Adverse Events Policy

Policy Statement: Zumbro House investigates all adverse events, incidents, accidents, variances or unusual occurrences that involves care of a person and develops a plan of correction to prevent the same or similar event from occurring again. Events include, but are not limited to, the following

- Unexpected death of a person
- Act of violence
- Serious injury (including falls)
- Psychological injury
- Significant adverse drug reaction
- Significant medication error

Procedure:

1. The Incident Report is used as part of Zumbro House's integrated risk management and performance improvement program. The form will be completed for all adverse events.

2. Staff will take immediate action to protect, comfort and arrange for emergency medical treatment as necessary if the person has sustained an injury.

3. Staff is responsible for reporting adverse events immediately to their supervisor or the on call Nurse (if after hours). The Nurse will provide direction regarding contacting the physician.

4. When an adverse event occurs, an Incident Report is completed by the staff aware of the occurrence. The Incident Report should

    a. Be completed in its entirety
    b. Contain facts, direct observations and witness statements, not opinions

5. The staff member completing the Incident Report will immediately (on day of occurrence) submit the form electronically for review and follow-up.

6. The information obtained from the reports will be categorized and trended over time in order to:
    a. Improve the management of care, treatment and services to persons by assuring that appropriate and immediate intervention occurs for the person's safety and to assure the prevention of adverse events
    b. Provide a database for Zumbro House so that care, treatment and services can be analyzed, evaluated and acted upon

7. The Program Director and/or the Director of Operations or designee will provide additional supervision, counseling and/or education for staff based on the evaluation of the adverse events.

Policy Reviewed and Authorized by: Ceallaigh Estepp, Director of Quality and Compliance

Date of Last Revision: 2/1/17

Assessment for Medication Management Program Policy

Policy Statement: Prior to providing medication management services, Zumbro House will provide an assessment by a registered nurse, licensed health professional or authorized prescriber to determine what medication management services will be provided and how they will be implemented.

Procedure:

1. The RN will provide and document a face-to-face assessment with the person.

2. The assessment includes the following elements.
    a. Identification of all medications, including over-the-counter and herbal/dietary supplements
    b. Medication reconciliation, including
        i. Indication for medications
        ii. Effectiveness of drug therapy
        iii. Side effects
        iv. Immediate desired effects
        v. Unusual and unexpected effects
        vi. Actual or potential drug interactions
        vii. Duplicate drug therapy
        viii. Non-adherence with drug therapy
        ix. Drug therapy currently associated with laboratory monitoring
        x. Allergic reactions
        xi. Changes in condition that contraindicate continued administration of the medication
    c. Potential for diversion of medication by the person or others with access to it. The risk (high, moderate or low risk) for diversion will be measured according to the following criteria.
        i. “Street value” of medications being used by client
        ii. Location of residence
        iii. Presence of other residents or visitors to home with access to medications
        iv. Other risk factors/lack of protection of medications
        v. High risk means the presence of 3-4 of the criteria, moderate risk means the presence of 2-3 criteria and low risk means the presence of 0-1 criteria.
    d. The reassessment will occur at the following times
        i. Person symptomology

ii. Problems or concerns that may be medication-related
iii. With new prescription, OTC or herbal products
iv. Annually

e. The RN will educate the person regarding the consequences of and document any person's refusal to participate in all of or part of the medication assessment
f. Based on the results of the assessment, the RN will document an individualized medication management plan, including the following elements
    i. Description of medication management services to be provided
    ii. Description of medication storage based on person's need, preference, risk of diversion and per manufacturer's direction
    iii. Documentation procedures
    iv. Procedures for verification that medications are administered as prescribed
    v. Procedures for monitoring medication use to prevent complications or adverse reactions
    vi. Identification of person(s) responsible for monitoring medication supplies and ensuring refills are ordered in a timely manner
    vii. Identification of medication management tasks delegated to unlicensed staff
    viii. Procedures for notifying the registered nurse or licensed health profession regarding problems arising with medication management services

3. The Medication Management and Care Plan will be evaluated/updated as needed and at least annually

Policy Reviewed and Authorized By: Ceallaigh Estepp, Director of Quality and Compliance

Date of Last Revision: 2/1/17

Assessment Policy

Policy Statement: An individualized initial evaluation of all new persons shall be completed on admission by a Registered Nurse in order to develop a personalized care plan. The assessment shall be revised regularly and as appropriate.

Procedure

1. The RN will provide the admission visit and conduct a comprehensive assessment, including the following
    a. Evaluation of the Person
    b. Falls Risk Assessment (if appropriate)
    c. Mental Status Assessment (if appropriate)
    d. Medication Profile
    e. Emergency Information

2. The initial assessment must be completed within five (5) days of the initiation of services. If the assessment is not completed on initiation of services, a temporary plan and agreement with the person may be established until the assessment is completed.

3. The RN will provide a reassessment visit to update the evaluation of the person and services no more than 14 days after initiation of services.

4. No later than 14 days after the initiation of services, the Medication and Care Plan is finalized if not already completed.

5. Ongoing monitoring and reassessment of the person must be conducted as needed based on changes in the needs of the person, but cannot exceed 90 days from the last date of assessment.

6. The monitoring and reassessment may be conducted at the person's residence or through the utilization of telecommunication methods based on practice standards that meet the person's needs.

7. If the RN or other staff from Zumbro House believes that a person is in need of other medical or health services, the Program Director or designee will:
    a. determine the person's preferences with respect to obtaining the service, and
    b. inform the person and/or person's representative of resources available to assist in obtaining the service

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Care of the Diabetic Person

Procedure

1. Blood Glucose Monitoring (Blood Sugar Checks)
    a. Glucometers are available for persons to monitor their blood sugar results and make necessary adjustments with medication, diet or exercise as instructed by their physicians. Blood sugars are checked regularly on these portable instruments according to the physician's recommendations and when a person is concerned that his or her blood sugar level is abnormal.

    b. Fasting blood sugars are drawn in the morning before the person eats or drinks anything. The fasting blood sugar (FBS) should be measured because the blood sugar level will increase as soon as the person eats.

    c. Normal blood sugar is 70-110.
        i. Hypoglycemia: Hypoglycemia means a low blood sugar (below 70) and is also called an insulin reaction. It results from too little food, too much insulin and/or extra exercise.
            1. The onset is sudden
            2. Symptoms vary with individuals, but generally include
                a. Cold, clammy skin
                b. Anxiety
                c. Shakiness
                d. Sweatiness (diaphoresis)
                e. Irritability
            3. Action: **Treatment is urgent!**
                a. If possible immediately check the blood sugar of a person you suspect has hypoglycemia. However, if you do not have a machine nearby, do not delay treatment to check a blood sugar.
                b. Give the person a cup of orange juice or several hard candies (simple sugar).
                c. If the person will not be eating a meal in the next ½ hour, give a snack with carbohydrates such as crackers or a peanut butter sandwich and milk.
                d. Contact the nurse and document what happened and your treatment.
                e. Continue to monitor the person frequently and recheck his/her blood sugar as instructed by the nurse (generally, 30 minutes after eating).

ii. Hyperglycemia: Hyperglycemia means high blood sugar (over 200). It results from too much food, too little insulin or other diabetic medication, illness or stress.
    1. The onset is gradual.
    2. Symptoms include
        a. Frequent urination
        b. Thirst
        c. Hunger
        d. Dry skin
        e. Drowsiness
        f. Nausea
    3. Action: Check the person's blood sugar and notify the nurse.

2. Diet: The responsibility of the staff is to follow the established meal plan when cooking for person and to encourage them to stay on their recommended diet.

3. Exercise: If a person has a routine exercise program, be sure it is followed. If it changes or if the person is not following it, let the nurse or supervisor know.

4. Foot Care: Diabetes dulls the sensitivity of nerves (called peripheral neuropathy) so the person may not notice a sore spot caused by tight shoes or pressure from walking. If ignored, the sore can become infected and, because of the poor circulation, take longer to heal. Follow the care plan established by your nursing supervisor in caring for the person's feet. Below are some important points in foot care.
    a. If instructed to soak or wash the feet, use warm (not hot) water. Thoroughly pat them dry, especially between the toes. If needed, lamb's wool can be inserted between toes that rub or overlap.

    b. Feet should be checked regularly for cuts or sore spots. Look at the tops and soles of the feet, the heels and the area between toes.

    c. ***Never cut a diabetic's toenails or fingernails*** or file calluses or use commercial removers. Many people with diabetes regularly visit their podiatrists for foot care.

    d. If a person's feet tend to perspire, your nurse might instruct you to apply a bland foot powder.

    e. Avoid knee-high stockings or elastic bands. Encourage persons to avoid crossing their legs as it also impairs circulation to the lower extremities.

f. Some persons may use shoe inserts or special shoes to prevent pressure on feet. The soles of shoes should be flexible and nonskid, and the shoes themselves should be sturdy and nonrestrictive.

g. Persons should wear clean stockings every day and not go barefoot.

h. Regular exercise improves circulation to the lower extremities. For example, instruct the person to elevate, rotate, flex and extend the feet at the ankles.

i. Do not apply heat to the feet. Avoid heating pads or hot water bottles. Use warm soaks or extra covers instead.

j. **Any sore on the foot or leg, whether or not it's painful, requires immediate attention**. Treatment can help sores heal and prevent new ones from developing. Problems with the feet and legs can cause life-threatening problems that require amputation if not treated early.

5. Illnesses: People with diabetes must be extremely careful when sick with a cold, flu, infection or other illness. Being sick can raise one's blood sugar. When caring for ill persons with diabetes, follow these guidelines.
   a. Notify the nurse.

   b. Test the blood sugar up to every hour based on medical advice. Document the results of the tests.

   c. Check the person's weight daily. Losing weight without trying is a sign of high blood sugar.

   d. Check the person's temperature in the morning and evening. A fever may be a sign of infection.

   e. Be sure that the person continues to take his diabetes medication. Even if s/he can't keep food down, the medication is still needed.

   f. Encourage plenty of fluids if the blood sugar is too high. For instance, give at least 1/2 cup to 3/4 cup of fluids every half-hour to hour, even if only able to take small sips. These liquids should not have calories. Water is best.

g. Try giving crackers, jello, popsicles or soup if the person is nauseated.

h. Encourage clear liquids, such as ginger ale, if s/he can't eat at all. Eating or drinking something with sugar in it is important if the person is having trouble keeping food down.

Policy Reviewed and Authorized by: Ceallaigh Estepp, Director of Quality and Compliance

Date of Last Revision: 2/1/17

Confidentiality Policy

Policy Statement: Zumbro House respects that an integral part of providing quality care is to gain the trust of the person in an effort to work on mutually agreed upon goals. Maintaining confidentiality is an essential ingredient in gaining and maintaining the person's trust.

Procedure:

1. Clinical and billing records are kept in a locked file not accessible to the public.

2. All identifying information for persons served, including but not limited to personal, financial and medical data, will be kept confidential and released only in the following situations
    - To authorized persons with an appropriate Release of Information
    - According to law
    - To employees or contractors of Zumbro House
    - To another home care provider, a health care practitioner or provider, or an inpatient facility that requires information to provide services to the resident, but only the information that is necessary to provide services.
    - To representatives of the commissioner authorized to survey or investigate home care providers.

3. Home care paper work left in the person's home will be placed in a folder.

4. Person served information is not discussed with anyone except those involved with providing care or service to the person.

5. All employees shall adhere to the Home Care Bill of Rights.

6. Persons served are informed of their rights at the initiation of home care services.

7. When the safety or vulnerability of a person is in question, a report to the MAARC will be made with or without the consent of the person/caregiver/legal representative. However, when appropriate, they will be notified that a report is being initiated.

