inspection instrument for the community homes for individuals with an intellectual disability or autism regulations to measure and record compliance.

(c) A copy of the agency's self-assessment results and a written summary of corrections made shall be kept by the agency for at least 1 year.

§ 6400.18. [Reporting of unusual incidents.] Incident report and investigation.

[(a) An unusual incident is abuse or suspected abuse of an individual; injury, trauma or illness of an individual requiring inpatient hospitalization; suicide attempt by an individual; violation or alleged violation of an individual's rights; an individual who is missing for more than 24 hours or who could be in jeopardy if missing at all; alleged misuse or misuse of individual funds or property; outbreak of a serious communicable disease as defined in 28 Pa. Code § 27.2 (relating to specific identified reportable

diseases, infections and conditions); an incident requiring the services of a fire department or law enforcement agency; and any condition that results in closure of the home for more than 1 day.

(b) Written policies and procedures on the prevention, reporting, investigation and management of unusual incidents shall be developed and kept at the home.

(c) The home shall orally notify the county intellectual disability program of the county in which the home is located, the funding agency and the appropriate regional office of the Department, within 24 hours after abuse or suspected abuse of an individual or an incident requiring the services of a fire department or law enforcement agency occurs.

(d) The home shall initiate an investigation of the unusual incident and complete and send copies of an unusual incident report on a form specified by the Department to the county intellectual disability program of the county in which the home is located, the funding agency and the appropriate regional office of the Department, within 72 hours after an unusual incident occurs.

(e) The home shall send a copy of the final unusual incident report to the county intellectual disability program of the county in which the home is located, the funding agency and the appropriate regional office of the Department at the conclusion of the investigation.

(f) A copy of unusual incident reports relating to an individual shall be kept in the individual's record.

(g) A copy of unusual incident reports relating to the home itself, such as those requiring the services of a fire department, shall be kept.

(h) The individual's family or guardian shall be immediately notified in the event of an unusual incident relating to the individual, if appropriate.]

(a) The home shall report the following incidents, alleged incidents and suspected incidents ~~in~~ THROUGH the Department's information management system or on a form specified by the Department within 24 hours of discovery by a staff person:

(1) Death.

(2) ~~Suicide attempt.~~ A PHYSICAL ACT BY AN INDIVIDUAL IN AN ATTEMPT TO COMPLETE SUICIDE.

(3) Inpatient admission to a hospital.

(4) ~~Visit to an emergency room.~~

~~(5)~~ Abuse, INCLUDING ABUSE TO AN INDIVIDUAL BY ANOTHER INDIVIDUAL.

~~(6)~~ (5) Neglect.

~~(7)~~ (6) Exploitation.

~~(8)~~ (7) An individual who is missing for more than 24 hours or who could be in jeopardy if missing at all.

~~(9)~~ (8) Law enforcement activity THAT OCCURS DURING THE PROVISION OF A SERVICE OR FOR WHICH AN INDIVIDUAL IS THE SUBJECT OF A LAW ENFORCEMENT INVESTIGATION THAT MAY LEAD TO CRIMINAL CHARGES AGAINST THE INDIVIDUAL.

~~(10)~~ (9) Injury requiring treatment beyond first aid.

~~(11)~~ (10) Fire requiring the services of the fire department. THIS PROVISION DOES NOT INCLUDE FALSE ALARMS.

~~(12)~~ (11) Emergency closure.

~~(13) Use of a restraint.~~

~~(14)~~ (12) Theft or misuse of individual funds.

~~(15)~~ (13) A violation of individual rights.

(B) THE HOME SHALL REPORT THE FOLLOWING INCIDENTS, ALLEGED INCIDENTS AND SUSPECTED INCIDENTS THROUGH THE DEPARTMENT'S INFORMATION MANAGEMENT SYSTEM OR ON A FORM SPECIFIED BY THE DEPARTMENT WITHIN 72 HOURS OF DISCOVERY BY A STAFF PERSON:

(1) USE OF A RESTRAINT.

(2) A MEDICATION ERROR AS SPECIFIED IN § 6400.166 (RELATING TO MEDICATION ERRORS), IF THE MEDICATION WAS ORDERED BY A HEALTH CARE PRACTITIONER.

~~(b)~~ (C) The individual and ~~the~~ persons designated by the individual shall be notified ~~immediately upon~~ WITHIN 24 HOURS OF discovery of an incident relating to the individual.

~~(c)~~ (D) The home shall keep documentation of the notification in subsection ~~(a)~~ (C).

~~(d)~~ (E) The incident report, OR A SUMMARY OF THE INCIDENT, THE FINDINGS AND THE ACTIONS TAKEN, redacted to exclude information about another individual and the reporter, unless the reporter is the individual who receives the report, shall be available to the individual, and persons designated by the individual, upon request.

~~(e)~~ (F) The home shall take immediate action to protect the health, safety and well-being of the individual following the initial knowledge or notice of an incident, alleged incident ~~and~~ OR suspected incident.

~~(f)~~ (G) The home shall initiate an investigation of an incident, ALLEGED INCIDENT OR SUSPECTED INCIDENT within 24 hours of discovery by a staff person.

~~(g)~~ (H) A Department-certified incident investigator shall conduct the investigation of the ~~incident listed in subsection (a).~~ FOLLOWING INCIDENTS:

(1) DEATH THAT OCCURS DURING THE PROVISION OF SERVICE.

(2) INPATIENT ADMISSION TO A HOSPITAL AS A RESULT OF AN ACCIDENTAL OR UNEXPLAINED INJURY OR AN INJURY CAUSED BY A STAFF PERSON, ANOTHER INDIVIDUAL OR DURING THE USE OF A RESTRAINT.

(3) ABUSE, INCLUDING ABUSE TO AN INDIVIDUAL BY ANOTHER INDIVIDUAL.

(4) NEGLECT.

(5) EXPLOITATION.

(6) INJURY REQUIRING TREATMENT BEYOND FIRST AID AS A RESULT OF AN ACCIDENTAL OR UNEXPLAINED INJURY OR AN INJURY CAUSED BY A STAFF PERSON, ANOTHER INDIVIDUAL OR DURING THE USE OF A RESTRAINT.

(7) THEFT OR MISUSE OF INDIVIDUAL FUNDS.

(8) A VIOLATION OF INDIVIDUAL RIGHTS.

~~(h)~~ (I) The home shall finalize the incident report ~~in~~ THROUGH the Department's information management system or on a form specified by the Department within 30 days of discovery of the incident by a staff person UNLESS THE HOME NOTIFIES THE DEPARTMENT IN WRITING THAT AN EXTENSION IS NECESSARY AND THE REASON FOR THE EXTENSION.

~~(i)~~ (J) The home shall provide the following information to the Department as part of the final incident report:

(1) Additional detail about the incident.

(2) The results of the incident investigation.

(3) ~~A description of the corrective action taken in response to an incident.~~ ACTION TAKEN TO PROTECT THE HEALTH, SAFETY AND WELL-BEING OF THE INDIVIDUAL.

(4) ~~Action taken to protect the health, safety and well-being of the individual.~~ A DESCRIPTION OF THE CORRECTIVE ACTION TAKEN IN RESPONSE TO AN INCIDENT AND TO PREVENT RECURRENCE OF THE INCIDENT.

(5) The person responsible for implementing the corrective action.

(6) The date the corrective action was implemented or is to be implemented.

§ 6400.19. [Reporting of deaths.] Incident procedures to protect the individual.

[(a) The home shall complete and send copies of a death report on a form specified by the Department to the county intellectual disability program of the county in which the home is located, the funding agency and the regional office of the Department, within 24 hours after a death of an individual occurs.

(b) The home shall investigate and orally notify the county intellectual disability program of the county in which the home is located, the funding agency and the appropriate regional office of the Department within 24 hours after an unusual or unexpected death occurs.

(c) A copy of death reports shall be kept in the individual's record.

(d) The individual's family or guardian shall be immediately notified in the event of a death of an individual.]

(a) In investigating an incident, the home shall review and consider the following needs of the affected individual:

(1) Potential risks.

(2) Health care information.

(3) Medication history and current medication.

(4) Behavioral health history.

(5) Incident history.

(6) Social needs.

(7) Environmental needs.

(8) Personal safety.

(b) The home shall monitor an individual's risk for recurring incidents and implement corrective action, as appropriate.

(c) The home shall work cooperatively with the ~~PSP~~ INDIVIDUAL PLAN team to revise the ~~PSP~~ INDIVIDUAL PLAN if indicated by the incident ~~investigation~~.

§ 6400.20. [Record of incidents.] Incident analysis.

[The home shall maintain a record of individual illnesses, seizures, acute emotional traumas and accidents requiring medical attention but not inpatient hospitalization, that occur at the home.]

(a) The home shall complete the following for each confirmed incident:

(1) Analysis to determine the ~~root~~ cause of the incident.

(2) Corrective action, IF INDICATED.

(3) A strategy to address the potential risks to the ~~affected~~ individual.

(b) The home shall review and analyze incidents and conduct AND DOCUMENT a trend analysis at least every 3 months.

(c) The home shall identify and implement preventive measures to reduce:

(1) The number of incidents.

(2) The severity of the risks associated with the incident.

(3) The likelihood of an incident recurring.

(d) The home shall educate staff persons and the individual based on the circumstances of the incident.

(e) The home shall ~~analyze~~ MONITOR incident data ~~continuously~~ and take actions to mitigate and manage risks.

§ 6400.24. Applicable ~~laws~~ STATUTES and regulations.

The home shall comply with applicable ~~Federal, State and local laws, regulations and ordinances~~ FEDERAL AND STATE STATUTES AND REGULATIONS AND LOCAL ORDINANCES.

§ 6400.25. CHILDREN'S SERVICES.

(A) THE CHILD, THE CHILD'S PARENTS AND THE CHILD'S LEGAL GUARDIAN SHALL BE PROVIDED THE OPPORTUNITY TO PARTICIPATE IN THE EXERCISE OF RIGHTS, DECISION-MAKING AND INDIVIDUAL PLAN ACTIVITIES, UNLESS OTHERWISE PROHIBITED BY COURT ORDER.

(B) THE PROVISIONS OF THIS CHAPTER REGARDING RIGHTS, DECISION-MAKING AND INDIVIDUAL PLAN ACTIVITIES SHALL BE IMPLEMENTED IN ACCORDANCE WITH GENERALLY ACCEPTED, AGE-APPROPRIATE PARENTAL DECISION-MAKING AND PRACTICES FOR CHILDREN, INCLUDING BEDTIMES, PRIVACY, SCHOOL ATTENDANCE, STUDY HOURS, VISITORS AND ACCESS TO FOOD AND PROPERTY, AND DO NOT REQUIRE A MODIFICATION OF RIGHTS IN THE INDIVIDUAL PLAN IN ACCORDANCE WITH § 6400.185 (RELATING TO CONTENT OF THE INDIVIDUAL PLAN).

(C) THE INDIVIDUAL PLAN IN § 6400.185 SHALL INCLUDE DESIRED OUTCOMES RELATING TO STRENGTHENING OR SECURING A PERMANENT CAREGIVING RELATIONSHIP FOR THE CHILD.

(D) AN UNRELATED CHILD AND ADULT MAY NOT SHARE A BEDROOM.

(E) FOR PURPOSES OF THIS SECTION, A CHILD IS AN INDIVIDUAL WHO IS UNDER 18 YEARS OF AGE.

INDIVIDUAL RIGHTS

§ 6400.31. [Informing and encouraging exercise] Exercise of rights.

[(a) Each individual, or the individual's parent, guardian or advocate, if appropriate, shall be informed of the individual's rights upon admission and annually thereafter.

(b) Statements signed and dated by the individual, or the individual's parent, guardian or advocate, if appropriate, acknowledging receipt of the information on rights upon admission and annually thereafter, shall be kept.

(c) Each individual shall be encouraged to exercise his rights.]

(a) An individual may not be deprived of rights as provided under § 6400.32 (relating to rights of the individual).

(b) ~~An individual shall be continually supported to exercise the individual's rights.~~

~~(c) An individual shall be provided the support and~~ THE HOME SHALL EDUCATE, ASSIST AND PROVIDE THE accommodation necessary ~~to be able~~ FOR THE

INDIVIDUAL to MAKE CHOICES AND understand ~~and actively exercise~~ the individual's rights.

~~(d)~~ (C) An individual may not be reprimanded, punished or retaliated against for exercising the individual's rights.

~~(e)~~ (D) A court's written order that restricts an individual's rights shall be followed.

~~(f)~~ (E) A court-appointed legal guardian may exercise rights and make decisions on behalf of an individual in accordance with ~~a court order~~ THE CONDITIONS OF GUARDIANSHIP AS SPECIFIED IN THE COURT ORDER.

~~(g)~~ (F) An individual who has a court-appointed legal guardian, or who has a court order restricting the individual's rights, shall be involved in ~~decision-making~~ DECISION-MAKING in accordance with the court order.

~~(h)~~ (G) An individual has the right to designate persons to assist in ~~decision-making~~ DECISION-MAKING AND EXERCISING RIGHTS on behalf of the individual.

§ 6400.32. Rights of the individual.

[An individual may not be deprived of rights.]

(a) An individual may not be discriminated against because of race, color, creed, disability, religious affiliation, ancestry, gender, gender identity, sexual orientation, national origin or age.

(b) An individual has the right to civil and legal rights afforded by law, including the right to vote, speak freely, ~~and~~ practice the religion of ~~his~~ THE INDIVIDUAL'S choice ~~or to~~ AND practice no religion.

(c) An individual may not be abused, neglected, mistreated, exploited, abandoned or subjected to corporal punishment.

(d) An individual shall be treated with dignity and respect.

(e) An individual has the right to make choices and accept risks.

(f) An individual has the right to refuse to participate in activities and ~~supports~~ SERVICES.

(g) An individual has the right to control the individual's own schedule AND ACTIVITIES.

(h) An individual has the right to privacy of person and possessions.

(i) An individual has the right of access to and security of the individual's possessions.

(j) An individual has the right to voice concerns about the ~~supports~~ SERVICES the individual receives.

(k) An individual has the right to participate in the development and implementation of the ~~PSP~~ INDIVIDUAL PLAN.

(l) An individual has the right to receive scheduled and unscheduled visitors, and to communicate and meet privately with ~~persons of the individual's choice~~ WHOM THE INDIVIDUAL CHOOSES, at any time.

(m) An individual has the right to unrestricted access to send and receive mail and other forms of communications, unopened and unread by others, INCLUDING THE RIGHT TO SHARE CONTACT INFORMATION WITH WHOM THE INDIVIDUAL CHOOSES.

(n) An individual has the right to unrestricted and private access to telecommunications.

(o) An individual has the right to manage and access ~~his own~~ THE INDIVIDUAL'S finances.

(p) An individual has the right to choose persons with whom to share a bedroom.

(q) An individual has the right to furnish and decorate the individual's bedroom and the common areas of the home IN ACCORDANCE WITH § 6400.33 (RELATING TO NEGOTIATION OF CHOICES).

(r) An individual has the right to lock the individual's bedroom door.

(1) LOCKING MAY BE PROVIDED BY A KEY, ACCESS CARD, KEYPAD CODE OR OTHER ENTRY MECHANISM ACCESSIBLE TO THE INDIVIDUAL TO PERMIT THE INDIVIDUAL TO LOCK AND UNLOCK THE DOOR.

(2) ACCESS TO AN INDIVIDUAL'S BEDROOM SHALL BE PROVIDED ONLY IN A LIFE-SAFETY EMERGENCY OR WITH THE EXPRESS PERMISSION OF THE INDIVIDUAL FOR EACH INCIDENCE OF ACCESS.

(3) ASSISTIVE TECHNOLOGY SHALL BE PROVIDED AS NEEDED TO ALLOW THE INDIVIDUAL TO LOCK AND UNLOCK THE DOOR WITHOUT ASSISTANCE.

(4) THE LOCKING MECHANISM SHALL ALLOW EASY AND IMMEDIATE ACCESS BY THE INDIVIDUAL AND STAFF PERSONS IN THE EVENT OF AN EMERGENCY.

(5) DIRECT SERVICE WORKERS WHO PROVIDE SERVICES TO THE INDIVIDUAL SHALL HAVE THE KEY OR ENTRY DEVICE TO LOCK AND UNLOCK THE DOOR.

(S) AN INDIVIDUAL HAS THE RIGHT TO HAVE A KEY, ACCESS CARD, KEYPAD CODE OR OTHER ENTRY MECHANISM TO LOCK AND UNLOCK AN ENTRANCE DOOR OF THE HOME.

(1) ASSISTIVE TECHNOLOGY SHALL BE PROVIDED AS NEEDED TO ALLOW THE INDIVIDUAL TO LOCK AND UNLOCK THE DOOR WITHOUT ASSISTANCE.

(2) THE LOCKING MECHANISM SHALL ALLOW EASY AND IMMEDIATE ACCESS BY THE INDIVIDUAL AND STAFF PERSONS IN THE EVENT OF AN EMERGENCY.

(3) DIRECT SERVICE WORKERS WHO PROVIDE SERVICES TO THE INDIVIDUAL SHALL HAVE THE KEY OR ENTRY DEVICE TO LOCK AND UNLOCK THE DOOR.

~~(s)~~ (T) An individual has the right to access food at any time.

~~(t)~~ (U) An individual has the right to make ~~informed~~ health care decisions.

(V) AN INDIVIDUAL'S RIGHTS MAY ONLY BE MODIFIED IN ACCORDANCE WITH § 6400.185 (RELATING TO CONTENT OF THE INDIVIDUAL PLAN) TO THE EXTENT NECESSARY TO MITIGATE A SIGNIFICANT HEALTH AND SAFETY RISK TO THE INDIVIDUAL OR OTHERS.

§ 6400.33. [Rights of the individual.] Negotiation of choices.

[(a) An individual may not be neglected, abused, mistreated or subjected to corporal punishment.

(b) An individual may not be required to participate in research projects.

(c) An individual has the right to manage personal financial affairs.

(d) An individual has the right to participate in program planning that affects the individual.

(e) An individual has the right to privacy in bedrooms, bathrooms and during personal care.

(f) An individual has the right to receive, purchase, have and use personal property.

(g) An individual has the right to receive scheduled and unscheduled visitors, communicate, associate and meet privately with family and persons of the individual's own choice.

(h) An individual has the right to reasonable access to a telephone and the opportunity to receive and make private calls, with assistance when necessary.

(i) An individual has the right to unrestricted mailing privileges.

(j) An individual who is of voting age shall be informed of the right to vote and shall be assisted to register and vote in elections.

(k) An individual has the right to practice the religion or faith of the individual's choice.

(l) An individual has the right to be free from excessive medication.

(m) An individual may not be required to work at the home, except for the upkeep of the individual's personal living areas and the upkeep of common living areas and grounds.]

(a) An individual's rights shall be exercised so that another individual's rights are not violated.

(b) ~~Choices shall be negotiated by~~ THE PROVIDER SHALL ASSIST the affected individuals TO NEGOTIATE CHOICES in accordance with the ~~home's~~ PROVIDER'S procedures for the individuals to resolve differences and make choices.

§ 6400.34. [Civil] Informing of rights.

[(a) An individual may not be discriminated against because of race, color, religious creed, disability, handicap, ancestry, national origin, age or sex.

(b) The home shall develop and implement civil rights policies and procedures. Civil rights policies and procedures shall include the following:

(1) Nondiscrimination in the provision of services, admissions, placement, use of the home, referrals and communication with non-English speaking and nonverbal individuals.

(2) Physical accessibility and accommodations for individuals with physical disabilities.

(3) The opportunity to lodge civil rights complaints.

(4) Informing individuals of their right to register civil rights complaints.]

(a) The home shall inform and explain individual rights AND THE PROCESS TO REPORT A RIGHTS VIOLATION to the individual, and persons designated by the individual, upon admission to the home and annually thereafter.

(b) The home shall keep a copy of the statement signed by the individual, or the individual's court-appointed legal guardian, acknowledging receipt of the information on individual rights.

STAFFING

§ 6400.44. Program specialist.

(a) A minimum of [one] 1 program specialist shall be assigned for every 30 individuals. A program specialist shall be responsible for a maximum of 30 ~~people~~ INDIVIDUALS, including ~~people~~ INDIVIDUALS served in other types of services.

(b) The program specialist shall be responsible for the following:

[(1) Coordinating and completing assessments.

(2) Providing the assessment as required under § 6400.181(f) (relating to assessment).

(3) Participating in the development of the ISP, ISP annual update and ISP revision.

(4) Attending the ISP meetings.

(5) Fulfilling the role of plan lead, as applicable, under §§ 6400.182 and 6400.186(f) and (g) (relating to development, annual update and revision of the ISP; and ISP review and revision).

(6) Reviewing the ISP, annual updates and revisions under § 6400.186 for content accuracy.

(7) Reporting content discrepancy to the SC, as applicable, and plan team members.

(8) Implementing the ISP as written.

(9) Supervising, monitoring and evaluating services provided to the individual.

(10) Reviewing, signing and dating the monthly documentation of an individual's participation and progress toward outcomes.

(11) Reporting a change related to the individual's needs to the SC, as applicable, and plan team members.

(12) Reviewing the ISP with the individual as required under § 6400.186.

(13) Documenting the review of the ISP as required under § 6400.186.

(14) Providing the documentation of the ISP review to the SC, as applicable, and plan team members as required under § 6400.186(d).

(15) Informing plan team members of the option to decline the ISP review documentation as required under § 6400.186(e).

(16) Recommending a revision to a service or outcome in the ISP as provided under § 6400.186(c)(4).

(17) Coordinating the services provided to an individual.

(18) Coordinating the training of direct service workers in the content of health and safety needs relevant to each individual.

(19) Developing and implementing provider services as required under § 6400.188 (relating to provider services).]

(1) Coordinating the completion of assessments.

(2) Participating in the ~~PSP~~ INDIVIDUAL PLAN process, ~~PSP~~ development, ~~PSP~~ team reviews and ~~the~~ implementation ~~of the PSP~~ in accordance with this chapter.

(3) Providing and supervising activities for the individuals in accordance with the ~~PSP~~ INDIVIDUAL PLANS.

(4) Supporting the integration of individuals in the community.

(5) Supporting individual communication and involvement with families and friends.

(c) A program specialist shall have one of the following groups of qualifications:

(1) A master's degree or above from an accredited college or university and 1 year of work experience working directly with individuals with an intellectual disability or autism.

(2) A bachelor's degree from an accredited college or university and 2 years of work experience working directly with individuals with an intellectual disability or autism.

(3) An associate's degree or 60 credit hours from an accredited college or university and 4 years of work experience working directly with individuals with an intellectual disability or autism.

§ 6400.45. Staffing.

(a) A minimum of one staff person for every eight individuals shall be awake and physically present at the home when individuals are awake at the home.

(b) A minimum of [one] 1 staff person for every 16 individuals shall be physically present at the home when individuals are sleeping at the home.

(c) An individual may be left unsupervised for specified periods of time if the absence of direct supervision is consistent with the individual's assessment and is part of the ~~individual's~~ [ISP] ~~PSP~~ INDIVIDUAL PLAN, as an outcome which requires the achievement of a higher level of independence.

(d) The staff qualifications and staff ratio as specified in the [ISP] ~~PSP~~ INDIVIDUAL PLAN shall be implemented as written, including when the staff ratio is greater than required under subsections (a), (b) and (c).

(e) An individual may not be left unsupervised solely for the convenience of the ~~residential~~ home or the direct service worker.

§ 6400.46. [Staff] Emergency training.

[(a) The home shall provide orientation for staff persons relevant to their responsibilities, the daily operation of the home and policies and procedures of the home before working with individuals or in their appointed positions.

(b) The home shall have a training syllabus describing the orientation specified in subsection (a).

(c) The chief executive officer shall have at least 24 hours of training relevant to human services or administration annually.

(d) Program specialists and direct service workers who are employed for more than 40 hours per month shall have at least 24 hours of training relevant to human services annually.

(e) Program specialists and direct service workers shall have training in the areas of intellectual disability, the principles of integration, rights and program planning and implementation, within 30 calendar days after the day of initial employment or within 12 months prior to initial employment.

(f)] (a) Program specialists and direct service workers shall be trained before working with individuals in general fire safety, evacuation procedures, responsibilities during fire drills, the designated meeting place outside the building or within the fire safe area in the event of an actual fire, smoking safety procedures if individuals or staff persons smoke at the home, the use of fire extinguishers, smoke detectors and fire alarms, and notification of the local fire department as soon as possible after a fire is discovered.

[(g)] (b) Program specialists and direct service workers shall be trained annually by a fire safety expert in the training areas specified in subsection [(f)] (a).

[(h)] (c) Program specialists and direct service workers and at least one person in a vehicle while individuals are being transported by the home[,] shall be trained before working with individuals in first aid techniques.

[(i)] (d) Program specialists, direct service workers and drivers of and aides in vehicles shall be trained within 6 months after the day of initial employment and annually thereafter, by an individual certified as a trainer by a hospital or other recognized health care organization, in first aid, Heimlich techniques and cardio-pulmonary resuscitation.

[(j) Records of orientation and training, including the training source, content, dates, length of training, copies of certificates received and staff persons attending, shall be kept.]

§ 6400.50. ~~Annual training plan.~~ TRAINING RECORDS.

~~(a) The home shall design an annual training plan based on the needs of the individuals as specified in the individuals' PSPs, other data and analysis indicating staff person training needs and as required under §§ 6400.46 and 6400.52 (relating to emergency training; and annual training).~~

~~(b) The annual training plan must include the orientation program as specified in § 6400.51 (relating to orientation program).~~

~~(c) The annual training plan must include training aimed at improving the knowledge, skills and core competencies of the staff persons to be trained.~~

~~(d) The annual training plan must include the following:~~

~~(1) The title of the position to be trained.~~

~~(2) The required training courses, including training course hours, for each position.~~

(A) RECORDS OF ORIENTATION AND TRAINING, INCLUDING THE TRAINING SOURCE, CONTENT, DATES, LENGTH OF TRAINING, COPIES OF CERTIFICATES RECEIVED AND STAFF PERSONS ATTENDING, SHALL BE KEPT.

(B) THE HOME SHALL KEEP A TRAINING RECORD FOR EACH PERSON TRAINED.

§ 6400.51. Orientation ~~program~~.

(a) Prior to working alone with individuals, and within 30 days after hire, the following shall complete the orientation ~~program~~ as described in subsection (b):

(1) Management, program, administrative and fiscal staff persons.

(2) Dietary, housekeeping, maintenance and ancillary staff persons. THIS PROVISION DOES NOT INCLUDE A PERSON WHO PROVIDES DIETARY, HOUSEKEEPING, MAINTENANCE OR ANCILLARY SERVICES, IF THE PERSON IS EMPLOYED OR CONTRACTED BY THE BUILDING OWNER AND THE LICENSED FACILITY DOES NOT OWN THE BUILDING.

(3) Direct service workers, including full-time and part-time staff persons.

(4) Volunteers who will work alone with individuals.

(5) Paid and unpaid interns who will work alone with individuals.

(6) Consultants AND CONTRACTORS WHO ARE PAID OR CONTRACTED BY THE HOME AND who will work alone with individuals, EXCEPT FOR CONSULTANTS AND CONTRACTORS WHO PROVIDE A SERVICE FOR FEWER THAN 30 DAYS WITHIN A 12-MONTH PERIOD AND WHO ARE LICENSED, CERTIFIED OR REGISTERED BY THE DEPARTMENT OF STATE IN A HEALTH CARE OR SOCIAL SERVICE FIELD.

(b) The orientation ~~program~~ must encompass the following areas:

(1) The application of person-centered practices, ~~including respecting rights, facilitating~~ community integration, ~~honoring~~ INDIVIDUAL choice and supporting individuals ~~in maintaining~~ TO DEVELOP AND MAINTAIN relationships.

(2) The prevention, detection and reporting of abuse, suspected abuse and alleged abuse in accordance with ~~sections 701—708 of~~ the Older Adults Protective Services Act (35 P.S. §§ ~~10225.701—10225.708~~ 10225.101—10225.5102), THE CHILD PROTECTIVE SERVICES LAW (23 Pa.C.S. §§ 6301—6386) ~~(relating to Child~~

~~Protective Services Law)~~, the Adult Protective Services Act (35 P.S. §§ 10210.101—10210.704) and applicable protective services regulations.

(3) Individual rights.

(4) Recognizing and reporting incidents.

(5) Job-related knowledge and skills.

§ 6400.52. Annual training.

(a) The following ~~staff persons~~ shall complete 24 hours of training RELATED TO JOB SKILLS AND KNOWLEDGE each year:

(1) Direct service workers.

(2) Direct supervisors of direct service workers.

(3) Program specialists.

(b) The following ~~staff persons~~ shall complete 12 hours of training each year:

(1) Management, program, administrative and fiscal staff persons.

(2) Dietary, housekeeping, maintenance and ancillary staff persons. THIS PROVISION DOES NOT INCLUDE A PERSON WHO PROVIDES DIETARY, HOUSEKEEPING, MAINTENANCE OR ANCILLARY SERVICES, IF THE PERSON IS EMPLOYED OR CONTRACTED BY THE BUILDING OWNER AND THE LICENSED FACILITY DOES NOT OWN THE BUILDING.

(3) Consultants AND CONTRACTORS WHO ARE PAID OR CONTRACTED BY THE HOME AND who work alone with individuals, EXCEPT FOR CONSULTANTS AND CONTRACTORS WHO PROVIDE A SERVICE FOR FEWER THAN 30 DAYS WITHIN A 12-MONTH PERIOD AND WHO ARE LICENSED, CERTIFIED OR REGISTERED BY THE DEPARTMENT OF STATE IN A HEALTH CARE OR SOCIAL SERVICE FIELD.

(4) Volunteers who work alone with individuals.

(5) Paid and unpaid interns who work alone with individuals.

(c) ~~A minimum of 8 hours of the~~ THE annual training hours specified in subsections (a) and (b) must encompass the following areas:

(1) The application of person-centered practices, ~~including respecting rights, facilitating~~ community integration, ~~honoring~~ INDIVIDUAL choice and supporting individuals ~~in maintaining~~ TO DEVELOP AND MAINTAIN relationships.

(2) The prevention, detection and reporting of abuse, suspected abuse and alleged abuse in accordance with ~~sections 701—708 of~~ the Older Adults Protective Services Act (35 P.S. §§ ~~10225.701—10225.708~~ 10225.101—10225.5102), THE CHILD PROTECTIVE SERVICES LAW (23 Pa.C.S. §§ 6301—6386) ~~(relating to Child Protective Services Law)~~, the Adult Protective Services Act (35 P.S. §§ 10210.101—10210.704) and applicable protective services regulations.

(3) Individual rights.

(4) Recognizing and reporting incidents.

(5) The safe and appropriate use of ~~positive interventions~~ BEHAVIOR SUPPORTS if the ~~staff~~ person ~~will provide a support to an individual with a dangerous behavior~~ WORKS DIRECTLY WITH AN INDIVIDUAL.

(6) IMPLEMENTATION OF THE INDIVIDUAL PLAN IF THE PERSON WORKS DIRECTLY WITH AN INDIVIDUAL.

~~(d) The balance of the annual training hours must be in areas identified by the home in the home's annual training plan in § 6400.50 (relating to annual training plan).~~

~~(e) All training, including those training courses identified in subsections (c) and (d), must be included in the provider's annual training plan.~~

~~(f) Records of orientation and training, including the training source, content, dates, length of training, copies of certificates received and staff persons attending, shall be kept.~~

~~(g) A training record for each person trained shall be kept.~~

MEDICATIONS

§ 6400.161. [Storage of medications.] Self-administration.

[(a) Prescription and nonprescription medications shall be kept in their original containers, except for medications of individuals who self-administer medications and keep the medications in personal daily or weekly dispensing containers.

(b) Prescription and potentially toxic nonprescription medications shall be kept in an area or container that is locked, unless it is documented in each individual's assessment that each individual in the home can safely use or avoid toxic materials.

(c) Prescription and potentially toxic nonprescription medications stored in a refrigerator shall be kept in a separate locked container, unless it is documented in each individual's assessment that each individual in the home can safely use or avoid toxic materials.

(d) Prescription and nonprescription medications shall be stored under proper conditions of sanitation, temperature, moisture and light.

(e) Discontinued prescription medications shall be disposed of in a safe manner.]

(a) ~~A~~ THE home shall provide an individual who has a prescribed medication with assistance, as needed, for the individual's self-administration of the medication.

(b) Assistance in the self-administration of medication includes helping the individual to remember the schedule for taking the medication, offering the individual the medication at the prescribed times, opening a medication container and storing the medication in a secure place.

(c) The ~~provider~~ HOME shall provide or arrange for assistive technology to ~~support the individual's self-administration of~~ ASSIST THE INDIVIDUAL TO SELF-ADMINISTER medications.

(d) The ~~PSP~~ INDIVIDUAL PLAN must identify if the individual is unable to self-administer medications.

(e) To be considered able to self-administer medications, an individual shall do all of the following:

(1) Recognize and distinguish the individual's medication.

(2) Know how much medication is to be taken.

(3) Know when the medication is to be taken. ~~This knowledge may include reminders~~ ASSISTANCE MAY BE PROVIDED BY STAFF PERSONS TO REMIND THE INDIVIDUAL of the schedule and ~~offering~~ TO OFFER the medication at the prescribed times as specified in subsection (b).

(4) Take or apply ~~his own~~ THE INDIVIDUAL'S medication with or without the use of assistive technology.

§ 6400.162. [Labeling of medications.] Medication administration.

[(a) The original container for prescription medications shall be labeled with a pharmaceutical label that includes the individual's name, the name of the medication, the date the prescription was issued, the prescribed dose and the name of the prescribing physician.

(b) Nonprescription medications shall be labeled with the original label.]

(a) A home whose staff persons or others are qualified to administer medications as specified in subsection (b) may provide medication administration for an individual who is unable to self-administer the individual's prescribed medication.

(b) A prescription medication that is not self-administered shall be administered by one of the following:

(1) A licensed physician, licensed dentist, licensed physician's assistant, registered nurse, certified registered nurse practitioner, licensed practical nurse ~~or~~, licensed paramedic OR OTHER HEALTH CARE PROFESSIONAL WHO IS LICENSED, CERTIFIED OR REGISTERED BY THE DEPARTMENT OF STATE TO ADMINISTER MEDICATIONS.

(2) A person who has completed the medication administration ~~training~~ COURSE REQUIREMENTS as specified in ~~§ 6400.169~~ § 6400.168 (relating to medication administration training) for the ~~medication~~ administration of the following:

(i) Oral medications.

(ii) Topical medications.

(iii) Eye, nose and ear drop medications.

(iv) Insulin injections.

(v) Epinephrine injections for insect bites or other allergies.

(VI) MEDICATIONS, INJECTIONS, PROCEDURES AND TREATMENTS AS PERMITTED BY APPLICABLE STATUTES AND REGULATIONS.

(c) Medication administration includes the following activities, based on the needs of the individual:

(1) Identify the correct individual.

(2) Remove the medication from the original container.

(3) ~~Crush or split~~ PREPARE the medication as ordered by the prescriber.

(4) Place the medication in a medication cup or other appropriate container, or in the individual's hand, mouth or other route as ordered by the prescriber.

(5) If indicated by the prescriber's order, measure vital signs and administer medications according to the prescriber's order.

(6) Injection of insulin ~~or~~ AND INJECTION OF epinephrine in accordance with this chapter.

§ 6400.163. [Use of prescription] Storage and disposal of medications.

[(a) Prescription medications shall only be used by the individual for whom the medication was prescribed.

(b) If a medication is prescribed to treat symptoms of a diagnosed psychiatric illness, there shall be a written protocol as part of the ISP to address the social, emotional and environmental needs of the individual related to the symptoms of the diagnosed psychiatric illness.

(c) If a medication is prescribed to treat symptoms of a diagnosed psychiatric illness, there shall be a review with documentation by a licensed physician at least every 3 months that includes the reason for prescribing the medication, the need to continue the medication and the necessary dosage.]

(a) Prescription and nonprescription medications shall be kept in their original labeled containers. PRESCRIPTION MEDICATIONS SHALL BE LABELED WITH A LABEL ISSUED BY A PHARMACY.

(b) A prescription medication may not be removed from its original labeled container ~~more than 2 hours~~ in advance of the scheduled administration, EXCEPT FOR THE PURPOSE OF PACKAGING THE MEDICATION FOR THE INDIVIDUAL TO TAKE WITH THE INDIVIDUAL TO A COMMUNITY ACTIVITY FOR ADMINISTRATION THE SAME DAY THE MEDICATION IS REMOVED FROM ITS ORIGINAL CONTAINER.

(c) If insulin or epinephrine is not packaged in an individual dose container, assistance with or the administration of the injection shall be provided immediately upon removal of the medication from its original labeled container.

(d) Prescription medications and syringes, with the exception of epinephrine and epinephrine auto-injectors, shall be kept in an area or container that is locked.

(e) Epinephrine and epinephrine auto-injectors shall be stored safely and kept easily accessible at all times. The epinephrine and epinephrine auto-injectors shall be easily accessible to the individual if the epinephrine is self-administered or to the staff person who is with the individual if a staff person will administer the epinephrine.

(f) Prescription medications stored in a refrigerator shall be kept in an area or container that is locked.

(g) Prescription medications shall be stored in an organized manner under proper conditions of sanitation, temperature, moisture and light and in accordance with the manufacturer's instructions.

(h) Prescription medications that are discontinued or expired shall be destroyed in a safe manner according to ~~the Department of Environmental Protection and~~ applicable Federal and State STATUTES AND regulations.

(i) ~~Subsections (a)—(d) and (f) do~~ THIS SECTION DOES not apply for an individual who self-administers medication and stores the medication in the individual's private bedroom OR PERSONAL BELONGINGS.

§ 6400.164. [Medication log.] ~~Labeling of medications.~~ (RESERVED).

[(a) A medication log listing the medications prescribed, dosage, time and date that prescription medications, including insulin, were administered and the name of the person who administered the prescription medication or insulin shall be kept for each individual who does not self-administer medication.

(b) The information specified in subsection (a) shall be logged immediately after each individual's dose of medication.

(c) A list of prescription medications, the prescribed dosage and the name of the prescribing physician shall be kept for each individual who self-administers medication.]

~~The original container for prescription medications must be labeled with a pharmacy label that includes the following:~~

~~(1) The individual's name.~~

~~(2) The name of the medication.~~

~~(3) The date the prescription was issued.~~

~~(4) The prescribed dosage and instructions for administration.~~

~~(5) The name and title of the prescriber.~~

§ 6400.165. [Medication errors.] Prescription medications.

[Documentation of medication errors and follow-up action taken shall be kept.]

(a) A prescription medication shall be prescribed in writing by an authorized prescriber.

(b) A prescription order shall be kept current.

(c) A prescription medication shall be administered as prescribed.

(d) A prescription medication shall be used only by the individual for whom the prescription was prescribed.

(e) Changes in medication may only be made in writing by the prescriber or, in the case of an emergency, an alternate prescriber, except for circumstances in which oral orders may be accepted by a ~~registered nurse in accordance with regulations of the Department of State~~ HEALTH CARE PROFESSIONAL WHO IS LICENSED, CERTIFIED OR REGISTERED BY THE DEPARTMENT OF STATE TO ACCEPT ORAL ORDERS. The individual's medication record shall be updated as soon as a written notice of the change is received.