8. A breach of person served confidentiality by any employee is grounds for disciplinary action.

9. Employees are oriented to this policy, as well as HIPAA, at orientation.

10. Records may be removed from the company's jurisdiction and safekeeping only in accordance with a court order, subpoena, or law and regulation.

Policy Reviewed and Authorized by: Ceallaigh Estepp, Director of Quality and Compliance

Date of Last Revision: 2/1/17

Coordination in the Medication Management and Care Plan Policy

Policy Statement: Zumbro House will provide coordinated care for medication management, including a person/family-centered and health care team-based approach to assess and meet the needs of the person, while helping him or her to navigate effectively through the health care system related to medications.

Procedure:

1. The RN is responsible for coordinating the Medication Management and Care Plan with other health care providers serving the person.

2. When any staff member of Zumbro House becomes aware of any medication or dietary supplement being used by the person that was not included in the assessment for medication management services, the staff member will advise the Registered Nurse (RN) and document this in the medical record.

3. When indicated, a care conference may be convened to assure that medication services are coordinated.

4. Activities of care coordination will be documented in the medical record.

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Date of Last Revision: 2/1/17

Delegation of Home Care Tasks Policy

Policy Statement: The Registered Nurse is responsible for appropriately delegating tasks to staff that are competent and possess the knowledge and skills consistent with the complexity of the tasks in accordance with the appropriate Minnesota Practice Act.

Procedure:

1. An RN will complete an assessment of all persons receiving delegated services prior to the initiation of those services.

2. The assessment will evaluate the person's functional status and need for home care services.

3. A vulnerable adult assessment will be completed upon initiation and annually thereafter.

4. Following the assessment, the RN will develop the Medication and Care Plan that specifies the activities to be completed by the staff and addresses the areas of identified in the assessment.

5. The Medication and Care Plan is prepared with the client or responsible party and incorporates the person's needs and preferences.

6. The assessment and Medication and Care Plan are parts of the person's record.

7. The RN may delegate procedures according to the following.
   a. The RN instructed the staff in the proper methods to perform the procedure with respect to each person.
   b. The RN provided the staff with written instructions specific to the client.
   c. The staff demonstrated to the RN competence in the procedure.
   d. The procedure is documented in the person's medical record.
   e. The staff's competence is documented in his/her personnel file.

8. The RN will have access to the staff members' personnel files or other reports to determine level of competence prior to delegation of any task.

9. If a staff member has not regularly performed a delegated home care task for a period of 24 consecutive months, the staff will demonstrate competency in the task to the RN prior to performing the task.

10. All staff providing delegated nursing services to persons served by Zumbro House is oriented by the RN prior to initiation of the service. This orientation may be verbal, written, electronic or on-site according to the RN's clinical judgment.

11. An RN will be readily available to staff performing delegated services via phone or by other appropriate means during times when the staff is performing services.

Policy Reviewed and Authorized by: Ceallaigh Estepp, Director of Quality and Compliance

Date of Last Revision: 2/1/17

Disposition/Disposal of Medications

Policy Statement: The disposal and disposition of discontinued medications for persons receiving the Medication Management and Care Plan will be completed in a safe manner by appropriate personnel.

Procedure:

1. Discontinued medications may be kept until the expiration dates if there is a possibility of resuming the medication. If not resumed before the expiration date, it will be disposed of according to this policy.

2. Unused portions of medications will be returned to the pharmacy or a responsible party when the persons service plan ends, medication management services are no longer provided under the service plan, or upon discharge; and a note regarding this placed in the clinical record.

3. Medications stored in the person's private living space may be given to the person or person's responsible party for disposal when discontinued or upon expiration; medications stored in the person's private living space may be given to the person's responsible party for a client who is deceased.

4. Any medications, other than controlled substances, under Zumbro House's storage after the termination of the medication management and care plan for a person, that are discontinued or expired or upon their death will be disposed of according to instructions provided on the drug label or the following by a licensed nurse
    a. Household trash: Take the drugs out of their original containers, mix them with an undesirable substance, such as coffee grounds or kitty litter and place them in a sealable bag, empty can or other container to prevent the medication from leaking or breaking out of a garbage bag.
    b. Prescription medications should not be flushed down the toilet unless specifically instructed on the drug label or accompanying information.
    c. Use a community drug take-back program allowing the public to bring unused drugs to a central location for proper disposal, if available.
    d. Before disposing of an empty medication container, all identifying information will be scratched off to make it unreadable.
    e. Questions regarding drug disposition should be referred to the pharmacy.

5. Disposal of Schedule II medications will follow directions of the US Drug Enforcement Administration (DEA) and U.S. Food and Drug Administration (FDA). Options for disposal of controlled substances include the following.
    a. Collection Sites: Retail pharmacies may be registered with the DEA as an authorized collection site for the disposal of controlled substances. Local pharmacies may be located through the DEA Office of Diversion Control's Registration Call Center at 1-800-882-9539.
    b. Take-Back Events: Local law enforcement agencies offer Take-Back Events or drop off locations for controlled substances.
    c. FDA Recommendations for disposal

6. Upon disposition, Zumbro House will document the following information in the clinical record
    a. Name, strength and prescription number of medication, as applicable
    b. Quantity
    c. Method of disposition or to whom the medications were given
    d. Date of disposition
    e. Name(s)/signature(s) of staff involved in disposition

7. When a loss or spillage of a Schedule II Controlled Substance occurs, an explanatory note is made in the clinical record. The notation is signed by the person responsible for the loss or spillage and includes verification that any contaminated substance was disposed of according to state/federal regulation and by one witness who must also observe the destruction of any remaining contaminated drug by mixture with an undesirable substance such as coffee grounds or wiping up the spill.

8. Zumbro House will conduct an investigation of any known loss or unaccounted for prescriptions drugs and will take action as required under state or federal regulations. The investigation will be documented as part of the Quality Improvement policy.

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Date of Last Revision: 2/1/17

Grievance Policy - Program

I. Policy

It is the policy of Zumbro House, Inc. to ensure that people served by this program have the right to respectful and responsive services. We are committed to providing a simple complaint process for the people served in our program and their authorized or legal representatives to bring grievances forward and have them resolved in a timely manner.

II. Procedures

A. Service Initiation
A person receiving services, their authorized or legal representative, and their case manager will be notified of this policy, and provided a copy, within five working days of service initiation.

B. How to File a Grievance
1. The person receiving services or person's authorized or legal representative:
   a. should talk to a staff person that they feel comfortable with about their complaint or problem;
   b. clearly inform the staff person that they are filing a formal grievance and not just an informal complaint or problem; and
   c. may request staff assistance in filing a grievance.
2. If the staff person was unable to solve the complaint or problem, the person receiving services or the person's authorized or legal representative can talk to the Program Director for that location. They can be reached by calling 651-264-1000.
3. If the person or person's authorized or legal representative does not believe that their grievance has been resolved they may bring the complaint to the highest level of authority in this program.
   - That person is Christopher Onken, President.
   - He can be reached at 651-264-1000 or 525 Commons Drive, Woodbury, MN 55125

C. Response by the Program
1. Upon request, staff will provide assistance with the complaint process to the service recipient and their authorized representative. This assistance will include:
   a. the name, address, and telephone number of outside agencies to assist the person; and
   b. responding to the complaint in such a manner that the service recipient or authorized representative's concerns are resolved.
2. Zumbro House, Inc. will respond promptly to grievances that affect the health and safety of service recipients.
3. All other complaints will be responded to within 14 calendar days of the receipt of the complaint.
4. All complaints will be resolved within 30 calendar days of the receipt.

5. If the complaint is not resolved within 30 calendar days, this program will document the reason for the delay and a plan for resolution.
6. Once a complaint is received, the program is required to complete a *Complaint Review Form.* The complaint review will include an evaluation of whether:
   a. related policy and procedures were followed;
   b. related policy and procedures were adequate;
   c. there is a need for additional staff training;
   d. the complaint is similar to past complaints with the persons, staff, or services involved; and
   e. there is a need for corrective action by the license holder to protect the health and safety of persons receiving services.
7. Based on this review, the license holder must develop, document, and implement a corrective action plan designed to correct current lapses and prevent future lapses in performance by staff or the license holder, if any.
8. Zumbro House, Inc. will provide a written *Complaint Summary and Resolution Notice* to the person, the legal representative, and case manager that:
   a. identifies the nature of the complaint and the date it was received;
   b. includes the results of the complaint review; and
   c. identifies the complaint resolution, including any corrective action.

D. The *Complaint Summary and Resolution Notice* must be maintained in the person's record.

I. Where to Get Help When You Make a Complaint

These are people you or someone you authorize can call for help if the above procedures have not provided a satisfactory resolution to your complaint.

Arc Minnesota

651-523-0823

1-800-582-5256

Office of Ombudsman for Long Term Care

651-431-2555

1-800-657-3591

Office of Health Facility Complaints

651-201-4201

1-800-369-7994

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Incident Response, Reporting and Review Policy

Policy Statement: It is the policy of Zumbro House, Inc. to respond to, report, and review all incidents that occur while providing services in a timely and effective manner in order to protect the health and safety of and minimize risk of harm to persons receiving services.

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

A. Serious injury of a person;
   a. Fractures;
   b. Dislocations;
   c. Evidence of internal injuries;
   d. Head injuries with loss of consciousness;
   e. Lacerations involving injuries to tendons or organs and those for which complications are present;
   f. Extensive second degree or third degree burns and other burns for which complications are present;
   g. Extensive second degree or third degree frostbite, and other frostbite for which complications are present;
   h. Irreversible mobility or avulsion of teeth;
   i. Injuries to the eyeball;
   j. Ingestion of foreign substances and objects that are harmful;
   k. Near drowning;
   l. Heat exhaustion or sunstroke; and
   m. All other injuries considered serious by a physician.

B. A person’s death.

C. Any medical emergencies, unexpected serious illness, difficulty breathing, chest pain, or significant unexpected change in an illness or medical condition of a person that requires the program to call 911, physician treatment, or hospitalization.

D. Any mental health crisis that requires the program to call 911 or a mental health crisis intervention team.

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

F. A person’s unauthorized or unexplained absence from a program.

G. Conduct by a person receiving services against another person receiving services that:
   1. Is so severe, pervasive, or objectively offensive that it substantially interferes with a person’s opportunities to participate in or receive service or support;
   2. Places the person in actual and reasonable fear of harm;

3. Places the person in actual and reasonable fear of damage to property of the person; or
4. Substantially disrupts the orderly operation of the program.

H. Any sexual activity between persons receiving services involving force or coercion.
   - "Force" means the infliction, attempted infliction, or threatened infliction by the actor of bodily or commission or threat of any other crime by the actor against the complainant or another, harm which (a) causes the complainant to reasonably believe that the actor has the present ability to execute the threat and (b) if the actor does not have a significant relationship to the complainant, also causes the complainant to submit.
   - "Coercion" means words or circumstances that cause the complainant reasonably to fear that the actor will inflict bodily harm upon, or hold in confinement, the complainant or another, or force the complainant to submit to sexual penetration or contact, but proof of coercion does not require proof of a specific act or threat).

I. A report of alleged vulnerable adult maltreatment.

J. A significant medication error or significant adverse drug reaction.

I. Response Procedures

A. Serious injury

1. In the event of a serious injury, staff will provide emergency first aid following instructions received during training.
2. Summon additional staff, if they are immediately available, to assist in providing emergency first aid or seeking emergency medical care.
3. Seek medical attention, including calling 911 for emergency medical care, as soon as possible.

B. Death

1. If staff are alone, immediately call 911 and follow directives given to you by the emergency responder.
2. If there is another person(s) with you, ask them to call 911, and follow directives given to you by the emergency responder.