(F) IF A MEDICATION IS PRESCRIBED TO TREAT SYMPTOMS OF A DIAGNOSED PSYCHIATRIC ILLNESS, THERE SHALL BE A WRITTEN PROTOCOL AS PART OF THE INDIVIDUAL PLAN TO ADDRESS THE SOCIAL, EMOTIONAL AND ENVIRONMENTAL NEEDS OF THE INDIVIDUAL RELATED TO THE SYMPTOMS OF THE PSYCHIATRIC ILLNESS.

(G) IF A MEDICATION IS PRESCRIBED TO TREAT SYMPTOMS OF A PSYCHIATRIC ILLNESS, THERE SHALL BE A REVIEW BY A LICENSED PHYSICIAN AT LEAST EVERY 3 MONTHS THAT INCLUDES TO DOCUMENT THE REASON FOR

PRESCRIBING THE MEDICATION, THE NEED TO CONTINUE THE MEDICATION AND THE NECESSARY DOSAGE.

§ 6400.166. [Adverse reaction.] Medication record.

[If an individual has a suspected adverse reaction to a medication, the home shall notify the prescribing physician immediately. Documentation of adverse reactions shall be kept.]

(a) A medication record shall be kept, including the following for each individual for whom a prescription medication is administered:

(1) Individual's name.

(2) Name ~~and title~~ of the prescriber.

(3) Drug allergies.

(4) Name of medication.

(5) Strength of medication.

(6) Dosage form.

(7) Dose of medication.

(8) Route of administration.

(9) Frequency of administration.

(10) Administration times.

(11) Diagnosis or purpose for the medication, including pro re nata.

(12) Date and time of medication administration.

(13) Name and initials of the person administering the medication.

(14) Duration of treatment, if applicable.

(15) Special precautions, if applicable.

(16) Side effects of the medication, if applicable.

(b) The information in subsection (a)(12) and (13) shall be recorded IN THE MEDICATION RECORD at the time the medication is administered.

(c) If an individual refuses to take a prescribed medication, the refusal shall be documented on the medication record. The refusal shall be reported to the prescriber ~~within 24 hours, unless otherwise instructed by the prescriber. Subsequent refusals to take a prescribed medication shall be reported as required~~ AS DIRECTED by the prescriber OR IF THERE IS HARM TO THE INDIVIDUAL.

(d) The directions of the prescriber shall be followed.

§ 6400.167. [Administration of prescription medications and injections.] Medication errors.

[(a) Prescription medications and injections of a substance not self-administered by individuals shall be administered by one of the following:

(1) A licensed physician, licensed dentist, licensed physician's assistant, registered nurse or licensed practical nurse.

(2) A graduate of an approved nursing program functioning under the direct supervision of a professional nurse who is present in the home.

(3) A student nurse of an approved nursing program functioning under the direct supervision of a member of the nursing school faculty who is present in the home.

(4) A staff person who meets the criteria specified in § 6400.168 (relating to medications administration training) for the administration of oral, topical and eye and ear drop prescriptions and insulin injections.

(b) Prescription medications and injections shall be administered according to the directions specified by a licensed physician, certified nurse practitioner or licensed physician's assistant.]

(a) Medication errors include the following:

(1) Failure to administer a medication.

(2) Administration of the wrong medication.

(3) Administration of the wrong ~~amount~~ DOSE of medication.

(4) Failure to administer a medication at the prescribed time, which exceeds more than 1 hour before or after the prescribed time.

(5) Administration to the wrong person.

(6) Administration through the wrong route.

(7) ADMINISTRATION WHILE THE INDIVIDUAL IS IN THE WRONG POSITION.

(8) IMPROPER PREPARATION OF THE MEDICATION.

(b) Documentation of medication errors, follow-up action taken and the prescriber's response, IF APPLICABLE, shall be kept in the individual's record.

(C) A MEDICATION ERROR SHALL BE REPORTED AS AN INCIDENT AS SPECIFIED IN § 6400.18(B) (RELATING TO INCIDENT REPORT AND INVESTIGATION).

(D) A MEDICATION ERROR SHALL BE REPORTED TO THE PRESCRIBER UNDER ANY OF THE FOLLOWING CONDITIONS:

(1) AS DIRECTED BY THE PRESCRIBER.

(2) IF THE MEDICATION IS ADMINISTERED TO THE WRONG PERSON.

(3) IF THERE IS HARM TO THE INDIVIDUAL.

§ 6400.168 [Medications administration training.] Adverse reaction.

[(a) In a home serving eight or fewer individuals, a staff person who has completed and passed the Department's Medications Administration Course is permitted to administer oral, topical and eye and ear drop prescription medications.

(b) In a home serving eight or fewer individuals, a staff person who has completed and passed the Department's Medications Administration Course and who has completed and passed a diabetes patient education program within the past 12 months that meets the National Standards for Diabetes Patient Education Programs of the National Diabetes Advisory Board, 7550 Wisconsin Avenue, Bethesda, Maryland 20205, is permitted to administer insulin injections to an individual who is under the care of a licensed physician who is monitoring the diabetes, if insulin is premeasured by licensed or certified medical personnel.

(c) Medications administration training of a staff person shall be conducted by an instructor who has completed the Department's Medications Administration Course for trainers and is certified by the Department to train staff.

(d) A staff person who administers prescription medications and insulin injections to an individual shall complete and pass the Medications Administration Course Practicum annually.

(e) Documentation of the dates and locations of medications administration training for trainers and staff persons and the annual practicum for staff persons shall be kept.]

(a) If an individual has a suspected adverse reaction to a medication, the home shall immediately consult a health care practitioner or seek emergency medical treatment.

(b) An adverse reaction to a medication, the health care practitioner's response to the adverse reaction and the action taken shall be documented.

§ 6400.169. [Self-administration of medications.] Medication administration training.

[(a) To be considered capable of self-administration of medications an individual shall:

(1) Be able to recognize and distinguish the individual's medication.

(2) Know how much medication is to be taken.

(3) Know when medication is to be taken.

(b) Insulin that is self-administered by an individual shall be measured by the individual or by licensed or certified medical personnel.]

(a) A staff person who has successfully completed a Department-approved medications administration course, including the course renewal requirements, may administer the following:

(1) Oral medications.

(2) Topical medications.

(3) Eye, nose and ear drop medications. MEDICATIONS, INJECTIONS, PROCEDURES AND TREATMENTS AS SPECIFIED IN § 6400.162 (RELATING TO MEDICATION ADMINISTRATION).

(b) A staff person may administer insulin injections following successful completion of both:

(1) The MEDICATION ADMINISTRATION course specified in subsection (a).

(2) A Department-approved diabetes patient education program within the past 12 months.

(c) A staff person may administer an epinephrine injection by means of an auto-injection device in response to anaphylaxis or another serious allergic reaction following successful completion of both:

(1) The MEDICATION ADMINISTRATION course specified in subsection (a).

(2) Training WITHIN THE PAST 24 MONTHS relating to the use of an auto-injection epinephrine injection device provided by a ~~licensed, registered or certified health care~~ professional WHO IS LICENSED, CERTIFIED OR REGISTERED BY THE DEPARTMENT OF STATE IN THE HEALTH CARE FIELD ~~within the past 12 months~~.

(d) A record of the training shall be kept, including the person trained, the date, source, name of trainer and documentation that the course was successfully completed.

PROGRAM

§ 6400.181. Assessment.

***** ***** ***** ***** *****

(b) If the program specialist is making a recommendation to revise a service or outcome in the [ISP as provided under § 6400.186(c)(4) (relating to ISP review and revision)] ~~PSP~~ INDIVIDUAL PLAN, the individual shall have an assessment completed as required under this section.

* * * * *

(f) The program specialist shall provide the assessment to the ~~SC, as applicable, and~~ [plan] ~~PSP~~ INDIVIDUAL PLAN team members at least 30 calendar days prior to [an ISP meeting for the development, annual update and revision of the ISP under §§ 2380.182, 2390.152, 6400.182 and 6500.152 (relating to development, annual update and revision of the ISP)] ~~a PSP~~ AN INDIVIDUAL PLAN meeting.

§ 6400.182. ~~Development~~ [, annual update and revision of the ISP] ~~of the PSP.~~ DEVELOPMENT, ANNUAL UPDATE AND REVISION OF THE INDIVIDUAL PLAN.

[(a) An individual shall have one ISP.

(b) When an individual is not receiving services through an SCO, the residential program specialist shall be the plan lead when one of the following applies:

(1) The individual resides at a residential home licensed under this chapter.

(2) The individual resides at a residential home licensed under this chapter and attends a facility licensed under Chapter 2380 or 2390 (relating to adult training facilities; and vocational facilities).

(c) The plan lead shall be responsible for developing and implementing the ISP, including annual updates and revisions.

(d) The plan lead shall develop, update and revise the ISP according to the following:

(1) The ISP shall be initially developed, updated annually and revised based upon the individual's current assessment as required under §§ 2380.181, 2390.151, 6400.181 and 6500.151 (relating to assessment).

(2) The initial ISP shall be developed within 90 calendar days after the individual's admission date to the facility.

(3) The ISP, annual updates and revisions shall be documented on the Department-designated form located in the Home and Community Services Information System (HCSIS) and also on the Department's web site.

(4) An invitation shall be sent to plan team members at least 30 calendar days prior to an ISP meeting.

(5) Copies of the ISP, including annual updates and revisions under § 6400.186 (relating to ISP review and revision), shall be provided as required under § 6400.187 (relating to copies).]

(a) ~~An individual shall have one approved and authorized PSP at a given time.~~

~~(b) An individual's service implementation plan must be consistent with the PSP in subsection (a).~~

~~(c)~~ The ~~support coordinator, targeted support manager or~~ program specialist shall coordinate the development of the ~~PSP~~ INDIVIDUAL PLAN, including revisions, ~~in cooperation~~ with the individual and the ~~individual's PSP~~ INDIVIDUAL PLAN team.

~~(d)~~ (B) The initial ~~PSP~~ INDIVIDUAL PLAN shall be developed based on the individual assessment within ~~60 days~~ 90 DAYS of the individual's date of admission to the home.

~~(e)~~ (C) The ~~PSP~~ INDIVIDUAL PLAN shall be initially developed, revised annually and revised when an individual's needs change based upon a current assessment.

~~(f)~~ (D) The individual and persons designated by the individual shall be involved ~~in~~ and supported in the INITIAL development and revisions of the ~~PSP~~ INDIVIDUAL PLAN.

~~(g) The PSP, including revisions, shall be documented on a form specified by the Department.~~

§ 6400.183. [Content of the ISP.] ~~The PSP~~ INDIVIDUAL PLAN team.

[The ISP, including annual updates and revisions under § 6400.186 (relating to ISP review and revision), must include the following:

(1) Services provided to the individual and expected outcomes chosen by the individual and individual's plan team.

(2) Services provided to the individual to increase community involvement, including volunteer or civic-minded opportunities and membership in National or local organizations as required under § 6400.188 (relating to provider services).

(3) Current status in relation to an outcome and method of evaluation used to determine progress toward that expected outcome.

(4) A protocol and schedule outlining specified periods of time for the individual to be without direct supervision, if the individual's current assessment states the individual may be without direct supervision and if the individual's ISP includes an expected outcome which requires the achievement of a higher level of independence. The protocol must include the current level of independence and the method of evaluation used to determine progress toward the expected outcome to achieve the higher level of independence.

(5) A protocol to address the social, emotional and environmental needs of the individual, if medication has been prescribed to treat symptoms of a diagnosed psychiatric illness.

(6) A protocol to eliminate the use of restrictive procedures, if restrictive procedures are utilized, and to address the underlying causes of the behavior which led to the use of restrictive procedures including the following:

(i) An assessment to determine the causes or antecedents of the behavior.

(ii) A protocol for addressing the underlying causes or antecedents of the behavior.

(iii) The method and timeline for eliminating the use of restrictive procedures.

(iv) A protocol for intervention or redirection without utilizing restrictive procedures.

(7) Assessment of the individual's potential to advance in the following:

(i) Residential independence.

(ii) Community involvement.

(iii) Vocational programming.

(iv) Competitive community-integrated employment.]

(a) The ~~PSP~~ INDIVIDUAL PLAN shall be developed by an interdisciplinary team, including the following:

(1) The individual.

(2) Persons designated by the individual.

(3) The individual's direct care staff persons.

(4) The program specialist.

(5) The support coordinator, targeted support manager or a program representative from the funding source, if applicable.

(6) The program specialist for the individual's day program, if applicable.

(7) Other specialists such as health care, behavior management, speech, occupational and physical therapy as appropriate for the ~~individual~~ INDIVIDUAL'S needs.

(b) At least three members of the ~~PSP~~ INDIVIDUAL PLAN team, in addition to the individual and persons designated by the individual, shall be present at a ~~PSP~~ meeting at which the ~~PSP~~ INDIVIDUAL PLAN is developed or revised.

(c) ~~Members of the PSP team who attend the meeting shall sign and date the PSP.~~ THE LIST OF PERSONS WHO PARTICIPATED IN THE INDIVIDUAL PLAN MEETING SHALL BE KEPT.

§ 6400.184. [Plan team participation.] ~~The PSP~~ INDIVIDUAL PLAN process.

[(a) The plan team shall participate in the development of the ISP, including the annual updates and revisions under § 6400.186 (relating to ISP review and revision).

(1) A plan team must include as its members the following:

(i) The individual.

(ii) A program specialist or family living specialist, as applicable, from each provider delivering a service to the individual.

(iii) A direct service worker who works with the individual from each provider delivering services to the individual.

(iv) Any other person the individual chooses to invite.

(2) If the following have a role in the individual's life, the plan team may also include as its members, as applicable, the following:

(i) Medical, nursing, behavior management, speech, occupational or physical therapy specialists.

(ii) Additional direct service workers who work with the individual from each provider delivering services to the individual.

(iii) The individual's parent, guardian or advocate.

(b) At least three plan team members, in addition to the individual, if the individual chooses to attend, shall be present for an ISP, annual update and ISP revision meeting.

(c) A plan team member who attends a meeting under subsection (b) shall sign and date the signature sheet.]

The ~~PSP~~ INDIVIDUAL PLAN process shall:

(1) Provide ~~necessary~~ information and support to ensure that the individual directs the ~~PSP~~ INDIVIDUAL PLAN process to the ~~maximum~~ extent possible.

(2) Enable the individual to make ~~informed~~ choices and decisions.

(3) ~~Be conducted to reflect~~ REFLECT what is important to the individual to ensure that ~~supports~~ SERVICES are delivered in a manner reflecting individual preferences and ensuring the individual's health, safety and well-being.

(4) ~~Be timely in relation to the individual's needs and occur~~ OCCUR TIMELY at intervals, times and locations of choice and convenience to the individual and to persons designated by the individual.

(5) Be communicated in clear and understandable language.

(6) Reflect cultural considerations of the individual.

(7) Include guidelines for solving disagreements among the ~~PSP~~ INDIVIDUAL PLAN team members.

(8) Include a method for the individual to request updates to the ~~PSP~~ INDIVIDUAL PLAN.

§ 6400.185. [Implementation of the ISP.] Content of the ~~PSP~~ INDIVIDUAL PLAN.

[(a) The ISP shall be implemented by the ISP's start date.

(b) The ISP shall be implemented as written.]

The ~~PSP~~ INDIVIDUAL PLAN, including revisions, must include the following:

(1) The individual's strengths ~~and~~, functional abilities AND SERVICE NEEDS.

~~(2) The individual's individualized clinical and support needs.~~

~~(3)~~ The individual's ~~goals and~~ preferences related to relationships, COMMUNICATION, community participation, employment, income and savings, health care, wellness and education.

~~(4)~~ (3) ~~Individually identified, person-centered~~ THE INDIVIDUAL'S desired outcomes.

~~(5)~~ (4) ~~Supports~~ SERVICES to assist the individual to achieve desired outcomes.

~~(6) The type, amount, duration and frequency for the support specified in a manner that reflects the assessed needs and choices of the individual. The schedule of support delivery shall be determined by the PSP team.~~

~~(7) Communication mode, abilities and needs.~~

~~(8) Opportunities for new or continued community participation.~~

~~(9) Risk factors, dangerous behaviors and risk mitigation strategies, if applicable.~~

(5) RISKS TO THE INDIVIDUAL'S HEALTH, SAFETY OR WELL-BEING, BEHAVIORS LIKELY TO RESULT IN IMMEDIATE PHYSICAL HARM TO THE INDIVIDUAL OR OTHERS AND RISK MITIGATION STRATEGIES, IF APPLICABLE.

~~(10)~~ (6) Modification of individual rights as necessary to mitigate ~~risks~~ SIGNIFICANT HEALTH AND SAFETY RISKS TO THE INDIVIDUAL OR OTHERS, if applicable.

~~(11) Health care information, including a health care history.~~

~~(12) Financial information including how the individual chooses to use personal funds.~~

~~(13) The person responsible for monitoring the implementation of the PSP.~~

§ 6400.186. [ISP review and revision.] Implementation of the ~~PSP~~ INDIVIDUAL PLAN.

[(a) The program specialist shall complete an ISP review of the services and expected outcomes in the ISP specific to the residential home licensed under this chapter with the individual every 3 months or more frequently if the individual's needs change which impacts the services as specified in the current ISP.

(b) The program specialist and individual shall sign and date the ISP review signature sheet upon review of the ISP.

(c) The ISP review must include the following:

(1) A review of the monthly documentation of an individual's participation and progress during the prior 3 months toward ISP outcomes supported by services provided by the residential home licensed under this chapter.

(2) A review of each section of the ISP specific to the residential home licensed under this chapter.

(3) The program specialist shall document a change in the individual's needs, if applicable.

(4) The program specialist shall make a recommendation regarding the following, if applicable:

(i) The deletion of an outcome or service to support the achievement of an outcome which is no longer appropriate or has been completed.

(ii) The addition of an outcome or service to support the achievement of an outcome.

(iii) The modification of an outcome or service to support the achievement of an outcome in which no progress has been made.

(5) If making a recommendation to revise a service or outcome in the ISP, the program specialist shall complete a revised assessment as required under § 6400.181(b) (relating to assessments).

(d) The program specialist shall provide the ISP review documentation, including recommendations, if applicable, to the SC, as applicable, and plan team members within 30 calendar days after the ISP review meeting.

(e) The program specialist shall notify the plan team members of the option to decline the ISP review documentation.

(f) If a recommendation for a revision to a service or outcome in the ISP is made, the plan lead as applicable, under §§ 2380.182(b) and (c), 2390.152(b) and (c), 6400.182(b) and (c), 6500.152(b) and (c) (relating to development, annual update and revision of the ISP), shall send an invitation for an ISP revision meeting to the plan team members within 30 calendar days of receipt of the recommendation.

(g) A revised service or outcome in the ISP shall be implemented by the start date in the ISP as written.]

The home shall implement the ~~PSP~~ INDIVIDUAL PLAN, including revisions.

§ 6400.187. [Copies.] (Reserved).

[A copy of the ISP, including the signature sheet, shall be provided to plan team members within 30 calendar days after the ISP, annual update and ISP revision meetings.]

§ 6400.188. [Provider services.] ~~(Reserved).~~ HOME SERVICES.

~~[~~(a) The ~~residential~~ home shall provide services, including assistance, training and support for the acquisition, maintenance or improvement of functional skills, personal needs, communication and personal adjustment.

(b) The ~~residential~~ home shall provide opportunities and support to the individual for participation in community life, including volunteer or civic-minded opportunities and membership in National or local organizations.

(c) The ~~residential~~ home shall provide services to the individual as specified in the ~~individual's ISP~~ INDIVIDUAL PLAN.

(d) The ~~residential~~ home shall provide services that are age and functionally appropriate to the individual.~~]~~

[RESTRICTIVE PROCEDURES] POSITIVE INTERVENTION

§ 6400.191. [Definition of restrictive procedures.] Use of a positive intervention.

[A restrictive procedure is a practice that limits an individual's movement, activity or function; interferes with an individual's ability to acquire positive reinforcement; results in the loss of objects or activities that an individual values; or requires an individual to engage in a behavior that the individual would not engage in given freedom of choice.]

(a) A positive intervention shall be used to prevent, modify and eliminate a dangerous behavior when the behavior is anticipated or occurring.

(b) The least intrusive method shall be applied when addressing a dangerous behavior. For each incidence of a dangerous behavior, every attempt shall be made to modify and eliminate the behavior.

(c) As used in this section, the following words and terms have the following meanings, unless the context clearly indicates otherwise:

Dangerous behavior—An action with a high likelihood of resulting in harm to the individual or others.

~~*Positive intervention*—An action or activity intended to prevent, modify and eliminate a dangerous behavior. This includes improved communications, reinforcing appropriate behavior, an environmental change, recognizing and treating physical and behavioral health symptoms, voluntary physical exercise and other wellness practices, redirection, praise, modeling, conflict resolution and de-escalation.~~

§ 6400.192. [Written policy.] ~~PSP.~~

[~~A~~ THE HOME SHALL DEVELOP AND IMPLEMENT A written policy that defines the prohibition or use of specific types of restrictive procedures, describes the circumstances in which restrictive procedures may be used, the STAFF persons who may authorize the use of restrictive procedures~~,~~ AND a mechanism to monitor and control the use of restrictive procedures. ~~and a process for the individual and family to review the use of restrictive procedures shall be kept at the home.~~]

~~If the individual has a dangerous behavior as identified in the PSP, the PSP must include the following:~~

~~(1) The specific dangerous behavior to be addressed.~~

~~(2) A functional analysis of the dangerous behavior and the plan to address the reason for the behavior.~~

~~(3) The outcome desired.~~

~~(4) A description of the positive intervention aimed at preventing, modifying or eliminating the dangerous behavior and the circumstances under which the intervention is to be used.~~

~~(5) A target date to achieve the outcome.~~

~~(6) Health conditions that require special attention.~~

§ 6400.193. [Appropriate use of restrictive procedures.] ~~Prohibition of restraints.~~

[(a) A restrictive procedure may not be used as retribution, for the convenience of staff persons, as a substitute for the program or in a way that interferes with the individual's developmental program.

(b) For each incident requiring restrictive procedures:

(1) Every attempt shall be made to anticipate and de-escalate the behavior using methods of intervention less intrusive than restrictive procedures.

(2) A restrictive procedure may not be used unless less restrictive techniques and resources appropriate to the behavior have been tried but have failed.]

~~The following procedures are prohibited:~~

~~(1) Seclusion, defined as involuntary confinement of an individual in a room or area from which the individual is physically prevented or verbally directed from leaving.~~

~~(2) Aversive conditioning, defined as the application of startling, painful or noxious stimuli.~~

~~(3) Pressure point techniques, defined as the application of pain for the purpose of achieving compliance.~~

~~(4) A chemical restraint, defined as use of drugs or chemicals for the specific and exclusive purpose of controlling acute or episodic aggressive behavior. A chemical restraint does not include a drug ordered by a health care practitioner or dentist to treat the symptoms of a specific mental, emotional or behavioral condition, or as pretreatment prior to a medical or dental examination or treatment.~~

~~(5) A mechanical restraint, defined as a device that restricts the movement or function of an individual or portion of an individual's body. Mechanical restraints include a geriatric chair, handcuffs, anklets, wristlets, camisole, helmet with fasteners, muffs and mitts with fasteners, restraint vest, waist strap, head strap, papoose board, restraining sheet, chest restraint and other locked restraints.~~

(i) The term does not include a device prescribed by a health care practitioner that is used to provide post-surgical care, proper balance or support for the achievement of functional body position.

(ii) The term does not include a device prescribed by a health care practitioner to protect the individual in the event of a seizure, as long as the individual can easily remove the device.

(6) A manual restraint, defined as a hands-on physical method that restricts, immobilizes or reduces an individual's ability to move his arms, legs, head or other body parts freely, on a nonemergency basis, or for more than 15 minutes within a 2-hour period. A manual restraint does not include physically prompting, escorting or guiding an individual to provide a support as specified in the individual's PSP.

(7) A prone position manual restraint.

(8) A manual restraint that inhibits digestion or respiration, inflicts pain, causes embarrassment or humiliation, causes hyperextension of joints, applies pressure on the chest or joints, or allows for a free fall to the floor.

§ 6400.194. [Restrictive procedure review committee.] ~~Permitted interventions.~~ HUMAN RIGHTS TEAM.

[(a) If a restrictive procedure is used, there shall be a restrictive procedure review committee.

(b) The restrictive procedure review committee shall include a majority of persons who do not provide direct services to the individual.

(c) The restrictive procedure review committee shall establish a time frame for review and revision of the restrictive procedure plan, not to exceed 6 months between reviews.

(d) A written record of the meetings and activities of the restrictive procedure review committee shall be kept.]

~~(a) Voluntary exclusion, defined as an individual voluntarily removing himself from his immediate environment and placing himself alone to a room or area, is permitted in accordance with the individual's PSP.~~

~~(b) A physical protective restraint may be used only in accordance with § 6400.193(6)—(8) (relating to prohibition of restraints).~~

~~(c) A physical protective restraint may not be used until §§ 6400.52(c)(5) and 6400.185(9) (relating to annual training; and content of the PSP) are met.~~

~~(d) A physical protective restraint may only be used in the case of an emergency to prevent an individual from injuring the individual's self or others.~~

~~(e) A physical protective restraint may not be used as a behavioral intervention, consequence, retribution, punishment, for the convenience of staff persons or as a substitution for individual support.~~

~~(f) A physical protective restraint may not be used for more than 15 minutes within a 2-hour period.~~

~~(g) A physical protective restraint may only be used by a staff person who is trained as specified in § 6400.52.~~

~~(h) As used in this section, a "physical protective restraint" is a hands-on hold of an individual.~~

(A) IF A RESTRICTIVE PROCEDURE IS USED, THE HOME SHALL USE A HUMAN RIGHTS TEAM. THE HOME MAY USE A COUNTY MENTAL HEALTH AND INTELLECTUAL DISABILITY PROGRAM HUMAN RIGHTS TEAM THAT MEETS THE REQUIREMENTS OF THIS SECTION.

(B) THE HUMAN RIGHTS TEAM SHALL INCLUDE A PROFESSIONAL WHO HAS A RECOGNIZED DEGREE, CERTIFICATION OR LICENSE RELATING TO BEHAVIORAL SUPPORT, WHO DID NOT DEVELOP THE BEHAVIOR SUPPORT COMPONENT OF THE INDIVIDUAL PLAN.

(C) THE HUMAN RIGHTS TEAM SHALL INCLUDE A MAJORITY OF PERSONS WHO DO NOT PROVIDE DIRECT SERVICES TO THE INDIVIDUAL.

(D) A RECORD OF THE HUMAN RIGHTS TEAM MEETINGS SHALL BE KEPT.

§ 6400.195. [Restrictive procedure plan.] ~~**Access to or the use of an individual's personal property.**~~ **BEHAVIOR SUPPORT COMPONENT OF THE INDIVIDUAL PLAN.**

[(a) For each individual for whom restrictive procedures may be used, a restrictive procedure plan shall be written prior to use of restrictive procedures.

(b) The restrictive procedure plan shall be developed and revised with the participation of the program specialist, the individual's direct care staff, the interdisciplinary team as appropriate and other professionals as appropriate.

(c) The restrictive procedure plan shall be reviewed, and revised, if necessary, according to the time frame established by the restrictive procedure review committee, not to exceed 6 months.

(d) The restrictive procedure plan shall be reviewed, approved, signed and dated by the chairperson of the restrictive procedure review committee and the program specialist, prior to the use of a restrictive procedure, whenever the restrictive procedure plan is revised and at least every 6 months.

(e) The restrictive procedure plan shall include:

(1) The specific behavior to be addressed and the suspected antecedent or reason for the behavior.

(2) The single behavioral outcome desired stated in measurable terms.

(3) Methods for modifying or eliminating the behavior, such as changes in the individual's physical and social environment, changes in the individual's routine, improving communications, teaching skills and reinforcing appropriate behavior.

(4) Types of restrictive procedures that may be used and the circumstances under which the procedures may be used.

(5) A target date for achieving the outcome.

(6) The amount of time the restrictive procedure may be applied, not to exceed the maximum time periods specified in this chapter.

(7) Physical problems that require special attention during the use of restrictive procedures.

(8) The name of the staff person responsible for monitoring and documenting progress with the plan.

(f) The restrictive procedure plan shall be implemented as written.

(g) Copies of the restrictive procedure plan shall be kept in the individual's record.]

~~(a) Access to or the use of an individual's personal funds or property may not be used as a reward or punishment.~~

~~(b) An individual's personal funds or property may not be used as payment for damages unless the individual consents to make restitution for the damages as follows:~~

~~(1) A separate written consent by the individual is required for each incidence of restitution.~~

~~(2) Consent shall be obtained in the presence of the individual, a person designated by the individual and in the presence of and with the support of the support coordinator or targeted support manager.~~

~~(3) There may not be coercion in obtaining the consent of an individual.~~

~~(4) The home shall keep a copy of the individual's written consent.~~

(A) FOR EACH INDIVIDUAL FOR WHOM A RESTRICTIVE PROCEDURE MAY BE USED, THE INDIVIDUAL PLAN SHALL INCLUDE A COMPONENT ADDRESSING BEHAVIOR SUPPORT THAT IS REVIEWED AND APPROVED BY THE HUMAN RIGHTS TEAM IN § 6400.194 (RELATING TO HUMAN RIGHTS TEAM), PRIOR TO USE OF A RESTRICTIVE PROCEDURE.

(B) THE BEHAVIOR SUPPORT COMPONENT OF THE INDIVIDUAL PLAN SHALL BE REVIEWED AND REVISED AS NECESSARY BY THE HUMAN RIGHTS TEAM, ACCORDING TO THE TIME FRAME ESTABLISHED BY THE TEAM, NOT TO EXCEED 6 MONTHS BETWEEN REVIEWS.

(C) THE BEHAVIOR SUPPORT COMPONENT OF THE INDIVIDUAL PLAN SHALL INCLUDE:

(1) THE SPECIFIC BEHAVIOR TO BE ADDRESSED.

(2) AN ASSESSMENT OF THE BEHAVIOR, INCLUDING THE SUSPECTED REASON FOR THE BEHAVIOR.

(3) THE OUTCOME DESIRED.

(4) A TARGET DATE TO ACHIEVE THE OUTCOME.

(5) METHODS FOR FACILITATING POSITIVE BEHAVIORS SUCH AS CHANGES IN THE INDIVIDUAL'S PHYSICAL AND SOCIAL ENVIRONMENT, CHANGES IN THE INDIVIDUAL'S ROUTINE, IMPROVING COMMUNICATIONS, RECOGNIZING AND TREATING PHYSICAL AND BEHAVIOR HEALTH CONDITIONS, VOLUNTARY PHYSICAL EXERCISE, REDIRECTION, PRAISE, MODELING, CONFLICT RESOLUTION, DE-ESCALATION AND TEACHING SKILLS.

(6) TYPES OF RESTRICTIVE PROCEDURES THAT MAY BE USED AND THE CIRCUMSTANCES UNDER WHICH THE PROCEDURES MAY BE USED.

(7) THE AMOUNT OF TIME THE RESTRICTIVE PROCEDURE MAY BE APPLIED.

(8) THE NAME OF THE STAFF PERSON RESPONSIBLE FOR MONITORING AND DOCUMENTING PROGRESS WITH THE BEHAVIOR SUPPORT COMPONENT OF THE INDIVIDUAL PLAN.

(D) IF A PHYSICAL RESTRAINT WILL BE USED OR IF A RESTRICTIVE PROCEDURE WILL BE USED TO MODIFY AN INDIVIDUAL'S RIGHTS IN § 6400.185(6) (RELATING TO CONTENT OF THE INDIVIDUAL PLAN) THE BEHAVIOR SUPPORT COMPONENT OF THE INDIVIDUAL PLAN SHALL BE DEVELOPED BY A PROFESSIONAL WHO HAS A RECOGNIZED DEGREE, CERTIFICATION OR LICENSE RELATING TO BEHAVIORAL SUPPORT.

§ 6400.196. [Staff training.] ~~Rights team.~~

[(a) If restrictive procedures are used, there shall be at least one staff person available when restrictive procedures are used who has completed training within the past 12 months in the use of and ethics of using restrictive procedures including the use of alternate positive approaches.

(b) A staff person responsible for developing, implementing or managing a restrictive procedure plan shall be trained in the use of the specific techniques or procedures that are used.

(c) If manual restraint or exclusion is used, a staff person responsible for developing, implementing or managing a restrictive procedure plan shall have experienced use of the specific techniques or procedures directly on themselves.

(d) Documentation of the training program provided, including the staff persons trained, dates of training, description of training and training source shall be kept.]

~~(a) The home shall have a rights team. The home may use a county mental health and intellectual disability program rights team that meets the requirements of this section.~~

~~(b) The role of the rights team is to:~~

~~(1) Review each incident, alleged incident and suspected incident of a violation of individual rights as specified in §§ 6400.31—6400.34 (relating to individual rights).~~

~~(2) Review each incidence of the use of a restraint as specified in §§ 6400.191—6400.194 to:~~

~~(i) Analyze systemic concerns.~~

~~(ii) Design positive supports as an alternative to the use of a restraint.~~

~~(iii) Discover and resolve the reason for an individual's behavior.~~

~~(c) Members of the rights team shall include the affected individual, persons designated by the individual, a family member or an advocate if the individual is unable to speak for~~

~~himself, the individual's support coordinator, a representative from the funding agency and a home representative.~~

~~(d) Members of the rights team shall be comprised of a majority who do not provide direct support to the individual.~~

~~(e) If a restraint was used, the individual's health care practitioner shall be consulted.~~

~~(f) The rights team shall meet at least once every 3 months.~~

~~(g) The rights team shall report its recommendations to the individual's PSP team.~~

~~(h) The home shall keep documentation of the rights team meetings and the decisions made at the meetings.~~

(A) A STAFF PERSON WHO IMPLEMENTS OR MANAGES A BEHAVIOR SUPPORT COMPONENT OF AN INDIVIDUAL PLAN SHALL BE TRAINED IN THE USE OF THE SPECIFIC TECHNIQUES OR PROCEDURES THAT ARE USED.

(B) IF A PHYSICAL RESTRAINT WILL BE USED, THE STAFF PERSON WHO IMPLEMENTS OR MANAGES THE BEHAVIOR SUPPORT COMPONENT OF THE INDIVIDUAL PLAN SHALL HAVE EXPERIENCED THE USE OF THE PHYSICAL RESTRAINT DIRECTLY ON THE STAFF PERSON.

(C) DOCUMENTATION OF THE TRAINING PROVIDED, INCLUDING THE STAFF PERSONS TRAINED, DATES OF TRAINING, DESCRIPTION OF TRAINING AND TRAINING SOURCE, SHALL BE KEPT.

§§ 6400.197—6400.206. (Reserved).

§ 6400.207. PROHIBITED PROCEDURES.

THE FOLLOWING PROCEDURES ARE PROHIBITED:

(1) SECLUSION, DEFINED AS INVOLUNTARY CONFINEMENT OF AN INDIVIDUAL IN A ROOM OR AREA FROM WHICH THE INDIVIDUAL IS PHYSICALLY PREVENTED OR VERBALLY DIRECTED FROM LEAVING. SECLUSION INCLUDES PHYSICALLY HOLDING A DOOR SHUT OR USING A FOOT PRESSURE LOCK.

(2) AVERSIVE CONDITIONING, DEFINED AS THE APPLICATION OF STARTLING, PAINFUL OR NOXIOUS STIMULI.

(3) PRESSURE-POINT TECHNIQUES, DEFINED AS THE APPLICATION OF PAIN FOR THE PURPOSE OF ACHIEVING COMPLIANCE. A PRESSURE-POINT TECHNIQUE DOES NOT INCLUDE A CLINICALLY-ACCEPTED BITE RELEASE TECHNIQUE THAT IS APPLIED ONLY AS LONG AS NECESSARY TO RELEASE THE BITE.

(4) A CHEMICAL RESTRAINT, DEFINED AS USE OF A DRUG FOR THE SPECIFIC AND EXCLUSIVE PURPOSE OF CONTROLLING ACUTE OR EPISODIC AGGRESSIVE BEHAVIOR. A CHEMICAL RESTRAINT DOES NOT INCLUDE A DRUG ORDERED BY A HEALTH CARE PRACTITIONER OR DENTIST FOR THE FOLLOWING USE OR EVENT:

(I) TREATMENT OF THE SYMPTOMS OF A SPECIFIC MENTAL, EMOTIONAL OR BEHAVIORAL CONDITION.

(II) PRETREATMENT PRIOR TO A MEDICAL OR DENTAL EXAMINATION OR TREATMENT.

(III) AN ONGOING PROGRAM OF MEDICATION.

(IV) A SPECIFIC, TIME-LIMITED STRESSFUL EVENT OR SITUATION TO ASSIST THE INDIVIDUAL TO CONTROL THE INDIVIDUAL'S OWN BEHAVIOR.

(5) A MECHANICAL RESTRAINT, DEFINED AS A DEVICE THAT RESTRICTS THE MOVEMENT OR FUNCTION OF AN INDIVIDUAL OR PORTION OF AN INDIVIDUAL'S BODY. A MECHANICAL RESTRAINT INCLUDES A GERIATRIC CHAIR, A BEDRAIL THAT RESTRICTS THE MOVEMENT OR FUNCTION OF THE INDIVIDUAL, HANDCUFFS, ANKLETS, WRISTLETS, CAMISOLE, HELMET WITH FASTENERS, MUFFS AND MITTS WITH FASTENERS, RESTRAINT VEST, WAIST STRAP, HEAD

STRAP, RESTRAINT BOARD, RESTRAINING SHEET, CHEST RESTRAINT AND OTHER SIMILAR DEVICES. A MECHANICAL RESTRAINT DOES NOT INCLUDE THE USE OF A SEAT BELT DURING MOVEMENT OR TRANSPORTATION. A MECHANICAL RESTRAINT DOES NOT INCLUDE A DEVICE PRESCRIBED BY A HEALTH CARE PRACTITIONER FOR THE FOLLOWING USE OR EVENT:

(I) POST-SURGICAL OR WOUND CARE.

(II) BALANCE OR SUPPORT TO ACHIEVE FUNCTIONAL BODY POSITION, IF THE INDIVIDUAL CAN EASILY REMOVE THE DEVICE OR IF THE DEVICE IS REMOVED BY A STAFF PERSON IMMEDIATELY UPON THE REQUEST OR INDICATION BY THE INDIVIDUAL, AND IF THE INDIVIDUAL PLAN INCLUDES PERIODIC RELIEF OF THE DEVICE TO ALLOW FREEDOM OF MOVEMENT.

(III) PROTECTION FROM INJURY DURING A SEIZURE OR OTHER MEDICAL CONDITION, IF THE INDIVIDUAL CAN EASILY REMOVE THE DEVICE OR IF THE DEVICE IS REMOVED BY A STAFF PERSON IMMEDIATELY UPON THE REQUEST OR INDICATION BY THE INDIVIDUAL, AND IF THE INDIVIDUAL PLAN INCLUDES PERIODIC RELIEF OF THE DEVICE TO ALLOW FREEDOM OF MOVEMENT.

§ 6400.208. PHYSICAL RESTRAINT.

(A) A PHYSICAL RESTRAINT, DEFINED AS A MANUAL METHOD THAT RESTRICTS, IMMOBILIZES OR REDUCES AN INDIVIDUAL'S ABILITY TO MOVE THE INDIVIDUAL'S ARMS, LEGS, HEAD OR OTHER BODY PARTS FREELY, MAY ONLY BE USED IN THE CASE OF AN EMERGENCY TO PREVENT AN INDIVIDUAL FROM IMMEDIATE PHYSICAL HARM TO THE INDIVIDUAL OR OTHERS.

(B) VERBAL REDIRECTION, PHYSICAL PROMPTS, ESCORTING AND GUIDING AN INDIVIDUAL ARE PERMITTED.

(C) A PRONE POSITION PHYSICAL RESTRAINT IS PROHIBITED.

(D) A PHYSICAL RESTRAINT THAT INHIBITS DIGESTION OR RESPIRATION, INFLICTS PAIN, CAUSES EMBARRASSMENT OR HUMILIATION, CAUSES HYPEREXTENSION OF JOINTS, APPLIES PRESSURE ON THE CHEST OR JOINTS OR ALLOWS FOR A FREE FALL TO THE FLOOR IS PROHIBITED.

(E) A PHYSICAL RESTRAINT MAY NOT BE USED FOR MORE THAN 30 CUMULATIVE MINUTES WITHIN A 2-HOUR PERIOD.

§ 6400.209. EMERGENCY USE OF A PHYSICAL RESTRAINT.

IF A PHYSICAL RESTRAINT IS USED ON AN UNANTICIPATED, EMERGENCY BASIS, §§ 6400.194 AND 6400.195 (RELATING TO HUMAN RIGHTS TEAM; AND BEHAVIOR SUPPORT COMPONENT OF THE INDIVIDUAL PLAN) DO NOT APPLY UNTIL AFTER THE RESTRAINT IS USED FOR THE SAME INDIVIDUAL TWICE IN A 6-MONTH PERIOD.

§ 6400.210. ACCESS TO OR THE USE OF AN INDIVIDUAL'S PERSONAL PROPERTY.

(A) ACCESS TO OR THE USE OF AN INDIVIDUAL'S PERSONAL FUNDS OR PROPERTY MAY NOT BE USED AS A REWARD OR PUNISHMENT.

(B) AN INDIVIDUAL'S PERSONAL FUNDS OR PROPERTY MAY NOT BE USED AS PAYMENT FOR DAMAGES UNLESS THE INDIVIDUAL CONSENTS TO MAKE RESTITUTION FOR THE DAMAGES. THE FOLLOWING CONSENT PROVISIONS APPLY UNLESS THERE IS A COURT-ORDERED RESTITUTION:

(1) A SEPARATE WRITTEN CONSENT IS REQUIRED FOR EACH INCIDENCE OF RESTITUTION.

(2) CONSENT SHALL BE OBTAINED IN THE PRESENCE OF THE INDIVIDUAL OR A PERSON DESIGNATED BY THE INDIVIDUAL.

(3) THE HOME MAY NOT COERCE THE INDIVIDUAL TO PROVIDE CONSENT.

INDIVIDUAL RECORDS

§ 6400.213. Content of records.

Each individual's record must include the following information:

(1) Personal information, including:

(i) The name, sex, admission date, birthdate and [social security] Social Security number.

(ii) The race, height, weight, color of hair, color of eyes and identifying marks.

(iii) The language or means of communication spoken or understood by the individual and the primary language used in the individual's natural home, if other than English.

(iv) The religious affiliation.

(v) The next of kin.

(vi) A current, dated photograph.

(2) [Unusual incident] Incident reports relating to the individual.

(3) Physical examinations.

(4) Dental examinations.

(5) Dental hygiene plans.

(6) Assessments as required under § 6400.181 (relating to assessment).

[(7) A copy of the invitation to:

(i) The initial ISP meeting.

(ii) The annual update meeting.

(iii) The ISP revision meeting.

(8) A copy of the signature sheets for:

(i) The initial ISP meeting.

(ii) The annual update meeting.

(iii) The ISP revision meeting.

(9) A copy of the current ISP.

(10) Documentation of ISP reviews and revisions under § 6400.186 (relating to ISP review and revision), including the following:

(i) ISP review signature sheets.

(ii) Recommendations to revise the ISP.

(iii) ISP revisions.

(iv) Notices that the plan team member may decline the ISP review documentation.

(v) Requests from plan team members to not receive the ISP review documentation.

(11) Content discrepancy in the ISP, The annual update or revision under § 6400.186.]

(7) ~~PSP~~ INDIVIDUAL PLAN documents as required by this chapter.

[(12) Restrictive procedure protocols and] ~~(8) Positive intervention records related to the individual.~~

[(13)] ~~(9)~~ (8) Copies of psychological evaluations, if applicable.

[(14)] ~~(10) Recreational and social activities provided to the individual.~~

CHAPTER 6500. [FAMILY LIVING] LIFE SHARING HOMES

GENERAL PROVISIONS

§ 6500.1. Introduction.

[Family living] Life sharing is based on the importance of enduring and permanent relationships as the foundation for learning life skills, developing self-esteem and learning to exist in interdependence with others; the opportunity for each individual with an intellectual disability or autism to grow and develop to their fullest potential; the provision of individualized attention based on the needs of the individual with an intellectual disability or autism; and the participation of the individual with an intellectual disability or autism in everyday community activities. [Family living] Life sharing offers an opportunity for an individual with an intellectual disability or autism and a family to share their lives together.

§ 6500.2. Purpose.

The purpose of this chapter is to protect the health, safety and well-being of individuals with an intellectual disability or autism, through the formulation, implementation and enforcement of minimum requirements for [family living homes] life sharing.

§ 6500.3. Applicability.

(a) This chapter applies to [family living] life sharing homes, except as provided in subsection (f).

(b) This chapter contains the minimum requirements that shall be met to obtain a certificate of compliance. A certificate of compliance shall be obtained prior to an individual with an intellectual disability or autism living or receiving respite care in a [family living] life sharing home.

(c) This chapter applies to profit, nonprofit, publicly funded and privately funded [family living] life sharing homes.

(d) Each agency administering one or more [family living] life sharing homes shall have at least a sample of ~~their~~ ITS homes inspected by the Department each year. Each new [family living] life sharing home administered by an agency shall be inspected by the Department prior to an individual with an intellectual disability or autism living or receiving respite care in the home. The certificate of compliance issued to an agency shall specify the location and maximum capacity of each [family living] life sharing home.

(e) A [family living] life sharing home that is not administered by an agency will be inspected by the Department each year.

(f) This chapter does not apply to the following:

(1) Private homes of persons providing care to a relative with an intellectual disability or autism.

(2) A community home for individuals with an intellectual disability or autism licensed by the Department in accordance with Chapter 6400 (relating to community homes for individuals with an intellectual disability or autism).

(3) A foster family care home licensed by the Office of Children, Youth and Families of the Department that serves only foster care children.

(4) A home serving exclusively personal care home, drug and alcohol, mental health or domiciliary care residents.

(5) A home providing room and board for one or two people with an intellectual disability or autism who are 18 years of age or older and who need a yearly average of 30 hours or less direct training and assistance per week per home, from the agency, the county intellectual disability program or the family.

(6) A home providing 90 or fewer calendar days of respite care per calendar year.

§ 6500.4. Definitions.

The following words and terms, when used in this chapter, have the following meanings, unless the context clearly indicates otherwise:

Agency—A person or legally constituted organization administering one or more [family living] life sharing homes.

[*Content discrepancy*—A difference between what was determined at the ISP meeting by the plan team and what is documented in the written ISP.]

Autism—A developmental disorder defined by the edition of the *Diagnostic and Statistical Manual of Mental Disorders*, or its successor, in effect at the time the diagnosis is made. The term includes autistic disorder, Asperger's disorder and autism spectrum disorder.

Department—The Department of Human Services of the Commonwealth.

Direct service worker—A person whose primary job function is to provide services to an individual who resides in the ~~provider's~~ [family living] ~~life sharing~~ home.

[*Documentation*—Written statements that accurately record details, substantiate a claim or provide evidence of an event.

Family living home or *home*—

(i) The private home of an individual or a family in which residential care is provided to one or two individuals with an intellectual disability, except as provided in § 6500.3(f) (relating to applicability).

(ii) The term does not include a home if there are more than two individuals, including respite care individuals, living in the home at any one time who are not family members or relatives of the family members.

(iii) If relatives of the individual live in the home, the total number of people living in the home at any one time who are not family members or relatives of the family members may not exceed four.]

HEALTH CARE PRACTITIONER—A PERSON WHO IS AUTHORIZED TO PRESCRIBE MEDICATIONS PURSUANT TO A LICENSE, REGISTRATION OR CERTIFICATION BY THE DEPARTMENT OF STATE.

[*ISP—Individual Support Plan*—The comprehensive document that identifies services and expected outcomes for an individual.]

Individual—

(i) A person with an intellectual disability or autism who resides, or receives residential respite care, in a [family living] life sharing home and who is not a relative of the owner ~~of~~ OR the family members.

(ii) The term does not include family members.

INDIVIDUAL PLAN—A COORDINATED AND INTEGRATED DESCRIPTION OF ACTIVITIES AND SERVICES FOR AN INDIVIDUAL.

Intellectual disability—Subaverage general intellectual functioning which originates during the developmental period and is associated with impairment of one or more of the following:

(i) Maturation.

(ii) Learning.

(iii) Social adjustment.

[*Outcomes*—Goals the individual and individual's plan team choose for the individual to acquire, maintain or improve.

Plan lead—The family living specialist, when the individual is not receiving services through an SCO.

Plan team—The group that develops the ISP.]

Life sharing home or *home*—

(i) The private home of an individual or a family in which residential care is provided to one or two individuals with an intellectual disability or autism, except as provided in § 6500.3(f) (relating to applicability).

(ii) The term does not include a home if there are more than two individuals, including respite care individuals, living in the home at any one time who are not family members or relatives of the family members.

(iii) If relatives of the individual live in the home, the total number of people living in the home at any one time who are not family members or relatives of the family members may not exceed four.

~~*PSP*—Person-centered support plan.~~

~~*Provider*—An entity or person that enters into an agreement with the Department to deliver a service to an individual.~~

Relative—A parent, child, stepparent, stepchild, grandparent, grandchild, brother, sister, half brother, half sister, aunt, uncle, niece or nephew.

Respite care—Temporary [family living] care not to exceed 31 calendar days for an individual in a calendar year.

Restraint—A physical, chemical or mechanical intervention used to control acute, episodic behavior that restricts the movement or function of the individual or a portion of the individual's body, including an intervention approved as part of the ~~PSP~~ INDIVIDUAL PLAN or used on an emergency basis.

~~*SC—Supports coordinator*—An SCO employee whose primary job functions are to locate, coordinate and monitor services provided to an individual when the individual is receiving services from an SCO.~~

~~*SCO—Supports coordination organization*—A provider that delivers the services of locating, coordinating and monitoring services provided to an individual.~~

Services—Actions or assistance provided to the individual to support the achievement of an outcome.

GENERAL REQUIREMENTS

§ 6500.15. Responsibility for compliance.

(a) If an agency is the legal entity administering the [family living] home, the agency is responsible for compliance with this chapter.

(b) If the [family living] life sharing home is the legal entity, the [family living] home is responsible for compliance with this chapter.

§ 6500.17. Self-assessment of homes.

(a) If an agency is the legal entity for the [family living] home, the agency shall complete a self-assessment of each home the agency is licensed to operate within 3 to 6 months prior to the expiration date of the agency's certificate of compliance, to measure and record compliance with this chapter.

(b) The agency shall use the Department's licensing inspection instrument for this chapter to measure and record compliance.

(c) A copy of the agency's self-assessment results and a written summary of corrections made shall be kept for at least 1 year.

§ 6500.20. [Reporting of unusual incidents.] <u>Incident report and investigation.</u>

[(a) An unusual incident is abuse or suspected abuse of an individual; injury, trauma or illness of an individual requiring inpatient hospitalization; suicide attempt by an individual; violation or alleged violation of an individual's rights; an individual who is missing for more than 24 hours or could be in jeopardy if missing at all; misuse or alleged misuse of individual funds or property; outbreak of a serious communicable disease as defined in 28 Pa. Code § 27.2 (relating to specific identified reportable diseases, infections and conditions); or an incident requiring the services of a fire department or law enforcement agency.

(b) Written policies and procedures on the prevention, reporting, investigation and management of unusual incidents shall be kept.

(c) Oral notification of the county intellectual disability program of the county in which the home is located, the funding agency if applicable, and the appropriate regional office of the Department shall be given within 24 hours after abuse or suspected abuse of an individual or an incident requiring the services of a fire department or law enforcement agency occurs.

(d) An investigation of the unusual incident shall be initiated and an unusual incident report shall be completed on a form specified by the Department. Copies of the unusual incident report shall be sent to the county intellectual disability program of the county in

which the home is located, the funding agency if applicable, and the appropriate regional office of the Department, within 72 hours after an unusual incident occurs.

(e) A copy of the final unusual incident report shall be sent to the county intellectual disability program of the county in which the home is located, the funding agency if applicable, and the appropriate regional office of the Department at the conclusion of the investigation.

(f) A copy of unusual incident reports relating to an individual shall be kept in the individual's record.

(g) A copy of unusual incident reports relating to the home itself, such as those requiring the services of a fire department, shall be kept.

(h) The individual's family or guardian shall be immediately notified in the event of an unusual incident relating to the individual, if appropriate.]

(a) The agency and the home shall report the following incidents, alleged incidents and suspected incidents ~~in~~ THROUGH the Department's information management system or on a form specified by the Department within 24 hours of discovery by a staff person:

(1) Death.

(2) ~~Suicide attempt.~~ A PHYSICAL ACT BY AN INDIVIDUAL IN AN ATTEMPT TO COMPLETE SUICIDE.

(3) Inpatient admission to a hospital.

(4) ~~Visit to an emergency room.~~

~~(5)~~ Abuse, INCLUDING ABUSE TO AN INDIVIDUAL BY ANOTHER INDIVIDUAL.

~~(6)~~ (5) Neglect.

~~(7)~~ (6) Exploitation.

~~(8)~~ (7) An individual who is missing for more than 24 hours or who could be in jeopardy if missing ~~at all~~ FOR ANY PERIOD OF TIME.

~~(9)~~ (8) Law enforcement activity THAT OCCURS DURING THE PROVISION OF A SERVICE OR FOR WHICH THE INDIVIDUAL IS THE SUBJECT OF A LAW ENFORCEMENT INVESTIGATION THAT MAY LEAD TO CRIMINAL CHARGES AGAINST THE INDIVIDUAL.

~~(10)~~ (9) Injury requiring treatment beyond first aid.

~~(11)~~ (10) Fire requiring the services of the fire department. THIS PROVISION DOES NOT INCLUDE FALSE ALARMS.

~~(12)~~ (11) Emergency closure.

~~(13) Use of a restraint.~~

~~(14)~~ (12) Theft or misuse of individual funds.

~~(15)~~ (13) A violation of individual rights.

(B) THE AGENCY AND THE HOME SHALL REPORT THE FOLLOWING INCIDENTS, ALLEGED INCIDENTS AND SUSPECTED INCIDENTS THROUGH THE DEPARTMENT'S INFORMATION MANAGEMENT SYSTEM OR ON A FORM SPECIFIED BY THE DEPARTMENT WITHIN 72 HOURS OF DISCOVERY BY A STAFF PERSON:

(1) USE OF A RESTRAINT.

(2) A MEDICATION ERROR AS SPECIFIED IN § 6500.136 (RELATING TO MEDICATION ERRORS), IF THE MEDICATION WAS ORDERED BY A HEALTH CARE PRACTITIONER.

~~(b)~~ (C) The individual and ~~the~~ persons designated by the individual shall be notified ~~immediately upon~~ WITHIN 24 HOURS OF discovery of an incident relating to the individual.

~~(c)~~ (D) ~~The agency and the home shall keep documentation~~ DOCUMENTATION of the notification in subsection ~~(b)~~ (C) SHALL BE KEPT.

~~(d)~~ (E) The incident report, OR A SUMMARY OF THE INCIDENT, THE FINDINGS AND THE ACTIONS TAKEN, redacted to exclude information about another individual and the reporter, unless the reporter is the individual who receives the report, shall be available to the individual and persons designated by the individual, upon request.

~~(e)~~ (F) ~~The agency shall take immediate action~~ IMMEDIATE ACTION SHALL BE TAKEN to protect the health, safety and well-being of the individual following the initial knowledge or notice of an incident, alleged incident ~~and~~ OR suspected incident.

~~(f)~~ (G) ~~The home shall initiate an~~ AN investigation of an incident, ALLEGED INCIDENT OR SUSPECTED INCIDENT SHALL BE INITIATED within 24 hours of discovery by a staff person.

~~(g)~~ (H) A Department-certified incident investigator shall conduct the ~~incident~~ investigation of the ~~incident listed in subsection (a).~~ FOLLOWING INCIDENTS:

(1) DEATH THAT OCCURS DURING THE PROVISION OF SERVICE.

(2) INPATIENT ADMISSION TO A HOSPITAL AS A RESULT OF AN ACCIDENTAL OR UNEXPLAINED INJURY OR AN INJURY CAUSED BY A STAFF PERSON, ANOTHER INDIVIDUAL OR DURING THE USE OF A RESTRAINT.

(3) ABUSE, INCLUDING ABUSE TO AN INDIVIDUAL BY ANOTHER INDIVIDUAL.

(4) NEGLECT.

(5) EXPLOITATION.

(6) INJURY REQUIRING TREATMENT BEYOND FIRST AID AS A RESULT OF AN ACCIDENTAL OR UNEXPLAINED INJURY OR AN INJURY CAUSED BY A STAFF PERSON, ANOTHER INDIVIDUAL OR DURING THE USE OF A RESTRAINT.

(7) THEFT OR MISUSE OF INDIVIDUAL FUNDS.

(8) A VIOLATION OF INDIVIDUAL RIGHTS.

~~(h)~~ (I) ~~The agency shall finalize the~~ THE incident report SHALL BE FINALIZED THROUGH ~~in~~ the Department's information management system or on a form specified by the Department within 30 days of discovery of the incident by a staff person UNLESS

THE AGENCY OR HOME NOTIFIES THE DEPARTMENT IN WRITING THAT AN EXTENSION IS NECESSARY AND THE REASON FOR THE EXTENSION.

~~(i)~~ (J) The ~~agency shall provide the~~ following information SHALL BE PROVIDED to the Department as part of the final incident report:

(1) Additional detail about the incident.

(2) The results of the incident investigation.

(3) ~~A description of the corrective action taken in response to an incident.~~ ACTION TAKEN TO PROTECT THE HEALTH, SAFETY AND WELL-BEING OF THE INDIVIDUAL.

(4) ~~Action taken to protect the health, safety and well-being of the individual.~~
A DESCRIPTION OF THE CORRECTIVE ACTION TAKEN IN RESPONSE TO AN INCIDENT AND TO PREVENT RECURRENCE OF THE INCIDENT.

(5) The person responsible for implementing the corrective action.

(6) The date the corrective action was implemented or is to be implemented.

§ 6500.21. [Reporting of deaths.] Incident procedures to protect the individual.

[(a) A death report shall be completed on a form specified by the Department and sent to the county intellectual disability program of the county in which the home is located, the funding agency and the regional office of the Department, within 24 hours after a death of an individual occurs.

(b) An investigation shall be initiated and oral notification of the county intellectual disability program of the county in which the facility is located, the funding agency and the appropriate regional office of the Department shall be given within 24 hours after an unusual or unexpected death occurs.

(c) A copy of death reports shall be kept.

(d) The individual's family or guardian shall be immediately notified of the death of an individual.]

(a) In investigating an incident, ~~the agency shall review and consider~~ the following needs of the affected individual SHALL BE REVIEWED AND CONSIDERED:

(1) Potential risks.

(2) Health care information.

(3) Medication history and current medication.

(4) Behavioral health history.

(5) Incident history.

(6) Social needs.

(7) Environmental needs.

(8) Personal safety.

(b) The agency shall monitor an individual's risk for recurring incidents and implement corrective action, as appropriate.

(c) The agency shall work cooperatively with the ~~PSP~~ INDIVIDUAL PLAN team to revise the ~~PSP~~ INDIVIDUAL PLAN if indicated by the incident investigation.

§ 6500.22. Incident [record] analysis.

[A record shall be kept of individual illnesses, seizures, acute emotional traumas and accidents requiring medical attention but not inpatient hospitalization, that occur at the home.]

(a) ~~The agency shall complete the~~ THE following SHALL BE COMPLETED for each confirmed incident:

(1) Analysis to determine the ~~root~~ cause of the incident.

(2) Corrective action, IF INDICATED.

(3) A strategy to address the potential risks to the affected individual.

(b) The agency shall review and analyze incidents and conduct AND DOCUMENT a trend analysis at least every 3 months.

(c) The agency shall identify and implement preventive measures to reduce:

(1) The number of incidents.

(2) The severity of the risks associated with the incident.

(3) The likelihood of an incident recurring.

(d) The agency shall educate staff persons and the individual based on the circumstances of the incident.

(e) The agency shall ~~analyze~~ MONITOR incident data ~~continuously~~ and take actions to mitigate and manage risks.

§ 6500.25. Applicable ~~laws~~ STATUTES and regulations.

The home and agency shall comply with applicable ~~Federal, State and local, regulations and ordinances~~ FEDERAL AND STATE STATUTES AND REGULATIONS AND LOCAL ORDINANCES.

§ 6500.26. CHILDREN'S SERVICES.

(A) THE CHILD, THE CHILD'S PARENTS AND THE CHILD'S LEGAL GUARDIAN SHALL BE PROVIDED THE OPPORTUNITY TO PARTICIPATE IN THE EXERCISE OF RIGHTS, DECISION-MAKING AND INDIVIDUAL PLAN ACTIVITIES, UNLESS OTHERWISE PROHIBITED BY COURT ORDER.

(B) THE PROVISIONS OF THIS CHAPTER REGARDING RIGHTS, DECISION-MAKING AND INDIVIDUAL PLAN ACTIVITIES SHALL BE IMPLEMENTED IN ACCORDANCE WITH GENERALLY ACCEPTED, AGE-APPROPRIATE PARENTAL DECISION-MAKING AND PRACTICES FOR CHILDREN, INCLUDING BEDTIMES, PRIVACY, SCHOOL ATTENDANCE, STUDY HOURS, VISITORS AND ACCESS TO FOOD AND PROPERTY, AND DO NOT REQUIRE A MODIFICATION OF RIGHTS IN

THE INDIVIDUAL PLAN IN ACCORDANCE WITH § 6500.155 (RELATING TO CONTENT OF THE INDIVIDUAL PLAN).

(C) THE INDIVIDUAL PLAN IN § 6500.155 SHALL INCLUDE DESIRED OUTCOMES RELATING TO STRENGTHENING OR SECURING A PERMANENT CAREGIVING RELATIONSHIP FOR THE CHILD.

(D) AN UNRELATED CHILD AND ADULT MAY NOT SHARE A BEDROOM.

(E) FOR PURPOSES OF THIS SECTION, A CHILD IS AN INDIVIDUAL WHO IS UNDER 18 YEARS OF AGE.

INDIVIDUAL RIGHTS

§ 6500.31. [Informing and encouraging exercise] Exercise of rights.

[(a) Each individual, or the individual's parent, guardian or advocate if appropriate, shall be informed of the individual's rights upon admission and annually thereafter.

(b) A statement signed and dated by the individual, or the individual's parent, guardian or advocate if appropriate, acknowledging receipt of the information on individual rights upon admission and annually thereafter, shall be kept.

(c) Each individual shall be encouraged to exercise the individual's rights.]

(a) An individual may not be deprived of rights as provided under § 6500.32 (relating to rights of the individual).

(b) ~~An individual shall be continually supported to exercise the individual's rights.~~

~~(c)~~ An individual shall be provided the ~~support and accommodation necessary~~ ASSISTANCE NECESSARY FOR THE INDIVIDUAL ~~to be able~~ to understand ~~and actively exercise~~ the individual's rights.

~~(d)~~ (C) An individual may not be reprimanded, punished or retaliated against for exercising the individual's rights.

~~(e)~~ (D) A court's written order that restricts an individual's rights shall be followed.

~~(f)~~ (E) A court-appointed legal guardian may exercise rights and make decisions on behalf of an individual in accordance with ~~a court order~~ THE CONDITIONS OF GUARDIANSHIP AS SPECIFIED IN THE COURT ORDER.

~~(g)~~ (F) An individual who has a court-appointed legal guardian, or who has a court order restricting the individual's rights, shall be involved in ~~decision-making~~ DECISION-MAKING in accordance with the court order.

~~(h)~~ (G) An individual has the right to designate persons to assist in ~~decision-making~~ DECISION-MAKING AND EXERCISING RIGHTS on behalf of the individual.

§ 6500.32. Rights of the individual.

[An individual may not be deprived of rights.]

(a) An individual may not be discriminated against because of race, color, creed, disability, religious affiliation, ancestry, gender, gender identity, sexual orientation, national origin or age.

(b) An individual has the right to civil and legal rights afforded by law, including the right to vote, speak freely, ~~and~~ practice the religion of ~~his~~ THE INDIVIDUAL'S choice ~~or to~~ AND practice no religion.

(c) An individual may not be abused, neglected, mistreated, exploited, abandoned or subjected to corporal punishment.

(d) An individual shall be treated with dignity and respect.

(e) An individual has the right to make choices and accept risks.

(f) An individual has the right to refuse to participate in activities and ~~supports~~ SERVICES.

(g) An individual has the right to control the individual's own schedule AND ACTIVITIES.

(h) An individual has the right to privacy of person and possessions.

(i) An individual has the right of access to and security of the individual's possessions.

(j) An individual has the right to voice concerns about the ~~supports~~ SERVICES the individual receives.

(k) An individual has the right to participate in the development and implementation of the ~~PSP~~ INDIVIDUAL PLAN.

(l) An individual has the right to receive scheduled and unscheduled visitors, and to communicate and meet privately with ~~persons of the individual's choice~~ WHOM THE INDIVIDUAL CHOOSES, at any time.

(m) An individual has the right to unrestricted access to send and receive mail and other forms of communications, unopened and unread by others, INCLUDING THE RIGHT TO SHARE CONTACT INFORMATION WITH WHOM THE INDIVIDUAL CHOOSES.

(n) An individual has the right to unrestricted and private access to telecommunications.

(o) An individual has the right to manage and access the individual's ~~own~~ finances.

(p) An individual has the right to choose persons with whom to share a bedroom.

(q) An individual has the right to furnish and decorate the individual's bedroom ~~and the common areas of the home~~ IN ACCORDANCE WITH § 6500.33 (RELATING TO NEGOTIATION OF CHOICES).

(r) An individual has the right to lock the individual's bedroom door.

(1) LOCKING MAY BE PROVIDED BY A KEY, ACCESS CARD, KEYPAD CODE OR OTHER ENTRY MECHANISM ACCESSIBLE TO THE INDIVIDUAL TO PERMIT THE INDIVIDUAL TO LOCK AND UNLOCK THE DOOR.

(2) ACCESS TO AN INDIVIDUAL'S BEDROOM SHALL BE PROVIDED ONLY IN A LIFE-SAFETY EMERGENCY OR WITH THE EXPRESS PERMISSION OF THE INDIVIDUAL FOR EACH INCIDENCE OF ACCESS.

(3) ASSISTIVE TECHNOLOGY SHALL BE PROVIDED AS NEEDED TO ALLOW THE INDIVIDUAL TO LOCK AND UNLOCK THE DOOR WITHOUT ASSISTANCE.

(4) THE LOCKING MECHANISM SHALL ALLOW EASY AND IMMEDIATE ACCESS BY THE INDIVIDUAL AND STAFF PERSONS IN THE EVENT OF AN EMERGENCY.

(5) THE PRIMARY CAREGIVER SHALL HAVE THE KEY OR ENTRY DEVICE TO LOCK AND UNLOCK THE DOOR.

(S) AN INDIVIDUAL HAS THE RIGHT TO HAVE A KEY, ACCESS CARD, KEYPAD CODE OR OTHER ENTRY MECHANISM TO LOCK AND UNLOCK AN ENTRANCE DOOR OF THE HOME.

~~(s)~~ (T) An individual has the right to access food at any time.

~~(t)~~ (U) An individual has the right to make ~~informed~~ health care decisions.

(V) AN INDIVIDUAL'S RIGHTS MAY ONLY BE MODIFIED IN ACCORDANCE WITH § 6500.155 (RELATING TO CONTENT OF THE INDIVIDUAL PLAN) TO THE EXTENT NECESSARY TO MITIGATE A SIGNIFICANT HEALTH AND SAFETY RISK TO THE INDIVIDUAL OR OTHERS.

§ 6500.33. [Rights of the individual.] Negotiation of choices.

[(a) An individual may not be neglected, abused, mistreated or subjected to corporal punishment.

(b) An individual may not be required to participate in research projects.

(c) An individual has the right to manage the individual's personal financial affairs.

(d) An individual has the right to participate in program planning that affects the individual.

(e) An individual has the right to privacy in bedrooms, bathrooms and during personal care.

(f) An individual has the right to receive, purchase, have and use personal property.

(g) An individual has the right to receive scheduled and unscheduled visitors, communicate, associate and meet privately with the individual's family and persons of the individual's own choice.

(h) An individual has the right to reasonable access to a telephone and the opportunity to receive and make private calls, with assistance when necessary.

(i) An individual has the right to unrestricted mailing privileges.

(j) An individual who is of voting age shall be informed of the right to vote and shall be assisted to register and vote in elections.

(k) An individual has the right to practice the religion or faith of the individual's choice.

(l) An individual has the right to be free from excessive medication.

(m) An individual may not be required to work at the home except for the upkeep of the individual's bedrooms and in the upkeep of family areas and yard.]

(a) An individual's rights shall be exercised so that another individual's OR HOUSEHOLD MEMBER'S rights are not violated.

(b) THE HOME SHALL ASSIST ~~Choices shall be negotiated by~~ the affected individuals AND HOUSEHOLD MEMBERS TO NEGOTIATE CHOICES in accordance with the home's ~~procedures for the individuals~~ PRACTICES to resolve differences and make choices.

§ 6500.34. [Civil] Informing of rights.

[(a) An individual may not be discriminated against because of race, color, religious creed, disability, handicap, ancestry, national origin, age or sex.

(b) Civil rights policies and procedures shall be developed and implemented. Civil rights policies and procedures shall include the following:

(1) Nondiscrimination in the provision of services, admissions, placement, referrals and communication with non-English speaking and nonverbal individuals.

(2) Physical accessibility and accommodation for individuals with physical disabilities.

(3) The opportunity to lodge civil rights complaints.

(4) Informing individuals of their right to register civil rights complaints.]

(a) ~~The agency shall inform and explain individual rights~~ INDIVIDUAL RIGHTS AND THE PROCESS TO REPORT A RIGHTS VIOLATION SHALL BE EXPLAINED to the individual, and persons designated by the individual, ~~upon admission to~~ PRIOR TO MOVING INTO the home and annually thereafter.

(b) ~~The home shall keep a~~ A copy of the statement signed by the individual, or the individual's court-appointed legal guardian, acknowledging receipt of the information on individual rights SHALL BE KEPT.

STAFFING

§ 6500.41. Effective date of staff qualifications.

(a) Sections 6500.42(c) and ~~6500.43(c)~~ 6500.43(E) (relating to chief executive officer; and [family living] life sharing specialist) apply to chief executive officers and [family living] life sharing specialists hired or promoted after November 8, 1991.

(b) ~~[~~Sections~~]~~ ~~Section~~ 6400.43(c) and ~~§~~ 6400.44(c) (relating to CHIEF EXECUTIVE OFFICER; AND program specialist) as published as Chapter 9054 at 12 Pa.B. 384 (January 23, 1982) and which appeared in this title of the *Pennsylvania Code* at serial pages (133677) to (133678) apply to chief executive officers and [family living] life sharing specialists hired or promoted prior to November 8, 1991.

§ 6500.42. Chief executive officer.

(a) If an agency is the legal entity administering the home, there shall be one chief executive officer responsible for the [family living] life sharing program or agency.

* * * * *

§ 6500.43. [Family living] Life sharing specialist.

(a) There shall be a [family living] life sharing specialist for each individual.

(b) A [family living] life sharing specialist shall be assigned to no more than [8] eight homes.

(c) A [family living] life sharing specialist shall be responsible for a maximum of 16 people, including people served in other types of services.

(d) The [family living] life sharing specialist shall be responsible for the following:

[(1) Coordinating and completing assessments.

(2) Providing the assessment as required under § 6500.151(f) (relating to assessment).

(3) Participating in the development of the ISP, including annual updates and revisions of the ISP.

(4) Attending the ISP meetings.

(5) Fulfilling the role of plan lead, as applicable, under §§ 6500.152 and 6500.156(f) and (g) (relating to development, annual update and revision of the ISP; and ISP review and revision).

(6) Reviewing the ISP, annual updates and revisions for content accuracy.

(7) Reporting content discrepancy to the SC, as applicable, and plan team members.

(8) Implementing the ISP as written.

(9) Supervising, monitoring and evaluating services provided to the individual.

(10) Reviewing, signing and dating the monthly documentation of an individual's participation and progress toward outcomes.

(11) Reporting a change related to the individual's needs to the SC, as applicable, and plan team members.

(12) Reviewing the ISP with the individual as required under § 6500.156.

(13) Documenting the review of the ISP as required under § 6500.156.

(14) Providing the documentation of the ISP review to the SC, as applicable, and plan team members as required under § 6500.156(d).

(15) Informing plan team members of the option to decline the ISP review documentation as required under § 6500.156(e).

(16) Recommending a revision to a service or outcome in the ISP as provided under § 6500.156(c)(4).

(17) Coordinating the services provided to an individual.

(18) Coordinating the support services for the family.

(19) Coordinating the training of direct service workers and the family in the content of health and safety needs relevant to each individual.

(20) Developing and implementing provider services as required under § 6500.158 (relating to provider services).]

(1) Coordinating the completion of assessments.

(2) Participating in the ~~PSP~~ INDIVIDUAL PLAN process, ~~PSP~~ development, ~~PSP~~ team reviews and ~~the~~ implementation ~~of the PSP~~ in accordance with this chapter.

(3) Providing and supervising activities for the individuals in accordance with the ~~PSPs~~ INDIVIDUAL PLAN.

(4) Supporting the integration of individuals in the community.

(5) Supporting individual communication and involvement with families and friends.

(e) A [family living] life sharing specialist shall have one of the following groups of qualifications:

(1) A master's degree or above from an accredited college or university and 1 year of work experience working directly with persons with an intellectual disability or autism.

(2) A bachelor's degree from an accredited college or university and 2 years of work experience working directly with persons with an intellectual disability or autism.

(3) An associate's degree or 60 credit hours from an accredited college or university and 4 years of work experience working directly with persons with an intellectual disability or autism.

(4) A high school diploma or general education development certificate and 6 years of work experience working directly with persons with an intellectual disability or autism.

§ 6500.44. Supervision.

(a) An individual may be left unsupervised for specified periods of time if the absence of direct supervision is consistent with the individual's assessment and is part of the individual's [ISP] ~~PSP~~ INDIVIDUAL PLAN, as an outcome which requires the achievement of a higher level of independence.

(b) An individual requiring direct supervision may not be left under the supervision of a person under [the age of] 18 years of age.

(c) There shall be a [family living] life sharing specialist or designee accessible when the individual is in the home.

(d) Supervision as specified in the [ISP] ~~PSP~~ INDIVIDUAL PLAN shall be implemented as written when the supervision specified in the [ISP] ~~PSP~~ INDIVIDUAL PLAN is greater than required under subsections (a), (b) and (c).

(e) The staff qualifications and staff ratio as specified in the [ISP] ~~PSP~~ INDIVIDUAL PLAN shall be implemented as written, including when the staff ratio is greater than required under subsections (a), (b) and (c).

(f) An individual may not be left unsupervised solely for the convenience of the family or direct service worker.

§ 6500.45. [Training.] CPR, first aid and Heimlich maneuver training.

[(a) The adult family member who will have primary responsibility for caring for and providing services to the individual shall have at least 24 hours of training related to intellectual disability, family dynamics, community participation, individual service planning and delivery, relationship building and the requirements specified in this chapter, prior to an individual living in the home.

(b)] (a) The primary caregiver shall be trained by an individual certified as a trainer by a hospital or other recognized health care organization, in first aid and Heimlich techniques prior to an individual living in the home and annually thereafter.

[(c)] (b) The primary caregiver shall be trained and certified by an individual certified as a trainer by a hospital or other recognized health care organization, in cardiopulmonary resuscitation, if indicated by the medical needs of the individual, prior to the individual living in the home and annually thereafter.

§ 6500.46. ~~Annual training plan.~~ (RESERVED).

[(a) The adult family member who will have primary responsibility for caring for and providing services to the individual shall have at least 24 hours of training in the human services field annually.

(b) A family living specialist who is employed by an agency for more than 40 hours per month shall have at least 24 hours of training related to intellectual disability and the requirements specified in this chapter annually.]

~~(a) The agency shall design an annual training plan based on the needs of the individuals as specified in the individuals' PSPs, other data and analysis indicating person's training needs and as required under §§ 6500.45 and 6500.48 (relating to CPR, first aid and Heimlich maneuver training; and annual training).~~

~~(b) The annual training plan must include the orientation program as specified in § 6500.47 (relating to orientation program).~~

~~(c) The annual training plan must include training aimed at improving the knowledge, skills and core competencies of the person to be trained.~~

§ 6500.47. [Record of training.] Orientation ~~program~~.

[Records of preservice and annual training, including the training source, content, dates, length of training, copies of certificates received and persons attending shall be kept.]

(a) Prior to an individual living in the home, the primary caregiver and the life sharing specialist shall complete the orientation ~~program~~ as described in subsection (b).

(b) The orientation ~~program~~ must encompass the following areas:

(1) The application of person-centered practices, ~~including respecting rights, facilitating~~ community integration, ~~honoring~~ INDIVIDUAL choice and supporting individuals ~~in maintaining~~ TO DEVELOP AND MAINTAIN relationships.

(2) The prevention, detection and reporting of abuse, suspected abuse and alleged abuse in accordance with ~~sections 701—708 of~~ the Older Adults Protective Services Act (35 P.S. §§ ~~10225.701—10225.708~~ 10225.101—10225.5102), THE CHILD PROTECTIVE SERVICES LAW (23 Pa.C.S. §§ 6301—6386) ~~(relating to Child Protective Services Law)~~, the Adult Protective Services Act (35 P.S. §§ 10210.101—10210.704) and applicable protective services regulations.

(3) Individual rights.

(4) Recognizing and reporting incidents.

(5) Job-related knowledge and skills.

§ 6500.48. Annual training.

(a) The primary caregiver and the life sharing specialist shall complete 24 hours of training RELATED TO JOB SKILLS AND KNOWLEDGE each year.

(b) ~~A minimum of 8 hours of the~~ THE annual training hours specified in subsection (a) must encompass the following areas:

(1) The application of person-centered practices, ~~including respecting~~ rights, facilitating community integration, ~~honoring~~ INDIVIDUAL choice and supporting individuals ~~in maintaining~~ TO DEVELOP AND MAINTAIN relationships.

(2) The prevention, detection and reporting of abuse, suspected abuse and alleged abuse in accordance with ~~sections 701—708 of~~ the Older Adults Protective Services Act (35 P.S. §§ ~~10225.701—10225.708~~ 10225.101—10225.5102), THE CHILD PROTECTIVE SERVICES LAW (23 Pa.C.S. §§ 6301—6386) ~~(relating to Child Protective Services Law)~~, the Adult Protective Services Act (35 P.S. §§ 10210.101—10210.704) and applicable protective services regulations.