C. Medical emergency, unexpected serious illness, difficulty breathing, chest pain, or significant unexpected change in an illness or medical condition :

1. Assess if the person requires the program to call 911, seek physician treatment or hospitalization.
2. When staff believes that a person is experiencing a life threatening medical emergency they must immediately call 911.
3. Staff will provide emergency first aid as trained or directed until further emergency medical care arrives at the program or the person is taken to a physician or hospital for treatment. First Aid supplies are located in the medication cabinet at every Zumbro House, Inc. location.

4. Any changes in a person's medical condition requires staff to notify the nurse. If the nurse is unavailable or does not respond to staff within ten (10) minutes, staff will immediately contact the Lead Counselor. If the Lead Counselor is not available, staff will immediately contact the Program Director. If the Lead Counselor and Program Director are not available, staff will immediately contact the Director of Operations. If staff are not able to contact the supervisory staff listed here, staff will immediately contact the primary care provider/urgent care center and ask for immediate assistance/guidance.

D. Mental health crisis

When staff believes that a person is experiencing a mental health crisis they must call 911 or the mental health crisis intervention team at:
Anoka County 763-755-3801
Dakota County 952-891-7171
Hennepin County 612-596-1223
Olmsted County 507-328-6400

E. Requiring 911, law enforcement, or fire department

1. For incidents requiring law enforcement or the fire department, staff will call 911.
2. For non-emergency incidents requiring law enforcement or the fire department, staff will refer to the emergency phone number list posted.
3. Staff will explain to the need for assistance to the emergency personnel.
4. Staff will answer all questions asked and follow instruction given by the emergency personnel responding to the call.

F. Unauthorized or unexplained absence

When a person is determined to be missing or has an unauthorized or unexplained absence, staff will take the following steps:

1. If the person has a specific plan outlined in his/her Coordinated Services and Support Plan Addendum to address strategies in the event of unauthorized or unexplained absences that procedure should be implemented immediately, unless special circumstances warrant otherwise.
2. An immediate and thorough search of the immediate area that the person was last seen will be completed by available staff. When two staff persons are available, the immediate area and surrounding neighborhood will be searched by one staff person. The second staff person will remain at the program location. Other persons receiving services will not be left unsupervised to conduct the search.
3. If after no more than 15 minutes, the search of the facility and neighborhood is unsuccessful, staff will contact law enforcement authorities.
4. After contacting law enforcement, staff will again notify the supervisor, who will determine if additional staff are needed to assist in the search.
5. A current photo will be kept in each person's file and made available to law enforcement.
6. When the person is found, staff will return the person to the service site, or make necessary arrangements for the person to be returned to the service site.

G. Conduct of the person

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

1. Summon additional staff, if available. If injury to a person has occurred or there is eminent possibility of injury to a person, implement approved therapeutic intervention procedures following the policy.
2. As applicable, implement the Coordinated Service and Support Plan Addendum for the person.
3. After the situation is brought under control, question the person(s) as to any injuries and visually observe their condition for any signs of injury. If injuries are noted, provide necessary treatment and contact medical personnel if indicated.

H. Sexual activity involving force or coercion

If a person is involved in sexual activity with another person receiving services and that sexual activity involves force or coercion, staff will take the following steps:

1. Instruct the person in a calm, matter-of-fact, and non-judgmental manner to discontinue the activity. Do not react emotionally to the person's interaction. Verbally direct each person to separate area.
2. Summon additional staff if necessary and feasible.
3. If the persons are unclothed, provide them with appropriate clothing. Do not have them redress in the clothing that they were wearing.
4. Do not allow them to bathe or shower until law enforcement has responded and cleared this action.
5. Contact law enforcement as soon as possible and follow all instructions.
6. lf the person(s) expresses physical discomfort and/or emotional distress, or for other reasons you feel it necessary, contact medical personnel as soon as possible. Follow all directions provided by

I. Maltreatment

Follow the Maltreatment of Minors or Vulnerable Adult Reporting Policy.

J. Non-emergency medical intervention (onset of medical symptoms that require staff intervention, but does not require emergency response, such as sore throat, mild fever, headache, bug bites, bruises, minor localized swelling).

1. Assess if the person requires first aid care. Ask questions regarding the specific problem being reported by the individual. (If this is a medical emergency follow C. above).
2. Locate the standing orders.
3. Follow the directions as indicated on the Standing Orders for that person pertaining to the specific reported and assessed symptom(s). If staff has any questions, the Zumbro House nurse and the Lead Counselor will be contacted for direction. The standing order

medication may be given on a PRN (as needed) basis. Equivalent generic or store brands may be used. **Follow all instructions as listed on the standing orders document. This may include contacting the Zumbro House nurse for direction.** If the nurse is not available, staff will contact the Lead Counselor. If the Lead Counselor is not available, staff will immediately contact the Program Director. If the Lead Counselor and Program Director are not available, staff will immediately contact the Director of Operations. If staff are not able to contact the supervisory staff listed here, staff will immediately contact the primary care provider/urgent care center and ask for immediate assistance/guidance.

4. Chart standing order/PRN medications administered on the electronic Medication Administration Record(eMAR).
5. Document the reason for giving the medication and the person's response to the medication.
6. Contact the Lead Counselor (or Program Director if Lead Counselor is not immediately available or the Director of Operations if the Lead Counselor and Program Director are not readily available) and inform that standing orders were administered and the reason for the administration of standing order medication.
7. The Program Director will alert the Support Team as necessary.

II. Reporting Procedures

A. Completing a report

1. Incident reports will be completed as soon possible after the occurrence and within the shift if at all possible, but no later than 24 hours after the incident occurred or the program became aware of the occurrence. The written report will include:
    1. The name of the person or persons involved in the incident;
    2. The date, time, and location of the incident;
    3. A description of the incident;
    4. A description of the response to the incident and whether a person's coordinated service and support plan addendum or program policies and procedures were implemented as applicable;
    5. The name of the staff person or persons who responded to the incident; and
    6. The results of the review of the incident (see section IV).
2. When the incident involves more than one person, this program will not disclose personally identifiable information about any other person when making the report to the legal representative or designated emergency contact and case manager, unless this program has consent of the person. The written report will not contain the name or initials of the other person(s) involved in the incident.

3. Staff is responsible for reporting adverse events or changes in health status to the nurse.

B. Reporting incidents to support team members

1. All incidents as outlines in section I, subsection A-K above, must be reported to the person's legal representative or designated emergency contact and case manager:
   a. within 24 hours of the incident occurring while services were provided;
   b. within 24 hours of discovery or receipt of information that an incident occurred; or
   c. as otherwise directed in a person's coordinated service and support plan or coordinated service and support plan addendum.
2. This program will not report an incident when it has a reason to know that the incident has already been reported.

C. Additional reporting requirements for deaths and serious injuries

1. A report of the death or serious injury of a person must be reported to both the Office of Ombudsman for Long Term Care and the Office of Health Facility Complaints. The Serious Injury Form can be found at http://mn.gov.omhdd/images/si-form-editable.pdf. The Death Report Form can be found at http://mn.gov/omhdd/death-form-editable.pdf. Both forms should be accompanied with the Death or Serious Injury Report Fax Transmission Cover Sheet, which can be found at http://mn.gov/omhdd/images/DHS-5914-ENG.pdf. Contact information for these agencies is listed on the Fax Transmission Cover Sheet.
2. The report must be made within 24 hours of the death or serious injury occurring while services were provided or within 24 hours of receipt of information that the death or serious injury occurred.
3. This program will not report a death or serious injury when it has a reason to know that the death or serious injury has already been reported to the required agencies.

D. Additional reporting requirements for maltreatment

1. Follow the reporting requirements as outlined in the Vulnerable Adults Maltreatment Reporting and Internal Review Policy.
2. When reporting maltreatment, this program must inform the case manager of the report unless there is reason to believe that the case manager is involved in the suspected maltreatment.
3. The report to the case manager must disclose the nature of the activity or occurrence reported and the agency that received the maltreatment report.

IV. Reviewing Procedures

A. Conducting a review of incidents and emergencies

Zumbro House, Inc. will complete a review of all incidents.

1. The review will be completed by the Director of Operations, or designee.
2. The review will be completed within 5 working days of the incident.
3. The review will ensure that the written report provides a written summary of the incident.
4. The review will identify trends or patterns, if any, and determine if corrective action is needed.

5. When corrective action is needed, a staff person will be assigned to take the corrective action within a specified time period.

B. Conducting an internal review of deaths and serious injuries

Zumbro House, Inc. will conduct an internal review of all deaths and serious injuries that occurred while services were being provided if they were not reported as alleged or suspected maltreatment. (Refer to the Vulnerable Adults Maltreatment Reporting and Internal Review Policy when alleged or suspected maltreatment has been reported.)

1. The review will be completed by the Director of Operations, or designee.
2. The review will be completed within 5 working days of the death or serious injury.
3. The internal review must include an evaluation of whether:
   a. related policies and procedures were followed;
   b. the policies and procedures were adequate;
   c. there is need for additional staff training;
   d. the reported event is similar to past events with the persons or the services involved to identify incident patterns; and
   e. whether there is need for corrective action by the program to protect the health and safety of the persons receiving services and to reduce future occurrences.
4. Based on the results of the internal review, Zumbro House, Inc. must develop, document, and implement a corrective action plan designed to correct current lapses and prevent future lapses in performance by staff or the program, if any.

C. Conducting an internal review of maltreatment

Follow the Maltreatment of Vulnerable Adult Reporting Policy.

V. Record Keeping Procedures

A. The review of an incident will be include on the Incident Report Log.

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

Policy Reviewed and Authorized by: Ceallaigh Estepp, Director of Quality and Compliance

Date of Last Revision: 2/1/17

Infection Control Policy

Policy Statement: Zumbro House will observe the recommended precautions as identified by the Centers for Disease Control and Prevention (CDC). The precautions cover those persons with documented or suspected infection with highly transmissible or epidemiologically important pathogens that require additional precautions to prevent transmission. The practice of employees will conform with OSHA regulations, current law and currently accepted standards of practice.

Purpose:

1. To ensure employee and person served safety.
2. To reduce the risk of transmission of microbes from both recognized and unrecognized sources of infection.

Procedure: Standard Precautions – Tier One

1. Standard precautions apply to blood, all body fluids, secretions, excretions, non-intact skin, and mucous membranes. All are to be treated as a potential source of infection regardless of whether or not the person has a communicable disease.

2. Hands are washed if contaminated with blood or body fluid, immediately after gloves are removed, between contact with other persons, and when indicated to prevent transfer of microorganisms between person or the environment.

3. Gloves are worn when touching blood, body fluids, secretions, excretions, non-intact skin, mucous membranes, or contaminated items.

4. Masks, eye protection, or face shields are worn if personal care activities may generate splashes or sprays of blood or body fluid.

5. Gowns are worn if clothing is likely to be soiled from blood or body fluid. Hands are washed after removing gown.

6. Equipment used for personal care is properly cleaned and reprocessed. Single-use items are discarded.

7. Contaminated linen is placed in a leak proof bag and carefully handled to prevent skin and mucous membrane exposure.

8. All sharp instruments and needles are discarded in a puncture-resistant container. The CDC recommends needles be disposed of without capping or that a mechanical device be used for recapping.

Disease-Specific Standard Precautions – Tier Two

This approach provides isolation guidelines with new transmission categories based on airborne, droplet, and contact transmission of infectious disease.

1. Airborne Precautions: Use mask or respiratory protection.
2. Droplet Precautions: Use mask. Isolate persons from those at risk of infection.
3. Contact Precautions: Use gowns, gloves, and masks as appropriate.

Bloodborne Diseases

Diseases to which staff could be exposed in home care include non "A" hepatitis, non "B" hepatitis and deta hepatitis as well as syphilis, malaria and human immunodeficiency virus. In particular, risks with hepatitis "B" (HBV) and human immunodeficiency (HIV) include the following.