(3) Individual rights.

(4) Recognizing and reporting incidents.

(5) The safe and appropriate use of ~~positive interventions~~ BEHAVIOR SUPPORTS. ~~if the primary caregiver will provide a support to an individual with a dangerous behavior.~~

(6) IMPLEMENTATION OF THE INDIVIDUAL PLAN.

~~(c) The balance of the annual training hours must be in areas identified by the agency in the agency's annual training plan in § 6500.46 (relating to annual training plan).~~

~~(d) All training, including those training courses identified in subsections (b) and (c), must be included in the agency's annual training plan.~~

§ 6500.49. Training records.

(a) Records of orientation and training, including the training source, content, dates, length of training, copies of certificates received and persons attending, shall be kept.

(b) A training record for each person trained shall be kept.

PHYSICAL SITE

§ 6500.69. Indoor temperature.

(a) The indoor temperature in individual bedrooms and [family living] life sharing areas may not be less than 62°F during nonsleeping hours while individuals are present in the home.

(b) The indoor temperature in individual bedrooms and [family living] life sharing areas may not be less than 55°F during sleeping hours.

(c) When the indoor temperature in individual bedrooms or [family living] life sharing areas exceeds 85°F, mechanical ventilation such as fans shall be used.

(d) If an individual's medical needs indicate an indoor temperature that is different from that required under subsections (a)—(c), the medical recommendations for temperature shall be met.

§ 6500.76. Furniture.

Furniture in individual bedrooms and [family living] life sharing areas shall be nonhazardous, clean and sturdy.

MEDICATIONS

§ 6500.131. [Storage of medications.] Self-administration.

[(a) Prescription and nonprescription medications of individuals shall be kept in their original containers, except for medications of individuals who self-administer medications and keep their medications in personal daily or weekly dispensing containers.

(b) Prescription and potentially toxic nonprescription medications shall be kept in an area or container that is locked or made inaccessible to the individuals, unless it is

documented in each individual's assessment that each individual in the home can safely use or avoid toxic materials.

(c) Prescription and potentially toxic nonprescription medications stored in a refrigerator shall be kept in a separate locked container or made inaccessible to the individuals, unless it is documented in each individual's assessment that each individual in the home can safely use or avoid toxic materials.

(d) Prescription and nonprescription medications of individuals shall be stored under proper conditions of sanitation, temperature, moisture and light.

(e) Discontinued prescription medications of individuals shall be disposed of in a safe manner.]

(a) ~~An agency shall provide an~~ AN individual who has a prescribed medication SHALL BE PROVIDED with assistance, as needed, for the individual's self-administration of the medication.

(b) Assistance in the self-administration of medication includes helping the individual to remember the schedule for taking the medication, offering the individual the medication at the prescribed times, opening a medication container and storing the medication in a secure place.

(c) ~~The agency shall provide or arrange for assistive~~ ASSISTIVE technology SHALL BE PROVIDED to support the individual's self-administration of medications.

(d) The ~~PSP~~ INDIVIDUAL PLAN must identify if the individual is unable to self-administer medications.

(e) To be considered able to self-administer medications, an individual shall do all of the following:

(1) Recognize and distinguish ~~his~~ THE INDIVIDUAL'S medication.

(2) Know how much medication is to be taken.

(3) Know when the medication is to be taken. ~~This knowledge may include reminders~~ ASSISTANCE MAY BE PROVIDED TO REMIND THE INDIVIDUAL of the schedule and ~~offering~~ TO OFFER the medication at the prescribed times as specified in subsection (b).

(4) Take or apply the individual's own medication with or without the use of assistive technology.

§ 6500.132. [Labeling of medications.] Medication administration.

[(a) The original container for prescription medications of individuals shall be labeled with a pharmaceutical label that includes the individual's name, the name of the medication, the date the prescription was issued, the prescribed dose and the name of the prescribing physician.

(b) Nonprescription medications used by individuals shall be labeled with the original label.]

(a) ~~An agency whose staff~~ STAFF persons or others WHO are qualified to administer medications as specified in subsection (b) may provide medication administration for an individual who is unable to self-administer the individual's prescribed medication.

(b) A prescription medication that is not self-administered shall be administered by one of the following:

(1) A licensed physician, licensed dentist, licensed physician's assistant, registered nurse, certified registered nurse practitioner, licensed practical nurse ~~or~~, licensed paramedic OR OTHER HEALTH CARE PROFESSIONAL WHO IS LICENSED, CERTIFIED OR REGISTERED BY THE DEPARTMENT OF STATE TO ADMINISTER MEDICATIONS.

(2) A person who has completed the medication administration ~~training~~ COURSE REQUIREMENTS as specified in § 6500.138 (relating to medication administration training) for the medication administration of the following:

(i) Oral medications.

(ii) Topical medications.

(iii) Eye, nose and ear drop medications.

(iv) Insulin injections.

(v) Epinephrine injections for insect bites or other allergies.

(VI) MEDICATIONS, INJECTIONS, PROCEDURES AND TREATMENTS AS PERMITTED BY APPLICABLE STATUTES AND REGULATIONS.

(c) Medication administration includes the following activities, based on the needs of the individual:

(1) Identify the correct individual.

(2) Remove the medication from the original container.

(3) ~~Crush or split~~ PREPARE the medication as ordered by the prescriber.

(4) Place the medication in a medication cup or other appropriate container, or in the individual's hand, mouth or other route as ordered by the prescriber.

(5) If indicated by the prescriber's order, measure vital signs and administer medications according to the prescriber's order.

(6) Injection of insulin ~~or~~ AND INJECTION OF epinephrine in accordance with this chapter.

§ 6500.133. [Use of prescription] Storage and disposal of medications.

[(a) A prescription medication shall only be used by the individual for whom the medication was prescribed.

(b) If a medication is prescribed to treat symptoms of a diagnosed psychiatric illness, there shall be a written protocol as part of the ISP to address the social, emotional and environmental needs of the individual related to the symptoms of the diagnosed psychiatric illness.

(c) If a medication is prescribed to treat symptoms of a diagnosed psychiatric illness, there shall be a review with documentation by a licensed physician at least every 3

months that includes the reason for prescribing the medication, the need to continue the medication and the necessary dosage.]

(a) Prescription and nonprescription medications shall be kept in their original labeled containers. PRESCRIPTION MEDICATIONS SHALL BE LABELED WITH A LABEL ISSUED BY A PHARMACY.

(b) A prescription medication may not be removed from its original labeled container ~~more than 2 hours~~ in advance of the scheduled administration, EXCEPT FOR THE PURPOSE OF PACKAGING THE MEDICATION FOR THE INDIVIDUAL TO TAKE WITH THE INDIVIDUAL TO A COMMUNITY ACTIVITY FOR ADMINISTRATION THE SAME DAY THE MEDICATION IS REMOVED FROM ITS ORIGINAL CONTAINER.

(c) If insulin or epinephrine is not packaged in an individual dose container, assistance with or the administration of the injection shall be provided immediately upon removal of the medication from its original labeled container.

(d) Prescription medications and syringes, with the exception of epinephrine and epinephrine auto-injectors, shall be kept in an area or container that is locked.

(e) Epinephrine and epinephrine auto-injectors shall be stored safely and kept easily accessible at all times. The epinephrine and epinephrine auto-injectors shall be easily

accessible to the individual if the epinephrine is self-administered or to the staff person who is with the individual if a staff person will administer the epinephrine.

(f) Prescription medications stored in a refrigerator shall be kept in an area or container that is locked.

(g) Prescription medications shall be stored in an organized manner under proper conditions of sanitation, temperature, moisture and light and in accordance with the manufacturer's instructions.

(h) Prescription medications that are discontinued or expired shall be destroyed in a safe manner according to ~~the Department of Environmental Protection and~~ applicable Federal and State STATUTES AND regulation~~s~~.

(i) ~~Subsections (a)—(d) and (f) do~~ THIS SECTION DOES not apply for an individual who self-administers medication and stores the medication in the individual's private bedroom OR PERSONAL BELONGINGS.

§ 6500.134. **[Medication log.] ~~Labeling of medications.~~ (RESERVED).**

[(a) A medication log listing the medications prescribed, dosage, time and date that prescription medications, including insulin, were administered, and the name of the

person who administered the prescription medication or insulin shall be kept for each individual who does not self-administer medication.

(b) The information specified in subsection (a) shall be logged immediately after each individual's dose of medication.

(c) A list of prescription medications, the prescribed dosage and the name of the prescribing physician shall be kept for each individual who self-administers medication.]

~~The original container for prescription medications must be labeled with a pharmacy label that includes the following:~~

~~(1) The individual's name.~~

~~(2) The name of the medication.~~

~~(3) The date the prescription was issued.~~

~~(4) The prescribed dosage and instructions for administration.~~

~~(5) The name and title of the prescriber.~~

§ 6500.135. [Medication errors.] Prescription medications.

[Documentation of medication errors and follow-up action taken shall be kept.]

(a) A prescription medication shall be prescribed in writing by an authorized prescriber.

(b) A prescription order shall be kept current.

(c) A prescription medication shall be administered as prescribed.

(d) A prescription medication shall be used only by the individual for whom the prescription was prescribed.

(e) Changes in medication may only be made in writing by the prescriber or, in the case of an emergency, an alternate prescriber, except for circumstances in which oral orders may be accepted by a ~~registered nurse in accordance with regulations of the Department of State.~~ HEALTH CARE PROFESSIONAL WHO IS LICENSED, CERTIFIED OR REGISTERED BY THE DEPARTMENT OF STATE TO ACCEPT ORAL ORDERS. The individual's medication record shall be updated as soon as a written notice of the change is received.

(F) IF A MEDICATION IS PRESCRIBED TO TREAT SYMPTOMS OF A DIAGNOSED PSYCHIATRIC ILLNESS, THERE SHALL BE A WRITTEN PROTOCOL AS PART OF

THE INDIVIDUAL PLAN TO ADDRESS THE SOCIAL, EMOTIONAL AND ENVIRONMENTAL NEEDS OF THE INDIVIDUAL RELATED TO THE SYMPTOMS OF THE DIAGNOSED PSYCHIATRIC ILLNESS.

(G) IF A MEDICATION IS PRESCRIBED TO TREAT SYMPTOMS OF A DIAGNOSED PSYCHIATRIC ILLNESS, THERE SHALL BE A REVIEW BY A LICENSED PHYSICIAN AT LEAST EVERY 3 MONTHS TO DOCUMENT THE REASON FOR PRESCRIBING THE MEDICATION, THE NEED TO CONTINUE THE MEDICATION AND THE NECESSARY DOSAGE.

§ 6500.136. [Adverse reaction.] Medication record.

[If an individual has a suspected adverse reaction to a medication, the family shall notify the prescribing physician immediately. Documentation of adverse reactions shall be kept in the individual's record.]

(a) A medication record shall be kept, including the following for each individual for whom a prescription medication is administered:

(1) Individual's name.

(2) Name ~~and title~~ of the prescriber.

(3) Drug allergies.

(4) Name of medication.

(5) Strength of medication.

(6) Dosage form.

(7) Dose of medication.

(8) Route of administration.

(9) Frequency of administration.

(10) Administration times.

(11) Diagnosis or purpose for the medication, including pro re nata.

(12) Date and time of medication administration.

(13) Name and initials of the person administering the medication.

(14) Duration of treatment, if applicable.

(15) Special precautions, if applicable.

(16) Side effects of the medication, if applicable.

(b) The information in subsection (a)(12) and (13) shall be recorded in the medication record at the time the medication is administered.

(c) If an individual refuses to take a prescribed medication, the refusal shall be documented on the medication record. The refusal shall be reported to the prescriber ~~within 24 hours, unless otherwise instructed by the prescriber. Subsequent refusals to take a prescribed medication shall be reported as required~~ AS DIRECTED by the prescriber OR IF THERE IS HARM TO THE INDIVIDUAL.

(d) The directions of the prescriber shall be followed.

§ 6500.137. [Administration of prescription medications and insulin injections.] Medication errors.

[(a) Prescription medications and insulin injections shall be administered according to the directions specified by a licensed physician, certified nurse practitioner or licensed physician's assistant.

(b) An insulin injection administered by an individual or another person shall be premeasured by the individual or licensed medical personnel.]

(a) Medication errors include the following:

(1) Failure to administer a medication.

(2) Administration of the wrong medication.

(3) Administration of the wrong ~~amount~~ DOSE of medication.

(4) Failure to administer a medication at the prescribed time, which exceeds more than 1 hour before or after the prescribed time.

(5) Administration to the wrong person.

(6) Administration through the wrong route.

(7) ADMINISTRATION WHILE THE INDIVIDUAL IS IN THE WRONG POSITION.

(8) IMPROPER PREPARATION OF THE MEDICATION.

(b) Documentation of medication errors, follow-up action taken and the prescriber's response, IF APPLICABLE, shall be kept in the individual's record.

(C) A MEDICATION ERROR SHALL BE REPORTED AS AN INCIDENT AS SPECIFIED IN § 6500.20(B) (RELATING TO INCIDENT REPORT AND INVESTIGATION).

(D) A MEDICATION ERROR SHALL BE REPORTED TO THE PRESCRIBER UNDER ANY OF THE FOLLOWING CONDITIONS:

(1) AS DIRECTED BY THE PRESCRIBER.

(2) IF THE MEDICATION IS ADMINISTERED TO THE WRONG PERSON.

(3) IF THERE IS HARM TO THE INDIVIDUAL.

§ 6500.138. [Medications training.] Adverse reaction.

[(a) Family members who administer prescription medications or insulin injections to individuals shall receive training by the individual's source of health care about the administration, side effects and contraindications of the specific medication or insulin.

(b) Family members who administer insulin injections to individuals shall have completed and passed a diabetes patient education program that meets the National Standards for Diabetes Patient Education Programs of the National Diabetes Advisory Board, 7550 Wisconsin Avenue, Bethesda, Maryland 20205.

(c) Documentation of the training specified in subsections (a) and (b) shall be kept.]

(a) If an individual has a suspected adverse reaction to a medication, the home shall immediately consult a health care practitioner or seek emergency medical treatment.

(b) An adverse reaction to a medication, the health care practitioner's response to the adverse reaction and the action taken shall be documented.

§ 6500.139. Medication administration training.

(a) A person who has successfully completed a Department-approved medications administration course, including the course renewal requirements, may administer ~~the following:~~

~~(1) Oral medications.~~

~~(2) Topical medications.~~

~~(3) Eye, nose and ear drop medications~~ MEDICATIONS, INJECTIONS, PROCEDURES AND TREATMENTS AS SPECIFIED IN § 6500.132 (RELATING TO MEDICATION ADMINISTRATION).

(b) A person may administer insulin injections following successful completion of both:

(1) The MEDICATION ADMINISTRATION course specified in subsection (a).

(2) A Department-approved diabetes patient education program within the past 12 months.

(c) A person may administer an epinephrine injection by means of an auto-injection device in response to anaphylaxis or another serious allergic reaction following successful completion of both:

(1) The MEDICATION ADMINISTRATION course specified in subsection (a).

(2) Training WITHIN THE PAST 24 MONTHS relating to the use of an auto-injection epinephrine injection device provided by a ~~licensed, registered or certified health care~~ professional WHO IS LICENSED, CERTIFIED OR REGISTERED BY THE DEPARTMENT OF STATE IN THE HEALTH CARE FIELD. ~~within the past 12 months.~~

(d) A record of the training shall be kept, including the person trained, the date, source, name of trainer and documentation that the course was successfully completed.

PROGRAM

§ 6500.151. Assessment.

(a) Each individual shall have an initial assessment within 1 year prior to or 60 calendar days after admission to the [family living] home and an updated assessment annually thereafter. The initial assessment must include an assessment of adaptive behavior and level of skills completed within 6 months prior to admission to the [family living] home.

(b) If the [program] life sharing specialist is making a recommendation to revise a service or outcome in the [ISP as required under § 6500.156(c)(4) (relating to ISP review and revision)] ~~PSP~~ INDIVIDUAL PLAN, the individual shall have an assessment completed as required under this section.

(c) The assessment shall be based on assessment instruments, interviews, progress notes and observations.

(d) The [family living] life sharing specialist shall sign and date the assessment.

* * * * *

(f) The [program] life sharing specialist shall provide the assessment to the ~~SC, as applicable, and~~ [plan] ~~PSP~~ INDIVIDUAL PLAN team members at least 30 calendar days prior to [an ISP meeting for the development of the ISP, the annual update, and revision of the ISP under §§ 2380.182, 2390.152, 6400.182 and 6500.152 (relating to development, annual update and revision of the ISP)] ~~a PSP~~ AN INDIVIDUAL PLAN meeting.

§ 6500.152. ~~Development~~ **[, annual update and revision of the ISP]** ~~**of the PSP**~~**.**

DEVELOPMENT, ANNUAL UPDATE AND REVISION OF THE INDIVIDUAL PLAN.

[(a) An individual shall have one ISP.

(b) When an individual is not receiving services through an SCO, the family living program specialist shall be the plan lead when one of the following applies:

(1) The individual resides at a family living home licensed under this chapter.

(2) The individual resides at a family living home licensed under this chapter and attends a facility licensed under Chapter 2380 or 2390 (relating to adult training facilities; and vocational facilities).

(c) The plan lead shall be responsible for developing and implementing the ISP, including annual updates and revisions.

(d) The plan lead shall develop, update and revise the ISP according to the following:

(1) The ISP shall be initially developed, updated annually and revised based upon the individual's current assessments as required under §§ 2380.181, 2390.151, 6400.181 and 6500.151 (relating to assessment).

(2) The initial ISP shall be developed within 90 calendar days after the individual's admission date to the family living home.

(3) The ISP, annual updates and revisions shall be documented on the Department-designated form located in the Home and Community Services Information System (HCSIS) and also on the Department's web site.

(4) An invitation shall be sent to plan team members at least 30 calendar days prior to an ISP meeting.

(5) Copies of the ISP, including annual updates and revisions under § 6500.156 (relating to ISP review and revision), Shall be sent as required under § 6500.157 (relating to copies).]

(a) ~~An individual shall have one approved and authorized PSP at a given time.~~

~~(b) An individual's service implementation plan must be consistent with the PSP in subsection (a).~~

~~(c)~~ The ~~support coordinator, targeted support manager or~~ life sharing specialist shall coordinate the development of the ~~PSP~~ INDIVIDUAL PLAN, including revisions, ~~in cooperation~~ with the individual and the ~~individual's PSP~~ INDIVIDUAL PLAN team.

~~(d)~~ (B) The initial ~~PSP~~ INDIVIDUAL PLAN shall be developed based on the individual assessment within ~~60 days~~ 90 DAYS of the individual's date of admission to the home.

~~(e)~~ (C) The ~~PSP~~ INDIVIDUAL PLAN shall be initially developed, revised annually and revised when an individual's needs change based upon a current assessment.

~~(f)~~ (D) The individual and persons designated by the individual shall be involved ~~in~~ and supported in the INITIAL development and revisions of the ~~PSP~~ INDIVIDUAL PLAN.

~~(g) The PSP, including revisions, shall be documented on a form specified by the Department.~~

§ 6500.153. [Content of the ISP.] ~~The PSP~~ INDIVIDUAL PLAN team.

[The ISP, including annual updates and revisions under § 6500.156 (relating to ISP review and revision) must include the following:

(1) Services provided to the individual and expected outcomes chosen by the individual and individual's plan team.

(2) Services provided to the individual to increase community involvement, including volunteer or civic-minded opportunities and membership in National or local organizations as required under § 6500.158 (relating to provider services).

(3) Current status in relation to an outcome and method of evaluation used to determine progress toward that expected outcome.

(4) A protocol and schedule outlining specified periods of time for the individual to be without direct supervision, if the individual's current assessment states the individual may be without direct supervision and if the individual's ISP includes an expected outcome which requires the achievement of a higher level of independence. The protocol must include the current level of independence and the method of evaluation used to determine progress toward the expected outcome to achieve the higher level of independence.

(5) A protocol to address the social, emotional and environmental needs of the individual, if medication has been prescribed to treat symptoms of a diagnosed psychiatric illness.

(6) A protocol to eliminate the use of restrictive procedures, if restrictive procedures are utilized, and to address the underlying causes of the behavior which led to the use of restrictive procedures including the following:

(i) An assessment to determine the causes or antecedents of the behavior.

(ii) A protocol for addressing the underlying causes or antecedents of the behavior.

(iii) The method and time line for eliminating the use of restrictive procedures.

(iv) A protocol for intervention or redirection without utilizing restrictive procedures.

(7) Assessment of the individual’s potential to advance in the following:

(i) Residential independence.

(ii) Community involvement.

(iii) Vocational programming.

(iv) Competitive community-integrated employment.]

(a) The ~~PSP~~ INDIVIDUAL PLAN shall be developed by an interdisciplinary team, including the following:

(1) The individual.

(2) Persons designated by the individual.

(3) The individual's direct care staff persons.

(4) The ~~program~~ LIFE SHARING specialist.

(5) The support coordinator, targeted support manager or a program representative from the funding source, if applicable.

(6) The program specialist for the individual's day program, if applicable.

(7) Other specialists such as health care, behavior management, speech, occupational and physical therapy as appropriate for the ~~individual~~ INDIVIDUAL'S needs.

(b) At least three members of the ~~PSP~~ INDIVIDUAL PLAN team, in addition to the individual and persons designated by the individual, shall be present at a ~~PSP~~ meeting at which the ~~PSP~~ INDIVIDUAL PLAN is developed or revised.

(c) ~~Members of the PSP team who attend the meeting shall sign and date the PSP.~~ THE LIST OF PERSONS WHO PARTICIPATED IN THE INDIVIDUAL PLAN MEETING SHALL BE KEPT.

§ 6500.154. [Plan team participation.] ~~The PSP~~ INDIVIDUAL PLAN process.

[(a) The plan team shall participate in the development of the ISP, including the annual updates and revision under § 6500.156 (relating to ISP review and revision).

(1) A plan team shall include as its members the following:

(i) The individual.

(ii) A program specialist or family living specialist, as applicable, from each provider delivering a service to the individual.

(iii) A direct service worker who works with the individual from each provider delivering services to the individual.

(iv) Any other person the individual chooses to invite.

(2) If the following have a role in the individual's life, the plan team may also include as its members, as applicable, the following:

(i) Medical, nursing, behavior management, speech, occupational or physical therapy specialists.

(ii) Additional direct service workers who work with the individual from each provider delivering a service to the individual.

(iii) The individual's parent, guardian or advocate.

(b) At least three plan team members, in addition to the individual, if the individual chooses to attend, shall be present for the ISP, annual update and ISP revision meeting.

(c) Plan team members who attend a meeting under subsection (b) shall sign and date the signature sheet.]

The ~~PSP~~ INDIVIDUAL PLAN process shall:

(1) Provide ~~necessary~~ information and support to ensure that the individual directs the ~~PSP~~ INDIVIDUAL PLAN process to the ~~maximum~~ extent possible.

(2) Enable the individual to make ~~informed~~ choices and decisions.

(3) ~~Be conducted to reflect~~ REFLECT what is important to the individual to ensure that ~~supports~~ SERVICES are delivered in a manner reflecting individual preferences and ensuring the individual's health, safety and well-being.

(4) ~~Be timely in relation to the individual's needs and occur~~ OCCUR TIMELY at intervals, times and locations of choice and convenience to the individual and to persons designated by the individual.

(5) Be communicated in clear and understandable language.

(6) Reflect cultural considerations of the individual.

(7) Include guidelines for solving disagreements among the ~~PSP~~ INDIVIDUAL PLAN team members.

(8) Include a method for the individual to request updates to the ~~PSP~~ INDIVIDUAL PLAN.

§ 6500.155. [Implementation of the ISP.] Content of the ~~PSP~~ INDIVIDUAL PLAN.

[(a) The ISP shall be implemented by the ISP's start date.

(b) The ISP shall be implemented as written.]

The ~~PSP~~ INDIVIDUAL PLAN, including revisions, must include the following:

(1) The individual's strengths ~~and~~, functional abilities AND SERVICE NEEDS.

(2) ~~The individual's individualized clinical and support needs.~~

~~(3)~~ The individual's ~~goals and~~ preferences related to relationships, COMMUNICATION, community participation, employment, income and savings, health care, wellness and education.

~~(4) Individually identified, person-centered~~ (3) THE INDIVIDUAL'S desired outcomes.

~~(5) Supports~~ (4) SERVICES to assist the individual to achieve desired outcomes.

~~(6) The type, amount, duration and frequency for the support specified in a manner that reflects the assessed needs and choices of the individual. The schedule of support delivery shall be determined by the PSP team.~~

~~(7) Communication mode, abilities and needs.~~

~~(8) Opportunities for new or continued community participation.~~

~~(9) Risk factors, dangerous behaviors and risk mitigation strategies, if applicable.~~

(5) RISKS TO THE INDIVIDUAL'S HEALTH, SAFETY OR WELL-BEING, BEHAVIORS LIKELY TO RESULT IN IMMEDIATE PHYSICAL HARM TO THE INDIVIDUAL OR OTHERS AND RISK MITIGATION STRATEGIES, IF APPLICABLE.

~~(10)~~ (6) Modification of individual rights as necessary to mitigate ~~risks~~ SIGNIFICANT HEALTH AND SAFETY RISKS TO THE INDIVIDUAL OR OTHERS, if applicable.

~~(11) Health care information, including a health care history.~~

~~(12) Financial information including how the individual chooses to use personal funds.~~

~~(13) The person responsible for monitoring the implementation of the PSP.~~

§ 6500.156. [ISP review and revision.] Implementation of the ~~PSP~~ INDIVIDUAL PLAN.

[(a) The family living specialist shall complete an ISP review of the services and expected outcomes in the ISP specific to the family living home licensed under this chapter with the individual every 3 months or more frequently if the individual's needs change, which impacts the services as specified in the current ISP.

(b) The family living specialist and individual shall sign and date the ISP review signature sheet upon review of the ISP.

(c) The ISP review must include the following:

(1) A review of the monthly documentation of an individual's participation and progress during the prior 3 months toward ISP outcomes supported by services provided by the family living home licensed under this chapter.

(2) A review of each section of the ISP specific to the family living home licensed under this chapter.

(3) The family living specialist shall document a change in the individual's needs, if applicable.

(4) The family living specialist shall make a recommendation regarding the following, if applicable:

(i) The deletion of an outcome or service to support the achievement of an outcome which is no longer appropriate or has been completed.

(ii) The addition of an outcome or service to support the achievement of an outcome.

(iii) The modification of an outcome or service to support the achievement of an outcome in which no progress has been made.

(5) If making a recommendation to revise a service or outcome in the ISP, the family living specialist shall complete a revised assessment as required under § 6500.151(b) (relating to assessment).

(d) The family living specialist shall provide the ISP review documentation, including recommendations if applicable, to the SC, as applicable, and plan team members within 30 calendar days after the ISP review meeting.

(e) The family living specialist shall notify the plan team members of the option to decline the ISP review documentation.

(f) If a recommendation for a revision to a service or outcome in the ISP is made, the plan lead as applicable, under §§ 2380.182(b) and (c), 2390.152(b) and (c), 6400.182(b) and (c), 6500.152(b) and (c) (relating to development, annual update and revision of the ISP), shall send an invitation for an ISP revision meeting to the plan team members within 30 calendar days of receipt of the recommendation.

(g) A revised service or outcome in the ISP shall be implemented by the start date in the ISP as written.]

The home and the agency shall implement the ~~PSP~~ INDIVIDUAL PLAN, including revisions.

§ 6500.157. [Copies.] (Reserved).

[A copy of the ISP, including the signature sheet, shall be provided to plan team members within 30 calendar days after the ISP, annual update and ISP revision meetings.]

§ 6500.158. ~~[Provider~~ LIFE SHARING services.~~]~~ ~~(Reserved).~~

~~[~~(a) The ~~family living~~ LIFE SHARING home shall provide services, including assistance, training and support for the acquisition, maintenance or improvement of functional skills, personal needs, communication and personal adjustment.

(b) The ~~family living~~ LIFE SHARING home shall provide opportunities to the individual for participation in community life, including volunteer or civic-minded opportunities and membership in National or local organizations.

(c) The ~~family living~~ LIFE SHARING home shall provide services to the individual as specified in the individual's ~~ISP~~ INDIVIDUAL PLAN.

(d) The ~~family living~~ LIFE SHARING home shall provide services that are age and functionally appropriate to the individual.~~]~~

§ 6500.159. Day services.

(a) Day services such as employment, education, training, volunteer, civic-minded and other meaningful opportunities shall be provided to the individual.

(b) Day services and activities shall be provided at a location other than the [family living] home where the individual lives, unless one of the following exists:

(1) There is written annual documentation by a licensed physician that it is medically necessary for the individual to complete day services at the [family living] home.

(2) There is written annual documentation by the plan team that it is in the best interest of the individual to complete day services at the [family living] home.

§ 6500.160. Recreational and social activities.

(a) The [family living] home shall provide recreational and social activities, including volunteer or civic-minded opportunities and membership in National or local organizations at the following locations:

(1) The [family living] home.

(2) Away from the [family living] home.

(b) Time away from the [family living] home may not be limited to time in school, work or vocational, developmental and volunteer facilities.

(c) Documentation of recreational and social activities shall be kept in the individual's record.

~~[~~RESTRICTIVE PROCEDURES~~]~~ ~~POSITIVE INTERVENTION~~

§ 6500.161. ~~[~~Definition of restrictive procedures.~~]~~ ~~Use of a positive intervention.~~

~~[~~A restrictive procedure is a practice that limits an individual's movement, activity ~~of~~ OR function; interferes with an individual's ability to acquire positive reinforcement; results in

the loss of objects or activities that an individual values; or requires an individual to engage in a behavior that the individual would not engage in given freedom of choice.]

(a) A positive intervention shall be used to prevent, modify and eliminate a dangerous behavior when the behavior is anticipated or occurring.

(b) The least intrusive method shall be applied when addressing a dangerous behavior. For each incidence of a dangerous behavior, every attempt shall be made to modify and eliminate the behavior.

(c) As used in this section, the following words and terms have the following meanings, unless the context clearly indicates otherwise:

Dangerous behavior—An action with a high likelihood of resulting in harm to the individual or others.

Positive intervention—An action or activity intended to prevent, modify and eliminate a dangerous behavior. This includes improved communications, reinforcing appropriate behavior, an environmental change, recognizing and treating physical and behavioral health symptoms, voluntary physical exercise and other wellness practices, redirection, praise, modeling, conflict resolution and de-escalation.

§ 6500.162. [Written policy.] ~~PSP.~~

[A written policy that defines the prohibition or use of specific types of restrictive procedures, describes the circumstances in which restrictive procedures may be used, the persons who may authorize the use of restrictive procedures, a mechanism to monitor and control the use of restrictive procedures, and a process for the individual and family to review the use of restrictive procedures shall be kept.]

~~If the individual has a dangerous behavior as identified in the PSP, the PSP must include the following:~~

~~(1) The specific dangerous behavior to be addressed.~~

~~(2) A functional analysis of the dangerous behavior and the plan to address the reason for the behavior.~~

~~(3) The outcome desired.~~

~~(4) A description of the positive intervention aimed at preventing, modifying or eliminating the dangerous behavior and the circumstances under which the intervention is to be used.~~

~~(5) A target date to achieve the outcome.~~

~~(6) Health conditions that require special attention.~~

§ 6500.163. [Appropriate use of restrictive procedures.] ~~Prohibition of restraints.~~

[(a) A restrictive procedure may not be used as retribution, for the convenience of the family, as a substitute for the program or in a way that interferes with the individual's developmental program.

(b) For each incident requiring restrictive procedures:

(1) Every attempt shall be made to anticipate and de-escalate the behavior using methods of intervention less intrusive than restrictive procedures.

(2) A restrictive procedure may not be used unless less restrictive techniques and resources appropriate to the behavior have been tried but have failed.]

~~The following procedures are prohibited:~~

~~(1) Seclusion, defined as involuntary confinement of an individual in a room or area from which the individual is physically prevented or verbally directed from leaving.~~

~~(2) Aversive conditioning, defined as the application of startling, painful or noxious stimuli.~~

(3) Pressure point techniques, defined as the application of pain for the purpose of achieving compliance.

(4) A chemical restraint, defined as use of drugs or chemicals for the specific and exclusive purpose of controlling acute or episodic aggressive behavior. A chemical restraint does not include a drug ordered by a health care practitioner or dentist to treat the symptoms of a specific mental, emotional or behavioral condition, or as pretreatment prior to a medical or dental examination or treatment.

(5) A mechanical restraint, defined as a device that restricts the movement or function of an individual or portion of an individual's body. Mechanical restraints include a geriatric chair, handcuffs, anklets, wristlets, camisole, helmet with fasteners, muffs and mitts with fasteners, restraint vest, waist strap, head strap, papoose board, restraining sheet, chest restraint and other locked restraints.

(i) The term does not include a device prescribed by a health care practitioner that is used to provide post-surgical care, proper balance or support for the achievement of functional body position.

(ii) The term does not include a device prescribed by a health care practitioner to protect the individual in the event of a seizure, as long as the individual can easily remove the device.

~~(6) A manual restraint, defined as a hands-on physical method that restricts, immobilizes or reduces an individual's ability to move his arms, legs, head or other body parts freely, on a nonemergency basis, or for more than 15 minutes within a 2-hour period. A manual restraint does not include physically prompting, escorting or guiding an individual to provide a support as specified in the individual's PSP.~~

~~(7) A prone position manual restraint.~~

~~(8) A manual restraint that inhibits digestion or respiration, inflicts pain, causes embarrassment or humiliation, causes hyperextension of joints, applies pressure on the chest or joints, or allows for a free fall to the floor.~~

§ 6500.164. [Restrictive procedure review committee.] ~~Permitted interventions.~~ HUMAN RIGHTS TEAM.

[(a) If restrictive procedures are used, there shall be a restrictive procedure review committee.

(b) The restrictive procedure review committee shall include a majority of persons who do not provide direct services to the individual.

(c) The restrictive procedure review committee shall establish a time frame for review and revision of the restrictive procedure plan, not to exceed 6 months between reviews.

(d) A written record of the meetings and activities of the restrictive procedure review committee shall be kept.]

~~(a) Voluntary exclusion, defined as an individual voluntarily removing himself from his immediate environment and placing himself alone to a room or area, is permitted in accordance with the individual's PSP.~~

~~(b) A physical protective restraint may be used only in accordance with § 6500.163(6)—(8) (relating to prohibition of restraints).~~

~~(c) A physical protective restraint may not be used until §§ 6500.48(b)(5) and 6500.155(9) (relating to annual training; and content of the PSP) are met.~~

~~(d) A physical protective restraint may only be used in the case of an emergency to prevent an individual from injuring the individual's self or others.~~

~~(e) A physical protective restraint may not be used as a behavioral intervention, consequence, retribution, punishment, for the convenience of staff persons or as a substitution for individual support.~~

~~(f) A physical protective restraint may not be used for more than 15 minutes within a 2-hour period.~~

~~(g) A physical protective restraint may only be used by a staff person who is trained as specified in § 6500.48.~~

~~(h) As used in this section, a "physical protective restraint" is a hands-on hold of an individual.~~

(A) IF A RESTRICTIVE PROCEDURE IS USED, A HUMAN RIGHTS TEAM SHALL BE USED. A COUNTY MENTAL HEALTH AND INTELLECTUAL DISABILITY PROGRAM HUMAN RIGHTS TEAM THAT MEETS THE REQUIREMENTS OF THIS SECTION MAY BE USED.

(B) THE HUMAN RIGHTS TEAM SHALL INCLUDE A PROFESSIONAL WHO HAS A RECOGNIZED DEGREE, CERTIFICATION OR LICENSE RELATING TO BEHAVIORAL SUPPORT, WHO DID NOT DEVELOP THE BEHAVIOR SUPPORT COMPONENT OF THE INDIVIDUAL PLAN.

(C) THE HUMAN RIGHTS TEAM SHALL INCLUDE A MAJORITY OF PERSONS WHO DO NOT PROVIDE DIRECT SERVICES TO THE INDIVIDUAL.

(D) A RECORD OF THE HUMAN RIGHTS TEAM MEETINGS SHALL BE KEPT.

§ 6500.165. [Restrictive procedure plan.] ~~Access to or the use of an individual's personal property.~~ BEHAVIOR SUPPORT COMPONENT OF THE INDIVIDUAL PLAN.

[(a) For each individual for whom restrictive procedures may be used, a restrictive procedure plan shall be written prior to the use of restrictive procedures.

(b) The restrictive procedure plan shall be developed and revised with the participation of the family living specialist, the family, the interdisciplinary team as appropriate and other professionals as appropriate.

(c) The restrictive procedure plan shall be reviewed, and revised if necessary, according to the time frame established by the restrictive procedure review committee, not to exceed 6 months.

(d) The restrictive procedure plan shall be reviewed, approved, signed and dated by the chairperson of the restrictive procedure review committee and the family living specialist, prior to the use of a restrictive procedure, whenever the restrictive procedure plan is revised and at least every 6 months.

(e) The restrictive procedure plan shall include:

(1) The specific behavior to be addressed and the suspected antecedent or reason for the behavior.

(2) The single behavioral outcome desired stated in measurable terms.

(3) Methods for modifying or eliminating the behavior, such as changes in the individual's physical and social environment, changes in the individual's routine, improving communications, teaching skills and reinforcing appropriate behavior.

(4) Types of restrictive procedures that may be used and the circumstances under which the procedures may be used.

(5) A target date for achieving the outcome.

(6) The amount of time the restrictive procedure may be applied, not to exceed the maximum time periods specified in this chapter.

(7) Physical problems that require special attention during the use of restrictive procedures.

(8) The name of the person responsible for monitoring and documenting progress with the plan.

(f) The restrictive procedure plan shall be implemented as written.

(g) Copies of the restrictive procedure plan shall be kept in the individual's record.]

~~(a) Access to or the use of an individual's personal funds or property may not be used as a reward or punishment.~~

~~(b) An individual's personal funds or property may not be used as payment for damages unless the individual consents to make restitution for the damages as follows:~~

~~(1) A separate written consent is required for each incidence of restitution.~~

~~(2) Consent shall be obtained in the presence of the individual, a person designated by the individual and in the presence of and with the support of the support coordinator or targeted support manager.~~

~~(3) There may not be coercion in obtaining the consent of an individual.~~

~~(4) The agency shall keep a copy of the individual's written consent.~~

(A) FOR EACH INDIVIDUAL FOR WHOM A RESTRICTIVE PROCEDURE MAY BE USED, THE INDIVIDUAL PLAN SHALL INCLUDE A COMPONENT ADDRESSING BEHAVIOR SUPPORT THAT IS REVIEWED AND APPROVED BY THE HUMAN

RIGHTS TEAM IN § 6500.164 (RELATING TO HUMAN RIGHTS TEAM), PRIOR TO USE OF A RESTRICTIVE PROCEDURE.

(B) THE BEHAVIOR SUPPORT COMPONENT OF THE INDIVIDUAL PLAN SHALL BE REVIEWED AND REVISED AS NECESSARY BY THE HUMAN RIGHTS TEAM, ACCORDING TO THE TIME FRAME ESTABLISHED BY THE TEAM, NOT TO EXCEED 6 MONTHS BETWEEN REVIEWS.

(C) THE BEHAVIOR SUPPORT COMPONENT OF THE INDIVIDUAL PLAN SHALL INCLUDE:

(1) THE SPECIFIC BEHAVIOR TO BE ADDRESSED.