1. HBV: May severely damage the liver leading to cirrhosis and almost certain death.
2. HIV: Attacks the body's immune system, causing the disease known as AIDS or Acquired Immune Deficiency Syndrome.

AIDS and Hepatitis are spread by sexual contact, needle sharing or, less commonly, through transfused blood or its components. The risk of infection with either virus is increased by having multiple sexual partners, either homosexual or heterosexual, or by sharing needles among those using illicit drugs. The AIDS virus may be transmitted from infected mother to infant before, during or shortly after birth.

There is no evidence to suggest that the AIDS virus is transmitted by casual contact, through the air or by contact with objects handled by a person with the AIDS virus infection.

Health care workers may be exposed to blood and body fluids while performing their duties. Since it is frequently not known which persons are infected with the Hepatitis or AIDS virus, all blood products, body fluids and contaminated needles for all clients should be considered potentially infectious.

Methicillin Resistant Staphylococcus Aureus (MRSA)

1. MRSA is a strain of Staphylococcus Aureus that is resistant to most antibiotics. Vancomycin is the most reliable antibiotic for treatment.

2. Persons who are colonized with MRSA can act as reservoirs for transmission to family, employees and other health care personnel

3. It can be transmitted via unwashed hands, contaminated equipment, or clothing.

4. Staff who touch their nose with unwashed hands are at risk for colonization of MRSA.

5. MRSA can live up to 14 days in the environment.

Procedure: Standard precautions will be used with all clients

- Handwashing must be done before and after all contact with other persons.
- Personal protective equipment including gloves, mask or gown will be used when appropriate for care.
- No special treatment is needed for linens, clothing, or waste.

Cleaning/Decontaminating Spills of Blood/Body Fluids

1. Chemical germicides such as those used as hospital disinfectants can be used to decontaminate spills for blood and other body fluids. They should be diluted according to label directions.

2. Staff should remove all visible material and decontaminate the area.

3. Gloves should be worn during the cleaning and decontamination.

4. Soiled linens should be handled as little as possible and with minimum agitation to prevent gross microbial contamination of the air and of persons handling the linen.

5. All soiled linen should be bagged at the location where it was used; it should not be sorted or rinsed in personal care areas.

6. If hot water is used, linen should be washed with detergent in water at least 71 C (160F).

7. If low temperature laundry cycles are used, chemicals suitable for low-temperature washing at concentrations as per labeled directions should be used.

Exposure Determination

The job classifications for employees are identified on the OSHA Bloodborne Pathogens Exposure Determination Grid related to their risk of exposure to blood or other potentially infectious body fluids.

Handwashing

1. All persons may be carriers of disease-producing microorganisms and therefore a possible source of infection.

2. Caring for persons requires the hands to be almost constantly touching the person, articles of clothing and equipment used for care.

3. Hands should be washed at the following times.
   a. After changing beds
   b. Before assisting with medications
   c. Before and after treatments
   d. After all pet care
   e. After housekeeping
   f. After emptying bedpans
   g. After assisting the person to the toilet
   h. After removing items from the floor
   i. Before preparing food
   j. Before feeding persons served
   k. After using the bathroom
   l. After coughing or sneezing
   m. After smoking
   n. After handling plants
   o. After removing gloves

Policy Reviewed and Authorized by: Ceallaigh Estepp, Director of Quality and Compliance

Date of Last Revision: 2/1/17

Maltreatment of Vulnerable Adults Reporting and Internal Review Policy

I. Policy

It is the policy of Zumbro House, Inc. to protect the adults served by this program who are vulnerable to maltreatment and to require the reporting of suspected maltreatment of vulnerable adults.

II. Procedures

A. Who should report suspected maltreatment of a vulnerable adult

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

B. Where to report - You can make an external or an internal report.

1. You may make an external report to the Common Entry Point at **Minnesota Adult Abuse Reporting Center (MAARC)** 844-880-1574.

2. You may make an internal report to a Program Director or the Director of Operations. Both can be reached at 651-264-1000.

   If this person is involved in the alleged or suspected maltreatment, you must report to Christopher Onken, President. He can also be reached at 651-264-1000.

C. Internal report

1. When an internal report is received, the Director of Operations is responsible for deciding if a report to the Common Entry Point is required. If that person is involved in the suspected maltreatment, Christopher Onken, President, will assume responsibility for deciding if the report must be forwarded to the Common Entry Point.
2. The report to the Common Entry Point must be as soon as possible, but no longer than 24 hours from the time initial knowledge that the incident occurred has been received.
3. If you have reported internally, you must receive, within two working days, a written notice that tells you whether or not your report has been forwarded to the Common Entry Point. The written notice must be given to you in a manner that protects your confidentiality as a reporter. It shall inform you that if you are not satisfied with the action taken by the facility on whether to report the incident to the common entry point, you may still make an external report to the Common Entry Point. It must also inform you that you are protected against retaliation by the program if you make a good faith report to the Common Entry Point.

D. Internal Review
    1. When the program has reason to know that an internal or external report of alleged or suspected maltreatment has been made, the program must complete an internal review and take corrective action, if necessary, to protect the health and safety of vulnerable adults.
    2. The internal review must include an evaluation of whether:
        a. related policies and procedures were followed;
        b. the policies and procedures were adequate;
        c. there is a need for additional staff training;
        d. the reported event is similar to past events with the vulnerable adults or the services involved; and
        e. there is a need for corrective action by the program to protect the health and safety of vulnerable adults.

E. Primary and secondary person or position to ensure internal reviews are completed

    The internal review will be completed by the Director of Operations.

    If this individual is involved in the alleged or suspected maltreatment, the internal review will be completed by Christopher Onken, President.

F. Documentation of the internal review

    Zumbro House, Inc. must document completion of the internal review and provide documentation of the review to the DHS upon the commissioner's request.

G. Corrective action plan

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

H. Orientation for persons receiving services
    1. Zumbro House, Inc. shall provide an orientation to the internal and external reporting procedures to all persons receiving services. The orientation shall include the telephone number for the Common Entry Point. A person’s legal representative must be notified of the orientation.
    2. The program shall provide this orientation for each new person within 24 hours of admission, or for persons who would benefit more from a later orientation, the orientation may take place within 72 hours.

I. Staff training

    Zumbro House, Inc. shall ensure that each new mandated reporter receives an orientation within 72 hours of first providing direct contact services to a vulnerable adult and annually thereafter. The orientation and annual review shall inform the mandated reporter of the reporting requirements and definitions under

Minnesota Statutes, sections 626.557 and 626.5572, the requirements of Minnesota Statutes, section 245A.65, the program's program abuse prevention plan, and all internal policies and procedures related to the prevention and reporting of maltreatment of individuals receiving services.

Zumbro House, Inc. must document the provision of this training, monitor implementation by staff, and ensure that the policy is readily accessible to staff, as specified under Minnesota Statutes, section 245A.04, subdivision 14.

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

Policy Reviewed and Authorized By: Ashley Goetzke, Director of Quality and Compliance

Date of Last Revision: 12/1/15

Maltreatment of Vulnerable Adults Reporting and Internal Review Policy
Addendum A: Definitions

Abuse means:

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

(1) assault in the first through fifth degrees as defined in sections 609.221 to 609.224;

(2) the use of drugs to injure or facilitate crime as defined in section 609.235;

(3) the solicitation, inducement, and promotion of prostitution as defined in section 609.322; and

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

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

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

(1) hitting, slapping, kicking, pinching, biting, or corporal punishment of a vulnerable adult;

(2) use of repeated or malicious oral, written, or gestured language toward a vulnerable adult or the treatment of a vulnerable adult which would be considered by a reasonable person to be disparaging, derogatory, humiliating, harassing, or threatening;

(3) use of any aversive or deprivation procedure, unreasonable confinement, or involuntary seclusion, including the forced separation of the vulnerable adult from other persons against the will of the vulnerable adult or the legal representative of the vulnerable adult; and

(4) use of any aversive or deprivation procedures for persons with developmental disabilities or related conditions not authorized under section 245.825.

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

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

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

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

2) a caregiver to offer or provide or refuse to offer or provide therapeutic conduct.

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

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

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

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

Accident. "Accident" means a sudden, unforeseen, and unexpected occurrence or event which:

(1) is not likely to occur and which could not have been prevented by exercise of due care; and

(2) if occurring while a vulnerable adult is receiving services from a facility, happens when the facility and the employee or person providing services in the facility are in compliance with the laws and rules relevant to the occurrence or event.

Caregiver. "Caregiver" means an individual or facility who has responsibility for the care of a vulnerable adult as a result of a family relationship, or who has assumed responsibility
for all or a portion of the care of a vulnerable adult voluntarily, by contract, or by agreement.

Common entry point. "Common entry point" means the entity designated by each county responsible for receiving reports under section 626.557.

Facility. (a) "Facility" means a hospital or other entity required to be licensed under sections 144.50 to 144.58; a nursing home required to be licensed to serve adults under
section 144A.02; a residential or nonresidential facility required to be licensed to serve adults
under sections 245A.01 to 245A.16; a home care provider licensed or required to be licensed
under section 144A.46; a hospice provider licensed under sections 144A.75 to 144A.755; or a
person or organization that exclusively offers, provides, or arranges for personal care assistance services under the medical assistance program as authorized under sections 256B.04, subdivision 16, 256B.0625, subdivision 19a, 256B.0651 to 256B.0656, and 256B.0659.

(b) For home care providers and personal care attendants, the term "facility" refers to the
provider or person or organization that exclusively offers, provides, or arranges for personal care services, and does not refer to the person’s served home or other location at which services are rendered.

False. "False" means a preponderance of the evidence shows that an act that meets the definition of maltreatment did not occur.

Final disposition. "Final disposition" is the determination of an investigation by a lead investigative agency that a report of maltreatment under Laws 1995, chapter 229, is substantiated, inconclusive, false, or that no determination will be made. When a lead investigative agency determination has substantiated maltreatment, the final disposition also identifies, if known, which individual or individuals were responsible for the substantiated maltreatment, and whether a facility was responsible for the substantiated maltreatment.

Financial exploitation. "Financial exploitation" means:

(a) In breach of a fiduciary obligation recognized elsewhere in law, including pertinent regulations, contractual obligations, documented consent by a competent person, or the obligations of a responsible party under section 144.6501, a person:

(1) engages in unauthorized expenditure of funds entrusted to the actor by the vulnerable adult which results or is likely to result in detriment to the vulnerable adult; or

(2) fails to use the financial resources of the vulnerable adult to provide food, clothing, shelter, health care, therapeutic conduct or supervision for the vulnerable adult, and the failure results or is likely to result in detriment to the vulnerable adult.

(b) In the absence of legal authority a person:

(1) willfully uses, withholds, or disposes of funds or property of a vulnerable adult;

(2) obtains for the actor or another the performance of services by a third person for the wrongful profit or advantage of the actor or another to the detriment of the vulnerable adult;

(3) acquires possession or control of, or an interest in, funds or property of a vulnerable adult through the use of undue influence, harassment, duress, deception, or fraud; or

(4) forces, compels, coerces, or entices a vulnerable adult against the vulnerable adult's will to perform services for the profit or advantage of another.

(c) Nothing in this definition requires a facility or caregiver to provide financial management or supervise financial management for a vulnerable adult except as otherwise required by law.

Immediately. "Immediately" means as soon as possible, but no longer than 24 hours from the time initial knowledge that the incident occurred has been received.

Inconclusive. "Inconclusive" means there is less than a preponderance of evidence to show that maltreatment did or did not occur.

Initial disposition. "Initial disposition" is the lead investigative agency's determination of whether the report will be assigned for further investigation.

Lead investigative agency. "Lead investigative agency" is the primary

administrative agency responsible for investigating reports made under section 626.557.