(2) AN ASSESSMENT OF THE BEHAVIOR, INCLUDING THE SUSPECTED REASON FOR THE BEHAVIOR.

(3) THE OUTCOME DESIRED.

(4) A TARGET DATE TO ACHIEVE THE OUTCOME.

(5) METHODS FOR FACILITATING POSITIVE BEHAVIORS SUCH AS CHANGES IN THE INDIVIDUAL'S PHYSICAL AND SOCIAL ENVIRONMENT, CHANGES IN THE INDIVIDUAL'S ROUTINE, IMPROVING COMMUNICATIONS, RECOGNIZING AND TREATING PHYSICAL AND BEHAVIOR HEALTH CONDITIONS, VOLUNTARY

PHYSICAL EXERCISE, REDIRECTION, PRAISE, MODELING, CONFLICT RESOLUTION, DE-ESCALATION AND TEACHING SKILLS.

(6) TYPES OF RESTRICTIVE PROCEDURES THAT MAY BE USED AND THE CIRCUMSTANCES UNDER WHICH THE PROCEDURES MAY BE USED.

(7) THE AMOUNT OF TIME THE RESTRICTIVE PROCEDURE MAY BE APPLIED.

(8) THE NAME OF THE PERSON RESPONSIBLE FOR MONITORING AND DOCUMENTING PROGRESS WITH THE BEHAVIOR SUPPORT COMPONENT OF THE INDIVIDUAL PLAN.

(D) IF A PHYSICAL RESTRAINT WILL BE USED OR IF A RESTRICTIVE PROCEDURE WILL BE USED TO MODIFY AN INDIVIDUAL'S RIGHTS IN § 6500.155(6) (RELATING TO CONTENT OF THE INDIVIDUAL PLAN), THE BEHAVIOR SUPPORT COMPONENT OF THE INDIVIDUAL PLAN SHALL BE DEVELOPED BY A PROFESSIONAL WHO HAS A RECOGNIZED DEGREE, CERTIFICATION OR LICENSE RELATING TO BEHAVIORAL SUPPORT.

§ 6500.166. [Training.] ~~Rights team.~~ STAFF TRAINING.

[(a) If a restrictive procedure is used, there shall be at least one person available when restrictive procedures are used who has completed training within the past 12 months in

the use of and ethics of using restrictive procedures including the use of alternate positive approaches.

(b) Persons responsible for developing, implementing or managing a restrictive procedure plan shall be trained in the use of the specific techniques or procedures that are used.

(c) If manual restraint or exclusion is used, persons responsible for developing, implementing or managing a restrictive procedure plan shall have experienced the use of the specific techniques or procedures directly on themselves.

(d) Documentation of the training program provided, including the persons trained, dates of training, description of training and training source shall be kept.]

~~(a) The agency shall have a rights team. The agency may use a county mental health and intellectual disability program rights team that meets the requirements of this section.~~

~~(b) The role of the rights team is to:~~

~~(1) Review each incident, alleged incident and suspected incident of a violation of individual rights as specified in §§ 6500.31—6500.34 (relating to individual rights).~~

(2) Review each incidence of the use of a restraint as specified in §§ 6500.161—6500.164 to:

(i) Analyze systemic concerns.

(ii) Design positive supports as an alternative to the use of a restraint.

(iii) Discover and resolve the reason for an individual's behavior.

(c) Members of the rights team shall include the affected individual, persons designated by the individual, a family member or an advocate if the individual is unable to speak for himself, the individual's support coordinator, a representative from the funding agency and an agency representative.

(d) Members of the rights team shall be comprised of a majority who do not provide direct support to the individual.

(e) If a restraint was used, the individual's health care practitioner shall be consulted.

(f) The rights team shall meet at least once every 3 months.

(g) The rights team shall report its recommendations to the individual's PSP team.

~~(h) The agency shall keep documentation of the rights team meetings and the decisions made at the meetings.~~

(A) A PERSON WHO IMPLEMENTS OR MANAGES A BEHAVIOR SUPPORT COMPONENT OF AN INDIVIDUAL PLAN SHALL BE TRAINED IN THE USE OF THE SPECIFIC TECHNIQUES OR PROCEDURES THAT ARE USED.

(B) IF A PHYSICAL RESTRAINT WILL BE USED, THE STAFF PERSON WHO IMPLEMENTS OR MANAGES THE BEHAVIOR SUPPORT COMPONENT OF THE INDIVIDUAL PLAN SHALL HAVE EXPERIENCED THE USE OF THE PHYSICAL RESTRAINT DIRECTLY ON THE STAFF PERSON.

(C) DOCUMENTATION OF THE TRAINING PROVIDED, INCLUDING THE STAFF PERSONS TRAINED, DATES OF TRAINING, DESCRIPTION OF TRAINING AND TRAINING SOURCE, SHALL BE KEPT.

§§ 6500.167—6500.176. (Reserved).

§ 6500.177. PROHIBITED PROCEDURES.

THE FOLLOWING PROCEDURES ARE PROHIBITED:

(1) SECLUSION, DEFINED AS INVOLUNTARY CONFINEMENT OF AN INDIVIDUAL IN A ROOM OR AREA FROM WHICH THE INDIVIDUAL IS PHYSICALLY

PREVENTED OR VERBALLY DIRECTED FROM LEAVING. SECLUSION INCLUDES PHYSICALLY HOLDING A DOOR SHUT OR USING A FOOT PRESSURE LOCK.

(2) AVERSIVE CONDITIONING, DEFINED AS THE APPLICATION OF STARTLING, PAINFUL OR NOXIOUS STIMULI.

(3) PRESSURE-POINT TECHNIQUES, DEFINED AS THE APPLICATION OF PAIN FOR THE PURPOSE OF ACHIEVING COMPLIANCE. A PRESSURE-POINT TECHNIQUE DOES NOT INCLUDE A CLINICALLY-ACCEPTED BITE RELEASE TECHNIQUE THAT IS APPLIED ONLY AS LONG AS NECESSARY TO RELEASE THE BITE.

(4) A CHEMICAL RESTRAINT, DEFINED AS USE OF A DRUG FOR THE SPECIFIC AND EXCLUSIVE PURPOSE OF CONTROLLING ACUTE OR EPISODIC AGGRESSIVE BEHAVIOR. A CHEMICAL RESTRAINT DOES NOT INCLUDE A DRUG ORDERED BY A HEALTH CARE PRACTITIONER OR DENTIST FOR THE FOLLOWING USE OR EVENT:

(I) TREATMENT OF THE SYMPTOMS OF A SPECIFIC MENTAL, EMOTIONAL OR BEHAVIORAL CONDITION.

(II) PRETREATMENT PRIOR TO A MEDICAL OR DENTAL EXAMINATION OR TREATMENT.

(III) AN ONGOING PROGRAM OF MEDICATION.

(IV) A SPECIFIC, TIME-LIMITED STRESSFUL EVENT OR SITUATION TO ASSIST THE INDIVIDUAL TO CONTROL THE INDIVIDUAL'S OWN BEHAVIOR.

(5) A MECHANICAL RESTRAINT, DEFINED AS A DEVICE THAT RESTRICTS THE MOVEMENT OR FUNCTION OF AN INDIVIDUAL OR PORTION OF AN INDIVIDUAL'S BODY. A MECHANICAL RESTRAINT INCLUDES A GERIATRIC CHAIR, A BEDRAIL THAT RESTRICTS THE MOVEMENT OR FUNCTION OF THE INDIVIDUAL, HANDCUFFS, ANKLETS, WRISTLETS, CAMISOLE, HELMET WITH FASTENERS, MUFFS AND MITTS WITH FASTENERS, RESTRAINT VEST, WAIST STRAP, HEAD STRAP, RESTRAINT BOARD, RESTRAINING SHEET, CHEST RESTRAINT AND OTHER SIMILAR DEVICES. A MECHANICAL RESTRAINT DOES NOT INCLUDE THE USE OF A SEAT BELT DURING MOVEMENT OR TRANSPORTATION. A MECHANICAL RESTRAINT DOES NOT INCLUDE A DEVICE PRESCRIBED BY A HEALTH CARE PRACTITIONER FOR THE FOLLOWING USE OR EVENT:

(I) POST-SURGICAL OR WOUND CARE.

(II) BALANCE OR SUPPORT TO ACHIEVE FUNCTIONAL BODY POSITION, IF THE INDIVIDUAL CAN EASILY REMOVE THE DEVICE OR IF THE DEVICE IS REMOVED BY A STAFF PERSON IMMEDIATELY UPON THE REQUEST OR INDICATION BY

THE INDIVIDUAL, AND IF THE INDIVIDUAL PLAN INCLUDES PERIODIC RELIEF OF THE DEVICE TO ALLOW FREEDOM OF MOVEMENT.

(III) PROTECTION FROM INJURY DURING A SEIZURE OR OTHER MEDICAL CONDITION, IF THE INDIVIDUAL CAN EASILY REMOVE THE DEVICE OR IF THE DEVICE IS REMOVED BY A STAFF PERSON IMMEDIATELY UPON THE REQUEST OR INDICATION BY THE INDIVIDUAL, AND IF THE INDIVIDUAL PLAN INCLUDES PERIODIC RELIEF OF THE DEVICE TO ALLOW FREEDOM OF MOVEMENT.

§ 6500.178. PHYSICAL RESTRAINT.

(A) A PHYSICAL RESTRAINT, DEFINED AS A MANUAL METHOD THAT RESTRICTS, IMMOBILIZES OR REDUCES AN INDIVIDUAL'S ABILITY TO MOVE THE INDIVIDUAL'S ARMS, LEGS, HEAD OR OTHER BODY PARTS FREELY, MAY ONLY BE USED IN THE CASE OF AN EMERGENCY TO PREVENT AN INDIVIDUAL FROM IMMEDIATE PHYSICAL HARM TO THE INDIVIDUAL OR OTHERS.

(B) VERBAL REDIRECTION, PHYSICAL PROMPTS, ESCORTING AND GUIDING AN INDIVIDUAL ARE PERMITTED.

(C) A PRONE POSITION PHYSICAL RESTRAINT IS PROHIBITED.

(D) A PHYSICAL RESTRAINT THAT INHIBITS DIGESTION OR RESPIRATION, INFLICTS PAIN, CAUSES EMBARRASSMENT OR HUMILIATION, CAUSES HYPEREXTENSION OF JOINTS, APPLIES PRESSURE ON THE CHEST OR JOINTS OR ALLOWS FOR A FREE FALL TO THE FLOOR IS PROHIBITED.

(E) A PHYSICAL RESTRAINT MAY NOT BE USED FOR MORE THAN 30 CUMULATIVE MINUTES WITHIN A 2-HOUR PERIOD.

§ 6500.179. EMERGENCY USE OF A PHYSICAL RESTRAINT.

IF A PHYSICAL RESTRAINT IS USED ON AN UNANTICIPATED, EMERGENCY BASIS, §§ 6500.164 AND 6500.165 (RELATING TO HUMAN RIGHTS TEAM; AND BEHAVIOR SUPPORT COMPONENT OF THE INDIVIDUAL PLAN) DO NOT APPLY UNTIL AFTER THE RESTRAINT IS USED FOR THE SAME INDIVIDUAL TWICE IN A 6-MONTH PERIOD.

§ 6500.180. ACCESS TO OR THE USE OF AN INDIVIDUAL'S PERSONAL PROPERTY.

(A) ACCESS TO OR THE USE OF AN INDIVIDUAL'S PERSONAL FUNDS OR PROPERTY MAY NOT BE USED AS A REWARD OR PUNISHMENT.

(B) AN INDIVIDUAL'S PERSONAL FUNDS OR PROPERTY MAY NOT BE USED AS PAYMENT FOR DAMAGES UNLESS THE INDIVIDUAL CONSENTS TO MAKE RESTITUTION FOR THE DAMAGES. THE FOLLOWING CONSENT PROVISIONS APPLY UNLESS THERE IS A COURT-ORDERED RESTITUTION:

(1) A SEPARATE WRITTEN CONSENT IS REQUIRED FOR EACH INCIDENCE OF RESTITUTION.

(2) CONSENT SHALL BE OBTAINED IN THE PRESENCE OF THE INDIVIDUAL OR A PERSON DESIGNATED BY THE INDIVIDUAL.

(3) THE HOME OR AGENCY MAY NOT COERCE THE INDIVIDUAL TO PROVIDE CONSENT.

~~INDIVIDUALS~~ INDIVIDUAL RECORDS

§ 6500.182. Content of records.

(a) A separate record shall be kept for each individual.

(b) Entries in an individual's record must be legible, dated and signed by the person making the entry.

(c) Each individual's record must include the following information:

(1) Personal information, including:

(i) The name, sex, admission date, birthdate and Social Security number.

(ii) The race, height, weight, color of hair, color of eyes and identifying marks.

(iii) The language or means of communication spoken or understood by the individual and the primary language used in the individual's natural home, if other than English.

(iv) The religious affiliation.

(v) The next of kin.

(vi) A current, dated photograph.

(2) ~~Unusual incident~~ INCIDENT reports relating to the individual.

(3) Physical examinations.

(4) Dental examinations.

(5) Assessments as required under § 6500.151 (relating to assessment).

[(6) A copy of the invitation to:

(i) The initial ISP meeting.

(ii) The annual update meeting.

(iii) The ISP revision meeting.

(7) A copy of the signature sheet for:

(i) The initial ISP meeting.

(ii) The annual update meeting.

(iii) The ISP revision meeting.

(8) A copy of the current ISP.

(9) Documentation of ISP reviews and revisions under § 6500.156 (relating to ISP review and revision), including the following:

(i) ISP review signature sheets.

(ii) Recommendations to revise the ISP.

(iii) ISP revisions.

(iv) Notices that the plan team member may decline the ISP review documentation.

(v) Requests from plan team members to not receive the ISP review documentation.

(10) Content discrepancy in the ISP, the annual updates or revisions under § 6500.156.]

(6) ~~PSP~~ INDIVIDUAL PLAN documents as required by this chapter.

[(11) Restrictive procedure protocols] ~~(7) Positive intervention records related to the individual.~~

[(12) Restrictive procedure records related to the individual.

(13)] ~~(8) Recreational and social activities provided to the individual.~~

[(14)] ~~(9)~~ (7) Copies of psychological evaluations and assessments of adaptive behavior, as necessary.

§ 6500.183. Record location.

Copies of the most current record information required in [§ 6500.182(c)(1)—(14)] § 6500.182(c)(1)—~~(9)~~ (7) (relating to [individual] content of records) shall be kept in the [family living] home.

* * * * *

§ 6500.185. Access.

The individual, and the individual's parent, guardian or advocate, shall have access to the records and to information in the records. If the [family living] life sharing specialist documents, in writing, that disclosure of specific information constitutes a substantial detriment to the individual or that disclosure of specific information will reveal the identity of another individual or breach the confidentiality of persons who have provided information upon an agreement to maintain their confidentiality, that specific information identified may be withheld.

Regulatory Analysis Form

(Completed by Promulgating Agency)

(All Comments submitted on this regulation will appear on IRRC's website)

INDEPENDENT REGULATORY REVIEW COMMISSION

(1) Agency: Department of Human Services (Department)

(2) Agency Number: 14

Identification Number: 540

IRRC Number: 3160

(3) PA Code Cite: 55 Pa.Code Chapters 51, 2380, 2390, 6100, 6200, 6400 and 6500

(4) Short Title: Home and Community-Based Services and Licensing

(5) Agency Contacts (List Telephone Number and Email Address):

Primary Contact: Julie Mochon, Director, Division of Policy and Program Innovation, Office of Developmental Programs, 717-783-5771, jmochon@pa.gov

Secondary Contact: Kristin Ahrens, Director, Bureau of Policy and Quality Management, Office of Developmental Programs, 717-783-5197, kahrens@pa.gov

(6) Type of Rulemaking (check applicable box):

- ☐ Proposed Regulation
- X Final Regulation
- ☐ Final Omitted Regulation
- ☐ Emergency Certification Regulation;
  - ☐ Certification by the Governor
  - ☐ Certification by the Attorney General

(7) Briefly explain the regulation in clear and nontechnical language. (100 words or less)

The final-form regulation supports Pennsylvanians with an intellectual disability or autism to live and participate in the life of their community, to achieve greater independence and to have opportunities enjoyed by all citizens of this Commonwealth. The final-form regulation strengthens community services and supports to promote person-centered approaches, community integration, personal choice, quality in service delivery, health and safety protections, competitive integrated employment, accountability in the utilization of resources and innovation in service design.

The final-form regulation governs the program, operational and fiscal aspects of the following: (a) home and community-based services (HCBS) provided through the 1915(c) waiver programs; (b) Medicaid State plan HCBS for individuals with an intellectual disability or autism, including targeted support management; and (c) services funded exclusively by grants to counties under the Mental Health and Intellectual Disability Act of 1966 or Article XIV-B of the Human Services Code, commonly referred to as "base-funding."

(8) State the statutory authority for the regulation. Include specific statutory citation.

Sections 201(2), 403(b), 403.1 (a) and (b), 911 and 1021 of the Human Services Code (62 P.S.

§§ 201(2), 403(b), 403.1(a) and (b), 911 and 1021) and section 201(2) of the Mental Health and Intellectual Disability Act of 1966 (50 P.S. § 4201(2)).

(9) Is the regulation mandated by any federal or state law or court order, or federal regulation? Are there any relevant state or federal court decisions? If yes, cite the specific law, case or regulation as well as, any deadlines for action.

Although State regulation is not mandated by Federal law, many of the HCBS provisions are governed by 42 CFR Part 441-Services: Requirements and Limits Applicable to Specific Services, Subpart G, Home and Community-Based Services: Waiver Requirements, §§ 441.300—441.310.

Commentators note that under 42 U.S.C.A. § 1396a(a)(13)(A), the Department must provide public notice of the methodologies that underlie the rates and the justification used to establish the rates. In addition, the same commentators cite to the decision in Christ the King Manor Inc. v. Secretary of U.S. Dep't of Health & Human Servs., et al., 730 F.3d 291 (3d Cir. 2013) (Christ the King Manor) and two other cases (Pa. Pharmacists v. Houstoun, 283 F.3d 531 (3d Cir. 2002); Rite Aid v. Houstoun, 171 F.3d 842 (3d Cir. 1999)) for the proposition that the Department must adopt a rate setting methodology that is reasonable, considers more than simple budgetary factors, results in payments to providers that are sufficient to meet individuals' needs, addresses provider viability and allows a retained revenue factor. The Department acknowledges the applicability of cited Federal statutory provisions, specifically 42 U.S.C.A. §§ 1396a(a)(13)(A) and 1396a(a)(30)(A), as they relate to Medicaid State plan requirements. In its approved HCBS waivers under rate determination methods, the Department establishes the fee schedule rates to fund services at a level sufficient to ensure access, encourage provider participation and promote provider choice, while ensuring cost effectiveness and fiscal accountability.

In accordance with 42 CFR § 441.304(e) (relating to duration, extension, and amendment of a waiver), the Department publishes in the *Pennsylvania Bulletin* a description of its rate setting methodology, including a discussion of the data and data sources used and the rate setting factors. See § 6100.571(d) (relating to fee schedule rates). Section 6100.571(a)) Requires that payment rates are consistent with efficiency, economy and quality of care. In addition, under general Medical Assistance payment regulations, fee schedule rates, procedures and services are authorized to be added or deleted by publication of a notice in the *Pennsylvania Bulletin*. See 55 Pa. Code § 1150.61(a) (relating to guidelines for fee schedule changes).

In addition, the cost-based rates and allowable costs are specifically identified in §§ 6100.641—6100.672. The Department publishes a notice in the *Pennsylvania Bulletin* relating to the cost-based rate methodology, including outlier analysis, vacancy factor and rate assignment processes. See § 6100.645(e) (relating to rate setting). The Department looked to the CMS guidance in identifying the factors used to develop rates. See *Fee Schedule HCBS Setting: Developing a Rate for Direct Support Workers* at https://www.medicaid.gov/medicaid/hcbs/downloads/hcbs-1a-ffs-rate-setting.pdf and *Rate Methodology in a FFS HCBS Structure* at https://www.medicaid.gov/medicaid/hcbs/downloads/rate-setting-methodology.pdf.

The commentators' reliance on Christ the King Manor is misplaced because under these regulations, the rates apply to waiver services and do not contain a budget adjustment factor (BAF). Christ the King Manor involved litigation against the Federal Department of Health and Human Services (HHS) and the Department that challenged HHS's approval of the Department's Medicaid State plan amendment that applied a budget adjustment factor (BAF) to nursing facility reimbursement rates. The BAF decreased nursing facility provider rates, as established by the Department's case-mix payment regulations, by

more than 9%. The nursing facility providers that brought the action claimed HHS improperly approved the BAF Medicaid State plan amendment by failing to take into consideration the quality of care factor required under 42 U.S.C.A. § 1396a(a)(30)(A). The providers further claimed that the Department's notice announcing the BAF failed to comply with the notice content requirements of 42 U.S.C.A. § 1396a(a)(13)(A).

The Court determined that the Department satisfied the public process and notice content requirements of 42 U.S.C.A. § 1396a(a)(13)(A), but that HHS failed to properly conclude, on the evidence before it, that the Department complied with 42 U.S.C.A. § 1396a(a)(30)(A). Specifically, the Court found that it could not "discern from the record a reasoned basis for the agency's decision" in approving the BAF Medicaid State plan amendment. Christ the King Manor, 730 F.3d at 314. HHS's treatment of the Department's overall increase in appropriations for nursing facility providers and the Department's assertions that payment rates are sufficient to ensure continued access to nursing facility services, were not sufficient evidence for HHS to determine compliance with 42 U.S.C.A. § 1396a(a)(30)(A). Id. at 313-15. The case was remanded and HHS reconsidered its determination and again approved the Department's Medicaid State plan amendment. Subsequent litigation resulted in judgment in favor of HHS.

Therefore, Christ the King Manor has no application to the Chapter 6100 rate setting process because Chapter 6100 does not relate to Medicaid State plan services and does not contain a BAF. In addition, Chapter 6100 specifically identifies the factors considered for rate setting purposes and employs a public process to establish rates.

(10) State why the regulation is needed. Explain the compelling public interest that justifies the regulation. Describe who will benefit from the regulation. Quantify the benefits as completely as possible and approximate the number of people who will benefit.

The final-form regulation is needed to continue the Commonwealth's eligibility for Federal financial participation in the HCBS waiver programs. The final-form regulation protects the health, safety and well-being of the individuals receiving services in individual directed, family-based, community residential and day programs funded through the Federal waivers, the Commonwealth's Title XIX State plan and base-funding, as well as individuals who receive services in community residential and day programs funded through private pay or another funding source.

Benefits for the individuals, families and advocates include strengthened individual rights and service involvement; strict involuntary discharge conditions and procedures; the prohibition of restraints except for the emergency use of a protective physical hold; a team, including a behavior specialist to approve the use of a restrictive procedure prior to use; strengthened health and safety protections; reasonable program and operational standards for programs serving individuals with an intellectual disability or autism; and the administration of medication by trained staff persons.

Benefits for providers include the reduced administrative burden by coordinating multiple chapters of departmental regulations; the inclusion of autism programs in the core standards to alleviate the administrative burden of managing dual processes; the significant reduction in the conflict of interest protocol requirements; the change in the reserved capacity provisions to provide reimbursement through fee schedule rates to support the return of an individual after extended medical, hospital or therapeutic leave; clarity of the documentation required to support a claim; a 3-year update of the data used to establish the fee schedule rates; the delineation of specific factors to be examined and used to develop

fee schedule rates; elimination of the requirement to report and deduct donations; and significant reduction and simplification of the cost-based payment requirements.

Benefits for county intellectual disability programs include clarity and consistency of roles for the support coordinators, base-funding coordinators and targeted support managers; deletion of conflicting individual plan time frames between the Federal waivers and the multiple chapters of regulations; acknowledgement of the county human rights committees; and the strengthened regulation of exclusively base-funding services. The final-form regulation provides consistent program and operational requirements across all Office of Developmental Programs (ODP) service system funding sources on a Statewide basis to support the ease of individual transitions from county to county, as well as individual transitions across the various funding sources. The final-form regulation eases the delays and roadblocks for individual transitions from services funded through base-funding only to HCBS Federal funding.

Additional benefits of the regulation include compliance with the Federal requirements to support continued Federal HCBS funding; the reduced volume of regulations with improved coordination efforts across multiple chapters of regulations providing an opportunity for streamlined compliance monitoring; consistent program requirements and health and safety protections for the individuals across multiple funding sources; aligning intellectual disability and autism standards to the benefit of both programs; and establishing a baseline of core values across multiple programs.

As requested by IRRC and commentators, quality management provisions in this regulation are necessary to protect the health, safety and well-being of individuals receiving services. However, the Department significantly reduced the content and specificity of § 6100.45 (relating to quality management). The proposed list of nine specific areas to be reviewed and evaluated in the quality management plan is restructured and reduced to five broad components, including performance measures; performance improvement targets and strategies; feedback methods, including feedback from individuals and staff; data sources; and the role of the quality management staff. These five broad component areas allow the provider significant discretion to design a quality management plan that meets the provider's needs to target specific goals and establish priorities.

Chapter 6100 applies to 1,060 HCBS and base-funding provider agencies providing services to more than 53,000 individuals with an intellectual disability or autism. Chapter 6100 applies to the Department's ODP service system funded by the Department, including those facility-based services that are licensed under Chapters 2380, 2390, 6400 and 6500, as well as many services that are funded, but that do not require licensure under Articles IX and X of the Human Services Code (See §§ 911 and 1021 of the Human Services Code (62 P.S. §§ 201(2), 403(b), 403.1(a) and (b), 911 and 1021)).

Chapter 2380 contains licensing regulations to protect the health, safety and well-being of adults who receive services in Pennsylvania's 416 licensed adult day training facilities with a maximum Statewide licensed capacity of 26,429 individuals. Chapter 2380 contains the minimum requirements that apply regardless of the payment agency. For instance, Chapter 2380 applies to a facility that provides services exclusively to individuals with blindness, deafness or a mental illness, including those facilities that are not funded by the Department through the ODP service system. Services for some individuals, and services provided by some facilities, are funded exclusively through private insurance, private-pay or out-of-state sources. Providers funded by the Department through the ODP waivers must enroll in the program and sign an ODP waiver provider agreement. The number of licensed adult day training facilities in which there is no ODP waiver provider agreement is 15.

Chapter 2390 contains licensing regulations to protect the health, safety and well-being of adults who receive services in Pennsylvania's 166 licensed vocational facilities with a maximum Statewide licensed capacity of 21,754 individuals. Chapter 2390 contains the minimum requirements that apply regardless of the payment agency. For instance, Chapter 2390 applies to a facility that provides services exclusively to individuals with blindness, deafness or a mental illness, including those facilities that are not funded by the Department through the ODP service system. Services for some individuals, and services provided by some facilities, are funded exclusively through private insurance, private-pay or out-of-state sources. The number of licensed vocational facilities in which there is no ODP waiver provider agreement is nine.

Chapter 6400 contains licensing regulations to protect the health, safety and well-being of children and adults who receive services in Pennsylvania's 5,413 licensed community homes for individuals with an intellectual disability or autism with a maximum Statewide licensed capacity of 18,713 individuals. Chapter 6400 contains the minimum requirements that apply regardless of the payment agency. For instance, Chapter 6400 applies to a facility that provides services exclusively to individuals who are not funded by the Department through the ODP service system. Services for some individuals, and services provided by some facilities, are funded exclusively through private insurance, private-pay or out-of-state sources. The number of licensed community homes in which there is no ODP waiver provider agreement is 113.

Chapter 6500 contains licensing regulations to protect the health, safety and well-being of children and adults who receive services in Pennsylvania's 1,583 licensed life sharing homes for individuals with an intellectual disability or autism with a maximum Statewide licensed capacity of 2,504 individuals. Chapter 6500 contains the minimum requirements that apply regardless of the payment agency. There are fewer than ten privately-funded licensed life sharing homes.

(11) Are there any provisions that are more stringent than federal standards? If yes, identify the specific provisions and the compelling Pennsylvania interest that demands stronger regulations.

Chapter 6100 incorporates and applies the Federal requirements, such as community integration, employment and person-centered planning. The regulation coordinates with the Department's HCBS waivers, which have been approved by the Centers for Medicare and Medicaid Services (CMS).

Chapter 6100 addresses additional areas that are not comprehensively regulated by the Federal requirements, including regulatory waiver procedures, innovation projects, transition procedures, fee schedule rates, cost-based rates, room and board provisions and special programs, including agency with choice, organized health care delivery system, base-funding services and vendor goods and services.

The licensing regulations, however, are not generally governed by Federal law. Several areas of the licensing chapters, including medication administration, abuse and incident reporting, staff training and the prohibition of restraints, which are amended by this regulation, are not governed by Federal law.

(12) How does this regulation compare with those of the other states? How will this affect Pennsylvania's ability to compete with other states?

Pennsylvania, like other states has begun to revise its policies, procedures and regulations to meet the new Federal requirements.

The Department studied the HCBS programs of the states of New York, Maryland, New Jersey, Ohio, Illinois, Massachusetts and Wisconsin because of the close proximity of some of these states and based on readily available information regarding other states. Since no two states have the same administrative, program or funding structures, nor do they share the same historical development, a strict data comparison is not possible; however, in a comparison of the HCBS standards in other states across staff training, individual plans, behavior support and incident management, the Pennsylvania regulation is compatible with the standards, policies, practices and procedures of other states.

This regulation's purpose is not about competing with other states and does not affect Pennsylvania's ability to compete with other states.

(13) Will the regulation affect any other regulations of the promulgating agency or other state agencies? If yes, explain and provide specific citations.

No, this regulation will not affect other regulations of the Department or another State agency.

(14) Describe the communications with and solicitation of input from the public, any advisory council/group, small businesses and groups representing small businesses in the development and drafting of the regulation. List the specific persons and/or groups who were involved. ("Small business" is defined in Section 3 of the Regulatory Review Act, Act 76 of 2012.)

The Department has continually supported, encouraged and managed an active and open community participation process throughout the development of the proposed rulemaking and the final-form regulation. The Department values, commends and greatly appreciates the expertise, time and attention contributed by the public commentators, and in particular the regulation work group comprised of 45 persons representing a broad range of interests, experiences and ideas, including individuals, families, advocates, universities, county programs, providers and provider organizations. The regulation work group met for 13 days over a 3-year period to advise the Department of its collective and individual concerns and suggestions, cultivate constructive dialogue and promote an understanding of the views of others.

Following the close of the proposed rulemaking public comment period, a 3-day meeting was held to discuss the public comments relating to the 20 regulatory areas that were of most concern to the public commentators. In response to various sections of the final-form regulation, a diversity of opinions continues to be evident; however, for several regulatory areas, including consistency across the four licensing chapters and Chapter 6100, children's services and quality management, reasonable agreement was reached.

On August 19, 2017, the Department published an advance notice of final rulemaking in the *Pennsylvania Bulletin* at 47 Pa.B. 4831 to solicit additional public comments regarding the changes the Department is recommending to § 6100.571 (relating to fee schedule rates) as included in the proposed rulemaking published at 46 Pa.B. 7061 (November 5, 2016).

In October 2017, a regulation work group meeting was held to review 11 specific portions of the final-form regulation and discuss implementation planning with the external stakeholders.

The advice of the regulation work group and the public comments received in response to the proposed rulemaking and the advance notice of final rulemaking were thoroughly analyzed and considered as the Department prepared the final-form regulation.

During the course of the development of the final-form regulation, more than 40 meetings were held with Statewide and regional self-advocacy, advocacy, family, provider and county organizations to review and discuss specific areas of the regulation. These discussions focused on the constituent issues that are important to the affected parties. The Department values the constructive advice and the unique perspectives provided during these meetings and the final-form regulation encompasses these varying views.

(15) Identify the types and number of persons, businesses, small businesses (as defined in Section 3 of the Regulatory Review Act, Act 76 of 2012) and organizations which will be affected by the regulation. How are they affected?

Providers of an HCBS or a block-grant or based-funding service, as well as licensed providers of day and residential services, will be affected by the final-form regulation because they are the regulated community under the regulation. The final-form regulation applies to 1,060 HCBS and block-grant/base-funding service providers. Of the 1,060 providers that deliver State or Federally-funded services and supports through the ODP, approximately 800 providers are small businesses with annual revenue of less than $15 million.

Also affected by the final-form regulation are 5,413 licensed community homes, 1,583 licensed family living homes, 416 licensed adult training facilities and 166 licensed vocational facilities, the majority of which are also providers of HCBS included in the total number of 1,060.

While the final-form regulation governs providers of the direct and indirect services covered under Chapter 6100 and providers licensed under Chapters 2380, 2390, 6400 and 6500, other interested and affected parties include the more than 53,000 individuals who receive services; the families and friends of the individuals who receive services; advocates who provide support and representation for the individuals to assure that their rights are protected; county governments who provide authorization for the use of base-funding under Chapter 6100; and the designated managing entities that are often county governments in overseeing the provision of the HCBS. The final-form regulation affects this group of individuals because they either receive the services or advocate on behalf of individuals who receive the services by the regulated community.

(16) List the persons, groups or entities including small businesses that will be required to comply with the regulation. Approximate the number that will be required to comply.

Providers of an HCBS or a block-grant or based-funding service, as well as licensed providers of day and residential services, must comply with the final-form regulation. The final-form regulation applies to 1,060 HCBS and block-grant/base-funding service providers. Of the 1,060 providers that deliver State or Federally-funded services and supports through the ODP, approximately 800 providers are small businesses with annual revenue of less than $15 million.
Also required to comply with the final-form regulation are 5,413 licensed community homes, 1,583 licensed family living homes, 416 licensed adult training facilities and 166 licensed vocational facilities, the majority of which are also providers of HCBS included in the total number of 1,060.
(17) Identify the financial, economic and social impact of the regulation on individuals, small businesses, businesses and labor communities and other public and private organizations. Evaluate the benefits expected as a result of the regulation.

The provider's regulatory compliance management and associated self-monitoring costs will be reduced. By simplifying and shortening the length of the final-form regulation, and by coordinating the program and operational requirements across multiple chapters of licensing regulations as well as across multiple funding streams, the complexity of regulatory compliance management is significantly simplified. The reduced cost impact for a provider will vary based on the pay scale and number of management positions devoted to regulatory compliance management.

Some new costs will be associated with the regulation regarding background checks since a wider net has been cast as to who shall submit a background check. This provision is supported by many individuals and advocates. It is also required under recent amendments to the Child Protective Services Law. In the final-form regulation, all persons who provide services that are funded by the Department must submit a background check to identify any history of abuse, assault, theft or other crimes that may impact the well-being of an individual. The fee for a Pennsylvania State Police background check is $8.00. The fee for a Pennsylvania child abuse check is $8.00, which is rarely required since approximately 87% of the individuals who receive services under this chapter are adults. The fee for a Federal Bureau of Investigation (FBI) check is $25.75, which includes fingerprinting. For a person who will provide services to adults, the Older Adults Protective Services Act requires an FBI check only if the person lived outside of Pennsylvania within the past 2 years. See 35 P.S. § 10225.502(a)(2), regarding information relating to prospective facility personnel. The Child Protective Services Law requires an FBI check for all paid staff who provide services to children. See 23 Pa.C.S. § 6344(b)(3), regarding employees having contact with children; adoptive and foster parents.

The Child Protective Services Law (See 23 Pa.C.S. §§ 6301—6386) requires an FBI check for all paid staff who provide services to children, and also for volunteers who have lived outside of Pennsylvania within the previous 10 years. The impact of this requirement is limited, however, since only 13% of the individuals covered by the final-form regulation are children. The cost for the majority of prospective staff persons is $8.00. The cost for the background check may be borne by the job applicant or by the provider agency. The overall cost impact relating to background checks will vary, as some providers already require background checks on all persons, thus negating or minimizing the cost impact. The increased background check costs are factored into the new HCBS rates.

Significant additional revenue to the providers will result immediately from the revised § 6100.55 (relating to reserved capacity) that changes the provider's approved program capacity to allow for an increase in the provider's rates for the time period of an individual's extended absence because of medical, hospital or therapeutic leave.

Some new costs will be associated with the final-form regulation regarding staff training since more staff persons must receive training in areas such as rights, abuse prevention and incident reporting. It is critical that all persons who provide services, including ancillary services, have the minimum training necessary to identify and know what to do if they observe abuse, an incident or a violation of rights. The ODP has developed and will offer online training courses free of charge related to the required core training topics. While use of the ODP courses is optional, these courses meet the requirements of the final-form regulation, while saving training development costs for providers. Annual training can be provided on the job as part of the staff person's scheduled work day, through supervisory conferences, staff meetings or training provided for individuals and staff persons at the same time. For an ancillary position, an average of 1 hour of training must be provided each month, which can be provided on the job. For instance, an administrative staff person may complete an online course on the agency's new word processing software; a fiscal staff person may complete an online course on the agency's required accounting methods; a maintenance staff person may be taught the Federal Occupational Safety and

Health Administration (OSHA) rules for safe use of a new lawn care machine by his supervisor; or a dietary staff person may watch and learn new cooking techniques or recipes from a televised cooking show. Many providers will experience no increase in training costs as they already provide incident management, abuse reporting and other value-based training to all staff, including ancillary staff; however, for those providers who do not currently train ancillary staff, the ODP fee schedule rates provide sufficient HCBS reimbursement for the training of all staff positions.

Cost savings related to staff training in § 6100.143 (relating to annual training) will be realized over the course of the first year of implementation of the new regulation with the reduction of the number of training hours from 40 hours to 24 hours for support coordinators and from 24 to 12 hours for chief executive officers.

A requirement that the human rights team include a behavior specialist who did not develop the behavior support component of the plan is added to the final-form regulation as suggested by public comment. See §§ 2380.154, 2390.174, 6100.344, 6400.194 and 6500.164. The qualifications of the behavior specialist are intentionally broad to permit an array of professionals to serve in this capacity. Many providers already employ or contract with a behavior specialist to provide consultation to develop and review individual plans for individuals for whom a restrictive procedure is appropriate. If the provider does not have a behavior specialist on staff or under contract, the provider may utilize a county mental health, intellectual disability and autism program human rights team that meets the requirements of this chapter or coordinate with other providers to share this position. If the provider has a behavior specialist or if a county team is used, there will be no new costs to implement this section. For a provider that provides services to multiple individuals for whom restrictive procedures are used and that employs or contracts directly with a behavior specialist to meet this requirement, the annual program-wide cost is estimated at $6,048, based on an hourly rate of $84, meeting twice monthly for three hours per meeting, during all 12 months a year.

A requirement is added for a behavior specialist to develop the initial behavior support component of an individual plan if a physical restraint will be used or if a restrictive procedure will be used to modify an individual's rights. See §§ 2380.155(d), 2390.175(d), 6100.345(d), 6400.195(d) and 6500.165(d). The estimated cost for a behavior specialist to develop the behavior support component of an individual plan is $1,680 per individual, based on an hourly rate of $84 and providing an average of 20 hours of observation and consultation necessary to design the initial plan.

The increased behavior specialist consultation costs are factored into the new HCBS rates and are absorbed in the ODP fee schedule rates.