(a) The Department of Health is the lead investigative agency for facilities or services licensed or required to be licensed as hospitals, home care providers, nursing homes, boarding care homes, hospice providers, residential facilities that are also federally certified as intermediate care facilities that serve people with developmental disabilities, or any other facility or service not listed in this subdivision that is licensed or required to be licensed by the Department of Health for the care of vulnerable adults. "Home care provider" has the meaning provided in section 144A.43, subdivision 4, and applies when care or services are delivered in the vulnerable adult's home, whether a private home or a housing with services establishment registered under chapter 144D, including those that offer assisted living services under chapter 144G.

(b) The Department of Human Services is the lead investigative agency for facilities or services licensed or required to be licensed as adult day care, adult foster care, community residential settings, programs for people with disabilities, family adult day services, mental health programs, mental health clinics, chemical dependency programs, the Minnesota sex offender program, or any other facility or service not listed in this subdivision that is licensed or required to be licensed by the Department of Human Services.

(c) The county social service agency or its designee is the lead investigative agency for all other reports, including, but not limited to, reports involving vulnerable adults receiving services from a personal care provider organization under section 256B.0659.

Legal authority. "Legal authority" includes, but is not limited to: (1) a fiduciary obligation recognized elsewhere in law, including pertinent regulations; (2) a contractual obligation; or (3) documented consent by a competent person.

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

Mandated reporter. "Mandated reporter" means a professional or professional's delegate while engaged in: (1) social services; (2) law enforcement; (3) education; (4) the care of vulnerable adults; (5) any of the occupations referred to in section 214.01, subdivision 2; (6) an employee of a rehabilitation facility certified by the commissioner of jobs and training for vocational rehabilitation; (7) an employee or person providing services in a facility as defined in subdivision 6; or (8) a person that performs the duties of the medical examiner or coroner.

Neglect. "Neglect" means:

(a) The failure or omission by a caregiver to supply a vulnerable adult with care or services, including but not limited to, food, clothing, shelter, health care, or supervision which is:

(1) reasonable and necessary to obtain or maintain the vulnerable adult's physical or mental health or safety, considering the physical and mental capacity or dysfunction of the vulnerable adult; and

(2) which is not the result of an accident or therapeutic conduct.

(b) The absence or likelihood of absence of care or services, including but not limited to,
food, clothing, shelter, health care, or supervision necessary to maintain the physical and mental health of the vulnerable adult which a reasonable person would deem essential to obtain or maintain the vulnerable adult's health, safety, or comfort considering the physical or mental
capacity or dysfunction of the vulnerable adult.

(c) For purposes of this section, a vulnerable adult is not neglected for the sole reason that:

(1) the vulnerable adult or a person with authority to make health care decisions for the
vulnerable adult under sections 144.651, 144A.44, chapter 145B, 145C, or 252A, or sections
253B.03 or 524.5-101 to 524.5-502, refuses consent or withdraws consent, consistent with that
authority and within the boundary of reasonable medical practice, to any therapeutic conduct,
including any care, service, or procedure to diagnose, maintain, or treat the physical or mental
condition of the vulnerable adult, or, where permitted under law, to provide nutrition and hydration parenterally or through intubation; this paragraph does not enlarge or diminish rights
otherwise held under law by:

(i) a vulnerable adult or a person acting on behalf of a vulnerable adult, including an involved family member, to consent to or refuse consent for therapeutic conduct; or

(ii) a caregiver to offer or provide or refuse to offer or provide therapeutic conduct; or

(2) the vulnerable adult, a person with authority to make health care decisions for the
vulnerable adult, or a caregiver in good faith selects and depends upon spiritual means or prayer for treatment or care of disease or remedial care of the vulnerable adult in lieu of medical care, provided that this is consistent with the prior practice or belief of the vulnerable adult or with the expressed intentions of the vulnerable adult;

(3) the vulnerable adult, who is not impaired in judgment or capacity by mental or emotional dysfunction or undue influence, engages in consensual sexual contact with:

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

(ii) a personal care attendant, regardless of whether the consensual sexual personal
relationship existed prior to the caregiving relationship; or

(4) an individual makes an error in the provision of therapeutic conduct to a vulnerable adult which does not result in injury or harm which reasonably requires medical or mental health care; or

(5) an individual makes an error in the provision of therapeutic conduct to a vulnerable adult that results in injury or harm, which reasonably requires the care of a physician, and:

(i) the necessary care is provided in a timely fashion as dictated by the condition of the vulnerable adult;

(ii) if after receiving care, the health status of the vulnerable adult can be reasonably expected, as determined by the attending physician, to be restored to the vulnerable adult's preexisting condition;

(iii) the error is not part of a pattern of errors by the individual;

(iv) if in a facility, the error is immediately reported as required under section 626.557, and recorded internally in the facility;

(v) if in a facility, the facility identifies and takes corrective action and implements measures designed to reduce the risk of further occurrence of this error and similar errors; and

(vi) if in a facility, the actions required under items (iv) and (v) are sufficiently documented for review and evaluation by the facility and any applicable licensing, certification, and ombudsman agency.

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

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

Report. "Report" means a statement concerning all the circumstances surrounding the alleged or suspected maltreatment, as defined in this section, of a vulnerable adult which are known to the reporter at the time the statement is made.

Substantiated. "Substantiated" means a preponderance of the evidence shows that an act that meets the definition of maltreatment occurred.

Therapeutic conduct. "Therapeutic conduct" means the provision of program services, health care, or other personal care services done in good faith in the interests of the vulnerable adult by: (1) an individual, facility, or employee or person providing services in a facility under the rights, privileges and responsibilities conferred by state license, certification, or registration; or (2) a caregiver.

Vulnerable adult. (a) "Vulnerable adult" means any person 18 years of age or older who:

(1) is a resident or inpatient of a facility;

(2) receives services at or from a facility required to be licensed to serve adults under sections 245A.01 to 245A.15, except that a person receiving outpatient services for treatment of chemical dependency or mental illness, or one who is served in the

Minnesota sex offender program on a court-hold order for commitment, or is committed as a sexual psychopathic personality or as a sexually dangerous person under chapter 253B, is not considered a vulnerable adult unless the person meets the requirements of clause (4);

(3) receives services from a home care provider required to be licensed under section 144A.46; or from a person or organization that exclusively offers, provides, or arranges for personal care assistance services under the medical assistance program as authorized under sections 256B.04, subdivision 16, 256B.0625, subdivision 19a, 256B.0651, 256B.0653 to 256B.0656, and 256B.0659; or

(4) regardless of residence or whether any type of service is received, possesses a physical or mental infirmity or other physical, mental, or emotional dysfunction:

(i) that impairs the individual's ability to provide adequately for the individual's own care without assistance, including the provision of food, shelter, clothing, health care, or supervision; and

(ii) because of the dysfunction or infirmity and the need for care or services, the individual has an impaired ability to protect the individual's self from maltreatment.

(b) For purposes of this subdivision, "care or services" means care or services for the health, safety, welfare, or maintenance of an individual.

Medication Administration Policy

Policy Statement: Persons served by Zumbro House are entitled to the safe administration of medications by qualified personnel according to a written Medication Management and Care Plan.

Procedure:

1. As part of the Medication Management and Care Plan, the RN determines with the person/person's legal representative the method for medication administration.

2. Medications may be administered by a nurse, physician, other licensed health practitioner authorized to administer medications.

3. The Registered Nurse may delegate medication administration to an unlicensed staff member according to the following protocol:
    a. All staff have passed a competency evaluation with respect to all medication routes to be administered
    b. The Registered Nurse has prepared written instructions for the staff in the proper methods to administer medications with respect to each person
    c. The Registered Nurse has communicated with/provided orientation to the staff regarding the individual needs of the client

4. Zumbro House will maintain documentation of the competency evaluation for the staff in the personnel file and the orientation/instruction with respect to the Medication Management and Care Plan for each individual person in the clinical record.

5. No prescription drug supply for one person may be used or saved for use by anyone other than that person.

6. All staff with responsibility for medication administration have access to information about the medication being administered, including but not limited to:
    a. Purpose
    b. Dosage
    c. Route
    d. Frequency

e. Instructions related to the medication and specific to the person, as appropriate
f. Side effects
g. Person’s allergies to medications

Policy Reviewed and Authorized by: Ceallaigh Estepp, Director of Quality and Compliance

Date of Last Revision: 2/1/17

Medication Documentation Policy

Policy Statement: Each medication administered by Zumbro House staff will be documented in the person's medical record. Documentation will be complete and accurate. The person's needs will be met related to the Medication Management and Care Plan.

Procedure:

1. Complete documentation of medication administration includes the following
    a. Person's name
    b. Medication name
    c. Medication dosage
    d. Date and time of administration
    e. Method/route of administration
    f. Initials of staff administering the medication

2. If the administration of one or more medications was not completed, staff will
    a. Document the reason why the medication was not administered
    b. Follow up to meet the person's needs in compliance with the Medication Management and Care Plan
    c. Provide notification to RN or other persons as instructed regarding missed dosages
    d. Document the error or omission

3. Zumbro House will document medication set up according to the following
    a. Date of medication set up
    b. Name of medication
    c. Quantity of dose
    d. Times to be administered
    e. Route of administration
    f. Name/title of staff completing the set up

4. Documentation of medication administration and medication set up will be completed promptly.

5. For PRN medications, documentation will include, when appropriate, the reason for the medication and follow-up to determine its effectiveness.

6. When medication administration is delegated to unlicensed personnel, the medical records and/or personnel files will contain documentation of appropriate competency, education and orientation.

Policy Reviewed and Authorized by: Ceallaigh Estepp, Director of Quality and Compliance

Date of Last Revision: 2/1/17

Medication Incidents/Errors

Policy Statement: Zumbro House will recognize and promptly address medication errors/incidents. Medication errors/incidents will be monitored and tracked through the organization's Quality Improvement.

Procedure:

1. The staff member identifying a medication error or incident will promptly report it to the RN.

2. If the person is in immediate danger, the appropriate emergency response is initiated by the staff member on site.

3. The person's physician will be notified of significant medication incidents.

4. Internal reporting includes documenting medication discrepancies.

5. Medication discrepancies will be submitted to the appropriate supervisor or RN within 48 hours of occurrence.

6. All significant occurrences will be reviewed as part of the organization's Quality Improvement, with trends noted.

7. Quality improvement activities will be initiated if review of errors/incidents indicates the need.

8. External reporting includes notification of the pharmacist, supplier and/or manufacturer when an error/incident occurs as a result of medication packaging, labeling, delivery, etc.

Policy Reviewed and Authorized by: Ceallaigh Estepp, Director of Quality and Compliance

Date of Last Revision: 2/1/17

Medication Management and Care Plan for Persons Away from Home Policy

Policy Statement: As part of the Medication Management Program, Zumbro House will arrange for the safe provision of medications for persons with planned/unplanned times away from home.

Procedure:

1. For planned times away from home, the medications will be obtained from the pharmacy and/or set up by the Registered Nurse according to standards of practice and applicable laws/regulations.

2. For unplanned times away from home for temporary periods when an adequate medication supply cannot be obtained from the pharmacy or set up by the Registered Nurse in a timely manner, the Registered Nurse may delegate an unlicensed personnel (staff) to set up the medications based on the following
    a. The staff has documentation of passing a competency evaluation for medication administration
    b. The Registered Nurse has instructed the staff to ensure that all appropriate precautions are taken
    c. The staff may not set up more than a 72-hour supply of the person's medications

3. Zumbro House will maintain documentation of instruction, as indicated, and medication set up in the medical record, including the following for each medication set up
    a. Name
    b. Strength
    c. Dose
    d. Route
    e. Administration time
    f. Amount of medication provided to the person
    g. Name of Responsible Person to whom the medications were given

4. Preparation of medications for persons away from home includes the following
    a. Medications are taken from the original containers prepared by the pharmacist and then placed in a suitable container

b. Over-the-counter and dietary supplements that are not prescribed will be set up from the original labeled container that identifies directions for use.
c. The label for the suitable container includes the following
    i. Person's name
    ii. Medication name, strength, dose and route
    iii. Dates and times the medication is to be taken by the person
    iv. Any other information that should be known regarding the medication
d. For those medications that cannot be prepared in advance, the responsible person will be given the original container and complete directions/information for the administration of that medication

5. The Zumbro House's name and contact information for the Registered Nurse will be provided in writing to the person or Responsible Person.