Cost savings will result from the development of a new modified medication administration training course in § 6100.468(d) (relating to medication administration training) for those providers who have been providing the full medication administration training course for all life sharers and others who will now be eligible for the shortened, modified course. This cost reduction will be realized over the course of the first year of implementation of the new regulation. Numerous life sharing provider agencies already require completion of the full medication administration training course by their life sharers, so completion of the new modified course will be a cost reduction. The cost of the certified train-the-trainer program is paid by the Department for a certified medication administration trainer who assists the life sharer through the modified medication administration training course. For those life sharers who do not currently complete the medication administration training course, a slight cost increase will result; however, the cost will be minimal as the new modified course will take only several hours to complete online and the cost is factored into the new HCBS rates.

In response to IRRC's comment on the reasonableness, feasibility and economic impact of the requirement for a provider to facilitate personal relationships as requested by individuals, the regulatory requirement codifies current practice. See § 6100.186 (relating to facilitating personal relationships). The Department does not anticipate additional costs attributed to this requirement.

Beginning in January 2018, the current cost-based system for residential HCBS converted to a fee schedule rate resulting in significant cost savings for the providers and reduced administration costs for the Department. The fee schedule rates were determined based upon the cost to deliver each service based upon the factors addressed in § 6100.571(b) (relating to fee schedule rates). The provider will realize an administrative cost savings since the provider is no longer required to complete and submit cumbersome and detailed cost reports, nor do providers need to track and monitor cost-based regulatory compliance data. The requirements contained in the current §§ 51.71—51.103 and in the final §§ 6100.641—6100.672 no longer apply for residential services, since the payment methodology transitioned to a fee schedule rate in January 2018. The Department will realize a cost savings through the reduction of the administrative review and approval of cost reports. The reporting of donation section at § 51.82 (relating to revenues that off-set allowable costs) is deleted. This results in additional revenue to the provider, because the provider no longer has to declare and deduct donations from its cost reports.

(18) Explain how the benefits of the regulation outweigh any cost and adverse effects.

Benefits for the individuals, families and advocates include strengthened individual rights and service involvement; strict involuntary discharge conditions and procedures; the prohibition of restraints except for the emergency use of a protective physical hold; a team, including a behavior specialist to approve the use of a restrictive procedure prior to use; strengthened health and safety protections; reasonable program and operational standards for programs serving individuals with an intellectual disability or autism; and the administration of medication by trained staff persons.

Benefits for providers include the reduced administrative burden by coordinating multiple chapters of departmental regulations; the inclusion of autism programs in the core standards to alleviate the administrative burden of managing dual processes; the significant reduction in the conflict of interest protocol requirements; the change in the reserved capacity provisions to provide reimbursement through fee schedule rates to support the return of an individual after extended medical, hospital or therapeutic leave; clarity of the documentation required to support a claim; a 3-year update of the data used to establish the fee schedule rates; the delineation of specific factors to be examined and used to develop fee schedule rates; elimination of the requirement to report and deduct donations; and significant reduction and simplification of the cost-based payment requirements.

Benefits for county intellectual disability programs include clarity and consistency of roles for the support coordinators, base-funding coordinators and targeted support managers; deletion of conflicting individual plan time frames between the Federal waivers and the multiple chapters of regulations; acknowledgement of the county human rights committees; and the strengthened regulation of exclusively base-funding services. The final-form regulation provides consistent program and operational requirements across all ODP funding sources on a Statewide basis to support the ease of individual transitions from county to county, as well as individual transitions across the various funding sources. The final-form regulation eases the delays and roadblocks for individual transitions from services funded through base-funding only to HCBS Federal funding.

Additional benefits of the regulation include compliance with the Federal requirements to support continued Federal HCBS funding; the reduced volume of regulations with improved coordination efforts across multiple chapters of regulations providing an opportunity for streamlined compliance monitoring; consistent program requirements and health and safety protections for the individuals across multiple funding sources; aligning intellectual disability and autism standards to the benefit of both programs; and establishing a baseline of core values across multiple programs.

The new costs are outweighed by the cost savings and the benefits to all affected parties. There are no anticipated adverse effects.

(19) Provide a specific estimate of the costs and/or savings to the **regulated community** associated with compliance, including any legal, accounting or consulting procedures which may be required. Explain how the dollar estimates were derived.

The provider's regulatory compliance management and associated self-monitoring costs will be reduced. By simplifying and shortening the length of the final-form regulation, and by coordinating the program and operational requirements across multiple chapters of licensing regulations as well as across multiple funding streams, the complexity of regulatory compliance management is significantly reduced. The reduced cost impact for a provider will vary based on the pay scale and number of management positions devoted to regulatory compliance management.

Some new costs will be associated with the regulation regarding background checks since a wider net has been cast as to who shall submit a background check. This provision is strongly supported by many individuals and advocates. It is also required under recent amendments to the Child Protective Services Law. See 23 Pa.C.S. § 6344.2, regarding volunteers having contact with children. In the final-form regulation, all persons who provide services that are funded by the Department must submit a background check to identify any history of abuse, assault, theft or other crimes that may impact the well-being of an individual. The fee for a Pennsylvania State Police background check is $8.00. The fee for a Pennsylvania child abuse check is $8.00, which is rarely required since approximately 87% of the individuals who receive services under this chapter are adults. The fee for a FBI check is $25.75, which includes fingerprinting. For a person who will provide services to adults, an FBI check is required only if the person lived outside of Pennsylvania with the past 2 years. The Child Protective Services Law (See 23 Pa.C.S. §§ 6301—6386) requires an FBI check for all paid staff who provide services to children, and also for volunteers who have lived outside of Pennsylvania within the previous 10 years. The impact of this requirement is limited, however, since only 13% of the individuals covered by the final-form regulation are children. The cost for the majority of prospective staff persons is $8.00. The cost for the background check may be borne by the job applicant or by the provider agency. The overall cost impact relating to background checks will vary, as some providers already require background checks on all persons, thus negating or minimizing the cost impact. The increased background check costs are factored into the new HCBS rates and are absorbed in the ODP fee schedule rates.
Significant additional revenue to the providers will result immediately from the revised § 6100.55 (relating to reserved capacity) that changes the provider’s approved program capacity to allow for an increase in the provider’s rates for the time period of an individual’s extended absence because of medical, hospital or therapeutic leave.

Some new costs will be associated with the final-form regulation regarding staff training since more staff persons must receive training in areas such as rights, abuse prevention and incident reporting. It is critical that all persons who provide services, including ancillary services, have the minimum training

necessary to identify and know what to do if they observe abuse, an incident or a violation of rights. The ODP has developed and will offer online training courses free of charge to providers related to the required core training topics. While use of the ODP courses is optional, these courses meet the requirements of the final-form regulation, while saving training development costs for providers. Annual training can be provided on the job as part of the staff person's scheduled work day, through supervisory conferences, staff meetings or training provided for individuals and staff persons at the same time. For an ancillary position, an average of 1 hour of training must be provided each month, which can be provided on the job. For instance, an administrative staff person may complete an online course on the agency's new word processing software; a fiscal staff person may complete an online course on the agency's required accounting methods; a maintenance staff person may be taught the Federal OSHA rules for safe use of a new lawn care machine by his supervisor; or a dietary staff person may watch and learn new cooking techniques or recipes from a televised cooking show. Many providers will experience no increase in training costs as they already provide incident management, abuse reporting and other value-based training to all staff, including ancillary staff; however, for those providers who do not currently train ancillary staff, the ODP fee schedule rates provide sufficient HCBS reimbursement for the training of all staff positions.

Cost savings related to staff training in § 6100.143 (relating to annual training) will be realized over the course of the first year of implementation of the new regulation with the reduction of the number of training hours from 40 hours to 24 hours for support coordinators and from 24 to 12 hours for chief executive officers. It is difficult to estimate the cost savings at this time because training requirements for support coordinators and chief executive officers have been previously met in various ways and at differing costs.

A requirement that the human rights team include a behavior specialist who did not develop the behavior support component of the plan is added to the final-form regulation as suggested by public comment. See §§ 2380.154, 2390.174, 6100.344, 6400.194 and 6500.164. The qualifications of the behavior specialist are intentionally broad to permit an array of professionals to serve in this capacity. Many providers already employ or contract with a behavior specialist to provide consultation to develop and review individual plans for individuals for whom a restrictive procedure is appropriate. If the provider does not have a behavior specialist on staff or under contract, the provider may utilize a county mental health, intellectual disability and autism program human rights team that meets the requirements of this chapter or coordinate with other providers to share this position. If the provider has a behavior specialist or if a county team is used, there will be no new costs to implement this section. For a provider that provides services to multiple individuals for whom restrictive procedures are used and that employs or contracts directly with a behavior specialist to meet this requirement, the annual program-wide cost is estimated at $6,048, based on an hourly rate of $84, meeting twice monthly for three hours per meeting, during all 12 months a year.

A requirement is added for a behavior specialist to develop the initial behavior support component of an individual plan if a physical restraint will be used or if a restrictive procedure will be used to modify an individual's rights. See §§ 2380.155(d), 2390.175(d), 6100.345(d), 6400.195(d) and 6500.165(d). The estimated cost for a behavior specialist to develop the behavior support component of an individual plan is $1,680 per individual, based on an hourly rate of $84 and providing an average of 20 hours of observation and consultation necessary to design the initial plan.

The increased behavior specialist consultation costs are factored into the new HCBS rates and are absorbed in the ODP fee schedule rates.

Section 6100.444(c) (relating to size of service location) specifies a maximum size limit of 25 individuals for new day programs that are funded on or after March 16, 2019. This subsection clarifies that the size limit applies liberally based on the number of individuals present in the service location at any one time, rather than by program capacity or licensed capacity. The costs to operate smaller settings, including staffing costs, are included in the ODP fee schedule rates. In relation to the economic impact of the size limitations for day service locations in the final-form regulation, roughly 40% of day service locations funded by the Department currently provide services to 25 or fewer individuals, demonstrating that smaller service locations are fiscally sustainable. Given the grandfathering of existing service locations with application of the size limits only for new service locations, as well as a fee schedule payment structure that accounts for an individual's needs, there is no negative economic impact to the regulated community.

Cost savings will result from the development of a new modified medication administration training course in § 6100.468(d) (relating to medication administration training) for those providers who have been providing the full medication administration training course for all life sharers and others who will now be eligible for the shortened, modified course. This cost reduction will be realized over the course of the first year of implementation of the new regulations. Numerous life sharing provider agencies already require completion of the full medication administration training course by their life sharers, so completion of the new modified course will be a cost reduction. The cost of the certified train-the-trainer program is paid by the Department for a certified medication administration trainer who assists the life sharer through the modified medication administration training course. For those life sharers who do not currently complete the medication administration training course, a slight cost increase will result; however, the cost will be minimal as the new modified course will take only several hours to complete online and the cost is factored into the new HCBS rates.

Beginning in January 2018, the current cost-based system for residential HCBS will convert to a fee schedule system resulting in significant cost savings for the providers and reduced administration costs for the Department. The fee schedule rates were determined based upon the cost to deliver each service based upon the factors addressed in § 6100.571(b) (relating to fee schedule rates). The provider is no longer required to calculate, complete and submit cumbersome and detailed cost reports, nor do providers need to track and monitor regulatory compliance data. The requirements contained in the current §§ 51.71—51.103 and in the final §§ 6100.641—6100.672 will no longer apply for residential services once the payment methodology transitions to a fee schedule program in January 2018. The Department will realize a cost savings through the reduction of the administrative review and approval of cost reports. However, the specific cost savings is unknown at this time.

The reporting of donation section at § 51.82 (relating to revenues that off-set allowable costs) is deleted. This results in a significant cost savings, because a provider no longer has to declare and deduct donations from its cost reports.

(20) Provide a specific estimate of the costs and/or savings to the **local governments** associated with compliance, including any legal, accounting or consulting procedures which may be required. Explain how the dollar estimates were derived.

There is no cost for local government; county intellectual disability programs will experience increased efficiency in existing practices and administrative oversight of the providers through the improved coordination between HCBS, base-funding only programs and licensing programs.

(21) Provide a specific estimate of the costs and/or savings to the **state government** associated with the implementation of the regulation, including any legal, accounting, or consulting procedures which may be required. Explain how the dollar estimates were derived.

There is negligible cost to State government to administer the regulation.

There is the opportunity for reduced paperwork, administrative workload and coordinated monitoring efforts with the improved coordination between the Department's licensing and HCBS regulatory monitoring functions. Because of the consolidation and compatibility of five chapters of regulation across six major program areas (individual rights, staff training, individual plans, incident management, restrictive procedures and medication administration), rather than implementing two separate administrative regulatory oversight processes, data collected through the Department's licensing process will be shared, analyzed and utilized to measure compliance with the HCBS regulations (Chapter 6100).

As a result of moving from a cost-based system to fee schedule residential rates, providers are no longer required to submit cost reports. This will result in reduced administrative expenses for the Department.

While the Department will design new training programs to meet the needs of providers as prescribed in the new regulation, no new costs will be realized by the Department. The Department's training resources will be redirected to focus on the training topics required by the regulation.

There will be a cost of approximately $20,000 to print and distribute Pa. Code pamphlet copies of the new regulation to self-advocates, families, advocates, providers and other interested parties. The benefit of a wide distribution of the new regulation across the intellectual disability and autism service system to educate the community about the new regulation and enhance Statewide regulatory compliance outweighs the cost of printing and distributing paper copies of the regulation.

Training programs will be provided to teach the regulated community and others about the application of the new regulation. Training will be provided by Department staff as part of their regular job duties, thus resulting in no new costs.

The overall cost savings outweigh the negligible costs to the Department to implement the new regulation.

(22) For each of the groups and entities identified in items (19)-(21) above, submit a statement of legal, accounting or consulting procedures and additional reporting, recordkeeping or other paperwork, including copies of forms or reports, which will be required for implementation of the regulation and an explanation of measures which have been taken to minimize these requirements.

Decreased paperwork will result from the reduction of the provider's regulatory compliance efforts due to the coordination of multiple chapters of regulations and the reduction in the number of regulations. An opportunity is provided for the Department and the county programs to better coordinate and reduce duplicative monitoring efforts between licensing and waiver compliance management; this monitoring reduction will reduce paperwork for the provider, the county program, the designated managing entity and the Department.

Decreased provider paperwork will result from the elimination of the specific requirements regarding the content of the conflict of interest policy in § 6100.53 (relating to conflict of interest). In the current § 51.33 (relating to conflict of interest), there are detailed requirements regarding five areas governing

an internal conflict of interest protocol and disclosure to the Department. The final-form regulation requires only that a policy be developed and implemented by the provider. There are no longer any requirements as to the content of the policy.

Quality management plans and the quality management monitoring cycle is extended from the current 2-year cycle to a 3-year cycle, reducing paperwork requirements.

Increased paperwork for the provider may result from the expansion of the scope of the persons for whom background checks and training are required. Many providers already require and track background checks and training across a larger segment of employees than was previously required, thus minimizing the paperwork increase for many providers. In addition, better protections for the individuals who receive services outweighs any increased paperwork related to the background checks.

The individual plan in § 6100.223 (relating to content of the individual plan) is significantly simplified and the process is streamlined, thus reducing paperwork.

Decreased provider paperwork will result from the elimination of duplicate and conflicting incident reporting requirements for licensing and waiver compliance. In § 6100.401 (relating to types of incidents and timelines for reporting), incident reports for emergency room visits and non-prescribed over-the-counter medications are no longer required, reducing the number of incidents to be reported. Also eliminated is the provider paperwork required by licensing regulations to maintain a record of incidents that are not reportable, such as minor illnesses. While many providers will choose to retain this documentation as best practice, the Department will no longer review this documentation for regulatory compliance.

The reporting of donation section currently at § 51.82 (relating to revenues that off-set allowable costs) is deleted. This results in a reduction of paperwork for the provider, as well as additional revenue to providers, because a provider does not have to declare and deduct donations from its cost reports.

In § 6100.686 (relating to room and board rate), the paperwork required to complete the proration of the board costs is reduced from the current daily proration requirement in § 51.121(d)(2) (relating to room and board) to the final-form regulation set at a consecutive period of 8 or more days. This regulation change will result in reduced paperwork for the provider.
(22a) Are forms required for implementation of the regulation?

Yes, the following forms are required by the final-form regulation:

Incident Report.

§§ 2380.17, 2390.18, 6400.18 and 6500.20. Incident report and investigation.

(a) The facility shall report the following incidents, alleged incidents or suspected incidents in the Department's information system or on a form specified by the Department.

Corrective Action Plan.

§ 6100.42. Monitoring compliance.

(f) The provider shall complete the corrective action plan on a form specified by the Department.

Request for Regulatory Waiver.

§ 6100.43. Regulatory waiver.

(b) The waiver shall be submitted on a form specified by the Department.

Provider Enrollment Application and Waiver Provider Agreement.

§ 6100.82. HCBS enrollment documentation.

An applicant who wishes to operate an HCBS in accordance with this chapter shall complete and submit the following completed documents to the Department:

(1) A provider enrollment application on a form specified by the Department.

(2) An HCBS waiver provider agreement on a form specified by the Department.

Request for and Approval of Changes.

§ 6100.441. Request for and approval of changes.

(a) A provider shall submit a written request to the Department on a form specified by the Department and receive written approval from the Department prior to increasing or decreasing the Department-approved program capacity of a facility.

Room and Board Residency Agreement.

§ 6100.687. Completing and signing the room and board residency agreement.

(a) The provider shall ensure that a room and board residency agreement, on a form specified by the Department, is completed and signed by the individual annually.

Cost Report.

§ 6100.644. Cost report.

(b) The cost report must contain information for the development of a cost-based rate as specified on the Department's form.

(22b) If forms are required for implementation of the regulation, **attach copies of the forms here.** If your agency uses electronic forms, provide links to each form or a detailed description of the information required to be reported. **Failure to attach forms, provide links, or provide a detailed description of the information to be reported will constitute a faulty delivery of the regulation.**

A copy of the forms are included with the regulatory analysis form.

(23) In the table below, provide an estimate of the fiscal savings and costs associated with implementation and compliance for the regulated community, local government, and state government for the current year and five subsequent years.

	Current FY Year	FY +1 Year	FY +2 Year	FY +3 Year	FY +4 Year	FY +5 Year
SAVINGS:	**$**	**$**	**$**	**$**	**$**	**$**
Regulated Community	0	0	0	0	0	0
Local Government	0	0	0	0	0	0
State Government	0	0	0	0	0	0
Total Savings	0	0	0	0	0	0
COSTS:						
Regulated Community	0	0	0	0	0	0
Local Government	0	0	0	0	0	0
State Government	0	0	0	0	0	0
Total Costs	0	0	0	0	0	0
REVENUE LOSSES:						
Regulated Community						
Local Government						
State Government						
Total Revenue Losses						

(23a) Provide the past three year expenditure history for programs affected by the regulation.

*As proposed in the Fiscal Year 2017-2018 General Appropriations Bill

Program	FY -3	FY -2	FY -1	Current FY
Intellectual Disabilities Community Waiver Program	$1,074,887,000	$1,202,683,000	$1,349,113,000*	$1,527,602.000*
Intellectual Disabilities Community Base Program	$149,681,000	$148,229,000	$149,950,000	$150,734,000*

Autism Intervention and Services	$19,169,000	$21,501,000	$22,496,000*	$26,908,000*
Intellectual Disabilities Lansdowne	$340,000	$340,000	$340,000	$340,000*

(24) For any regulation that may have an adverse impact on small businesses (as defined in Section 3 of the Regulatory Review Act, Act 76 of 2012), provide an economic impact statement that includes the following:

(a) An identification and estimate of the number of small businesses subject to the regulation.
(b) The projected reporting, recordkeeping and other administrative costs required for compliance with the proposed regulation, including the type of professional skills necessary for preparation of the report or record.
(c) A statement of probable effect on impacted small businesses.
(d) A description of any less intrusive or less costly alternative methods of achieving the purpose of the proposed regulation.

There is no adverse impact on small businesses.

(a) Of the 1,060 providers that deliver State or Federally-funded services and supports through the ODP, approximately 800 providers are small businesses with annual revenue of less than $15 million.

(b) Recordkeeping is reduced by coordinating multiple chapters of regulations, thus reducing compliance documentation, reducing the time frame for quality management plans, simplifying the individual plan process, eliminating donation reporting, reducing the conflict of interest documentation and reducing paperwork associated with room and board rate calculations. The minimal added paperwork required to record background checks and training for non-direct care staff are offset by the reduced paperwork requirements.
(c) Small businesses will experience a decrease in reporting, recordkeeping and compliance efforts as described in (b).

(d) Since the final-form regulation significantly reduces paperwork requirements and coordinates regulatory provisions, no less intrusive or costly alternative methods were identified.

(25) List any special provisions which have been developed to meet the particular needs of affected groups or persons including, but not limited to, minorities, the elderly, small businesses, and farmers.

The final-form regulation affects individuals with intellectual disabilities and autism and provides greater access and opportunities for integration into the community.

(26) Include a description of any alternative regulatory provisions which have been considered and rejected and a statement that the least burdensome acceptable alternative has been selected.

The Department chose provisions that protect the health and safety of individuals, while at the same time reducing paperwork requirements and streamlining regulatory provisions. The least burdensome acceptable alternative has been selected.

Applicable Federal and State laws require the promulgation of regulations relating to licensing and compliance with the Federal requirements.

Alternatives for each section of the regulation have been reviewed and considered as part of the Department's rigorous and inclusive public development process. The recommendations of the individuals, advocates, families, providers and county governments weigh heavily to inform the Department in its proposed rulemaking. See the Response to Question #14 for a description of the public involvement opportunities in the regulation development process.

(27) In conducting a regulatory flexibility analysis, explain whether regulatory methods were considered that will minimize any adverse impact on small businesses (as defined in Section 3 of the Regulatory Review Act, Act 76 of 2012), including:

a) The establishment of less stringent compliance or reporting requirements for small businesses;
b) The establishment of less stringent schedules or deadlines for compliance or reporting requirements for small businesses;
c) The consolidation or simplification of compliance or reporting requirements for small businesses;
d) The establishment of performing standards for small businesses to replace design or operational standards required in the regulation; and
e) The exemption of small businesses from all or any part of the requirements contained in the regulation.

This regulation has no negative impact on small businesses.

a) Federal regulation requires consistent compliance and reporting requirements for all HCBS waiver providers. The final-form regulation is drafted to meet the Federal requirements; therefore, the regulation has consistent standards for all providers. The Department did not create different standards for small and large businesses, but the final-form regulation reduces administrative, compliance and reporting responsibilities for all providers, the vast majority of which are small businesses.

b) Federal regulation requires consistent schedules and deadlines for all HCBS waiver providers; however, the final-form regulation reduces administrative, compliance and reporting responsibilities for all providers.

c) Federal regulation requires consistent compliance and reporting requirements for all HCBS waiver providers; however, the final-form regulation consolidates multiple chapters of regulations and simplifies the regulatory compliance requirements for all providers.

d) Federal regulation requires consistent performance standards for all HCBS providers. While outcome measures were considered, outcome measurement does not meet the Federal requirements or the licensing measurement and enforcement requirements.

e) The final-form regulation includes exemptions from certain requirements for unique programs, such as the agency with choice, organized health care delivery system, base-funding and vendor goods and services, many of which are provided by small businesses.

(28) If data is the basis for this regulation, please provide a description of the data, explain in detail how the data was obtained, and how it meets the acceptability standard for empirical, replicable and testable data that is supported by documentation, statistics, reports, studies or research. Please submit data or supporting materials with the regulatory package. If the material exceeds 50 pages, please provide it in a searchable electronic format or provide a list of citations and internet links that, where possible, can be accessed in a searchable format in lieu of the actual material. If other data was considered but not used, please explain why that data was determined not to be acceptable.

The Department studied the HCBS regulations of the states of New York, Maryland, New Jersey, Ohio, Illinois, Massachusetts and Wisconsin because of the close proximity of some of these states and based on readily available information regarding other states. Since no two states have the same administrative, program or funding structures, nor do they share the same historical development, a strict data comparison is not possible; however, in a comparison of the HCBS standards in other states across staff training, individual plans, restrictive procedures and incident management, the proposed Pennsylvania regulation is reasonably consistent with the standards, policies, practices and procedures of other states.

(29) Include a schedule for review of the regulation including:

A. The length of the public comment period:
45 days following proposed rulemaking

B. The date or dates on which any public meetings or hearings will be held:
A three-day external regulation work group meeting was held on January 31, February 1 and February 2, 2017. A subsequent regulation work group meeting was held on October 18, 2017.

C. The expected date of delivery of the final-form regulation:
Anticipated by August 31, 2018

D. The expected effective date of the final-form regulation:
Upon publication for §§ 6100.55 (relating to reserved capacity), 6100.226 (relating to documentation of claims), 6100.227 (relating to progress notes), 6100.481—6100.485 (relating to general payment provisions), 6100.571 (relating to fee schedule rates), 6100-641—6100.672 (relating to cost-based rates and allowable costs), 6100.741—6100.744 (relating to enforcement), 6100.802 (relating to agency with choice), 6100.804 (relating to organized health care delivery system) and 6100.806 (relating to vendor goods and services).

March 17, 2019 for § 6100.444(c) (relating to size of service location).

120 days following publication of the final-form regulation for the sections of the final-form regulation not listed above.

E. The expected date by which compliance with the final-form regulation will be required:
Variable-See C.

F. The expected date by which required permits, licenses or other approvals must be obtained: Licensing inspections will follow the normal sequencing; while regulatory compliance is mandated upon the effective dates specified in D, licensing inspections will occur throughout a 12-month period, on a staggered basis.

(30) Describe the plan developed for evaluating the continuing effectiveness of the regulations after its implementation.

The Department will continue to evaluate the effectiveness and efficiency of the new regulation through its numerous public participation venues, by conducting research particularly relating to the payment options and methodologies and through its compliance monitoring and licensing inspection efforts.

pennsylvania
DEPARTMENT OF HUMAN SERVICES

Final Approval _____ Date_____

55 Pa. Code Chapter 6100
Services for Individuals with an Intellectual Disability or Autism
Corrective Action Plan. § 6100.42

Reviewer Contact Information Name/Title: ODP or Designated Managing Entity: Phone/Email: Date of Report: Person Responsible for Monitoring Compliance:	CAP Due Date: Submission Date: Approved Date: Returned Date: Validation Date:

SECTION	SUMMARY OF NON-COMPLIANCE	CORRECTIVE ACTION	PERSON RESPONSIBLE FOR COMPLETING THE CORRECTIVE ACTION	TARGET DATE	COMPLETED DATE

pennsylvania
DEPARTMENT OF HUMAN SERVICES

55 Pa. Code Chapter 6100
Services for Individuals with an Intellectual Disability or Autism
Request for Regulatory Waiver. §6100.43

Provider Name:		
Street Address/City/State/Zip:		
Person Completing Request / Contact:	Phone Number (include area code):	Email Address:
MPI #:	Service Location Code:	License/Certificate Number (If Applicable):
Service Location Address (Street/City/State/Zip)		
Date of Request:	Type of Request: ☐ New ☐ Renewal	
Name of Individual for Whom the Regulatory Waiver is Being Requested (If Applicable):		MCI Number (If Applicable):
Section Title of Regulation (Regulation Heading):		
Subsection Number (Complete a separate form for each section/subsection/paragraph/subparagraph):		
Describe the Reason for the Regulatory Waiver Request:		
Describe how Granting this Request will Not Jeopardize the Individual's Health, Safety, and Well-Being:		
Describe how Granting this Regulatory Waiver will Benefit an Individual or Group of Individuals through Increased Person-Centered practices, Integration, Independence, Choice or Community Opportunities:		
Department Decision:	Department Conditions of Approval:	
Effective Date:	Expiration Date:	
Signature of the Secretary of the Department or the Secretary's Designee:		

Attach Additional Pages as Necessary

pennsylvania
DEPARTMENT OF HUMAN SERVICES

Enrollment Information | Contact Information | Help

Welcome

New Application

Revalidation

Reactivation

Resume Application

Application Status

Provider Enrollment Application

Welcome to the Pennsylvania (PA) Department of Human Service (DHS) Medical Assistance (MA) Program On-line Provider Enrollment Application

In order for providers to participate with the Department of Human Services, they must first enroll. To be eligible to enroll, practitioners in Pennsylvania must be licensed and currently registered by the appropriate state agency. Out-of-state practitioners must be licensed and currently registered by the appropriate agency in their state and they must provide documentation that they participate in that state's Medicaid program. Other providers must be approved, licensed, issued a permit, certified by the appropriate state agency, or if applicable certified under Medicare.

To enroll, providers can complete an on-line provider enrollment application and supply any required supporting documentation. This includes providers who are not billing PA Medicaid but provide services to beneficiaries. All applications will be screened based on Federal and State guidelines prior to an enrollment decision. Please retain copies of your application materials for your records. You will receive a response upon approval or denial of your enrollment with PA Medicaid.

Types of Provider Enrollment Applications

There are three types of enrollment applications and each requires a provider to complete an entire application. Please click the appropriate navigation item on the left hand side of the page to start a "New Application", "Revalidation" or "Reactivation".

- "New Application" - Brand new provider never enrolled with PA Medicaid
- "Revalidation" - Provider currently enrolled with PA Medicaid
- "Reactivation" - Provider re-enrolling with PA Medicaid

Tracking Provider Enrollment Applications

A unique number called the "Application Tracking Number" (ATN) will be assigned when a "New Application", "Revalidation" or "Reactivation" is started. Prior to exiting the application, write down this number and keep it for your records. If you need to access the application later, please click the appropriate navigation item on the left hand side of the page to "Resume Application" or to check the "Application Status". Note: Information will not be retained and the application will be deleted if the provider does not complete the application, supply the required supporting documentation and click the "Submit Application" button on the "Summary" page when finished.

Additional Information

The following buttons will open a web page in a new browser window so information can be viewed while continuing with the application. Please click the appropriate heading at the top of the page to obtain additional information.

- "Enrollment Information" - Opens the DHS website provider "Enrollment Information" page
- "Contact Information" - Opens the DHS "Contact Information/Help for MA Providers" page; includes telephone number and address information
- "Help" - Opens the document that provides navigation tips for the on-line provider electronic enrollment application.

If you have any questions about completing an application, please refer to "Contact Information" and call the appropriate toll free number for your provider type.

System Requirements

At a minimum this site requires Microsoft Internet Explorer version 11 with 256 bit encryption. All enrollment attachments must be uploaded in Adobe PDF format. You must have a copy of Adobe Acrobat Reader installed on your system to view certain supporting documents.

pennsylvania
DEPARTMENT OF HUMAN SERVICES

Enrollment Information | Contact Information | Help

- Welcome
- Request Information
- Service Location Address
- Other Addresses
- Specialties
- Provider Eligibility Program (PEP)
- Provider Identification
- Additional Information
- Provider Disclosures
- Ownership / Control Interest
- Attachments
- Agreements
- Summary

Application Tracking Number (ATN): [illegible] | Type: New Enrollment | Start Date: 06/14/2015 | Completion By: 07/14/2015

Click to See Application Comments

Request Information

You are initiating a provider enrollment application for the Pennsylvania Department of Human Services (DHS) Medical Assistance (MA) program. Complete the fields on this page and select the Save and Continue button to continue with this application.

If you exit the application before it has been submitted, you can resume your provider enrollment application at a later time by providing the system generated Application Tracking Number (ATN), the Federal Tax Identification Number (FEIN or SSN) and password you established.

* Indicates a required field.

Indicates an attachment is required

Initial Enrollment Information

Verify your provider type and enrollment type selections prior to saving this page. Once this information is saved, it cannot be changed. If this information is incorrect, you will need to begin a brand new application.

*Provider Type: 31 - Physician

*Enrollment Type: Individual with FEIN

Tax Identifier

Based on the Enrollment Type selected above, you are required to specify either a Social Security Number (SSN) or Federal Tax Identification Number (FEIN). A Federal Tax Identification Number (FEIN) is used to identify a business entity. A Social Security Number (SSN) is used to identify an individual.

*Social Security Number (SSN): 123456789

*Confirm Social Security Number (SSN): 123456789

*FEIN: [illegible]

*Confirm FEIN: [illegible]

Name of Enrollee

Based on the Enrollment Type selected above, you are required to specify either an Entity Name or an Individual's Name.

*Last Name: Kent

*First Name: Clark

Middle Initial:

*Entity Name:

Medicaid Enrollment Information

Enter your 13-digit PA Medicaid Provider Number.

*Provider Number

*Was your previous enrollment and participation in the MA Program terminated by the Department based on violations that led to the termination? ☑ Yes ☐ No

Providers who are seeking to re-enroll must include three (3) statements from peer review bodies, probation officers where appropriate, or professional associates, giving factual evidence of why they believe the violations leading to the termination will not be repeated. Providers must include a statement setting forth the reasons why he or she should be re-enrolled in the MA Program.

Contact Information

Contact information will be used for correspondence regarding this application. Please provide a contact person who can assist with questions regarding this application.

The password you enter will allow you to continue the application at a later time and to check the status of the application. If forgotten, the password cannot be reset and your application information will no longer be available. At that point, you will need to begin a brand new application.

*Last Name

*First Name

Title

*Phone Number

Phone Extension

Toll Free Number

Toll Free Extension

Fax Number

*Email myemail@domain.com

*Confirm Email myemail@domain.com

*Password

*Confirm Password

Finish Later | Save & Continue

pennsylvania
DEPARTMENT OF HUMAN SERVICES

Enrollment Information | Contact Information | Help

- Welcome
- Request Information
- Service Location Address
- Other Addresses
- Specialties
- Provider Eligibility Program (PEP)
- Provider Identification
- Additional Information
- Provider Disclosures
- Ownership / Control Interest
- Attachments
- Agreements
- Summary

Application Tracking Number (ATN)	Type: New Enrollment	Start Date:	Completion By: 07/04/2015
[redacted]		05/04/2015	

Click to See Application Comments

Service Location Address

Complete the fields on this page and select the Save and Continue button to continue with this application

* indicates a required field.

🔗 indicates an attachment is required.

Service Location Physical Address

This address must be a physical address where a practitioner maintains an office, holds office hours/sets appointments and renders services. A post office box is not a valid Service Location Physical Address.

Verify your selection of the service location physical address state prior to saving this page. Once this information is saved, it cannot be changed. If this information is incorrect, you will need to begin a brand new application.

*Street	123 Reality Drive	Room/Suite	
*City	Morning Heights	*State	PA - Pennsylvania
*Zip+4	12345-6789	*County	Adams
*Email	homer@simpson.biz	*Confirm Email	homer@simpson.biz
*Phone Number	123-465-7980	Phone Extension	
Fax Number	[redacted]		

General Historical Questions

The following questions pertain to the service location you are enrolling.

After this information is saved, you will have the option to enter different address information for Mail-To, Pay-To, and Home Office Addresses on a separate page

*For providers whose primary practice is in Pennsylvania, do you participate with the Medical Care Availability and Reduction of Error Act (MCare)? 🔗	☐ Yes ☑ No
*Do you bill for a mobile medical unit from this location?	☐ Yes ☑ No
*Do you bill for a mobile dental unit from this location?	☐ Yes ☑ No

*Does the office have exterior steps leading to the main entrance doorway? ☑ Yes ☐ No

*Does the office have interior steps leading to the main entrance doorway? ☑ Yes ☐ No

*Does the office have a permanent wheelchair ramp? ☐ Yes ☑ No

*Does the office have a portable wheelchair ramp? ☐ Yes ☑ No

*Is there an alternate entrance that has no exterior or interior steps or has a wheelchair ramp? ☑ Yes ☐ No

☐ No Exterior Steps ☐ No Interior Steps
☐ Permanent Ramp ☐ Portable Ramp

*Is this address an active Rural Health Clinic or FQHC? ☐ Yes ☑ No

Has screening been performed at this location for this provider within the last 12 months by:

*Medicare? ☑ Yes ☐ No

*Screening Date mm/dd/yyyy

*Children's Health Insurance Program (CHIP)? ☑ Yes ☐ No

*Screening Date mm/dd/yyyy

*Screening State Select a State

*Phone Number

*Email myemail@domain.com

*Confirm Email myemail@domain.com

*Another State's Medicaid? ☑ Yes ☐ No

*Screening Date mm/dd/yyyy

*Screening State Select a State

*Phone Number

*Email myemail@domain.com

*Confirm Email myemail@domain.com

Finish Later Save & Continue

pennsylvania
DEPARTMENT OF HUMAN SERVICES

Enrollment Information | Contact Information | Help

- Welcome
- Request Information
- Service Location Address
- **Other Addresses**
- Specialties
- Provider Eligibility Program (PEP)
- Provider Identification
- Additional Information
- Provider Disclosures
- Ownership / Control Interest
- Attachments
- Agreements
- Summary

Application Tracking Number (ATN): 1000000217 | Type: New Enrollment | Start Date: 06/05/2015 | Completion By: 07/05/2015

Other Addresses

On this page you have the option to assign a Mail-To, Pay-To or Home Office address that is different from the Service Location Physical Address.

Below is the physical address of your service location. This address is currently being set as the default address for all other address types. If you would like to specify a different address, please check the box next to the corresponding address type. Leaving a box unchecked will default that address to your service locations address.

Complete the fields on this page and select the Save and Continue button to continue with this application.

* Indicates a required field.

Service Location Physical Address

Street	123 Reality Drive	**Room/Suite**	
City	Morning Heights	**State**	PA - Pennsylvania
Zip+4	13213-1231	**County**	Adams
Email	test@test.com		
Phone Number	(123) 465-7980	**Extension**	
Fax Number			

Other Address Information

Select the address type that you would like to be different than the Service Location Physical Address:

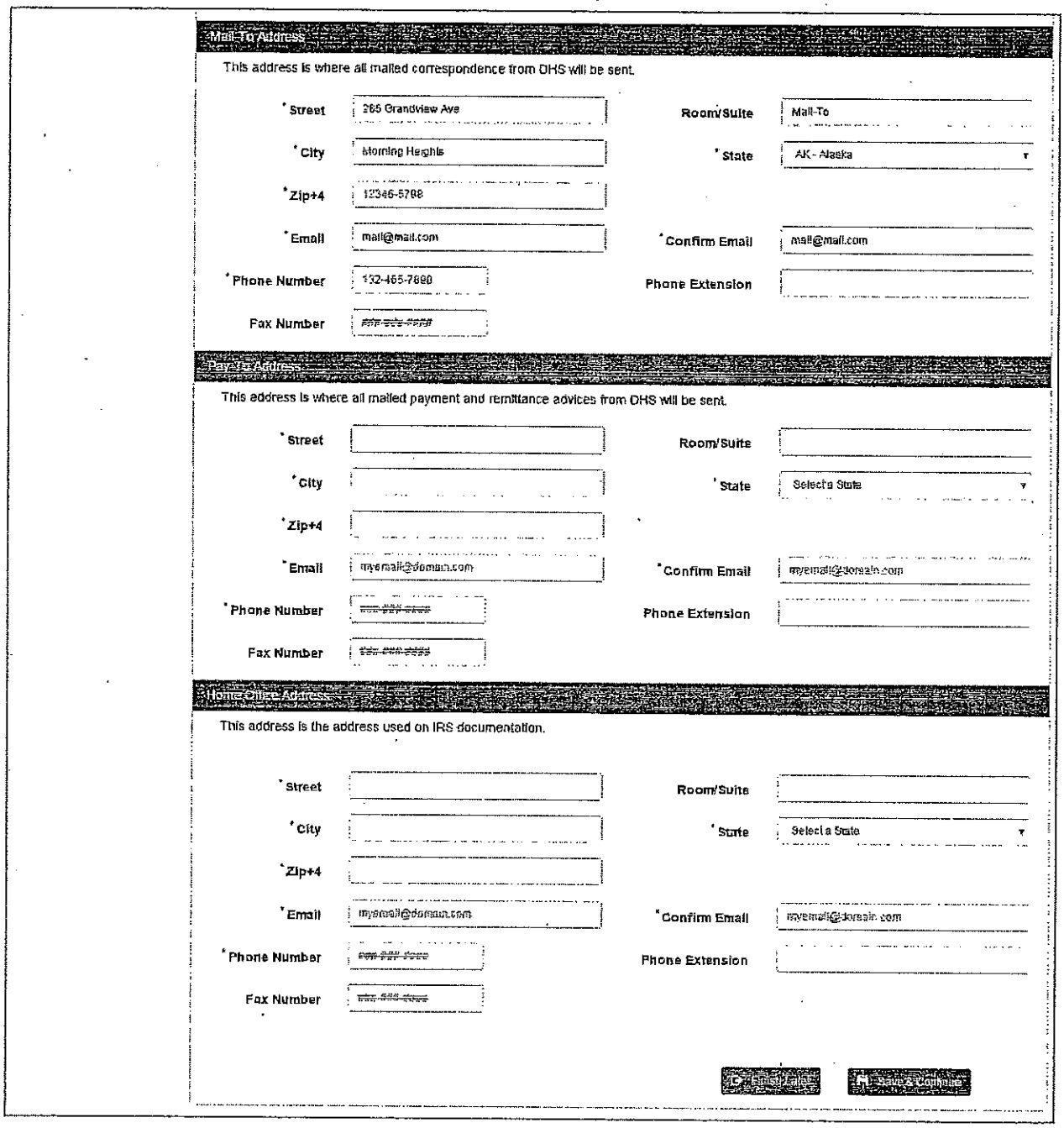
☑ Mail-To
☑ Pay-To
☑ Home Office

If you wish to utilize the Electronic Funds Transfer Direct Deposit Option please visit the following link for further information: http://www.dhs.state.pa.us/provider/doingbusinesswithdhs/electronicfundstransferdirectdepositinformation

Once enrolled, you can retrieve RAs from PROMISe™ online. If you require paper RAs, please call 1.800.537.8862 option 1 to see if you meet the requirements.