Policy Reviewed and Authorized by: Ceallaigh Estepp, Director of Quality and Compliance

Date of Last Revision: 2/1/17

Person Served Education Policy

Policy Statement: Zumbro House recognizes that the person is an integral participant in the Medication Management and Care Plan and is committed to providing appropriate education to promote compliance with medications consistent with the prescribed regimen.

Procedure:

1. The RN is responsible for assessing a peson's knowledge regarding the medication regimen on admission.

2. The RN will provide education to the person based on assessed need.

3. Throughout the Medication Management and Care Plan, the RN will continue to assess the person's compliance with and knowledge of the medications administered.

4. In addition to verbal instruction, written materials may be provided to the person as appropriate.

5. The RN will assure that anyone who administers medications, including the person, have access to information regarding the medication, including but not limited to the following.
    a. Purpose
    b. Dosage
    c. Route
    d. Frequency
    e. Instructions related to the medication and specific to the person, as appropriate
    f. Side effects
    g. Person's allergies to medications

6. Any education provided to a person served will be documented in the medical record.

Policy Reviewed and Authorized by: Ceallaigh Estepp, Director of Quality and Compliance

Date of Last Revision: 2/1/17

Personnel Records Policy

Policy Statement: A record of each paid employee, regularly scheduled volunteer providing home care services, and each individual contractor providing home care services for Zumbro House will be maintained.

Procedure:

1. A personnel record will be started for each staff member upon hire.

2. At a minimum, the following documents are kept in the personnel record, as applicable to job requirements
   - Evidence of current professional licensure, registration or certification
   - Results of background studies and Office of Inspector General exclusion list
   - Records of annual training and infection control training
   - Documentation of orientation
   - RN Staff Supervision
   - Competency evaluations
   - Signed job description
   - Documentation of annual performance reviews identifying areas of improvement needed and training needs

3. A job description is maintained that includes qualifications, responsibilities and identification of supervisors for each job classification.

4. Each personnel record shall be maintained for at least three years after an employee, home care volunteer or contractor ceases to be employed by or under contract with Zumbro House. The President/Owner will arrange for safe storage in the event that the agency is closed.

5. Results of required health screening and medical examinations will be maintained in a separate, private file.

Policy Reviewed and Authorized by: Ceallaigh Estepp, Director of Quality and Compliance

Date of Last Revision: 2/1/17

Physician/Prescriber Orders Policy

Policy Statement: Zumbro House will administer medications as prescribed by the authorized prescriber and in accordance with all the rights defined in the Home Care Bill of Rights and in the Health Insurance Portability and Accountability Act.

Procedure:

1. Zumbro House will maintain a current written or electronically recorded prescription for all prescribed medications managed for the person.

2. Medication orders will be renewed at least every 12 months or as required by the physician, the RN assessment and/or regulation.

3. Verbal prescription orders from an authorized prescriber will be received by a nurse or pharmacist.
    a. The pharmacist, LPN or RN acting on behalf of the prescriber may communicate to the pharmacy provider a prescription drug order by a practitioner authorized to prescribe drugs or devices.
    b. The prescription drug orders will be transmitted via facsimile or a secure electronic format to the pharmacy.
    c. Schedule II controlled substances require an original written prescription drug order manually signed by the authorized practitioner except in an emergency
        i. Immediate administration of the controlled substance is necessary for the proper treatment of the intended user
        ii. No appropriate alternative treatment is available
        iii. It is not reasonably possible for the prescribing practitioner to provide a written prescription drug order to the pharmacy.

4. When a written or electronic prescription is received, it must be communicated to the registered nurse and recorded or placed into the person's medical record.

5. All prescriptions and orders received by Zumbro House either verbally, in writing, or electronically will be kept confidential.

6. Zumbro House has determined not to require a prescription for dietary supplements. However, these medications will be included on medication lists and those lists provided to all physicians/medical prescribers.

Policy Reviewed and Authorized by: Ceallaigh Estepp, Director of Quality and Compliance

Date of Last Revision: 2/1/17

Quality Improvement Policy

Policy Statement

Zumbro House, Inc. has established a quality improvement program based on the organization's size and appropriate to the type of services provided in order to assure that effective, comprehensive and appropriate plans are operational for all persons receiving services within the organization.

The quality improvement program assists the organization in focusing on key activities to maintain quality care and effective utilization of services and resources. Zumbro House, Inc. intends to improve systems and build quality into all processes in order to meet or exceed the expectations of individuals receiving Zumbro House, Inc. residential services.

I. Procedure

Goals of Program

1. To conduct an ongoing assessment of residential services.
2. To approach quality as a management strategy.
3. To focus efforts on key organizational processes.
4. To pursue opportunities which have the potential for improving systems of care delivery, including changes in services, staffing and/or other procedures.
5. To build quality into all processes and continually work to improve services to meet the needs of individuals served and manage costs.
6. To systematically monitor and evaluate the quality, safety and appropriateness of care provided to individuals receiving services.
7. To identify, take action and re-evaluate problems identified within the organization.
8. To assure compliance with regulatory agencies.
9. To identify educational needs of staff related to quality improvement and processes.
10. To assist staff in determining opportunities for improvement.

Quality Improvement Indicators

1. Complaint/Grievance Reports: All reports are reviewed following the established procedure. The President or designee is responsible for analyzing and trending the data, which is incorporated into the Quality Improvement program.

2. Record Audits: Records are kept for each person served and are regularly audited throughout the year based on established criteria. Results are reviewed by the management team and follow up is implemented by the Director of Quality and Compliance or designee as appropriate.

3. Incident Reports: Incident reports are reviewed by the management team in order to:

a. Correct safety concerns for persons receiving services
b. Monitor organizational trends related to safety and/or care
c. Address unsafe practices for persons receiving services and employees

4. Surveys of persons receiving services: surveys are conducted with persons receiving services at the discretion of the President to evaluate the effectiveness of Zumbro House residential services.

5. Personnel Files: Personnel records are audited as indicated based on established criteria in order to assure compliance with policies and applicable government regulations. Results are reviewed and follow up is implemented by the Director of HR or designee.

6. Additional Quality Improvement Indicators may be developed by management staff based on program evaluation, including but not limited to the following:

   a. Staff surveys and exit interviews
   b. Finance Department, COLA Increase QI Plan
   c. Staff Advisory Committee

7. Documentation of Quality Improvement activities is maintained and updated as needed, but not less than annually.

8. Documentation of the Quality Improvement Program is maintained for at least two years and will be provided to the commissioner at the time of survey, investigation or renewal as requested.

Ongoing Customer Service

A. Employees and management of the company will be available to respond to customer needs, questions or concerns at any time.

B. Staff will actively listen to the requests or opinions of persons, family members, case managers and other agency personnel and respond or make recommendations in a professional and polite manner.
   1. Staff will make and implement decisions regarding these requests or opinions as soon as possible according to their authority. If a staff person does not have authority to make the decision or change he or she will forward the request or concern to the supervisor/designee.
   2. Staff will document all such contacts, verbal or otherwise, with persons, family members, case managers and other agency personnel.

C. Staff will respond to all complaints from persons served or complaints from the person's legally authorized representative according to the "Grievance Policy."
   1. Staff will resolve complaints from family members, case managers and other agency personnel according to their level of delegated authority or refer the issue to their supervisor.

Policy Reviewed and Authorized By: Ceallaigh Estepp, Director of Quality and Compliance

Date of Last Revision: 2/1/17

Records Policy

Policy Statement: A current record shall be maintained for all clients.

Procedure:

1. A record will be started for each person on admission to home care.

2. All entries into the record will be legible, permanently recorded in ink/electronically, dated and authenticated with the name and title of the person making the entry.

3. Documentation will be entered into the record no later than 24 hours after the service was provided.

4. Paper records will be stored in a locked, secured location accessible to employees and contractors authorized to access the records. Electronic records are maintained and accessed only by those with credentials.

5. Records will be maintained in such a manner that allows for timely access, printing or transmission of the records.

6. The record contains the following information
   - Person's name
   - Address
   - Telephone number
   - Date of birth
   - Admission/discharge dates
   - Names, addresses and telephone numbers of an emergency contact, family members or responsible parties
   - Pertinent health information
   - Medical history
   - Allergies
   - Advance directives, if any
   - Service Plans
   - Nursing assessments
   - Medications, treatment and/or therapies, if pertinent
   - Documentation of communication/coordination pertinent to the person's home care services
   - Documentation of incidents and/or significant changes in the person's status and actions taken in response to the needs of the person, including reporting to the appropriate supervisor or health professional
   - Documentation of services provided as identified in the service plan

- Documentation that the person has received and reviewed the following
    - Home Care Bill of Rights
    - Statement of Home Care Services
- Grievances and resolution, as applicable
- Discharge summary and related documentation, including service termination notice, when applicable
- Names, addresses and telephone numbers of the person's health and medical services providers and other home health agencies, if known
- Other information needed to provide comprehensive home care service

7. All of Zumbro House employees may make entries into the record.

8. In the event the person is transferred to another home care provider or health care practitioner or is admitted to an inpatient facility, Zumbro House will, upon request of the person or responsible party, send a copy or summary of the record to the new provider, facility or to the person, as appropriate.

9. Records may be removed from the company's jurisdiction and safekeeping only in accordance with a court order, subpoena, or law and regulation.

10. Following the person's discharge or termination of services, Zumbro House will retain the record for at least five (5) years or as otherwise required by state or federal regulation.

11. The President/Owner is responsible for assuring the secure storage and retrieval of records should Zumbro House cease business.

Policy Reviewed and Authorized by: Ceallaigh Estepp, Director of Quality and Compliance

Date of Last Revision: 2/1/17

Service Plan for Medication Management Policy

Policy Statement: Zumbro House will prepare and document a Medication Management Plan as part of the Service Plan for each person receiving medication management services.

Procedure:

1. The written Medication Management and Care Plan include the following provisions.
    a. A statement describing the medication management services to be provided
    b. A description of the storage of medications based on the client assessment and addressing
        i. Client preference
        ii. Risk of diversion
        iii. Instructions per manufacturer
    c. Documentation procedures
    d. Procedures for verifying the prescription medications are administered as prescribed
    e. Procedures for medication reconciliation
    f. Identification of person(s) responsible for monitoring medication supplies and ensuring refills are ordered/timely
    g. Description of medication management tasks to be delegated to unlicensed personnel
    h. Plans for notifying licensed health professional when/if a problem with medication management services arises

2. The Registered Nurse is responsible for preparing and documenting the Medication Management and Care Plan.

3. The Registered Nurse will review the Medication Management and Care Plan as part of the Service Plan with the person prior to implementation.

Policy Reviewed and Authorized by: Ceallaigh Estepp, Director of Quality and Compliance

Date of Last Revision: 2/1/17

Service Plan Policy

Policy Statement: An individualized service plan is implemented for all persons. Zumbro House will provide all services required by the current service plan.

Procedure

1. Beginning with the initiation of services, a service plan is developed for the client based on an agreement with the person/responsible party and on the assessed needs.

2. The service plan will be finalized no later than 14 days after the initiation of services, if not already completed.

3. Revisions to the service plan may be based on person served review or reassessment.

4. The initial service plan and any revisions are signed by a representative from Zumbro House and the person or person's legal representative, indicating agreement with the services to be provided.