***Would you like to receive E-Mail notification of new bulletins to the email address assigned to your mail-to address? If you did not provide a different address for your mail-to address, the email address assigned to your service location address will be used.** ☐ Yes ☑ No

By answering NO you are agreeing to be responsible to check for new MABs on your own by visiting the following website: http://www.dhs.state.pa.us/publications/bulletinsearch OR by signing up to receive notifications of new MABs through the MA Electronic Bulletins Listserv. If you wish to continue receiving paper bulletins call 1.800.537.8862 option 1 to see if you meet the requirements.



Mail-To Address

This address is where all mailed correspondence from DHS will be sent.

*Street	265 Grandview Ave	Room/Suite	Mail-To
*City	Morning Heights	*State	AK - Alaska
*Zip+4	12345-5788		
*Email	mail@mail.com	*Confirm Email	mail@mail.com
*Phone Number	132-465-7890	Phone Extension	
Fax Number	[illegible]		

Pay-To Address

This address is where all mailed payment and remittance advices from DHS will be sent.

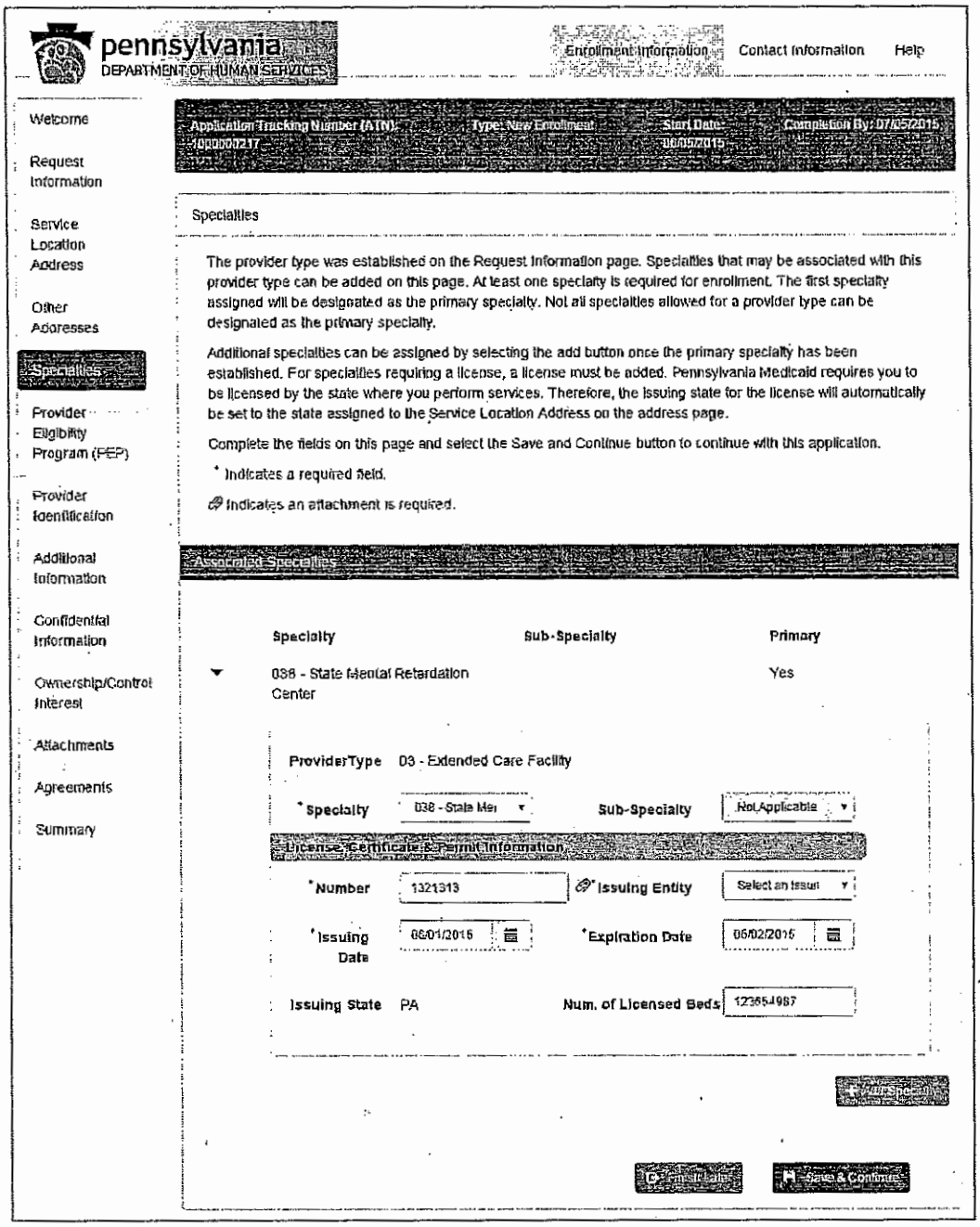
*Street		Room/Suite	
*City		*State	Select a State
*Zip+4			
*Email	myemail@domain.com	*Confirm Email	myemail@domain.com
*Phone Number	[illegible]	Phone Extension	
Fax Number	[illegible]		

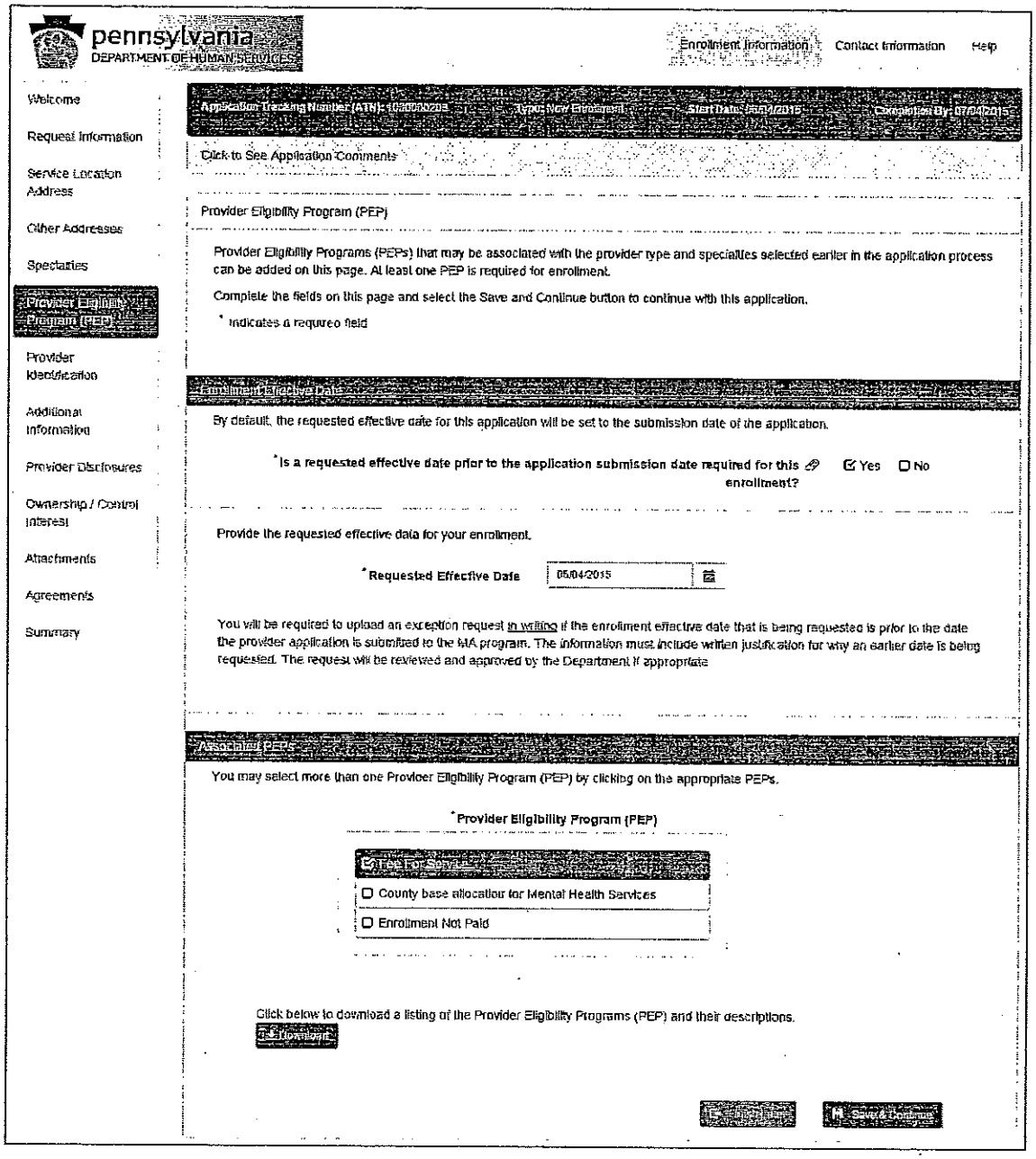
Home Office Address

This address is the address used on IRS documentation.

*Street		Room/Suite	
*City		*State	Select a State
*Zip+4			
*Email	myemail@domain.com	*Confirm Email	myemail@domain.com
*Phone Number	[illegible]	Phone Extension	
Fax Number	[illegible]		

[illegible] [illegible]


pennsylvania
DEPARTMENT OF HUMAN SERVICES
Enrollment Information
Contact Information
Help
Welcome
Request Information
Service Location Address
Other Addresses
Specialties
Provider Eligibility Program (PEP)
Provider Identification
Additional Information
Confidential Information
Ownership/Control Interest
Attachments
Agreements
Summary
Application Tracking Number (ATN): 10000000217
Type: New Enrollment
Start Date: 06/05/2015
Completion By: 07/05/2015
Specialties
The provider type was established on the Request Information page. Specialties that may be associated with this provider type can be added on this page. At least one specialty is required for enrollment. The first specialty assigned will be designated as the primary specialty. Not all specialties allowed for a provider type can be designated as the primary specialty.
Additional specialties can be assigned by selecting the add button once the primary specialty has been established. For specialties requiring a license, a license must be added. Pennsylvania Medicaid requires you to be licensed by the state where you perform services. Therefore, the issuing state for the license will automatically be set to the state assigned to the Service Location Address on the address page.
Complete the fields on this page and select the Save and Continue button to continue with this application.
* Indicates a required field.
Indicates an attachment is required.
Associated Specialties
Specialty
Sub-Specialty
Primary
038 - State Mental Retardation Center
Yes
Provider Type 03 - Extended Care Facility
*Specialty 038 - State Men
Sub-Specialty Not Applicable
License, Certificate & Permit Information
*Number 1321313
*Issuing Entity Select an issuer
*Issuing Date 06/01/2015
*Expiration Date 06/02/2015
Issuing State PA
Num. of Licensed Beds 123654987
Cancel
Save & Continue


pennsylvania
DEPARTMENT OF HUMAN SERVICES
Enrollment Information
Contact Information
Help
Welcome
Request Information
Service Location Address
Other Addresses
Specialties
Provider Eligibility Program (PEP)
Provider Identification
Additional Information
Provider Disclosures
Ownership / Control Interest
Attachments
Agreements
Summary
Application Tracking Number (ATN): 0
Type: New Enrollment
Start Date: 5/4/2015
Completion By: 7/3/2015
Click to See Application Comments
Provider Eligibility Program (PEP)
Provider Eligibility Programs (PEPs) that may be associated with the provider type and specialties selected earlier in the application process can be added on this page. At least one PEP is required for enrollment.
Complete the fields on this page and select the Save and Continue button to continue with this application.
* Indicates a required field
Enrollment Effective Date
By default, the requested effective date for this application will be set to the submission date of the application.
*Is a requested effective date prior to the application submission date required for this enrollment?
Yes
No
Provide the requested effective date for your enrollment.
*Requested Effective Date
05/04/2015
You will be required to upload an exception request in writing if the enrollment effective date that is being requested is prior to the date the provider application is submitted to the MA program. The information must include written justification for why an earlier date is being requested. The request will be reviewed and approved by the Department if appropriate
Associated PEPs
You may select more than one Provider Eligibility Program (PEP) by clicking on the appropriate PEPs.
*Provider Eligibility Program (PEP)
Fee For Service
County base allocation for Mental Health Services
Enrollment Not Paid
Click below to download a listing of the Provider Eligibility Programs (PEP) and their descriptions.
Download

pennsylvania
DEPARTMENT OF HUMAN SERVICES

Enrollment Information | Contact Information | Help

- Welcome
- Request Information
- Service Location Address
- Other Addresses
- Specialties
- Provider Eligibility Program (PEP)
- Provider Identification
- Additional Information
- Provider Disclosures
- Ownership / Control Interest
- Attachments
- Agreements
- Summary

Application Tracking Number (ATN): 10032002269 | Type: New Enrollment | Start Date: 06/04/2015 | Completion By: 07/04/2015

Click to See Application Comments

Provider Identification

Additional information identifying the provider is collected on this page.

Complete the fields on this page and select the Save and Continue button to continue with this application.

* Indicates a required field.
Indicates an attachment is required.

Provider IRS/Legal Name and Address

Enter the legal Name as it is filed with the IRS and as it appears on the IRS generated document. The address entered below is where your 1099 tax document will be sent.

*Entity Name			
*Street	123 Main St	Room/Suite	
*City	Springfield	*State	IL - Illinois
*Zip+4	12345-6789		

Contact IRS/Legal Name and Address

Enter the contact information for the IRS address.

*Last Name	Burns		
*First Name	Montgomery		
Title	Title		
*Phone Number	123-456-7890	Phone Extension	
Toll Free Number	[illegible]	Toll Free Extension	
Fax Number	[illegible]		
*Email	mrwonderful@mrwonderful.com		
*Confirm Email	mrwonderful@mrwonderful.com		

Individual Provider

*Birth Date	06/09/1980	*Gender	Male
Title/Degree			

*Are you Board Certified? ☑ Yes ☐ No

*Issuing Date	mm/dd/yyyy	*Expiration Date	mm/dd/yyyy
* SSN	[illegible]	*Confirm SSN	[illegible]

Organizational Structure

Select the appropriate type of Practice Organization from the drop down list.

*Type: Business Corporation, For Profit

*Does the provider operate under a Fictitious business / doing business as (d/b/a) name? ☐ Yes ☑ No

NPI

NPI is a unique identification number for healthcare providers.

*NPI: 1295339932

*Taxonomy

You may select more than one Taxonomy by clicking on the appropriate taxonomies.

☑ 283Q00000X - Hospitals - Psychiatric Hospital - Detailed Specialty

*Do you want Medicare claims to crossover to this location? ☑ Yes ☐ No

CLIA Certification

*Are a CLIA Certificate and a Pennsylvania Department of Health Lab Permit associated with this Service Location? ☑ Yes ☐ No

*CLIA Number:

*DOH Lab Permit Number:

*Do you have a lab permit from your home state for this Service Location Address? ☑ Yes ☐ No

*OOS Lab Permit Number:

*Issuing State:

DEA Number

*Is a Drug Enforcement Administration (DEA) Number associated with this provider? ☑ Yes ☐ No

*DEA #:

CMS Certificate

*Is a CMS Certificate Number associated with this provider? ☑ Yes ☐ No

*CMS Certificate Number:

Finish Later | Save & Continue

pennsylvania
DEPARTMENT OF HUMAN SERVICES

Enrollment Information | Contact Information | Help

- Welcome
- Request Information
- Service Location Address
- Other Addresses
- Specialties
- Provider Eligibility Program (PEP)
- Provider Identification
- **Additional Information**
- Provider Disclosures
- Ownership / Control Interest
- Attachments
- Agreements
- Summary

Application Tracking Number (ATN): 1000000208 | Type: New Enrollment | Start Date: 08/04/2015 | Completion By: 07/04/2015

Application Comments Provided by Pennsylvania Department of Human Services (DHS) Medical Assistance (MA)

This is a test of the emergency broadcast system!

Additional Information

Additional information for the provider is collected on this page.

Complete the fields on this page and select the Save and Continue button to continue with this application.

* Indicates a required field.
🖉 Indicates an attachment is required.

Enrollment Languages

*In addition to English, do you or your staff communicate with patients in another language? ☑ Yes ☐ No

- ☐ Arabic
- ☐ Chinese
- ☐ Czech
- ☐ English
- ☐ French
- ☐ Hebrew
- ☐ Hindi
- ☐ Hungarian

Enrollment Questions

*Do you provide Diabetes Training Education? 🖉 ☑ Yes ☐ No

*Do you provide Mammography Services? 🖉 ☑ Yes ☐ No

*Do you employ any practitioners by salary or contract? 🖉 ☑ Yes ☐ No

*Do you have a certificate of completion for the application of Topical Fluoride Varnish? 🖉 ☑ Yes ☐ No

Medical Director

*What is the 13-digit provider ID for the Licensed Medical Director? 1234567890133

Pharmacists

Enter employed pharmacists below. At least one pharmacist is required for enrollment. Additional pharmacists can be assigned by selecting the add pharmacist button.

Last Name	First Name	NPI
Duck	Dewey	1234556789

*Last Name: Duck
*First Name: Dewey
Middle Initial:
*License #: 123ASD
*NPI Number: 1234556789

*Is the pharmacist an owner of the enrolling pharmacy? ☐ Yes ☑ No

*Is the pharmacist a manager of the enrolling pharmacy? ☐ Yes ☑ No

Tax Exempt Status

*Do you currently have tax exempt status? ☐ Yes ☑ No

Cost Reporting

*Fiscal Year End Date: Select Fiscal Year End

*Projected Resident Days for the next 12 months: ###

Fee Assignments

*Would you like to be fee assigned (linked) to a group? ☑ Yes ☐ No

*Provider Number

000550073-0006 Farmer, Lenora

*Would you like to associate members to your group? ☑ Yes ☐ No

*Provider Number

000550073-0006 Farmer, Lenora

pennsylvania
DEPARTMENT OF HUMAN SERVICES

Enrollment Information | Contact Information | Help

- Welcome
- Request Information
- Service Location Address
- Other Addresses
- Specialties
- Provider Eligibility Program (PEP)
- Provider Identification
- Additional Information
- Provider Disclosures
- Ownership / Control Interest
- Attachments
- Agreements
- Summary

Provider Disclosures

Respond to the following provider disclosure questions and select the Save and Continue button to continue with this application.

* Indicates a required field.
Indicates an attachment is required.

Definitions

Agent means any person who has been delegated the authority to obligate or act on behalf of a provider.

Managing employee means a general manager, business manager, administrator, director, or other individual who exercises operational or managerial control over, or who directly or indirectly conducts the day-to-day operation of an institution, organization or agency.

Have you, any agent, or managing employee ever:

* Been terminated, excluded, precluded, suspended, debarred from or had their participation in any federal or state health care program limited in any way, including voluntary withdrawal from a program for an agreed to definite or indefinite period of time?	☐ Yes	☑ No
* Been the subject of a disciplinary proceeding by any licensing or certifying agency, had his/her license limited in any way, or surrendered a license in anticipation of or after the commencement of a formal disciplinary proceeding before a licensing or certifying authority (e.g., license revocations, suspensions, or other loss of license or any limitation on the right to apply for or renew license or surrender of a license related to a formal disciplinary proceeding)?	☐ Yes	☑ No
* Had a controlled drug license withdrawn?	☐ Yes	☑ No
* Been convicted of a criminal offense related to Medicare or Medicaid; practice of the provider's profession; unlawful manufacture, distribution, prescription or dispensing of a controlled substance; or interference with or obstruction of any investigation?	☐ Yes	☑ No
* In connection with the delivery of a health care item or service, been convicted of a criminal offense relating to neglect or abuse of patients or fraud, theft, embezzlement, breach of fiduciary responsibility, or other financial misconduct?	☑ Yes	☐ No

If you answered "YES" to any of the questions above, you MUST provide a detailed explanation on a separate piece of paper) and submit three (3) statements from professional associates or peer review bodies giving factual evidence of why they believe the violation(s) will not be repeated and attach it to your application. Include the following information as applicable to the situation:

1. Name and title of individual
2. Name of federal or state health care program
3. Name of licensing/certifying agency taking the action
4. Date of action
5. Type of action taken
6. Length of action
7. Basis for action
8. Disclosed/Stale
9. Date license was surrendered
10. Name of court
11. Date of conviction
12. Offense(s) committed
13. Sentence(s)
14. Categorization of offense (e.g. felony, misdemeanor)

Previous | Save & Continue

Have you ever:

*Had clinical privileges or hospital privileges denied, suspended, restricted, revoked, or not renewed; either voluntarily or involuntarily for an agreed to definite or indefinite period of time?	☐ Yes ☑ No
*Had any judgments entered against you or settlements been agreed to in any professional liability cases?	☐ Yes ☑ No
*Are there any professional liability lawsuits pending against you at the present time?	☐ Yes ☑ No
*Do you have physical or mental health condition(s) which in any way impairs your ability to practice your profession, with or without accommodations?	☐ Yes ☑ No
*Do you have any physical or mental health condition(s) which in any way poses a risk of harm to your patients?	☐ Yes ☑ No
*Are you currently using, or have you used in the past five years, drugs or any other chemical substance that has or may impair your ability to practice your profession?	☑ Yes ☐ No

If you answered "Yes" to any of the questions above, you MUST provide a detailed statement of the circumstances relating to the "YES" response as well as an explanation as to why you think this response should not result in a denial of your enrollment to participate in MA Program. You may also submit statements from professional associates or peer review bodies. Include in your statement the following information as it applies to each situation:

1. Name and title of the individual applicant
2. Date of professional malpractice action
3. Description of professional malpractice action
4. Explanation of any physical or mental health condition(s) that impairs your ability to practice your profession
5. Explanation of any physical or mental health condition(s) that poses a risk of harm to your patients
6. Explanation of drug or chemical substance use

Have you or anyone in your employ ever:

*Been terminated, excluded, precluded, suspended, debarred from or had your participation in any federal or state health care program or hospital privileges limited in any way, including voluntary withdrawal from a program for an agreed to definite or indefinite period of time?	☐ Yes ☑ No
*Been the subject of a disciplinary proceeding by any licensing or certifying agency, had your license limited in any way, or surrendered a license in anticipation of or after the commencement of a formal disciplinary proceeding before a licensing or certifying authority (e.g., license revocations, suspensions, or other loss of license or any limitation on the right to apply for or renew license or surrender of a license related to a formal disciplinary proceeding)?	☐ Yes ☑ No
*Had a controlled drug license withdrawn?	☐ Yes ☑ No
*Been convicted of a criminal offense related to Medicare or Medicaid, or a state health care program?	☐ Yes ☑ No
*Been convicted of a criminal offense relating to the unlawful manufacture, distribution, prescription or dispensing of a controlled substance?	☐ Yes ☑ No
*Been convicted of interference with or obstruction of any investigation?	☐ Yes ☑ No
*In connection with the delivery of a health care item or service, or with respect to any act or omission in a health care program, been convicted of any criminal offense relating to neglect or abuse of patients or fraud, theft, embezzlement, breach of fiduciary responsibility, or other financial misconduct?	☐ Yes ☑ No
*Been in default on repayments of scholarship obligations or loans in connection with your education as a health professional?	☐ Yes ☑ No
*Been subject to a civil penalty or assessment for any act or omission related to Medicare, Medicaid, or a state health care program?	☑ Yes ☐ No

If you answered "YES" to any of the questions above, you MUST provide a detailed statement of the circumstances relating to the "YES" response as well as an explanation as to why you think this response should not result in a denial of your enrollment to participate in the MA Program. Include in your statement the following information as it applies to each situation:

1. Name of individual
2. Name of licensing, certifying or other agency taking action
3. Date of action or criminal conviction
4. Type of action
5. Length of suspension/preclusion or other action
6. Disposition (current status or outcome)
   - Sentence
   - Civil penalties
   - Restitution
7. Offense(s) convicted of
   - Date
8. Categorization of offense (e.g. felony, misdemeanor)
9. Date license was surrendered or withdrawn (if applicable)

Previous | Save & Continue

Welcome
Request Information
Service Location Address
Other Addresses
Specialties
Provider Eligibility Program (PEP)
Provider Identification
Additional Information
Provider Disclosures
Ownership/Control Interest
Attachments
Agreements
Summary

Click to See Application Comments

Ownership/Control Interest

Note: Ownership and control information is required in accordance with Federal Regulations 42 CFR Part 455, Subpart B published July 17,1979, and expanded through additional subparts on February 02,2011 through the Provider Enrollment and Screening provisions of the Affordable Care Act

* Indicates a required field.

Indicates an attachment is required.

Definitions

The definitions below are designed to clarify certain questions on the following Ownership and Control Disclosure forms. The full text of the regulations governing the disclosure of information by providers and fiscal agents can be found in 42 CFR Part 455 Subpart B.

Agent means any person who has been delegated the authority to obligate or act on behalf of a provider.

Managing employee means a general manager, business manager, administrator, director, or other individual who exercises operational or managerial control over, or who directly or indirectly conducts the day-to-day operation of an institution, organization or agency.

Significant business transaction means any business transaction or series of transactions that, during any one fiscal year, exceed the lesser of $25,000 and 5 percent of a provider's total operating expenses.

Subcontractor means:

a. An individual, agency, or organization to which a provider has contracted or delegated some of its management functions or responsibilities of providing medical care to its patients; or
b. An individual, agency, or organization with which a fiscal agent has entered into a contract, agreement, purchase order, or lease (or leases of real property) to obtain space, supplies, equipment, or services provided under the Medicaid agreement.

Supplier means an individual, agency, or organization from which a provider purchases goods and services used in carrying out its responsibilities under Medicaid (e.g., a commercial laundry, a manufacturer or hospital beds, or a pharmaceutical firm).

Wholly owned supplier means a supplier whose total ownership interest is held by a provider or by a person, persons, or other entity with an ownership or control interest in a provider.

Managing Employee or Agent Disclosure

*Does the enrolling individual practitioner have any Managing Employees or Agents? ☑ Yes ☐ No

Please enter the full name, address, social security number, and date of birth of any person who is a managing employee or agent of the enrolling individual practitioner

Name

Nagori Monal

*Last Name	Nagori		
*First Name	Monal	Middle Initial	I
*Birth Date	03/03/1975		
*SSN	123-45-6789	*Confirm SSN	123-45-6789
*Street	123 Lemar St	Room/Suite	Suite 205
*City	Hamp	*State	PA - Pennsylvania
*Zip+4	23456-7456		

*Is this individual a managing employee or agent? Managing Employee

*Has the individual listed above been convicted of a criminal offense related to that person's involvement in Medicare, Medicaid, Title XX, Title XXI (CHIP), or a state health care program? ☑ Yes ☐ No

Description of Offense

This is a huge text.This is a huge text.This is a huge text.This is a huge text.This is a huge text.This is a huge text.This is a huge text.This is a huge text.This is a huge text.This is a huge text.This is a huge text.This is a huge text.This is a huge text.This is a huge text.This is a huge text.This is a huge text.This is a huge text.This is a huge text.This is a huge text.

Direct Or Indirect Ownership

*Are there any subcontractors in which the enrolling individual practitioner has a direct or indirect ownership interest of 5% or more? ☑ Yes ☐ No

Please enter the full name and federal tax identification number of all subcontractors in which the enrolling individual practitioner has a direct or indirect ownership interest of 5% or more.

Name

▼ Monal Nagori

*Entity Name: Monal Nagori

*FEIN: 12-3456789 *Confirm FEIN: 12-3456789

Please enter the percentage and ownership type that the enrolling individual practitioner has in the subcontractor?

*Direct Percent: 10%

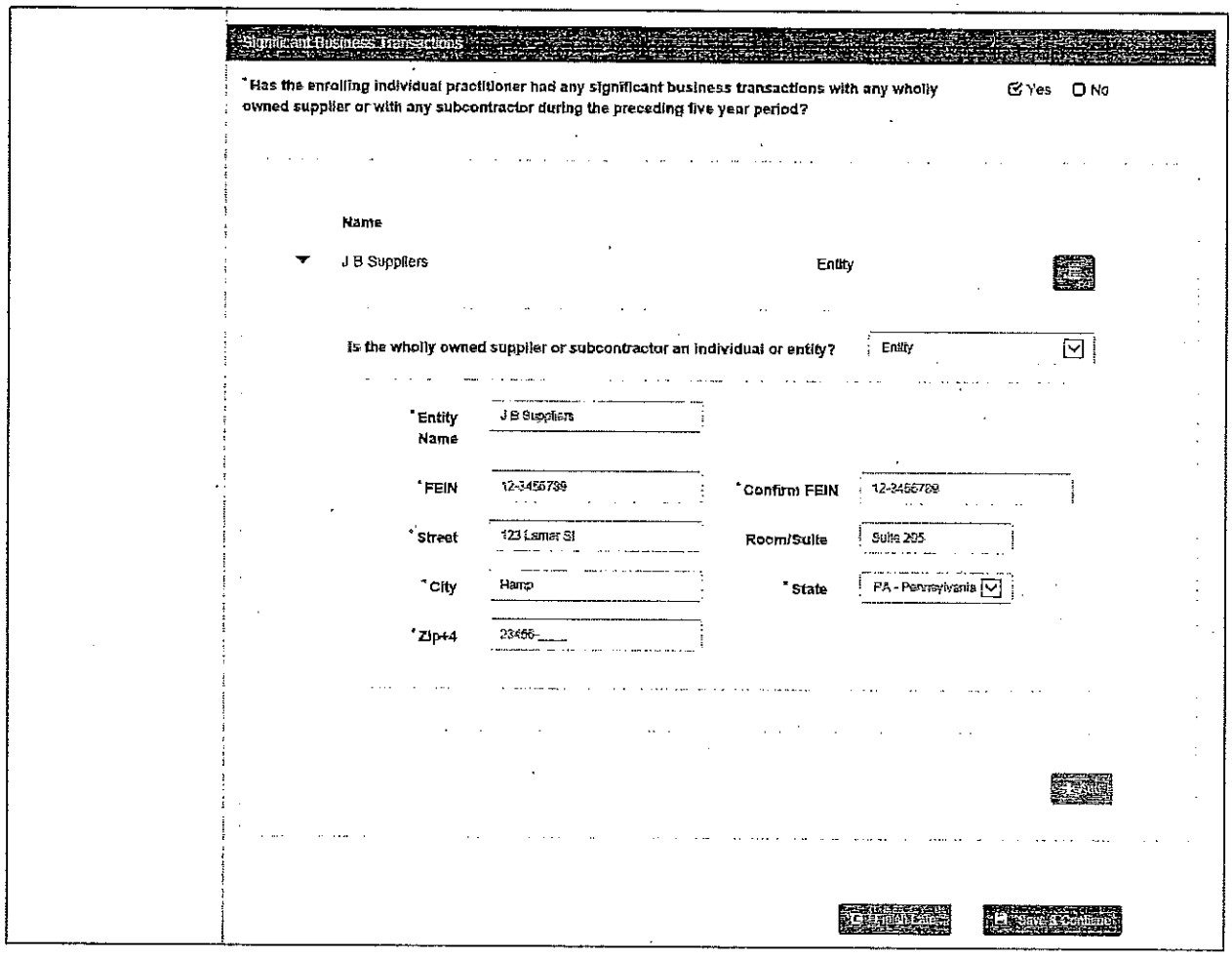
*Indirect Percent: 20%

*Name of Entity Owned: J B Suppliers

Criminal Offense

*Has the enrolling individual practitioner been convicted of a criminal offense related to Medicare, Medicaid, Title XX, Title XXI (CHIP), or a state health care program? ☑ Yes ☐ No

Description of Offense


Significant Business Transactions
*Has the enrolling individual practitioner had any significant business transactions with any wholly owned supplier or with any subcontractor during the preceding five year period?
Yes
No
Name
J B Suppliers
Entity
Is the wholly owned supplier or subcontractor an individual or entity?
Entity
*Entity Name
J B Suppliers
*FEIN
12-3456789
*Confirm FEIN
12-3456789
*Street
123 Lamar St
Room/Suite
Suite 295
*City
Hamp
*State
PA - Pennsylvania
*Zip+4
23456-

Welcome
Request Information
Service Location Address
Other Addresses
Specialties
Provider Eligibility Program (PEP)
Provider Identification
Additional Information
Provider Disclosures
Ownership/ Control Interest
Attachments
Agreements
Summary

Ownership/Control Interest

Note: Ownership and control information is required in accordance with Federal Regulations 42 CFR Part 455, Subpart B published July 17,1979, and expanded through additional subparts on February 02,2011 through the Provider Enrollment and Screening provisions of the Affordable Care Act

* indicates a required field.

🔗 indicates an attachment is required.

Definitions

The definitions below are designed to clarify certain questions on the following Ownership and Control Disclosure forms. The full text of the regulations governing the disclosure of information by providers and fiscal agents can be found in 42 CFR Part 455 Subpart B.

Agent means any person who has been delegated the authority to obligate or act on behalf of a provider.

Disclosing Entity means a Medicaid provider (other than an individual practitioner or a group of practitioners), or a fiscal agent.

Other Disclosing entity means any entity that does not participate in Medicaid, but is required to disclose certain ownership and control information because of participation in any of the programs established under title V, XVIII, or XX of the Act. This includes:

a. Any hospital, skilled nursing facility, home health agency, independent clinical laboratory, renal disease facility, rural health clinic, or health maintenance organization that participates in Medicare (title XVIII);
b. Any Medicare intermediary or carrier; and
c. Any entity (other than an individual practitioner or group of practitioners) that furnishes, or arranges for the furnishing of, health-related services for which it claims payment under any plan or program established under title V or title XX of the Act.

Fiscal agent means a contractor that processes or pays vendor claims on behalf of the Medicaid agency.

Group of practitioners means two or more health care practitioners who practice their profession at a common location (whether or not the share common facilities, common supporting staff, or common equipment).

Indirect ownership interest means an ownership interest in an entity that has an ownership interest in the disclosing entity.

Note: The amount of indirect ownership interest is determined by multiplying the percentages of ownership in each entity. For example:

If you own 10 percent of the stock in Corporation A, which owns 80 percent of the stock of the disclosing entity, you would have an 8 percent indirect ownership interest in the disclosing entity.

If you own 20 percent of the stock in Corporation A, which owns 50 percent of the stock in Corporation B which owns 80 percent of the stock of the disclosing entity, you would have an 8 percent indirect ownership interest in the disclosing entity.

Managing employee means a general manager, business manager, administrator, director, or other individual who exercises operational or managerial control over, or who directly or indirectly conducts the day-to-day operation of an institution, organization or agency.

Ownership interest means the possession of equity in the capital, the stock, or the profits of the disclosing entity.

Person with an ownership or control interest means a person or corporation that:

a. Has an ownership interest totaling 5 percent or more in a disclosing entity.
b. Has an indirect ownership interest equal to 5 percent or more in a disclosing entity.
c. Has a combination of direct and indirect ownership interests equal to 5 percent or more in a disclosing entity.
d. Owns an interest of 5 percent or more in any mortgage, deed of trust, note, or other obligation secured by the disclosing entity if that interest equals at least 5 percent of the value of the property or assets of the disclosing entity.
   Note: The percentage of ownership of a mortgage, deed of trust, note, or other obligation is determined by multiplying the percentage of interest owned in the obligation by the percentage of the disclosing entity's assets used to secure the obligation. For example:
   If you own 10 percent of a note secured by 60 percent of the disclosing entity's assets, you would have a 6 percent interest in the disclosing entity's assets.
e. Is an officer or director of a disclosing entity that is organized as a corporation; or.
f. Is a partner in the disclosing entity that is organized as a partnership

Significant business transaction means any business transaction or series of transactions that, during any one fiscal year, exceed the lesser of $25,000 and 5 percent of a provider's total operating expenses.

Subcontractor means:

a. An individual, agency, or organization to which a provider has contracted or delegated some of its management functions or responsibilities of providing medical care to its patients; or
b. An individual, agency, or organization with which a fiscal agent has entered into a contract, agreement, purchase order, or lease (or leases of real property) to obtain space, supplies, equipment, or services provided under the Medicaid agreement.

Supplier means an individual, agency, or organization from which a provider purchases goods and services used in carrying out its responsibilities under Medicaid (e.g., a commercial laundry, a manufacturer or hospital beds, or a pharmaceutical firm).

Wholly owned supplier means a supplier whose total ownership interest is held by a provider or by a person, persons, or other entity with an ownership or control interest in a provider.

Managing Employee or Agent Disclosure

*Does the enrolling disclosing entity have any Managing Employees or Agents? ☑ Yes ☐ No

Please enter the full name, address, social security number, and date of birth of any person who is a managing employee or agent of the enrolling disclosing entity

Name

▼ Nagori Monal

*Last Name: Nagori

*First Name: Monal Middle Initial: I

*Birth Date: 08/10/1975

*SSN: 123-45-6789 *Confirm SSN: 123-45-6789

*Street: 123 Lamar St Room/Suite: Suite 205

*City: Hamp *State: PA - Pennsylvania

*Zip+4: 23456-7456

*Is this individual a managing employee or agent? Managing Employee

*Has the individual listed above been convicted of a criminal offense related to that person's involvement in Medicare, Medicaid, Title XX, Title XXI (CHIP), or a state health care program? ☑ Yes ☐ No

*Description of Offense

This is a huge text.This is a huge text.This is a huge text.This is a huge text.This is a huge text.This is a huge text.This is a huge text.This is a huge text.This is a huge text.This is a huge text.This is a huge text.This is a huge text.This is a huge text.This is a huge text.This is a huge text.This is a huge text.This is a huge text.This is a huge text.