5. The service plan must be revised, if needed, based on person served review or reassessment.

6. Zumbro House will provide information to the person about changes to the provider's fee for services and how to contact the Office of the Ombudsman for Long-Term Care.

7. The service plan and all revisions are entered in to the person's record, including notice of a change in a person's fees when applicable.

8. Zumbro House will implement and provide all services required by the current service plan.

9. The service plan includes the following
    a. A description of the home care services to be provided, the fees for services and the frequency of each service, according to the person's current review of assessment and preferences
    b. The identification of the staff or categories of staff who will provide the services
    c. The schedule and methods of monitoring reviews or assessments of the person
    d. The frequency of sessions of supervision of staff and type of personnel who will supervise staff

e. A contingency plan that includes the following
    i. Action to be taken by the home care provider and by the person or person's legal representative if the scheduled service cannot be provided
    ii. Information and method for a person or person's legal representative to contact the home care provider
    iii. Names and contact information of persons the person served wishes to have notified in an emergency or if there is a significant adverse change in the person's condition, including identification of and information as to who has the authority to sign for the person in an emergency
    iv. Circumstances in which emergency medical services are not to be summoned and declarations made by the person related to health care directives.

10. Staff providing home care services are oriented to the Medication and Care Plan, derived from the service plan.

Policy Reviewed and Authorized by: Ceallaigh Estepp, Director of Quality and Compliance

Date of Last Revision: 2/1/17

Staff Orientation and Education Policy

Policy Statement: All staff providing comprehensive home care through Zumbro House will be prepared to provide safe, effective services to all clients through a thorough orientation and education program pertinent to the needs of the clientele.

Procedure

1. Upon hire and before providing service to persons, all employees attend a general orientation conducted by Zumbro House. Those providing direct services will complete a competency evaluation as part of the orientation process.

2. Non-clinical orientation is provided by the Director of Quality and Compliance, Training Coordinator, or other assigned staff. All clinical topics will be addressed by the RN or other appropriately licensed health care professional.

3. Orientation topics will include, but not be limited to, the following
    a. Overview of Minnesota Home Care Statute Sections 144A.43 to 144A.4798
    b. Review of the employee's job description and responsibilities
    c. Review of the organization's policies and procedures related to the provision of home care services
    d. Handling of emergencies and the use of emergency services
    e. Compliance with Minnesota's Vulnerable Adult and specific requirements per organizational policy, including information on the MAARC
    f. Home Care Bill of Rights
    g. Grievance Policy/Process
    h. Consumer advocacy services, including
        i. Office of Ombudsman for Long-Term-Care
        ii. Office of Ombudsman for Mental Health
        iii. Office of Ombudsman for Developmental Disabilities
        iv. Managed Care Ombudsman at the Department of Human Services
        v. County managed care advocates
        vi. Other advocacy services
    i. Organization's Scope of Services/Statement of Service

4. The Staff Orientation Training Record will be used to document and verify the completion of orientation for each employee. Upon completion of the orientation, the signed/dated record will be retained in the employee record.

5. Zumbro House does provide training related to Alzheimer's Disease. Staff providing or supervising care to persons with Alzheimer's Disease will receive education prior to providing care regarding the following.
    a. Current explanation of Alzheimer's Disease and Related Disorders
    b. Providing assistance with ADL's
    c. Approaches to problem solving when working with a person's challenging behavior
    d. Communicating with persons who have dementia

6. Following general orientation, employees providing direct care receive specific orientation to each individual person and the services to be provided.

7. Staff providing home care will also be oriented to the individual person's services. This orientation may be provided in person, in writing or electronically.

8. No one may provide direct care to clients on behalf of Zumbro House before successfully completing the organization's orientation program.

9. The education program at Zumbro House is directed by the Director of Quality and Compliance or delegate.

10. All staff providing direct home care will complete at least eight (8) hours of education for every twelve (12) months of employment.

11. Education topics will include, but not be limited to, the following
    a. Reporting of maltreatment of adults
    b. Review of Home Care Bill of Rights
    c. Review of the organization's policies and procedures related to implementation of home care services
    d. Infection control techniques used in the home
        i. Implementation of infection control standards based on current recommendations per the CDC
        ii. Hand washing
        iii. Need for/use of personal protective equipment (PPE)
        iv. Appropriate disposal of contaminated materials and equipment, such as dressings, needles, syringes and razor blades
        v. Disinfection of reusable equipment
        vi. Disinfection of environmental surfaces
        vii. Reporting of communicable diseases

12. Additional topics for education will be based on the identified needs of the organization's home care clients. Education topics may be determined by the following.
    a. The quality improvement initiatives
    b. Staff surveys
    c. Feedback from persons, families, caregivers or supervisory staff
    d. Strategic plan or business development objectives

13. Zumbro House will maintain proof of education in the personnel files.

Policy Reviewed and Authorized by: Ceallaigh Estepp, Director of Quality and Compliance

Date of Last Revision: 2/1/17

Storage/Control of Medications

Policy Statement: When Zumbro House is providing storage of medications outside of the person's private living space, all prescription drugs are securely locked in substantially constructed compartments according to the manufacturer's directions. Only authorized personnel have access to the stored medications.

Procedure:

1. As specified in the person's Medication Management and Care Plan, a staff will regularly set up medications container based on the person's medication regimen. At this time, the staff check medication expiration dates and notes any medications needing to be reordered.

2. The medication is labeled completely and legibly. The medication label should contain the following.
    a. Prescription number and name of medication
    b. Strength and quantity
    c. Expiration date for time-dated drugs
    d. Directions for use
    e. Person's name
    f. Prescriber's name
    g. Date issued
    h. Name and address of licensed pharmacy issuing the medication

3. Over-the-counter (OTC) medications and dietary supplements that are not prescribed should be retained in their original, labeled container with directions for use.

4. Medications are stored in a secured medication cabinet. Only authorized personnel have access to the locked cabinet.

5. If a sample medication is used, the same package will be labeled with the client's name and kept with the client's other medications. The registered nurse is responsible for assuring that there are no contraindications for the medication.

6. Schedule II controlled substances are stored in a separately locked compartment. The registered nurse is responsible for establishing the protocol related to monitoring/securing controlled medications based on the initial assessment and risk of diversion.

7. Medications requiring refrigeration are clearly labeled and stored in an enclosed container or area separated from foods. Temperature is maintained at 35-40 degrees.

8. Over the counter medications will be kept in the original labeled containers and may be retained in general stock supply.

Policy Reviewed and Authorized by: Ceallaigh Estepp, Director of Quality and Compliance

Date of Last Revision: 2/1/17

Supervision of Medication Administration Policy

Policy Statement: Zumbro House unlicensed personnel providing delegated services to persons served, will be supervised to assure that the work is being performed competently and to identify problems and solutions to address issues relating to the staff's ability to provide the services to persons of Zumbro House.

Procedure:

1. A Registered Nurse (RN) is available for consultation to staff performing medication administration
   a. The RN is available either in person, by phone or by other means at times when the staff is providing medication administration services.
   b. Staff is instructed regarding the system for accessing consultation during orientation and as needed or when change occurs.

2. Staff performing medication administration will be supervised by the RN periodically where the services are being provided.

3. Supervision includes verification that medication administration is being performed competently and problems/solutions related to the unlicensed staff's ability to perform the service are identified.

4. The RN will observe staff administering the medication and interacting with the person.

5. Direct supervision of staff performing medication administration will be provided within 30 days after s/he begins working and thereafter as needed based on performance.

6. For staff who have not performed medication administration tasks for one year or longer, the RN will provide direct supervision within 30 days.

7. The RN or other licensed health care professional will document supervision of medication administration using the Home Care Staff Supervision by RN.

Policy Reviewed and Authorized by: Ceallaigh Estepp, Director of Quality and Compliance

Date of Last Revision: 2/1/17

Supervision of Staff Policy

Policy Statement: Zumbro House staff providing delegated services to persons served through home care will be supervised to assure that the work is being performed competently and to identify problems and solutions to address issues relating to the employee's ability to provide the services to persons served.

Procedure

1. A Registered Nurse (RN) and, when indicated for therapy or other appropriately delegated services, another licensed health professional are available for consultation to staff performing delegated nursing tasks
   a. The RN and/or other licensed health professional are available either in person, by phone or by other means at times when the staff is providing services.
   b. Staff are instructed regarding the system for accessing consultation during orientation and as needed or when change occur.

2. Staff performing delegated nursing or therapy home care tasks will be supervised by the RN or other licensed health professional periodically where the services are being provided.

3. Supervision includes verification that the work is being performed competently and problems/solutions related to the staff's ability to perform the tasks are identified.

4. Supervision of staff performing medication or treatment administration shall be provided by the RN and include observation of the staff administering the medication or treatment and interaction with the person.

5. Direct supervision of staff performing delegated tasks will be provided within 30 days after the staff begins working for the home care providers and thereafter as needed based on performance.

6. For staff that have not performed delegated tasks for one year or longer, the RN or other licensed health professional will provide direct supervision within 30 days.

7. The RN or other licensed health care professional will document supervision in the clinical record and in the employee's personnel file related to performance management.

Policy Reviewed and Authorized by: Ceallaigh Estepp, Director of Quality and Compliance

Date of Last Revision: 2/1/17

Tuberculosis Screening/Prevention Policy

Policy Statement: Zumbro House will observe the recommended precautions related to TB prevention as identified by the Centers for Disease Control and Prevention (CDC) and the Minnesota Department of Health (MDH). The precautions include the following elements.

- Risk Assessment
- Frequency of Screening
- Serial Testing
- Staff Education

Purpose: To reduce the risk for exposure to persons who might have TB disease.

Terms/Glossary:

- TST: The term "tuberculin skin tests" (TSTs) is used instead of purified protein derivative (PPD).
- BAMT: Blood assay for *M. tuberculosis.* The whole-blood interferon gamma release assay (IGRA), QuantiFERON®TB Gold test (QFTG) (Cellestis Limited, Carnegie, Victoria, Australia), is a Food and Drug Administration (FDA)--approved in vitro cytokine-based assay for cell-mediated immune reactivity to *M. tuberculosis* and might be used instead of TST in TB screening programs for Health Care Workers (HCWs). This IGRA is an example of a blood assay for *M. tuberculosis* (BAMT).
- Baseline Testing: Baseline TB screening at the time of hire is required for all HCWs in Minnesota. Baseline TB screening consists of two components: (1) assessing for current symptoms of active TB disease, and (2) testing for the presence of infection with *Mycobacterium tuberculosis* by administering either a two-step TST or single TB blood test.
- Serial Testing: Serial TB testing, sometimes called annual or ongoing TB testing, refers to TB screening performed at regular intervals following baseline TB screening. Serial TB screening consists of two components: (1) assessing for current symptoms of active TB disease, and (2) testing for the presence of infection with *Mycobacterium tuberculosis* by administering either a TST or single TB blood test.
- Conversion: A conversion is when a person's TST or TB blood test result changes from negative initially to positive with subsequent testing. For surveillance purposes, an increase of >10 mm is defined as a TST conversion.
- Latent TB infection (LTBI): Certain bacilli remain in the body and are viable for multiple years. This condition is referred to as latent tuberculosis infection (LTBI). Persons with LTBI are asymptomatic (they have no symptoms of TB disease) and are not infectious.
- Staff include both paid and unpaid direct care givers.