Individuals with an Ownership or Control Interest in The Disclosing Entity

If the provider is organized as a corporation, partnership, estate trust or is a government entity that is organized as a corporation, complete this section.

In completing this section, an individual with at least 5% direct or indirect ownership interest includes individuals that have a combination of direct and indirect ownership interests equal to 5 percent or more in a disclosing entity and individuals who own an interest of 5 percent or more in any mortgage, deed of trust, note, or other obligation secured by the disclosing entity if that interest equals at least 5 percent of the value of the property or assets of the disclosing entity.

Please enter the full name, social security number, date of birth, and address of individuals with an ownership or control interest in the disclosing entity and all officers, partners, and directors.

Name

Nagori Monal

*Last Name: Nagori

*First Name: Monal

Middle Initial: I

* Birth Date: 06/10/1975

* SSN: 123-45-6789

* Confirm SSN: 123-45-6789

*Street: 123 Lamar St

Room/Suite: Suite 205

*City: Hamp

*State: PA - Pennsylvania

*Zip+4: 28456-____

If the individual listed above has an ownership interest in the disclosing entity, please enter the percentage and ownership type that the individual listed above has in the disclosing entity.

Direct Percent: 10%

Indirect Percent: 20%

Name of Entity Owned: J B Suppliers

What position is held by the individual listed above?

Select a Position Type

*Is the individual listed above the spouse, parent, child, or sibling of any other individual with at least 5% direct or indirect ownership or a control interest in the disclosing entity? ☐ Yes ☐ No

Individual: Ford A Henry

Relationship: Child

*Is the individual listed above the spouse, parent, child or sibling of any other individuals with at least 5% direct or indirect ownership or a control interest in any subcontractor of the disclosing entity? ☑ Yes ☐ No

Name of Subcontractor | Relationship

Child

*Does the individual listed above have an ownership or control interest in other Medicare or Medicaid providers, fiscal agents, managed care entities, or any "other disclosing entities"? ☐ Yes ☐ No

Entity Name

J B Suppliers

*Entity Name: J B Suppliers

*Street: 123 Lamer St | Room/Suite: Suite 205

*City: Ramp | *State: PA - Pennsyl

*Zip+4: 23456-____

*Has the individual listed above been convicted of a criminal offense related to that person's involvement in Medicare, Medicaid, Title XX, Title XXI (CHIP), or a state health care program? ☑ Yes ☐ No

*Description of Offense

Corporate Entities with Ownership or Control Interest in Disclosing Entity

*Do any corporate entities have at least 5% direct or indirect ownership interest in the disclosing entity? ☑ Yes ☐ No

Please enter the full name, tax identification number, and primary business address of corporate entities that have at least 5% direct or indirect ownership interest in the disclosing entity.

Entity Name

▼ J B Suppliers

*Entity Name	J B Suppliers		
*FEIN	12-3456789	*Confirm FEIN	12-3456789
*Street	123 Lamar St	Room/Suite	Suite 205
*City	Hemp	*State	PA - Pennsylvania
*Zip+4	23456-____		

Please enter the percentage and ownership type that the corporate entity listed above has in the disclosing entity.

*Direct Percent	10%
*Indirect Percent	20%
*Name of Entity Owned	J B Suppliers

*Does the corporate entity listed above have any additional business locations and PO Boxes? ☑ Yes ☐ No

Please enter additional business locations and PO Boxes for the corporate entity listed above.

Address

123 Lamar St, Hamp, PA 23456

*Street: 123 Lamar St Room/Suite: Suite 205

*City: Hamp *State:

*Zip+4: 23456-____

*Does the corporate entity listed above have an ownership or control interest in other Medicare or Medicaid providers, fiscal agents, managed care entities, or any "other disclosing entities"? ☐ Yes ☐ No

Entity Name

J B Suppliers

*Entity Name: J B Suppliers

*Street: 123 Lamar St Room/Suite: Suite 205

*City: Hamp *State: PA - Penns

*Zip+4: 23456-____

Individuals with an Ownership or Control Interest in Subcontractors

*Are there any individuals with an ownership or control interest in any subcontractor in which the disclosing entity has a direct or indirect ownership interest of 5% or more? ☐ Yes ☐ No

Please enter the full name, date of birth, and address of each person with an ownership or control interest in any subcontractor in which the disclosing entity has a direct or indirect ownership interest of 5% or more.

Name

▼ Nagori Monal

*Last Name	Nagori		
*First Name	Monal	Middle Initial	I
* Birth Date	06/10/1975		
* SSN	123-45-6789	* Confirm SSN	123-45-6789
*Street	123 Lamer St	Room/Suite	Suite 205
*City	Hemp	*State	PA - Pennsylvania
*Zip+4	23456-____		

Please enter the Subcontractor name and Tax ID.

*Entity Name			
*FEIN	12-3456789	*Confirm FEIN	12-3456789

Please enter the percentage and ownership type that the disclosing entity has in the subcontractor.

*Direct Percent	10%
*Indirect Percent	20%
*Name of Entity Owned	J B Suppliers

Please enter the percentage and ownership type that the individual listed above has in the subcontractor.

*Direct Percent	40%
*Indirect Percent	10%
*Name of Entity Owned	ABC Corp

*Is the individual listed above the spouse, parent, child, or sibling of any other individual with at least 5% direct or indirect ownership or a control interest in the disclosing entity? ☐ Yes ☐ No

Individual	Relationship
Ford A Henry	Child

*Is the individual listed above the spouse, parent, child or sibling of any other individuals with at least 5% direct or indirect ownership or a control interest in any subcontractor of the disclosing entity? ☐ Yes ☐ No

Name of Subcontractor	Relationship
	Spouse

*Has the individual listed above been convicted of a criminal offense related to that person's involvement in Medicare, Medicaid, Title XX, Title XXI (CHIP), or a state health care program? ☐ Yes ☐ No

*Description of Offense

Corporate Entities with an Ownership or Control Interest in Subcontractors

*Are there any corporate entity with an ownership or control interest in any subcontractor which the disclosing entity has a direct or indirect ownership interest of 5% or more? ☐ Yes ☐ No

Please enter the full name, tax identification number, and primary business address of any corporate entity with an ownership or control interest in any subcontractor in which the disclosing entity has a direct or indirect ownership interest of 5% or more.

Entity Name

▼ J B Suppliers

*Entity Name: J B Suppliers

*FEIN: 12-3456789 *Confirm FEIN: 12-3456789

*Street: 123 Lamar St Room/Suite: Suite 205

*City: Hamp *State: PA - Pennsylvania

*Zip+4: 23456-____

Please enter the percentage and ownership type that the disclosing entity has in the subcontractor.

*Direct Percent: 10%

*Indirect Percent: 20%

*Name of Entity Owned: J B Suppliers

Please enter the percentage and ownership type that the Corporate entity listed above has in the subcontractor.

*Direct Percent: 40%

*Indirect Percent: 10%

*Name of Entity Owned: ABC Corp

Subcontractors of Disclosing Entity

*Does the disclosing entity have a direct or indirect ownership interest of 5% or more in any subcontractors? ☐ Yes ☐ No

Please enter the full name, tax identification number, and primary business address of all subcontractors in which the disclosing entity has a direct or indirect ownership interest of 5% or more.

SubContractor Name

▼ J B Suppliers

Please enter the Subcontractor name and Tax ID.

*Entity Name

*FEIN 12-3456789 *Confirm FEIN 12-3456789

Please enter the percentage and ownership type that the individual listed above has in the subcontractor.

*Direct Percent 40%

*Indirect Percent 10%

*Name of Entity Owned ABC Corp

Ownership or Control Interest in Other Entities

*Does the disclosing entity have an ownership or control interest in other Medicare or Medicaid providers, fiscal agents, managed care entities, or any "other disclosing entities"? ☐ Yes ☐ No

Entity Name

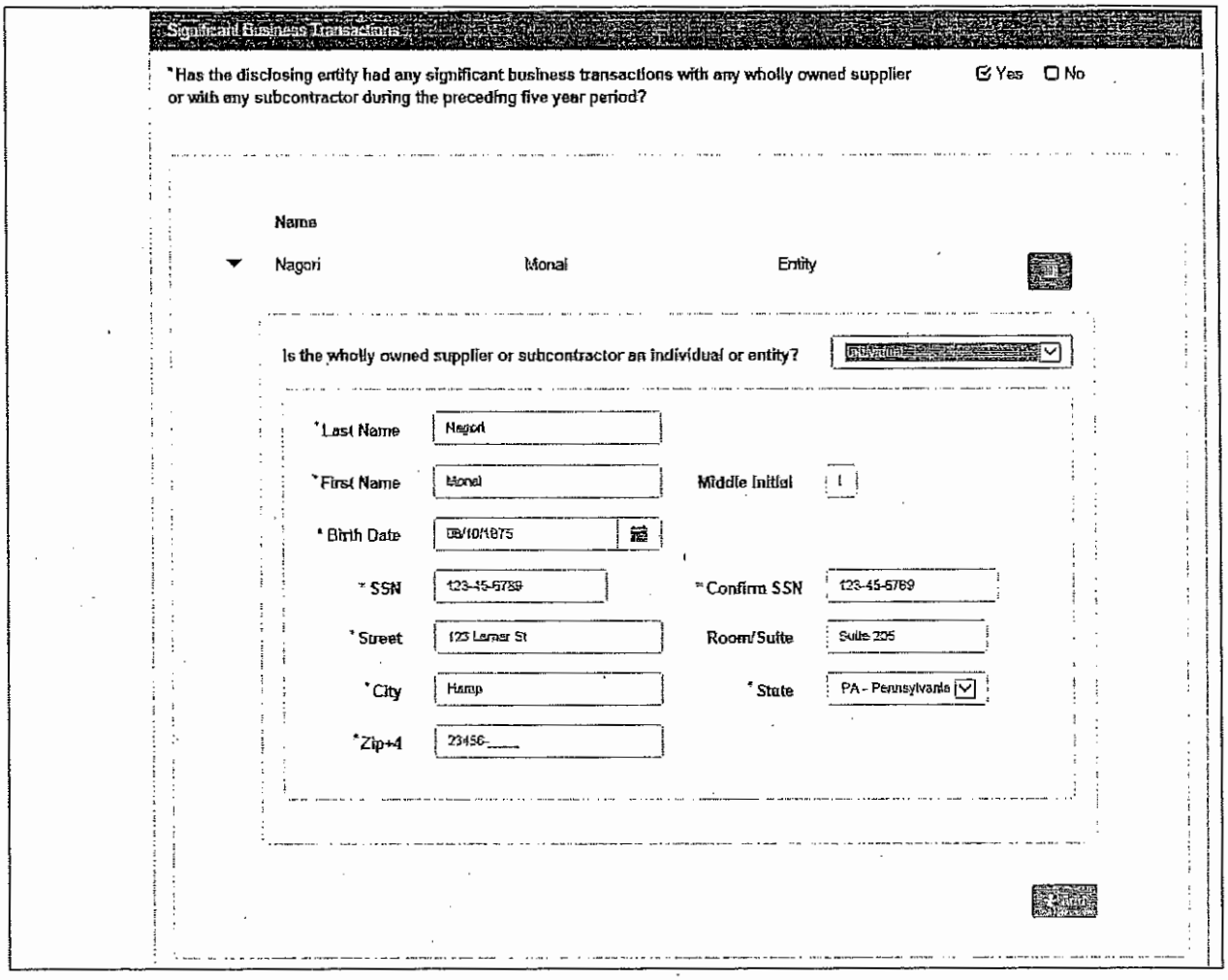
▼ J B Suppliers

*Entity Name J B Suppliers

*Street 123 Lemar St Room/Suite Suite 205

*City Hamp *State PA - Pennsylvania

*Zip+4 23456-____


Significant Business Transactions
*Has the disclosing entity had any significant business transactions with any wholly owned supplier or with any subcontractor during the preceding five year period?
Yes
No
Name
Nagori
Monal
Entity
Is the wholly owned supplier or subcontractor an individual or entity?
Individual
*Last Name
Nagori
*First Name
Monal
Middle Initial
I
* Birth Date
08/10/1975
* SSN
123-45-6789
* Confirm SSN
123-45-6789
* Street
123 Lamar St
Room/Suite
Suite 205
* City
Hamp
* State
PA - Pennsylvania
*Zip+4
23456-

Non-Profit Organization Disclosure (Not Organized as a Corporation)

Please enter the full name, address, social security number, and date of birth of any person who is a director (board member) or officer of the disclosing entity.

Name

Nagori Monsi

*Last Name	Nagori		
*First Name	Monsi	Middle Initial	I
*Birth Date	08/10/1979		
*SSN	123-45-6789	*Confirm SSN	123-45-6789
*Street	123 Lamar St	Room/Suite	Suite 205
*City	Harrp	*State	PA - Pennsylvania
*Zip+4	29456-		

What position is held by the individual listed above?

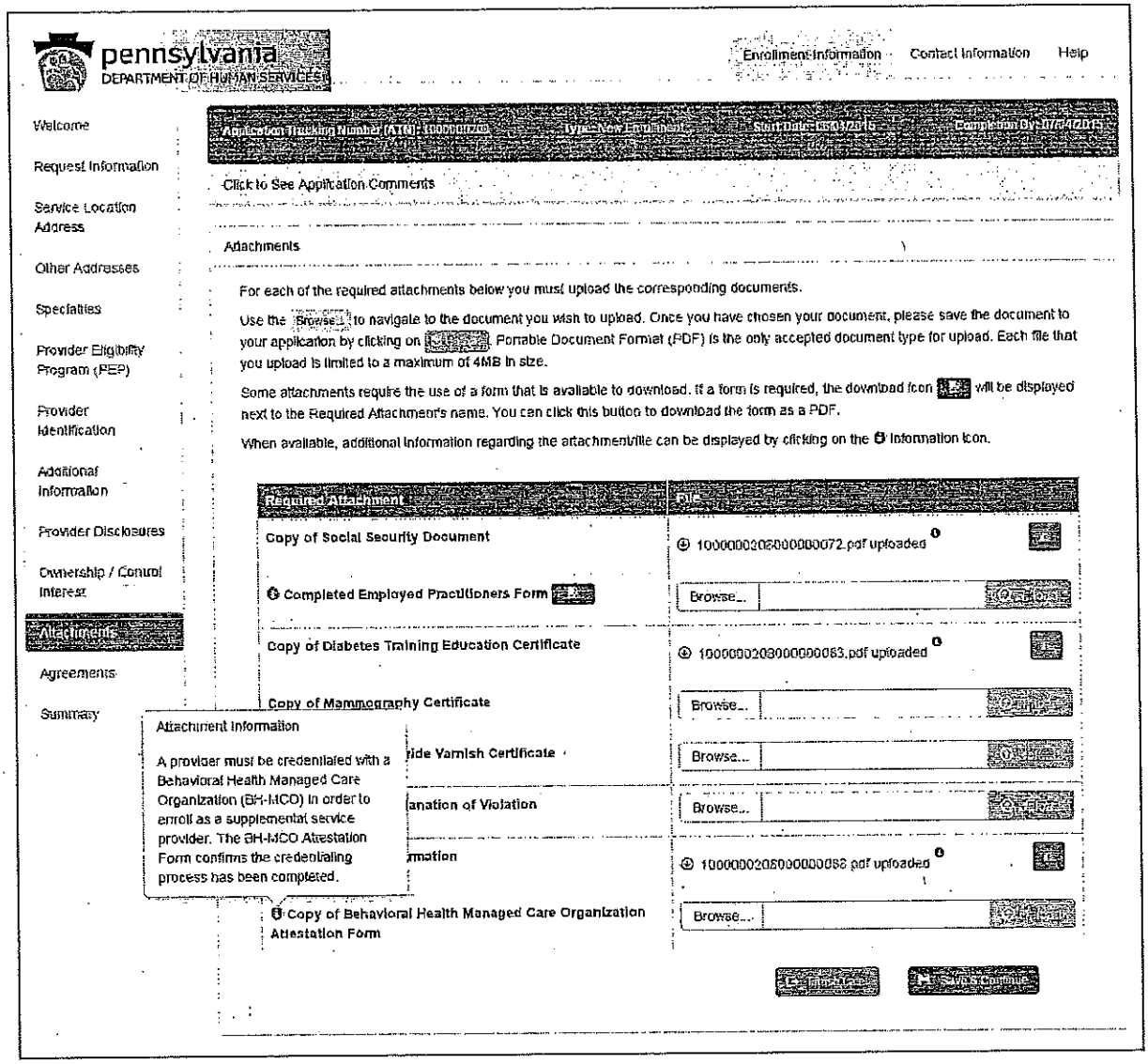
Select a Position Type

*Has the individual listed above been convicted of a criminal offense related to that person's involvement in Medicare, Medicaid, Title XX, Title XXI (CHIP), or a state health care program? ☐ Yes ☐ No

*Description of Offense

Add

Print Later Save & Continue


pennsylvania
DEPARTMENT OF HUMAN SERVICES
Enrollment Information
Contact Information
Help
Welcome
Request Information
Service Location Address
Other Addresses
Specialties
Provider Eligibility Program (PEP)
Provider Identification
Additional Information
Provider Disclosures
Ownership / Control Interest
Attachments
Agreements
Summary
Application Tracking Number (ATN): 10000002
Type: New Enrollment
Start Date: 03/27/15
Completion By: 07/24/2015
Click to See Application Comments
Attachments
For each of the required attachments below you must upload the corresponding documents.
Use the Browse... to navigate to the document you wish to upload. Once you have chosen your document, please save the document to your application by clicking on Save. Portable Document Format (PDF) is the only accepted document type for upload. Each file that you upload is limited to a maximum of 4MB in size.
Some attachments require the use of a form that is available to download. If a form is required, the download icon will be displayed next to the Required Attachment's name. You can click this button to download the form as a PDF.
When available, additional information regarding the attachment/file can be displayed by clicking on the Information icon.
Required Attachment
File
Copy of Social Security Document
10000002080000000072.pdf uploaded
Completed Employed Practitioners Form
Browse...
Upload
Copy of Diabetes Training Education Certificate
10000002080000000083.pdf uploaded
Copy of Mammography Certificate
Browse...
Upload
ride Varnish Certificate
Browse...
Upload
anation of Violation
Browse...
Upload
rmation
10000002080000000088.pdf uploaded
Copy of Behavioral Health Managed Care Organization Attestation Form
Browse...
Upload
Attachment Information
A provider must be credentialed with a Behavioral Health Managed Care Organization (BH-MCO) in order to enroll as a supplemental service provider. The BH-MCO Attestation Form confirms the credentialing process has been completed.

55 Pa. Code Chapter 6100
Services for Individuals with an Intellectual Disability or Autism
Waiver Provider Agreement. § 6100.82

This agreement is effective July 1, 2018, for purposes of [Provider's Name]'s (hereinafter "Waiver Provider") participation in Pennsylvania's Consolidated Waiver, Person/Family Directed Support Waiver, Community Living Waiver and/or Adult Autism Waiver.

Whereas, the Department of Human Services ("Department"), Office of Developmental Programs ("ODP") administers Pennsylvania's Consolidated Waiver, Person/Family Directed Support Waiver, Community Living Waiver and/or Adult Autism Waiver ("Waiver Programs"); and

Whereas, Waiver Provider seeks to provide services to persons eligible to receive waiver services ("Waiver Participants"); and

Whereas, waiver services are supported by federal and state funds, and ODP must administer the Waiver Programs consistent with the terms of the waivers approved by the Centers for Medicare and Medicaid Services ("CMS") ("approved waivers");

Now, therefore, Waiver Provider, as a condition of participation in the Waiver Program, agrees:

1. To comply with the following (collectively, "Waiver Program Standards"): federal and state statutes and regulations that apply to the Waiver Programs and Waiver Provider, including but not limited to those governing participation in the Pennsylvania Medical Assistance Program, confidentiality, and nondiscrimination; and policy bulletins governing the Waiver Programs issued by ODP (including but not limited to monitoring of Waiver Provider's service delivery and of claims submitted for services delivered); provided, however, that Waiver Provider does not thereby waive any rights it has under state and federal law relating to the Waiver Program Standards, including but not limited to ODP's interpretation and application of the Waiver Program Standards to Waiver Provider.

2. To comply with the approved waivers; including all standards enumerated in the service definition(s) which the Waiver Provider will be rendering, provider qualification requirements and other requirements established by the Department as outlined in the approved waivers.

3. To deliver waiver services in accordance with the terms of the Individual Plan of each individual served by Waiver Provider in a manner that meets professionally recognized standards of care. For the purpose of this paragraph, the Individual Plan is the Individual Plan that is in the possession of Waiver Provider, after Waiver Provider has made good faith efforts to obtain the most current Individual Plan.

4. To provide records, as requested, to the Department, the United States Department of Health and Human Services, the Pennsylvania Office of Attorney General (Medicaid Fraud Control Unit), and other authorized federal and state agencies, or their designees, regarding waiver services delivered and payments received by Waiver Provider.

5. This Agreement shall continue in effect until it is terminated by either provider or the Department upon thirty (30) days prior written notice to the other party or until it is superseded by a new agreement. The notice of termination must state the date of termination.

(Provider signature) (Date)

(Printed name of signatory) (Title of signatory)

(Printed name of provider) (Master or National Provider Index- MPI or NPI number)

(Provider address)

(Federal Employer Identification Number- Federal EIN)

(Telephone number) (E-mail address)

pennsylvania
DEPARTMENT OF HUMAN SERVICES

55 Pa. Code Chapters 2380, 2390, 6400 and 6500
Services for Individuals with an Intellectual Disability or Autism
Incident Report

*Enterprise Incident Management (EIM) users should use this form **only** if unable to report an incident through the EIM system. The Incident Report must be entered into EIM when access to EIM can be established.*

DATE OF SUBMISSION (MM/DD/YYYY):	SECTION OF INCIDENT BEING REPORTED: ☐ INITIAL REPORT ☐ INITIAL AND FINAL REPORT
NAME OF LEGAL ENTITY:	MPI #/EIN#:

INITIAL REPORT

TO BE SUBMITTED WITHIN 24 HOURS OR 72 HOURS OF DISCOVERY OF THE INCIDENT

INDIVIDUAL INFORMATION

INDIVIDUAL FIRST AND LAST NAME:	MCI#:	DATE OF BIRTH (MM/DD/ YYYY):
ADDRESS OF THE INDIVIDUAL:		
MENTAL HEALTH AND INTELLECTUAL DISABILITY COUNTY (IF APPLICABLE):	FUNDING AGENCY:	
REGION:	WAIVER/PROGRAM ENROLLMENT:	

STAFF PERSON WHO DISCOVERED THE INCIDENT

ORGANIZATION NAME:	MPI# AND SERVICE LOCATION ID#:
NAME OF STAFF PERSON WHO DISCOVERED THE INCIDENT:	PHONE NUMBER:

INCIDENT CLASSIFICATION

DISCOVERY DATE AND TIME (MM/DD/ YYYY):	OCCURRENCE DATE AND TIME (MM/DD/ YYYY):
TYPE OF INCIDENT (PRIMARY CATEGORY):	TYPE OF INCIDENT (SECONARY CATEGORY), IF APPLICABLE:
ASSIGNED DEPARTMENT-CERTIFIED INCIDENT INVESTIGATOR, IF APPLICABLE:	
WAS THE INCIDENT REFERRED TO THE APPROPRIATE PROTECTIVE SERVICES AGENCY: ☐ YES ☐ NO	
IF YES, WHICH AGENCY WAS THE INCIDENT REFERRED TO:	
IF NO, PLEASE EXPLAIN:	

55 Pa. Code Chapters 2380, 2390, 6400 and 6500
Services for Individuals with an Intellectual Disability or Autism
Incident Report

INCIDENT DESCRIPTION

DESCRIBE WHAT HAPPENED PRIOR TO, DURING AND AFTER THE INCIDENT, INCLUDING DATES, TIMES AND ALL PEOPLE INVOLVED INCLUDING STAFF. INDICATE THE CURRENT STATUS OF THE INDIVIDUAL:

ACTIONS TAKEN TO PROTECT HEALTH, SAFETY AND RIGHTS

DESCRIBE THE ACTIONS TAKEN TO PROTECT THE HEALTH AND SAFETY AND WELL-BEING OF THE INDIVIDUAL (DESCRIBE ADMINISTRATIVE, HEALTH/SAFETY , TREATMENT, AND TARGETED INDIVIDUAL ACTIONS TO ADDRESS THE INCIDENT TO DATE INCLUDING SUPPORTS OFFERED):

WAS THE INDIVIDUAL SEPARATED FROM THE PERSON WHO CAUSED THE INCIDENT?

☐ YES ☐ NO

IF NO, PLEASE SPECIFY:

INCIDENT FINAL REPORT

TO BE SUBMITTED WITHIN 30 DAYS OF DISCOVERY OF THE INCIDENT

WITNESS INFORMATION:

WITNESS (FIRST NAME and LAST NAME)	WITNESS RELATIONSHIP TO THE INDIVIDUAL

INFORMATION ABOUT THE PERSON WHO CAUSED THE INCIDENT (IF APPLICABLE)

PERSON WHO CAUSED THE INCIDENT IDENTIFIER:

PERSON'S RELATIONSHIP TO THE INDIVIDUAL:

NOTIFICATION INFORMATION

PERSON NOTIFIED (FIRST NAME and LAST NAME)	DATE NOTIFIED (MM/DD/YYYY)

PERSON MAKING CONTACT (FIRST NAME and LAST NAME):

ADDITIONAL DETAIL ABOUT THE INCIDENT

PROVIDE ADDITIONAL DETAILS DISCOVERED ABOUT THE INCIDENT SINCE THE INCIDENT WAS INITIALLY REPORTED, IF APPLICABLE:

ACTIONS TAKEN TO PROTECT HEALTH, SAFETY AND RIGHTS

DESCRIBE THE ACTIONS THAT HAVE BEEN TAKEN TO PROTECT THE HEALTH AND SAFETY AND WELL-BEING OF THE INDIVIDUAL SINCE THE INITIAL REPORT (DESCRIBE ADMINISTRATIVE, HEALTH/SAFETY , TREATMENT, AND TARGETED INDIVIDUAL ACTIONS TO ADDRESS THE INCIDENT TO DATE INCLUDING SUPPORTS OFFERED):

CORRECTIVE ACTION DESCRIPTION

DESCRIBE THE CORRECTIVE ACTION TAKEN IN RESPONSE TO THE INCIDENT AND TO PREVENT RECURRENCE (INCLUDING THE DATE COMPLETED AND THE PERSON RESPONSIBLE FOR COMPLETION):

PROVIDER INVESTIGATION
ENTER THE PRIMARY INVESTIGATORY QUESTION:
SUMMARY OF INVESTIGATOR'S FINDINGS:
INDICATE PROVIDER INVESTIGATION DETERMINATION: ☐ CONFIRMED ☐ NOT CONFIRMED ☐ INCONCLUSIVE ☐ N/A
HAS THE INDIVIDUAL'S DESIGNATED PERSON BEEN NOTIFIED OF THE OUTCOME OF THE INVESTIGATION? ☐ YES ☐ NO
IF NO, PLEASE EXPLAIN:

pennsylvania
DEPARTMENT OF HUMAN SERVICES

55 Pa. Code Chapter 6100
Services for Individuals with an Intellectual Disability or Autism
Request for Approved Program Capacity. § 6100.441

SECTION A

Legal Entity Name:		
Street Address/City/State/Zip:		
Contact Name:	Phone Number (include area code):	Email Address:
MPI #:	Service Location Code:	

Check the type of service location for which Approved Program Capacity is being requested:

☐ Licensed 55 Pa. Code Ch. 6400 Community Living Home	☐ Licensed 55 Pa. Code Ch. 6500 Family Living Home	☐ Licensed 55 Pa. Code Ch. 5310 Community Residential Rehabilitation	
☐ Licensed 55 Pa. Code Ch. 6400 Community Living Home (For Respite Only)	☐ Licensed 55 Pa. Code Ch. 3800 Child Residential and Day Treatment	☐ Supported Living	☐ Unlicensed Life Sharing
☐ Unlicensed Residential Habilitation	☐ Licensed 6 Pa. Code Chapter 11 Older Adult Daily Living Centers	☐ Licensed 55 Pa. Code Ch. 2390 Vocational Facility	☐ Licensed 55 Pa. Code Ch. 2380 Adult Training Facility

Service Location Street Address/City/State/Zip

Type of Request (Check all that apply.)

☐ Request to Establish Approved Program Capacity for a New Residential Service Location Licensed Under 55 Pa. Code Ch. 6400 Community Living Home, Ch. 6500 Family Living Home, Ch. 5310 Community Residential Rehabilitation or Ch. 3800 Child Residential and Day Treatment Facility (proceed to section B)

☐ Request to Establish Approved Program Capacity for a New Residential Service Location that will be an Unlicensed home (proceed to section C)

☐ Request to Establish Approved Program Capacity for a New Day Service Location Licensed Under 55 Pa. Code Ch. 2380 Adult Training Facility, Ch. 2390 Vocational Facility or 6 Pa. Code Ch. 11 Older Adult Daily Living Center (proceed to section D)

☐ Request to Change Current Approved Program Capacity For Any Type of Service Location (proceed to section E)

☐ Request to Close a Licensed Residential Service Location – Date of Closure: _____

☐ Request for an Expedited Review (section F)

SECTION B – REQUEST TO ESTABLISH APPROVED PROGRAM CAPACITY FOR A NEW RESIDENTIAL SERVICE LOCATION THAT IS LICENSED		
License Effective Date	Licensed Capacity	Requested Program Capacity
Justification for Requested Program Capacity – Describe how the needs of the individual(s) to be served require and/or meet the level of service requested:		

SECTION C – REQUEST TO ESTABLISH APPROVED PROGRAM CAPACITY FOR A NEW RESIDENTIAL SERVICE LOCATION THAT IS UNLICENSED		
Type of Home (Life Sharing, Residential Habilitation, Supported Living)	Requested Program Capacity	Requested Effective Date
Justification for Requested Program Capacity– Describe how the needs of the individual(s) to be served require and/or meet the level of service requested:		

SECTION D – REQUEST TO ESTABLISH APPROVED PROGRAM CAPACITY FOR A NEW DAY SERVICE LOCATION THAT IS LICENSED AS AN ADULT TRAINING FACILITY, A VOCATIONAL FACILITY OR AN OLDER ADULT DAILY LIVING CENTER		
License Effective Date	Licensed Capacity	Requested Program Capacity
Justification for Requested Program Capacity (Please note, effective March 17, 2019, new day service locations may not serve more than 25 individuals in the service location at any one time.)		

SECTION E – REQUEST TO CHANGE APPROVED PROGRAM CAPACITY – ADDITIONAL CRITERIA REQUIRED		
Current Approved Program Capacity	Requested Change in Approved Program Capacity	Planned Type of Service & W Code
Describe the circumstances surrounding the change:		
Describe how the change in approved program capacity will meet the service location size, staffing patterns, assessed needs, and outcomes for the individual(s) in the service location:		

SECTION F – REQUEST FOR EXPEDITED REVIEW

Describe the reason an expedited review is necessary:

ODP DETERMINATION		
☐ Program Capacity Approved As Requested	☐ Program Capacity Approved With Amendments.	☐ Program Capacity Denied
Approved Program Capacity:		
Approved Program Capacity Effective Date:		

Signature of Regional ODP Waiver Capacity Manager

Date (mm/dd/yyyy)

55 Pa. Code Chapter 6100
Services for Individuals with an Intellectual Disability or Autism
Cost Report. § 6100.644

CERTIFICATION PAGE

1	Provider Name:			
2	Address:			
3	City:	State:	ZIP:	
4	Period of Report:	From:	To:	06/30/2016
5	Officer or Administrator Name:			
6a	Primary Contact Person Regarding Questions about Cost Report:			
6b	Secondary Contact Person Regarding Questions about Cost Report:			

1a	MPI Number:
1b	IRS Tax ID Number:
2a	Date of Fiscal Year End:
3a	Primary Contact Telephone Number:
3b	Primary Contact Email Address:
4a	Secondary Contact Telephone Number:
4b	Secondary Contact Email Address:

7 **Public Transportation Providers Only:**
I attest our organization does have dedicated vehicles for individuals who are receiving ID services under the Waivers or base program and a different rate is charged to the ID participants (as compared to the general public). ☐

8 Form of Certification by Officer or Administrator of Provider:
I CERTIFY that I have examined the accompanying schedules of revenues and expenses and the calculations of cost-of-service prepared for this Provider and that, to the best of my knowledge and belief, they are true and correct. I also certify these schedules were prepared from the books and records of the Provider in accordance with instructions contained in this report and allowable cost of care excludes expenses that were not necessary or allowable to provide this care. I also certify that no modifications or changes have been made to the Cost Report protected cells or formulas. I understand that any false claims, statements, documents or concealment of material facts may be prosecuted under applicable federal and state law.

_____
(Officer or Administrator of Provider)

_____
(Title, Date)

9 Statement of Preparer (If Other Than Provider)
I have prepared this report and, to the best of my knowledge and belief, it represents true and accurate data of the Provider stated above.

_____
(Preparer Name, Date)

PROVIDER NAME: 0
MPI NUMBER: 0
PERIOD OF REPORT: 01/00/1900 to 06/30/2016

CERTIFICATION PAGE – PROVIDER SERVICE LOCATIONS

	(A)	(B)	(C)	(D)	(E)	(F)	(G)	(H)	(I)
	MPI Number	Service Location Code During Historical Reporting Period	Service Location Code Change After June 30, 2016 (if applicable)	County of Service Location Code	Begin Date of Service	End Date of Service	Transportation Procedure Codes		
							W7274 (Zone 1)	W7275 (Zone 2)	W7276 (Zone 3)
							Transportation trip service with trips that are greater than 0 and up to 20 miles.	Transportation trip service with trips that are greater than 20 miles and up to 40 miles.	Transportation trip service with trips that are greater than 40 miles and up to 60 miles
1									
2									
3									
4									
5									
6									
7									
8									
9									
10									
11									
12									
13									
14									
15									
16									
17									
18									
19									
20									
21									
22									
23									
24									
25									
26									
27									
28									
29									
30									
31									
32									
33									
34									
35									
36									
37									
38									
39									
40									
41									
42									
43									
44									
45									
46									
47									
48									
49									
50									

Commonwealth of Pennsylvania
Office of Developmental Programs

Transportation Cost Report, January 2017

PROVIDER NAME: 0
MPI NUMBER: 0
PERIOD OF REPORT: 01/00/1900 to 06/30/2016

COST REPORT FOR CONSOLIDATED & P/FDS WAIVER TRANSPORTATION SERVICES

SCHEDULE A: EXPENSE REPORT

	Column Reference:	(A)	(B)	(C)	(D)	(E)	(F)	(G)	(H)
	Cost Category	Total Provider Expenses	Other LOB Expenses	Base Expenses	Expenses For Services Contracted By Residential Providers	Total Waiver Expenses	Zone 1 (W7274) Expenses (>0 - 20 Miles)	Zone 2 (W7275) Expenses (>20 - 40 Miles)	Zone 3 (W7276) Expenses (>40 - 60 Miles)
1	Personnel - Drivers, Dispatchers	$ -				$ -			
2	Personnel - Aides	$ -				$ -			
3	Vehicle Lease/Depreciation	$ -				$ -			
4	Insurance	$ -				$ -			
5	Vehicle Repairs and Maintenance	$ -				$ -			
6	Fuel	$ -				$ -			
7	Expenses For Contracted Services	$ -				$ -			
8	Other*	$ -				$ -			
9	Administration*	$ -				$ -			
10	Total Expenses	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
11	Contributions/Revenue (Offset) (Includes PennDOT Grants)	$ -				$ -			
12	Total Net Expenses	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
13	Units								
14	Cost per Unit						$ -	$ -	$ -
15	Mileage Range (lower bound)						>0	>20	>40
16	Mileage Range (upper bound)						20	40	60
17	Average Mileage (per trip)								
18	Average Number of Individuals with ID (per trip)								
19	Average Cost per Individual Per Mile						$ -	$ -	$ -

* If the total waiver expense in Column E for Line 8 (Other) or Line 9 (Administration) is greater than 5% of Total Waiver Expenses on Line 10, an itemization of expenses needs to be provided on Schedule B, Line 2. Refer to the Instructions for more detail.

PROVIDER NAME: 0
MPI NUMBER: 0
PERIOD OF REPORT: 01/00/1900 to 06/30/2016

COST REPORT FOR CONSOLIDATED & P/FDS WAIVER TRANSPORTATION SERVICES

SCHEDULE B: PROVIDER COMMENTS

1 Expense allocation method description:
2 Additional comments or supporting documentation:

55 Pa. Code Chapter 6100
Services for Individuals with an Intellectual Disability or Autism
Room and Board Residency Agreement. § 6100.687

I. This Agreement, made on _____ between
(effective date of agreement)

_____,
(name of individual)
hereinafter referred to as individual, and,

_____ at
(provider agency administering program)

_____
(address of administering provider agency)
hereinafter referred to as provider agency. Whereas, individual is participating in a residential program administered by the provider agency; and room and/or board is furnished by provider agency at

_____
(address of residence)

II. INDIVIDUAL'S RESPONSIBILITES:

1. Individual agrees to pay provider agency a total of $_____ for room and board. Individual shall pay no more than 72% of the SSI maximum rate plus the Pennsylvania Supplement. (This section should be completed if provider agency provides both room and board to individual.)

2. Individual agrees to pay provider agency $_____ for board. Individual shall pay no more than 32% of the SSI maximum rate plus PA Supplement. (This section should be completed if individual pays their own rent directly to a landlord, but food is supplied through provider agency.)

3. Individual agrees to pay provider agency $_____ for room. Individual shall pay no more than 40% of the SSI maximum rate plus PA Supplement. (This section should be completed if individual pays rent to provider agency, but individual purchases their own food.)

4. If individual's available income is less than the SSI maximum rate plus PA Supplement, provider shall charge 72% of individual's available monthly income as individual's monthly obligation for room and board; 32% for board if food is supplied through provider agency; or 40% for room if individual purchases their own food. Individual shall receive at least the monthly amount as established by the Social Security Administration related to the specific type of setting, for the individual's personal needs allowance.

5. The total amount charged for individual's share of room and board may not exceed the actual documented room and board costs at individual's residence, minus the benefits received.

6. Payment shall be made on a monthly basis and shall be due and payable the first day of each month. Payments for periods of less than a month shall be due and payable prior to leaving the residence.

7. Monies for room and board shall be paid to the person designated by the provider agency. Such person shall issue a receipt showing amount of payment and period covered.

III. PROVIDER AGENCY'S RESPONSIBILITES:

1. Provider agency agrees to comply with §§ 6100.681-694 relating to Room and Board.

2. Provider agency agrees to comply with 55 Pa. Code Chapter 6400 (relating to Community Homes for Individuals with an Intellectual Disability or Autism) or 55 Pa. Code 6500 (relating to Life Sharing Homes), if licensing requirements apply to the residence.

IV. TERMINATION OF THE AGREEMENT:

1. If provider agency wishes to terminate this agreement, provider agency agrees to comply with §§ 6100.301-307 relating to Transition to a New Provider.

VI. SIGNED:

Provider Agency	Date
Witness	Date
Individual or Person Signing on Individual's Behalf (include relationship to individual)	Date
Representative Payee, if other than Provider Agency or individual	Date
Court Appointed Legal Guardian, if applicable	Date