***Training**:*

1. *All staff who provide care or visit persons served (including volunteers) will receive education, including the following.*
    - *General training on TB*
    - *The importance of evaluation of symptoms or signs of TB disease for early detection and treatment of TB disease*
    - *The role of the caregiver in educating persons regarding the importance of reporting symptoms or signs of TB disease*
    - *The importance of reporting any adverse effects to treatment for LTBI or TB disease*
2. *On-going education will be provided annually as part of the infection control training based on the availability of new information.*
3. *All direct care providers will receive annual education on Infection Control.*

Risk Classification

1. The three risk classifications are:
    a. Low risk, in which persons with active TB disease are not expected to be encountered and exposure to TB is unlikely.
    b. Medium risk, in which health care workers will or might be exposed to persons with active TB disease or clinical specimens that might contain *M. tuberculosis.*
    c. Potential ongoing transmission, in which there is evidence of person-to-person transmission of *M. tuberculosis.* This is a temporary classification. If it applies to the home health agency, the Minnesota Department of Health TB Prevention and Control Program should be contacted (651-201-5414) for guidance.
2. Related to medium-risk settings:
    a. Staff with positive TST's or IGRA's and who work in a medium risk setting should be assessed for current TB symptoms on an annual basis.
    b. TB training should be conducted annually.
    c. Procedures should be reviewed annually and updated if necessary.

Zumbro House has had no persons served with TB and is classified as **low risk**.

1. The need for TB training will be evaluated annually, and training will be conducted as needed.
2. The TB Prevention Plan will be reviewed every other year and updated, if necessary.

TB Screening: Baseline testing is completed on hire for all direct care providers and anyone who visits clients (including volunteers). Test results 1) provide a basis for comparison in the event of a potential or known exposure to *M. tuberculosis* and 2) facilitate the detection and treatment of LTBI or TB disease in a staff member before employment begins and reduces the risk to patients and other staff members.

1. Employees receive baseline TB screening upon hire to test for infection with *M. tuberculosis*.
2. Baseline screening includes an assessment for current TB symptoms.
3. An employee's history of BCG vaccination will be disregarded when administering and interpreting TST results.
4. The baseline test may be either TST (2-step) or BAMT.
5. If the first-step TST is negative, the second-step TST will be administered 1--3 weeks after the first TST result was read.
6. If the first and second-step TST results are both negative, the person is classified as not infected with *M. tuberculosis*. Additional TB screening is not necessary unless an exposure to *M. tuberculosis* occurs.
7. Written documentation for all TST results includes the mm induration, the interpretation (either positive or negative), the date read and a signature on letterhead.
8. Employees with written documentation of a previous positive TST or BAMT do not need a repeat TST or BAMT:
   - Assess for current TB symptoms
   - If they provide written documentation of the results of a chest x-ray indicating no active TB disease that is dated after the date of the positive TST or TB blood test result, they do not need another chest x-ray at the time of hire.
   - If they do not have the written documentation from above, they must receive a chest x-ray to exclude a diagnosis of infectious TB disease before having direct patient contact.
   - Assess these employees annually for current TB symptoms. Instruct them to seek medical evaluation if TB symptoms develop at any time.
   - After the baseline chest x-ray is performed and the result is documented, repeat x-rays are not needed unless symptoms or signs of TB disease develop or a clinician recommends a repeat chest radiograph.
9. Employees with a verbal, but undocumented, history of a previous positive TST or BAMT will undergo the same screening process as those without previous positive results. Staff should be encouraged to keep copies of the results of the TB screening, for future use.
10. Employees with a documented history of prior treatment for LTBI or active TB disease do not need a TST or BAMT:
    - Assess for current TB symptoms.

- Keep written documentation on file of a chest x-ray indicating no active TB disease that is dated after the date of the initial diagnosis of LTBI or active TB disease.
- Assess these employees annually for current TB symptoms. Instruct them to seek medical evaluation if TB symptoms develop at any time.
- Repeat chest x-rays are not needed unless symptoms or signs of active TB disease develop or a clinician recommends a repeat chest radiograph.
- Consult with the MDH TB Prevention and Control Program (651-201-5414) regarding employees with a history of previous active TB disease, as needed.

11. Employees with a newly-identified positive TST or BAMT:
    - Assess for current TB symptoms and risk factors for progression to active TB disease.
    - Obtain a chest x-ray to exclude a diagnosis of active infectious TB disease before direct client contact.
    - For employees with LTBI, consult a physician regarding the need for treatment to prevent progression to active TB disease.
    - After documentation of negative results from a baseline chest x-ray, repeat x-rays are not needed unless signs/symptoms of active TB disease develop or a clinician recommends a repeat chest x-ray.
    - Assess these employees annually for current TB symptoms. Instruct them to seek medical evaluation if TB symptoms develop at any time.
12. Pregnant employees
    - Pregnant and nursing women will be included in the same baseline and serial TB screening program as other health care workers. Pregnancy is not a contraindication for TB skin testing.
    - A pregnant employee with a newly identified positive TST or BAMT or signs and symptoms of active TB disease is at increased risk for active TB disease and can receive a chest radiograph, using an abdominal shield.
13. A second TST is not needed if the employee has a documented TST result within 12 months of date of hire. If a new employee has had a documented negative TST result within the previous 12 months, a single TST can be administered in the new setting within 90 days before hire. This additional TST represents the second stage of two-step testing. The second test decreases the possibility that boosting on later testing will lead to incorrect suspicion of transmission of *M. tuberculosis* in the setting.
14. If the second test result of a two-step TST is not read within 48--72 hours, administer a TST as soon as possible (even if several months have elapsed) and ensure that the result is read within 48--72 hours.
15. All reports or copies of the TST or BAMT, chest x-ray results and medical examinations will be maintained in the employee's record.
16. Any employee with symptoms consistent with active TB disease, regardless of the results of the TST or TB blood test, must be evaluated by a physician within 72 hours in order to exclude a diagnosis of active TB

disease and may not return to work until determined to be non-infectious. The evaluation should include a medical examination and symptom screen, a chest x-ray and collection of sputum specimens or additional testing if indicated. If active TB disease is confirmed or suspected, the diagnosing clinician should notify the Minnesota Department of Health within one working day.

Additional Information (*from CDC, 2009*)

A positive TST reaction as a result of BCG wanes after 5 years. Therefore, employees with previous BCG vaccination will frequently have a negative TST result. Because HCWs with a history of BCG are frequently from high TB prevalence countries, positive test results for *M. tuberculosis* infection in HCWs with previous BCG vaccination should be interpreted as representing infection with *M. tuberculosis*. Although BCG reduces the occurrence of severe forms of TB disease in children and overall might reduce the risk for progression from LTBI to TB disease, BCG is not thought to prevent *M. tuberculosis* infection. Test results for *M. tuberculosis* infection for HCWs with a history of BCG should be interpreted by using the same diagnostic cut points used for HCWs without a history of BCG vaccination.

Staff with positive TST's or IGRA's and who work in a medium risk setting (not applicable for Zumbro House) should be assessed for current TB symptoms on an annual basis.

Persons Served with Suspected or Confirmed TB Disease

According to the CDC, the following parameters apply to hospitalized persons with suspected or confirmed TB disease.

If the person is deemed medically stable (including those with positive AFB sputum smear results indicating pulmonary TB disease), the person can be discharged from the hospital before converting the positive AFB sputum smear results to negative AFB sputum smear results, if the following parameters have been met:

- A specific plan exists for follow-up care with the local TB control program;
- The person has been started on a standard multidrug antituberculosis treatment regimen, and DOT has been arranged;
- No infants and children aged <4 years or persons with immunocompromising conditions are present in the household;
- All immunocompetent household members have been previously exposed to the client; and
- The person is willing to not travel outside of the home except for health-care--associated visits until the person has negative sputum smear results.

Persons with suspected or confirmed infectious TB disease should not be released to health-care settings or homes in which the person can expose others who are at high risk for progressing to TB disease if infected (e.g., persons infected with HIV or infants and children aged <4 years). Coordination with the local health department TB program is indicated in such circumstances.

Administration

1. *The President is responsible for TB infection control in the home care setting and for coordinating efforts with MDH when indicated. According to the MDH (2009), active TB disease most commonly affects the lungs (pulmonary), but approximately 40% of TB cases in Minnesota involve only an extrapulmonary site of disease.*
2. The President is responsible for reporting TB, when indicated. According to MDH, Tuberculosis preferably should be reported by phone at 651-201-5414 (or 877-676-5414). Tuberculosis reports also may be faxed to 651-201-5500. MDH requests that tuberculosis cases be reported by phone or fax (i.e., not by mail) to help ensure timely public health follow-up measures.

Pathogenesis, Epidemiology, and Transmission of *M. tuberculosis (from CDC, 2009)*

M. tuberculosis is carried in airborne particles called droplet nuclei that can be generated when persons who have pulmonary or laryngeal TB disease cough, sneeze, shout, or sing. The particles are approximately 1--5 μm; normal air currents can keep them airborne for prolonged periods and spread them throughout a room or building. *M. tuberculosis* is usually transmitted only through air, not by surface contact. After the droplet nuclei are in the alveoli, local infection might be established, followed by dissemination to draining lymphatics and hematogenous spread throughout the body. Infection occurs when a susceptible person inhales droplet nuclei containing *M. tuberculosis*, and the droplet nuclei traverse the mouth or nasal passages, upper respiratory tract, and bronchi to reach the alveoli. Persons with TB pleural effusions might also have concurrent unsuspected pulmonary or laryngeal TB disease.

Usually within 2--12 weeks after initial infection with *M. tuberculosis*, the immune response limits additional multiplication of the tubercle bacilli, and immunologic test results for *M. tuberculosis* infection become positive. However, certain bacilli remain in the body and are viable for multiple years. This condition is referred to as latent tuberculosis infection (LTBI). Persons with LTBI are asymptomatic (they have no symptoms of TB disease) and are not infectious.

Persons with active TB disease may have 1 or more of the following **symptoms:**

- Prolonged cough (≥ 3 weeks)

- Hemoptysis
- Weight loss
- Night sweats
- Fatigue
- Fever, chills
- Poor appetite
- Chest pain
- Other symptoms may be present, depending on the site of disease

Policy Reviewed and Authorized by: Ceallaigh Estepp, Director of Quality and Compliance

Date of Last Revision: 2/1/17

Treatment and Therapy Management Policy

Policy Statement: Zumbro House will use treatment and therapy protocols consistent with current evidence-based practice standards and guidelines. The Registered Nurse is responsible for assessing and developing the treatment and/or therapy service plan for the person served.

Procedure:

1. A Registered Nurse (RN) will complete an assessment of all persons receiving treatment or therapy services prior to the initiation of those services.

2. The RN will obtain orders or prescriptions for all treatments and therapies. The order will include the following elements.
   a. Persons Name
   b. Description of the treatment or therapy to be provided
   c. Frequency
   d. Other pertinent information

3. If the RN delegates treatments or therapies, the RN will monitor and evaluate its effectiveness on a regular basis as specified in the service plan.

4. The RN will provide education to the client regarding the treatment or therapy and may, as appropriate, instruct other team members, including paraprofessionals, to provide on-going teaching based on the person's written education instructions prepared by the RN.

5. The RN will, as appropriate, provide coordination of care related to the treatment or therapy activities with the following.
   a. Person
   b. Caregivers/family
   c. Primary care provider
   d. Other health care providers

6. The RN will prepare an individualized treatment or therapy management plan for each client receiving ordered or prescribed treatments or therapy services, which addresses
   a. Type of service to be provided
   b. Procedures for documenting treatments or therapies
   c. Procedures for monitoring treatments or therapies to prevent possible complications or adverse reactions
   d. Identification of treatment or therapy tasks delegated to unlicensed personnel

e. Procedures for notifying the RN when a problem arises related to the treatment or therapy service

7. Each staff member who administers a treatment or therapy is responsible for documenting this in the medical record.

8. When a treatment or therapy is not administered as ordered or prescribed, staff will document the reason why it was not administered and any follow-up procedures provided to meet the person's needs.

Policy Reviewed and Authorized by: Ceallaigh Estepp, Director of Quality and Compliance

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